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Ministry of Health and Social Welfare

Mid Term Review of the Health Sector Strategic Plan III 2009-2015

Main Report

October 2013

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Main Report

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Acronyms

ACT	Artemisin Combination Therapy
ADDO	Accredited Drug Distribution Outlet
AfDB	African Development Bank
AHSPPR	Annual Health Sector Performance Profile Report
AIDS	Acquired Immuno-Deficiency Syndrome
AMO	Assistant Medical Officer
ANC	Antenatal Care
ARI	Acute Respiratory Infection
ART	Antiretroviral Therapy
ARV	Antiretroviral
BCG	Bacillus Calmette–Guérin
BMAF	Benjamin Mpaka AIDS Foundation
BEmOC	Basic Emergency Obstetric Care
BEmONC	Basic Emergency Obstetric and Neonatal Care
BFC	Basket Fund Committee
CA	Chief Accountant
CAG	Controller and Auditor General
CBO	Community Based Organisation
CDC	US Government Centre for Disease Control and Prevention
CCHP	Comprehensive Council Health Plan
CEmOC	Comprehensive Emergency Obstetric Care
CEmONC	Comprehensive Emergency Obstetric and Neonatal Care
CEPD	Continuing Education and Professional Development
CFR	Case Fatality Rate
CFS	Consolidated Fund Service
CHF	Community Health Fund
CHMT	Council Health Management Teams
CHSB	Council Health Services Board
CIDA	Canadian International Development Agency
CLTS	Community Led Total Sanitation
CMO	Chief Medical Officer
CMR	Child Mortality Rate
CO	Clinical Officers
COSTECH	Commission for Science and Technology
CPS	Community Perspectives Study
CPR	Couple years Protection Rate

CSD	Civil Service Department
CSO	Civil Society Organization
CSSC	Christian Social Services Commission
CYP	Couple Years of Protection
DALYs	Disability Adjusted Life Years
DANIDA	Danish International Development Agency
DAP	Director of Administration and Personnel
D-by-D	Decentralisation by Devolution
DC	District Council
DED	District Executive Director
DFID	Department for International Development
DHIS	District Health Information System
DHIS 2	District Health Information Software 2
D-HMIS	District Health Management Information System
DHR	Director of Human Resource
DHS	Demographic and Health Surveys
DHS	Director of Hospital Services
DMO	District Medical Officer
DOT	Directly Observed Therapy
DP	Development Partner
DPP	Director of Health Policy and Planning
DPS	Director of Preventive Services
DSS	Demographic Surveillance Systems
DSW	Department of Social Welfare
DTP	Diphtheria, Tetanus, Pertussis
eGov	Electronic Governance
EmOC	Emergency Obstetric Care
EmONC	Emergency Obstetric and Newborn Care
eMTCT	Elimination of Mother To Child Transmission
EOP	Emergency Operational Plan
EPI	Expanded Programme on Immunization
FBO	Faith-Based Organization
FGM/C	Female Genital Mutilation or Circumcision
FY	Financial Year
GBS	General Budget Support
GDP	Gross Domestic Product
GF	Global Fund
GNP	Gross National Product
GOT	Government of Tanzania
HBF	Health Basket Fund

HDSS	Health and Demographic Surveillance System
HF	Health Facility
HFGC	Health Facility Governing Committee
HFS	Health Financing Strategy
HIS	Health Information System
HIU	Health Information Unit
HIV	Human Immunodeficiency Virus
HIV/AIDS	Human immuno-deficiency virus/Acquired Immuno-deficiency Syndrome
HMIS	Health Management Information Systems
HMT	Hospital Management team
HR	Human Resources
HRD	Human Resources Development
HRH	Human Resource for Health
HRHIS	Human Resources for Health Information System (MOHSW)
HRHSP	Human Resource for Health Strategic Plan
HRIS	Human resources Information System (PMO-RALG)
HRM	Human Resources Management
HS	Household Surveys
HSDG	Health Sector Development Grant
HSR	Health Sector Reforms
HSR	Health Systems Research
HSSP III	Health Sector Strategic Plan III (2009 – 2015)
HSSP	Health Sector Strategic Plan
ICD	International Classification of Diseases
ICT	Information Communication Technology
IDSR	Integrated Disease Surveillance and Response
IEC	Information, Education and Communication
IHI	Ifakara Health Institute
ILS	Integrated Logistics System
IMCI	Integrated Management of Childhood Illnesses
IMR	Infant Mortality Rate
IMTC	Inter Ministerial Technical Committee
IPC	Infection Prevention and Control
IPD	In-Patient Department
IPT	Intermittent Presumptive Treatment
ISC	Inter-Ministerial Steering Committee
ITN	Insecticide Treated Nets
JAHSR	Joint Annual Health Sector Review
JICA	Japan International Cooperation Agency
JRF	Joint Rehabilitation Fund

KfW	German Development Bank
KNTH	Kibong'oto National Tuberculosis Hospital
LGA	Local Government Authority
LGDG	Local Government Development Grant
LMIS	Logistics Management Information System
LMU	Logistics Management Unit
MAT	Medical Association of Tanzania
MC	Municipal Council
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MDA	Mass Drug Administration
MDA	Ministries, Departments, Agencies
MDGs	Millennium Development Goal(s)
MDR	Multi-Drug Resistant
MESI	M&E Strengthening Initiative
MFL	Master Facility List
MKUKUTA	Mkakati wa Kukuza Uchumi na Kupunguza Umaskini Tanzania
MMAM	Mpango wa Maendeleo wa Afya ya Msingi
MMM	Monitoring Master Plan
MMR	Maternal Mortality Ratio
MNH	Muhimbili National Hospital
MNCH	Maternal ,Newborn and Child Health
MO	Medical Officer
MOCS&T	Ministry of Communication, Science and Technology
MOEVT	Ministry of Education and Vocational Training
MOFEA	Ministry of Finance and Economic Affairs
MOH	Ministry of Health
MOHSW	Ministry of Health and Social Welfare
MPEE	Ministry of Planning and Economic Empowerment
MRCC	Medical Research Coordinating Committee
MRDT	Malaria Rapid Diagnostic Test
MSD	Medical Stores Department
MTC	Medicines Therapeutics Committee
MTEF	Medium Term Expenditure Framework
MTR	Mid Term Review
MTSP	Medium Term Strategic Plan
MTUHA	Mfumo wa Takwimu wa Uendeshaji wa Huduma za Afya
MUCHS	Muhimbili University College of Health Sciences
MUHAS	Muhimbili University of Health and Allied Sciences
NACP	National AIDS Control Programme

NACTE	National Accreditation Council for Technical Education
NAO	National Audit Office
NBS	National Bureau of Statistics
NCD	Non Communicable diseases
NEHP	National Essential Health Package
NGO	Non-Governmental Organization
NHA	National Health Accounts
NHIF	National Health Insurance Fund
NID	National Immunization Day
NIMR	National Institute for Medical Research
NM	Nurse Midwife
NMCP	National Malaria Control Programme
NMP	National Medicines Policy
NPPP	National Public Procurement Policy
NSGRP	National Programme for Economic Growth and Poverty Reduction (MKUKUTA)
NSSS	National Sentinel Surveillance System
NTD	Neglected Tropical Diseases
NTLP	National Tuberculosis and Leprosy Programme
OP	Outpatient
OOP	Out of Pocket (expenses)
OPD	Outpatient department
OPRAS	Open Performance Review and Assessment System
OPV	Oral Polio Vaccine
OVC	Orphans and Vulnerable Children
P4P	Pay for Performance
PEM	Protein Energy Malnutrition
PEPFAR	President's Emergency Plan for AIDS Relief
PER	Public Expenditure Review
PF	Policy Forum
PHA	Public Health Act
PHC	Primary Health Care
PHDR	Poverty and Human Development Report
PHAST	Participatory Hygiene and Sanitation Training
PHSDP	Primary Health Services Development Plan [MMAM]
PIFS	Pharmaceutical, Infrastructure and Food Safety (TWG)
PLHIV	Persons Living with HIV/AIDS
PLWD	People Living With Disabilities
PMO-RALG	President's Office – Regional Administration & Local Government
PMTCT	Prevention of Mother to Child Transmission
PPP	Public-Private Partnership

PO-PSM	President's Office – Public Service Management
POW	Programme of Work
PPP	Public-Private Partnership
PSRP	Public Service Reforms Programme
PSS	Pharmaceutical Services Section
PSU	Pharmaceutical Services Unit
QA	Quality Assurance
RAS	Regional Administrative Secretary
RCH	Reproductive and Child Health
REPOA	Research on Poverty Alleviation
RHHSB	Regional Hospital Health Services Board
RHMT	Regional Health Management Team
RMO	Regional Medical Officer
RRH	Regional Referral Hospital
RS	Regional Secretariat
SA	Service Agreement
SARA	Service Availability and Readiness Assessment
SAVVY	Sample Vital registration with Verbal Autopsy
SC	Steering Committee
SO	Strategic Objective
SOP	Standard Operating Procedures
SP	Sulphadoxine-Pyrimethamine
SPD	Sentinel Panel of Districts
STEPS	WHO STEPwise approach to Surveillance for Chronic Diseases
STI	Sexually Transmitted Infections
SUN	Scaling Up Nutrition
SWAp	Sector-Wide Approach
SWIS	Social Welfare Information System
SWO	Social Welfare Officer
SWOC	Strengths, Weaknesses, Opportunities, and Challenges
TA	Technical Assistance
TACAIDS	Tanzania Commission for AIDS
TANHER	Tanzania National Health Research Forum
TASAF	Tanzanian Social Action Fund
TB	Tuberculosis
TB/L	Tuberculosis and Leprosy
TBS	Tanzania Bureau of Standards
TC	Technical Committee SWAp
TC	Town Council
TDHS	Tanzania Demographic and Health Survey

TDS	Tanzania Disability Survey
TFDA	Tanzania Food and Drug Authority
TFNC	Tanzania Food and Nutrition Centre
TG	Treatment Guidelines
THIS	Tanzania HIV/AIDS Indicator Survey
THMIS	Tanzania HIV/AIDS and Malaria Indicator Survey
TIKA	Tiba Kwa Kadi (CHF in urban areas)
TJHR	Tanzania Journal of Health Research
TMIS	Malaria Indicator Surveys
TNB	Tanzania National Bibliography
TOR	Terms of Reference
TPEHI	Tanzania Package of Essential Health Interventions
TPHA	Tanzania Public Health Association
TPRI	Tropical Pesticides and Research Institute
TQIF	Tanzania Quality Improvement Framework
TSH	Tanzanian Shilling
TT	Tetanus toxoid
TWG	Technical Working Group
TZS	Tanzania shillings
UNAIDS	United Nations Program on HIV/AIDS
UNESCO	The United Nations Education, Scientific and Cultural Organisation
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
U5MR	Under-five Mortality Ratio
USAID	United States Agency for International Development
USD	United States Dollar
UTI	Urinary Tract Infection
WASH	Water, Sanitation and Hygiene
WB	World Bank
WDC	Ward Development Committee
WFP	World Food Programme
WHO	World Health Organization
WHO/AFRO	World Health Organization - Africa
WMS	Warehouse Management System
ZHRC	Zonal Health Resource Centre

Executive Summary

Introduction

This report summarises the findings, assessment and recommendations of the Mid Term Review (MTR) of Tanzania's Third Health Sector Strategic Plan (HSSP III) for the period July 2009–June 2015. The HSSP III covers both the health sector and social welfare sector. In addition to this main report, there are nine specific technical reports, on District and Hospital Services, Maternal Neonatal and Child Health (MNCH), Social Welfare Services, Human Resources for Health (HRH), Monitoring and Evaluation (M&E), Pharmaceutical Supplies, Capital Development, Health Care Financing and Governance. There also are three Field Trip Reports of the MTR.

In the context of the MTR the Government of Tanzania's Ministry of Health and Social Welfare (MOHSW) and partners produced a Mid Term Analytical Review (MTR-AR 2013) with extensive analysis of available health sector information. The MOHSW and partners also commissioned as part of the MTR an independent Community Perspectives Study to provide an unbiased community input to the MTR, also referenced within this report.

The MTR assessed the overall coherence and implementation of HSSP III with the specific aim of informing the development of HSSP IV. A team of 12 national and international consultants carried out the review. They took stock of achievements with special attention to the implementation of the Mpango wa Maendeleo wa Afya ya Msingi (MMAM) and MNCH Services. They also reviewed implementation of financing and the Sector-Wide Approach (SWAp).

The MTR Steering Committee provided overarching guidance to the review process and Technical Working Groups (TWGs) worked closely with the consultants. The global Health Finance and Governance Project, led by Abt Associates Inc., managed the review.

District and Hospital Services Delivery

The analytical team performed a trend analysis of the progress for the indicators and concluded Tanzania will achieve most of HSSP III targets for child health (with the exception of stunting) and in the areas of malaria, HIV/AIDS and tuberculosis (TB). Some progress, though not enough to achieve the targets in 2015, was noted for neonatal mortality in health facilities; little or no progress was noted for most of the other reproductive health indicators, e.g. antenatal care (ANC).

Over the period 2009 to 2013, the Government has continued to expand the number of health facilities and increase the number of health workers deployed. However the MMAM targets for 2012 will not be realised. In contrast to disease-specific interventions, utilisation of general and reproductive health services is not increasing as planned for the HSSP III period. As the Community Perspectives Study found, users are not satisfied with general health services because of poor staff attitudes, high out-of-pocket costs and poor access to medicines. They are happy with the free, high-quality services offered by disease control programmes and the vaccination programme.

The MOHSW has developed the Tanzania Quality Improvement Framework (TQIF), with guidelines, tools and training to improve quality of service delivery. However health facilities are not yet using those instruments routinely. The MOHSW is in the process of designing an accreditation system, but it will take time before the system can be rolled out.

All districts produce a Comprehensive Council Health Plan with technical support from Regional Health Management Teams (RHMTs). Only half of the Health Facility Governing Committees (HFGCs) are functional and involved in planning. Overall, the quality of those plans is improving, but due to financial constraints, the Council Health Management Teams (CHMTs) can implement only part of the plans. In general, RHMTs and CHMTs provide supervision but it is often more administrative than technical.

The Regional Referral Hospitals visited during the MTR have shortages of clinical specialists and were essentially functioning as district hospital. Quality Improvement activities are limited and there is no viable Hospital Reform Programme in place, as planned in HSSP III.

Disease Control Programmes

Surveillance in disease control programmes is improving and the services of Integrated Management of Childhood Illnesses (IMCI), HIV control, Sexually Transmitted Infections, Reproductive and Child Health and Prevention Mother To Child Transmission (PMTCT) are delivered in a more integrated way.

There is a broad range of community-based programmes for disease prevention and control, e.g. in malaria, HIV/AIDS, TB, sanitation and hygiene. However community participation in disease prevention and control depends mainly on local programmes and funding, and is not widely available in the country.

HSSP III HIV/AIDS strategies for the period 2009–2013 are likely to achieve targets, particularly for utilisation of HIV/AIDS care and treatment services. Activities are noted for increasing safe blood supply, safety of injections, male circumcision etc. However marginalised groups, like intravenous drug users, sex workers, men having sex with men and the disabled or mentally handicapped, get insufficient attention. HIV prevalence is decreasing only slowly, and women remain more at risk than men.

The malaria strategies for the period 2009–2013 are successful, particularly for malaria diagnosis and treatment and the distribution of insecticide-treated nets (ITNs). Three-quarters of the population, in all wealth quintiles, now uses ITNs.

TB and leprosy strategies for the period 2009–2013 are generally implemented according to plan. Most of the progress of the TB programme can be attributed to the home-based Directly Observed Therapy, Short course (DOTS) strategy. An area with limited progress is leprosy elimination and prevention of disabilities.

Most HSSP III strategies for neglected tropical diseases for the period 2009–2013 are expanding, in particular surveillance, diagnosis and treatment; this is not the case for prevention strategies. Good progress has been made in onchocerciasis control.

Recent surveys have provided much more insight into the upcoming epidemic of non-communicable diseases (NCDs). The planned NCD strategies for the period 2009–2013 have not been implemented as planned. Tackling the relevant risk factors for NCDs has yet to start.

The environmental health strategy 2009–2013 has been implemented, particularly the Public Health Act 2008. The majority of the population in Tanzania still does not have access to toilets, latrines or safe water. The National Sanitation Campaign was launched in 2012 to improve toilets and standard hand washing facilities in schools and homes. The MOHSW is working closely with other ministries as most improvements in environmental health are related to water, waste management, education etc.

Tanzania has developed a good system for addressing health emergencies, but implementation is often constrained by a lack of human and financial resources.

Maternal Neonatal and Child Health

Reproductive Health

Reproductive Health Services (RHS) are not performing well in Tanzania, despite investments in this area. ANC services will not reach their HSSP III targets, as many women only attend once or twice. The number of facilities that offer RHS is increasing, but the facilities face shortages of staff and supplies. Quality of services often is substandard. However disease control services delivered as part of ANC (PMTCT, ITN distribution) appear to be doing well.

Overall HSSP III targets for delivery care will not be met, even though additional resources have been put into maternal health programmes. There is a slight increase in skilled birth attendance (from 43% to 52%) and in facility deliveries (now 62%). There has been an increase in Basic Emergency Obstetric Care, but the targets for 2015 are unlikely to be met. Expansion of service delivery has not improved the quality of services delivered. Maternal mortality in hospitals is not decreasing. The Community Perspectives Study and other studies show that women are not satisfied with delivery care because of staff attitudes, lack of privacy and high costs for supplies, which women have to bring when delivering in a health facility.

Postnatal care is not being provided as planned, despite initiatives for improvement. Too many women and health workers don't understand the importance of this service.

There is a slight improvement in utilisation of family planning, especially among women in rural areas, but the HSSP III targets will not be met. Just over one quarter of women use modern methods. Recent commitments to improve access may bring change, if accompanied by additional resources.

RHS receive a lot of extra funds, but the highly fragmented approach will prevent the comprehensive improvements needed to make the system work from community and dispensary to hospital level from being achieved.

Child Health

Most child health programmes are performing well, with the exception of neonatal care (related to maternal health), which is a serious concern, given the high neonatal mortality in the country. The limited progress in reducing neonatal mortality hampers progress toward overall reduction of infant and child mortality.

Vaccination services are well on track in achieving the HSSP III goals. Tanzania is one of the best-performing countries in the sub-Saharan region. Nearly all children are vaccinated, with few geographic or wealth-related inequalities.

There has been a gradual improvement of the nutrition status of children in Tanzania, but not all HSSP III targets will be met. Stunting remains a problem because of repeated episodes of ill health of children and inadequate infant and young child feeding practices. Exclusive breastfeeding is not yet a common practice in Tanzania, especially in rural areas.

There has been good progress in malaria control. Malaria is no longer the killer disease it used to be, although it is still an important cause of morbidity and mortality in endemic areas. School health programmes are picking up, with increasing attention for prevention, vaccination and disease control. Hygiene and sanitation remain weak points in schools.

Social Welfare

The Department of Social Welfare (DSW) plays a marginal role in the MOHSW. The Social Welfare Strategic Plan has been finalised, but is not yet officially approved by the Cabinet. The DSW budget is minimal. Provision of modern, developmental and rights-based social welfare services depends almost entirely on work carried out by external agencies (multi-laterals, bi-laterals, non-governmental and faith-based organisations etc.).

The Government of Tanzania provides social protection services through other ministries and through Tanzanian Social Action Fund. In general social welfare programmes, which deal with different vulnerable groups, are unable to reach the whole country. There is a gap between the standards, guidelines and protocols for service delivery, and what external agencies actually understand and use at local levels. There are no mechanisms, as yet, through which to institutionalise and embed successful model programmes. While steps for increasing human resources and for integration of the DSW into the MOHSW are being made, the relationship between the health and social welfare services is still undefined. In general, social welfare interventions are off-track, largely because of the lack of resources and capacities within the DSW. Social welfare indicators in HSSPIII are unlikely to be met in full. Social welfare interventions cannot currently contribute optimally to cross-cutting goals for fulfilment of rights, equity, gender balance and community ownership.

Human Resources for Health

In the first part of HSSP III actions have been carried out not only to increase the supply of HRH but also to improve their deployment, recruitment and retention. The number of health workers especially of medical and paramedical personnel, is increasing. However remote rural areas still face major shortages. HRH planning is improving at the district level, strengthened by a functional Human Resources Information System (HRIS). There are still challenges to harmonise and link with other HRIS, especially the ones used by Local Government Authorities (LGAs) and the President's Office–Regional Administration and Local Government (PMO-RALG).

Bottlenecks and bureaucracy in HRH management are still prevalent, leading to limited absorptive capacity in the system. At present the health sector can absorb only part of the newly trained health workers, despite HRH shortages. Leadership, coordination and partnership challenges exist at various levels. Equitable distribution of HRH is still not realised, disadvantaging rural areas.

Poor HRH management affects the productivity of staff and the quality of services. There is little guidance and technical supervision of young staff, and morale is affected by poor working and living environments in many health facilities. There is no system of performance management in place; the Open Performance Review and Appraisal System (OPRAS) is only partially implemented.

The output of training institutions has increased considerably over the last years. Quality of training is not yet consistent is but improving with increasing accreditation by National Council for Technical Education. Production is not always in line with other development plans, e.g. MMAM. Continuing Education and Professional Development (CEPD) is still the domain of vertical programmes with limited continuity and impact on the health system as a whole. There is no system of accreditation and obligatory attendance to CEPD.

HRH issues are addressed in many research programmes and studies and are well documented, but there is need to focus more on effects of scaling up pilots in the country.

Pharmaceuticals and Supplies

Availability of key medicines in health facilities remains low; no clear trend for improvement can be established since the start of HSSP III. This negatively affects quality of care and performance of service provision in general. Guidelines for improving the use of medicines are available but they are not used. The Community Perspectives Study concluded that citizens consider poor availability of medicines as the major problem in the health sector, affecting their willingness to participate in the Community Health Fund (CHF).

Funding of medical supplies is not improving in real per capita terms and disbursement issues continue to affect the efficient use of limited funds. However the major problems are in the area of procurement and management of medicines by CHMTs and health facilities. The number of Accredited Drug Dispensing Outlets (ADDOs) is increasing, but only barely in rural areas. Not all ADDOs are providing quality services.

Procurement of medicines through parallel systems using donor funds poses a management challenge to the Medical Stores Department (MSD), because information is not always provided on time.

On the positive site, better procurement and (information) management procedures are under development, with the potential to increase efficiency, reduce waste and improve availability of medicines to the population. The Tanzania Food and Drug Authority increased the annual number of test for quality of medicine products and established mobile testing kits at 15 regional hospital sites, which allows testing of medicines procured by the hospitals from MSD and other sources.

Capital Investment

The health sector infrastructure in Tanzania is expanding, especially the number of dispensaries, although the MMAM targets for 2012 have not been met. In some regions in the country availability of facilities is still limited, with more than 50% of the population living further than 5 km from a facility. The quality of construction is reasonable, but nearly all projects are delayed and overshoot the budget. So far, the construction activities have exceeded the deployment of staff, leading to underutilisation of the infrastructure. Infrastructure maintenance also is a challenge. The majority of health facilities need maintenance to improve service readiness and equipment, especially for providing delivery care.

Maintenance of equipment is not yet a priority for health facilities, and this has a negative impact on the effectiveness of service delivery. Starting next year new cadres of medical equipment technicians will join the health sector; they may contribute to institutionalising maintenance at the district level, when CHMTs are able to increase funding for maintenance.

Monitoring and Evaluation System

There is a viable strategy for developing M&E in Tanzania's health sector. Innovative disease surveillance and sentinel information systems are under development or being rolled out, with a potential to get in-depth knowledge on health issues.

The health management information system (HMIS) is developing well with the introduction of automated systems. When integrated into planning and decision-making processes, the HMIS can become the backbone for evidence-based management and accountability and thus play a role in performance management systems. The reporting systems of the PMO-RALG and MOHSW are still mostly parallel, with duplication in several areas. The culture and capacities for a data-for-decision-making approach are not yet in place at district and facility level. Reporting is more an obligation than a management tool at these levels.

Research is increasing and national reports are more available, e.g. through websites of research institutes. Feedback loops between the research community and MOHSW for evidence-based policy-making still need to be established.

The developments of information and communication technologies are promising and have a potential to change the face of health service delivery. The Tanzanian government gives high priority to developing e-Government. The e-Health Strategy was launched recently. There are already many initiatives in the area of e-health and m-health. But this innovation still requires huge investments and capacity building in the country.

Health Financing and Financial Management

There is growth in total health expenditure in Tanzania, but the per capita expenditure corrected for inflation remains flat in the HSSP III period. Government spending on health as a percentage of the total government budget is decreasing, as is government's share in health expenditure. After an initial increase, the Health Basket Fund (HBF) is decreasing in US dollar terms. Contrary to the goals of HSSP III, the public health budget has become increasingly reliant on foreign funds (especially non-basket donor funding), which may not be sustainable.

Funding continues to lag far behind the planned resource requirement in HSSP III (less than 50% of the envisaged budget for 2013/14), but HSSP III priorities were never adjusted to reflect the more limited resources.

The health financing strategy is long overdue and now is three years behind schedule, but its development may begin in the near future.

Countrywide effective measures for removing financial barriers for the poorest and vulnerable are not in place, although locally actions are undertaken (often with support from NGOs or local donors).

Relying on National Health Insurance Fund, CHF and TIKA (urban CHF) to increase financing has not proven successful. The goal of increasing complementary funding to 10% of health financing has not been achieved, and probably will not be achieved in the near future. The general public is not ready to join a voluntary insurance scheme so long as quality of services and availability of medicines remains low.

Management of complementary funds is now fully the responsibility of LGAs. Because Community Health Services Boards (CHSBs) no longer oversee the CHF accounts, community participation in management of funds has been diminished.

There has been progress under HSSP III in improving financial management as an avenue toward greater efficiency and effectiveness, but these measures have limited impact on service delivery. Performance management could be an option for improved efficiency. Disbursement problems and delays in financial flows affect service delivery, both for government and HBF funding. Aligning various types of resources from non-basket partners is still a challenge.

Governance

Governance in the Tanzanian health sector is well documented, and guided by laws, regulations, memoranda of understanding, agreements etc. Recent appointments of top officials in the MOHSW and PMO-RALG remove concerns raised during the MTR with regard to effective management. Management capacities of MOHSW and PMO-RALG civil servants at mid-management levels are not always sufficient, translating into inefficiencies.

There is viable operational planning at all levels of the health sector. However there is limited embedding in HSSP III and no relation to performance management.

Decentralisation by Devolution is progressing, but not always efficiently because of duplication of systems by the MOHSW and PMO-RALG. Some donor-funded programmes do not respect government policies on administration and management. Decentralised priority-setting and decision-making is hampered by resource constraints and interference from national levels.

The concepts of public-private partnership (PPPs) has been properly developed, with strategies, tools and instruments, as well as advocacy and training. Service Agreements (SAs) are in place between LGAs and around 50% of faith-based organisations service providers. There are no SAs with private (for-profit) providers. Private providers feel that Government is not willing to create a level playing field in the health sector, and private investments are smaller than expected according to MMAM. At the grassroot level informal types of PPP are observed, e.g. in vaccination activities, distribution of bed nets, and antiretroviral treatment.

With regard to the SWAp, the arrangements laid down in the Code of Conduct and Agreements provide an example for the sub-Saharan region. The TWGs, instituted under HSSP III, are an excellent mechanism for concerted action between all stakeholders, but coordination is limited. Communication between TWGs and the senior management level in the ministry is not always adequate to contribute to effective decision-making.

The Technical Committee-SWAp and Joint Annual Health Sector Review (JAHSR) are outstanding instruments for collaboration between stakeholders, with open and transparent discussions. Procedures for formulation and follow-up of priorities and milestones are not always effective, with limited reference to HSSP III.

The HBF plays a crucial role in health care financing. These funds offer the districts opportunities for implementing health programmes. The demands and capacities for timely accounting and reporting do not always match.

Analysis Using Assessment Criteria

Construction of new facilities is expanding overall geographic **accessibility** to health care, but the expanded accessibility is not equitable nationwide. Financial accessibility is not improving, as waivers and exemption schemes do not provide enough relief and out-of-pocket expenses are increasing. Many women consider maternal health services neither acceptable nor affordable. With regard to access to medicines, small improvements have been made, but overall availability remains a serious concern, especially from the perspective of the general population.

With regard to **quality**, major steps have been made in systems development with the introduction of TQIF. However the positive developments are only reaching the facility level if accompanied by intensive support, as shown in HIV, malaria and TB programmes. The increasing output of health training institutions has the potential to improve the quality of care, but only if the absorptive capacity of the health sector can be increased; continuing professional development and maintaining professional standards also are concerns.

The quality of M&E systems is improving with innovative methods of data collection and analysis. This has not yet translated into an information culture leading to evidence-based planning and decision-making. Potentially, pay for performance approaches and accreditation systems could be instrumental in establishing a quality focus, as shown in evaluation of pilots in Tanzania. However, these are still in an early stage of development.

In general, equity is improving for many indicators (although inequities in most indicators are still large). Only under-five mortality shows an increasing regional divide.

There is not sufficient attention in communities and amongst health workers for the concept of vulnerability. Vulnerable people may encounter various negative social determinants of health and the health and social welfare services do not take these social determinants into account. In general terms social protection in the communities is weak, and principally dependent on charity organisations and NGOs.

Sexual and other gender-based violence are not high on the agenda in the health sector. The multiple linked vulnerabilities of women – higher levels of HIV infection in teenage girls, female genital mutilation, rape and sexual abuse – are hardly addressed. Gender balance in CHSBs and HFGCs is rare, with men dominating the committees representing the population.

Efficiency is a major issue in the health service delivery. In general, resource shortages constrain the productivity of health workers. Distribution of health workers is not equitable and is usually not based on health system needs. Issues of service readiness can negatively influence staff efficiency as well. Efficiency losses occur through duplication of work, e.g. parallel information systems between the MOHSW and PMO-RALG, or NGOs or development partners. Delays in disbursement of funding also are a major contributor to inefficiency, with consequences directly impacting the availability of services at the district and facility levels.

Sustainability is an issue of concern. Where many countries show a positive trend of increasing relative government contribution to the health sector, Tanzania is experiencing the opposite. There is increasing donor dependency, whereby non-basket funding has become the major source of donor funding. Funding for the health sector is far less than envisaged in HSSP III, in fact nearly half the amount estimated in the plan. It is highly unlikely that in the remaining period significant increase in budget will be realised.

Conclusions and Recommendations

The health sector is making progress in implementation of the six-year HSSP III. Positive developments can be noted in all strategic areas. Overall however the pace is slower than anticipated. Generally speaking, there has been more progress in systems development (policies, strategies, guidelines, work plans etc.) than in the implementation of service delivery. Innovations are only slowly trickling down to the grassroot-level facilities. Also in general, specific disease control programmes seem to be performing better than general and reproductive health services. Attendance rates for outpatient and maternal health services show clearly that the population is not satisfied with the services, and findings of the Community Perspectives Study point in a similar direction. The sector is still not equipped to tackle gender and equity issues especially in rural areas.

The MTR found RHS to be a primary area of concern. This is not due to lack of resources alone. Many organisations and projects are active in the area. RHS can only improve if the total system improves.

Recommendations for HSSP III Going Forward

Remaining Period of HSSP III

The MTR team recommends the action points below for the remaining period of HSSP III (2013–2015). They call for two underlying features:

The focus for the remaining HSSP III period should be on:

- Value for money: make optimal use of available resources, cognisant that financial resources will not grow as planned in HSSP III;

- Transparency and accountability: show the results and engage the community in strengthening the health services.

The proposed programme of action is summarised in eight action points:

1. Embrace the opportunities of decentralisation; use D-by-D systems effectively.
2. Promote quality as a central theme of the health sector; roll out a simple accreditation system.
3. Manage health commodities and medicines more effectively, especially through better logistical management and reduction of wastage.
4. Disburse funds on time, and engage in high-level advocacy for efficiency in government financial procedures.
5. Tailor resource allocation to need; use available information to identify the most serious inequities and tackle areas with targeted support.
6. Increase community participation in health and revive community health programmes. Improve communication and transparency: make health service accountable to the people.
7. Institute performance management systems, through a P4P approach, as well as functional OPRAS.
8. Focus on urban PPPs, and establish collaboration with all private providers, also the smaller clinics not organised in umbrella organisations.

The MTR team suggests instituting a task force for planning and monitoring of the actions, in a joint venture between the MOHSW and PMO-RALG. The chairs of the TWGs should join the task force. Senior MOHSW management should closely monitor the performance of the task force and the TWGs. The activities should be accompanied by a public information campaign on the benefits of the health services. Development partners could assist in making technical assistance and financial resources available for execution of the tasks involved.

Specific recommendations for the strategic areas of HSSP III are in the MTR technical reports.

Preparation of HSSP IV

The timeframe for producing HSSP IV is tight; however it is feasible to produce a plan by October 2014, in time to prepare budgets for the coming fiscal year. Preparation in a short time is possible because the functional TWGs can do much of the preparatory work. The process of preparation of HSSP IV should start with the JAHSR meeting of October 2013.

Around the time that HSSP III ends, other major strategies in Tanzania and worldwide also will end, e.g. MKUKUTA II, the agreement for cooperation with development partners in the health sector and the MDGs will end in 2015; the MMAM will expire in 2017. These developments have to be considered in the preparation of HSSP IV.

1. Introduction

This report summarises the findings, assessment and recommendations of the Mid Term Review (MTR) of the Third Health Sector Strategic Plan (HSSP III) for the period 2009-2015 in Tanzania. In addition to this main report, there are nine technical reports, on District and Hospital Services, Maternal Neonatal and Child Health (MNCH), Social Welfare Services, Human Resources for Health (HRH), Monitoring and Evaluation (M&E), Pharmaceutical Supplies, Capital Investment, Health Care Financing and Governance. There also are three Field Trip Reports of the MTR.

In the context of the MTR the Government of Tanzania's Ministry of Health and Social Welfare (MOHSW) and partners produced a Mid Term Analytical Review (MOHSW MTR-AR 2013) with extensive analysis of available health sector information. The MOHSW and partners also commissioned as part of the MTR an independent Community Perspectives Study to provide an unbiased community input to the MTR, also referenced within this report. A list of all MTR reports is provided in Annex 4.

Within this report, Chapter 2 describes the MTR methodology. Service delivery is discussed in Chapter 3, support services in Chapter 4 and facilitating activities in Chapter 5. Chapter 6 presents a performance assessment and Chapter 7 conclusions and recommendations. Where necessary, this main report refers to the other publications in the context of the MTR for detailed information.

1.1 MTR Objectives and Process

1.1.1 Objectives of the MTR

The MTR of HSSP III is guided by the MTR Steering Committee, in which the MOHSW, development partners and other stakeholders are represented. The Steering Committee approved the Terms of Reference (TOR) for this review (Annex 1). The primary objective of the HSSP III MTR is to review, analyse and document progress, challenges and lessons learnt from the first half of HSSP III implementation (2009-2012). MRT recommendations suggest improvements for the final period of HSSP III implementation and inform the design and formulation of HSSP IV.

The specific objectives of this MTR are:

- To assess the overall coherence and implementation of HSSP III with the specific aim of informing HSSP IV conceptualisation.
- To review the implementation of HSSP III thus far and take stock of quantitative and qualitative achievements.
- To assess the overall level of implementation of the Primary Health Care Service Development Programme, better known as the MMAM, in areas where the MMAM objectives are directly linked to the HSSP III.
- To assess the performance of systems for provision of medicines, equipment and health technologies and its impact on HSSP III implementation.
- To review and assess the contribution of HSSP III to improvements in the five health services identified: health promotion, preventive health services, care and treatment, and rehabilitative services and provision of services to the chronically ill.

- To review user perceptions of the availability, affordability and accessibility of quality MNCH services to aid fuller understanding of HSSP III performance.
- To review the financing of the sector for the period 2009-2013 in terms of various funding mechanisms and modalities, e.g. the Health Basket Fund (HBF), General Budget Support, complementary financing, commitment and contributions of the Government of Tanzania and development partners, fund utilisation, reporting, and overall efficiency and harmonisation of these modalities in delivering HSSP III strategic objectives.
- To assess the progress of Sector-Wide Approach (SWAp) implementation including the role played by the sector stakeholders and the extent to which all partners are optimally supporting the SWAp and suggest how this can be improved.
- To review operation of the 13 health sector Technical Working Groups (TWGs) and their respective impact on health improvement, including as related to service delivery.
- To assess how intersectoral political, institutional and governance factors affect systems strengthening and the implementation of the HSSP III.

1.1.2 MTR Process

The MTR Steering Committee provided overarching technical and strategic oversight and guidance to the review process, whilst a Health Sector Resources Secretariat coordinated the day-to-day operations of the MTR. The global Health Finance and Governance Project, led by Abt Associates Inc., was engaged for the management of the review. Seven international and five national consultants were hired to undertake this assignment, assisted by a logistics manager.

The MTR consisted of several components, in alignment with the TOR. The MTR team performed a document review of more than 1,000 documents to trace relevant information on the health sector (Annex 3). The MTR team performed in-country work with field visits, key stakeholders' interviews and meetings with TWGs (Annex 2). At the end of the in-country work, the consultants presented their findings to the stakeholders in meetings with the TWGs and with other stakeholders. The consultants produced draft reports (one main report and nine specific reports) for feedback and comments by selected stakeholders. On 25 September 2013, a consultative meeting was conducted to exchange views with stakeholders on the conclusions and recommendations of the MTR, whereafter the reports were finalised. The final MTR reports were presented in the Technical Review Meeting of the Joint Annual Health Sector Review (JAHSR) on 23 October 2013, where stakeholders discussed implementation of the recommendations.

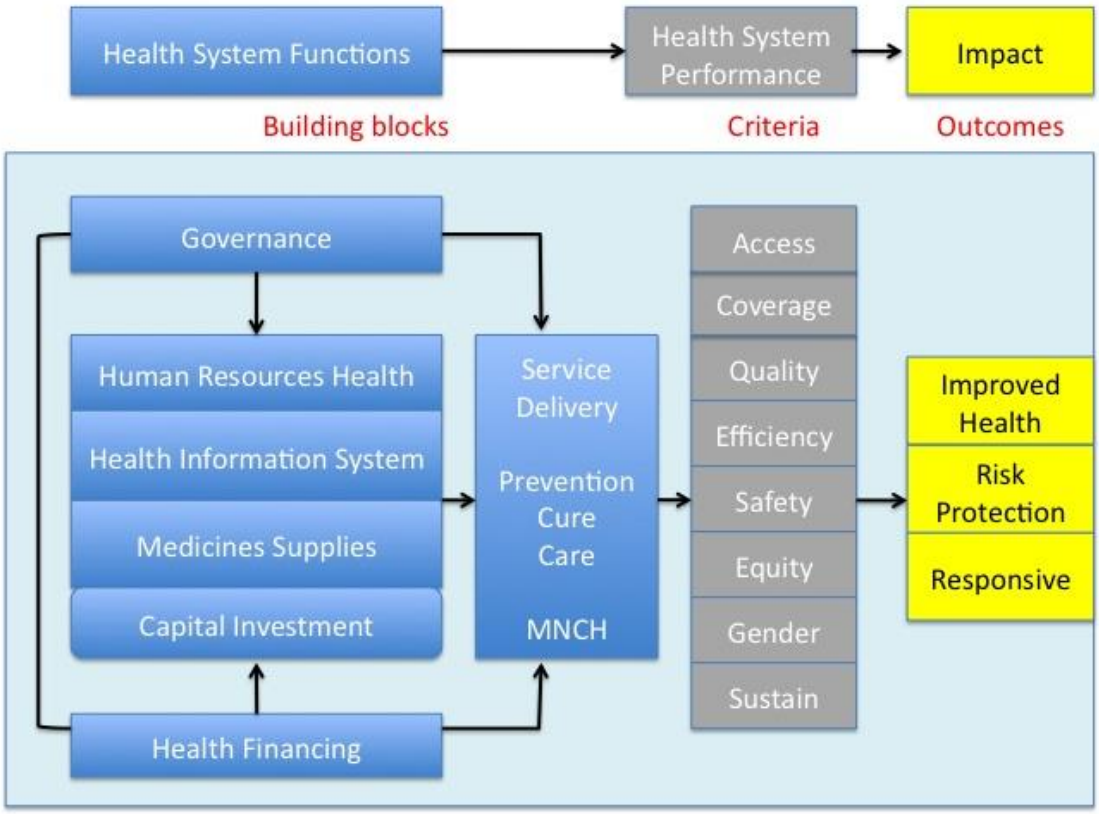
The MTR was conducted through a participatory and consultative approach. The MTR Steering Committee has been closely involved throughout the process. In addition, the TWGs for each of the strategic objectives in the HSSP III gave inputs on several occasions in the MTR process, including dialogue on the MTR findings and recommendations, and planning for implementation of the recommendations.

1.2 Approach in the MTR

1.2.1 Analytical Framework Health Sector

The HSSP III MTR applied an adjusted version of the World Health Organisation's (WHO) analytic framework for health sector analysis (De Savigny and Taghreed 2009; Health Systems 20/20 2012). This framework is internationally recognised for its robust approach to health systems analysis. The framework (shown in figure 1) distinguishes three main components: health system functions (the "building blocks"), performance and impact (which reflect inputs, processes, outputs and outcomes). Minor adjustments were made in this framework to show more explicitly the priority areas identified in the MTR TOR.

Figure 1. Adjusted WHO Framework for Health Systems Analysis



The health system's most visible building block is the service delivery block representing *District and Hospital Services and MNCH. Human resources, medicines and supplies and infrastructure (capital investment) together support service delivery. The health information system* is not an input as such, but rather a health system component close to service delivery. Governance and financing facilitate all the other building blocks.

The *criteria* for assessing the health system's performance include standard WHO criteria, coverage, access, quality, efficiency, safety, equity, gender and sustainability. These criteria are also mentioned in the cross-cutting issues of HSSP III. The *outcomes* of service delivery are *improved health, protection* of the population against risks and prevention to avoid risks, and flexible *response* to emerging needs.

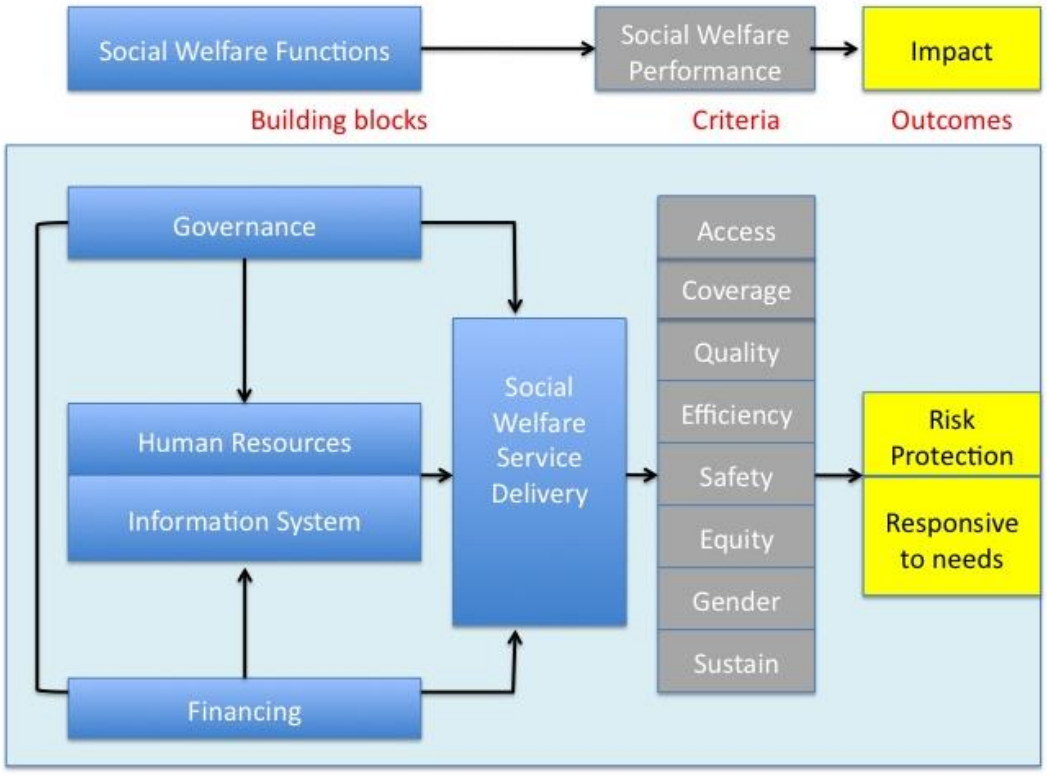
The WHO building blocks reflect the factors of universal health coverage, which has a central place in the Post-2015 Health Agenda (WHO 2013). The goal of universal health coverage is to ensure that all people obtain the health services they need without suffering financial hardship when paying for them. To achieve universal health coverage, several factors must be in place, including:

1. A strong, efficient, well-run health system that meets priority health needs through people-centred integrated care (including services for HIV, tuberculosis (TB), malaria, non-communicable diseases (NCDs), MNCH);
2. A system for financing health services, which prevents people from suffering financial hardship when using those services;
3. A system for provision of essential medicines and technologies to diagnose and treat medical problems; and
4. A sufficient capacity of well-trained, motivated health workers to provide the services to meet patients' needs based on the best available evidence.

1.2.2 Analytical Framework Social Welfare

For the assessment of social welfare, which is part of the MOHSW's responsibilities, the MTR applied a similar - albeit simplified - model because not all building blocks are the same as those for health services.

Figure 2. Adjusted Framework for Social Welfare Analysis



2. Background

2.1 General Policy and Aid Framework

In Tanzania a coherent system of government policies, legislation, strategies and programmes is emerging, giving direction to development. Consistency between general and sectoral policies is increasing.

2.1.1 Vision 2025

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

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

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

2.1.2 MKUKUTA

The National Strategy for Growth and Reduction of Poverty, known in Kiswahili as the MKUKUTA, represents Tanzania's commitment to the achievement of the MDGs (URT/VPO 2005). It focuses on growth and governance, and is a framework for all government development efforts and for mobilising resources.

The MKUKUTA aims to foster greater collaboration amongst all sectors and stakeholders. It has mainstreamed cross-cutting issues (gender, environment, HIV/AIDS, disability, children, youth, elderly, employment and settlements). All sectors are involved in a collaborative effort rather than segmented activities. Therefore this document is of crucial importance for the MOHSW strategies.

The MKUKUTA seeks to deepen ownership and inclusion in policymaking, paying attention to address laws and customs that retard development and negatively affect vulnerable groups.

The strategy identifies three clusters of broad outcomes:

1. Growth and reduction of income poverty;
2. Improvement of quality of life and social well-being; and
3. Good governance.

2.2 Health Sector Policy Framework

2.2.1 Health Policy

The MOHSW revised the 1990 National Health Policy in 2003 (MOHSW 2003). Ongoing socio-economic changes, new government directives, emerging and re-emerging diseases and changes in science and technology necessitated the policy update. The policy outlines achievements and challenges facing the health sector. Resource constraints (especially human resources) constitute the major obstacle to coping adequately with health problems.

The vision of the Government of Tanzania is to have a healthy society, with improved social well-being that will contribute effectively to personal and national development. The mission is to provide basic health services in accordance with geographical conditions. The health services, which are of acceptable standards, affordable and sustainable, will focus on those most at risk and will satisfy the needs of the citizens in order to increase the lifespan of all Tanzanians (MOHSW 2003).

Specifically the Government aims to:

1. Reduce morbidity and mortality in order to increase the lifespan of all Tanzanians by providing quality health care;
2. Ensure that basic health services are available and accessible;
3. Prevent and control communicable and non-communicable diseases;
4. Sensitise the citizens about the preventable diseases;
5. Create awareness on the part of the individual citizen to his/her responsibility on his/her health and health of the family;
6. Improve partnership between public sector, private sector, religious institutions, civil society and community in provision of health services;
7. Plan, train, and increase the number of competent health staff;
8. Identify and maintain the infrastructures and medical equipment; and
9. Review and evaluate health policy, guidelines, laws and standards for provision of health services.

2.2.2 MMAM

In 2007 the MOHSW developed the Primary Health Care Service Development Programme, better known as the MMAM 2007–2017 (MOHSW 2007b). The objective of the MMAM is to accelerate the provision of primary health care services for all by 2012, whilst the remaining five years of the programme will focus on consolidation of achievements.

The main areas are strengthening the health systems, rehabilitation, human resource development, the referral system, increasing health sector financing and improving the provision of medicines, equipment and supplies. The MOHSW implements this plan in collaboration with other government administrative structures, which include the Prime Minister's Office-Regional Administration and Local Government (PMO-RALG), Regional Secretariats (RSs), Local Government Authorities (LGAs) and Ward Development Committees.

2.2.3 HSSP III

HSSP III is the cross-cutting strategic plan of the health sector and social welfare sector of Tanzania for the period July 2009– June 2015. It provides an overview of the priority strategic directions across the health sector (MOHSW 2008a). HSSP III is guided by the National Health Policy, Vision 2025, MKUKUTA MMAM and the Millennium Development Goals (MGDs). HSSP III serves as the sector's comprehensive national plan and guiding framework for the detailed planning and implementation of health sector activities by all levels and partners. Partnership, in particular, is a key focus area of HSSP III. HSSP III consolidates existing health sector reforms, retains key strategic priorities of HSSP II and adds new identified priorities such as MNCH.

2.2.4 Specific Policies, Strategies, Work Plans and Programmes

Within the health sector specific policy and strategy documents have been produced, guiding the implementation of activities in those areas. These are listed in the MTR-AR and in the specific MTR technical reports.

3. Service Delivery

3.1 Performance Indicators

The MOHSW Health Information Unit, together with the National Institute for Medical Research (NIMR), Ifakara Health Institute (IHI) and WHO performed an analysis of available information in the health sector. Table 1 summarises the findings of performance indicators of HSSP III (MOHSW MTR-AR 2013). Not all information is up to the year 2012, especially not when it concerns community-based information, extracted from surveys.

The analytical report provides a trend analysis of the overall progress for the indicators (second column) and given a green colour code for indicators, which will achieve the target of HSSP III, an orange code for indicators with progress, but not enough to likely achieve the target in 2015, and a red code for indicators with little or no progress, which certainly will not achieve the target by 2015.

Table 1. Performance indicators service delivery HSSP III

HSSP III indicators	Overall progress	Achievement	Target 2015	Equity	Compare (rank)
HEALTH STATUS					
Life expectancy (years)		61 (F) /58 (M) (2011)	62/59		
Under-5 mortality rate		81/1,000 (2006-10)	54		1
Neonatal mortality rate		26/1,000 (2006-10)	19		1
Infant mortality rate		51/1,000 (2006-10)	-		1
Child stunting rate		35% (2011)	22%	G R W	3
Child underweight rate		14% (2011)	14%		5
Maternal mortality ratio		454/100,000 (2004-10)	156	G	2
Total fertility rate		5.4 (2008-10)	5.1	G R W	4
Adolescent fertility rate		44% (2010)	39%	G R W	5
HIV prevalence among young people		2.0% (2011/2)	-	G	
HIV prevalence, pregnant women (15-24)					
TB notification rate		75% (2011) 52% (2012)	70%		
Leprosy cases diagnosed and treated					
Cholera incidence rate		343 cases	0		
Cholera case fatality rate		4.1%	<1%		
Malaria prevalence among OPD (lab)	-	33% (under 5) (2012)	-		
Parasitemia prevalence (children)		9.2% (2012)	5%		
COVERAGE OF INTERVENTIONS					
Measles immunization coverage		100% (2012)	85%		1
DTP-Hb 3 immunization coverage		95% (2012)	85%		4
Vit A coverage (2 doses)		60% (2010)	-	G W	7
TT2 immunization coverage		88% (2011)	90%		
ANC first visit > 16 weeks		15% (2006-10)	60%		5
ANC at least 4 visits		36% (2009-10)	90%	R	7
Births in health facilities		58% (2011)	70%	G R W	
Skilled birth attendance		62% (2010-11)	80%	G R W	8
Postnatal care coverage		31% (2006-10)	-		
Contraceptive prevalence rate		27% (2010)	60%*	G R W	5
ITN use (children / pregnant women)		73% /75% (2011/2)	80%		3
eMTCT coverage among pregnant women		77% (2011)	80%		
ART coverage among those in need		65% (2012)	60%		
TB treatment success rate		90% (2011)	85%		2

Source MOHSW MTR-AR 2013

The table also shows an equity analysis (fifth column) and trends of the indicators. Indicators with moderate or large inequity are coloured orange or red. Where possible the types of inequity are identified (G=gender, R=place of residence (urban-rural, or region) and W=wealth quintile). In the sixth column a comparison is presented for the African sub-region with Tanzania's ranking as far as data are available.

The table of performance indicators with the trend analysis offers a good starting point for assessing progress. More background data and further explanation of the methodology of data selection, triangulation and trend analysis is provided in the MTR analytical report. The sections below discuss the progress of District and Hospital Services, MNCH and Social Welfare Services, and provide where required additional facts and figures from other sources.

3.2 District and Hospital Services

3.2.1 District Health Services Strategies

Accessibility

The MMAM 2007-2017 is the major health sector strategy to improve access and expand health services in underserved areas, with the aim of establishing one dispensary per village and one health centre per ward. The Government has realised continued expansion of the number of health facilities and has increased the number of health workers deployed in the country (MRT-AR 2013). The Government has also achieved improved availability and geographic accessibility of health services. However, as discussed below, financial accessibility of services has not developed to the extent envisioned in the HSSP III. Based on general indicators of outpatient per capita, of antenatal care (ANC) and of deliveries in health facilities, utilisation of health services is not increasing in the HSSP III period, whilst indicators for disease-specific interventions show increased utilisation (MOHSW MTR-AR 2013).

HSSP III Objectives

District Health Services Strategies

1. Increase accessibility to health services based on equity and gender-balanced needs
2. Improve quality of health services

Management of District Health Services Strategies

1. Strengthen and decentralise management of District Health Services and harmonise MOHSW and PMO-RALG management procedures

Quality

The Tanzania Quality Improvement Framework (TQIF) in Health Care (2011-2016) is a comprehensive national reference document for Tanzania's health sector (MOHSW 2011b). Of its main elements, national Infection Prevention and Control guidelines in particular and 5S-Continuous Quality Improvement/KAISEN training have reached the districts, as observed in the field visits. The draft national Quality Improvement Strategic Plan is under review by the Health Services Quality Assurance Department of the MOHSW.

To date, operationalisation of the TQIF at regional- and council-level health facilities has been limited. During field visits in three regions it was noted that few district hospitals have active Quality Improvement Teams. Staffs interviewed in health facilities hardly know the TQIF and guidelines; manuals or Standard Operating Procedures (SOPs) are not generally available in health facilities, as observed in the field visits. As demonstrated below, quality improvement of services is mainly based on specific disease control programmes.

The MOHSW has taken up the development of an accreditation system, based on experiences in disease-specific programmes. The assessment criteria are being developed, and methods of verification are being discussed. It will take time before the system can be rolled out.

Management

The preparation of annual Comprehensive Council Health Plans (CCHP), with technical support from Regional Health Management Teams (RHMTs), is one of the most structured management actions at Council Health Management Team (CHMT) level. Some CHMTs visited during the MTR were unclear on how they should prioritise activities in their CCHPs, based on locally identified needs or on central-level instructions. CHMTs see it as a major constraint that they plan without knowing a budget. CCHPs are only partially implemented due to lower than expected disbursements. Most health facilities have only limited involvement in the CCHP decision-making process and do not receive feedback after their inputs.

In general, RHMTs provide quarterly supportive supervision to CHMTs. In turn, CHMTs provide (often monthly) supportive supervision to health facilities but face challenges with transport or funding. Supervision is therefore more administrative than technical. There is no system of mentoring and professional coaching in place. None of the CHMTs or District Hospital in-charges met during the MTR were aware of the national Hospital Strengthening Programme.

Quarterly reporting takes place through technical and administrative channels, from CHMTs to RHMTs and then to both MOHSW and PMO-RALG at the national level. Part of the reporting is duplicated in the two streams.

Community Involvement

Health Facility Governing Committees (HFGCs) should play an important role in voicing the community interests in the management of health facilities. Only half of HFGCs are functional and few have approved the CCHPs or annual Hospital Plans to date (Simon 2012). These findings were in line with the general conclusion from IHI (2011) that HFGCs need more training on their fundamental roles (IHI 2011a).

Consultations during the Community Perspectives Study showed that citizens think that their participation in decision-making processes is important, but that it is currently without meaning: their priorities are not given weight in budgets and they have no real part in improving service governance. Further, the study showed that, despite protocols to encourage participation of women, younger people and people living with disabilities (PLWDs) in local-level committees and decision-making forums, their participation is still weak. Women, younger people and PLWDs do not think they are welcome or will be chosen as representatives. They think they are not listened to and that their concerns are not taken seriously.

Health services do little to promote themselves to the general public. For example, both health workers and the people interviewed agree that there has been great progress in provision of the Expanded Programme on Immunisation (EPI) and HIV prevention, treatment and care. Equally, the distribution of bed nets has been successful. However, that does not trickle through. Currently, whilst the Government may be able to demonstrate improvements in numerous aspects of health status, citizens are often unaware of these achievements.

3.2.2 Referral Hospital Services Strategies

Strengthening the role of Regional Referral Hospitals (RRH) since the beginning of HSSP III may be challenged with the unavailability of key clinical staff. According to the MOHSW, out of 24 Regional Referral Hospitals, 54% (13 RRHs) have at least 4 specialists. While not a representative sample, in three regional visits during the MTR, two RRHs were operating as district hospitals instead of their designated role as specialised referral facilities. Plotkin et al concluded that RRHs did not perform better than district hospitals in maternal and neonatal care (Plotkin 2011). A reassessment in 2012 gave a similar picture (MAISHA 2012). Besides staffing problems, there are also challenges with medical supplies, blood transfusion services, and laboratory services.

HSSP III Objectives

Referral Hospital Services Strategies

2. Increase access for patients in need of advanced medical care
3. Improve quality of clinical services in hospitals

Referral Hospital Care Objectives

1. Improve management of the hospitals through implementation of Hospital Reform Programme
2. Strengthen hospital governance

Regional Hospitals have been exposed to training and capacity building in TQIF, but none of the RRHs visited by the MTR team had an operational Quality Assurance Unit. One did have a Quality Improvement Team (QIT), which met on an ad hoc basis. The MTR review did not find significant signs of a viable Hospital Reform Programme as planned in HSSP III.

All 23 hospitals which were officially recognized as RRHs have been coached on hospital planning, and have developed both 2009-2015 strategic plans and annual plans since 2010. Regional Hospital Health Services Boards (RHHSB) are in place in a number of RRHs. The MOHSW has recently approved nominations of 14 RHHSBs, which are not operational. While RHHSB members have received training on Board functions, the terms of reference of RHHSB may require further clarifications, especially with regard to accountability of the MOHSW and PMO-RALG.

Summary: District and Hospital Services

In district and hospital service availability is increasing, but the overall improvement of the quality of service is lagging behind the objectives of HSSP III. At the district level, health sector management is improving at least with respect to most annual CCHP preparation and reporting functions. The Hospital Reform Programme is making limited impact, and RRHs cannot consistently provide services according to their status. Community involvement in management of health institutions appears to be limited. Communities do not feel to be part of decision-making.

3.3 Disease Prevention and Control Strategies

3.3.1 General Strategies

Disease Surveillance

A surveillance system is in place whereby district hospitals and CHMTs have staff in charge of disease surveillance. The HMIS reporting system has tools that facilitate disease surveillance. However, according to informants in the districts visited, the Outpatient Department (OPD) register is not always filled completely when there is no qualified staff. Therefore it is not always possible to accurately review the occurrence and incidence of notifiable diseases.

HSSP III Objectives

General Strategies for Disease Prevention and Control

1 Improve disease surveillance of communicable and non-communicable diseases

3. Improve disease case management in health facilities through integrated disease control activities at health facility level
4. Enhance community participation in health promotion and disease prevention
5. Improve home-based treatment and care

Case Management

Integrated disease control programmes include Integrated Management of Childhood Illnesses (IMCI), HIV control and services for Sexually Transmitted Infections (STI), Reproductive and Child Health (RCH) and Prevention Mother To Child Transmission (PMTCT). According to the Tanzania Service Availability and Readiness Assessment (SARA) (SARA 2012) malaria services, IMCI, PMTCT and STI services are available in 75% or more of all sampled health facilities, whilst antiretroviral therapy (ART) for HIV was available in less than 30% of the sampled facilities. TB and leprosy management services are available at all the levels of health facilities. Health facilities visited during the MTR fieldwork show evidence of integration of RCH services with IMCI, PMCT and STI services. Thus provision of disease case management of the major diseases (malaria, STIs, TB and leprosy) seem to be provided in an integrated manner at the health facility level whilst ART services have not been integrated in the majority of health facilities.

Community Participation

Village health committees are responsible for enhancing community participation in health promotion and disease prevention. The activities which the MTR team found in CCHPs include:

- Strengthening community-based HMIS and disease surveillance;
- Activities for national environmental health days
- Communicable diseases control (e.g., Community-Based Malaria Control);
- NCD control:
- Community-based iodinated salt monitoring;
- Solid waste management;
- Community participatory planning and management of community-based water hygiene and sanitation projects using Participatory Hygiene And Sanitation Training (PHAST);
- Community Led Total Sanitation activities;
- Treatment of Neglected Tropical Diseases (NTDs) by mass medicine administration;
- Traditional and alternative medicine by involving traditional birth attendants and traditional healers;

- Tracing of HIV-exposed infants using community volunteers and advocacy meetings with traditional healers.

The budget for community-based initiatives in the CCHPs studied during the MTR is minimal. Most community activities are financed through externally funded projects or non-governmental organisations (NGOs) that use a variety of approaches in identification of community needs, different methodologies in community participation and different training and involvement of community health workers. Therefore community participation approaches in health are not uniform in the country, and not comprehensive.

Community-based health care interventions have been used over many years in Tanzania for distribution of contraceptive commodities, in HIV/AIDS care and in RCH services. In relation to HIV/AIDS care and support, since 2003 there has been a concerted effort to scale-up care, support and treatment for HIV/AIDS by home-based care. About half of the districts in Tanzania have home-based care HIV/AIDS services implemented by NGOs, faith-based organisations (FBOs) and community organisations with support from several donors. Guidelines, curricula and monitoring tools are in place as part of standardisation, harmonisation and quality control; providers were trained through health facilities, FBOs, private health providers, and NGOs.

MTR field visits to select regions established that due to inadequate resources, outreach services are limited. Home-based care activities are mainly provided through FBOs, civil society organisations (CSOs) and donor-funded projects.

3.3.2 HIV/AIDS Strategies

MOHSW HIV/AIDS strategies include accelerating access to and utilisation of HIV care and treatment services, scaling up integration of TB and HIV services and scaling up of STI control. In general these services are performing well, shown by increased utilisation figures in testing and counselling, PMTCT, increasing blood supply, safety of injections, male circumcision, etc. (MOHSW MTR-AR 2013). Despite increasing blood supply, availability of blood in hospitals is extremely inadequate, and does not meet the high demand (SARA 2012)

HSSP III Objectives

HIV/AIDS Strategies

1. Maximise the health sector contribution to HIV prevention
2. Accelerate the access and utilisation of HIV/AIDS care and treatment services
3. Scale up integrated TB and HIV services
4. Scale up STI control

Various CSOs and NGOs address early sex and unsafe sex practices by adolescents. But vulnerable groups (drug users, homosexuals) are not part of the HIV/AIDS Programme. Despite the ongoing HIV prevention interventions, the incidence of new HIV infections is hardly decreasing although HIV prevalence is showing a slight downward trend (MOHSW MTR-AR 2013).

3.3.3 Malaria Strategies

HSSP III Objectives

Malaria Strategies

1. Implement universal access to malaria interventions, through effective and sustainable collaborative efforts.

As explained in the MRT-AR, Tanzania has made major progress in reducing morbidity and mortality due to malaria, although it is still the most prevalent disease in the country. In the past years the number of facilities with malaria treatment services increased two-fold. Use of artemisin-based combination therapy (ACT) in children with fever increased; ACT was available in 80% of health facilities, according to facility surveys (SARA 2012). For the period of review, there was an overall decrease in the percentage of children age 6 to 59 months who were tested positive for malaria. Diagnosis of malaria as a proportion of total OPD attendance, in both children under five years and over five years, decreased gradually from 2009 to 2012.

MOHSW malaria prevention includes insecticide-treated bed net (ITN) use, Indoor Residual Spraying (IRS), larviciding and environmental management methods. According to the 2012 Tanzania HIV-Malaria Indicator Survey (TACAIDS 2013), 74% of the household population slept under a mosquito net as compared to 56% in the 2004-5 THMIS. Nationally, 78% of children under age 5 and 80% of pregnant women slept under a mosquito net the night before the survey. There has been limited implementation of IRS except in the Lake Zone where, based on data from a sentinel surveillance site in Muleba District, IRS was associated with reduction in hospital admissions and deaths attributable to malaria.

3.3.4 TB and Leprosy Strategies

HSSP III Objectives

TB and Leprosy Strategies

1. Expand and mainstream Directly Observed Therapy, Short course (DOTS) strategy to the general health system and involve FBOs and NGOs in DOTS
2. Introduce and implement MDR/XDR TB management
3. Leprosy elimination prevention of disabilities and social economic rehabilitation of people affected by leprosy..

Preliminary results of the National Tuberculosis Prevalence Survey 2012 show that the TB prevalence is 295 per 100,000 population, confirming that TB is still a major disease burden in the country. Most of the progress of the TB programme can be attributed to the home-based DOTS strategy under which 78% of all TB cases are managed at home. TB case detection rate is 75% of estimated cases. TB treatment success rate remains high at about 90% thus reaching the target of the Global Plan to Stop TB 2011-2015 (MOHSW MTR-AR 2013).

Multi-drug resistant TB (MDR-TB) case management was launched in 2009 at Kibong'oto National TB Hospital (KNTH), which serves as the national referral centre for all MDR-TB cases. To date 155 MDR patients have been treated at KNTH with a cure rate of 73%.

In 2011, according to the National Tuberculosis and Leprosy Programme 2011 Annual Report, the national leprosy prevalence rate was 0.4 per 10,000 population, which was below the WHO leprosy elimination target of 1 per 10,000 population. Overall, the prevalence of leprosy has showed a steady decline since 2002. Leprosy elimination to a level of below 1 per 10,000 population has not been achieved in 26 districts.

3.3.5 NTD Strategies

In 2012, the Tanzania Neglected Tropical Diseases Control Programme (TZNTDCP) completed a five-year Strategic Master Plan for 2012-2017 that includes 11 NTDs. In 2012, the implementation of the TZNTDCP was scaled up to 94 districts in 14 regions, i.e. 70% epidemiological coverage.

HSSP III Objectives

NTD Strategies

1. Strengthen surveillance, prevention, diagnosis and treatment of NTDs and other epidemic-prone diseases.

From 2009 to date, all Onchocerciasis control activities are implemented through the integrated TZNTDCP. To date, all meso-endemic and hyper-endemic communities in 19 districts are implementing mass drug administration. Surveys in Tanga (2010) and Tukuyu (2011) showed that transmission of Onchocerciasis has been interrupted after 10 years of mass drug administration. Implementation of the Schistosomiasis control programme has been facilitated by the presence of a guide and sentinel sites for monitoring the progress. Trachoma control programmes take place in 47% of affected areas.

3.3.6 NCD Strategies

NCDs are becoming more important in Tanzania as a cause of death and ill health. The mission of the MOHSW Non-Communicable Diseases Surveillance Programme is to monitor trends in the major risk factors and to support an integrated approach to the reduction of relevant risk factors at population level. Various policy guidelines for the control and prevention of NCDs have been developed such as Mental Health Policy Guideline, National Guideline for Prevention and Control of NCD, National Diabetic Policy Guideline, National NCD Sensitization and Advocacy Guideline, National Cancer Control Strategy, and the National Healthy Eating Style Guideline. A draft of the new NCD Strategy 2013-2020 has been developed in line with the Global NCD Strategy.

HSSP III Objectives

NCD Strategies

1. Reduce the burden of NCDs, mental disorders and substance abuse
2. Develop NCD, mental disorders and substance abuse advocacy and sensitisation programmes

In recent studies on the prevalence of NCD risk factors amongst adults in Tanzania the most common risk factors identified were high blood pressure, overweight and high cholesterol. Data from the cancer registry show that the three most common cancers were cervical cancer, Kaposi's sarcoma and breast cancer. Since 2007, the number of road deaths has increased by an average of 10% per year, and traffic injuries by an average of 7% per year (MTR-AR 2013). There are no recent figures on mental disorders in the country.

At the facility level, there is limited knowledge about prevention and treatment of NCDs, and often medicines for hypertension or diabetes are not available. Information materials are generally not available, and targeted prevention strategies are lacking. The upcoming epidemic of NCDs is not yet addressed in practice, and so far few development partners have shown interest in this area.

3.3.7 Environmental Health Strategies

HSSP III Objectives

Environmental Health Strategies

1. Operationalise the Public Health Act 2008 and health elements of the Environment Management Act (2008)

In the first half of HSSP III implementation, much has been achieved with respect to regulatory mechanisms for environmental health and sanitation. Regulations for sanitation and hygiene, sanitary fitments, plumbing and latrines and management of waste and human remains have been developed to support enforcement of the Public Health Act, 2009 (URT 2009). Similarly, guidelines for solid waste management have been developed and rolled out nationally (MOHSW 2012c). Environmental health practitioners that enforce compliance of the PHA and other public health related laws are being registered and given licenses by the Environmental Health Practitioner Registration Council to enforce the public health laws. About 1,485 environmental health practitioners have been registered.

The MOHSW is working to establish a national environmental health and sanitation data management system. The Ministry has also signed memoranda of understanding with the Ministry of Water, Ministry of Education and Vocational Training and PMO-RALG, with regard to implementation of environmental sanitation issues. In addition, an intersectoral group for Environment Management was formed. The curriculum for certificate course in environmental health is being reviewed in the effort to address the EHP understaffing levels.

RHMTs visited during the MTR were generally aware of the Public Health Act and the Environmental Management Act. One district visited (Geita) inaugurated a three-year sanitation campaign, through which the Public Health Act will be used as a guiding tool on legal issues concerning sanitation and hygiene. However, most activities in districts for improvement of hygiene are dependent on NGOs and DPs (see Social Welfare Specific Report). Hygiene remains a constraint in many parts of the country, with many areas facing limited access to safe water and toilets or latrines. Urbanisation exposes large, and increasing, segments of the population to such risks.

3.3.8 Emergency Health Strategies

HSSP III Objectives

Emergency Health Strategies

1. Establish systems at all levels for immediate emergency response to health disasters and disasters with health problems

The MOHSW 2007 Emergency Operations Plan is a well-structured and comprehensive national reference for health sector emergency preparedness and response (MOHSW 2007a). It is currently under review by the Health Emergency Preparedness and Response Unit (HEPRU) with a revised plan expected in due course.

Notwithstanding the clear guidance of the 2007 plan, the MTR found weak or no regular application of any SOPs at health facilities. Budget provision for disease outbreak pharmaceuticals (especially for cholera outbreaks) was found in some CCHP budgets, but nothing else emergency preparedness and response-related, including staff training, hazard surveillance and emergency logistics.

Summary: Disease Control Programmes Emergency Health Strategies

Surveillance in disease control programmes is improving and services are delivered in a more integrated way. Community participation in disease prevention and control is mainly dependent on local initiatives and programmes, and so not uniformly available throughout the country.

HSSP III HIV/AIDS strategies for the period 2009-2013 are likely to achieve targets, particularly for utilisation of HIV/AIDS care and treatment services.

The malaria strategies for the period 2009-2013 are successful, particularly for malaria diagnosis and treatment as well as ITNs.

TB strategies for the period 2009-2013 are generally implemented according to plan. Tanzania has achieved the targets for elimination of leprosy. An area with limited progress is leprosy elimination and prevention of disabilities.

HSSP III NTD strategies for the period 2009-2013 are expanding, particularly for strengthening surveillance, diagnosis and treatment with the exception of prevention strategies.

With regard to NCDs, policy guidelines have been developed but not yet implemented at the facility level. Recent surveys have provided more insight into the size of the NCD health risk factors affecting Tanzania.

The environmental health strategy 2008-2017 is implemented, particularly the Public Health Act (2009). However, vulnerable people both in urban and rural areas are yet to be adequately reached for improving their environmental conditions.

In Tanzania a good system for addressing health emergencies has been developed, but implementation lags behind.

3.4 Service Provision: MNCH

The National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania (2008-2015) was developed to guide implementation of all MNCH interventions in Tanzania. The plan stipulates important strategies to guide all stakeholders (MOHSW 2008c).

HSSP III Objectives

MNCH Strategies

1. Increase access to MNCH services
2. Strengthen the health systems to provide quality MNCH and nutrition services

3.4.1 Reproductive Health Services

ANC

Almost all pregnant women in Tanzania (98%) make at least one ANC visit. Only 15% made their first ANC visit before the fourth month of pregnancy instead of the targeted 60%. ANC attendance for four ANC visits has declined, from 64% in 2005 to 36% in 2010, whilst 90% is the target (MTR-AR 2013)[1].

According to the SARA survey in 2012, three-quarters of all health facilities offered ANC services. This proportion was significantly higher in public than in private facilities. However, less than 60% of those facilities had staff qualified to perform ANC; less than 15% could perform lab tests. The MTR field confirmed these findings of low service readiness for ANC.

[1] The MTR-AR singled out the attendance over 2009 and 2010 from the TDHS figures. Over the whole period 2006-2010, the figure is 43% as mentioned in the TDHS 2009/2010.

Tetanus Toxoid Vaccination (TTV) second dose is given to half of the pregnant women, whilst 88% of women reaches life-long protection through other vaccination programmes, e.g. in schools (MTR-AR 2013).

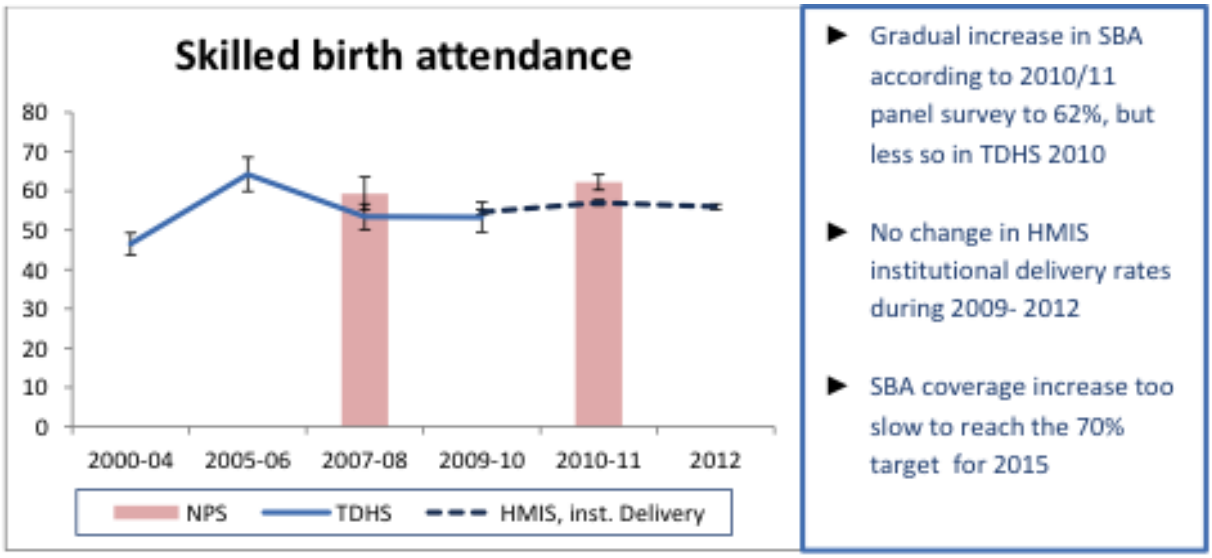
National Guidelines on Prevention of Mother-to-Child Transmission of HIV were developed in 2007 and integrated into ANC services (MOHSW 2012f). Testing and counselling for HIV is offered to all mothers at ANC. Access to and coverage of PMTCT and ART continue to increase and appear to be on track to meet HSSP III targets (TACAIDS 2013).

Malaria prevention is integrated into ANC services through ensuring access to subsidised ITNs. Now 76% of pregnant women, in all wealth quintiles, use a bed net. A second strategy for malaria prevention in pregnancy is to provide two doses of Intermittent Preventive Treatment (IPT) during routine ANC visits. Not all pregnant women receive IPT 2 because of low follow-up attendance in ANC. Coverage amongst the poorest is 25% and amongst the rich 45%, with no improvement over the last years (MTR-AR 2013).

Delivery Care

Tanzania has made slow progress in coverage of deliveries by skilled birth attendants (SBAs), which increased from 43% to 51% from 2005 to 2010. The HMIS 2012 data show that 62% of deliveries took place in health facilities (MOHSW MTR-AR 2013). Not all health facility deliveries are attended by an SBA, despite the increase in the number of nurse-midwives in the country. Still 30% of health facilities do not have a proper delivery room and adequate facilities (SARA 2012). In rural areas 42% of women delivered in a health facility, compared to 83% in urban areas. There is also a wealth gap in skilled birth attendance as 93% of the women in the highest quintile had attended births compared to only 33% in the lowest wealth quintile (Tanzania Demographic and Health Survey (TDHS) 2010).

Figure 3. Skilled birth attendance (MOHSW MTR-AR 2013)



Some of the barriers faced by women in accessing care include distance to the health facility, inability to purchase delivery kits, lack of money and transport, and the perceived quality of care, including non-availability of competent providers. Studies have also shown that the poor attitude of health providers and lack of respect of the provider, such as use of abusive language, also contribute to women preferring home delivery or choosing for delivery in private health facilities (Lugalla et al. 2011, Mackintosh et al. 2013; Mselle et al. 2013). This was also confirmed in the Community Perspectives Study of this MTR.

Internationally Tanzania is lagging behind in increase of safe deliveries compared with other countries in the region.

In Tanzania Basic Emergency Obstetric and Neonatal Care (BEmONC) is provided at primary health care facilities, whilst Comprehensive Emergency Obstetric and Neonatal Care (CEmONC) is provided in hospitals and upgraded health centres. Table 2 shows the progress in expansion of the maternal (not neonatal) service delivery infrastructure. Although there is an increase, especially in BEmOC, the targets for service delivery in 2015 are unlikely to be met.

Table 2. BEmONC and CEmONC performance (SARA 2012)

	BEmONC Target	BEmOC Baseline 2007	BEmOC Provided 2012	CEmONC Target	CEmONC Baseline 2007	CEmOC Provided 2012
Dispensaries	70%	5%	20%			
Health centres	70%	5%	39%	50%		
Hospitals				100%	65%	73%

According to the TDHS 2010 (NBS 2011), the Caesarean Section rate was only 4.5% in Tanzania, whilst WHO estimates that 15% is needed. Delivery by Caesarean Section is not equitably distributed across the country, varying between 3.2% and 9.6% according to urban/rural, geographical zones and between 1.2% and 12% by wealth strata. This suggests that pregnant women in rural areas or from poor families have limited access to life-saving obstetric surgery.

Reducing maternal and newborn deaths requires a functioning health system including adequate skilled health providers available 24/7, adequate infrastructure, and effective communication and transport to ensure a prompt referral in the event of an obstetric emergency. The recent SARA survey showed that only 52% of public facilities that provide delivery care had emergency transport available, and this is an improvement compared to 2006 when only 40% of facilities had emergency transport. During the MTR field visits, the districts visited had on average only one ambulance each to cater to all medical referral cases including MNCH. In some cases where transport is difficult, women spend the last few weeks of pregnancy at a waiting home near the referral hospital, so that emergency obstetric care is readily available. However, the availability of waiting homes has not been well documented and the effects have not been evaluated.

According to the TDHS, the Maternal Mortality Ratio (MMR) is slowly decreasing. The reported institutional maternal mortality rates remained stable over the last three years at around 160 per 100,000 live births (MOHSW MTR-AR 2013).

Across Tanzania, there are many initiatives and projects to support the reduction of the MMR by multilateral donors, bilateral donors, and international and national NGOs. The initiatives include facility construction, supply of equipment, transportation approaches, pre- and in-service training as well as sensitisation and community mobilisation. It was impossible for the MTR team to get a clear perspective of the initiatives and their effectiveness because of the large number and diversity of programmes. Such a large number of examples show that there is a lot of fragmentation, duplication and even resource wastage. The MOHSW is planning a mapping exercise to get oversight over the initiatives. This will enable identification of existing gaps in the implementation of priority interventions and the geographical coverage.

None of the MMR projects observed in the MTR had a comprehensive approach; they focus on single elements (e.g. care for premature babies, waiting homes). They had no strategy for the scale-up of evidence-based interventions across the continuum of care or of ensuring equitable distribution of such interventions. Reproductive health cannot be organised like a separate disease control programme,

which can function as a stand-alone service. For this reason maternal health indicators can only improve if general health services improve.

Postnatal Care

Postnatal care services are not well developed in Tanzania. Most women who deliver at a health facility are discharged home within 24 hours, without organised follow-up at home for the mother and the neonate. About 65% of women whose last live birth occurred in the five years preceding the 2010 TDHS did not receive a postnatal check-up, although 75% of neonatal deaths occurring during the first 24 hours (NBS 2011).

One study done in rural southern Tanzania revealed that the concept of postnatal care was not well understood by either the women or the health care providers (Mrisho et al. 2009). A new model of an integrated facility-/ community-based postnatal care is being tested in Morogoro Region to improve the health of mother and child, and already the training model is being scaled up though training in two other regions, to expand the lessons learnt.

Family Planning

In Tanzania, only 27% of currently married women use a modern method of family planning, and the unmet need for family planning stands at 25%. The injectable and the pill are the most commonly used methods. The use of modern family planning varies by residence and region: 34% of women in urban areas compared to 25% of women in rural areas use a modern method of family planning (MOHSW MTR-AR 2013). Also of concern is a large gap between the poorest and the wealthiest women in the use of contraception.

The contraceptive prevalence rate (CPR) by modern methods has gradually increased between 2005 and 2011 from 20 to 27%, but this is inadequate for achieving the "One Plan" target of 60% CPR by 2015. Over the last years the CPR is also staying steady. In public facilities there is still a lack of trained personnel to provide family planning services, and frequently stock-outs of medicines and supplies are recorded. Challenges include spousal refusal, clients' general misconception regarding family planning use, and provider poor attitudes towards clients, including refusing to counsel clients on some of the long-term methods such as the IUCD (intrauterine contraceptive device).

Moreover, in most areas family planning services are dependent on the support of national and international NGOs, which poses questions about sustainable development of those services after phasing out of the external funding. The MOHSW-RCH section in partnership with key development partners developed the National Family Planning Costed Implementation Program Strategy to bring the family planning programme up to speed. The programme aims to reposition family planning in the national agenda and as a key strategy to improve MNCH. The repositioning of family planning has also benefited from high-level political commitment by His Excellency President J. Kikwete. He committed the Government to achieve a 60% CPR by 2015. This will mean doubling the number of family planning users from the current 2.1 million to 4.2 million by 2015. However budgets for this activity have not yet increased.

Adolescents constitute 31% of the total population (NBS 2011). Sexual and reproductive health risks for the adolescents and young people include early marriages, underage pregnancies and unprotected sexual activities - exposing young women to the risk of STI/HIV, unintended pregnancies, unwanted childbearing and unsafe abortions. In Tanzania teenage pregnancy is high as, according to the TDHS 2010, 23% of women age 15-19 years are pregnant or already have children; this is a slight decrease from 26% in 2004/05. Teenage pregnancy and motherhood are more common amongst young women living in rural areas and those from poor families. Use of modern methods of family planning amongst young women age 15-24 is only 16% and varies according to rural 15% versus urban residence 20%.

Sixteen per cent of currently married young women age 15-19 and 24% of those age 20-25 has an unmet family planning need (MTR-AR 2013).

The MOHSW has developed an Adolescent Reproductive Health Strategy, and the standards for adolescent-friendly sexual and reproductive health services. However according to the SARA survey, even though 70% of facilities indicated they provide adolescent services, none had the relevant guidelines, and availability of staff trained on adolescent service provision was low ranging from 16% in lower-level facilities to 48% in hospitals. Only 30% of facilities providing family planning services for adolescents had staff trained to do so (SARA 2012). The 80% target of facilities with adolescent-friendly services is unlikely to be met.

Summary: Reproductive Health Services

Reproductive health services are not performing well. The general ANC services will not achieve the HSSP III targets, although the disease control activities during ANC such as PMTCT and ITN distribution appear to be doing well.

Overall, the delivery care targets of the HSSP III will not be met, despite all additional resources put into improved delivery care. Expansion of service delivery has not improved quality of services. Maternal hospital mortality is not reducing.

In postnatal care dearly needed initiatives for improvement, based on the postnatal care guideline, are not yet implemented countrywide.

Family planning targets are not met, but with new commitments improvements may be expected. Adolescent reproductive healthcare is slowly improving, but still far from meeting the demands.

Reproductive health services receive a lot of extra funds, but due to the highly fragmented approach, the comprehensive improvements needed to make the system work are not achieved.

3.4.2 Child Health Services

Neonatal Health Care

Neonatal mortality covers deaths in the first month after birth. The major causes of neonatal deaths generally differ from those of under-fives. In Tanzania, 80% of child deaths occur at home, and 60% of these without prior contact with any health facility. The main causes of newborn mortality in Tanzania are infections (29%), asphyxia (27%) and prematurity (23%) (MOHSW and STC 2009).

Whilst significant progress has been made to reduce child mortality in Tanzania, the neonatal mortality rate remains high at 26 per 1,000 live births, and accounts for slightly over half of the infant mortality rate and a third of child mortality.

Currently few facilities have the necessary essential neonatal equipment available for offering services (21% had a neonatal bag and mask and 35% had a suction apparatus) (SARA 2012). The target of the One Plan is to increase the proportion of health facilities offering essential newborn care to 75%.

Exclusive Breastfeeding

The percentage of children age less than six months who are exclusively breastfed in Tanzania doubled from 23% to almost 50% in 2010. Approximately 94% of infants were breastfed within 24 hours after birth (NBS 2011).

Child Mortality

Child survival continued to improve throughout the period 2000-2011 and appears to be on track to meet the MDG target in 2015. As a result of the basic health services extension policy and massive expansion of immunisation embedded in the IMCI programme, the health status of children in Tanzania has improved considerably as shown by the drop in the infant mortality rate from 162 per 1000 live births in the 1960s to the current 51 per 1000 in 2010. The main causes of child mortality in the country are malaria, pneumonia, diarrhoea and HIV/AIDS.

Vaccinations

Tanzania's immunisation coverage rates are amongst the highest in the sub-Saharan Africa region. Coverage of child immunisation in Tanzania is high with more than 90% of children receiving pentavalent and measles vaccines. Access to services is good, with three-quarters of health facilities offering child immunisation services. According to a facility survey conducted in 2012, over 90% of facilities had key supplies such as vaccines and needles in stock at the time of the survey (MOHSW MTR-AR2013). However the MTR field visits in all the six districts visited in three regions identified vaccine stock-outs of more than four months, especially BCG.

Tanzania introduced two new vaccines into its immunisation schedule in January 2013 - pneumococcal and rotavirus vaccines, which help prevent pneumonia and diarrhoea, respectively. These two diseases are the main causes of death of children under 5, so the vaccines represent another huge step to promote child survival.

Nutrition

The prevalence of anaemia in children under 5 dropped by 18% between 2005 and 2010, from 72% to 59% (NBS 2011). Tanzania has put in place a number of interventions to address anaemia in children. These include deworming of children age 2 to 5 years every six months and promotion of use of ITNs by children under 5.

Every six months children age 6 to 59 months are targeted for Vitamin A supplements. Vitamin A supplementation was integrated with de-worming program a few years after the latter's inception, which helped to improve its coverage[2]. Other measures to improve the nutrition status of children include food fortification targeting children age 6 to 23 months and children age 6 to 59 months as well as pregnant and lactating women.

Child anthropometric indicators are improving but at a slow rate. The greatest improvement is observed in the proportion of children who are underweight (below minus 2 standard deviations of the global standard). According to the 2005 WHO reference, the prevalence of underweight has decreased from 25% in 1991 to 16% in 2010 (NBS 2011). Therefore the country is in a good position to reach the 2015 target of 12.5% for underweight.

In terms of chronic malnutrition, Tanzania is one of the 10 worst-affected countries in the world with 42% of children age less than five years being stunted. It is estimated that in 2014 more than 3,000,000 children will be affected by stunting. Children in Tanzania are at risk of malnutrition because of repeated episodes of ill health (malaria, diarrhoea, pneumonia and other illnesses) and inadequate infant and young child feeding practices. Other underlying causes include inadequate health care for women and children, insufficient health services and an unhygienic environment. The proportion of children who are stunted declined slower than the proportion of underweight. Over a 10-year period, prevalence of stunting declined from 48% to 42%. Children in rural areas were more likely to be stunted (45%) than those in

[2] Vitamin A coverage is much higher than reported in the MTR-AR. The figure stands at 90% according to recent programme information.

urban areas (32%) (NBS 2011). Disparities were also noted across regions. Children of mothers with at least secondary education had the lowest stunting levels (22%); in children of mothers with no education or only with an incomplete primary education, stunting levels were 40% and 49% respectively. Stunting also varied by wealth strata; the lowest household wealth quintile had a stunting level of 48% compared to a 26% stunting level amongst children from the highest wealth quintile (NBS 2011).

In terms of acute malnutrition, the prevalence of global acute malnutrition has decreased from 8% in 1991 to 3.5% in 2005. However in 2010, the level has increased to 5%, including 1.3% of severe acute malnutrition forms. The expected caseload in 2014 is more than 220,000 severely acute malnourished children and more than 380,000 moderately acute malnourished children.

Malaria Prevention and Treatment

Malaria is a leading cause of child illness, but mortality and morbidity rates in the Tanzania mainland have declined during the first half of the HSSP III period (MOHSW 2013). ITN use increased dramatically: three-quarters of children and pregnant women used ITNs in 2012, and use is close to the 2015 target (MOHSW MTR-AR 2013). The large increase in ITN coverage can be attributed to health programmes, which now target the whole population and also focusing on pregnant women and under-5 children through a subsidised voucher system for ITNs.

The use of ACT in children with fever increased from 24% in 2008 to 33% in 2011 (TACAIDS 2013), whilst ACT availability in clinics remained at 80% (SARA 2012). The availability of malaria Rapid Diagnostic Tests in health facilities more than doubled, from 30% in 2008 to 75% in 2011 (MOHSW MTR-AR 2013).

School Health

The School Health Policy Guidelines and Strategic Plan are currently under review by the MOHSW and Ministry of Education and Vocational Training. The existing health education curriculum was integrated into the school curricula. Teachers provide health education as part of regular subjects; they also deliver school first aid, and provide deworming drugs and health guidance. Pupils are screened for vaccination (BCG and TTV), for their anthropometric measurements (age, weight) and for diseases. There is also a programme to promote school hygiene and sanitation, which covers many schools, in targeted regions. In the Community Perspectives Study lack of school hygiene and sanitation were important concerns for the girls consulted.

Summary: Child Health

Most child health programmes are performing well, with the exception of neonatal care, which is a serious concern, given the high neonatal mortality in the country. The limited progress in reducing neonatal mortality hampers progress to overall reduction of infant mortality.

Vaccination services are well on track in achieving the HSSP III goals. There is good progress in malaria control and school health programmes are picking up.

There is a gradual improvement of the nutrition status of children in Tanzania, but not all HSSP III targets will be met. Stunting remains a problem and exclusive breastfeeding need to be improved.

3.5 Social Welfare Services

3.5.1 Social Welfare Strategic Plan

The Social Welfare Strategic Plan 2007-2010 has been finalised, but is not yet officially approved by the Cabinet (MOHSW 2008e). This plan advocates rights-based, community-based developments, which are mostly visible in work supported by partner agencies and organisations. There is now a second National Costed Plan of Action, which is a strong example of good-quality policies, strategies and plans that have been developed at the central level (MOHSW 2012e). But it is also indicative of the gap which can exist between the central level and district/ward levels, and between policy and possibilities for mainstream practice; in addition, few staff at the district level are aware of the plan.

HSSP III Objectives

Social Welfare Services

1. Operationalise the Social Welfare Strategic Plan (2008)
2. Integrate social welfare and health offices at regional and council levels
3. Ensure gender-sensitive socio-economic well-being and establish an efficient system for delivery of social welfare services
4. Improve social protection in the community

With a budget for Social Welfare of only 1% of the HSSP III total budget, and even less in some districts, the MOHSW is very dependent on external funding and on support from NGOs to put modern social welfare approaches into operation. Social welfare carried out by the ministry itself, therefore, remains largely focused on traditional case-work and institutional care.

3.5.2 Integration of Social Welfare and Health Offices

Steps have been undertaken to integrate the offices of Social Welfare and Health. In the establishment of RHMTs there is now a position for a Social Welfare Officer (SWO) and there is now an SWO in around half of the country's districts. The number of SWOs increased from 210 in 2009 to around 400 at the time of the MRT. However, this number is still far from the target of 3,892 officers needed. Despite the increase in SWOs, there is heavy reliance on para-professionals, such as community volunteers, community justice facilitators and community development officers. It is unrealistic to expect proper quality control in these circumstances. At local levels SWOs are not core members of the CHMT and may be unable to ensure that social welfare issues are properly integrated into CCHPs: the actual budgets are very low. M&E is minimal in social welfare and development of the evidence base is piecemeal. No part of the MOHSW is making much effort to communicate successes to the general public. This means that opportunities to get the public "on-side" are not being optimised.

3.5.3 Social Welfare Service Delivery

The approach to vulnerability, taken in HSSP III, is to develop interventions aimed at meeting the needs of specific vulnerable groups (e.g., Most Vulnerable Children (MVC), People Living with HIV, PLWD, the elderly, families in conflict). There are advantages and disadvantages to this approach. Using the "vulnerable groups" approach can enable targeting, but it also misses the complex and dynamic nature of vulnerability and misses opportunities to work in a rights-based and holistic way to reduce vulnerability and increase health and well-being (see Social Welfare technical report). In addition, the identification of vulnerable people, who need support, is not adequate. Support to vulnerable people, especially those who are poorest and most vulnerable, is therefore low.

There is a gap between the standards, guidelines and protocols for service delivery, and what external agencies actually understand and use at local levels. There are three reasons for this: it is not yet possible for the DSW to have full oversight and control over the work of external agencies (international and national); some agencies may have different levels of knowledge and understanding of the guidelines; and SWOs do not all yet have the experience or expertise to supervise all work which may be undertaken by external agencies in their areas. At present, a functioning accreditation system cannot be put into operation because there are no resources, at any level, to do so.

There are some excellent model programmes being undertaken, especially in relation to MVC. However, there are four major issues:

1. There are many small- and medium-scale interventions, by NGOs, FBOs and other CSOs, which appear to show promise for positive change and reduction of vulnerability. There is no guarantee, as yet, that successes will be properly evaluated, or sustainable.
2. The DSW has developed strong partnerships with a number of agencies working with vulnerable groups (e.g. UNICEF, ADD, Sight-Savers, PACT) but it does not have the finances or other resources to roll out approaches modelled by external organisations. Therefore the MOHSW is almost entirely dependent on external funding to progress towards greater equity, gender equity, and high-quality services to improve the socio-economic well-being of vulnerable people in Tanzania.
3. Presently, district, ward and village levels do not give enough focus to social welfare and equity issues. Vulnerability and social welfare are not well understood by people on the various representative decision-making committees; women are poorly represented, and young people and PLWD have hardly any representation at all.
4. Some aspects of vulnerability such as female genital mutilation/circumcision and early childhood marriages - which affect significant numbers of girls and women - are ignored or inadequately addressed.

The Community Led Total Sanitation programme is making achievements and improving sanitation for sections of the rural population. This is important, because it is the poorest and most marginalised people who are most vulnerable to environmental health threats (poor shelter, sanitation etc.).

3.5.4 Social Protection in the Community

In some districts exemption and waiver schemes for vulnerable people in health services are properly implemented, but in general many people cannot get access to free services. In some areas traditional community-based solidarity schemes are operational and cater to people in need. The Community Health Fund (CHF) insurance scheme is not working well enough to encourage large numbers of poorer people to join (national average 7.5%). Information on the CHF at health facilities is not adequate. The Community Perspectives Study found that, in general, women claim to have little or no knowledge of the CHF.

Visits carried out under the MTR and the Community Perspectives Study showed that many citizens (men, women, girls, boys, highly vulnerable people etc.) are dissatisfied with exemption systems because of out-of-pocket costs (payment for nursing care, drugs, equipment, gate costs, transport etc.). The poorest and most vulnerable people currently "slip through the net": they may not be identified as vulnerable, or they may feel socially unable to access services.

Summary: Social Welfare

The DSW plays a marginal role in the MOHSW. Provision of modern, developmental and rights-based social welfare services is almost entirely dependent on work carried out by external agencies (multi-laterals, bi-laterals, NGOs, FBOs etc.) The Government of Tanzania also provides social protection services through other ministries and through Tanzania social Action Fund. In general, social welfare programmes, dealing with different vulnerable groups are unable to reach the whole country. There are no mechanisms, as yet, through which to institutionalise and embed successful model programmes. Whilst steps for increasing human resources and integrating the DSW into the MOHSW are being made, the relationship between the health and social welfare services is still undefined. In general social welfare interventions are off-track. This is largely because of the lack of resources and capacities within the DSW. Social welfare indicators in HSSPIII are unlikely to be met in full. Social welfare interventions cannot currently contribute optimally to cross-cutting goals for fulfilment of rights, equity, gender balance and community ownership.

4. Health System Support

4.1 Performance Indicators of the Health System

Table 3 summarises the findings of HSSP III performance indicators (MOHSW MTR-AR 2013). Not all information is up to the year 2012, especially not when it concerns community-based information, extracted from surveys. Where more recent information was available, the MTR team provides that information in the sections below.

Table 3. Health system performance indicators (MOHSW MTR-AR 2013)

HSSP III indicators

	Overall progress	Achievement	Target 2015	Equity	Compare (rank)
HEALTH SYSTEMS					
Government expenditure on health (%)		7.3% (2011)	15%		
Total health expenditure per capita		$37			
Insurance coverage (CHF / TIKA)		3% (2010)	80%		
Health worker density: doctors & AMO		0.9 / 10,000	-		
Health worker density: nurse - midwives		4.9 / 10,000	-		
Health worker density: pharmacists		0.12 / 10,000	-		
Outpatient visits per capita / year		0.73 per person	-		
Training institutes with full accreditation		56	30		
Stockouts of tracer meds & vaccine					

4.2 Human Resources for Health

The health sector began implementing HSSP III amidst severe understaffing. Addressing the HRH challenge was imperative during the implementation of HSSP III, and guided by the HRH Strategic Plan 2008-2013. Actions were planned not only to increase the supply of human resources but also in deployment, recruitment and retention of health workers.

The HRH profile for 2012 recorded a total of 64,449 health workers in the health sector. This corresponds to 52% of the need, using 1999 staffing norms, or 36% of the need, using the new (draft) staffing norms (MOHSW 2013f). However a major constraint is still the inclusion of HRH in the private sector. For example although the statistics show that the number of pharmacists is declining, the actual number is increasing due to higher outputs

HSSP III Objectives

HRH Strategies

1. Develop policies and regulations on human resources for health and social welfare, coherent with government policies
2. Strengthen HRH planning
3. Maximise effective utilisation of HRH
4. Increase production and improve quality of training (pre-service, in-service and continuous education) with support of Zonal Health Resource Centres (ZHRCs)
5. Improve use of HRH applied research for planning and advocacy.

from universities. Most pharmacists find employment in private pharmacies and are not captured in human resource plans or statistics. Registers of the Medical Council or the Pharmacy Council may also produce different numbers of professionals than official statistics.

Table 4. HRH per population in Tanzania: 2008 compared to 2012

HRH Cadre	2008	2012
Medical Officer (MO)	0.3	0.5
Assistant Medical Officer (AMO)	0.4	0.4
AMO and MO together	0.7	0.9
Nurse/Midwife	2.6	4.8
Pharmacist/pharmacy technician	0.15	0.13

Health worker per 10,000 population. Sources 2008 HMIS, 2012 HRHIS

4.2.1 HRH Policies, Strategies and Regulations

There have been notable achievements in the formulation of human resource policy, strategies and regulations. However enforcement of regulations such as the Open Performance Review and Appraisal System (OPRAS) (BMAF 2011) has been weak. The major implementation constraints are discussed below.

4.2.2 HRH Planning

One of the major activities over the last years was improving information about HRH. The MOHSW established a Human Resources for Health Information System (HRHIS) and a Training Institutions Information System (TIIS). The HRHIS was found to have flaws, which are being addressed. At the same time, PMO-RALG engaged in developing human resource information systems (HRIS) that run in parallel (HRIS, TIIS under MOHSW and HRIS under PMO-RALG-DED).

According to the HRH Public Expenditure Review (PER) of 2010, the HRH gap (24%) identified at the district level by LGAs, differs drastically with that put forward by the MOHSW (60%) and the 37% gap found in the 11 LGAs reached in a survey (MOHSW 2011h). As this shows, up to now, HRH data from different sources are not consistent, using similar data definitions, but different data collection and recording methods. Lack of reliable information makes good human resource planning impossible.

Human resource plans are available in those districts where Human Resource Focal Persons are well established in their posts and where they have been trained in HRIS use. They need to update the automated system frequently based on staff movements, using personnel files. The MTR team found human resource plans in all districts in two of the three regions visited.

4.2.3 HRH Utilisation

Various actors have HRH responsibilities. POPSM oversees staff establishment, schemes of service and promotions and the issuing of approvals of vacancies against which postings are based. LGAs and Ministries, Departments and Agencies (MDAs) are responsible for lodging requests with POPSM for staff to fill their local needs. LGAs also recruit posted staff who report for duty. The MOHSW has been assigned the role of posting staff in accordance with POPSM-approved vacancies. The Ministry of Finance and Economic Affairs (MOFEA) allocates funds for salaries as per approved vacancies and activates the salaries through the employees' data captured using the Lawson computerised system. Problems experienced in this complex system result in limited absorption of newly trained health workers, even though shortages exist.

Observations from various studies indicate that health workers are not attracted to work in rural areas in Tanzania (Petit-Mshana 2011). Even if recruited, a significant proportion of HRH professionals posted by the MOHSW to LGAs do not report to their stations. The MTR-AR 2013 shows an inequitable distribution of health staff disadvantaging rural areas, which cannot be explained by location of referral and tertiary hospitals alone.

Factors that influence attraction and stay behaviour include provision of housing and other essential items. The MTR field visits found that after recruitment, most staff do not get job orientations and induction to internalise their roles, tasks and responsibilities. The lack of this essential priming input leaves staff disoriented in their initial employment as they learn haphazardly on the job about their work environment, linkages with other staff and expected performance or outputs.

Variations in performance and attitudes are not only influenced by salary and incentives, but also by factors such as availability of medicines, supplies, allowances, supportive supervision, leadership and mentoring, continuing education and isolation of the duty station. Several studies indicate an alarmingly low level of staff productivity (Manzi 2012). The potential to enhance performance through application of the OPRAS has been insufficiently realised. Limited utilisation of the OPRAS led to violation of objectives, scope and intent of the Public Service Pay and Incentive Policy (POPSM 2010).

In the context of the HRH strategy, activities are undertaken to improve retention of staff. The Benjamin Mpaka AIDS Foundation (BMAF) is building staff houses in many rural areas; district councils provide settling-in or duty allowances and non-financial incentives (e.g. transport). Training and upgrading is another way to keep staff motivated. However, Petit-Mshana et al. concluded in their comprehensive analysis in 2011 that there is no comprehensive evidence-based retention programme in the health sector. Retention is too much dependent on local opportunities and challenges.

Human resource management is a rare skill in the health sector. Only Health Secretaries get human resource management in their training and get support from the District Human Resources Officer, who is responsible for all staff in the district. Also it was observed in the MTR that District Medical Officers are not trained in human resource management except in tailor-made in-service courses. As such human resource management practices at district level tend to be limited and practiced poorly.

4.2.4 HRH Production

In 2011, there were 134 training institutions of which half were government; 68 institutions were nursing and midwifery training schools. There are eight medical schools, two government, four not-for-profit and two for-profit. By 2012 56 of the 134 training institutions had been fully accredited by the National Council for Technical Education (NACTE). In addition, 14 had received a provisional license. There has been an increase of enrolment of students in professional training programmes for health from 3,025 in the year 2007 to 7,458 in 2011/12. This is to get adequate numbers of health workers for MMAM requirements. The output of training institutions in 2012 was high for doctors and non-physician clinicians. In 2012 830 physicians graduated, which is 37% of the total number of physicians working in 2012. If these medical doctors could be absorbed by the system, the medical doctor densities would increase very rapidly in Tanzania. For other cadres the output of training institutions is more in proportion to the numbers currently employed. For AMOs, Clinical Officers and nurses/midwives the output of training institutions was 13%, 9% and 12% respectively of the numbers working.

With regard to the institutional arrangements, there is a big difference between private training institutions and government training institutions. The private institutions have their own staffing, budget and finances. They select their own candidates, determine their own fees etc. Government institutions are highly dependent on MOHSW headquarters. Staff are directly under the ministry. The MOHSW determines the budget and the subventions, selects candidates and determines the cost-sharing fees for students. This may lead to big differences in quality of training.

There are various providers for Continuing Education and Professional Development (CEPD) in the country with varied levels of competences. There is lack of standards for CEPD. CEPD is still mainly the domain of vertical programmes, with varying levels of professionalism. Most CEPD programmes are one-off for limited numbers of health workers. Also there are no systems in place to accredit those providing CEPD. According to the HSSP III, the ZHRCs were to play a crucial role in CEPD. However there are gaps in the ability of ZHRCs to realise their roles. There is no link between the MOHSW through the ZHRC with regions and districts in the areas of training and human resource development. There is no mechanism to coordinate quality training in pre-service and in-service in the zones. Strengthen district and regional capacity through CEPD is on an ah-hoc basis. There is no supportive supervision conducted at health training institutions in the ZHRC. There is no established human resource and trainer's inventory. There are no established Health Resource Centres (Libraries) in training institutions and health facilities and no established and strengthened information and communication technology (ICT) to improve the quality of training.

Re-licensing is not normally practiced and where practiced, academic updating is not a requirement. The system of life-long learning and quality assurance of health staff is not yet in place in Tanzania.

4.2.5 HRH Research

Petit-Mshana et al. in 2011 identified 168 documents covering research into HRH in Tanzania, on topics such as planning, production, management, staff attitudes and competencies. The MTR team found at least 20 additional documents published in the last two years. The considerable research produced various recommendations, few of which have been implemented due to lack of mechanisms to do so. Petit-Mshana et al. proposed that future research should include multi-factorial human resource projection studies using models. Studies designed with the explicit intention of scaling up effective interventions should give serious attention to earmarking sufficient funds, time, personnel, policy advocacy and strategies for influencing change.

Summary: HRH

Human resources planning is improving at the district level and is strengthened by a functional HRIS and TIIS. There are still challenges to harmonise and link with other HRIS, especially the ones used by LGAs.

Bottlenecks and bureaucracy in human resource management still, exist, leading to limited absorptive capacity of the system. Leadership, coordination and partnership challenges exist at various levels. Equitable distribution is still not realised, disadvantaging rural areas. Poor HRH management affects the productivity of staff and the quality of services.

The supply of health workers has increased overall, but the cadre mix is unbalanced. The quality of training is not yet consistent, but it is improving with increasing accreditation by NACTE. Also the production is not always in line with other development plans, such as the MMAM. CEPD is still the domain of vertical programmes, with limited continuity and impact on the health system as a whole.

HRH issues are addressed in many research programmes and studies and well documented, but there should be more focus on effects of scaling up.

4.3 Pharmaceuticals and Supplies

4.3.1 Access to Medicines and Medical Supplies

HSSP III focuses on the enabling environment, pre-conditions and critical inputs required to ensure that pharmaceutical supplies are available in public and private sectors in all parts of the country.

In 2009 the National Medicines Policy was revised and the related implementation plan was drafted (MOHSW 2013c, MOSHW 2013d). The revised draft is currently awaiting MOHSW approval and submission to the Cabinet.

The pooled budget (Government of Tanzania and HBF) for essential medicines and medical supplies mainly held in health facility accounts at the Medical Stores Department (MSD) increased by 62% (in monetary terms) during the period under review. However in real terms the budget only increased marginally from US$0.80 per capita in 2009/10 to US$0.84 per capita in 2011/12 (adjusted for inflation, exchange rate and population growth) (PIFS TWG 2012). The share of the government contribution to the pooled fund decreased from 2009 to 2012 with a slight nominal increase in the present budget. (See figure 4.)

HSSP III Objectives

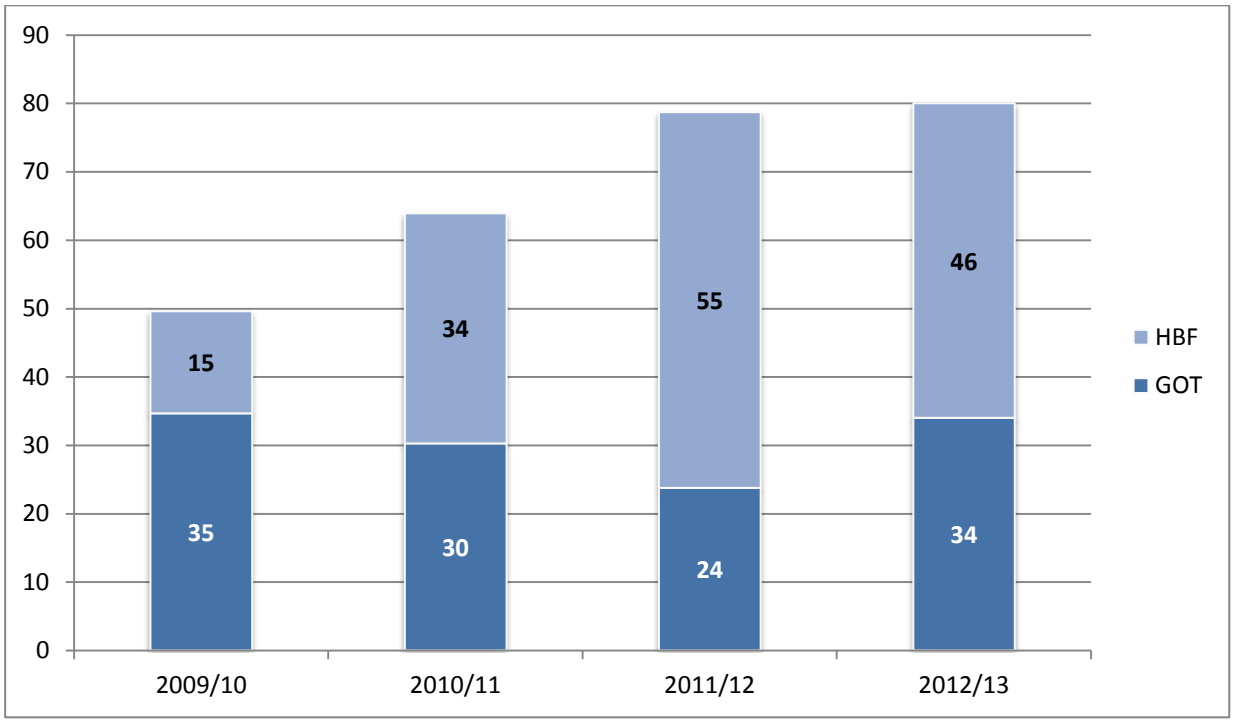
Pharmaceuticals Strategies

1. Ensure accessibility at all levels to safe, efficacious pharmaceuticals, medical supplies and equipment
2. Strengthen control of quality, safety and efficacy of pharmaceuticals, medical supplies, medical equipment
3. Ensure gender sensitive, equitable availability and rational use of quality pharmaceuticals, medical supplies and equipment in health facilities
4. Enhance harmonisation and coordination and information management of procurement, stocking and distribution of medicines and supplies for specific health programmes.

In addition to the pooled budget, around US$5 per capita per year is made available primarily from global health initiatives for procurement of HIV/AIDS, malaria and TB supplies, as well as new vaccines; USAID, DfID and AusAid support procurement of family planning commodities. For HIV/AIDS and malaria treatments and tests alone a value of US$2 per capita per year was established for 2011/12 (MOHSW 2013g).

Budgetary shortfalls are exacerbated by disbursement practices (e.g. less than approved budget is disbursed by Treasury to the MOHSW; irregular disbursements; long lead times for disbursed funds to be credited to health facility accounts at MSD), as noted in JAHSR meetings and recent assessments (Printz et al. 2013, Innovex 2011, PIFS TWG 2012). Measures to address this problem have not yet produced the expected results. MSD's limited cash flow and working capital negatively affects the provision of medicines.

Figure 4. Composition of pooled fund for essential medicines (in TSH billion)



Updated from PIFS TWG 2012

More positively the resource allocation formula to apportion the essential medicines budget to primary health facilities was revised in 2011 and does now take into account the health facility workload. It is expected that this will lead to a decrease of the range of either over- or underspent health facility budgets. An assessment of efficiency and equity gains has not yet been performed.

In 2002 the MOHSW launched the Accredited Drug Dispensing Outlet (ADDO) Programme to increase access to affordable quality medicines in the private sector in rural areas. There has been good progress in terms of the HSSP III expected result, i.e. the number of ADDOs increased from 2,215 in 2010 to 3,591 in 2013 (White et al. 2013 and Pharmacy Council). However national- and council-level stakeholders interviewed concur that there are challenges with sustaining quality of services and products provided by ADDOs. Infractions include illegal selling of non-authorised, stolen or poor quality medicines. Regulatory and supervision capacity at the council level seems to be insufficient. One study found that medicines are sold at high prices and expansion of ADDOs in rural areas is limited (SHOPS 2012).

Whilst some ADDOs are accredited as providers under the National Health Insurance Fund (NHIF), CHF benefits are not extended to ADDOs, which is a disincentive for prospective owners to establish ADDOs in rural areas.

4.3.2 Quality, Safety and Efficacy

The Tanzania Food and Drug Authority (TFDA) is mandated to ensure quality, safety and efficacy of medical products marketed in Tanzania. TFDA was able to increase the annual number of medicine samples to be tested (from 340 to 675 between 2010 and 2012), as well as the number of samples actually processed in its WHO pre-qualified quality control laboratory (from 52% to 96% between 2010 and 2012) (TFDA 2013). TFDA has also established mobile testing kits at 15 regional hospital sites,

which allows testing of medicines procured by the hospitals from MSD and other sources. TFDA has published guidelines for pharmaco-vigilance; forms for reporting adverse drug reactions are available for download at the TFDA website and were distributed to health facilities. There is collaboration with the MOHSW Pharmaceutical Services Section (PSS) to support decentralised pharmaco-vigilance activities.

A recent Tanzania Private Sector Assessment documented views that not all medicines available for sale in the private sector are of guaranteed quality and often do not have TFDA approval (White et al. 2013). Recognising market monitoring as a weak area, TFDA has included post-marketing surveillance and related staff training as priorities in the current strategic plan (TFDA 2012).

4.3.3 Equitable Availability and Rational Use of Medicines in Health Facilities

Availability of medicines is a crucial issue for the MOHSW, partners and the population more broadly. During the MTR field visits the issue came up time and again, e.g. in relation to readiness of people to join the CHF, with in the strongest expression: "no medicines, no CHF". It also was the main concern in the Community Perspectives Study. Availability of medicines has been the subject of various studies, surveys and routine HMIS as shown in table 5.

Table 5. Medicines Availability - Various Sources

Indicator	Indicator Value	Data Source
Availability at day of visit all facilities (21 items, mean)	37%	SARA 2008/09
Availability at day of visit all health facilities (14 items, mean)	41%	SARA 2012
Availability at day of visit public sector facilities (14 items, mean)	37% (range 2-100%)	SARA 2012
Availability at day of visit private sector (14 items, mean)	55% (range 7-100%)	SARA 2012
Availability throughout reporting month (10 items, mean)	<8: 9 districts >8: 8 districts	SPD 09-11/2011 (17 districts)
Facilities with no stock-out of 10 tracer medicine in reporting month	28.6% (range between districts: 5.8 to 54.1%)	DHIS2 05/2012 (1 region)

Whilst the data presented in the table above are not necessarily comparable (different sample sizes, different number and type of tracer medicines, different methodologies) the overall picture shows that there is no clear indication of improvement of medicines availability during the review period. This is also supported by more recent preliminary analysis of data from the District Health Information System (DHIS 2) software (see MTR pharmaceutical report). The SARA 2012 survey also established that medicines are more available in urban areas than in rural ones, and more in the private sector than in the public one. In addition, it was shown that generic medicines for the treatment of NCDs are rarely available (SARA 2012). A previous study showed that district factors (stock management, procurement) more frequently cause shortages than do zonal factors (availability at MSD zonal stores) (Chimnani et al. 2010). Apart from actual shortages of medicines, the MTR found that the community perception is that medicines are often not available, and that patients are frequently referred to private pharmacies to buy medicines.

Performance issues arising throughout the supply chain from central-level procurement down to health facility-level inventory management affect medicines availability. This has been comprehensively documented in two recent studies (Innovex 2011, Printz et al. 2013); for more detail see the MTR technical report on pharmaceuticals.

Appropriate medicines use by health workers and the community is a precondition for quality health care provision. During the period under review Medicines and Therapeutics Committee (MTC) guidelines were developed (MOHSW 2012h), training conducted and MTCs re-established at public sector hospitals. The National Medicines and Therapeutics Committee was re-established, and the Standard Treatment Guidelines and National Essential Medicines List from 2007 revised (MOHSW 2013b). Challenges reported during field visits are that district-level MTC meetings are not held regularly and tend to focus on medicines procurement rather than on improving the use of medicines or monitoring adverse drug reactions. In health facilities no treatment guidelines could be found during the MTR.

4.3.4 Harmonisation, Coordination and Information Management

Procurement of medicines through parallel systems using donor funds poses a management challenge to MSD, because information is not always provided on time and items can overlap, with the consequence of overstocks and expiry. SOPs that are agreed and adhered to by all partners have not yet been developed, but the activity will be included in the Strategic Plan 2014-2016 for MSD (currently being drafted).

The main Logistics Management Information System (LMIS) in use is the paper-based Integrated Logistics System, which does not provide easily accessible information at council, PSS or MSD level, and which health workers struggle to use properly. The MOHSW and partners are currently developing the eLMIS. Logistics Management Units will be established with representation at MSD zonal stores to facilitate data processing and support pharmaceutical inventory management at health facilities.

Summary: Pharmaceuticals

Funding of medical supplies is not improving in real per capita terms and disbursement issues continue to affect the efficient use of limited funds.

The overall finding of the MTR is that availability of key medicines remains low and that no clear trend for improvement can be established yet. This negatively affects quality of care and performance of service provision in general. Guidelines for improving the use of medicines are available but a lot remains to be done so that these will be institutionalised and applied in practice.

On the positive site, better procurement and (information) management procedures are under development, with the potential to increase efficiency, reduce wastage, and improve availability of medicines to the population.

4.4 Capital Investment

4.4.1 Health Infrastructure Network

Expansion of the Health Infrastructure

HSSP III is guided by the MMAM 2007-2017, accelerating the provision of primary health care services, including construction and rehabilitation of infrastructure. The aim of the MMAM was to complete the construction activities of new facilities by 2012 (table 6).

HSSP III Objectives

Capital Investment Objectives

1. Expand the health infrastructure network based on the MMAM
2. Maintain and improve the existing health infrastructure, equipment and means of transport to meet the demands for service delivery

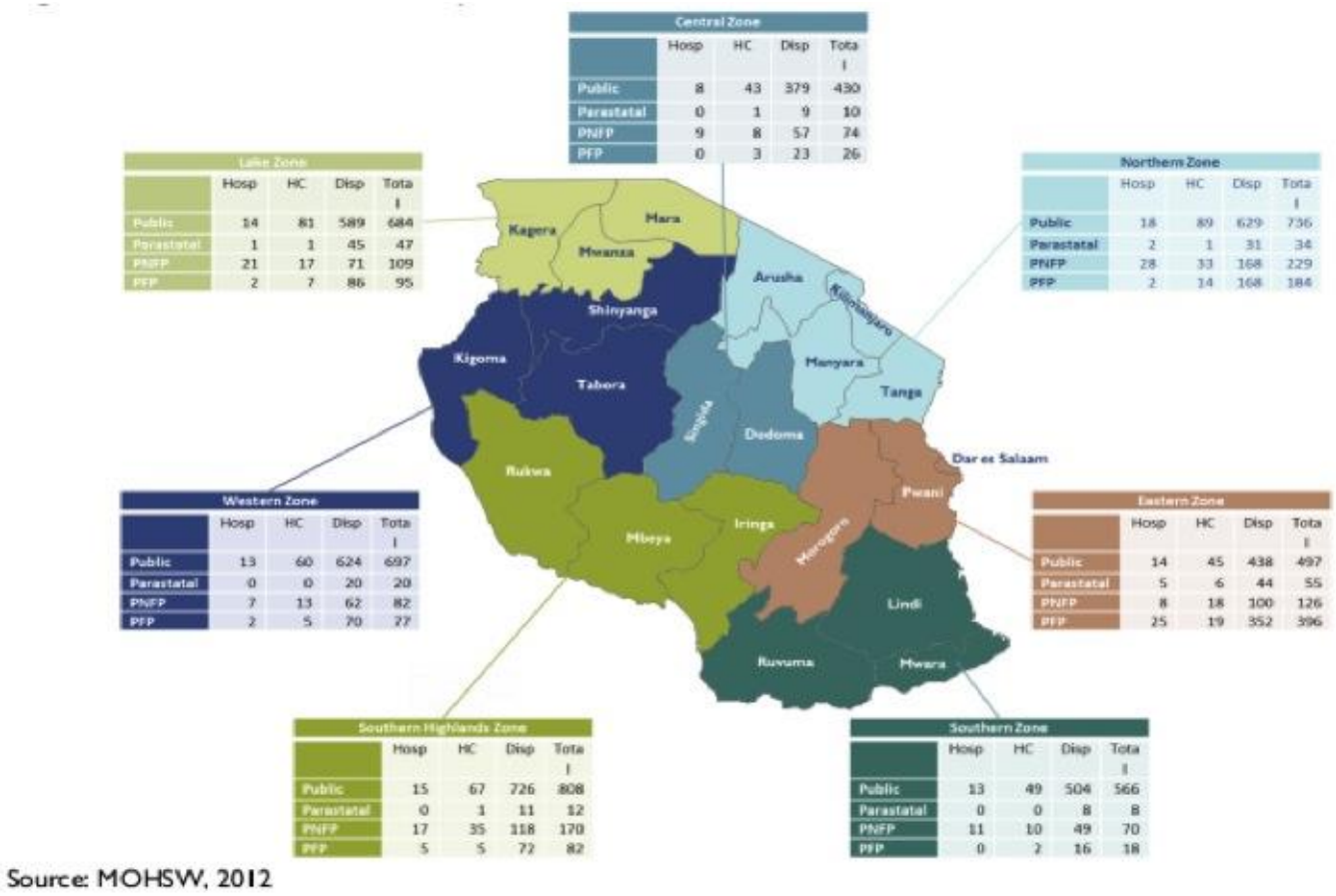
Table 6. Increase in number of health facilities 2005-2012

	Baseline 2005	Achievement 2012	MMAM target
Dispensaries	4,679	5,776	7,767
Health centres	481	694	2,074
Hospitals	219	264	238
Mat. waiting homes	No data	No data	95
Total	5,379	6,734	10,174

Source: MOHSW performance profiles

Since the start of the emphasis was on expanding the number of dispensaries in rural areas. In total, 66.4% of the Tanzanian population lives within 5 kilometres of a health facility, ranging from 25% in Kagera Region to 100% in Dar es Salaam (PMO-RALG-PlanRep 2012). In terms of per capita coverage, there are major differences in the country, ranging from 1.1 health facility per 10,000 people in Kagera Region to 2.7 per 10,000 people in Lindi Region. Figure 5 below gives specifications per Zone. Overall, between 2009 and 2012 there has been no significant increase in per capita coverage, stable at 1.5 health facility per 10,000 people (MOHSW MTR-AR 2013). The population growth keeps pace with the expansion of facilities.

Figure 5. Health facilities in Tanzania in 2010



Source: MOHSW, 2012

In Dar es Salaam over 70% of the health facilities are private (for-profit) institutions, whilst in Lindi the percentage is less than 5%. The number of private (for-profit and not-for-profit) health facilities is not expanding at the same pace as government facilities. Therefore the percentage of health facilities owned by the private (for-profit and not-for-profit) sector declined from 32.8% in 2005 to 27.4% in 2012.

In fact the number of structures is larger than those shown in table 6, as there is a number of non-functional health facilities, such as those newly built, but not opened due to staff shortages, or closed due to collapse of structures or unavailability of staff houses. This number may be as high as 500 (public and private) facilities, according to the HMIS unit of the MOHSW.

The MMAM not only aims at construction of new facilities, but also at improvement of existing ones: 250 dispensaries, 120 health centres and 54 district hospitals should be rehabilitated. In 2,555 health centres and 62 district hospitals CEmOC should be strengthened. A total of 128 training institutions should also be rehabilitated, built or upgraded. Figures regarding rehabilitation, refurbishment or expansion of facilities over the last three years are not available. The percentage of facilities with RCH services increased from 70% in 2007 to 80% in 2012. Delivery services could be provided in 70% of facilities in 2012, compared to 60% in 2007 (SARA 2012).

Unfortunately, no comprehensive national-level information is available with regard to the status of infrastructure, patient privacy, availability of electricity, water supply, toilets and staff houses. The SARA survey of 2012 found major shortcomings, especially in dispensaries, where less than 25% are fully up to

standard. The National Bureau of Statistics plans an inventory to get a better understanding of the status of the health infrastructure in the country.

Financing Expansion of the Health Infrastructure

Construction and rehabilitation projects are financed through the Local Government Development Grant, bilateral projects or loans (e.g. African Development Bank (AfDB) or Global Fund) and international NGOs or community initiatives. The AfDB grant was US$36 million and the Global Fund grant US$50 million.

The Local Government Development Grant has a core Capital Development Grant, of which LGAs spent around 12% on health infrastructure and a Health Sector Development Grant (HSDG), to which government and donors contributed (KfW and Danida). The HSDG budget for 2009-2012 was 68.3 billion TZS. Of the HSDG budget around 55% went to construction, 35% to rehabilitation and 10% to equipment, furniture and other expenses. A review last year estimated that in a period of five years approximately 3,000 projects were realised through the HSDG (DEGE 2012).

Often construction projects in rural areas face challenges with delayed disbursements, problems of recruiting quality contractors, delayed construction activities etc. All programmes of the AfDB, Global Fund and HSDG report these delays. The 2012 review found that often facilities could not be immediately opened after construction due to lack of staff, partly caused by lack of staff houses (DEGE 2012).

In the context of efforts to reduce maternal mortality, several development partners provide support (sometimes through contracted NGOs) for the construction of labour wards and theatres or the supply of equipment. The MTR team was shown various examples that this takes place in a highly uncoordinated way (e.g. construction of theatres without equipment, or ill-fitting or inadequate equipment). At times donated equipment does not meet required standards; distribution and installation is not budgeted. This puts an extra burden on the capacity of the MOHSW, trying to ensure effective use of the donations.

4.4.2 Maintenance

The system of preventive maintenance of buildings, medical equipment and means of transport is in an early stage of achieving the HSSP III targets, although the National Health Care Technology Policy Guideline was already formulated in 2002 (MOHSW 2002). Guidelines for maintenance of medical equipment have been developed. There are five zonal workshops which service the country for maintenance of medical equipment. However district hospitals and health facilities make limited use of those services due to prohibitive costs, e.g. of spare parts. The SARA survey of 2012 showed that around 30% of health facilities face problems with equipment, which affects service provision. There is a problem of availability of spare parts for donated medical equipment that does not comply with Tanzanian standards.

A new training course for the cadre of biomedical technicians started two years ago. They could be posted in 2014 to districts for maintaining equipment. CHMTs are being sensitised to incorporate budgets for maintenance in their CCHPs.

In Dodoma Region a pilot for decentralised equipment maintenance is being carried out, which should build a business case for cost-effective preventive maintenance. The pilot is testing public-private partnerships (PPPs), whereby private companies are contracted for maintenance.

According to the 2012 Health Sector Performance Profile there are 1,110 motor vehicles in the regions; 20% are not functioning. There also are 1,183 motorcycles, 14% of which are not functioning. The statistics do not mention whether these means of transport are permanently grounded, nor do they

provide information on the type and state of the functioning vehicles. During the field visits, lack of working vehicles was often mentioned as reason for not performing outreach, or not providing transport for referral.

Summary: Capital Investment

The health sector infrastructure in Tanzania is expanding, although the MMAM targets for 2012 have not been met. So far, construction has exceeded the deployment of staff, leading to underutilisation of the infrastructure. The majority of health facilities is not yet up to quality standards as regards building and equipment.

Maintenance of equipment is not yet making an impact on effective service delivery, although from next year new cadres may contribute to institutionalising maintenance at the district level.

4.5 M&E System

4.5.1 Comprehensive M&E Strategy

The Monitoring and Evaluation Strengthening Initiative (MESI) work programme is, in effect, an M&E Strategy (MESI 2011). MESI is a five-year strengthening program being implemented by a consortium of funding and implementing partners to enhance evidence-based decision-making in the Tanzanian health sector. It considers information needs in the whole sector, and of all programmes, although further work is required to ensure those needs are met. Work has also started within MESI to clarify roles and responsibilities for Health Sector Monitoring, and on developing a harmonised set of indicators, data elements and data sources, but further work is needed. A Data Dissemination and Use Strategy is currently in development. There is a work package within MESI looking at surveillance, surveys and research, which aims to improve some areas of health research, but it does not appear that a comprehensive plan for research has yet been produced. National Health Research Priorities for 2013-2018 (NIMR 2013) have been produced, but work is still needed to take this forward to facilitate improved surveys, linkages to other data sources and use of results in practice.

HSSP III Objectives

M&E Strategies

1. Develop a comprehensive M&E and Research Strategy for the health and social welfare sector
2. Strengthen integrated systems for disease surveillance
3. Strengthen integrated routine HMIS
4. Introduce data aggregation and sharing systems based on ICT
5. Enhance surveys and operational research

ICT Objectives

1. Produce ICT strategy to make use of technology
2. Expand countrywide information network at national, regional and district level

4.5.2 Strengthen Integrated Systems for Disease Surveillance

There has been some progress in improving disease surveillance through the MESI work package on surveillance, surveys and research, but little progress so far on integrating systems for disease surveillance. As mentioned before, quality of the surveillance system is affected by poor registration of diseases at the grassroot level especially when no sufficiently qualified staff is involved.

Currently, the vital registration system is not functioning properly: complete national information on births and mortality is not available. A pilot has started in Mbeya to use child health programmes for birth registration.

A community-based data collection and reporting system has been set up, which generates health facility and population-based information from 27 nationally representative districts (IHI 2011b). The information available from this initiative can project mortality trends at the area-specific level and national level, as well as provide understanding of drivers of mortality. It will be important to ensure that this information is made available and used.

4.5.3 Strengthen Integrated Routine HMIS

In the past five years extensive work has been done to update the HMIS (MTUHA) tools, including registers, tally sheets and summary forms, to meet the needs of all stakeholders, and to manage a harmonised set of indicators that monitors key health programs, systems and policies at all levels. The DHIS2 software has been in use in the test region since the start of the M&E Strengthening Initiative. HMIS officers in the councils and the regional offices are able to work with DHIS2. DHIS2 is presently being rolled out. Many users in the councils can use the pre-defined reports and some can create custom reports.

Implementation of the revised HMIS is almost complete, and reporting requirements for the MKUKUTA, PMO-RALG and MOHSW have been considered as part of this revision. However the systems still operate in parallel, leading to duplication of efforts. Further work is needed to ensure that the revised HMIS delivers the expected results stated in HSSP III, in particular facilitating the integration of related systems, and facilitating the availability of integrated technical and financial progress reports from LGAs.

Use of information at the grassroot level for planning and decision-making is still limited. The culture around the HMIS is still producing figures for the higher levels. Some work has started on improving capacity for data collection, analysis and use across the sector as part of the MESI work package on in-service and pre-service training, but more work is required in this very important area.

There is no progress so far on ensuring that participation in HMIS becomes part of accreditation of health facilities. When criteria for accreditation are being considered, this requirement will need to be specified in more detail.

4.5.4 Introduce Data Aggregation and Sharing Systems Based on ICT

A data warehouse has been set up at the MOHSW to hold the information that is being submitted from the revised HMIS. However this is only a first step towards the expected results for this objective, which refers to data warehouses being established at the district, regional and national level, sharing information from LGAs (PlanRep), HMIS, disease programmes and other sources.

The development of data warehouses has not yet been linked to capacity development for data extraction and use, and therefore very few people are able to use the information available.

4.5.5 Enhance Surveys and Operational Research

NIMR in collaboration with other stakeholders has recently updated the national priorities for research (NIMR 2013). Some work has been carried out on enhancing surveys within the MESI work package on surveys, surveillance and research - in particular via the Sentinel Surveillance System. However there has been limited progress so far with the other expected results for this objective, as there is no annual research implementation plan, or collaboration between programmes leading to one joint research programme. Research is carried out by universities and institutes and often guided by availability of resources and international collaboration. There is also no research data availability within a data warehouse, although it is understood that two of the main health research institutions in Tanzania, NIMR and IHI, have current initiatives to make research results more available. Availability of publications and reports on research is improving through Internet libraries. The Tanzania National Health Research (TANHER) Forum is offering a platform for coordination and joint ventures in research.

4.5.6 Produce ICT Strategy

The e-Government Strategy for Tanzania (Sept 2012), states that the Government is committed to implementing e-Government across the country, but notes that "more effort and more innovation" are needed to provide value-added e-Government services. It mentions as health priorities: introducing ICT-supported access to health and nutrition services, reducing the prevalence of HIV/AIDS and other infectious and communicable diseases and managing proactive health care systems for preventive and curative services (URT 2012).

At the time of the MTR there was no ICT Strategy for the health sector, although an e-Health Strategy is expected to include a move towards an integrated e-health infrastructure and enterprise architecture, and it is expected that m-Health initiatives will form part of the e-Health Strategy. The e-Health Strategy was launched on 30 September 2013.

4.5.7 Information Network at National, Regional and District Level

An important step towards achieving the Government of Tanzania's ICT vision is the constructing of the National Fibre Optic Cable network (the National ICT Broadband Backbone). Telecommunications are rapidly improving in Tanzania. Technical barriers for communication are quickly removed, although remote rural areas will still see limited access to the Internet for years to come.

There have been recent improvements in the national information technology network, and an important part of the e-Health Strategy will be to ensure that this is built to expand the countrywide information network for the health sector.

Government is committed to extend the network to the periphery. An Information and Communication Technology Unit is included within the new organisational structure of the Regional Office of PMO-RALG (POPSM 2011).

There are many initiatives in Tanzania in the area of e-health and m-health, often in collaboration with international partners, e.g. in the area of logistics management, diseases information systems, distance learning and community participation. It is a challenge for the MOHSW to keep abreast of these developments and guide interoperability, quality standards and sustainable systems development.

Summary: M&E

There is a viable strategy for developing M&E into the health sector in Tanzania. Innovative disease surveillance and sentinel information systems are under development with a potential to get in-depth knowledge on health issues.

The HMIS is developing well and when integrated into planning and decision-making processes, it can become the backbone for evidence-based management and accountability and thus play a role in performance management systems.

The culture and capacities for a data-for-decision-making approach are not yet in place at district and facility level.

Research is increasing and reports are better available. Feedback loops for evidence-based policy-making still need to be established.

The developments with regard to ICT are promising and have a potential to change the face of health service delivery, but still require huge investments and capacity building in the country.

5. Health Services Facilitation

5.1 Health Financing and Financial Management

5.1.1 Health Sector Budget

A key objective of HSSP III was to mobilise adequate resources and ensure the sustainability of resources for the health sector. To that end, government budget, donor funding, as well as household contributions were all targeted as sources of funding to reduce the budget gap.

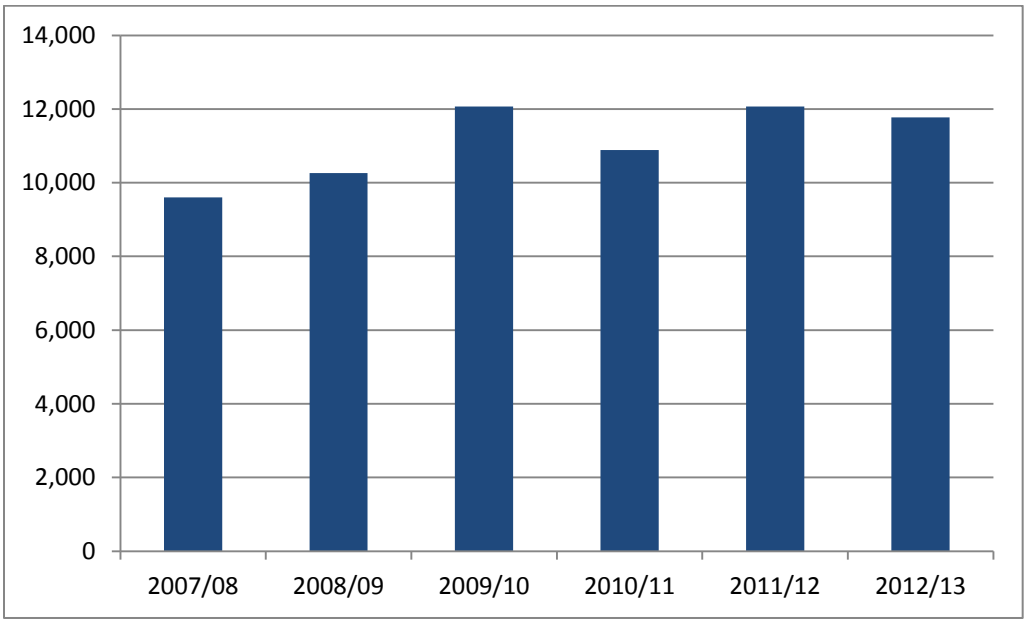
Although public sector expenditures for health are increasing in terms of total shillings allocated, they have remained flat on a real per capita basis.

HSSP III Objectives

Health Financing Strategies

1. Reduce the budget gap in the health sector by mobilising adequate and sustainable financial resources
2. Enhance complementary financing for provision of health services, increasing the share in the total health budget to 10% by 2015
3. Improve equity of access to health services
4. Improve management of complementary funds raised at the local level
5. Increase efficiency and effectiveness in use of financial resources

Figure 6. Per Capita Public Health Expenditure (2003 Tsh)



Provisional data from PER 2011/12. Data for 2012/13 are budgeted.

HSSP III targeted increased government expenditures for health, but government funding as a proportion of total public funding for health has been decreasing. As shown in Table 7, government funding as a share of total public funding was 66% in 2007/08, but decreased to 63% in 2009/10, and stands at 59%, based on the 2011/12 budget (MOHSW 2012g). Contrary to the goals of HSSP III, the public health budget has become increasingly reliant on foreign funds, which may not be sustainable.

Table 7. Sources of public health funding

	2007/08		2008/09		2009/10		2010/11		2011/12		2012/13	
	Actual	% of Total	Actual	% of Total	Actual	% of Total	Actual	% of Total	Actual	% of Total	Budget	% of Total
Govt Funds	378,114	66%	461,504	65%	578,793	63%	576,858	62%	710,096	67%	848,559	69%
Foreign Funds												
Donor basket	80,957	14%	85,401	12%	128,796	14%	126,822	14%	151,013	14%	159,647	13%
Non-basket	112,003	19%	154,168	22%	200,049	22%	213,979	23%	189,825	27%	226,373	18%
Tot Foreign Funds	192,960	33%	239,569	34%	328,845	36%	340,801	37%	340,839	32%	386,019	31%
Off-budget	5,696	1%	5,858	1%	10,784	1%	14,212	2%	10,414	0%	-	0%
GRAND TOTAL	576,770	100%	706,931	100%	918,422	100%	931,871	100%	1,061,349	100%	1,234,578	100%

Sources: Provisional data from PER 2011/12 and GOT budget.

HSSP III envisioned increasing government expenditures for health, targeting the Abuja goal of 15% of government expenditures dedicated to the health sector. Nonetheless government health expenditure data show that investments in the sector have stalled in the last several years. Table 8 shows that 13.1% of government spending (excl. Consolidated Fund Service) was allocated to health in 2009/10, but that only 10.4% of government budget was allocated to health in 2012/13. As a share of GDP, government health expenditures have declined from 3.0% in 2009/10 to 2.6% in 2012/13 (based on budget.)

Table 8. Health expenditure as share of total government expenditures

	2007/08 Actual	2008/09 Actual	2009/10 Actual	2010/11 Actual	2011/12 Actual	2012/13 Budget
Health spending as share of govt budget excl. CFS	12.3%	12.1%	13.1%	11.9%	12.1%	10.4%
Health spending as share of govt budget Incl. CFS	11.1%	10.8%	9.9%	9.5%	9.5%	8.5%
Health spending as% of GDP	2.52%	2.67%	3.03%	2.63%	2.80%	2.62%

Provisional data from PER 2011/12

Increasing basket funding is one of the targets of HSSP III. In the first three years, there were positive achievements, with the HBF increasing from US$82 million in 2009/10 to US$104 million in 2012/13. However, over the last two years, three donors representing approximately US$28 million (27%) of the total funding discontinued HBF contributions. In interviews these donors stated that the decision was not based on their assessment of performance of the health sector, but rather on general or domestic policies. As can be seen in table 9, the MOHSW will bear the brunt of the hardship of lower HBF contributions.

Chapter 8 on finances in HSSP III has a budget that distinguishes between resources required, resources available and the resource gap (MOHSW 2008a). The figures above show that not even the expected available resources were mobilised, let alone fill the resource gap. This has not resulted in reformulating priorities in HSSP III, or introducing a phased approach in the planning of activities.

Table 9. Allocation of HBFs

(billion Tsh)	2009/10	2010/11	2011/12	2012/13	2013/14
District	66.40	68.25	80.99	89.30	87.90
MSD	0.00	10.50	31.15	27.50	20.30
MOHSW	50.00	46.00	41.09	36.20	23.00
Region	4.20	4.20	4.20	4.20	3.80
PMO-RALG	0.79	0.69	0.69	0.69	0.62
Total	121.39	129.64	158.12	157.89	135.62

Health Financing Strategy

Development of a health financing strategy was envisioned as an early activity within HSSP III that would be used to guide financing policy, but a strategy has not yet been developed. In the last year, partners have restarted efforts to develop a comprehensive financing strategy. A road map was developed in early 2013, identifying clear outputs and responsible organisations. As part of the road map, partners have agreed to prepare nine policy papers that will feed into development of the strategy. Most informants are optimistic that there is now sufficient commitment and interest to ensure that a draft financing strategy will be prepared by the end of 2013.

5.1.2 Increase Complementary Funding to 10% of Total Financing

HSSP III identified measures for the achievements in the increase complementary funding: increased enrolment in the NIHF, CHF and Urban-CHF (TIKA) schemes; community participation in management of the CHF; institutionalisation of the functional health insurance regulatory body; development of Social Health Insurance; and number of private facilities contracted for services.

The NHIF and CHF together cover 5,867,140 beneficiaries, which is approximately 13.6% of the total population in the mainland. The NHIF, CHF and Social Health Insurance Benefit programme contributed only 2.2% of funding at the LGA level (MOHSW 2012g).

Whilst there has been significant growth in enrolment in NHIF and contributions, the proportion of total NHIF income paid out as benefits stands at only 33%. Government health facilities claim relatively little from the NHIF, which is building up considerable reserves. At the moment, about 10% (about 50,000 individuals) of total National Social Security Fund members have registered with the Social Health Insurance Benefit programme. This insurance option is heavily underutilised. CHF coverage has remained low over time (now officially 8.9%) with enrolment far below the HSSP III enrolment target of 30% of the population (Bultman and Mushi 2013). In some cases, local donors boost participation in the CHF by buying cards for the poor (IHI 2012a).

During the MTR field visits it appeared that most people do not consider the CHF benefit package to provide value for money. Frequent non-availability of medicines is indicated as a major obstacle for enrolling in CHF. A series of measures over the last year has made access to the funds more difficult and has undermined community ownership of the CHF.

At this moment several studies are being implemented to assess the viability of health insurance, as part of the development of a health financing strategy.

5.1.3 Improve Equity of Access

The HSSP III envisioned equity in health care financing and delivery as a cross-cutting theme. The proportion of identified poor and vulnerable enrolled in insurance schemes was identified as the indicator in measuring progress in improving equity of access, however data on the proportions of poor enrolled in CHF were not available. From anecdotal evidence the MTR team knows that some districts or NGOs pay for enrolment of identified poor in CHF, or SWOs provide exemption letters. However, this is not countrywide or systematic.

Out-of-pocket payments constitute a sizeable share of total health care funding in Tanzania (Mtei 2012). According to the National Health Accounts 2010, the share of household contribution to total health expenditure increased from 25% in 2005/06 to 32% in 2009/10 (MOHSW 2010a). There is a serious equity concern as high out-of-pocket expenditures limit access to care for the poorest groups. Recent studies show that the implementation of exemption and waiver systems is widely ineffective and does not meet the objective of ensuring access to quality services for the needy poor (Crawford 2013a; Stoermer et al 2012).

5.1.4 Improved Management of Complementary Funds

HSSP III sought to ensure that funds from patient fees and the CHF were managed and used in ways to improve health services, relying on the percentage of facilities using fund management SOPs as an indicator of performance. There is no information with regard to this indicator. The NHIF has reports on the use of CHF funds, but more than half the expenditures are not categorised.

The PMO-RALG has instructed LGAs to reduce their number of bank accounts to six, and as a result most CHF accounts were closed, and CHF funds are now deposited into the District Executive Director (DED) Miscellaneous Account. Whereas previously Council Health Services Boards (CHSB), which included community representatives, were owners of the CHF bank account, they may no longer have a direct say in use of CHF funds now that it is under DED authority. Although there are reports that some councils have maintained their CHF accounts, and other councils where CHSBs approve expenditures prior to DED authorisation, guidance on the practical role of CHSBs and community members in management of CHF funds is unclear.

5.1.5 Increase Efficiency and Effectiveness of Funds

HSSP III aimed to increase the efficiency and effectiveness of limited funds within the health sector. The specific indicator of performance included in HSSP III for this strategic objective was percentage of MDAs and LGAs with clean National Audit Office (NAO) auditing report, with no reference to the specifics of the health sector. NAO audit reports of LGAs for the fiscal year ending June 2012 show improvements in audit results, with 78% of councils receiving unqualified or clean audits in 2011/12 (NAO 2013). Those audits were general, but included expenditure on health. This is good progress, but for assessing efficiency and effectiveness more information is needed, e.g. from value-for-money audits. A recent value-for-money audit of the LGDG Health Window found funds were generally used as intended, but it recorded critical issues around underfunding of projects and lack of budget for staff or equipment, undermining the effectiveness of these funds (DEGE 2012).

Delayed disbursement of funds came up in the MTR as a problem in many areas, be it government funds, HBFs, or MSD funds. This affects implementation of activities. MOHSW budget execution in 2010/11 was 70%, improving to 87% in 2011/12. It is unclear the extent to which the poor execution was caused by lower than budgeted disbursements, late disbursements that prevented implementation of planned activities by year's end or other reasons.

In fact the issue of efficient and effective use of funds is much wider than correct procedures in the financial department. It should address theft and pilferage of medicines and supplies, productivity of the work force and many other areas where better use of available resources is possible. Efficiency as a cross-cutting issue does not appear to be high on the agenda and is no topic within CCHPs or MTEF plans.

In 2008 the Government of Tanzania approved a Pay for Performance (P4P) strategy as a means to motivate staff and improve health service delivery. In 2011 the MOHSW initiated a pilot in Pwani region. The preliminary results from this pilot show that staff are more motivated and proactive in solving challenges (Mamdani et al. 2013; MOHSW 2013i). An assessment of P4P currently underway found general consensus throughout the country on the potential power of P4P to strengthen health services. Within the MOHSW, there appears to be broad commitment to some element of performance-based payments as a means to motivate staff and improve services.

Another area of inefficiency is the uncoordinated work of development partners in the country. As discussed in previous sections, the MTR team did see various examples of projects duplicating each other, working in isolation, not looking at sustainability beyond the project's lifetime, etc. Non-basket funding is increasing as share of the health sector budget, but it is not always contributing to achieving HSSP III objectives.

Summary: Health Financing

Despite growth in total health expenditure, the per capita expenditure corrected for inflation remains flat in the HSSP III period. The government share in health expenditure is decreasing. The health sector is increasingly dependent on donor funding, especially non-basket funding. Funding stays far behind the planned resources requirement in HSSP III (less than 50% of envisaged budget for 2013/2014) and is even less than the amount assumed to be certain income.

The health financing strategy is delayed, but may be developed in the near future.

Countrywide effective measures for removing financial barriers for the poorest and vulnerable are not in place, although locally actions are undertaken (often with support from NGOs or local donors).

Relying on NHIF, CHF and TIKA to increase financing has not proven successful. The goal of increasing complementary funding to 10% of health financing has not been achieved.

The role of CHSBs in overseeing the CHF accounts is not clear in all districts.

There has been progress under HSSP III in improving financial management as a route towards greater efficiency and effectiveness, but these measures have limited impact on service delivery. Performance management could be an option for improved efficiency. Disbursement problems and delays in financial flows affect service delivery. Aligning various types of resources from non-basket partners is still a challenge.

5.2 Governance

Governance is a political process that involves balancing competing influences and demands. It includes: maintaining the strategic direction of policy development and implementation; monitoring trends and developments; articulating the case for health in national development; regulating the behaviour of a wide range of actors, from health care financiers to health care providers; and establishing transparent and effective accountability mechanisms (WHO website).

In Tanzania Decentralisation by-Devolution (D-by-D) plays an important role in governance of the health sector. Where the MOHSW undoubtedly has the exclusive task of maintaining the policy development and articulating the case of health, it shares regulatory and accountability functions with other MDAs, especially with the PMO-RALG. Implementation of district health is the full responsibility of the LGA and implementation of health services in regional hospitals the responsibility of regional authorities (PMO-RALG 2007).

HSSP III Objectives

Central Support Headquarters

1. Enhance decentralisation of MOHSW headquarters
2. Strengthen governance in the MOHSW
3. Strengthen the operational planning process of MOHSW headquarters, and institutions and agencies under MOHSW
4. Institutionalise traditional and alternative health practice in the established health sector

PPP Strategies

1. Ensure conducive policy and legal environment for operationalisation of PPPs
2. Ensure effective operationalisation of PPPs
3. Enhance PPPs in the provision of health and nutrition services

SWAp Process

1. Organisational arrangements
2. Coordination of development partners

5.2.1 Central Support Headquarters

Governance in the MOHSW

In the MTR interviews many persons raised concerns about a long period of instability at the top management level in the MOHSW, with too many senior officials in acting positions. As a result of the recent appointments of the Permanent Secretary and the Chief Medical Officer in August 2013 this period has now come to an end, starting a new era of development in the MOHSW. Respondents in the review applaud the role of the Minister of Health and Social Welfare in enabling interministerial high-level collaboration by calling regular meetings of top officials from MDAs involved in health sector issues.

In general, roles and responsibilities in the MOHSW and its departments and agencies are clear and there are well-elaborated policy and strategy documents guiding the management of services (MOHSW 2003). The relations to other ministries, development partners and private sector and civil society are described in laws, regulations, agreements and other formal documents. However, the MOHSW is facing a human resources problem: not all civil servants have the necessary knowledge about policies and strategies (key documents are not available via intranet or library), and they have limited capacities to translate concepts into practical programmes and projects. Information is not always shared and collaboration between departments and agencies is not always optimal. This leads to a tension between espoused values and practice, e.g. in the relations with other ministries.

Operational Planning in the MOHSW

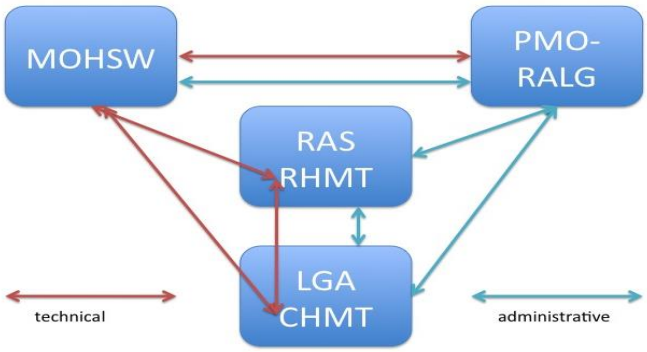
The Government has a well-established system of Medium-Term Expenditure Framework (MTEF) planning, reporting and accounting, which is applied in the MOHSW. It provides clear priorities and enables progress reporting against those priorities. Most of the agencies also have their annual work plans. However this planning and reporting is mainly handled administratively. There is no clear link in the MTEF plans to the HSSP III priorities and timeframes. Furthermore, the Strategic Plan for the MOHSW Headquarters 2012–2016, which should be guiding the annual planning, is still in preliminary draft form. Disease control and other health programmes have their work plans, often as part of collaboration with partners, e.g. the One Plan, HIV/AIDS or National Malaria Control Programme. The harmonisation of these plans as envisaged in the HSSP III has not yet been realised; the plans remain as stand-alone plans.

Operational planning – according to government policy – should be related to performance management. There is no evidence of a functional OPRAS system in the ministry, where performance is measured against plans.

Decentralisation

The HSSP III aims at decentralisation of MOHSW functions to PMO-RALG and the LGAs. Like in any decentralisation, there is a technical component and an administrative component in the relations between parties; similarly, there is a national component and a local component in the relations.

Figure 7. Technical and Administrative Relations in D-by-D in the Health Sector



As illustrated in figure 7, in principle, there are administrative and technical relations: the central-level MOHSW supports the regional level technically and RHMTs support the CHMTs; in administrative issues the PMO-RALG supports the Regional Administrative Secretaries, which in turn support the LGAs and the DED.

There are examples of excellent collaboration between the MOHSW headquarters, the PMO-RALG and LGAs, but also examples of duplication and unnecessary overlap, even of conflicting methods of working. The integration of planning and reporting systems is most challenging. PlanRep, EpiCor (LGA automated systems) and HMIS don't "talk" to each other. There are two parallel information systems for human resources. Few people in the MOHSW make use of PMO-RALG-processed information (e.g. PlanRep). The duplication creates inefficiency in the management of the health sector, e.g. in relation to the HBF. Recently, a new function was created in the PMO-RALG: deputy PS-Health, who leads the Health

Department. In the education sector having a high-level civil servant in the PMO-RALG was instrumental in improving coordination. Therefore the expectations are high in the health sector.

Not all CHMTs the MTR team met feel empowered to set priorities according to local needs or to take autonomous management decisions. Budget constraints, local interference and national directives reduce the effectiveness of decentralisation. HFGCs, CHSBs and the general public often hold the MOHSW responsible for delivering health services and have little understanding of the D-by-D principles. Community participation in management is very limited, as confirmed by the Community Perspectives Study and a recent study (Frumence 2013).

The plan to give the ZHRCs a place in capacity building, technical support and supervision has not materialised during the HSSP III period. These institutions do not have a legal status, and perform few functions other than training. This means the MOHSW officers reach out directly to 25 regions in the country.

5.2.2 PPPs

According to the HSSP III, PPPs can take a variety of forms with differing degrees of public and private sector responsibilities and risks. A number of key policy and guiding documents for the operationalisation of PPP were completed in 2009 including the MOHSW National PPP Policy (2009), the PPP Act (2010), PPP Regulations (2011), PPP Strategic Plan (2010–2015), Health and Social Welfare Sector PPP Policy Guideline (2012) and PPP Comprehensive Annual Operational Plan (2013/2014) (SHOPS 2013). Some experts interviewed argued that PPP activities in the Government of Tanzania are more geared towards productive sectors, e.g. joint ventures in the energy sector, than towards social sectors.

The PPP TWG offers the platform for joint action, in which private (for-profit) providers and FBOs collaborate with government ministries and development partners. The TWG has produced guidelines for the CHMTs to develop Service Agreements (SAs), as well as guidelines for inclusion of PPPs in CCHPs (MOHSW 2013a). The PPP TWG advocates for implementation of SAs, mobilising additional funds to support SAs for service delivery, developing a PPP databank at the MOHSW (for two zones initially) and supporting establishment of a regular Public Private Health Forum at the national level, as well as in 50% of all regions.

Most of the private providers, especially the small clinics and ADDOs, are not part of an umbrella organisation and are difficult to reach. There is a genuine complaint by private providers, that there is no level playing field in the health sector, as the registration requirements for the private sector are different from those of the government sector. There is underreporting by private providers in HMIS, who fear that this health information will be used for tax purposes. This underreporting leads to incorrect health sector performance figures for the city of Dar es Salaam (MTR-AR 2013).

As of now, there are 53 SAs signed between district councils and FBO district hospitals or FBO health centres (of the 99 FBO health institutions). In general, HBF funding is used for payment, but due to limited budgets, it is difficult to honour the SAs. There are no SAs with private (for-profit) providers, and – according to the PPP coordinator in the ministry – this is only possible when government is convinced that such contracts offer value for money. The MTR team concludes that there is still a high level of mistrust between government and the private for-profit sector in health.

However there are examples of informal public-private collaboration "under the radar", e.g. vaccination activities, where the CHMT provides vaccines and needles whilst private facilities provide labour. Public-private collaboration also exists in disease control programmes, e.g. the ITN voucher scheme or ART. There are also contracts for maintenance of vehicles or equipment, or cleaning of hospitals, which can be considered PPP.

As mentioned in the section on Capital Investment (section 4.4) the number of private health facilities is not growing as fast as the number of public facilities, although the MMAM envisaged that the private health sector would increase at the same pace. Private-for-profit facilities are still concentrated in urban areas and the FBOs are not expanding in view of reducing support from overseas.

Dar es Salaam is one of the fastest growing cities in Africa, with 4.3 million people (NBS census 2012), where 70% of the health facilities is private. About 50% of the Tanzanian population now lives in urban areas, with a steep increase due to economic growth. The contribution of the private sector to health service delivery will be more and more important in the HSSP IV period.

5.2.3 SWAp

The SWAp management mechanisms are clearly outlined, e.g. in the Code of Conduct, and agreed by stakeholders e.g. in documents such as the Memorandum of Understanding (MoU) or TORs (MOHSW 2007e). Under this HSSP III TWGs were initiated for each of the strategic areas, feeding into the Technical Committee-SWAp (TC-SWAp) meetings and the JAHSR with a technical arm and policy arm. A SWAp meeting is held twice per year; the JAHSR is the topic of one meeting. The HBF is steered by a Basket Finance Committee with representatives from government ministries and development partners.

TWGs

A TWG has been instituted for each of the strategic areas of the HSSP III and for some other important areas of work (e.g. pharmacy, health promotion). Some TWGs (e.g. MNCH) have sub-TWGs for specific areas of concern. The TWGs are chaired by a senior MOHSW official, sometimes a Deputy Director or programme coordinator. The Health Resources Secretariat is supposed to provide support to the TWGs. Some TWGs overlap with specific task groups, like the Steering Committee for the One Plan, or the Steering Committee of the Monitoring an Evaluation Strengthening Initiative. Similar topics are discussed in different forums.

The participation in the TWGs is open for representatives from ministries, from private sector and civil society, national and international NGOs and development partners. In general, there are no restrictions to participation. In practice participation fluctuates: some TWGs have a consistently high level of participation, whilst others may see at times only few members showing up. The participation of members from other ministries in general is low; PMO-RALG's contributions in particular are missed. At times some members use the TWGs as platform for advocating their own agendas, unrelated to HSSP III.

In principle the TWGs meet monthly, but in practice the frequency of meetings depends on the leadership and effectiveness of the chairperson. Well-functioning TWGs are able to set in motion coordination and joint work of stakeholders.

The TWGs are supposed to oversee over the implementation of the HSSP III strategies. In practice, this does not appear to be the case. As an illustration, none of the TWGs was aware of the process indicators in HSSP III (chapter 6) and none of them was monitoring progress against HSSP III targets.

There are two mechanisms designed for coordination of the various streams of work. First, TWG chairs should report on TWG discussions to their respective directors, who would take up relevant issues with MOHSW senior management. In practice it is difficult for the chairs to brief their directors regularly. Senior management in the ministry is not sufficiently kept up-to-date on the work of TWGs. The second mechanism is through the TC-SWAp, which meets regularly. In practice, that forum is too large and meetings too infrequent to have in-depth discussion on issues. With exceptions, most TWGs work on their own, exchange little information and have only indirect relations to decision-making at the top level in the ministry.

TC-SWAp and JAHSR

The framework of TC-SWAp, SWAp meetings and JAHSR (Technical and Policy Meetings) offers an excellent method for joint planning and monitoring of HSSP III. The reports and minutes show a very open and transparent process of critical analysis and frank discussions. In fact, most of the issues raised in this review can be found in the meeting reports of previous years. Dialogue is a strong feature in the Tanzanian SWAp process. Many respondents feel that the policy meeting of JAHSR is often a repetition of the previous technical meeting; in their view a smaller group (as per the TOR) should attend the policy meeting to do business, reach agreements and take decisions.

The process of formulating annual milestones in the JAHSR and assessing progress against the formulated indicators gives clear guidance. However the process of prioritisation of those milestones is not clearly linked to HSSP III topics. At times milestones are not met. Certain urgent issues (e.g. defining an essential health care package, or formulating a health financing strategy) are pushed forward year after year. The timing of the JAHSR is not harmonised with the MTEF planning, which makes it difficult to incorporate agreed actions in budgets.

TC-SWAP and JAHSR are not systematically monitoring the implementation of HSSP III; these meetings never discussed the process indicators for the strategies. Soon after initiating HSSP III it became clear that the resources would not be sufficient to implement all areas of the plan. However, there was never a discussion on reformulating the targets.

Health Basket Fund

The HBF in the health sector in Tanzania is well established with clear procedures and working arrangements, laid down in the MoU and the Annual Side Agreements (MOHSW 2008d). The MoU will expire in 2015.

Over recent years three development partners have withdrawn. For the first time, contributions to the basket decreased, and in US dollar terms, now are lower than in 2009, when HSSP III started. Given political developments in their home countries, development partners are not sure about the future: some consider moving to General Budget Support or to project support; others may reduce their contributions further. Development partners insist that withdrawal from the basket is not based on their assessment of the performance of the health sector.

Non-basket donor funding over the last two years has reached a level of more than twice the basket funding. Still, basket funding is crucial for districts as it provides important recourses of health programmes (development budget), whilst the major share of the government funds is tied to personal emoluments, amenities, etc. Unfortunately, disbursement of HBF funds also faces delays at times, which can affect service delivery. The reporting and accounting requirements for the HBF and related deadlines are agreed in the Side Agreement, which the MOHSW and PMO-RALG cannot always meet. Part of delays in disbursement is found in the late submission of the so-called trigger documents. In MTR interviews CHMTs expressed their concerns about delays, because their operations come to a stand-still when the HBF funds are not transferred in time.

DPG Health

The Development Partners Group for Health (DPG Health) is a collection of 17 bi-lateral and multi-lateral agencies supporting the health sector in Tanzania. DPG Health is organised based on TORs and the Code of Conduct and has a troika chairing structure (an incoming, present and outgoing chairing arrangement). This coordination mechanism reduces transaction costs for the MOHSW, although according to the MOHSW there are still many parallel processes of planning and reporting which could be streamlined further.

In general, development partners are satisfied with this mode of operation. The TWG structure allows development partners to interact with each other and ministry officials on many occasions and therefore enhances interaction and coordination.

Summary: Governance

Governance in the health sector in Tanzania is well documented, and guided by laws, regulations, MoUs, agreements, etc. Recent appointments of top officials in the MOHSW and PMO-RALG take away concerns raised during the MTR with regard to effective management. Management capacities of MOHSW and PMO-RALG civil servants at mid-management level are not always sufficient, resulting in inefficiencies.

In the health sector there is viable operational planning at all levels, with limited embedding in HSSP III and no relation to performance management.

D-by-D is progressing, but not always efficiently because of duplication of systems by the MOHSW and PMO-RALG. Decentralised priority setting and decision-making is hampered by resource constraints and interference.

The concepts of PPP have been properly developed, whilst at the grassroot level is implementation is slow.

With regard to the SWAp, the TWGs are an excellent mechanism for concerted action between all stakeholders, but coordination is limited. Communication between TWGs and senior management in the ministry does not always contribute to effective decision-making.

TC-SWAp and JAHSR are excellent instruments for collaboration between stakeholders. Procedures around formulation and follow-up of priorities are not always effective, with limited relation to HSSP III.

The HBF plays a crucial role in health care financing, whilst demands and capacities for timely accounting and reporting do not always match.

6. Analysis of the System Performance

6.1 Performance Indicators Results Framework Analytical Report

Table 10 puts performance indicators, discussed in previous sections, in the results framework (MOHSW MTR-AR 2013). Some of the indicators used in this framework are not part of the HSSP III set of indicators, but they help to create better oversight of the health sector performance in total.

Table 10. Tanzania Health Sector Performance Indicators Results Framework

Results framework and HSSP III indicators with progress

INPUTS	OUTPUTS	OUTCOMES (COVERAGE)	IMPACT
Government expenditure on health (%)	Stockouts of tracer meds & vaccine	Measles immunization coverage	Life expectancy (years)
Total health expenditure per capita		DTP-Hb 3 immunization coverage	Under-5, infant, neonatal mortality
		Vit A coverage (2 doses)	Child stunting rate
Health worker density: doctors (& other clinicians)	Outpatient visits per capita / year	TT2 immunization coverage	Child underweight rate
Health worker density: nurse - midwives		ANC first visit > 16 weeks	Maternal mortality ratio
Health worker density: pharmacists	Insurance coverage (CHF / TIKA)	ANC at least 4 visits	Total fertility rate
		Births in health facilities	Adolescent fertility rate
Training institutes with full accreditation	TB treatment success rate	Skilled birth attendance	HIV prevalence among young people
		Contraceptive prevalence rate	HIV prevalence, pregnant women (15-24)
		ITN use (children / pregnant women)	TB notification rate
		PMTCT coverage among pregnant women	Leprosy cases diagnosed and treated
		ART coverage	Cholera incidence rate
			Cholera case fatality rate
			Malaria prevalence in OPD
			Parasitemia prevalence (children)
Additional			
Expenditure by program	Service availability	TB case detection	Causes of death
	General Service readiness & quality	Risk behaviours for STI/HIV	Causes of morbidity
	Specific service readiness & quality	Risk behaviours for NCD	
		Postnatal care	Out of pocket expenditure
		Treatment of childhood illness	Catastrophic expenditure on health

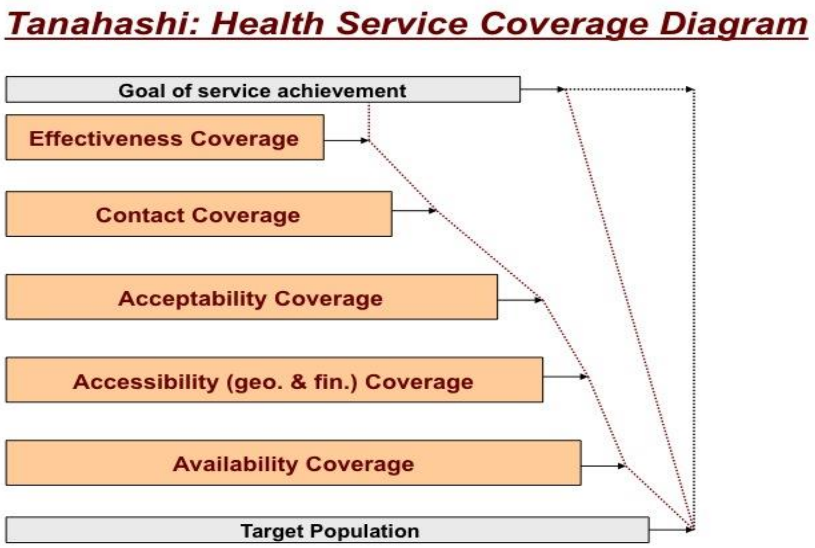
6.2 Analysis Using Assessment Criteria

The health system performance criteria mentioned in the MTR methodology include coverage, access, quality, efficiency, safety, equity, gender and sustainability.

Coverage and Access

The MRT team applies definitions formulated by Tanahashi for coverage and access. Coverage is the comparison between needs of the population and the services offered. Tanahashi distinguishes between various elements of coverage (see figure 8), which cover geographical, financial, cultural, logistical, HRH and quality factors.

Figure 8. Tanahashi Diagram



Source: Tanahashi T. Bulletin of the World Health Organization, 1978, 56 (2)

The first step in achieving health service coverage is increasing **availability** of health services. The MMAM programme is achieving increased availability of health services, although not at the pace foreseen in the plan. The expansion of the health infrastructure (physical availability of services) is mainly by construction of dispensaries in underserved areas.

More than 80% of the population does find the distance to the nearest health facility acceptable (TDHS 2010) and 66.4% of the population lives within 5 KM from a health facility (PMO-RALG PlanRep 2012). In general, **geographic accessibility** is increasing with construction of new facilities. However not all health facilities provide all basic health services. For example only 70% of the health facilities provide delivery care. The health system's referral system is weak, with limited options for patient transport and at times limited availability of referral services at the hospital level. At present geographic access is insufficient for many population groups, particularly those in rural areas.

In terms of **financial accessibility**, the MTR team found little progress has been made during the HSSP III period. Exemption and waiver systems are insufficient or not fully operational. The CHF does not seem to have to improved access to health services for the poor. Non-availability of medicines or supplies (e.g. delivery kits) may further increase financial hurdles for the poor: out-of-pocket payments by patients are rising. (Indirect costs, such as travel, food, lodging for relatives, and others, continue to contribute to patient specific health costs.)

On the positive side, services that are free and reach through to community level are highly accessible, such as vaccinations and ITNs leading to high coverage figures.

Acceptability is part of health services coverage, as it addresses the patient perspective of quality of services and contributes to health seeking behaviour. The Community Perspectives Study showed that many women do not accept maternal health services because of challenges related to both treatment (treated without respect, non-qualified staff, etc.) as well as the situation where patients must provide their own delivery supplies. Similarly, the MTR team was informed in the field visits that at times, people might not accept CHF membership when there is no guarantee for proper treatment of illnesses. Findings from the Community Perspectives Study suggest that citizens, especially poor citizens in urban and in rural areas, mistrust public health services and the staff who provide them.

The opinions that people voiced in interviews for the Community Perspectives Study explain low utilisation of reproductive health services, low OPD attendance and low participation in CHF, as shown in table 10. Other studies (Mselle 2013; Penfold 2013; Sikika 2012; Kruk 2009; Juma 2009) confirm the picture of the Community Perspectives Study: people's dissatisfaction with parts of the services, especially reproductive health services, unavailability of medicines and high out-of-pocket expenditure.

Contact coverage refers to quality of staff and addresses the question of right qualifications of staff. For example, a consultation or delivery by a nursing attendant may be documented as a service provided, but does not reflect the type of professional coverage that is expected (from both the system and client perspectives). An increase in qualified staff is contributing to improved contact coverage, although it is unequally distributed over the country. Remote rural areas face specific challenges, where qualified staff is less willing to accept rural postings.

Effectiveness coverage addresses all the other aspects of service provision. For example, once the patient is in the consultation room: does (s)he get the right diagnosis, the right treatment? Are diagnostic supplies and equipment available? Are medicines available? The 2012 SARA report presents a serious picture – showing that Tanzania's public health facilities have a service readiness of 39%, whilst private health facilities have a service readiness of 51% (combination of scores in all domains).

Furthermore aspects of adherence to guidelines, SOPs, rational drug prescription, etc. contribute to effectiveness coverage. At the peripheral level quality tools developed at the central level could not be found during the MTR field visits. Continuing professional development, supervision and coaching is not systematically implemented, and not all health workers have up-to-date levels of knowledge and skills.

Utilisation figures constitute a proxy for coverage. Utilisation of health services in Tanzania presents a mixed picture. On the negative side, general OPD attendance declined from 0.85 in 2009 to 0.69 per capita per year in 2012 (MOHSW MTR-AR 2013). When compared to other countries in the sub-Saharan region, this represents a low OPD attendance rate; most other countries have rates above 1.00. The HSSP III target of 0.80 is not met. The coverage of ANC, institutional deliveries, and postnatal care has remained relatively steady during the HSSP III implementation period, but not increased as planned. On the positive side, several disease-specific-related services such as PMTCT and TB, as well as basic immunisation programmes, show a high or even increasing coverage.

Quality

There are many aspects to quality: perceived quality, technical quality, human resource quality, pharmaceutical quality, quality systems, quality practices, etc. Together these aspects constitute and overall picture of quality.

Perceived quality has already been addressed under acceptability. The general public does not see quality in parts of the services, and this explains low attendance in the areas of reproductive health and OPD. Where perceived quality is high, there is good attendance.

With regard to **technical quality**, major steps have been made in systems development with the introduction of TQIF, the framework, the tools, the approach, etc. However the positive developments are only reaching the facility level if accompanied by intensive support, as shown in HIV, malaria and TB programmes. Years of investment in disease control programmes with financial resources, highly qualified staff and competent technical assistance, are now paying off in those programmes, and offer lessons to be learnt.

Quality is not only an issue in service delivery, but also in the support services. In the previous chapters **quality of human resources** development and management were mentioned. The increasing number of accredited training institutions is a positive sign, whilst the major concern is now on continuing professional development and professional standards.

With regard to **quality of medical supplies**, improvements are being made, with better quality control. However there are still loopholes, allowing poor-quality medicines to enter the private sector. This needs further attention.

With regard to **quality of the infrastructure**, newly built infrastructure is of reasonable quality, but there is not enough information at the national level to assess the overall quality of the infrastructure. Whilst there is now more attention to maintenance of infrastructure and equipment, this still has to reach the peripheral levels of the health system.

The **quality of M&E systems** is improving, with innovative methods of data collection and analysis. This has not yet translated into an information culture leading to evidence-based planning and decision-making.

Potentially, P4P approaches and accreditation systems could be instrumental in establishing a quality focus, as shown in evaluation of pilots in Tanzania. However these are still in an early stage of development.

The overall assessment of quality should be slightly positive: systems have been developed, and with more emphasis on sector-wide implementation, results can be achieved within the coming years.

Equity

The MTR Analytical Report assessed several health status and service delivery indicators with regard to equity: urban and rural, rich and poor, as well as region. Table 11 gives an overview. For most indicators the trend is between 2005 and 2010. Inequity in maternal mortality in health facilities is reported over 2012.

Table 11. Trends in equity of indicators (MOHSW MTR-AR 2013)

	Urban-rural	Rich-poor	Regional
Under-five mortality	Small, decreasing	Large, decreasing	Large, increasing
Stunting	Large, decreasing	Large, decreasing	Large, decreasing
Vaccinations	Small, stable	Small, stable	Small, stable
Skilled birth attendance	Large, stable	Large, stable	Large, stable
Family planning needs satisfied	Small decreasing	Large, stable	Large, stable
Maternal mortality in health facility			Large
HIV	Large, decreasing	Large, stable	Large, decreasing
ITN use	Small, decreasing	Small, decreasing	Small, decreasing

In general, inequity is decreasing for many indicators (although inequities in most indicators are still large). Only under-five mortality shows an increasing regional divide. In terms of financial access equity is not improving, as has been explained above. There is not sufficient attention in communities and amongst health workers for the concept of vulnerability. Life pathways may expose people to several types of vulnerability. Vulnerable people may encounter various negative social determinants of health and the health and social welfare services do not take these social determinants into account. In general terms social protection in the communities is weak, and principally dependent on charity organisations and NGOs.

Increasing information in many areas now offers the opportunity to identify weak spots, and places where inequity is high, whilst service provision is poor.

Gender

In general terms, gender in the health sector is understood as reproductive health for women, which is a very narrow approach. Involvement of men in reproductive health is limited. As mentioned above, under acceptability, the reproductive health services are poorly performing and are not well accepted by clients. Issues of privacy and confidentiality are not properly addressed in most health facilities.

Sexual and other types of gender-based violence are not high on the agenda in the health sector. The multiple linked vulnerability of women, such as higher levels of HIV infections amongst teenage girls, is hardly addressed. Although issues of female genital mutilation, rape and sexual abuse were recognised in HSSP III, they have not reached the mainstream of the health services. Addressing gender issues in health is mainly a concern for the (inter)national NGOs in the health sector.

Gender balance in CHSBs and HFGCs is often not observed, with men dominating the committees representing the population. Little attention being given to women's issues and concerns as shown in the Community Perspectives Study.

Efficiency

Efficiency is a major issue in the health services in Tanzania, as observed by the MTR team. In the previous sections examples have been given. Some of the most prominent issues are discussed below.

In general in health facilities, health worker productivity shows a mixed picture: in some situations health workers have little work (in terms of numbers of patients attended or services provided), whilst in other situations, health workers are overburdened. Distribution of health workers is not equitable and is usually not based on health system needs. Issues of service readiness can negatively influence staff efficiency as well.

Efficiency of continuing professional development is not sufficiently guaranteed in absence of accreditation of CEPD. Inefficient training results in wasting time of participants and other resources.

Another major efficiency issue concerns medical supplies, where many medicines expire in the health facilities, are not prescribed rationally or are stolen. According to small-scale experiments, most problems could be solved through efficiency measures such as better logistics management and rational drug prescription.

Efficiency problems also are created when the health infrastructure is expanded whilst no staff is available for those facilities.

Efficiency decreases through duplication of work, such as parallel information systems between the MOHSW and PMO-RALG, or NGOs or development partners engaging in similar types of activities without coordination (a feature seen in Maternal Health programmes). Not using the decentralised system and continuing central operations is highly inefficient.

In health financing the delays in disbursement, with long periods of non-availability of funds, constitute a major issue of inefficiency, with consequences directly impacting the availability of services at the district and facility levels.

The production of strategy documents, policies, guidelines and tools is a waste of resources if the documents and tools are not distributed and not used.

Given the limited resources, a clear focus on efficiency is of paramount importance in the remaining period of HSSP III.

Sustainability

Tanzania, like many other countries in sub-Saharan Africa, is heavily dependent on donor support to run the health sector. Where many countries show a positive trend of an increasing relative government contribution to the health sector, Tanzania is doing the opposite. Year-by-year the percentage of government funding to the health sector is declining (now less than 60% of total health financing). There is increasing donor dependency, whereby non-basket funding has become the major source of donor funding (now 27% of the total funding).

Funding for the health sector is far less than envisaged in HSSP III, in fact not quite half of the amount estimated. It is highly unlikely that in the remaining period a significant increase in the budget will be realised.

6.3 Impact of Health Services

Health Status

Overall, there is reason for optimism: little by little the health status of the population of Tanzania is improving. Many health indicators, such as life expectancy, child mortality and infant mortality, are improving. Tanzania's MDG targets may be achieved for such indicators. The MMR and neonatal mortality rate are modestly improving, but are unlikely to achieve the MDG targets.

There are of course remaining challenges. For example, acute malnutrition is decreasing, but stunting is not. The burden of malaria is on the decline, but not so the burden of TB and HIV/AIDS. Some tropical diseases are under control, but NCDs are on the rise, as is the number of road traffic accidents.

Improvement of the health status of the population depends on many factors outside the health sector, including economic development, education (especially of women), safe water, food security and road safety. It was outside of the scope of the MTR to consider the implications and/or relative contribution of each of those factors on changing health status. However the international literature documents that more than 75% of health is created outside the health sector. Health in all policies, whereby the MOHSW advocates interventions in other sectors with a positive impact on health, is a needed strategy to improve the health status of the population.

Responding to Needs

In many areas there is progress in addressing the needs of the population, especially in disease control programmes. However, vulnerable people are not sufficiently benefiting from the increasing service delivery. Remote rural areas are still disadvantaged compared to urban areas. Health issues of women are not adequately addressed, to cover their needs. Improving information in Tanzania now enables a targeted approach to address people's needs where they are highest.

7. Conclusions and Recommendations

7.1 Overall Conclusions

The health sector is making progress towards implementation of HSSP III. Positive developments can be noted in all strategic areas. Overall however the pace is slower than anticipated. Generally speaking, there has been more progress in systems development (policies, strategies, guidelines, work plans etc.) than in the implementation of service delivery. Innovations are only slowly trickling down to the grassroot-level facilities. Also in general, specific disease control programs seem to be performing better than are general and reproductive health services. Attendance rates for OPD and maternal health services show clearly that the population is not satisfied with the services, and findings of the Community Perspectives Study point in a similar direction. The sector is still not equipped to tackle gender and equity issues especially in rural areas.

From the MTR team's perspective, a main obstacle to realising the objectives of HSSP III is the lack of resources, specifically financial and human resources. Expected growth of funding for the health sector has not materialised and this is unlikely to change in the near term. Furthermore, increased production of human resources is only gradually allowing for increased and improved service delivery, because of limited capacity of the system to absorb newly trained staff.

Another constraint is limited harmonisation of health sector development partners, which means less than optimal efficiency in the use of available resources. However in the view of the MTR the management systems in place or under development could possibly result in a quick turnaround when applied in a coherent manner.

Reproductive health services also are a concern. This cannot be attributed to lack of resources alone. Many organisations and projects are active in the area. Reproductive health services can only improve if the total system improves, ranging from infrastructure that provides for patient privacy, to the availability of qualified and empathic staff, needed medicines and supplies, and functional transport vehicle. Every piece of the health system puzzle has to fit to make reproductive health services work. Therefore the MTR team recommends making the whole system work smoothly to achieve results in MNCH.

7.1.1 Recommendations for HSSP III Going Forward

The MTR team recommends the eight action points listed below for the remaining period of HSSP III (2013–2015). They call for two underlying features:

- Value for money: make optimal use of available resources, recognising that financial resources will not grow as planned when HSSP III was first developed;
- Transparency and accountability: show the results and engage the community in strengthening the health services.

Health sector potential must be transformed into service-quality improvements that the general public and other stakeholders perceive. Demonstrating the added value of health services should lead to enhanced service utilisation, improvements in poor-performing areas, and hopefully new investments in the health sector.

MTR Proposed Action Points

1. Embrace the opportunities of decentralisation

   The MTR team advises the MOHSW to work closely with the PMO-RALG and make health service delivery into a joint venture and share the successes of increased performance.

   Health is now represented at a high level of PMO-RALG management. Under D-by-D, responsibility for implementation of health policy lies with the PMO-RALG and LGAs. They should be incorporated in planning the implementation strategies and should share ownership of activities. Local priority setting and resource allocation should be stimulated. Also, the general public should be able to see that LGAs take the responsibility for providing public health services.

   The PMO-RALG and LGAs have viable planning, monitoring and accounting systems in place. They generate a lot of information that the MOHSW can use for planning and monitoring. Integrate HMIS, HRHIS and reporting systems and enhance local analysis and action.

   District and regional officials know the local constraints and opportunities, and should create partnerships at the local level with the private sector and with NGOs. The ministry can consider providing incentives for engaging in local partnerships as part of P4P.

2. Promote quality as a central theme of the health sector

   In the health sector, the TIQF offers a good basis for quality management and quality improvement efforts. Guidelines, SOPs, tools and instruments have been developed and can be implemented. At the same time, quality improvement tools and instruments are in place in disease control and RCH programmes, and they could be applied in other service areas as well. They should be disseminated throughout the country, using modern communication methods and involving ZHRCs, peer educators etc. Use the knowledge and experience of work of (inter)national NGOs in quality management. Demand from them full transparency. Create a clearinghouse where information is available and actively shared.

   The MOHSW is preparing a facility accreditation system, and other actors, like NHIF and PharmAccess have experience with accreditation. The ministry could out a **simplified accreditation** system in preparation for a full accreditation system and share the feedback with stakeholders at the district and facility level. Communities should be invited to participate in achieving the accreditation of local facilities and take ownership. It is necessary to bring the private sector on board by creating similar accreditation standards for all providers, and by ensuring independent assessment. Insurance schemes could adopt the accreditation as registration of the facility for reimbursement.

3. Manage health commodities and medicines more effectively

   Availability of medicines is in the view of the population the most important issue for ensuring the public's credibility in the health system. It can also be a major determinant in clients' willingness to participate in insurance schemes, as shown in the Community Perspectives Study.

   Tools are in place for **better logistical management** and experiences exist to reduce stock-outs or wastage. There is an opportunity for the countrywide implementation of those instruments. Existing reporting mechanisms (like text messages) could be scaled up so that health workers and the HFGCs can report stock-outs and resolve the problem immediately. Community monitoring of medicines provided exists (by HFGCs) but could be expanded, e.g. involving CSOs. Make use of alternative supply opportunities if MSD cannot deliver supplies.

4. Disburse funds on time

   To achieve results, it is necessary to improve **timely disbursement** of health sector funding to regional, district and facility levels (government and basket funds alike). Reduce bureaucratic requirements and/or conditions that prevent timely disbursement. The MTR team asks senior levels of the MOHSW to take responsibility and advocate removing barriers outside the health sector.

5. Go for tailor-made resource allocation

   Improved M&E systems, HRHIS systems, surveillance and other information systems make it possible to identify problems within the health sector; these include geographic discrepancies in attendance or resource allocation, where the disease burden and thus the workload are higher, which recently constructed facilities are not in use and which facilities have non-functioning equipment. MOHSW and PMO-RALG can strengthen data collection and utilisation at the district, regional and national level. The information can be used to **prioritise distribution of resources** (e.g. human resources, medicines, equipment) according to need. The ministry and DPs can investigate opportunities for improved equity-focused resource allocation.

   The LGA should encourage that persons posted to rural areas indeed can go and start working there, e.g. through salary advances, temporary top-ups or loans.

6. Increase community participation in health

   Tanzania's experiences in community health once inspired the global health community to adopt the Alma Ata Declaration. Existing and new experiences could help to create a new momentum for community involvement. Community-based instruments for identifying and supporting vulnerable persons exist in some areas. Community-based measures for improving equity can be applied. Experiences in different districts in Tanzania show that communities can create health in society. Partnership requires that responsibilities are shared and **accountability** to the **community** is applied.

   CHSBs and HFGCs should be given serious management responsibilities and should feel responsible for things like the CHF and utilisation of funds. Representation of women in those committees should be reinforced.

7. Institute performance management systems

   OPRAS should be adopted into wider practice in collaboration with MDAs responsible for human resources management. The Public Service Pay and Incentive Policy of 2010 could be operationalised in collaboration with other MDAs. Successful performance management experiences in one region should be scaled up to other regions. Incentives in **performance management** are broader than individual financial incentives and can be linked to accreditation. Community accountability and feedback from communities on service delivery should be incorporated into performance management systems, as has been shown in international experience of performance management programmes.

8. Focus on urban PPPs

   For improvement of urban health it is necessary to establish close collaboration with urban private providers.

   Nearly half of Tanzanians live in urban areas, where private providers provide the majority of health services. Most of the smaller providers operate under the radar, and are hardly engaged in quality improvement, reporting or other types of collaboration. Bringing them to collaboration could improve quality and accessibility of health services, e.g. in Dar es Salaam. Facility accreditation, as discussed above, is an instrument for achieving these improvements.

Management of Priority Activities

The action points listed above are interrelated and therefore require concerted actions. Only when there is collaboration, harmonisation and coherence between the action points will there be success. Quality is the central theme, but it is the result of all other actions (see figure 9).

Figure 9. Quality focus

The MOHSW and PMO-RALG could jointly institute a task force for planning and monitoring of the actions. Other MDAs, like MOFEA and POPSM, could be invited to join for individual elements. TWG chairs also should participate to ensure the linkage to the existing structures. For each of the strategic areas, an inventory should be made of activities or plans that are ready for rolling out ("low hanging fruit") and could be included in the action points. This should result in a list of prioritised actions, and a timeline for the actions; responsible officials, with clear instructions regarding accountability, should also be indicated.

Senior MOHSW management must assume the important role of monitoring the performance of the task force and the TWGs. Development partners could assist by making technical assistance and financial resources available for execution of the tasks involved.

The activities should be accompanied by a campaign to inform the general public of the actions being taken, such as the accreditation of health facilities and the availability of medicines, to improve the quality of health services. The campaign should also encourage communities to take responsibility for their own health and for the vulnerable people in their community.

Specific Recommendations

The consultants' specific MTR technical reports on the specific strategic areas provide many recommendations. The summary of part of the recommendations is in table 12. Please consult the technical reports for further explanation.

Table 12. Summary of recommendations from the MTR Technical Reports

Access
Enable full utilisation of approved posts for HRH, whilst collaborating with LGAs for enhanced attraction of staff to work stations and retention in rural areas.
Create an enabling environment for maternity care such as provision of labour ward space with water and electricity, construction of staff houses and provision of essential equipment and supplies.
Strengthen the role of public relations sections and include in their responsibilities the promotion of trust between citizens and services at local levels. Improve MOHSW communication, internally and externally, with a vibrant website and public campaigns on the achievements of the health sector.
Develop model programmes of Citizen-Service Engagement and Participatory Planning, Monitoring and Evaluation on specific issues.
Utilise community health workers who are formally trained, supervised and employed by the health system in order to provide promotional and preventive health services in general.
Improve partnerships with communities (enhance community ownership) with local investors (improve PPPs) and with local partners (NGOs).
Make "under the radar" PPPs in districts more visible and use such efforts as stepping stones for building trust and increasing investments in the private health sector especially in rural areas.
Equity
Prioritise MMAM implementation for the remainder of the HSSP III period against the opportunities and practical limits in areas of high need.
HIV/AIDS prevention, treatment and care interventions need to be formulated to target most at risk populations, i.e. commercial sex workers, men who have sex with men, mobile workers, prisoners and injecting drug users.
Focus on regions with poor indicators for nutrition. Improve in these areas the management of illnesses in children in health facilities.
Address the issue of discrimination against and mistreatment of poor and vulnerable people within health services.
Intensify design and implementation of model approaches in social welfare using existing policy for increased equity (e.g. parts of the MVC plan).
Decentralise recruitment of the health workforce, and initiate attraction and retention strategies with equity in focus.
Strengthen the capacity to implement existing exemption systems within the health sector.
Adopt a comprehensive financing strategy that mobilises adequate funding and provides financial risk protection for all, including improved insurance options, and funded waiver and exemption systems.
Quality
Proceed with full operationalisation and roll-out of the TQIF, including an accreditation system.
Review the status of the current Hospital Reforms Programme to identify the top three barriers and ways forward.
Initiate a community-based follow-up and patient tracing system in all districts to ensure continuity of care for patients on ART.
Accelerate setting up of the National NCD Programme.
Provide targeted support to the weakest councils and health facilities in management of pharmaceuticals.
Institute continuing medical education as a moral and ethical obligation to continue lifelong learning in order to maintain and improve their competence and performance.
The distance-learning programme should be developed to maximise the use of ICT.
Standardise training and employment of SWOs and formalise the working relationship with PMO-RALG at region, district and ward levels.

Integrate Help Babies Breathe training to in-service and pre-service BEmONC training of health providers. Establish clinical mentors and training for BEMONC and CEmONC ensuring the right skills mix (theatre nurse, anaesthetist and AMO surgeon).
Efficiency
Train CHSBs and HFGCs to better understand, and work according to, their TOR (regulations).
Ensure that all RRHs produce hospital annual plans next year, i.e. 2014/15.
Establish a task force to address as a priority all issues related to disbursement of funds to health facility accounts at MSD.
Consider a pooled procurement system for additional medicines procurement (next to MSD) using health facility cost sharing and council funds.
Develop a prioritised Supply Chain Action Plan as a follow-up to the Strategic Supply Chain Review.
Enhance appropriate prescribing and use of medicines, and improved inventory management at all levels (fewer stock-outs, less expiry and pilferage).
Explore new ways to network and dialogue effectively with POPSM, PMO-RALG, and MOFEA on key HRH policies, strategies and enforcement of existing regulations with regard to human resources management.
Strengthen HRH task management, HR management practices and action follow-up teams at national, regional and LGA levels.
Produce focused implementation plans for each area of M&E development, included those planned within the e-Health Strategy.
Better utilise decentralised systems, which are part of the PMO-RALG management system; cut out duplication of work in information and reporting systems; maintain strict work planning between MOHSW and PMO-RALG to meet deadlines jointly.
Establish a national coordination mechanism of capital investment and maintenance, preferably with participation of both MOHSW and PMO-RALG.
Ensure more timely and predictable fund transfers.
Strengthen relations between senior management in MOHSW and TWGs, as well as improve coordination and interaction amongst TWGs; ensure regular reporting; enhance joint meetings and work to avoid overlap or duplication.
Coordinate between DPs and the MOHSW contributions and donations. Adhering to MOHSW standards is necessary for efficiency and sustainability.
Gender
Establish collaboration between reproductive health services and the HIV/AIDS Programme in a programme that will increase men's attendance in ANC and voluntary counselling and testing.
Increase women's representation in decision-making fora.
Safety
Raise awareness of the high incidence of accidents and injuries and collaborate with the relevant sectors to prevent the accidents and injuries.
Sustainability
Guide LGAs in more balanced infrastructure development to ensure that facilities are fully equipped and adequately staffed before construction begins.
Make a serious effort to improve equipment maintenance. Continuously establish new, and equip and strengthen existing zonal, regional and district HCTS workshops.

7.2 Recommendations to Inform HSSP IV

7.2.1 Timeframe for Preparation of HSSP IV

The timeframe for producing HSSP IV is tight; however it is feasible to produce a plan by October 2013, in time to prepare for budgets for the coming fiscal year. Preparation in a short time is possible because the functional TWGs can do a large part of the preparatory work.

- Preparation should start with the JAHSR meeting of October 2013. It is proposed to institute a Preparatory Committee during the meeting, which will oversee and guide the process (like the approach of the MTR). TOR and the composition of the committee should be agreed during the meeting.
- In October–November 2013 the committee should define the priority themes of HSSP IV, which reflect the strategic areas to be covered. To choose the themes the committee will interview officials in the health sector and government wide. The selected themes will be presented for approval of senior management.
- In December 2013–February 2014 TWGs and other forums will formulate detailed strategies for the priority themes of HSSP IV, with the MTR as status report in the background.
- In March 2014 a working group will formulate a realistic resources envelope for the health sector, including financial resources (based on reliable predictions) and human resources (based on available budgets)
- In April–May 2014 the preparatory committee will review the priority themes and feasible implementation based on expected resources, and fine-tune targets and objectives.
- In June 2014 the committee will formulate indicators and M&E for HSSP IV.
- The first draft strategic plan will be approved by the TC-SWAp meeting in July 2014 and presented to senior management.
- In October 2014 the final HSSP IV will be approved by MOHSW and presented in the JAHSR 2014

7.2.2 Themes of HSSP IV

Context for the HSSP IV

Around the time that HSSP III ends, other major strategies in Tanzania and worldwide will expire. The new strategies will have an important bearing on HSSP IV.

- The HSSP IV will operate within the Government of Tanzania context, and adhere to overarching government strategies. One of those is the Tanzania Development Vision 2025, which provides a long-term vision. MKUKUTA II runs from 2010 to 2015. At this moment it is not known if there will be a next MKUKUTA III.
- The Government has launched the Big Results Now programme. Although that programme has its focus mainly on implementation, it may have a bearing on strategic planning as well. As the health sector will be included in the programme by next year, it may give relevant guidance.
- The MMAM runs from 2007 to 2017. Its follow-up or extension is not yet under discussion. If there is a follow-up it will overlap with HSSP IV.
- The MDGs played an important role in HSSP III. They will be replaced by post-MDG goals; Heads of State began discussing these in the UN General Assembly in September 2013 and they will conclude

the new goals by September 2014. Tanzania will make its commitments to the post-MDG goals, including health targets.

- Finally the framework for cooperation with development partners in the health sector will expire in 2015. Continuation or new types of collaboration will be discussed.

Suggested Themes in HSSP IV

Based on its findings, the MTR team offer the preparatory committee the suggestions below for themes in HSSP IV.

In the health sector in Tanzania technical knowledge and expertise is abundantly available. Strategies in the area of MNCH, TB, malaria etc. have been developed and are updated from time to time. Strategies for HRH, pharmaceutical services or M&E are also available. The challenge for the coming period is to pull these elements together. In terms of the WHO building blocks of the health sector: it is not the building blocks, but the cement that needs to be strengthened.

1. Health financing strategy

   The health financing strategy, which is now under preparation, should be ready before planning the next health sector strategic plan and should provide clear guidance to resource mobilisation for health services (e.g. insurance, tax-based system). Implementation of the health financing strategy should be an important area of work in the next strategic phase.

   It is very important to define a realistic resource envelope for the coming strategic period, and avoid planning based on an identified resource gap. The financing strategy should also contain procedures to monitor funding trends and anticipate adjustment of plans, reformulating priorities and phasing planned interventions.

2. Integrated quality system

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

   Experience has shown that quality improvement of (isolated) parts of the health sector does not result in the desired effects.

   Designing an integrated approach linking quality systems is the central theme for the coming period to realise progress for the health sector as a whole.

3. Harmonisation

   The health sector faces challenges in ensuring consistent performance – that the fact that disease control programmes achieve more successes than general and MNCH services is problematic. Similarly, geographic discrepancies must be addressed. This requires a robust system of monitoring and learning to document experiences, ensuring information exchange, mutual learning etc. Here important lessons can be learnt from other sectors, like education and water, especially in interministerial collaboration. These harmonisation strategies have to be institutionalised. Furthermore, effective strategies for scaling up and rolling out have to be developed (using experiences from the past) and implemented right from the start of projects. Development partners have a major responsibility in producing results which outlive the project period.

4. Evidence-based management

   New information technology brings exciting opportunities for improved communication and improved management of health services from the micro-level (in the facility) to the macro-level (at the central level of Government). Information technology is a cross-cutting theme at the government level and will change the way of doing business in all sectors, including health. The development of M&E in the health sector (and other sectors) offers new opportunities for evidence-based decision-making and management. Two conditions have to be met: an information culture and capacities to handle and analyse information.

5. MMAM after 2017

   The present MMAM runs until 2017 and is a strategy for improving equitable service delivery in the country. The MMAM has proven its importance within the health sector and has achieved results within the given resources constraints. Its next phase has to be prepared. In line with the present there are two major areas of expansion: PPP and community ownership. PPPs are crucial because private providers could make a positive contribution to equitable provision of health services (especially when linked to a new health financing strategy). Urbanisation is an important upcoming theme. Strategies to stimulate private investments in the health sector need to be developed. Community ownership is important to develop social protection strategies for vulnerable people and to enhance people to take responsibility for their own health. A gender-balanced response to health needs should be part of a new MMAM strategy.

ANNEXES

Annex1 Terms of Reference

Mid Term Review of
Health Sector Strategic Plan III (HSSP III), July 2009 – June 2015

1. Background

The Health Sector Strategic Plan III (HSSP III) is the cross cutting strategic plan for the health sector of Tanzania for the period July 2009 – June 2015. It provides an overview of the priority strategic directions across the health sector, and is in turn guided by the National Health Policy, Vision 2025, the National Strategy for Growth and Reduction of Poverty Reduction (MKUKUTA) and the Millennium Development Goals. HSSP III serves as the sector's comprehensive national plan and guiding framework for the detailed planning and implementation of health sector activities by all levels and partners. Partnership, in particular, is a key focus area of HSSP III.

Findings and recommendations resulting from the 2007 Joint External Evaluation of the Health Sector informed the formulation of HSSP III. The HSSP III development process was led by the Health Sector Reform Secretariat under the Division of Policy and Planning, Ministry of Health and Social Welfare (MOHSW). The HSSP III consolidates existing Health Sector Reforms, retains key strategic priorities of HSSP II, and adds new identified priorities such as Maternal, Newborn and Child Health.

The Mid Term Review (MTR) of the Health Sector Strategic Plan III (HSSP III) is called for in the HSSP III, as part of Chapter 9 Monitoring and Evaluation. The MTR HSSP III, aimed at GoT, Development Partners (DPs), and relevant stakeholders, will guide further implementation of HSSP III and future design of HSSP IV. It will focus on implementation of the service delivery and reforms objectives and suggest improvements and course corrections for the remaining period of HSSP III. It will also explore the extent to which the strategy has been translated to quality service delivery at the district and facility level.

The MTR will be carried out under the guidance of a joint stakeholder MTR Steering Committee (SC), which is headed by the Permanent Secretary, MOHSW, and comprises the following members: (i) Deputy PS, and Director Sector Coordination, PMO-RALG; (ii) Asst. Commission External Finance, MOF; (iii) MOHSW Directors of Policy & Planning, Curative Services, Preventive Services, Health Quality Assurance, Human Resources for Health, and Procurement Services; Commissioner Social Welfare; Asst. Directors for Policy and for Budget and planning; Coordinator District Health Services; and Head, RCH Unit; (iv) High level representative, TACAIDS; (v) RMO Dar es Salaam; (vi) DMO Temeke Municipal; (vii) DPG-Health Troika (Danida, GIZ and USAID); DP Health Basket Fund coordinator (Irish Aid); and representative from WHO; (viii) CSSC and BAKWATA representing faith-based organizations; (ix) SIKIKA representing civil society; and (ix) APHFTA representing the private sector.

This MTR Steering Committee will be primarily responsible for the following: (i) to oversee the MTR planning and implementation process; (ii) to ensure the timely submission of key reports requested for the MTR; (iii) to agree on Terms of Reference for and selection of the MTR Consultancy Team; iv) to lead the Policy Dialogue; and (v) to ensure that the wrap up discussions are carried out in the spirit of partnership.

2. Objectives of the HSSP III Mid-Term Review

Overall Objective

The primary objective of the HSSPIII MTR is to review, analyze, and document progress, challenges, and lessons learned from the first half of HSSP III implementation. Recommendations from HSSP III MTR will suggest improvements to the final period of HSSP III implementation and inform the design and formulation of HSSP IV.

Specific Objectives

To assess the overall coherence and implementation of HSSP III as articulated through the eleven specific strategies, six crosscutting issues, monitoring and evaluation plan, financing, and the strategic objectives' indicators selected as a proxy for expected results (see page 53 HSSP III), with specific aim of informing HSSP IV conceptualization.

- To review the implementation of the HSSP III thus far and take stock of quantitative and qualitative achievements as related to the eleven HSSP III strategies and the six cross cutting issues and levels in the health sector (quality, equity, gender sensitivity, community ownership, coherence, and governance).
- Assess the overall level of implementation of the Mpango wa Maendeleo wa Afya ya Msingi (MMAM) in areas where the MMAM objectives are directly linked to the HSSP III, i.e. volumes and distribution of health infrastructure development and HRH expansion.
- Assess the performance of systems for provision of medicines, equipment and health technologies and its impact on HSSP III implementation.
- To review and assess contribution of HSSP III to improvements in the five health services identified: health promotion, preventive health services, care and treatment, and rehabilitative services and provision of services to the chronically ill.
- To review user perceptions of the availability, affordability, and accessibility of quality Maternal, Newborn and Child Health Services to aid fuller understanding of HSSP III performance.
- To review the financing of the sector from the period 2009 - 2013 in terms of various funding mechanisms and modalities (Health Basket Fund, General Budget Support, complementary financing (including Community Health Fund, user fees, and health insurance schemes), Global Health Initiatives etc.), commitment and contributions of GOT and DPs, fund utilization, reporting, and overall efficiency and harmonization of these modalities in delivering HSSP III strategic objectives.
- Assess the progress of SWAp implementation including the role played by the sector stakeholders and the extent to which all partners are optimally supporting the SWAp and suggest how this can be improved. In addition, review the working arrangement between development partners and government and how well DP support (including parallel support) is presently supporting the HSSP III and what can be done to further enhance their support.
- Review operation of the 13 Technical Working Groups and their respective impact on health improvement, including as related to service delivery.
- To assess how inter-sectoral political, institutional and governance factors affect systems strengthening and the implementation of the HSSP III.

3. Description of MTR Team and Process

The overall MTR will be conducted under the leadership and guidance of the Joint Review Team (JRT) Leader, contracted by the MTR SC. The JRT Leader, a senior health specialist, will in collaboration with the MTR SC put together a JRT comprising of national and international consultants, with expertise in the areas of health service delivery, district health services, financial management, monitoring and evaluation, human rights and equity, health economics, procurement, human resources for health, gender, institutions and other relevant disciplines. The JRT should comprise of between 6-8 International consultants and 6-8 national consultants.

Contracting of JRT consultants including all logistical arrangements related to the consultants' work on the MTR will be managed by an organization with specific experience from executing such undertakings.

The JRT leader will have a short preparatory visit to Dar es Salaam where s/he will work with the MTR SC to develop the MTR work plan. During this visit, the MTR SC will finalise a detailed TOR for each individual national and international consultant, including the JRT Leader, drafts of which will have been prepared in advance with support from the executing organization contracted as above. S/he will also submit an Inception Report at the end of this visit.

The Joint Review Team is expected to develop guides and tools for data collection, summarization, organization and analysis, in consultation with the MTR SC. The tools will receive comment from MTR SC to assure the review is comprehensive. The JRT will collect information through a four step process including document reviews; semi-structured interviews with government officials (including from MDAs and LGAs), representatives from the 13 Technical Working Groups, Development Partners/ private sector / FBO, and civil society stakeholders; field visits; and a community health service experience study.

a. **Document Review:** The document review will include information from HSSP III, 2007 Joint External Evaluation of HSSP II, information generated routinely within the health delivery system / CCHP, information from Tanzania DHS, information from MOF, annual performance profiles, annual MOH and WB PERs, annual health sector review documentation, other relevant and recent studies on the health sector in Tanzania, etc.

   Ongoing reviews of specific health sector strategies and plans, such as the One Plan for the Maternal, Newborn and Child Health are anticipated to feed into the HSSP III MTR.

b. **Semi-structured Interviews:** Semi-structured interviews are to be conducted with a variety of stakeholders in the health sector including members of the MTR SC; MoHSW; PMO-RALG; MOF; MSD; Regional and District Health Facility Staff; Private/FBO staff and coordinating bodies; CSO's; community members/ health service users; DPs; training institutions; professional associations, etc.

c. **Field Visits:** The JRT will spend at least one week visiting selected hospitals, health centers, and dispensaries, encompassing both rural service delivery and urban service delivery as well as high resource allocations and the under-served areas. The MTR SC will identify LGAs for field visit that have differing characteristics in terms of human and financial resources. Members of the MTR SC will accompany the JRT during the field visits. Particular emphasis is to be placed on the delivery of maternal, newborn and child health services.

d. **Community perspective on Health Service Experiences:** A consultant (individual or agency) will be contracted to conduct focus group discussions with HSSP III related users and community members. Emphasis shall be placed on Maternal, Newborn and Child Health issues and will elicit views of stakeholders including poor pregnant women, users of public, private and NGO services, as well as service providers including NGOs, public sector health

providers, and private sector health providers. Based on this, the consultant will prepare a Community perspective on Health Service Experiences that will be an important input into the MTR process.

e. **Mid-term analytical report:** a team of national stakeholders will prepare an analytical report which will provide an in-depth analysis and synthesis of all relevant data, including health and other household surveys, census (if available), health facility and disease surveillance data, facility assessments, administrative data (such as human resources and financing), policy data and research studies. The analysis will focus on the priority areas of HSSP III and prepare a monitoring and evaluation plan that indicates the results to be achieved and whether the indicators are suitable or should either be changed or refined in the future. Based on available health service output data, provide the best possible estimate of numbers of lives saved through the Tanzanian health system outputs in the year 2011.

MTR Report

The Team Leader JRT will draft the MTR Report drawing on the above mentioned modes of information collection. The outline of the MTR Report will be provided to the MTR SC for review and comment early in the main mission.

To assess HSSP III Performance the MRT will provide a detailed analysis of a selected core objective of the program (Maternal Health Service Delivery) as interacting with associated strategies (i.e. district health services, referral hospitals, central level support, human resources for health, health care financing, public private partnerships, prevention of communicable diseases, social welfare and social protection, monitoring and evaluation); the six cross cutting issues; infrastructure development as outlined in the MMAM; as well as broader issues related to political economy, procurement, and institutional challenges/dialogue. This MTR will use the '**Maternal, Newborn and Child Health**' service delivery goal to highlight the interaction of the various areas to achieving improved HSSP III performance.

The JRT Leader will present the mid-term review report to the MRT SC. Both have the responsibility of overseeing that the review process is conducted in accordance with the TOR and it is their joint responsibility to submit their final report.

The issues identified in the MTR Report, and associated pieces of work, will inform the Joint Annual Health Sector Technical Review 2013 o take place in October 2013. The JAHSR 2013 will:

- Discuss key findings and recommendations proposed by the MTR Report
- Discuss MOHSW, PMO-RALG, and Development Partner comments on the MTR Report;
- Prioritize HSSP III Issues; and
- Agree on Proposed Actions required to improve HSSP III and to move forward to HSSP IV.
- Provide final approval for the MTR Report.

4. Deliverables

- An Inception Report from the JRT TL, including a detailed work plan with responsibilities and deliverables
- The Mid Term Analytical Report, and the report on the Community Perspective on Health Service Experiences

- A written MTR Report, submitted by the JRT Leader to the MTR SC, including:
    - A summary of findings, achievements and recommendations in a main report of maximum 40 pages, including priority actions for follow-up and to guide future HSSP IV design.
    - The technical reports of all consultants and key findings from the stakeholder consultation meeting.

The JRT Leader will also be expected to facilitate one or more consultative workshops on the draft MTR.

5. MTR Schedule

The timetable will be as follows:

Deliverable/Activity	To be Completed By
Finalization of MTR TOR	February 2013
Engaging organization for contracting of MTR JRT consultants and logistical arrangements for JRT	February 2013
Selection of Team Leader	February 2013
Team Leader Visit	May 2013
Finalization of TOR for the Joint Review Team and Leader	May 2013
Shortlist of Team Members	Early June 2013
Contracting Team Members	Mid June 2013
MTR team Document Review	Late June 2013
Draft Community Health Service Experience Study	Mid July 2013
Draft Mid-Term Analytical Report	Mid July 2013
MTR team Data Collection	July/early Aug2013
Zero draft presented to MTR SC (debriefing meeting)	Early Aug 2013
Draft MTR submitted to SC	Early September 2013
Steering Committee comments on draft MTR report	Mid September 2013
Revised draft submitted to SC	Mid September 2013
Consultative Meeting(s) with Stakeholders / MTR SC / MoHSW including TC SWAp	End September 2013
Submission of Final Report for Review	Early October 2013
Presentation by Team Leader at JAHSR TRM	Early – mid October 2013
Discussion, agreement on way forward at JAHSR Policy Meeting	Late October 2013

Annex 2 Persons Contacted During the MTR

Name	Position	Organisation
Ms Regina Kikuli	A/ Permanent Secretary	MOHSW
Dr Donan Mmbando	A/ Chief Medical Officer	MOHSW
Dr Margareth Mhando	Director Curative Services	MOHSW
Mr Josibert Rubona	A/ Director Policy and Planning	MOHSW
Ms Mariam Ally	A/Dir Policy	MOHSW
Mr Bernard Konga	A/Dir Budget and Planning	MOHSW
Dr Bumi Mwamasage	A/ Director Human Resources Development	MOHSW
Ms Tabu A Chando	Director Administration & HR	MOHSW
Dr Neema Rusibamayila	A/Dir Preventive Services, NMCH	MOHSW
Dr Mohamed A. Mohamed	Director Health Quality Assurance	MOHSW
Dr Anna Nswilla	Coordinator DHS	MOHSW
Ms Hellen Saria Mwakipunda	Chief Accountant	MOHSW
Dr Rosina Lipyoga	Secretary, P4P Task Force	MOHSW
Mr Claud John Kumalija	Head HMIS	MOHSW
Mr Mture	Head ICT	MOHSW
Mr F. Masaule	Head Advocacy	MOHSW
Mr Clavery Mpandana	Chief Nursing Officer	MOHSW
Ms Grace Tufumo	CAG Representative	MOHSW
Ms Winna Shango	Pharmaceutical Services Section	MOHSW
Mr Henry Irunde	CP/ADPS	MOHSW
Ms Anita Masenge	Pharmaceutical Services Section	MOHSW
Dr Mariam Ongara	PPP Coordinator	MOHSW
Dr Azma Simba	Epidemiologist M&E	MOHSW
Ms Siana Mapunjo	GF Liaison Pharmaceuticals	MOHSW
Ms Hiltruda Temba	Global Fund Coordinator	MOHSW
Dr Njako	Tuberculosis Programme Coordinator	MOHSW
Dr Makwani	Program officer –Safe Motherhood	MOHSW
Eng Kigula Mwambene	Chief Engineer	MOHSW
Mr Rodney Mbuya	Senior Quantity Surveyor	MOHSW
Mr E. Mvanga	Head Health Care Technology Services	MOHSW
Ms Sally Lake	Advisor, HPPM	MOHSW
Dr Bjarne Jensen	Advisor, HSS	MOHSW
Mr Nick Bain	Advisor, PFM	MOHSW
Mr Andy O'Connel	Advisor, PPP	MOHSW
Mr Hanif Nazerali	Advisor, Pharmaceuticals	MOHSW
Dr Lyimo	EPI Program Manager	MOHSW
Dr Mohamed Ally	Manager NMCP	MOHSW
Mr Richard Mnyenyele	Officer Planning and Financing	MOHSW

Name	Position	Organisation
Mr Fadhile Nkony	Officer Planning and Financing	MOHSW
Ms Levina Kimaro	Officer Policy and Planning	MOHSW
Ms Regina Ndakidemi	Officer Policy and Planning	MOHSW
Dr Mnungu	Officer Policy Planning	MOHSW
Dr Koleth Winani	Coordinator Safe Motherhood	MOHSW
Dr Ahmed Makwani	Programme Officer Safe Motherhood	MOHSW
Dr Clement Kahigwa	Coordinator HMIS and Research RCH Section	MOHSW
Mr Hiza	Officer Family Planning-RCH Section	MOHSW
Dr Mapela	Coordinator-Adolescent Health	MOHSW
Mr Peter Mabwe	PHO HEU	MOHSW
Mr Said Makora	HCO HEU	MOHSW
Ms Borah J Muze	PNO HEU	MOHSW
Ms Grace Mashi	Nutrition Officer HEU	MOHSW
Dr R. Alli	PMO HEU	MOHSW
Mr Charles Mambali	PHO	MOHSW
Dr. Neema Kileo	HPR	WHO
Mr Cosmas Nalimi	M&E	MSD
Mr Cosmas Mwaifwani	Act Director General	MSD
Mr Beatus Nsoma	Vertical Programme Manager	MSD
Mrs Grace Shimwela	Senior Drug Inspector	TFDA
Mr Hiiti Sillo	Director General	TFDA
Ms. M. Kinyawa	Registrar	Pharmacy Council
Mr J Bula	Education Officer	Pharmacy Council
Dr R Malele	School of Pharmacy	MUHAS
Dr Sebalda Leshabari	Dean of School of Nursing, Secretary of Tanzania Midwifery Association (TAMA)	MUHAS
Dr Projestine Muganyizi	Head Dept Obstetrics/Gynaecology, President of the Association of Gynaecologists/ Obstetricians in Tanzania	MUHAS
Mr Hamis Mdee	A/Executive Director	NHIF
Mr Rehani	Coordinator CHF	NHIF
Dr Mboera	Senior Researcher	NIMR
Dr Susan Rumisha	Senior Researcher	NIMR
Dr Aldegunda Komba	Head of Social Surveys	NBS
Mr Peter Maduki	Executive Director	CSSC
Dr Samwel Ogillo	Chief Executive Officer	APHFTA
Mr Irenei Kiria	Executive Director	SIKIKA
Mr Zakayo Mahindi	Community Monitoring of Accountability	SIKIKA
Dr Honorati Masanja	Chief Research Officer	IHI
Prof. Senga Pemba	Director TTCIH Ifakara	IHI
Dr Rufaro Chatora	Country Representative	WHO
Mr Max Mapunda	Programme Officer	WHO
Dr Theopista John	Programme Officer NMCH	WHO
Dr Irya	Programme Officer Child Health	WHO
Dr Ties Boerma	Senior Health Information Officer	WHO

Name	Position	Organisation
Dr Pamphil Silayo	Health Specialist	UNICEF
Mr Andy Brooks	Child Protection Officer	UNICEF
Mr Dominic Haazen	Country Desk Officer	World Bank
Ms Rena Eichler	P4P Consultant	World Bank
Mr Christian Pfleiderer	GIZ	GIZ
Ms Birte Frerick	GIZ	GIZ
Ms Nina Siegert	Health Financing Policy Adviser	GIZ
Mr Kai Straehler-Pohl	GIZ	GIZ
Mr Olivier Praz	Deputy Director Development Cooperation, Head Health Sector	SDC
Ms Jacqueline Matoro	Health Advisor	SDA
Ms Kira Thomas	Programme Officer	SDC
Ms Alisa Cameron	Health Office Director	USAID
Mr Andrew Rebold	CBHS Team Leader	USAID
Mr Gene Peuse	PPP Advisor	USAID
Ms Raz Stevenson	HR Advisor	USAID
Mr Ibadat Dhillon	Health Consultant	Danida
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