United Republic of Tanzania
Ministry of Health and Social Welfare

Health Sector Strategic Plan

July 2015 – June 2020

(HSSP IV)

Reaching all Households with Quality Health Care

Foreword

As Tanzania strives to reach middle income status, the health sector has resolved to give more attention to the quality of health services in tandem with the pursuit of universal access. At the same time, better health for the entire population will be promoted through the adoption of health in all policies.

The country has made impressive gains in reducing under-five and infant mortality, through declines in morbidity and mortality from malaria and other childhood diseases. HIV prevalence has also fallen. Some decline in Maternal Mortality has been noted but this was not fast enough to reach the Millennium Development Goal (MDG) targets; Neonatal mortality has also gone down but less than planned. The unfinished work on reaching some of the MDG 2015 targets is taken forward in the HSSP IV, driven by the call for sustainability under the MDG successor global theme, “Sustainable Development Goals”.

Evidence shows an epidemiological transition with non-communicable diseases showing an upsurge and a consequent rise in health care costs. Challenges posed by current health financing levels and modalities require change to the way financial access to health care is organized, greater efforts on resource mobilization, transparency and social accountability, as well as more determined measures to strengthen the health system as a whole.

This HSSP is given impetus by the Big Results Now (BRN) initiative underlining the need for better performance of health facilities as well as individuals within the health system, improved prioritization to attain equity in health and social welfare, and ensuring well-stocked health facilities in terms of medicines, supplies and staff. Through the Star Rating, quality assurance system, BRN has paved the way towards improving the quality of care at primary level, moving our health facilities towards certification and then accreditation. Re-commitment to community-based health care will extend coverage of key maternal and neonatal interventions, and stronger health promotion, disease prevention and social welfare services within Local Government Authorities (LGAs).

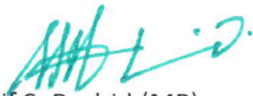
LGAs have been mandated to be in charge of delivering social services, and the Prime Minister’s Office - Regional Administration and Local Government (PMO-RALG) given the task to supervise, coordinate and monitor their activities, in line with the policies and guidelines of the Sectoral Ministries, a key role that shall continue during HSSP IV. The Decentralization-by-Devolution approach will continue to improve governance and management responsibilities and capacities at the health facility level, including strengthening the voice of citizens in health service delivery and management. Performance management shall be emphasized at all levels of the sector to increase outputs and impact.

Integrated delivery of a reviewed package of essential healthcare interventions, strengthened Comprehensive Council Health Planning decentralized to the facility level, better management of health facilities at all levels, and health system strengthening in aspects such as Integrated Logistics System, Human Resource, and District Health Information Systems are key features to achieve harmonization and a coordinated approach.

Strengthening the health system is aimed at attainment of better health of the population. Promotion of healthy living and an environment conducive for health protection at households and workplaces will improve the quality of life. Prevention of communicable and non-communicable diseases, including healthy diets and action against malnutrition, will receive high priority at national, regional, district, community and household levels. Paid cadres at community level for social welfare, health promotion and disease prevention will complement measures to increase access to essential services at facilities and higher levels of the system. Further integration of social welfare and health services and closer collaboration with other ministries, agencies and non-governmental organisations (NGOs) will increase accessibility to social welfare services for those most in need. Gender equity will receive increased attention through concrete measures such as focus on prevention of HIV amongst adolescent girls, and addressing violence against women. Equal representation of women will be prioritised in committees and boards, and rights and obligations of duty-bearers and rights-holders will be observed.

Tanzania has a successful Sector Wide Approach (SWAp) that will be streamlined to improve joint planning, monitoring and implementation by all stakeholders. The Public Private Partnership (PPP) Policy already being implemented need further enhancement. Partnership with PMO-RALG at Central, Regional and LGAs levels focuses on administrative and governance responsibilities. Engagement with Ministry of Finance, President's Office Public Service Management and health-related ministries shall address the increased financing needs, human resource supply, deployment and retention, nutrition, water, social welfare and environment-related issues. Government shall continue its collaboration with Faith-Based Organisations, as well as encouraging NGOs, Community-Based Organisations and all other private health providers to expand coverage to the population.

This HSSP is the guiding reference document for the preparation of annual plans at the agency, department, programme, health facilities and council levels. I therefore invite you all to consult and use it extensively for the betterment of national health and social welfare outcomes over the next five years.



Hon. Dr. Seif S. Rashid (MP)

Minister of Health and Social Welfare

August, 2015

Acknowledgement

The HSSPIV has been developed to guide the continued transformation of the health sector, to address the unfinished MDG agenda, and the increasing demand for decentralised, affordable, equitable and quality health services in a performance-oriented mode. In developing this plan, an intensive and comprehensive consultative process has been employed among health and Social welfare stakeholders, beginning with the Mid Term Review of HSSP III, Big Results Now (BRN) prioritisation process and subsequent needs identification.

Preparation of this document was constantly guided by the HSSP IV Steering Committee that included participation of the Government and Non-Government stakeholders, and I would like to thank them for this commitment which I expect to continue in the subsequent implementation stage.

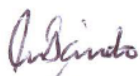
Thanks to the 14 Technical Working Groups, which grew over the course of HSSP III, for providing a very clear gap analysis related to HSSP III implementation and hence informing the needs for HSSP IV.

Representative participation of the Council and Regional Health Management Teams, Zonal Resource Centres, the Prime Minister's Office – Regional Administration and Local Government, MOF, POPSM, civil society and the private sector significantly enhanced the ownership of this document.

The health sector Development Partners deserve appreciation for their continued technical and financial support towards development of this document.

I would like to specifically acknowledge the contribution in developing this document of the Team Leader (Dr. Jaap Koot), National Consultant (Dr. Elihuruma Nangawe), Costing Expert (Ms. Catherine Barker), the SWAp task force and the Health Sector Resource Secretariat.

The MOHSW remains committed to the dissemination and utilisation of HSSP IV for central and decentralised annual planning, monitoring and evaluation.



Dr. Donan W. Mmbando

Permanent Secretary

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Acronyms

ADDO	Accredited Drug Distribution Outlet
AFSRHR	Adolescent Friendly Sexual and Reproductive Health Services
AHSPPR	Annual Health Sector Performance Profile Report
AIDS	Acquired Immuno-Deficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
ASPM	Annual Sector Planning Meeting
BEmOC	Basic Emergency Obstetric Care
BEmONC	Basic Emergency Obstetric and Newborn Care
BFC	Basket Fund Committee
BRN	Big Results Now
CBHP	Community Based Health Programme
CBO	Community Based Organisation
CBR	Community Based Rehabilitation
CCHP	Comprehensive Council Health Plan
CEmOC	Comprehensive Emergency Obstetric Care
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CFS	Consolidated Fund Service
CHF	Community Health Fund
CHMT	Council Health Management Teams
CHSB	Council Health Services Board
CHW	Community Health Worker
CPD	Continuing Professional Development
CPR	Contraceptive Prevalence Rate
CPT	Child Protection Team
CRP	Community Rehabilitation Programme
CSC	Community Score Card
CSO	Civil Society Organization
CSSC	Christian Social Services Commission
CPRP	Community Prevention and Reintegration Programme
D-by-D	Decentralisation by Devolution
DCF	Development Cooperation Framework
DHIS	District Health Information System
DHIS 2	District Health Information Software 2
D-HMIS	District Health Management Information System
DHS	Demographic and Health Surveys
DOTS	Direct Observed Therapy Short Course
DP	Development Partner
DPG-AIDS	Development Partners Group AIDS
DPG-H	Development Partners Group Health
DSW	Department of Social Welfare
eMTCT	Elimination of Mother To Child Transmission
EOP	Emergency Operational Plan
FBO	Faith-Based Organization
FP	Family Planning
GBS	General Budget Support
GBV	Gender Based Violence
GDP	Gross Domestic Product
GF	Global Fund
GOT	Government of Tanzania
HBF	Health Basket Fund

HBFC	Health Basket Financing Committee
HFGC	Health Facility Governing Committee
HFS	Health Financing Strategy
HIS	Health Information System
HIU	Health Information Unit
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System [MTUHA]
HMT	Hospital Management team
HR	Human Resources
HRD	Human Resources Development
HRH	Human Resources for Health
HRHSW	Human Recourses for Health and Social Welfare
HRHIS	Human Resources for Health Information System
HRHSP	Human Resource for Health Strategic Plan
HRIS	Human Resources Information System
HRM	Human Resources Management
HSR	Health Sector Reforms
HSRS	Health Sector Reforms Secretariat
HSSP III	Health Sector Strategic Plan III (2009 – 2015)
HSSP IV	Health Sector Strategic Plan IV (2015 – 2020)
HSSP	Health Sector Strategic Plan
HSTC	Health Sector Technical Committee
HSWG	Health Sector Working Group
ICT	Information Communication Technology
IDSR	Integrated Disease Surveillance and Response
IEC	Information, Education and Communication
IHI	Ifakara Health Institute
IHR	International Health Regulations
ILS	Integrated Logistics System
IMCI	Integrated Management of Childhood Illnesses
IMR	Infant Mortality Rate
IPC	Infection Prevention and Control
IPD	In-Patient Department
ITN	Insecticide Treated Nets
JAHSR	Joint Annual Health Sector Review
KRA	Key Result Area
KPI	Key Performance Indicator
LGA	Local Government Authority
LLIN	Long Lasting Insecticidal Nets
LMIS	Logistics Management Information System
LMU	Logistics Management Unit
M&E	Monitoring and Evaluation
MBP	Minimum Benefit Package
MCT	Medical Council of Tanganyika
MDA	Mass Drug Administration
MNCH	Maternal Newborn and Child Health
MDA	Ministries, Departments, Agencies
MDA	Mass Drug Administration
MDGs	Millennium Development Goal(s)
MDR TB	Multi Drug Resistant Tuberculosis
MDU	Ministerial Delivery Unit
MKUKUTA	Mkakati wa Kukuza Uchumi na Kupunguza Umaskini Tanzania [NSGRP]
MMAM	Mpango wa Maendeleo ya Afya ya Msingi [PHSDP]
MNCH	Maternal, Newborn and Child Health
MOCS&T	Ministry of Communication, Science and Technology
MOEVT	Ministry of Education and Vocational Training
MOF	Ministry of Finance

MOHSW	Ministry of Health and Social Welfare
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 [HMIS]
MUCHS	Muhimbili University College of Health Sciences
MVC	Most Vulnerable Children
MVCC	Most Vulnerable Children Committee
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
NBTS	National Blood Transfusion Service
NCD	Non Communicable Diseases
NEHCIP	National Essential Health Care Interventions Package
NGO	Non-Governmental Organization
NHA	National Health Accounts
NHIF	National Health Insurance Fund
NIMR	National Institute for Medical Research
NKRA	National Key Result Area
NMCP	National Malaria Control Programme
NMP	National Medicines Policy
NSGRP	National Strategy for Growth and Reduction of Poverty[MKUKUTA]
NSHP	National School Health Programme
NTD	Neglected Tropical Diseases
NTLP	National Tuberculosis and Leprosy Programme
OPD	Outpatient department
OPRAS	Open Performance Review and Appraisal System
OPP	Out-of Pocket Payment
OVC	Orphans and Vulnerable Children
PDB	Presidential Delivery Bureau
PER	Public Expenditure Review
PFM	Public Finance Management
PHA	Public Health Act
PHC	Primary Health Care
PHDR	Poverty and Human Development Report
PHSDP	Primary Health Services Development Programme [MMAM]
PMO-RALG	Prime Minister's Office – Regional Administration & Local Government
PMTCT	Prevention of Mother to Child Transmission
PLHIV	People living with HIV
PNC	Post-natal Clinic
PO-PSM	President's Office – Public Service Management
POW	Programme of Work
PPHF	Public Private Health Forum
PPP	Public Private Partnership
PSRP	Public Service Reforms Programme
PWDs	People With Disabilities
QA	Quality Assurance
QI	Quality Improvement
QIT	Quality Improvement Team
RAS	Regional Administrative Secretary
RBF	Results Based Financing
RCH	Reproductive and Child Health
RHHSB	Regional Hospital Health Services Board

RHMT	Regional Health Management Team
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
RRH	Regional Referral Hospital
RAS	Regional Administrative Secretariat
SA	Service Agreement
SARA	Service Availability and Readiness Assessment
SAVVY	Sample Vital registration with Verbal Autopsy
SCD	Sickle Cell Disease
SDG	Sustainable Development Goal
SMC	Senior Management Committee
SNHI	Single National Health Insurer
SOPs	Standard Operating Procedures
SPD	Sentinel Panel of Districts
STEPS	WHO Stepwise approach to Surveillance for Chronic Diseases
STIs	Sexually Transmitted Infections
SWAp	Sector-Wide Approach
SWCA	Stepwise Certification Towards Accreditation
SWIS	Social Welfare Information System
SWO	Social Welfare Officer
TACAIDS	Tanzania Commission for AIDS
TASAF	Tanzanian Social Action Fund
TB	Tuberculosis
TB/L	Tuberculosis and Leprosy
TC	Technical Committee SWAp
TDHS	Tanzania Demographic and Health Survey
TFDA	Tanzania Food and Drug Authority
TFNC	Tanzania Food and Nutrition Centre
THMIS	Tanzania HIV Malaria Indicator Survey
TIKA	Tiba Kwa Kadi (CHF in urban areas)
TNCM	Tanzania National Coordinating Mechanism
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
TWG	Technical Working Group
TZS	Tanzania shillings
U5MR	Under-five Mortality Ratio
VMMC	Voluntary Medical Male Circumcision
VRS	Vital Registration System
WASH	Water, Sanitation and Hygiene
WDC	Ward Development Committee
WHO	World Health Organization
ZHRC	Zonal Health Resource Centre

Key Messages of HSSP IV

Background

The Health Sector Strategic Plan 2015 – 2020 (HSSP IV) was conceived in a **participatory process** under the leadership of the Ministry of Health and Social Welfare (MOHSW), with inputs from Governmental, Non-Governmental and Private Sector Partners, with contributions from Ministries, Departments and Agencies (MDAs), especially the Prime Minister's Office for Regional Administration and Local Government (PMO-RALG) and from Development Partners (DPs). For the first time a thorough effort was made to make **reliable cost estimates**, **prioritise interventions** based on available resources and **define realistic targets** for the health and social welfare sector.

Tanzania Development Vision 2025 (Vision 2025) is a document providing direction and philosophy for long-term development. The Government Health Policy aims to improve the health of all Tanzanians, especially those at risk, and to increase the life expectancy, by providing health services that meet the needs of the population. The health and social welfare sector programme of Big Results Now (BRN) 2015 - 2018, the national programme for accelerating development, is fully incorporated in this strategic plan. The Sustainable Development Goals (SDGs) as successors to the Millennium Development Goals (MDGs) provided important input to the planning process of this HSSP IV. Achievement of SDGs and the unfinished business of the MDGs have been considered in formulating HSSP IV.

The health status of the population is slowly improving and life expectancy is increasing. The trends in Child Mortality and Infant Mortality are downwards, and Tanzania is expected to meet the targets of the MDGs in 2015. The trends in Neonatal Mortality and Maternal Mortality are also downwards, but less, and not meeting MDG targets.
While Disease Control Programmes in HIV/AIDS, Malaria and Tuberculosis are quite successful in early detection and treatment, there is room for improvement in the area of prevention. Reproductive, Maternal, Neonatal, Child, and Adolescent Health (RMNCAH) in general is performing less effectively than control of communicable diseases. Overall service utilisation is not reaching the required level. Non-communicable diseases are increasing and unhealthy life styles are becoming more prominent. However, the country does not yet have the capacity for an adequate response.

Health and social welfare services are provided from the grassroots level up through higher levels of care, beginning with community health care, dispensaries and health centres, and proceeding through first level hospitals, regional referral hospitals and zonal and national hospitals, all providing increasingly sophisticated and well-defined services. Due to constraints in human resources and supplies of medicines and health products, not all primary health services are of sufficient quality. In certain geographical areas, populations still live far away from health services. This is especially problematic in terms of maternal and newborn care. The referral system does not always function as required, sometimes due to a lack of adequate transport to the next level of care or due to an inability at the referral level to provide adequate services.

Strategic Objectives

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

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

HSSP IV proposes a multilevel Health Systems Strengthening (HSS) programme, with a focus on quality of care in health institutions from the primary care to the tertiary and national levels. Quality Improvement will be enhanced by the BRN activities under four Key Result Areas. The health and social welfare sector will take the BRN approach further, to all regions in the country and beyond 2018 (when the BRN programme ends).

Health facilities will ensure that **essential services** are provided. The MOHSW will further refine the National Essential Health Care Intervention Package (NEHCIP) as well as a Minimum Benefit Package for the Single National Health Insurance. The country will strengthen emergency preparedness and response to disasters.

The **Star Rating and Improvement** system will set objective criteria for minimum standards to be achieved. The development of a stepwise certification and accreditation system and linkage of quality to performance and insurance payments will stimulate the health facilities to improve.

Stepping up recruitment, retention and (re)distribution of Human Resources for Health (HRH) will ensure **adequate staffing** of all primary health care facilities in all Regions. Council Health Management Teams (CHMTs) and Regional Health Management Teams (RHMTs) will improve coaching, mentoring and supervision.

Performance management systems will motivate health staff and social welfare workers to provide quality services. There will be measures to ensure accountability, deterring pilferage and corruption. Cases of corruption will be dealt with immediately. Quality will also improve through an **adequate supply of medicines and health products** and through refurbishment and equipping of health facilities.

Maternal and newborn services will reach under-served areas and under-served groups and will meet the quality standards for primary and referral care. **Basic and Emergency Obstetric and Newborn Care** will be available throughout the country. This will result in considerable reduction in both maternal and neonatal mortality. Adolescent girls and young women are at a higher risk of HIV infection and will receive adequate care. Increased availability of safe blood will reduce maternal mortality as well as mortality due to severe accidents.

The country will maintain the high level of quality of HIV and AIDS programmes, prevention and control of malaria, as well as early detection and treatment of tuberculosis and leprosy.
Non-communicable diseases (NCDs) put an increasing burden on the health sector, with quickly increasing demands for services, especially for cardio-vascular diseases, diabetes and cancer. The health facilities will as much as possible respond to this demand and gradually **step up the diagnostic and therapeutic capacities for NCDs**.

Health facilities will maintain high levels of vaccination coverage; improvements in access to addition geographical areas will be provided where needed, and new types of vaccinations will be introduced as they are developed and approved. Curative services for children will be provided in an integrated way in all health facilities at the appropriate level, including services for malnourished children. The country will step up nutrition interventions to bring down the numbers of stunting in children under-5 years of age, in the course of promoting optimal nutrition and control of emerging obesity in specific population groups.

In the area of social welfare, quality will be maintained through **integration of social welfare and health services** at all levels and through the creation of an inspectorate and development of a monitoring framework. Social welfare services will focus on child wellbeing and on family and household security for better living. Vulnerable groups, *e.g.*, people living with disabilities, will be assisted to participate optimally in society.

Prevention of communicable and non-communicable diseases will receive high priority. Improved facility and service quality will generate the trust of the population and create demand for the Single National Health Insurance. In addition, this will stimulate people to take ownership of the health services in their communities.

There will be emphasis on applying a **human rights** based approach in health programmes and clients' rights by revitalising the Client's Charter. In the area of social welfare, the rights of vulnerable groups (persons with disabilities, orphans, elderly, female headed households, persons with chronic diseases, homeless, *etc*.) will be protected. The MOHSW and partners will engage in a public awareness campaign to sensitise the population about their rights and responsibilities and will reach all households in this effort.

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

Priority setting based on epidemiological analysis will become standard, targeting under-served populations and vulnerable groups, and responding to high priority health needs.

Improving **community health and social welfare services** by professional Community Health Workers in integrated health programmes will include a Social Welfare Attendant that will attend to social welfare issues in community settings, including under-served populations living far from health facilities. Further integration of social welfare and health services and closer collaboration with other ministries, agencies and non-governmental organisations will make social welfare services more accessible to people in need of assistance.

Gender equity will receive increased attention in concrete measures, *e.g.*, focus on prevention of HIV among adolescent girls, addressing violence against women. Also, in committees and boards, equal representation of women will be prioritised.

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

Partnership with community based organisations will contribute to revitalising primary health care and community based social welfare services. Strengthening communities will improve health literacy and health seeking behaviors of the population. More community

participation in the management of health facilities will contribute to regaining trust in the health care system. A system of social accountability will be put in place to strengthen bottom-up planning and transparent reporting to Boards and Committees.

The health and social welfare sector will engage with the population in modern interactive communication via e-health platforms to establish partnerships between the government and citizens.

The new health care financing strategy, which promotes the development of a single national health insurance with effective risk-pooling and social protection, will increase the affordability of health care, also for the poorer citizens, and will enhance sustainable development of the health care sector.

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

Improvement of health and social welfare services can be realised through increased **effectiveness** and **efficiency**. Improving the technical competency of health workers and ensuring adherence to quality standards will increase the overall effectiveness of services. Further decentralisation of responsibilities to the health facility level will enhance efficiency. The sector will strengthen the evidence base for interventions through robust Monitoring and Evaluation (M&E) systems and operational research, including monitoring adherence to quality standards. Better use of these information systems will improve **efficient communication and decision-making** concerning the utilisation of scarce resources. Improvement of the **logistics systems** for the supply of medicines and health products and strengthened management of the Medical Stores Department is a high priority.

The **Health Financing Strategy** (HFS) includes a key innovation, the concept of a legally established **Single National Health Insurer** (SNHI), which will increasingly generate and pool resources for the sector while protecting the poor and vulnerable groups. Other innovative ways of resource mobilisation including sin taxes, levies and trust funds will be considered as a part of the strategy.

In the implementation of the HFS, **partnership** in the health and social welfare sector is crucial, at all levels. Public and private providers will work together in the delivery of health services, with the intention to provide room for **innovative approaches** (*e.g.,* new contracting arrangements) in service delivery and for the promotion of private sector engagement.

In health care financing, **opportunities for public private partnership** will be created, which allow the business community to collaborate with public as well as private partners in the health sector. The government's role will be to facilitate these investments in the health sector.

Recognising that the country is still largely relying on external financial and technical support for health and social welfare services, the MOHSW will continue to **uphold the Sector Wide Approach** in the health and social welfare sector, strengthening financing of one sector plan, country level partnerships and international collaboration, while addressing donor dependency through financial sustainability plans and exit strategies.

Strategic Objective 5: *To address the **social determinants of health**, the health and social welfare sector will collaborate with other sectors, and advocate for the inclusion of health promoting and health protecting measures in other sectors' policies and strategies.*

The sector will mobilise non-governmental and private partners to promote health and wellbeing through their strategies. Improved health and social wellbeing of the nation are essential towards realising the Nation's Vision 2025. Investing in health is therefore a necessity for the country to meet its development objectives.

The health and welfare sector alone cannot achieve optimal health and wellbeing for all individuals. **Social determinants of health and wellbeing**, like nutrition, housing, safe water, safe and hygienic environment, individual behaviours and security are crucial. For addressing the social determinants of health, economic development, housing, education, roads and communication are of great importance. One approach for addressing social determinants of health is for the MOHSW to advocate for **health impact assessments** prior to major developmental initiatives in other sectors.

Social welfare interventions focus on achieving acceptable standards of social wellbeing and protection for vulnerable groups in society, and enable those **groups to fully participate in society** and contribute to development of the country. The social welfare sector interacts with many other sectors and areas, like economic development, education, or food security. Like health, social welfare has to be integrated in other sectoral policies.

Advocating for health considerations in all policies is not only a responsibility for the MOHSW, but also for local and regional health and social welfare organisations in the decentralised government systems.

Governance and Implementation

The management of health services takes place within the legal context of the Government of Tanzania, which extends beyond the health sector. The MOHSW plays a stewardship role in the health sector while PMO-RALG plays a prominent role in implementation. The **Decentralisation by Devolution** (D-by-D) policy will continue to be applied down to the level of the health facilities. There are also many private and non-governmental players in the sector, who will be invited to play a bigger role in service provision. Citizens and communities also play a critical role in the health sector. **Social accountability** interventions will give them a bigger voice and more responsibilities. The government encourages shared policies and programs among sectors, with common participants working together beyond health sector specific interventions, towards common goals.

The successful **Sector Wide Approach (SWAp) will be streamlined** to serve joint planning, monitoring, and implementation of all stakeholders, especially the DPs who contribute to financing the health and social welfare sector.

Financing HSSP IV

The five-year cost of the HSSP IV is estimated to be TZS 21,945 billion. Costs increase each year from TZS 4,013 billion in 2015/2016 to TZS 4,859 billion in 2019/2020. This is equivalent to a stable per capita expenditure of around USD $42. Increases in costs keep pace with population increases. Approximately half of the HSSP IV financial resource requirements are for health services, which include commodity and programme management costs. Two disease control programmes (HIV/AIDS and NCDs, including mental health) account for

about half of total health service costs. These costs reflect the MOHSW's prioritised scale-up of health interventions, given the fiscal space and health system constraints.

Several scenarios for income generation for the health sector show that, even in a pessimistic scenario, income will be around 2,600 billion Tanzania Shillings annually (TZS). In the most optimistic scenario, income will rise from 2,600 billion TZS in 2015/16 to 3,650 TZS in 2016/17 and 2018/19, and slowly decrease to 3,250 TSZ in 2020/21.

In all scenarios there will be a funding gap, which can vary from 500 billion TZS to 2,500 billion annually, depending on realised income over the years. This has to be covered by additional resources mobilisation, or, if this is not feasible, the targets defined in this HSSP IV have to be adjusted.

Monitoring the HSSP IV implementation

The MOHSW has defined a framework for HSSP IV Performance Assessment and Follow-Up, which includes a set of national HSSP IV indicators (see below) covering all areas of population health, service delivery outputs, support systems performance, as well as governance and financial areas. Furthermore, the M&E framework incorporates the Key Performance Indicators as formulated for the BRN National Key Result Area for Health.

Finally, the M&E framework contains a number of more qualitative indicators which monitoring implementation activities of HSSP IV strategies. M&E will take place at regular intervals, with an emphasis on measuring annual health sector performance, drawing from the three indicator sets. The Joint Annual Health Sector Review (JAHSR) will have the necessary inputs for strategic decisions for improvement on the performance of the health and social welfare sector.

1 Introduction

Tanzania has a long-standing history of participatory strategic planning in the health and social welfare sector, under the leadership of the Ministry of Health and Social Welfare (MOHSW). Over the past 10 years, the Health Sector Strategic Plans (HSSP) have been guiding the annual Comprehensive Council Health Plans (CCHP) of the Local Government Authorities (LGA) and the Strategic Plans of Departments, Agencies and Programmes in the health and social welfare sector. The HSSPs have oriented the Sector Wide Approach (SWAp) involving other Ministries, especially the Prime Minister's Office – Regional Administration and Local Government (PMO-RALG), national non-governmental and private partners and the international Development Partners (DPs).

The planning process has always been guided by the development objectives of the Government of Tanzania (GOT), through analysis of the needs of the population and the identification of bottlenecks in services provided, as well as international agreed health goals, especially the Millennium Development Goals (MDGs). Over the years, the plans became more complete, with better description of available resources and improved monitoring methodology. The planning process has been increasingly inclusive, involving many stakeholders in the health and social welfare sector from different levels and different backgrounds.

The Health Sector Strategic Plan 2015 – 2020 (HSSP IV) was conceived in a participatory process, guided by the HSSP IV Steering Committee chaired by the Permanent Secretary of the MOHSW and co-chaired by the Deputy Permanent Secretary Health of the PMO-RALG. Representatives from Ministries, Departments and Agencies (MDAs), Non-Governmental Organisations (NGOs) and the Private Sector, as well as Development Partners (DPs) participated in the Steering Committee. A Task Force consisting of members of the Health Resources Secretariat within the Department of Policy and Planning (DPP) and representatives from various stakeholders managed the day-to-day process. In the process, two work streams, which initially were running parallel, were combined: the technical priority setting on the one hand and the costing of interventions and estimation of the fiscal space on the other hand.

The process started with inputs from the fourteen Technical Working Groups (TWGs) in the health and social welfare sector to produce the Zero Draft HSSP IV, reflecting their priorities and planned actions. This draft was shared and comments were discussed in a workshop in January 2015, where overarching topics and priorities were agreed. Draft One was disseminated widely and many stakeholders gave their inputs to the proposed strategies: health care professionals, interest groups, governmental and non-governmental organisations, departments, agencies, development partners and international organisations. Thereafter a revised draft was produced.

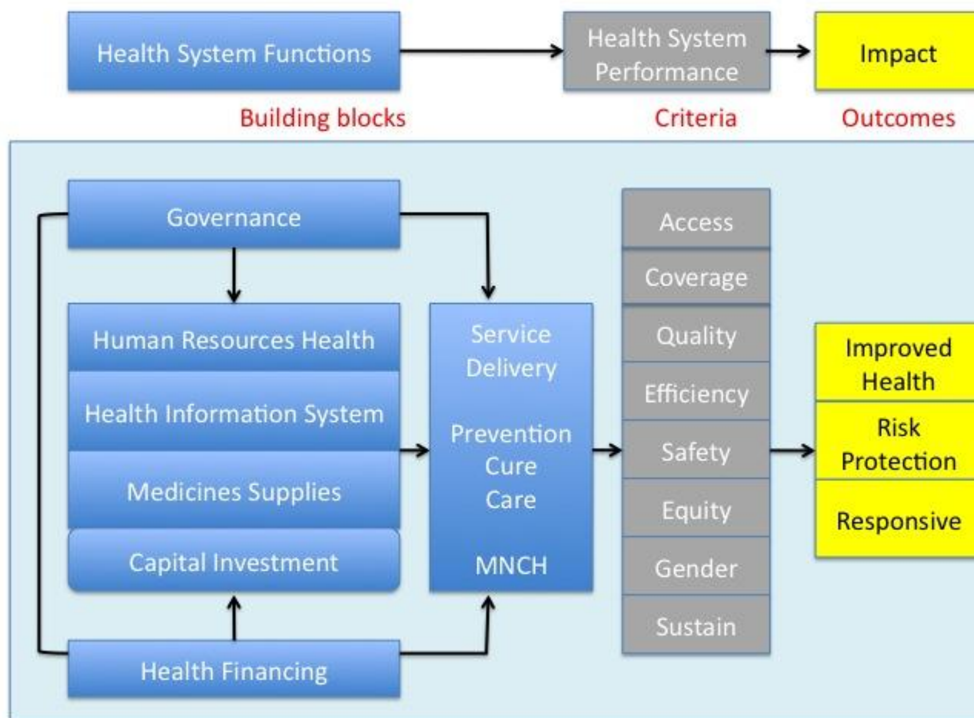
In the final phase of formulation, technical strategic priorities were matched with the financial projections. Those were thoroughly discussed in two meetings with all stakeholders in April 2015 resulting in an evidence-based, realistic HSSP IV, guiding development in the health sector in the coming five years.

The health and social welfare sector programme of Big Results Now 2015 - 2018, the national programme for accelerating development, has been fully incorporated in this strategic plan.

HSSP IV shortly describes the relevant Government Policies and Strategies (Section 2). Section 3 provides an overview of the current status of the health and social welfare sector. The strategic framework with overall and specific objectives is found in Section 4. The strategies are presented according to the (modified) system building blocks, as frequently used in publications of the World Health Organisation (see figure 1 below). The description of the planned activities starts with client services (Section 5) and continues with support services (Section 6). Section 7 explains the implementation modalities and governance arrangements and Section 8 discusses the fiscal space available for the health and social welfare sector. The framework of measuring and assessing the health and social welfare sector and the implementation of HSSP IV is discussed in Section 9. Risks and risk mitigation are presented in Section 10.

Annex 1 shows the list of laws and regulations and background strategic documents concerning specific areas. Annex 2 shows the background to the resources calculations presented in Section 8. Annex 3, 4 and 5 provide the indicators for monitoring of the health sector and HSSP IV implementation as discussed in Section 9.

Figure 1 Building Blocks of the Health and Social Welfare System



2 Government Policies

2.1 General Policy Framework

In Tanzania a coherent system of government policies, legislation, strategies and programmes exists to give direction to development. Consistency between general and sectoral policies is improving. The pace of policy implementation has been varied in application and enforcement.

2.1.1 Tanzania Development Vision 2025

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

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

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

2.1.2 MKUKUTA and Five Years' Development Plan 2011/12-2015/16

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. MKUKUTA II covers the period 2010/11 – 2014/15. It focuses on growth, social well-being and governance, and is a framework for all government development efforts and for mobilising resources.

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

The Five Years' Development Plan (FYDP I) 2011/12 – 2015/16 aims to mobilise Tanzania's resource potential in order to fast-track the provision of the basic conditions for broad-based and pro-poor growth. Five crucial elements will generate this growth momentum: (i) large investments in energy and transport infrastructure, (ii) strategic investments to expand productive sectors: high value crops and production of food for self-sufficiency and exports; tapping the large natural gas and phosphate deposits; development of Special Economic

Zones (SEZs) to foster economic growth; (iii) enhancing skills development, (iv) drastically improving the business environment, and (v) institutional reforms for an effective implementation, monitoring and evaluation of the Plan.

The FYDP I sets as goals for the health sector:

- Increase accessibility to health services, based on equity and gender-balanced needs
- Improve quality of health services
- Strengthen management of the health system
- Strengthen management of policies and regulations of health services
- Enhance human resource development for health and social welfare

2.1.3 Big Results Now

In 2014, the National Key Result Area (NKRA) in health care was introduced in the Big Results Now approach, to join other NKRAs that were adopted by the Government of Tanzania (GOT) in 2013, in order to enhance the implementation of the Five Years' Development Plan 2011/12 – 2015/16 and the Vision 2025. The health care NKRA is the eighth NKRA under the Big Results Now programme.

The BRN approach or methodology emphasises prioritisation, focused planning, and efficient resource management. The BRN approach aims to instil a sense of accountability, and discipline in implementation through focused monitoring and evaluation. The Presidential Delivery Bureau (PDB) manages and directs the implementation of the NKRAs and monitors the performance of the outcomes. The PDB also supports the Ministerial Delivery Units (MDU) at ministerial levels to implement and monitor priority initiatives. The BRN focus in the Health Sector is elaborated in section 2.2.3.

2.2 Health Sector Policy Framework

2.2.1 Health Policy

The MOHSW revised the 1990 National Health Policy in 2003 and 2007. On-going socio-economic changes, new government directives, emerging and re-emerging diseases and advances in science and technology have necessitated these policy updates. The policy outlines achievements and challenges facing the health sector. The Government aims to improve the health of all Tanzanians, especially those at risk, and to increase the life expectancy, by providing health services that meet the needs of the population.

In summary, specifically the Government aims to:

1. Reduce morbidity and mortality in order to increase the life expectancy of all Tanzanians by providing quality health care as needed;
2. Ensure that basic health services are available and accessible for all people;
3. Prevent and control communicable diseases, especially AIDS, Malaria, Tuberculosis, and non-communicable diseases resulting from mismanagement of chemicals, poor nutrition, environmental and working conditions.
4. Sensitise the citizens about preventable diseases and measure to improve health;
5. Create awareness on the part of the individual citizen to his/her responsibility on his/her health and the health of their family;

6. Build partnership between public sector MDAs, private sector (including traditional and alternative medicine providers) actors, religious institutions, civil society and community based organizations in the provision of health services;
7. Plan, train, and increase the number of competent health staff for all levels of health care;
8. Identify needs for health services in communities; construct and maintain health infrastructure and medical equipment; and
9. Review, evaluate and produce health policy, guidelines, laws and standards for provision of health services.

2.2.2 MMAM

In 2007 the MOHSW developed the Primary Health Care Services Development Programme, better known as the MMAM 2007–2017 (MOHSW 2007). The objective of MMAM is to accelerate the provision of primary health care services for all by 2017, while the remaining five years of the programme would 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, health care waste management, sanitation, equipment and supplies. The MOHSW supervise implementation of this plan in collaboration with other government administrative structures, which include PMO-RALG, Local Government Authorities (LGAs) and Ward Development Committees.

2.2.3 National Key Result Area in Healthcare (BRN)

In 2014, the National Key Result Area in healthcare was introduced and four broad outcomes (Key Result Areas, KRAs) were identified with twenty-two initiatives to be implemented for three years, from 2015/16 to 2017/18, in order to achieve the set targets and goals. These initiatives are to be implemented in collaboration with the MOHSW, PMO-RALG, PO-PSM and Medical Stores Department (MSD). The four key results areas that were formulated in the Health and Social Welfare sector include:

1. **Human Resources for Health** (HRH) interventions aim to attain 100% balanced distribution of skilled health workers at the primary level in thirteen underserved regions by 2017/18. There are six distinctive initiatives that include: prioritise allocation of employment permits to regions with critical shortage of skilled HRH, provision of skilled HRH through public private partnership and private sector engagement, and redistribution of health workers within regions. Also, optimising the pool of new recruits, empowering the LGAs in Human Resource Management and synchronising the recruitment process at the central level are among the goals.

2. **Health Commodities** targets focus on ensuring 100% stock availability of essential medicines in all primary health facilities in the country, through the implementation of the following six initiatives: (1) improved governance and accountability to the health commodity supply chain, (2) eliminating frequent stock outs and pilferages, (3) strengthening the management of MSD's working capital and complementing MSD in the procurement and distribution of medicines through engagement with the private sector, and therefore improving accountability. The other initiatives include: (4) introducing an ICT mobile application platform, (5) expanding the SMS reporting system

and (6) scaling up Total Quality Management initiatives to the primary facility level using the 5S-KAIZEN approach.

3. **Health facility performance management improvement** goals include achieving 80% of primary health facilities at the 3-stars and above rating by 2017/18 in twelve identified priority regions. This is to be achieved through four initiatives: (1) assess, rate and develop specific facility performance improvement plans for health facilities below 3-stars at primary level with introduction of the Star Rating system of certification; (2) increase social accountability at facility and community level, (3) introduce performance targets and contracts, and (4) implement decentralisation of fiscal management from council level to health facility level.

4. **Reproductive Maternal Neonatal Adolescent and Child Health** (RMNCAH) services target the achievement of 20% reduction in maternal and neonatal mortality rates in five identified priority regions by 2017/18. The following six initiatives will be implemented to achieve the stated goals: (1) mobilise Community Health Workers (CHWs) to improve RMNCAH services, (2) use of m-Health (SMS) and Maternal CHW App (Internet) through PPP, (3) Expansion of Comprehensive Emergency Obstetric and Neonatal Care (CEmONC) and (4) Basic Emergency Obstetric and Neonatal Care (BEmONC) services, (5) construction of Satellite Blood Bank facilities at regional level and (6) development of integrated mass media campaigns through PPP. The RMNCAH services will be provided through a continuum of care from family planning, antenatal care, labour and delivery and care during the postnatal period for both mother and the newborn.

Across the four KRAs there will be baseline assessments to get accurate starting information on data for target setting and assessment of performance. Baseline assessments will be conducted by the MOHSW with collaboration from the respective LGAs. At all levels, there will be weekly reporting and monitoring of key performance indicators from facilities to the MOHSW and to the President's Office. Data for quarterly monitoring of the progress of the NKRAs and other initiatives will be readily available for utilization in the HMIS and DHIS2.

Of the twenty-two initiatives, PMO-RALG will implement the following nine initiatives:

- Redistribution of health care workers within regions;
- Empowering LGAs in Human Resource Management;
- Increase of social accountability interventions at facility and community level;
- Introduction of performance targets and contracts, including strengthening of OPRAS;
- Implementation of fiscal decentralisation by devolution, from Council level to health facility level;
- Improvement of governance and accountability in the health commodity supply chain, to eliminate frequent stock outs and pilferages;
- Mobilisation of CHWs to improve RMNCAH;
- Expansion of CEmONC services; and
- Expansion of BEmONC services.

The MOHSW will facilitate implementation of the following initiatives, where needed, in collaboration with PMORALG:

- Prescribe the characteristic of the new recruits through reinforcing the bonding policy and introduce compulsory attachments;
- Advice on provision of skilled workers through PPP/Private engagement;
- Facilitate the implementation of baseline assessments for all initiatives, including baseline assessment and Star Rating of health facilities and provision of specific improvement facility interventions;
- Establish national guidelines to SMS reporting system for commodities and general quality of services;
- Establish national guidelines for the use of m-Health (SMS) and Maternal CHW App through PPP to facilitate utilisation of RMNCAH services;
- Coordinate training for CHWs, BEmONC and CEmONC staffs at primary facility level;
- Coordinate training for scaling up 5S-KAIZEN TQM initiatives to primary facility level;
- Coordinate the construction of Satellite Blood Bank facilities at regional level; and
- Coordinate the development of integrated Mass Media Campaigns through PPP.

PO-PSM will implement two initiatives:

- Prioritisation of allocation of employment permits to underserved regions with critical shortage; and
- Synchronisation of recruitment process at the central level.

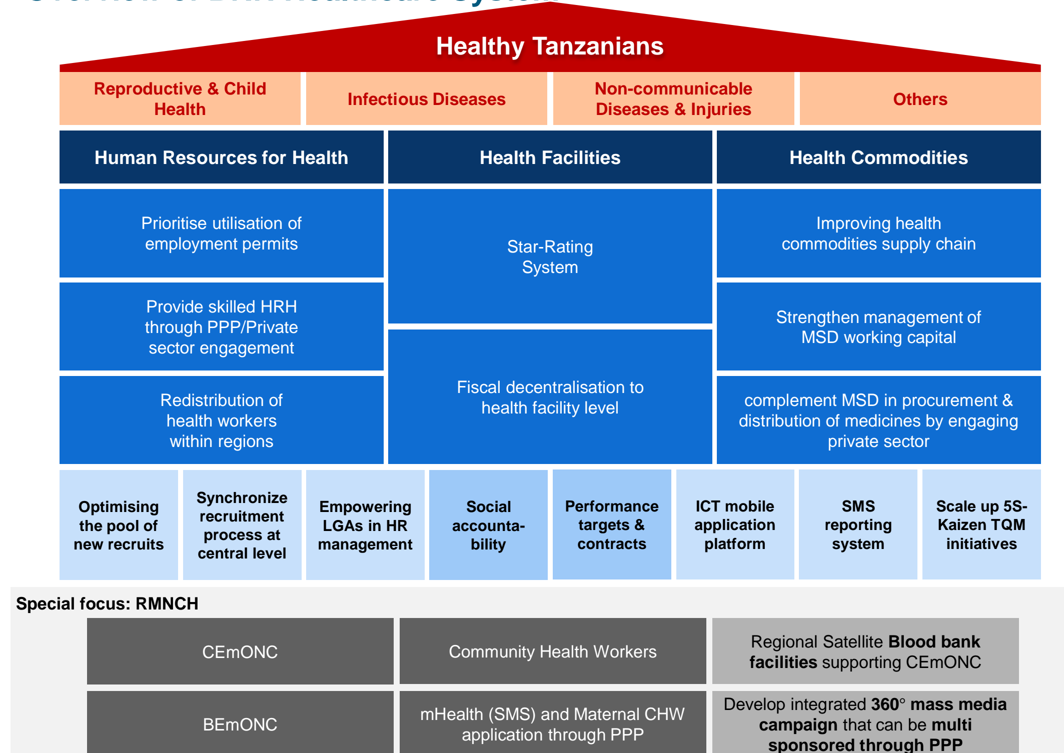
The MSD will implement the following two initiatives:

- Strengthening management of MSD working capital; and
- Engagement with the private sector to complement MSD in proc urement and distribution of medicines.

The RCHS section in particular will in close coordination with PMO-RALG facilitate training and mentoring to CHWs and health care workers as well as to their supervisors, while mobilization of the CHWs at community level will be implemented by the LGA in PMO-RALG.

The BRN activities are summarised in figure 2 below.

Figure 2 BRN in Health



The BRN has identified priority regions for actions, based on a thorough situation analysis. Most underserved or under-performing regions will be targeted first. BRN activities constitute the core of HSSP IV and are fully integrated in the HSSP IV. The 22 initiatives listed above will continue beyond June 2018. Similar achievements as planned for BRN target regions will be achieved or surpassed countrywide by the end of the HSSP IV period.

2.3 Health and Social Welfare Legislation, Policies and Strategies

The MOHSW is mandated to prepare for Government health and social welfare legislation and policies, as well as oversee their implementation through sector wide monitoring and evaluation. The Ministry and its Departments and Agencies produce strategies, work plans, guidelines and other documents elaborating the policy documents and legislation. PMORALG oversees implementation of health services by LGAs. The MOHSW monitor that all Tanzanians access quality health and social welfare services.

The existing health and social welfare sector legislation is mainly divided into:

- Public Health legislation which is for the control of epidemics, infectious diseases and environmental health protection;
- Health professional legislation which governs the practice and conduct of health professions and professionals such as doctors, dental practitioners, pharmacists, nurses and allied health personnel;
- Legislation, which establishes autonomous health and social welfare institutions for a particular need, such as National Institute for Medical Research, National and Special Hospitals, Institute of Social Work, etc.;

- Health financing legislation, which seeks to provide alternative health financing mechanism with the aim of complementing government efforts to finance health services in the country; and
- Legislation, which guarantees the rights of vulnerable groups like persons with disabilities, children, destitutes, etc. which the Minister responsible for social welfare is empowered to make Regulations for the better implementation of the law.

These laws and its regulations need to be effectively implemented in order to accomplish the intended objectives of their enactment. Furthermore, due to a number of socio-economic changes, policy and political changes, enactment and review of the existing health and social welfare legislation is an on-going undertaking. In annex 1 an overview is provided of relevant government documents informing the HSSP IV, arranged according to the building blocks of the health and social welfare sector.

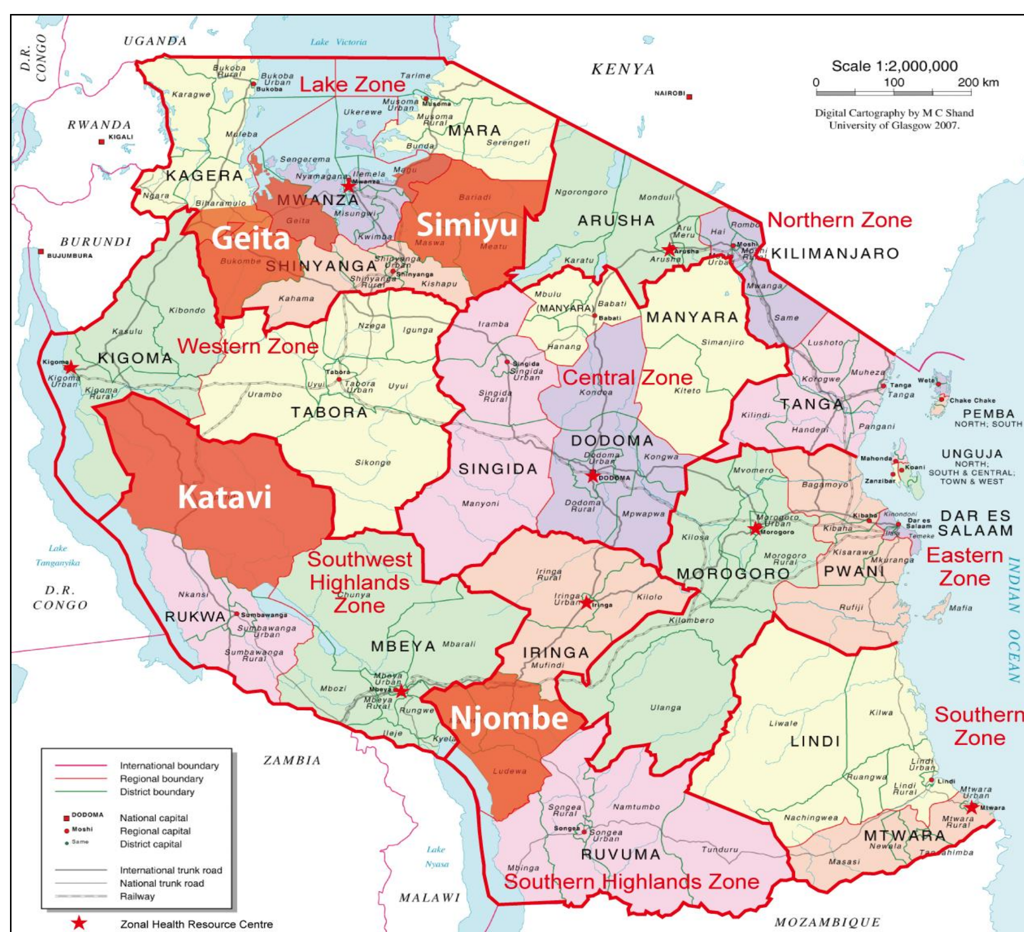
3 Health and Social Welfare at a Glance

3.1 Demography, Statistics and Structures of Health and Social Services

3.1.1 Tanzania Geography and Population

The United Republic of Tanzania (comprising of Tanzania mainland and the semi-autonomous Islands of Zanzibar) is the largest country in East Africa covering 947,300 square kilometres. Tanzania Mainland has 27 administrative Regions, 133 Districts and 162 Councils. Each Council is divided into Divisions, which in turn are composed of 3-4 Wards (with 5-7 villages each). The Local Governments (LGs or Councils) are the most important administrative and implementation units for public services.

Figure 3 Map of Tanzania with Regions and Zones



According to the latest Population and Housing Census of 2012, Tanzania Mainland had a population of 43,625,354 comprised of 21,239,313 males and 22,386,041 females with an average annual growth rate of 2.7%. In 2015 the projected population is 48,366,270. The crude birth rate is 41.6 per 1,000 people, and life expectancy at birth is 63 years for women and 60 years for men. Less than one third (29%) of the population resides in urban areas, whereas the majority (71%) of the population are rural dwellers. (Tanzania Bureau of Statistics, 2013)

The country's Gross Domestic Product (GDP) was USD $695 per capita in 2013 (World Bank, 2014). The Tanzanian economy is dependent on the labour intensive sectors of agriculture, industry, mining and construction.

3.1.2 Health Statistics and Trends

Table 1 Health Indicators in Tanzania Mainland

Description	Figure	Sources
Total Population:	**47.8 million (mainland)**	**NBS 2015 projection**
Under 15 years old	44.2% (mainland)	NBS 2015 projection
15-64 years old	52.2% (mainland)	NBS Census 2012
65 years& above	3.9% (mainland)	NBS Census 2012
Women of reproductive age (15-49)	24.3% (mainland)	NBS 2015 projection
Annual Population Growth rate	2.7%	NBS Census 2012
Life expectancy at birth (years)	61 (63 F, 60 M)	NBS Census 2012
Total Fertility Rate (TFR)	5.2	NBS Census 2012
Under 5 Mortality Rate /1,000 live births	81	TDHS 2010
Infant Mortality Rate / 1,000 live births	45	NBS Census 2012
Neonatal Mortality/1,000 live births	26	TDHS 2010
Maternal Mortality Ratio/per 100,000 live birth	432	NBS Census 2012
Births in health facilities	77%	HMIS 2014
Skilled Birth Attendance	69%	HMIS 2014
Leading Cause Admission/Death in Hospitals	Malaria	SPD 2013
Prevalence of Malaria Parasitemia (6-59 months)	9.2% (MRDT), 4.1% (micro)	THMIS 2012
HIV Prevalence, 15-49 years	5.3% (6.2% F, 3.9% M)	THMIS 2012
ART Coverage persons with advanced HIV	67%	AHSPPR HMIS 2013
Hospital admission per 100 persons per year	2.4	HMIS 2014
OPD visits for new cases per person per year	0.64	HMIS 2014

The trends in Child Mortality and Infant Mortality are downwards; and Tanzania is expected to meet the targets of the MDGs in 2015. The trends in neonatal mortality and maternal mortality are also downwards, but less, and not meeting MDG targets. According to the HSSP III MTR analytic report, the skilled births attendance rate is slowly increasing (around 62% in 2012). Figures on antenatal care are hardly improving and ANC 4th visit even reduced to 39% in 2012. These figures missed the target from HSSP III. Family planning figures are low (Contraceptive Prevalence Rate 27.4%), while the total fertility rate is very slowly reducing, also below target.

Figures on child vaccinations are very high with coverage of measles vaccination over 95%, as well as for (DPT) Penta vaccination. The rate of underweight children under five is reducing, but stunting remains high (42% TDHS) and off-target.

Malaria is the leading cause of morbidity, although slowly reducing in children under-5 years old (33% of all registered diseases in 2012). Malaria meanwhile is the leading cause of death of hospital admitted patients (around 30%). Prevention is improving: nearly 75% of vulnerable groups slept under a bed net in 2012. The second largest cluster of diseases consists of upper respiratory tract infections and pneumonia, followed by diarrhoeal diseases and skin diseases.

Although the 2012 Tanzania HIV and Malaria Indicator survey (THMIS) depicted a decline in HIV prevalence from the previous THMIS 2008, from 5.7% to 5.3%, the difference was not

statistically significant. The overall prevalence of HIV has not diminished, although the numbers of patients treated continues to rise. By the end of December 2014, Tanzania had 1,411,829 of its population living with HIV, of whom 28% are children under 14, and 11.2% of whom are young people aged 15-24. There are nearly 80,000 new HIV infections occurring annually. Adult non-communicable diseases are slowly increasing, to nearly 10% of all diagnoses in 2012. Life style related diseases like diabetes type 2 and cardio-vascular diseases are increasing.

Overall the health status of the population is improving, with differences between urban and rural areas, whereby some regions show an unfavourable epidemiological profile. There are also differences between socio-economic strata with on average a poorer health status among deprived groups (HSSP III MTR-Analytic Review 2013).

3.1.3 Health and Social Welfare Service Structure

Primary health care services constitute the basis of the pyramidal structure of health care services (figure 4). Community-based health activities bring health promotion and prevention to the families in villages and neighbourhoods, often along the lines of Disease Control Programmes. Public and private providers are working in dispensaries and health centres. Dispensaries provide preventive and curative outpatient services, while health centres can also admit patients, and sometimes provide surgical services.

Council hospitals provide health care to referred patients and provide medical and basic surgical services. Regional Referral Hospitals (RRH) function as referral hospitals to provide specialist medical care. Zonal and National Hospitals offer advanced medical care and are teaching hospitals for medical, paramedical and nursing training.

Pharmaceutical services are provided through public as well as Faith Based Organisations' (FBO) health facilities, private pharmacies and Accredited Drug Dispensing Outlets (ADDOs).

Social services are provided by social welfare officers and social workers under the Councils or by non-governmental organisations, supervised and coordinated by the Head of the Social Welfare Department (SWD) of the Council.

Figure 4 The health care pyramid in Tanzania (public and private equivalent)

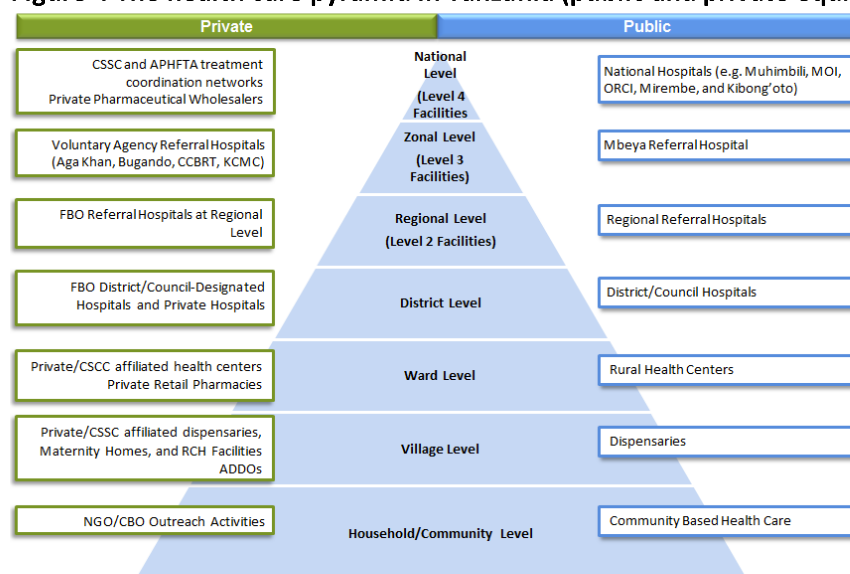


Table 2 Current health service facilities (public and private)

Public Sector Facilities including FBO (2014)	Number	Total No. Of Beds
National general hospitals	1	1,362
National specialised hospitals	4	1,497
Regional referral hospitals (Gov)	15	3,449
Regional referral hospitals (FBO)	12	4,581
Zonal hospitals	5	2,327
Council hospital	63	7,267
Council designated hospital	37	6,742
Voluntary Agency hospital	103	5,595
Parastatal hospitals and health centres	29	1,214
Health centres	614	14,959
Dispensaries	5,819	
Parastatal dispensaries	168	
Specialised clinics	12	
Total	6,882	48,993
Private Sector Facilities (2014)		
Private hospitals	39	1,187
Private health centres	78	800
Dispensaries	1,123	
Private clinics	40	
Private dental clinics	26	
Private eye clinics	5	
Maternity homes	22	
Total	1,333	1,987
Health Sector (Total)	8,215	50,862

Source: MOHSW, Department of Curative Services, HMIS report 2013/14, CSSC 2015

3.1.4 Management of Health and Social Welfare Services

Tanzania has decentralised most Government functions through Decentralisation by Devolution (D-by-D). The PMO-RALG is responsible for the management and administration of public services at Regional and Council level. At the local level the LGAs are responsible for planning, delivering and overseeing public services, for example health services, social welfare services, primary and secondary education, agriculture extension and livestock, water supply, and local road maintenance. LGAs and facilities owned by LGAs have responsibilities in social accountability and in establishing partnerships with communities, NGOs and private providers in health and social welfare. They are the main interface between citizens and Government in day-to-day life.

The Council Health Management Teams (CHMTs) manage health care and social welfare services at the Council level. Council health services consist of Primary Referral Hospitals and Primary Health Care Facilities (health centres and dispensaries). The LGAs employ personnel working in Council health services. All CHMTs produce an annual Comprehensive Council Health Plan (CCHP), which shows the activities and budgets for the services. There are still many activities off-plan and off-budget, initiated through NGOs or Disease Control Programmes (HSSP III-MTR 2013).

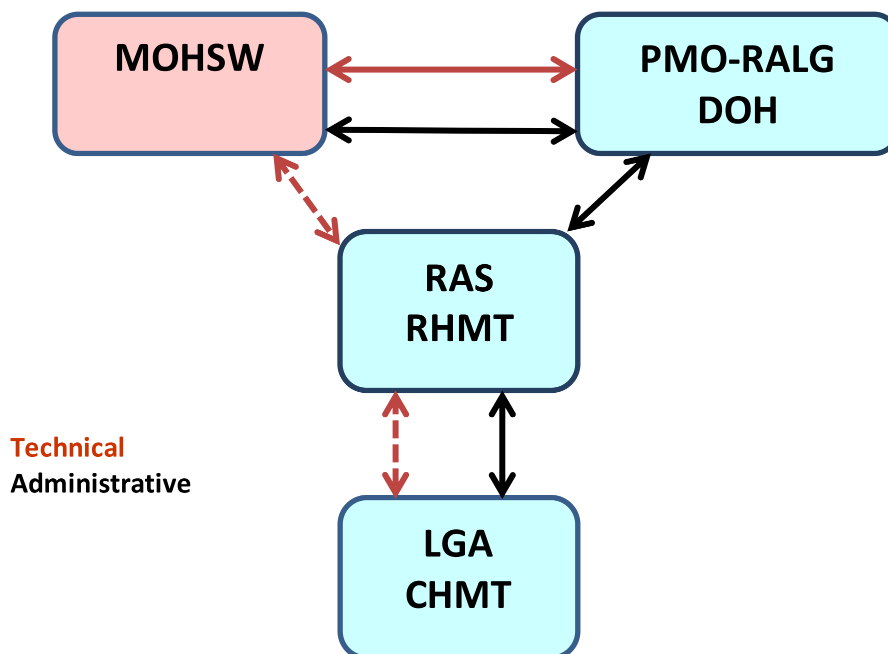
Health Facility Governing Committees (HFGCs) and Council Health Services Boards (CHSBs) are bodies with community representatives that ideally contribute to management of the health institutions, but which are sometimes dysfunctional (HSSP III-MTR 2013).

The Regional Health Management Teams (RHMTs) work under the Regional Administration under PMO-RALG. They have as role to oversee the work of the Regional Referral Hospitals and the CHMTs. RHMTs provide technical and administrative support to those entities.

The Department of Health (DOH) in PMO-RALG oversees the Council and Regional health services administratively. PMO-RALG supervises planning, reporting and financial accounting. It follows local government procedures, which have their own management systems, for example software of EpiCor and PlanRep.

The MOHSW has the overall responsibility over the health and social welfare services and defines priorities for services in the health and social welfare sector, e.g. the National Essential Health Care Interventions Package – Tanzania (NEHCIP-Tz) (See Section 5.3). The MOHSW provides technical guidance to organisations involved in service delivery and defines, controls and promotes maintenance of quality standards and sets the policy for social welfare, see Figure 5 below. The MOHSW mobilises resources and has the lead in policy and international relations in the area of health and social welfare. The MOHSW delegates some stewardship functions to PMO-RALG and other statutory health agencies, *e.g.*, Medical Stores Department, Tanzania Food and Drug Authority, *etc*.

Figure 5 Relations between levels of management in health and social services



The Ministry of Finance (MOF) manages the overall revenue, expenditure, and financing of the Government of the United Republic of Tanzania and provides the Government with advice on the broad financial affairs of Tanzania in support of the Government's economic and social objectives. Its duties include preparing the Central Government budget and determining expenditure allocations to different Government institutions. The Ministry has

an important say over the health and social welfare sector budget and also over income generating activities (*e.g.*, insurance schemes).

The President's Office, Public Service Management (PO-PSM) assists in matters of human resources management pertaining to Public Service across the entire government system. This includes responsibilities for personnel policies, administration and coordination of training and recruitment. This office plays a crucial role in human resources for health in the country.

3.2 Service Delivery of the Health and Social Welfare Sector

3.2.1 Services in Community and Health Institutions

Communities

There are a broad range of community-based programmes for disease prevention and control, *e.g.*, in malaria (bed nets and spraying), HIV/AIDS, TB, sanitation, hygiene, and community based rehabilitation. However, relatively few communities are reached with a comprehensive set of interventions. Activities mainly depend on local programmes and funding, often by NGOs. Preventive chemotherapy against Neglected Tropical Diseases reaches a geographical coverage of above 60% countrywide.

Health institutions

Over the period 2009 to 2014, the Government has expanded the number of health institutions with around 500 mainly primary health care facilities and has increased the number of health workers deployed. In 2013, sixty six thousand (66,000) health workers were employed, out of the 149,000 required. Per capita utilisation of outpatient health services did not increase significantly during the HSSP III period and was around 0.7 per capita in 2013. This is attributed to low quality of care and limited access to medicines and products. The Regional Referral Hospitals are still facing shortages of specialists and are struggling with quality issues. Some are failing to cope with the demands for services, due to shortages of personnel, supplies and equipment, and limited revenues.

Services, such as Integrated Management of Childhood Illnesses (IMCI), malaria, tuberculosis, HIV prevention and control, Sexually Transmitted Infections (STIs), Reproductive Maternal Newborn, Child and Adolescent Health (RMNCAH) and Prevention of Mother to Child Transmission (PMTCT), are increasingly delivered in an integrated way at the primary health care level ("one-stop-shop"), while the utilisation of these services is improving. Services for Non-Communicable Diseases are still not yet provided according to the needs of the population, based on epidemiological estimates.

The MOHSW has developed the Tanzania Quality Improvement Framework (TQIF) and a Quality Improvement Strategic Plan (2013-2018), with guidelines, tools and training for improvement of the quality of service delivery. The Quality Improvement (QI) programme is still expanding.

The country has developed a good system for addressing health emergencies; however, implementation is often constrained by lack of human and financial resources.

3.2.2 Disease Control Programmes

The trend analysis of the progress for the HSSP III indicators showed Tanzania would achieve most of targets in the strategic plan in disease control and child health. The targets set in the HIV/AIDS strategic plan for the period 2009–2013 are likely to be achieved, particularly for those in the areas of utilisation of HIV/AIDS care and treatment services. Activities are noted for increasing safe blood supply, safety of injections, access to voluntary medical male circumcision *etc*. However, marginalised groups, like people who inject drugs, sex workers, men who have sex with men and people living with disabilities or mentally handicapped, get insufficient attention. HIV prevalence is decreasing only slowly, while women remain more at risk than men. Challenges include the large gap between adult and paediatric anti-retroviral treatment coverage, weak integration of HIV within RMNCAH services, and lack of age-disaggregated data to understand the situation regarding coverage of HIV and Sexual and Reproductive Health services among adolescents.

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 use ITNs.

TB and leprosy strategies for the period 2009–2013 have generally been implemented according to plan. However, new estimates following the first TB prevalence survey in Tanzania indicated much lower case detection rates and less TB-HIV co-infection than previously estimated. 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 (NTDs) for the period 2009–2014 were being implemented on an expanded scale, in particular surveillance, diagnosis and treatment. Around 64% (101 out of 160) of the Councils where NTDs are endemic are implementing Integrated NTD control activities. Good progress has been made in Onchocerciasis control, interrupting transmission of Lymphatic Filariasis and Trachoma.

Recent surveys have provided much more insight into the upcoming epidemic of non-communicable diseases (NCDs). Urbanisation and social change are increasingly leading to unhealthy lifestyles (*e.g.,* poor diet, excessive salt intake, limited physical activity). 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.

3.2.3 Reproductive, Maternal, Newborn, Child & Adolescent Health and Nutrition

Reproductive Health Services (RHS) are not performing as hoped in Tanzania, despite investments in this area. Most of the targets of HSSP III in this area are not being achieved. The number of facilities that offer RHS is increasing; however, the facilities face shortages of skilled staff and in supplies. There was a slight increase in skilled birth attendance and in post-natal care during the HSSP III period, as well as in utilisation of Family Planning (FP) services. (See statistics under 3.1.2.) In many rural areas, the pace of quality improvement and availability of health services lags behind that of urban areas. In the BRN planning process, under-performing regions with significant numbers of rural populations have been identified for priority action. Expansion of service delivery has not been moving in tandem with improved quality of services delivered, and especially referral of complicated maternal cases in rural areas is still insufficient.

Most child health programmes are performing well, with the exception of newborn care (related to poor quality of maternal health care around birth), which is a serious concern, given the high neonatal mortality in the country. Vaccination services are well on track and nearly all children are vaccinated; at the national level, the coverage of all antigens has been maintained above 90% for three consecutive years. Four new and under used vaccines Rotavirus vaccine, Pneumococcal vaccines, Combined Measles Rubella vaccine and 2nd dose of Measles Rubella have been introduced in the routine immunisation schedule. Coverage of the newly introduced vaccines has not yet reached 90%. Despite high coverage of vaccinations, there are districts with few geographic or wealth-related inequalities. These districts have a high number of children who are not vaccinated or under-vaccinated.

There has been a gradual improvement in the nutritional status of children in Tanzania, but stunting remains a problem because of repeated episodes of ill health of children and inadequate infant and young child feeding practices. Stunting remains a problem with prevalence of 42% among under-five children (DHS 2010). Exclusive breastfeeding is not yet a common practice in the country, especially in rural areas. There has been no improvement on prevalence of micronutrient deficiencies among children and women of reproductive age. Coverage of Vitamin A Supplementation (VAS) has increased significantly.

3.2.4 Social Welfare

The Department of Social Welfare (DSW) is responsible for services to vulnerable populations in communities or in institutions. Social Welfare Officers in Councils are responsible for the provision of child protection services and supervision of other welfare services. Integration of Social Welfare Services in LGAs is still challenged by inadequate capacities to handle complexity and emerging social welfare problems and by financial constraints.

In addition to social protection services, social welfare officers have a legal responsibility under the Law of the Child Act for the delivery of child protection services for local government authorities. The Violence against Children Report published in 2011 noted the high levels of physical and sexual violence and the physical and mental health consequences of suffering such abuse, as well as the social and cultural legitimacy of violence. The Second National Costed Plan of Action (2013-2017) and the Multi-sector Task Force on Violence against Children, Implementation, Monitoring and Evaluation Results Framework Plan all give prominent attention to the need of developing services to protect children from all forms of violence. An initial pilot project in eight Councils has now been extended to 15 Councils.

The Government is only in the early stages of developing services for children who are without parental or family care, and have yet to develop fully the fostering, fit persons, adoption and residential services necessary to meet need. At present, social welfare services for children are assisted by the Most Vulnerable Children Committees, which have been established in virtually all Councils. NGOs provide most of the residential care, but a rigorous monitoring and inspection framework has yet to be developed.

In addition to child protection services, the Government provides social protection services through other ministries and through the Tanzanian Social Action Fund (TASAF). External agencies (multi-laterals, bi-laterals, non-governmental and faith-based organisations, *etc*.) are important partners in local service provision, but are unable to reach the whole country, leading to inequities in access to services. External agencies may also apply their own criteria for access to services.

Special programmes for disabled people are in place in some regions in the country. There are community based rehabilitation services (mostly run by NGOs), and some institutions provide care and rehabilitation. There are four centres for surgical care for disabled people.

Social Welfare policy issues include financing access to essential education and health care services among the vulnerable population groups, which needs to be anchored within a comprehensive Social Welfare Policy and supported with social welfare legislative provisions. Access for the poor to health insurance schemes is an upcoming issue for Social Welfare Officers in the country.

In 2014, an Inter-Ministerial Memorandum of Understanding was signed for the Implementation of the National Under-Five Birth Registration Strategy between Ministry of Constitutional and Legal Affairs, PMO-RALG, and MOHSW. Health facilities increasingly play a role in the system of Birth Registration because the majority of children are born in health facilities and nearly all children are vaccinated. Tanzania follows the internationally agreed "Reaching Every Child" (REC) approach.

3.3 Health Care Support Systems

3.3.1 Human Resources for Health

Human Resources for Health (HRH) planning is improving at the Council level, strengthened by a functional Human Resources Information System (HRIS). Bottlenecks in HRH management are still prevalent, leading to limited absorptive capacity in the system (as thoroughly analysed in the BRN planning process). As a result, newly trained staff have problems finding quickly employment, while vacancies exist.

The number of health workers, especially clinical personnel, is increasing. However, remote and rural areas still face major shortages and many primary health facilities do not have enough qualified staff, resulting in an inefficient use of resources. This has been identified as one of the key constraints in the NKRA formulation. Population ratios for laboratory and pharmaceutical personnel remain well below expectation. Critical under-financing and limitations enforcing the Public Service Pay and Incentive Policy (2010) intensify the misdistribution or shortage of health workers.

The system of performance management not fully operational; the Open Performance Review and Appraisal System (OPRAS) is only partially implemented and actually unpopular among the administrators who are supposed to put it to use.

The output of training institutions has increased considerably over the last several years, but the quality of training is not yet consistent. Continuing Professional Development (CPD) has limited continuity; the impact on the health system as a whole is insufficient, as the approach is fragmented and ad-hoc. There is no system of accreditation and re-registration of professionals based on attending CPD. There is no system of quality assurance of competencies of health professionals.

Table 3 Health workforce supply in the base year 2014

Occupation	Supply in 2014	% of the total work-force	% FTE in public sector	FTEs by sector		Density of health worker per 10,000 population
				Public	Private	
1.Medical Specialists	929	1.4	70.0	650	279	0.20
2.Medical Doctors	1,157	1.7	80.0	926	231	0.25
3.Dental Specialists + Dental Officers	104	0.2	95.0	99	5	0.02
4.Assistant Dental Officers + Dental Therapists	933	1.4	87.7	818	115	0.20
5.Assistant Medical Officers	1,710	2.6	90.0	1,539	171	0.37
6.Clinical Officers + Clinical Assistants	6,496	9.8	70.0	4,547	1,949	1.42
7.Pharmasists	707	1.1	96.5	682	25	0.15
8.Pharmact Technologists + Assistant Pharmacy Technologists	1,132	1.7	95.4	1,080	52	0.25
9.Nursing Officers	2,843	4.3	97.7	2,777	66	0.62
10.Assistant Nursing Officers	4,861	7.3	90.0	4,375	486	1.06
11.Enrolled Nurses +NMs	13,848	20.9	80.0	11,078	2,770	3.03
12.Health Laboratory Scientists	93	0.1	89.2	83	10	0.02
13.Health Laboratory Technologists + Assistant Health Lab. Technologists	2,508	3.8	92.1	2,310	198	0.55
14.Environmental Health Officers	1,205	1.8	99.8	1,202	3	0.26
15. Assistant Environmental Health Officers+ Environmental H. Assistants	1,119	1.7	100.0	1,119	0	0.24
16.Allied Health Professionals	1,245	1.9	97.5	1,214	31	0.27
17.Managers	384	0.6	98.4	378	6	0.08
18.Allied non-Health Professionals	2,235	3.4	91.5	2,046	189	0.49
19.Support Staff	3,460	5.2	95.6	3,309	151	0.76
20.Medical Attendants	19,379	29.2	96.1	18,632	747	4.24
TOTAL	66,348	100.0	88.7	58,864	7,484	14.50

Source: MOHSW, Human Resources Planning Division, Human Resources for Health Information Systems (HRHIS) and Training Institutions Information System (TIIS) (2014)

Social work is a relatively new profession in Tanzania. At present there are an inadequate number of trained social workers to meet the needs of all LGAs (four social welfare officers in each Council and a social assistant at each ward). The Department of Social Welfare is enhancing the professionalism of social workers through both formal training and short courses. A common core of training materials has been developed and common modules will be made available for all training institutes and organisations during the period of HSSP IV. The MOHSW is planning to implement a Social Welfare Workforce Production Plan, which ensures that the increased workforce is capable of managing emerging and complex social problems. The Social Work Council and the Association will be facilitated to undertake their duties to enhance professional conduct in social welfare functions.

3.3.2 Essential Medicines and Health Products

The availability of key medicines in health facilities remains low, with no clear trend of improvement during HSSP III. A number of factors (internal and external) affect overall management of commodities in the sector. According to the BRN analysis, internal factors include inadequate funding, poor planning and coordination, inadequate tracking mechanisms and tools, as well as inadequate pharmaceutical human resources at the facility

level resulting in poor inventory management. External factors include a lack of coordination of externally funded vertical programmes' medicines and health products and donated supplies, and pilferage. This negatively affects the quality of care and performance of service provision in general.

The number of Accredited Drug Dispensing Outlets (ADDOs) has increased from 2,215 in 2010 to 3,591 in 2013, leading to better availability of some medicines and health products in rural areas. However there are still some challenges with sustaining quality of services and products within ADDOs. Ensuring the rational use of medicines is still a major challenge in spite of some positive developments that include the development of Medicines and Therapeutics Committee (MTC) guidelines, training on MTCs at public sector hospitals and the update and wider distribution of Standard Treatment Guidelines and National Essential Medicines List.

Funding of medical supplies is not improving in real per capita terms and disbursement issues continue to affect the efficient use of limited funds. Budgetary shortfalls are exacerbated by disbursement practices (*e.g.*, less than approved budget is disbursed by Treasury to the MOHSW; irregular disbursements, late in the financial year; long lead times for disbursed funds to be credited to health facility accounts at MSD). In addition, failure to budget for distribution costs for externally financed products has eroded MSD working capital. MSD's limited cash flow negatively affects the stock levels and order fulfilment rate for medicines and other products. Local manufacturing to increase availability of medicines in the country is still low at about 30% of the requirements.

On the positive side, better procurement and information management procedures are under development (e-LMIS), with the potential to increase efficiency, reduce waste and improve availability of medicines to the population. Similarly the regulatory framework through the Tanzania Food and Drug Authority (TFDA) has improved over the years. 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 (from 52% to 96% between 2010 and 2012) in its WHO pre-qualified quality control laboratory. However, there are still medicines and health products of questionable quality and some are not registered circulating in the market.

3.3.3 Capital Investment

The health sector infrastructure in Tanzania is expanding, especially the number of dispensaries (around 500 in the past five years). In some regions in the country the number of facilities is still inadequate. The number of staff houses is insufficient, and most of the health facilities in remote areas lack electricity and reliable water supply. Construction activities over the last years have exceeded the deployment of staff, leading to underutilisation of the infrastructure and thus efficiency losses. The MOHSW does not have a meaningful role in quality control of infrastructure and does not have a good overview of available health institutions in the country, especially not the private facilities.

Infrastructure maintenance is a major challenge, affecting the majority of institutions. Maintenance of equipment is not yet a priority for health facilities, and this has a negative impact on the effectiveness and quality of service delivery. Equally, acquiring and maintaining means of transport is a challenge for most institutions.

3.3.4 Monitoring and Evaluation

A comprehensive Monitoring and Evaluation Strengthening Initiative (MESI) has been developed and implemented since 2009. The customised DHIS-2 software was disseminated and health workers were trained. Indicators across the HMIS tools were harmonised and data collection tools for Disease Control Programmes were realised, allowing for integration of systems. Developments in information and communication technologies are paving the way for establishing the clearing house and have a potential to change the face of health service delivery.

The reporting systems of the PMO-RALG and MOHSW are still in the process of integration. The quality of analysis of available information requires further coordination and capacity development for this to be institutionalised: the data-for-decision making approach is not yet commonplace in most CHMTs and RHMTs. More sex- and age disaggregation of many health service indicators are also needed in order to understand gaps in coverage.

The country has a well-established system of sentinel surveillance to assess performance and regular surveys to get information on trends in development, demography, poverty, health and social wellbeing. Research is increasing and national reports are more available; the research outputs are not yet incorporated in the health information-clearing house.

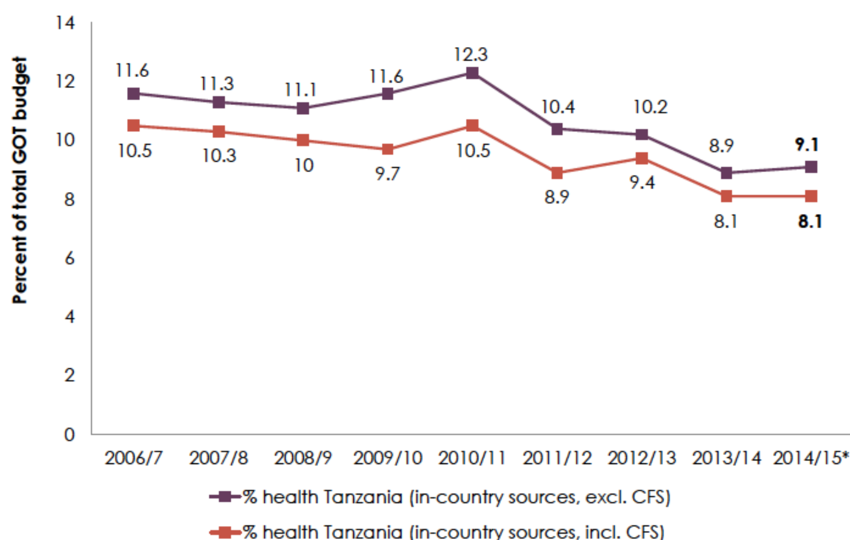
3.3.5 Health Financing

Countrywide measures for removing financial barriers for the population are slowly taking off. The Community Health Fund (CHF) and TIKA (a scheme for urban, peri-urban areas) aim at reduction of health care costs in primary care. The highly needed Health Financing Strategy (HFS) under development aims at providing universal and equitable access to essential health services, while improving sustainability of the health sector.

There has been progress under HSSP III in improving financial management as an avenue toward greater efficiency and effectiveness, but aligning various types of resource management from non-basket partners is still a challenge.

Through a participatory process led by the MOHSW, a new HFS has been developed, which will align with the HSSP IV and continue thereafter as the country aims to achieve universal health coverage. The HFS shares the vision of HSSP IV in improving the quality of health services and increasing equitable access. One of the key barriers to improvement in quality and access is the lack of effectiveness and efficiency in health financing. It is recognised that the health financing architecture is fragmented, which means that individual health insurance schemes are covering different population segments, rather than combining them. They do not yet achieve efficiencies in scale and cross-subsidisation (by creating one joint risk and financial pool). Furthermore the large number of different funding streams, health-purchasing agencies (e.g. health insurances) and different regulatory institutions are also making financial stewardship of the health sector challenging. The HFS aims to solve these problems by moving towards a more sustainable and efficient architecture for raising (particularly domestic financing), combining, and deploying overall funding for health, with defined roles for certain critical institutions.

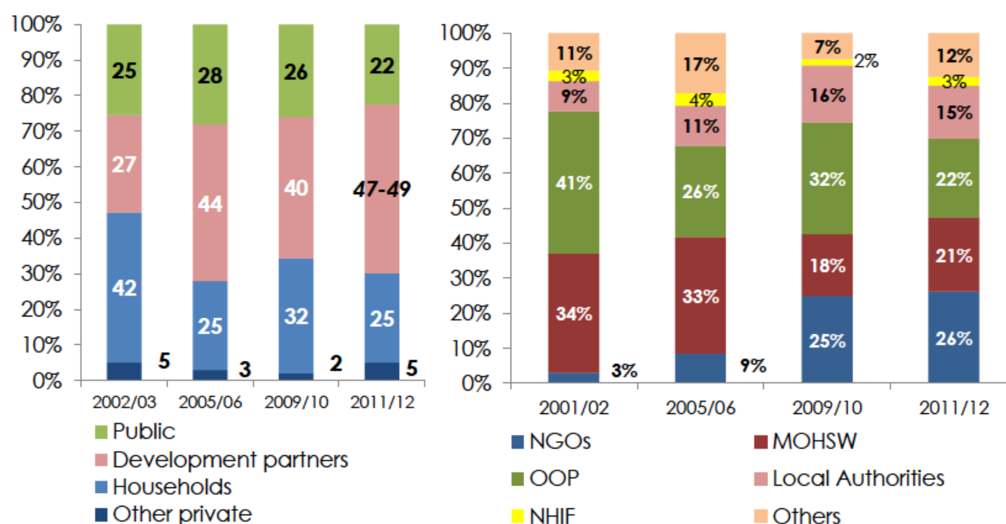
Figure 6 Percentage of GOT budget 2006/07 - 2014/15



Source: PER presentation to JAHSR 2014

There is growth in the total health expenditure in Tanzania, but the per capita expenditure corrected for inflation remained flat in the HSSP III period. Tanzania spends between 9% and 10% of its budget on health. See figure 6 above. The public health budget has become increasingly reliant on foreign funds.

Figure 7 Total Health Expenditure by Financing Source and Financing Agent



Source: National Health Accounts 2011/12

The Health Basket Fund plays a crucial role in health care financing, although in recent years contributions are dwindling. The funds offer the LGAs assured opportunities for implementing service delivery. The demands and capacities in LGAs for timely accounting and reporting do not always match the requirements. However financial decentralisation is aimed at conferring autonomy to health facilities on financial management.

3.3.6 Leadership and Governance

In recent years, new health and social welfare legislation has been enacted. However, there is still limited understanding of the holistic nature of health and social welfare legislation. Similarly, laws are not self-executing instruments; additional support is needed to empower all those who are statutorily mandated to oversee their implementation. This lack of understanding has affected the implementation by relevant stakeholders. Furthermore, there is a number of health and social welfare related international conventions or agreements initiated by other sectors and partners, which need to be adopted and implemented. Based on this, specific implementation support is needed in order to ensure enforcement and compliance of relevant legislation.

There is viable operational planning at all levels of the health sector. Decentralisation by Devolution is progressing, but requires further harmonisation of systems by the MOHSW, PMO-RALG, PO-PSM and MOF as well as reaching the communities and households in a coordinated coherent manner.

A key strategy for the strengthening of public governance in Tanzania is through the concept of public-private partnerships (PPPs). PPP has been properly developed, with strategies, tools and instruments for operationalisation, as well as advocacy and training at national, regional and council levels. Service Agreements (SAs) are in place between LGAs and faith-based health service providers. Some Councils face constraints in meeting the financial obligations of those agreements. The potential for expansion is not yet fully utilised to make a significant impact on the sector. The private-for-profit sector is not yet fully organised and has not yet managed to enter into Service Agreements.

With regard to the Sector Wide Approach (SWAp), the arrangements laid down in the Code of Conduct and Basket Funding Agreements provide a model for the sub-Saharan region. The Technical Committee-SWAp and Joint Annual Health Sector Review (JAHSR) are outstanding instruments for collaboration between stakeholders, with open and transparent discussions. However, efficiency of procedures has to increase, and harmonisation between monitoring of HSSP IV and SWAp is required.

Recent reviews and studies (MTR HSSP III) have endorsed the principles and operation of the SWAp but have also highlighted some weaknesses in its operations. The participation of civil society is still limited and other Ministries, Departments, Agencies (MDAs), especially PMO-RALG, face constraints in attending meetings.

The Technical Working Groups (TWGs) are an asset for joint planning and implementation but are not always functioning as desired. Attendance varies and there is overlap with each other and with other committees or task groups. The coordination or exchange of information across TWGs is not optimal and weak linkages are maintained with the management structure of the MOHSW.

4 Strategic Framework for the Health Sector

4.1 Introduction

Strategic Direction: As Tanzania is heading towards middle-income country status, its performance in health care and social welfare services will head towards that of other middle-income countries (both in coverage and quality). Better health will contribute to increasing productivity and growth as well as rising GDP.

The health and social welfare sector follows the overall Tanzania Development Vision 2025: achieving a higher quality of life for the people of Tanzania at the status of a middle-income country and a health care and social welfare system at this level of development. The Tanzania Health Policy defines the Vision 2025 Goals for the health sector. The Big Results Now (BRN) Programme accelerates developments toward Vision 2025 and has formulated a set of tangible objectives and targets for the health sector (see Section 2.)

Sustainable Development Goals (SDGs)

The SDGs provide the strategic context for international development, and more specifically Universal Coverage of health and social welfare services. The SDGs compel this HSSP to take forward the unfinished agenda from the MDGs with more attention paid to maternal health (MDG5). Also, sustaining gains made in child health indicators (MDG4) and primary and secondary prevention gains in the high burden communicable diseases (malaria, TB, HIV) receive attention along with addressing conditions resulting from epidemiological transition in terms of prevention and management of NCDs. The challenge posed by NCDs presents a sufficient justification for addressing social determinants of health in education, environment, economic, cultural and other sectors: to this end, sustainable measures for poverty eradication, environmental protection and preservation, household food security, quality basic education for all and healthy lifestyles shall be promoted in the context of health in all policies.

Figure 8 Strategic Framework for HSSP IV

4.2 Mission and Vision of HSSP IV

The Mission, Vision and Core Values are crosscutting for all activities in the sector, integrated in all work plans of all stakeholders in the sector.

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

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

4.3 Overall and Specific Objectives of HSSP IV

The mission and vision of the health and social welfare sector inspire the Overall and Specific Objectives, which elaborated in this strategic plan.

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

The specific objectives are:

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

Quality Improvement of primary health care and social welfare services in communities, households and primary health care facilities will be the major focus of HSSP IV, enhanced by the BRN activities under four Key Result Areas. The health sector will take the BRN approach further, to all regions in the country and beyond 2018 (when phase one of the BRN programme ends). Targets for quality improvement (to be achieved by 2018) are:

- **20% reduction in maternal mortality ratio and neonatal mortality rate in 5 poorly performing regions:** Maternal and newborn services shall reach under-served areas and meet the quality standards for primary and referral care (see Section 5.4.)

- **100% balanced distribution of skilled health workers at primary level in targeted underserved regions:** Recruitment, retention and (re)distribution of Human Resources for Health (HRH) will ensure adequate staffing of all primary health care facilities.

- **80% of primary health facilities to be rated 3 Stars and above by 2018:** The process is guided by the Star Rating system for primary level health facilities, which sets objective criteria for minimum standards to be achieved. The further development of a stepwise certification and accreditation system and linkage of quality to insurance payments will stimulate the health facilities to go beyond 3 stars as further development from the BRN priming (see Section 5.1). Performance management systems and involvement of health facility teams in self-assessments will stimulate health staff and social welfare workers to provide quality services (see Section 6.1). There will be measures to enforce accountability and deter pilferage and corruption. Cases of corruption will be dealt with immediately through the legal framework of the government of Tanzania.

- **100% stock availability of essential medicines:** Quality will also improve through adequate supply of medicines and health products (see Section 6.2) and through refurbishment and equipping of health facilities (see Section 6.4).

For social welfare, quality will be maintained through the creation of an inspectorate and development of a monitoring framework. The health and social welfare sector will ensure that **essential services** are provided. It will further refine the National Essential Health Care Intervention Package (NEHCIP) as well as a Minimum Benefit Package for the Single National Health Insurance (see Section 5.3). Promotion of healthy living and an environment conducive for healthy households and workplaces will help to achieve a quality living standard in health and social welfare among communities. Prevention of communicable and non-communicable diseases will receive high priority (see Section 5.3). The country will address nutrition issues, especially stunting of under-5 year old children (see Section 5.4).
Improved quality will generate trust in the national health and social welfare services and will stimulate people to join the Single National Health Insurance. It will stimulate people to take greater ownership of the health services in their communities.

There will be emphasis on applying **human rights** based approach in health programmes and clients' rights by revitalising the Client's Charter (see Section 7.3). In social welfare the rights of vulnerable groups (persons with disabilities, orphans, elderly, female headed households, persons with chronic diseases, homeless, etc.) will be protected. MOHSW and partners will engage in a public awareness campaign to sensitise the population about their rights and responsibilities and will reach all households (see Sections 5.2. and 7.3).

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

Under HSSP IV, significant steps will be made to increase **equitable access** by improving the geographical spread of health services, as well as individual and social protection through the Single National Health Insurance (SNHI).

- The BRN focus on most underserved Regions and Councils, where health outcomes are below average, will enhance equity of **access for rural populations**. Under this strategic period, (re)distribution of qualified staff over the country will receive attention in order to improve accessibility of services (see Section 6.1).

- **Improving community health services** by professional Community Health Workers in integrated health programmes will include a Social Welfare Attendant that will attend to social welfare issues at grassroots, also in areas where distances to health facilities are bigger (see Section 5.3).

- Further integration of social welfare and health services and closer collaboration with other ministries, agencies and non-governmental organisations will make **social welfare services more accessible** to people in need of assistance (see Section 5.7).

- **Reproductive health** will be a major priority for the health sector, with special attention for access to care by **vulnerable groups** (see Section 5.4). Adolescent girls and young women are at a higher risk of HIV infection and will receive adequate care (see Section 5.4).

- **Gender equity** will receive increased attention in concrete measures, e.g. focus on prevention of HIV amongst adolescent girls, addressing violence against women. Also in committees and boards equal representation of women will be prioritised (see Section 7.3).

The health sector will continue the BRN approach during the whole HSSP IV period, which includes priority setting based on epidemiological analysis, targeting under-served populations and vulnerable groups, and responding to high priority health needs.

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

Acceptability of the services will also improve by increased community health care guided by:

- A newly articulated Community Based Health Programme, in partnership with organisations in society, by **revitalising primary health care** and community based social welfare services (see Section 5.3).

- More **community participation in management** of the health facilities will contribute to regaining trust in the health care system and increased acceptability (see Section 7.2).

- The health and social welfare sector will engage with the population in modern **interactive communication** via e-health to establish partnerships (see Section 6.5).

To ensure that interventions formulated in this strategic plan are measured and assessed with beneficiary interests a system of **social accountability** will be put in place to strengthen bottom-up planning, transparent reporting to Boards and Committees, by:

- Optimising mechanisms that provide room for community voice to be heard in health care management (see Section 7.2).

- Promoting innovations such as user rating, customer satisfaction surveys, and a community scorecard (see Section 7.2).

- Using information and communication technology to promote transparency, and performance management (see Section 6.5).

- Strengthening monitoring and evaluation systems (see Section 6.4).

The new health care financing strategy, which promotes the development of a single national health insurance with effective risk-pooling and social protection, will increase the **affordability** of health care, also for the poorer citizens, and will enhance sustainable development of the health care sector (see Section 6.6).

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

Improvement of the health and social welfare services can be realised at a higher rate through increased **effectiveness** and **efficiency**. Improving the technical competency of health workers and their adherence to standards will increase overall effectiveness. Better use of information systems will improve efficient communications and better inform decision-making concerning the utilisation of scarce resources (see Section 6.4). In the implementation of health sector interventions, **partnerships** across the health and social welfare sector are crucial, at all levels. Public and private providers will work together in the delivery of health services, with a view to give room for **innovative approaches** (*e.g.* new contracting arrangements) in service delivery and for the promotion of private sector engagement.

In health care financing, **opportunities for public private partnership** will be created which allow the business community to enter into collaboration with public as well as private partners in the health sector. Government will facilitate investments in the health sector (see Section 6.6).

Recognising that the country is still largely relying on support from abroad for health and social welfare services, the MOHSW will continue to uphold the Sector Wide Approach in the health and social welfare sector, strengthening financing of one sector plan, country level partnerships and international collaboration, while addressing donor dependency through financial sustainability plans and exit strategies (see Section 7.4).

5. ***For improving the social determinants affecting health and welfare, the health and social welfare sector will achieve close collaboration with other sectors, and advocate for inclusion of health promoting and health protecting measures in other sectors' policies and strategies. It will mobilise non-governmental and private partners to promote health and wellbeing through their strategies.***

The vision of the health sector is to have a healthy nation with improved social wellbeing contributing to national development. Health is a valuable individual asset enabling people to better contribute to social development. Improved health and social wellbeing of the nation are essential towards realising the Nation's Vision 2025. Investing in health is therefore a necessity for the country to meet its development objectives.

The health and welfare sector alone cannot achieve the desired health and wellbeing for all individuals. **Social determinants of health and wellbeing**, like nutrition, housing, safe water, safe and hygienic environment, individual behaviours and security are crucial to realising these goals. For addressing the social determinants of health, economic development, housing, education, roads and communication are of great importance.

In order to achieve a healthier nation, health aspects must be part of policies in all sectors. The MOHSW will be the advocate for policies protecting and advancing health and social welfare, *e.g.,* in reduction of point source environmental pollution, building resilient interventions for the reduction of harmful effects of climate change, improve road safety, protection from the double burden of Non-Communicable Diseases and Communicable Diseases through promotion of healthier lifestyles, safety of consumer goods and food products. The MOHSW will advocate for **health impact assessments** prior to major developmental initiatives (see Section 5.5).

Social welfare focuses on achieving acceptable standards of social wellbeing and protection for vulnerable groups in society, and enables those **groups to participate in society** and contribute to development of the country. Social welfare interacts with many other sectors, like economic development, education, or food security. Like health, social welfare has to be integrated in other sectors' policies (see Section 5.7).

The private sector (companies, businesses, farms, *etc*.) plays a critical role in health and social wellbeing of the population, not only by employing people, but also by producing health products, or in some cases exposing people to health risks. Partnership with the private sector is necessary in health promotion and health protection. Similarly, the non-governmental sector contributes to service delivery, advocacy, awareness raising and training, and is partner in both the health and social welfare sector. There is also a growing awareness among private sector companies regarding their corporate social welfare sector responsibility to their employees and to the communities where they operate. Currently, corporate social responsibility is voluntary, but the private sector needs to be educated to its benefits, both for individuals and for a company's growth (see Section 7.2).

Advocating for informed health interventions in conjunction with all policies is not only a responsibility for the MOHSW, but also for local and regional health and social welfare organisations advising in decentralised government systems (see Section 7.2).

Annex 3, 4 and 5 shows relevant indicators for health sector performance, for BRN and for HSSP IV implementation, with baseline and targets for the HSSP IV period.

5 Service Delivery

5.1 Introduction

The Section on Service Delivery reflects strategic directions in services with an overarching theme of quality assurance, which is presented first. Next, this Section presents the essential health care intervention package per level of service delivery in the communities, primary health care facilities, council and referral hospitals, and national hospitals. This Section continues elaborating the types of services provided. Specific health services on promotion, prevention and curative services for communicable and non-communicable diseases are reflected in this Section. Finally, the social welfare services are presented.

Service delivery is the visible part of health care, the interface between the population and the health sector. Health sector system building blocks that provide inputs for, and enable service delivery are discussed in the next Section (see figure 1).

5.2 Quality Assurance

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

The health sector will introduce a step-wise improvement of quality of care as part of the BRN approach and beyond. By 2020 over 80% of health facilities all over the country will score good performance ratings in patient satisfaction surveys and 80% of the primary health facilities will have a 3 Star Rating or higher.

Certification towards Accreditation

The ministry will introduce stepwise certification towards accreditation (SWCA) system based on objective independent assessments of quality of service provision using an agreed set of valid, quality of health care indicators. This will cover both service delivery topics and support systems' topics (see table 4 below). This will start with the introduction of a Star Rating mechanism for all primary health care facilities under the BRN programme. The Star Rating will provide a national overview of the status of these health facilities and guide further priority setting for identifying bottlenecks for health facility quality improvements to be addressed. Under-performing health facilities will get support from the Councils to bring them up to the desired standard, *e.g.*, refurbishment of infrastructure, recruitment of additional staff, training, mentoring and supportive supervision. At facilities, there will be improvements in the organisation of services, clinical care and support, emergency care and in referral mechanisms.

The facilities attaining three stars and above will be enrolled in SWCA using Safe Care international standards, to be adapted by the MOHSW. The phased introduction of the SWCA system will roll out to incorporate hospitals. The health sector will establish an independent body for accreditation of facilities.

Table 4 Criteria for Star Rating of Primary Health Facilities

Assessment Area	Characteristics of Facility at 5 Star level
Facility Management & Governance	• Strong governance structure with decentralisation of fiscal management • Implements best practices for managing resources • Appropriate skilled staffing complement as per staffing establishment • Excellent working conditions/environment for staff including housing and appropriate incentives
Use of Facility Data	• Accurate and comprehensive data • Staff who can perform data analysis • Staff who use data for service improvement
Staff Performance Assessment	• Functioning performance system for staff • Staff who have met over 80% of their performance targets
Organisation of Services	• Well-organised setup for service delivery • Well-organised and efficient process for maintaining and accessing records
Emergency Care and Referral Mechanism	• Fully trained staff and a strong functioning system to triage, refer if needed • Successfully handle emergency cases as per the norms for the facility type
Client Focus and Social Accountability	• Strong functioning HFGC/Council Health Service Board that is responsive to the needs of the community • Facilitates an inclusive planning process for HF plans and by fully executing these plans
Health Infrastructure & Infection Prevention Control	• Consistently available power, running water, and functional equipment • Infection prevention and control and waste management systems that are implemented according to national guidelines
Clinical Services	• RMNCAH, FP, outpatient and inpatient, and specialist services are fully provided according to standard protocols • Minimal patient waiting times
Clinical Support Services	• Continuous availability of medicines that are appropriately stored and rationally used • Availability of quality diagnostic services according to the standards of the facility type • For HC and Hospitals, they must have fully functioning operating theatre with measures in place to prevent sepsis

Clients' Charter

Client and service provider rights and responsibilities are to be attained at optimal level with maximum use of available resources. The health sector will review and adapt the Clients' Charter that applies a human rights-based approach in health and social welfare. It will introduce the Community Score Card (CSC) as a tool for social accountability. There will be an automated system for receiving users' ratings and complaints, being fed back to the facilities. This will continuously assess customer satisfaction and guarantee fair client complaints' handling procedures and improve accountability to clients and communities.

Quality Improvement
The safety and effectiveness of services, procedures and working environment will be strengthened. The health sector will continue to standardise clinical management and use of appropriate, safe and cost-effective medicines, and improve the availability of functional medical equipment and high standards of diagnostic services. The health sector will consolidate and sustain gains made under HSSP III in Infection Prevention and Control (IPC) in Health Services Waste Management and in improving working environments.

The integrated Quality Improvement (QI) programme will implement a national QI toolkit and monitoring system based on a commonly agreed set of QI indicators, capacity building on QI that includes facility teams' self-assessments as a key to the self-driven approach, comprehensive supportive supervision, mentoring and coaching. There will be harmonisation, coordination, integration and operationalisation of QI approaches among disease control programmes and a mechanism for motivating quality improvement and performance measurement and management at all levels. Quality will be mainstreamed by incorporation into Comprehensive Council Health Plans (CCHPs) and a responsibility for tracking and communicating quality matters to respective management and leadership shall be formally assigned at all health facilities, CHMTs and RHMTs.

MOHSW will publish basic standards for health care provision from the community level to the national level (Basic Standards for Heath Facilities, 2015). The MOHSW will ensure that key information in the health and social welfare sector shall be translated, transcribed and disseminated in a user-friendly format.

QI topics will be incorporated in all pre-service training programmes for health and social welfare workers. The MOHSW will develop integrated training modules on QI assessments, planning, implementation and evaluation for inclusion into health and social welfare training curricula. In a move to widen quality thinking and practice, peer learning and exchange of lessons and experiences from best practices shall be promoted at health care settings and locally organised forums.

Pay for Performance
Linking payments by Health Insurance Funds, by companies or by Results Based Financing (RBF) programmes to quality of services provided will enhance compliance with Standard Operating Procedures (SOPs) and health care standards. Health facility management and staff performance will be continually assessed and employees will be made accountable to local governance structures.

Where necessary, more emphasis will be put on enforcement of laws and regulations, and interventions from health professional councils, once standards have been developed and disseminated and the involved persons have been trained.

5.3 Package of Intervention by Levels of Care

5.3.1 National Essential Health Care Intervention Package

The National Essential Health Care Interventions Package – Tanzania (NEHCIP-Tz) from 2013 outlines the services that are expected to be provided in the public health facilities. The NEHCIP-Tz encompasses those interventions with the greatest impact on Tanzania's burden of disease, which ideally should be provided across the levels of the health care system. The

package also defines which support systems (capacities of human resources, essential medicines and health products, etc.) should therefore be available. Further refining and detailing of the NEHCIP-Tz will take place during the HSSP IV period taking into account provisions made in the Basic Standards for Health Facilities documents (Volumes 1-5) and the managerial support needed. Core interventions, which can be provided with available resources, will be identified. The refined NEHCIP-Tz will feed into the formulation of the Minimum Benefit Package of the Single National Health Insurance. This essential package will guide interventions and activities to be prioritised, staff to be engaged, medicines to be procured, etc. Based on further increase of funding for the health sector, the package can be widened over time.

5.3.2 Community Health

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

Health is affected by both the home and work environment. Community engagement in health is crucial to addressing the social determinants of health. Even before the Alma Ata Declaration in 1978, Tanzania promoted community-based health services, generally based on voluntarism. Tanzania will revitalise community-based health activities with employed basic cadres incorporated in the health system, providing quality and continuity of services. By the end of the HSSP IV period it is intended that the Community-Based Health Programme will cover 50% to 60% of communities, focusing on under-served and remote communities.

Formalisation and integration of CHWs and their training

The Community-based Health Programme will be finalised, with prioritisation of the underserved regions. A cadre of Community Health Workers will be formalised, their role in providing health promotion, preventive and curative services will be defined, and a standard remuneration scheme established. Their training curriculum will be finalised accordingly, and training and deployment will take place as part of the Human Resources for Health planning. A clear plan for transitioning from existing CHW schemes involving health volunteers to a professional CHW cadre linked to the local health systems will be developed. However, over the HSSP IV period both formalised and non-formalised CHW will continue to operate as the formal CHW cadre will be not large enough to replace the non-formal. Untrained Health Facility Attendants shall be formalised based on an approved curriculum and deployed at primary and other health facilities according to the needs. The same cadre entry point shall be utilised for formalising the CHW and the Para Social Attendant.

Communities will be responsible and will take the lead in pursuit of community-based health services. Local resource mobilisation to support this is necessary, both from the local community and as part of the Comprehensive Council Health Plans. There will be close collaboration with NGOs and Community-Based Organisations involved in health promotion and health protection or care for vulnerable groups, to incorporate their activities into the broader Comprehensive Council Health Plans.

Health facilities will be responsible for coordination and support to health promotion and community-based health initiatives. Monitoring of community-based activities will be integrated in the HMIS and in the sector-wide Monitoring and Evaluation plans.

Health action in schools

The National School Health Programme (NSHP) will be strengthened, as it is important to capacitate youth towards positive health actions. It will contribute to more adolescent-friendly health and social welfare services. The policy guideline and strategy for the NSHP will be revised to include positive behaviour change for prevention of both communicable and non-communicable diseases, promotion of healthy life styles, promotion of sexual health and rights, including the importance of healthy eating and physical fitness. Capacity building of school health coordinators will take place to improve the leadership and quality of school health promotion as part of the integrated health promotion packages. The NSHP is coordinated and implemented jointly with the Ministry of Education and Vocational Training (MOEVT). The guideline and strategy for the NSHP will be disseminated and monitored during the HSSP IV period.

Intensified Health Communication

Health Communication (Social and Behaviour Change Communication) aims to increase health literacy, promote positive health behaviour and adoption of appropriate coping strategies. A strategic focus will be promoting the devising of life-long health learning ventures among established institutions, organisations, forums, mechanisms (*e.g.,* household prayer groups, pre-schools, schools, ceremonies, events, clubs, mosques, churches, meetings, *etc*.). The sector will use of a broad range of communication channels and processes including interpersonal (education and counselling), electronic (television, radio, video, telephone and internet), print (posters, pamphlets, leaflets, billboards) and traditional means of communication (songs, drama, poems). New information media (mobile text messaging and internet social media) will be harnessed to empower communities with knowledge and skills to effect behavioural change. MOHSW will strengthen and oversee information, education and communication processes and actions for better social mobilisation, community empowerment and advocacy to promote health among communities. The ministry will make a viable website to show meaningful communication.

5.3.3 Council Health Services

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

The Council Health Services constitute the backbone of health care in the country, especially in rural areas where the number of private health providers is limited. Dispensaries, Health Centres and First Level Referral Hospitals provide the National Essential Health Care Interventions Package. These services address common health conditions, and refer complicated cases to higher levels. Mentoring and technical support by the Council Hospital and Council Health Management Team (CHMT) will contribute to quality improvement of

primary health care facilities. As mentioned before (under quality, section 5.2), all primary health care facilities, public and private, will be assessed and will be facilitated to develop a quality improvement plan to reach the minimum standard level of services (3 Star Rating and beyond), starting in identified BRN regions, spreading all over the country in the HSSP IV period.

The CHMT will oversee administrative and governance issues of the Council health services. The Council Social Welfare Officer is a core member of the CHMT. Under the CHMTs a Technical Committee (TC) shall be put in place. In the TC, those who will participate include core CHMT members, co-opted members and also new members who will be given responsibility to manage areas that are not currently contained in CHMT. The TC has a duty to oversee and discuss the technical and professional issues on improving quality of health promotion, preventive, curative and rehabilitative health services at the Council level.

The Council or District Hospitals provide the first level of referral services for primary health care facilities, providing medical care for common health problems and emergency care for obstetrics and surgical cases. These services are part of the NEHCIP-Tz.

Integrated and evidence-based health planning and decision making at LGAs
The CHMTs will play an important role in evidence-based planning and decision-making, through the Comprehensive Council Health Plans and support to lower level health facility plans. PMO-RALG with support from MOHSW will continue development and integration of planning, budgeting and reporting tools, using ICT systems. By the end of the HSSP IV period, 100% of the Councils will have approved annual plans.

The planning will be inclusive, bringing on board all relevant actors in health care in local councils (including public and private first line health facility managers) and incorporating support from disease control programmes and (inter)national NGOs. The TC will do the groundwork of data analysis and epidemiological profiling to feed into the CCHP process. Parallel programming and implementation in the health sector will be discouraged and instead integrated capacity-building in planning, management and continuing support will be promoted. Councils will be empowered to withhold operating licences for NGOs not adhering to defined standards of collaborative action.

Decentralisation of financial management to the facility level
Social accountability is a priority in the health sector. Council Health Service Boards (CHSBs) and Health Facility Governing Committees (HFGCs) will be revitalised to oversee and co-manage health services and demand accountability on the use of resources, including finances, at the health facility level. By the end of the HSSP IV period, 80% of the HFGCs will be fully functional.

Revised Terms of Reference and regulations will guide these bodies and their activities. The Councils will decentralise more powers to the lower level Health Centres and Dispensaries and empower local staff to manage health services. The health facilities will produce their own plans and budgets in coordination with HFGCs. Primary health care facilities will open their own bank accounts (decentralisation of financial management) and will increasingly manage their own income and expenditures, including procurement of medical supplies and commodities, primarily through the Medical Stores Department. The private sector will contribute to the availability of medicines and supplies through prime vendors supplying MSD as well as through direct supplies to health facilities, contracted at the regional level to serve LGAs, ensuring checks and balances that will focus on value for money and quality.

A system of performance management and results-based financing will provide incentives for better service provision at the grassroots level, both for individual health workers and for health facilities.

Partnership with Private Providers

Private providers will be encouraged to contribute to service provision and will find a level playing field as a result of the certification/accreditation system and the fee for services system (health insurance system). In targeted regions, 25% of public health facilities will optimise PPP Forums to engage the private sector in service provision. (See Section 7.2 Public Private Partnership.)

5.3.4 Regional Referral Level

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

The Regional Referral Hospitals (RRHs) will continue the improvement of quality of care and management of general and specialised medical care (focussing increasingly on specialised care). In response to the demand for referral services at the regional level, the Government gazetted ten faith-based voluntary agency hospitals as Referral Hospitals at the Regional Level (RHRL). A Memorandum of Understanding will be finalised between the Government and the owners of these facilities to guide the partnership arrangements.

Electronic medical records and e-health expansion

The RRHs will strive to achieve improved clinical management and referral through the use of Information Communication Technology (ICT). Hospitals will improve the ICT infrastructure and connectivity for patient recording, aggregation of patient data and administration. By the end of the HSSP IV period, 80% of the RRHs will have electronic patient management systems in place.
The RRHs will improve and scale up e-health and connect to the lower health facilities for better referral, while ensuring inter-operability across the nation. Regional Referral Hospitals will establish a forecasting and monitoring system of essential medicines and supplies through better supply management systems.

SOPs, clinical audits and mentoring

Clinical guidelines and SOPs for clinical management of patients will be reviewed, updated as necessary and disseminated to all RRHs and the Regional Technical Committee. Medicines and Therapeutics Committees will establish an internal monitoring and evaluation system using the computerised hospital information management system, and clinical and death audits will be institutionalised. The performance management system will provide incentives to improve and sustain quality of care.

Further capacity building for improved customer care will be provided to all health professionals in RRHs. Through Quality Improvement Teams (QITs) and Work Improvement Teams (WITs) assessments on adherence to quality standards will be carried out. There will be quarterly mentoring and coaching of clinical management of patients.

Leadership, planning and resource management capacity

RRHs' management will be improved through capacity building in governance, leadership, planning, financial management, and resources management including planned preventive maintenance. Hospitals will prepare and implement annual Comprehensive Hospital Operating Plans, which will be monitored quarterly.

Improvement of governance and leadership at RRHs will be stimulated through Regional Hospital Health Services Boards (HSBs) with community representation to which the hospital management will be accountable. The functions of the boards will be laid down in legislation and members will be trained in monitoring and evaluation. The Ministry established a special project to strengthen the managerial capacity of RRH Management Teams and Health Services Boards for next five years. By the end of the strategic period all RRHs will have functional HSBs in place.

Regional Health Management Teams (RHMTs) will conduct supportive supervision and provide technical backstopping to RRHs and will perform data quality audits. The Regional Social Welfare Officer is a core member of the RHMT. The RHMT shall oversee administrative and health governance issues at the region. Under the RHMTs a Technical Committee shall be put in place. In this committee core RHMT members, co-opted members and also new members will take place who will be given responsibility to manage areas that are not currently contained in RHMT. Competency in epidemiological analysis shall be a requirement for effective technical functionality of this technical team. The TC has duty to oversee and discuss the technical and professional issues on improving quality of health promotion, preventive, curative and rehabilitative health services to LGAs and the region as a whole.

5.3.5 Zonal and National Level, including International referral

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

Zonal Referral Hospitals

Zonal Hospitals will provide specialised and super-specialised care to patients referred from Regional level hospitals. There will be improvement of quality of care in Zonal hospitals by ensuring these hospitals have adequate skilled Human Resources for Health as per established staffing levels, modern medical equipment and infrastructure. Currently there are five Zonal referral hospitals, both public and private, serving the Lake (Bugando Hospital), Northern (Kilimanjaro Hospital, Southern Highlands (Mbeya Hospital) and Eastern Zones (CCBRT Hospital). To further enhance accessibility of specialised services to all, the MOHSW will establish a Zonal referral hospital in Mtwara to serve the population in the Southern Zone. Furthermore, in collaboration with the private sector, the MOHSW will establish another Zonal hospital in Dodoma for the Central zone and if funds allow another one will be established for Kigoma (Western Zone). The MOHSW will continue to deploy specialist doctors to these hospitals. Hospital Management Teams and specialists from Zonal hospitals will provide outreach services and conduct clinical supportive supervision to lower level facilities in their respective Zones.

Zonal Hospitals will strive to achieve improved clinical management and referral through the use of ICT. Hospitals will improve the ICT infrastructure and connectivity for patient recording, aggregation of patient data and administration. By the end of the HSSP IV period all Zonal hospitals will have electronic patient records in place.

Hospitals will establish a monitoring and evaluation system using the computerised hospital information management system. The government will continue to equip Zonal hospitals with necessary functional medical, diagnostic equipment and supplies. The Hospital Health Services Boards to which the hospital management will be accountable, will guide improvement of governance, accountability and leadership at Zonal hospitals.

National Level, including International referral

National Hospitals including Special Hospitals will provide super specialised care to patients referred from Zonal and Regional level hospitals. There will be improvement of quality of care in National hospitals by ensuring these hospitals have adequate skilled human resources for Health (super specialists and specialists) as per established staffing levels and scheme of service, modern medical equipment and infrastructure. Currently there are five such hospitals, one national level Hospital (Muhimbili National Hospital (MNH) and four special hospitals (Muhimbili Orthopedic Institute, Ocean Road Cancer Institute, Mirembe Mental Health Services Hospital, Kibong'oto Infectious Diseases Center). The Government aims to reduce the cost incurred in treating patients who are referred abroad due to lack of infrastructure and expertise in the country. PPPs should be used in areas of diagnostics, treatment and optimisation of existing expertise. The Cardiac centre under MNH will be upgraded to a fully-fledged institution for treatment of cardiac conditions.

5.4 Health Service Provision by type of Service

5.4.1 Health Promotion

Strategic Direction: Invest in health promotion interventions that give emphasis to multi-sectoral approaches in addressing the preventable causes of disease, disability and premature deaths in all population groups throughout the course of life.

The MOHSW and partners have formulated the National Health Promotion Policy Guideline (2014) and Strategic Plan of Action (2015 – 2020) according to the Ottawa Charter for Health Promotion (1986), enabling people to increase control over, and to improve, their health. The ultimate outcomes of effective health promotion interventions include increased community health awareness, participation and empowerment, and other positive changes in health-related behaviours. The MOHSW will ensure better coordination of advocacy, social and behavioural change communication across different initiatives, programmes and interventions. To do so, the MOHSW will provide national standards and guidelines for designing, development and delivery, monitoring and evaluation of health communication interventions. The MOHSW will also establish a national resources centre for health communication. This resources centre will produce and archive integrated health promotion packages, which include paper, audio-visual and e-health materials.

To strengthen community capacity for health promotion, the MOHSW, through the implementation of a Community Health Strategy, will ensure effective active community engagement in the design, planning, implementation monitoring and evaluation of health promotion interventions, and linkage with social welfare, nutrition, and environmental

health. In addition, the MOHSW will oversee capacity building for and professionalisation of CHWs to plan, implement, monitor and evaluate health promotion interventions at the community level. The MOHSW also recognises the contribution of health promotion in improving young people's health and well-being, and subsequently in the adult life; therefore, it will invest in the National School Health Program for better health and education outcomes (as referred to in section 5.3.2).

5.4.2 Nutrition Services

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

The Essential Nutrition Action Approach (ENA) aims to reach at least 80% of caregivers through health services. The percentage of underweight children will reduce from 16% (TDHS 2010) to 11% in 2020. The percentage of stunting children will reduce from 42% to 27% in 2020.

The sector will work within the institutional framework for implementation of nutrition services involving nutrition experts at national, regional and council levels, to sustain nutrition service delivery. This will institutionalise nutrition interventions in the country. The MOHSW will oversee the revision of the Food and Nutrition Policy of 1992, develop its implementation strategy (2015/1616 – 2025/26) and develop and implement a National Nutrition Action Plan for 2015 – 2020 based on the outcomes of the National Nutrition Survey 2014.

MOHSW and MDAs will review and update guidelines to address maternal and infants and young child feeding, management of acute malnutrition, control of micronutrient deficiencies and healthy eating and lifestyle issues as needed. A pool of nutrition professionals is sustained through skill based in-service and pre-service training programs integrated in existing curricula.

The health and social welfare sector will promote appropriate maternal, infant and young child feeding practices in households and in communities and will advocate towards reducing food insecurity among households. More attention will be paid to strengthening compliance to exclusive breast feeding and infant and young child feeding practices, and promoting hygiene and sanitation practices. Strategies for control of micronutrient deficiencies will be integrated in the Community Health Programme.

At the health facility level, nutrition services are integrated within RMNCAH using already skilled professionals. Routine provision of nutrition counselling and essential vitamins and micronutrients to pregnant and lactating women and children under the age of five-years will be strengthened.

The MOHSW will strengthen the capacity for management of acute malnutrition. Children with nutrition disorders will be identified, investigated for underlying diseases, and, when necessary, treated or referred for nutrition rehabilitation and family support. Social welfare services will be provided where necessary. The MOHSW will ensure regular provision of nutrients for supplementation, fortification and promote dietary intervention for control of micronutrient deficiencies.

Through integrated Health Promotion interventions, health workers will encourage people to shift to healthy diets and avoid unhealthy foods (high in carbohydrate, fat, sugar, and salt). Through campaigns, the MOHSW will intensify awareness creation and public sensitisation on life-style related illnesses, to prevent behaviour risk factors contributing to becoming overweight or obese; these campaigns aim to reduce hypertension risk factors, coronary heart disease, stroke, diabetes and some forms of cancer.

5.4.3 Reproductive, Maternal, Newborn, Child & Adolescent Health

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

Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) will continue to be a priority for the country. Maternal and newborn health has been identified as one of the Key Result Areas (KRAs) under BRN. BRN has prioritised interventions in regions with high mortality and morbidity, but during the five years of this strategic plan the activities will spread from these initially selected regions to the whole country. By the end of the HSSP IV period, quality RMNCAH services will be within reach of the whole population in the country.

RMNCAH is fully integrated in health services at the primary level. Improving these services has an impact on most health system strengthening pillars, *e.g.,* the quality of HRH, ensuring adequate commodities, including essential medicines and vaccines, supplies, equipment, infrastructure, and the referral system. Strengthening RMNCAH therefore is not a vertical programme and will function as an engine for improving the broader range of health services.

Community health programmes will contribute to improved community mobilisation, bringing services closer to the population (*e.g.* family planning), advocating utilisation of the available services (*e.g.* ANC, skilled birth attendance) and stimulating families to seek early medical assistance, *e.g.* in outreach activities, or use of m-health supported by text message campaigns. The health sector will collaborate with other stakeholders, *e.g.,* the Ministry of Gender, Women and Children and the MOEVT in achieving greater accessibility of services.

Ensuring accountability and transparency for RMNCAH services is part of overall health systems strengthening. Maternal and perinatal death surveillance and response will be implemented countrywide to assess quality of care, to perform critical incident analyses, and to identify opportunities for improvement. By the end of the HSSP IV period, at least 75% of maternal and perinatal deaths will be evaluated, leading to actions for improvement of services.

Best practices in maternal, newborn and childcare shall be monitored, documented and shared for scaling up. The RMNCAH scorecard will be disseminated countrywide at National, Regional and Council levels and used to improve accountability, transparency and monitor progress in the implementation of RMNCAH interventions. The use of data for planning and decision-making will improve as part of HMIS strengthening. Innovative approaches to HR motivation and retention in all vital services will be encouraged and brought to scale.

5.4.3.1 Maternal and Newborn Care

By the end of the HSSP IV period, Skilled Birth Attendance will have increased to over 80%. The initiatives will result in a reduction of maternal mortality ratio from 432 (Census 2012) to 292 per 100,000 live births and neonatal mortality rate from 21 (IGME 2012) to 16 per 1,000 live births.

The health sector will continue to expand the provision of quality services during pregnancy, childbirth and the post-natal period. Emphasis will be on the provision of Basic Emergency Obstetric and Newborn Care (BEmONC), and Comprehensive Emergency Obstetric and Newborn Care (CEmONC), starting in strategically located areas (along the lines of BRN), to address the needs of larger populations, and in facilities with high burden of RMNCAH problems. By 2020, 70% of primary health facilities will provide BEmONC; 50% of health centres and 100% of hospitals will provide CEmONC.

Community awareness activities will reach every household in the country, informing pregnant women on prevention of low birth weight through proper feeding, convincing clients to make use of available ANC and delivery services. The ANC 4 visits coverage should reach 90% by 2020. Postnatal and newborn follow up at the household level will be encouraged to identify problems and provide timely referral. Postnatal care will reach 80% in 2020. Innovative approaches like m-Health, community level emergency transport systems will be encouraged to support CHWs. The link between community health worker and health facility will be strengthened to ensure a continuum of care down to households as needed.

Clinical guidelines for maternal and new born care will be adapted, disseminated and monitored. Capacity building of human resources for RMNCAH services will continue. Review of legislation and regulations will take place to enable cadres to perform required services through task shifting, *e.g.*in anaesthesia.

The sector will facilitate supply of essential medicines, other commodities and equipment. Regional Satellite Blood Bank Services will be established to increase availability of blood close to CEmONC centres in the country. The National Blood Transfusion Service will be strengthened for providing quality assurance to the regional satellite blood banks. The referral system will be fully operational, to guarantee that pregnant women get the services they need.

As with RMNCAH, Prevention of Mother to Child Transmission (PMTCT) of HIV will be fully integrated into health services and postnatal care services will be provided in all health facilities. By 2020 all (100% of) eligible patients will receive PMTCT. Subsequent HIV testing after first testing will be strengthened as per protocols (*e.g.*, second test for pregnant women at ANC, after delivery, and after breastfeeding).

5.4.3.2 Child Health

Under-five mortality will reduce from 54 (IGME 2012) per 1,000 to 40 per 1,000 and infant mortality will reduce from 45 (census 2012) per 1,000 to 25 per 1,000 in the HSSP IV period; and the stunting status will improve from 42% (TDHS 2010) to 22%.

The sector will continue to provide quality child health services to further reduce child mortality. Prevention of major causes of child death, such as pneumonia, diarrhoea and

malaria, will be addressed and health seeking behaviour will be stimulated (also for congenital disorders). Care of newborn children at delivery and post-delivery care will receive focused attention to cut down on day-one and week-one mortality, eventually cutting down on overall neonatal mortality. Community health workers will provide information, and encourage uptake of vaccines and other preventive interventions. Through the Community-Based Health Programme, the health sector, in collaboration with other sectors, will promote nutrition specific and sensitive practices (see below under section 5.5).

Access to treatment will be improved by scaling up the Integrated Management of Childhood Illnesses (IMCI) protocols. This will include capacity building of health workers by distance learning, provision of essential medicines, equipment and supplies. The achievements in the immunisation services will be sustained in line with the Global Vaccine Action Plan Goals with coverage over 90% in 90% of all districts. These goals include polio eradication, elimination of neonatal tetanus, measles, rubella and congenital Rubella syndrome, and introducing new vaccines to prevent other vaccine preventable diseases in the country. Strategies will be instituted to ensure accessibility and utilisation of the immunisation services using the Reach Every Child approach by provision of daily immunisation services at health facilities and strengthened outreach services in hard to reach areas.

Early infant diagnosis of HIV at eight weeks and further tests as per protocol for HIV exposed children or per medical indication will be integrated in different settings (*e.g.*, child clinic, immunisation, growth monitoring). Early infant male circumcision will be considered as a potential sustainability plan for Voluntary Medical Male Circumcision (VMMC).

5.4.3.3 Adolescent Health

Adolescent Fertility Rate will drop from 118 to less than 100 pregnancies per 1,000 women and HIV prevalence in girls will drop from 2.0% to less than 0.8% in 2020.

Adolescent Friendly Sexual and Reproductive Health Services (AFSRHS) will be expanded. Focusing on adaptation and use of Adolescent friendly guidelines and standards, demand creation and utilisation of AFSRHS, adolescents and youth will be encouraged to access VMMC, STI diagnosis and treatment, condoms and other contraceptives, and HIV testing and counselling services through age-appropriate IEC, peer education and mobilisation of young people. Risks of multiple sexual partners, unprotected sex and predisposing factors such as alcohol and substance abuse, unsafe injections and unsafe blood shall be key messages in IEC and peer education. VMMC will also be considered as an entry point to engaging with adolescent boys more broadly on ASRH and HIV-related health promotion, preventive and treatment interventions and services. Peer education will be encouraged for in and out of school adolescents, in partnership with other Ministries and NGOs. The education shall target transfer of knowledge, skills and, for the sake of eliminating stigma, positive peer pressure, positive socio-cultural appeals, applied in a rights-based approach will be utilized to shape attitudes (zero-tolerance to stigma). Other aspects of adolescent health will also be addressed through linkages with other programmes, including HIV, immunisation, mental health services and school health services as avenues to expand health services and increase adolescents' access and use of health services.

Health workers will become advocates of AFSRHS. Available adolescent-friendly RHS education and service guidelines will be disseminated to health workers. Supervisors and health care providers will receive training on AFSRHS. The utilisation of AFSRH services by adolescents should double in the HSSP IV period, with, for example, a clear impact on

incidence of HIV among girls or STIs among adolescents. To address the deficiency in data and improve accurate estimations of the disease burden in the adolescent population, data disaggregation in the HMIS will be a priority during HSSP IV.

5.4.3.4 Family Planning

The uptake of FP methods in the country will increase significantly by 2020. Contraceptive Prevalence Rate (married women 15-49) will increase from 27.4% to 60% in 2020 and Adolescent Fertility Rate (under 20) will reduce from 11.6% to less than 10% in 2020.

Family Planning (FP) using modern methods will continue to receive high priority to delay the age of first pregnancy, to space birth, and to limit the number of children to be born to the women's choice. Barriers to access of FP services, *e.g.*, limited provider capacity, misinformation, sometimes stock-outs of commodities will be removed. The number of FP acceptors will increase through demand creation on a rights-based approach that ensures information and choices are optimised through peer learning. Here also, as in the HIV programme, positive peer pressure and positive socio-cultural appeals shall merit attention for effective demand creation. Mass media campaign and community outreach services (providing commodities) will be enhanced to improve accessibility for all adolescents and adults in need of services.

Capacity building of health care providers will continue to provide the full range of FP methods to ensure high quality service delivery. FP services will continue to be integrated with other RMNCAH services. Opportunities like counselling on FP at ANC, PNC, and immunisation clinics will be exploited.

5.4.3.5 Violence against Women and Children

Prevention of and response to violence against women, adolescents and children will get more attention through demand creation in the community and capacity-building of health staff and ensuring services and support are provided to the survivors of violence. Within the Local Government Authority's jurisdiction, collaboration will be built with other sectors to strengthen or establish One Stop Centres catering for the treatment, protection, legal, prevention and rehabilitation needs of women and children affected by violence (see Section 7.3 and section 5.7). Current pilots in collaboration with Police, social welfare and other government entities and NGOs will be expanded.

5.4.4 Communicable Diseases

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

Disease Control Programmes, *e.g.*, malaria, tuberculosis and HIV/AIDS require specific knowledge and skills in some areas, *e.g.*, vector control, contact tracing, diagnostics and treatment regimes. In other areas, common knowledge on health promotion, disease prevention, laboratory diagnostics or supervision, monitoring and evaluation is applicable. In the HSSP IV period, emphasis will be on maintaining the high level performance of control of communicable diseases, while reducing costs considerably through integration of services.

5.4.4.1 Malaria

The country will continue the successful reduction of malaria mortality and morbidity through preventive and curative measures. The overarching goal is to reduce the average country malaria prevalence from the current 10% to 5% by 2016 and further down to less than 1% by 2020. Priority will be given to areas of endemic malaria transmission.

Community sensitisation will result in 95% of households showing positive behaviours with regard to malaria prevention and with regard to early health seeking for suspected cases. Council health services will reduce the transmission of malaria by scaling-up and maintaining effective and efficient vector control interventions. By 2020 at least 85% of the population living in all transmission settings and control stages, will have access to Long Lasting Insecticidal (LLIN) within their households. The Councils in endemic areas will consolidate and expand Indoor Residual Spraying in epidemiologically and operationally suitable areas, covering at least 20% of house structures in the country by 2020. The sector will implement larviciding interventions in selected urban areas where breeding sites are few, fixed, and findable, in order to reduce the larval density in the selected sites by 75% by 2020.

Primary and referral health services will prevent the occurrence of severe morbidity and mortality related to malaria infection through promotion of universal access to appropriate early diagnosis and prompt treatment and provision of preventive therapies in vulnerable groups. The health sector will provide universal access to appropriate, quality and timely malaria diagnosis to at least 80% of people with signs and symptoms of malaria by 2020.
Health services will provide universal access to appropriate, quality and timely treatment to at least 80% of people who have malaria by 2020.

The country will ensure that commodities used in malaria patient care and prevention are consistently safe, quality assured and available at 100% of the points of care by 2020.

5.4.4.2 HIV/AIDS

By 2020, the coverage of the national response to HIV and AIDS will have improved to ensure that 90% of all people living with HIV know their HIV status, and 100% of pregnant women eligible for PMTCT will receive treatment in 2020. The HIV care and treatment programme will improve coverage in at-risk children and adolescents so that overall, 90% of all people diagnosed with HIV are followed and receive timely and efficacious highly active antiretroviral therapy, and 90% of all people receiving the antiretroviral therapy will attain sustainable viral suppression.

During the HSSP IV period, health experts will continue implementing HIV and AIDS interventions to further reduce the incidence of new cases of HIV infection and provide access to HIV prevention, care, treatment, and support services. A special focus will be on geographical areas characterised by higher than national average HIV prevalence, high burden in terms of number of People Living with HIV, increasing prevalence over several years, and relatively lower performance on key HIV and TB indicators. Maintenance activities will continue in other areas, but active scale up will be the approach of choice in the prioritised geographical areas.

HIV prevalence in women is higher than in men in all age groups, but differentials are the highest among young women and girls, reflecting the strong gender element in risks of and

vulnerability to HIV infection in the country. Prevention is a priority, especially in vulnerable groups like adolescent girls. Awareness about HIV risks and prevention of sexually transmitted infections in adolescents is key, *e.g.*, through access to condoms. Other high-risk groups like people using drugs, sex workers and men who have sex with men will have high priority for preventive activities.

VTC will continue as an integral part of adolescent friendly health services. VMMC activities will be stepped up as well.

The Government in collaboration with partners and stakeholders will scale up quality anti-retroviral therapy (ART) services for adults, adolescents, pregnant and breastfeeding women and children through decentralised and integrated care and treatment services, as well as improved monitoring of response to ART and retention in care. The limited access to services by children, particularly for TB diagnosis, early infant diagnosis for HIV and paediatric ART, will be prioritised through stronger integration of HIV care and treatment into the RMNCH platform. Investments will be targeted to ensure improved access to optimum care and treatment for HIV exposed babies. Co-infections and co-morbidities in people living with HIV (PLHIV) will be addressed while community-based HIV and AIDS services will be strengthened, in particular, follow up systems and linkages between health systems and communities for people in care and treatment. The planned joint TB and HIV program reviews, supervisory visits, joint planning and training activities, co-location of ART, TB and RMNCAH services ("one stop shop") will facilitate service integration and promote efficiency. There will be more attention for reducing stigma by providing integrated care and by counteracting acts of discrimination in order to enable PLHIV to live a normal life. In close collaboration with TACAIDS, the campaign against multiple sex partners and unsafe sex practices shall be intensified.

The National Blood Transfusion Service (NBTS) will continue to play the core role of mobilising and recruiting blood donors to ensure increased availability and access to safe and quality blood and blood products, preventing HIV transmission from blood donors to recipients.

The national response to HIV and AIDS will benefit from health system strengthening, like Quality Improvement programmes, integrated procurement and pharmacovigilance and laboratory services. Surveys & studies, surveillance, evaluation and research will complement routine, age-disaggregated HMIS data and information collection for improved HIV and AIDS programming and policy decisions.

5.4.4.3 Tuberculosis and Leprosy

By 2020 the Tuberculosis Case Detection Rate will reach 72% and the TB Cure Rate will be above 90%. By 2020, less than 7% of new leprosy cases will have Grade 2 disabilities, and less than 2% of new leprosy cases will be children.

The health services will scale up active case finding measures in addition to routine case detection. The sector will concentrate on finding and treating TB in key affected populations (elderly, prisoners, diabetics). It will improve treatment of patients.

The country will strengthen integrated childhood TB management in health facilities, including contact tracing. It will integrate childhood TB and TB-HIV services in maternal and child health care settings, including PMTCT services in the country. Collaboration between TB and other programmes (HIV, RMNCAH) will intensify reaching more PLHIV, families, and

communities. TB is a special risk in the mining sector. TB screening and active case finding among mine workers, their families and surrounding communities will be stepped up. The Community-Based Health Programme will improve health seeking behaviour among miners, their families and surrounding communities.

The laboratory system will be improved and 50% of underperforming diagnostic centres will be brought up to standard. Health services will expand the use of chest X-ray and digital imaging in the diagnosis of tuberculosis. The health sector will establish an electronic case-based recording and reporting system for both TB and Leprosy diseases that is integrated with DHIS and will improve the TB surveillance system's ability to accurately measure the burden of TB disease.

Multi Drug Resistant TB (MDR-TB) will be tackled with new TB diagnostic technologies for testing of presumptive MDR-TB cases. The health sector will improve specimen referral and feedback systems between diagnostic centres and TB culture laboratories. MDR-TB management services for early initiation of treatment and care will be decentralised, while maintaining Kibong'oto Infectious Disease Hospital as a centre of excellence for TB services.

Tanzania will reduce new leprosy cases with disability grade 2 from 0.7 to 0.3 per 100,000 population by early case finding and treatment of leprosy patients. Through community involvement and participation TB, TB-HIV and leprosy prevention, care and treatment will improve.

5.4.4.4 Neglected Tropical Diseases

By 2020, transmission of Neglected Tropical Diseases (NTDs) targeted for preventive chemotherapy such as Onchocerciasis, lymphatic filariasis and trachoma will be interrupted in over 90% of the endemic districts.

NTDs are often associated with life-long disability and very serious chronic social and economic consequences. More than 10 NTDs affect rural poor communities and contribute to increasing poverty in the affected communities.
The health and social welfare sector will scale up access to interventions and treatment of neglected tropical diseases. Community structures, including schools, will promote health and behavioural change for the prevention, control and elimination of these diseases.
The health services will conduct Mass Drug Administration (MDA) in communities for lymphatic filariasis, onchocerciasis, trachoma, soil transmitted helminthiasis and schistosomiasis. For morbidity alleviation, specialised treatment will be available (surgery for hydroceles and trachomatoustrichiasis, and lymphoedema management).

The country will work to improve the detection and management of other NTDs including Human African trypanosomiasis, rabies, and plague. Relevant interventions and diseases diagnosis will be improved and reporting integrated into the national and council health information systems.

NTDs reporting systems will be integrated with the surveillance and epidemic preparedness efforts like the IDSR. Operations research will be conducted to ascertain the prevalence of tick borne relapsing fever, cysticercosis, and taeniasis. Impact assessments and surveillance of MDA programmes will be conducted to ascertain prevalence trends and break of transmission cycles where relevant.

5.4.5 Non Communicable Diseases

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

During the HSSP IV period, the country will prevent the further increase of overweight (26%), high blood pressure (26%) and if possible revert the trend of lifestyle related risk factors and ill health conditions.

Strengthening the prevention and treatment of Non-Communicable Diseases (NCDs) is currently a major challenge in this country. The health sector recognises the need for action to reverse the trend of increasing NCDs due to changing lifestyles and ageing of the population. The MOHSW will update the National Multi-sectoral Plan for Non-Communicable Diseases (NCDs), with attention to health promotion, prevention and care. Strengthening NCDs services in regular health services will be a priority, avoiding new vertical approach in this cluster of health conditions. Health care workers will be trained on NCD management. The STEPS Survey on NCD risk factors conducted in 2012 shows the priority areas; the survey will be repeated for trend analysis.

The health sector will improve health service provision for older people (≥ 60 years) in public health facilities. The MOHSW will develop a strategic plan for the provision of equitable health services for older people and will develop clinical guidelines in the area of geriatric medicine. It will facilitate the inclusion of specific training in the curriculum of health professionals and the introduction of postgraduate training in geriatric medicine.

5.4.5.1 Mental Health and Substance Abuse Disorders

The country will develop and implement a national policy and plan in line with the 2013-2020 global mental health action. This will include mental health promotion, prevention, treatment and recovery services. As much as possible mental health services will continue to be integrated in health services and community programmes, through better guidance and tools for health care professionals. Collaboration with relevant sectors will be pursued in dealing with substance abuse disorders (alcohol, drugs, tobacco) in terms of prevention, treatment, and social and physical rehabilitation. Stigma reduction for people with mental illnesses will be part of health promotion programmes.

Where necessary, legislation will be put in place. The country will oversee full implementation of existing treaties such as the WHO Framework Convention on Tobacco Control by putting in place appropriate regulations for legal enforcement.

5.4.5.2 Cancer

By 2020, 80% of women between 30 and 50 years will be screened for cervical cancer.

The MOHSW will develop national strategies and programmes for cancer prevention and control. The health sector will scale up cancer prevention, cure and care services. Attention will initially be given to public awareness campaigns, to increase the demand for screening and early detection and treatment. The MOHSW will also stimulate community involvement in home based care and palliative care for patients.

The health sector will scale up the prevention and response to reproductive organs cancers. There will be information campaigns to inform the public about the risks. Capacity building for screening and treatment for reproductive organs cancers (cervical, breast and prostate) will take place. By 2020, reproductive organ screening will be in place in all council hospitals. The current pilot of HPV vaccine will be considered for scale up.

Diagnosis and referral will be improved in hospitals, especially in regional referral hospitals. There is also need to attend to palliative care for cancer patients. The sector will advocate for increased resource allocation, increased joint action, multi-sectoral collaboration and cancer control partnerships with relevant stakeholders. The MOHSW will promote cancer clinical and epidemiological research.

5.4.5.3 Oral Health

In collaboration with private partners and NGOs, Council health services will provide appropriate health promotion and education activities for school children and for communities through outreach programmes. They will contribute to early diagnosis of HIV infection and the onset of AIDS, and treatment of oral infections associated with HIV and AIDS. The MOHSW will advocate for the availability of effective and affordable fluoride toothpaste.

In addition, the MOHSW will coordinate and facilitate the appropriate and uninterrupted curative, rehabilitative and corrective quality oral health care services at all levels of service delivery, in line with the National Essential Health Care intervention Package. This includes availability of emergency oral health care services in primary health care facilities.

5.4.5.4 Diabetes and Hypertension

Prevention of lifestyle related NCDs, like diabetes and hypertension, increasingly has become a national priority. More attention will be paid to healthy eating and physical activities, especially among at-risk communities. School health programmes will incorporate this in their work. Early detection through regular medical examinations promotion will be pursued to reduce disability eventualities.

Existing, separate NCD clinics will be integrated into the health care system to enhance accessibility. Existing facilities for managing chronic communicable diseases such as HIV-AIDS and TB at the health centre level may be adapted for management of diabetes and hypertension. The MOHSW will continue to elaborate the National Diabetes Programme in collaboration with stakeholders. By 2020, all council hospitals will be able to perform diabetes screening and provide basic treatment.

5.4.5.5 Sickle Cell Diseases (SCD)

The MOHSW will develop a national screening programme for congenital disabilities and for Sickle Cell Disease (SCD). It will develop genetic counselling and testing for SCD. The health sector will integrate care for children with asthma and SCD with clinics run for children with diabetes. It will develop treatment protocols and establish patient support groups.

5.5 Intersectoral Collaboration for Health

Strategic Direction: The health sector will advocate for intersectoral action and actively engage in partnerships in addressing the Social Determinants of Health including implementation of the approach

5.5.1 Water and Sanitation

By 2020, 75% the population will have access to safe drinking water, compared to 52% in 2010 and 90% of the population will have access to minimum sanitary facilities, compared to 60% in 2010. All schools will have adequate sanitary facilities.

The provision of safe water, improved sanitation and adequate hygiene (WASH) is key towards prevention of the majority of communicable diseases, which are prevalent in the country, *e.g.*, cholera, typhoid, dysentery, diarrhoea, soil transmitted helminths and schistosomiasis.

The health sector will advocate for the enforcement of the Public Health Act, 2009 and by-laws on sanitation and hygiene. Capacity building of communities and Regional and Local Government Authorities will take place. Promotion materials will become available for community programmes and community-based events will be organised.

Under the HSSP IV, the WASH interventions will be effectively implemented within the sector to ensure the country attains Open Defecation Free status by 2020. The interventions will be twofold: through provision of hygiene education targeting the household level (reached through CHW and local media channels) and through rehabilitation or construction of sanitation facilities in public facilities, transport hubs and highway's bus stops. The MOHSW in collaboration with PMO-RALG and LGAs will ensure health care facilities are provided with adequate sanitation and hygiene services both in rural as well as urban areas. Also waste collection, especially proper disposal of medical waste, is an area of attention for the health and social welfare sector.

5.5.2 Occupational health

Workplace health programmes focus on occupational safety and health. The Ministry will advise on safety measures to prevent injuries and diseases and will perform workplace inspections to enforce legislation. The MOHSW will prioritise high-risk industries, where exposure to hazardous situations and substances is high, *e.g.,* the mining industry.

Prevention and control of workplace HIV, TB and Hepatitis B Virus will be initiated to prevent transmission of communicable diseases. Healthy lifestyles will be promoted, including enhancing the growing interest to invest in sports among employers. Periodic health screening shall be encouraged to pick occupational health related problems early enough for definitive intervention.

5.5.3 General and Health Care Waste Management

By 2020, 80% of health facilities will meet the standards for safe health care waste management. The management of health care waste is an integral part of a national health care system. The MOHSW is developing guidelines to assist LGAs, Health care facilities and other implementers on proper management of health care waste. Health facilities will segregate waste at the point of generation, in order to store, label, treat, transport and

dispose of all waste in the manner prescribed in the policy and other laws and regulations. These interventions will ensure the safety of health care workers, patients, community and the environment. Other waste management interventions outside of health facilities will be organised by Local Governments to meet legal requirements for optimal sanitary standards. To this end, close collaboration with the National Environmental Management Council will be encouraged.

5.5.4 Port Health services

The health sector will continue to take practical measures to protect the health and wellbeing of citizens and residents against the international spread of diseases and other threats by executing International Health Regulations, 2005, through strengthening national IHR focal point, provision of public health measures and strengthening surveillance systems to public health risks at points of entry. It will expand port health services and ensure that by 2020 at least 50% of the 20 major points of entry have core capacity developed and are able to provide access to appropriate medical services, including diagnostic facilities to allow prompt assessment and care of ill travellers. Close collaboration with the Emergency Preparedness and Response unit in the Ministry that links up with the Prime Minister's Office will be of essence.

5.5.5 Road Safety

The health sector will have to cope with increasing traffic in the country. All Councils and Regions will have effective systems in place for treatment and referral of injuries and road traffic accidents. Effective orthopaedic treatment in RRHs will reduce the need for further referral. They will improve their emergency response and trauma care. Specialised centres provide support rehabilitation and care of road injury victims and will provide advice, support and legal redress for victims and their families.

Through PPPs the sector will promote the continuation of intersectoral initiatives on prevention of road traffic injuries and other injuries. The Health Sector will also advocate for improvement and enforcement of Road Safety legislation (such as speeding, drinking and driving, use of safety belts and children's seats, helmets, timely maintenance of infrastructure, civil education for road users).

5.6 Emergency Preparedness and Response

Strategic Direction: The MOHSW (in collaboration with other MDAs) will put systems and structures in place to be able to respond immediately to health related epidemics and crises, using modern means of communication to ensure global health security.

Recently, health disasters in Africa and on other continents have underlined the necessity to remain alert on potential crises and intervene immediately when they occur. The MOHSW will update the multi-sectoral Plan for Emergency Preparedness and Response (EPR), covering health related emergencies, epidemics and events with a public health impact. Tanzania will establish a permanent coordinating body which will oversee all Disaster Risk Management and Health Risks Management activities in line with the International Health Regulations (IHR) 2005. The MOHSW will produce and monitor an IHR annual action plan, operationalized through Technical Committees at Regional and Council levels, under RHMTs and CHMTs respectively.

Early Warning Institutions (EWI) will inform relevant Ministries regularly, which will take necessary actions for updating and implementing Emergency Plans. The ministry will activate an Emergency Operational Centre when needed for daily monitoring, reporting, and feedback. It will share the reports with stakeholders and will implement corrective measures, including post-disaster support.

The Health Sector will roll out the electronic Integrated Disease Surveillance and Response (IDSR) system, for immediate action at all levels. Case detection, notification and investigation will be done according to international standards. The sector will set up a mechanism for emergency medical services at all levels including guidelines and protocols for specific situations.

Emerging and re-emerging zoonoses may cause new epidemics that need to be analysed through molecular technologies. Veterinary experts and molecular biologists will be consulted by the health system. There will be comprehensive training in the different areas of medical care and disaster relief, including the community level. All emergencies will be documented and evaluated and experiences and lessons will be documented to inform future interventions.

The MOHSW will set-up and manage Call Centre(s) for the public to contact the authorities. The MOHSW will conduct awareness campaigns using modern means of communication, but also local community mobilisers. The MOHSW will develop strategies for psychosocial support to victims of emergencies.

5.7 Social Welfare service delivery

Strategic Direction: Social welfare will be further decentralised and become a fully–fledged department in the LGAs. Health channels will be used to reach communities and vulnerable groups for sensitisation and referral to organisations providing social welfare support.

5.7.1 General

Social welfare services are decentralised to LGAs (operating in villages, neighbourhoods and wards), which provide a response to the increased social welfare issues in the community, including catering for Family and Child rights, MVCs, the elderly and people with disabilities. Councils will be responsible for social welfare and social protection interventions for most vulnerable groups. In order to harmonise integration of social welfare and health services, the CHMTs and RHMTs will have social welfare specialists in their teams, to jointly plan and implement activities.

Gradually, social welfare services will be further devolved and institutionalised in public health facilities by 2020. Professionals will perform risk assessments that are linked to a referral system involving a range of sectors and services to determine and respond to the immediate and long-term protection needs of children and vulnerable groups. Health facilities increasingly play a role in the system of Birth Registration because the majority of children are born in health facilities and nearly all children are vaccinated.

5.7.2 Policies and Strategies

The government will soon endorse the Social Welfare Policy document and Social Work Council. The National Costed Plan of Action for the Most Vulnerable Children (MCV) II (2013 –2017) will be operationalised to provide child protection services and services to children out of family care, children with disabilities, and children in conflict with the law. MOHSW will develop national policies and implementation of community based prevention and reintegration services for children in conflict with the law, in accordance with the UN Convention on the Rights of the Child.

The Cabinet Paper and Elderly Act will be finalised in 2015 and guidelines on instituting social protection and services to person with disabilities, MVCs and elderly persons will be in place by June 2016. The National Guideline for early identification and interventions for children with disabilities in Tanzania will be finalised by 2016. Guidelines for care, support and protection of victims of human trafficking will be prepared.

The MOHSW will establish a comprehensive data base system for Social Welfare services namely Social Welfare Management Information System by June 2016. This information system will incorporate the Child Protection Management Information System presently under development. A Monitoring and Evaluation framework on social welfare services will be operational by June 2016.

5.7.3 Vulnerable groups

5.7.3.1 Services to People with Disabilities

The MOHSW in collaboration with non-governmental partners will strengthen Community-Based Rehabilitation (CBR), support and protection services for persons with disabilities. The identification of persons in need and the care for these groups in the communities will improve through the LGAs. The MOHSW in collaboration with PMO-RALG will raise awareness on CBR, develop guidelines and provide training to LGAs.

Children with disabilities will get access to fundamental services through the communities, for example health care, education, rehabilitation services and assistance in referral to institution-based rehabilitation. The government will renovate Vocational Rehabilitation Training Centres and ensure that human resources, equipment and training materials are in place. Experts in rehabilitation shall be integrated at all levels of care.

5.7.3.2 Family, Child Welfare and Early Childhood Development

The government will strengthen multi-disciplinary, evidence-based prevention and response services for children who are victims of violence (including genital mutilation), abuse, neglect, exploitation and trafficking through scaling up of a children's protection system in the LGAs. This will involve the development of community services to support and strengthen families and to prevent separation of children from the family, effective systems of referral of children suffering or at risk, and the development of alternative family services, including kinship care, fostering, fit person and adoption services as well as services for children leaving the care of the local government authority. In addition, the Government will enhance the existing monitoring and inspection system for children's residential homes, setting and maintaining quality standards. The government will roll out regulations, guidelines and other relevant tools and sensitise, train and equip frontline workers and LGAs.

The Social Welfare sector will strengthen the economic capacity of the Most Vulnerable Children (MVC) households and parenting skills to facilitate the provision of adequate care and support services to identified children. The sector will advocate for the review of the legal framework and development of programmes to strengthen family stability. This will require, but not limited to, review of the Marriage Act, sensitisation and information on family welfare and matrimonial issues. Conflict resolution and mediation for marriage practitioners will be stimulated.

5.7.3.3 Services for the Older People

The government will anticipate changing cultural patterns with regard to care for older people. The government will enact the Older Persons Act, and engage in better care for elderly in homes. It will stimulate PPP to establish homes, and at the same time improve quality control on homes. Geriatric care will improve especially when there will be more attention for non-communicable diseases and cancer treatment. National, zonal and regional hospitals will develop expertise and disseminate this to lower level hospitals.

5.7.4 Juvenile Justice

5.7.4.1 Corrective Treatment

The MOHSW will scale up community-based Prevention and Reintegration Programmes in order to prevent juvenile offenses and to promote alternative measures to judicial proceedings against children and the detention of children in conflict with the law and children at risk of offending. Likewise the MOHSW will provide services to children detained in various retention homes. In addition, the Government will renovate retention homes and approved schools to ensure that human resources, equipment, and training materials are in place.

5.7.4.2 Rehabilitative Youth Services

The Department of Social Welfare will create a Juvenile Justice Specialisation to ensure the rights of children in conflict and in contact with the Law are upheld. Social welfare officers will be trained in the subject. The sector will raise public awareness and engagement in protection of the rights of children living and working in the streets. It will re-unify children with their families and initiate retention mechanisms.

5.7.5 Accountability mechanisms for child protection

The Department of Social Welfare already provides supervision and guidance to local government authorities on child protection and provides for a case management system. The government intends to strengthen the role of the department to include the setting of performance targets, quality standards and data collection as well as a research and analysis management programme.

6 Health Care Support Systems

6.1 Human Resources for Health and Social Welfare

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

By the end of the HSSP IV period, 90% of the public primary health facilities in Tanzania will have qualified staff according to minimum norms, while there is a sufficient number in the country for private providers to employ staff according to accreditation standards. In at least 150 public health facilities in selected regions, the private sector will contribute to HRH through PPP arrangements.

6.1.1 HRHSW planning and management

The development of Human Resources for Health and Social Welfare (HRHSW) continues to be a main health sector priority in the HSSP IV. This is also reflected in the BRN work streams that emphasises the effective distribution and performance of health staff. The MOHSW will strengthen leadership and management capacities of HRH officers for adequate planning at all levels and will enhance inter-ministerial coordination.

The Directorate of Human Resources Development will plan, regulate and monitor HRHSW activities in Tanzania, with a focus on equitable distribution of staff over the country in the context of the BRN strategies. The MOHSW will be increasingly responsive to HRHSW needs, based on developments in the health sector, *e.g.*, with upcoming use of ICT in health. It will improve its recruitment policies. The MOHSW will revise staffing norms, replacing fixed staffing in institutions with evidence-based staffing norms, taking into account workload, burden of disease, trends in staffing and attrition. The MOHSW will reconsider professional profiles and propose adjustment of legislation and regulations if needed, *e.g.*, to enable task shifting of medical and other related professionals, as well as formalise current untrained Ward Attendants to skilled Health Attendants, by taking them through competency-based training.

LGAs will be capacitated to plan their local human resources needs based on the revised staffing norms for health facilities and institutions and to manage human resources adequately, including induction and coaching of new staff. The MOHSW will develop criteria for bonding and rural placements to stimulate equitable distribution of staff; the PMO-RALG and LGAs will enforce compliance.

6.1.2 Distribution of staff

One of the BRN priorities is a balanced distribution of health professionals over the country and simplification of administrative processes to enable such distribution within the Regions between Councils and within Councils. Distribution of skilled HRHSW will be strategically aligned with priority service delivery areas (*e.g.*, a sufficient number of skilled health workers

in facilities that have been strategically selected for EmONC) and prioritise underserved areas in line with BRN plans. The Staffing Levels 2014 – 2019 (establishment) will guide the distribution process. The MOHSW will also improve distribution of specialised cadres, *e.g.*, with mental health training, so that their capacities are optimally utilised.

The health sector will improve systems of recruitment, career development and retention of HRHSW. Better information on available posts, active recruitment and provision of incentives will assist in moving personnel to areas most in need. The system of allocation of recruitment permits and personal emoluments (PO-PSM) and of deployment and incentives (MOHSW-DAP and DHR) will be synchronized to ensure proper matching of the appropriate numbers and skills of HRH needed by the councils. LGAs will be stimulated to use incentives for retention of health care workers. Two year compulsory attachments for recently graduated clinicians and nurses will be introduced and strictly implemented. By 2020, over 90% of these critical cadres will take part in the attachments.

Private providers will be engaged in providing professional health services in public facilities through innovative PPP contractual arrangements in at least 25% of identified Councils.

6.1.3 Performance management

By 2020, performance management systems will be in place in all health facilities, both collective (Star Rating) and individual (OPRAS).

During the HSSP IV implementation period, operationalising the HR Performance Management System is a priority as it is reflected in the BRN interventions. The MOHSW will develop minimum performance standards in line with service delivery requirements on which the performance assessments will be based. Performance Management will take place at facility level (certification or accreditation) and at individual level (OPRAS and Results-Based Financing). There will be a mix of monetary and non-monetary incentives for high performers.

Human Resource managers at all levels need to be trained in this new approach towards HR management. It will require introduction of effective, internal, supportive supervision and coaching to ensure that health and social welfare professionals perform to the best of their abilities.

6.1.4 Information and research

The health sector will improve coverage and quality of HRHSW information systems and strengthen the inter-operability of different systems (including HRHIS,TIIS, HMIS, EPICOR and LOWSON systems). HRH operational research will take place to measure the effects of policies with regard to performance management, productivity and retention. This research will inform policy decisions.

6.1.5 HRHSW development

The health sector will further develop and maintain high quality HRHSW production, to meet the demands of the health sector. The number of qualified health staff will increase to over 150,000 in 2020. The MOHSW will support Health and Social Welfare Training Institutions to achieve this.

The emphasis will be on increased production of middle level cadres (AMO, CO, nurses, midwives, SWOs) as per HRHSW production plan. The HRH production plan will be revised according to agreed staffing norms and in the HSSP IV. The production of pharmaceutical and laboratory staff will increase to cover the needs of the sector. There will be better coordination of training activities to meet standards of quality and quantity of numbers to be trained in pre-service training. Collaboration with NACTE will be improved. The health sector will engage in public-private partnerships for increasing training of health staff. By 2020, there will be a balance between the need for new cadres in the health sector and production of new graduates for critical professions, based on joint planning between training institutions, MOHSW, PO-PSM and PMO-RALG.

As part of the new Community-Based Health Strategy 2015, Community Health Workers (CHW) will be formalised and standardised. The role of CHW cadre for curative services (iCCM/IMCI and others) and health promotion shall be clearly defined in line with the task sharing policy guidelines and implementation plan. The curriculum for this one-year training course is being developed and accreditation by NACTE will be obtained. At the same time, other shorter training programmes for CHWs have to be phased out or integrated as modules in this CHW training. A clear plan for transitioning from existing CHW schemes involving health volunteers to a professional CHW cadre linked in the local health system will be developed. The HRH production plan will be revised to project CHW output numbers per year and distribution over the country, and a financing plan will be developed.

The health sector will enhance the quality and effectiveness of Continuing Professional Development (CPD) Programmes and reduce fragmentation. Academic institutions and Professional Associations will participate in CPD, offering accredited modules, which can also be used in upgrading of staff through coordination with Professional Councils. Institutions will make use of modern teaching methods, *e.g.*, distance-learning using ICT, *etc.* Efficiency gains will be achieved by coordination and streamlining all CPD activities in the country. The MOHSW will regulate in-service training. By 2020 all CPD activities (also provided by Disease Control Programmes and NGOs) will require accreditation.

The MOHSW has established eight Zonal Health Resource Centres (ZHRCs) in order to support health care delivery. The zones cover two to six regions and provide linkages between national, regional and Council levels. Their roles include development of human resources for health (RHMT, CHMTs and health facility capacity building support and participation in Star Rating), conducting research and dissemination of health information. In order for ZHRC to effectively perform their roles, their position will be reflected in the MOHSW organisational structure, the linkage to national, regional and Councils level be clearly stipulated.

6.1.6 Nursing and Midwifery Services

The nurses and midwifes, individually and collectively, as the biggest professional group in health care, carry a strong obligation to provide quality services. Thus, in the current HSSP IV, nursing and midwifery services will focus on increasing skills for nurses and midwives which will contribute to the government commitment in reaching public expectations by providing quality services. Nursing Services will contribute to QI efforts (described in section 5.2). The Tanzania Nurses and Midwives Council will champion ethics for clinical practice to safeguard patients' rights (as described below).

During the HSSP IV period, the nursing and midwifery services will concentrate on creation of a clinical instructors' programme for students and interns, in collaboration with the

nursing schools. This program will facilitate learning and adaptation of skills. The MOHSW in collaboration with CHMTs will introduce an orientation plan to newly and relocated staff and employees. This will facilitate the understanding of the new working environment. The MOHSW will facilitate exchange of experiences of initiatives done by community nurses and midwives in the provision of care particularly at the family level.

6.1.7 Professional Regulatory Councils

Professional regulatory bodies in the Health Sector are either Councils or Boards. The Councils include the Medical Council of Tanganyika, the Tanzania Nurses and Midwives Council, the Pharmaceutical Council, the Health Laboratory Practitioners Council, the Medical Radiology and Imaging Professionals Council, the Optometry Council, the Environmental Health Practitioners Registration Council) and the Traditional and Alternative Health Practice Council. On the other side the Boards are the Private Health Laboratory Board and the Private Hospitals Advisory Board. These bodies will contribute to CPD coordination and accreditation. They will accredit CPD providers and courses and provide technical assistance in preparation and implementation of CPD activities. By 2020 all CPD activities in the health sector will be subject to accreditation. Gradually, a system of re-registration for health professionals will be introduced, as part of the quality assurance system.

The professional regulatory bodies will enhance compliance to professional ethics. They will update existing documents on medical and professional ethics and share those with professionals. Through decentralised structures, they will monitor compliance and perform regular studies and evaluations. Promotion of gender and rights-based approaches in health is an area of work for organisations that will involve advocacy among leaders and decision makers to promote the institutionalisation of gender and human rights concepts and methods (tools) in schools, colleges and other training institutions (see Section 7.3 for further detail on gender and UN publications (UNICEF, WHO) on applications of rights-based approach in health).

Professional associations have an important role in promoting professional standards, commitment, attitudes and ethics *e.g.*, during annual scientific conferences. There is no structured mechanism to present their inputs in policy forums. The Federation of Tanzania Health Professionals' Associations will be formalised to be the voice of health professionals in policy and decision-making bodies in the health sector. Professional associations will be capacitated to organise and conduct regular CPD activities in line with national CPD guidelines approved by the statutory regulatory bodies.

6.2 Essential Medicines and Health Products

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

During the HSSP IV period, well-coordinated, responsive and reliable procurement and distribution systems, incorporating private sector participation, will be in place at the national level, fulfilling demand for quality assured medicines and health commodities. By the end of the HSSP IV period, stock-outs of essential medicines for the main health

interventions and most common (top 10) conditions in health facilities will happen only incidentally.

6.2.1 Stewardship from the national level

The MOHSW will expedite the structural changes and organisational development for improved governance, ownership and accountability in the supply chain, in line with the BRN commodities work stream recommendations and the National Pharmaceutical Action Plan 2014-2020 (NPAP 2020). The MOHSW will put in place appropriate systems for planning, quantification and co-ordination of procurement, storage and delivery of donated consignments of health care commodities as well as those for vertical programmes.

Enhanced regulatory capacity and resources of the Tanzanian Food and Drug Authority (TFDA) and Pharmacy Council will manage market control of medicines, diagnostics and medical devices, and oversee professional conduct in the practice of pharmacy, in the interest of public safety. Existing mechanisms at TFDA for pharmacovigilance will be reinforced, including the process for providing feedback to the source of the report on adverse drug reactions and quality problems.

The MOHSW will review the regulatory and oversight strategies for the pharmacy profession and for distribution outlets (ADDOs), and through the Pharmaceutical Council will develop and enforce codes of conduct and guidelines for the management of inspections at all levels. The MOHSW will encourage the ADDOs to engage in greater self-regulation and build their own capacity so that there is greater access to approved medical products, especially in rural areas.

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

The tendering and procurement processes at MSD will be improved to ensure timely availability of good quality and affordable medicines as well as enough safety stock at all levels at all times. The product range at MSD will be rationalised on the basis of the clinical importance of an item, as well as the products annual turnover and frequency of demand. MSD’s capacity in the forecasting of demand and stock control will be improved.

Accurate information needed for the management and monitoring of the health commodity supply chain will be available to ensure that adequate quantities of the right health commodities are consistently available at the point of service to meet patient needs. The MOHSW will roll out the e-LMIS to councils, hospitals, and primary health care facilities, where appropriate infrastructure exists. The information systems will support increased data visibility, data quality, and access to information, improving health commodity related decision-making. The MOHSW places information in the public domain regarding the resources provided to, and used by health facilities, in line with the Open Government Partnership.

The MOHSW and PMORALG will quarterly appraise the supply chain, perform benchmarking, and adjust management strategies that aim to improve the use of data for decision-making for key supply chain decisions at various levels.

6.2.3 Facility Planning, Quantification, Costing, Procurement and Utilisation of Medicines and Health Products

Evidence-informed selection and rational use of medicines and health technologies will take place in public and private sector health facilities and the community, based on a list of standardised health technologies, with effective mechanisms for continuous maintenance.

CHMTs will establish technical committees or task teams to oversee commodity management systems, procedures and performance, as well as the rational use of medicines and laboratory supplies across all council facilities. Health facilities will have Medicines and Therapeutics Committees. RHMTs and CHMTs will promote best practices in medicines and supplies management and effective and well-targeted supportive supervision using the toolkit for medicines management and governance.

CHSBs and HFGCs will perform their functions to oversee and supervise commodities management, performance monitoring mechanisms, incentives and rewards. Civil Society Organisations (CSOs) will be involved in supporting local accountability and governance structures. Public accountability will reduce pilferage and misuse of medicines and supplies.

MSD zones and Councils will agree on service agreements that specify the roles and responsibilities of both parties. Appropriate models for procurement at the local level will be identified, evaluated, and adopted (*e.g.*, pooled procurement, prequalified suppliers, redistribution, *etc.*). Adequate systems of distribution to end-users (*e.g.,* involving the private sector) will be put in place.

There will be medicines information, education and communication strategies for health workers and communities through medicines and poison information centres at zonal and regional 'hubs'.

6.2.4 Research and Production

The MOHSW will promote investing in domestic pharmaceutical production through the implementation of the Tanzania Pharmaceutical Manufacturing Plan of Action (TPMPA 2014 -2018) so that they can be able to meet 60% of the national medicine need by the year 2018. MOHSW, COSTECH and academic institutions will create an enabling environment that will maximise the research and development capacity of local pharmaceutical industries. The MOHSW will facilitate Public Private Partnerships in local production of 'right-priced' quality pharmaceutical products, while ensuring sufficient competition through importation. TFDA will also encourage more qualified suppliers and manufacturers to enter the market in Tanzania for the purpose of sourcing additional quality medical products at reduced prices.

There will be a regional databank of African traditional medicines, medicinal plants in order to ensure their protection in accordance with regimes and related intellectual property rights governing genetic resources, plant varieties and biotechnology.

6.2.5 Financing Medicines, Commodities, Devices and Supplies

The MOHSW will develop a medium term financial plan for medicines, health technologies and supply chain operations that is harmonised and aligned with HSSP, and effectively implemented and monitored. Price regulations will be introduced to address affordability of pharmaceuticals in both public and private sectors. Under the HFS, the country will develop

regulatory mechanisms for fair pricing and avoidance of monopolistic behaviour.

The MOHSW, in collaboration with PMO-RALG, will formulate transparent and efficient procedures for access to funds that are generated by health facilities through various means including insurance, cost-sharing or results based financing in order to replenish medicines at those facilities and avoid out of stocks.

By 2018, the Government debt to MSD will be cleared. This will enable timely and adequate disbursement of funds for international procurement of commodities and supplies. MSD's operational and service charges will be based on the results of an independent analysis of MSD's current and projected operational costs. The service charges will ensure that MSD grows its capital to match the increase in demand from expanding health services and cater for integration of vertical programmes' medicines and health products into MSD operations.

6.3 Infrastructure, Transport and Equipment

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

In the HSSP IV period, the health and social welfare sector will construct nearly 800 dispensaries, 35 health centres, 9 district hospitals and 4 regional hospitals, as well as social welfare institutions. Around 5,800 health facilities (around 70% of all facilities) will undergo maintenance works. Maintenance and replacement of equipment will be incorporated into the Star Rating improvement programme, reaching 80% of facilities.

6.3.1 Infrastructure

In the HSSP IV period, the number of health centres and dispensaries in rural areas will increase to improve geographic accessibility in most under-served areas. Existing information systems will be used to disclose those areas of high need, and Councils will plan for construction. PMO-RALG and funding agencies will allocate adequate funds and disburse timely as per approved budgets for rehabilitation and construction of health facilities. Around 600 new facilities will be constructed in the five year period.

The MOHSW will review the health facilities standard infrastructure guidelines to guide LGAs in more balanced infrastructure development, ensuring that facilities are constructed and rehabilitated to meet accreditation standards. Both newly constructed and refurbished facilities will ensure adequate space for storage of pharmaceuticals and medical products, private treatment rooms for patients and for delivery of pregnant women. Disability friendliness shall be adhered to in the design and subsequent construction of infrastructure.

PMO-RALG and MOHSW will introduce a monitoring system of health facilities and actual status to have better overview of specific needs and constraints and anticipate renovations and replacement of equipment (as part of the Star Rating activities).

As part of the BRN programme 2015 – 2018, health facilities in selected regions will be refurbished, upgraded, electrified and furnished with a safe water supply, in order to provide BEmONC or CEmONC services. This programme will also improve other services

through a focus on quality improvement. LGAs, CHMTs and RHMTs will ensure that completed facilities are fully equipped and adequately staffed before construction of new ones begins. At the same time, these government entities will look for equitable distribution of facilities to reach populations in underserved areas, and will avoid duplication where private health facilities exist.

6.3.2 Maintenance of equipment

Maintenance of equipment will be further decentralised to LGAs, who will employ new cadres of biomedical engineers and will equip basic maintenance workshops.

The MOHSW will produce guidelines for LGAs/CHMTs to introduce a system of preventive maintenance. The MOHSW in collaboration with MSD will produce lists of standardised equipment and will negotiate with international agencies to adhere to guidelines for standardised equipment, in order to plan, procure and stock spare parts efficiently.

6.3.3 Transport and Ambulance Services

CEmONC under the BRN programme requires a functional referral system, with operational ambulances. The MOHSW will coordinate the setting up of a mechanism for emergency medical services at all levels, including guidelines and protocols. The MOHSW will also investigate options to establish a toll free telephone number 115, for emergency calls.

The CHMTs will develop fleet management plans that include preventive maintenance of vehicles and schedules for replacements of means of transport for both health and social welfare services. This will be included in CCHPs. The MOHSW will implement a monitoring system to follow up on service readiness of means of transport.

The Government aims at reduction of donor dependency for the provision of vehicles and will produce an investment plan. The MOHSW will investigate possibilities for engaging the private sector in transport services for health. It will advocate for streamlining a mechanism for ambulance specification, registration and management.

6.4 Monitoring and Evaluation Systems in Health and Social Welfare Sector

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

By 2020, over 95% of health institutions will provide timely and complete data of services and systems using automated data transfer systems. 100% of the KRA indicators will be monitored quarterly, and actions will be undertaken based on analysis.

The MOHSW will provide publicly accessible information on the HSSP IV indicators listed in annexes 3, 4 and 5 according to the time frames mentioned in the indicator list.

The country has a functional organisation of routine health management information system (HMIS), specific information systems, sentinel surveillance, surveys, census and specific research, to provide information on the health status and the performance of the health

sector. Improvement of data quality and exchange between data systems will be one of the focuses of HSSP IV.

6.4.1 HMIS

The health sector will achieve improved efficiency of the Health Management Information Systems (HMIS) and its associated processes to meet health sector Monitoring and Evaluation (M&E) requirements. The MOHSW will reduce the burden of HMIS on health workers by prioritising data elements and expanding the use of electronic tools. Electronic registers for service provision and electronic medical records will enable automated aggregate reporting incrementally. In addition, the age-disaggregation of routine reporting will be improved so that decision makers and implementers better understand the coverage of various health services by different segments of the population (*e.g.,* children, adolescents, youth) and address gaps through health promotion and other strategies. Capture of referral, zonal and national hospital data will improve resulting in more complete information.

HMIS data quality will improve by strengthening accuracy, completeness, and timeliness of data. MOHSW will work with partners to agree on data quality attributes and data quality check instruments for consistent use. Data quality checks will be integrated into routine supportive supervision, routine monitoring of data accuracy indicators including validation and outliers, automated interpolation for missing data. The DHIS-2 web-based software will allow for real time data control and feedback to facilities. The BRN quarterly progress assessment will provide immediate feedback on data quality.

MOHSW will coordinate the approach to facility assessments across ministries, directorates and disease control programmes to increase efficiency of operations. There will be a coordinated approach for the health sector that addresses all facility assessment requirements and merges different methods, for example Service Availability and Readiness Assessment, Service Provision Assessment, BRN Star Rating, disease programmes balanced scoring cards, etc.

6.4.2 Other Data Systems

The health and social welfare sector will improve and integrate systems including data collection tools, planning, budgeting and reporting tools across government (Council Health Profile, Health Facility Profile, DHIS, HRHIS, e-LMIS, Lower Level Facility Planning Templates Comprehensive Hospital Operational Planning template, CCHP planning Templates and PlanRep and Epicor database systems, as well as specific disease control planning and reporting systems). The technical integration will be discussed under section 6.5 ICT. The MOHSW will develop an indicator registry, which can be accessed by all systems. The MOHSW will work with PMO-RALG and partners to develop a Geographic Administration Registry.

The health and social welfare sector will continue to use surveys and sample-based sentinel sites to provide nationally representative evidence on community health status and vital statistics. Collaboration with the Agency responsible for births and deaths registration shall be important to determine the readiness of this source for generating vital registration data. A coordinated approach for sustaining and increasing the use of survey data and SAVVY will be introduced. This will enable more in-depth analysis and identification of regional priorities and constraints.

The sector will improve data collection and analysis with regard to nutrition, linking information on food security to data concerning malnutrition. This will enable identification of weak spots and vulnerable areas.

6.4.3 Operational Research and Surveys

Research in health and social welfare is increasing in Tanzania, in eight medical universities in the country and in research institutes like National Institute for Medical Research (NIMR) and Ifakara Health Institute (IHI). The country has identified and documented the national health research priorities. The MOHSW will stimulate more joint research together with academic institutions that fits within these priorities, to be relevant for the country. It will share the research priorities with international agencies.

More research will be shared with policy makers and practitioners. The MOHSW will advocate an open access policy to share research outcomes on the internet and make information available for interested parties. The MOHSW will activate the National Health Research Forum, to become a platform for exchange of knowledge.

6.4.4 Use of Data and Knowledge Management

Increasingly, information coming from the health and social welfare sector will be used for priority setting, *e.g.*, distribution of personnel or procurement of medicines. Analysis, synthesis, and dissemination of information will improve through automated systems, and made accessible for many stakeholders. This will facilitate data use and accountability for evidence-informed decision making. The quarterly assessment of progress in KRAs will be enabled through timely and correct provision of information on selected indicators. Information will be available for annual planning at Council and regional level. Indicators, which are in use at all levels, will be available online for direct use.

The MOHSW will contribute to legal frameworks for protecting individual patient data and will guide the sharing of aggregated data in order to guarantee privacy Information will be used for planning and management decision making. Indicators are in use at all levels and will be monitored regularly. The MOHSW will build capacity in translating scientific results into policy briefs and encourage dialogue with policy makers. The recently developed Data Dissemination and Use Strategy will provide guidance toward implementation.

The MOHSW will revitalise and strengthening its library and electronic archiving of key documents and will encourage Hospitals and RHMTs, CHMTs to manage electronic libraries for ease of retrieval and future use of guiding documents. The Ministry will provide courses and certifications for M&E, and will develop consistent training for all cadres, and common definitions of key terminology.

6.5 Information and Communication Technology and e-Health

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

By 2020, all hospitals in the country will make use of ICT applications for administrative and medical processes. At least 25% of the primary health care facilities will also use ICT utilities, starting in urban areas.

In the HSSP IV period, major developments are expected around Information and Communication Technology (ICT), including web-based and mobile data transmission. The previous sections refer to specific computing systems and tools that address the high-priority needs of the health sector to improve efficiency and effectiveness (e.g. DHIS-2, LMIS, HRIS, PlanRep).

The e-Health Strategy (2013 – 2018) will be the basis for further development of infrastructure and applications. ICT will be used to streamline and improve administrative processes (*e.g.*, in planning and reporting) and will be used for specific medical purposes (*e.g.*, electronic patient files) or communication with the population, also called TeleHealth (*e.g.*, websites, SMS text messages). ICT will also be used for teaching, training and communication with professionals in the health and social welfare sector.

The e-Health Strategy focuses on the use of available resources and solutions to facilitate the transformation towards ICT uses in the health sector. The National e-Health Steering Committee of the MOHSW will guide the process, and the MOHSW ICT Unit will serve as Secretariat. The ICT Unit will provide e-Health standards, rules, and protocols for information exchange and protection. It will coordinate management of existing and newly established systems within the health sector to eliminate silos and duplication of efforts.

The first priority in ICT is to enable data exchange between existing systems (mentioned in the sections above) in order to facilitate data analysis with information from different sources. Some of the relevant systems are managed by LGAs or PMO-RALG and require close collaboration between ministries. The linked systems will constitute the National Health Information System. By 2018, the system will be fully functional.

In ICT, many private providers are actively offering a wide range of applications and software solutions. This area therefore is very suitable for public private partnerships and for international collaboration. The MOHSW will guide the quality of private initiatives, the privacy of personal data, and interoperability of systems.

6.6 Health Financing

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

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

6.6.1 Health Financing Strategy 2015-2025

Through a participatory process led by the MOHSW, stakeholders have developed a new health financing strategy (HFS), which will align with the HSSP IV and continue thereafter as the country aims to achieve universal health coverage. The HFS shares the vision of HSSP IV in improving the quality of health services and increasing equitable access. It will harmonise the fragmented health financing architecture by combining insurance schemes to achieve

efficiencies in scale and cross-subsidisation (by creating one joint risk and financial pool). HFS aims to moving towards a more sustainable and efficient architecture for raising (particularly domestic financing), combining, and deploying overall funding for health, with defined roles for certain critical institutions.

A primary focus of the HFS will be to make a standard minimum benefit package of primary and secondary health care services fully accessible to all Tanzanians with a particular focus on the poor and vulnerable groups, and to ensure that these services are fully funded. As an essential part of this vision, the country will aim to reduce the dependency on external funding sources and move towards more sustainable domestic avenues for funding, with a clearly defined role for the private sector. The following sections describe the key elements of the proposed HFS and its alignment with HSSP IV goals.

6.6.2 Single National Health Insurance

It is widely accepted that pre-payment mechanisms such as social health insurance help to increase financial protection against the consequences of ill health. Currently, many different health insurance schemes operate in Tanzania, *e.g.*, CHF/TIKA, NHIF, NSSF-SHIB, *etc*., which have not reached sufficient scale as a proportion of the total population covered. There is some progress in raising coverage with the existing schemes. The HFS hence proposes an expansion and consolidation of health insurance around a new mandatory SNHI programme. All Tanzanian citizens are expected to participate through contribution payments. The poor and vulnerable will be identified, based on the national socio-economic targeting mechanism applied by TASAF, and will receive full subsidisation. Additional resources from government revenues, including new tax levies as necessary, and continuing external development partner funding sources will be combined (or pooled) into the SNHI.

6.6.3 Minimum Benefit Package

The SNHI will use its combined financial resources to procure the health services that are agreed as a part of the standard minimum benefit package (MBP). The MBP will be a formal legal entitlement for the entire population and is discussed next. Appropriate legislation and the establishment of an appropriate health insurance regulatory system will support the establishment of the SNHI. The NEHCIP-Tz of 2013 defined those interventions with the greatest impact on the burden of disease across the levels of the health care system. It needs further refining based on new insight of priority setting in context of available resources in the country. Drawing from the core of the NEHCIP-Tz, the MBP is formulated as the standard minimum package of services that can be sustainably funded within the available resources pooled for the SNHI. When citizens require MBP services from their nearest health facility, they can be assured of availability of essential medicines and health products, and of health care worker time. SNHI will pay health facilities the services to reinvest in procurement of medicines, health products and other supplies, as well as maintenance of infrastructure. As more resources are sustainably combined, the HFS allows for a gradual transition towards a more comprehensive MBP for the entire population.

6.6.4 Financing Public Health Activities

The focus of the MBP procured by the SNHI is on individual level interventions around preventive and curative services. It is assumed that community-level, health promotion and certain public health interventions (*e.g.*, environmental health, mass drug administration for neglected tropical diseases) will remain with the MOHSW and PMO-RALG and will be financed as per current norms.

6.6.5 Mobilising Resources for Health and Social Welfare

Currently, about 8% of the GOT budget is allocated to health while only 1% of the health budget is allocated to social welfare services. External resources play a prominent part, with large contributions from DPs, through basket funding, programme funding and off-budget funding. As external resources plateau or decline, other funding sources will have to come into play, and the government will need to raise its contribution from general revenue to the health sector budget. These issues are discussed in more detail in Section 8. The principle of the HFS, which echoes the HSSP IV, is partnership. In this context, the HFS anticipates that those Tanzanian citizens with the ability to pay will contribute a fair amount to the SNHI, in addition to general taxation. Resources will also be sought via special levies from certain economic activities, including those harmful to health, such as alcohol and tobacco sales. Levies through vehicle insurances could contribute to covering expenses for medical and rehabilitative services caused by road traffic accidents. General or more specific Trust Funds or Revolving Funds could be initiated to cover costs, maybe contributing through the SHNI.

Resource mobilisation at community and Council level can be strengthened further, when communities take increased ownership of health facilities through decentralisation. Local philanthropy can contribute to health and welfare related activities. Councils can allocate considerable funds for social welfare as has been shown in examples. Such local resource mobilisation has not been incorporated in the scenarios, as the size and geographical distribution is not known.

6.6.6 Allocating resources for the health sector

The suggested purchaser-provider split recommended in the health financing strategy will facilitate efficient use of resources, particularly for disease treatment. The MOHSW will devise mechanisms to ensure that technical and allocative efficiency in the allocation and use of resources is also attained, taking into consideration the geographical, age, sex and income groups involved. The MOHSW will identify the pattern of health expenditures and will undertake regular and periodic studies on allocative efficiency to get a full picture of allocation, disbursements and expenditures.

6.7 Financial Management System

Strategic Direction: The MOHSW and partners in the health sector will develop an action plan for improvement of Public Financial Management in line with the national reform programme to enhance transparency and accountability.

The aim of Public Financial Management (PFM) is to guarantee the flow of public funds to service delivery units, ensure efficient and effective use of resources, attain development results, while working in a transparent and accountable manner.

Tanzania is in the fourth phase of the PFM Reform Programme (2012/13 – 2016/17). The programme sets the national agenda for PFM, initially with five Key Result Areas: Revenue Management; Planning and Budgeting; Budget Execution, Accountability and Transparency; Budget Control and Oversight; Change Management and Programme Monitoring and Communications. In 2014/15, a sixth Key Results Area has been added – LGA PFM Reform.

The MOHSW together with the MOF and PMO-RALG will produce and monitor an action plan to implement the PFM Reform Programme at all levels of the health sector.

With regard to the action plan the following will be included and implemented in line with the targets of the National PFM Reform Programme:

Revenue management: Procedures will be formulated for management, reporting and accountability of all health revenue streams including insurances. Decentralised forms of resources mobilisation will be accounted for properly, without transferring these funds to central level (decentralisation of fiscal management);

Planning and budgeting: the sector will transform to activity-based budgeting for the health and social welfare sector, which will enable results-based budget analysis at all levels (clarifying the link between investments and results);

Budget Execution, Accountability and Transparency: The sector will aim for improved procurement and cash management, improved management of assets, and benefitting from opportunities to improve financial management provided by the move to International Public Services Accounting Standards' accrual accounting. Further clarification with regard to Decentralization-by-Devolution; most of the institutions in the health sector are under PMO-RALG. The financial responsibilities are further decentralised to the facility level, with attention for community accountability;

Budget Control and Oversight: Within PMO-RALG and the MOHSW, additional capacity will be created to analyse reports and financial flows, to link expenditure to performance, and analyse value for money. The analysis can also highlight gross under-expenditure and delays in utilisation of project funds. Improved arrangements will be put in place to monitor financial management, value for money, reporting and accounting by institutions which receive grants from the MOHSW, *e.g.*, Muhimbili, DDH hospitals, Agencies and Boards. Strengthen collaboration between internal audit functions on issues relevant to the health sector.

Change Management and Programme Monitoring and Communications: MOHSW will institute a committee in collaboration with PMO-RALG and MOF, which guides and monitors the PFM health action plan, and communicates to relevant authorities on progress.

LGA PFM Reform: Procedures with regard to decision-making and procurement need to be simplified and follow the value-for-money principles, in order to work efficiently for small institutions like dispensaries or health centres.

7 Management of Implementation and Governance

Strategic Direction: In line with the BRN approach, the health sector will strengthen Leadership, Accountability and Partnership to ensure that all involved parties can make their contributions to improving the health system.
Governance will be inclusive, i.e., empowering communities, involving partners, being gender sensitive.

7.1 Governance in the Tanzanian Health and Social Welfare Sector Context

There are different national and sectoral laws and regulations that guide and regulate governance in the Tanzanian health sector. Some of those are listed in annex 1. Management of health services will take place within the national legal context, which stretches far beyond the health sector. In the governance framework, different rules, responsibilities, relationships and interactions among different actors are determined and organised. In the previous sections under the general policy framework, MKUKUTA, service delivery, human resources *etc.*, different governance issues have been addressed. This section highlights key issues, strategies and mechanisms specific to health governance, that were not dealt with in the previous sections.

The health sector is a complex sector, with many Ministries, Government Departments, and Agencies involved, especially with a prominent role of PMO-RALG in implementation. There are also many private and non-governmental players in the sector. In addition, other stakeholders from outside the health sector may have a major bearing on health, as explained in Section 3.3.6.

Last, but not least, citizens and communities have high stakes in the health sector. Governance seeks to encourage shared actions among sectors and actors beyond health, public and private and citizens for a common goal. It is in the interest of the people and the Government that communities take jointly responsibility for their own health and wellbeing.

7.2 Specific Areas for Action on Implementation Management and Governance

7.2.1 Decentralisation by Devolution

PMO-RALG will strengthen its principal role in coordination and administration of service delivery at Regional and Council levels. The role of the MOHSW is to provide technical advice and policy guidance as well as capacity building, and to monitor and coordinate all health and social welfare actors in order to achieve better health for the nation. In addition, the MOHSW shall have oversight over national, specialised and zonal Hospitals services. The government will formalise inter-ministerial consultation among MOHSW, PMO-RALG, MOF and PO-PSM to enhance efficiency in their operations.

LGAs, through CHMTs as part of PMO-RALG, will be overall responsible for implementation, supervised and guided by RHMTs under the Regional Administration. To this effect CHMTs and RHMTs will be strengthened in staffing and in levels of capacity including epidemiology

competencies. At the local and regional level, strengthening of intersectoral collaboration to realise health in all policies will be further institutionalised, *e.g.*, by strengthening the human resource base of the RHMTs.

RRHs will continue to improve governance, by equipping their Hospital Health Services Boards with a legal mandate, and strengthening the Management Boards. Standardised management systems will be systematically applied and monitored

Social welfare and social protection will become part of the decentralised sector planning and management system. MOHSW and partners will build the capacity for integrated planning based on the Social Welfare Policy. The social welfare set up at LGs will concentrate on family and child rights, elderly care services, and disability services. Coordination units for food and nutrition focus on childhood, adult nutrition and dietetics and on production, manufacturing and trading.

Partners in the health and social welfare and nutrition sub-sectors will strengthen evidence-informed planning and management in primary health care facilities, Council hospitals and in the CHMTs. Facilities will produce their own improvement plans (*e.g.,* to achieve desired Star Ratings). Facilities will manage their own funds using their own bank accounts.

The decentralisation of financial management will go hand in hand with (social) accountability and performance management. The CHMTs will produce their support activities based on the needs of communities and health facilities, in line with the proposed decentralisation.

7.2.2 Social Accountability

Social accountability will go hand in hand with community sensitisation to inform the population, regarding rights and commitments. The MOHSW will revitalise the Client Charter showing patients' rights and disseminating it widely among the population. LGAs will introduce local community scorecards, which enable feedback to health facilities on performance. The Star Rating System (initial phase of accreditation) will show to the general public the level of quality of their facility in a transparent way. Performance management (individual and facility-based) will enhance a culture of accountability.

The sector will improve social accountability through strengthening the HFGCs, which will have more gender-balanced representation. HFGCs will have specific responsibilities with regard to management of the health facilities and will relate to Ward Development Committees. The health sector will work with community-based organisations, civil society organizations and other non-governmental organizations in this area. LGAs will strengthen the CHSBs and give them more controlling responsibilities and formal relations to Council Social Services Committees. The PMO-RALG will develop further guidance on the roles and responsibilities of management structures and their interactions.

As part of social accountability, M&E systems will become more transparent and accessible for stakeholders, both at local levels and at the national level. Tools to facilitate application of a rights based approach in health shall be disseminated and applied among health managers and communities.

7.2.3 Performance Management

Performance management will be a crucial innovation during the HSSP IV period. This will be at the institutional level through the certification and accreditation system, and introduction of a complaints handling system and feedback mechanism to health facilities. Results Based Financing will be instrumental in this. At the personnel level, an individual performance management system will be applied, based on the national OPRAS. National systems will be developed for local implementation. LGAs, regions and PMO-RALG will be tasked with making performance agreements, and in following up during their implementation and in reporting. Harmonisation of automated reporting systems will be stimulated to enhance inter-operability and transparency of performance assessments. There will be close monitoring guided by the MOHSW to ensure transparency and accountability.

7.2.4 Partnership

Partnerships in health and social welfare will help to achieve equitable, accessible and quality health and social welfare services. The MOHSW, PMO-RALG and other MDAs will put concrete measures in place to implement the Public Private Partnership Policy.

The MOHSW will realign the PPP policy and guidelines with review of PPP legislation and will continue to sensitise stakeholders. The MOHSW will institutionalise the responsibilities for implementation of the PPP Strategy at the national level. The MOHSW will establish and strengthen functional dialogue structures between public and private sectors (including traditional medicine and alternative healing) to promote effective, sector-wide PPPs at the national level. For the regional and council levels, the MOHSW will facilitate and provide support to PMO-RALG to establish and strengthen these structures. In order to understand the roles and responsibilities at the local and regional levels, further mapping of stakeholders will be undertaken.

The MOHSW will work in collaboration with the private sector and other government agencies to identify innovative approaches to financing PPP projects. The government will facilitate private organisations willing to invest in rural health service delivery and will offer service level contracts, based on transparent certification and accreditation criteria. The government will create a level playing field for full participation of the private sector in service delivery, based on objective criteria for certification and accreditation. The BRN initiative aims to increase private sector participation in rural areas via PPP agreements to ensure that at least 25% (135) of the 544 dispensaries identified will be manned with private skilled health workers by 2017/2018.

The government will stimulate more investments in the health care industry, ranging from infrastructure development (*e.g.,* leasing solar power plants) to production of pharmaceuticals and equipment, as well as human resources development, *e.g.*, in training institutions. The development of e-health and telemedicine will also offer investment opportunities for the private sector. Partnerships will provide opportunities for learning about new technologies as well as skills transfers and assist the growth of the health and social welfare sector.

During the implementation of HSSP IV, stronger partnerships will be built with traditional and alternative health care providers. Greater coordination will be established at all levels, from national and regional to the council level. The main areas of partnership will be specifically to promote awareness and accessibility to improved traditional and alternative

health services, quality improvement, strengthened management of services, research and improvement in the utilisation of traditional medicine research findings.

In order to achieve optimal health for the nation, it is necessary to address social determinants of health. Many health and social welfare issues require intersectoral collaboration with other public and private sectors (see Section 4.3). The growth of the gas, mining, power and tourism sectors and private companies operating in those sectors offer increased demand for health services and reciprocal ability to invest in the health sector. The proposal to provide a MBP by a SNHI still provides space for private health insurers to offer market niche products for companies and individuals that will mobilise additional revenue to improve the health system. The MOHSW will also work in partnership with the private sector to promote their corporate social responsibility to their employees and to the communities where they operate. Currently corporate social responsibility is voluntary but its benefits will be documented and promoted to the private sector.

7.3 Gender in Health

7.3.1 Gender Mainstreaming

Gender mainstreaming is a priority for the health and health-related sectors. The MOHSW will enhance integration, monitoring and coordination of gender affirmative action within the health sector and related sectors (Women, Gender, and Children, Water and Energy, Agriculture, Education). Through the CCHP guidelines, the MOHSW will ensure gender concerns are addressed distinctly. One of the key focus points will be to increase the understanding of gender equity and its relation to family life improvement, using the agency of the new CBHP which already addresses gender as a strategic area of action at community and household levels. Orientation to a rights-based approach in health will be provided at facility and community levels, to clarify the distinctions between rights holders, duty bearers, and obligations for stakeholders. Through such an orientation, coupled with application of the Client's Charter, the health rights of women and men, adolescent girls and boys, and health rights of youth shall be promoted and protected. The MOHSW will promote culturally sensitive information, education and communication materials through mobile phone applications for the health sector, to benefit maternal health and choice and access to FP methods, in particular targeting women, girls, boys and young couples.

The MOHSW will produce further analysis of gender issues and underlying causes of inequities, including structural, policy and budget processes, based on disaggregated indicators in the HSSP IV or in Disease Control Programmes, or based on specific research activities to be commissioned.

The MOHSW will support pragmatic measures for reducing Gender Based Violence (GBV) in society as elaborated in paragraph 5.4 of this strategic plan. It will advocate for the countrywide use of the National Management Guidelines for the Health Sector Prevention and Response to Gender Based Violence. Through the CHMTs, it will advise LGAs on establishing and sustaining GBV Drop-In centres building on already tested experience in the country and tapping on local NGOs' experience in constructive, male involvement.

7.3.2 Gender Equity

The health sector will continue to promote gender equity, equal opportunities to access health services for all people. In practice, it is about female empowerment in decision making about health issues and male involvement in care for the family. The MOHSW will conduct operational research to identify good practices and lessons learnt about promoting gender equity, to share widely with stakeholders. The MOHSW and PMO-RALG will ensure that governance structures (HFGCs, CHSBs, Hospital Boards etc.) and other decision-making mechanisms have balanced representation of men and women.

The MOHSW will direct training institutions to develop distance learning initiatives to tackle gender and health issues, such as gender equity and gender affirmative action. Such initiatives could be delivered intermittently through the use of mobile phones and other ICT channels to reach all RHMTs, CHMTs and health facility staff.

7.3.3 Equity

In the health and social welfare sector, equitable service provision will remain apriority, giving preference to those in the society who are most vulnerable, living in remote area and in the poorest Councils. Targeted interventions under different departments are designed according to the needs. The risk pooling under Health Insurance provides for gender equity by design, where the package covers households inclusive of both men and women. The anticipated SNHI and its MBP shall guarantee access to individuals that would be unable to pay (often women without means of earning income).

7.4 SWAp Co-ordination and Management

The Sector Wide Approach (SWAp) facilitates coordination and collaboration among stakeholders within the health sector in Tanzania since 1999. Stakeholders include the MOHSW, PMO-RALG, MOF, NGOs and civil society, private sector, and development partners, including UN Agencies, active in health. It aims to create synergies and reduce transaction costs through coordinating financing, planning and monitoring of all health interventions, on and off-budget, in line with the alignment and harmonisation policy framework.

The 2007 Code of Conduct for the SWAp set out expectations and commitments of all parties based on the principles of the Joint Assistance Strategy of Tanzania (JAST). The Government of Tanzania is in the process of finalizing a new Development Cooperation Framework (DCF) to replace the JAST with a greater role for civil society and the private sector as well as emerging development partners. Under the new DCF the Health Sector Working Group (HSWG) will continue to promote a sector wide approach (SWAp) to health.

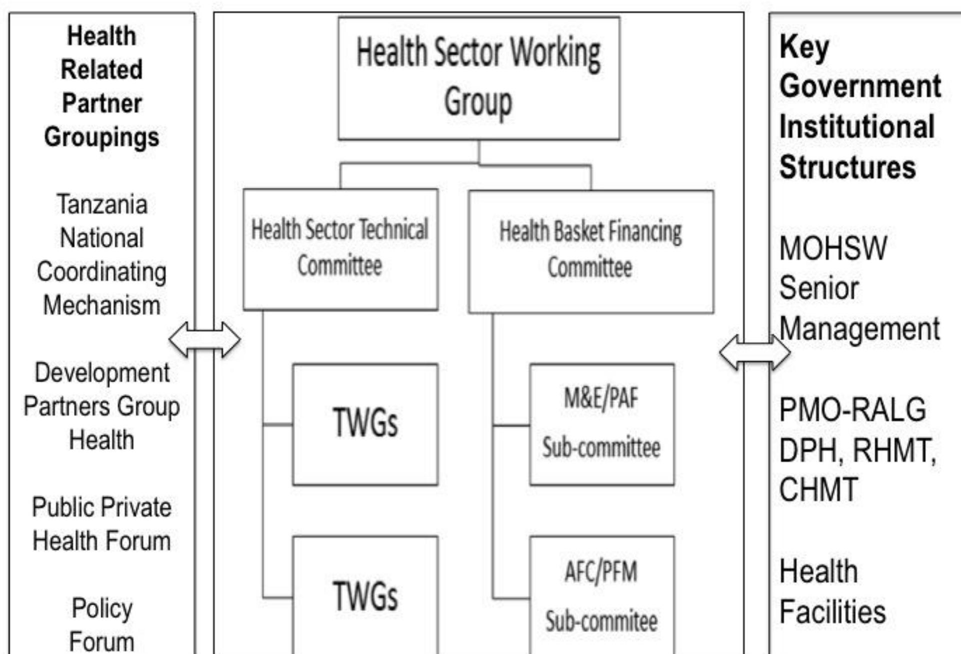
At the national level coordination of the Health SWAp will be through the following:

- Health Sector Working Group (HSWG)
- Health Sector Technical Committee (HSTC) (replacing the TC SWAp)
- Technical Working Groups (TWG)

Coordination and management of the SWAp at regional and council level will also be strengthened through use of the recently approved Regional and Council Health Technical Committee structures. Linkages will also be strengthened with the governance structure of

the Tanzania National Coordinating Mechanism (TNCM) for financing through the Global Fund to fight AIDS, TB, and malaria, and other health related constituent groupings such as the Development Partner Group for Health (DPG-H), Development Partner Group for AIDS (DPG-AIDS), the Joint Thematic Working Group on HIV & AIDS, the Public Private Health Forum (PPHF), the Policy Forum, and other groupings that emerge and that are seen as strategic partners to the health SWAp. The reporting relationship between the SWAp governance and the institutional structures of Government will also be strengthened. A special emphasis will be on incorporating new initiatives into the SWAp governance structure that aim to accelerate the progress of the sector such as the BRN, RBF, *etc.* Figure 9 below provides a summary of the SWAp governance structure.

Figure 9 Health SWAp Coordination Structure and tentative linkages



The **Health Sector Working Group** (HSWG) will provide a platform for sector dialogue among relevant stakeholders under Government leadership on national health policies, strategies and plans. The HSWG membership shall include MOHSW, PMO, TACAIDS, PMO-RALG, MOF, PO-PSM, development partners, private sector, NGOs and Civil Society. The Health Sector Reform Secretariat (HSRS), Department of Policy and Planning will act as secretariat to the HSWG.

The HSWG will meet biannually during the Annual Sector Planning Meeting (ASPM). It will review the annual sectoral work plans and budgets and the general progress on implementation of the HSSP. It will also discuss other relevant topics like the findings of the Health Sector Public Expenditure Review, Summary Audit Reports, etc. The Joint Annual Health Sector Review (JAHSR) will provide the overall policy direction for the sector and mobilise resources for the sector. The JAHSR will approve the sector policy priorities for the coming financial year and undertake advocacy for the sector and resource mobilization efforts for the sector including GOT budget commitments.

In addition the HSWG will provide the link to the Cluster Working Groups under the DCF and ensure efficient and effective coordination with all stakeholders through inter-sector collaboration and coordination.

The **Health Sector Technical Committee** (HSTC) will have a advisory role; it will advise senior management of government on technical issues of the HSSP IV and it is related more specific strategies and plans. The HSTC will promote coordinated and coherent technical support and policy dialogue. The members of the HSTC will be a selection from HSWG. The HSRS will provide secretariat support. The HSTC will link with the TCs at Regional level.

The **Health Basket Financing Committee** (HBFC) comprises of representatives of the MOHSW, PMO-RALG, MOF and basket-DPs. The HBFC is responsible for overseeing operation of the joint funding mechanism, including approving the release of resources against the HSSP, MTEF and CCHPs and ensuring that the use of basket resources follows set financial, administrative and management procedures.

The **Technical Working Group**s (TWG) will be regrouped for a high level of joint planning, coordination and monitoring of specific investments in the sector. The number and theme of the TWGs will be proposed by the HSTC and decided by the HSWG. All TWGs will report to the HSWG through the HSTC. TWGs shall meet monthly and hold ad hoc meetings as required.

The **Regional and Council Management Teams** (RHMT) will operate through Management or Governance Committees (chaired by RMOs and DMOs respectively) and Regional and Council Technical Committees (co-chaired by the Hospitals' in-charges and epidemiologists). These will bring together sector partners operating within the Regions and Councils. Membership and Terms of Reference shall be similar to those of the HSTC.

Within the Ministry of Health and Social Welfare, the **Senior Management Committee** (SMC) is responsible for overseeing the implementation of the programme of work as detailed in the HSSP IV and will review and approve all budgets, plans and reports before submission to the HSWG. On a monthly basis the DP-Troika will be invited to join the SMC to discuss critical issues relating to the implementation of the HSSP IV programme of work.

The **Development Partners Group for Health** (DPG Health), a collection of bi-lateral and multi- lateral agencies supporting the health sector in Tanzania, will continue to provide a platform for dialogue among development partners, with a three person lead arrangement (Troika). The Troika will continue to represent the DPG Health at high level sector dialogue meetings, with opportunities for individual partners to participate in TWGs in areas of specific interest.

The **Development Partners Group for AIDS** (DPG AIDS), a collection of bi-lateral and multi-lateral agencies supporting the multi-sectoral national response to HIV and AIDS, will continue to provide a platform for dialogue between development partners and TACAIDS.

The **Public-Private Health Forum** (PPHF) was launched in 2014 to improve public-private dialogue in the sector. The PPHF is working to organise the private sector into representatives of different constituents engaged in health and social welfare in Tanzania, ranging from service providers, NGOs, Civil Society, professional bodies, private medical training institutions, manufactures, insurance companies, etc. Strengthening the linkages between the PPHF membership and the SWAp coordination arrangements will further enhance the sector dialogue and will increase the breadth and depth of the SWAp

In 2007, the MOHSW, PMO-RALG, MOF and Development Partners developed and signed a **Code of Conduct** to facilitate an effective partnership between government and developing partners in the health sector. A new Code of Conduct will be developed in line with the structures outlined in Figure 9 above and will include the wider partnership of civil society and the private sector.

8 Resource Planning for HSSP IV

Estimates of the financial resources required and available in the health sector are needed to guide implementation of the HSSP IV. This Section shows the estimated costs, fiscal space, and funding gap from 2015/2016 to 2019/2020.

8.1 Resource Needs

8.1.1 Methodology

The One Health Tool, a model for medium- to long-term strategic planning in the health sector, was used to estimate the costs of the HSSP IV. The tool estimates the normative costs of health programmes, comprising of commodity and programme support costs, as well as the resource needs of health system components, including infrastructure, human resources for health, logistics, health information systems, health financing, and governance. MOHSW staff, clinicians, regional and district medical officers, and staff from other organisations in the health sector, such as MSD, provided all cost assumptions. Data from individual strategic plans, HMIS, demographic and health surveys, and other health and disease-burden studies informed the development of assumptions. The cost results include BRN implementation costs and service delivery costs borne in both the public and private health sectors.

8.1.2 Total resource needs

The five-year cost of the HSSP IV is estimated to be TZS 21,945 billion. Costs increase each year from TZS 4,013 billion in 2015/2016 to TZS 4,859 billion in 2019/2020. This is equivalent to a stable per capita expenditure of around US$ 42. Increase in costs keeps pace with population increase. The costs by programme area and health system component are shown in Table 5 below. Approximately half of the HSSP IV financing requirement is related to health services, and another half relates to health system costs.

Table 5 HSSP IV costs (TZS billions) by programme and health system component

	2015/2016	2016/2017	2017/2018	2018/2019	2019/2020
Programmes, interventions and services					
HIV/AIDS	602	598	594	630	644
NCDs and mental health	340	415	499	585	674
Malaria	260	188	186	185	185
Maternal, newborn, and reproductive health	139	153	158	171	169
Immunizations and vaccines	126	120	116	105	97
Oral care	134	146	158	172	188
General health services	130	132	135	137	139
Child and adolescent health	82	103	115	131	127
Tuberculosis and leprosy	92	121	112	113	119
Environmental health	50	43	49	43	43
Orthopaedic and trauma services	40	41	42	43	43

	2015/2016	2016/2017	2017/2018	2018/2019	2019/2020
Neglected tropical diseases	27	24	20	19	20
Department of Social Welfare	14	15	17	21	23
Ophthalmology	5	5	4	3	3
Nutrition*	4	5	5	5	6
Health promotion	4	4	4	2	2
Alternative and traditional medicine	1	0.4	0.4	0.3	0.3
Subtotal (TZS billion)	**2,054**	**2,112**	**2,214**	**2,366**	**2,481**
Health systems					
Human resources	740	807	879	948	1,034
Infrastructure	590	610	574	548	565
Logistics^	388	414	440	469	509
Governance	117	119	124	120	134
Health financing	92	34	51	78	74
Health information systems	33	35	76	54	63
Subtotal (TZS billion)	**1,959**	**2,020**	**2,145**	**2,217**	**2,377**
Grand total (TZS billion)	**4,013**	**4,133**	**4,359**	**4,582**	**4,859**
Grand total (USD million)~	**$1,942**	**$2,000**	**$2,110**	**$2,218**	**$2,352**
USD per capita	**$36**	**$36**	**$37**	**$38**	**$40**

*Some nutrition costs are included in maternal and child health. For the complete costs of nutrition interventions and programs, see Annex 2.

^Logistics costs include the costs of freight, insurance, clearance, quality assurance, procurement, storage and distribution, and wastage for all commodities.

~Using the exchange rate of 2065.95 TZS per 1 USD.

Note: Subtotals and grand total are subject to rounding.

8.1.3 Costs of health services

The five-year cost of programmes, interventions and services is TZS 11,226 billion, with costs increasing from TZS 2,054 to 2,481 billion from 2015/16 (Year 1) to 2019/2020 (Year 5). This financing requirement includes commodity and programme management costs for 228 interventions (note: the commodity costs do not include any logistics costs). Programme management costs decrease from TZS 573 to 480 billion from 2015/2016 to 2019/2020 due to front-loaded investments in training programmes and other support activities in HSSP IV. Commodity costs, exclusive of logistics (procurement and supply chain management and other costs); represent 78% of the financial requirements for health services and increase from TZS 1,480 to 2,001 billion by the end of the HSSP IV period.

Commodity costs that are earmarked for vertical programmes and primarily financed externally (*i.e.,* commodity costs for HIV/AIDS, immunisation, malaria, TB/L, and NTDs) account for TZS 761 billion (Year 1) and remain much the same in Year 5 at TZS 772 billion. Costs for RMNCAH commodities and other essential medicines and health products are TZS 718 billion in Year 1, increasing to TZS 1,230 billion in Year 5. However, unlike the disease control programmes, commodities for these general services and integrated programmes are probably substantially underfunded, and consequently these interventions may be "under-treated" at the baseline of HSSP IV.

The commodity costs reflect the MOHSW's prioritised scale-up of health interventions given the fiscal space and health system constraints. Through a multi-stakeholder process, the MOHSW identified high-priority interventions to scale-up for maximum health impact and lower-priority interventions, which will have flat coverage from 2015/2016 to 2019/2020.

About half of the 228 interventions in the costing are scaled-up in full. If all interventions were scaled-up according to programmes' ambitions, the HSSP IV would require TZS 2,546 billion more for commodities, including wastage, freight, clearance, and quality assurance.

Two disease control programmes (HIV/AIDS and NCDs including mental health) account for nearly half of total health service costs. The HIV/AIDS resource requirements take into account that 90% of all people living with HIV will receive ART by 2020.The cost analysis assumes the prevalence of NCDs will increase over time, resulting in increased need of preventive and curative NCD services. Other key health service targets used in the cost analysis are included in Annex 2.

8.1.4 Costs of health systems

The five-year cost of health system components totals TZS 10,719 billion, with costs increasing from TZS 1,959 to 2,377 billion from 2015/2016 to 2019/2020. Financial resource requirements are greatest for human resources for health. By the end of the HSSP IV, there will be an estimated 108,635 human resources for health in the country, including 5,000 formalised community health workers. Infrastructure resource requirements, which include operating and capital costs of facilities and vehicles, peak in 2016/2017 as new construction will not begin until that year. From 2015/2016 to 2019/2020, 834 and 5,783 facilities will be constructed and rehabilitated, respectively. (See Annex 2 for more information.)

The remaining health system components represent about 16% of the total HSSP IV costs. Logistics costs explicitly capture MSD's operating costs, which cover the procurement and supply chain management costs in-country, as well as the cost of commodity wastage, freight, clearance, and quality assurance (note: MSD's working capital is not included in the costing). Governance includes management and governance activity costs for multiple government actors across different levels of the health system (e.g. MOHSW, PMO-RALG, RHMTs, and CHMTs). The costs of RBF and implementation of a SNHI are under the health financing resource requirements. Health information systems comprise the costs of electronic and paper-based M&E systems, including investments in ICT at the facility level.

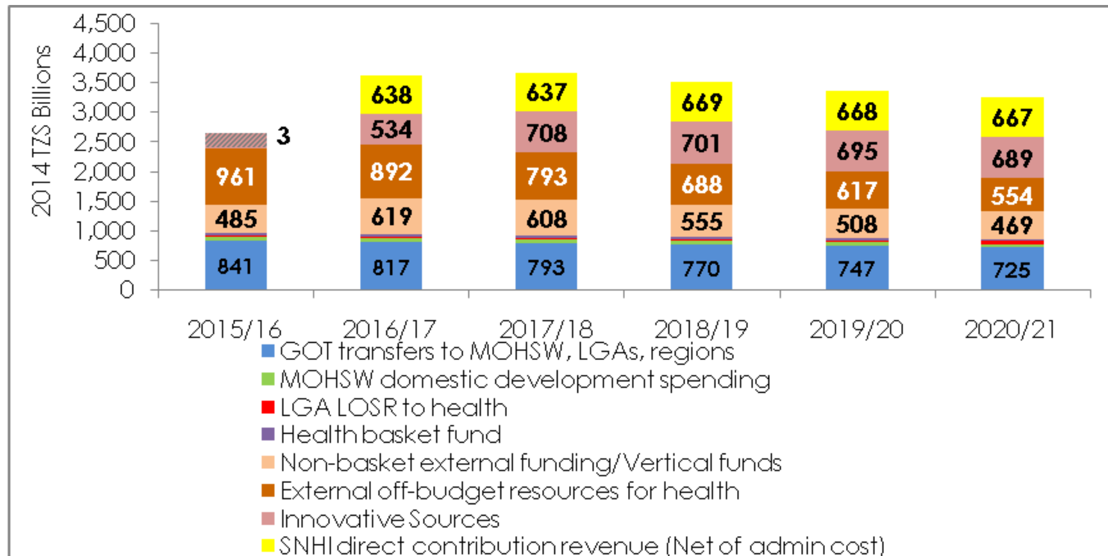
8.2 Available Resources

Fiscal space for health can be defined as the combined potential annual financial resources that can be mobilised across government, development partners, health insurers, individual and corporate philanthropy, and households' own expenditure out-of-pocket (distinct from purchasing health insurance). Combined with resource need estimates from section 8.1, such analysis can help to determine if current sources of financing health will be sufficient or if new sources or new efficiencies must be found, and whether scale-up targets should be adjusted. Fiscal space analyses should be regularly updated, utilising the insight from extrapolation of actual trends. New analyses should also be responsive to potential opportunities for other sources and innovation. A fiscal space analysis for the Tanzanian health sector was conducted in 2014. However, given proposed reforms to the health financing structure (section 6.6), availability of new data and discussions on innovative sources, a revision was required. This section provides a summary of the revised fiscal space analysis, with further details in Annex 2.

A detailed macroeconomic model was built for years 2014/15 to 2019/20 and data from bilateral as well as health basket fund partners were used to disaggregate all on-budget and off-budget funding sources. Sources such as domestic allocation to health via MOHSW, Regions, and specifically for recurrent and development heads were projected. LGA revenue

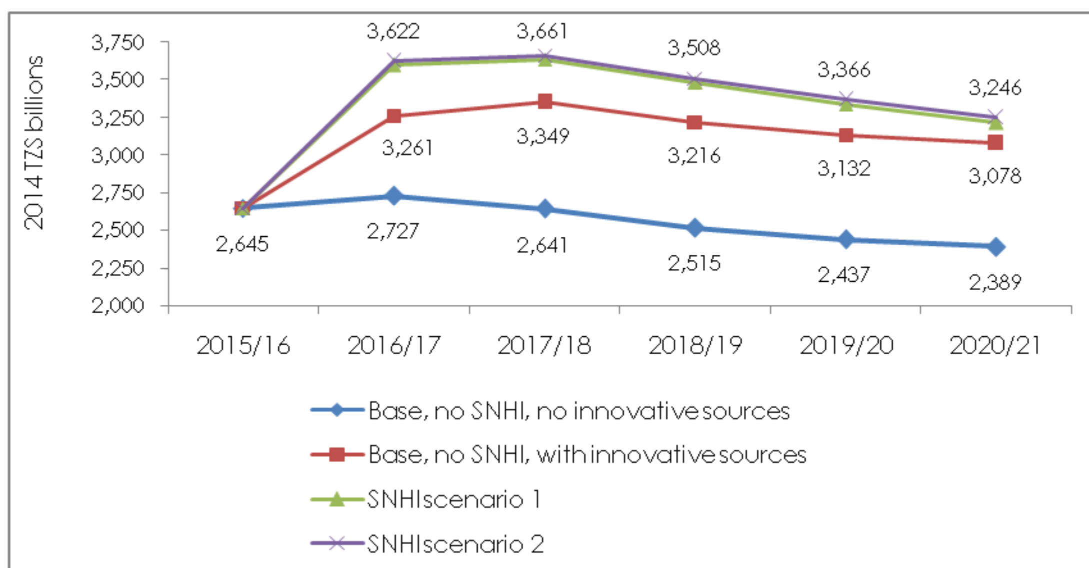
and allocation to health were also estimated. Moderately ambitious targets were set for allocation to health from such sources, where required. Analysis was based on scenarios, e.g., an ambitious scenario – incorporating innovative financing sources – as well as a baseline scenario for the continuation of current trends. Within the ambitious scenario, two options being considered for SNHI contributions (see section 6.6) were further explored.

Figure 10 Ambitious Scenario for Fiscal Space, with Higher Contributions for SNHI



However, the future fiscal space may be more constrained if optimistic forecasts and innovative sources are not realised or if the SNHI is not promulgated during the HSSP IV period. Figure 11 shows the different possibilities in terms of the scenarios. Without the SNHI or innovative financing as a proportion allocated to health from sources such as sin taxes, ability to tap the retained revenues of parastatal bodies, and taxes on mobile communication, the fiscal space is significantly smaller.

Figure 11 Comparison of Scenarios showing Impact of Innovative Financing and SNHI

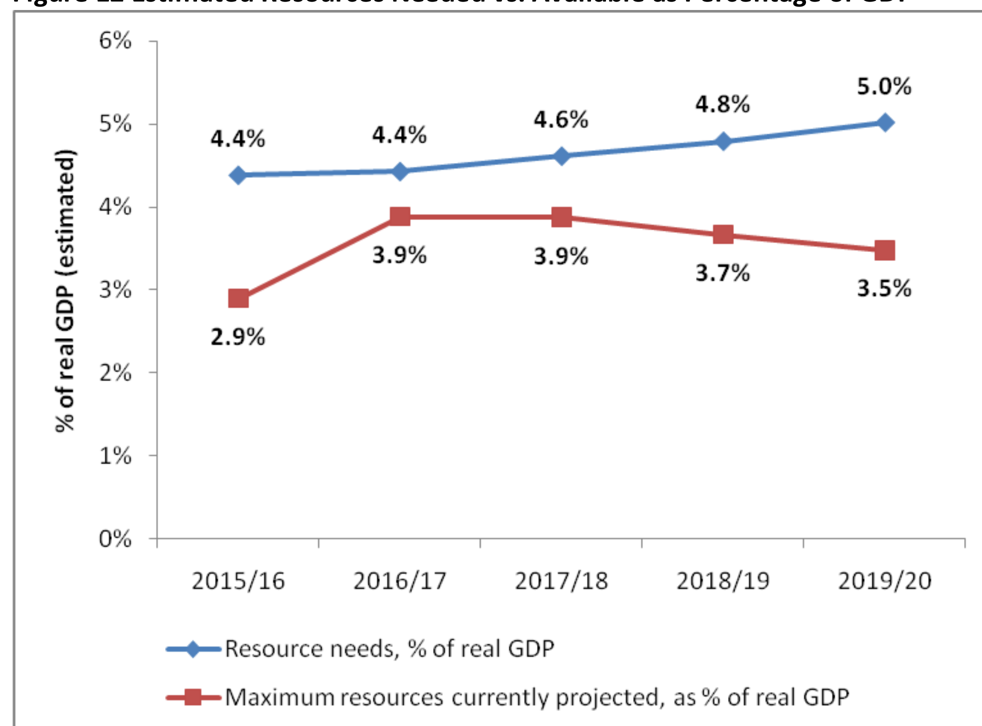


8.3 Funding Gap

The difference between the estimated fiscal space and costs reveals the potential funding gap for implementing the HSSP IV. The fiscal space analysis did not explicitly model out-of-pocket payments (OPP), meaning that some of the funding gap could be partially understood as OPP. However, the funding gap indicates the additional financial resources that need to be mobilised in order to meet the HSSP IV targets.

Figure 12 shows the funding gap each year by comparing the HSSP IV costs to the highest fiscal space scenario as a percentage of GDP. The estimated funding gap in 2015/2016 is TZS 1,354 billion. Under the most ambitious fiscal space scenario, the funding gap will increase from TZS 511 billion in 2016/2017 to TZS 1,493 billion in 2019/2020. Without innovative financing sources or SNHI, the funding gap could be as large as TZS 1,406 billion in 2016/2017 and grow to TZS 2,421 billion by 2019/2020.

Figure 12 Estimated Resources Needed vs. Available as Percentage of GDP



The funding gaps can only be overcome by OPP, increased Government funding, or postponement of ambitions laid down in this HSSP IV document. Innovative funding will only come in during the next fiscal years. DPs are reducing their commitments rather than increasing them and will probably not fill the gap.

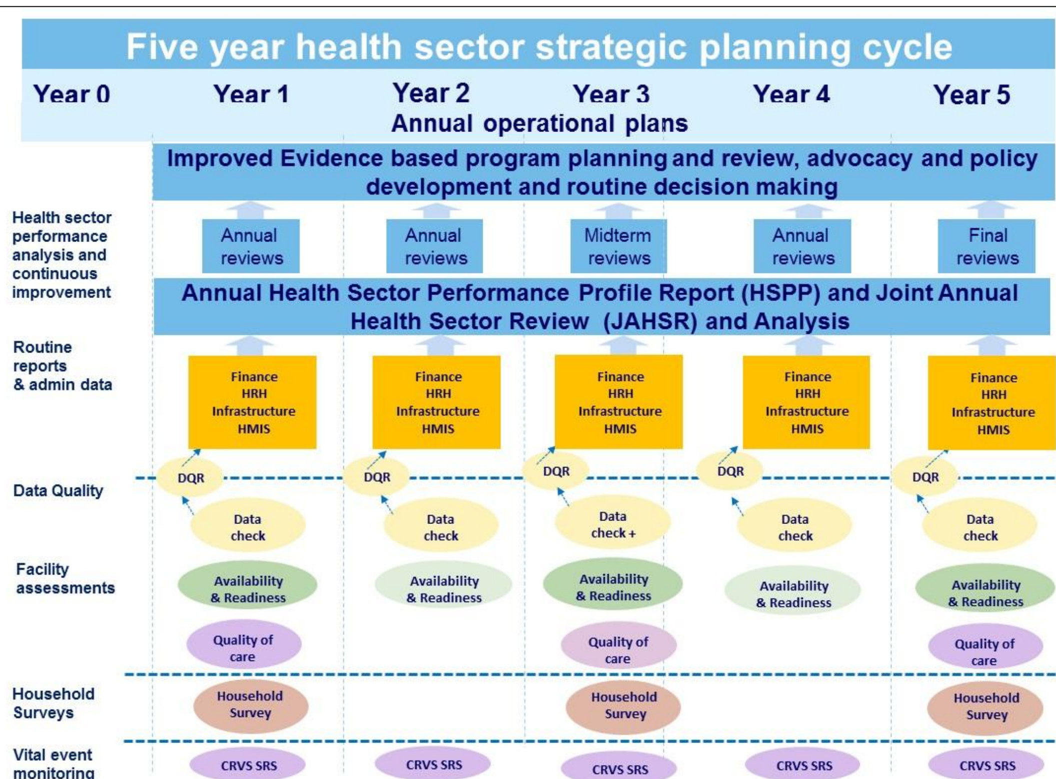
It is clear that the ambitions of HSSP IV are beyond the predictions of the most optimistic scenario of the HFS. If Government increases its commitment to the health sector compared to the historic trend, ambitions may be realised. The annual update of the fiscal space analysis should go hand in hand with an annual review of the ambitions and performance targets for the health and social welfare sector. Ambitions should be adjusted to what is realistically feasible within the available resources for the sector.

9 HSSP IV Performance Assessment and Follow Up

9.1 Introduction

The MOHSW is using the following framework for HSSP IV Performance assessment and follow-up, which includes a standardised and shared approach as to how M&E will be conducted. This framework is supported by M&E strengthening, nationally agreed upon HSSP IV indicators and M&E for the implementation of HSSP IV. Monitoring HSSP IV is narrowly connected to monitoring performance of the health sector as a whole, as will be elaborated below.

Figure 13 HSSP Performance Assessment and Follow-Up



The HSSP IV M&E framework has two time horizons and two types of indicators. One provides a long-range view of 10-20 years across several strategic planning cycles and focuses on indicators of sustained improvement in health of the population (*e.g.,* life expectancy, mortality). The second time horizon provides a midrange view of 5 years over the lifetime of a single health sector strategic plan and focuses on indicators required to monitor the service delivery or programme implementation as described in the HSSP IV strategic plan (*e.g.*, attendance rates, cure rates, nutrition status, implementation of activities).

A third monitoring perspective concerns whether changes in the indicators correspond to the health sector's specific objectives as formulated in Section 4.3. For example, are there improvements in quality, equity, and accountability in the health sector?

The indicators and monitoring modalities have been selected to accord with three priorities: national priorities, international priorities (SDGs), and M&E priorities. National priorities include the strategic health and service issues and initiatives identified in this document, the strategic objectives of the health sector, and alignment of national initiatives, including both programmes and cross-cutting initiatives, such as BRN, HBF, RBF, and the CCHPs. International priorities include the requirements of various international agreements, including the successor to the MDGs: the SDGs. M&E priorities include the selection of parsimonious and multipurpose indicator sets consistent with, and drawn from, existing health information systems, and the provision of timely and quality information on demand – when needed, with multiple visualization options: tables, charts, maps.

9.2 Monitoring Health and Social Welfare Performance

Health sector performance indicators are reflected in detail in Annex 3. The 64 indicators include 43 routinely collected input, output, and outcome indicators that can be monitored annually and usually quarterly or monthly. The performance indicators are monitored annually through a report prepared by the MOHSW and reviewed by stakeholders at the JAHSR; 10 of these can also be measured by survey, which provide a population-based calibration of facility-based indicators and often reflect equity stratifications by socio-economic characteristics. Population-based health status, fertility, and mortality rates are measured by 21 survey or census indicators that reflect impact and policy goals; some of these can be compared with annual rates obtained through IHI's Sample Vital registration with Verbal autopsy (SAVVY) system. The Sentinel Panel of Districts (SPD) reflects national trends and provides morbidity and mortality estimates.

In addition to monitoring overall performance, indicators that reflect the performance of several initiatives can be used to compare the effects of these initiatives. For example, facilities that implement RBF can be compared with those that do not, or performance of facilities that implement both BRN and RBF can be compared with those that implement only one or neither. Before and after performance comparisons can also be made.

Table 6 Selection of Health Sector Performance Indicators from HMIS (full list Annex 3)

No	Description
1	Antenatal care coverage: before 12 weeks gestational age
2	Institutional delivery coverage
3	Vaccination rate: measles under one year
4	Vitamin A supplementation coverage
5	Children under 5 who are stunted
6	Prevention of Mother-to-Child Transmission
7	Confirmed malaria cases
8	Case detection rate for all forms of tuberculosis
9	Children among newly detected leprosy cases
10	Cervical cancer screening
11	Availability of Medicines and Health Products
12	Outpatient attendance.
13	Completeness of HMIS report

9.3 Monitoring HSSP IV implementation progress

9.3.1 BRN Monitoring

Monitoring HSSP IV implementation requires tracking progress towards the objectives of BRN, programme, and sector-wide initiatives singled out for special attention in the HSSP IV strategy. The BRN provides both a challenge and an opportunity. The challenge is to provide accurate and consistent information, processed and analysed in a timely fashion, for regular review at the highest levels – weekly by senior MOHSW and PMO-RALG managers, monthly by the Ministerial Delivery Unit (MDU), chaired by Minister of MOHSW, and quarterly by Presidential Delivery Bureau (PDB).

The opportunity is for MOHSW to take the BRN monitoring process as an example of best practice. It uses a framework of well-defined quantifiable indicators for internal monitoring of the implementation progress. In the BRN framework the four KRAs have top line Key Performance Indicators (KPI) showing the expected health sector results. In turn, each KRA comprises four to six initiatives, which measure attainment of their objectives through their own KPIs. Each of these 22 initiatives comprises a series of activities (tasks) that come together to produce the results expected through the initiative and reflected in its KPI. (See Section 2.2.3 for details.) The top line and initiative KPIs are reviewed sometimes weekly, and always monthly and quarterly at national and sub-national levels. This BRN framework provides a model for monitoring HSSP IV implementation in other areas.

The HSSP IV plans to take the National Key Performance Area in Health (BRN) countrywide after 2018, and therefore the Key Performance Indicators will have a countrywide coverage, not only restricted to the identified BRN Regions.

Table 7 Top Line key indicators for BRN

Number	Indicator or Target
HRH 1	All Regions at or above 2013/2014 National Average (Density of Skilled HRH/10k population at primary care level)
HRH 2	Percentage utilisation of employment permits for HRH
HRH 3	70% reduction in the number of facilities without Skilled HRH nationwide
Performance 1	80% of health facilities rated at level 1 Star rating and 2 in 12 regions identified and elevated to level 3 Star rating and above by June 2018.
Performance 2	80% of health facilities to achieve 75% and above customer satisfaction by June 2018.
Performance 3	80% of health facilities use facility funds (self- generated and allocated) for improving service delivery by June 2017
Performance 4	80% LGAs have functioning social accountability mechanisms by June 2017
Medicines 1	Stock availability (HMIS) Percentage of facilities with availability of each key medicine Percentage of facilities with availability of all 10 key medicines
Medicines 2	Order fill rate Percentage of items ordered that are actually received by HF
RMNCAH 1	Percentage of pregnant women attending ANC first visit by 12 weeks
RMNCAH 2	Percentage of pregnant women attending ANC 4 visits
RMNCAH 3	Percentage of deliveries by SBA
RMNCAH 4	Percentage of Institutional deliveries
RMNCAH 5	Percentage of PNC (2/7 days) for mother
RMNCAH 6	Percentage of PNC (2/7 days) for newborn

9.3.2 Monitoring Achievements of Specific Objectives of the HSSP IV

HSSP IV has five specific objectives, which can be summarised as follows:

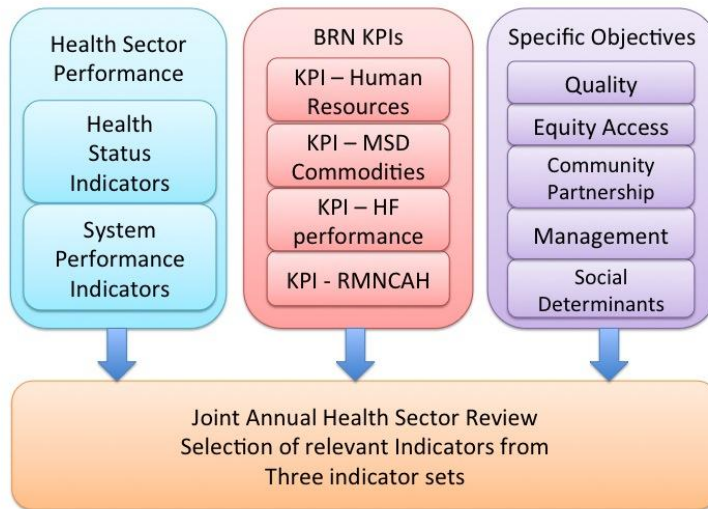
1. Quality Improvement of primary health care and delivering of a MBP
2. Equitable access to services, based on geographical and vulnerability criteria
3. Community partnership in service delivery and management
4. Effective management and innovative partnerships
5. Addressing social determinants of health through intersectoral collaboration

Table 8 Indicators for Measuring Performance of Specific Objectives

Specific Objectives	*Areas where Indicators can be derived from*
Quality and Essential Package	Star Rating, Service Utilisation Figures, Facilities Staffing, Medicines Availability, Social Welfare Utilisation
Equity and Accessibility	Health Facility Network Coverage, BEmONC and CEmONC coverage, HRH distribution, CHW coverage, RMNCAH & RBF, Gender disaggregated utilisation
Community Partnerships	Community Health Programme performance, CHW coverage, HFGC performance, CHSB performance, Community Score Cards
Effective Management and Innovative Partnerships	CCHP performance, Financial Management health Facilities, MSD performance, HMIS performance, Service Agreements, Contractual Arrangements, Financial Indicators
Social Determinants of Health	Nutrition indicators, Health Impact Assessments, Water and Sanitation, School Health Programme, Road Safety, Participation Vulnerable Groups, School Disabled Children

The Health Sector Performance Indicators and the BRN-KPIs will contribute to measuring progress of the specific objectives indicators (shown in Annex 3 and 4). In addition more qualitative process indicators will be used for certain HSSP IV activities. Annex 5 shows qualitative indicators for specific objectives as reflected in the HSSP IV, in addition to the health sector performance indicators and BRN KPI. Indicators in Annex 5 are comparable with milestones used previously in JAHSRs.

Figure 14 Annual progress monitoring using indicators from sets



The Health Sector Technical Committee will select annually from the three indicator sets those indicators that will be monitored specifically, related to the action plans and proposed milestones for that year. These indicators will be reviewed in the JAHSR to assess progress of the implementation. See figure 14 above for the indicator sets, which feed into the annual review process.

10 Assumptions and Risks

Political stability and commitment: Tanzania has known decades of political and social stability. The assumption that it will continue like this is fair. The Government approach in BRN, with emphasis on performance and accountability, is likely to make a positive impact on the health sector. In BRN, the government has expressed commitment towards a prioritised approach to health services (targeting under-served regions and vulnerable groups. It is assumed that this is sustained and embedded across the system.

Resource allocation: Tanzania has experienced strong economic growth over the past decade and prospects for further growth are positive. However, the economic developments have not yet translated into increased availability of resources for health. It is assumed that in the HSSP IV period the health sector will benefit more from available resources due to economic growth. At the same time, the trend of dwindling external support to the health sector is likely to continue. To mitigate the effects of low resource allocation the sector will focus on better prioritisation, higher efficiency and on curbing corruption and pilferage. The HFS suggests innovative methods of resource mobilisation. HSSP IV has defined its ambitions knowing that there is a funding gap. Annual review of the funding gap and adjustment of the ambitions will enable the health and social welfare sector to formulate realistic annual targets.

Natural disasters and epidemics: Recent history has shown the high risks of natural disasters and epidemics in Africa. Tanzania is building up its resilience by strengthening food security, addressing vulnerable regions and populations (*e.g.*, in the BRN programme) and by stepping up the Epidemics Preparedness and Response.

Availability of human resources: The health sector depends mainly on the availability of human resources. It competes with other sectors to get the best people to join the workforce. Salaries, working conditions and career perspectives must be attractive to get those people. On the one hand the redistribution of health workers and compulsory attachments may reduce attractiveness of the health sector; on the other hand performance management systems and incentives may attract more people to work in the health sector. Good human resources management is crucial in addressing availability of HRH.

Commitment of the population to health: Increasingly in Tanzania, there is an appeal to the population to take responsibility for health matters, in terms of paying for insurance, financing for health interventions, in terms of adopting preventive health activities, and in terms of participating in management of health facilities. Trust is extremely important. Measures regarding community accountability and transparency should build and maintain trust of the population.

Annex 1 Background Documentation

General

Health Acts
Tanzania Food, Drugs and Cosmetics Act No. 1 of 2003
Tanzania Food, Drugs and Cosmetics Act No. 1 of 2003
Tanzania Food, Drugs and Cosmetics Act No. 1 of 2003
The Disabled Persons (Care And Maintenance) Act, 1982
The Environmental Health Practitioners (Registration) Act, 2007 - (Act No. 20/07)
The HIV and AIDS (Prevention and Control) Act, 2008 (Act No. 28/08)
The HIV and AIDS (Prevention and Control) Act, 2008 (Act No. 28/08)
The Health Laboratory Practitioners Act, 2007 - (Act No. 22/07)
The Health Laboratory Technologists Registration Act, 1997
The Human DNA Regulation Act, 2009
The Medical Radiology and Imaging Professionals Act, 2007 - (Act No. 21/07)
The Mental Health Act, 2008
The National Health Insurance Fund Act, 1999
The Pharmacy Act, 2002 - (Act No. 7)
The Private Health Laboratories Regulation Act 1997
The Protection From Radiation Act, 1983
The Public Health Act, 2009
The Tanzania Commission for AIDS Act, 2001 - (Act No.22)
The Tanzania Food, Drugs And Cosmetics Act, 2003 Fees Regulations
The Tanzania Food, Drugs and cosmetics Act, 2003
The Tobacco Industry Act, 2001
The Tobacco Product (Regulation) Act, 2003
The Tobacco Product (Regulation) Act, 2003
The Traditional and Alternative Medicines Act, 2002

Quality

Title of document	Period
National Health and Social Welfare Quality Improvement Strategic Plan: 2013-2018 (2013)	2013
Tanzania Quality Improvement Framework, 2nd edition 2011-2016 (2011)	2011
National Infection Prevention and Control Guidelines for Healthcare Services in Tanzania, MoHSW (2004) National Infection Prevention and Control **Pocket Guide** for Healthcare Services in Tanzania, MoHSW (2007) MwongozowaTaifawaKukinganaKudhibitiMaambukizokatikaUtoajiwaHudumaza Afya: **Kiongozi cha Mfukoni** kwa Watoa Hudumaza Afya Tanzania, MoHSW (2007)	2004 2007 2007
National Infection Prevention and Control Standards for Hospitals in Tanzania, MoHSW (2012)	2012
National Communication Strategy for Infection Prevention and Control 2012-2017, MoHSW (2012)	2012
National Guidelines on Post-Exposure Prophylaxis following Occupational and Non Occupational Exposures to Blood and Other Body Fluids, MoHSW (2014)	2014
National Recognition Guidelines for Health Care Quality Improvement Programs, MoHSW (2014)	2014
Implementation Guidelines for 5S-CQI-TQM Approaches in Tanzania: “Foundation of all Quality Improvement Programme” MoHSW, Third Edition	2013

Title of document	Period
(2013) Mwongozo wa Utekelezaji wa Njia za S5-UUE(KAIZEN)-UUU Tanzania "Msingi wa Programu zote za Uimarishaji Ubora," MoHSW (2013)	2013
National Supportive Supervision Guidelines for Healthcare Services, MoHSW (2010)	2010
Quality Improvement – Infection Prevention and Control Orientation: Guide for Participants, MoHSW (2009)	2009
National Guidelines for Safecare Standards for Dispensaries, Health Centers and District Hospitals (2014)	2014
National Guidelines on Quality Improvement of HIV and AIDS Service	2010
A Manual for Comprehensive Supportive Supervision and Mentoring on HIV and AIDS Services	2013
Tools for Supportive Supervision and Mentoring of HIV and AIDS Services	2013

Council Health Care

Title of document	Period
Planning template for developing Dispensary and Health Centre plans	2009
Comprehensive Council Health Planning Guideline for Local level	2011
National Essential Health Care Interventions Package – Tanzania (NEHCIP – Tz)	2013
Primary Health Services Development Programme- MMAM 2007- 2017	2007 - 2017
Council Health Services Board	2013

Hospital Care

Title of document	Period
Guideline for Reforming Hospitals at Regional and District level	2005
Training Modules on Management of and district and Regional Referral Hospitals: **Module one : Quality Health Care in Hospitals**	2010
Training Modules on Management of Regional Referral and district Hospitals **Module Management of Hospital Services**	2010
Training **Modules on Management of Regional Referral and district Hospitals**	2010
Module: Planning module	2010
National Essential Health Care Interventions Package (NEHCIP)	2013
Comprehensive Council Health Plan Guidelines	June 2011
Planning CHOP template	2010
Guideline for implementation of 5S KAIZEN –TQM MoHSW	2014 - 2019
Functions of Regional Health Management System	2008
Tanzania Quality Improvement Framework	2014 -2016

Regional Health Management Team

Title of document	Period
Functions of Regional Health Management System	2014-2019
RHMT Planning and Reporting Guideline	2014-2019
Regional Management Supportive Supervision to Councils (RMSS-C)	2014-2019
Regional Management Supportive Supervision to Regional Referral Hospitals (RMSS-H)	2014-2019

Services Delivery

Reproductive Maternal Newborn Child & Adolescent Health

Title of document	Period
National Guideline for Comprehensive Care services for Prevention of Mother to Child Transmission of HIV and Keeping mothers Alive	Sept, 2013
Tanzania Elimination of Mother to Child Transmission of HIV Plan, 2012 – 2015	2012 - 2015

Title of document	Period
National Communication Strategy for the Elimination of Mother to Child Transmission of HIV (e-MTCT)	2014 - 2017
The National Road Map to accelerate reduction of Maternal, Newborn and Child deaths in Tanzania 2008-2015	2008-2015
National Roadmap Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Death 2008 – 2015, Sharpened One Plan, MOHSW, 2014	2014
National Cervical Cancer Prevention and Control Strategic Plan	2011-15
Tanzania Delivery Guidelines for Cervical Cancer Prevention and Control, MOHSW	2010
National Adolescent Reproductive Health Strategy	2010 – 2015
National Family Planning Costed Implementation Programme	2010 – 2015
National Operational guidelines for Integration of Maternal, Newborn, Child Health and HIV/AIDS services in Tanzania	2012
Tanzania National Family Planning Research Agenda	2013- 2020
National Family Planning Guidelines and Standards	2013
National Family Planning Outreach guidelines	2014
Tanzania National Family Planning 2020 Action Plan	2013
National package of Essential Family Planning Interventions for CCHP	2014
National Communication Strategy for MNCH	2011 – 2015
National Policy Guideline for Health Sector Prevention and response to Gender-based Violence	2011
National Integrated Community MNCH Guidelines, MOHSW,	2012
National Package of Essential Reproductive and Child Health Interventions	
National Policy Guideline for Reproductive and Child Health	2003
National Kangaroo Mother Care Guideline	2008
National Paediatric Standard Treatment guideline	2014
National Postpartum Care guidelines	2011

HIV/AIDS

Title of document	Period
Draft HIV Policy	
Health Sector HIV Strategic Plan III	2013-17
2 year Operational Plan for implementation of Health Sector HIV Strategic Plan III	2013-15
eMTCT Plan	2012-15
Draft VMMC Country Operation Plan	2014-17

Malaria

Title of document	**Period**
Malaria Strategic Plan	2014-2020
Business Plan	2013/14-2015/16
Monitoring and Evaluation Plan	2014 -2020
National Guidelines for Diagnosis & Treatment of malaria	Version 2013
Integrated Malaria Vector Control Guidelines	Version 2014
Malaria Communication Guidelines	Version 2014
Malaria Partners' interventions oversight Plan	Version 2014
Malaria resource Mobilisation Plan	

Tuberculosis

Title of document	**Period**
National TB and Leprosy strategic plan IV	2009 -2015
Draft National TB and Leprosy strategic plan V	2015-2020
National Policy Guidelines for Collaborative TB/HIV activities,	2007
National TB and Leprosy Programme, Advocacy Communication and Social	2013

Mobilization Strategy,	
National Operational Guidance on Integrating community based TB activities in the work of NGOs and CSOs,	2012

Neglected Tropical Diseases

Title of document	Period
Strategic Master plan for the neglected Tropical diseases	2012 - 2017

Nutrition

Title of the document	Period
Food and Nutrition Policy	2009
National Nutrition Strategy	2011 - 2016
TFNC Strategic Plan	2013 - 2018
Infant and Young Child Nutrition Strategy	2014
Infant and young Child Feeding National Guidelines	2013
Social Behavioral Change Communication (SBCC)	2013 - 2018
National Fortification Guidelines and Standards on wheat and maize flour edible oil	2011
National Vitamin A guideline	2011
National Micronutrient powders (MNP) guideline	2012
Districts Nutrition Plans and budget	
National guidelines on Management of acute malnutrition	
National Nutrition Survey (SMART methodology)	2014
Tanzania Demographic and Health Survey	2010

NCDs

Title of Document	Period
National Eye Care Program Strategic Plan	2011-2016
National Strategy for Non Communicable Diseases	2009 – 2015
National Guideline for prevention and control of Non Communicable Diseases	2007
National Road safety Policy	September 2009
Strategic Oral Health Plan	2012 - 2017
National Cervical Cancer Strategy	
National Tobacco Control Strategic Plan	2010-2015
National Alcohol Policy Guideline	
National Mental Health Policy Guideline	

Emergency Preparedness

Title of document	Period
Emergency Operations Guideline	2013
Mass Casualty Management Guideline	2013
Health Sector All Hazard Emergency preparedness and Response Plan	2010
Mass casualty management Training Manual	2014
Regional and District Health Disaster Management teams Guideline	2014
Disaster Risk Management Country Capacity Assessment Report	2012
Disaster Risk Management Roadmap	2012
National Chemical Emergency Preparedness and Response Plan	
Nutritional Emergencies preparedness and Response Plan	
Tanzania Emergency preparedness and Response Plan	2012
National Operations Guideline	2003
National Disaster management Policy	2011
Tanzania Disaster Communication Strategy	2012

Surveillance

Title of document	Period
Public Health Act 2009	2009
IHR 2005 Core Capacity Assessment	2010
National IDSR guidelines	2011
National Avian and Pandemic l Influenza Emergency Preparedness and Response Plan	2010-2014
National IHR 2005 Action Plan	2014-2016
National Rift Valley Strategic Plan	2010-2014
National Health Laboratory Strategic Plan	2009-2015
Framework for cross border Surveillance and Response	2012

Health Promotion

Title of document	Period
The National Policy guidelines for Health Promotion	
The National Strategy for Health Promotion	
The National Policy Guideline for Community Health Services	
The National Strategy for Community Health Service	
Guideline for planning and budgeting for health promotion at council levels	
MOU between MOHSW, MUHAS and JHU in support of harmonized and sustainable CHW initiatives in TZ	
Advocacy toolkit for community health services	
MOU between the MOHSW and TCDC in strengthening health communication	

Water and Sanitation

Title of document	Period
The Draft Sanitation and Hygiene Policy	draft
National Environmental Health Hygiene and Sanitation Strategy (NEHHSAS), 2007/15	2007-2015
National Action Plan for Health Care Waste Management	2009-2013
National Policy Guidelines for Health care Waste Management	2006
National Standards for Health Care Waste Management	2006
National Catalogue for Health Care Waste Management	2006
National Community Led Total Sanitation Facilitation Guideline	2012
National Sanitation Option and Construction Guidelines	2012
National Sanitation Campaign Implementation Guideline	2014
The strategic plan II for the prevention and control of workplace HIV, TB and HBV for Health Workers at their workplaces	2013-2017
Sanitation Options User Guide	2014
The Sanitation and Hygiene Operational Memorandum of Understanding	2011
International Health Regulation, 2005	2005
Guide to Hygiene and Sanitation in Aviation of 2009	2009
Public Health Act, 2009	2009
International Health Regulation ,2005	2005
National Waste and Human Remains Policy Guidelines	2011
National Plan for Building Climate Change Adaptation in Health through resilient water, sanitation and hygiene	2014 - 2017

Social Welfare

Title of document	Period
The National ageing policy	2003
National Disability Policy	2004
The child development policy	2008
The persons with disability Act	2010
WHO Wheel chair Guideline	2009

Title of document	Period
The Law of the child Act	2009
Anti-Trafficking in persons Act	2008
Health Sector Strategic Plan III	2010-2015
National Costed Plan of Action for most vulnerable children –II	2013-2017
Sexual offences (with Special Provision Act)	1998
The Destitute Ordinance	1923
The Law of marriage Act No: 5	1971
Multi-sectorial Action plan on violence Against children	2013-2016
The Social welfare Policy	
The multi-Sector National Plan of Action to Prevent and Respond to violence Against Children	July 2013 – June 2016
Violence Against Children in Tanzania; Findings from a National Survey 2009	2011
Five year Strategy for Progressive Child Justice Reform 2013 – 2017, (report')	2014
Mpango Mkakati wa miaka mitano wa haki za watoto 2013 – 2017	2013
Disability Mainstreaming Strategic plan 2010-2015	2010
Department of Social Welfare Strategic Plan 2007 – 2011	2007
National Human Rights Action Plan 2013-2017	2013

Support Systems

Human Resources for Health

Title of document	Period
Human Resource for Health and Social Welfare Policy Guideline	2014-2019
Human Resource for Health and Social Welfare Strategic Plan	2014-2019
Human Resource for Health and Social Welfare Production Plan	2014-2019
Human Resource for Health and Social Welfare Staffing Levels Guideline	2014-2019
Human Resource for Health and Social Welfare Country Profile	2014
Human Resource for Health and Social Welfare Information System and Training Institutions Information System Data Utilisation Guideline	2013

Pharmaceuticals and Supplies

Title of document	Period
National Medicines Policy (NMP) 2013	n/a
NMP Implementation Strategy 2014 (Addendum to NMP, above)	2014-2024
National Pharmaceutical Sector Action Plan 2020 (PSAP 2020)	2014-2020
PSAP 2020 Costed Implementation Plan (Initial 3-year rolling plan, addendum to PSAP 2020, above)	2014-2017
MSD Medium-Term Strategic Plan (MTSP)	2014-2020
TFDA Strategic Plan	2012/13 to 2016/17
Pharmacy Council Strategic Plan	2013-2018
Tanzania Pharmaceutical Manufacturing Plan of Action	2014-2018
SADC Pharmaceutical Business Plan	2015 -2019

Monitoring and Evaluation

Title of document	Period
M&E Strengthening – 5 Year Strategy – A Tanzanian Platform for Health Information and Accountability	2015 – 2020
M&E Strengthening Initiative – Annual Work plans, Budgets and Reports	2010 to 2015
Global Fund Round 9 M&E Strengthening Phase 2	2014 - 2016
HSSP IV – M&E Plan	2015 – 2020

Title of document	Period
TACAIDS M&E Strategy Tanzania Third National Multi-Sectoral Strategic Framework For HIV AIDS (2013/14 – 2017/18); Nov 2013. Section 6 Monitoring, Evaluation and Research	
NACP M&E Strategy NACP Third Health Sector HIV and AIDS Strategic Plan (HSHSP - III) 2013-2017, section 9, M&E plan, page 69	
NMCP M&E Strategy	
RCHS M&E Strategy and Sharpened One Plan The National Road Map Strategic Plan To Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania; Section 6 Monitoring Framework, page 47	
TB/L M&E Strategy The NTLP Strategic Plan 2009/2010 - 2015/2016. M&E, section 11, page 48	
PMORALG M&E Strategy PMORALG Strategic Plan 2011/12 - 2015/2016 Performance Indicators are listed on page 26.	
DSW M&E Strategy	
WASH M&E Strategy Water Aid Tanzania strategy, 2011-2016 includes objectives, and M&E discussion. NATIONAL STRATEGIC PLAN FOR SCHOOL WATER, SANITATION AND HYGIENE (SWASH) 2012 -2017 (Under MOE), M&E in Section 5, page 38 Multi-sectoral; Under MKUKUTA, National Water Sector Development Strategy (NWSDS) 2006 - 2015, section 7 focused on performance M&E, page 68	
Draft Data Use and Dissemination Strategy The Tanzania national DDU strategy 2015 - 2020, includes M&E as a core strategic objective, and a logic model that links activities to outputs, outcomes and impact. M&E framework, Section 5, page 15	
e-Health Strategy The Tanzania e-Health Strategy, 2013 - 2018. The e-Health strategy M&E framework, section 5, page 14	
NIMR Strategy NIMR Strategic Plan IV, 2014-2019 Part 2, the M&E framework, page 18.	
Community Based Data Management systems Guidelines	
PPP Strategy and M&E Plan	
National Nutrition Strategy and M&E Plan	
List of 100 Core Health Indicators	October 2014
Monitoring, Evaluation and Review of national health Strategies - A Country-Led Platform for Information and Accountability	November 2011
Improving Data Use in Decision making- An Intervention to Strengthen Health Systems	August 2012

Governance and Financing

Public Private Partnership

Title of document	Period
National Public Private Partnership 2009	2009
PPP Act 2010	2010
PPP Regulations 2011	2011
PPP Amendment Bill 2014	2014
MOHSW PPP Policy Guidelines	2012
MOHSW PPP Strategic Plan	2010-15
MOHSW PPP Strategic Plan Review	2014
PPP TWG Plan of Action	2014-15

Health Care Financing

Title of document	Period
Cost-sharing policy guidelines	Dec 1997
CHF Act of 2001	To date
NHIF Act of 1999	To date
MOU between MOHSW, PMO-RALG and NHIF	2012 - 2015
RBF design document	2015 -
Health Basket Fund MOU	2009 –2015
Health Financing Strategy (HFS)	2015 –2025
NHIF Strategic Plan	2010 - 2015

Annex 2 Detailed cost results, targets and fiscal space assumptions

Cost and Targets

Commodity costs (TZS billions) by program

Program	2015/2016	2016/2017	2017/2018	2018/2019	2019/2020	Total
HIV/AIDS	415	453	466	490	518	**2,342**
NCDs	299	372	453	538	627	**2,290**
Oral care	132	144	156	170	186	**786**
General services	130	132	135	137	139	**672**
Malaria	183	123	121	119	118	**665**
Immunization & vaccine	127	120	116	105	97	**564**
Maternal, newborn, and reproductive health	65	76	86	94	102	**425**
Child & adolescent health	25	46	70	86	98	**325**
Orthopedic/Trauma	39	40	41	41	42	**202**
Mental health	25	28	30	31	31	**144**
TB and leprosy	16	19	21	23	26	**106**
NTDs	21	17	13	13	13	**76**
Ophthalmology	3	3	3	2	2	**12**
Nutrition*	2	2	2	2	2	**10**
Environmental Health	0.1	0.1	0.1	0.1	0.1	**0.3**
Total	1,480	1,574	1,711	1,852	2,001	**8,619**

Note: Not all programs procure commodities (ex: health promotion).

**Excludes nutrition costs under maternal and child health.*

Cross-cutting nutrition commodity costs (TZS billions)

Type of cost	2015/2016	2016/2017	2017/2018	2018/2019	2019/2020	Total
Maternal health	0.8	2	3	4	5	**13**
Child health	10	26	47	60	70	**212**
Other	2	2	2	2	2	**10**
Total	**13**	**30**	**52**	**66**	**77**	**235**

Includes cost of vitamin and micronutrient supplementation, food fortification, treatment of MAM and SAM, treatment of anaemia, and nutrition supplementation for people living with HIV

Key coverage targets used in commodity costing by program

Program	Highest cost intervention within each program	2015/2016 coverage*	2019/2020 coverage*
HIV/AIDS	Antiretroviral therapy (ART)	64% of PLHIV	90% of PLHIV
NCDs	Treatment of type I diabetes	20%	100%
Immunization & vaccine	Pneumococcal vaccine	95%	95%
Oral care	Oral cancer treatment	21%	21%
General services	Hearing loss	3%	3%
Malaria	Insecticide treated materials	Campaign distribution of 18,765,840 LLINs	8,000,000 LLINs distributed per year

Program	Highest cost intervention within each program	2015/2016 coverage*	2019/2020 coverage*
Maternal, newborn, and reproductive health	Labour and delivery management	50%	80%
Child & adolescent health	Management of severe acute malnutrition	2%	10%
Orthopedic/Trauma	Internal fixation	32%	32%
TB and leprosy	Smear tests for TB	70% of all TB & MDR cases	70% of all TB & MDR cases
Mental health	Identification and assessment of new cases of drug use	10%	10%
NTDs	Lymphatic filariasis control and treatment	80% of those in endemic areas	80% of those in endemic areas
Ophthalmology	Treatment for infectious diseases of the eye	50%	50%
Nutrition	Salt iodization	8,000 kg per year	8,000 kg per year

**Coverage is defined as the percentage of people in need of an intervention who are reached.*

Program management costs by program(TZS billions)

Program	2015/2016	2016/2017	2017/2018	2018/2019	2019/2020	Total
HIV	188	145	129	140	126	**728**
TB and leprosy	76	103	91	89	93	**451**
Maternal, newborn, and reproductive health	74	76	72	77	67	**365**
Malaria	77	64	65	66	67	**339**
Child & adolescent health	57	57	45	45	28	**232**
Environmental health	50	43	49	43	43	**229**
Department of Social Welfare	14	15	17	21	23	**90**
NCDs and mental health	16	15	16	16	16	**79**
NTDs	7	7	7	7	7	**34**
Health promotion	4	4	4	2	2	**16**
Nutrition	2	3	3	3	4	**15**
Oral care	2	2	2	2	2	**12**
Ophthalmology	3	2	1	1	1	**8**
Orthopedic/trauma	2	1	1	1	1	**7**
Alternative and traditional medicine	1	0.4	0.4	0.3	0.3	**2**
Total	**573**	**538**	**503**	**514**	**480**	**2,608**

Note: Not all programs have separate program management costs (ex: general services).

Detailed HRH costs (TZS billions) and targets (personnel)

	2015/2016	2016/2017	2017/2018	2018/2019	2019/2020	Total
HRH costs						
Salaries	607	664	726	788	858	**3,643**
Benefits	109	119	130	141	154	**653**
Human resource administration*	24	24	25	19	23	**115**
Total	**740**	**807**	**881**	**948**	**1,034**	**4,411**
HRH targets in numbers of personnel						
No. of service providers	70,883	76,049	81,731	87,417	94,141	
Nurses	*16,882*	*17,952*	*19,021*	*20,091*	*21,160*	
Formalized CHWs	*320*	*840*	*1,880*	*2,920*	*5,000*	

No. of support staff	8,946	10,332	11,719	13,105	14,494	
Total no. of HRH	**79,829**	**86,381**	**93,450**	**100,522**	**108,635**	

**Includes costs for training, retention incentives, HRHIS maintenance, etc.*

Detailed Logistics costs (TZS billions)

Type of cost	2015/2016	2016/2017	2017/2018	2018/2019	2019/2020	Total
Commodity freight, clearance, and quality assurance costs	192	205	222	241	260	**1,120**
Commodity wastage costs	144	1547	168	182	197	**845**
Warehouse construction and operating costs	13	18	13	11	16	**71**
Vehicle purchase, maintenance, and fuel costs	20	25	22	29	30	**126**
Warehouse worker wages costs	4	4	4	4	4	**21**
Third party logistics contracts	1	2	2	2	2	**8**
BRN costs related to commodity management	10	5	7	0	0	**22**
Total logistics costs	**388**	**414**	**440**	**469**	**509**	**2,219**

Detailed Infrastructure costs (TZS billions)

Type of cost	2015/2016	2016/2017	2017/2018	2018/2019	2019/2020	Total
New construction costs	54	87	44	34	35	**254**
Rehabilitation costs	90	90	83	76	76	**414**
Equipment and furniture costs	4	31	29	27	27	**119**
Facility operating costs	227	229	232	234	237	**1,158**
Vehicle purchase costs	66	43	45	45	45	**244**
Vehicle operating costs^	125	126	128	129	130	**638**
Infrastructure program management*	24	4	14	3	14	**59**
Total	**590**	**610**	**574**	**548**	**565**	**2,887**

^Includes cost of fuel, drivers, and maintenance

**Includes costs related to infrastructure under BRN*

Detailed Infrastructure targets (number of facilities)

Facility type	Number to be constructed	Small-scale rehabilitation (No.)	Equipment maintenance and replacement (No.)
Dispensaries	790	3,057	2,205
Health centers	35	242	160
District hospitals	9	60	42
Regional referral hospitals	0	7	5
National, special, zonal hospitals	0	3	2
Total	**834**	**3,369**	**2,414**

Fiscal space

Generally, there are no publicly available future commitment values from development partners. Data are entered into the aid management portal (http://amp.mof.go.tz/) when available. However, these data were not made available for this fiscal space exercise and hence figures were sourced where possible directly from DPs or appropriate assumptions were made in concert with MOHSW. All values were converted into constant FY 2014 Tanzanian shillings using appropriate deflators prior to comparison with HSSP IV costs. However, all tables below display current Tanzanian shillings.

On-budget, non-basket funding sources, current TZS billions

Sources	*2013/14*	*2014/15*	**2015/16**	**2016/17**	**2017/18**	**2018/19**	**2019/20**	**2020/21**
Global Fund	*346*	*207*	450	588	558	530	504	479
UNICEF	*12*	*11*	11	11	11	11	11	11
World Bank	*28*	*17*	17	53	104	104	104	111
UNDP	*15*	*18*	18	18	18	18	18	18
Others	*49*	*12*	12	12	12	12	12	12
Total	*450*	*266*	**509**	**682**	**703**	**676**	**649**	**631**

Notes: Where possible, data were sourced from recent commitments or from values provided by DPs. World Bank values are mixed, comprising grant (GFF related trust fund monies) and IDA concessional loan. For the Global Fund, values after 2017/18 are assumed, based on 5% decline p.a.

External resources off-budget, current TZS billions

Sources	*2013/14*	*2014/15*	**2015/16**	**2016/17**	**2017/18**	**2018/19**	**2019/20**	**2020/21**
USAID	*602*	*602*	602	594	564	536	509	484
GIZ	*10*	*10*	10	10	10	10	10	10
DANIDA	*56*	*56*	56	56	56	56	56	56
CDC	*62*	*62*	62	62	59	56	54	51
DFID	*41*	*43*	55	38	34	6	6	6
SDC	*7*	*7*	7	7	7	7	7	7
DOD	*71*	*71*	71	71	67	64	60	57
Canada	*119*	*119*	119	119	95	76	61	49
IrishAid	-	*4*	6	6	6	6	6	6
UN Agencies	*20*	*20*	20	20	20	20	20	20
Total	*988*	*994*	1,008	983	918	837	789	746

Notes: Where possible, data were sourced from recent commitments or from values provided by DPs. Values were kept constant due to a lack of data for GIZ, SDC, and UN Agencies. For Canada, some of the planned resources are included in the GFF trust fund managed by the World Bank. The remaining bilateral funds from Canada were assumed to decline 20% p.a. from 2017/18. USAID resources were assumed to decline 5% p.a. from 2017/18.

Innovative financing sources (other than SNHI), current TZS billions

Sources	**2015/16**	**2016/17**	**2017/18**	**2018/19**	**2019/20**	**2020/21**
Allocation from the surplus of public corporations	-	129	138	146	156	166
Airtime taxes	-	100	106	113	120	128
Alcohol and tobacco taxes	-	260	276	294	313	333
AIDS Trust Fund (GOT and non-GOT contrib.)	3	100	300	300	300	300
Total	**3**	**589**	**820**	**853**	**889**	**926**

Notes: These values are based on detailed analysis of actual tax or revenue collections for all but the AIDS Trust Fund. Proportional allocations from these sources to the health sector were based on discussions with MOHSW and feedback from stakeholders. MOF stakeholders were also present in these discussions. For the *20% allocation* from the surplus of public corporations to health, analysis of FY 2013/14 values suggests that vs. the estimated nominal GDP for that year, a level of 0.126% of GDP is appropriate going forward, which assumes that revenues will rise proportionately with GDP. Similarly, for the 17% allocation from mobile communication/airtime taxes to health, a value of 0.097% of GDP per year was estimated; and the same value for the 33% allocation from alcohol and tobacco taxes was 0.253% of GDP. The AIDS Trust Fund values are based on discussion with TACAIDS and are speculative.

Government of Tanzania and the Health Basket Fund, current TZS billions

Sources	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**	**2019/20**	**2020/21**
GOT domestic resources for health	*804*	*1,031*	**1,052**	**1,073**	**1,094**	**1,116**	**1,138**	**1,161**
Health Basket Fund	*135*	*109*	**47**	**45**	**42**	**40**	**38**	**36**

Notes: GOT sources are an aggregation of allocation to recurrent and development spending across MOHSW, PMO-RALG, regions, and LGAs. This included LGA own source revenues, which were estimated based on recent actuals and an increasing allocation to health was projected. Overall, for non-LGA sources, an increase of 2% p.a. was estimated from FY 2015/16. For the Health Basket Fund, values up to 2014/15 were based on available data, and from FY 2015/16, in the absence of details for the renewed commitment; an assumption was based on a 5% projected annual decline per year.

Annex 3 Health Sector Performance Indicators

Indicator	*Definition*	*Numerator*	*Denominator*	*2015 Baseline*	*2020 Target*	*Data Source*	*Frequency*	*Type*	*Disaggr*	*nat'l*	*int'l*
Health Status											
Mortality											
Neonatal mortality rate	The number of newborn deaths that occur within the first 28 days of life per 1000 live births in a given period.	Number of newborns who die within the first 28 days of life	Number of live births per 1000 in a given period	26 (TDHS 2010; 2006-2010)	16	TDHS Census	TDHS, census intervals	Impact	res sex wea edu	BRN RMNCAH	SDG GRL100
Infant mortality rate	The number of infants who die within the first year of life per 1000 live births in a given period.	Number of infant deaths within the first year of life.	Number of live births per 1000 in a given period	45 (Census 2012)	35	TDHS Census SPD SAVVY	TDHS, census intervals SAVVY (annual)	Impact	res sex wea edu		MDG GRL100
Under-five mortality rate	The number of children who die within the first five years of life per 1000 live births in a given period.	Number of child deaths within the first five years of life.	Number of live births per 1000 in a given period	81 (TDHS 2010; 2006-2010)	55	TDHS Census SAVVY	TDHS, census intervals SAVVY (annual)	Impact	res sex wea edu	RMNCAH	MDG SDG GRL100

Indicator	*Definition*	*Numerator*	*Denominator*	*2015 Baseline*	*2020 Target*	*Data Source*	*Frequency*	*Type*	*Disaggr*	*nat'l*	*int'l*
Maternal mortality ratio	The number of women who die of causes related to pregnancy, delivery, and post-partum per 100 000 live births in a given year or other period. *Causes of maternal death*: any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes) during pregnancy and childbirth or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy.	Number of women who die of causes related to pregnancy, delivery, or post-partum	Number of live births x 100,000	432 (Census 2012)	292	TDHS Census SAVVY (CoD)	TDHS, census interval SAVVY (annual)	Impact	res wea edu	BRN RMNCAH	MDG SDG GRL100
Life expectancy at birth	The average number of years that a newborn could expect to live, if he or she were to pass through life exposed to the sex- and age-specific death rates prevailing at the time of his or her birth, for a specific year, in a given country, territory, or geographic area. Calculated from life tables.			61 F: 63 y M: 60 y (Census 2012)	Trend	Census Survey	census interval	Impact	res sex wea edu	Vision 2025	SDG GRL100

Indicator	*Definition*	*Numerator*	*Denominator*	*2015 Baseline*	*2020 Target*	*Data Source*	*Frequency*	*Type*	*Disaggr*	*nat'l*	*int'l*
Fertility											
Total fertility rate	The average number of children a hypothetical cohort of women would have at the end of their reproductive period if they were subject during their whole lives to the fertility rates of a given period and if they were not subject to mortality.It is expressed as children per woman.	Sum of age specific fertility rates for age groups comprising 15-49 age group.	None	5.2 (Census 2012)	Trend	TDHS census SAVVY	TDHS interval census interval SAVVY (annual)	Impact	res wea edu		GRL100

Indicator	*Definition*	*Numerator*	*Denominator*	*2015 Baseline*	*2020 Target*	*Data Source*	*Frequency*	*Type*	*Disaggr*	*nat'l*	*int'l*
Service delivery											
Reproductive Health											
Contraceptive prevalence rate (modern methods)	*Survey*: Percentage of women aged 15-49 years who are currently using, or whose sexual partner is using, at least one modern method of contraception, regardless of the method used. *HMIS*: The percentage of women aged 15-49 years, regardless of marital status, who have received at least one modern method of contraception from a health facility during the year, regardless of the method used.	Number of women 15-49 years of age who are currently using a modern contraceptive method x 100	*Survey*: Number of women between 15 and 49 years of age in survey. *HMIS*: Number of women between 15 and 49 years of age in catchment area	All methods: 36% Modern methods: 27% (TDHS 2010) 48% (HMIS 2014)	All methods:60 % Modern methods: 45% (TDHS) 60% (HMIS)	HMIS TDHS	HMIS Annual TDHS interval	Outcome	res wea method edu star brn rbf	BRN RBF RMNCAH	SDG GRL100

Indicator	*Definition*	*Numerator*	*Denominator*	*2015 Baseline*	*2020 Target*	*Data Source*	*Frequency*	*Type*	*Disaggr*	*nat'l*	*int'l*
Adolescent fertility rate Adolescence fertility (pregnant before 20 years old)	Annual number of births to women aged below 20 years per 1 000 women in that age group.	Annual number of births to women aged below 20 years	Total number of women in the age group below 20 years per 1 000	116 (TDHS 2010)	80 per 1000 women	TDHS Population Census SAVVY	TDHS interval census interval SAVVY (annual)	Outcome	res wea edu	RMNCAH	MDG SDG GRL100
Antenatal care coverage: first visit before 12 weeks gestational age	Percentage of pregnant women who start ANC before 12 weeks of gestational age	Number of pregnant women who start ANC before 12 weeks of gestational age x 100	Estimated number of pregnant women.	15% (< 4 months TDHS 2010) 15% (HMIS 2014)	40% (< 4 months TDHS) 40% (HMIS)	HMIS TDHS (< 4 months)	HMIS (Monthly) TDHS interval	Outcome	res wea edu star brn rbf	BRN RBF RMNCAH	
Antenatal care coverage: 4 visits	Percentage of pregnant women who attended antenatal care four or more times in a given time period.	Number of pregnant women who received antenatal care four or more times x 100	Estimated number of pregnant women.	43% (TDHS 2010) 40% (HMIS 2014)	60% (TDHS) 60% (HMIS)	HMIS TDHS	HMIS (Monthly) TDHS interval	Outcome	res wea edu star brn rbf	BRN RBF RMNCAH	MDG GRL100

Indicator	*Definition*	*Numerator*	*Denominator*	*2015 Baseline*	*2020 Target*	*Data Source*	*Frequency*	*Type*	*Disaggr*	*nat'l*	*int'l*
Institutional delivery coverage *PAF*: Percentage of councils in which at least 60% of deliveries take place in health facilities	Percentage of women who delivered in a health facility during a specified time period	Number of who delivered in a health facility x 100	Estimated number of deliveries	50% (TDHS 2010) 54.7% (HMIS 2014)	65% (TDHS) 65% (HMIS)	HMIS TDHS	HMIS (Monthly) TDHS interval	Outcome	res wea edu star brn rbf	PAF BRN RBF RMNCAH	GRL100
Percentage deliveries assisted by skilled health attendants	Percentage deliveries assisted by skilled health attendants (doctors, clinical officers, nurses, nurse midwives)	Number of deliveries assisted by skilled health attendants x 100	Estimated number of deliveries	51% (TDHS 2010)	60%	TDHS	TDHS interval	Outcome	nat		MDG GRL100
Postnatal care: within 7 days after delivery	Percentages of mothers and of infants who received postnatal care within seven days of childbirth (regardless of place of delivery)	Number of mothers and number of infants who received postnatal care within seven days of childbirth x 100	I: Estimated number of live births M: Estimated number of deliveries	I: 56% M: 57% (HMIS 2014)	I: 68% M: 70% (HMIS 2014)	HMIS TDHS	HMIS (Monthly) TDHS interval	Outcome	res wea edu star brn rbf	BRN RBF RMNCAH	

Indicator	*Definition*	*Numerator*	*Denominator*	*2015 Baseline*	*2020 Target*	*Data Source*	*Frequency*	*Type*	*Disaggr*	*nat'l*	*int'l*
BEmONC at dispensaries and health centers	Percentage of 1) dispensaries and 2) health centres that provide BEmONCseven signal functions as defined in EHP.	Number of 1) dispensaries and 2) health centres that provide BEmONC as defined in EHP	Total number of 1) dispensaries and 2) health centres.	1) 20% 2) 39% (SARA 2012)	1) 70% 2) 70%	special study	study interval	Input	res star brn rbf	BRN RMNCAH	
CEmONC at health centers and hospitals	Percentage of 1) health centres and 2) hospitals that provide CEmONC nine signal functions as defined in EHP.	Number of 1) health centres and 2) hospitals that provide CEmONC as defined in EHP	Total number of 1) health centres and 2) hospitals.	1) 9% 2) 73% (SARA 2012)	1) 50% 2) 100%	special study	study interval	Input	res star brn rbf	BRN RMNCAH	
Vaccinations											
Vaccination rate: measles under one year	Proportion of children under one received measles vaccine in a given year or other period.	Total number of children under one year vaccinated against measles x 100	Total number of children under one year targeted in the period	75% (TDHS 2010) 90.51% (HMIS 2014)	90% (TDHS) 90% (HMIS)	HMIS TDHS	HMIS (Monthly) TDHS interval	Outcome	res sex wea edu star brn rbf	RBF RMNCAH	MDG GRL10 0

Indicator	*Definition*	*Numerator*	*Denominator*	*2015 Baseline*	*2020 Target*	*Data Source*	*Frequency*	*Type*	*Disaggr*	*nat'l*	*int'l*
Vaccination rate: Penta3 under one year	Proportion of children under one received Penta3 vaccine in a given year or other period.	Total number of children under one year vaccinated 3 times against DPT - Hb x 100	Total number of children under one year targeted in the period	86% (TDHS 2010) 82.07% (HMIS 2014)	90% (TDHS) 90% (HMIS)	HMIS TDHS	HMIS (Monthly) TDHS interval	Outcome	res sex wea edu star brn rbf	RMNCAH	GRL100
Vitamin A supplementation coverage	*Survey*: Proportion of children 6–59 months who received 1 dose of vitamin A in the past 6 months. *HMIS*: Ratio of Vitamin A doses given to children 12–59 months in past 12 months to number of children 12–59 months.	*Survey*: Total number of children aged 6–59 months who received 1 dose of vitamin A in the past 6 months x 100 *HMIS*: Number of Vitamin A doses given to children 12–59 months in past 12 months	*Survey*: Total number of children aged 6–59 months in the sample. *HMIS*: Number of children 12–59 months	61% (TDHS 2010) 51% (HMIS 2014)	75% (TDHS) 65% (HMIS)	HMIS TDHS	HMIS (Monthly) TDHS interval	Outcome	res sex wea edu star brn rbf	RBF RMNCAH	GRL100

Indicator	*Definition*	*Numerator*	*Denominator*	*2015 Baseline*	*2020 Target*	*Data Source*	*Frequency*	*Type*	*Disaggr*	*nat'l*	*int'l*
Nutrition											
Children under 5 who are underweight	Proportion of under-fives who are underweight (weight for age)	Number of children who are underweight (weight-for-age less than -2 standard deviations of the WHO Child Growth Standards median) among children aged 0-4 years x 100	Number of children under five years of age	16% (TDHS 2010)	11% (TDHS)	TDHS	TDHS interval	Impact	res wea edu	Nut TWG	MDG
Children under 5 who are stunted	Proportion of under-fives who are stunted (height for age)	Number of children who are stunted (height-for-age less than -2 standard deviations of the WHO Child Growth Standards median) among children aged 0-4 years x 100	Number of children under five years of age	42% (TDHS 2010)	27% (TDHS)	TDHS	HMIS (Monthly) TDHS interval	Impact	res wea edu	Nut TWG	GRL100

Indicator	*Definition*	*Numerator*	*Denominator*	*2015 Baseline*	*2020 Target*	*Data Source*	*Frequency*	*Type*	*Disaggr*	*nat'l*	*int'l*
Incidence of low birth-weight among newborns	Percentage of live births that weigh less than 2500 g out of the total of live births during the same time period.	Number of live births that weigh less than 2500 g x 100	Number of live births	7.3% (HMIS 2014) 6.9% (TDHS 2010)	<2% (TDHIS & HMIS)	HMIS TDHS	HMIS (Monthly) TDHS interval	Output	res wea edu star brn rbf	Nut TWG RMNCAH	GRL100
Percentage of pregnant women with anaemia	Percentage of women (15-49 years) who have haemoglobin concentration <11 g/dl)	Number of cases of women who are Anemic	Number of women aged between 15 - 49 years who have haemoglobin concentration<11 g/dl	59% (TDHS 2010)	35% (TDHS&HMIS)	HMIS (to be added) TDHS THMIS	Monthly	Impact	res weaedu	Nut TWG	GRL 100
HIV/AIDS											
HIV prevalence in 15-24 year age group	Percentage of young people aged 15–24 years who are living with HIV	Number of people aged 15 –24 years who were tested to be HIV positive x 100	Total population [tested] in the age group 15 – 24 years	15-19: 1.0%; 20-24: 3.2% (THMIS 2012)	15-19: 0.8%; 20-24: 2.4% by 2017(NACP)	THMIS	THMIS interval	Impact	age	NACP SP	MDGGRL100

Indicator	*Definition*	*Numerator*	*Denominator*	*2015 Baseline*	*2020 Target*	*Data Source*	*Frequency*	*Type*	*Disaggr*	*nat'l*	*int'l*
ARV Coverage	Number and percentage of eligible adults and children currently receiving antiretroviral therapy	Number of adults and children eligible for ART receiving ART (disaggregated under 5 and over 5 and sex) x 100	Estimated number of eligible adults and children	Adults: 60%; Children: 25% in 2012 (NACP)	Adults: 95%; Children: 80% by 2017 (NACP)	model + RHIS	Annual	Outcome	Sex, Age: <1 1-4 5-14 15+	NACP SP	MDG SDG GRL100
Prevention of Mother-to-Child Transmission	Percentage of HIV-infected pregnant women receiving ARVs to reduce the risk of PMTCT	Number of HIV-infected pregnant women receiving ARVs for PMTCT x 100	Number of HIV-infected pregnant women	65% in 2012 (NACP)	90% in 2017 (NACP)	model + RHIS	Annual	Outcome	New to ART, Already on ART	NACP SP RBF RMNCAH	MDG GRL100

Indicator	*Definition*	*Numerator*	*Denominator*	*2015 Baseline*	*2020 Target*	*Data Source*	*Frequency*	*Type*	*Disaggr*	*nat'l*	*int'l*
Malaria											
Intermittent preventive therapy for malaria during pregnancy (IPTp)	*Survey*: Proportion of mothers who received two doses of preventive intermittent treatment for malaria during last pregnancy. *HMIS*: Proportion of mothers who received two doses of preventive intermittent treatment for malaria during pregnancy during a specified time period.	*Survey*: Number of mothers receiving 2 or more doses SP during last pregnancy within past 2 yrs *HMIS*: Number of mothers receiving 2 or more doses SP during pregnancy	*Survey*: Number of mothers surveyed who had a live birth in past 2 years *HMIS*: Total number of first ANC visits	33% (THMIS 2012) 34% (HMIS 2014)	80% (THMIS) 80% (HMIS)	TDHS TMIS and other household surveys HMIS	TMIS & TDHS intervals HMIS (Monthly)	Output	res wea edu star brn rbf	RBF NMCP RMNACH	GRL100 (3 doses)
Use of long lasting insecticide treated nets (LLIN)	Proportion of vulnerable groups (pregnant women 15-49 yrs of age, children under 5) sleeping under an LLIN the previous night	Number of children <5 or pregnant women 15-49 years sleeping under ITN night before survey	Number of children <5 or pregnant women 15-49 yrs who reside in surveyed households	<5 yrs: 72% PW: 75% (THMIS 2012)	<5 yrs: 80% PW: 80%	TDHS TMIS and other household surveys	TMIS & TDHS intervals	Outcome	res edu wea	NMCP	MDG GRL100

Indicator	*Definition*	*Numerator*	*Denominator*	*2015 Baseline*	*2020 Target*	*Data Source*	*Frequency*	*Type*	*Disaggr*	*nat'l*	*int'l*
Children with blood test in febrile illness	Proportion of children under 5 (2-59 months) who had a blood test taken in febrile illness in last 2 weeks	Number of children under 5 (2-59 months) who had a blood test taken in febrile illness in last 2 weeks x 100	Number of children under 5 (2-59 months) who had a febrile illness in last 2 weeks	25% (THMIS 2012)	80% (HMIS)	TDHS TMIS and other household surveys	TMIS & TDHS intervals	Outcome	res edu wea	NMCP	
Confirmed malaria cases	Proportion of confirmed malaria cases out of total malaria cases (clinical + confirmed)	Number of confirmed malaria cases x 100	Total number of malaria cases (clinical + confirmed)	64% (HMIS 2014)	95% (NMCP)	HMIS	Monthly	Outcome	res <5 >5		
Malaria parasite prevalence among children 6-59 months	Percentage of children aged 6–59 months who test positive for malaria by microscopy	Number of children positive by microscopy x 100	Number of children tested by microscopy x 100	4.1% (THMIS 2012)	<1% (NMCP)	TMIS and other household surveys	TMIS intervals	Impact	res edu wea	NMCP	GRL100

Indicator	*Definition*	*Numerator*	*Denominator*	*2015 Baseline*	*2020 Target*	*Data Source*	*Frequency*	*Type*	*Disaggr*	*nat'l*	*int'l*
Tuberculosis and Leprosy											
Case detection rate for all forms of tuberculosis The term "rate" is used for historical reasons; the indicator is actually a ratio (expressed as percentage) and not a rate.	The proportion of estimated new and relapse tuberculosis (TB) cases detected in a given year under the internationally recommended tuberculosis control strategy. The term "case detection", as used here, means that TB is diagnosed in a patient and is reported within the national surveillance system, and then to WHO.	The number of new and relapse TB cases diagnosed and treated in national TB control programmes and notified to WHO x 100 (TB notification rate)	WHO's estimate of the number of incident TB cases for the given year. Available online at www.who.int/tb/data	56% in 2013 (NTLP)	72%	NTLP HMIS WHO	Annual	Outcome	res star brn rbf	NTLP	GRL100

Indicator	*Definition*	*Numerator*	*Denominator*	*2015 Baseline*	*2020 Target*	*Data Source*	*Frequency*	*Type*	*Disaggr*	*nat'l*	*int'l*
Treatment success rate for all forms of tuberculosis	Proportion of all TB cases, all forms, bacteriologically confirmed plus clinically diagnosed, successfully treated among all TB cases registered for treatment during the specified period.	Number of TB patients who successfully completed treatment x 100	Number of tuberculosis cases registered for treatment	90% in 2013 (NTLP)	>90%	NTLP HMIS	Quarterly	Outcome	res star brn rbf	NTLP	GLR100
Disability grade at leprosy diagnosis	Proportion of patients with disability grade 2 among newly diagnosed leprosy patients	Number of patients with disability grade 2 at diagnosis x 100	Number of newly diagnosed leprosy cases	13% in 2013 (NTLP)	7%	NTLP HMIS	Quarterly	Impact	res star brn rbf	NTLP	
Children among newly detected cases	Proportion of patients under age 15 years among newly diagnosed leprosy patients	Number of patients under age 15 years x 100	Number of newly diagnosed leprosy cases	5% in 2013 (NTLP)	<2%	NTLP HMIS	Annual	Impact	res star brn rbf	NTLP	

Indicator	*Definition*	*Numerator*	*Denominator*	*2015 Baseline*	*2020 Target*	*Data Source*	*Frequency*	*Type*	*Disaggr*	*nat'l*	*int'l*
Infectious and non-communicable diseases											
Obesity and overweight among adults	Percentage of adults 25-64 years who are overweight (defined as having a BMI ≥25 kg/m^2)Percentage of adults 25-64 years who are obese (defined as having a BMI ≥ 30 kg/m^2)	Number of adults 25-64 years who are overweight (defined as having a BMI ≥25 kg/m^2) x 100Number of adults 25-64 years who are obese (defined as having a BMI ≥ 30 kg/m^2) x 100	Adult (24-65 years) population surveyed.	o'weight: 26.0% M: 15.1% F:37.1% Obese8.7% M: 2.5% F: 15.0% (STEPS 2012)	no increase in obesity (NCD AP)*	STEPS	STEPS interval	Impact	sex	NCD	SDGGRL100
Raised blood pressure among adults	Percentage of adults 25-64 years with BP > 140/90 or are currently on BP medication	Number of adults (24-65 years) with BP ≥ 140/90 or are currently on BP medication x 100	Adult (24-65 years) population surveyed.	26.0% M: 25.4% F: 26.5% (STEPS 2012)	reduced by 25% 19.5% M: 19.1% F: 19.9% (NCD AP)*	STEPS	STEPS interval	Impact	sex	NCD	SDG GRL100

Indicator	*Definition*	*Numerator*	*Denominator*	*2015 Baseline*	*2020 Target*	*Data Source*	*Frequency*	*Type*	*Disaggr*	*nat'l*	*int'l*
Raised glucose / diabetes among adults	Percentage of adults 25-64 years with raised fasting blood glucose (capillary whole blood value 6.1 mmol/L (110 mg/dl)) or are currently on medication for raised blood glucose	Number of adults (24-65 years) with with raised fasting blood glucose (capillary whole blood value 6.1 mmol/L (110 mg/dl)) or are currently on medication for raised blood glucose x 100	Adult (24-65 years) population surveyed.	9.1% M:8.0% F: 10.0% (STEPS 2012)	reduced by 10% 8.2% M: 7.2% F: 9.0% (NCD AP)*	STEPS	STEPS interval	Impact	sex	NCD	SDG GRL10 0
Cervical cancer screening	Proportion of women aged 30-50 who were screened for cervical cancer with Visual Inspection with Acetic Acid/vinegar (VIA).	Total number of women between 30 and 50 who were screened with Visual Inspection with Acetic Acid/vinegar (VIA) x 100	Number of women aged 30–50 years	11% (HMIS 2014)	Tbd	HMIS	Monthly	Output	res star brn rbf		SDG GRL10 0

Indicator	*Definition*	*Numerator*	*Denominator*	*2015 Baseline*	*2020 Target*	*Data Source*	*Frequency*	*Type*	*Disaggr*	*nat'l*	*int'l*
Social Welfare											
Direct Services											
Children in need of care and protection who received services.	Proportion of vulnerable children and children in need of care and protection provided with appropriate services from the social welfare office in collaboration with other key service providers. Disaggregated by type of service: Most Vulnerable Children (MVC); Victims of Violence, Abuse, Neglect and Exploitation (VANE); Juvenile Offenders; disability).	Number of eligible children who received services as determined by the assessed needs x 100	Number of children in need of care, protection and support services reported to the social welfare offices or other local government authorities	27.6% (Census 2012)	50%	HMIS (to be added) Gender and Children Desk Register; Police Register	Annual	Outcome	res MVC; VANE; Juvenile Offenders; disability		

Indicator	*Definition*	*Numerator*	*Denominator*	*2015 Baseline*	*2020 Target*	*Data Source*	*Frequency*	*Type*	*Disaggr*	*nat'l*	*int'l*
Adults in need of welfare and protection who received services.	Proportion of adults who are elderly, disabled, with matrimonial cases or living in poor households who received appropriate services from the social welfare office, other local government authorities or non-state actors. Disaggregated by type of service.	Number of eligible adults (elderly, disabled or extremely poor) who received services as determined by the assessed needs X 100	Number of eligible adults (elderly, disabled and extremely poor) who sought services reported to the social welfare offices or other local government authorities (health facilities/One Stop Centres, schools) and Police	Elderly: 5.6% Disabled: 5.8% (Census 2012)	Elderly: 50% Disabled: 50%	HMIS (to be added); Police Register	Annual	Outcome	res Elderly Poor Disability		

Indicator	*Definition*	*Numerator*	*Denominator*	*2015 Baseline*	*2020 Target*	*Data Source*	*Frequency*	*Type*	*Disaggr*	*nat'l*	*int'l*
Capacity											
LGAs with improved capacity to provide quality welfare and protection services	Proportion of LGAs with improved coordination of prevention and response services to children and adults in need of welfare and protection services. LGAs will be considered to have improved capacity if observe staffing, training and budgeting norms. Disaggregated by Most Vulnerable Children Committees (MVCC), District Child Protection Teams (DCPT) and adult services X 100	Total number of LGAs that have coordinated mechanisms for the provision of preventive and response services.	Total number of LGAs	70% have MVCCs without increased resources; 18% have DCPTs with increased resources	100% of all the districts have improved capacity coordination the services	HMIS CPMIS Programmes	Outcome	Annual	DCPTs MVCCs; adult services		

Indicator	*Definition*	*Numerator*	*Denominator*	*2015 Baseline*	*2020 Target*	*Data Source*	*Frequency*	*Type*	*Disaggr*	*nat'l*	*int'l*
Health facilities providing birth registration and birth certification services	Proportion of health facilities that are implementing the new decentralized system for registration of births and issuance of birth certificates. X 100	Number of health facilities consistently registering births and issuing birth certificates x 100	Total number of health facilities in regions where RITA has decentralized the new birth registration services	0% (RITA)	30% in regions rolling out the new system	RITA HDSS	tbd	Output	res star brn rbf registratio n; certificatio n		
Health Systems											
Financial											
Share of total Government expenditure allocated to Health	Proportion of government expenditures allocated to health in total government expenditures (excl. CFS) x 100	total on-budget health budget(MOF definition)	Total on-budget Government budget	9.1% (PER 2014)	10.0%	MOF data in PER	Annual	Input		HFS	
Enrollment in social health Insurance schemes	Proportion of population enrolled in any of the following schemes - NHIF, NSSF-SHIB, CHF, TIKA, CHIF, and others	Population enrolled in any of the following schemes - NHIF, NSSF-SHIB, CHF, TIKA, CHIF, and others	Total population	19% (NHIF data 2013)	50%	PER	Annual	Output	res (others for survey data)	HFS	UHC
Human Resources											

Indicator	*Definition*	*Numerator*	*Denominator*	*2015 Baseline*	*2020 Target*	*Data Source*	*Frequency*	*Type*	*Disaggr*	*nat'l*	*int'l*
Medical Officers and AMO per 10 000 population	Number of Medical Officers / Assistant Medical Officers per 10,000 population in the whole country	Number of Med. Specialists MOs / AMOs in the whole country	Total population ÷ 10 000 in the whole country								
Clinicians per 10 000 people in the 9 BRN Regions	Number of Medical Officers / Assistant Medical Officers and COs / ACOs per 10,000 population in the 9 BRN Regions	Number of Med. Specialists MOs / AMOs and COs / ACOs in the 9 BRN Regions	Total population ÷ 10 000 in the 9 BRN Regions	2.21		HRHIS	Annual	Input	Region council		
Clinicians per 10 000 people in the whole country	Number of Medical Officers / Assistant Medical Officers and COs / ACOs per 10,000 population in the whole country	Number of Med. Specialists MOs / AMOs and COs / ACOs in the whole country	Total population ÷ 10 000 in the whole country			HRHIS	Annual	Input	Region council		
Nurses and midwives per 10 000 people at the primary care level in the 9 BRN Regions	Number of Nurses and Midwives per 10,000 population at the primary care level in the 9 BRN Regions	Number of Nurses and Midwives available at the primary care level in the 9 BRN Regions	Total population ÷ 10 000 in the 9 BRN Regions	4.21	7.50	HRHIS	Annual	Input	Region council		

Indicator	*Definition*	*Numerator*	*Denominator*	*2015 Baseline*	*2020 Target*	*Data Source*	*Frequency*	*Type*	*Disaggr*	*nat'l*	*int'l*
Density of Nurses and Midwives – entire country (BRN monitors 9 critical regions *PAF*: Reduced proportion of Councils with Nurses and Midwives < 3 per 10 000 population)	Number of Nurses and Midwives per 10 000 population	Number of Nurses and Midwives available	Total population ÷ 10 000	5.60 (HRHIS & TIIS 2014)	7.50	HRHIS	Quarterly	Input	zone region council facility HI type star brn rbf	BRN PAF	

Indicator	*Definition*	*Numerator*	*Denominator*	*2015 Baseline*	*2020 Target*	*Data Source*	*Frequency*	*Type*	*Disaggr*	*nat'l*	*int'l*
Logistics											
Availability of Medicines and Health Products	Continuous availability of 10 tracers (medicines, vaccine, medical device) for essential health interventions in a facility for a reporting month. [3 types of analysis] 1. [LGA-CCHP] Number of tracers available per facility, on average, for reporting period; 2. [BRN, HSSP IV] Percentage of facilities having all 10 tracers; 3. [HSSP IV - Programmes] Percentage of facilities having each specified tracer.	During reporting month: 1. Total number of tracers available in facilities 2. Number of facilities having all 10 tracers; 3. Number of facilities having specified tracer. (Sum for reporting months)	During reporting month: (1, 2 and 3) Number of facilities reporting (X number of reporting months)	[3 types of analysis] 1.[LGA-CCHP] Average 7.7 tracers available in facilities in 2014 (HPPR) 2. [BRN, HSSP IV] All 10 tracers available in 31%of facilities in 2014 3.[HSSP IV - Programmes] Specified tracer available in >90% of facilities:5 out of 10 tracers (HPPR)	[3 types of analysis] 1.[LGA-CCHP] Average > 9.0 tracers available in facilities 2.[BRN, HSSP IV] All 10 tracers available in 80% of facilities [HSSP IV 2020]; 100% of facilities [BRN 2018] 3. [HSSP IV - Programmes] Specified tracer is available in >90% of facilities:9 out of 10 tracers	HMIS Facility survey	Monthly	Input	zone region council facility HI type star brn rbf	BRN	

Indicator	*Definition*	*Numerator*	*Denominator*	*2015 Baseline*	*2020 Target*	*Data Source*	*Frequency*	*Type*	*Disaggr*	*nat'l*	*int'l*
Order fill rate from supply agency	Percentage of items [value] ordered that are supplied to [and received by] health facility in the correct quantities with the correct products	Number of items [value] supplied to [and received by] health facility in the correct quantities with the correct products	Total number of items [value] ordered	MSD supplied 66 % of items [and 66 % of value] of orders from facilities in 2014	MSD supplied 90 % of items [and 90 % of value] of orders from facilities	eLMIS					
Facilities											
Utilization											
Outpatient attendance.	New outpatient (OPD) cases per capita in a given year or other period.	Total number of outpatients presenting for a new condition	Total population	0.64 (HMIS 2014)	0.8	HMIS Survey	Monthly	Output	res HI type star brn rbf	RBF	GRL100
Inpatient admissions	Number of Inpatient (IPD) admissions per 100 population per year	Total number of IPD admissions	Total population ÷ 100	2.41 (HMIS 2014)	2.50	HMIS	Monthly	Output	res HI type star brn rbf		GRL100
Service quality											

Indicator	*Definition*	*Numerator*	*Denominator*	*2015 Baseline*	*2020 Target*	*Data Source*	*Frequency*	*Type*	*Disaggr*	*nat'l*	*int'l*
Three Star rated primary health facilities.	Percentage of primary health facilities with 3 star rating or higher	Number of primary health facilities with 3 star rating or higher x 100	Total number of primary health facilities	NA	50%	HMIS	Monthly	Output	zone region council facility HI type star brn rbf	BRN	
Council Management											
Council annual health plan (CCHP)	Percentage of councils whose annual plan was approved according to first round assessment criteria.	Number of councils whose annual plan was approved according to first round assessment criteria X 100	Total number of councils	20% (CCHP ANNUAL PLAN 2014)	45%	HMIS (to be added)	Annual	Output	zone region council		
Percentage of council whose annual comprehensive Council Health Plan (CCHP) implementation report (Technical & Financial) passes the first round assessment	Percentage of councils whose annual comprehensive Council Health Plan (CCHP) implementation report (Technical & Financial) passes the first round assessment	Number of LGAs which passed the first round of annual CCHP performance assessment (Technical & Financial)	Total LGAs assessed	41% (2013/2014)	75%	CCHP Administrative data	Annual	Output	zone region		

Indicator	*Definition*	*Numerator*	*Denominator*	*2015 Baseline*	*2020 Target*	*Data Source*	*Frequency*	*Type*	*Disaggr*	*nat'l*	*int'l*
Environment											
Clean water	Proportion of population using an improved drinking water source	Number of persons using an improved water source: piped water, public tap, tube well, dug well, protected spring, or rainwater x 100	Total number of persons in sample	56% (Census 2012)	70%	census TDHS	census interval TDHS interval	Output	urban / rural		MDG SDG GRL100
Sanitation	Proportion of population using an improved sanitation facility	Number of persons using an improved sanitation facility: flush toilet, ventilated improved pit latrine (VIP), or pit latrine x 100	Total number of persons in sample	14% (Census 2012)	30%	census TDHS	census interval TDHS interval	Output	urban / rural		MDG SDG GRL100

Indicator	Definition	Numerator	Denominator	2015 Baseline	2020 Target	Data Source	Frequency	Type	Disaggr	nat'l	int'l
HMIS Performance											
Completeness	Proportion of expected reports (ANC, L&D, child health, OPD, IPD, FP) submitted in a given year or other period.	Number of reports received in a given year or other period.	Number of reports expected in a given year or other period.	90% (HMIS 2014)	95%	HMIS	Monthly	Output	Zone Region Council Facility HI type Star Brn rbf		

*Target not adjusted to reflect projected funding.

Sources:

SAVVY = Sample Vital registration with Verbal autopsY

SPD = Sentinel Panel of Districts

TDHS = Tanzania Demographic and Health Survey

THMIS = Tanzania HIV & Malaria Information Survey

Disaggregation categories

brn = BRN implementation

edu = educational level of mother or patient / client

rbf = results based-finance

res = residence: health facility, district, region, zone, urban / rural

sex = female / male

star = star rating

wea = wealth quintile

Used in national monitoring procedures

NACP SP = National AIDS Control Program Strategic Plan

NMCP SP = National Malaria Control Program Strategic Plan

NTLCP = National Tuberculosis & Leprosy Control Program

Nut TWG = Nutrition TWG

PAF = Partnership Agreement Framework

PER = Performance Expenditure Review

RMNCAH = RMNCAH One Plan II

Used in international monitoring procedures

GRL100 = Global Reference List (100 indicators)

MDG = Millennium Development Goals

SDG = Sustainable Development Goals

UHC = Universal Health Coverage

Annex 4 BRN Key Performance Indicators

BRN TopLine Key Performance Indicators (KPIs)

These definitions and targets are provisional. They are in process of harmonization with recent HMIS indicator definitions and HSSP IV program targets.

Indicator	*Definition*	*Numerator*	*Denominator*	*Baseline*	*Target*	*Data Source*	*Frequency*	*Type*	*Disaggr*	*nat'l*	*int'l*
Human Resources for Health											
Number of clinicians and nurses per 10 000 population in the BRN Regions	Density of clinicians and nurses (Medical Officers / Assistant Medical Officers and Clinical Officers / Assistant Clinical Officers and Nurses / Midwives) in the BRN Regions per 10 000 population	Number of clinicians and nurses available in the BRN Regions	Total population ÷ 10 000	7.74 average, including NGOs	7.74 in all regions	HRHIS HCMIS need to include NGOs	Quarterly	Input	zone region council facility HI type star brn rbf	HSSP IV	WHO. A Universal Truth: No health without a workforce, 2013 p. 18
1. Equitable distribution of clinicians / nurses in the BRN Regions	Proportion of regions attaining the 2014 baseline national average of density of skilled HRH per 10k population in the BRN Regions.	Number of regions with average of density of 7.74 clinicians / nurses per 10k population. (Precise 2014 density to be determined.)	Total number of regions	tbd	2016: 60% 2017: 80% 2018: 100% (BRN)	HRHIS HCMIS need to include NGOs	Annually	Input			
2. Utilization of employment permits for HRH in the BRN Regions	Proportion of employment permits for HRH utilized in the BRN Regions	Number of employment permits for HRH utilized	Total number of employment permits allocated to MoHSW by PO-PSM	68% (BRN 2013-14)	2016: 75% 2017: 80% 2018: 90% (BRN)	Source to be identified	Annually	Input			

Indicator	*Definition*	*Numerator*	*Denominator*	*Baseline*	*Target*	*Data Source*	*Frequency*	*Type*	*Disaggr*	*nat'l*	*int'l*
3. Primary Health Facilities with at least one clinician / nurse in the BRN Regions	Number and percentage of Primary Health Facilities with at least one clinician / nurse in the BRN Regions	Number of Primary Health Facilities with at least one clinician / nurse x 100 in the BRN Regions	Total number of Primary Health Facilities in the BRN Regions	498 dispensaries without clinician / nurse in thirteen critical regions 91% (HMIS 2014) In process of verification	2016: 348 2017: 198 2018: 148 -or- 70% reduction in number of facilities without clinician / nurse nationwide (BRN) 98% (HSSP IV 2020)	HRHIS HCMIS	Quarterly	Input	zone region council facility HI type star brn rbf	HSSP IV	
Health facilities											
4. Primary health facilities with 3 star and above rating in the BRN Regions	Proportion of primary health facilities at 3 star rating and above in the BRN Regions	Number of primary health facilities with 3 star rating or higher x 100 in the BRN Regions	Total number of primary health facilities	In process of verification	2016: 20% 2017: 60% 2018: 80% (BRN preliminary) 2020: 50% of facilities (HSSP IV)	system under development	???	Output	zone region council facility HI type star brn rbf	HSSP IV	

Indicator	*Definition*	*Numerator*	*Denominator*	*Baseline*	*Target*	*Data Source*	*Frequency*	*Type*	*Disaggr*	*nat'l*	*int'l*
Health Commodities											
5. Availability of Medicines and Health Products	Continuous availability of 10 tracers (medicines, vaccine, medical device) for essential health interventions in a facility for a reporting month. [**3 types of analysis**] 1. [LGA-CCHP] Number of tracers available per facility, on average, for reporting period; 2. [Supply chain] Percentage of facilities having all 10 tracers; 3. [Programmes] Percentage of facilities having specified tracer.	1) Total number of tracers continuously available in facilities (X reporting months) 2) Number of facilities having all 10 tracers; 3) Number of facilities having specified tracer.	(1, 2 and 3) Number of facilities (X reporting months)	[3 types of analysis] 1. Average 7.7 tracers available in facilities in 2014. (HMIS) 2. All 10 tracers available in 31% of facilities in 2014 (HMIS) (33%, BRN) 3. Specified tracer available in > 90% of facilities in 2014: 5 out of 10 tracers (HMIS) (33%, BRN)	[3 types of analysis] 1. Average > 9.0 tracers available in facilities 2. All 10 tracers available in % of facilities. 2016: 80% 2017: 100% 2018: 100% (BRN) 2020: 80% (HSSP IV) 3. [HSSP IV - Programmes] Specified tracer is available in > 90% of facilities: 9 out of 10 tracers	HMIS	Monthly	Input	zone region council facility HI type star brn rbf	HSSP IV	

Indicator	*Definition*	*Numerator*	*Denominator*	*Baseline*	*Target*	*Data Source*	*Frequency*	*Type*	*Disaggr*	*nat'l*	*int'l*
6. Order fill rate from supply agency	Percentage of items [value] ordered that are supplied to [and received by] health facility in the correct quantities with the correct products	Number of items [value] supplied to [and received by] health facility in the correct quantities with the correct products	Total number of items [value] ordered	MSD supplied 66% of items [and 66% of value] of orders from facilities in 2014 (eLMIS) (65%, BRN)	MSD supplied % of items [and of value] of orders from facilities 2016: 80% 2017: 100% 2018: 100% of facilities (BRN) 2020: 90% of facilities (HSSP IV)	eLMIS	Monthly	Input	zone region council facility HI type star brn rbf	HSSP IV	
RMNCH											
7. Prepregnancy											
Contraceptive prevalence rate (effective modern methods: depo-provera, pills, diaphragm, Norplant, vasectomy, tubal ligation)	The percentage of women aged 15-49 years, regardless of marital status, who have received, or whose partner has received, at least one effective modern method of contraception from a health facility during the year.	Number of active effective modern contraceptive users x 100	Number of women between 15 and 49 years of age.	36% (HMIS 2014) 15% (BRN Lab 2014)	2016: 50% 2017: 60% 2018: 70% RMNCAH 2020: 60%	HMIS	HMIS Annual TDHS interval	Outcome	res wea method edu star brn rbf	HSSP IV RBF RMNCAH	SDG GRL100
8. Pregnancy											
Antenatal care coverage: before 12 weeks gestational age in BRN Regions	Percentage of pregnant women who start ANC before 12 weeks of gestation age in the BRN Regions	Number of pregnant women in the BRN Regions who start ANC before 12 weeks of gestation age x 100	Estimated number of pregnant women in the BRN Regions.	12% (HMIS 2014) 18% (BRN Lab 2014)	2016: 50% 2017: 70% 2018: 80% RMNCAH 2020: 60%	HMIS	Monthly	Outcome	res wea edu star brn rbf	HSSP IV RBF RMNCAH	

Indicator	*Definition*	*Numerator*	*Denominator*	*Baseline*	*Target*	*Data Source*	*Frequency*	*Type*	*Disaggr*	*nat'l*	*int'l*
Antenatal care coverage in the BRN Regions: 4 visits	Percentage of pregnant women in the BRN Regions who received antenatal care four or more times in a given time period.	Number of pregnant women in the BRN Regions who received antenatal care four or more times x 100	Estimated number of pregnant women in the BRN Regions.	28% (HMIS 2014) 43% (BRN Lab 2014)	2016: 50% 2017: 70% 2018: 80% RMNCAH 2020: 90%	HMIS	Monthly	Outcome	res wea edu star brn rbf	HSSP IV RBF RMNCAH	MDG GRL100
9. Delivery											
Skilled attendant delivery coverage in the BRN Regions	Percentage of deliveries in the BRN Regions attended by a skilled attendant during a specified time period	Number of deliveries in the BRN Regions attended by a skilled attendant x 100	Estimated number of deliveries	???% (HMIS 2014) 70% (BRN Lab 2014)	2016: 70% 2017: 75% 2018: 80%	HMIS	Monthly	Outcome	res wea edu star brn rbf	RMNCAH	
Institutional delivery coverage in the BRN Regions	Percentage of deliveries in a health facility in the BRN Regions during a specified time period	Number of deliveries in health facilities in the BRN Regions x 100	Estimated number of deliveries in the BRN Regions	44.72% 2014 data	2016: 70% 2017: 75% 2018: 80% RMNCAH 2020: 90%	HMIS	Monthly	Outcome	res wea edu star brn rbf	HSSP IV PAF RBF RMNCAH	GRL100
10. Newborn health											
Postnatal care: within 7 days after delivery in the BRN Regions	Percentages of mothers and of infants in the BRN Regions who received postnatal care within seven days of childbirth (regardless of place of delivery)	Number of mothers and number of infants in the BRN Regions who received postnatal care within seven days of childbirth x 100	I: Estimated number of live births in the BRN Regions M: Estimated number of deliveries in the BRN Regions	I: 65% (HMIS 2014) M: 68% (HMIS 2014)	2016: 70% 2017: 75% 2018: 80% RMNCAH 2020: 80%	HMIS (to be added)	Monthly	Outcome	res wea edu star brn rbf	HSSP IV RBF RMNCAH	

Annex 5 HSSP IV Specific Objectives Process Indicators

These indicators are monitored in addition to health sector performance indicators and BRN Key Performance Indicators

Indicator	*Definition*	*Numerator*	*Denominator*	*2015 Baseline*	*2020 Target*	*Data Source*	*Frequency*	*Type*	*Disaggr*	*nat'l*	*int'l*
Strategic Objective 1: Quality											
National Essential Health Care Intervention Package	Availability of revised NEHCIP-Tz which can serve as starting point for Minimum Benefit Package for insurance	Revised NEHCIP-Tz in place			Target 2016			Process			
Community Score Cards	Percentage of health facilities apply community score cards	Number of health facilities with community scorecards in place	Number of health facilities where score cards were introduced	0	100%	CHMT annual report	Annual	Process			
Infection Prevention and Control (IPC)	Percentage of Hospitals with functional IPC standards	Number of Hospitals with functional IPC standards (= evidence of actual implementation during supervision	Number of First referral level hospitals and Regional referral Hospitals		100%	RHMT Annual report	Annual	Process			
Quality Improvement Awareness	Percentage of (para)medical training programmes with QI in curriculum	Number of training curricula audited with modules on Quality Improvement Assessment and Implementation	Number of training curricula audited	0	80%	MOHSW HR Dept and QI Dept	Annual	Process			

Indicator	*Definition*	*Numerator*	*Denominator*	*2015 Baseline*	*2020 Target*	*Data Source*	*Frequency*	*Type*	*Disaggr*	*nat'l*	*int'l*
Strategic Objective 2: Equitable access											
Annual Analysis of Inequity	Epidemiological analysis of inequities based on development major health conditions disaggregated per Council	Availability of annual analysis of data on major health conditions from DHIS-2 disaggregated per Council		See BRN	Annual analysis	DHIS-2	Annual	Process	Per Council		
Gender equity in health facility governing committees	Percentage of positions in HFGCs held by women	Number of women in HFGCs	Total number of HFGCs			Council Health Reports	Annual	Process	Per HF		
Strategic Objective 3: Community Partnership											
Roll out of National Community Health Programme	Coverage of National Community Health Programme	Number of Councils with trained Community Health Workers (formal curriculum) employed	Total number of Councils			Council health reports	Annual	Process	Per Council		
Dissemination of health information	MOHSW website with health education materials, and documentation methodology health promotion	Functional and updated website MOHSW accessible for health workers and general public				MOHSW report					
Strategic Objective 4: Effective Management											

Indicator	*Definition*	*Numerator*	*Denominator*	*2015 Baseline*	*2020 Target*	*Data Source*	*Frequency*	*Type*	*Disaggr*	*nat'l*	*int'l*
Analysis and follow up of quarterly BRN monitoring meetings	Percentage of planned quarterly monitoring meetings taking place with information on progress	Monitoring meetings implemented satisfactory (= required documentation available	Quarterly monitoring meetings planned			MDU reports	quarterly	Process			
PPP implementation	Percentage of planned service agreements realised	Number of service agreements signed between LGAs and private or NGO providers	Number of service agreements planned between LGAs and private or NGO providers			CCHPs	Annually	Process			
Performance Health Sector Working Group	Percentage of HSWG successful meetings	Number of HSWG meetings performed with 90% of the invited participants present	Number of HSWGs planned (twice per year)			HSRS	Annually	Process			
Strategic Objective 5: Social Determinants of Health											
Health Impact Assessment	Percentage of health impact assessment implemented	Number of informative health impact assessments implemented	Number of cases where MOHSW indicated that Health Impact Assessment was needed			MOHSW Dept. Preventive Service	Annually	Process			