The United Republic of Tanzania
Ministry of Health and Social Welfare

Health Sector Strategic Plan III

"Partnerships for Delivering the MDGs"

July 2009 – June 2015

Draft Version
29 August 2008

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Acronyms

ADDO	Accredited Drug Distribution Outlet
AIDS	Acquired Immuno – Deficiency Syndrome
APHFTA	Association of Private Health Facilities in Tanzania
BAKWATA	Baraza Kuu La Waislam Tanzania(The National Muslim Council Of Tanzania)
BFC	Basket Fund Committee
CBO	Community Based Organisation
CCHP	Comprehensive Council Health Plans
CFR	Case Fatality Rate
CHF	Community Health Fund
CHMT	Council Health Management Teams
CHSB	Council Health Services Board
CMO	Chief Medical Officer
CSO	Civil Society Organization
CSSC	Christian Social Services Commission
D by D	Decentralisation by Devolution
DHS	Demographic and Health Surveys
DP	Development Partner
EPI	Expanded Programme on Immunization
FBO	Faith Based Organisation
GBS	General Budget Support
GDP	Gross Domestic Product
GNP	Gross National Product
GOT	Government of Tanzania
HBF	Health Basket Fund
HEPRU	Health Emergency Preparedness Unit
HIR	Health Information and Research
HIU	Health Information Unit
HMIS	Health Management Information System
HMT	Hospital Management team
HRD	Human Resources Development
HRH	Human Resource for Health
HRIS	Human resources Information System
HSSP	Health Sector Strategic Plan
HSR	Health Sector Reforms
IEC	Information, Education and Communication
IMCI	Integrated Management of Childhood Illnesses
IMR	Infant Mortality Rates
JAST	Joint Assistance Strategy Tanzania
JRF	Joint Rehabilitation Fund
LGA	Local Government Authority
LGCDG	Local Government Capital Development Grant
MCH	Maternal and Child Health
MDA	Ministries, Departments, Agencies
MDG	Millennium Development Goals
MKUKUTA	Mkakati wa Kukuza Uchumi na Kupunguza Umaskini Tanzania (in English: NSGRP)
MMAM	Mpango wa Maendeleo wa Afya ya Msingi (in English: Primary Health Services Development Programme)
MMM	MKUKUTA Monitoring Master Plan
MOFEA	Ministry of Finance and Economic Affairs
MOHSW	Ministry of Health and Social Welfare
MTEF	Medium Term Expenditure Framework
MSD	Medical Stores Department
NCD	Non Communicable diseases

NGO	Non Government Organization
NSGRP	National Programme for Economic Growth and Poverty Reduction (in Kiswahili: MKUKUTA)
NTDs	Neglected Tropical Diseases
PER	Public Expenditure Review
PHC	Primary Health Care
PHDR	Poverty and Human Development Report
PHSDP	Primary Health Services Development Programme (in Kiswahili: MMAM)
PMO-RALG	Prime Minister's Office, Regional Administration and Local Government
PPP	Public Private Partnership
PSRP	Public Service Reforms Programme
QA	Quality Assurance
RHMT	Regional Health Management Teams
RS	Regional Secretariat
SWAp	Sector Wide Approach
TA	Technical Assistance
TC	Technical Committee SWAp
TFNC	Tanzania Food and Nutrition Centre
TFDA	Tanzania Food and Drugs Authority
TIKA	Tiba Kwa Kadi (CHF in urban areas)
TQIF	Tanzania Quality Improvement Framework
WDC	Ward Development Committee
WHO	World Health Organisation

Executive summary and key messages

Introduction
This third Health Sector Strategic Plan reflects the strategic intentions of the health sector for the period 2009 – 2015. It does not go into detail of operational activities, which are provided in specific strategic plans and work plans of institutions and programmes. This document is a guide for strategic planning at sub-national levels and for annual planning.

Health and Poverty Situation
Tanzania is classified by the UN as one of the least developed countries. About 25 % of Tanzanians were living below the poverty line in 2007. Over the past ten years Under Five Mortality Rate and Infant Mortality have reduced. However Maternal Mortality and Neonatal Mortality remain persistently high. The health system is gradually expanding, but not enough to cover the unmet needs of the population. There is an acute shortage of staff: only 35% of the required personnel is in place to provide health services.

Government policies
The health sector is guided by national policies, such as Government Reforms. The National Strategy for Development and Poverty Reduction (MKUKUTA) provides the global direction for achievement of the Millennium Development Goals (MDGs). The Health Policy was updated in 2007, providing Government's vision on long-term developments in the health sector. The Health Sector Reforms programme continues with further strengthening of Local Government Authorities and hospitals to improve their performance. The Primary Health Care Strengthening Programme aims at improving accessibility and quality of the health services. The Human Resources for Health plan targets at solving the human resources crisis in the sector.

HSSP III Framework
HSSP III consists of four dimensions: the eleven strategies concentrate on specific topics in the health service delivery related to diseases and management. The crosscutting issues elaborate on the approach towards quality, equity, gender and governance. The document explains which types of services or provided in the health sector, and also explains what are the role and responsibilities of each level in the health system.
Levels in the sector

HSSP III Strategies
1. The accessibility to District Health Services will be improved, amongst other through implementation of the Primary Health Care Strengthening Programme (MMAM in Kiswahili). All facilities will provide a complete package of essential health interventions in accordance with the guidelines for their level. Community involvement will be strengthened, to improve health. The referral system in the district (horizontal and vertical) will be strengthened to ensure appropriate treatment for patients.
   The Tanzania Quality Improvement Framework (TQIF) provides guidance for introduction of quality systems, including accreditation. Supervision by Regional Health Management Teams (RHMTs) and Regional Hospital staff will contribute to quality improvement.
   With regard to management of District Health Services, further decentralisation to health facilities will improve needs-based planning and implementation. Further integration of MOHSW and LGA management systems will streamline operations.
   Performance-based systems like Pay-for-Performance (P4P) will enhance motivation and productivity of health workers
2. Referral Hospital Services will be more accessible to patients who need advanced care through an adequate referral system, and measures to prevent bypass. The quality of care will improve by implementation of the TQIF ; hospitals will have a Quality Assurance unit to promote quality.
   The hospital reforms programme will improve financial management and human resources management. Hospitals will develop strategic plans and capital investment plans. Hospital boards will ensure community participation in management.

3. The central level support by headquarters departments and agencies will be streamlined. More functions will be delegated to operational level. Further integration of programmes will lead to more coherence in the health services. Head quarters will introduce a rigorous system of annual action planning
   Strengthening of RHMTs is very important for technical supervision on behalf of the MOHSW. Zonal Resources Centres provide training and technical support to training institutions.
4. Increase of numbers and improvement of the quality of human resources for health (HRH) are most important for improve accessibility and quality of health services. The HRH planning and information system will be strengthened. Recruitment and retention of staff will be institutionalised in close collaboration with LGAs. The introduction of performance-based systems will improve motivation and productivity of health staff. Continuing Professional Development (CPD) is necessary to keep health workers updated. Training institutions will increase their production by higher numbers of graduates and will improve their quality through update of the curricula.
5. Health Care Financing is fundamental for realising the ambitions of the MOHSW. The Ministry aims at increasing the health budget to 15% of the Government budget. Increasing the funding through the Health Basket Fund is another way of resource mobilisation. The Ministry will develop strategies to increase complementary financing through the Community Health Fund and National Health Insurance Fund. The management of these funds will improve and a regulatory body for health insurances will be created. Increased collaboration with the private sector will open up opportunities for investments in health.
6. Public Private Partnerships will be important for achieving the goals of the health sector. PPP forums will be installed at national, regional and district level. The Service Agreements will be used in all LGAs to contract private providers for service delivery.
   The private training institutions will be more involved in production of HRH, based on their specific competencies.
7. Maternal Newborn and Child Health will improve as result of general measures like increasing the number of primary health facilities, increasing the number of competent staff and improving equipment and supplies in health facilities. A better referral system will increase access to emergency obstetric care. The communities will be more involved in MNCH to improve behaviour and practices with regard to reproductive health.
8. Diseases control programmes will equally benefit from general improvements in health facilities. The diagnostic capacity (in labs) will improve and equipment and supplies increased.The TQIF will stimulate further introduction of treatment guidelines and clinical standards.
   The HIV/AIDS programme will continue with increased access to ARV treatment to PMTCT and Post Exposure Prophylaxis. Prevention and Voluntary Counselling and Testing will be stimulated, as well as treatment of sexually transmitted diseases. All hospitals will guarantee safe blood transfusions.
   In the malaria programme vector control through Insecticide Treated Nets and Indoor Residual Spraying will be stepped up. The adequate diagnosis and treatment will be further expanded.
   In the tuberculosis programme the DOTs strategy will continue, while vigilance for Multi Drug Resistant TB will be high. The leprosy control and disability prevention programme will be implemented in all districts.
   There will be more attention for neglected diseases, even if they have only regional importance, by training of staff and provision of medicines, to reduce unnecessary suffering and death.
   Non-Communicable Diseases become more and more important with the shifting demographic situation. More attention for healthier lifestyles and better treatment will be stimulated.
   With regard to environmental health, the focus is on implementing the new Public Health Bill, and on introducing adequate measures for adherence to the legislation.
9. Emergency Preparedness is a new theme in the strategic plan, but important now due to globalisation health threats may come up unexpectedly. Capacity building of all levels is planned to deal with emergencies or prevent them. Quick mobilisation of resources will be realised, when needed.

10. Social welfare is also a new and challenging theme in the HSSP. The capacity has to be built in all districts to provide social welfare and protection services. The regulatory framework has to be developed and community-based programmes have to be initiated or strengthened, shifting from a charity approach to a rights-based approach.
11. Monitoring & Evaluation help to improve evidence-based decision making and to enhance public accountability. The Ministry will develop a comprehensive M&E and Research policy and strategy, to ensure that more integration and harmonisation will be achieved. Integration of the MOHSW monitoring systems with the PMO-RALG and MKUKUTA systems will be achieved. The Health Management Information System will be revisited. At national level there will data warehouses, where information from several sources is merged, and used for further analysis.
12. Other issues
    Capital investments need to be made to expand the health service network. Standards for infrastructure, maintenance, equipments, and means of transport need to be developed or revised, to increase efficiency and quality. The MOHSW and zonal workshops will provide support to districts and hospitals
    Medicines and medical supplies may never be missing in health facilities. The zonal warehousing and distribution improved of medicines will be improved. Management of medicines and supplies at district and health facility level will be improved, together with more rational prescription of medicines.

Crosscutting issues

- Quality improvement is a major aim of the Ministry: in service delivery, in human resources and in management.
- Equity needs to be emphasised: geographic equity for underserved populations and equity for vulnerable groups, who cannot fend for themselves.
- Gender in health needs attention, because of specific health needs of women and men. The health services should be more alert to respond to those needs, especially of women who are more vulnerable to health problems. The involvement of men in family programmes will be stimulated.
- Communities own their health: healthier lifestyles will reduce suffering. Ownership of health should also extent to participation in management of health facilities, in order to make those facilities more responsive to specific health needs.
- Coherence between health reforms and health programmes, MKUKUTA and MDGs activities, government reforms and LGA reforms will enhance efficiency and effectiveness.
- The health sector should benefit from complementarity: more delegation and more partnerships, cutting back duplication and unhealthy competition.

Managing the health sector

All stakeholders have to play their role. The MOHSW head quarters will concentrate more on its stewardship role, and delegate more operational tasks to LGAs, PMO-RALG and departments and agencies. Coordination with other ministries, partnerships with the private sector and with Development Partners will improve the implementation of the strategic plan. Mechanisms are in place for joint planning, monitoring and evaluation through the SWAp.

Financing the health sector

There has been a gradual increase in Government funding over the last years. It may be expected that this increase will continue. Also the funding through the Health Basket Fund will increase. However, due to planned large investments, there will still be a funding gap of 24% during the implementation period of the strategic plan. Innovative ways of raising funds, from Government, from Development Partners and from the Private Sector will be used to fill this gap.

Monitoring and Evaluation

A coherent system of quarterly, annual and periodic monitoring is planned, using selected indicators. Coherence between MOHSW and LGA monitoring and discipline in reporting will ensure timely and reliable provision of information on progress and constraints in implementation of the strategic plan.

1 Introduction

1.1 Introduction to the HSSP III

This Health Sector Strategic Plan III (HSSP III) is the crosscutting strategic plan for the health sector of Tanzania for the period July 2009 – June 2015. It provides an overview of the priority strategic directions across the sector. Policies, strategies and work plans are in place for health related issues and for disease control (see table 6). HSSP III does not reiterate those, but summarises their strategic directions. It serves as the guiding document for development of Council and hospital strategic plans and for annual implementation plans.

The Second Health Sector Strategic Plan 2003 – 2008 (HSSP II) was extended until June 2009, in order to incorporate the findings of the Joint External Evaluation of the Health Sector, which was conducted in 2007. The formulation process of the Third Health Sector Strategic Plan 2009 – 2015 (HSSP III) was lead by the Health Sector Reform Secretariat under the Division of Policy and Planning, Ministry of Health and Social Welfare (MOHSW), involving key stakeholders from relevant levels and institutions including the Prime Minister's Office for Regional and Local Government (PMO-RALG). The HSSP III was adopted at the Joint Annual Health Sector Review 2008 for the implementation period July 2009 to June 2015. After this six-years' period health plans will be synchronised with Government planning cycle.

The structure of the document is as follows. This chapter provides general background information on the health situation and health services structure in the country. The second chapter summarises the most important Tanzanian development and health policies and strategies. Chapter 3 provides the strategic framework of the HSSP III. In chapter 4 eleven strategies are presented and explained, while in chapter 5 the crosscutting themes are elaborated. Chapter 6 summarises the strategies in tables for quick overview of major strategic objectives and targets. Chapter 7 explains how the management of the health sector is planned. Chapter 8 provides information on the financing of the sector and chapter 9 explains on the monitoring of the implementation of HSSP III.

1.2 Background Information

1.2.1 Geography and Population

The United Republic of Tanzania is a union between Tanganyika and Zanzibar, which was formed in April 1964. It is the largest country in East Africa, occupying an area of about 945,087 sq. km, and has common boarder with 8 neighbouring countries.

Table 1: Key population facts and figures

Estimated Population July 2008	37,990,563
Population density	38 pr km2
Population composition	Males 48.9% Female 51.1%
Population growth per year	2.9
Total Fertility Rate	5.7 pr woman
Life expectancy	Male 53 yrs Female 56 yrs

Source www.tanzania.go.tz/population/
Source http://www.nbs.go.tz/National_Projections/Tbl3_6.pdf

Figure 1. Map of Tanzania

1.2.2 Poverty situation

Tanzania is classified by the UN as one of the least developed countries. The average national income (GNI) per person was US$350 in 2006. About 25 % of Tanzanians were living below the poverty line in 2007[1]. The incidence of poverty in rural areas was 39 per cent; in Dar es Salaam it was 18 percent.
In the period 2006 - 2007, real GDP growth was 6%[2]. Also GDP in agriculture has increased in recent years. The GDP growth has not reduced poverty in an equitable manner. Productivity has remained low, especially among smallholder farmers who constitute the majority of agricultural producers in Tanzania. A combination of low production, low productivity and low quality of agricultural produce has significant limiting effects on rural growth and therefore on poverty reduction.

The enrolment in primary schools is close to universal. However, attendance rates are lower than enrolment, with little gender differential, though boys tend to be in school at an older age than girls. Children with disabilities are much less likely to be in school than other children. The number of teachers lags behind the increasing enrolment[3].

Overall, the 2004/05 Tanzania Demographic and Health Survey reports that 10 % of children under the age of 18 have lost their mother, or their father, or both. In 10 districts more than 15% of children have been orphaned[4].

[1] Household and Budget Survey 2007
[2] Source: http://www.repoa.or.tz/documents_storage/PHDR_2007_Brief%201.pdf
[3] Source: http://www.repoa.or.tz/documents_storage/PHDR_2005_Chap1.pdf
[4] Tanzania Demographic and Health Survey 2004/05

Less than 40% of rural households have access to an improved source of drinking water. In seven districts, less than 10 % of households have such access. Over 90 % of households report having toilet facilities – mostly pit latrines of which a considerable part does not meet hygienic standards.[5]

Tanzania has made some important progress in the last decade to address gender inequality, for example in establishing quotas for female representation in Parliament, increasing the number and position of women in cabinet, dramatically boosting elementary school enrolment of boys and girls, and in correcting discriminatory laws. However, many of these changes have not translated into real changes in the lives of the majority of the men and women in the country, especially in rural areas.

1.2.3 Health situation and link with poverty

Over the past ten years positive trends on different health indicators have been seen with a decreasing Under Five Mortality Rate and Infant Mortality. Other positive developments have been seen concerning the coverage of child immunisation and vitamin A supplementation. Contrary, almost three quarters of children under five are anaemic and chronic malnutrition is still common (table 2)[6].

Table 2: child health indicators

Indicator	**1999**	**2004**	
Under 5 mortality rate (1)	147	112	Deaths per 1000 live births
Infant mortality (1)	99	68	Deaths per 1000 live births
Neonatal mortality (2)	36	32	Deaths per 1000 live births
Immunisation level		71 %	Children 12-23 months
Vitamin A supplementation level (2)		85 %	Children aged 6-59 months
Anaemia among under fives (2)		72%	
Stunting (3)	44% (1996)	38%	Height for age
Under-weight (2)		22%	Weight for age

Factors influencing this positive trend include sustained high coverage of vaccination and increased coverage of effective interventions, e.g. vitamin A distribution. 75% of health facilities are providing immunisation services. The IMCI strategy was adopted in Tanzania in 1996 as a key strategy for reduction of Under Five Mortality and presently 93.8% of districts are implementing IMCI. More effective prevention and treatment of malaria are likely to be important contributors to improved health, especially in reducing infant and under-five mortality.

However, there remain substantial urban-rural, regional and socio-economic differences. Rural poor children are more likely than their urban counterparts to die, and when they survive, they are more likely to be malnourished. Analysis of infant mortality in the 1990s suggests a widening gap between the poorest and less poor.

Life expectancy at birth was estimated at 53 years in the national projections report, 2006, based on the Population and Household Census in 2002. The three main causes of death among adults are malaria, HIV/AIDS and Tuberculosis, for children below five years of age they are malaria, pneumonia and anaemia [7]

[5] Poverty and Human Develop Report 2007

[6] Source: 1 Poverty and Human Development Report 2007
2. Demographic and Health Survey 2004/05
3. Health Sector Performance Profile Report , MOHSW, 2007

[7] Health Sector Performance Profile Report , MOHSW, 2007

The maternal mortality ratio is estimated at 578/100,000 live births. More than 50% of women aged 19 years are pregnant or already mothers, increasing their vulnerability to sexual and reproductive health (RH) problems[8].

Micronutrient deficiencies and chronic energy deficiency (low body mass index) during pregnancy increase the risk of maternal mortality and poor outcomes for infants, including preterm delivery, foetal growth retardation, low birth weight, increased risk of dying, impaired cognitive development and increased risk of Non Communicable Diseases (NCD) later in life.

Table 3: Maternal Health Indicators

Maternal Mortality Ratio	578/100,000	Pregnancy related deaths per 100,000 live births
Fertility rate	5.7	Births per woman
Average age first birth	19.4	Years
One Antenatal visit	94%	
Four or more antenatal visits	62%	
Births in health facilities	47%	
Births assisted by skilled personal	46%	
Proportion of health centres with emergency obstetric equipment available	5.5%	
Post natal care attendance	13%	
Knowledge of contraception	90%	Of adult population
Married women using contraception	20%	
Unmet need for family planning	22%	

Table 4: Disease related indicators

HIV/AIDS Prevalence	7%	Tanzania HIV/AIDS Indicator Survey 2003/2004
Tuberculosis treatment success rate (2005)	82,6%	Poverty and Human Development Report 2007
Malaria		Annual Health Statistical Abstract 2006
Cholera cases 2006	14,297	PHDR 2007

There are some geographic concentrations of districts which have a more general pattern of relatively poor indicators. Districts in the Southeast have the worst adult literacy rates, under five mortality rates and access to improved water. There is more and more evidence of an increasing rural urban divide, with pockets of poverty and ill-health in remote rural areas, where services are poor, people's capacities to improve their own health are minimal, and thus disease statistics are worse.

1.2.4 Health System in Tanzania

Mainland Tanzania is divided into 21 administrative regions and 113 districts with 133 Councils. There are a total of about 10,342 villages. Primary Health Care services form the basement of the pyramidal structure of health care services with a number of dispensaries, health centres and one District hospital at the district level. Currently the health facilities for both public and private include 4,679 dispensaries, 481 health centres distributed throughout the country[9]. The geographical accessibility of the current primary health facilities is reported to be at about 90% of people living with five kilometres.

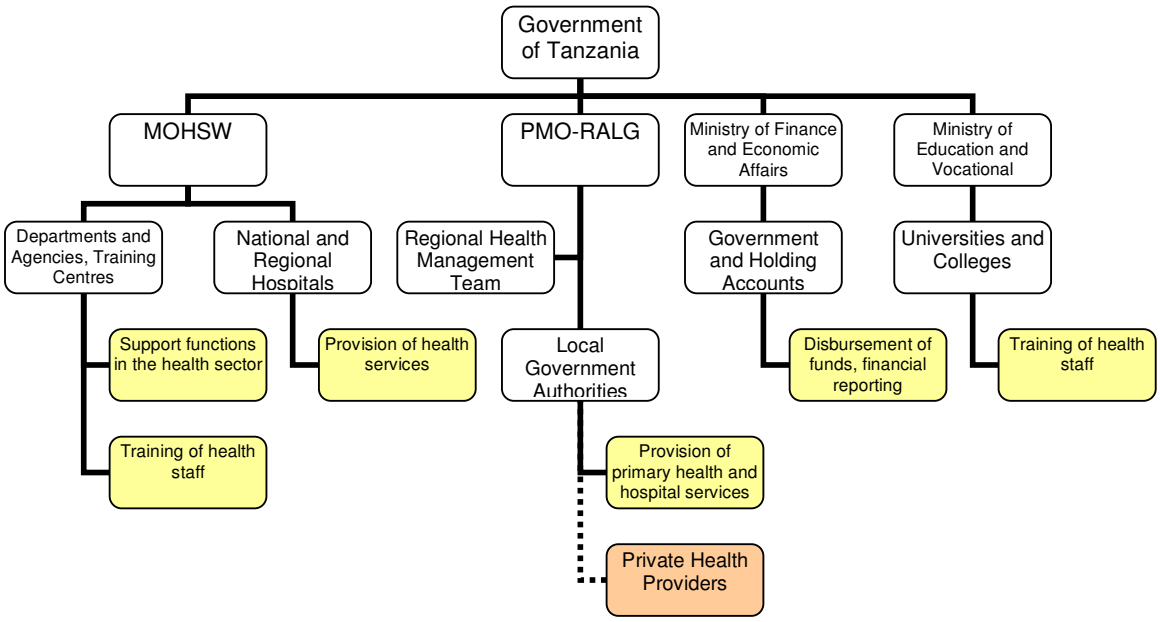
[8] The National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania 2008 - 2015

[9] Tanzania Service Provision Assessment Survey 2006

There are 55 district hospitals owned by Government, 13 designated district hospitals, owned by Faith Based Organisations (FBO) and 86 other hospitals at a first referral level (owned by Government, parastatals and private sector). There are 18 Regional Hospitals, functioning as referral hospital for district hospitals and 8 consultancy and specialised hospitals in the country[10]. Government staffing norms for health facilities exist. When comparing these to existing level of staffing only 35% of positions are filled with qualified health workers leaving Tanzania with a severe Human Resource crisis[11].

Tanzania has decentralised many Government functions through Decentralisation by Devolution. Local Government Authorities (LGAs) are responsible for delivering public services in local health services, primary education, agriculture extension and livestock, water supply, and local road maintenance.

Figure 2. Ministries, Departments and Agencies and their responsibilities in health sector (in yellow)



In medical, paramedical, or technical areas, Tanzania has 116 training institutions of which government owns 72 and 44 are owned by the private sector and faith based organisations. There are also seven medical universities, of which six are privately owned. The total annual intake in the pre-service training institutions has been increasing over the past 4 year with enrolment of 3,500 students in 2007[12]. The total output from health training institutions in the past nine years was 23,536, which is not sufficient to cover the needs.

The MOHSW is responsible for recruitment and distribution of health staff throughout the country. Shortage of health staff in remote areas is a reason for concern and emergency plans for tackling this situation have been developed.

[10] Source: http://www.moh.go.tz/health%20facilities.php
[11] Human Resource for Health Strategic Plan 2008-2013
[12] Human Resource for Health Strategic Plan 2008-2013

2 Government policies

2.1 Policy and Aid Framework

In Tanzania a coherent system of Government policies, legislations, strategies and programmes is emerging, giving direction to development. Consistency between general and sectoral policies is increasing. Step-by-step a national framework for monitoring of economic and social development is created into which sectors provide input. Devolution has a far-reaching impact on the health sector, whereby Local Government Authorities have become responsible and the MOHSW has withdrawn from direct service provision at district and municipal level.

Table 5: Policies and support mechanisms in Tanzania explained in this document

General	Vision 2025 MKUKUTA (NSGPR) Millennium Development Goals Public Service Reform Programme (PSRP)
Local Government	Local Government Reform Programme (LGRP)
Health Sector	National Health Policy MMAM Health Sector Strategic Plan Specific Strategic Plans

2.1.1 General Policy Framework

Vision 2025

The Arusha Declaration in 1967 was the first vision document of the country after independence. The Vision 2025 (formulated in 1998) can be considered an update of that declaration. Tanzania Vision 2025 is a document providing direction and a philosophy for long-term development. Tanzania wants to achieve by 2025 a high quality of livelihood for its citizens, peace, stability and unity, good governance, a well-educated and learning society and a competitive economy capable of producing sustainable growth and shared benefits.

The document identifies health as one of the priority sectors contributing to a higher quality livelihood for all Tanzanians. This is expected to 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 service for all individuals of appropriate ages;
- Reduction in infant and maternal mortality rates by three quarters of current levels in 1998;
- Universal access to clean and safe water;
- Life expectancy comparable to the level attained by typical middle-income countries.
- Food self sufficiency and food security;
- Gender equality and empowerment of women in all health parameters.

MKUKUTA

The National Strategy for Growth and Reduction of Poverty (NSGRP), known in Kiswahili as the MKUKUTA (Mkakati wa Kukuza Uchumi na Kupunguza Umaskini Tanzania) was approved by Cabinet in February 2005 for implementation over five years and is the successor to the Poverty Reduction Strategy Paper. The MKUKUTA is informed by Vision 2025 and committed to the achievement of the Millennium Development Goals (MDGs). It focuses on growth and governance, and is a framework for all government development efforts and for mobilising resources.
The MKUKUTA aims to foster greater collaboration among all sectors and stakeholders. It has mainstreamed cross-cutting issues (gender, environment, HIV/AIDS, disability, children, youth, elderly, employment and settlements). All sectors are involved in a collaborative effort rather than segmented activities. Therefore this document is of crucial importance for the MOHSW strategies.
The MKUKUTA seeks to deepen ownership and inclusion in policy making, paying attention to address laws and customs that retard development and negatively affect vulnerable groups.
The strategy identifies three clusters of broad outcomes:

(i) growth and reduction of income poverty;
(ii) improvement of quality of life and social well -being, and
(iii) good governance.

Health is part of the second cluster, improvement of quality of life and social wellbeing.

The MKUKUTA Monitoring Master Plan (MMM) of 2006 outlines the guiding principles of national development monitoring, which also has a bearing on sector monitoring activities. The MKUKUTA monitoring framework offers the basis for progress monitoring of national and sectoral activities, contributing to poverty reduction. The framework defines the frequency and type of reporting, both on achievements and on finances. Health sector reporting is incorporated in the MKUKUTA reporting.
The MKUKUTA Monitoring System routinely prepares national reports on the national indicators (including health). It produces a Poverty and Human Development Report (PHDR) every two years. In the year when the PHDR is not produced, a Status Report on the indicators is prepared. Like the PHDR, this report analyses the current data against baselines and targets. Various Development Partners (DPs) use the information provided in the PHDR to assess progress. They base their budget support decisions on this information, instead of performing parallel evaluations.

2.1.2 Local Government Policy and Aid Framework

Local Government Reform and Decentralization by Devolution (D-by-D)

Since 1994 Tanzania has embarked on a Local Government Reforms Programme (LGRP). The aim of the reforms is to establish decentralisation by devolution (D-by-D). This implies that Local Government Authorities (LGAs) take full responsibility for planning, budgeting and management of government services, including health, education, and water supply.

In the country there are 133 Councils, in districts, municipalities and towns. There are 21 Regions. At national level the councils are overseen by the Prime Minister's Office for Regional Administration and Local Government (PMO-RALG). At the national level laws, systems and guidelines are developed, helping Local Government Authorities to perform their tasks.

In 1996 the Government decided to restructure the regional administration, giving more room for development of the Councils. Regions became facilitators, rather than implementers. In the devolution process the Regional Health Management Teams became part of the Regional Administration, instead of being part of the MOHSW.

A new LGRP phase for the period July 2008 – June 2013 has started, which aims to eliminate the institutional, legal, organisational and operational bottlenecks to realisation of D-by-D policy at all levels of government, and improve collaboration with line ministries. There will be further fiscal decentralisation, and further decentralisation of human resources management. Line ministries will delegate more operational tasks to LGAs. The LGRP will build the capacity of LGAs to be efficient and effective organisations in the planning and implementation for delivery of basic social services, socio-economic development and poverty reduction interventions. The LGRP will empower citizens to demand accountability and integrity as well as efficient and effective use of public resources.

The Government of Tanzania (GOT), through PMO-RALG, implements the Local Government Capital Development Grant (LGCDG). This system provides discretionary development funds for rehabilitation and expansion of infrastructure to local authorities. Over time the LGCG is intended to become the mechanism through which all development funds will be transferred to Local Government Authorities (LGAs), in accordance with GOT's commitment to Decentralization by Devolution. A separate window for health for rehabilitation of health facilities as been established in 2008.

2.1.3 Health Sector Policies, Strategies and Programmes

Health Sector Reform

Health Sector Reforms (HSR) started in 1994 and aims at improvement of access, quality and efficiency health service delivery. Primary health care was adopted as the most cost-effective strategy to improve health of the people. The major focus of the HSR is therefore on strengthening the District Health Services, as well as strengthening and reorientation of secondary and tertiary service delivery in hospitals in support of primary health care. The programme also aims at strengthening of support services at the central level, in the MOHSW, it agencies and training institutions. The HSR introduced a programmatic approach, replacing the project approach, in order to create coherence between activities and continuity. Initially a Plan of Work was developed defining the priorities of the reforms, which in 2003 was replaced by the HSSP II.

The Health Sector Reforms are in the following dimensions: decentralisation of health services; financial reforms, such as enhancement of user-charges in government hospitals, introduction of health insurance and community health funds and public/private partnership reforms such as encouragement of private sector to complement public health services. They also include organisational reforms such as integration of vertical health programmes into the general health services; and propagation of demand oriented researches in the health sector. In a later stage hospital reforms were added as element of the reforms, because the quality of hospital services was not improving in line with the sector reforms.

The HSR got a new dimension when local government and public service reforms programme gained momentum and devolution was introduced in 2001: District Health Services became part of the Local Government Authority. New relations with other government players in the health sector were established in the context of these reforms. The need for systematic planning, budgeting and monitoring and evaluation became more urgent, now the MOHSW was separated from most of the operational functions in district health care. The Comprehensive Council Health Plan was introduced as management instrument, offering stakeholders full insight into the Councils' health activities.

Following the introduction of a new budgetary instrument, by the MoF in 2001, the Medium Term Expenditure Framework (MTEF) was developed to incorporate the necessary planning and financing of the three year programme of work for the Ministry of Health, for both recurrent and development activities into one document.

Important in the HSR was building up the Sector Wide Approach (SWAp) as mechanism for sustainable relations with other service providers in health and with Development Partners

(DPs). An important achievement under the HSR was the introduction of the Health Basket Fund in 1999. From 2002 onwards the Councils started to receive funds from the HBF.
Under the SWAp the mechanism for collaboration between the health sector and the DPs has been regulated.

Health Policy

The MOHSW has revised the 1990 National Health Policy and presented the revised Health Policy in 2007. Ongoing socio-economic changes, new government directives, emerging and re-emerging diseases and changes in science and technology necessitated to update the policy. The policy outlines achievements and challenges facing the health sector. The resource constraints (especially human resources) constitute the major problem for not being able to cope adequately with health problems.
The vision of the Government is to have a healthy society, with improved social wellbeing that will contribute effectively to personal and national development. The mission is to provide basic health services in accordance to geographical conditions, which are of acceptable standards, affordable and sustainable. The health services will focus on those most at risk and will satisfy the needs of the citizens in order to increase the lifespan of all Tanzanians.

Specifically the Government aims to:
(i) reduce morbidity and mortality in order to increase the lifespan of all Tanzanians by providing quality health care;
(ii) ensure that basic health services are available and accessible;
(iii) prevent and control communicable and non- communicable diseases;
(iv) sensitize the citizens about the preventable diseases;
(v) create awareness to individual citizen on his/her responsibility on his/her health and health of the family;
(vi) improve partnership between public sector, private sector, religious institutions, civil society and community in provision of health services
(vii) plan, train, and increase the number of competent health staff;
(viii) identify and maintain the infrastructures and medical equipment; and
(ix) review and evaluate health policy, guidelines, laws and standards for provision of health services.

The document formulates health policies and statements in the following areas:
- Preventive services: control disease incidences and disability
- Epidemics: control communicable diseases, especially diseases from outside
- Non-communicable diseases: promote healthier lifestyles and treat adequately
- Maternal and child health: reduce maternal and child mortality in line with MDGs
- Reproductive health: make services available especially for youth and men
- Primary Health Care: make PHC accessible for all citizens
- Health education and advocacy: Convey that every individual can improve his or her health status
- Environmental Health: promote a sustainable healthy environment for the whole community
- Occupational health: protect and improve workers' health status
- Curative care: deliver safe health care services to the community
- Medicines and supplies: ensure quality and availability of sufficient medicines and supplies
- Safe Blood Transfusion: make safe blood available throughout the country
- Mental health: promote mental health in the community and prevent illnesses
- Traditional medicine and traditional midwives: increase coordination and partnerships
- Cells and genome: develop proper use of technology of genetic engineering
- Control of Food, Medicines, etc: ensure goods are safe and meet defined standards
- Diagnosis of diseases: provide accurate diagnosis and forensic investigations
- Quality improvement and standards: attain at least agreed minimum standards
- Coordination in health sector: participatory, transparent and sustainable system for all stakeholders
- Human resources development: provide sufficient staff with required skills mix

MMAM

In 2007 the MOHSW developed the Primary Health Care Service Development Programme (PHCSDP). This programme is better known by the Kiswahili name of Mpango wa Maendeleo ya Afya ya Msingi 2007-2017 (MMAM). The objective of the MMAM programme is to accelerate the provision of primary health care services for all by 2012, while the remaining five years of the programme will focus on consolidation of achievements.

The main areas will be strengthening the health systems, rehabilitation, human resource development, the referral system, increase health sector financing and improve the provision of medicines, equipment and supplies. This programme will be implemented by the Ministry of Health and Social Welfare in collaboration with other sectors by the existing Government administrative set-up including PMO-RALG, RSs, LGAs and Village Committees.

The first element is increasing the workforce in health by increasing the throughput in the existing training institutions by 100%, upgrading 4 schools for enrolled nurses, production of health tutors and upgrading the skills of existing staff by provision IT skills and acquiring new medical technology.

The rehabilitation of existing health facilities and construction of new ones is planned as well as improving the outreach services. This includes 8,107 primary health facilities, 62 district hospitals, 128 training institutions by year 2012. The Referral System will be strengthened by improving information communication system and transport.

The Programme will address the revised Health Policy and the health related Millennium Development Goals in the areas of maternal health, child health and priority diseases. The programme costs are estimated to be around 11.8 trillion TSH, which is beyond the presently available budget range. Innovative modalities of financing are therefore required.

HSSP II

The Health Sector Strategic Plan II (HSSP II) articulated a process of health sector reform aimed at addressing the recognizable deficiencies in the sector and achieving specific goals and targets in health as set out in the Millennium Development Goals (MDGs) and the National Strategy for Growth and Reduction of Poverty (MKUKUTA). According to the sector evaluation in 2007 the HSSP II established the guiding framework for the implementation of Government policy and sector reforms as well as DPs' assistance. The strategic planning document has been coherent with national policies and the priorities it identified can be directly linked to constraints identified during the evaluation at the central, regional and council levels.
The strategies included: strengthening District Health Services, hospital reforms, role of the Central Ministry and central support systems for health, Human Resources for Health, health sector financing, Public Private Partnership, sector coordination and HIV/AIDS programming. (In Chapter 5 achievements and constraints in these areas are summarised.)
HSSP III to a large extent follows the structure of the HSSP II document, which has proved its value in the past years.

Specific Policies, Strategies, Work Plans and Programmes

Within the health sector specific work documents have been produced, guiding the implementation of activities in those areas. These are listed in the following table.

Table 6. Specific Policies, Strategies, Work Plans and Programmes

Name	***Period***	***Area***
General		
Ministry of Health and Social Welfare (Headquarter office) Medium Term Strategic Plan	2007-2010	Role of MOHSW in delivery of health and social welfare services
Human Resource for Health Strategic Plan	2008-2013	Human Resource planning, development, retention and financing

National Package of Essential Health Interventions in Tanzania	2000	Outline of cost-effective, priority services to be delivered at health facilities
Health Education Section Strategic Plan	2003-2007	Health Education and Promotion to community level
Tanzania National Health Research Priorities	2006-2010	National Health Research Priorities
Health Issues		
National HIV/AIDS policy	2001	HIV/AIDS
Strategic Plan National Tuberculosis & Leprosy Programme	2004/5-2008/9	Tuberculosis and Leprosy
National Malaria Medium Term Strategic Plan (NMMTSP)	2008 - 2013	Malaria control in context of global focus on eradication
National Adolescent Health and Development Strategy	2004-2008	Adolescent reproductive health, mental health, social development
National Eye Care Strategic Plan	2004-2008	Eye diseases prevention and control
The National Trachoma Control Programme Strategic Plan	2004-2008	Trachoma prevention and control
Tanzania Food and Nutrition Centre Strategic Plan	2005/06-2009/10	Policy and planning, community nutrition, food science and technology, education and institutional development
National Road Map Strategic Plan to Accelerate Reduction of Maternal and Newborn and Child Deaths (one plan)	2008-2015	Accelerated improvement of Maternal, Newborn and Child Health
Expanded programme on Immunization Comprehensive multi year plan (EPI)	2006-2010	Cold Chain, Immunization
The National Environmental Health, Hygiene and Sanitation Strategy (final draft)	2007-2016	Strategy for enforcement of new Public Health Law
National Cancer Control Strategy	2008	Cancer prevention, control and treatment
Government Chemist Laboratory Agency Strategic Plan	2008-2011	Quality laboratory analysis, regulation of chemicals, forensic services, research
National Multi-Sectoral Strategic Framework on HIV AIDS	2008-2012	Multi-sectoral approach for prevention and control of HIV/AIDS
Health Sector HIV and AIDS strategy II	2008 – 2013	Prevention, treatment and health systems strengthening for HIV/AIDS
National Strategy for Non Communicable Diseases (draft)	2008	Cancer, Chronic Respiratory diseases, Diabetes, Cardiovascular diseases, Injuries and RTA, Renal disease, Sickle cell disease, Mental Health and Substance Abuse
Medicines and medical supplies		
National Drug Policy and the Pharmaceutical Master Plan	1992-2000	Medicines
Tanzania Medical Stores Department, Medium Term Strategic Plan	2006-2012	Main direction and activities planned for MSD
Tanzania Food and Drug Authority Strategic Plan	2003-2008	Regulatory instruments for control of quality of food and drugs

Health Legislation

Government policies may require legislation to enforce adherence.
The existing health 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 professionals such as doctors, dental practitioners, pharmacists, nurses etc,
- Legislation which establishes autonomous health institutions for a particular need, such as institutions for medical research, national and special hospitals etc.
- Health financing legislation which is aiming at providing alternative health financing mechanism with the aim of complementing government efforts to finance health services

in the country.

These laws 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 changes, and political changes, enactment and review of the existing health legislation is apparent.

3 Health Sector Strategic Framework

3.1 Introduction

The MOHSW has developed a framework to reform the health sector in order to improve the impact of health services at all levels in the country. The emphasis of the strategic health plan is on Council Health Services, where most of the essential health services are provided close to the communities, and on hospital services to save lives of people who cannot be treated in first line health facilities. The thrust is to improve significantly the quality of essential health services, make CHMTs, Council Health Providers and Hospital Management Boards more accountable to the community.
Delegation of authority means that the dispensaries, health centres and hospitals should be the key actors in the planning process. It also means that they will be held responsible for implementing what they have planned. The services to improve health status of the people should be directed towards the following types of services.

Types of services

- **Health Promotion** activities to enhance behaviour change and to ensure that life styles of individuals are conducive to personal development and environmental safety. Community participation and ownership is key to success of the primary health service delivery programme;
- **Preventive health services** to prevent diseases by promoting and control of infectious diseases transmission, curtail epidemics and improvement of working environment to maintain highest standards of occupational health;
- **Care and treatment** (curative services) This is to treat correctly diseases or conditions to reduce the likelihood of complications or death by improving quality and quantity of care to patients and ensuring availability of basic services and supplies;
- **Rehabilitation services** to patients such as physical rehabilitation, mental rehabilitation and psychological support to vulnerable groups;
- Provision of **services to the chronically ill** and the elderly; this includes catering for life long treatment like hypertension, diabetes, AIDS patients on ARVs, renal conditions, Cancer and any other chronic conditions.

The health sector consists of components or **levels in the health sector**:

- **Council health services** (in district or municipality), consisting of:
    - Household and community health
    - Dispensaries and Health Centres (public and private)
    - District Hospital and other hospitals (public and private)
- **Regional health services**, consisting of
    - Regional Referral Hospitals
    - Regional Health Management Teams
- **National level services**, consisting of
    - Specialised Hospitals and Special Hospitals (public and private)
    - Training Institutions, Zonal Resources Centres
    - Ministries, Departments and Agencies

The MOHSW has identified **eleven strategies**, which the health sector should achieve during the period of implementation:

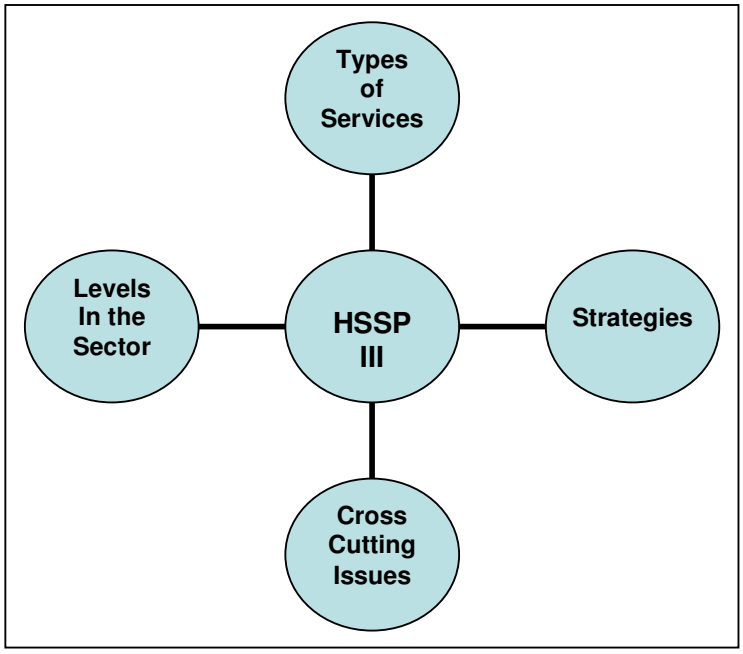
- Strategy 1: District Health Services
- Strategy 2: Referral Hospital Services
- Strategy 3: Central Support
- Strategy 4: Human Resources for Health
- Strategy 5: Health Care Financing
- Strategy 6: Public Private Partnerships
- Strategy 7: Maternal, Newborn and Child Health
- Strategy 8: Disease Prevention and Control
- Strategy 9: Emergency Preparedness
- Strategy 10: Social Welfare and Social Protection
- Strategy 11: Monitoring & Evaluation

In this strategic plan, **crosscutting issues** which affect all programmes and activities are highlighted: quality, equity, gender sensitivity, community ownership, coherence, and complementary in governance.

3.2 Dimensions of HSSP III

The HSSP III has four dimensions, i.e. types of services, levels in the health sector, strategies and crosscutting issues, which each serve as entry point for addressing key strategic choices, and which together result in one consistent strategic plan.

Figure 3: Dimensions of the strategic plan



The next chapter provides a situation analysis and way forward for each of the eleven strategies. In the paragraphs the types of services are explained, where applicable. Chapter 5 elaborates the crosscutting issues and their impact on the levels of the health sector. In chapter 6 the strategies are summarised in tabular form. In the tables types of services and cross-cutting issues are included.
The strategic plan serves as reference document for developing specific hospitals and Council strategic plans, and for annual work plans. The four dimensions offer reference information that can be used in further more specific planning.

4 Strategies

4.1 Strategy 1: District Health Services

Situation Analysis

In recent years the Councils (Local Government Authorities) established and improved the decentralised health systems. At the Council level a separate health sector account is maintained (account number 6), where earmarked funding for health is kept. The Comprehensive Council Health Plan (CCHP) is a well-established tool for planning and monitoring health activities. The management structure, consisting of Council Health Management Team (CHMT) and Hospital Management Team (HMT), facilitates the implementation of health services at district level, together with a functional community health structure (Council Health Services Board and Health Facility Committees)

The financing of District Health Services improved, with increase in Government funding and Health Basket funding. Complimentary financing options of the National Health Insurance Fund (NHIF), Community Health Fund (CHF) and user fees have been introduced to provide sustainable sources of funds to bridge the gap in the budget for health services provision. However bureaucratic procedures, along with the lack of bank accounts at health centre and dispensaries have hindered the potential use of these funds. Councils hardly use own discretionary funds to support health services.

District Health Services still face problems with low geographical coverage of health services in remote areas and a non-functional referral system. The infrastructure of some health facilities does not meet the official standards. Also policies, standards and guidelines are not fully used at implementation level. They may not be known or understood by health workers or not read due to the human resource crisis and the ongoing sector reforms leaving the health workers with little time to study sector development. Occasionally, health workers in peripheral institutions do not function well: cases have been found of unacceptable attitude of health staff and corruption in the health sector. Provision of the comprehensive National Package of Essential Health Interventions therefore cannot be fully provided.

Other challenges included inadequate managerial skills of staff in various areas. Supervision within the district to facilities needs improvement and supervision from the RHMT to backstop CHMTs is not optimal. As a result health programmes are not always implemented as designed. The integration and coordination of health programmes in general is poor. Programmes sometimes seem to compete for attention from health facility staff. But, most importantly, there is inadequate human resource for health service delivery at the primary level, both in numbers and in skill mix.

Council Management Teams are not fully informed on health policies, programmes, or specific activities, and may therefore not appreciate their importance. Furthermore, the Decentralisation by Devolution has not reached the grass root level, leaving health workers and communities disempowered. Decision making is too much concentrated in the district centres. Motivation of staff to perform is not always as required for good performance.

Way forward in district health service provision

In the strategies of the health sector priority will be given to equitable access to health services for all. The MMAM is the major strategy for improving access and expansion of health services in underserved areas. Its implementation is part of this strategic plan.
Interaction between community and health services to promote healthier lifestyles will be intensified. Community based strategies in health promotion, nutrition, disease control and reproductive health will be used to create more ownership of health in the community. Health activities will be gender sensitive, taking care of the special needs of women, and incorporating men in family-centred advocacy. The integration of health and social welfare

services will creates synergies, which benefit the poorest, most vulnerable, handicapped and chronically ill.

The Tanzania Quality Improvement Framework (TQIF) will be operationalized, with the introduction of an accreditation system, to guarantee defined standards of quality in the health sector. Standards and protocols in service delivery will be promoted and updated where necessary.
Improvement of diagnostic services (including laboratories), curative care, and rehabilitation services will be achieved through capacity building and provision of necessary resources to health facilities. More coherence of service delivery can be achieved through integration of health programmes at service delivery level. Enhanced collaboration with other sectors will be required to improve nutrition, water, health education, etc.
The district hospital together with other hospitals in the district will provide first level referral care, and be fully integrated in the districts health services. A functional referral system will guarantee that patients, in need of advanced care, will indeed receive it. All facilities will function according to their mandated roles, and measures to reduce by-pass of facilities will enhance efficient use of resources.

Way forward in management of District Health Services

District Health Services are the focus of nearly all the policies and strategies in the health sector. Therefore, it is crucial that the capacities for implementation are available at district and facility level . Improvement of the management capacity of District Health Services and availability of human resources for health in the periphery are priorities in the HSSP III.

The Councils will develop health strategic plans for the period 2009-2015, following the HSSP III.
The Councils will produce annual Comprehensive Council Health Plans (CCHP), based on the inputs from health facilities, which will plan for interventions based on the prioritised essential health and nutrition issues, as well as burden of disease taking into account the available financial means. Further decentralisation within the District Health Services will take place. Health facilities will produce their own annual plans and will increasingly manage their own funds, in collaboration with the Health Facility Committee, representing the community. The management capacity of peripheral health staff for planning, coordination and monitoring will be strengthened. Collaboration with the private sector will be strengthened through service agreements.

The Council Health Services Boards (CHSB) and Health Facility Committees will be stimulated to take their responsibilities in planning and monitoring of the health services including facilitating the introduction of sound financial and accounting management systems.
.
In collaboration with PMO-RALG simplified management procedures will be developed for District Health Services, reducing district bureaucracy. CHMT supervision of health facilities will focus on coaching based on guidelines and standards, and evidence based medicine. The RHMTs will be given more responsibilities in supporting the District Health Services.

M&E of the District Health Services will be strengthened, using LGA and PMO-RALG procedures and systems within the context of monitoring and evaluation of achievements towards MKUKUTA and MDG targets. Also the capacity for information sharing and utilisation will be strengthened with the aim to enhance health managers' evidence based planning and decision making.

Motivation is a cornerstone for sound management in the human resource intensive health sector. A combination of supportive supervision and performance based incentive systems will be rolled out in the coming years. Pay for performance (P4P) and Results Based Bonuses (RBB) will be introduced.

4.2 Strategy 2: Referral Hospital Services

Situation Analysis

The Tanzanian health sector has a pyramid structure with provision of referral services from primary hospital to secondary (regional) hospital and final to tertiary (central) hospital or specialised hospital. The referral health care is not working as planned due to a number of challenges. There are no referral guidelines and therefore patients at their own discretion can enter at a higher level of care than necessary. Regional hospitals are operating as district hospitals instead of performing their role as further specialised referral hospitals in support of district hospitals[13].
The zonal structure for referrals is not operational and the number of highly specialised hospitals is not sufficient. The resources are inadequate, such as skilled staff (e.g. medical specialists in regional hospitals), funds, medicines and supplies, equipment and infrastructure.

With regard to management of hospitals the roles and responsibilities of MOHSW and PMO-RALG have not yet been harmonised. The Hospital Boards are not yet in place and collaboration between ministries is insufficient. There is too much bureaucracy to access cost sharing and other health funds which negatively affect motivation of staff to collect these health funds.

Way forward in hospital service provision

Regional hospitals will be reformed in order to competently perform their referral role of handling cases requiring specialised care, rather than providing primary health care. The Hospital Reforms Programme will be taken forward. The Tanzania Quality Improvement Framework programme will be reinforced, with a Quality Assurance Unit in each referral hospital. Health workers will be sensitised to follow available standard treatment guidelines. A hospital accreditation system will be put in place.

The referral structures (horizontal and vertical) will be strengthened, with clear guidelines and protocols. Specialist outreach programmes from tertiary to regional referral hospitals will be institutionalised. The zonal referral structure will be endorsed and made operational. Regional hospitals will be involved in supervision of district hospitals.

Social welfare services in hospitals will be expanded, to ensure that vulnerable groups get the care they need. Emergency preparedness and response in hospitals will improve based on a national programme.

Way forward in hospital management

Hospital management capacity building will continue in the coming period. The hospital reforms programme will be fully implemented. National and regional Hospital Boards will be created based on a sound legal framework. Community representatives will take part in the Boards. Inter-ministerial consultations between MOHSW and PMO-RALG will clarify the division of roles and responsibilities particularly between the technical and the administrative functions of all stakeholders in hospital management (including the role of community representatives).
Referral hospitals will be encouraged to introduce and maintain financial and accounting management software systems. Hospitals will generate additional income from services and will engage in relations with health insurance schemes. The hospitals will develop strategic plans for the period 2009-2015, following the HSSP III and will produce annual plans and budgets. Hospital capital investments and maintenance will be planned to bring the infrastructure up to standard.

[13] To operate as regional hospital a minimum of four specialist is needed (Internal Medicine, Paediatrics, Surgery and Obstetrics and Gynaecology)

4.3 Strategy 3: Central Level Support

Situation analysis central level

Central level support to health service providers is given by the MOHSW headquarters, its departments and by several agencies and institutions operating under direct responsibility of headquarters. Medical Stores Department (MSD), Tanzania Food and Drug Authority (TFDA), Tanzania Food and Nutrition Centre, National Institute for Medical Research, Government Chemical Laboratory Agency and Health Regulatory Authorities provide indispensable services to the health facilities and health professions.

The health sector in Tanzania is extensive both in scope and geographic coverage. The performance of central level support plays a key role in the effective delivery of health care services by Councils and programmes. Quite often the quality of service delivery is compromised by delayed delivery of resources e.g. funds, medicines and supplies, equipment, shortage of skilled staff or means of transport.

Bureaucratic red tape, over-centralised or delayed decision making can be the cause of delays. The use of outdated rules and regulations can be a contributing factor. Developed policies and plans are sometimes not implemented, and the enforcement of existing regulations is not always taking place. This results in a gap between theory and practice. Collaboration between key players and stakeholders in the health sector is not optimal. Interaction between the MOHSW and the PMO-RALG concerning programmes is insufficient. The decentralisation is not yet fully internalised by the system. Supervision or quality control is not systematically done. Central level managers too often are involved in running basic operations instead of strategic decision-making.

In the last years, new health legislation has been enacted, but there is still lack of understanding of the holistic nature of health legislation. This has affected the implementation by other stakeholders. Similarly, laws are not self executing instruments; hence they require implementation support to ensure their effective enforcement. Furthermore, there are a number of health related international conventions/agreements initiated by other sectors and partners, which need to be adopted and implemented.

Way forward head quarters

During the strategic plan period the health sector will attain the required institutional capacity and organisation structure necessary in the decentralisation framework. Operational decisions will be left to PMO-RALG, the LGAs, and where possible to the health facilities. This will enable headquarters to concentrate more on stewardship functions, rather than operational issues. These strengthened stewardship functions will include promoting harmonisation and alignment of sector financing, policy and planning. Where necessary, the MOHSW will develop new policies, legislation and operational guidelines, and revisit old ones. The MOHSW will improve its performance as custodian of health related legislation. The MOHSW will formulate a Health Legislation Implementation Support Plan which will outline different activities to be carried out, including dissemination, enforcement, monitoring and evaluation of legislation. PMO-RALG will be main partner in this, as supervisor of LGAs.
Coherence between policies, legislation and plans will be high on the agenda. A gender sensitive and human rights-based governance system that ensures accountability, transparency and adherence to leadership ethics is another output expected during the HSSP III period.

Improvement of the planning process in the Ministry will take place leading to integrated operational plans for support services to programmes, departments, regions and districts. The MTEF planning will be comprehensive, more than annotated budgets. Workable plans will be formulated to enhance the support system. Improved coordination will be achieved by integrating support services provided by programmes, department and units. Uncoordinated and unplanned activities, disrupting the implementation of CCHPs will be halted.

The ministry will support specialised hospitals, regional hospitals, zonal training centres and other training institutions, as well as Councils to develop strategic plans for the period 2009-2015, following the HSSP III.
Improvement of monitoring and evaluation is discussed below (strategy 11).

Situation analysis Regional Level

The regional level takes up an intermediate position as arms of the central ministries in the organisational structure of the health care system in Tanzania. This level is closer to the Councils (districts). The Local Authorities Act and the decentralisation framework have exhaustively defined the roles and functions at the local authorities' level, but have inadequately defined the roles and functions at the Regional Secretariat.

The regional level performs merely administrative supervision of District Health Services as part of PMO-RALG, rather than technical supervision on behalf of the MOHSW. The role of the RHMT in quality improvement of district plans and reports is limited. Only administrative verification takes place after submission of plans and reports. The Regional Health Management Teams (RHMT), including the regional hospitals, are not only understaffed, but also lack the finances and equipment to discharge their functions.

Way forward regional level

The Regional Secretariat is strategically positioned to assist the centre in its supervisory and technical support role. The main focus is to have a regional health structure that has the capacity to provide both managerial and technical support. First the RHMTs will be internally strengthened. The competency of RHMT members will be created to interpret policies, regulations and conduct supportive supervision. Funding, equipment and means of transport will be made available to the teams.

The recognition of RHMT as regional officials, with a well-defined relation has now been formally done. The RHMT will function more as coaches and advisers of CHMTs, to boost the capacities of District Health Services in meeting defined quality standards. Social welfare will be incorporated into the RHMT functions. Coordination with other regional departments, e.g. water, agriculture, education, will be improved in the context of the MKUKUTA monitoring activities.

4.4 Strategy 4: Human Resources for Health

Situation Analysis

Health care is and always will be a labour-intensive sector. Certainly in a country like Tanzania, with a wide-spread population, delivering services to the population requires many health workers in health facilities, from dispensary level to tertiary hospital level. The health sector is understaffed. The total of staffing in the health sector stands at 35% of the actual need according to defined staffing norms. The available number of professional health workers in the public sector is 35,202 and deficit is 90,722. Shortages in the private sector, especially in FBO institutions are also immense.

There is an enormous shortage of human resources for health across all cadres: clinicians, nurses, pharmaceutical technicians, laboratory technicians, radiographers, physiotherapists, health officers and health administration cadres. The shortage is more severe in rural districts. The high attrition rate is a threat and is compounded by HIV/AIDS epidemic.

The policies and regulations with regard to human resources for health depend to a large extent on other ministries (e.g. PMO-RALG), especially for civil servants. In the past the MOHSW was not always able to sufficiently advocate for increase of personnel or even to halt reductions. Partly this was due to insufficient planning capacity to make predictions of staff needs. But financial constraints in Government were a major contributing factor to the

shortages. The decentralisation to LGAs affected the employment of health workers and the Ministry was not able to respond to these changes.

The collaboration between the public sector and private sector was not always optimal; at times there was competition for the few staff available. Inappropriate planning of new facilities and services sometimes resulted in under-utilisation of infrastructure and staff.

The capacity of health training institutions is limited. Consequently there is a low output of trained health personnel. Training institutions have several setbacks (understaffing, neglected infrastructure) to match the existing demand. Staff currently in the field requires reliable and accessible Continuing Professional Development to meet training needs, but capacity building of staff is often fragmented, linked to vertical programmes, not targeting the right cadres. There is little follow-up to ensure that health workers indeed use the acquired skills. The impact of such capacity building is limited.

Way forward

The Human Resource for Health Strategic (HRH) Plan 2008-2013 has been formulated and agreed upon.
Improvement of the human resources situation is priority number one for the health sector in Tanzania. It must be a well-concerted joint effort of the Public Service Management, Ministry of Finance, PMO-RALG, PO-PSM, the MOHSW and other stakeholders.
The MOHSW will achieve more coherence in policies on Human Resource for Health & Social Welfare by entering into dialogue with other Ministries, Departments and Agencies, and by increasing the lobby for better remuneration, conditions of service and career development opportunities. The leadership in the Ministry will be strengthened to implement those tasks.

The planning capacity for human resources will be improved at all levels, based on an effective and a comprehensive human resource information system. Collaboration between public and private sectors will be improved, to come to joint planning of staffing needs, and to improve rational use of available resources. Sufficient financing is crucial for the improvement of staffing. Besides the regular government funding innovative financing methods will be introduced, e.g. basket financing, project funding, external sponsoring.

In collaboration with LGAs the human resources management in management teams in the districts and health facilities will improve, with better trained HR managers, who can improve working conditions and productivity of the workforce. Incentive structures for health workers will be implemented to improve performance and motivation of existing health workers. A performance management system (P4P) will be introduced to that effect. This also will enhance the retention of staff.

The production of new staff through training will increase further to meet the demands. At the same time the quality of training (pre-service, in-service and continuing professional development) will improve at all levels for both public and private sector. Curricula will be regularly updated, linked to developments in science and technology. A system of accreditation of training institutions will be introduced including a development and succession programme for teaching staff.

Zonal Resource Centres will be strengthened to support regions and districts in continuing education. Vertical programmes will improve collaboration, and incorporate their training activities in CCHPs and MTEF plans.

Follow-up and coaching will become integrated part of on-the-job training. Opportunities in the private health sector will be used where possible. HRH training can be boosted by utilising the already existing private facilities for training, as well as encouraging investment in the area by the private sector. Research into human resources issues will be used better to direct plans and actions for improvement of HRH.

4.5 Strategy 5: Health Care Financing

Situation analysis

During the implementation of the Health Sector Strategic Plan II (2003-2008) emphasis was on targeting resources to the priority interventions. Moreover, implementation of cost sharing in Government health facilities, through the Community Health Funds (CHF) and National Health Insurance Fund (NHIF), was implemented. An exemption and waiver system was also put in place to cater for the poor and vulnerable groups.

During this period the health sector has registered an increase of public health per capita spending from US$ 5.8 in 2004 to US$ 9.0 in 2007. However, on-budget actual health sector expenditure as a proportion of GDP has remained stagnant (at less than 3%). The increase in the financial resources to the health sector in absolute terms during the period of HSSP II was largely due to additional donor support. Often this donor support had little flexibility, making it impossible to fund priorities, defined in HSSP II. The financial picture is also marked by large amount of funds from Global Health Initiatives, which are off-budget. The government has little discretion power over these types of funding. Continuity of such funding is never guaranteed.

The gap between approved estimates and actual expenditures in general has gone down, leading to better budget performance, although there is a noticeable gap between approved estimates and expenditure in the area of HIV/AIDS.

All Councils have adopted the District Health Accounts tools developed by the National Package of Essential Health Interventions in Tanzania which outlines the cost effective interventions. The allocation to the hospitals compared to the primary health facilities is disproportionate, indicating that people in urban areas have more than their share for the health expenditures. However, since the introduction of the new Resource Allocation Formula for the health basket and block grants, a more equitable distribution of funds has been realised.

There are increasing health needs and demands that result from increasing disease burden (communicable and non-communicable diseases) as well as emerging and re-emerging diseases. Furthermore, the costs for health interventions are going up, for example, the cost of anti-malaria, antiretroviral and newly introduced vaccines.
There are various studies into the gap between available resources and health sector needs. These include the costing of health services in MKUKUTA, World Bank reports, and macroeconomic reports in health. Information from these reports has not been used sufficiently in the planning and priority setting.

Way forward

The MOHSW is committed to advocate for increased funding for the health sector, meeting the Abuja targets (15% of Government budget), in order to ensure access to health services, equity, and increase in coverage of health promotion, prevention and care. The Ministry in partnership with Development Partners maintains the Health Basket Fund, and aims at increasing the number of partners and amounts pledged in this fund. The MOHSW will also advocate for more budget flexibility in donor support and for support to health systems as a whole, rather than earmarked funding.

The implementation of cost sharing and prepayment schemes has demonstrated a great potential for raising additional revenues to the health sector. It provides flexible funding to health facilities. The MOHSW prefers improvement of health insurance schemes rather than increase of out-of-pocket expenditure by patients. The future perspective of health insurance in Tanzania is the introduction of a comprehensive Social Health Insurance. Regulatory and financing mechanisms will be put in place to enrol the poorest in prepayment schemes. There is still room for improvements in the management and performance of cost sharing. It will be possible to increase the revenue (e.g. in hospitals) and reduce administration costs. Community involvement in decision making on spending of generated funds in health facilities

will guarantee transparency and accountability. The MOHSW will create a regulatory body to guide and supervise health insurance schemes.

The MOHSW in collaboration with all partners will increase efficiency and effectiveness in the use of financial resources. Budgeting, accounting and auditing processes will be strengthened, in coordination with PMO-RALG, leading to transparency in health care financing.

In the coming years, the Government plans massive investments in health infrastructure to improve accessibility and quality. It will try as much as possible to involve the private sector in order to reduce government expenditure. The government will provide an environment conducive for the private sector to invest in areas where coverage of essential services by public providers is limited (e.g. through service agreements). The government will avoid construction of public facilities in places where adequate services are provided by FBOs or other providers working closely in the health system. Community initiatives and local sponsorship will be embraced. Studies will be commissioned to get a clear picture on capacity, potential and utilisation of private sector providers and the source of capital and recurrent income in FBO and Private for Profit Providers.

4.6 Strategy 6: Public Private Partnerships

Situation Analysis

In Tanzania about 40% of the health facilities are owned by private sector, which include Faith Based Organisations (FBO), CSOs and Private-for-Profit providers. In nearly all districts national or international NGOs are present, working in the health sector. A National Public Private Partnership (PPP) Steering Committee has been established, and zonal and regional PPP forums are present in a number of zones and regions. At district level CHSBs, CHPTs and FGCs are in place and they facilitate PPP collaboration. However, the Ministry has no guiding policy how to put the PPP concept in practice.
At the end of 2007, the MOHSW, the PMO-RALG, BAKWATA, CSSC and APHFTA finalised the national template for the Service Agreement between the government and service providers in the country and introduction in the districts has started.

In practice, there is general inadequate conceptual recognition and understanding of PPP at all levels. The private sector is regarded as a separate system co-existing with the public in provision of health services, instead of one system with equal actors providing complementary services. The capacity of private providers is not exhaustively used, and often national health programmes are not implemented in private facilities. Therefore clients do not always have access to life saving medicines or supplies.
The capacity of the MOHSW, the regional level, the district and the private stakeholders in managing negotiations and contractual arrangements in the policy and Service Agreement template is inadequate. There is inadequate mainstreaming of PPP at all levels.

Way forward

The health policy (June 2007) acknowledges the contribution of the private sector in health service provision. One of the objectives is increased participation of the private sector in achieving access to health services at all levels.

The PPP steering committee will propose a policy, which will regulate the involvement and cooperation of all providers and which will ensure that capacities in private institutions are used to improve the health of the people.

It is crucial that LGAs, non-state health providers and civil society organisations improve collaboration, working in a complementary way. Distinctive competencies of service providers across the sector have to be recognised and incorporated in CCHPs and other relevant plans (e.g. opportunities for horizontal referral of patients). There is no need to initiate government

services, where private sector is already providing adequate services, which are incorporated in the CCHP. Service agreements will provide mutual benefit for Councils and private providers ensuring government programs are also delivered by private providers who are sufficiently remunerated. Private providers will be granted access to government funding on the basis of these Service Agreements.

Private providers will be stimulated to step up service provision to vulnerable groups and in remote areas. They will be incorporated in insurance schemes, when they meet the standards for accreditation. Private facilities will benefit from supportive supervision by RHMTs. Provision of essential medicines through the private sector will be stimulated in a regulatory way (e.g. ADDOs). Private initiatives in training of health workers will continue to be promoted.

4.7 Strategy 7: Maternal, Newborn and Child Health

Situation analysis

Progress has been realised in reduction of under-five mortality, improvement of the nutritional status of children, and increased coverage of effective interventions (Vitamin A supplementation, exclusive breast feeding, immunization, IMCI, improved malaria management). Adolescent and newborn interventions have been initiated and the Hepatitis B vaccine has been introduced in the immunisation programme. But 72% of under-fives are anaemic, 38% are stunted and 22% are under-weight.

The Maternal Mortality Ratio (MMR) estimated at 578/100,000 live births remain persistently high. Although 95% of the pregnant mothers attend ANC services at least once, less than 50% of them deliver in a health facility. Insufficient numbers of health facilities are equipped and staffed according to standards to provide emergency obstetric care. There is no functional referral system in many districts, leading to delays in provision of comprehensive emergency obstetric care.
The neonatal mortality rate is 32 per 1,000 live births. Neonatal deaths constitute approximately half the number of infants who die and this has not decreased in the last decade, leading to concerns of poor peri-natal care in the country.

Despite the gains and various efforts to improve MNCH service delivery, the coverage of Maternal, Newborn, and Child Health (MNCH) interventions is still low. There are obvious urban rural disparities as well as significant differentials among the districts. In addition to low coverage, there is inadequate resource allocation for MNCH services, poor service quality, limited access, insufficient community participation, and weak linkages between MNCH and related programmes.

Way forward

The One Plan for Maternal Newborn and Child Health is the core strategy for improvement of MNCH, accepted by all stakeholders. The plan will focus on strengthening MNCH advocacy and communication in the community, using all possible means to reach both men, women and children. The communities will play a more important role in promotion of positive behaviours and practices for better child health and reproductive health.

Increasing access to MNCH interventions is part of the MMAM programme. Increased coverage of primary health care in remote areas will provide MNCH closer to the community. The EPH provides guidance on which MNCH services should be delivered at each level, and increasing the number of health facilities that can provide the appropriate EPH will reduce maternal and neonatal mortality. Provision of youth-friendly reproductive health services will be promoted.

The health system will be strengthened to provide quality MNCH services. The MOHSW will review regulations, guidelines and standards, and will improve standardised supervision, at all

levels of the health services. Most important is improving the workforce in health facilities, not only in numbers but also in competencies to provide quality MNCH care. Improving quality of MNCH services is part of the Tanzania Quality Improvement Framework, and will be implemented in a comprehensive context. Linkages with other relevant programmes will be strengthened, so that health facilities will provide appropriately integrated MNCH services and other related services. The referral system will be strengthened and the response to obstetric and newborn emergencies will be improved through better provision of equipments and supplies, as well as means of communication and transport as appropriate.

The MOHSW aims at increasing resources for MNCH through advocacy with policy makers and planners (also in LGAs), as maternal and child health is dependent on so many other factors, besides health care provision (e.g. nutrition, education, access to safe water).

4.8 Strategy 8: Prevention and Control of Communicable and Non-Communicable Diseases

Situation analysis

The burden of diseases in Tanzania is high, with communicable diseases still prevailing. Increasingly the country is confronted with the "double burden of disease" due to non-communicable diseases. HIV/AIDS, tuberculosis and malaria are among the most important infectious diseases in Tanzania, and are targeted worldwide for control, or even eradication in the case of malaria. For these diseases national strategies and work plans have been developed, which are under implementation.

In the area of HIV/AIDS voluntary counselling and testing (VCT) and anti-retroviral treatment (ART) have been intensified in the past years. For malaria, new diagnostics tests and new medicines were introduced, the distribution of insecticide-treated nets (ITN) was stepped-up and indoor residual spraying (IRS) implemented in selected regions. For tuberculosis control, DOTS Strategy is being implemented in the country with 100% DOTs coverage. This is in line with the new Global Stop TB Strategy. Funds for combating these diseases are available from several sources. However, the results of the programmes are sub-optimal due to constraints in human resources and weaknesses in health systems.

Unfortunately, the focus on these priority diseases has reduced attention for diseases, which can be classified as 'neglected': cholera, helmintiasis, diarrhoeal diseases, plague and rabies. Although prevalence of these diseases is not high, they pose a public health threat to the country. There are insufficient capacities to diagnose and handle these diseases and no funds for control programmes. Other diseases like trachoma, onchocerciasis, lymphatic filariasis, schistosomiasis, rift valley fever, avian influenza, ebola, typhoid, trypanosomiasis and relapsing fever are important in certain regions, but insufficiently tackled. Many of these vector-borne or food- and waterborne diseases could be controlled by adequate environmental health activities.

The Public Health Bill is going to be presented before the National Assembly in the October-November 2008 Parliamentary Session. The Environmental Management Act is not yet fully enforced, as regulations are still being formulated. These require adaptations in the work in environmental health. Threats from an unhealthy environment, often caused by inappropriate human behaviour, are not always handled in the correct way. Capacities of health workers and employees in other sectors are limited. Health threats at the workplace continue to be unacceptably high.

With increasing life expectancy non communicable diseases (NCD) and conditions are becoming more prominent in the population: cancer, cardio-vascular diseases, nutritional disorders, diabetes mellitus, chronic respiratory diseases, renal disease, congenital abnormalities and injuries/trauma. Dental problems and blindness due to cataract increase with an aging population. All these conditions are predominantly physical, requiring medical and psychosocial interventions. Mental disorders and substance abuse contribute significantly

to the morbidity burden. They contribute significantly to NCD risk factors, such as alcohol and tobacco dependency and to causation, maintenance and lack of recovery from most physical illnesses. Mental disorders and substance abuse predominantly require behavioural interventions..

Way forward in service delivery in disease control

The implementation of disease specific strategies and programmes will continue, as defined in the approved strategic plans. (See list of plans in table 6). Improvement of District Health Services and hospital services will create better conditions for achieving targets mentioned in specific programmes. It is the strategy of the Ministry to address service improvement issues in an integrated way.

The MOHSW is fully committed to implement that Tanzania National Multi-Sectoral HIV/AIDS Framework 2008 – 2012. Programmes for prevention of mother to child transmission (PMTCT), for VTC, for ART, etc. will continue. Care for people living with HIV/AIDS will be improved. HIV/AIDS work place policies will be introduced in all health facilities.

Malaria diagnosis, treatment and prevention will be strengthened. Measures for vector control (ITNs and IRS) will be further extended, according to the Malaria Control Strategic Plan.
Implementation of DOTs Strategy will continue, while more attention will be given to scale-up of quality collaborative TB/HIV services. Management of Multi-Drug Resistant TB (MDRTB) will be improved. In leprosy control, efforts will be concerted on targeted leprosy elimination in districts that have not attained global leprosy elimination targets, maintaining quality leprosy services and prevention of disabilities. Health promotion, disease prevention and control, care and rehabilitation will be integrated further.

The Ministry will develop policies, guidelines and protocols for infectious diseases and Non-communicable diseases. More capacities will be mobilised to handle Non-communicable diseases. Health staff will be (re)trained in these areas; supplies and equipment for diagnosis and therapy will be procured. The emphasis will be on promotion of healthier lifestyles, prevention, and protection especially for mental disorders and for the chronic Non-communicable disease that share common risk factors and therefore can be cost-effectively targeted. In collaboration with social welfare programmes care for the chronically ill and handicapped will improve. Community participation in disease prevention and control will be important.

The Public Health Bill and Environment Management Law provide guidance in future developments. The ministry will develop regulations based on these acts. It will stimulate compliance through advocacy. The inspectorate will ensure enforcement where possible. The reinforcement of the tobacco products act will be enhanced.
More research will be carried out into the actual burden of diseases in Tanzania and into proper intervention strategies.

Way forward in management of disease control programmes

Integration of service delivery at the implementation level is important, offering comprehensive services to the population. Programme managers at district, regional and central level should focus on coherence in their planning and support. All activities will become part of CCHPs, and no longer run in parallel. Training will be linked to comprehensive human resources development plans, abandoning isolated activities.

The MOHSW will take the lead at central level in intersectoral collaboration on hygiene and protection from health hazards. This collaboration will be further developed under the lead of PMO-RALG at council level. The private sector will be more involved in the disease control programmes and environmental health activities.

4.9 Strategy 9: Emergency preparedness and response

Situation analysis

The health sector can be confronted with general disasters (natural or human-made) which have medical aspects, or typical health threats. Due to intensive cross-border contacts and globalisation those threats may quickly come to Tanzania, for example Avian Flue or SARS.
The Health Emergency and Disaster Preparedness and Response Unit (HEPRU) in the MoHSW is responsible for preparing for and responding to Emergencies and Disaster at all levels (Central Government and Local Government). The MOHSW HEPRU collaborates with the Disaster Management Department under the Prime Minister's Office and with other stakeholders.

Since the inception of the unit, it has managed to develop an emergency operational plan and emergency guidelines. Response teams are established at the national, regional and district level, which have come into action on several occasions. Health emergency preparedness and response operations have been facing challenges mostly due to inadequate funds for operational activities and delay in release of funds for responding to emergencies.

The regional and district level do not have a budget line for emergency preparedness and response. For the same reasons it has been difficult to train adequate staff at all levels. The information management system for emergency preparedness and response is not functional and communication is not well coordinated.

Way forward

Capacity building will take place in emergency preparedness and response at all levels (awareness, training, guideline finalisation and dissemination, protocols for response, communications, etc.). An effective surveillance and information system for emergency preparedness and response (risk assessment and early warning system) will be created in coordination with other information systems in the sector (e.g. epidemiology) and in coordination with other sectors (e.g. meteorology).

Resources will be mobilised for immediate response, and when necessary funds will be made available bypassing bureaucratic procedures. National and international networks will be developed, which monitor potential threat, provide timely warnings and which evaluate disasters and responses, in order to learn lessons for the future.

4.10 Strategy 10: Social Welfare and Social Protection

Situation analysis

Social welfare concentrates on vulnerable groups in the society. The actual needs in the country are not yet fully mapped. Presently social welfare is fragmented and mostly institution-based. Social welfare is weak at LGA level; only 56 among 133 councils provide social welfare services. In Councils and village governments the concepts of social welfare and social protection are often not fully understood. Vulnerable groups are not sufficiently recognised and risks not identified. In rural areas where most people are active in the informal sector, support to vulnerable groups is left to traditional systems, which are not always functioning well in catastrophic situations.

There is a shortage of skilled human resources and funds. Currently the department only has 210 welfare officers, compared to the 3,892 needed. Not all districts and regions have social welfare officers in place. There is not much collaboration between health and social welfare officers yet, both at district and at regional level. The private sector (NGOs and FBOs) provides social welfare for vulnerable groups, either in institutions or in communities. Orphans, vulnerable children, people living with HIV/AIDS are targeted for such support. The M&E of social welfare is weak.

The draft Social Welfare Strategy has been developed recently, but operational guidelines have not yet been formulated.

Way forward

Once the Social Welfare Strategy has been approved, implementation can start. A paradigm shift must be promoted from institution-based social welfare to community-based social protection. A rights-based approach will be stimulated through employing strategic techniques where policies and programmes are designed to reduce poverty and vulnerability by promoting efficient labour market, diminishing people's exposure to risks, enhancing their capacity to protect themselves against hazards. Gender-sensitivity and equity are important concepts which will be promoted. Laws and regulations will be updated; guidelines will be formulated and disseminated.
Synergies will be created in prevention and care for vulnerable groups (e.g. nutrition, HIV/AIDS, disabled people). Equally collaboration between health and social welfare officers will result in better use of the community based insurance system, CHF, rather than depending on exemption regulations for vulnerable groups.
An accreditation system in social welfare will be developed and enforced, to ensure that quality care is provided by all social welfare services, public or private.

With regard to management, the incorporation of social welfare officers in CHMTs and RHMTs will create more collaboration. Community activities can be planned jointly, and health facilities can play a bigger role in protection of vulnerable groups. Also integration of Social Welfare into the Health Monitoring and Evaluation system will be advantageous for both sides.

Intersectoral collaboration will be strengthened and strategic alliances at all levels will be made, with e.g. private sector and NGOs for protection of vulnerable groups. Close collaboration with charity organisations will result in better coverage of services. At the regional level new Regional Social Welfare Officers will be recruited and incorporated in the RHMTs.

4.11 Strategy 11: Monitoring, Evaluation and Research

Situation analysis

The M&E system in health in Tanzania consists of routine systems (HMIS, demographic and disease surveillance) and non-routine systems (household surveys, research). The MOHSW is in charge of HMIS and disease surveillance, while non-routine information systems are often done by other government or research entities. Tanzania can provide overall information of reasonable quality on the health status of the population, on diseases and on health services provision. The information is not only relevant for the health sector, but also for Government as part of the MKUKUTA and MDG monitoring. Development Partners have great interest as part of the accountability for funds.

In the collection of data in routine systems (HMIS), there are weaknesses: data from health facilities are not always complete or not reliable. Often data collection is delayed. Feedback to collecting facilities, particularly from the district level is practically non existent. FBOs in general comply with national information systems, but private-for-profit facilities do not provide any information at all. Disease surveillance is improving steadily, but still meeting reporting delays. The registration of vital events (births, deaths) does not have a good coverage, while this information is required for planning health services.
The reporting system through LGAs, PMO-RALG and MOFEA (in the context of MKUKUTA) operates parallel to information systems within the sector. The quarterly technical and financial progress reports do not have any function in the monitoring by the MOHSW. The Councils are supposed to report on the 20 CCHP indicators. However, most Councils cannot provide the information partly because the indicators are not well-elaborated.

Operational research is under-funded, while the census has gaps in terms of detailed information, and research findings most often only shared in international journals without any feedback to policymaking level.

More problematic is that data are not analysed, organised or presented in a user-friendly way. Interpretation is difficult and therefore there is limited use of data for local planning, starting from the collecting facilities to the CHMTs As a result, resources are not always allocated to where they would be needed most.

MOHSW programmes have de-linked from the HMIS and set up their own information system. These systems operate in parallel and do not share information and expertise. There is an over-reliance on programme-driven surveys and surveillance systems, and information from those surveys is not sufficiently shared. Existing administrative data on finances or human resources are not used within MOHSW, while separate databases are being created.

Human resources are inadequately skilled in all steps of the information cycle (data collection, processing, analysis, epidemiology, research etc.) and do not know how to use routine information in planning and performance appraisal. Peripheral staff are not really aware of what they could do, or should be doing, with data. MOHSW has problems keeping skilled ICT staffs who are attracted to the "greener pastures" in the private sector. Funding for M&E is insufficient to meet the demands from different stakeholders.

The way forward

M&E needs to be strengthened in order to achieve evidence-based planning, and to establish transparent accountability. The MOHSW will develop an M&E policy and strategic plan that spells out roles and responsibilities of all actors at all levels. Besides the health facilities, CHMTs, RHMTs and MOHSW, also LGAs, PMO-RALG, and MOFEA have an interest in M&E in health, as reporting on health services is incorporated in local government monitoring and in MKUKUTA monitoring. Collaboration in this field is therefore mandatory.

A first priority for strengthening M&E in health is the formulation of a Health Sector Monitoring Framework, satisfying the information needs of all stakeholders, with a harmonised set of indicators, data elements and data sources (routine and non-routine).

The HMIS will be reviewed and strengthened to improve the data flow and analysis, and to integrate related systems (performance appraisal, programme monitoring, etc.). Participation in HMIS will become part of accreditation of health facilities. The volume of routine data collected at facility level needs to be streamlined and data collection simplified. Existing tools will be refined at all levels. Where possible, automation of data aggregation and analysis will be introduced. A National Information and Communication Strategy will guide operations in the health sector. Health facilities and CHMTs will be the prime users of data in routine operational planning and in formulation of annual CCHPs.
The Council indicators will be brought in line with the HSSP III indicators, and the MOHSW in conjunction with PMO-RALG will ensure that the annual technical progress reports by LGAs are fully harmonised with the HMIS and thus get a place in the overall monitoring system.

The HIR unit needs to be strengthened to include capabilities in epidemiological analyses; M&E structures and systems will be given prominence in the Ministry. At the national level, the existing fragmented databases need to be replaced by a flexible data warehouse. A system of organising data on morbidity and mortality to link up with available data on resources (financial, human, material and others) will be developed to ensure use of such data as a comprehensive package for decision making and planning. This will ensure that all data is available and well managed, to provide a balance between accessibility and security. Existing and new data from vertical programmes (HIV/AIDS, Malaria, TB, etc), as well as from laboratories and administrative databases (HR, Finance), population–based surveys and operational research etc. will also be incorporated into the data warehouse. New technologies will enable data communication and exchange between stakeholders, where and when needed.

Appropriate training programmes on data collection and use will be introduced (in-service and pre-service) to strengthen the health workers' capacity. Regular supportive supervision linked to information use will be key to in-service capacity development. The M&E system will learn from good programmes (TB, EPI, HIV/AIDS) and adapt tools and models for better performance of the overall system.
Disease and demographic surveillance will continue. More collaboration between programmes will be created to come to one joint research programme.

4.12 Other important issues:

4.12.1 Capital investments

Situation analysis

The infrastructure network of the health sector is enormous, with more than 6,000 existing buildings to be maintained. Most of the buildings are owned by LGAs or the private sector. Investments in infrastructure and equipment have been insufficient, despite special funding through rehabilitation programmes. At the same time new elements of service provision require more space (e.g. emergency obstetric care, VCT). New standards for buildings have been developed, but most health facilities do not meet those standards. With new programmes new equipment is required, e.g. laboratory or operation theatre equipment.

Huge investments in infrastructure and equipment are needed to cover unmet needs of the population. In the MMAM an investment programme has been developed, but implementation will take time due to financial and human resource constraints. The programme is dependent on collaboration of LGAs and private sector to renovate and create infrastructure. There are also community initiatives to create infrastructure. Therefore, duplication of efforts should be avoided, and priorities must be formulated jointly. Besides construction for health facilities, construction of training institutions, offices and staff houses is needed.

The transport system is the nerve of the system in the health sector. This includes the ambulances for patients and the supervision vehicles for the provision of medicines, supplies and managerial purposes. The transport maintenance system is poor and inadequate for vehicles and medical equipment.

Way forward

Expansion of infrastructure is planned, with priority for underserved rural areas. A strategy for maintenance and replacement of vehicles will be developed. Innovative approaches will be developed to increase the private sector and community contribution to service delivery within the context of the MMAM. A new health infrastructure window under the Local Government Capital Development Grant has been created to ensure earmarking of funds for rehabilitation of health facilities.
The Ministry will develop guidelines and the CHMTs will engage in programmes of preventive maintenance, and will ensure that through better care for equipment and means of transport their lifespan is extended.

The MOHSW head quarters will continue to update quality standards and will build the capacity of owners of infrastructure (government and private) to build in compliance with those standards. The Ministry (through the RHMTs and zonal maintenance workshops) will also improve technical assistance in procurement and maintenance of equipment to LGAs. Repair of equipment will be offered in zonal workshops. Capacity building of CHMTs will take place to introduce a system of preventive maintenance. More supervision will take place to enhance adherence to maintenance protocols.

4.12.2 Medicines and supplies

Situation analysis

Overall, there has been an improvement in the supply of pharmaceuticals and medical supplies in public health facilities. But still too often these facilities face shortages. The disbursement of funds for medicines and supplies has been irregular and less than pledged in budget allocation. Capacity to forecast and quantify needs in public health facilities at all levels is low. Storage conditions in some health facilities are poor.

Shortage of qualified pharmaceutical staff is critical in both the public and private sectors. Irrational use of pharmaceuticals and medical supplies remains a challenge. The inadequate transport system at district level is affecting peripheral distribution of pharmaceuticals and medicines supplies as well as supervision.

The National Drug Policy of 1991 is outdated and is in the final stages of being revised. The MOHSW has not yet produced essential lists of medical supplies, according to health service packages delivered by different levels of health facilities.

The Medical Stores Department faces shortages of human resources and is overloaded with logistics for parallel programmes. It faces warehouse and storage management problems, especially in the zonal stores. Its fleet for distribution of medicines to districts is aging. The Logistics Management Information System is weak.

Substandard and counterfeit pharmaceuticals, cosmetics, medical supplies, traditional and alternative medicines circulating in the market bring health threats to the population. In rural areas there are few or no private sources of pharmaceuticals and medical supplies, which meet quality standards. Affordability of pharmaceuticals and medical supplies especially to the poor and vulnerable groups is a challenge. Roll out of the Accredited Drug Dispensing Outlets (ADDOs) across the country in all the regions has been slow due to the huge costs involved.

The capacity of the local pharmaceutical industry is low and accounts for only 30% of the national requirements.

Way forward

The MOHSW will prioritise the adequate and timely disbursement of financial resources for provision of essential medicines, medical supplies, equipment and vaccines at all levels. It will ensure constant and adequate availability of pharmaceuticals, medical supplies and equipment of acceptable quality in the supply chain system for public health facilities and accredited private facilities. The national medicine policy will be developed, implemented and monitored on a regular basis.

As part of the HRH strategy more pharmaceutical personnel will be trained and recruited. The pharmacy council will ensure the provision of quality and efficient pharmaceutical services in the public and private sectors. Rational drug prescription and dispensing will be promoted through introduction of up-to-date standard treatment guidelines and dispensing guidelines. In hospitals Drugs and Therapeutic Committees will be introduced as part of quality improvement. The essential drugs list will be regularly reviewed and adapted to new treatment insights as well as distributed to health workers on time. Donors will be stimulated to comply with the Tanzanian procurement and donation systems, rather than providing non-requested drugs in kind. The roll out of the ADDO scheme towards improving medicine quality and access to medicine supply, particularly in rural areas will continue.

MSD will decentralise part of its functions to the zonal stores, which will be able to respond quicker to client needs. It will automate more of its stores management, making on-line information available for clients. Monitoring, evaluation and operational research in medicines supply and utilisation will improve, using ICT solutions.

Hospitals and District Health Services will be able to use generated funds more flexible and procure approved medicines and supplies where available.

The government, through TFDA, will step up control of quality, safety and efficacy of pharmaceuticals, medical supplies, medical equipment, traditional and alternative medicines in both public and private sectors. Domestic production of pharmaceuticals and establishment of private outlets in rural areas will be promoted.

4.12.3 ICT in health

Situation analysis

The use of information and communication technology is quickly spreading. Also in the health sector in Tanzania computers are common. Presently the main use is for information aggregation and analysis, and for word processing. In LGAs automated planning and accounting systems are applied, also for District Health Services. Gradually access to internet is created for CHMTs and hospitals. However, the systems are weakened by poor maintenance of computers and invasion of viruses. There is no good storage and back-up policy leading to loss of critical information. Opportunities for web-based communication and collaboration are insufficiently used.

Way forward

The MOHSW (as part of the M&E strategy) will formulate an ICT strategy and implementation plan. It will outline the way forward in automation and integration of information systems (data warehousing), in use of web-based communications in the health sector, information for the general public (websites), telemedicine, etc. Computer-assisted distance learning will be introduced gradually. Experiences from other ministries (e.g. PMO-RALG) and the private sector will be used to jump-start the development and to enhance exchange of information.

The MOHSW will provide clear directions for data storage and security. Capacity building in ICT will take place, as part of introduction of programmes.

5 Crosscutting issues and levels in the health sector

For each of the crosscutting issues, the concepts, approach, implementation mechanisms and activities per level in the health sector are listed.

5.1 Quality

Concept of quality
Quality in health services means working according to specific standards, which aim at improving the health status of individuals and communities, reducing suffering due to diseases and illnesses, and increasing clients' satisfaction. At the same time effectiveness and efficiency is increased. In all activities in the health sector the focus on quality will be enhanced and centred on evidence-based medicine and public health and rational decision making.

Approach to quality improvement
Quality improvement is an iterative process that never stops. Even in a resource-constrained environment, quality should be a priority. Over the last decade, mechanisms have been developed worldwide, which translate general quality concepts into tangible tools and interventions in the area of clinical medicine, public health and management.

The MOHSW has developed policies, strategies, work plans and manuals for quality improvement, both general as well as disease specific. Standard Operational Procedures (SOP), Treatment Guidelines (TG) and standards are available or under development. During the implementation of HSSP III, the emphasis will be on putting developed quality improvement systems in place and introduce a quality culture in the health sector, which makes health workers proud and self-confident.

Quality of services

The development of an accreditation system for all service providers (government and private) and the implementation of the Quality Improvement Framework Programme will make the quality improvement process concrete and transparent. It will provide guidance where health managers should target specific improvement measures.
All health workers and trainees in health will become conversant with the adherence to treatment guidelines based on evidence based medicine.

District:
Accreditation of facilities and programmes for health and social welfare will be introduced gradually, and implementation of Quality Improvement Framework Programme will take place.
Region:
Accreditation of referral hospitals will start, and Quality Assurance Units will be initiated. The Quality Improvement Framework Programme will be implemented.
The RHMT will take up a coaching role in the Quality Improvement Framework Programme
Central level:
Accreditation of national hospitals will start, and Quality Assurance Units will be initiated. The Quality Improvement Framework Programme will be implemented.
Training institutions will also be accredited, and the curriculum will include quality assurance concepts.
In the Ministry a regulatory body for accreditation will be initiated and programmes will continue to provide guidance and support for quality improvement.

Quality of infrastructure, equipment, medicines and supplies

Quality will be enhanced through standards and protocols for design of buildings and their maintenance. The same applies for equipment. SOPs for procurement of medicines and

medical supplies, for distribution and storage, as well as prescription will ensure best use of resources.

District, Region:
As part of registration and accreditation all health facilities will meet minimum standards of design. Capacity building will take place for (preventive) maintenance of infrastructure, equipment, and means of transport. Qualified cadres will manage effectively medicines and supplies.
Central level
The Ministries, Departments and Agencies have the task to provide updated and accurate standards, and provide resources and support for adherence to the standards.

Quality of human resources

Improvement of the quality of human resources will be one of the priorities for the sector through improvement of the pre-service and in-service training, through continuing professional development and supervision/coaching of health workers, combined with performance based management. Focus will also be on maintaining health worker discipline and ethical standards.

District, Region
Continuing Professional Development and performance assessment will be part of human resources management. Incentives for good performance of health staff will be introduced, accompanied by institutionalised coaching, supervision and monitoring mechanisms. The RHMTs and regional hospital staff will take up a role in coaching.
Central:
Accreditation and quality improvement of training institutions will take place. Curricula will be updated, and a system of regular revision, linked to developments in the health sector, will be introduced.

Quality of management

The expansion and decentralisation of health services demands from nearly every health worker to take up managerial functions. Through improvement of human capacities, introduction of standardised operational procedures health workers will be capable of managing their institution. The information system will focus on data-for-decision-making approach, automation and countrywide on-line communication.
Partnerships with MDAs, LGAs and private sector will enhance

District
Capacity building health facility staff in planning, budgeting and management will enable further decentralisation of the health services. The annual Health Facility Planning will serve as the basis for Comprehensive Council Health Plan. The revision of the Health Management Information System will link it more to decision making. Council Health Services Boards will be stronger, to assume their role of community representation in management of services.
Region
Hospital Boards will be created and capacity building of regional hospitals in management will take place.
RHMTs will be strengthening to take up their crucial role of supervision and support of health service providers.
Central level
National hospitals will become Autonomous Hospital Boards under the MOHSW.
Pre- and in-service institutions will train more staff for management functions and include management in the standard curriculum.
Development of standard operating procedures and other standards is the task of head quarters in collaboration with other ministries, as well as monitoring and evaluation of the health sector performance.

5.2 Equity

Concept
Equity in health means a fair distribution of services, whereby all citizens enjoy similar rights of access, independent of income, gender, religion, geographic location, etc.
In health and social welfare equitable service provision will have priority, giving preference to those in the society who are most vulnerable and who have the least possibilities to fend for themselves.

Approach
Despite efforts by the Government of Tanzania since independence to create an equitable society, more and more evidence is generated that inequity is increasing. In recent years mechanisms have been developed, to identify poor and vulnerable people through social welfare offices. Targeted interventions have taken place. Resource allocation mechanisms have been developed favouring remote and poor districts. Further strengthening of tools and practices will get priority. Special attention will be given to creating synergies between social welfare and health activities in the country.

Geographic equity

Remote rural areas with pockets of poverty and ill-health will receive special attention as outlined in the MMAM (PHSDP), health financing strategies, and social welfare strategies.

District:
Health funding mechanisms favouring remote districts will be strengthened. In the programme of expansion of health facilities priority will be given to the most remote and underserved areas.
Staffing improvement in primary health care facilities in remote rural areas has priority. Incentives for health staff working in disadvantaged areas will be put in place and implementation accelerated.

Vulnerable groups' equity

Access to health services and social welfare for vulnerable groups in the society at all times is the commitment of the government.

District, Region:
Health service interventions in communities will concentrate more on tackling the social determinants underlying existing health problems (e.g. low education, poverty, exclusion, and stigmatisation). Advocacy for social inclusion is an important role for integrated health and social welfare services.
Exemption mechanisms for fee payment will be fully operational for the poorest and most vulnerable in society at the time of need. Inclusion of the poor and vulnerable in insurance systems, such as the Community Health Fund through subsidies and sponsoring will be enhanced.
Targeted actions will take place to provide social welfare services and social protection to vulnerable groups
Central level
Integration of the work of the Social Welfare Department and the work of health programmes (e.g. HIV/AIDS, TB, Malaria, Environmental Health, MNCH) will improve the developed of targeted action plans, assisting the poorest and most vulnerable.

5.3 Gender sensitivity

Concept
Gender sensitivity starts from the principle of equality of women and men, addressing specific services needs of each of the groups. Under the existing socio-economic situation in Tanzania, women are more vulnerable to health threats than men. Women have defined

needs in reproductive health: contraception, care during pregnancy, delivery and post-delivery. They also need more care for sexually transmitted diseases, especially HIV/AIDS, prevention of harmful practices including female genital mutilation and rape. Often, women have special needs because of their disadvantaged position, not being empowered to exercise their rights and being exposed to domestic violence. They often have a lower level of education and carry heavy responsibilities for the care for family and home. The women in general are responsible for the care of children and elderly.

Approach
In policies and strategies gender issues are addressed. Translation into practical measures has to take place. Health workers are trained in recognising and addressing specific health problems of women and men. More security and privacy will be offered to clients attending the health services and confidentiality will be improved. HIV/AIDS and reproductive health will be priority areas of intervention. Men should be made aware of the special health needs of women and should take their responsibility in family health affairs.
Gender sensitivity should also be a part of management: to ensure that women are offered opportunities for higher management positions, and ensure that women are participating in decision making bodies, like health facility boards and committees.

Gender and health

The health sector addresses specific gender-related health problems. It addresses the girl-child's health, women's health problems and stimulates the involvement of men in family health issues (MDG 4, 5, and 6).

District:
Collaboration between social welfare officers and health staff will enhance the gender focus. Exemption mechanisms for fee paying for pregnant and delivering women are in place and will be adhered to. The focus on reproductive health rights in service delivery will be increased, and there will be special attention on vulnerability of women in HIV/AIDS and STI and female genital mutilation. Privacy and confidentiality for clients will be guaranteed.
In community health the involvement of men in Behaviour Change Communication (BCC) for family health will be targeted.
The gender balance in management and village committees will be improved.
Region:
The technical assistance by the RHMT will be focusing on gender issues, with the contribution of the social welfare department. Gender balance in the team will be addressed
Central level:
The MOHSW will ensure a gender focus in all policy development, guidelines and protocols.
It will prioritise funding of gender sensitive activities, stimulating equality of men and women.
The Ministry will increase the gender balance in management and committees

5.4 Community ownership

Concept
Individuals and families hold the key to maintaining and improving their own health. Healthy lifestyles reduce the risk of diseases and illnesses. Proper care at home enhances recovery and reduces risk of complications. Communities and health services have a shared interest in this matter.

Approach
Individuals, families and communities are empowered to be more pro-active in health promotion, prevention and care. Awareness raising is important, combined with information and education. Programmes will incorporate community elements. At the same time, communities should feel more ownership of health services in their neighbourhood and take responsibility in the management of the health facilities, in committees or boards.

Healthy lifestyles

The change of unhealthy life styles to a large extent reduces individual susceptibility to diseases. Individuals must be empowered to adopt lifestyles favourable to health.

District:
The health sector promotes empowerment of individuals, families and communities to improve their life styles and reduce harms from the environment, through Behaviour Change Communication in communicable and non-communicable diseases. Collaboration with other governmental and non-governmental stakeholders is crucial in this regard.
Health facilities will perform outreach to the communities to take promotion and prevention close to the family.
Region and Central level
Technical support will be provided and programmes will include elements for community empowerment in their activities.

Care in the family

The care for the sick and treatment of small ailments is the responsibility of the family. In serious cases professional assistance is required or in cases where continuity of care is necessary.

District
Collaboration between social welfare officers and health facility staff will improve assistance to families, looking after patients at home. In partnership with CBOs and NGOs they will empower the families to engage in adequate home-based care. Innovative approaches towards social protection will be introduced.

Community – health services interface

Interactions between communities and health service providers are to be strengthened for mutual trust building and support.

District:
The Health facility Committees will be strengthen and will execute their decision-making powers in health facilities, especially in decision making on the use of generated funds.
Health workers and Village Health Committee members will work with Ward Development Committees to ensure that health issues are included in Ward development Plans
The Council Health Services Boards will be strengthened and their roles and responsibilities as community representatives in decision making will be clarified.

5.5 Coherence in health services planning and implementation

Concept
The final beneficiaries of all health and social welfare services are the individuals and families. They are best served through a holistic approach, when a coherent package of services is offered, which is linked to improvement of quality of life. Primary health facilities are small entities, with few staff responsible for comprehensive care. They can function better if they are trained and if they can work in an integrated way.

Approach
Creation of coherence between disease programmes is required, as well as linkages with educational, nutritional, and water sector activities. Fragmentation will be reduced: Comprehensive Council Health Plans offer opportunities for collaboration and integration. With improvement of the quality of the plans, there will be less and less room for unscheduled activities outside the CCHP.

The support from central level will concentrate more on coherence, rather than stimulating fragmentation. The joint planning and implementation at Regional and central level will be stimulated. Further integration in training programmes of health workers is necessary, ensuring that peripheral health workers are capable of addressing the health needs of the communities.

Coherence with MKUKUTA and MDGs

Improvement of health is put in the context of improvement of the quality of life, and thus contributing to growth and poverty reduction. The GOT has delegated to LGAs as the adequate level for management of delivery of social services.

District:
Intersectoral collaboration for better nutrition, healthier environment, improved education and social wellbeing will get more emphasis.
Region:
RHMTs will provide technical support to LGAs in collaboration with other sectors in relevant areas (e.g. water, education, and environment).
Central level:
The Ministry will ensure the integration of health in MKUKUTA planning, monitoring and evaluation and will actively contribute the planning and implementation of the new phase of MKUKUTA.

Coherence of programmes

Coherence of disease control programmes, health programmes and social welfare activities will create synergies for better results and will enhance efficiency.

District:
The service delivery at facility level will be comprehensive, and provided by the health facility team. There will be some level of specialisation, but all qualified staff must be capable of providing essential services.
All health and health related activities will be incorporated into the CCHP and ad-hoc unplanned programme activities will be reduced.
Region:
The RHMTs will provide integrated technical support and capacity building.
Central:
Structured and comprehensive annual planning of all activities will take place using the MTEF methodology, cutting back ad-hoc activities in districts, not incorporated in CCHP. Monitoring and evaluation of health services will be integrated, moving away from parallel systems. The SWAp mechanisms will be maintained for improvement of coherence in support by Development Partners.

Coherence of capacity building

Integration of training and capacity building activities will lead to improved performance of all workers in all institutions, and improved career development

Pre-service training:
Curricula will be improved, covering relevant technical and managerial areas, to prepare future peripheral health workers on the full range of tasks
In-service and on-the-job training:
Training will be institutionalised and part of Continuing Professional Development programme
Central level:
Coordination of all training will take place to avoid duplication and insufficient time management. Zonal Resources Centres will make a contribution to integration and quality improvement of capacity building.

5.6 Complementarity in Governance

Concept
Stakeholders in health have distinct competencies, which have to be used optimally, avoiding overlaps, gaps and unnecessary competition. In the health sector the subsidiarity principle will be guiding ("don't do centrally what can be done in the periphery"). Decision making should take place as close as possible to the place of service delivery.

Approach
Decentralisation and partnerships contribute to decongestion of central government, and result in more effective and efficient service delivery. Trust is the main requirement for this. The institutions, which were traditionally in charge, have to trust that local authorities or private partners can perform as well that they would do. Capacity building and support are necessary to empower peripheral institutions to take charge. Transparent standard operating procedures, management protocols, performance assessment tools, auditing tools, etc. will be improved to guide decentralised governance.

Complementarity in management

Government's policy of devolution makes LGAs responsible for implementation of health services, and regions responsible for supervision. The central level provides leadership and stewardship in the health sector.

District:
Council institutions will take full responsibility for executive tasks in health and social welfare, applying LGA and PMO-RALG administrative procedures, with technical support from the MOHSW.
Human resources in facilities will be prepared for management functions, to facilitate further decentralisation.
Region:
RHMTs concentrate on technical support to improve quality of the Council health services, without taking over operational responsibilities.
Central level:
MOHSW head quarters will create an enabling environment for the health services, leaving executive functions to the appropriate stakeholders (in MDAs, LGAs and private sector). The Ministry will decentralise more executive functions to agencies and institutions under MOHSW

Complementarity in Public – Private Partnership

Public Private Partnership creates a level playing field for all health service providers, based on added value of stakeholders and (where appropriate) competition on quality. Making better use of the distinct competencies of private (non-state) partners will contribute to improvement of health of the population.

District:
Service agreements between Councils and private (non-state) providers in health and social welfare will ensure availability of quality services to the population. Private providers with a service agreement will be given access to public resources, to funding through health programmes and access to purchase medicines from MSD when value for money can be achieved. Private investments in health services will be stimulated.
Collaboration between public and private providers will be stimulated to make optimal use of human resources, e.g. in training and supervision, or for applying (para)medical skills.
Region:
The RHMT will provide technical support to all public and private health service providers
Central level:
The MOHSW will stimulate coordination mechanisms that attract new public and private partners willing to contribute to the improvement of the nation's health status. It will lead PPP forum for joint planning and action.

6 HSSP III Implementation

The strategies (including cross-cutting issues) are presented in tabular format below. The tables present global strategic priorities, which the MOHSW plans to implement during the HSSP III period. In order to keep the overview short, elements of programmes have been summarised. In the specific strategies and work plans (see table 6) more details can be found. Furthermore, programmes in general consist of coherent sets of interventions: formulation, roll-out, training, resource mobilisation, supervision, monitoring and evaluation. Those details are not reflected under every strategy, but summarised under general headings.

The expected results listed below include outputs, outcomes or impacts (following the logical framework model), which are formulated in general terms, because this is a strategic plan. They are to be quantified in MTEF work plans and annual action plans using specific targets. The indicators can be used in evaluations of programmes and in reviews. For verification of part of the indicators information from the routine system can be used, while for another part data collection has to be carried out during the evaluation. For this purpose samples need to be taken from reports, which normally are not aggregated neither forwarded to the Ministry. In a number of cases on the spot assessments have to be made to verify the indicator. The indicators below also provide guidance of strengthening of the M&E system, planned in the coming time

6.1 District Health Services

Strategic Objectives	Expected Results HSSP III	Indicator	Means of Verification
1. To increase accessibility to health services, based on equity and gender-balanced needs	The number of health facilities providing comprehensive health services based on Essential Health Package (EHP) is increased, including diagnostic capacity (with laboratory), treatment and follow-up.	Proportion of health facilities providing service as defined in EHP Proportion of HF attaining Payment for Performance targets	HMIS Annual Report
	The referral system for emergency obstetric care within the district is effective, applying guidelines, using communication and ambulance services	Proportion of patients treated in higher level facilities, referred from lower level facilities	HMIS Quarterly Report
	The coverage of health services in remote areas is increased through implementation of the MMAM	Proportion of villages with functional health facilities	Review LGA reports

Strategic Objectives	Expected Results HSSP III	Indicator	Means of Verification
	Community participation is increased in health promotion, prevention and home based care for communicable and non-communicable diseases, Maternal Newborn and Child health and nutrition.	Number of functioning Village Health Committees	CCHP annual report
2. To improve quality of health services[14]	Adherence to standards, technical tools, guidelines and protocols is improved through implementation of the Tanzania Quality Improvement Framework (TQIF)	Proportion of health staff (in sampled health facilities) working according to TQIF standards	Review of supervision reports
	The accreditation system for health facilities is in place	Proportion of district health facilities accredited	Inspectorate report
3. To strengthen management of District Health Services	Councils have strategic health plans, based on HSSP III	Proportion of LGAs with strategic health plan	
	Decentralisation of management (planning budgeting, implementation and monitoring) from district level to health facility and community level in place	Proportion of health facilities with annual plans of operation	CCHP
	Inter-sectoral collaboration in Ward Development Committees and Council Health Services Boards is in place to advocate health issues	Meetings of WDCs and CHSBs	Review LGA reports
	Technical support and supervision of public and private health facilities is provided by regional hospitals staff	Number of supervision visits	Review CHMT report
	Performance based management systems (P4P and Result-Based Bonuses) are in place to increase productivity	Number of out-patient consultations per health worker in health facility (work load) Bed occupancy rate	HMIS quarterly report
	All health programmes' activities incorporated in Comprehensive Council Health Plan, and services in health facilities provided in an integrated way	CCHPs covering all health activities in district All services provided according to defined schedule (during working hours) in sampled health facilities	Review CCHP Survey

[14] See also under strategies Reproductive and Child Health, Diseases Control, Medicines and Supplies

6.2 Referral Hospital Services

Strategic Objectives	Expected results HSSP III	Indicator	Means of Verification
1. To increase access for patients in need of advanced medical care	The referral system is functional both horizontally (based on capacities of public and private facilities) and vertically from district to regional and from regional to zonal level.[15]	Proportion of patients treated in health facilities referred from other facilities (horizontal or vertical referral)	Survey
2. To improve quality of clinical services in hospital	TQIF programme is in place, with Hospital QA units, clinical guidelines, staff development, supplies and maintenance programs	Proportion of hospitals with QA unit	Review MOHSW supervision report
	The accreditation programme for hospitals is in place	Proportion of health facilities accredited	Inspectorate report
	Specialist out-reach programmes from tertiary to secondary levels are carried out; clinical attachments by specialists are implemented	Number of Hospitals covered with out-reaches services and supervision visits Number of staff performing clinical attachments	Survey
	Presence of medical doctors during working hours is guaranteed in zonal, regional and other hospitals as result of Intramural Private Practice Management (IPPM)	Number of specialists doing IPPM Presence of medical doctors during point in time check	Survey
3. To improve management of the hospitals through implementation of the Hospital Reforms Programme	Planning, budgeting financial and general management systems and capacities in hospitals are in place	Proportion of hospitals with annual plan, and annual report and with capital investment plan	Review hospital annual plans, investment plans
	Hospitals have budgets in place including component of health insurance funding	Proportion of hospitals with annual budget and annual financial report	Review hospital financial reports
4. To strengthen hospital governance	Boards for National, Zonal and Regional Hospitals are functional	Proportion of Hospitals with functional Boards	Review hospital annual reports
	Collaboration mechanisms between PMO-RALG and MOHSW for management of Regional Hospitals are established	Number of meetings between RAS and Regional Hospital Management held annually	Review minutes meeting

[15] The referral system includes: guidelines, communication, transport, staffing, equipment, supplies for treatment at the appropriate level

Strategic Objectives	Expected results HSSP III	Indicator	Means of Verification
	Community participation and feed-back mechanisms (Board representation, surveys, complaints) are functional	Proportion of hospitals with community representative on the Board	Review minutes meeting

6.3 Central level support

Strategic Objectives	Expected results HSSP III	Indicator	Means of Verification
1. To enhance decentralisation of MOHSW head quarters	Decentralisation of operational management of district health care to PMO-RALG and LGAs strengthened, and of management of Regional and Tertiary Hospitals to Boards in place	Proportion of approved Comprehensive Council Health Plans Proportion of approved hospital annual plans	Review of CCHPs and Hospital plans
	Delegation of operational responsibilities to agencies under MOHSW in place	Proportion of agencies with approved annual plans and reports	Review agencies' annual plans and reports
2. To strengthen governance in the MOHSW	Gender sensitive governance system in place, ensuring accountability, transparency and adherence to leadership ethics	JAHSR milestone indicators approved	JAHSR reports
	Health sector policies, strategies and plans are updated regularly, in order to harmonise with government policies and maintain coherence in the sector	Availability of updated policies, strategies and plans	MOHSW document review
3. To strengthen operational planning process of MOHSW head quarters	Integrated annual planning by MOHSW HQ in place, operationalising health sector strategic plan and specific strategic plans	Availability of comprehensive MOHSW annual plan	Review MOHSW HQ MTEF annual plan
	Database of all relevant MOHSW documentation, publicly accessible	MOHSW intranet and website in place	Review intranet and website
4. To strengthen the Regional Health Management Team (RHMT) in supervision and support of the health service delivery	RHMT legal mandated as part of the government system, including funding	Budget in PMO-RALG	Review PMO-RALG MTEF
	Management system of annual planning, budgeting, financial management and annual reporting by RHMTs is in place	Proportion of RMHTs with annual technical and financial progress report	Review of RHMTs annual reports
	RHMTs perform regular supportive supervision of District Health Services	Number of standardised district supervision visits performed	Review RHMTs supervision reports

6.4 Human Resources

Strategic Objectives	Expected results HSSP III	Indicator	Means of Verification
1. Develop policies and regulations on human resources for health & social welfare coherent with government policies	Human Resources for Health (HRH) policies are updated in line Civil Service Reforms and Local Government Reforms through multi-sectoral National Coordinating Committee	Availability of updated regulations, approved by taskforce	Review National Coordinating Committee minutes
2. Strengthen HRH planning	HRH planning and Human Resources Information System (HRIS) is in place incorporating at all levels	Availability of HRH plans in districts and hospitals Availability of accurate HRIS information	Review of CCHPs and hospital plans HRIS
3. To maximise effective utilisation of HRH	Strong leadership, coordination and partnership is implemented at all levels (government inter-sectoral and private sector) in order to remove bottlenecks and reduce bureaucracy in HRH management	Memorandum of Understanding and National Coordinating Committee in place	Review minutes National Coordinating Committee
	HR tasks of recruitment, management and retention are implemented at the appropriate level by appropriate Ministries, Departments or Agencies (MDA)	Availability of comprehensive HRH plans and reports in districts and hospitals, actively supported by LGAs and PMO-RALG	HRIS Review CCHPs and hospital plans
	Recruitment and retention of health staff in LGAs, hospitals and training institutions is improved, reducing the HRH shortage	Number of health workers in the country	HRIS annual report
	Productivity and effectiveness of health staff is improved through improvement of attitude and performance based systems	Staff work load	HMIS annual report HRIS annual report
4. Increase production and improve quality of training (pre-service, in-service and continuous education)	Production of required health workforce increased, in order to match with demands in health sector (both in numbers as in competencies of graduates)	Number of graduates by cadre	HRIS annual report
	The private sector is increasingly engaged in HRH development and utilisation	Number of private training institutions in health accredited	Review NACTE accreditation reports

Strategic Objectives	Expected results HSSP III	Indicator	Means of Verification
	All regions and districts have adopted standardised Work Based Training of workforce (Continuing Professional Development, CPD)	Number of districts with Work Based Training in place	Review RHMT supervision report
	All training institutions have up-to-date curricula and are fully accredited	Proportion of training institutions with full accreditation	Review NACTE reports
	Zonal Health Resources Centres (ZHRCs) function autonomously, providing capacity building services to regions and districts	ZHRC annual plans and annual reports in place	Review ZHRC reports
5. Improve use of HRH applied research for planning and advocacy	Relevant HRH studies are implemented, contributing to improvement of planning and management of HRH	Number of HRH studies performed commissioned by MOHSW and relevant conclusions implemented	Review study reports

6.5 Health Care Financing

Strategic Objectives	Expected results HSSP III	Indicator	Means of Verification
1. Reduce the budget gap in the health sector by mobilising adequate and sustainable financial resources	Government budget levels to reach 15% of the total Government budget by 2015.	Percentage of government budget for health	Annual government budget
	Annual budget of Health Basket Fund (HBF) increased	Annual funding of HBF	Annual BFC report
2. Enhance complementary financing for provision of health services, increasing the share in the total health budget to 10% by 2015	Coverage of prepayment schemes, with Community Health Fund (CHF) and TIKA and the National Health Insurance Fund (NHIF) increased.	Enrolment in CHF/TIKA and NHIF	Review annual CHF/TIKA reports and annual NHIF reports
	Community participation in management of CHF generated funds at facility and district level	Percentage of health facilities with functioning Health Facility Committee	CCHP annual report
	Regulatory body for prepayment and health insurance schemes is in place (NHIS, NSSF, etc.)	Functional regulatory body	Review annual report regulatory body
	Maximise NHIF and CHF/TIKA financing options in public and private health facilities	Rate of reimbursement	Annual NHIF report

Strategic Objectives	Expected results HSSP III	Indicator	Means of Verification
	Social Health Insurance development undertaken for introduction in next strategic period	State of development of Social Health Insurance	Review end of period
	Private sector investments in infrastructure in health increased	Number of new health facilities opened by private providers and contracted for services	Review end of period
3. Improve equity of access to health services	Effective subsidies and waiver mechanisms in place for the poor and vulnerable, using prepayment schemes and other options	Proportion of identified poor and vulnerable enrolled in insurance scheme	Review CHF/TIKA reports
4. Improve management of complementary funds raised at local level	Efficient and transparent collection of patient fees and CHF/TIKA premiums at public and private health facilities in place, applying Standard Operational Procedures (SOP)	Percentage of health facilities using fund management SOP	Review RHMT supervision reports
	Corruption in the health sector is prevented through adequate control and fair performance management systems	Percentage of health facilities using fund management SOP	Review RHMT supervision report
5. Increase efficiency and effectiveness in use of financial resources	Government budgeting, accounting and auditing processes are implemented in a transparent way	Percentage of MDAs and LGAs with clean auditing report	Review NAO reports

6.6 Public Private Partnership[16]

Strategic Objectives	Expected results HSSP III	Indicator	Means of Verification
1. Ensure conducive policy and legal environment for operationalisation of the PPP	National PPP policy and legal frameworks are in place, which enable public private partnerships (PPP) at national, zonal, regional and district level.	Availability of policy and legal frameworks	Review PPP steering committee minutes
2. Ensure effective Operationalisation of PPP	PPP forums at National, Regional and District level are functional for joint planning, implementation and M&E of health services	Functional forums at all levels	National PPP committee minutes

[16] The private sector includes Faith Based Organisations, national and international non-governmental organisations, community based organisations and private-for-profit organisations operating in the health and social welfare sector

Strategic Objectives	Expected results HSSP III	Indicator	Means of Verification
3. Enhance PPP in the provision of health and nutrition services	Participation of the private sector in the formulation of the CCHP takes place in all districts	Percentage of CCHPs with private sector participation	Review CCHPs
	Rational allocation of health funds is made to public and private health providers, based on competencies and performance, using service contract mechanisms	Disbursements by districts for payments of service contracts	Review LGA financial reports
	Private facilities are involved to the maximum extent possible in health programmes, disease control programmes using service agreements	Percentage of private health facilities with service agreement with Council	Review CHMT annual reports
	Mechanisms are in place for optimal mutual utilisation of human resources for health in public and private health facilities	Percentage of health facilities with memorandum of understanding on HRH sharing	Review CHMT annual reports
	Private sector motivated and supported to increase the availability of fortified foods	Percentage of wheat, sugar and vegetable oil fortified with micronutrients	Sample survey

6.7 Maternal Newborn and Child Health

Strategic Objectives	Expected results HSSP III	Indicator	Means of Verification
1. Increase access to Maternal, Newborn and Child Health (MNCH) services	The number of health facilities is increased that can provide quality MNCH services as regulated in the Essential Health Package	Number of health facilities with MNCH services according to EHP	HMIS annual report
	The referral system at all levels is in place, to guarantee adequate services in emergencies	Number of emergency MNCH cases referred	HMIS annual report
	Community participation in MNCH (including nutrition) is increased through Information Education and Communication (IEC) and strengthened advocacy	Community involvement in MNCH programmes	Qualitative Surveys
2. Strengthening the health systems to provide quality MNCH and nutrition services	Policies and guidelines, capacity development, and supervision in MNCH and nutrition reach all health facilities	Availability of policies and guidelines in MNCH in health facilities and numbers of health workers trained in using those guidelines	Review RHMT supervision reports

Strategic Objectives	Expected results HSSP III	Indicator	Means of Verification
	Availability of essential equipment and supplies is guaranteed, integrated in one logistics management system	Availability of tracer medicines and supplies	HMIS annual report
	Linkage with other health programmes is improved to deliver services in an integrated way	MNCH activities incorporated in CCHP	Review CCHPs
	Service delivery to women, newborns and children is improved	Maternal Mortality Ration, Neonatal Mortality Rate and Child Mortality Rate	DHS
	Nutrition interventions have improved reducing nutritional disorders in vulnerable groups	Anaemia under pregnant women and under five children	Survey

6.8 Disease control

General[17]

Strategic Objectives	Expected results HSSP III	Indicator	Means of Verification
1. Improve disease surveillance of communicable and non-communicable diseases	Integrated disease surveillance systems is functional providing timely and accurate information for prevention and control measures (early warning systems, EWS)	Number of notifiable diseases reported Number of epidemic control interventions based on EWS	Disease surveillance reports, HEPRU reports
2. Enhance community participation in health promotion and disease prevention	IEC and advocacy programmes in the community are implemented	Community involvement in disease control programmes	Qualitative survey
3. Improve disease case management in health facilities through integrated disease control activities at health facility level	Guidelines are available in health facilities; diagnostic capacity is in place; medicines and equipment are provided; supervision and capacity building of health workers is implemented as well as monitoring and evaluation of diseases through an integrated	Per capita utilisation of health services Number of laboratory investigations performed Number of specific disease diagnosed an treated Availability of tracer medicines and supplies	HMIS annual report

[17] All specific disease control programmes (infectious diseases, HIV/AIDS, TB, malaria, non-communicable diseases) have similar elements which are summarised under general disease control to avoid repetition.

	approach, resulting in increasing utilisation rates and lower case fatality rates	Disease specific case fatality rates in health facilities	
4. Improve home-based treatment and care	Home-based treatment of simple ailments and care for chronically ill and disabled is provided	Number of clients served through home-based care activities	Review CHMT reports

Malaria

Strategic Objectives	**Expected results HSSP III**	**Indicator**	**Means of Verification**
1. Implement effective Integrated Malaria Vector Control	ITN use, Indoor Residual Spraying (IRS), larviciding and environmental management methods in malaria vector control are increased	Proportion of pregnant women and children under five sleeping under ITN Proportion of households protected by IRS	Annual Malaria Survey
	The disease burden caused by malaria will decrease	Malaria specific case fatality rate (CFR)	DHS

HIV/AIDS

Strategic Objectives	**Expected results HSSP III**	**Indicator**	**Means of Verification**
1. Maximize the health sector contribution to HIV prevention	Prevention Mother to Child Transmission (PMTCT), Voluntary Testing and Counselling (VCT), Control of Sexually Transmitted Infections (STI) are provided in all health facilities as per EHP	Number of PMTCT clients Number of VCT clients Number of STI diagnosed and treated	HMIS/ National AIDS Control Programme (NACP) annual report
	Blood Safety is in place and needle hygiene in health facilities observed and Post Exposure Prophylaxis (PEP) provided in all health facilities	Percentage of health facilities with 100% blood safety Number of needle stick incidents followed by PEP treatments	Review RHMT supervision report
	Percentage of people infected with HIV is reduced	HIV prevalence rate	NACP surveys
2. Accelerate the access and utilisation of HIV/AIDS care and treatment services	Number of eligible adults and children with HIV infection receiving antiretroviral therapy (ART) is increased	Number of patients enrolled in ART	HMIS/ NACP annual reports
	Percentage of eligible adults, children and infants receiving co-trimoxazole prophylaxis is increased	Percentage of eligible clients receiving co-trimoxazole prophylaxis	HMIS/ NACP annual reports
3. Scale up integrated TB and HIV services	Number of people with HIV and TB receiving treatment for TB and HIV	Percentage of eligible TB patients receiving HIV treatment	HMIS/ NACP annual reports

Tuberculosis and Leprosy

Strategic Objectives	Expected results HSSP III	Indicator	Means of Verification
1. Expand and mainstream DOTs strategy to the general health system and involve CBOs and NGOs in DOTs	Number of public and private health facilities which provide Direct Observed Treatment (DOT) increased, as well as Community Based Organisations (CBOs) and Non-Governmental Organisations (NGOs)	Percentage of health facilities providing DOT Number of CBOs and NGOs in DOTs	NTLP reports
	Number of patients cured from TB is increased	TB cure rate	NTLP reports
2. Introduce and implement MDR/XDR – TB management	All general referral hospitals (including Kibongoto hospital) provide treatment for Multi-Drug Resistant (MDR) tuberculosis	Proportion of general referral hospitals providing MDR/XDR TB treatment	NLTP reports
3. Leprosy elimination, prevention of disabilities and social economic rehabilitation of people affected by leprosy	All districts achieve global leprosy elimination targets and all people affected by leprosy (PAL) receive prevention of disability services (POD)	Percentage of districts achieving leprosy elimination targets Percentage of PAL receiving POD	NLTP reports

Neglected Tropical Diseases[18] and Epidemic-prone Diseases

Strategic Objectives	Expected results HSSP III	Indicator	Means of Verification
1. Strengthen surveillance, prevention, diagnosis and treatment of neglected tropical diseases and other epidemic-prone diseases	Surveillance system is functional and inter-sectoral disease prevention activities of neglected tropical and epidemic-prone infectious diseases improved	Number of notifications of relevant tropical and epidemic diseases	HMIS annual reports
	Capacity of health facilities to diagnose and treat adequately specific tropical and epidemic-prone infectious diseases and provide necessary means to that effect, resulting in better treatment of patients	Case fatality rates of relevant tropical and epidemic diseases	HMIS annual reports

Non Communicable Diseases

Strategic Objectives	Expected results HSSP III	Indicator	Means of Verification
1. To reduce the burden of	Preventive and curative services for Non-	Number of cases of relevant non-	HMIS annual reports

[18] Neglected diseases are: cholera, rift valley fever, avian influenza, ebola, plague and rabies. Other diseases like trachoma, onchocerciasis, lymphatic filariasis, schistosomiasis, helmintiasis, diarrhoeal diseases, typhoid, trypanosomiasis and relapsing fever are important in certain regions.

Non Communicable Diseases, mental disorders and substance abuse	communicable Diseases (NCD), Mental Health and Substance Abuse (MH&SA) are integrated into the existing health services at all level, through capacity building and provision of necessary resources	communicable diseases treated	
2. Develop NCD MH&SA advocacy and sensitisation programmes	Partnerships at all levels put in place to stimulate healthier lifestyles and early treatment of ill-health conditions	Number of function partnerships in place	Review RHMT supervision reports

Environmental Health

Strategic Objectives	Expected results HSSP III	Indicator	Means of Verification
1. To operationalise the Public Health Act (PHA) (2008) and health elements of the Environment Management Act (2008)	Regulations and law updated based on PHA and enforcement mechanisms put in place based on new acts	Number of regulations formulated	Review MOHSW reports
	Partnerships to promote environmental health and implement relevant regulations	Number of functional partnerships	Review MOHSW reports
	Environmental health promotion provided in the community in collaboration with other sectors	Environmental health activities implemented	Review CHMT reports
	Morbidity and mortality of diseases preventable through environmental protection reduced	Number of cholera cases	HMIS annual reports

6.9 Emergency preparedness

Strategic Objectives	Expected results HSSP III	Indicator	Means of Verification
1. Establish systems at all levels for immediate emergency response to health disasters	Taskforces in place in health facilities, districts and regions for preparing emergency responses and overseeing implementation of activities	Percentage of districts and regions with functioning taskforces for Emergency Preparedness and Response	HEPRU reports
	Surveillance system functional and international exchange of information	Timely availability of information on emergencies and disasters	HEPRU reports
	Inter-sectoral collaboration for surveillance and response to emergencies in place	Memoranda of Understanding with relevant authorities available	HEPRU reports
	Necessary resources (human, financial, material)available for immediate response to (threatening) emergencies	Percentage of identified emergencies with adequate response from the health sector	HEPRU reports

6.10 Social Welfare

Strategic Objectives	Expected results HSSP III	Indicator	Means of Verification
1. To operationalise Social Welfare strategy (2008)	Regulatory framework and guidelines based on the new SW strategy in place, involving partners from other sectors and private providers	Regulations and guidelines produced	Review MOHSW report
2. To integrate social welfare and health offices at Regional and Council level	Social welfare officers incorporated into CHMT and RHMTs	Percentage of RHMTs and CHMTs with social welfare officers	Review HRIS reports
	Joint planning implementation and monitoring of health and social welfare activities is in place in order to create synergies in programmes for vulnerable groups and poorest in the society	CCHP expanded with social welfare chapter	Review CCHPs
3. To ensure gender sensitive socio-economic wellbeing and to establish an efficient system for delivery of social welfare services	Partnership agreements are in place at all levels	Number of partnership contracts in districts	Review MOHSW report
	Accreditation system for all service providers is in place	Number accredited institutions and organisations	
	Client liaison and referral system is functional for effective social welfare services delivery and protection at Council level.	Number of referred cases in SW	Review CHMT reports
4. To improve social protection in the community	Collaboration between social welfare officers, CHF and health facilities is in place to improve equitable health service delivery, using prepayment, exemption and waiver systems	Number of identified poor and vulnerable enrolled in prepayment schemes	Review CHF reports
	The traditional and modern system structure of social protection is strengthened. Social insurance schemes in formal and informal organisations are established. Social assistance programmes are implemented	Prevalence of traditional system in social protection. Number of social insurance schemes in the country. Number of social assistance programmes. Number of effective micro and area-based schemes	Qualitative Survey

6.11 M&E

Strategic Objectives	Expected results HSSP III	Indicator	Means of Verification
1. To develop a comprehensive M&E and Research Strategy for the health and social welfare sector	Comprehensive plan in place, taking stock of information needs in the whole sector, and of all programmes, outlining strategy for comprehensive and integrated monitoring and evaluation and research, formulation of a Health Sector Monitoring Framework	Availability of M&E and Research Strategic Plan	HIS reports
2. Strengthen integrated systems for disease surveillance	Disease surveillance systems are re-aligned and implemented for integrated approach	Availability of surveillance data provided by HIS	HIS reports
3. Strengthen integrated routine HMIS	Information systems are integrated into one HMIS, covering sector-wide information needs, as implemented by all stakeholders	Availability of re-designed HMIS information	HIS reports
	MKUKUTA, PMO-RALG and MOHSW reporting requirements are harmonised, sharing information at all levels	Availability of integrated technical and financial progress reports from LGAs, providing relevant information on District Health Services	PMO-RALG reporting
4. Introduce data aggregation and sharing systems based on ICT	Data warehouses established at district, regional and national level, sharing information from LGA (PlanRep), HMIS, disease programmes and other sources	Functional data warehouse at national level	HIS reports
5. Enhance surveys and operational research	Annual action plan for operational research implemented to provide necessary additional information for health planning	Annual research implementation plan	Review HIS reports
	Surveys and research information shared in data warehouse	Research data availability in data warehouse	Review HIS reports
	Demographic and Health Surveys conducted, providing information in the context of MKUKUTA and MDG monitoring	Relevant community based information available for monitoring	District Health Services reports

6.12 Other important issues

Capital Investments

Strategic Objectives	Expected results HSSP III	Indicator	Means of Verification
1. To maintain and improve the existing health infrastructure, equipment and means of transport to meet the demands for service delivery	Guidelines and standard operating procedures for infrastructure maintenance (including waste disposal and water supply) and rehabilitation, for maintenance of equipment as well as for means of transport available in CHMTs and hospitals.	Guidelines and SOPs available	Review RHMT supervision reports
	Councils, hospitals, regions, training institutions MDAs implement[19] maintenance and replacement programme, using available financing options	Number of health facilities rehabilitated Number of running vehicles per Council	Review annual district reports
	Zonal workshops provide on-demand services to CHMTs and health facilities in maintenance of equipment	Number of repairs in zonal workshops	Review Zonal workshop reports
2. Expand the health infrastructure network based on the MMAM	Extension of health infrastructure done in close coordination with PMO-RALG, LGAs and other stakeholders based on standard designs of health facilities and master plan for implementation	Number of new health facilities constructed	Review annual district reports

Pharmaceuticals

Strategic Objectives	Expected results HSSP III	Indicator	Means of Verification
1. To ensure accessibility at all levels of safe, efficacious pharmaceuticals, medical supplies and equipment	National medicine policy developed, implemented and monitored	Availability of policy	MOHSW report
	Necessary (human, financial and material) resources for procurement and distribution of medicines and supplies available	Disbursement of funds for medicines and medical supplies	MSD annual reports
	Domestic production of quality and affordable pharmaceuticals in place	Certificates of Registration of pharmaceutical producers	TFDA report

[19] This includes a comprehensive programme of recruitment of staff, capacity building, provision of resources, supervision, monitoring and evaluation

Strategic Objectives	Expected results HSSP III	Indicator	Means of Verification
	Number of Accredited Drugs Dispensing Outlets (ADDOs) in Tanzania increases	Number of ADDOs	TFDA report
2. Strengthen control of quality, safety and efficacy of pharmaceuticals, medical supplies, medical equipment	Perform systematic pre-procurement and post-marketing sampling and testing as well as pharmaco-vigilance in both public and private sectors	Number of quality tests performed	TFDA report
3. Ensure gender sensitive, equitable availability and rational use of quality pharmaceuticals, medical supplies and equipment in health facilities	Health facility and district level competent in forecasting, procurement, stocking and rational prescription of medicines	Availability of tracer medicines in health facilities	HMIS
	Adequate MSD warehousing, communication and distribution capacities at zonal level in place	Lead time between district order and delivery of medicines and supplies to district	MSD report
4. Enhance harmonisation and coordination and information management of procurement, stocking and distribution of medicines and supplies for specific health programmes	Standard Operating Procedures in place for Development Partners and other stakeholders for procurement of medicines and supplies to be utilised in the Tanzanian health system	Percentage of partners following SOP for procurement	MSD report
	Standard Operating Procedures in place for stocking and distribution of donated medicines and medical supplies	Percentage of partners following SOP for stocking and distribution	MSD report
	Logistics management information system introduces and used in all facilities	MSD awareness of actual stock-outs in sentinel health facilities	Survey

ICT

Strategic Objectives	Expected results HSSP III	Indicator	Means of Verification
1. Produce ICT strategy to make use of technology for information sharing	ICT strategy and work plan made as part of review of HMIS	ICT strategy and work plan available	HIS report
2. Expand country wide information network at national, regional and district level	Computer network, with countrywide access to critical information for health staff in all areas	Functional ICT network in place	MOHSW report

7 HSSP Implementation Arrangements for the health sector

7.1 Introduction

The organisation responsible for implementing the health sector strategic plan is complex and includes several public institutions, as well as non-government stakeholders as central regional and district levels.
The challenge for this composite sector governance system is to achieve high productivity through effective management. This requires the transfer of information for evidence-based management decisions, and subsequently efficient performance of implementation. The system must be structured adequately to ensure that the right information is channelled to the appropriate management level, and appropriate management entity, where efficient management decisions can be taken.
Management of the health sector requires competent staff, motivated to deliver high quality of work.
The management arrangements must be geared towards efficiency, effectiveness and motivation of staff.

7.2 Sector management and administration

7.2.1 MOHSW Head Quarters

The Ministry of Health headquarters on behalf of Government is responsible for the overall stewardship of the health sector. The Ministry is responsible for policy development, strategic planning, resource mobilisation and monitoring and evaluation in the health sector.
Government provides the overall political and policy guidance to the Ministry, whereby the MKUKUTA programme provides the overall guidance to development programmes in Tanzania. Further integration and harmonisation of MOHSW activities with the MKUKUTA management and monitoring is expected in the coming period.
As result of the Decentralisation by Devolution the Ministry does not have direct responsibilities for operational service delivery at the LGA level. However, the Ministry provides guidance to service providers and monitors the quality of the service delivery. The Tanzania Quality Assurance Framework, with an accreditation system, will be an important new tool for the Ministry in guiding the health sector. The technical guidance by the ministry to the service providers is mainly given through the health programmes, which are based in head quarters. These programmes provide treatment guidelines, standard operational procedures and contribute to capacity building of service providers. In the future this support will be more integrated and coordinated, in order to improve efficiency.
For resource mobilisation the Ministry relates to Government, and produces budgets in collaboration with the MOFEA. Government budgets are approved by Parliament. The Ministry also closely collaborates with Development Partners who are part of the Sector Wide Approach, and other DPs in health. The basket funding is an important source of funding. The Ministry mobilises resources from the Global Health Initiatives and multi-lateral agencies. Monitoring and evaluation is important in the Ministry, for reasons of accountability and for planning. In this the Ministry works closely with other state agencies for statistics and research. The routine information system is managed in the ministry, while non-routine information (surveys, research) is provided by others. The information generated by the Ministry is important for Government for determining budget allocations, for reporting performance to Parliament, as well as international organisations. It is necessary to attract development assistance. Strengthening the monitoring and evaluation is an important part of the strategies under HSSP III.

The Ministry has its annual planning cycle in the context of the Medium Term Expenditure Framework (MTEF), which is applied in all institutions of government. The planning concerns only those activities which are directly under head quarters responsibility. The planning will be strengthened, concentrating more on contents and priorities, in addition to financial planning.

7.2.2 Institutions and agencies under MOHSW

Under the Ministry there are semi-autonomous agencies, regulatory bodies, associations which are assigned specific tasks. Also national hospitals are directly under the MOHSW.
The Medical Stores Department (MSD) is responsible for the procurement, storage and distribution of medicines and medical supplies on behalf of the government. Improvement of the procurement and further decentralisation of service, to serve customers better is planned for the coming period (see 4.12.2).
The Tanzania Food and Drugs Authority is responsible for the control of quality of food medicines and other consumables. Further improvement of quality control is necessary to guarantee quality for the population, especially when more medicines and medical supplies are produced locally. The Tanzania Food and Nutrition Centre (TFNC) develops activities in the area of food and nutrition, working closely together with other sectors. The National Institute for Medical Research (NIMR) is responsible for carrying out, controlling, coordinating, registration, monitoring, evaluation and promoting of health research in Tanzania. It will be involved in developing the information and R&D strategy in the country.
Specialised and special hospitals function under responsibility of the Ministry. Improvement of their performance, becoming stronger as referral hospital will be aimed for in the coming time. (See 4.2.)
Training institutions for pre-service training of paramedical staff are also directly under the Ministry. There are 116 training institutions in the country (including private sector institutions.) Eight Zonal Resources Centres under the Ministry provide Continuing Professional Development. Further decentralisation of operational responsibilities is planned. The training institutions will be strengthened to that effect. (See 4.4.)

7.3 The Role of the Other Actors in Implementing this Strategy

7.3.1 PMO-RALG and LGAs

Local Government Authorities are responsible for delivering three types of public services in Tanzania Mainland: (1) concurrent functions; (2) exclusive local functions; and (3) delegated functions. Concurrent functions are public services which are funded and regulated by the central government, but for which the provision is devolved by the sector ministries to the local government level. Health services belong to these concurrent services.

All Councils produce annually a Comprehensive Council Health Plan (CCHP), which incorporates all activities of the District Health Services, and all sources of funding at the council level (government funds, locally generated funds, local donor funds, etc.). The CCHP is produced by the CHMT, with inputs from the health facilities, the non-state actors and other co-opted members. It is approved by the Council Health Services Board (CHSB), which consists of community representatives, officers from other departments, and representatives from the private sector. The final plan is approved by the Full Council Meeting. The Regional Secretariat (Regional Health Management Team) approves the CCHP and forwards it to national level. The PMO-RALG together with the MOHSW assesses the CCHPs and gives final approval, before funds can be disbursed to the LGAs.
In the future, further decentralisation will give more responsibilities to the health facilities to plan and manage health activities in collaboration with communities and village governments.
The LGAs provide quarterly technical and financial progress reports (including the health component) to the respective Regional Administrations, as part of the local government monitoring system. The Regional Administrations approve the health part of the reports, which are forwarded to national level and aggregated by PMO-RALG. In the future improvement of the quality of the technical progress reporting of these reports and better utilisation by the MOHSW for monitoring is planned.

The funds for health services are managed by the Council and kept on a separate account (called account no. 6). Funds for health are released by the MOFEA, including funds from the Health Basket Fund, kept in a holding account at that ministry. Funds generated through insurance schemes and cost-sharing are kept in separate accounts under supervision of the CHSB. The Health Facility Committees with community representatives decide on utilisation of those funds in their respective health facilities, within guidance provided by the CHSB.

The Regional Administration is part of PMO-RALG and directly supervises the work of the LGAs. The Regional Medical Officer is an officer of the Regional Administration. The RHMT is located in the Regional Hospital and performs its duties of supervision and support to the District Health Services. The functions had been reduced as part of the local government reforms, but now agreement has been reached that stronger technical support by the RHMTs on behalf of the MOHSW is mandatory to improve the quality of the health services. During the implementation of the HSSP III these intentions will be concretised.

7.3.2 Other ministries

The Prime Minister's Office (PMO) is the central office for government coordination, and also manages the Regional Administration and Local Government as explained above. It also has the central office for emergency preparedness, with which the HEPRU in MOHSW works closely. The Tanzania Commission for AIDS (TACAIDS) operates as an agency under the PMO, and provides leadership for a National Multi-sectoral Response to HIV and AIDS. It is also mandated to coordinate and strengthen efforts of all stakeholders involved in the fight against HIV and AIDS. The NACP works in close collaboration with TACAIDS.
The Ministry of Finance and Economic Affairs has an important role in disbursement of funds for health and in accounting for the expenditure. The Ministry provides the annual budget indications, which are crucial in the planning process. Therefore there is close collaboration with this ministry. MOFEA transfers funds for health to MoHSW and earmarked funds for health directly to the LGAs, on request of the MOHSW. Better communication should reduce delays in disbursement of funds.
The National Auditing Office is responsible for annual auditing of accounts of all government entities, including MDAs and LGAs. On-budget donor funding is also subject to auditing by this office. Its collaboration is crucial for timely auditing, avoiding delays in disbursement of this funding.
The Poverty Eradication Division, in the Ministry of Planning, Economy and Empowerment (MPEE) manages the MKUKUTA Secretariat and coordinates the MKUKUTA Monitoring System.
The Ministry of Education is responsible for all education up to university level. The health cadres with university education qualifications are produced under responsibility of this ministry. Increasing higher qualified health staff needs collaboration from this ministry. The National Council for Technical Education (NACTE) is responsible for registration and accreditation of training institutions under health. NACTE will play a role in the expansion and quality improvement of training in health.
Other ministries are important for elements of the health programmes, e.g. Agriculture and Food with respect to nutrition, Water and Energy with respect to sanitation and water borne diseases, Industries and Trade with respect to international trade agreements, Gender Women and Children with respect to gender issues and maternal and child health, Justice and Constitutional Affairs with respect to health legislation. The Ministry is dependent on all these ministries to achieve the strategic objectives of HSSP III. The senior management in the Ministry maintains working relations and promotes attention for health related issues. Divisions collaborate in programme implementation.

7.3.3 Private Sector Partners

Private sector partners are coordinated by two major umbrella organisations. The Christian Social Service Commission (CSSC) represents a large number of Faith Based Organisations, from Catholic and Protestant background. These organisations have health institutions and health programmes all over the country. The Association of Private Health Facilities in Tanzania (APHFTA) represents a smaller number of private hospitals and clinics, mainly based in urban areas. Some of the NGOs, working in the health sector, are member of the Policy Forum or the Tanzania Association of NGOs (TANGO). These umbrella organisations – so far – have not taken up functions of representing their members in relations with the MOHSW
The Ministry chairs a PPP steering committee, in which representatives from the private sector participate. Private sector partners also participate in other forums in the context of the Sector Wide Approach.
Increasingly the PPP at Council level will determine the collaboration between government and private sector. The service agreements will regulate collaboration between service providers and Councils. Further strengthening of the PPP forums at district level will be realised in the coming period.

7.4 Co-ordination and management of the SWAp processes including sector DPs

7.4.1 SWAP committee and sub-committees

The Sector Wide Approach (SWAp), initiated in 1999 in the health sector in Tanzania, provides the framework of collaboration among the stakeholders, MOHSW, PMO-RALG, MOFEA, civil society, private sector and DPs including UN agencies active in Health. It coordinates financing, planning, and monitoring mechanisms and therefore aims at creating synergies, while reducing transaction costs. Central in the SWAp is the implementation of MOHSW policies and the HSSP.
The stakeholders in the SWAp agreed on a Code of Conduct in the health sector Tanzania. It aims at increasing transparency, improved predictability and allocation of financing, reduced transaction costs and reduced administrative demands placed upon government.
The SWAp Committee is the agreed overall body for dialogue among all stakeholders in health. There is one annual planning meeting and one Joint Annual Health Sector Review (JAHSR). Topics discussed are the MTEF, the progress of implementation of the HSSP, the Public Expenditure Review and jointly agreed topics.
The SWAp technical committee serves as a joint monitoring body of the goals and activities of the health sector. There are several sub-committees of the Technical Committee which ideally comprise a range of stakeholders, including the PPP technical sub-committee, the Monitoring and Evaluation Technical Working Group, the Health Financing Committee, the Maternal, Newborn & Child Health Partnership, the NATNETS Steering Committee within the malaria programme, the HIV/AIDS Committee, the Human resources for Health Task Force.
The Development Partners Group for Health (DPG Health) is a collection of 20+ bi-lateral and multi-lateral agencies supporting the health sector in Tanzania. The DPG Health group has organised itself in accordance with the JAST, with a three person lead arrangement (troika) and the WHO providing secretariat functions.

7.4.2 Health Basket Fund Committee

The Health Basket Fund (HBF), a joint funding mechanism, was created in June 1999 and is part of the SWAP approach.
The basket consists of two elements:

- The **central basket**, funding the Ministry of Health head quarters and other central organisations with central support functions.
- The **district basket**, funding running costs for District and Municipal Council health services based on the CCHPs. The district basket aims at providing a stable and predictable resource base for local councils, complementing the District Health Block Grant from the Government of Tanzania. It also provides funds for PMO-RALG and RHMTs to oversee implementation of the district basket funds.

The Basket Financing Committee (BFC), comprising representatives of the MOHSW, PMO-RALG, MOF and basket-donors, is responsible for overseeing operation of the joint funding mechanism.
Tasks of the BFC are:

- Approve the release of resources against the HSSP, MTEF and CCHPs; and
- Ensure that the use of basket resources follow set financial, administrative and management procedures.

8 Financing the HSSP

8.1 Introduction

Financing of the HSSP III takes note of the critical shortage of resources facing developing countries like Tanzania. It also recognises the existence of non-discretionary resources, which are mostly found outside the Government budget frame. The strategy is therefore planning service provision based on the package of essential health interventions that are cost-effective, with the view that the off-budget resources are gradually captured in the Government budget and will provide flexibility for funding Government priorities.

1.2 Resources for the HSSP

The HSSP III will be financed from various sources, both domestic and foreign as summarised in Table 7.

Table 7. Sources of funds to finance HSSPIII

Source	*On-budget*	*Off-budget*
Domestic	Central Government Funds National Health Insurance Fund	Health Services Fund (User fees) Community Health Fund/ TIKA Drug Revolving Fund Council Own-Sources
Foreign	General Budget Support Health Sector Basket Fund Foreign Funded Projects and Programmes	Foreign Funded Projects and Programs

It may be expected that funding from domestic resources will gradually increase in the coming period, since health sector is and continues to be one of the priority areas. It may also be expected that funding from foreign resources will increase, as Development Partners have already signed a new Memorandum of Understanding for continuation of the basket funding in July 2008, and other partners – not participating in the basket – have signed agreements with the government of Tanzania for financial assistance. Other sources of funds come from insurance and cost sharing schemes (CHF, NHIF, GRF, etc), from the private sector and from out-of pocket expenditure.

Since 2000, nominal public per capita health expenditure has been growing at approximately 21%[20]. Using this growth rate (linear extrapolation), the projected per capita health expenditure for the next five years is as shown in the next table.

Table 8. Projected per capita expenditure (PCE) on health in Tanzania in USD

Fiscal Year	***PCE (in US$***
2009/10	15.75
2010/11	17.92
2011/12	20.09
2012/13	22.26
2013/14	24.43
2014/15	26.60

Although the growth of the budget is impressive, the budget available for health will still fall short of 2001 WHO Commission on Macroeconomics and Health estimates of US$ 34 per capita per year.

[20] Update of health Public Expenditure Review reports of 2000-2006

Given the projected/targeted inflation rate of single digit and assuming a stable value of Tanzanian Shilling against the US$, 21% nominal increase translates to double digit real growth in health expenditure, surpassing the growth rate of GDP.

Linear projection of the on-budget expenditure estimates base on the last five years are:

Fiscal Year	*Recurrent* [21]	*Development*	*On-budget*
FY 09/10	579.90	281.55	861.46
FY 10/11	647.96	323.96	971.94
FY 11/12	716.023	366.38	1,082.42
FY 12/13	784.089	408.80	1,192.90
FY 13/14	852.15	451.21	1,303.38
FY 14/15	924.48	489.37	1,413.86

Amounts in USD (x 1 million)

For these projections the following assumptions were made:
- The historical nominal annual growth rate of the recurrent budget is around 21%
- The historical nominal annual growth rate of the development budget is around 31%
- The historical nominal annual growth rate of total on-budget estimates is around 24%

Note that nominal growth rate of GDP is around 14%, with an inflation rate of 5 -7%. Therefore the real GDP growth is 7%. All this suggests plateau in the future of the growth of health expenditure and its share in both GDP and total government expenditure.

8.2 Financing requirement for health interventions

In order to determine the financing requirement of the HSSP III, triangulation of various and methods was used, depending on the availability of information. The basic approach was to analyse the recurrent costs of the suggested interventions and project their future costs. In this way most of the recurrent costs such as salaries, drugs, and general management are already included in the costed interventions. The cost analysis also took care of scaling up of these interventions and new investments in the sector.
Suggested interventions outlined in this HSSP III document were matched with those outlined in MKUKUTA cost analysis of planned health interventions: these covered the intervention of Maternal, Newborn and Child Health as well as disease specific programmes.
Other cost analysis were taken from the recently developed documents such as the Primary Health Care Development Program (MMAM) and Human Resources for Health Strategy. These include planned expenditure on human resources for health development and management, strengthening District Health Services and future infrastructural development.
For those components for which estimates of future expenditure were not available the costing was based on estimates that were done in previous Ministry of Health Medium Term Expenditure Reviews and historical records of expenditures found in the updates of the health sector Public Expenditure Reviews.
On the basis of the triangulation of planned and extrapolated historical cost figures, the projected estimates for the health sector expenditure in the next five year was calculated. The figures are presented in table 9 below.

[21] Expenditures can be divided into recurrent expenditures (expenditures that recur continually or very frequently, such as salary expenditures or other recurring operational costs) and development expenditures (non-recurrent expenditures, such as spending on capital infrastructure). Recurrent public expenditures in Tanzania are commonly broken down further into wages and wage-related expenditures (Personal Emoluments, or PE) and non-wage expenditure (Other Charges, or OC).

Table 9. The estimated costs of HSSP III (All amount in US$)

COMPONENTS	FY09/10	FY10/11	FY11/12	FY12/13	FY13/14	FY14/15	TOTAL
Human Resource for health	68,991,999	79,399,937	80,129,572	75,231,618	76,652,360	76,652,360	457,057,846
Referral Health Care	48,774,804	152,459,034	198,682,803	258,287,644	335,773,937	436,506,118	1,430,484,339
Maternal, newborn and child health	194,083,333	194,083,333	175,477,083	175,477,083	269,291,667	269,291,667	1,277,704,166
Disease Specific Programs							
Malaria	70,708,333	70,708,333	81,500,000	81,500,000	101,083,333	101,083,333	506,583,332
HIV/AIDS	51,354,930	51,515,789	51,691,093	51,871,135	52,056,046	52,245,957	310,734,950
TB/leprosy	6,741,667	6,741,667	6,591,667	6,591,667	7,366,667	7,366,667	41,400,002
Noncommunicable diseases	173,333	208,369	220,871	234,123	248,170	263,060	1,347,926
Neglected diseases	256,667	270,978	303,997	340,477	360,905	382,560	1,915,584
District Health Services and Health Infrastructure	801,488,625	801,488,625	566,723,671	566,723,671	1,068,174,233	1,068,174,233	4,872,773,058
Health care financing	594,451	712,676	777,568	1,001,423	1,307,485	1,207,485	5,601,090
Emergency preparedness and response	1,091,411	1,091,411	1,091,411	1,091,411	1,091,411	1,091,411	6,548,464
Social Welfare and protection	2,504,042	2,451,250	1,925,000	2,973,958	33,333	-	9,887,583
Monitoring, Evaluation and Research	133,690	138,297	163,962.17	200,034	244,041	297,730	1,177,755
TOTAL RESOURCES REQUIRED	**1,246,897,284**	**1,361,269,699**	**1,165,278,698**	**1,221,524,243**	**1,913,683,589**	**2,014,562,581**	**8,923,216,095**
AVAILABLE RESOURCES	**861,460,000**	**971,940,000**	**1,082,420,000**	**1,192,900,000**	**1,303,380,000**	**1,413,860,000**	**6,825,960,000**
RESOURCE GAP	**385,437,284**	**389,329,699**	**82,858,698**	**28,624,243**	**610,303,589**	**600,702,581**	**2,097,256,095**
Note: Exchange rate is assumed to be 1US$ = Tshs 1200							

Comparing the expected resource envelop and the estimated costs of implementing the plan, it must be concluded that HSSP III is left with a financing gap of about 24% of the total requirements for the next five years. However, the gap varies annually: it is larger in first two years (2009/10 and 2010/11) and then begins to decline in the next two years in the final year (2014/15) it rises again beyond the previous levels. Two major investment plans (the MMAM and HRH plan) require large initial investments and were developed independently, not against the background of a total resource envelop. As a result the total health sector requirements are not evenly spread over the coming years. The needs are reflected in the plans, but the MTEF planning process will result in more evenly spread of investments and thus to less extreme differences over the years.

To address this imbalance, it is necessary either to improve the resource envelop or to scale down some of the interventions or a combination of both if priorities are shifted. The likeliness of scaling down the interventions is small since the package that is being proposed is already at a very minimum. The strategy will therefore focus on seeking additional resources. The MOHSW will undertake strong advocacy for contributions from LGAs, private sector providers, FBOs and NGOs, which operate at local level, as well as the communities. Achievement of the MDGs in Tanzania is only possible through major investments, beyond the capabilities of the MOHSW. Partnerships for achieving the MDGs should extent to partnerships in investments in health services. At the same time it will be beneficial to bring the off-budget resources into the budget frame, in order to reduce the gap. Moreover, resource allocation and utilisation will have to concentrate on increasing efficiency and effectiveness.

9 Monitoring and Evaluation

9.1 Introduction

Integration
Monitoring and evaluation is essential for evidence-based decision making and for accountability. According to the health sector evaluation in 2007 the M&E for accountability purposes is acceptable in Tanzania, as essential information can be provided to government and the international community. However, there is room for improvement. The M&E for decision-making is much weaker, not least because available information is not used appropriately.

For monitoring the developments in the health sector three elements come together:

- The MKUKUTA monitoring, which is the comprehensive monitoring of development and poverty alleviation in Tanzania, and which incorporates the monitoring progress towards achieving targets of the Millennium Development Goals (MDGs). The MKUKUTA and MDG indicators for health activities are incorporated in the monitoring of the strategic plan.
- The health services routine and non-routine monitoring systems (Disease Surveillance, Health Management Information System, Health Programmes Reporting Systems, Demographic Health Surveys, Health Systems Survey, and other health surveys and research) collect information on health services on regular basis (quarterly, annually or four-yearly) in addition to ad hoc.
- The Local Government monitoring system, which feeds information the PMO-RALG and sectoral ministries. The CCHP indicators are reported annually as part of the LGA technical and financial progress monitoring.

The monitoring of the HSSP III makes use of the three systems, and combines information coming from different sources. Indicators produced for existing systems are integrated into the HSSP III monitoring.

Strategic and annual planning
The strategic planning concentrates on expected results. In the logical framework methodology expected results encompass impacts, outcomes and outputs. The six years' period of HSSP III does not allow realistic formulation of quantified targets. However, the MTEF planning and annual update of that planning is the right moment for targeting and formulation of specific outputs. The translation process from strategic to annual planning, therefore, is crucial. At all levels serious annual planning has to be implemented, and the eleven strategies have to be the guiding topics in that planning.

9.2 Monitoring HSSP implementation progress

9.2.1 Indicators

For the purpose of monitoring the health sector and progress of the HSSP III, a series of indicators has been developed, divided into health status indicators, health services indicators and health systems indicators. (Please, see the table at the end of this chapter.) The indicators can also be categorised in input, process, output, outcome and impact. Some of the indicators can only be measured every four years, when a democratic health survey is undertaken, others can be measured annually or even quarterly, when using the routine information system. Few indicators can only be measured through a special surveys, as the information is not collected in the existing system.
The indicators were selected covering most critical issues of HSSP III implementation. However, a number of indicators also have operational importance for quarterly planning of activities at various levels.
In addition, in programme specific strategic plans, other indicators are mentioned. The information on those indicators will be collected as planned, and will be used for monitoring and evaluation of those specific programmes.
As mentioned above, the strategic indicators are to be translated into quantified annual targets and outputs in the MTEF planning process.

9.2.2 Data Collection Systems

The health sector performance assessment will be based on six data collection systems:

Demographic Health Surveys and other surveys
In Tanzania every four years a Demographic Health Survey (DHS) is undertaken, which collects essential information on health status and health services utilisation of the population. It is the most reliable source of comprehensive community-based health information in Tanzania. It provides the major source of information for measuring health status information, or health services' impact indicators. In addition, there are other surveys and research projects, which can provide important health status information.

Routine health information systems
In Tanzania the HMIS (or MTUHA) provides information on health services outputs, diseases diagnoses and other health systems information on quarterly and annual basis. In addition, many programmes have their parallel information system, providing information on their service delivery. Integration of those information systems is targeted during the coming HSSP III period. Adaptation to information requirements is planned. The routine systems provide information which can be aggregated and analysed annually in the Health Statistics Abstract and the Health Sector Performance Profile.

LGA quarterly technical progress reporting
The annual LGA reporting is supposed to make use of 20 CCHP indicators. In practice, the technical progress reporting is insufficiently used, not least because not all existing indicators are geared towards decision-making at the CHMT level. During the HSSP III period, harmonisation of HMIS and CCHP progress reporting will be achieved. The indicators formulated for the HSSP III will be incorporated into the LGA progress reporting system, replacing the present CCHP indicators. With the improved system, the CHMT will provide quarterly information on locally analysed key indicators.

Mid-Term Review and End-Review
During the implementation of HSSP III two reviews are foreseen: the mid-term and end-of-period review. These reviews will provide in-depth analysis of the eleven strategies. Internal and extern experts will present a joint analysis and give recommendations on further implementation of the HSSP III. For this reviews, the teams will make an analysis of the indicators which are provided in chapter 6.

Baseline and End Survey
The MOHSW in collaboration with PMO-RALG and LGAs will perform two surveys: at the beginning and at the end of the HSSP III period. These surveys will concentrate on important information, which is not collected routine wise, but is needed to make an assessment of status of the infrastructure, PPP, work procedures, etc. The information will enable a profound end-of-period analysis, necessary for defining priorities for the next HSSP period.

Milestones
The milestones are agreed annually between stakeholders in the Joint Annual Health Sector Review (JAHSR) and often concentrate on processes of HSSP implementation.

9.3 Time planning

The time planning of the information collection is based on quarterly, annual, periodic and five-years data collection and analysis. Some surveys are planned outside the health sector and the time planning may not coincide with the HSSP III planning period. The systems together provide a comprehensive information system, that can be used for planning activities, for reviewing progress and for end-evaluation of HSSP III.

The annual reporting to the JAHSR will include progress reporting on the key HSSP III indicators, integrated in the Health Sector Performance Profile.

Figure 4: relation between four reporting systems, feeding into comprehensive monitoring of the health sector

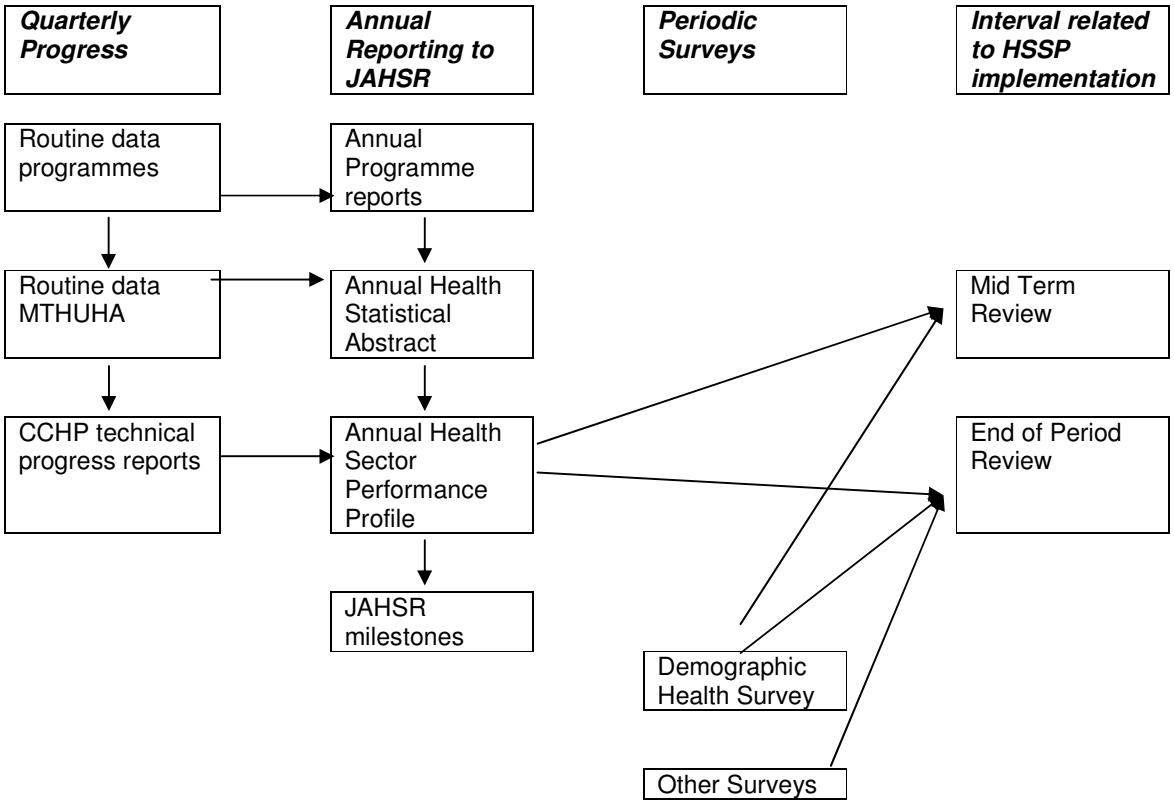


Table 10: HSSP III indicators

Indicator	*Numerator*	*Denominator*	*Source*	*Type*	*Frequency*
Health Status					
Neonatal mortality rate (per 1,000 live births)			DHS	Impact	DHS interval
Infant mortality rate (per 1,000 live births)			DHS	Impact	DHS interval
Ratio of the IMR of the poorest quintile compared to the IMR of the least poor quintile			DHS	Impact	DHS interval
Under-five mortality rate (per 1,000 live births)			DHS	Impact	DHS interval
Proportion of under-fives moderately or severely underweight (weight for age)			DHS	Impact	DHS interval
Proportion of under-fives moderately or severely stunted (height for age)			DHS	Impact	DHS interval
Maternal mortality ratio (per 100,000 live births)			DHS	Impact	DHS interval
Percentage women under 18 years becoming pregnant			DHS	Impact	DHS interval
Total fertility rate of women 15-49 years			DHS	Impact	DHS interval
HIV Prevalence Among 15-24 year old pregnant women			DHS	Impact	DHS interval
HIV Prevalence Among 15-24 year old population			DHS	Impact	DHS interval
Number of children orphaned by AIDS			DHS	Impact	DHS interval
Service delivery					
General					
Proportion of health facilities capable of providing National Package of Essential Interventions according to level			Baseline and End Survey	Input	Twice in HSSP III period
Proportion of villages with functional health facility			Baseline and End Survey	Input	Twice in HSSP III period
Proportion of health facilities accredited			Baseline and End Survey	Process	Twice in HSSP III period
Outpatient attendance per capita			HMIS	Output	Annual
Bed Occupancy Rate			HMIS	Output	Annual
Vaccinations					
Proportion of children under one vaccinated against measles			HMIS DHS	Outcome	Annual DHS interval

Indicator	*Numerator*	*Denominator*	*Source*	*Type*	*Frequency*
Proportion of children under one vaccinated 3 times against DPT –Hb			HMIS DHS	Outcome	Annual DHS interval
Proportion of children under 5 receiving vitamin A twice per year			HMIS DHS	Outcome	Annual DHS interval
Proportion of women receiving at least 2nd dose of TT vaccination			HMIS DHS	Outcome	Annual DHS interval
Reproductive Health					
Proportion of pregnant women attending ANC al least once during pregnancy			HMIS DHS	Outcome	Annual DHS interval
Proportion of births attended by skilled health personnel			HMIS DHS	Outcome	Annual DHS interval
Proportion of births attended in health facility			HMIS DHS	Outcome	Annual DHS interval
Maternal Case Fatality Rate in health facilities			HMIS	Output	Annual
Proportion of maternal deaths with performed maternal audit			Baseline and End Survey	Output	Twice in HSSP III period
Contraceptive prevalence rate			HMIS DHS	Outcome	Annual DHS interval
Percentage of health facilities that can provide EOC as defined in EHP			Baseline and End Survey		Twice in HSSP III period
HIV/AIDS					
Percentage of HIV positive women receiving ARVs to PMTCT			NACP	Output	Annual
Percentage of women receiving pre PMTCT VCT during pregnancy			NACP	Output	Annual
Number of persons with advanced HIV infection receiving ARV combination treatment (disaggregated under 5 and over 5)			NACP	Output	Annual
Malaria					
Percentage of women who received two doses of malaria prophylactic treatment during pregnancy			HMIS	Output	Annual
Number of clinical malaria cases treated (disaggregated under 5 and over 5) and incidence (cases per 100,000)			HMIS	Output	Annual
Number of confirmed malaria cases treated (disaggregated under 5 and over 5) and incidence (cases per 100,000)			HMIS	Output	Annual
Malaria CFR (under 5 and over 5)			HMIS	Output	Annual

Indicator	*Numerator*	*Denominator*	*Source*	*Type*	*Frequency*
Proportion of vulnerable groups (pregnant women, children under 5) using ITN			NMCP	Outcome	Annual
Tuberculosis and Leprosy					
Number of tuberculosis cases diagnosed and incidences (cases per 100,000)			NTLCP	Output	Annual
Proportion of Tuberculosis Cases Detected and Cured under DOTS			NTLCP	Output	Annual
TB treatment completion rate			NTLCP	Output	Annual
Proportion of Leprosy cases completed treatment			NTLCP	output	Annual
Infectious and non-communicable diseases					
Top 10 causes of morbidity among OPDs attendees and top 10 causes of mortality of admitted patients			HMIS	Output	Annual
Incidence of cholera cases			HMIS	Outcome	Annual
Proportion of treated cases of cholera who died			HMIS	Output	Annual
Number of patients treated infected with STDs			HMIS	Output	Annual
NCD indicator					
Health Systems					
Financial					
Total GoT and donor (budget and off-budget) allocation to health per capita			PER	Input	Annual
Recurrent expenditure broken down by level Central Support Services, Referral Hospital Services, and District Health Services			PER	Input	Annual
GoT funds actually disbursed to District Health Services against GoT funds budgeted for District Health Services			PER	Process	Annual
Percentage of DHS expenditure generated through cost sharing, prepayment and insurance schemes			PER	Process	Annual
Proportion of population enrolled in CHF/TIKA			PER	Process	Annual
PPP					
Proportion of districts with service agreements in place			Baseline and End Survey	Process	Twice in HSSP III period
Human Resources					

Indicator	*Numerator*	*Denominator*	*Source*	*Type*	*Frequency*
Number of Medical Officers compared to standards (manning level or establishment)			Annual	Input	Annual
Medical officers per population			Annual	Input	Annual
Number of Assistant Medical Officers compared to standards (manning level or establishment)			Annual	Input	Annual
Assistant Medical Officers per population			Annual	Input	Annual
Number of Nurse-Midwives compared to standards (manning level or establishment)			Annual	Input	Annual
Nurse-Midwives per population			Annual	Input	Annual
P4P indicator					
Number of training institutions with full NACTE accreditation			Baseline and End Survey	Process	Twice in HSSP III period
Planning Monitoring and Evaluation					
Proportion of LGAs using PLANREP for reporting			Baseline and End Survey	Process	Twice in HSSP III period
Proportion of RHMT which performed standardized supervision visit in each district in the region at least twice in previous year			Baseline and End Survey	Process	Twice in HSSP III period
Proportion of years with timely availability of Annual Statistical Health Abstract, Health Sector Performance Report			Baseline and End Survey	Process	Twice in HSSP III period
Logistics					
Percentage of public health facilities without any stock outs of 4 tracer drugs and 1 vaccine			HMIS	Input	Annual