Tanzania
Joint Annual Health Sector Review

Technical Review September 2009

HSSP III and
CCHP Planning 2010

Priorities

Desk Study for Technical Review
Final Report
1 September 2009

Dr. Jaap Koot, Public Health Consultants, Amsterdam
Dr. Peter Kilima, Public Health Consultant, Dar es Salaam

Table of Contents

This desk study for Technical Review has been financed by the Swiss Agency for Development and Cooperation (SDC).

Acronyms

ADDO	Accredited Drug Distribution Outlet
AIDS	Acquired Immuno – Deficiency Syndrome
AMMP	Adult Morbidity and Mortality Project
CBO	Community Based Organisation
CCHP	Comprehensive Council Health Plans
CHF	Community Health Fund
CHMT	Council Health Management Teams
CHSB	Council Health Services Board
CSO	Civil Society Organization
CSSC	Christian Social Services Commission
CPD	Continuing Professional Development
DED	District Executive Director
DMO	District Medical Officer
DP	Development Partner
DPP	Directorate of Policy and Planning
EPI	Expanded Programme on Immunization
FBO	Faith Based Organisation
HBF	Health Basket Fund
HEPRU	Health Emergency Preparedness Unit
HMIS	Health Management Information System
HMT	Hospital Management team
HRD	Human Resources Development
HRH	Human Resource for Health
HSSP	Health Sector Strategic Plan
HSR	Health Sector Reforms
IMCI	Integrated Management of Childhood Illnesses
IPT	Intermittent Preventive Treatment
ITN	Insecticide Treated Net
JRF	Joint Rehabilitation Fund
LGA	Local Government Authority
LGCDG	Local Government Capital Development Grant
MCH	Maternal and Child Health
MDA	Mass Drug Administration
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)
NMCH	Maternal Newborn and Child Health
MOHSW	Ministry of Health and Social Welfare
MTEF	Medium Term Expenditure Framework
MSD	Medical Stores Department
NCD	Non Communicable diseases
NGO	Non Government Organisation
NPEHI	National Package of Essential Health Interventions

NSGRP	National Programme for Economic Growth and Poverty Reduction (in Kiswahili: MKUKUTA)
NTDs	Neglected Tropical Diseases
OPRAS	Objective Performance Review and Appraisal System
PHC	Primary Health Care
PHDR	Poverty and Human Development Report
PHSDP	Primary Health Services Development Programme (in Kiswahili: MMAM)
PICY	Provider Initiated Testing and Counselling
PMO-RALG	Prime Minister's Office, Regional Administration and Local Government
P4P	Pay for Performance
PPP	Public Private Partnership
QA	Quality Assurance
RHMT	Regional Health Management Teams
TIKA	Tiba Kwa Kadi (CHF in urban areas)
TQIF	Tanzania Quality Improvement Framework
WDC	Ward Development Committee
WHO	World Health Organisation
ZHRC	Zonal Health Resources Centres

1 Introduction

1.1 HSSP and CCHP

On 30 June 2009 the third Health Sector Strategic Plan (HSSP III) was officially launched by The President of the United Republic of Tanzania, His Excellency Jakaya Mrisho Kikwete. The strategic plan covers a period of six years, from July 2009 to June 2015. (See summary in annex 3.) HSSP III incorporates new strategic areas, which were not featuring in the previous strategic plan, e.g. social services, epidemic preparedness and non-communicable diseases. It also has important updates on other strategies, based on development in recent years, e.g. on public private partnership and on quality assurance.
In line with the government system in Tanzania, the Ministry of Health and Social Welfare (MOHSW) issues the policies and strategies in health and gives guidance for the implementation, while the Local Government Authorities (LGAs) or District Councils are responsible for the actual implementation. These LGAs therefore hold the key for achieving the objectives of HSSP III.

Every (fiscal) year the District Councils produce Comprehensive Council Health Plan (CCHP), which outline planned activities and budgets for health services in the district. The hospitals will also come up with comprehensive hospital plans in phases through hospital reforms. In order to ensure that the CCHPs and hospital plans are in line with national strategies in health, the MOHSW issues planning guidelines. In chapter 1 of the District guidelines MOHSW explains the National Package of Essential Health Interventions (NPEHI) and the targets, which the LGAs should consider in their planning.
The partners in the Joint Annual Health Sector Review 2009 have decided to discuss during the technical review meeting of September the translation of HSSP III at district level and beyond. The final product of this discussion will be recommendations to the team that will formulate the revised CCHP guidelines and the hospital guidelines for the HSSP III.

1.2 Methodology

In order to prepare the discussion during the Technical Review, the Health Sector Reforms (HSR) Secretariat in the Department of Policy and Planning (DPP) in the MOHSW has requested two consultants (Dr. Jaap Koot and Dr. Peter Kilima) to perform a desk study on relevant topics. The instruction was to study those topics, which were new in the HSSP III, compared to the existing CCHP guidelines, or which were evaluated critically during the Health Sector External Evaluation of 2007. Based on these instructions, the consultants selected fifteen topics, in the area of health service delivery and management. The focus was on those areas in which the Council health services could make a difference (with exception of one topic on regional hospital performance).

The consultants studied literature, which could give insight into the actual situation around the selected topics and formulated a problem statement, summarising the status of health care and management at grass root level (while the HSSP III gives a general overview of the whole sector).

The consultants identified per topic best practices, policies and strategies, using MOHSW documentation, scientific studies and project and programme reports, which were summarised as proposed actions.
Those proposed actions only reflect what Regional Health Management Teams (RHMTs), Council Health Management Teams (CHMTs), hospitals and primary health care facilities can implement. The consultants did not propose activities at another level in the health system. These can be found in the HSSP III and in relevant strategic plans of ministerial departments and units.
However, in this discussion document the consultants put in yellow boxes some points for discussion during the technical review, which relate to proposed action by the district health services (and often represent preconditions for success).
In the selection of proposed interventions the consultants concentrated on actionable and affordable (simple and low-cost) interventions, which in the view of the consultants can be realised within the mandate and period of the HSSP III.

1.3 This document

In the following chapters the topics are elaborated, more or less following the structure of the NPEHI. In chapter 2 different health services related topics are presented and in chapter 3 management-related topics are presented. After each paragraph topics are summarised in boxes. There are yellow boxes, in which topics are mentioned, that depend on national level facilitation to enable implementation at districts level. Chapter 4 gives recommendations for the planning in 2010.
Annex 1 summarises the topics, comparing HSSP III and CCHP planning, and indicating what is new or different and proposed decisions for change. Annex 2 gives a literature overview, and annex 3 the summary of HSSP III.

2 Quality of Care

2.1 Reproductive and Child Health: maternal and neonatal mortality

Problem statement

Child mortality is going down in Tanzania, but neonatal mortality remains very high, now accounting for 30% of the under-five deaths, and equivalent of 135 babies dying every day. Half of the neonatal deaths occur during the first day of life, mainly due to asphyxia or low birth weight. Maternal mortality did not reduce at all in the last decade. The major causes of maternal death are haemorrhage, eclampsia and sepsis. Teenage pregnancy is high (24% of women get pregnant before 18 years) and associated with a higher risk of dying. Furthermore, about 15% of the women who had an abortion, die.

The reasons for high maternal and neonatal mortality are composite and complex. First of all, mortality is higher among the poorest in society, who have a poorer general health condition. Access to care and knowledge of danger signs is a major problem, especially in rural areas, where distances are long and means of transport are scarce. The quality of care is often poor, especially in rural areas. In health facilities there are shortages of staff and lack of competencies. Currently, only 15% of dispensaries is able to provide 24 hours maternity services by qualified personnel. But even if services are provided they often are of poor quality. For example, in antenatal care (attended by more than 90% of pregnant women), blood pressure is not measured, Hb not analysed, Intermittent Preventive Treatment (IPT) for malaria not provided, or even ferrous sulphate or folic acid not given. From studies into ITN voucher schemes for pregnant women it is clear that in urban areas, many women – especially of wealthier socio-economic strata use private for profit clinics for antenatal care, where services are better!

One study found that less than a quarter of women were informed on danger signs during pregnancy. During delivery in most health facilities partographs are not used in the right way. Postnatal care is minimal; family planning advice is not adequate after delivery.

There is often a lack of basic equipment, e.g. delivery sets or resuscitation material, and essential medicines are frequently not available, e.g. magnesium sulphate and oxytocin.

In many hospitals the treatment of women with (pre)eclampsia is particularly poor and standard treatment protocols are neglected, resulting in maternal deaths or stillbirths.

The problems of maternal and neonatal mortality are well known and described in various documents, for example the Joint External Evaluation of the Health Sector in Tanzania in 2007. Unfortunately the response by the health services to this national emergency situation has been insufficient. Many CHMTs and health

facilities have left the maternal health problems to the RCH department to solve, while this problem requires commitment from all.
Recently, President Kikwete has made an explicit commitment to reduction of maternal mortality. Even if Tanzania does not achieve Millennium Development Goal 5, there should be measurable improvement by 2015. HSSP III has selected maternal and neonatal mortality as one of the top priorities to be tackled during the coming six years' period.

Proposed Actions

Reduction of maternal and neonatal mortality is only possible with a series of measures, principally at community and primary health care level backed up by a functioning referral system.
Council health services should plan for the complete package of interventions. The National Road Map Strategic Plan clearly outlines the actions to be taken.
First of all, Councils should build capacities of human resources in the district, not only nurse-midwives, but also other cadres involved in maternal health services, like clinical officers, or even medical attendants in dispensaries, where no qualified staff is available. In the country, excellent training programmes exist in life saving skills, in basic emergency obstetric care, in neonatal resuscitation, Kangaroo method, family planning and post-abortion care, as well as prevention of teenage pregnancies. The Districts should plan for a systematic training programme (taking several years) with the help of Zonal Health Resources Centres (ZHRCs) and the Zonal referral hospitals of Bugando, KCMC, Mbeya and Muhimbili in clinical areas to take all relevant staff through training in these areas, starting with at least one person per health facility by 2010/11.
Secondly, equipment and supplies should be according to standard, which means the procurement of essential equipment, like BP machines, weighing scales, delivery sets, suction devices, AMBU-sets, and Manual Vacuum Aspiration (MVA) sets. When health facilities have a laboratory (which they should), urine and Hb analysis should be made possible (using simple but accurate testing methods). CHMTs and Hospital Management Teams should ensure the procurement of medicines, e.g. oxytocin, magnesium sulphate, ferrous sulphate and folic acid. All health facilities should have basic equipment, materials and supplies. All these investments are affordable by Councils.
The improvement of infrastructure for obstetric care may require bigger investments, like improvement of labour wards or construction of maternity waiting homes. It may require longer term planning to bring all health facilities up to standard (see infrastructure, below).
The referral system requires improvement, starting with community mobilisation to take women in labour (or with complications during pregnancy) to the hospital in time. Health facilities have to educate pregnant women and their families in recognition of danger signs. CHMTs should develop community transport systems e.g. motor ambulances, voucher system for use of commercial transport, ambulances, etc. (see referral system below). Important part of the referral system is proper handling in health facilities upon reception of patients, by capable staff working in 24 hours shifts. Referral from primary health facility to hospital is another important area to be tackled by CHMTs with use of

ambulances and communication (mobile phones). Private facilities, including private maternity homes, could be contracted for services.
Improvement of maternal and neonatal health is not achieved by major interventions, but by a coherent series of small activities, which are consistently implemented. Antenatal care has to focus on risk detection, adequate advice and simple preventive measures; it requires application of the complete ANC package. Some pregnancy complications require immediate action, especially pre-eclampsia and abortion. Deliveries require meticulous monitoring using the partograph, and immediate action in case of complications. The first minutes after birth bring acute danger to a baby, which in general can be easily controlled by staff competent in neonatal resuscitation. Post-natal care is equally concentrating on risk detection (anaemia, infection) and health advice (FP).
All hospitals should be capable of handling managing complicated pregnancies including undertaking caesarean section and providing post-abortion care with manual vacuum aspiration.
Maternal death audits in communities and health facilities are necessary and need to be documented and reported to a responsive supervision system. Corrective action has to be taken in response to the audits.
Probably, interventions for reduction of maternal mortality are among the most cost-effective, which Council health services can provide, but only bear results when the whole set is put in place. It is therefore required that the CHMT organises good and regular supervision, performing on-the-job training and coaching of health workers. The staff of the district hospital could play a role in the clinical supervision of health workers.
ZHRCs, RHMTs and Regional Hospitals could play a role in capacity building.
Many regions' RHMTs and Regional Hospitals, lack sufficient specialist capacity to guide, monitor and supervise the interventions required to reduce maternal and neonatal mortality. The zonal referral hospitals need to play the role of clinical supervision and capacity building of both regional district and regional hospitals. It is essential to establish a supervision system with a number of Centres of Excellence responsible for securing a well functioning cascade supervision system. These centres must have financial resources, relevant health information and sufficient specialist capacity in obstetrics/gynaecology, paediatrics, and systems management to carry out the role as principal supervising agents.

Maternal and neonatal mortality simple low-cost interventions

CHMTs, primary health facilities and hospitals can make a major impact on reduction of maternal and neonatal mortality, not by major investments, but by implementing a comprehensive package of interventions:

- Life saving skills: perform ANC according to protocol, recognise and act on danger signs, use partographs during delivery, refer when necessary, provide essential neonatal care and post-natal care
- Equipment: equip all facilities with simple standard equipment
- Medicines: provide medicines and supplies for maternal emergencies
- Referral: organise community initiatives for early healthcare seeking behaviour
- Hospitals: provide care for eclampsia and post-abortion and caesarean

section
- Provision of nurse midwives at dispensary, health centre and district hospital
- Communities: inform communities on family planning, danger signs of pregnancy (especially in adolescents) and perform maternal death audits

RHMTs and Regional Hospitals should plan for supportive supervision and capacity building (on-the-job- training).

National level facilitation to improve district health services

- The ZHRC capacity needs to be built in facilitating training in practical life saving skills and other reproductive health aspects, in conjunction with Zonal referral hospitals, which will be expected to also capacitate the Regional Hospitals and RHMTs.
- Centres of Excellence should be appointed and resourced to act as principal agents for establishing and running a cascade supervision system.
- Basic equipment and medical supplies for maternal and child health have to be available for purchase by CHMTs.

2.2 Infectious diseases: Tuberculosis – HIV integration

Problem statement

The TB/Leprosy programme in Tanzania, which was launched in the seventies, represents a "flag-ship" programme for the control of tuberculosis. It was a major break through. However with the advent of HIV /AIDS things changed and achievements started to disappear. Tuberculosis continues to be one of the major problems in the country with a steady increase in the number of cases from 11,753 in 1983 to a staggering number of about 65,665 in 2004 . The detection rate of TB is now less than 50% of expected cases and has been declining since 2004. This calls for rethinking and identifying innovative mechanisms to increase case finding, including active case finding among HIV-positive persons.
One study found that of all TB cases 60% is HIV positive. Since 2006 collaborative TB/HIV activities started using the Provider Initiated Testing and Counselling (PITC) approach, with clear guidelines for HIV testing. Where operational, 85% of TB patients accepts PITC and treatment, if found HIV-positive. International NGOs and Development Partners support the GOT TB and AIDS programmes, but scaling up of programmes is slow due to lack of facilities, which can provide HIV testing and ART. The increase of ART clients may also cause too high demands for district ART programmes.

Proposed Actions

In all districts, TB and HIV programme activities have to be integrated at health facility level, with HIV testing and counselling. PITC is required to diagnose the co-infection and to treat patients according to standards. The protocol for PITC is simpler than for Voluntary Ccounselling and Testing. Better referral between TB and HIV clinics needs to be established, which have to be sufficiently staffed and supplied for receiving the increase in clients.
Active case finding and contact tracing for HIV/TB cases is necessary and can be achieved through establishing links between the HIV and TB programmes. More private health providers should be incorporated in case finding of TB, testing for HIV, if possible through service contracts.

TB and HIV/AIDS integration simple low-cost interventions

- PITC for all TB patients and appropriate HIV treatment.
- Active case finding among HIV patient and their contacts using the TB screening tool.
- Service contracts for NGO and private provider involvement in TB case finding.

National level facilitation to improve district health services

- Nearly all collaboration between TB and HIV/AIDS programmes is funded and facilitated by international NGOs and Development Partners. For achieving nationwide results direct collaboration between national programmes (using MTEF funding) is necessary.

2.3 Neglected Tropical Diseases

Problem Statement

Poor communities with poor hygiene suffer most from diseases, which WHO has labelled as Neglected Tropical Diseases (NTDs). These diseases include: Schistosomiasis, soil-transmitted Helminths, Lymphatic Filariasis, Onchocerciasis and trachoma as well as zoonotic diseases, such as Human African Trypanosomiasis (HAT), Rabies, Tick born Relapsing Fever, and Echinococcus. In general, the communities do not know these diseases so they do not attribute any sufferings to them. Even the leadership at higher levels is not aware of these infections, and – if they are – they do not give them the due importance and hence allocate few resources to combat them.
In Tanzania 36 million people are at risk of infection with Lymphatic Filariasis and 6 million have clinical manifestations of the disease. Trachoma is endemic

in about half the country and is a main cause of preventable blindness. Schistosomiasis and soil transmitted Helminths are prevalent throughout the country, being among the main causes of morbidity. Health Sector Strategic Plan III mentions NTDs' strengthening of surveillance, prevention, diagnosis and control.

Currently there is a window of opportunity to control or eliminate five of these diseases by Preventive Chemotherapy Therapy (PCT) through Mass Drug Administration (MDA). MDA is effective against Schistosomiasis, soil-transmitted Helminths, Lymphatic Filariasis, Onchocerciasis and Trachoma.

Some of the drugs for MDA are donated by pharmaceutical companies e.g. Mectizan by GSK, Zythromax® by Pfizer. Fortunately these pharmaceutical companies have given long-term commitment and the assumption is that they will honour their commitment. The drug for Schistosomiasis, praziquentel, is not donated. It is an expensive drug and therefore requires commitment of resources both at national and district level apart from donor support.

Proposed Actions

The CCHP should be updated to include surveillance on NTDs and treatment by MDA. Districts should identify which NTDs are threatening their population, e.g. through community assessment, as diagnostic capacities in most dispensaries are low (and diseases go unregistered in the MTUHA). The appropriate strategy for control of NTDs is intersectoral collaboration and community mobilisation. District should identify modalities of assisting communities and villages, e.g. in selection and training of their own drug distributors.

For Schistosomiasis control, one of the strategies is to use schools as places of treatment for school age children. This means involving the Ministry of Education and Vocational Training (MoEVT) officials at national, regional and district level and teachers in schools.

NTDs should stand independently as a budget item on the budget template, which would then be broken into the different diseases for convenience of costing. Currently diseases of the NTDs family are grouped under "*treatment and care of common diseases of local priority within the district". This general reference does not give the NTDs their true picture as major contributors of morbidity for the communities*.

As surveys are very expensive there is need to find other affordable methods to inform the progress on the effect of control measures on these disease, e.g. through community-based surveillance or sentinel panels in districts.

NTDs simple low-cost interventions

- CHMTs map the prevalence of NTDs in their districts.
- Use community and school health approach for MDA.
- Use donated medicines for free treatment or locate funds for medicines if not donated.

National level facilitation to improve district health services

- For sustainability purposes there is need for the MOHSW head quarters to coordinate the implementation of the key preventive aspects of NTDs.
- There should be national advocacy for strengthening the implementation at district and community level.

2.4 Non-Communicable Diseases

Problem statement

Non-communicable diseases are on the increase, particularly in the urban areas where 25% of the population resides, with obesity among urban women tripling from 4% in 1991 to 12% in 2004. The effects of increasing risk factors, including unhealthy lifestyles (diet, alcohol, smoking) have led to an explosion of diabetes mellitus, hypertension, and ischemic heart diseases. Increased use of Highly Active Antiretrovirals (HAART) is also contributing to an increase in Non-Communicable Diseases. Public attention to Cervical and Breast cancers has recently gained media publicity challenging epidemiological analysis to determine their priority ranking. Injuries particularly from road traffic accidents are rising as well. Mental problem increase with changes in society, while traditional coping mechanisms disappear.

In the past it was common knowledge that developing countries had only infectious disease contributing to the bulk of burden of disease. Current evidence from studies shows that Tanzania is facing a ***double burden of disease*** – both from *communicable* and *non-communicable* disease. The Adult Morbidity Mortality Project (AMMP) has done a lot of work in the area of investigating disease patterns in non-communicable diseases and this bulk of knowledge needs to be shared as part of advocacy on importance of NCDs in the country. The primary health facilities are not well equipped in terms of human resources and equipment to detect early signs of the major NCDs. Most CHMTs do not have a plan of action for prevention of obesity, alcoholism or smoking.

From international experience it is known that for changing of lifestyles intersectoral collaboration is the best approach, with inputs from the education sector, mass media, sports clubs, private employers, etc. and with a strong political commitment to ban smoking and control sale of alcohol.

Proposed Actions

The programme of control of non-communicable diseases could start in urban areas, where the concentration of problems is higher, as well as the opportunities for intervention. Sentinel populations could be selected to assist in assessing progress or trends of NCDs. A mechanism should be designed to disseminate the work of the AMMP – creating awareness on NCD.

NCD advocacy and sensitisation programmes could start with mass media campaigns and in intersectoral collaboration, e.g. in school health programmes.

Also churches, mosques and social organisations should be approached for health promotion interventions.

NCDs simple low-cost interventions

- Initiate sentinel surveillance in urban areas; disseminate findings of AMMP
- Start intersectoral and public private collaboration for health promotion in urban areas.
- Equip facilities with instruments capable of detecting early signs of disease

National level facilitation to improve district health services

- Advocacy for national legislation with regard to smoking, alcohol and drugs
- Dissemination of national strategy and work plan on NCDs

2.5 Epidemic and disaster preparedness

Problem statement

The risk of epidemics or disasters due to natural or man-made disasters has existed for ages, but only since 10 – 15 years, the necessity of control of such health problems has become a worldwide topic of discussion. Tanzania shares borders with 8 countries and is prone to epidemic disease outbreaks such as plague, measles, meningitis, cholera and Rift Valley Fever, which caused a serious epidemic in the country in 2006-2007. The presence of refugees from neighbouring countries may facilitate such spread. Twenty five percent of districts in Tanzania with unstable malaria experience malaria outbreaks from time to time, affecting the whole population.
The system of integrated disease surveillance is operational at district and health facility level, but needs strengthening, not to miss health threats. A review showed that even after training less than 50% of the districts provide timely and complete reporting.
The Government produced the National Disaster Management Policy (2004) and the National Operational Guidelines for Disaster Management (NOG 2003). The Ministry established a Health Emergency and Disaster Preparedness and Response Unit (HEPRU), which produced a national health emergency operations plan and standard operation procedures for health facilities in 2006. Part of the RHMTs has been exposed to this plan, but the districts have not yet reached a stage of producing their own plan.

Proposed Actions

CHMTs need to develop standard health emergency and disaster preparedness plans, in conjunction with the District Council Administration and other sectors, e.g. police. They should collaborate with the Tanzanian Red Cross Society. RHMTs play an important role in training CHMTs and reviewing the operational plans. CHMTs should map their potential emergency areas (highways, flood areas, pastoral areas, refugee areas) and health facilities, which should be involved in emergency action. Health facilities and especially the district and regional hospitals need to be prepared for adequate action in disasters or epidemics. Districts should prepare a one-page instruction sheet for health facilities with clear actions to be taken, and with names and telephone numbers of persons to be identified immediately.

The district will have to strengthen disease surveillance system and early warning systems, involving communities, to be alerted when outbreaks of diseases occur, e.g. malaria in unstable transmission areas. The CHMT must know exactly when and who to notify in the district and the region in case urgent action is needed. The Council should have a Epidemic Outbreak Management Plan and Rapid Response Team in place.

The RHMTs have an important task in informing districts concerning emergencies and outbreaks in neighbouring districts, and in disseminating information coming from national and international level, where meteorological services and other services have early warning systems for climate factors (El Nino, drought, spreading of RVF, zoonoses, etc.)

Epidemic and Disaster Preparedness simple low-cost interventions

- Map risks in the district
- Develop district emergency preparedness plan with Red Cross and other stakeholders.
- Produce one page instruction sheets for health facilities

National level facilitation to improve district health services

- MOHSW has to produce a training manual and has to provide budgets for training in disaster preparedness.
- RHMTs should train districts in the Health Sector Emergency Operational Plan.
- The Disease Outbreak Management Guide for Council Health Management Teams should be updated.
- Use modern communication channels, e.g. e-mail alert, text message for dissemination and information from national/international early warning systems.

2.6 Social Welfare

Problem Statement

The MKUKUTA formulates ambitious targets with regard to social protection measures (e.g. reaching 40% of eligible elderly and 20% of disabled by social welfare programmes in 2010).
The exemption mechanisms are not working as, a result the poor and marginalised groups are denied free health care.
Formally social welfare services are integrated into the district health system, but only 56 of the 133 Councils have social welfare services in their activities. In practice in most districts the social welfare services still operate separately from health services, or are provided by NGOs and FBOs. The Council Comprehensive Health Plans do not incorporate these services, partly because no budget is available.

Proposed Actions

In the future all CHMTs should plan for social welfare services as part of the CHMT, and staff in social services should work with the CHMTs. At the same time CHMTs could intensify collaboration with NGOs and FBOs operating in social welfare programmes.
The link between social welfare and health can be strengthened through access to health services for the poor. There is need to establish a mechanism to identify the poor, and the elderly, disabled so that they can receive a Community Health Fund card that will allow them to access free health care.

Social welfare simple low cost interventions

- Incorporate social welfare officers in CHMT
- Include activities of social welfare department in CCHP
- Establish working relations between CHMTs and NGOs/FBOs/CBOs and others in the social welfare area
- Develop strategies of free access to health for the poor and the elderly and disabled people through the CHF

National level facilitation to improve district health services

- Guidance from national level is required, before CHMTs can start integration.
- Completion of the Social Welfare Strategic Plan, work plan and district guidelines is necessary.
- Budgets for social welfare activities have to be incorporated into the block grant, or designated budgets from Councils have to be made available.
- Develop type of standard service agreement to be applied/adapted by local partners at district level

2.7 Quality improvement in regional hospitals

Problem Statement

The situation analysis for the hospital reforms disclosed a series of critical shortfalls in management and in quality of hospitals services. For decades, hospitals have been understaffed, under-equipped and under-funded. Many hospitals therefore function below their required level: district hospitals function as health centres and regional hospitals operate as district hospitals. The lack of clinical specialists in Regional hospitals is one of the main reasons they cannot perform according to standards. Issues of incentives and limited possibilities for private practice in hospitals stop specialists from moving out to regions.

While for many of the problems the causes can be traced to shortages of human and financial resources, for a significant number of problems, lack of management capacity, technical competencies and commitment aggravates the problems. The system of checks and balances in clinical care and management has been undermined by complete lack of supervision and quality control. Here is where actionable solutions should be sought.

Proposed Actions

The Regional hospitals should have a core number of specialists and essential medical equipment, medicines and supplies to provide expected clinical referral services in medicine surgery, obstetrics/gynaecology and paediatrics. Hospitals should introduce (or revive) Quality Committees, which give guidance to development and enforcement of local operational standards. These should be based on national and international clinical guidelines and protocols. The quality committees should look at rational medicines prescriptions, hospital (near) accidents, and hospital deaths, complaints from patients and staff (Client Service Charter). At the same time supervision and clinical audit by higher levels in the health pyramid (Zonal and National Hospitals) should be reinstated, to endorse quality measures.

The management strengthening programme in the hospitals, as part of the hospital reforms, should be implemented under close supervision of the RHMTs. Regional hospitals should produce their plans including QI plans, and proper accounts of their activities, strictly monitored by higher authorities.

The Intra-Mural Private Practice arrangements have to be put into place for stimulating specialists to move to regions.

The Hospital Boards should be appointed, which should have an overseeing task over the performance of hospitals. The members of the boards need to be capacitated to perform their duties adequately.

Issues of quality improvement apply to district hospitals as well, and therefore – after introduction at regional level – should be taken forward to the district level as well.

Regional hospital quality assurance

- Initiate Quality Committees for clinical and technical guidance

- Implement management strengthening of hospital reforms programme
- Establish Hospital Boards for overseeing hospital performance

National level facilitation to improve regional health services

- Update and communicate clinical guidelines and standards to hospitals
- Supervision of regional hospitals by National Referral Hospitals
- Instructions on Intra-Mural Private Practice arrangements for specialists in regional hospitals
- Legal status of Hospital Boards

2.8 Referral System

Problem Statement

Currently the referral system from dispensary, health centre, district hospital and regional hospitals is not functioning as expected. Most health centres operate like dispensaries, district hospitals like health centres and regional hospitals perform like district hospitals, but all at a higher cost. Service provision below expectation causes bypassing of primary services and congested hospitals, which operate below their official level. This bypassing increases costs for patients and the health system.

At the same time, lack of capacity to treat emergencies in hospitals or health centres (accidents, eclampsia) results in loss of lives. Health workers (especially at night) do not have the skills to act adequately, or do not have the supplies to give the right treatment. The Health Sector Strategic Plan III clearly stipulates the advantages of a functioning referral system. All facilities will function according to their mandated roles, and measures to reduce by-pass of facilities will enhance efficient use of resources.

The problem of transport from community level to health facility and between primary health care facility and hospital are well-known. There have been several initiatives stimulating local transport in communities, using simple means of transport, voucher schemes or other initiatives, using community mobilisation.

Proposed Actions

The CHMTs should assign clear functions to dispensaries and health centres, and give health centres an intermediate function between dispensaries and hospitals; they should equip and staff the facilities accordingly. Job descriptions and standard operating procedures should provide clear instructions to staff of what they should deliver. Community sensitisation regarding the use of appropriate facilities should reduce bypassing. CHMTs can consider introduction of a bypass fee (only when the lower levels are equipped/staffed to perform their function) for direct entry in hospitals, and incentives (e.g. fee reduction) for patients who adhere to referral procedures. Bypass and referral issues can even better be

solved by a well-functioning health insurance system. Health Facility Governing Committees (HFGCs) should be engaged in monitoring referral systems.
Hospitals should provide 24-hours emergency medical services, with staff that can handle complicated cases. Horizontal referral should be used, when nearby hospitals at the same level, are able to provide certain services; referral between government and private hospitals should be encouraged. The hospitals should maintain a clear downward feedback mechanism to health institutions, which referred the patients (and send patients back for follow-on treatments. The CHMT can identify alternative and innovative ways of referral such as the motorcycle ambulance, vouchers for transport for delivery (using private transporters), maternity waiting homes, which would cut down on late referral from communities to dispensaries and health centres to district hospital.

Referral system simple low cost interventions

- Differentiate functions of health facilities and ensure that they can provide functions accordingly (especially emergency referral).
- Sensitise communities on correct points of entry to the system and empower HFGCs in monitoring
- Mobilise communities for early healthcare seeking behaviour of patients and community-based transport systems

National level facilitation to improve district health services

- Procurement of ambulances and communication systems for districts.
- Enhance CHF and insurance systems for regulating and funding referrals.
- Allow districts to purchase suppliers outside the MSD following a clear guideline.

3 Health Services Management

3.1 Human Resources Management

Problem statement

The problem of shortage of staff and high turnover of staff, especially in rural areas, is well known and well documented in Tanzania. Only 35% of the required work force is in place in the country. Especially rural areas face shortages of staff. Unfortunately more than 2,000 vacancies remained unfilled in the previous financial year. At the same time, health workers productivity is estimated at 55% of their time, due to travelling, workshops, salary or medicines collection and other reasons. In spite of staff shortages, the available health personnel is not always distributed according to facility workload. Some of the staff's clinical skills are low so there will be need to retrain them.
Many of the HR issues are beyond the authority of CHMTs to solve, e.g. the recruitment restrictions, the lack of training capacity in the country. Because of the Decentralisation by Devolution the Councils have their own responsibility in management of human resources and therefore the CHMT can be proactive, especially in the area of retention of staff and productivity of health workers. Research has shown that in many places health workers are frustrated and demoralised, and willing to leave in search of 'greener pastures'. However with a series of non-financial incentives it is possible to retain staff, of which the most important is recognition and respect by management. Correct promotion procedures, career development opportunities and support to work according to professional standards are other issues identified for staff retention. Health workers understand that improvements cannot come overnight, but they demand transparency and fairness in CHMT's HR management.
The performance-based payments (P4P) has started, but is still surrounded by many questions on fair external assessment of the performance, incentives for improvement of performance (not just achieving a defined level of services), and its place in a comprehensive package of motivating staff. In 2009 it did not get support from Development Partners; it needs further refinement to make an impact.

Actions proposed

Health workers need to have proper job descriptions, which explain clearly what is expected from them, especially if they have managerial responsibilities besides clinical health service tasks. The job descriptions constitute the reference for supervision and performance appraisal, for which the Open Performance Review and Appraisal System (OPRAS) has been developed. Research in Tanzania has shown that positive attention from management for staff, their work and personal circumstances is a great motivator. Performance appraisal should therefore be used to strengthen the relation between management and personnel.

Supportive supervision is crucial, if it indeed provides assistance to health personnel and helps to create an enabling environment. The TEHIP tool of Integrated Management Cascade, where hospital and health centres supervise dispensaries in the catchment area has proved its value. It takes a burden from the CHMT, and allows for much more quality of supervision. Districts should make an effort to implement this tool, which Zonal Health Resources Centres have been training countrywide in the past two years. Supportive supervision should go hand in hand with tangible support to enable workers according to professional standards: CHMTs should make equipment and supplies available, distribute medicines, provide means of communication (telephones), which make it possible for health workers to concentrate on their jobs, rather than moving around to search for necessary items. A staff management tool should be developed to provide CHMTs regular information on how available human resources match the workload and service outputs in the District's health facilities. The tool would guide the management team in its distribution of health staff.

When improving working conditions, CHMTs should also remember occupational health measures for health workers, in particular prevention of infection with HIV. CHMTs must develop a work place policy for HIV/AIDS and other infectous diseases. Safe needle disposal and protective materials (gowns, boots, masks, spectacles and gloves) should be available. At the same time Post Exposure Prophylaxis has to be provided immediately after needle stick accidents.

Another factor in retention is timely promotion of staff, following civil service regulations. Although the CHMT does not decides over promotion, it can advocate for it on behalf of the workers involved. Continuing Professional Development (CPD) is needed for all staff, also non-qualified staff. The personal file of health workers should contain aspects of training needs (discussed during the appraisal) and every health workers should be offered an opportunity for at least one course per year.

Career development possibilities create major incentives for personnel. Competent and motivated staff could be offered upgrading courses, in-service training (even with bonding conditions) using Council health funds.

Good accommodation or housing and electricity in houses are valued very much by health workers. CHMT could plan for this under the Local Government Development Grant (see below).

Performance-based incentives may help as token of appreciation, if used fairly and transparently. The existing P4P system needs to be refined, to ensure that incentives are transparent and within reach of health workers. Performance-based incentives must be achievable and transparent, and independently controlled. They should be incorporated in a comprehensive package of motivating health workers.

Human resources simple low cost interventions

- Provide job descriptions and performance assessment (OPRAS)
- Strengthen supervision using Integrated Management Cascade
- Ensure CPD for all health workers, career development and upgrading
- Create enabling environment (medicines, supplies, water infrastructure)

for quality performance
- Improve housing and accommodation
- Provide fair and transparent performance-based incentives

National level facilitation to improve district health services

- Recruitment, posting and transfers need to improve to enhance equitable distribution
- Develop management tool for rational allocation of human resources
- The performance-based incentive system has to be refined, made acceptable for all stakeholders, and re-launched
- Revise the use of the allocation formula for the Block-grant in order to allow discretionary power of Councils in attracting and retaining staff.

3.2 Medicines and supplies

Problem statement

Availability of medicines is a key issue for quality of care, trust of patients and credibility of the health system. Many health facilities still face critical shortages of essential medicines, despite the introduction of the indent system. Part of the shortage originates from the health facilities, for example not ordering medicines in time, or not in sufficient quantities. Sometimes CHMTs are to blame, with delays in distribution or in forwarding orders. However, often MSD is not able to supply requested items, when they are out of stock. At times the health facilities have depleted their accounts at MSD, or the ministry has failed to transfer funds to MSD.
Ironically, many health facilities sit on large sums of "sleeping money", generated through cost sharing and CHF, which cannot be used for purchase of medicines due to bureaucratic hurdles in procurement procedures.

Proposed Actions

The health facilities need continuing support from CHMTs in managing their medicines supply. Due to high turnover frequently new staff comes in place, not conversant with the ordering procedures. The long lead times between ordering and delivery necessitate good planning and estimation of quantities. Supervision and support by CHMT is therefore essential, especially in those health facilities where staff is new, or where no qualified staff is available. In this century of electronic communication, real-time exchange of information between MSD and districts should be possible, moreover because most CHMTs have internet in place.
CHMTs are free to procure additional medicines, when MSD is not able to deliver and when the Zonal MSD outlet grants permission. Funds generated from the Community Health Fund or from cost-sharing can be used for that purpose. The

government procurement procedures need to be followed, when purchasing medicines from reliable suppliers, but unnecessary bureaucracy should be avoided. Some districts have initiated a Drug Revolving Fund or buffer stock, which health facilities can access to purchase additional medicines. However, CHMTs must take sufficient precaution to handle procurement of medicines and distribution to health facilities diligently, with full accountability and transparency of procedures.
In some regions the Accredited Drug Dispensing Outlets (ADDOs) offer an opportunity for increase of access to medicines. CHMTs could develop service agreements with such pharmacies.

Medicines and Supplies simple low cost interventions

CHMTs have to take action to improve availability of medicines in health facilities:
- Provide assistance to health facilities (especially those with inexperienced staff) in proper management of the indent system/ILS
- Procure medicines from other sources, if MSD is not able to deliver requested medicines to health facilities

National level facilitation to improve district health services

- Timely fund transfers from MOHSW should enable MSD to supply medicines according to plan.
- On-line communication between CHMTs and MSD should be put in place for ordering and monitoring.
- Provide technical assistance to districts in management of drug revolving funds.

3.3 Financing Health Care

Problem statement

The funding of health services at district level is fragmented and unpredictable. There are at least 13 sources of funding, identified in the CCHP guidelines. The health block grant consists nearly exclusively of Personal Emoluments, leaving small amounts for Other Costs. The Health Basket Fund, Council funds and locally generated funds (CHF, NHIF, cost sharing) are the major sources of funding for Other Costs. MSD allocations, vertical programme or NGO allocations support the running of health services, but CHMTs have no discretional power over these funds. Most CHMTs do not have a full insight into funds that can be expected from all different sources, and may not utilise available options for resource mobilisation, e.g. from Local Government Authorities.

Payment for health services (cost-sharing) exists since about fifteen years. District Councils may determine the level of the fees, and village governments

may grant waivers for the poor, but should reimburse health facilities for services rendered. In addition, many waivers of payment are determined nationally, e.g. children under five, vaccinations, ANC, deliveries, TB treatment, elderly. Waiver schemes are not always clear, and local governments do not make reimbursements; or health workers do not adhere to instructions.
The Community Health Fund was created to offer patients access to health care without the burden of payment for services. Out of the 132 districts 72 have a CHF in place, but of those only 28 seem to be functional. The enrolment is often low (less that 5% of district population) and members often do not subscribe for a consecutive year, because they do not experience any benefit from it, mostly because medicines are not available. Despite the MOHSW matching fund (doubling the CHF income generated), few districts are able to manage the CHF adequately, missing an important opportunity to generate income. Research in Tanzania has shown that success or failure of the CHF is largely dependent on commitment by district and health facility managers for proper management of the scheme.
The NHIF and the NSSF are health insurance schemes for formally employed workers. Health facilities may submit claims for service provision to those insurances. However, often submission of claims is not correctly done, or even omitted, e.g. for children under five, leaving many opportunities for income unused.
Although income generated at health facilities constitute less than 5% of the government budget, it is an important part of funds directly available for Other Costs at facility level.

Without a comprehensive overview, CHMTs are not able to make a realistic allocation plan. If, in addition, disbursement is late and unpredictable, CHMTs are forced to operate on an ad-hoc basis. One study found that 25% of the annual government OC fund was disbursed in the last month of the fiscal year, and half of the development grant during the last quarter. In the process, most of the funds may be utilised for activities, which are not directly visible for patients and communities at large. Health facilities may be dirty, without water supply, without medicines, without stationery. CHMTs should prioritise before anything else to make the health facilities operate at least on minimum standards of quality.
It is disturbing that utilisation of funds from cost sharing in many districts are surrounded by non-transparent and bureaucratic procedures, which delay expenditure and limit health facilities' access to resources. Money may accumulate in district accounts, while health facilities face shortages of medicines or cleaning utensils. In districts where health facilities maintain their own accounts, such problems are less.

Proposed Actions

CHMTs must identify all sources of funding (table 15 of the CCHP), and expected amounts of funding through those sources. It requires approaching NGOs, Development Partners (which support specific district) and District Council to get information, not automatic incremental budgeting based on previous year's

disbursement. Contributions from NGOs or Faith-Based Organisations (FBO) in kind should be quantified.

CHMTs should explore possibilities to mobilise resources from the District Council and village governments, e.g. for health services for the poor. Exemptions and waivers should be terminated, and replaced by CHF cards, which provide free access (fair, not to be manipulated by health staff and non-stigmatising).

Districts should make an effort to revive or initiate the CHF, nominating a designated CHF manager; provide him or her with necessary training, and resources for administration of the Fund. Community mobilisation should be at the centre of the CHF revival. Savings and Credit Organisations, boarding schools, orphanages, NGOs and other institutions may be interested to pay for membership of persons and their dependents. The Council Health Services Boards play a key role in management of the Fund, providing guidance and contributing to community mobilisation. Availability of medicines, cleanliness of the facility and client centred attitudes of staff motivate CHF members to continue subscription. Because the MOHSW matching fund offers extra funding, the scheme could offer additional services, e.g. vouchers for transport of women in labour.

The CHMTs have to assist their health facilities in proper claiming from the NHIF. In several regions RHMTs have assisted in orientation programmes for health staff.

CHMTs should see to proper management of patient fees, with transparent fees, clear exemption schedules, and public accounting to the community.

Expenditure directly related to tangible improvement of service delivery in health facilities should have preference when financial resources are limited.

The principle is that resources mobilised in health facilities are utilised where they were raised: money from CHF, cost sharing, NIHF has to benefit the health facility, and the Health Facility Governing Committee must have a say in the choice of expenditure (within regulations). In principle health facilities should manage their own accounts.

Financing health care district level interventions

- Make inventory of financial sources and options for funding (from donors, NGOs, District Councils, etc.)
- Revive CHF, with designated fund management officer, using collaboration with partners, who are interested in reducing costs of acute health care
- Phase out exemptions and waivers, and provide poor and vulnerable with free CHF cards
- Improve claim management from NHIF
- Utilise funds at the place where income was generated (taking accounting procedures into account), and involve community in decision making on utilisation of funds
- Give clear instructions and supervision to health facility staff on financial accountability
- Ensure complete transparency with income and use of financial resources

National level facilitation to improve district health services

- Predictability and timeliness of transfer of Health Block Grants and Health Basket Fund grants to Councils has to improve for districts to increase their performance.
- Improve technical assistance to CHMTs and LGAs in financial management, using RHMT capacity
- Revise the HFGC regulations, to allow for maintaining facility accounts and decentralised management of generated income

3.4 Public Private Partnership

Problem Statement

The non-state actors, or private actors, consisting of local NGOs, FBOs, CBOs or for-profit organisations play an important role in health care and social services in all districts in the country. In some areas the non-state providers provide more than half of the services. The role of international NGOs at district level is often tied to implementation of donor-funded programmes. The relation of these NGOs to government health services is more the type of donor-client.
At national level the Public Private Partnership (PPP) has been developing over the last years, with a national steering committee and with a national PPP policy under formulation. At district level, the collaboration varies, dependent on local circumstances. But too often there is mistrust, lack of collaboration, or even concealed competition between governmental health services and private stakeholders. The concept of PPP is still poorly understood.
Although according to the CCHP guidelines representatives from non-state actors should be part of the district planning team, it is often not the case. Private organisations sometimes do not provide insight into their resources, and CHMTs do scarcely provide resources to non-state actors. As a result the non-state actors take little ownership of the CCHP.
The standard service agreements for contracts (developed in 2007) between Local Government Authorities and private providers are hardly used, partly because CHMTs fear the financial implications of these agreements. Subsidies for faith-based health services still flow from MOHSW through CSSC to health facilities. Most of the collaboration between government health services and NGOs is on an ad-hoc basis, with few guarantees for continuity. In nearly all areas, the opportunities for collaboration with NGOs, FBOs or CBOs exist, in disease control programmes, in health promotion, in medicine distribution, logistics, etc. Private for profit providers generally operate more in curative areas, but could play a role in the district health system.

Proposed Action

CHMTs have to intensify their collaboration with non-state partners in health. This collaboration should start with the formulation of the CCHP. The partners should incorporate their actions in the comprehensive plan and declare their

resources (without giving up autonomy of management of their organisations). CHMTs should allocate resources, based on service agreements. The CHMT and private providers should adapt these contracts to local needs and possibilities, if the national standard format does not suit circumstances. The budgeting for the service agreements should be part of the CCHP, and accounting should be done through the regular Council book keeping system.
Important is the sharing of information with stakeholders that should be invited regularly to meetings with the CHMT to discuss progress of the implementation of the CCHP. Such meetings could be around themes (e.g. HIV, malaria) to make them interesting for specific organisations.

PPP simple low-cost interventions

- CHMTs should ensure that all relevant non-state actors in health participate in the annual district planning process.
- Service agreements should be adapted to local needs and opportunities and be incorporated in plan and budget
- A good system, managed by CHMT, for sharing information between the stakeholders

National level facilitation to improve district health services

- CHMTs should receive sufficient funds to honour the service agreements
- MOHSW could provide a financial guarantee for Designated District Hospitals, Volunteer Agency hospitals and other service providers

3.5 Infrastructure

Problem statement

The District Councils in Tanzania face problems with maintaining the infrastructure of the health services. More than 50% of the health facilities are dilapidated, or in poor state of maintenance. Sixty percent of the dispensaries and health centres, built in the previous century, do not meet the present standards of buildings for hygiene, storage of medicines, maternal health, counselling and treatment of HIV patients, etc. The equipment is often insufficient or outdated. In general, there is a lack of staff houses and accommodation for health workers. Despite years of funding through the Joint Rehabilitation Fund, the needs are still overwhelming for most of the districts.
At the same time, there is a lack of access to primary health facilities in the country, on the one hand due to distances in rural areas, and on the other hand due to population growth in densely populated areas. The MMAM envisages the construction of more than 5,000 health facilities in the coming 10 years, together with improvement of human resources, transport and communication.

Actions Proposed

CHMT should develop a comprehensive infrastructure development plan for a medium – term period - time horizon (6 - 8 years), based on the assessment of existing health facilities, the infrastructure shortcomings and priorities for rehabilitation, extension and new constructions (including staff houses). For each health facility (existing or new), the infrastructure development plan has to show the additional cost for investment, staff and operation cost. The plan should be produced in collaboration with private providers, to avoid competition or overlap of planned facilities, and come to a coherent health service network.
For implementation of infrastructure development, the Councils can use the Local Government Development Grant's Health Window. Funds shall be used both for public and non-profit private health facilities (NGO / faith based).
CHMTs should plan at least 10% of OC (out of Health Block Grants and Health Basket Funds) for minor repairs, maintenance of buildings and repairs of technical equipment. The CHF could fund small repairs by local craftsmen, supervised by the Health Facility Governing Committee.
Last year, all CHMTs have been trained in opportunities for community-based rehabilitation (TEHIP tool), which is an instrument to enhance the commitment and involvement of local communities in health service delivery. Introduction of this tool in districts can enable improvement of the infrastructure.

Infrastructure CHMT interventions

- Produce medium term infrastructure plan for rehabilitation/maintenance plan and expansion of health service network (including HR consequences)
- Develop a district maintenance plan and allocate resources for it.
- Use LGDG – window health for financing
- Activate community-based rehabilitation (TEHIP) tool

National level facilitation to improve district health services

- Keep provision for maintenance and construction, as well as equipment in the OC budget

3.6 Governance

Problem statement

Although there are clear laws, bylaws and regulations Council Health Services Boards (CHSB) in many districts are non-functional, according to a recent evaluation. Implementation of by-laws and regulations quite often meets bureaucracy. Sometimes members are not active (no incentives), and not replaced. Often they do not know what is expected from them. In other cases, the

District Medical Officer does not present the most important topics for decision making to the Board, which then becomes a rubber-stamp committee. The relations between the District Council Social Services Committee and the Council Health Services Board are not always as stipulated in the law: the CHSB is bypassed or ignored. The Health Facility Governing Committees (HFGCs), with representatives from community of village health committees, are not always involved in decision making on crucial issues, e.g. the utilisation of locally generated funds. This undermines the community involvement in health matters. CHMTs or Councils sometimes obstruct bottom-up representation by monopolising selection and appointment of HFGC members.
Most regional hospitals apart from Kagera regional hospital and Mwanza have no hospital boards and the Board for Mwanza mainly deals with hospital infrastructure expansion so it is limited in the scope of work.

Proposed Actions

It is important to revitalise the CHSBs in all districts, to appoint members, and to provide them with the necessary information on rights and duties of boards. Appropriate incentives should be introduced for members of the Board based on actual participation. Involved parties, DMO, Social Services Committee, District Executive Director, should respect the functions of the CHSB. The CHSB should be involved in the planning process, quarterly reporting, and especially in the management of the CHF.
It is equally important to mobilise communities to revitalise the HFGCs, and ensure that they contribute to the decentralised health facility planning, and provide instructions to the health facility management on the utilisation of funds. These committees should link with communities and Ward Development Committee.

Governance simple low-cost interventions

- Revitalise the CHSBs and ensure that they are capacitated, to play their rightful role in the health system (With support from RHMTs)
- Ensure that all health facilities have their HFGCs, which have a role in decision making, fund management and community mobilisation
- Disseminate and advocate for implementation of the Client Charter

National level facilitation to improve district health services

- MOHSW and PMO-RALG should jointly send out instructions to the Councils, the DEDs and DMOs on roles and responsibilities of the boards.
- MOHSW and PMORALG, should jointly send out instructions to Regional Authorities to establish regional hospital boards

3.7 Monitoring and Evaluation

Problem statement

Information from communities and health facilities is crucial for proper understanding of the health status and health problems, as well as the performance of the health sector and decision making and planning. On the one hand, the routine information system provides regular information through the MTUHA, the Disease Surveillance System and through various health programmes, mostly based on service provision data. On the other hand, surveys and sentinel site research provide more detailed information from communities.
There are many complaints on the quality of the routine information, which is often dismissed as unreliable. However, in reality there is a huge variance in quality, among health facilities or among health programmes. Causes of poor quality could be competencies, commitment or resources (e.g. stationery). Within CHMTs officers are sometimes only committed to their vertical programme information system neglecting the MTUHA. Supervision of health facility staff, who may not fully understand the system, is insufficient. When information is used as basis for reward or punishment, health workers are tempted to inflate figures. The disease surveillance suffers from late or incomplete reporting, sometimes because of lack of diagnostic capacity of staff in dispensaries.
In many health facilities the local analysis of data and production of graphs and tables has disappeared, and therefore local quality control is absent.

Proposed actions
In principle, the existing MTUHA offers sufficient tools for data collection and data analysis at the health facility level (although it needs to be expanded, e.g. with a module on social welfare). Consistent analysis and utilisation can provide the district with a wealth of information.
CHMTs should ensure that the stationery and other required resources are available for facilities to work with. All facilities should use local analytic data tools (accumulative graphs for coverage services, monthly cases for trend analysis, etc.), and verify consistency of data. The CHMTs should provide supportive supervision (jointly analyse local data) and check on quality.
Within the CHMT the DMOs should take personal responsibility for the overall data collection, computerised data analysis and reporting, ensuring that the CHMT members indeed contribute to the health information system.
The supervision by the RHMT should focus on the commitment of CHMTs to facilitate local analysis and validation of collected information.

Monitoring and evaluation simple low-cost interventions

- CHMTs provide sufficient stationery to the health facilities
- Health facilities perform analysis of data and draw graphs and tables and utilise them for planning
- CHMTs provide supportive supervision
- DMO take final responsibility of HMIS and computerised data analysis
- RHMTs check on performance of districts

National level facilitation to improve district health services

- Revision of HMIS should lead to simple, clear structures with emphasis on data collection for local needs and local analysis
- Integration of PMO-RALG technical progress reporting and MOHSW reporting systems.

4 Recommendations

4.1 Concentrate on maternal and neonatal health as entry point for systems strengthening

The new areas in HSSP III and areas which the external valuation identified as priority areas (15 in total) produce a huge amount of activities and interventions for the district health services, which may be overwhelming, certainly because there are many other activities not listed here, which require attention, like the vaccination programme, the curative outpatient and inpatient care for children (IMCI) and adults, the care for HIV-positive patients, etc.
Given the limited resources, priority setting will be necessary for the planning and implementation of the proposed actions. Financial resources are limited, and most serious of all, the human resources are insufficient in numbers and levels of education to cope with all demands.

The consultants would propose to **make the fiscal year 2010/2011 the year of maternal and neonatal health**. It is high time that tangible progress is made in this area. It also provides an entry point for many other areas listed in this document: rehabilitation and equipment of basic facilities, supply of medicines, improvement of the referral system, supervision, involvement and improved awareness/knowledge within the communities, health information systems, as well as human resources development and retention. Maternal health has its ramifications to HIV/AIDS in PMTCT, to malaria in IPT and in ITN, and other disease control programmes.

Maternal and neonatal health provides an entry point to equity and gender aspects of health. The poorest and most vulnerable groups in society, often living in remote rural areas, suffer most. Putting their problems in the limelight draws the attention to their general problems of coping with disease and ill-health. The fact that maternal mortality has not shown any significant decline over the last decade, while the government and civil society put women's rights high on the agenda, is an anomaly. Apparently, the health sector has not been able to translate the gender policy into concrete actions. Improving the health of women is a first step in honouring their civil rights.

In this approach RHMTs and MOHSW head quarters will concentrate on this theme as well, not just leaving it to the Reproductive and Child Health Unit, but all departments in conjunction. This means for example that the health information unit concentrates on improving data collection of neonatal deaths, and maternal mortality audits, or that the malaria unit concentrates on increasing the uptake of the Tanzania National Voucher Scheme for pregnant women, or that the directorate of hospital services concentrates on treatment of eclampsia and post-abortion care, etc. Together, it is possible to make a real

difference and make progress in reduction of maternal and neonatal mortality and make achievement of MDG 4 and MDG 5 more tangible in Tanzania.

4.2 Human Resources for Health

The current level of human resources in primary health care facilities and hospitals is one of the major factors hindering the provision of quality services. District should implement the MMAM comprehensively, not just the infrastructure component, and therefore they should make a concrete plan on how to obtain adequate numbers of health staff for new health facilities, even before construction starts. Taking staff to upgrading courses (e.g. using distance learning), recruitment of local youth for training in health, improvement of the working environment, using bonding arrangements, etc. are options which districts should explore to increase staff. If communities are involved, they can contribute in terms of building the infrastructure for MMAM (as has happened in the education sector).
Innovative approaches in e.g. retaining or upgrading staff using distance learning should be encouraged, including deliberate efforts by the government to involve the community in staff accommodation and training (similar to what has happened with primary school teachers).

4.3 The CCHP planning process

The way the CCHP planning is approached at this moment is strictly annual. Every year, CHMTs start 'from scratch' making a problem analysis, identifying priorities and targets, budgets, etc. It seems logic, but either results in huge work and duplication of previous year's work, or results in 'mindless' copy and paste work, using modern computer technology.
The HSSP III suggests that districts should produce strategic plans, translating the HSSP in long-term district plans. This seems not to be feasible, for the time being, due to human resource problems in many districts. Presently, further decentralisation of district planning is introduced, with health facilities preparing their own plans, on which CHMTs should build their district plans.
The consultants would argue that planning should not become an annual ritual, which takes staffs weeks away from their regular duties. They propose to make a difference between the routine activities, like OPD service delivery, vaccination programme, supervision schedules on the one hand, and developmental activities, like quality improvement, expansion of health services network, human resources strengthening on the other hand. For the first type of activities, there could be more planning using standard templates (even electronic templates, which generate budgets) and for developmental activities the planning should have a multi-year perspective, as is the original meaning of Medium Term Expenditure Framework (MTEF). Especially in the areas of infrastructure development, human resources, communication network, referral system, there is need for producing 3-5 years' plans, with regular updates. In this regard, there is a need to harmonise the planning with PMO-RALG, making the

longer-term planning of district health services fitting into the Council planning. This could take the shape of a Council-based MMAM.

Furthermore, the planning process involving community representatives in Health Facility Governing Committees and Council Health Services Boards, and involving non-state actors (private partners) needs to be strengthened a lot. In practice at this moment most CCHPs are products of (selected) members of CHMTs, with private partners and community representing bodies at best operating as rubber stamp approving entities. There is a need to make the plans really comprehensive, and make them district health sector plans.

Plans are useful only if their implementation is monitored vigilantly, results analysed, and corrective actions are imposed when expected processes and results deviate from the plans. It is recommended that the supportive supervision system to a larger extent make use of the CCHPs and help the levels down-the-line not only to make realistic and useful planning in accordance with national and local priorities, but also assist the lower level health managers to follow-up on plans and to decide on and carry out corrective measures if plans are not followed or results are not forthcoming as expected.

Annex 1 Special issues reflected in HSSP III and CCHP

SN	HSSP III	CURRENT CCHP	COMMENT/SOLUTION
General observation: The HSSP has areas of emphasis, which relate to the current direction of operation for the Health Sector under the Local Government implementation. The CCHP needs to be reviewed to synchronise the areas of emphasis. Below are some of these areas.			
1	**Reproductive and Child Health (RCH)**		
	1.1 Waiting homes are mentions as one of the solutions for early referral	1.1 CCHP does not mention waiting home	1.1 Criteria to identify areas for construction of waiting homes should be included
	1.2 Early detection of danger signs is mentioned including HB estimation, BP measurement.	1.2 Emphasis of equipping health facilities with the instrument for early sign detection is lacking or the quality tests are not stressed. E.g the use of Talquist to estimate HB is not quality oriented	1.2 The CCHP should contain not only a list of tests to be made but also a guide on what sort of instruments to be used. E.g. for HB the HemoCue would be one of the equipment to be relied upon for quality result.
	1.3 Maternal Mortality audit	1.3 No mention	1.3 Proper instructions for maternal mortality audit at HF and Community level should be included
	1.4 Capacity building for all cadres involved in maternal health service	1.4 Only mentioned for nurse-midwives	1.4 Systematic training programme with help of ZHRC. Regular supervision, coaching and on-job training
	1.5 Improvement referral system		1.5 CHMT support with ambulances and communication. More awareness and involvement of community
	1.6 Equip all facilities with simple standard equipment and medicines for maternal emergencies		1.6 CHMT ensure the procurement of medicines and invest in basic equipment
2	**Communicable Disease Control**		
	2.1 Elaborate knowledge of communicable disease and an integrated approach whenever possible	2.2 Tb and HIV are mentioned separately – in fact HIV/AIDS is in the same line as STD and not TB	2.2 HIV/AIDS link to TB should be emphasized towards and integrated approach to these conditions. Provider initiated testing should be encouraged for all TB patients PITC for all TB patients and appropriate treatment and counselling

SN	HSSP III	CURRENT CCHP	COMMENT/SOLUTION
	2.2 Quality data should be collected and compiled 2.3 Improve case finding and better referral between TB and HIV clinics	2.2 There is no strategy/criteria for data audit	2.2 Introduce mechanism for data audit 2.3 Link home based care activities and the TB programme. Service contracts for NGO and private providers in TB case finding
3	**Non – Communicable Disease Control**		
	3.1 Non-communicable disease are emphasised 3.2 Creating awareness on NCD towards prevention via lifestyle change	3.1 Though NCD is outlined in the CCHP, there is no strategy to equip health facilitates to be able to detect NCD 3.2 No mention	3.1 CCHP should outline minimum package which could enable health facilities to detect and properly manage NCD patients 3.2 NCD advocacy and sensitisation programmes, intersect oral collaboration I community
4	**Neglected tropical diseases strategies (NTDs)**		
	4.1 Surveillance, prevention, diagnosis and treatment of NTDs is emphasized and attention for mapping the prevalence 4.2 Community involvement is mentioned 4.3 Free medicines for treatment	4.1 NTDs are mentioned under 'other common diseases of local, priority within the Council. Below which Schistosomiasis, Onchcerciasis, Soil transmitted Heminthiasis , trachoma and Lymphatic Filariasis are mentioned 4.2 No elaborate mention of how communities should be involved 4.3 nothing mentioned about availability of medicines within the communities	4.1 Taking into account the significant effect of NTDs to poor communities – these diseases should not be referred as 'other' diseases. The CCHP should be reviewed with a view of giving more prominence to this group of diseases 4.2: Revise the CCHP guideline to elaborate clearly on the strategies used for the community based surveillance, treatment and control of NTDs and promote community involvement. 4.3 Use donated medicines in the community or locate funds for non-donated medicines
	4.3 Surveillance for these diseases is stressed	4.3 Not even mention of the word surveillance is in the CCHP	4.3 Since prevalence of NTDs has direct relation to the methods used to treat them, particularly at community level the CCHP should have guidelines on how to assess these diseases and how to treat them.
5	**Health Promotion and environmental Health and Sanitation**		
	5.1 Health Promotion, environmental Health and Sanitation is one of the key	5.1 Health promotion is mentioned and broken down accordingly	5.1 Need to indicate the responsibility for environmental levels at

SN	HSSP III	CURRENT CCHP	COMMENT/SOLUTION
	areas		different levels otherwise there is a danger of mentioning everything and doing nothing!
6	**Epidemic and disaster preparedness**		
	6.1 CHMT develop health emergency and disaster preparedness plans (clear sequence of needed actions)	6.1 Clear action plan is not mentioned	6.1 Map the emergency areas and health facilities to prepare for adequate action in disaster or epidemic
	6.2 Disease surveillance system	6.2 Involvement of community is not mentioned	6.2 Involve communities
	6.3 RHMT train districts on emergency actions and provide budget for training	6.3 Training not mentioned	6.3 CHMT needs to get information and trained in new developments and risks in region and district
	6.4 Update disease outbreak management guide	6.4 Only need for Task force is mentioned	6.4 Districts strengthen disease surveillance system and inform CHMT with data
	6.5 Availability of modern communication channels at district level for access to information of early warning systems	6.5 Only need for information exchange is mentioned	6.5 mail alert, text message for dissemination etc
7	**Human Resource Management**		
	7.1 Proper job description for the different health workers	7.1 More clarity and protection for staff is not mentioned	7.1 Clarity of expectations and responsibilities
	7.2 Strengthen the relationship between management and personnel		7.2 Stimulate transparency, trust and motivation between facility team
	7.3 Implement the TEHIP tool of Integrated Management Cascade		7.3 Supportive supervision
	7.4 Improving working condition	7.4 Not mentioned	7.4 CHMT make equipment and supplies available and special attention for exposure to infections
	7.5 CHMT advocate for Continuing Professional Development for all staff	7.5 Nothing mentioned of non-qualified staff	7.5 promotion possibilities of all staff members motivates and stimulate retention
	7.6 Clear system for performance based incentives		7.6 System is fair and transparent (protect corruption)
8	**Referral System**		
	8.1 CHMT makes clear function description of dispensaries and health centres	8.1 Not mentioned	8.1 Make clear distinction between the different levels, sensitize community in proper use of the different levels (prevent

SN	HSSP III	CURRENT CCHP	COMMENT/SOLUTION
			bypass of first level)
	8.2 Actions in prevention of delay of referral	8.2 No attention for delay	8.2 Procurement of ambulance and communication system
9	**Medicines and supplies**		
	9.1 Actions from CHMT to improve availability of medicines in health facilities	9.1 Not specially mentioned	9.1 Good management in planning. Support and training to health facilities for good medicine management
	9.2 Procure medicines from different sources when is needed		9.2 e.g organizing Drug Revolving Fund or cooperation with Accredited Drug Dispensing Outlet
10	**Social Welfare**		
	10.1 Staff in social services will work with the CHMT	10.1 Not mentioned, only talk about collaboration	10.1 Budget for social welfare activities have to be incorporated
11	**Financing health Care**		
	11.1 CHMT have an insight into the funds from different sources (from all stakeholders)	11.1 Mentioned in table 15, not how to collect information	11.1 With a good overview CHMT can make a realistic allocation plan
	11.2 CHMT should prioritise the needed action in the investment planning	11.2 Not specially mentioned towards all facilities	11.2. All facilities need to be operational at least on minimum standards of quality
	11.3. Utilisation of funds from cost-sharing is transparent and non bureaucratic	11.3 Only adequate control is mentioned	11.3 Prevent misuse, increase understanding of community and decrease delay in expenditure
	11.4 Increase practice and management of CHF	11.4 Only talked about transparency of collecting fees	11.4 Stimulate membership and support from different private partners. Increase interest to join CHF and increase profit and transparency for members
	11.5 CHMT assist their health facilities in proper claiming from the NHIF		11.5 Proper financial management within facilities and in CHMT
12	**Public Private Partnership**		
	12.1 Increase of understanding of influence and importance of PPP at district level to all stakeholders	12.1 Private partners mentioned in list of participants, but timetable never mentions how private partners collaborate	12.1 Private partners to be part of the process, including approval of draf plans
	12.2 Service agreements as option of structured collaboration	12.2 service agreements not mentioned	12.2 Stimulate working with contracts between different partners, increase the reciprocal trust. Make service agreements. Promote open communication

SN	HSSP III	CURRENT CCHP	COMMENT/SOLUTION
13	**Infrastructure**		
	13.1 MMAM central part of HSP III 13.2 Introduction of TEHIP Tool to enhance commitment and involvement of communities	13.1 Has nothing on MMAM	13.1 The implementation of MMAM needs a very cautious approach. CHMTs should carefully plan it in their plans (three year plans) would be better with benchmarks and linking structures to human resource. 13.2 Community based rehabilitation can enable improvement in infrastructure
14	**Crosscutting issues Quality improvement in regional hospitals**		
	14.1. Quality of care extensively discussed including TQIF	14.1 The word "quality of care" appears 32 times in the CCHP Guideline document. But just as an adjective. There is need to define quality of care	14.1 The CCHP guideline should give an elaboration on quality of care and put up a criteria for achieving quality care at the different levels. E.g one cannot talk of quality of care for a dispensary staffed non-trained health workers. Or a dispensary without the appropriate equipment.
15	**Governance**		
	15.1 Revitalize Council Health Services Boards 15.2 Stimulate community empowerment and involvement	15.1 Mentioned in timeframe, but not as obligatory part of planning 15.2 Mentioned in health facility planning guide	15.1 Make planning a real participatory process with community involvement 15.2 Integrate in district planning approach
16	**Monitoring and Evaluation**		
	16.1 Mentioned as key for better planning	16.1 Plan Rep and integrated district health accounts have potential for better data analysis and planning	16.1 PlanRep3 has even better planning tools

Annex 2 References

1. **Amazigo U, Okeibunor J, Matovu V, Zoure H et al** (2007). Performance of predictors: Evaluating sustainability in community-directed treatment projects of the African programme for onchocerciasis control. Social Science & Medicine 64: 2070–2082.
2. **Basic Support for Institutionalizing Child Survival (BASICS) and the Rational Pharmaceutical Management (RPM) Plus Program for the United States Agency for International Development (USAID)** (2007)**.** Improving Child Health through the Accredited Drug Dispensing Outlet Program. Arlington, Virginia, USA.
3. **Boex J (2008),** Fiscal Decentralization and Financing of Local health Services in Tanzania, Public Finance and Development, Solutions
4. **Boex J (2008),** Supporting Improved Public Finance Management In Tanzania, Challenges to Effective Financing of the Health Sector, Public Finance and Development, Solutions
5. **Boulanger S, Dmytraczenko** (2007). Cost of Family Care International's Skilled Vare Initiative in Kenya and Tanzania. Bethesda, MD, Abt Associates Inc, www.healthsystems2020.org.
6. **Bovet P, Gervasoni JP, Mkamba M, Balampama M et al** (2008). Low utilization of health care services following screening for hypertension in Dar es Salaam (Tanzania): a prospective population-based study. Research article BMC Public Health, 8:407, http://www.biomedcentral.com/1471-2458/8/407.
7. **Brown H** (2007). Community workers key to improving Africa's primary care. Lancet Vol 370 September 29, 2007: 1115-1117.
8. **Cameron A, Ewen M, Ross-Degnan D, Ball D, Laing R** (2008). Medicine prices, availability, and affordability in 36 developing and middle-income countries: a secondary analysis. Lancet, DOI:10.1016/S0140-6736(08)61762-6 1.
9. **Chandler C, Jones C, Boniface G et al** (2008). Guidelines and mindlines: why do clinical staff over-diagnose malaria in Tanzania? A qualitative study. Malaria Journal 2008, 7:53.
10. **Clarke N, Davidson S** (2005). HR training and learning assessment: disaster preparedness and response in the Great Lakes, East and Horn of Africa. Interim report Inter-Agency working Group.
11. **COWI (2007)**, The Health Sector in Tanzania 1996 -2007, Joint External Evaluation
12. **DFID health resource centre, Grosse B** (2008). Continuing Professional Development Day on Non-Communicable Diseases.
13. **DFID Health Resource Centre, Lewis D** (2008). Continuing Professional Development Day on Health Workers. HLSP Ref:253983.
14. **Dinnes J, Deeks J, Kunst H, Gibson A et al** (2007). A systematic review of rapid diagnostic tests for the detection of tuberculosis infection. Health Technology Assessment HTA NHS R&D HTA Programme, www.hta.ac.uk.

15. **Dovlo D** (2007). Migration of Nurses from Sub-Saharan Africa: A Review of Issues and Challenges. Health Research and Educational Trust DOI: 10.1111/j.1475-6773.2007.00712.x. : 1373- 1388.
16. **Evjen-Olsen B, Evjen- Olsen O, Kvale G** (2009). Achieving progress in maternal and neonatal health through integrated and comprehensive healthcare services - experiences from a programme in Northern Tanzania. International Journal for Equity in Health , 8:27, http://www.equityhealthj.com/content/8/1/27.
17. **Family Care International Tanzania** (2007). Testing Approaches for Increasing Skilled Care During Childbirth: Key Findings from Igunga District, Tanzania. Dar es Salaam.
18. **GOT (2007)** Government of Tanzania, The HIV and AIDS (PREVENTION AND CONTROL) ACT, 2007
19. **GOT (2008)** Background Analytical Note for the Annual Review of General Budget Support 2008, Equity and Efficiency in Service Delivery: Human Resources
20. **HERA (2005),** Public Private Partnership For Equitable Provision Of Quality Health Services, Technical review 2005
21. **Kamuzora P, Gilson L** (2006). Factors influencing implementation of the Community Health Fund in Tanzania. Health Policy and Planning 2007;22:95–102 doi:10.1093/heapol/czm001.
22. **Kessy (2008)**, Kessy F et al, Technical Review Of Council Health Service Boards And Health Facility Governing Committees In Tanzania, Ifakara Health Institute, 2008
23. **Kiarie W et al. (2007)** A Report of an Assessment of Reproductive Health (RH) Manpower Allocation, Utilization, and Management in Tanzania, MOHSW 2007
24. **Kidanto H, Mogren I, Massawe S, Lindmark G, Nystrom L** (2009). Criteria-based audit on management of eclampsia patients at a tertiary hospital in Dar es Salaam, Tanzania. Research article BMC Pregnancy and Childbirth, 9:13, http://www.biomedcentral.com/1471-2393/9/13.
25. **Lahey T, Matee M, Mtei L et al** 92009). Lymphocyte proliferation to mycobacterial antigens is detectable across a spectrum of HIV-associated tuberculosis. Research article BMC Infectious Diseases, 9:21.
26. **Lankers C et al. (2008)** Suggestions towards a Framework for the Future Development of Health Insurance in Tanzania, for MOHSW, Synopsis AG, Switzerland
27. **Lehmann U, Damme van W, Barten F, Sanders D** (2009). Task shifting: the answer to the human resources crisis in Africa? Human Resources for Health 2009, 7:49 doi:10.1186/1478-4491-7-49, http://www.human-resources-health.com/content/7/1/49.
28. **Macklin R, Cowan E** (2009). Conducting Research in Disease Outbreaks. PLoS Negl Trop Dis 3(4): e335doi:10.1371/journal.pntd.0000335.
29. **Mamdani M, Bangser M** (2004). Poor People's experiences of Health Services in Tanzania. A literature review, Women's Dignity Project, http://www.womensdignity.org/Peoples_experience.pdf.

30. **Manongi N, Marchant T, Bygbjerg C (2006),** Improving motivation among primary health care workers in Tanzania: a health worker perspective, Human Resources for Health 2006, 4:6 doi:10.1186/1478-4491-4-6
31. **McIntyre D et al. (2008)**, Beyond fragmentation and towards universal coverage: insights from Ghana, South Africa and the United Republic of Tanzania, Bulletin of the World Health Organization 2008;86
32. **MEDA (2007),** Report on the Assessment of How Accredited Drug Dispensing Outlets Can Be Effectively Linked with Microfinance Service Providers, for Danida and TFDA
33. **MSH (2005),** Medicines supply in Africa. Management Sciences for Health Dar es Salaam (2005).BMJ VOLUME 331:709-710.
34. **MOH (2000)**, National Package of Essential Health Interventions
35. **MOH (2004)**, Client Services Charter
36. **MOH (2004)**, Tanzania Quality Improvement Framework, September 2004
37. **MOHSW (2007)**, Guidelines for Planning of Comprehensive Council Health Plans
38. **MOHSW (2007)**, National Infection Prevention and Control Guidelines for Health Services in Tanzania, a pocket guide for health care providers
39. **MOHSW (2007)** Primary Health Services Development Programme (MMAM) 2007 - 2017
40. **MOHSW (2008),** The National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania 2008 – 2015, April 2008
41. **MOHSW (2008),** National Environmental Health and Hygiene and Sanitation Strategic Plan 2007 - 2016
42. **MOHSW** (2008). Standard operating procedures for prevention of tuberculosis in health care facilities. Tanzania.
43. **MOHSW (2008),** Template for annual health planning for health centres and dispensaries
44. **MOHSW (2008),** Human Resource For Health Strategic Plan 2008 – 2013
45. **MOHSW (2008)** Rapid Assessment Of Ongoing Enrolment Trends Of Students In Health Training Institutions In Mainland Tanzania, HRH Working Group, November 2008
46. **MOHSW (2008),** National Tracer Standards and Indicators for Quality Improvement in Healthcare
47. **MOHSW (2008),** National Supportive Supervision Guidelines For Quality Health Care Services, 2008
48. **MOHSW (2008),** Guide For Assessing Health Facility Performance, Quality Improvement And Recognition Initiative
49. **MOHSW (2008),** Health Sector Performance Profile Report 2008 Update
50. **MOHSW (2009)**, Health Sector Strategic Plan III 2009 – 2015, Partnership for Delivering the MDGs
51. **MOHSW (2009)**, National Strategy for Non-Communicable Diseases 2009 – 2015
52. **MOHSW (2009)**, Neglected Tropical Diseases Country Plan 2009 – 2015 (draft)
53. **Mrisho M,Obrist B, Armstrong Schellenberg JA, Haws R et al** (2009). The use of antenatal and postnatal care: perspectives and experiences of women

and health care providers in rural southern. Research article BMC Pregnancy and Childbirth, 9:10.

54. **Mtei L, Matee M, Herfort O, Bakari M et al** (2005). High Rates of Clinical and Subclinical Tuberculosis among HIV-Infected Ambulatory Subjects in Tanzania. Clinical Infectious Diseases, 40:1500–7
55. **Mtei G et al (2007)** An Assessment Of The Health Financing System In Tanzania: Implications For Equity And Social Health Insurance, Report On Shield Work Package 1 , Ifakara Health Institute
56. **Mubyazi GM, Gonzalez-Block MA** (2005). Research influence on antimalarial drug policy change in Tanzania: case study of replacing chloroquine with sulfadoxine-pyrimethamine as the first-line drug. Malaria Journal 2005, 4:51.
57. **Muhondwa EPY, Fimbo BN**, (2006). Impact of HIV/AIDS On Human Resources for Health in Tanzania. Assessment Report Submitted to Ministry of Health and Social Welfare and ECSA Health Community Secretariat – Arusha, Dar es Salaam.
58. **Munga MA Mbilinyi DR (2008),** Non-financial incentives and the retention of health workers in Tanzania, National Institute for Medical Research (NIMR), Dar es Salaam, 2008 for Equinet Africa
59. **Mushi D** (2007). Financing Public Health Care: Insurance, user Fees, or Taxes? Welfare Comparison in Tanzania. Research Report, Research on Poverty Alleviation (REPOA), http://www.repoa.or.tz/documents_storage/RR_07.2_Mushi.pdf.
60. **Mtiwa J et al (2009),** Competency Gaps in Human Resource Management in the Health Sector: An Exploratory Study of Ethiopia, Kenya, Tanzania, and Uganda, AMREF and MSH, 2009
61. **Mwifadhi M et al. (2009),** The use of antenatal and postnatal care: perspectives and experiences of women and health care providers in rural southern Tanzania, BMC Pregnancy and Childbirth 2009, 9:10 doi:10.1186/1471-2393-9-10
62. **Naylor N and Simime A (2008),** Review of Hospital Component of HSPS III, programme MOHSW
63. **NBS (2006)** Tanzania Service Provision Assessment Survey 2006, National Bureau of Statistics, Tanzania and MACRO, USA
64. **Ngowi B J, Mfinanga S, Bruun JN, Morkve** O (2008). Pulmonary tuberculosis among people living with HIV/AIDS attending care and treatment in rural northern Tanzania. Research article BMC Public Health, 8:341.
65. **NMCP (2008)**, National Malaria Control programme, Medium term Malaria Strategic Plan 2008 - 2013
66. **Nyamtema (2009)** A. Nyamtema, D. Urassa, S. Massawe, A. Massawe, G. Lindmark, J. van Roosmalen, Partogram use in the Dar es Salaam perinatal care study, International Journal of Gynecology & Obstetrics, Volume 100, Issue 1, Pages 37-40
67. **Olsen E, Ndeki , Norheim OF** (2004). Complicated deliveries, critical care and quality in emergency obstetric care in Northern Tanzania. International Federation of Gynecology and Obstetrics. Published by Elsevier Ireland Ltd. doi:10.1016/j.ijgo.2004.07.002.

68. **Pembe A B, Urassa DP, Carlstedt A, Lindmark G et al** (2009). Rural Tanzanian women's awareness of danger signs of obstetric complications. Research article BMC Pregnancy and Childbirth 2009, 9:12, http://www.biomedcentral.com/1471-2393/9/12.
69. **Perkins M, Brazier E, Themmen E, Bassane B, Diallo D et al** (2009). Out-of-pocket costs for facility-based maternity care in three African countries. Health Policy and Planning 2009;24:289–300, Tanzania.
70. **Peters David H. et al (2009)** Improving health service delivery in developing countries: from evidence to action, the World Bank 2009
71. **PMO (2001)**, Prime Minister's Office United Republic of Tanzania, National Policy HIV AIDS , 2001
72. **PMO (2007),** Prime Minister's Office United Republic of Tanzania, National Multi - Sectoral Strategic Framework On HIV And AIDS (2008 – 2012)
73. **Reddy M, Gill SS, Wu W, Anderson PJ et al** (2007). Oral Drug Therapy for Multiple Neglected Tropical Diseases. JAMA, October 24/31, 2007—Vol 298, No. 16: 1911- 1924.
74. **Reyburn H, Mwakasungula E, Chonya S, et al** (2008). Clinical assessment and treatment in paediatric wards in the north-east of the United Republic of Tanzania. Bulletin of the World Health Organization 2008;86:132–139.
75. **SITAN (2009),** Securing child survival and maternal health rights in Tanzania: Situation 2009
76. **SITAN (2009)**, Tanzania: Situation, Trends and Disparities in Nutrition since 2001
77. **Schmid (2001)** Thomas ,Omari Kanenda,Indu Ahluwalia,and Michelle Kouletio,MPH Transportation for Maternal Emergencies in Tanzania: Empowering Communities Through Participatory Problem Solving, American Journal of Public Health October 2001,Vol 91,No. 10
78. **Smithson et al. (2007),** Performance-Based Financing, Report on Feasibility and Implementation Options, Ifakara Health Institute, Tanzania
79. **Steibrook R** (2007). Closing the Affordability Gap for Drugs in Low-Income Countries. n engl j med 357;20, www.nejm.org.
80. **Stoermer M and Tiba M (2009)** Strengthening of Claiming, Reimbursement and Use of Funds of the "National Health Insurance Fund" Experiences from the Pilot Region (Mbeya) and for Further Roll-out, GTZ Tanzania
81. **Stringhini S, Thomas S, Posy B et al** (2009). Understanding informal payments in health care: motivation of health workers in Tanzania. Human Resources for Health 2009, 7:53 doi:10.1186/1478-4491-7-53.
82. **Taché S, Mbembati N, Marshall N et al** (2009). Addressing gaps in surgical skills training by means of low-cost simulation at Muhimbili University in Tanzania. Human Resources for Health, 7:64, http://www.human-resources-health.com/content/7/1/64.
83. **Rutta et al (2009),** Tanzania: Accredited Drug Dispensing Outlet., Summary report, MUSE project, MSH, http://www.msh.org/seam/reports/SEAM_Final_Report_Summary-Tanzania_ADDOs.pdf.
84. **The Global Fund** (2009). Audit report on Global Fund Grants to Tanzania.
85. **TRCS (2008)** Tanzania Red Cross National Society. Executive summary Tanzania disaster preparedness and response plan 2009-2010.

86. **TFNC (2006), Tanzania Food and Nutrition Centre,** Strategic Plan 2006 - 2010
87. **UNICEF (2009)**, Rights to Water, Sanitation and Hygiene. Situation of women and children in Tanzania, 2009 (July 2009-draft)
88. **USAID and Famine Early Warning Systems Network** (2009). East Africa Regional Food Security Outlook. www.fews.net/east .
89. **Vialle-Valentin (2008)** Catherine E , DennisRoss-Degnan, JosephNtaganira and AnitaKWagner, Medicines coverage and community-based health insurance in low-income countries, Health Research Policy and Systems 2008, 6:11 doi:10.1186/1478-4505-6-11
90. **Walter (2009)** Nicholas D , Thomas Lyimo, Jacek Skarbinski, Emmy Metta, Elizeus Kahigwa, Brendan Flannery, Scott F Dowell, Salim Abdullab & S Patrick Kachurc Why first-level health workers fail to follow guidelines for managing severe disease in children in the Coast Region, the United Republic of Tanzania, Bull World Health Organ 2009;87:99–107 | doi:10.2471/BLT.08.050740
91. **Wandwalo E, Kapalata N, Tarimo E et al** (2004). Collaboration between the national tuberculosis programme and a non governmental organisation in TB/HIV care at a district level: experience from Tanzania . African Health Science, 4(2),109-114.
92. **World Health Organization** (2007). Towards better leadership and management in health. Working paper No.10, Accra, Ghana.
93. **World Health Organization** (2009). Global status report on road safety: time for action. Geneva, www.who.int/violence_injury_prevention/road_safety_status/2009.
94. **World Health Organization and African Programme for Onchocerciasis Control** (2007). Revitalising health care delivery in sub-Saharan Africa. The potential of community-directed interventions to strengthen health systems.
95. **World Health Organization and For research on diseases of poverty** (2007-2008). Innovation for health. Research that makes a difference, nineteenth programme report.
96. **World Health Organization and Stop TB Partnership** (2008). New laboratory diagnostic tools for tuberculosis control. Geneva, www.stoptb.org.
97. **World Health Organization.** Medicines strategy 2004-2007, countries at the core.Geneva.
98. **Worrall E, Connor S, Thomson M** (2008). Improving the cost-effectiveness of IRS with climate informed health surveillance systems. Malaria Journal 2008, 7:263.

Annex 3 Summary of the HSSP III

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 Service Development Programme (MMAM) 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. The One Plan for Maternal Newborn and Child Health (MNCH) will be implemented, addressing priority Reproductive and MNC Health interventions including key maternal and child health intervention, focus on youth, family planning and nutritional services. MNCH 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 should 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 to health 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.