19th JOINT ANNUAL HEALTH SECTOR POLICY MEETING

JOINT POLICY COMMITMENTS FOR 2019/2020

Preamble

Generally, there are improvements in several key areas in the health `sector in Tanzania. The Government of Tanzania (GoT) in collaboration with Partners have ensured reduction in child mortality, decrease in prevalence of communicable diseases and increased life expectancy. Stunting among children under five years was significantly reduced from 44% in 2005 to 34% in 2015. To sustain these efforts a continuous focus on quality of care and on improving the health systems are needed to cater for an increasing population. At the same time, Tanzania is striving to develop the health system geared towards combating the increasing prevalence of Non Communicable Diseases and setting strategies that will enable the country to achieve Universal Health coverage. There are still challenges and a number of areas that need further work in order to become a health system fit for a middle-level income and industrialized country. The most important and key focus areas were discussed in the 19th Joint Annual Health Sector Technical Review Meeting and are now turned in to Policy Commitments for the coming year.

The Health Sector Strategic Plan four (HSSP IV) 2015-2020 provides guidance for the implementation of desired health sector performance improvement in Tanzania. The 2019 /2020, Policy Commitments are set to achieve the following three major intentions. First – ensure the resource allocated across the prioritized interventions results into tangible health outcomes towards Universal Health Coverage The second intention is to accelerate a deliberate move towards the realization of sustainable health services delivery systems by setting strategies that gradually and systematically build both institutional and financial sustainability in the health sector. The third intention is to position the health sector as a learning organization by promoting operational research in order to generate evidence that will inform health sector programming and policy formulation. With the three aforementioned intentions, the GoT 2019/2020 Policy Commitments draw lessons from 2018/2019 and continues to prioritize majority of issues agreed upon in the previous year that were not fully implemented.

The focus of the 2019/2020 Policy Commitments still aims at addressing high MMR - 556/100000 live births (DHS 2016) and high neonatal death which is 28/1000 live births – ibid. The health sector considers addressing the MMR in a systemic focus will have a multiplier effect to variety of other problematic areas contributing to morbidity and mortality burden in the country- such as advancing health sector intentions in eliminating malaria,

achieving the HIV/AIDS 90-90-90 goals and the reduction of TB infections through increased case notification. In order to address the morbidity and mortality burden, the GoT will continue to have attention on broad aspects of the health sector priorities as indicated in HSSP IV. A new focus area in 2019/2020 Policy Commitments is investment in human capital as the country strives to achieve industrialization and middle-income country status. Based on the Human Capital Index analysis by the World Bank, Tanzania achieved a score of 0.4. This score means that a Tanzanian child born today will only be 40% as productive when she grows up as she could be if they enjoyed complete education and full health. High fertility (TFR=5.2) remains a key constraint to improving the human capital index. Therefore, more intensified and deliberate investments that prioritize health (including family planning) and nutrition (along with investments in quality education) across the major sectors will be critical to ensuring children are well-nourished, able to learn, attain real learning and enter the job market as healthy, skilled and productive adults.

The policy Commitments for 2019/20 will focus on acceleration of nine priorities: Reproductive, Maternal, New-born and Child Health; Adolescent Health; Human Resources for Health; Infrastructure Development and Quality Improvement; Health Care Financing; Health Commodities, Social Determinants of Health, Governance and Leadership; Data Systems, Data Use and Data generation; and Health Security / Emergency Preparedness.

The MOHCDGEC, PO-RALG and the Sister Sector Ministries in collaboration with all SWAp partners will implement the priority areas under HSSP IV and specifically on the following Commitments in 2019/20:

Priority 1 (a): Reproductive, Maternal, Newborn and Child Health

The 2019/2020 policy Commitments for RMNCH will be focus on addressing drivers leading to poor achievement in RMNCH and adolescent health related indicators. Global evidence indicates relationship between the quality, coverage, access and utilization of adolescent health services with the MMR and NMR burden. The Tanzania Demographic and Health Survey conducted in 2015/2016 (2015 TDHS) showed that maternal mortality has remained persistently and unacceptably high at 556 per 100,000 live births in 2015/16. About 30% of women deliver at home; only 17% start ANC in week 12 and ANC four booking is only 46%. There is significant region variation between regions in variety of aspects calling for differentiated approach and need for community-based strategies to improve coverage of interventions addressing MMR.

Nutrition among women of reproductive age and children under five remain a serious concern. The 2015 TDHS indicated high level of stunting among children under five (34%).

While almost all children (98%) are breastfed for some time during their life, only about 50% of infants are exclusively breastfed in the first 6 months. Only 9% of children age 6-23 months are fed according to the minimum acceptable dietary standards. Moreover, anaemia prevalence among women of reproductive age is high at 45%. Anaemia during pregnancy increases risk of postpartum haemorrhage (a major cause of maternal mortality). Efforts to improve maternal health and nutrition is critical for both mothers as well as their children's survival as health and developmental outcome of children born to malnourished mothers have long term consequences.

The GoT in collaboration with partners commit to:

1.1. **Scale up of BEMONC and CEMONC services** aiming for the entire country in order to provide population coverage of emergency obstetric care. This should include rehabilitation/construction of infrastructure including theatre, maternity wards, blood banks, equipment, staff houses, qualified and competent human resources, clean water supply, constant reliable electricity and training, mentoring and coaching

1.2. **Improve New-born Care services** aiming in providing comprehensive newborn care through equipping, construction of infrastructure of hospitals, training and mentoring of competent human resources.

1.3. **Scale up Comprehensive Family Planning Programme**

Access to voluntary family planning improves the health and well-being of women and their children. Global evidence shows that a reduction in unintended pregnancies, combined with full care for all pregnant girls, women and newborns, would result in a 73 percent decrease in maternal deaths. Continue to scale-up a comprehensive FP Programme, ensuring required commodities are available across the country are crucial to reduce the high-unmet need for family planning.

1.3.1. Ensure that forecasted commodities are procured 100%

1.3.2. Ensure 80% of the primary health facilities have at least three modern methods of contraceptives

1.3.3. 1.3.3 Scale up gender sensitive mobile community outreach program across the country for adolescents and adults

1.3.4. Expand the package of FP services under Health Assistant portfolio/service package, including addressing gender/socio-cultural barriers.

1.4. 1.4. Reach last miles towards elimination of HIV mother to child transmission in Tanzania by 2020.

This will be through addressing challenges/bottlenecks in achieving critical coverage of pregnant women with HIV multiple tests during pregnancy and of exposed infants with early HIV diagnosis, strengthening linkage to care and increasing adherence to ART among children and their mothers to reduce viral load, including through optimization of ARV drugs formulation.

1.5. Expand coverage of Community based RMNCH services

By intensifying community based ART services for achieving critical coverage of pregnant women in order to reach last miles towards elimination of HIV mother to child transmission in Tanzania by 2020. Strengthen community-based platform to deliver a comprehensive package of reproductive/family planning, maternal, newborn and child health and nutrition services for women and children.

1.6. Scale up facility and community based maternal, infant and young child nutrition interventions

There has been a gradual improvement in the nutritional status of children and women in Tanzania, but chronic malnutrition among children under age 5 and anaemia as well as overweight affect women of reproductive age including adolescents. Among the main immediate causes of malnutrition among children are sub-optimal maternal, infant and young child nutrition practices. Improvement in nutritional status of children and women require improved dietary and feeding practices that need to be promoted through scale-up of both facility and community-based maternal, infant and young child nutrition interventions. The GoT developed a national multispectral nutrition action plan (NMNAP) to provide a coordinated multispectral response to nutrition and will continue scaling-up nutrition interventions especially the most vulnerable groups (children, adolescents and women) by:

1.6.1. Develop and scale up a cost-effective package of facility and community-based nutrition interventions taking cognizance of the dietary and feeding practices of the different regions; interventions include promotion of feeding practices for expecting mothers, mothers and care givers as well as adolescents

1.6.2. Build synergies with other interventions in nutrition sensitive areas (ANC, family planning, HIV, WASH, education, agriculture, social protection).

Priority 2: Adolescent Health and Nutrition

Today, there are almost 12 million adolescents in Tanzania aged between 10 and 19 years – about 23 per cent of the population. The number of adolescents in Tanzania is expected to increase to almost 30 million by 2050. In addition, about 13 per cent of the population is 20-24 years old. The current health service provision concentrates on under-fives and childbearing age. There is no formal services package for above five and the teenage group. The 2015-16 Tanzania Demographic and Health Survey revealed that 27% of women between 15 and 19 have given birth which is 4 percentage point increase from TDHS 2010. Moreover, Tanzania has one of the highest adolescent birth rates in the world at 132 per 1,000 adolescent girls (aged 15 to 19).

According to the 2015 TDHS, prevalence of anaemia is higher among adolescent girls (age 15-19) at 47%, compared to 45% among women of reproductive age (15-49), complicated further by the relatively young age at first birth.

Adolescents and Young People (AYP) are the promise and a huge potential in terms of human capital for Tanzania's development. When adolescents and young people make the transition to adulthood in a safe, healthy, and empowered manner they are most likely to become active and productive citizens – making strong contributions to the economy and to society.

The GoT in collaboration with partners commit to enhance adolescent and young people's health and wellbeing through:

2.1. Comprehensive and adolescent friendly services

Comprehensive and adolescent friendly services are needed to reduce the current high rate of adolescent pregnancy. This would include SRH and nutrition education and awareness, in coordination with the Ministry of Education. The following key actions will be taken:

2.1.1. **Scale-up** weekly nutrition education programs for adolescents, and weekly iron and folic acid supplementation for adolescents using community, facility and school platforms through the:

2.1.2. Finalization and dissemination of NAAIA costed plan

2.1.3. Development of implementation plan including funding plan

2.2. Finalization, dissemination and implementation of National Standard for Quality Adolescent Friendly Reproductive Health Services (AFRHS)-in health facilities, schools and communities

2.3. Establishment of denominator and numerator for AFRHS facilities through National Assessment on availability of AFRHS

2.4. Strengthening of accountability for adolescent health and nutrition, monitoring and evaluation including formation of coordinating body established for NAAIA

Priority 3: Human Resources for Health

Availability of adequate and well-trained personnel is a key resource in planning, organizing, coordinating other resources for quality health services provision. The actual number of health workers required to deliver quality health services to reach all households is 197,932 while the available staff are 90,873, which is 46% of the total requirement. This means that the overall shortage of human resources for health stands at 54%, which threatens the road towards Universal Health Coverage. Although there is an increase in numbers of Medical Officers, Pharmaceutical and Health Laboratory Staff and Nurses Per 10,000 population; the HRH availability in the country is still below the national standard 7.2 per 10,000 populations (WHO standards is 22.8 per 10,000 population). Regional disparities in terms of HRH availability continues to be a challenge.

To achieve effective coverage of services, it is important to maintain a balance between scaling up curative services and putting in place community level efforts to promote health care and early diagnosis so as to prevent disease and complications before they happen. Health Assistant-Community cadre (HAs-C), who now are trained to work in the community after completing the one year community health training curriculum, can support disease prevention and promote health care at the household level, track all pregnant girls and women to support their attendanceat all of their ANC and PNC appointments, support access to family planning information and services and promote resting and good nutrition during pregnancy, potentially reducing some of the need for emergency obstetric care. HAs-C can also help ensure high risk deliveries are identified and support girls and women and their families to seek the healthcare services they will need in a timely manner to ensure a positive outcome. HAs-C are particularly important to reducing inequities in access to services, by bringing information, services and supplies to women and men in the communities where they live and work, rather than requiring them to visit distant or otherwise inaccessible facilities.

The GoT in collaboration with partners are commit to ensure skilled personnel by man all facilities by:

3.1. Ensuring that all health centres and dispensaries have qualified staff

3.2. Ensuring that all CEmONC facilities have a minimum required staff (MD/AMO, Anaesthetic Assistant, Theatre Nurse, Nurse Midwife, Laboratory Assistant).

3.3. Improving infrastructure for RMNCAH, specifically emergency obstetric and newborn care (EmONC), continue to prioritize permits to ensure that all upgraded health centres have the full skilled staffing complement required with the appropriate skill mix.

3.4. Updating and synchronizing the HRH Strategy and Costed HRH Action Plan with infrastructure

3.5. Advocating HRH production, recruitment, development and retention budget increase by:

3.5.1. Increasing production of specialists using models that are applied in other countries

3.5.2. Revisiting current policies for selection for training in order to promote the engagement of private sector in HRH production for middle level cadres which is currently dwindling due to policy change

3.5.3. Promoting roles of private sector to increase access to under-served areas- through various strategies such as the formalized and managed private practice mechanism

3.6. The GoT in collaboration with partner's commit to staffing community based health services by:

3.6.0 Supporting the deployment of Health Assistant-Community (HAs-C) from those selected by the community for training and deploying them back to their communities once they have completed the one year community health training curriculum.

3.6.1 Establishing a feasible long-term financing projection for the government to employ Community Health Assistants, to guide a deployment and production plan in collaboration with relevant ministries and partners

3.6.2 Undertaking a mapping of current HAs-C production and distribution and map the training institutions with capacity to deliver HAs-C training for the community based Health Assistants.

3.6.3 Finalizing the Health Assistants curriculum to give students two trajectories to choose from: specific facility-based skill building **or** modules to build competencies to provide a comprehensive package of community skills required for provision of preventive, promotive, rehabilitative and basic curative services with supervised community practical.

Priority Area 4: Health Services Coverage and Quality Improvement

Tanzania has 12,545 villages served by 6640 dispensaries (52% coverage) and 4,420 geographical wards served by 863 Health Centres (19.5% coverage). Of these health centres, 518 are government owned and only 115 (22%) are CEmONC friendly. Following the 2018/19 policy commitments, a joint effort from Government and Development partners enable securing funds to support rehabilitation/ construction of 350 health facilities. Out of

350 health facilities, 247 Health Centres have received funds to support their rehabilitation and equipment to become CEmONC compliant leaving behind 271 Health Centres in a bad state of repair and not offering comprehensive services especially for pregnant women.

It is further committed that the GoT in collaboration with Partners to

4.1. Address geographical inequities in health facilities distribution by constructing health Centres and upgrading dispensaries to health centers is done at strategic locations where there are no such services provided by the public or private sector, including CSO and FBOs.

4.2. Continue with I infrastructure improvement in a phased manner that ensures new facilities are functional (staff, equipment, water, electricity).

4.3. Undertake documentation of process, lessons of work done

4.4. Finalization and dissemination of Referral Guideline

4.5. Improve service delivery channels including for HIV, TB and Malaria services by strengthening the capacity of health centres and dispensaries to ensure that health planning is focusing on achieving effective coverage of health interventions

4.6. Continue with quality assessment and improvement by

4.6.1. Carrying forward commitment to harmonize external hospital assessment tools

4.6.2. Carry out External Hospital Performance Assessment for Regional Referral Hospitals as an official assessment tool

4.6.3. Initiating Medical audit system starting with tertiary care hospitals

4.6.4. Conducting the Star rating assessment of all primary facilities (both public and private) with improved harmonized tool

4.6.5. Conduct Star rating at Zonal, National and Specialized Care (both public and private) hospitals with regional standards for tertiary care

4.6.6 Continue with Implementation of Quality Improvement Plans

Priority Area 5: Health Care Financing

About 25.8 percent of total health expenditure is accounted for out of pocket. This exposes the populations to catastrophic health expenditures. Although there are ongoing efforts to ensure the population has access to health insurance services through National Health Insurance Fund, Community Health Insurance and other private health insurance schemes as a short run solution. Nutrition interventions and commodities are most underfunded. The long run solution is to broaden public health financing including establishment of a mandatory Single National Health Insurance Scheme. However, this intension was not realized despite being part of the 2018/19 commitments as the bill was not passed. The move is expected to contribute in increasing percent contribution of the domestic financing

for health and nutrition, and will as well protect Tanzania from financial hardship during the need of Health Care.

The GoT in collaboration with partners commit to:

5.1. Finalize the health financing strategy to provide clear long-term direction on the future health and nutrition financing system for Tanzania as well as immediate next implementation steps relating to the existing Community Health Fund in order to ensure that it paves the way for mandatory health insurance

5.2. Implement ICHF as an intermediary strategy (with subsidies to the poor) while finalizing the approval process of the health financing strategy

5.3. Advocate for SNHI to different stakeholders

5.4. Strengthen DHFF mechanism by channelling all financial sources related to Health and Nutrition (OC and other GoT grants including Health Insurance Funds)

5.5. Increase oversight and accountability to public funds at all levels by promoting adherence to financial management procedures including increased transparency, separation of power and appropriate recording reporting as well as Public Expenditure reviews

5.6. Scaling up the RBF so that we can sustain the gains realized so far

Priority Area 6: Health Commodities

Despite improved availability of tracer items (up to over 90% in HFs) and increased budget allocation from about 30 billion in 2015 to over 270 billion in 2018/19, overall availability of health commodities could improve further. Currently, there is no end-to-end visibility of supply chain data/information, data quality is still a problem In addition, over 90% of health commodities available in the country are imported. Lastly, as reported in the 2017 holistic supply chain review, stronger supply chain governance and accountability is needed for the GoT to improve availability and accessibility of quality health and nutrition commodities in the country.

It is agreed that the GoT in collaboration with partners commit to:

6.1. Improve end-to-end supply chain quality data visibility and use for decision making

6.2. Strengthen supply chain governance and accountability for better oversight, coordination and management

6.3. Ensure that procurement of essential nutrition commodities is funded using national mechanisms (DHFF) using domestic resources (including HBF)

6.4. Promote local manufacturing of health commodities

Priority 7: Social Determinants of Health, Governance and Leadership

Not all health and health related problem are addressable by interventions with the health sector alone. In order to ensure that health issues (maternal Health, adolescent health, environmental management, early healthy nutrition, NCDs, clean and safe water, and other social determinants issues) are reflected in other sector policies.

It is agreed that the GoT in collaboration with partners commit to:

7.1. Operationalize a Common Management Arrangement Framework for inter-ministerial collaboration

7.2. Create awareness of other ministries, NGOs, CSOs and the Private Sector of their engagement in health promotion and continuously incorporate health in their policies and strategies

7.3. Strengthen engagement with other sectors to expand and improve interventions that address fertility and population growth, health and nutrition, and education to improve human capital, through (1) quality early childhood development program; (2) increased female enrolment, retention and quality in secondary schools, combined with scale-up of skills development initiatives; (3) quality education; and (5) social protection systems that target the poor.

7.4. Institutionalize SWAp, Common Management Arrangement and Development Cooperation Framework at LGA level

7.5. Conduct comprehensive HSSP IV MTR

7.6. Review roles and responsibilities of the Regional Health Management Teams (RHMTs), Council Health Management Teams (CHMTs) and all PHC Health Facility Governing Committees (HFGCs) to align with DHFF

7.7. Strengthen TWGs performance and review the TWGs as part of the comprehensive review of the HSSP IV MTR, and consider aligning TWGs Plan of Action to 21 HSSP IV strategic objectives

7.8. MOHCDGEC and PORALG to enhance a joint and representative Health Sector Reform and SWAp Co-ordination Secretariat

7.9. Engage with research institutions to design scientific and cost effective ways to answer operational research questions

Priority 8: Data Systems, Data Generation and Data Use

The MOHCDGEC in collaboration with PORALG and other health stakeholders is commit to strengthen data collection in the health facilities and ensure data collected is of a better quality, reliable and is used at all levels for planning and decision making. Since the introduction of DHIS2 the web-based database in 2013, Monthly Summary Reporting (MSR) from health facilities has improved significantly. The data is generated from over 8,000 health facilities countrywide.

It is agreed that the GoT in collaboration with partners commit to improve data quality management, dissemination and use through:

8.1. Improving Maternal and Perinatal Death Surveillance and Response (MPDSR) by scaling up Village Vital Registration, Harmonizing, integrating all vital statistics registration systems (including maternal death reporting), aligning them to national CRVS Strategy, and collecting data on maternal and perinatal deaths, infant deaths and U5 deaths to provide real-time information and inform policy.

8.2. Strengthening use of disaggregated data for decision making through

8.2.1. Introduction and strengthening of electronic data collections at facility levels aiming to get rid of the hard copies

8.2.2. Strengthen data storage repository (Health Information Mediator -HIM and MUUNGANO Gateway) in order to facilitate data exchange among health data collection software

8.2.3. Improve ICT infrastructure at all levels to enable data sharing through interoperability

8.2.4. Introduction of DHIS2 health web portal and score cards to facilitate accessibility and use of data at all levels

8.2.5. Review of DHIS2 to add relevant nutrition indicators

Priority Area 9: Health Security / Emergency Preparedness

There is increased frequency and complexity of Public health emergencies of varying backgrounds. Recent disease epidemics include Aflatoxicosis, cholera epidemic, Anthrax, Rift Valley fever, measles and dengue fever. Other public health and humanitarian emergencies continue to pose a considerable threat to the lives and health security of many Tanzanians. Events like the Ebola Virus Disease outbreak in DRC and West Africa and plague in Madagascar have shown increasing effects of pathogens linked to the animal origin. Changes in the environment, including agricultural intensification, population growth, urbanization, climate change, and human encroachment into wildlife habitats are drivers for such diseases emergence. Lack of proper sanitation and vector control strategies perpetuate the occurrence of these emergencies. Prevention of health emergencies requires innovative for immediate containment and control of future outbreaks in order to control and manage the diseases outbreaks/events the following will be necessary to be undertaken.

It is agreed that the GoT in collaboration with partner's commit to

9.1. Strengthen multi-sectoral and multi-disciplinary coordination emergency response system for all hazards in One Health Approach by reinforcing the capacity of national authorities and local communities to manage health emergencies by taking an all-hazards approach and by building strong public health-oriented and people-centred health systems, institutions and networks based on the essential public health functions and capacities under the International Health Regulations (2005)

9.2. Strengthen disease surveillance and laboratory capacities by building capacity on data collection, compilation and analysis to enable monitoring of diseases trends, in addition to ensure that data quality meets the required standards.

9.3. Monitor National Health Security Plan for IHR 2005 implementation.

9.4. Allocate adequate resources to support implementation of the National Action plan for Health Security.(2017 – 2021) and the Emergency Response at all levels.

Signed, this 26th day of November, 2018

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