United Republic of Tanzania

Ministry of Health, Community Development, Gender, Elderly and Children

Mid Term Review of the Health Sector Strategic Plan IV 2015 - 2020

Thematic Report

GOVERNANCE

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Mid Term Review of the Health Sector Strategic Plan IV 2015 - 2020

Thematic Report

GOVERNANCE

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1 Mid Term Review of the Fourth Tanzania Health Strategic Plan (HSSP IV 2015 – 2020)

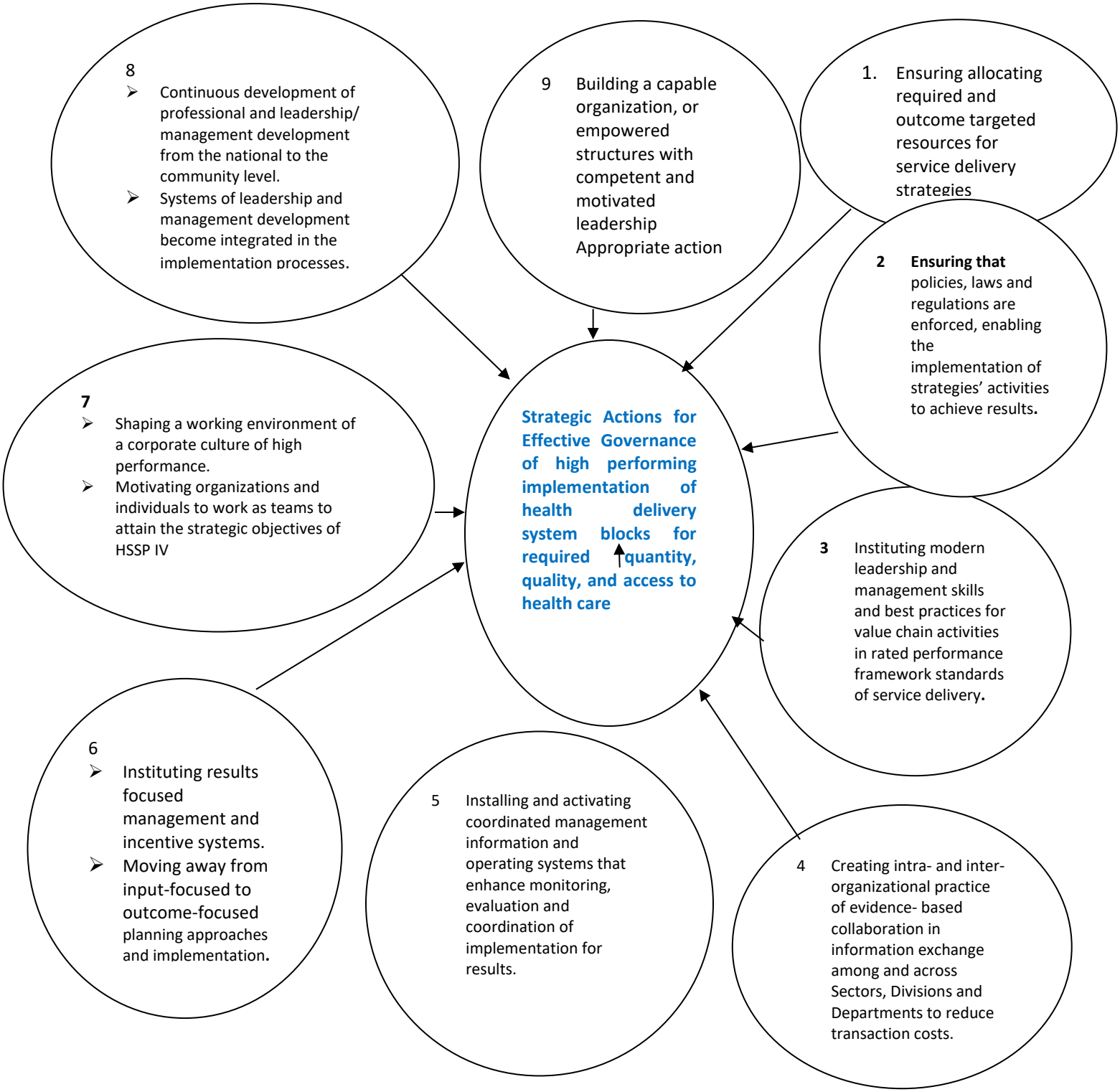
1.1 Introduction: Understanding Health Governance.

This report is a component part of the Mid-term Review of Tanzania's fourth Health Sector Strategic Plan (2015 – 2020), in short the HSSP IV 2015-2020. It focuses on the **governance of implementation of the plan.** For the purpose of this report we wish to assume a scenario of a shared health governance which envisions individuals, providers as governmental and non-governmental institutions and other stakeholders working together to create accountable systems of responsibilities of a social system and environment enabling health to be promoted and protected by all for all.

The challenge for the government, and in particular, the Ministry of health, Community development, Gender, the Elderly and Children (MOHCDGEC) is to build the capacity for ***efficient co-production of public health value*** in complex, interdependent networks of organizations and systems across the public, private and not-for-profit sectors and to measure outcomes and impacts of health related interventions. This calls for ***shared health governance*** responsibility encompassing consensus-building around substantive principles of coordination, collaboration, decentralization and distribution. Health governance is therefore a driving and facilitating function in the implementation of the Fourth Health Sector Strategic Plan.

The World Health Organization (WHO) views health governance as one of the health systems building blocks used for executing those functions which ensure strategic policy frameworks like Tanzania's Vision 2015, the National Five Years Development Plan, and Tanzania's National Health Policy as key frameworks to guide the formulation and implementation of programs to achieve specified strategic health objective. The HSSP IV and its programs are expected to be geared to, aligned, combined, and implemented with effective oversight, coalition building, the provision of appropriate laws, regulations, guidelines and incentives to create a transparent, participatory and accountable system for quality, accessible health services delivery. This is the operational and contextual definition in which the HSSP IV is getting implemented and reviewed from a health governance perspective.
Effective health governance, or stewardship, strives to create a high performing health services delivery processes that are efficient and effective in directing the health systems resources performance programs and stakeholder participation towards the strategic and the specific objectives attainment. For good health governance to happen, it is required that there be transparent, accountable, equitable and responsive delivery systems targeted at addressing the needs of the people been served. From the above operational and contextual understanding, health governance is a cross-cutting health systems function which organizes the other health systems blocks such as financing, human resources for health, health information management, medicines and supplies and technologies. The governance function processes are to be resulting into equitable, accessible, quality and affordable health services for people. It is expected that where there is an effective health governance institutionalization, the other health systems building blocks will function more effectively and efficiently. We summarize (in Figure 1) some nine health governance capability areas to be taken into consideration as we review the implementation of the HSSP IV.

Table 1: Health Governance Capability Actions Areas for HSSP IV Reviewing



1.2 Some Preliminary Observations on the Implementation of the HSSP IV

The Ministry of Health, Community Development, Gender, Elderly and Children (MOHCDGEC) understands that health is a responsibility beyond the Ministry in terms of health services promotion, and therefore calling for the significance of the inter-sectoral collaboration as a vital strategy. It has to adopt in coping with health transitions and addressing inefficiencies within the Ministry itself, and to face up with of understanding what other ministries and stakeholders are also doing in health promotion and protection. Therefore, inter-sectoral and multi-stakeholder collaboration in health services promotion and delivery is a critical success factor in improving an implementation of the HSSP IV for health outcomes of the population.

Since an effective implementation of health governance become a multi-ministerial and a multi-stakeholder concern, the implementation of the HSSP IV has to be contextualized in a typical view of government health related responsibilities in different administrative levels and sectors/lines of service delivery, specialized functional division of responsibilities, some of which are outside the MOHCDGEC and the PO-RALG portfolios. In effect, this calls for a governance of relationships that can be identified as functional division of labor made more effective by coordinating networks which can be formed at different levels such as:

- Intradepartmental coordination
- Interdepartmental coordination
- Inter-sectoral coordination
- Intergovernmental coordination

It results in functional systems thinking rather than siloed compartmentalized view of health governance activities. In other words it will be assessed how a ***whole of government approach*** works in implementing the HSSPIV. When a whole of government is functioning well, it includes ministries/agencies of government acting in coordinated and collaborative manner towards a common goal of a co-production quality health services delivery. We can call it a co-production of health outcomes. In Tanzania, we are more familiar with the terms like intersectoral initiatives and horizontal management, especially at the point of formulating the HSSP IV. A whole of government approach was initially at the point of constructing the HSSP IV strategy. A co-production should be a continuous habit because implementation goes beyond a single Ministry or Division, so as to include partnerships with other ministries, Development Partners and non-state organizations, for example the Faith Based Organizations, right from strategy formulation and planning throughout its implementation to realize health outcomes.

Whole of government denotes public service agencies working across portfolio boundaries to achieve a shared goal and an integrated government response to particular health problems. At the moment this has been noticed at higher echelons of the government than at the lower levels. A whole of Government approach needs to be as inclusive as possible, focusing on policy strategy development, strategic planning, implementation at all levels for the management and service delivery.

A decentralization framework exists in Tanzania which has given co-production opportunities down to the level of the community. It assumes working with the principles of co-production of health services, collaboration across sectors at all levels, as well as coordination of health related programming activities across sectors to the community level, taking on an implementation framework of a "***whole of society approach" or indeed an inclusive and an active participatory approach.***

2 Methodology and Approach to Getting Health Governance Data

2.1 Data collection Methods and Areas of Focus

Considering the fact that health governance is a cross-cutting series of processes embedded in policies across government ministries and agencies, laws and regulations; and noting that some of the governance instruments are administered outside the Ministry of Health, Community Development, Gender, Elderly and Children (MOHCDGEC), reviewing the implementation of the HSSP IV becomes more complex than we can simply assume. Our approach was to organize data collection according to the above 9 capability enhancing attributes summarized in Figure 1. Most of our data was based on qualitative methods, but basically a review of theoretical and official documents, and interviewing **a purposive sample of respondents**. In this regard we:

- Undertook theoretical and official documentary review, mainly focusing on health services management, organization, leadership, policies and regulations related to the facilitation or even challenges to an efficient and effective implementation of the HSSP IV.
- We developed and executed open-ended questions concerning coordination, collaboration, partnerships, programmatic information, management and alignment, decentralization etc.
- We examined operational governance issues such as transparency, accountability, efficiency, quality and access.
- We created purposive stratified sampling frames by the categories of senior government officials across sectors, government agencies, Development Partners, and the non - state sector actors who are health services stakeholders.

We carried out interviews with individuals from the above stratified categories, ***provided that they could be judged to be purposefully those respondents capable of informing us how the HSSP IV has been implemented, made achievements, or faced challenges, and opportunities experienced for future improvement.*** The list of interviewees is attached as Annex 2.

2.2 The Key Questions

The key questions this report attempt to address for the purposes of this Mid Term Review of the HSSP IV are:

1. Whether there has been **requisite collaboration** among sectors, Health in All Policies for example, collaboration and coordination across Divisions, Departments Development Partners, non-government actors (including the Faith Based Organizations) and communities of health consumers. We call this dimension ***a collaborative health governance*** which enhances:

    - **Structured communication** strategic actions for coordinated initiatives
    - **Commitment** by stakeholders to do their responsibilities.
    - **Transparency** in the processes and decision making.
    - **Accountability** (political, professional, managerial and social dimensions)

2. Whether the formulation of planned actions and strategies engaged citizens, that is, actively working with the citizens at the point of plan formulation and plan implementation. This is what we wish to perceive as health governance taking a **whole-of-society or a participatory perspective.** We anticipate the implementation of the HSSP IV to take ***a whole-of-government***

and a ***whole-of-society*** dimensions of governance. We will find out the extent to which this has happened.

2.3 Our Conceptual Framework and Approach.

We wish to distinguish between governance of health and governance for health. We conceive governance of health as administratively dealing with the six health systems building blocks under the health sector (MOHCDGEC). On the other hand we conceive governance for health as a multi-stakeholder, and if possible, ensuring multi-sectoral laws, regulations rewards, and processes taking place within and beyond the MOHCDGEC as a sector, and how stakeholders beyond the Ministry are enabled to create positive health outcomes in the context of co-production of health services (promotion and protection). This therefore calls for coordinating, harmonizing and collaborating with health sector stakeholders using resources, information sharing and networked structures of collaboration and coordination during the HSSP IV implementation.

We are taking governance for health approach as an ideal for inter-sectoral initiatives which in effect enhances joined-up government actions for health, or whole-of-government health governance. This approach enables possibilities of integrating and diffusing of responsibilities for health promotion and protection throughout governmental and non-state actors. It assumes that it is imperative to have health elements and orientation in all sectoral policies. This approach is already accommodated the current Government thinking on approaches such as the One Health Plan, the national Health Security and Emergency Preparedness and Response, the Health-in-All Policies and the multi-sectoral approach to implementation of nutrition and health security programs. Adopting and moving with the governance for health and doing lesser of governance of health (within the MOHCDGEC) somehow becomes a challenge in implementing the HSSP IV because this require a change of mind sets across sectors and agencies.

3 The HSSP IV Management of Implementation and Governance

3.1 A Strategic Direction for Health Governance

The HSSP IV has strategic direction for each area of its implementation. The strategic direction for health governance is stated as*:*

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

The implication for this strategic direction is about examining the HSSPIV in terms of co-production of health services by various stakeholders and by by adopting a whole of government and a whole of society approaches in the contexts of an accountable, partnership and collaboration, and an active involvement of communities. The ***HSSP IV strategic direction*** which states that the implementation from the health governance perspective and in line with the big Results Now (BRN) the ***Government is committed to a) strengthening leadership and management, and b) improving on accountability, transparency and inclusiveness.*** These are composed as essential attributes of good health governance.

In short the above strategic direction brings up five health governance issues of concern, namely:
Social accountability.

- Coordination and collaboration under the SWAp structural arrangements
- Decentralization.
- Partnership management.
- Performance management for quality improvement.

Each of the above in health governance is presumed to be an important driver for efficient and effective delivery on the implementation of the HSSP IV. This is based on the definitional fact that effective health governance is a process of competently mobilizing, managing and directing health system resources (human resources, finances, medicines and supplies, management information), enhancing performance focused on quality and outcomes, while actively involving stakeholders in ways that are transparent, participatory and accountable.

3.2 The findings with regard to the Strategic Direction

3.2.1 A Whole of Government Implementation and Governance for Health

An ideal expectation is to have **a *whole-of-government* in the form of a multi-sectoral approach.** This has been pursued to a large extent in the health in Tanzania as evidenced by the Health in All Policies (HiAP) initiative, programmatic consultations between the ministries of Health and Education with regards to the School Health Program and the mainstreaming health education into schools training curricula. Other cross-sectoral interactions are seen in the Water and Environment sectors.

The MOHCDGEC initiated a high level policy meeting of thirteen Ministries whose policies have actual or potential bearing health to discuss health related concerns and to explore what each of the participating ministries and other stakeholders were expected to do to promote health given their varying portfolios.
Following the high level policy (ministerial) meeting, a **high level technical committee** was created **composed of the relevant Permanent Secretaries** to continuously review how alignment of their health related interventions was being strategized in order to create a synergization for health promotion and protection to make them part and parcel of co-production of health outcomes. Ministries, agencies and other stakeholder were getting urged to ensure that their policies and policy reviews are conducted to accommodate health contents. This in effect is the Ministry's opportunity to make the implementation of the HSSP IV more multi-sectoral than it has been before. This means that the relevant health related ministries are relatively working together better than before in terms of implementing the HSSP IV. There is a need to review the gains and challenges of implementing the **Policy in All Policies following resolutions agreed at the Health in All Policies high level policy meeting.**

During the interviews it was observed that health related activities or interventions have been a concern of many sectors and stakeholders now than ever before. The MOHCDGEC and PO-RALG have been mindful in inviting other sectors to harmonize their interventions, for example the One Plan, Health in All policies, Multi-sectoral Approach to Nutrition etc. On the other hand other sectors are not mindful to invite representatives from the MOHCDGEC and the PO-RALG when they are developing or implementing their programs; some of which actually or potentially bear impacts on public health.
The 2018/19 Policy Commitment further called upon the MOHCDGEC to create awareness among other ministries, NGOs, CSOs, and the private sector on the need, role and functional participation or engagement in health promotion and health protection continuously, and to incorporate health contents in their policies, programs and regulations.
There has been a lot seen in the areas of nutrition, emergency response, infrastural improvement and Maternal and Child Health. But a lot more remains to be done.

The MOHCDGEC invites other ministries to their functional activities (including policy related) meetings, but how often is the Ministry invited to meetings taking place in other ministries? This is one of the questions raised during our interviews with one of Ministry's Director of a Division. There was an observation that Ministry's technical experts been called upon to provide technical inputs to other ministries was rather irregular or rare despite the fact that there are some ministries that are doing lots of interventions with actual or potential impacts on the health of the population.
There are doubts as to whether the MOHCDGEC regularly accesses other ministries' Strategic Plans, reviewing them and seeing to it that what these ministries and agencies practice as program interventions, licensing, or facilitating do not bear harmful outcomes to public health. One observer commenting on the multi-sectoral approach recommended that: there be pre-assessment of sectoral policies and plans, and this can be called '***Health Impact Assessment of Sectoral Policies and Programs*.** This should have a legislative enforcement in line with Health in All Policies'.

3.2.2 A Whole of Society Health Governance and Decentralisation

3.2.2.1 Active Community Participation

Another health governance ideal expectation is to have **a whole-of-society health governance** or active citizen and community engagement, a participatory approach ensuring transparency and accountability. There also exists the ***Decentralization-by-Devolution policy*** framework. It is through this policy framework that health services planning start at the facility and community levels. Community representatives are represented at health facilities (Hospitals, Health Centers and Dispensaries)

management and governing bodies. This is a n improvement from the past whereby the CHMTs were taking an upper hand in facility level planning and budgeting. Active community participation is gradually taking pace, but an active participation by the potential participating communities lack adequate information (information as an enabling knowledge power) to ensure effective oversight on accountability and transparency. Been information-deprived or been lesser technically informed means been rendered relatively powerless to participate effectively and actively. A lot of the information used at the planning and management sessions is facility sourced and technical, and less of community based information.

The Government is now implementing its D-by-D policy. It is through this policy framework that a Direct Health Facility Financing is taking place. Facilities including Health Centers and Dispensaries are empowered to create their own facility level strategic plans which are directly funded through the District Health Basket Fund. They identify problems, analyze them, prioritize them and generate activities that are costed and implemented targeting specific outputs and outcomes. This is intended to build capacity to improve health governance at the facility level.

Health facilities have their own management boards and committees to ensure accountable management of the facilities. These governing authorities have community representatives from communities in the neighborhood of the facilities. This representation gives the relevant communities to participate in the governing and managerial functions of the facilities. However that participation can be rendered symbolic and ineffective if those appointed to be in the governing boards and management committees are not adequately equipped in terms of knowledge and functional information. We also took note of the fact that the data used at the facilities is usually technical and facility based. That kind of biased information can render the the community representatives lesser powerful than the technical facility members of management. That being the case, the community representatives have lesser power than the facility management. They can therefore find it difficult to hold the facility managers to account.

Training programs to train health facility managers and the community Management and Board representatives have been conducted in several districts in regions such as Singida, Shinyanga and Kigoma. Such programs have aimed at improving health systems strengthening in areas such as Management and Leadership, Planning and Budgeting, Data Quality Assessment, Integrated Logistics and Supplies Management

3.2.2.2 Decentralization

One of our interviewees (the Director of Health and Nutrition Services Division) in the PO-RALG expressed concern and a wish to have SWAp effectively decentralized. Observations were made to the effect that SWAp remains mostly centralized as organized by the MOHCDGEC. Decentralization SWAp faces four challenges.

- Knowing the actual and potential partners at the Regional and the District level remains a gap to be addressed.
- To hold a Multi-sectoral consultative meetings at the Regional and District levels has not been systematized.
- Even when such meetings are to be held, there are no developed regional/district level terms of reference and guidelines in place to make such meetings fruitful.
- There are structure related challenges where the RHMTs and CHMTs are subjected to dual accountability, namely:
    - Accountability to the PO-RALG through the Regional Administrative Secretary, and
    - Accountability to the MOHCDGEC for technical operational matters

Sometimes it becomes difficult to know exactly how to correctly relate given the dual accountability relationships that exist. This has implications on the decentralization of the SWAp. However it simply translates to saying that the district level facilities are under the PO-RALG through the RAS/DAS, the

supervisory and administrative functions should be a responsibility of the PO-RALG, while the technical functions as guided by Policy Guidelines, codes of practice and policy management should remain a responsibility of the MOHCDGEC. Therefore there is social, administrative and political dimensions of accountability that should be a responsibility of the PO-RALG. The professional and technical dimensions of accountability should be a responsibility of the MOHCDGEC. Whenever there are medical accidents resulting from poor practice, it is the MOHCDGEC that is taken to account.
The decentralization that is envisaged within a multi-sectoral approach framework at the regional and district levels takes the form of

- Regional Consultative Meetings.
- Regional Primary Health Care Stakeholders Meetings
- Multi-sectoral Stakeholders Meetings.

There are overlaps in the functions of the above meetings**. In order to avoid confusion when it comes to enhancing health governance decentralization in a multi-stakeholder, multi-sectoral with a decentralized SWAp structure, there needs to be developed more specific and clear Terms of Reference and with responsibilities, the expected outcomes for each structure and a monitoring and reviewing strategy for the above initiatives.**

3.2.3 Partnerships, Collaboration in Planning and Implementation

Our field work found out that there are three categories of programs been implemented at the district and the sub-district levels, namely:

- The regular Government initiated programs under the normal annual planning cycle created through the Medium Term Expenditure Framework (MTEF)
- Donor direct funding of project, for example those funded by the Global Fund Facility, the PEPFA and the USAID projects.

Projects funded and implemented by some international and local NGOs, for example, the World Vision, Care International Save the Children, Plan International etc.
The three categories implemented at the district and the sub-district levels are often calling upon the attention of the front line leadership and workers at the primary health care level (health centers and dispensaries) to facilitate or collaborate in implementing such initiatives. One notices many incidences of parallelism, duplication and verticalism. Secondly some of these programs and projects operate under the direct **regulations of the sponsors and funders**, thereby creating situations of poor transparency and poor accountability. Thirdly the direct donor funded projects have funding cycles different from the Government of Tanzania planning and budgeting cycles. The HSSP IV is planned and implemented in period of five years while many of the direct donor funded projects have an implementation life cycle of three years. This creates poor inter-program alignment and poor interoperability or integration. It is difficult to say that they are part of the HSSP IV even though a lot of them to subscribe and complement to achievement of the HSSP IV Strategic goals and objectives.
There are some health governance related challenges presented by the direct partner funded projects. These are, for example:

- Poor coordination among partner initiatives in programming, funding and implementation.
- The funding does not go through the Tanzanian **Exchequer system** for the purposes been captured in the National Health Accounts. It is therefore been largely unaccountable to Government Planning, budgeting and implementation mechanisms. One senior official of the MOHCDGEC said that

"……the donor (direct) funded projects are seen like parachutes dropping unto the regular program implementation terrain. It is rather difficult to align them into our regular planning and implementation processes"

- Since not much is known in advance about the financial and technical contents of the partner direct funded projects, it is difficult for the national and primary health information frameworks which are quite vertical and unintegrated and accounted for locally.

3.2.4 Coordination and Collaboration

Since the implementation of the HSSP takes a whole-of-government approach, and taken on a dimension of health ***governance for health***, Coordination and Collaboration take on a central place. This means that those who have a stake in health services delivery have to coordinate and collaborate to avoid duplication and to reduce transaction costs. This calls for intra-sectoral and inter-sectoral collaboration in addressing health care and wellbeing problems.

Currently there have been notable actions which have been designed and implemented following the HSSP strategic orientation on Coordination and Collaboration. These include, *inter alia,*

Coordination and Collaboration with other key sectors which have a stake in health promotion and protection. Examples include School health education.

- Health related elements in curricula of education such as healthy behavior and good practice (eg sanitation) have been mainstreamed in school curriculum at different levels. The Tanzania Institute of Education (a curriculum design and development authority) of the Ministry of Education, Science and Technology ensure that whenever they design and approve subject matter of school curriculum, they consult with the MOHCDGEC to include health related technical inputs into the curriculum.
- There is now an active collaboration between the MOHCDGEC and the Ministry of Agriculture and Food Security to enhance nutrition related knowledge and actions, including food fortification at the cereals processing and packaging levels before reaching the consumers.
- It is now a Government policy to have health (promotion and protection) elements in all policies under the mandate of different ministries. Involvement of other sectors beyond the MOHCDGEC is on the driving agenda of the Government to address non-core health sectors such as Lands, Human Settlements and Housing, Water and Sanitation as well as embarking on health promotion initiatives like road safety, advocacy to change life style behaviors and food enrichment and security. These are addressed as the Social Determinants of Health in the HSSP IV strategic objective number five (5).

3.2.5 SWAp

3.2.5.1 SWAp arrangements

Tanzania has adopted the sector wide Approach (SWAp) to enhance coordination and collaboration in a multi-sectoral and multi-stakeholder dimension in the health services development and delivery. There have been established SWAp implementation structures which are currently more active at the national level than at the district level.

The SWAp Code of Conduct adopted in 2007 is expected to establish coordinating mechanisms and how partners should collaborate. The SWAp coordination is expected to be through:

- Joint Assistance Strategy of Tanzania (JAST)
- Health Sector Working Group (HSWG)
- Health Sector Technical Committee

- Technical Working Groups

Development Partners Group for Health as bilateral and multi-lateral agencies supporting the health sector a platform of dialogue among the DPs.
The above structural mechanisms operate and communicate through meetings. If these mechanisms were to be operationalized as per the SWAp Code of Conduct then the implementation of the HSSP IV would have been better performing like:

- Better coordination of partner interventions and collaboration among partners for the health sector. This is unfortunately at suboptimal performance as some of interviewees or respondents were dissatisfied with the practice of some development partners who were seen parachuting their programs and projects to some remote sites in which some duplication of efforts were said to occur.
- Creating synergies and alignment with local priority needs and existing priority health services interventions. The poor synergies were caused by poor levels of communication owing to the fact that some of the "parachuted interventions" come into the operational localities with their own forms of accountability and communication strategy.
- Reducing transaction costs if collaboration and ordination are enhanced.
- Promoting policy orientation and planned strategic actions if there could have been pre-planning communication to ensure programmatic alignment.

An Institutionalization of the SWAp implementation arrangement at the sub-national level was another part of the 2018/19 Policy Commitment. Some of the SWAp arrangements have been seen to enhance the implementation of the HSSP IV more effectively. The institutionalization is relatively better done at the national level than at the sub-national level. With the Policy of Decentralization, the SWAp institutionalization is expected to take effect at the district level. There are many ministries, Development Partners and other stakeholders whose activities can better be coordinated if the SWAp arrangement is institutionalized at the local level where the implementation front runners are creating and delivering services.
Malaria program, for example, is one of the vertical programs with lessons of experience for modified decentralized coordinated programming. One of our interviewees (the Malaria Program Manager), informed us that there has been a habit of holding a five days' regional Malaria review meetings involving the RHMTs and the CHMTs to discuss and deliberate on issues and strategies related to malaria control and prevention. These meetings involve various partners at the regional and the district levels. In a significant way, this points to an opportunity to decentralize the SWAp (governance) coordinating structures to the sub-national level using the Malaria Program approach. The problem still remains in the sense that such meetings are not systematically scheduled, and they are infrequent. They are seen to take **place when there are campaigns** initiated.

3.2.5.2 Functioning of the Technical Working Groups (TWGs)

There are three initiatives that have been instituted to address the challenges of partnership management, Collaboration, Integration and Accountability namely;
The institutionalization of SWAp, Common Management Arrangements and the Develop Cooperation Framework. As we have discussed, a lot still needs to be improvement in these areas:

- Activation and strengthening of the Technical Working Groups' meetings and their performance outcomes. As a part of partnership. Collaboration and coordination.

- Harmonization of programming amongst Development Partners and the Government at different levels of the HSSP IV implementation. This an area with a big challenges because of varying priorities and poor synergization.

The above have been called for at different forums involving the Government and the Development Partners such as the Joint Health Sector Review meetings, the Common Management Framework and the Development Cooperation Framework. There were observed some challenges as we review the implantation of the HSSP IV.

The implementation of the HSSP IV is expected to strengthen and use the SWAp arrangement especially the Technical Working Groups (according to the 2018/19 Policy Commitments) is expected. The TWGs are not working as effectively as anticipated because (according to the some of interviewees):

- They are not often attended to their expected capacity by senior technical GOT officials capable of making commitments making and handling.
- Some DPs use the TWGs as forums to discuss and endorse their own mission-agenda thereby alienating other DPs.
- Much seems to depend on the 'burning moments' and issues of the time, for example when there emergencies, budget cycle events and campaigns.
- The movement of the seat of Government from Dar-es-salaam to Dodoma has resulted into poor attendance at the TWG meetings. It appears to be a matter of cost ineffectiveness to travel to Dodoma for one day or two-hour meeting, like attending a TWG meeting.
- Even with the existing Terms of Reference for the TWGs meetings, they still remain mainly advisory, and without authority to ensure deliverables of such meetings.

It has been observed during our interview sessions that we cannot generalize that all the TWGs are not meeting as expected. Some are quite active depending on the issue of the time. During the budget processes, the TWG responsible for health financing become very active. Some TWG respondent argued that it is not cost-effective to travel to Dodoma for a couple of hours meeting. This partly explains some of the reasons for the poor attendance at the TWG meetings. Others argued that the agenda were not been distributed well in advance to enable them to prepare well in advance.

In line with the 2018/19 Policy Commitments, it has been called upon to decentralize the SWAp arrangements (including the TWGs) and the Common Management Arrangement. The question still remains as to whether or not, the national level challenges to having effective TWG meetings will not be repeated at the sub-national level.:

3.2.6 The Health Basket Fund (HBF)

Many of the DPs do not route their funds through the HBF, but through the direct financing arrangement. Those who are out of the HBF are, for example, the UKAID, the USAID, PEPFA, GIZ, etc which have their activities financed via vertical arrangements, and hardly accountable to the local authorities. Some of our interviewees tend to regard such programs and projects as parachuted from the donor countries to Tanzania. Such funds are unaccountable for by Tanzania's exchequer system.

The Swiss Development Cooperation (SDC), for example, supports the HBF but does not contribute to the General Budget Support or GBS. The SDC opted out of the GBS because of its **fear of failure to ensure accountability and transparency** as required by the DPs' funding arrangements and regulations. Our respondents argued that where and when funds are pooled into a general basket, it becomes difficult to account for the outcome and impact of the funds so contributed. Funding outcomes and impact cannot be accounted for on a basis of who contributed, and the extent of impact of the contribution. Reporting on accountability to each of the contributing funders becomes rather cumbersome and difficult.

The Swiss, are for example, are also involved in some vertical programs such as the **'Prime Vender'** project to try to address shortages of medicines and medical supplies at the facility level. This is very much in alignment with the Policy of Decentralization-by-Devolution (D-by-D) because facilities are enabled to supplement the MSD delivered supplies by procuring from approved prime venders. It started as a macro-macro approach, transforming itself into a macro-micro approach, with projects in Shinyanga, Dodoma and Morogoro. It has demonstrated to work so well in as far as assisting in diversifying the source of medical supplies and giving some autonomy to the facility managers to procure supplies undelivered by the MSD at an alternative source. This has in effect improved the availability of medicines at the health facilities, thus enhancing the dream mission of the HSSP IV implementation **"to reach more households with quality health services".**

The Swiss supported **prime vender project** is now getting scaled up country wide. This means that some vertical projects have significant impacting effects, if the knowledge and experience gained can inform performance improvement in the health services delivery. It also suggests the implementation of the HSSP can take an advantage of some existing impacting bilateral projects to achieve some of the HSSP IV strategic objectives.

3.2.7 The Public Private Partnerships and the HSSP IV Implementation

Tanzania has a long history of working with the private sector. The Faith Based Organizations (FBOs) delivers health services in remote and urban areas of the country. Currently there are some of their facilities have been categorized as Government Designated Hospitals. Government initiatives are seen into constructing new dispensaries, health centers and hospitals. The Christian Social Services Commission (CSSC) coordinates all the FBO health facilities operated under the ownership of the Christian denominations in the country. The construction of new facilities (by the Government) in places where there exist the FBO facilities is viewed by two lenses. It has been a tradition of a situation whereby where there is an FBO facility, a Government facility would not be established. This is the logic of the **Designated District Hospitals** where such hospitals operate under financial support by the Government using a "Service Agreement (SA)".

Our FBO respondents complain that the current investments to create new facilities where the FBO ones are located contradict earlier policy commitments not to create new (competing) facilities where there exists an FBO government supported facility. However another view is to argue that the population has increased, the demand for services is growing, and the FBOs are not expanding their structural facilities. The Government (call it the tenant of the FBOs) now has the ability to construct its own facilities and can work toward vacating the FBO facilities which have hitherto "rented to the government".

On the other hand some of the private health facilities have suffered because of the **Exemption Policy** which leaves only about 30% of services users as paying users. This bites into the revenue collection and unsustainability of services delivery operated by the FBOs who have render certain services free of charge. The not-for-profit health services actors are unhappy to see the existing their Service Agreement (SA) been put aside in some areas. For example it has been a matter of policy that where there exists an FBO hospital the Government should not build another one nearby. There are several FBO hospitals which serve as District Designated Hospitals. The FBOs do not anticipate a Government duplication of the services they offer in the neighborhood of their facilities. But as argued above their argument might not hold water.

On the issue of viewing the construction of new facilities by the Government as going against the SLA, one of our respondents made the following observation:

"***If a land lord has many tenants in his or her houses, and some of the tenants have now acquired capabilities to construct their own houses to move into, the land lord has no right to complain or deny tenancy- exit tenants from moving into their newly built homes***"

Service Charges as Impediment to Access

The indicative price list is attached to the 2007 Service Agreement instrument. A lot of things have happened to make the indicative prices inapplicable. Some private-for- profit providers have highly priced service making them inaccessible to the poor needy patients. **Privatization without regulated indicative pricing tends to make health services inaccessible to the poor.** Perhaps this service inaccessibility as a result of high prices will be resolved by an introduction of a compulsory National Health Insurance.. Given such conditions one envisages recommending that: Many of the burning issues in PPP implementation are expected to be addressed at the PPP TWG meetings. The PPP TWG has not met for about a year since the Government's move of offices to Dodoma. The argument could be discussed and resolved at such TWG meetings. It has often been observed that the private health facilities do not accept to treat accident or emergency cases. There is a need for a policy review and regulation in this area as suggested by some of our respondents.

4 Some Reflections on Specific Issues

We hereunder, summarize what and how our respondents responded on the issues of Health services accessibility, performance management, equity, decentralization accountability, partnership, collaboration and coordination. These are some of the essentials of good health governance to improve performance of health services delivery.

4.1 Access to Quality Health Services: The Case of Drugs Access

There are other dimensions other than reaching a facility such as access to specialists (referral access), **getting the right medication by qualified pharmaceutical staff,** failing to get treatment because the desired services are overpriced and out of those covered by health insurance etc. We had no time to critically examine these dimensions.

Upon having interviews with some respondents from the pharmacy Board, we realize that often we discuss shortage of health services staff in terms of clinicians and nursing staff. We tend to forget about pharmaceutical personnel. Tanzania went on a move to have a policy of 'Accredited Drugs Dispending' (ADDO). There are 14,760 ADDO shops which can claim to have a quality dispenser. However there are 22,000 altogether. This means that the existing capacity 6.6%. This is a serious situation because of the fact the ADDO shops were meant to enhance correct dispensing as well as to enhance geographical access to medicines.

There were two reasons given for the gap. One is that we have only one public pharmaceutical training school (Muhimbili). However there are a number of private sector pharmaceutical training institutions. They are mostly unemployed upon graduation.

Many of the pharmaceutical outlets are located in the urban areas. Sometimes some patient have to travel to distant urban areas to access qualified pharmacists and prescription drugs (not dispensed at the ADDOs). Therefore there is also distributional iniquity of qualified staff that hampers access to safe and quality health services.

In terms of structural organization, the pharmaceutical services are administered under a unit (not a Section or Division). However the unit has huge responsibilities such as:

- Overseeing safety and efficacy of pharmaceutical products.
- Surveillance over imports and distribution of pharmaceutical products in the country.
- Dealing with complaints and appeals from the consumers and operators of pharmaceutical outlets.
- Reporting on trends and incidences on matters related to pharmaceutical activities at border points, sea ports, airports etc.

The manning structure is Pharmacists, Pharmaceutical Assistants, Pharmaceutical Technicians and Pharmaceutical Dispensers (since 2016). The last cadre was to have more personnel at the primary level to enhance access and equity, but this important cadre has not been placed on the scheme of Service.

Indeed talking about equity and access, the Government has decided to integrate the hitherto volunteering Community Health Workers into the Scheme of Service of the MOHCDGEC personnel to enhance outreach services to remote communities. This is big plus to enhancing the primary goal of implementing the HSSP IV, reaching every household with quality health services. This goal can better enhance if the category of the Pharmaceutical Assistants can also be integrated into the ADDO dispensing outlets.

4.2 The Strategic Leadership Level Relationships: MOHCDGEC and PO-RALG

A successful implementation of the HSSP IV depends on understanding the responsibility and endowed powers, and effective management of collaboration and partnership management an understanding the role and functioning of the coordination structures is important. We make brief comments starting from the top policy governance level down to the operational services delivery level

There are many key players in the HSSP IV implementation but the MOHCDGEC and the PO-RALG. The HSSP IV clearly states that role of the MOHCDGEC concerns policy making and management and technical areas concerning quality assurance. The role of PO-RALG is simply stated as that of implementation. There are overlapping governance matters which need to be further clarified, especially relating to power and authority for accountability purposes.

Most often we talk about PO-RALG and the MOHCDGEC as if they are of equal authority in terms of hierarchy and structures. We need to understand that power related placement or hierarchy confers relative power, and the higher the placement, the higher the power and authority conferred. There are two types of ministries. First are the **central ministries** which are structurally higher with conferred power than the other ministries. By virtue of their **hierarchical power,** the central ministries are systemically enabled to make policies and decisions over, and cutting, or compelling compliance from other institutions including other ministries. Ministries in this category include those which are under our executive presidency eg PO-RALG, PO-PSMG, the Vice Presidents' Office (Environment) and others such as the Ministry of Finance and Planning, Laws and Constitutional Affairs and Home Affairs. Usually cross cutting responsibilities are placed in the central ministries. This is the main reason that we have One Plan, National Health Security and TACAIDS under the mandate and authority of central ministries.

The second category is composed of **sectoral ministries** such as the MOHCDGEC, Education, Agriculture, Industries and Commerce, Water and Natural Resources etc. These (sectoral) ministries are separated by the criterion of technical power or authoritative functionality, and they treat themselves as equals in terms of hierarchy of power and authority. There is no one of these ministries which can make binding decisions over the technical decisions of the other ministries. This is why we call for **harmonization and collaboration of policies programs and decisions** on matters most likely to affect or impact on the technical functions and responsibilities of the other ministries. This is the rationale for calling the high level meeting that discussed and agreed to have health aspects in all (sectoral and central) ministerial policies. Consensus in cooperation, collaboration and partnerships are key areas.

There are coordinating and collaboration structures (committees, meetings and focal offices) which have been created to implement the HSSP IV. We note that these are not at the level of operational processes involving technical compliance and enforcement of regulations.

4.3 Coordination Alignment and Collaboration of Donor Initiatives

During our interviews there were observed some weaknesses that can be addressed during the implementation of the HSSP IV and taken into account when formulating the successor plan, that is, the SSP V. There has been a tendency of '***projects chasing available funding opportunities',*** be they of priority or less priority. Some such opportunities have been of the vertical donor induced programs. Some respondents expressed their concerns that sometimes such initiatives undermine local and national level priorities. Such programs become unsustainable, difficult to align and integrate. This leads to situations where we see two or more DPs funding the same activity uncoordinatedly. For example, Korean International Development Agency (KOICA) and the Swiss Development Cooperation (SDC) undertook the training of Community Health Workers in Simiyu. KOICA trained 160 CHWs while the SDC trained 200

workers. There was no collaboration and harmonization. It was most likely that each was stepping on each other's feet. There are two things that the Government can do that we recommend.
There also seems to be a problem in the sense that some big programs have their own information for monitoring and evaluation, and they do not **systemically talk to each other**. This is yet another area of poor collaboration and coordination.

5 Analysis of Strengths, Weaknesses, Opportunities and Challenges (SWOC)

Health governance as defined earlier is not static, it is dynamic. There are areas of strengths and opportunities which can be exploited to enhance an effective implementation of the HSSP IV. There also weaknesses and challenges which need governance interventions. We summarize as follows, and according to some key health governance critical areas.

Table 2: Governance Strengths, Weaknesses Opportunities and Challenges (SWOC)Analysis

1. Decentralization and the HSSP IV Implementation

Strengths	Weaknesses
• There already exists a Policy of Decentralization -by-Devolution and legislation to facilitate decentralization. • Elaborate structures from the primary to the national level for health governance. • An elaborate (national, zonal, regional and district referral system is in place. • Development partners support the decentralization policy. • Tanzania has a long history of PHC since the Alma Alta Declaration. • D-by-D is now owned by local governments. • Facility Management Teams are constituted in the D-by-D framework.	• There still exists a supply driven approach where ministries and DPs behave like givers benevolent of services to communities of users • A demand driven approach is yet to grow its roots in the lower level and service user communities. • Poor leadership and management owing to low or poorly trained personnel in health governance matters. • Too much of information polarization and segmentation or segregation leading to poorly coordinated implementation. • Poor accountability and transparency • Poor Government, DP and private sector coordination of some of their projects.
Opportunities	Challenges
• The Government is currently reviewing the National Health Policy to accommodate new innovative health governance approaches. • Many Development Partners are willing to support the Government policy and programmatic approaches • Local communities are willing to contribute to health services development initiatives. • Government is currently developing a One Health National Insurance Framework that can enhance financing equity and service access.	• There are some stakeholders who wish to continue a system of verticalism, inhibiting transparency as they use their own information and accountability procedures. • Some good DP sponsored initiatives are difficult to sustain after the programs ending. • The demand for service gets increasing but the existing systems' resources remain constant. • Getting with HiAP at a multi-sectoral level.

2. Public-Private-Partnership Management

Strengths	Weaknesses
• The existence of the PPP policy and an enabling law. • Existence of several DPs willing to partner with the Government to support the health sector and the PPP policy implementation. • Existence of local and international health related NGOs which wish to work with the Government to improve quality and access to health services.	• Low level of local level investment capacity. • Not many banks are ready to finance loans for investment to the health services sector. • Existence ring-fenced information by investors in health on account of transparency, especially revenue. • Lack of guidelines on health service price structure for the consumption and use by investors
Opportunities	Challenges
• Diversity of areas of health services for support. • Existence of the service level Agreement through which partnering in service delivery can be managed. • The existence of the privatization policy which allows investment in the private sector.	• Managing a liberalized partnership without information and pricing structure. • Balancing between levels of profit, safe service and value for money is a problem. • How to give incentives to the would be investors without compromising on quality of care.

3. Innovative Leadership and Performance Management Systems

Strengths	Weaknesses
• The Government already adopted, and with performance improvement practice. • The initiation of the Bign Results now and Result-Based Financing becomes a significant leverage to improve management culture. • The Government has moved away from the in-put based planning to an outcome-base programming and implementation. • The Star-Rating and Accreditation mechanism can work well to improve service and to reward those who perform well.	• The leadership and managerial sciences have not been adopted or mainstreamed into the health services training curricula. • Many of the facility managers are used with the old public administration of adherence to routine than innovation. • The health services management is drifting into change management with its leaders and manager been trained in change management.
Opportunities	Challenges

• There are a number of on-line training opportunities to enhance required modern managerial knowledge and skills • Coaching and mentoring skills can be imparted for systematic knowledge and skill transfer on the job training to those who are lesser qualified. • There number of DPs who can be requested to build capacity and capability in innovative management practices. • Management and leadership knowledge contents can be mainstreamed into training schools curricula.	• Implementation of plans based innovative modern management approach with adequately trained managers. • The facilities are understaffed, such that sending out workers for training undermines the existing short team capacity for program implementation. • Leadership and Management as such is not core to the health services professional performance expectations. • High twin rates for those already trained becomes a norm than exception.

6 Performance According to the HSSP IV Strategic Objectives

The implementation of the HSSP IV is geared at achieving five strategic objectives. We summarize the strategic objectives and the state of their implementation by stating what been done from the governance point of view and what needs to be done further as recommendation.

6.1 Strategic Objective No. 1 Quality

The HSSP IV set out to achieve measurable quality improvement of primary health care in the country.
The Ministry has a Division of Quality Assurance which oversees and guides quality improvement processes.
The Division has created several quality improvement guidelines including the Supportive Supervision Check Points list that is adapted and used as the RHMTs and the CHMTs visit facilities to check on listed standard attributes that a particular facility should have or adhere to. The Supportive Supervision team discusses the achievements and challenges of delivering standard quality health services at the visited facility.
The Ministry has introduced and continued to use some innovative modern management concept and practices such as the 5S, the total Quality Management and some payment- for-performance approaches such as the Result Based Financing in which the meeting of facilities' performance criteria are used to make funds allocation decisions for in accordance with performance.
The Ministry has introduced rating and accreditation mechanisms such as the Star Rating procedure. Health facilities found to be at o-star rating status have been given some support to enhance structural and other forms support in order to qualify for farther climbing onto a better rating level. Many facilities have been improved to move from lower levels to high levels on the Star Rating criteria application. Even with the above performance based management innovations used to implement the HSSP IV, there are some points to be observed such as:

- The Supportive Supervisions' Checklist is useful, but the list is just too long to be comprehended and applied in two to three hours of Supportive Supervision visit at a health facility. Even where problems have been identified, it is difficult to make follow visits because of logistical inadequacies.

- In the past the Supportive Supervision used to take place monthly per a facility. That was a more closer supervision than the present practice of having a quarterly Supportive Supervision visits mainly because of financial constraints to handle the required logistical facilitation.

6.2 Strategic Objective No .2: Improvement of Equitable Access to Services.

During the implementation of the HSSP IV, the Government has embarked on massive facility structural improvement including the building of new hospitals, health centers and dispensaries country wide. This improves geographical access to health services rather significantly.
Much as there is an elaborate distribution of facilities country wide for enhancing structural geographical access, there are two dimensions which need to be addressed. Some people fail to access services because of the inability to pay, and the fact that a majority of the Tanzanian population have no health insurance. The Government / MOHCDGEC are working on and with a coming out Health Financing Strategy which is expected to address the wish to have universal health insurance.

6.3 Strategic Objective No.3: Active Community Participation and Partnerships

This objective relates to the extent to which communities of service users have an opportunity for voice and accountability to express their views and feelings on adequacy of the services (quality, quantity and value for money attributes). This also refers to the extent to which communities of health services consumers can participate in and influence priority setting and decision making at the health facilities in their environs.
The MOHCDGEC has institutionalized a number of steps on this dimension of health governance, including for example:

- Installation of suggestion boxes in many of the health facilities.
- Some health facilities have also introduced citizen charters, but this participation instrument has been poorly adopted even though it is enshrined in the country's Public Service Reforms.
- The introduction and adoption of the **Direct Health Facility Financing Policy** comes in with an institutionalization of Health Service Facility Governing Boards and Committees. The Boards and the Committees have representatives from the facilities neighborhoods, in which the representation gives opportunities to participate in planning priority interventions and financing decision making.

Notwithstanding the above Community level representation and participation, there still exists room for improvement.
First, there exists asymmetry of power between the health facility management and the community. The communities have less knowledge power than the health facility management staff. Where such a condition is predominant, then community participation becomes more symbolic than active.
Secondly, most of data for decision making at the facility are facility generated information. It hardly include regard some community representatives find themselves participating in issues for which they lesser information than the facility workers and managers. With this kind of knowledge and information power asymmetric relationships it becomes quite difficult for communities to hold the facility workers and managers accountable. This situation can become worse if it is shrouded by lack of transparency on the part of the management which may resort to guarded information to avoid questions related to professional, ethical, financial, administrative, and social forms.

6.4 Objective No. 5: Addressing the Social Determinants of Health, Collaboration with Other Sectors.

The implementation of the HSSP IV is engendered to take ***a whole-of- government approach*** to health services planning and implementation governance. The implementation of this approach
Has been seen to operate within the HSSP IV implementation in events such as:
One Plan II initiative as coordinated from Prime Minister's Office as a central ministry which has the power and authority to call for compliance as a central ministry from all the relevant sectoral ministries. The technical health related contribution is systematically secured from the MOHCDGEC.
Different Ministries have policies, laws and regulations having a bearing on health services. These instruments are base and implemented in ministries such as Education, Science and Technology, Agriculture and Food Security, the Vise Presidents' Office (Environment) Water and Sanitation, Lands, Housing and Human Settlement etc.
The Ministry has initiated the Health in All Policies with some coordinating implementation structures such as:

- High level Ministerial Coordinating Committee ensuring the mainstreaming of health impacting elements into their respective ministries.
- A high level Ministerial Steering HiAP Committee.
- National HiAP Technical Committee as a Technical Working Group.
- The last two organs are to **be replicated at the sub-national level** so that we have a District level HiAP Committee and a Coordinating Secretariat at the district level.
- One can make an observation to the effect that much as there is the HiAP initiative, this can presently be seen more easily at the national policy strategic level than at the operational level. But it is at the operational level where result based coordination, partnerships and collaboration can be monitored, evaluated and rectified. This means ensuring how well the laws, rules and regulations are well constructed and enforced to ensure **health promotion** and **health protection** should be pursued and monitored as the implementation of the HSSP IV continues.
- The existing rather "siloed" pyramidal information sharing and communication is rather inadequate and disintegrated for the purposes of trucking down how various programs, laws, rules and regulations, are to ensure health promotion and health protection.

7 Concluding Remarks

A lot has happened during this period of implementing the HSSP IV. Give the recent policy and planning and programmatic events. There have been other events like One Plan II and the National Health Security which were not in place at the the HSSP IV launching, not accommodated in this review, but they also contributed in achieving the HSSP IV strategic mission and objectives. Some MOHCDGEC Departments have created their own Strategic Plans but they are not covered in this review.
Much more has been achieved through combined effort of the HSSP IV stakeholders, but there is always a room for improvement. Some recommendations have made at the ,end of every major conclusions on generalizations made in this report. The study observations and recommendations are summarized in the table below.

Conclusion of Study Observations, Generalizations and Recommendations

Study Observations	**Recommendations**	**Time Frame**	**Responsibility**
1. There were observed some loop holes and gaps in working within the SWAp, and Common Management and SWAp Code of Conduct. The Health Sector Working Group, the Health Sector Technical Committee and Technical Working Groups are infrequent or p**oorly attended. If they** were to function as anticipated, collaboration would have been much better.	1. a) The coordination structures need to be reactivated and where necessary roles and terms and conditions of performance are set, schedules agreed and reporting strategy is agreed, and operationalized.	Immediate or as soon as possible	Director of Policy and Planning (DPP) MOHCDGEC
	b) The Government of Tanzania need to set out priority needs in advance with a plan after a needs assessment clearly known to the would be partners.	Medium Term	DPPs in MHCDGEC and PO-RALG
	c) There needs to be develop a communication strategy and framework to ease up efficient exchange of communication among partners and the government responsible officers.	Short to Medium Term	DPPs in MOHDGEC and PO-RALG.
2. The 2018/19 Policy Commitment calls for decentralization the SWAp coordinating structures to the District level. But this requires a communication strategy and consensus building at that level.	2. a) **The SWAp institutionalization will function better if some Guidelines get developed** to guide the initiative and its operations. If this move (decentralization of SWAp to the sub-national level) gets well developed, such a move has a high potential of profiling coordinated health, governance at that level. It will enhance inclusivity, collaboration, programmatic integration and alignment better communication, transparency and accountability at the district and the sub-district level. b) Have the Decentralized SWAp structures' meeting to operate	Immediate to Medium Term Medium Term	PO-RALG and MOHCDGEC PO-RALG and the MOHCDGEC.

	on an agree schedule known to all partners in advance.		

Study Observations	**Recommendations**	**Time Frame**	**Responsibility**
3. There were observed complaints of there been parachuted dono-sponsored vertical projects which were useful but mostly unaccounted for and unintegrated into the Governments planning and implementation frameworks.	The MOHCDGEC and the PO-RALG do a prioritized needs assessment and to have the priority potential donor – supported areas known by the would be partners well in advance for accommodation into the funders' plans as well as in the Governments planning system"	Medium and Long Term.	MOHCDGEC, PO-RALG and the DPs.
4. There are efforts to replicate national level SWAp coordinating mechanisms such as the TWGs. However these have not worked very effectively at the national level. Secondly given the diversity of DPs and other stakeholders at the sub-national level, proper observations need to be taken into account in order to avoid mistake experienced at the national level.	**Recommendation No 4.** a) Review and reactivation of the eleven (11) TWGs at the national level needs to be addressed in order to strengthen them by better defining responsibilities and their deliverables. b) Mapping of the potential health related stakeholders (GOT, DPs. NGOs, CSOs and the private sector operations) has to be done. Different regions and districts will have different volumes and capacities of the would-be stakeholders to compose the decentralized SWAp and the TWGs which may vary from region to region in terms of composition and expectations. c) The MOHCDGEC and PO-RALG need to come to consensus on the establishment and responsibilities for operationalizing the decentralized SWAp arrangements before calling the SWAp partners when the TWGs will have been reviewed.	Short to Medium term	MOHCDGEC (DPP) and PO-RALG Director of Health, Social Welfare and Nutrition

Study Observations	Recommendations	Time Frame		
	d) There will be a need to develop clear guidelines, Terms of Reference and Action Plans for the decentralized SWAp arrangements including the TWGs. The existing TWG Terms of Reference are to be reexamined.			
Some private for profit providers have overpriced services which are accessible by the rich. The non-state service providers have challenges owing to the implementation of the exemption Policy.	**Recommendation 5** a) The Universal Health Insurance and perhaps, compulsory health insurance be instituted to enhance lateral and vertical (referral) equities and accessibility to specialized services. b) The Government can develop or revisit the **health services pricing policy in order to set up indicative price lists for various categories of health care and treatment services.** At the moment some of the existing private health providers' prices cannot be accepted by some health insurance providers, and in effect denying access and undermining equity. c) There is a need to revisit the country's health services privatization so as to **create a regulated private health services sector and actors** because pricing liberalization without a properly regulated pricing regime might undermine equity, access; and indeed working against the spirit of the HSSP IV of reaching each household with quality health services.	Immediate or short – term but to be institutionalized	MOHCDGEC's, DPP and PO-RALG's Director of Health, Social Welfare and Nutrition.	

Study Observations	Recommendations	Time Frame	Responsibility
Very often we tend to limit our thinking of access in terms geographical service access without taking an account of the fact the Government has approved drug dispensing outlets (ADDOs) to ensure correctness of drug dispensing, even for shops located in distant remote places.	**Recommendation No 6:** a) It is recommended to increase the number of pharmaceutical dispensers and be integrated in the scheme of service to enhance equity and access. b) A close partnership between the Government training institutions and the private sector to develop an accredited cadre of approved drugs dispensers will enhance deployment and access to correctly dispensed drugs.	immediate	DHRD and the Pharmacy Council
Study Observations	**Recommendations**	**Time Frame**	**Responsibility**
The multi-sectoral approach as often understood is at the level of policies. However implementation as such is at the level of operations, outcome focused activities, law and regulatory enforcement, compliance management etc. This level of detail is hardly monitored across sectors and levels of services delivery.	**Recommendation No 7** a) There be institutionalized a **"Health Impact Assessment of Sectoral Ministrerial policies,** program and regulations". b) There be given a legislative power for compliance purposes to enforce the "Health Impact Assessment". c) It would a reasonable and practical idea to have a critical review of all the central and sectoral ministerial instruments of power and authority, policies, plan programs, laws and regulations in order to find out the extent of positive and negative effects and impacts on the health sector. The review team is recommended to be multi-disciplinary. It will make actionable recommendations shared across relevant sectors.	Medium term Short to Medium Term	PO-RALG and MOHCDGEC PO-RALG and MOHCDGEC

The implementation of the HSSP goes through two authoritative processes, namely, the **administrative and technical** processes.	**Recommendation No 8;** It is therefore recommended that a) The pyramidal central ministries and the sectoral structures embark on discussing and harmonizing their roles very clearly.		
Study Observations	**Recommendations**	**Time Frame**	**Responsibility**
The RHMT is administratively Accountable to the Regional Administrative Secretary (RAS). But the RHMT is also technically accountable to the MOHCDGEC (technical Divisions) but also through (routing) communication the RAS The same is replicated.	The PO-RALG and MOHCDGEC have to clarify as to which are their technical processes so as to ascertain responsibilities for and accountability to, or for which specific roles in the implementation of the HSSP IV. b) Efforts are made to ensuring the enforcement of laws, rules and regulations relating to, or impacting on, health and wellbeing of the population. c) All ministries need to be concerned with health promotion and health protection to reduce Non-communicable diseases.	Medium to Long Term.	MOHCDGEC, PO-RALG and other relevant Ministries.
Some of the Donor (DPs) assisted projects are not well coordinated. One finds several DPs wishing to or already investing in one region or district or one thematic area. Some of these projects are vertical, some sponsored by some international NGOs. They are all implemented along with the local MOHCDGEC programs which are in the HSSP IV and the CCHSPs.	**Recommendation No 9:** a) There is a need to create a 'User Manual on the basis of the proposed Development Cooperation Framework to guide the DPs conduct of collaboration in constituting their project to be implemented in Tanzania. b) During the SWAp or TWG meetings the Government needs state in advance (after a Needs Assessment exercise) what is required, and clear areas where DPs can factor into during the preparation of their development assistance projects to Tanzania. c) There be a Potential Donor Contribution Mapping Study involve the Government and the Donor.	Short to Long Term	MOHCDGEC, DPs and other stake holders.

Study Observations	Recommendations	Time Frame	Responsibility
Information exchange and efficiency of its flow is key to efficient and effective coordination of implementation. Most of the programs found at the implementation sites have their own information systems Programs like Malaria, TB, HIV and AIDS etc have their own information strategy and package which are hardly integrated into other ongoing programs.	**Recommendation No 10:** It is recommended that the envisage integrated health information system or GOTHOMIS take this gap into account with a bid to have systemic program information flows that facilitates knowledge of who is doing what, where and when, in order to enhance transparency, synergy, alignment, collaboration and coordination of Government, DP and other stakeholders interventions.	Immediate to Medium Term	PO-RALG and MOHCDGEC relevant Divisions.
There are quality improvement interventions and Guidelines which have been instituted during the HSSP IV implementation. Some of them eg the Supportive Supervision Check List need to be revisited, and also to institute other methods of quality improvement verification.	**Recommendation No 11:** a) Let a coaching and mentoring system be institutionalized as a mechanism of knowledge and skills transfer where each better knowledgeable practitioner becomes a mentor or coach of those who do not know as much. This will substantially complement or supplement the current practice of Supportive Supervision. b) Virtual visits to coaches and mentees, and vice versa, would be make the Supportive Supervision a continuous systematic process and, it would institutionalize continuous follow-up on progress made on an identified problem.	Short to Medium Long – Term when creating coaching and Mentoring institutionalizatio n an operational practice for all	MOHCDGEC-Quality improvement Division PO-RALG.
Study Observations	**Recommendations**	**Time Frame**	**Responsibility**
By and large, geographical health services access (if we use the criterion of having health facilities) is not a big problem. A major problem with access to services is with	**Recommendation No 12:** An institutionalization of compulsory health insurance for all citizens can be becomes a panacea to problems of access related to health financing. This	Short/ Immediate	DPP - MOHCDGEC

financial facilitation of service uses. This is why the Government is creating and adopting a "Health Financing Strategy in which a universal health insurance is one of the objectives.	recommendation needs to be stated clearly in the new National Health Policy.		
We discussed the need to adopt a "***whole-of-government***" and a *"whole of society"* approaches to enhance local community engagement. The implementation of the HSSP IV has raised some of these approaches, but more so, the whole –of- Government approach. Much needs to be done to attain a **whole of society** engagement.	**Recommendation No 13:** a) There is a need for development of Guidelines on the recruitment of knowledgeable representatives. The critical criteria for representation should have minimum qualification which should include awareness of the facilities' resourcing, management, planning and commitment rather political or social popularity. b) The profile of health services facility representatives should be guided. i. Inclusion local CSO or NGOs who have knowledge and stake on health services improvement. ii. Some patient groups such as those who societies of people living with HIV and AIDS and diabetes, underserved populations such as women's groups. iii. People or leaders of professional associations, the press and private providers. iv. Corporate representatives of health services providers and suppliers.	Short to Long Term	PO-RALG Division of Health, Social Welfare and Nutrition

Of recent the spread of the Non-Communicable Diseases (NCDs) has become a sounding problem in Tanzania. This is one of the reasons for the Governments' institutionalization of the HiAP initiative, health promotion and health protection. But much remains to be done especially where efforts are not adequately facilitated by exchange of information across sectors of the Government.	**Recommendation No 14:** Since the ministerial arrangement is that of pyramidal configuration, tracing and tracking how well health promotion and protection are ensured by laws, regulations and rules requires a **matrix communication structure** which ensures continuous exchange of management and operational technical information among equal (sectoral) ministries as well as the central ministries, those that have actual and potential effects and impacts on health of the population.	MOHCDGEC, PO-RALG Other relevant sectoral ministries.	MOHCDGEC, various Divisions, PO-RALG, Division of Health, Social Welfare and Nutrition.

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Appendix 2: List of People Interviewed

No.	**Name**	**Institution and Designation**	Date Interviewed
1	Hon. Umi Mwalimu	Minister, MOHCDGEC	June 18th 2019
2	Hon. Dr. Faustine Ndugulile	Deputy Minister, MOHCDGEC	June 18th 2019
3	Dr. Zainabu Chaula	Permanent Secretary, MOHCDGEC	June 18th 2019
4	Dr. AthumaniPembe	Global Coordinator.	June 18th 2019
5	Lusajo, Ndagile	Assistant Director Planning and Budgeting.	
6	Edward Mbanga	Director of Policy and Planning, MOHCDGEC.	
7	Jackob Kingazi	Assistant Director of Administration and Human Resources.	
8	Ndementria Vernand	Ag Director, Human Resources Development MOH.	
9	Saturnin Manangwa	Assistant Director, Quality Assurance Nursing.	
10	Macha,Tumainelli	Assistant Director, DPP, Monitoring and Evaluation.	June 19th 2019
11	Dr. Maongezi Sarah	Assistant Division of Curative Services.	June 20th 2019
12	Dr. NtuliKapologwe	Director, Health, Social Welfare and Nutrition Services, PO-RALG.	June 20th 2019
13	Dr. Mohamed Ally	Malaria Control Program Manager.	June 20th 2019
14	Dr. Boniface	Acting Director, National AIDS Control Program Manager.	June 21st 2019
15	Kissa Mwanvita	Manager, Clinical Trials and Acting Director. TFDA	June 21st 2019
16	Damas Matika	TFDA.	June 21st 2019
17	Elizabeth Boniface	Pharmacy Council of Tanganyika.	June 21st 2019
18	Alice Monyo	Head of Health, SIKIKA.	June 21st 2019
19	Aluswegibe	Human Resources, SIKIKA.	June 21st 2019
20	Kira Thomas	Head for, Health, Korean International Development Agency (KOICA).	June 25th 2019
21	Satoru Matsuyama	Head of Health. Japan International Cooperation Agency.	June 25th 2019
22	GraderineMinja	SWAp, Focal Person PPP and Development Partners.	July 5th 2019
23	Dr. Stefan Pacquette	First Secretary (Head for Health) Canadian Embassy.	July 5th. 2019
24	Dr. RutashaDadi	Global Affairs Canada, Dar-es-Salaam.	July 5th. 2019
25	Dr Leo Zekeng	Country Director and Representative, UNAIDS	
26	MsJacquilineMatoro	Program Manager Swiss Development Cooperation Agency	July 5th 2019
27	MaximillianMapunda	Health Economist, WHO	July 9th., 2019
28	Miriam Kimbe		
29	Godfrey Nyambi	USIAD	July 10th 2019
30	PatricSwai	USIAD	July 10th 2019

31	Aurora Amoah	USIAD	July 10th 2019
32	ChalesLumaze	Principal Economist, Ministry of Finance and Planning.	July 15th 2019
33	SixbertKavishe	Budget Analyst and Tracking, Ministry of Finance and Planning.	July 15th. 2019
34	Mary Maganga	Commissioner for Budget Ministry of Finance and Planning.	July 15th 2019
35	ElinoraSaitoria	Budget Officer, Ministries Departments and Agencies, Ministry of Finance and Planning .	July 15th., 2019
36	Edmund Ndolosi	Desk Officer for Health, Ministry of Education, Science and Technology.	July 15th. 2019
37	Dr. Leonard Subi	Director, Preventive services Division, MOHCDGEC.	July 16th 2019
38	Dr. GraceMagembe	Director of Curative Services Division MOHCDGEC.	July 16th 2019
39	DrMargret Natai	Principal Agriculture Officer, Food Security, Ministry of Nutrition Ministry of Agriculture.	July 16th 2019
40	Dr. Kyaw, MyntAung	Chief of Health, UNICEF.	July 23rd 2019
41	Mr. Peter Maduki	Executive Director Christian Social Service Commission	July 25th 2019

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