UNITED REPUBLIC OF TANZANIA

MINISTRY OF HEALTH, COMMUNITY DEVELOPMENT, GENDER, ELDERLY AND CHILDREN

ANNUAL HEALTH SECTOR PERFORMANCE PROFILE 2014/15

APRIL, 2016

ACRONYMS

AIDS	Acquired immune-Deficiency Syndrome
BEmOC	Basic Emergency Obstetric care
CCHP	Comprehensive Council Health Plan
CDC	Centers for Disease Control
CEmOC	Comprehensive Emergency Obstetric Care
CTC	Care and Treatment Clinic
DDU	Data Dissemination and Use
DHIS	District health Information System
EmOC	Emergency Obstetric Care
eMTCT	Elimination of Mother to Child Transmission
FY	Financial Year
HIV	Human Immuno-deficiency Virus
HMIS	Health Management Information System
HSSP III	Health Sector Strategic Plan III
IDD	Iodine Deficiency Disorders
ITN	Insecticide-Treated Net
IPT	Intermittent Preventive Treatment
LAN	Local Area Network
LLIN	Long Lasting Insecticide-treated Net
MMAM	Mpango wa Maendeleo ya Afya Msingi
NCD	Non-Communicable Diseases
NIMR	National Institute of Medical Research
PEM	Protein Energy Malnutrition
PHAST	Participatory Hygiene and Sanitation Transformation
PHSDP	Primary Health Services Development Plan [MMAM]
PMTCT	Prevention of Mother to Child Transmission
SPD	Sentinel Panel of Districts
TDHS	Tanzania Demographic and Health Survey
THMIS	Tanzania HIV and Malaria Indicator Survey
WASH	Water, Sanitation and Hygiene

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FOREWORD

This ***Health Sector Performance Profile Report*** presents the assessment of health system performance in Mainland Tanzania for the financial year 2014/2015, an update of the previous year's report. The Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDGEC) considers Monitoring and Evaluation as an important means for measuring effectiveness of the various inputs, processes, outcomes and ultimately their impact on the health system. In this way progress towards the National Health Policy objectives and international commitments can be measured with a high degree of certainty. The monitoring and evaluation process also identifies areas where performance has been lower than expected and so requiring remedial measures to be taken, on a continual basis.

This report covers an update of all the areas included in last year's Performance Assessment report, Midterm Analytical Review of Performance of the Health Sector Strategic Plan III. The major components of the report are: i) Health status of the population, ii) Core health status indicators iii) Health service delivery iv) Health systems strengthening v) Summary of progress against milestones and vi) Governance, management and leadership

Multiple sources of information have been used especially HMIS through DHIS2. The milestone assessment is a narrative report on actions taken and achievements registered.

Following the finalization of this report, the challenge ahead of us is in the use of the situation described for further improving on health sector performance for improved health service delivery that ensures availability, accessibility and quality, for the benefit of the population of Tanzania.

The Directorate of Policy and Planning through the Monitoring and Evaluation Section (M&E) prepared this report, with inputs from MoHCDGEC Management, Joint Annual Health Sector Review (JAHSR). Many thanks are extended to all who participated in one way or another in this endeavour.

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ACKNOWLEDGEMENTS

The Annual Health Sector Performance Profile Report (AHSPPR) 2014/15 is produced from the routine data collected from the health service outlets in the country. Data collected are compiled using the national standard data collection tools and counterchecked at the next level i. e district, regional and finally the national level.

The process of development of the AHSPPR report was highly consultative, participatory and transparent. The Monitoring and Evaluation Section of Directorate of Policy and Planning is responsible on coordinating the production of this report. The outline of this report is in line with the structure of the Government report format which identified specific chapters, sections and contents. This report was then reviewed jointly by teams comprising of the M & E Technical Working Group (TWG), MoHCDGEC Management and the Technical Committee of Sector- Wide Approach (TC-SWAp) before being adopted.

The Ministry of Health, Community Development, Gender, Elderly and Children wishes to acknowledge the contributions and efforts from various Institutions which, through their coordination, facilitated availability of quality assured data that led to the successful production of this report. These include the National Institute for Medical Research (NIMR), The Muhimbili University of Health and Allied Sciences (MUHAS), Ifakara Health Institute (IHI), University of Dar es Salaam (UDSM), Tanzania Food and Nutrition Centre (TFNC), MUHIMBILI National Hospital and Mzumbe University School of Monitoring and Evaluation. Participation of the MOHSW Departments these include Curative Services, Preventive Services, Human Resource, Administration and Personnel and Health Units where programs contributing major data including Reproductive Health, HIV/AIDS, TB&LP, Epidemiology, Human Resource for Health, Nutrition etc come from. On the other hand we thank the International Technical Assistants (TAs) including World Health Organization (WHO), Centre for Diseases Control and Prevention (CDC), MESAURE Evaluation, University of California San Francisco (UCSF) and the London School of Hygiene

We sincerely appreciate and acknowledge members of staffs from the Monitoring and Evaluation Section, Directorate of Policy and Planning (DPP) and comments from M & E TWG. The Management of the Ministry of Health, Community Development, Gender, Elderly and Children and members of the SWAp Committee are also thanked.

On behalf of the MoHCDGEC, I wish to express my appreciation to all of you for working tirelessly to develop the AHSPP report 2014/15. I look forward to the acceleration of the implementation of the M & E Plan for HSSP IV towards attainment of our national and international goals.

Prof. Muhammad B. Kambi

Chief Medical Officer

EXECUTIVE SUMMARY

The performance of the health sector for the period 2014/2015 is summarized below. Progress towards the 2015 set targets is shown as well as the corresponding data sources is provided. Appropriate colours make it easy for the reader to make an easy distinction on the performance of each indicator. Green coloured indicators indicate that set targets have been achieved. Orange indicate good progress and hopeful target to be achieved at the end of the HSSP III implementation, Red indicate targets to be un attainable this is probably the target were over ambitious or further strategies and approach are required and finally some indicator targets were not established but good trend has been observed

	Baseline		Achievement		Target 2015	Source latest data
	Year	Value	Year	Value		
Health impact						
Life expectancy (years) (M/F)	2002	51/52	2011	63/60	62/59	census 2012
Under-5 mortality rate (per 1,000 LB)	2008	91/1,000	2010	81/1,000	54/1,000	THMIS/TDHS
Neonatal mortality rate (per 1,000 LB)	2008	29/1,000	2010	26/1,000	19	THMIS/TDHS
Infant mortality rate (per 1,000 LB)	2002	95/1,000	2012	45/1,000	-	Census
Stunting rate among under 5 (%)	2010	42	2014	34.7%	22%	TDHS/HMIS
Underweight rate among under-fives (%)	2010	16	2014	13.4	12.5%	TDHS/Program
Maternal mortality ratio (per 100,000 LB)	2012	578	2014	432	265	Census/HMIS
Total fertility rate (children per woman)	2002	6.3	2012	5.2	5.1	Census
Adolescent fertility (% pregnant before 20)	2003-05	52	2010	44%	39%	TDHS 2010
HIV prevalence among young people	2008	5.8	2011	5.3	5%	THMIS
HIV prevalence, pregnant women (15-24)	2011	3.9	2014	6.8	1.62	ANC(2011)/HMIS
HIV prevalence, 15-49 years (both, %)	2007/08	6.0	2011/12/2014	5.3/5.3	5%	THMIS/HMIS
TB notification rate	2008	163	2014	133	82%	TB program
Leprosy cases diagnosed and treated	2008	95	2014	95	97	TB program

Cholera incidence rate (N of cases)	2008	2391	2013	262	0	Program
Cholera case fatality rate (%)	2008	3	2013	6	<1%	Program
Parasitemia prevalence (children) (%)	2007/ 08	18.1%	2011/12	9.5%	5%	THMIS
Coverage of intervention (%)						
Measles immunization coverage	2008	88	2014	99	85	HMIS/DHIS2
DTP-Hb 3 immunization coverage	2008	91	2014	90	85	HMIS/DHIS2
Vit A coverage children (2 doses)	2010	61	2014	72.6	-	Program
TT2 immunization coverage	2008	85	2014	62	85	HMIS
ANC first visit < 16 weeks	2011	42	2014	15	80	HMIS
ANC at least 4 visits	2010	43	2014	35	80	TDHS/HMIS
Births in health facilities	2011	62	2014	64	80	HMIS
Skilled birth attendance	2010	51	2014	58	80	TDHS/HMIS
Contraceptive prevalence rate	2011	42	2014	40.4	60	HMIS
ITN use (children / pregnant women)	2004/05	15	2011/12	34.2	80	THMIS/HMIS
IPT, two doses, pregnant women	2007/ 08	30	2013	31.5	80	THMIS/HMIS
PMTCT coverage among pregnant women	2010	68	2014	90	80	Program
ART coverage among those in need (adults/children)	2011	75/33	2014	73/83	-	Program
TB treatment success rate	2008	84.7	2014	90	-	TB program
Health system inputs and outputs						
Government expenditure on health (%)	2008-09	12	2012	10	15	NHA
Total health expenditure /capita (av. exch.USD)	2008	26	2011	37		NHA
Insurance coverage (CHF / TIKA)	2007	9	2012	14	80	NHIF
Doctors & assistant medical officer (per 10,000)	2008	0.7	2014	0.74	0.8	HRHIS
Nurses & midwives (per 10,000)	2008	2.6	2014	5.42	5.6	HRHIS
Pharmacists (per 10,000)	2008	0.15	2014	0.07	-	HRHIS
Outpatient visits per capita / year	2011	0.7	2014	0.62	-	HMIS
Training institutes with full	2008	1	2014	116	ALL	Human

accreditation						resource department
Basic emergency obstetric care ,% of facilities (dispensaries/health centres)	2005	0/5	2012	20/39	70	SARA/One Plan
Districts with timely surveillance reports (%)	2008	60	2012	73	>90	
10/10 availability of tracer medicine	2006	0	2014	30	80	HMIS

CHAPTER 1: INTRODUCTION

1.1 Background

The Annual Health Sector Performance Profile Report (AHSPPR) for year 2014/15 will be the last report to be produced to respond to the Health Sector Strategic Plan (HSSP) III as the new Health Sector Strategic Plan IV is about to be launched. The report is produced by the Monitoring and Evaluation (M&E) Session of the Ministry of Health, Community Development ,Gender, Elderly and Children (MoHCDGEC) supported by the M&E Technical Working Group with Technical Assistants (TAs) from World Health Organization HQ (WHO) and local research institutions namely National Institute for Medical Research (NIMR) and Ifakara Health Institute (IHI). In year 2013 the Health Sector conducted the Mid Term Analytical Report of the HSSP III in order to inform on the implementation status and guide on the future investment. The Sector if further looking to conduct the final evaluation of the Health Sector Strategic Plan III in order to inform the Public and the Health Stakeholders on the final attainment of the set indicators. Various studies and other set of information is currently collected including the Demographic and Health Survey (DHS), Tanzania Service Provision Assessment (TSPA), HIV/AIDS, Malaria and Nutrition as well as update from the routine system and administrative data. This will give relevant information required for the final evaluation of the Health Sector Strategic Plan III.

1.2 HSSP III Context

The Health Sector Strategic Plan III (HSSP III) is the guiding reference document for the preparation of the five-year regional, hospital and council health strategic plans. It guides the formulation of specific plans and programs including annual plans at all levels. The document describes types of services, which are provided in the health sector as well as roles, and responsibilities of each level. It provides eleven strategies, which focus on specific priority areas, and also cross-cutting issues which elaborate on approaches towards quality, equity, gender and governance. Consequently, it is an important document in achieving the Millennium Development Goals (MDGs). HSSP III has the following vision and mission.

1.2.1 Vision

Health and social welfare services of high quality, effective, accessible and affordable, delivered by a well performing and sustainable national health and welfare system that encourages responsiveness to the needs of the people.

1.2.2 Mission

To facilitate the provision of equitable and effective health and social welfare services by formulating policies and guidelines, delivered by an adequate, competent and well-motivated human resource to improve the health and wellbeing of the public with emphasis on those most at risk

1.2.3 Goal

According to the Tanzania Vision 2025, health is identified as one of the priority sectors contributing to high quality livelihoods for all Tanzanians. This will be achieved through realization of the following health services goals:

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

1.3 Demographic Projections for FY 2014/15

The Official Demographic projections from the National Census 2012 are not yet officially published however the provisional projection have been done by the National Bureau of Statistics (NBS) to enable the Health Sector to establish targets for the populations for the calendar year 2014. As these are not official projections, they are subject to change in the future however represent a best estimate for the purpose of calculating HSSP III indicators for the period 2014/15.

1.4 Framework for Achieving MDGs

The implementation of Millennium development Goals (MDGs) that started in year 2000 came to an end in June 2015. MDGs were translated and implemented internally through the HSSP III, 2009-2015. This was being driven by the National Health Policy, Vision 2025, and the National Program for Economic Growth and Poverty Reduction (MKUKUTA), with main goals to the attainment of the government's health sector goals and objectives. the United Nations Sustainable Development Summit on 25 September 2015, world leaders adopted the 2030 Agenda for Sustainable Development, which includes a set of 17 Sustainable Development Goals (SDGs) to end poverty, fight inequality and injustice, and tackle climate change by 2030. One of the goals target on health through "**Ensure healthy lives and promote well-being at all ages".**

The HSSP IV is formulated in line with the Sustainable Development Goals as aligned to the Primary Health Services Development Program and the Human Resources for Health Strategic Plan and is designed to improve accessibility and quality of health services. Therefore the National policy and strategic framework governing the health sector in Tanzania are aligned to the Sustainable Development Goals (SGDs) to which Tanzania is a member. The National Health Policy (through sector plans) and the HSSP III (2009-2015) are implemented in a Sector-Wide Approach (SWAP).

1.5 The Process of Developing the AHSPPR FY 2014/15

The process of developing this report started with a workshop in Bagamoyo that involved national stakeholders namely; Muhimbili University and Health and Allied Sciences (MUHAS), University of Dar Es salaam Computer Science and Engineering (UDSM), University Computing Centre (UCC) and Mzumbe University Department of Monitoring and Evaluation. Local research institutions also attended these were National Institute of Medical Research (NIMR) and Ifakara Health Institute (IHI). The workshop also attended by the Government staff from the Health related ministries, a range of staff from the Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDGEC) representing service delivery departments. The workshop involved international experts from World Health Organization, Oslo University, MEASURE Evaluation, University of San

Francisco, (USF) Research Triangle Institute (RTI), the London School of Hygiene and Tropical Medicine (LSHTM).

The workshop intended to orient staff on the five 5 principles for analysis of routine data. The principles included i) focusing on a limited set of standard indicators, ii) data quality review (DQR) iii) selection and description of denominators, iv) reconciliation of data with estimates from other sources such as household surveys, and v) communicating findings. These 5 principles formed the basis for the subsequent small group exercises. The final session was devoted to interactive instruction in use of DHIS2 to assess data quality and analyze the data to produce tables, graphs, maps and dashboards. In the end the team analyzed various subsets of indicators from DHIS2 database. These indicators are; Infrastructure (the Master Facility List); Human resources; Supplies of tracer drugs/vaccines; Morbidity; Mortality; Reproductive Maternal and New Born health (RMNH); Child health and Malaria; HIV/AIDS; TB and Comprehensive Council Health Plans (CCHP).

As a follow up, M&E team convened another workshop in Dar es Salaam to review and finalize tables, graphs and narratives for each table and figure that resulted in the production of the first draft. An independent reviewer from the Muhimbili University of Health and Allied Sciences (MUHAS) then reviewed this report, before being presented to the M&E Technical Working Group (TWG) for improvement, ownership and consensus. The final report was then presented to the Ministry of Health management and finally to the Technical Committee of Sector Wide Approach Technical (TC – SWAp) for approval and dissemination.

1.6 Data Sources and Data Quality Assessment

District Health Information System (DHIS2) is the main source of data used to produce this report. However the Comprehensive Council Health Plan (Plan-Rep), the Human Resource for Health Information System (HRHIS), Ministry Finance budget system, electronic Logistics Management Information System (eLMIS) and vertical program database were also accessed. National Census Projections done by the National Bureau Statistics (NBS) to generate denominators. Data from periodic studies, national assessment, routine supervision and management were also included, finally triangulation of data were done to examine the validity and consistence of data.

CHAPTER 2: HEALTH STATUS OF THE POPULATION

2.1 Background

Policy makers, planners, health managers and various stakeholders are interested in the overall provision of quality health services in the country. Provision of key health services to the entire population could generally be assessed through evaluation of key health status of the population indicators. Knowing the status of morbidity and mortality of the entire population as well as nutrition status of the children could reflect health status of the population.

2.2 Key morbidity and mortality statistics

The common statistical data for the health sector includes morbidity (incidence of disease in a population) and mortality (the number of people who die of a certain disease compared with the total number of people) rates. Knowing how many people die each year and why they have died is one of the most important means of assessing the effectiveness of a country's health system.

2.2.1 Core health status indicators

The three core demographic indicators that evaluates the status of health services provision to the children aged below five years of age includes:-

- Neonatal Mortality Rate (target for 2015 – 19 per 1000 live births)
- Infant Mortality Rate (target for 2015 – 38 per 1000 live births) and
- Under-five Mortality Rate (target for 2015 – 51 per 1000 live births)

These indicators are obtained from the community based demographic and health surveys being conducted periodically after every five years.

The table below summarizes Neonatal and infant mortality indicators and their progress since baseline

Table 2.1: Neonatal and Infant Mortality Indicators and their Progress since Baseline

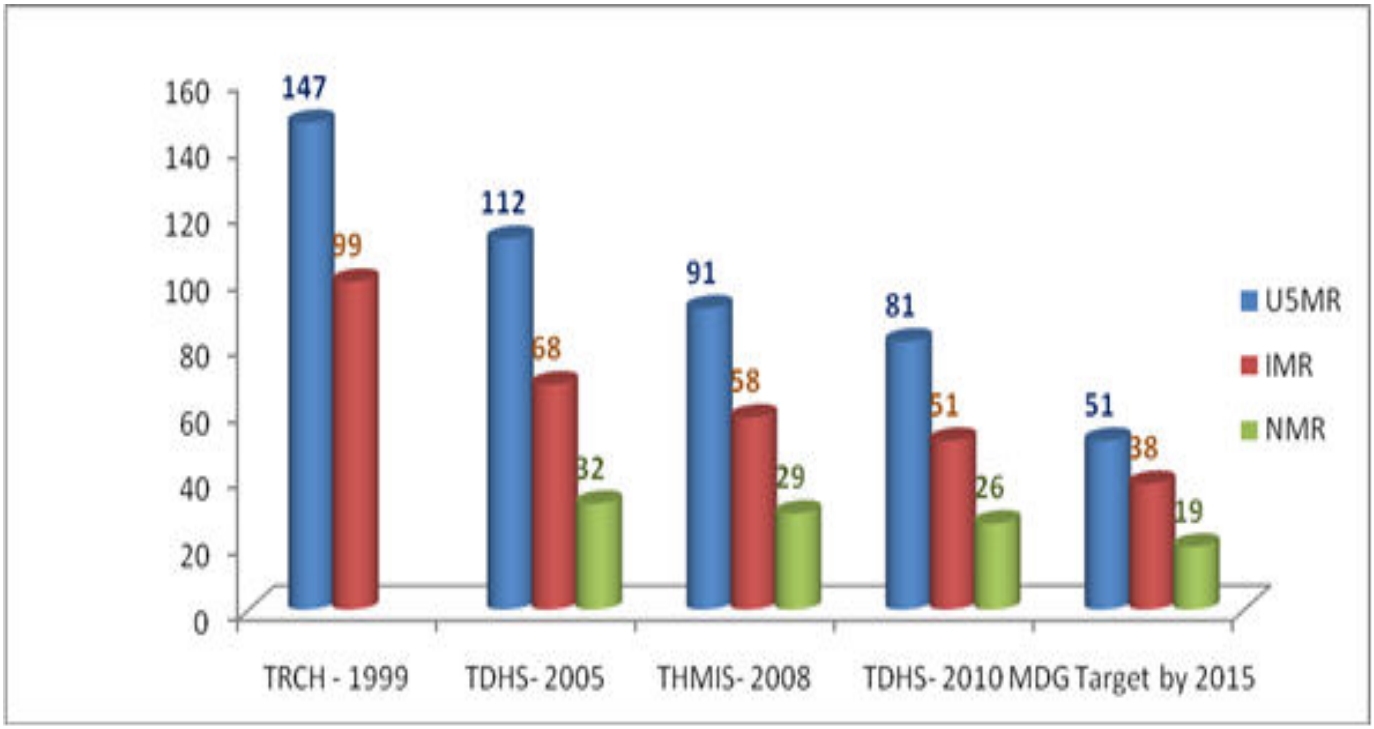
Indicator	Baseline (Year)	Achievement	Target 2015	Comments
Under-five mortality rate	91 (THMIS 2008 for period 2004-08)	81 (TDHS 2010 for 2006-10)	54	Major progress in the past decade, but still requires acceleration to achieve 2015 target
Infant mortality rate	58 (THMIS 2008 for 2004-08)	51 (TDHS 2010 for 2006-10)		Major progress in last decade, especially in the post neonatal period
Neonatal mortality rate	29 (THMIS 2008 for period 2004-08)	26 (TDHS 2010 for 2006-10)	19	Gradual progress, but requires acceleration to achieve 2015 target; neonatal deaths now 32% of under-5 mortality
Life expectancy	Female 52 years Male 51 years(Census 2002)	F: 61; M: 58 (WHO estimates for 2011)	F: 62; M:59; (2025)	Estimate derived from WHO Life Tables, based on new child and adult mortality rates; major progress and ahead of target

Apparently, child mortality rate in Tanzania continues to decline rapidly from 81 per 1,000 live births for 2006-2010. However, the set target of 54 by 2014 (MDG4) will not be achieved. Neonatal mortality is also declining but at a slower pace, with now almost one third of child deaths occurring in the first month of life.

2.2.2 Neonatal, Infant and Under Five Mortality Rate

Neonatal mortality measures the probability of dying in the first month of life, while Infant mortality is the probability of dying before the first birthday and under-five mortality provide probability of dying before the fifth birthday. These indicators reflect a country's level of socio-economic development and quality of life. Analyzing these three indicators is potentially predicting the overall performance of the health sector. The rise or decline of these indicators is attributed to various social economic factors. The results from TDHS 2010 shows significant decline of child mortality specifically infant and Under Five Mortality Rate (Figure 1). However, high neonatal deaths remain a significant challenge, accounting for 32% of all under five deaths in Tanzania.

Figure 2.1: Trends in Mortality for U5MR, IMR and NMR from Health Surveys



2.2.3 Leading Causes of Outpatients, Inpatients Diagnosis and Deaths

It has been a tradition for many countries, to identify the top ten causes of illness and deaths. Thus, knowing the leading causes of diseases and deaths will assist health managers to evaluate and come with appropriate interventions.

2.2.4 Most Common Outpatient Diagnoses

This section provides information on the ten leading causes of outpatient illnesses among those seeking care. The age groups focused here are those of below five years, and five years and above using the data from the health management information system (HMIS).

The incidence of morbidity and mortality for each diagnosis was calculated as follows:

- Morbidity: The number of patients with a particular disease during a given year divided by total number of all patients seen/admitted during the year
- Mortality: The number of patients dying from a particular disease during a given year divided by total number of all deaths in health facilities during the year

Table 2.2: Top ten outpatient diagnoses among under-fives

Rank	2012			2013			2014		
	Diagnosis	**Number**	**%**	**Diagnosis**	**Number**	**%**	**Diagnosis**	**Number**	**%**
1	Malaria	4,581,534	32	Malaria	4,355,583	34.4	Malaria	3,476,659	27
2	ARI	2,804,176	20	ARI	2,471,430	19.5	ARI	1,850,138	15
3	Diarrhoeal Disease	1,344,947	9	Pneumonia	1,146,484	9.1	Upper respiratory	921,104	7
4	Pneumonia	1,255,964	9	Diarrheal Diseases	1,101,692	8.7	Diarrhoea	856,496	7
5	Urinary Tract	907,116	6	Urinary Tract	602,917	4.8	Pneumonia	812,807	6
6	Intestinal Worms	541,847	4	Intestinal Worms	518,991	4.1	Urinary Tract	721,436	6
7	Others	459,975	3	Skin Infection	394,547	3.1	Skin Infections	545,104	4
8	Skin Infections	416,407	3	Eye Infection	355,277	2.8	Intestinal Worms	451,495	4
9	Eye Infections	354,456	2	Anaemia	232,683	1.8	Ill-defined Conditions	270,469	2
10	Anaemia	295,788	2	Ill-defined Conditions	217,650	1.7	Eye Infections	258,217	2
Total		**12,962,210**	**91**	**Total**	**11,397,254**	**90**	**Total**	**10,163,925**	**80**

Source: HMIS, 2012, 2013, 2014

The pattern of top two leading causes of outpatients' diagnoses remained the same for three consecutive years where malaria was leading followed by acute respiratory infection (ARI). The third leading cause in 2014 was upper respiratory infection followed by diarrhoea diseases in the fourth position.

Table 2.3: Top Ten Outpatient Diagnoses Among Persons Aged Five Years and Above

Rank	2012			2013			2014		
	Diagnosis	Number	%	Diagnosis	Number	%	Diagnosis	Number	%
1	Malaria	4,851,629	29.1	Malaria	4,227,351	26.2	Malaria	4,022,373	23
2	ARI	2,492,171	14.9	ARI	2,295,852	14.2	A R I	1,457,923	8
3	Pneumonia	923,232	5.5	Diarrhoea Diseases	886,110	5.5	U T I	1,255,553	7
4	Urinary Tract Infection	873,447	5.2	Pneumonia	841,110	5.2	Upper respiratory infections	1,068,806	6
5	Other STI	764,698	4.6	Intestinal Worms	785,213	4.9	Intestinal worms	649,522	4
6	Diarrhoea Diseases	747,050	4.5	Urinary Tract Infection	669,014	4.1	Diarrhoea	503,456	3
7	Intestinal Disease	708,079	4.2	Skin Infections	427,402	2.6	Ill defined conditions	485,223	3
8	Skin Infections	469,347	2.8	HIV/AIDS	375,743	2.3	Pneumonia	484,535	3
9	Minor Surgical Conditions	361,402	2.2	Minor Surgical Conditions	366,955	2.3	Surgical conditions	431,354	2
10	Eye Infections	343,641	2.1	Eye Infections	322,632	2.0	Skin infections	394,012	2
Total		**16,679,774**	**75.1**	**Total**	**16,138,647**	**69.3**	**Total**	**10,752,757**	**61**

Source: HMIS 2012, 2013, 2014

As was for under-fives malaria and acute respiratory infection have been leading causes of outpatient diagnoses in three consecutive years for patients aged five years and above. However in 2014 Urinary tract infections and upper respiratory infections emerged as third and fourth leading causes of OPD diagnoses for patients aged five years and above.

2.2.5: Most common inpatient diagnoses

This section provides information on the ten leading causes of inpatient illnesses among those seeking care. The information focuses age categories below five years and, five years and above using the health management information system (HMIS) data.

Table 2.4: Top Ten Leading Causes of Admission among Under-Fives

Rank	2012			2013			2014		
	Diagnosis	**Number**	**%**	**Diagnosis**	**Number**	**%**	**Diagnosis**	**Number**	**%**
1	Malaria complicated	150,408	22.3	Malaria severe	172,572	21.3	Malaria	248,593	37
2	Malaria uncomplicat	126,010	18.7	ARI	109,057	13.5	Pneumonia	99,936	15
3	Pneumonia	86,369	12.8	Malaria uncomplica	84,389	10.4	Anaemia	57,110	8
4	ARI	76,137	11.3	Pneumonia	79,588	9.8	Diarrhoea	48,593	7
5	Diarrhoeal Diseases	46,788	6.9	Diarrhoeal disease	71,472	8.8	Urinary tract Infections	37,883	6
6	Anaemia	34,277	5.1	Anaemia	47,689	5.9	Upper respiratory	22,670	3
7	Other Respiratory	17,658	2.6	Thyroid disease	36,885	4.6	Neonatal septicemia	11,626	2
8	Ill-defined symptoms	15,343	2.3	Urinary tract	17,712	2.2	Gastrointestinal	10,322	2
9	Pre-natal conditions	13,900	2.1	Intestinal worms	14,988	1.9	Low birth weight and prematurity	8,677	1
10	Urinary Tract	12,089	1.8	Poisoning	11,283	1.4	Birth asphyxia	6,476	1
Total		**730,059**	**85.9**	**Total**	**808,451**	**79.8**	**Total**	**551,886**	**82**

Source: HMIS, 2012, 2013, 2014

In 2014 malaria, anaemia and diarrhea diseases was the most three leading causes of inpatients below five years of age accounting for about 60 percent of total diagnosis in this particular age group.

Table 2.5: Top Ten Leading Causes of Admission for Persons Aged Five Years and Above

Rank	2012			2013			2014		
	Diagnosis	**Number**	**%**	**Diagnosis**	**Number**	**%**	**Diagnosis**	**Number**	**%**
1	Malaria severe	150,408	22.3	Malaria severe,	198,829	20	Malaria	302,419	27
2	Malaria uncomplicate	126,010	18.7	Malaria Uncomplicated	127,464	13	Pneumonia	58,341	5
3	Pneumonia	86,369	12.8	ARI	61,947	6	Anaemia	52,509	5
4	ARI	76,137	11.3	Diarrhoea Disease	58,525	6	Gynaecological diseases	46,222	4
5	Diarrhoea diseases	46,788	6.9	Pneumonia	49,107	5	Urinary tract Infections	42,853	4
6	Anaemia	29,485	4	Anaemia	44,427	4	Diarrhoea	35,292	3
7	Ill-defined symptoms, no diagnosis	25,420	3	HIV/AIDS	34,860	4	Hypertension	32,832	3
8	Fractures Dislocation	25,368	3	Urinary Tract Infection	27,444	3	Road traffic accidents	27,496	2
9	Urinary Tract Infection	23,229	3	Ill-defined symptoms	25,284	3	H I V infection	25,486	2
10	HIV/AIDS	17,035	2	Fracture Dislocation	23,942	2	Gastrointestinal diseases	20,138	2
Total		**801,742**	**79**	**Total**	**651,829**	**65**	**Total**	**643,588**	**58**

Source: HMIS 2012, 2013, 2014

In 2014, malaria was the most leading cause of inpatients accounting 27 percent of total diagnoses. This was followed by pneumonia and anaemia, which altogether accounting 10 percent of total diagnoses.

2.2.6 Most Common Causes of Death

This section provides information on the ten leading causes of deaths among those seeking care. The information focuses age categories below five years and, five years and above using the health management information system (HMIS) data.

Table 2.6: Top Ten Causes of Death among Under-Fives

Rank	2012			2013			2014		
	Cause of Death	**Number**	**%**	**Cause of Death**	**Number**	**%**	**Diagnosis**	**Number**	**%**
1	Malaria severe complicated	4,591	30.0	Malaria severe complicated	4,416	32.0	Malaria	3,230	41
2	Pneumonia	2,568	16.8	Pneumonia	2,191	15.9	Pneumonia	1,263	16
3	Anaemia	1,708	11.1	Anaemia	2,173	15.8	Neonatal Asphyxia	438	6
4	Perinatal and neonatal conditions	1,084	7.1	Perinatal conditions	965	7.0	Low birth weight or Prematurity Complication	359	5
5	Diarrhoe conditions	806	5.3	Diarrhoea diseases	774	5.6	Diarrhoea	338	4
6	Malaria uncomplicated	640	4.2	Malaria uncomplicated	466	3.4	Neonatal Septicemia	307	4
7	Respiratory diseases	385	2.5	Severe protein energy	325	2.4	Pneumonia	245	3
8	Severe protein energy malnutrition	369	2.4	Acute respiratory infection	322	2.3	Respiratory Infection Acute (ARI)	175	2
9	Acute respiratory Infections	330	2.2	HIV/AIDS	309	2.2	Stillbirth (macerated)	140	2
10	HIV/AIDS	310	2.0	Burns	142	1.0	Head injury	123	2
Total		**12,791**	**83.6**	**Total**	**12,083**	**87.6**	**Total**	**6,618**	**85**

Source: HMIS 2012, 2013, 2014

The three leading causes of deaths were confirmed malaria, pneumonia and neonatal asphyxia, which accounted about 60 percent of total deaths recorded at health facilities in 2014. Malaria and pneumonia have retained the two top positions for three consecutive years 2012-2014.

Table 2.7: Top Ten Leading Causes of Deaths for Persons Aged 5 Years and Above

Rank	2012			2013			2014		
	Diagnosis	**Number**	**%**	**Diagnosis**	**Number**	**%**	**Diagnosis**	**Number**	**%**
1	Malaria severe complicated	4,138	23	HIV/AIDS	4,782	20.6	Malaria	3860	20
2	HIV/AIDS	3,209	18	Malaria severe complicated	4,500	19.4	HIV/AIDS	1722	9
3	Anaemia	1,754	10	Anaemia	1,781	7.7	Hypertension	1301	7
4	Osteomyelitis	1,351	7	Pneumonia	1,423	6.1	Pneumonia	1172	6
5	Pneumonia	1,227	7	Tuberculosis	1,202	5.2	Cardiomyopathy	756	4
6	Cardiac failure	1,017	6	Hypertension	1,067	4.6	Diarrhoea	620	3
7	Tuberculosis	965	5	Cardiac failure	1,019	4.4	Diabetes	601	3
8	Ill-defined symptoms, no diagnosis	940	5	Fractures/Dislocation	651	2.8	Head injury	532	3
9	Hypertension	908	5	Diarrhoea diseases	624	2.7	Meningitis	465	2
10	Neoplasm	610	3	Diabetes mellitus	535	2.3	Cryptococcal meningitis	368	2
Total		**18,116**	**89**	**Total**	**23,220**	**75.8**	**Total**	**11,397**	**60**

Source: HMIS 2012, 2013, 2014

Malaria and HIV/AIDS had remained in the two most top positions for three years 2012 – 2014. More than half of all deaths are caused by the top ten leading causes of deaths.

2.3: Nutritional Status

Nutrition assessment is performed to identify people at risk of developing malnutrition and establish framework for managing them. Anthropometric measurements are used to assess the nutritional status of children by collecting anthropometrics data that includes age, height/length and weight measurement. The measurement and indices will be used to classify nutrition status categorized in three standard indices, which are: stunting (low

Height - for- Age), wasting (low Weight - for- Height) and underweight (low Weight - for- Age)

Key nutrition HSSP III indicators are:

- Proportion of under-fives severely stunted (low height for age)
- Proportion of children aged 0 to 59 months who are wasted (low weight for height)
- Proportion of under-fives severely underweight (low weight for age)
- Proportion of children under 5 receiving vitamin A

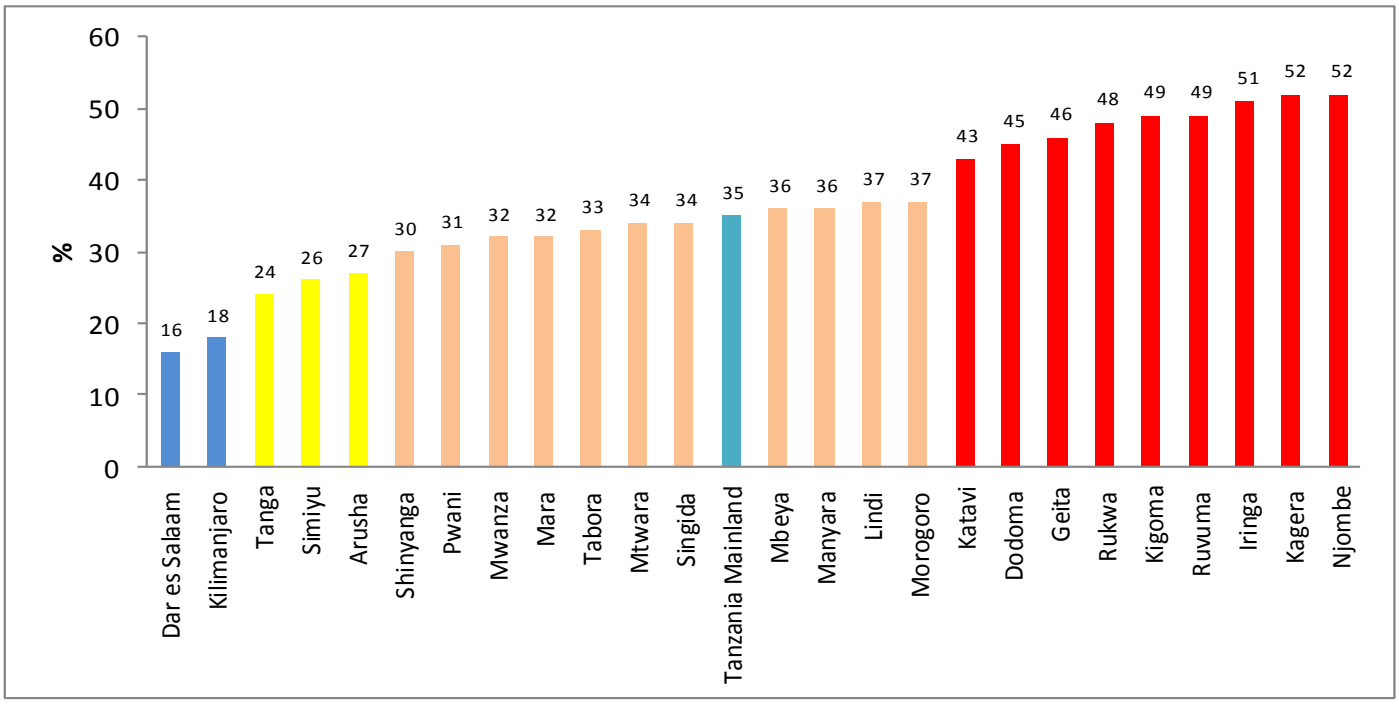
Other nutrition indicators include:

- Proportion of under-five children with anemia
- Proportion of infants exclusively Breastfed
- Proportion of children under-five with vitamin A deficiency
- Proportion of line ministries, regions and councils with Nutrition Focal Persons/Officers

Indicator 1: Proportion of Under-Fives Severely Stunted (Low Height – for - Age)

At national level, stunting or chronic malnutrition decreased from 42.0% (TDHS 2010) to 34.7% in 2014. Chronic malnutrition was considered “very high”, exceeding the 40% threshold, in 9 regions (Iringa, Njombe, Kagera, Dodoma, Ruvuma, Rukwa, Kigoma, Katavi and Geita) among which 3 regions are above 50%: Iringa (51.3%), Njombe (51.5%) and Kagera (51.9%). Stunting level for various regions can be seen in the Figure below

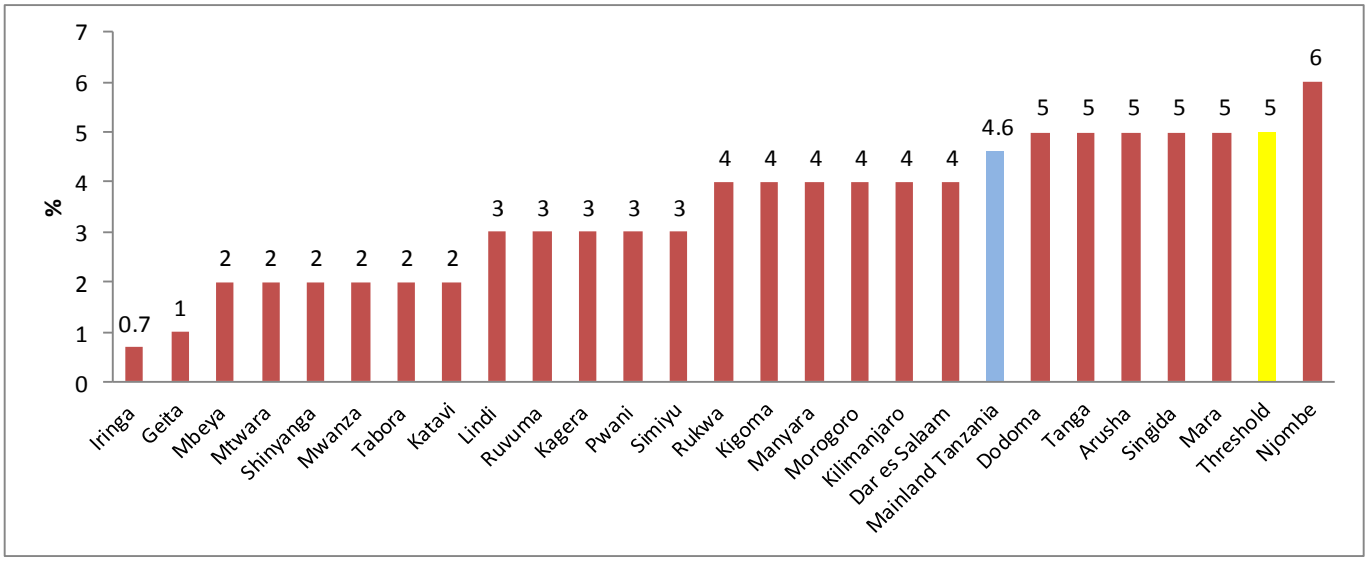
Figure 2.2: Proportion of Children Aged 0 to 59 Months who are stunted



Indicator 2: Proportion of Children under Five who are Wasted (WHZ < - 2SD)

The prevalence of wasting has basically remained the same in Tanzania during the last ten years with a rate ranging between 4 and 5%. In 2014, prevalence of wasting in all regions is equal or lower than in 2010 except for Mbeya (1.2% to 2.0%) and Kigoma (3.2% to 3.9%), Njombe had the highest prevalence of wasting with 6% of wasting. Various rates of wasting can be seen in figure 2.9 below

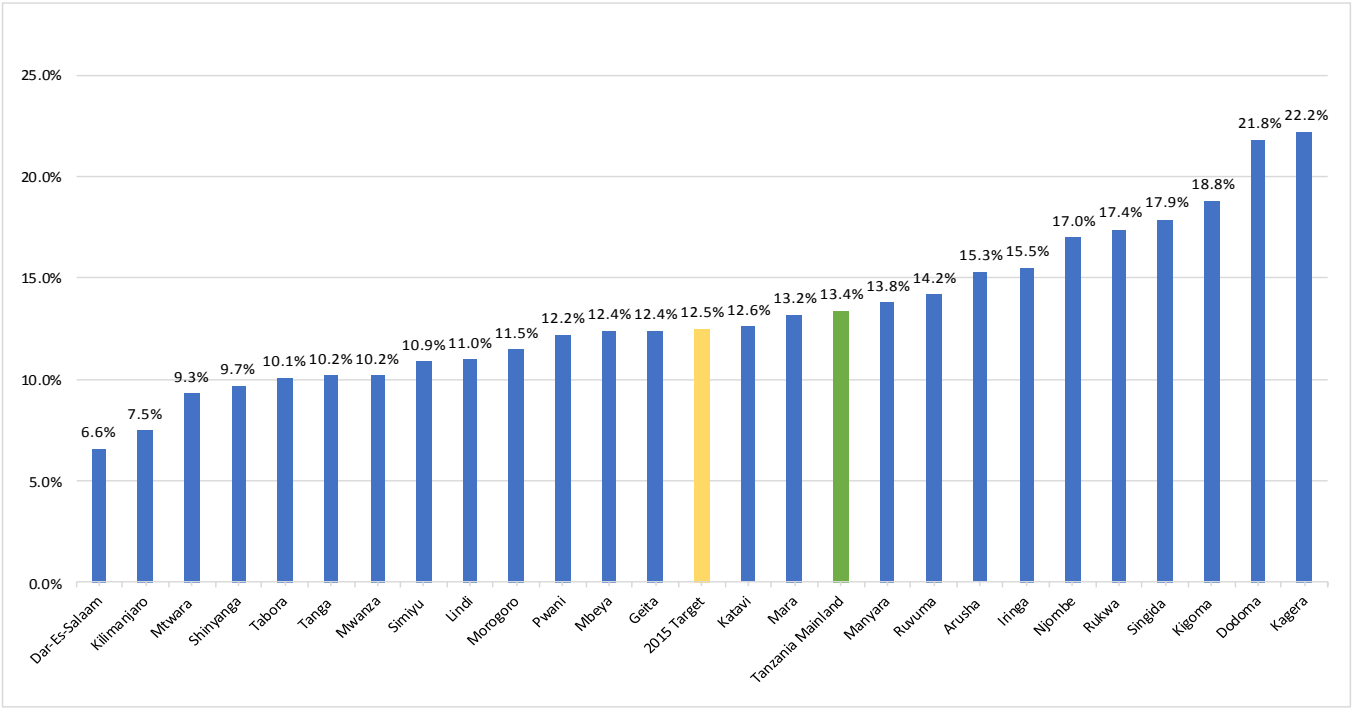
Figure 2.3: Proportion of Children under five who are wasted



Indicator 3: Proportion of Children under Five who are Underweight (WAZ<-2)

The prevalence of underweight among children under five years decreased from 27% in 1996 to 17% in 2005. But between 2005 and 2010, only 1% point decrease was observed on underweight level, whereby 15.7% of children aged 0 to 59 months were underweight and in 2014 the rates were 13.4%. In 2014, 10 regions had the prevalence of underweight higher than the national average level as seen in Figure 2.10

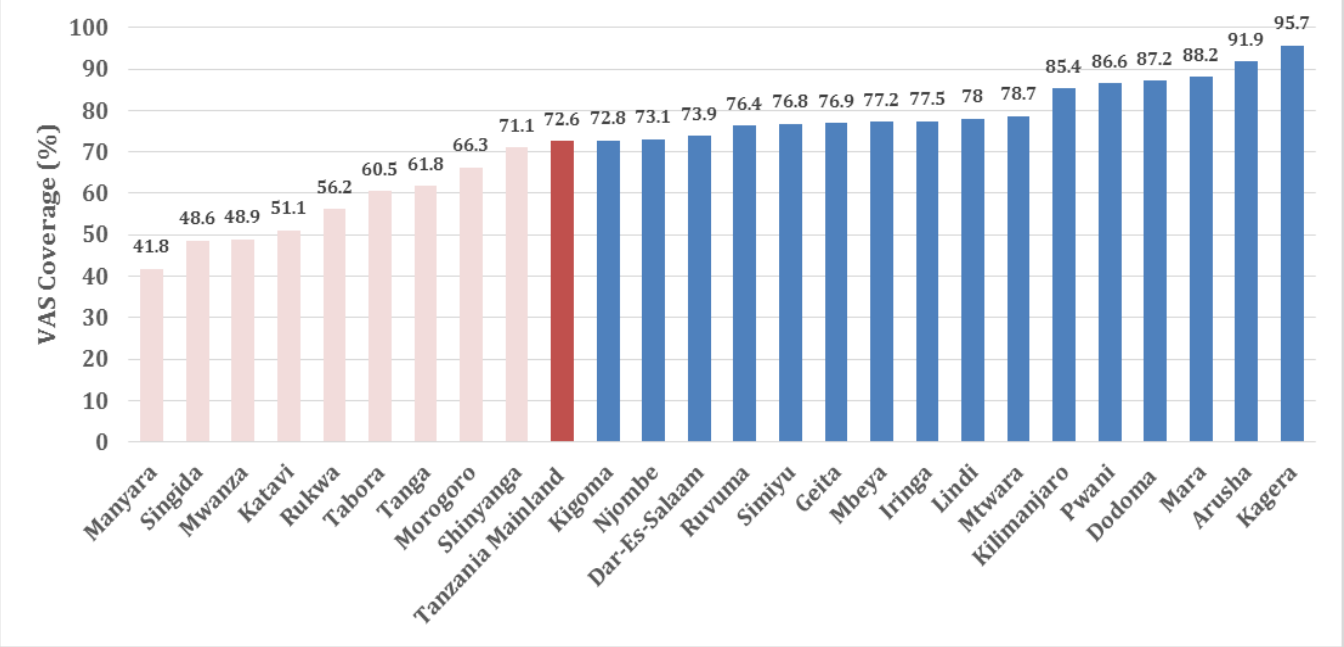
Figure 2.4: Proportion of Children under Five who are Underweight (WAZ<-2)



Indicator 6: Proportion of children under 5 receiving vitamin

Data on the coverage of children receiving vitamin A supplementation in 2014 shows that the proportion of all children aged 6-59 months who had received vitamin A in the last 6 months was 72.2%, which is better than in 2010 (61.0%). About 28.0% of the children did not receive vitamin A supplement, which is alarming. A high coverage of vitamin A supplementation was noted at Arusha and Kagera (>90%), while the lowest at Mwanza, Singida and Manyara with less than 50% coverage as depicted in Figure 2.11.

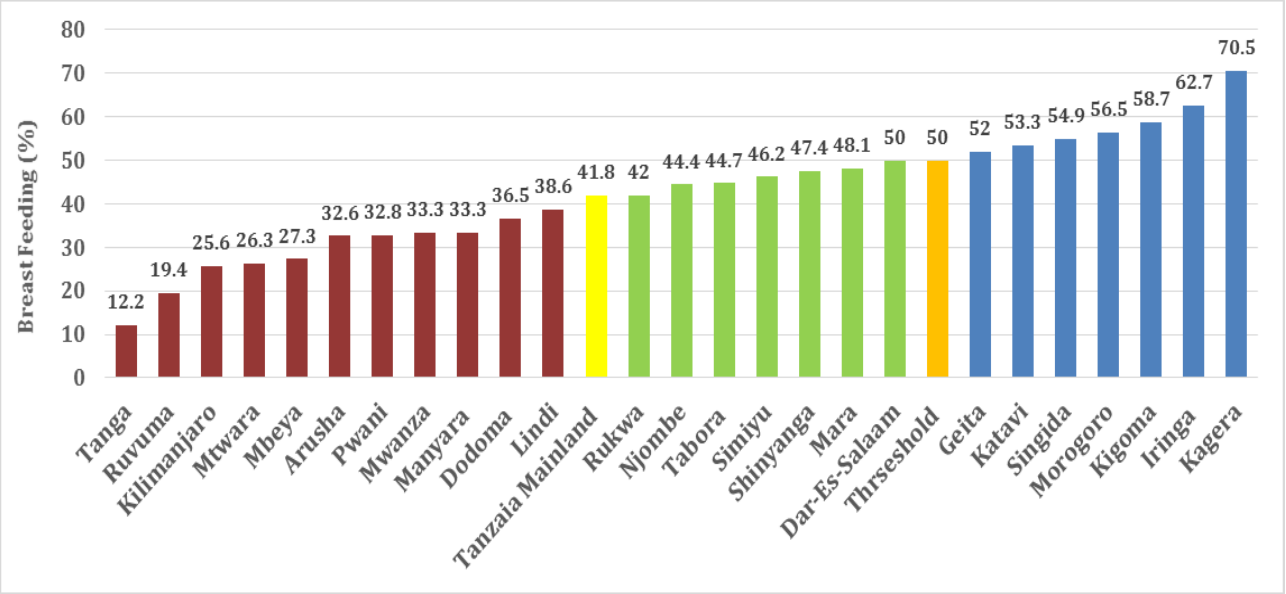
Figure 2.5: Proportion of Children under 5 Receiving Vitamin A



Indicator 7: Proportion of infants 0-5 months of age who are breastfed

At national level, less than 42% of infants under six months of age were exclusively breastfed as shown in Figure …The 2010 TDHS shows that the proportion of children exclusively breastfed was 49.8%, which means that there has been a decline in the proportion of children aged 0 – 5 months who are exclusively fed with breast milk. This also show that, only Geita, Katavi, Singida, Morogoro, Kigoma, Iringa and Kagera are above global target 5: Increase exclusive breast-feeding rates in the first six months up to at least 50% by 2025.

Figure 2.6: Proportion of infants 0-5 months of age who are fed exclusively with breast milk

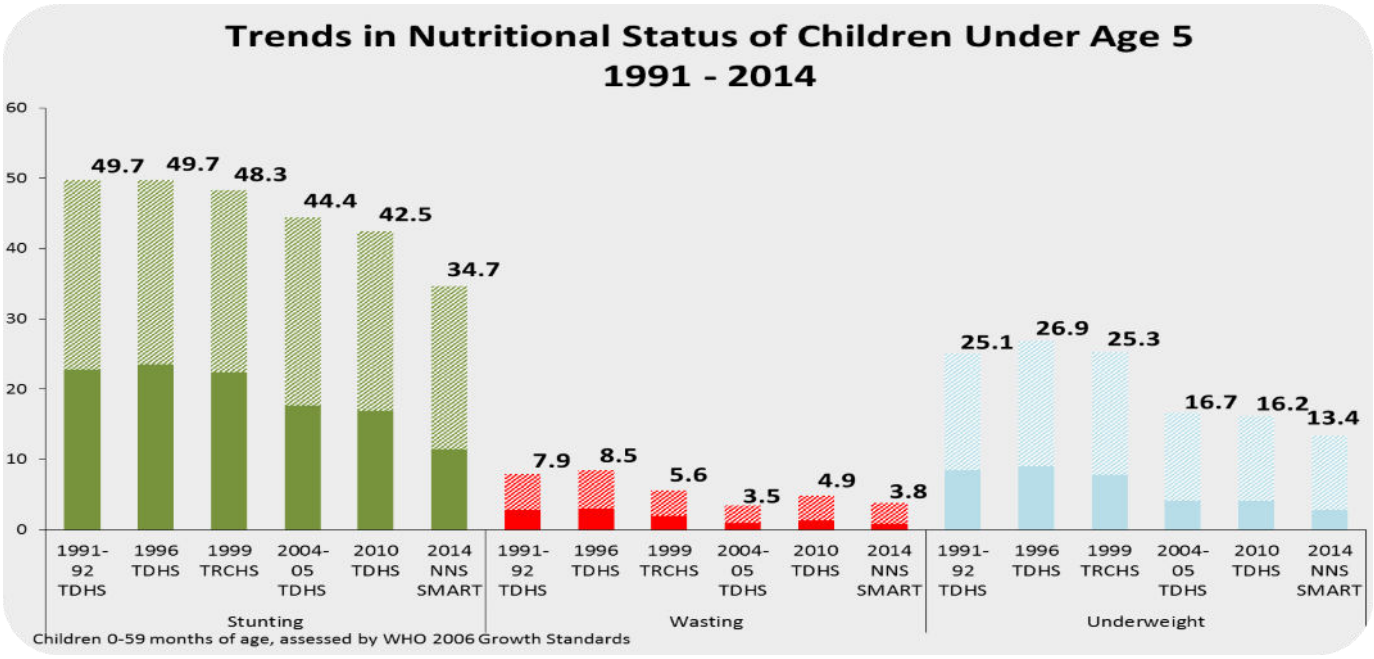


Discussion in Each Indicator

Trends in nutritional status of children under 5 years of age

Trends in nutritional status of children **under 5 years of age** for the period 1991-92 to 2014 are shown in 7the figure below. This figure shows a downward trend in stunting, which declined by 7 percentage points between 1991-1992 and 2010 and 8 percentage between 2010 and 2014 surveys. A similar pattern is observed for underweight, which dropped by 25.1% (1991-1992) in 13.4% (2014). The prevalence of wasting has remained basically the same during these last ten years with a rate between 4 and 5%.

Figure 2.8: Trends in Nutrition Status of Children under Age 5, 1991-2014



Other important issues are:

- According to WHO classification, the level of stunting in Tanzania varied from “very high” (>40%) in 2010 to “high” (30-39%) in 2014;
- The prevalence of underweight used for monitoring the MDG1 “Eradicate extreme poverty and hunger”. The level of underweight can be considered “medium” by WHO cut-offs for level of public health significance. Tanzania is very close to reach the target for 2015 (12.5%) with a national prevalence of 13.4%;
- The lowest rate of Global Acute Malnutrition (GAM) 0.7% was found in Iringa. The highest rates of GAM were found in Dodoma, Tanga, Mara, Singida and Njombe; and
- Despite this remarkable progress, the malnutrition levels are still very high, In 2015, it is estimated that more than 2,700,000 children under five years of age are stunted and that more than 430,000 children under five years will suffer from acute malnutrition.

Vitamin A Supplementation

TDHS 2010 indicated that 33 per cent of children under the age of 5 years were vitamin A deficient, which implies that the coverage of Vitamin A supplementation were low (61%). The SMART survey showed that in 2014, the proportion of all children aged 6-59 months who had received vitamin A in the last 6 months was 72.2%, which is better than the levels in 2010.

Nutrition Focal Persons/Officers in line Ministries, Regions and Councils.
The Government through the Ministry of Health and Social Welfare has decided to deploy nutrition staff down to community, starting with the council level. Table below shows progress from 2010 to date.

Table 2.8: Described Deployment of Nutrition Personnel's in the Country

Levels	2010	Current	Target by 2015
Line Ministries	0%	91%	100%
Regions	0%	92%	100%
Councils	0%	91%	100%

Anaemia among children under-five
General anaemia among under-fives according to TDHS 2010 stood at 59%. The Government in collaboration with partners and councils is currently establishing the causes at different areas so as to arrest the situation.

Challenges
- Nutritional data in all programs are not regularly collected due to poor surveillance system and inadequate integration of nutrition data into existing routine data collection systems.
- Inadequate multi – sector collaboration in reducing stunting levels; since its causes are nested in multiple sectors such as Health, Agriculture and Food Security, Water, Sanitation and Hygiene, Education, Community Development and Social Protection
- Inadequate financial resources to implement nutrition interventions at the community level
- Inadequate understanding of the importance of good nutrition to national development
- Treatment of severe acute malnutrition is still a challenge and stock out of therapeutic supplies for treatment of SAM.

Recommendations

- Establish a sustainable nutrition surveillance system in the existing health management information system to adequately enable the routine collection of nutrition data.
- Continue collaborating with the National Bureau of Statistics and key line ministries in collection of nutrition data
- Develop a plan targeting regions with the higher number of stunted children and strengthening nutrition-sensitive interventions to holistically address the causes of stunting.
- Improve planning at district level and increase financial resource mobilization at all levels including Ministries, Regional Secretariats and councils to incorporate nutrition into annual plans and budgets.
- Scale up treatment of severe acute malnutrition through health facilities and community management of acute malnutrition.
- Improving nutrition education and call for undertaking a comprehensive preventive measures nested in multiple development sectors and responses that draws from a cross-section of disciplines (trans-disciplinary).

The Way Forward

In order to address all forms of malnutrition it is important to strengthen nutrition-sensitive interventions to holistically address the causes of stunting. Among these, it will be important to include policies and programming in agriculture and food security; social safety nets; early child development; women's empowerment; child protection; girls schooling; water, sanitation, and hygiene; HIV/AIDS, health and family planning services.

Conclusion

Among the nutritional indicators under HSSP III, the proportion of children 0 – 59 months who are stunted in 2014 have been reduced but the numbers of children are very high; More efforts are still needed to reduce both the rates to the targeted level while considering the number of affected children's. The prevalence of underweight among children under five, which is an indicator, used to monitor progress on MDG1 "Eradicate extreme poverty and hunger" was reduced by 46% between 1991 and 2014. Showing that Tanzania is "on track" to reach the 50% target by 2015. In 2014, about 28.0% of the children aged 6 - 59 months did not receive vitamin A supplement, which is alarming. Additional efforts and strategies, through multisectoral approach with the global Scaling up of Nutrition initiative, are required to give extra impetus in efforts to combat malnutrition.

2.4: Community Based Surveillance

The Ministry of Health and Social Welfare have been collaborating with research institutions to obtain the community based information for the health sector through various standard systems. One of the systems is the sample vital registration with verbal

autopsy (SAVVY), which is a community based surveillance platform for generating information on causes of deaths. This system is implemented in 23 districts of Mainland Tanzania sampled to generate nationally representative data on causes of deaths disaggregated by age, sex, residence and zone. Ifakara Health Institute (IHI) manages the platform in collaboration with the Ministry of Health and Social Welfare, National Institute for Medical Research (NIMR) and the National Bureau of Statistics (NBS). SAVVY received financial support from CDC from 2009-2014 and is currently funded by Global Fund for AIDS, TB and Malaria.

SAVVY uses standardized verbal autopsy tools to capture information from the caregivers of the deceased on the symptoms and care seeking prior to death. Physicians are thereafter used to assign causes of deaths using the International Classification of Diseases tenth revision (ICD-10).

In this section, we provide some highlights of SAVVY findings from the implementing districts for two years of 2013 and 2014. A detailed analytical report on the SAVVY findings is available for sharing.

2.4.1 Top ten causes of deaths in sampled SAVVY districts

Acute Febrile Illness (AFI) including malaria was the leading cause of death in children younger than five years of age. One third of deaths in 2013 were due to AFI including malaria. Perinatal conditions were the second leading cause of death accounting for almost 30% in 2013 and approximately 25% in 2014. AFI including malaria was also the leading cause of death in children 5-14 years in both 2013 and 2014. Injury mortality was higher in males compared to females for both 2013 and 2014. Males were 18% in 2013 and 11% in 2014, while females were 14% in 2013 and 5% in 2014 deaths due to injuries.

HIV disease was the number one cause of deaths in women age 15-49 years. During the year 2014 HIV deaths declined from 29% to 23% in females. In males of the same age population the percent of deaths remained similar at 17% in both 2013 and 2014. Similarly deaths from injuries and accidents in males were 27% compared to 5% in female during 2013 and were the second leading cause of death. Maternal deaths accounted for 10% of all deaths in women of childbearing age.

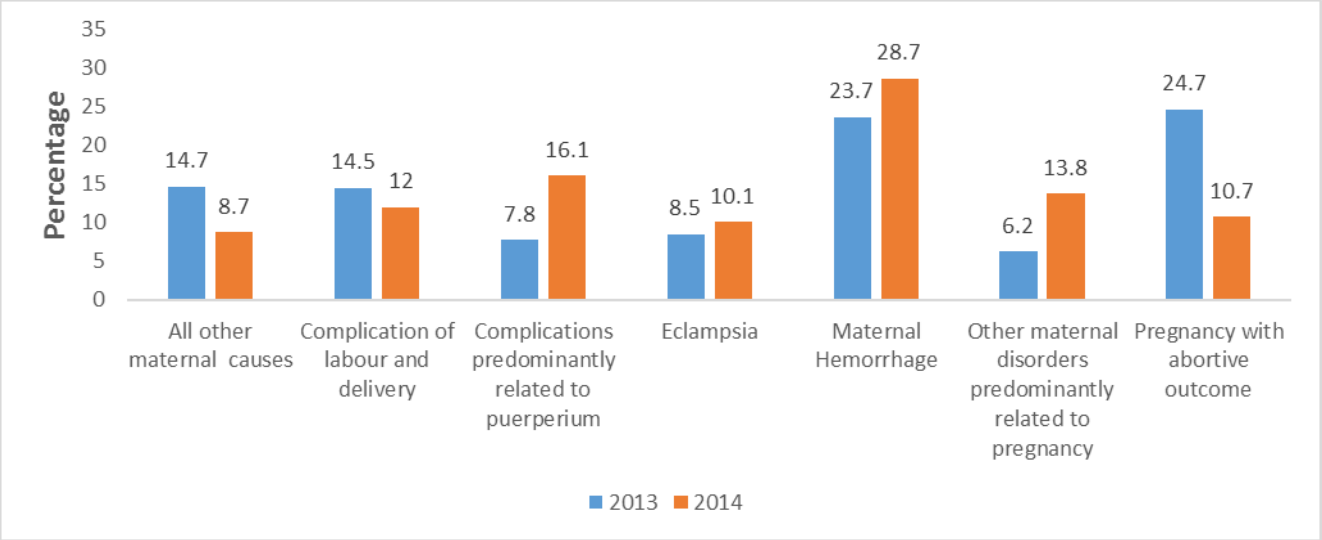
2.4.2 Child Mortality

Newborn mortality rates (NMR) remained high at 28 deaths per 1000 live births and 26 deaths per 1000 in 2013 and 2014 respectively. Infants mortality rate (IMR) was estimated at 43 and 41 per 1000 live births in 2013 and 2014 respectively. This is almost 10 points lower than TDHS 2010. Under-five mortality rate (U5MR) was approximately 68 per 1000 live births in both 2013 and 2014. These estimates are lower compared to the 2010 TDHS of 81 per 1000 and consistent with the declines observed in recent reports.

2.4.3 Maternal Mortality

10% of deaths in women of reproductive age were due to maternal related conditions. Maternal mortality ratio in 2013 was 269 deaths per 100,000 live births and 227 per 100,000 live births in 2014. Pregnancy with abortive outcome was leading cause of death in 2013 (25%) while maternal hemorrhage was the second leading cause of death accounting for almost one quarter of maternal deaths

Figure 2.9: Percent of causes of Maternal Death in 2013 and 2014



The percent of maternal deaths due to eclampsia were 9% in 2013 and 10% in 2014. Complications predominantly related to the puerperium doubled from 8% in 2013 to 16% in 2014. Similarly, other maternal disorders predominantly also doubled from 6% in 2013 to 13% in 2014. Complications of labor and deliver decrease slightly from approximately 15% in 2013 to 12% in 2014. We also noted a decrease in the percent of all other maternal causes from 15% in 2013 to 9% in 2014.

Table 2.9: Percent of maternal deaths by age in 2013 and 2014 Age group

Age Group	2013		2014	
	Percent	Weighted N	Percent	Weighted N
15-19	11.05	614.8	11.39	704.8
20-24	21.56	1330.6	22.43	1326.7
25-29	15.17	1327.4	12.39	788.4
30-34	10.11	926.3	11.30	964.7
35-39	8.82	881.4	7.67	790.8
40-44	3.32	282.5	1.08	95.9
45-49	1.50	108.1	0.00	0.0
Total	**9.88**	**5471.2**	**8.93**	**4671.4**

Maternal deaths accounted for approximately 10% and 9% of the total causes of deaths among women of reproductive age in 2013 and 2014 respectively. The percent of maternal deaths increased from 11% in the youngest women and reached a peak of 22% in age 20-24 before declining to less than 2% in the oldest age group. Percent of maternal deaths in 2014 followed the same patterns as in 2013. The highest percentage was also 22% in the 20-24 age group.

2.4.4 Malaria

One out of five individuals in the sample died from acute febrile illness including malaria. Children between 5-9 years of age had the highest percent with half of them dying from AFI including malaria. The percent of AFI including malaria was slightly higher in rural compared to urban areas 22% versus 17%.

2.4.5 HIV/AIDS

The percent of mortality from HIV disease declined between 2013 and 2014, from 9.7% to 8.9% of deaths. Large gains were observed in women where HIV deaths declined from 95 per 100,000 PYAR to 78 per 100,000 PYAR. HIV rates in urban areas declined from 97 to 67 per 100,000 PYAR

Recommendations and the way forward

- Looking for possible integration of electronic devises for data collection, management and storage
- To collaborate with POM-RALG and MOHSW, to ensure health facilities in-charges liaises with community local leaders and community own-resource peoples (CORPS) to advocate to their communities, the importance of keeping deceased medical records so as to be used when needed as it has valuable information for health planning.
- To recommend to the government (MOHSW) the possible roll-out of SAVVY approach to be adapted across the country to ensure the availability of community data, and the uses of community data for planning purposes
- Integrating SAVVY under M&E activities in annual council comprehensive health planning and budgeting (CCHP) annually a measures to overcome operational shortfalls
- To training central ToT on ICD.10 for training clinicians at district level as In-job training on verbal autopsies coding, and ensure the availability of simplified ICD.10 reference manuals at council level
- Efforts should be made to ensure that health facilities In-charges consistently use the ICD-10 to give correct disease codes for all causes of death.

CHAPTER 3: HEALTH SERVICE DELIVERY

3.1 Background

Service delivery indicators include outpatient attendance, vaccination coverage, access to reproductive health services, and indicators measuring HIV and AIDS, malaria, tuberculosis and leprosy, infectious and non-communicable disease performances.

3.2 Per capita outpatient attendances

In assessing the health services delivery one of the key indicators is the number of outpatient attendances per person per year. This is a proxy indicator for accessibility and utilization of health services that may affect the quality of services. The patient volume at health facilities is not a coverage indicator because the population in need is not well defined; however having very low outpatient attendance rates could a sign of poor availability and quality of services offered[1]. Reduction of fees, addition of new facilities closer to people could lead to more utilization of health facilities hence increases the outpatient attendances.

Goals

The goal of this tracking number of consultations offered to people is to track how people use health services, observing trends and potential causes for over or under utilization of the health services offered.

Key performance indicators

There is only indicator which is used to monitor outpatient attendances is the outpatient attendance per capita indicator, which is measured as the number of health facilities (public and private) visits per total population of the same administrative area.

Figure 3.1: Tanzania mainland Per capita outpatient attendance by age groups 2011 – 2014

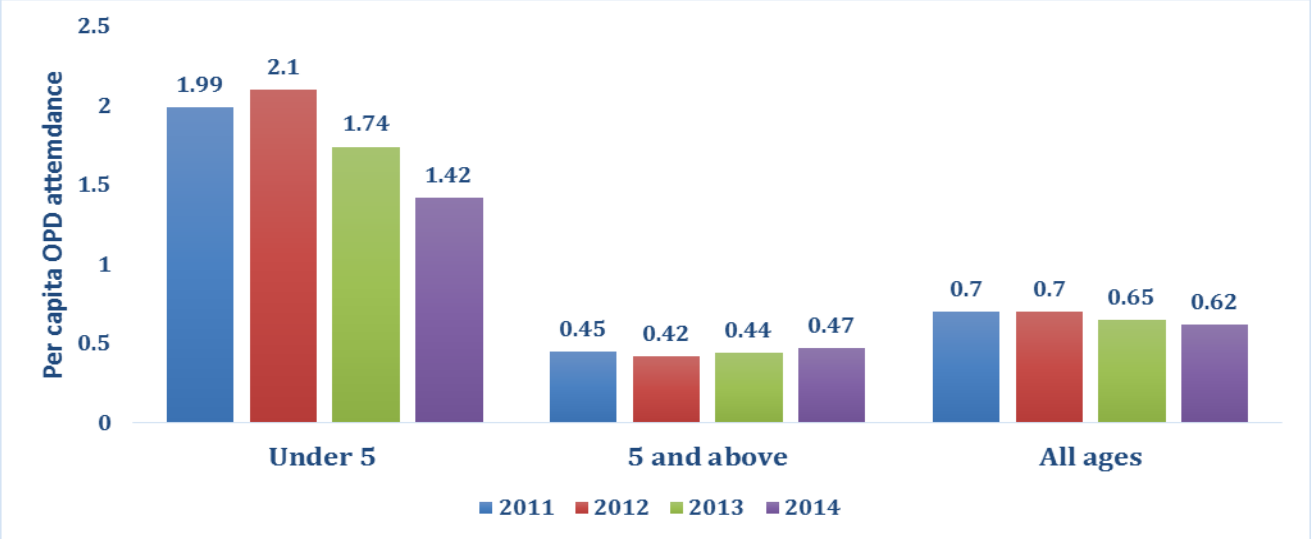
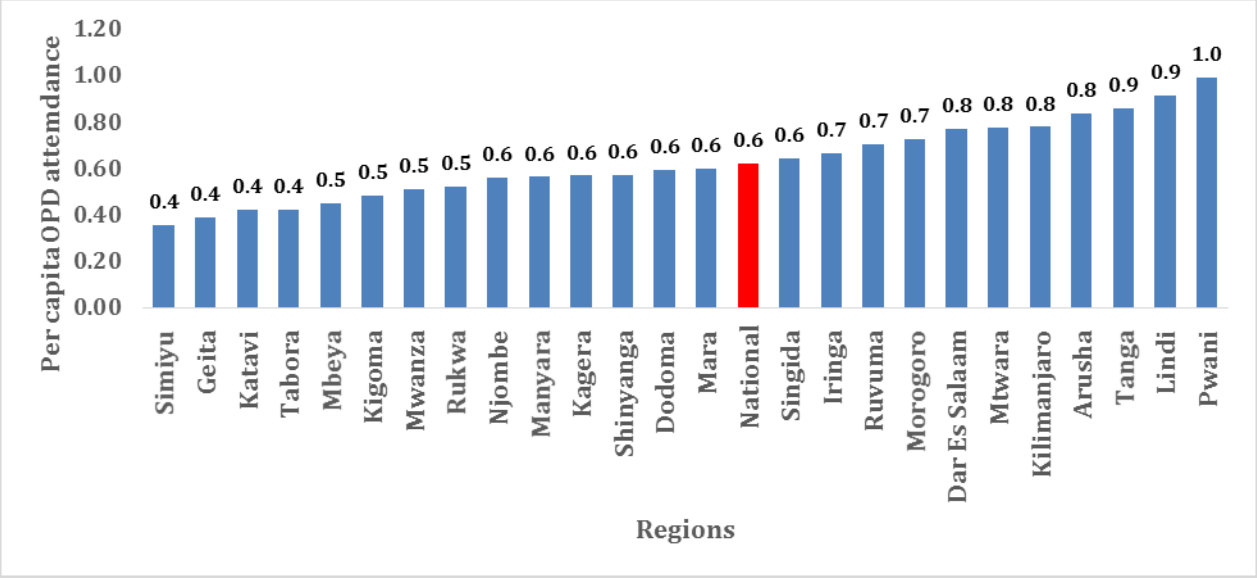


Figure 3.2: Regional per capita outpatient attendance 2014



Discussions (key observations, challenges and recommendations)

Compare to other years from 2011, in 2014 there were lowest values for both under 5 OPD attendances per capita and overall OPD per capita with all ages combined. The drop in under 5 OPD attendances capita could be a result of increase in specialized private

facilities offering services to under 5. Data in some of such facilities is not included in the national health management information system. Fact that in 2014 there was an increase in above 5 OPD attendances per capita suggests the drop in OPD attendance per capita when all ages are combined is mainly because of the drop in under 5 category.

Conclusion and/or Way forward

Overall a 0.3 decrease in OPD attendance per capita from 2013 to 2014 suggest a small change in how the general public utilizes health services. This drop is also observed as from 2011 to 2014. While the number of population (denominator) increases rapidly number of health facilities to serve them is not increasing at the same pace. In addition from 2011 to 2014 there is a significant increase of private services, which uses their own systems of health records keeping hence decreasing the number of attendances in facilities tracked by the national system. The significant increase in utilization of private health facilities could be attributed to the increase in the use of multiple health insurances schemes which have made it possible for general public to afford services offered by private facilities.

Limitations

Limitations in getting values for the performance indicator include:

- Data quality: there was no data quality assessment prior to calculation of the values which could verify records in the registers compared to the ones in the HMIS
- Inaccuracies in population figures: changes in formulation of new regions resulted in redistribution of population values which could lead to incorrect calculations.
- Unavailability of data from some health facilities: there a number of health facilities which uses their own health management information systems for tracking patients' records and the data is not entered into the national database. These facilities serve people from the same administrative areas which are considered in the national database when calculating OPD attendance per capita hence decreasing the numerator value.

3.3 Immunization and Vaccine Development

The main goal of the Immunization and Vaccines Development (IVD) Programme IVD is to contribute to the reduction of morbidity and mortality due to vaccines preventable diseases, towards achieving the Global and African Region goals. IVD is responsible for the coordination of the provision of quality immunization and vaccination services in the

country through policy and guideline formulation, training and supervision to ensure services are of quality, and accelerated diseases control activities (Polio Eradication, Measles Control Neonatal Tetanus (NNT) Elimination). Following implementation of Global Vaccines Action Plan (GVAP), the IVD programme expanded the target of vaccinating beyond infants and pregnant women in 2014 by introducing measles second dose vaccination at 18 months of age and Human Papilloma Virus vaccination to girls aged 9 years as a demonstration project in Kilimanjaro.

Key performance indicators

The key performance indicators for the national immunization programme as stipulated in the HSSP III and IVD comprehensive multiyear plan are as follows:

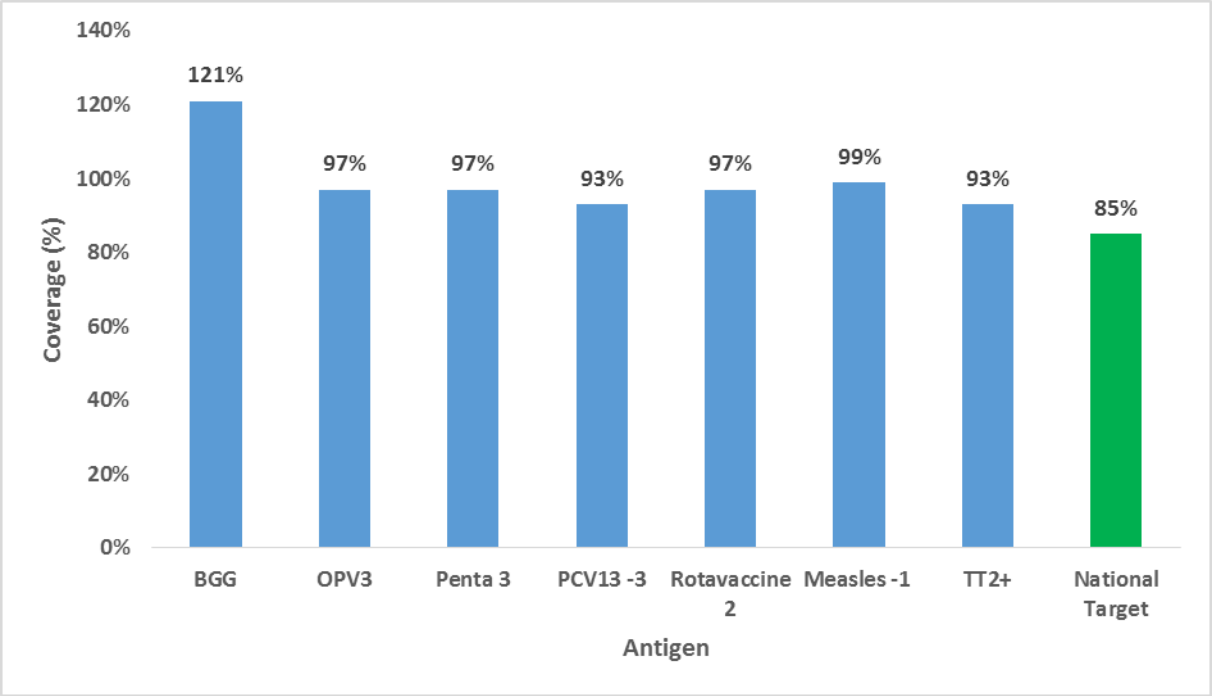
- Proportion of children under one year vaccinated three times against DTP-HepB-Hib vaccine (Penta 3) increased to 97% (baseline of 91 % in 2008). This had been planned in line with increased number of councils which had Penta 3 vaccination coverage equal or above 90% from 25 (in 2009) to 138 in 2014
- Proportion of children under one year vaccinated against measles increased to 99% (baseline of 92 % in 2008). This is in line with the decrease in number of reported from 1,622 confirmed measles cases in 2011 to only 88 in 2014.
- Increased quality IVD vaccines and related supplies stock availability to 90% and above of all Immunizing Health facilities

Achievements

Table 3.1: Progress in key vaccinations against 2015 set targets

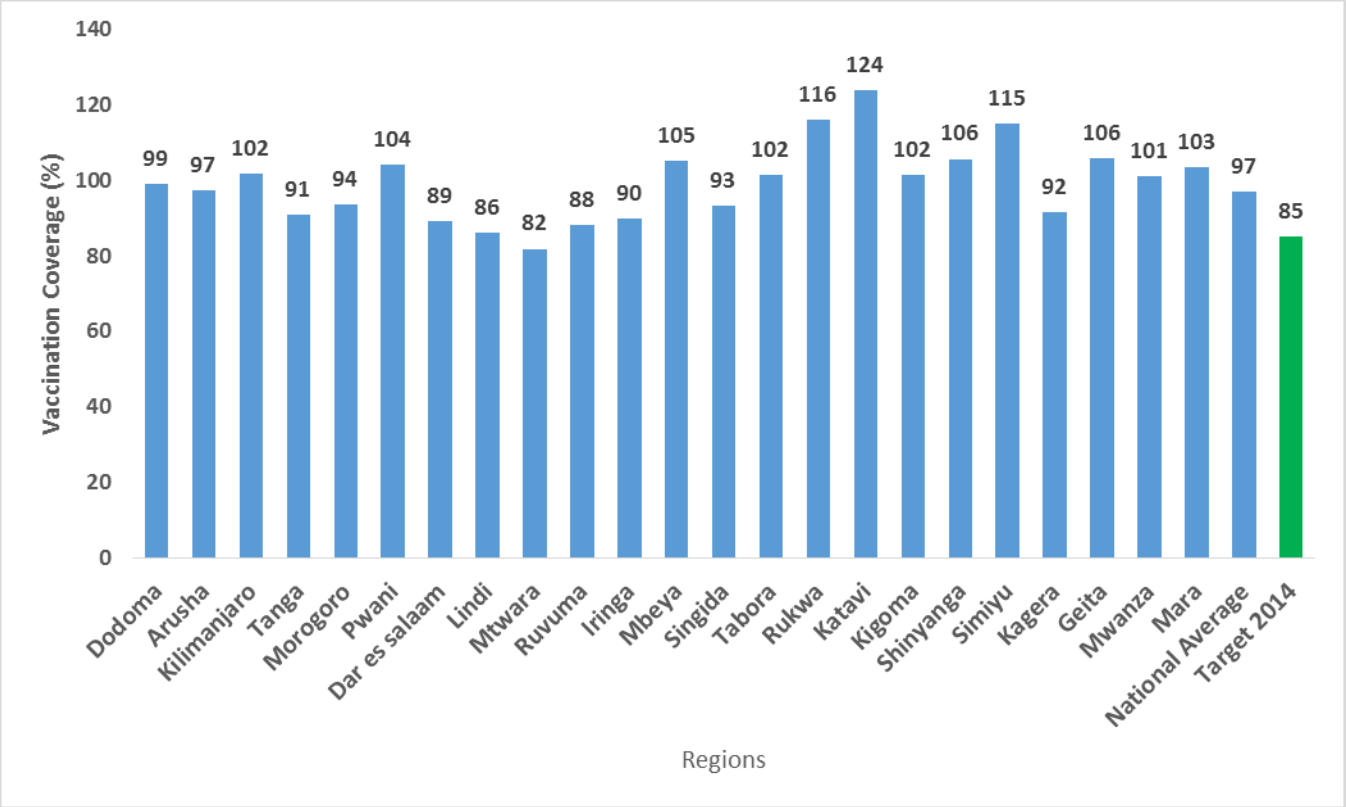
Vaccine	Baseline 2008 (%)	Coverage 2014 (DHIS-2) – (%)	Coverage 2014 (DVD -MT) (%)	Target 2015 (%)
Penta 3	91	90	97	85
Measles 1	88	99	99	85
TT2+	85	62	93	85
Rota 2	-	67	97	85
PCV13-3	-	64	93	85

Figure 3.3: Progress in key vaccination indicators, 2014



During year 2014, the regions achieved varying coverage rates for Penta 3, Measles 1 and TT2+.

Figure 3.4: The reported vaccination coverage of Penta 3 by Regions, 2014

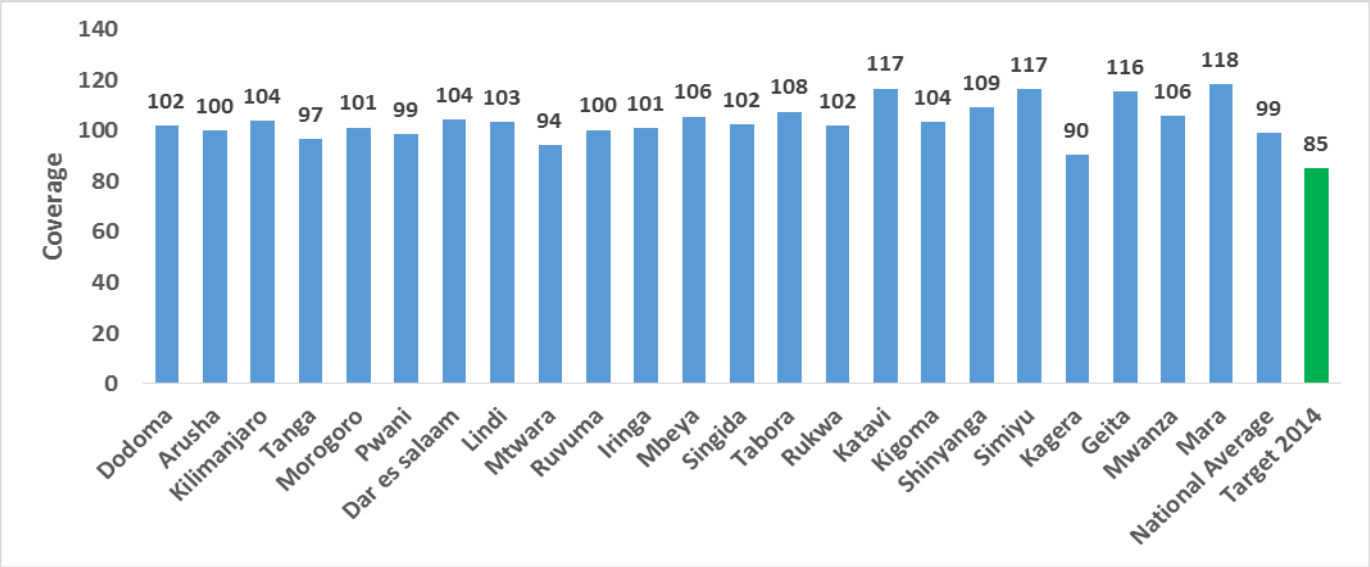


Source; IVD District Data Management Tool/WHO –UNICEF JRF, 2014

The Penta 3 vaccination coverage ranged from 82 % in Mtwara region to 124 % in Katavi region, with a national average of 97 %. One region (Mtwara) scored below the national target of 85 % as shown in the figure above.

Measles 1st dose vaccination coverage: The coverage ranged from 90% in Kagera region to 118 % in Mara region, with a national average of 99 %. All regions scored above the national target of 85 %. These scores are presented in the figure below:

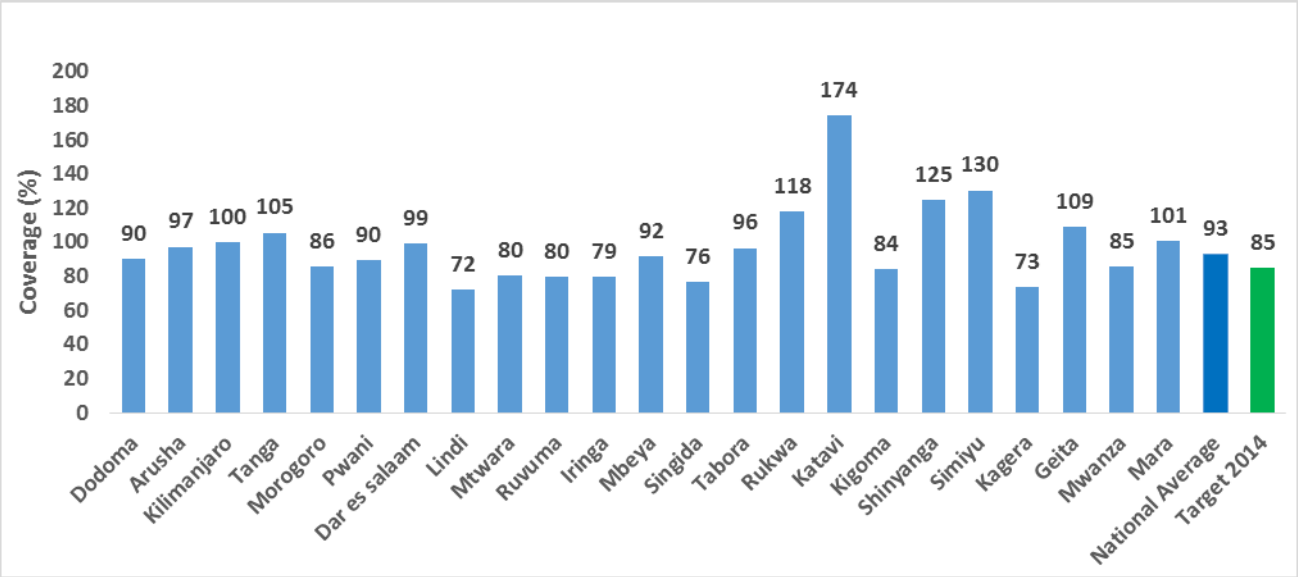
Figure 3.5: The reported vaccination coverage of Measles 1st dose by Regions, 2014



Source; IVD District Data Management Tool/WHO –UNICEF JRF, 2014

Regional TT2+ vaccination coverage ranged from 72 % in Lindi region to 174 % in Katavi region, with a national average of 93 %. Seven regions (Lindi, Mtwara, Ruvuma, Iringa, Singida, Kigoma, and Kagera) scored below the national target of 85 %. These scores are presented in the figure below:

Figure 3.6: The reported vaccination coverage of TT2+ dose by Regions, 2014



Discussions

The number of districts with Penta 3 coverage <80 has decreased from 56% (55/119) in 2009 to 11.9% (20/168) in 2014. Some districts/councils such as Councils of Kigoma Region have persistently low coverage below 80% since 2011. In 2014 coverage survey, 86.0% (95% CI 85.3-86.7%) of the children were fully immunized by the age of one year, using history and cards. Despite increased number of children vaccinated, Tanzania still having high number of un/under immunized children due to unavailability of vaccine on the day the child was taken to the facility. Other commonly mentioned reasons included; ignorance on the importance of vaccination, mother being too busy and distant service delivery points

Figure 3.7: Summary of Districts performance, 2009-2014

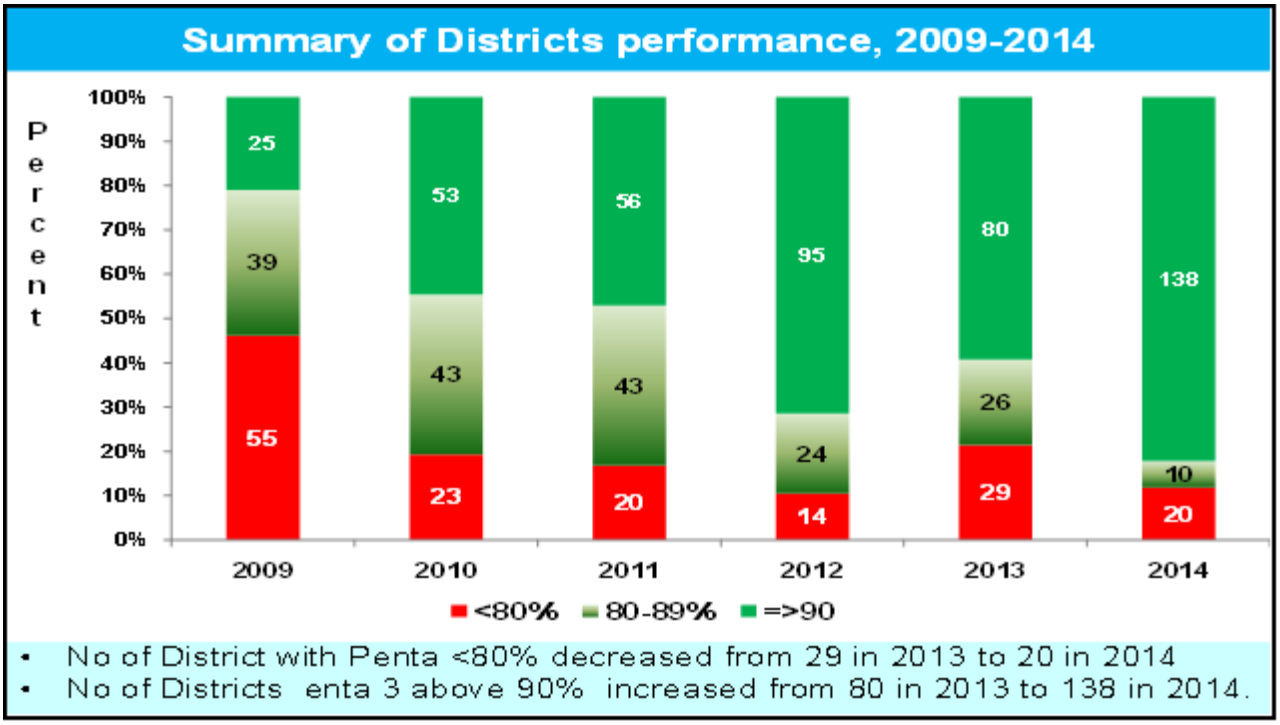
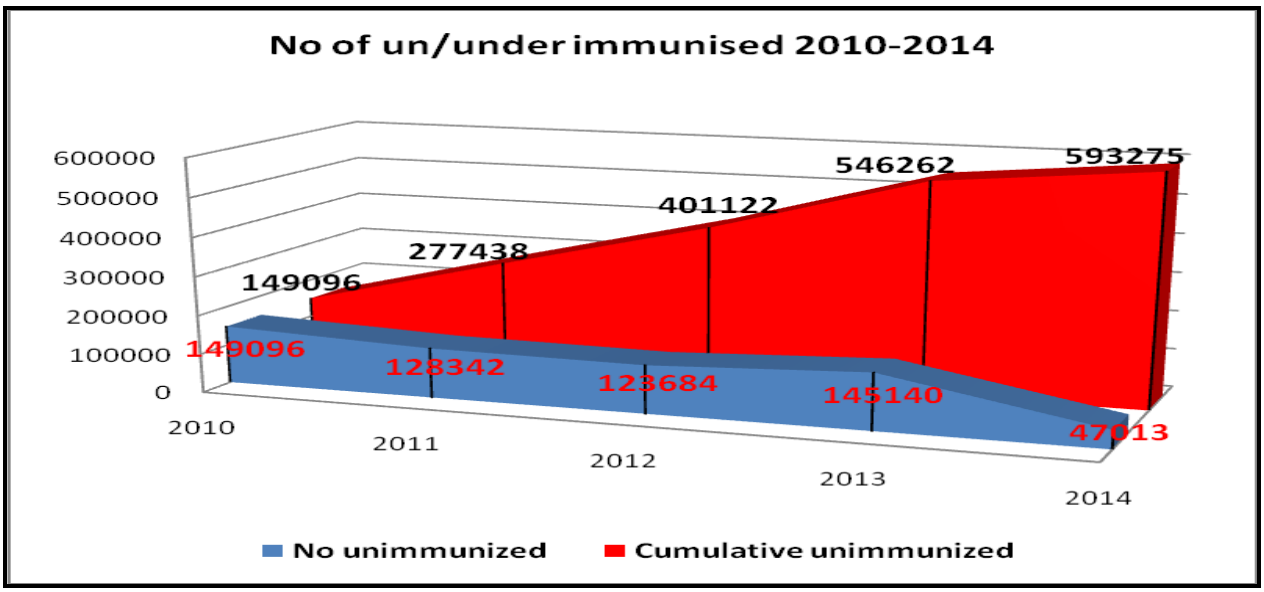


Figure 3.8: Number of Un/Under Immunised status for 2010 - 2014



Challenges

- Barriers of access and utilization of immunization services in poor performing Region/Councils, this includes cancellations of planned immunization outreach services;
- Unavailability of appropriate target population (denominators); the data provided by NBS stills resulted into coverage of over 100%.
- Inadequate availability of appropriate vaccines refrigerators; only 78% of Health Facilities have appropriate functional cold chain equipment;
- Data quality issues and data reporting systems variability; the DHIS 2 stills reports administrative data lower than the vertical reporting system regardless the two systems operates from same councils
- Inadequate supportive supervision by the immunization resources persons at councils, regional and nation level especially to services provisional levels;
- Decreased government spending on routine vaccine spending over the past three years, only 60% of the required immunization budget approved and 100% funded.

Recommendations

- Intensification of routine vaccination services to all councils through implementation of Reach Every Child strategy;
- Ministry of Health should work closely with NBS in reviewing the target population so that councils will be provided with a more précised denominator;
- Data harmonization (between data reporting systems), data review and data quality self-assessment should be done regularly to improve data quality and avoiding duplication of data reporting systems especially at subnational levels;
- Ministry of Health should increase financial allocation to EPI/IVD especially in the procurement of vaccines and for providing supportive supervision.

3.4 Reproductive Health

The implementation of Reproductive and Child Health interventions in 2014 was being guided by the HSSP III (2005-2015). Under HSSP III a set of key reproductive and child health indicators has been chosen to monitor and evaluate progress of RCH activities, as shown below.

- Contraceptive prevalence rate (2004 baseline 20 %, 2015 HSSP III target 30 % and One Plan target 60 % by 2015)
- Proportion of pregnant women starting ANC before 16 weeks of gestation (2008 baseline 14 %, 2015 target 80 %). The ANC start time was updated in 2012 to 12 weeks of gestation.

- Proportion of pregnant women attending ANC at least 4 times during pregnancy (2004/05 baseline 62 %, 2015 target 80 %)
- Proportion of births attended by trained personnel in health facilities (2008 baseline 15 %, 2015 target 80 %)
- Percentage of health centres and dispensaries that can provide emergency obstetric care (EmOC) as defined in the Essential Health Package document (2004/05 baseline 5%, HSSP III 2015 targets – all hospitals and 40% of health centres and dispensaries; One Plan targets of BEmONC to 70 % of Dispensaries and Health Centres; and CEmONC to 50 % of Health Centres and to 100 % of Hospitals by 2015).

This section summarizes progress made in implementing RCH activities for years 2012, 2013 and 2014 as measured by the indicators and set targets.

Family Planning

Family planning services when used properly are critical for the improvement of the health status women and children, and the reduction of both maternal and child mortality. The level of use of family planning services is measured using the contraceptive prevalence rate. This is the percentage of women of reproductive age who are currently using, or whose sexual partner is currently using, at least one contraceptive method, regardless of the method used. It is reported for women aged 15 to 49 who are married or in a union.

Performance Indicators

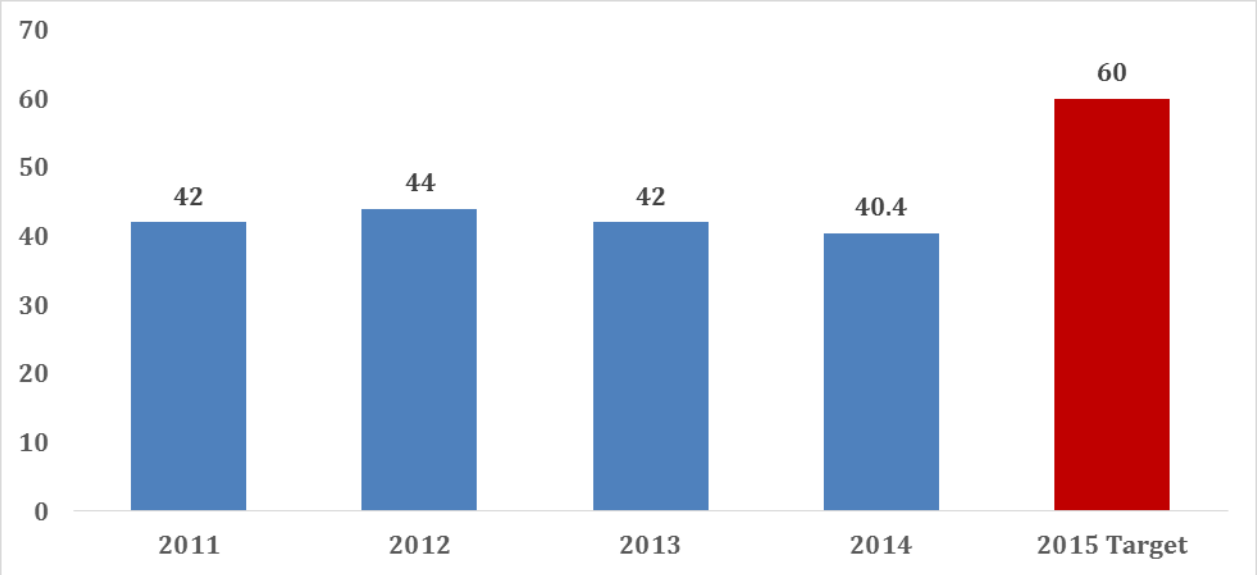
The key performance indicators for tracking family planning services as stipulated in the HSSP III and the Sharpened One Plan documents is as follows:

- Contraceptive prevalence rate (2004 baseline 20 %, 2015 HSSP III target 30 % and One Plan target 60 % by 2015)

Observation

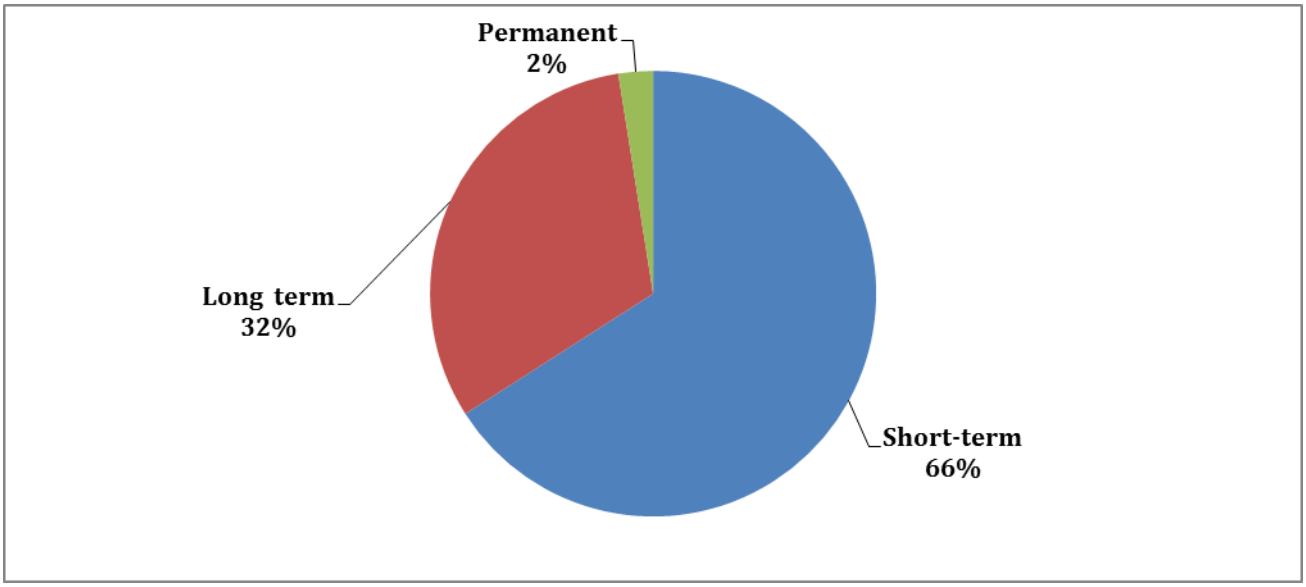
The percentage of modern contraceptive users in 2011was 42 % and this increased to 44 % in 2012. It then decreased to 42 % in 2013, and continued decreasing in 2014 to 40.4 %. This trend indicates that there has been a steady decline of the percentage of modern contraceptive users from 2012 to 2014 as displayed in Figure below.

Figure 3.9: Percentage of modern contraceptives users, years 2011 to 2014



Among all family planning clients in 2014, slightly more than a half (51 %) were new clients, and 49 % were returning clients indicating that some efforts were invested to attract the new clients and satisfy the continuation of old clients. Moreover, the majority of the family clients (66 %) in 2014 were using short term family planning methods (pills, condoms and injections) and the rest (34 %) were using long term and permanent methods as presented in the figure below.

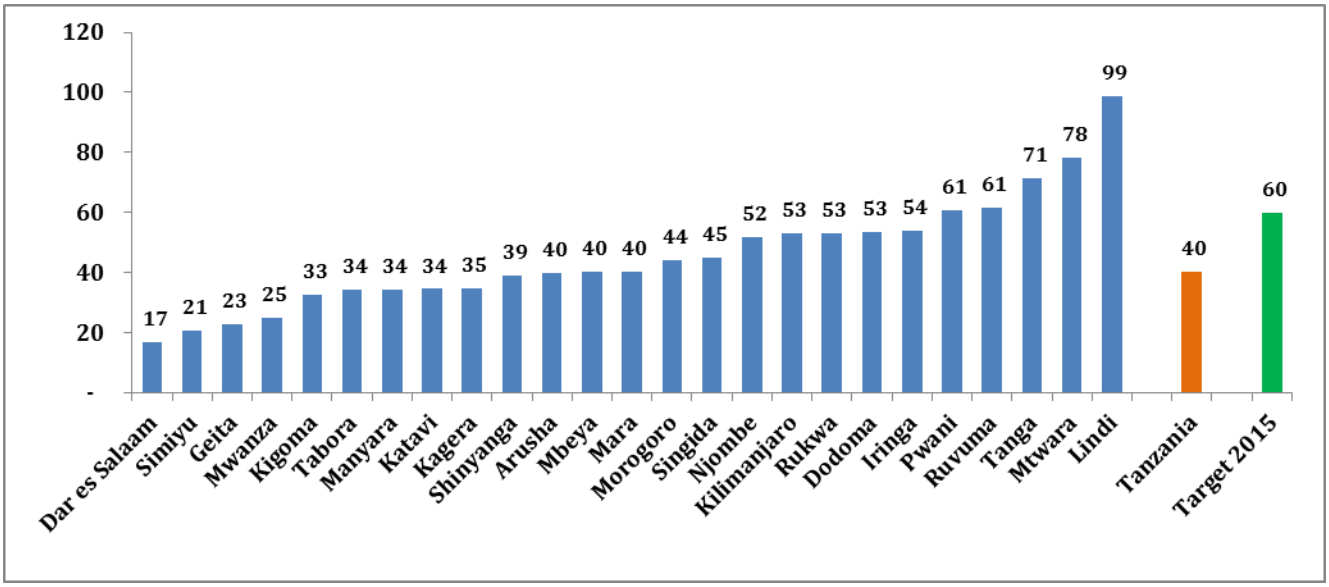
Figure 3.10: Family Planning Methods by Type



To reduce the number of missed opportunities, three services are integrated with family planning services. These include reproductive cancers (breast and cervical cancer), HIV counseling and testing and post abortion care services. During provision of family planning services, 23.8 % of the family clients were screened for breast cancer, 16.6 % were screened for HIV, 6 % were screened for cervical cancer and about 1.5 % was provided with post abortion care services.

HMIS service delivery data for year 2014 show that, the percentage of modern contraceptive users differed significantly across regions. Dar es Salaam region scored the lowest percentage of modern contraceptives users (16.7 %); whereas Lindi region scored the highest (98.8 %). From among all 25 regions, 5 regions scored a contraceptives use rate above the national target; whereas the rest 920 regions) scored below the national target of 60 % as shown in the figure below.

Figure 3.11: Percentage of modern contraceptives users by region, years 2014



Discussion

Family planning services is one of the interventions prioritized in the Sharpened One Plan (2014-2015) for the improvement of health status and reduction of both maternal and child mortality. In 2014 only 40.4 % of the target clients for these services were using the services, this rate is much lower as compared to the national target of 60 % to be attained by end of 2015. Moreover, most of the users of family planning services were on condoms, pills and injections signifying low couple year protection (CYP) attainment. Moreover, only a few regions attained satisfactory levels of family planning users; with regions in the Lake and western zones scoring the lowest. Contraceptive rate outlays in Dar and Lindi suggest that some data quality issues exist, and more notably those associated with capturing of the primary data, and those associated with denominators.

Challenges

- The four years (2011 to 2014) trend presented in the analysis shows that Tanzania is off track to attain the contraceptive prevalence rate target of 60 % by end of year 2015.
- The percentages of modern contraceptive users by end of year 2014 show that the majority of the regions have values that are lower than the set target for year 2015;
- Data quality issues are suspected during capturing of the primary data, and around determination of denominators from population projections.
- The data collected and compiled using HMIS/DHIS from health facilities is not well suited to estimate the contraceptive prevalence rate because it under estimates this indicator by not including contraceptives use from pharmacies, social

marketing sources and shops. In this respect, a proxy for the contraceptive prevalence rate was used by calculating the percentage of female and male clients who were using modern contraceptive in 2014, regardless of the method used; measured against the population of women of reproductive age (15 to 49 years).

Recommendations

- Given the slow increase of the percentage of family planning users in the country, there is a need to re-focus family planning interventions, including increased demand creation for family planning services and addressing family planning stock levels at health facilities.
- There is a need for RHMTs and CHMTs in regions with low family planning uptakes to come out with Council level family planning strategic plans.
- Data quality improvements need be put in place, especially at the primary data collection stage (during client provider interactions) and around the determination of denominators with the National Bureau of statistics.

Antenatal Care

Antenatal care (also known as prenatal care) refers to the regular medical and nursing care recommended for women during pregnancy. National guidelines require that, pregnant women for an early initiation of antenatal services before 12 weeks of pregnancy; and make a total of 4 or more visits during the duration of pregnancy. Before 2012, National Guidelines called for a pregnant woman to start attending antenatal services before 16 weeks of pregnancy. From 2012, the guidelines were revised and called for an early initiation of antenatal services before 12 weeks gestational age

Performance Indicators

To track the performance of antenatal services, the HSSP III calls for collection of data to measure the following:

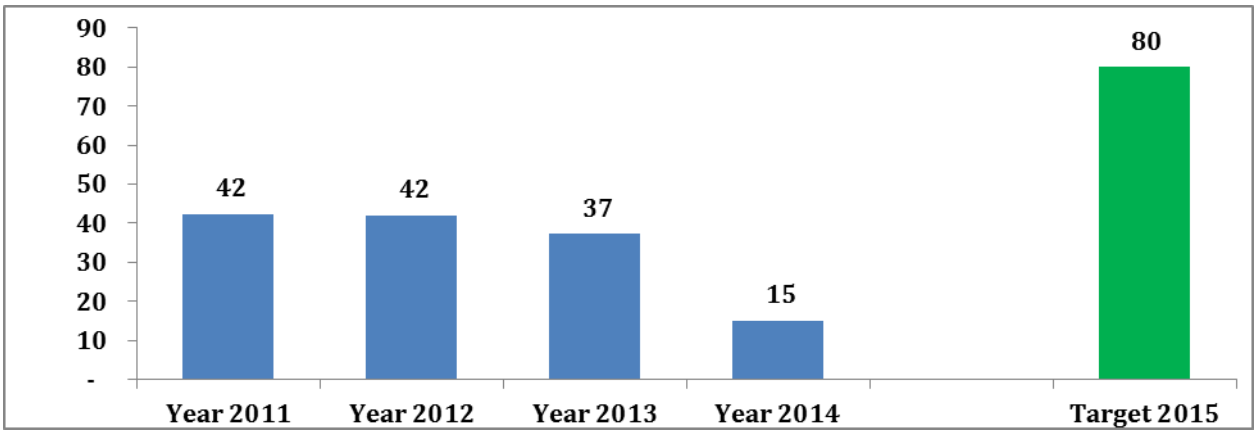
- Proportion of pregnant women starting ANC before 16 weeks of gestation (2008 baseline 14%, 2015 target 80%).
- Proportion of pregnant women attending ANC at least 4 times during pregnancy (2004/05 baseline 62%, 2015 target 80%)

Achievements

- Community data collected by the 2010 TDHS show that there was a high level of utilization of antenatal care services at 98% for at least one antenatal care visit. However the levels of early initiation of antenatal care services (15%) and those who complete 4 or more visits was much lower (43%).

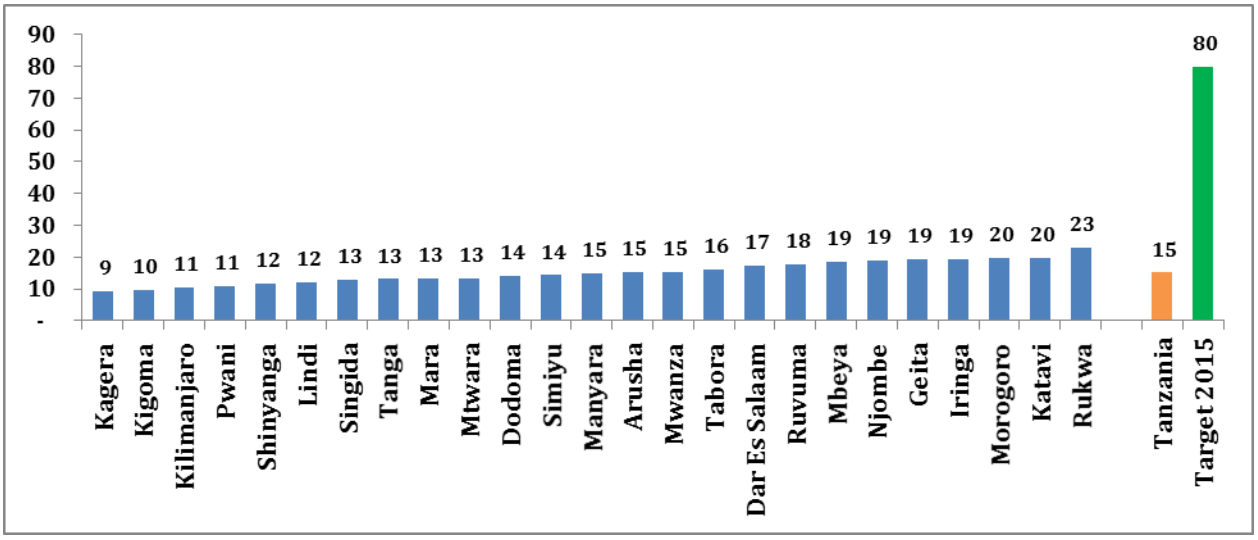
- Data from HMIS show that 42.4% of the pregnant women in 2011 attended services before 16 gestation weeks.
- In 2012 when the guidelines were revised, the percentage of pregnant women who started antenatal care before 12 weeks gestational age remained almost the same at 42.0%. In 2013 this rate dropped to 36.4% and then drastically decreased to 15% in 2014. However, the level of making any ANC first visit to health facilities in 2014 without considering the timing was almost universal (100%).
- When compared to the national target to be reached by 2015, the trend shows that, Tanzania will be off track to reach this important target by end of 2015. The figure below shows the percent of pregnant women who attended ANC services before 12 weeks gestational age, 2011 to 2014.

Figure 3.12: Percent-attending ANC services before 12 weeks gestational age, 2011 to 2014



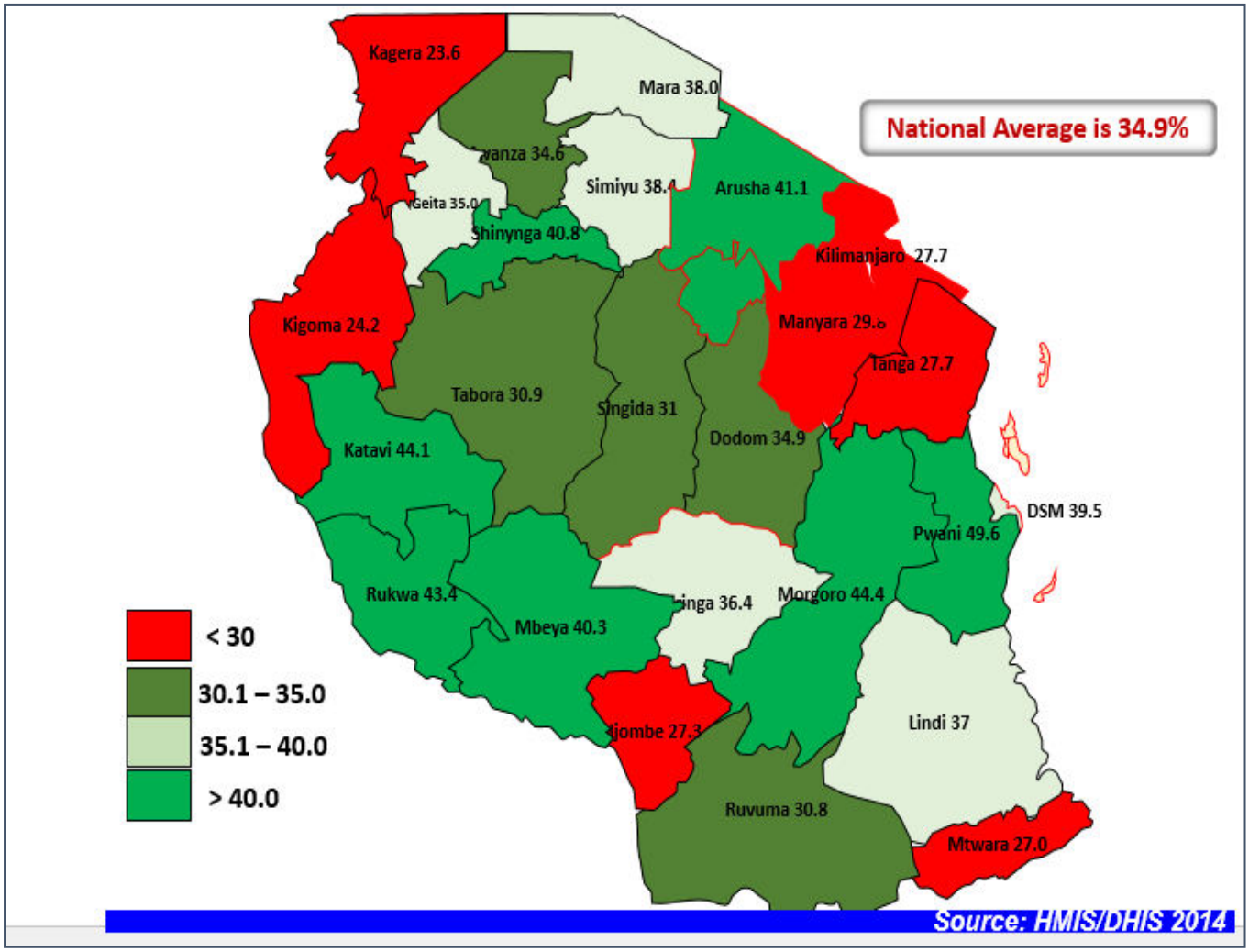
- Data from HMIS in 2014 show that 29.9 % of all pregnant women who visited the health facilities were screened for syphilis, of whom 3.8 % were infected.
- 44 % of all pregnant women who visited the health facilities were screened for anaemia syphilis; and among those screened, 2.3 % were found to have severe anaemia.
- Slightly more than a third (36 %) of all pregnant women who visited the health facilities were screened for malaria; and among those screened, of whom 8.2 % were infected.
- Data on early initiation of ANC services in 2014 across all regions show that Kagera scored the least (9.1 %) and Rukwa scored the highest (23.1 %). This attainment as shown in the figure below further confirms that attainment of the national target by 2015 is off track.

Figure 3.13: Percent of pregnant women attending ANC before 12 weeks by region in 2014



Community survey data show that the percentage of pregnant women attending ANC services 4 or more times decreased from 62 % in 2004/05 to 43 % in 2010 as per TDHS 2004/05 and 2010 TDHS results. HMIS data for four or more antenatal care attendance is available for 6 regions for year 2013. In 2014, the data is available for all 25 regions and only 35 % of the expected pregnant women completed 4 or more ANC visits as shown in the figure below. The findings show that the scores range from 24 % in Dar es Salaam region to 50 % in Singida region, with none of the regions attaining the national target.

Figure 3.14: Percent of pregnant women attending ANC 4 or more times by region in 2014



Discussion

Although the level of making any first ANC visit was universal in 2014, the attainment of an early initiation and completion of visits was very low and the achievements are far below the national targets. The early initiation of ANC services and the completion of 4 or more ANC visits in 2014 across all the regions are equally low. These attainments suggest that RCHS will not be able to attain the ANC set targets by end of year 2015. Moreover, a number of missed opportunities were identified where pregnant women did not receive the routine screening services when attending ANC services.

Challenges

- The current level of early initiation of ANC services (before 12 weeks) is too low to facilitate the attainment of the set national goal.
- The current level of percentages of pregnant women who make 4 or visits for ANC services is too low to facilitate the attainment of the set national goal.
- All pregnant women attending ANC services are not provided with all the routine screening services.

Recommendations

- Immediate actions need to be taken to increase the number of pregnant women seeking ANC services (before 12 weeks). This should include coming with a well-defined demand communication initiative.
- Outreach and mobile clinic services need to be expanded to beyond health facilities to facilitate reaching all pregnant women in communities.
- The newly introduced community MNCH initiatives need be expanded to all rural communities to facilitate promotion of ANC services and encouraging pregnant women to initiate ANC services early and complete all recommended visits.
- All pregnant women attending ANC services need be provided with all the routine screening services.

Labour and delivery

The presence of a skilled birth attendant during each and every delivery ensures that quality maternity and neonatal care services are available all the time to save the lives of women and newborns. In addition, these health professionals need to be motivated and located in the right place at the right time. In the Sharpened One Plan, the emphasis is on appropriate policies, essential supplies including medicines and appropriate regulatory frameworks.

Performance Indicators

To track the performance of antenatal services, the HSSP III calls for collection of data to measure the following:

- Proportion of births attended by trained personnel in health facilities (2008 baseline 15%, 2015 target 80%)
- Percentage of health centers and dispensaries that can provide emergency obstetric care (EmOC) as defined in the Essential Health Package document (2004/05 baseline 5%),
- HSSP III 2015 targets
    - – all hospitals and 40% of health centers and dispensaries;

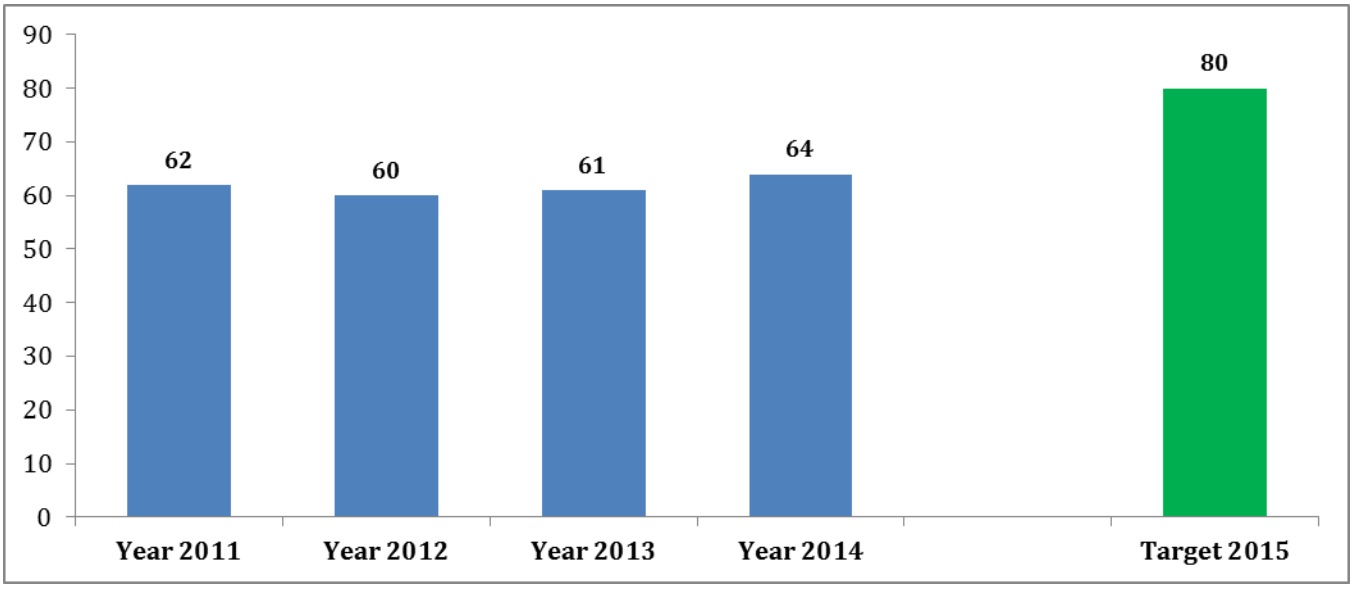
One Plan 2015 targets

- BEmONC to 70 % Dispensaries and Health Centers;
- CEmONC to 50 % of Health Centers and to 100 % of Hospitals

Achievements

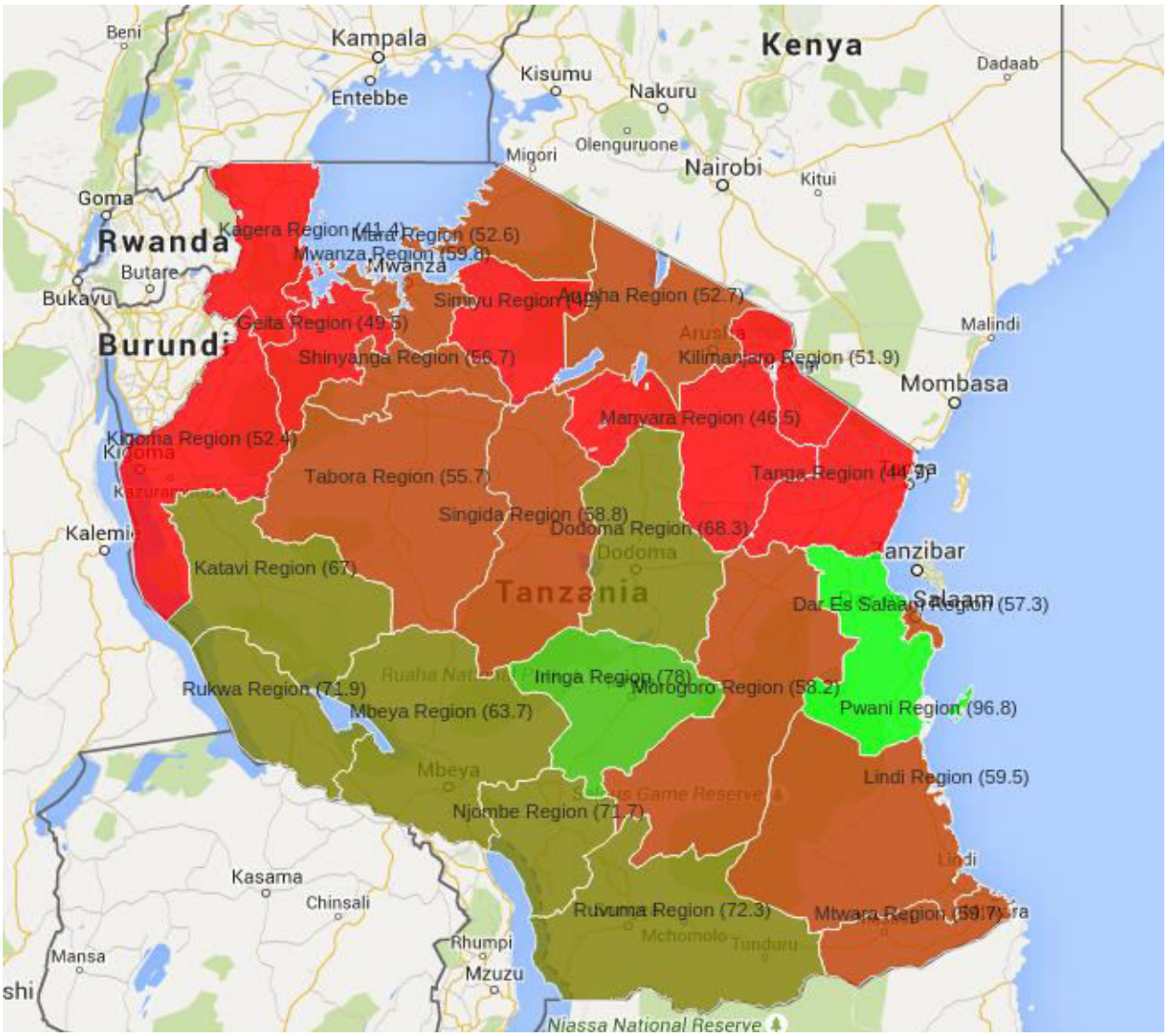
In 2014, 64.3% of all expected pregnant women delivered in a health facilities. This proportion has been fluctuating from 62% in 2011, to 60% in 2012, and then to 61% in 2013.

Figure 3.15: Percent of expected pregnant women who delivered in a health facility, 2014



The distribution of percentages of expected pregnancies that were delivered in health facilities with assistance from trained personnel by region is presented in the Figure below:

Figure 3.16: Proportion of Births Attended by Trained Personnel in Health Facilities



The percentages of expected pregnancies that were delivered in health facilities by region ranges from 41% in Kagera to 97% in Pwani region. In 2014, only one region (Pwani) scored above the national target of 80% by end of year 2015.

Among all deliveries conducted in a health facility in 2014; the majority (89.5 %) were assisted by trained personnel. Among all deliveries in health facilities 93.7 % were normal and 9.1 % were by caesarean section.

Proportion of health facilities providing Emergency Obstetric Care

Both the HSSP III and the One Plan target for an increased availability of BEmONC services from 0 % of dispensaries in 2005 to 70% in 2015; and increased availability of BEmONC services from 5% of health centers in 2005 to 70% by 2015 and an increased coverage of CEmONC services from 64% of hospitals in 2005 to 100% by 2015 and CEmONC services from 0% of health centers in 2005 to 50% by 2015.

Achievement

The SARA survey conducted in 2012 found that 73% of the hospitals fully functional CEmONC facilities, 9 % of the health centre fully functional CEmONC facilities, 39% of health centres fully functional BEmOC facilities and 20% of dispensaries fully functional BEmOC facilities. These findings are summarized in the table be**Discussions**

In 2014, a nationwide assessment to establish the levels of provision of BEmONC and CEmONC service was conducted. However, by end of 2014 the results were not ready, and thus the results of the SARA assessment are the current source of information.

Challenges

- The level of health facility delivery is still lower than the national target of 80%.
- The level of assistance by trained personnel during delivery in health facilities is still lower than the national target of 80%.
- The best available data on provision of BEmONC and CEmONC services is that realized from the SARA study conducted in 2012.

Recommendations

- More investments are required in promoting health facility delivery through design and dissemination of messages by a multimedia approach, using community health workers to promote facility delivery.
- More efforts are required in training, deploying and employing trained personnel in all health facilities that provide delivery services.

Way Forward for RCH Interventions

In 2015 a new strategic plan; the One Plan II (2016-2020) was developed to address all issues pertaining to RMNCH interventions for the next 5 years. This strategy, like the preceding one, puts special emphasis on strengthening accountability and monitoring mechanisms. The plan calls for strengthening the system by encouraging increased collection and use of high quality RMNCH at all levels, reinforcing partnerships for social mobilization, funding and technical assistance, and finalizing the resource mapping of all partners to facilitate realignments that address equity and accessibility.

3.5 HIV and AIDS

The Tanzania Government response to the epidemic started since 1985 following reports of AIDS cases from most of the regions. The government started implementation of HIV care and treatment programme through a scale up plan which resulted into increased number of clinics providing HIV care, treatment and support services from 521 in 2004 to 2,147 by December 2014.

Key performance indicators

Indicator 1: Proportion of persons with advanced HIV infections (eligible for ART) receiving ART disaggregated by age (< 15 years and ≥15yrs).

(Number and percentage of eligible adults and children currently receiving antiretroviral therapy)

Numerator: The number of people with advanced HIV infections who are receiving ART

Denominator: Estimated number of persons with advanced HIV infection.

- Baseline (2011): 266,428/390,160 (68%) (Adults and Children)
- Target for 2016: 76% (91,720) children; 89% (850,795) Adults

Indicator 2: HIV prevalence among pregnant women aged 15-24 years

(Percentage of young people aged 15–24 years who are living with HIV)

Numerator: Number of pregnant women aged 15-24 years who are HIV positive (19,333-ANC survey, 2011) =19,333)

Denominator: Total number of pregnant women aged 15-24 years

[All pregnancies in 2011 were 1,680,000 (ANC 2011) –Question: How many were aged 15-24 years then?]

- Baseline (2011): 3.9%, (ANC 2011)
- Target for 2016: 1.62% (Spectrum, 2014)

Other performance indicator: Percentage of adults and children with HIV known to be alive and on treatment 12, 24 and 36 months after initiation of ART

Numerator: Number of AIDS patients (adults and children) who are alive and on ART 12, 24 and 36 months after start of ART.

Denominator: Total number of patients (adults and children) who started ART

- Baseline (2010): 74% for adults (Cohort analysis data); 81% for children (Cohort analysis data)
- Target for 2015: 80% at 12 month for all (adults and children)

Progress in 2014

ART coverage

As of December 2014, it was estimated that a total of 1,499,394 people were living with HIV: of whom 868,302 (58 per cent) had advanced HIV disease in need of ART. Of those in need of ART, 598, 202 (73 per cent) and 41,882 (83 per cent) were adults and children, respectively. It should be noted that the definition of advanced HIV disease and ART eligibility changed from CD4 count of 200 cells/ul or less to 350ul or less in 2013. This change increased the number of patients who are eligible to ART, thus eroding coverage, which had been achieved.

Table 3.2: ART Coverage among adults and children, 2011 – 2014

Years	*PLHIV (Adult + Children)	*Adults needing ART	**Adults receiving ART (annual)	%	*Children needing ART	**Children receiving ART (Annual)	%
2011	1,490,895	330,043	248,707	75	60,117	19,697	33
2012	1,499,394	667,797	399,924	60	53,954	32,414	60
2013	1,491,731	706,674	473,707	67	50,742	38,848	77
2014	1,499,394	818,072	598,202	73	50230	41,882	83

Data source: *Spectrum 2014, **Annual Program Data (2011-2014)

Retention of patients on ART

Implementation of HIV and AIDS care and treatment services in Tanzania Report number four, of 2015, indicate that the '*Percentage of adults and children with HIV known to be alive and on ART 12 months after initiation* of ART was 73.7 percent and 77 percent respectively. Consequently, the attrition rate for adults and children on ART were 26.3 percent and 23 percent respectively.

Limitation of reported data

Estimation of number of people living with HIV is done using spectrum modeling where a number of assumptions are entered which may not be applicable to all parts of the country and age groups. Examples are:

- HIV prevalence data (THMIS 2011/12) is limited to the 15-49 years age group
- Methodology for estimation of the proportion of PLHIV with advanced HIV disease provides a crude estimate.

- Proportions of patients who are considered lost to follow up but are actually silent self-referral to other clinics and continuing to enjoy services is not known.

Challenges

- Prognosis of PLHIV eligible on ART who enroll to ART, mostly among male clients less than 30 years is poor with high mortality is a significant cause of low retention to ART
- Insufficient follow up of clients enrolled on ART to return them back to treatment, hence high attrition rate
- Weak linkage (continuum of care) in particular between HIV counseling and testing services (HTC) and care and treatment services.
- Ill-timed supply of HIV test kits and ARV drugs leading to point of care stock outs.
- Long turnaround time of CD4/viral load investigations, which delay ART initiation among potentially eligible patients.

Way forward

- Strengthen community based health services and linkage to health facilities so as to encourage community support for those on ART.
- Enhance the use of community-trackers (e.g. expert-patients and community health care workers) with good tracking records and who are believed to have the same feelings) as treatment supporters for patients on ART
- Establish simple and standard electronic monitoring systems to track lost to follow up clients in order to retain more clients on ART
- Use of point of care machine (PIMA) to health facilities that do not have the machines in order to reduce long turnaround time for CD4 investigations.
- Scale up the involvement of males in HIV couple counseling and testing.

Conclusion

In summary there has been an increase in the coverage of HIV care and treatment services to PLHIV: coupled with increase in the number of facilities (CTCs) providing these services from 1,047 in 2011to 2,147 in 2014. Moreover, in this year, the ART coverage in persons with advanced HIV disease receiving ART had increased in both adults and children

3.6 PMTCT

Tanzania adapted policy of providing lifelong ART for pregnant and lactating women living with HIV in 2013. This policy calls for immediate ART initiation upon diagnosis of HIV infection. The process of adaptation of lifelong ART to pregnant and lactating women (LLAPLA) involved various PMTCT stakeholders, including representatives of women living with HIV, PLHIV, policy, decision makers, partners, Institutions, NGOs, PMTCT health service providers, Regional and District Health management teams.

Implementation of this policy started In October 2013 in 9 regions with highest HIV/AIDS burden in the country and by June 2014, all regions had already started implementation of LLAPLA.

Key performance indicators

The key performance indicator for the PMTCT programme in HSSP is the percentage of HIV positive woman receiving ARVs to prevent Mother to Child Transmission of HIV.

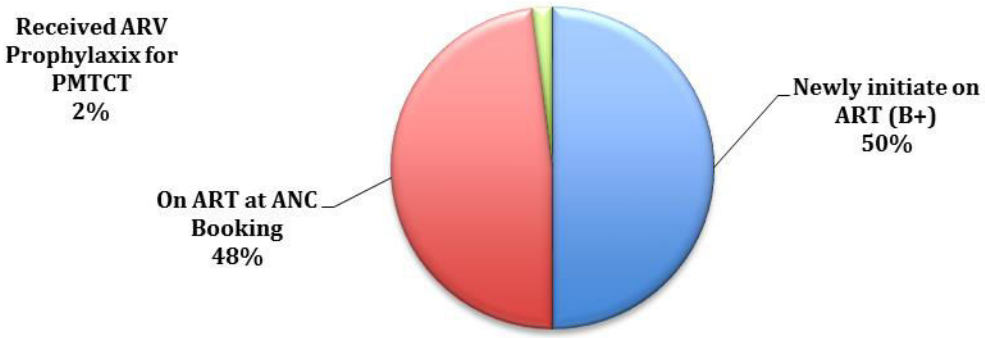
Baseline and 2015 target (s)

The baseline for this indicator was set at 68% in 2010 (the baseline year), while the set target for 2015 is 98%.

Progress in 2014

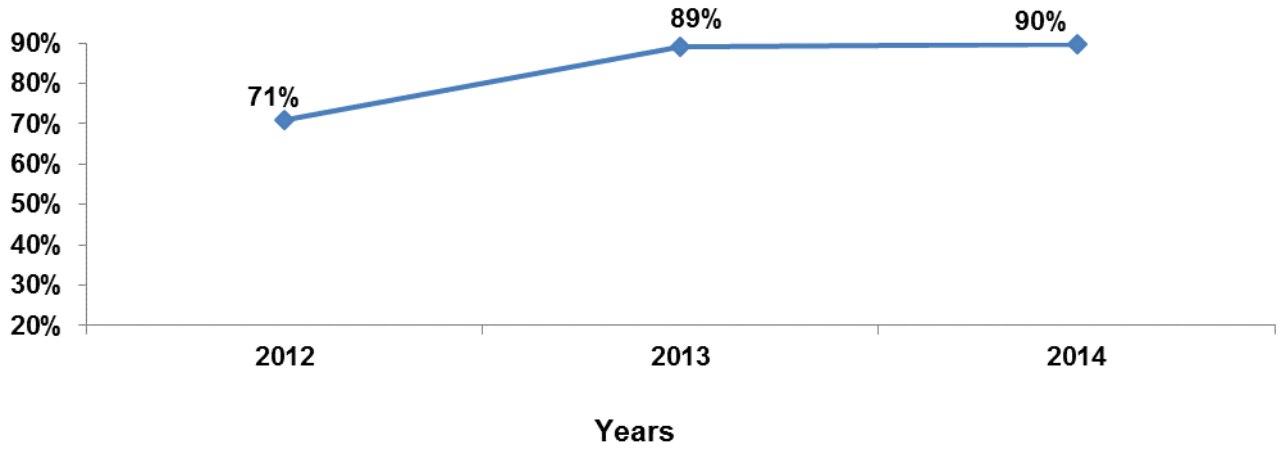
In 2014, SPECTRUM estimated the number of HIV infected pregnant women to be 83,913. The percentage of pregnant and lactating women who received ARVs to prevent Mother to Child Transmission of HIV was 90% (75,334 out of 83,913). Among 75,334 who received ARV, 36,366 (48%) were newly initiated in the course option B+ while 37,403 (50%) were already on ART at the time of ANC booking and only 1,565 (2%) were receiving prophylaxis.

Figure 3.17: Maternal ARVs Disaggregated by Region



The percentage of pregnant and lactating women who received ARVs to reduce Mother to child Transmission of HIV has increased from 71% in 2012 to 90% in year 2014.

Figure 3.18: Trend of ARV uptake between 2012 and 2014



Baseline target (s) and Performance for other Indicators

Below are the baseline, progress and targets for each of the other programme indicators for the period between 2012 and 2014 and associated remarks

Table 3.3: Progress with selected HIV-related indicators, FY 2012-14

S/N	Indicator	Baseline (2010)	2012	2013	2014	Target (2015)	Remark
1	Proportion of RCH facilities providing PMTCT services	93%	93%	97%	91%	100%	rogress
2	Percentage of pregnant women tested for HIV infection	86%	63%	78%	90%	99%	Major Progress
3	Percentage of HIV exposed infants receiving ARV	57%	72%	67%	71%	90%	There is progress but more effort is needed
4	Percentage of HIV exposed Infants receiving Cotrimoxazole	17%	38%	42%	57%	80%	There is progress but more effort is needed
5	Percentage of exposed Infants received virological test within 2 months of age	25%	36%	42%	43%	80%	There is slightly progress, effort is needed
6	Percentage of male partner tested for HIV at ANC	21%	21%	31%	40%	50%	There is progress, maintain to reach target

Source: Tanzania Elimination of Mother to Child Transmission of HIV plan, 2012-2015.

Challenges

Besides the abovementioned challenges, the PMTCT program has the following additional issues;

- Data quality issues, especially during the transition to Option B+, workload and capacity of health care workers.
- Inadequate linkage initiation and retention on ART once a pregnant woman is identified as HIV positive.

Way forward

- Ensuring consistent and adequate availability of HIV consumables (test kits and medicines) to improve and sustain effective coverage and utilization of PMTCT and HIV Early Infant Diagnosis using (virological testing) services.
- Conduction of regular data quality assessment and assurance to improve and sustain data quality.
- Provide continuous supportive supervision and mentoring to improve retention, and quality of care under option B+.

Conclusion

In summary, there has been an increase in the proportion of HIV-infected women receiving ARV prophylaxis for PMTCT from 71% in 2011 to 90% in 2014, which we believe eMTCT target will be achieved.

3.7 Malaria

The Goal of National Malaria Medium Strategic Plan 2015 /2020) is to reduce the average country malaria prevalence from 10% in 2012 to 5% in 2016 and to less than 1% in 2020. This goal is measured through the following HSSP III. Strategic Objectives:

- Proportion of mothers who received two doses of preventive intermittent treatment for malaria during last pregnancy (HSSP III 2015 target – 80%).
- Proportion of vulnerable groups (pregnant women 15-49 years of age, children under 5) sleeping under an ITN previous night (HSSP III 2015 target – 60%),

- Proportion of laboratory confirmed malaria cases among all OPD visits (disaggregated under 5 and over 5) (HSSP III 2015 target – pending) and
- Prevalence of malaria parasitemia in children under 5 years (HSSP III 2015 target - 5%)

Table 3.4: Progress in malaria intervention activities as measured by core

Indicator	2007/8 %	2010 %	2012 %	2013 %	2014 (%)	HSSP III 2015 TARGET	Comment/observation
Percentage of women who received two doses of preventive intermittent treatment for malaria during last pregnancy	30	27	32.7	32.7	34	80%	Reports from the two national surveys indicate, Access to IPTp is still very low. Major concerns are due Frequent SP stock outs, late antenatal booking by pregnant women and inadequate data recording by service providers in ANC clinics
Percentage of vulnerable groups (pregnant women 15-49 years of age) sleeping under an ITN previous night	27	57	75	75	75	80%	Despite achieving programme targets by increasing net coverage to 75%, utilization mosquito nets is still a challenge. The

							achievement is still below the national average. More efforts are needed to sensitize the community on LLINs usage.
Percentage of vulnerable groups (children under 5) sleeping under an ITN previous night	26	64	72	72	72	80%	The good achievement reached is still below the national average. More efforts are needed to sensitize the community on LLINs usage.
Proportion of laboratory confirmed malaria cases among all suspected malaria cases attended at the Out Patient Department (OPD)	-	-	20.9	12.6	64	80%	Negative attitude of service providers to newly introduced malaria diagnosis tool (mRDT) contributes to under reporting malaria cases.
Malaria parasite prevalence among children 6 - 59 months years of age	18	-	9.5	9.5	9.5	5%	National surveys data between year 2008 and 2012 indicates that malaria prevalence has decreased by 50% (from 19% to 9.5%) however by the end of 2014 the progress made was far below HSSP III. Strategic objective.

Percentage of women aged 15 - 49 years who received two doses of Intermittent Preventive Treatment for malaria (THMIS 2007/8 and 2012)

Progress towards achieving the HSSP III target of 80% remains a major challenge. Results from national surveys show that access to IPTp by pregnant women remained very low over the different surveys. Initially, it increased from 21% (2004/5) to 30% (2007/8), in 2010 it declined.

Table 3.5: **Percentage of pregnant women receiving 1st and 2nd doses of IPT malaria tests during ANC visits in the year 2014**

Region	PW tested for Malaria	PW tested positive	PW malaria test rate	PW Malaria positivity rate	IPT1	IPT2	% IPT1 Use	% IPT2 Use	First ANC visit
Arusha	41284	260	56	1	39556	32873	54	45	73568
Dar Es Salaam	98658	4422	54	4	59287	61267	33	34	181116
Dodoma	37642	1065	41	3	40843	35227	44	38	91965
Geita	24604	3447	23	14	28258	20631	27	19	105968
Iringa	8370	180	22	2	18006	15467	47	41	38190
Kagera	26699	5059	29	19	42429	39978	47	44	90817
Katavi	13227	1025	36	8	14129	9602	39	26	36426
Kigoma	29263	4378	38	15	33305	27202	44	36	76324
Kilimanjaro	24073	250	55	1	24986	22480	57	51	43927
Lindi	13259	1690	42	13	14992	13031	47	41	31938
Manyara	22526	1344	34	6	18824	14191	29	22	65765
Mara	26756	4123	30	15	37748	30025	43	34	87735
Mbeya	49401	1607	41	3	43657	42734	36	36	119786
Morogoro	32728	4188	33	13	36529	34698	37	36	97702
Mtwara	16030	2496	38	16	21755	18813	52	45	41727
Mwanza	26836	4016	20	15	44531	35892	33	27	133125

Njombe	16480	200	63	1	10953	12085	42	46	26358
Pwani	33516	2951	62	9	34213	40713	63	75	54250
Rukwa	24150	2091	38	9	16293	18537	26	29	62959
Ruvuma	17276	2138	30	12	25155	23935	44	42	57309
Shinyanga	21862	1801	26	8	37828	32463	44	38	85593
Simiyu	15933	1674	18	11	41026	35289	47	40	87790
Singida	28488	529	42	2	34686	26509	51	39	68276
Tabora	44230	5328	33	12	27843	16680	21	13	133378
Tanga	31929	2401	38	8	26696	17574	32	21	83795
Total	**725,220**	**58663**	**37**	**8**	**773,528**	**677,896**	**39**	**34**	**1,9755,787**

Source: HMIS 2014

Percentage of household members, pregnant women 15-49 years of age, and children aged 6 to 59 months who slept under an ITN during previous night of the survey (THMIS 2007/8 and 2011/12)

LLINs use has increased from 16% in 2004/5 to 72% in 2011/12 in children. Similarly LLINs use increased from 16% to 75% among pregnant women and from 15% to 68% among the general population during the same period. As a result of mass campaign, equity has been achieved in terms of access and use of LLINs among the different wealth quintiles in the population.

Malaria parasite prevalence among children 6 months to 59 months of age

Population surveys have shown that the prevalence of malaria among children 6 to 59 months of age to have declined by about 50%, from 18.1% in 2008 to 9.5% in 2012 (THMIS 2008, 2012). In both surveys, children in rural areas were more likely to have malaria parasites than those residing in urban areas.

Proportion of laboratory confirmed malaria cases among all suspected malaria cases attended at the Out Patient Department (OPD).

Data reported through MoHSW - HMIS 2013 shows at least more than half (55.7%) of cases reported were laboratory confirmed, mostly reported from Dar es Salaam, Katavi

and Kagera Regions, while Singida, Njombe and Iringa being the lowest (27%), as summarized in Table 14.

Table 3.6: OPD Malaria cases in year 2014

Region	Total malaria cases	Malaria burden	Confirmed Malaria cases	% Confirmed malaria cases	All cause OPD
Arusha	51,225	4	17,465	34	1291894
Dar Es Salaam	736,686	15	614,230	83	4796121
Dodoma	233,146	18	118,815	51	1272395
Geita	268,973	48	200,728	75	560471
Iringa	88,044	16	26,216	30	554162
Kagera	520,069	48	441,129	85	1085986
Katavi	76,545	37	58,101	76	206672
Kigoma	364,464	43	239,188	66	839733
Kilimanjaro	84,517	11	39,200	46	793133
Lindi	321,583	41	135,758	42	789476
Manyara	130,358	28	47,963	37	473535
Mara	389,280	44	268,643	69	874830
Mbeya	182,723	15	109,612	60	1230690
Morogoro	530,007	49	336,741	64	1076955
Mtwara	406,552	39	229,327	56	1049129
Mwanza	462,724	46	327,661	71	1009789
Njombe	42,024	17	13,285	32	243088
Pwani	433,625	35	292,342	67	1221531
Rukwa	139,746	30	79,312	57	462827

Ruvuma	355,975	48	187,481	53	743027
Shinyanga	315,837	34	198,142	63	922319
Simiyu	173,854	33	109,255	63	519480
Singida	155,054	18	63,037	41	848954
Tabora	406,492	59	233,215	57	688602
Tanga	481,395	40	285,823	59	1210434
Overall	**7,350,898**	**30**	**4,672,669**	**64**	**24765233**

Source: HMIS/DHIS 201

Challenges:

Despite the progressive decline in malaria prevalence, over the past decade, Tanzania remains highly vulnerable for malaria transmission due climatic conditions suitability.

- Frequent stock outs of Sulphadoxine Pyrimethamine (SP) for IPTp at Health Facilities and late booking of pregnant women.
- Incomplete, late and inadequate reporting of malaria indicators from routine system (HMIS)
- Non adherence to the National Diagnosis and Treatment Guidelines by service providers
- Low community LLINs utilization

Recommendations

- Scale up universal access to diagnostics and maintain affordable quality assured ACT including SP for IPTp in all public and private sector health facilities.
- Ensure service providers adhere to the guidelines for malaria diagnosis and treatment at all levels
- Improve data management by conducting regular data auditing of key performance indicators
- Establish and maintain mechanism for keep up of LLINs coverage and utilization.

Conclusions

Much effort is still needed to ensure high proportion of pregnant women benefit from IPTp intervention as well as improve the quality of data reported through DHIS platform. Also there is need for maintenance of the scale-up of recommended interventions to ensure communities are continuously protected against malaria.

3.8 Tuberculosis and leprosy

According to the TB global report 2014, Tanzania is among the 22 high-burden countries with an estimated TB incidence rate of 164 cases per 100,000 population and mortality rate (excluding HIV+TB) of 12 per 100,000 populations. TB has continued to be among the top ten cause of death and is ranked 6th among admission aged five years and above in the country. On the other there has been a rapid decline in the number of registered leprosy cases on treatment, from nearly 35,000 cases in 1983 to 2,019 in 2014. The decline is partly as a result of the introduction of WHO multidrug therapy (MDT) in 1983, reaching a countrywide coverage in 1990.

HSSP III indicators, their corresponding baselines and targets (year of targets)

- TB notification rate per 100,000 population, with a baseline of 163 in 2008 (and no 2015 target specified);
- The percentage of TB treatment success rate, with a baseline of 84.7% in 2008 and a target of 90% by 2015; and
- The proportion of leprosy cases diagnosed and successful completed treatment, with a baseline of 97% for pauci-bacillary (PB) and 91.7% for multi-bacillary (MB) leprosy.

Other indicators, their corresponding baseline and target

- Percentage of TB cases with known HIV status (WHO target 100%)
- Percentage of TB cases were co-infected with HIV
- Percentage of co-infected patients were put on Co-trimoxazole Preventive Therapy (CPT), WHO target 100%
- Percentage of HIV positive TB patients initiated or on ARVs (WHO target 100%)
- Number of MDR TB cases initiated second-line treatment
- Percentage of children diagnosed and started TB treatment,
- TB mortality rate (per 100,000 population), Target half death from that of 1990

Table 3.7: Progress during 2014, trends 2012, 2013 and 2014

Indicator	Baseline (2008)	2012	2013	2014	Target (2015)	Comment
TB notification rate per 100,000 population	163	142	142	133	No	*The target is decrease, although Prevalence survey2012 show there's detection rate is 50 -54%*
Tuberculosis treatment success rate (%)	84.7	88	89	90	No	*Attained WHO target*
The proportion of leprosy cases diagnosed and successful completed treatment pauci-bacillary (cohort registered receding yea) -%	95	95	96	95	97	
The proportion of leprosy cases diagnosed and successful completed treatment multi-bacillary (cohort registered preceding 2 year) -%	92	94	93	93	95	

Table 3.8: Other Indicators performance

Indicators	2012	2013	2014	Target	Comment
Proportional of TB cases counseled and tested for HIV – (%)	82	83	88	100	*Progressing well hoping to achieve target by near future*
Proportion of TB and HIV co–infected patients initiated Co-trimoxazole Preventive Therapy (CPT) - %	96	98	97	100	*Progressing well hoping to achieve target by near future*
Proportion of TB and HIV co–infected patients initiated on ARVs - %	54	73	83	100	*Progressing well after NACP revised ART guidelines*
Treatment success rate of MDRT	78	75	87	75	

Indicators	2012	2013	2014	Target	Comment
TB cases started treatment 2 years ago -%					
Estimated TB mortality rate excluding HIV + TB –(100,000 population)	14	13	12	16	*Already the country attained MDGs of having death from that of 1990*

Limitations/challenges

- Despite these remarkable achievements MoHSW is facing a number of challenges in implementing TB and leprosy control services. These include: **TB notification rate:** TB notification rate is still below the WHO estimated TB incidence rate (133 vs 164 /100,000) probably due to low number of diagnostic health facilities (945 country wide) including low capacity to diagnose MDR-TB cases.
- The proportion of leprosy cases diagnosed and successful completed treatment: Lack of funds to support leprosy elimination services and declining knowledge on leprosy diagnosis and management among clinicians affect this indicator

Way forward

- **TB notification rate:** The Ministry is rolling out new diagnostic technologies such as Gene-Xpert machines and intensifying community TB care interventions. Involvement of mining sector in TB control is another intervention that can increase TB case detection and improve treatment outcome.
- **The proportion of leprosy cases diagnosed and successful completed treatment:** The Ministry is planning to continue doing targeted leprosy elimination campaign in district with high leprosy burden and training health care workers on management of leprosy in order to improve and achieve this target.

Conclusion

Treatment success rate is one of the indicators the Ministry can achieve in short period, provided that community involvement is encouraged and provision of quality TB medicine is maintained. New interventions in TB control, including technologies to diagnose TB, can accelerate TB case notification and eventually meet the target.

3.9 Infectious (communicable) and non-communicable diseases

3.9.1 Non Communicable Diseases

In 2011 a high level meeting of world leaders at the United Nations made a political declaration for the Prevention and Control of NCDs. In response, WHO formulated a strategy aimed to reduce the current mortality related to NCDs by 25% by 2025 and suggested nine voluntary targets to guide action towards that end. These targets were endorsed by member states at the 2013 World Health Assembly, Tanzania included. Last year WHO reported on progress for each country, all of which are expected to develop National NCD Action Plans by 2015, and where they do not exist and report implementation progress by 2017.

Strategic Objectives: To reduce the burden of non-communicable diseases

Indicator: Number of cases of relevant non-communicable diseases treated

Targets: Proportion of cases of relevant non-communicable diseases treated among those who have the disease reduced 25 percent by 2025

Table 3.9: Number of patients attended and managed for selected documented non –communicable diseases in health facilities in Tanzania Mainland

Disease	***2009***		***2010***		***2011***	
	Number	**% of total attended**	**Number**	**% of total attended**	**Number**	**% of total attended**
Heart disorders	21, 785	2.8	56,140	2.8		
Hypertension	No record available		No record available		12,857	1.7
Rheumatic Fever	19,875	2.6	No record available		No record available	
Fracture	18,579	2.4	No record available		No record available	
	No of cataract surgeries	**(Cataract surgical rate)**	**No of cataract surgeries**	**(Cataract surgical rate)**	**No of cataract surgeries**	**(Cataract surgical rate)**
Cataract	21,075	500	21,611	500	22,275	500

Source: HMIS, Eye care database

Other performance indicators

Table 18 below presents some other selected country indicators, which are used in monitoring progress with NCD prevention and control. As shown, diabetes prevalence in 2008 was 3.3%, rising to 9.1% in 2012, while hypertension seems to be the same being about 30% in both years.

Table 3.10: Additional indicators used for monitoring non-communicable disease

Global Outcome targets	Indicators	2008*	2012**
Diabetes 10% relative reduction in prevalence of Diabetes	Prevalence of Diabetes among 25yrs +	3.3%	9.1%
Global Exposure targets:			
Obesity Halt the rise in obesity7 prevalence	Prevalence of Obesity among 25yrs +	-	8.2%
Blood pressure/Hypertension 25% relative reduction in prevalence of raised blood pressure9	Prevalence of Hypertension/Blood Pressure among 25yrs +	31.8%	30.7%

Source: *WHO 1st Steps survey and **WHO 2nd Steps survey

Challenges for the indicators performance

- Weak multi sectoral arrangements for NCD planning.
- Inadequate financial, human resources and equipment
- Interventions addressing disability-causing diseases such as eye conditions are not prioritized in the national health agenda.
- Low community awareness on NCDs.
- Poor data collection on NCDs

Recommendations

- Increasing access to community and home-based care and rehabilitation programmes for the chronically ill and visually disabled;
- Developing screening programmers at workplaces and health facilities for NCDs (hypertension, diabetes, cervical and breast cancers, Eye Diseases and conditions, Oral diseases and sickle cell disease;
- Improving the supply of medicines and diagnostic tools and other resources such financial and human to appropriate levels of health systems throughout the country;
- Improving data collection to health Facilities

Way forward

Tanzania's Multi sectoral approach to NCDs goes beyond strengthening health infrastructure. Some key highlights are:

- Developing and carrying out media, school, community and workplace-based health promotion activities;
- Integrating services HIV/AIDS and NCD services;
- Developing screening programmes at workplaces and health facilities for NCDs (hypertension, diabetes, cervical and breast cancers, Eye Diseases and conditions, Oral diseases and sickle cell disease;
- Improving systems for referral of patients and monitoring of NCDs interventions.
- Establishment of NCD Clinics in all Regions and Districts and recruiting NCD coordinators
- Incorporate NCD programs to curriculum of higher learning Institutions

Conclusion

Tanzania's National planning on NCDs is in its initial stages but quite promising. To succeed in the fight against NCDs and protect developmental gains made in recent years, Tanzania must urgently address the several challenges and obstacles impeding effective and sustainable NCD responses.

3.9.2 Communicable Diseases

In 2011, the IDSR National Guidelines were reviewed such that non-communicable diseases and Public Health Events of International concern (PHEIC), stipulated in the International Health Regulation 2005, and were also included. The MOHSW has selected a list of priority infectious diseases for immediate, weekly and monthly reporting under the coordination of the Epidemiology and Disease Control Section, within the Directorate of Preventive Services.

Strategic objectives: Integrated disease surveillance systems is functional, and is providing timely and accurate information, for prevention and control measures of infectious diseases

The aim is to improve availability and use of data in detecting and responding to public health problems affecting the community

Key performance indicators:

- Number of incident cholera cases notified
- Proportion of treated cases of cholera who died (CFR)
- Proportion of districts submitting weekly (or monthly) surveillance reports on time to the next higher level

Targets

- CFR for cholera <1%
- Timeliness of reporting >80%

Table 3.11: Regions with positive notified cholera cases and deaths, 2011 - 2014

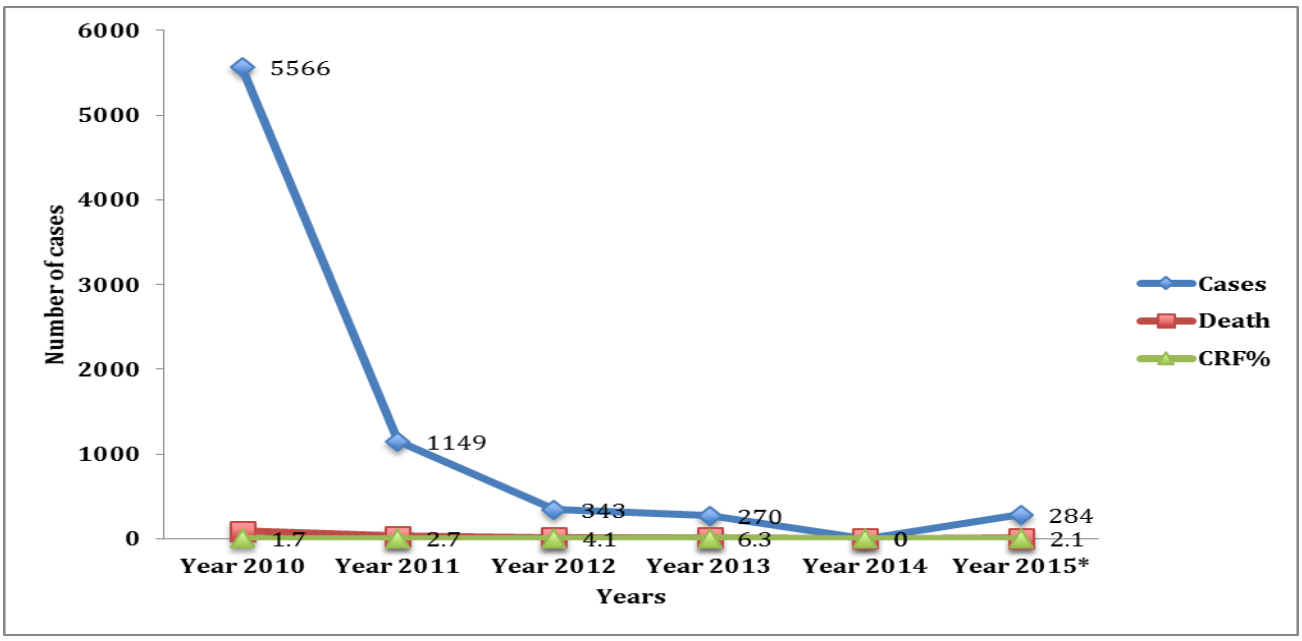
Regions	2011		2012		2013		2014	
	Cases	Deaths	Cases	Deaths	Cases	Deaths	Cases	Deaths
Arusha	0	0	1	0	0	0	0	0
Kigoma	108	0	0	0	0	0	0	0
Kilimanjaro	36	0	0	0	10	0	0	0
Lindi	485	15	12	3	0	0	0	0
Manyara	0	0	37	0	0	0	0	0
Mbeya	84	1	0	0	221	17	0	0
Morogoro	18	1	79	4	0	0	0	0
Mtwara	3	0	52	1	0	0	0	0
Pwani	30	2	120	2	0	0	0	0
Rukwa	61	1	0	0	30	0	0	0
Shinyanga	239	10	42	4	1	0	0	0
Tabora	1	0	0	0	0	0	0	0
Tanga	84	2	0	0	0	0	0	0
Total	1,149	32	343	14	262	17	0	0
CFR		*2.7%*		*4.1%*		*6.5%*	*0*	*.0%*

Table 3.12: Regions with the highest and lowest average cholera case fatality rate (CFR), 2011-2014

Highest CFR		**Lowest CFR**		**Regions with no cholera cases**
Region	***%***	***Region***	***%***	Dar es Salaam
Mbeya	5.90	Rukwa	0.09	Iringa
Morogoro	5.15	Arusha	0.0	Dodoma
Shinyanga	4.96	Kilimanjaro	0.0	Kagera
Lindi	3,01	Manyara	0.0	Mwanza
Pwani	2.70	Kigoma	0.0	Mara
Tanga	2.38	Tabora	0.0	Ruvuma
				Singida

As shown in Tables 3.13 and 3.14 above, the total number of cholera cases has decreased significantly from 343 incident cases in 2012 to 0 cases in 2014. The reduction is attributed to the strengthening of surveillance activities, included early reporting of cases and prompt control of outbreaks and the existence of water and sanitation programs like WASH, PHAST, targeting community level. Significant regional variations in the number of reported cases is seen, with a few regions like Lindi, Kigoma, Mbeya, Shinyanga and Morogoro having the highest number of cholera cases, possibly due to prevailing sanitary conditions.

Figure 3.19: Trend of cholera cases Tanzania, 2010-2015and deaths in



Of particular note is the fact that although the number of cholera cases has been decreasing, the CFR has been increasing from 1.7% (2010) to 6.3% (2013) and 2.1% (June 2015). This observation may be a reflection of the quality of care that cholera patients receive once they arrived in Health facilities. This is of concern since the increase in CFR is occurring despite the introduction of newly revised national guidelines for management of cholera cases since 2011.

Other performance indicator (based WHO IDSR strategy)

Indicator: Proportion of councils submitting weekly (or monthly) surveillance reports on time to the next higher level.

The target for timeliness is >80%

In 2014 a total of 161 Councils were required to submit paper-based surveillance reports on weekly and monthly basis to the region level. The proportion of Councils submitting weekly (or monthly) surveillance reports on time to the next higher level was 78%, a level slightly lower than the national target of >80%. Moreover, the introduction of electronic reporting system (eIDSR) improved reporting rate by more than 80% in the covered regions – Kagera, Mwanza, Kilimanjaro, Geita, Mara. Manyara, Singida, Dodoma and Dar es Salaam. This has drawn attention to increase more regions in future towards improved reporting rate in the country

Table 3.13: Summary of achievement of targets and indicators

Indicator	Baseline 2012	Target	Achievement 2014	Status / comment
Number of cholera incidence notified	75	0	0	Reduction in number of cases
Case fatality rate (%)	16.0	<1	0.0	Increase in CFR by 2-fold (3.78%)
Proportion (%) of districts submitting weekly (or monthly) surveillance reports on time to the next higher level	83%	>80%	78	Average reporting is lower than target

Challenges

- Low proportion of districts submitting immediately and weekly (or monthly) surveillance reports on time to the next higher level

Recommendations

- Reduce the number of deaths due to cholera by having preventive and curative supplies available at health facility level and emphasizing communities to seek health services when they experience signs and symptoms of cholera
- Scale up electronic reporting to increase proportion of districts submitting immediately and weekly (or monthly) surveillance reports on time to the next higher level

Way forward

- Solicit financial resources to scale up electronic reporting country wide
- Facilitate availability of preventive and curative supplies at health facility level for proper management of cholera patients

Conclusion

- Overall the incident cholera cases have decreased for the period of 2012 - 2014, due to effective preventive and control measure employed in the country. There is therefore a need of improving the quality of care and treatment of cholera patients by making full use of the recently revised national guidelines for management of cholera patient. Poor timeliness in reporting can be improved by rolling out of the electronic reporting from health facility level, which has been rolled out in piloted in 18 Councils and by strengthening community involvement in diseases surveillance and outbreak response at lower levels.

3.10 Other health and related services

3.10.1 Environmental health services

The Public Health Act No. 1 of 2009, and the National Environmental Health, Hygiene and Sanitation Strategy 2008- 2017 currently guide environmental health and sanitation services in the country. These provide a framework for addressing all physical, chemical, biological, and behavioural related factors impacting human health and wellbeing. For the period of 2014/2015 environmental health and sanitation services have been delivered under six-priority areas:-

- Latrine improvement at households and institutions (schools and health facilities);
- Advocacy for hand washing with soap at critical times;
- Waste management in towns and other urban areas;
- Household water treatment and safe storage at point of use;
- Healthy working environment, Chemical and pesticide management and healthcare waste management
- Control of diseases of international concern e.g. yellow fever and other emerging diseases.

Key Performance indicators

The key performance indicators include the following:-

- Proportions of households with access to improved sanitation facilities increased to 75% by 2019.
- Proportion of households that practice open defecation decreased to 0% in 2019

- Promote 812 primary schools to have improved WASH facilities increased by 2015
- Proportion of solid wastes collected and disposed off increased to 85% by 2015
- Proportion of climate prone Districts with WASH resilience plans increased to 30 by 2015
- Integration of occupational health services into Primary Health Care facilities to at least 50 facilities in the country
- Increase to at least 70% of the 22 big entry points with access to screening gadgets i.e. Thermal scanners, Public Health Surveillance Forms and IT equipment.
- Assess the core capacity to at least 50% of the 46 entry points for fully implementation of International Health Regulation.

Achievements

- The proportions of households with access to improved sanitation facilities (improved toilets, hand washing points, waste storage/disposal facility) increased from 12% 2013 to 52% by June 2015.
- 92% of 812 primary schools were supported with sanitation and hygiene facilities.
- Decrease proportion of households that practice Open defecation 12% in 2010 to 9% in June 2015.
- Collection and disposal of solid waste has increased from 54% in 2014 to more than 59% in 2015. Remarkable improvement was observed in Iringa Municipality, Moshi Municipality, Mwanza and Arusha City, Njombe Town Councils and Njombe District Council. Amount of waste collected and general environmental cleanliness has improved significantly in these councils.
- Increase in the proportion of climate change prone districts with WASH resilience plans from 9% in 2013 to 30% achieved to June 2015 with best performing districts of Kigoma Urban, Mpwapwa and Mwanza city.
- With the technical support from WHO Geneva and consultation from MUHAS, the MoHSW has developed the profile and the priority action for Occupational Health and Safety that could be integrated into primary health care facilities. The profile report that has highlighted areas to be integrated and in the FY 2015/16 selection of facilities will be done and build the capacity to at least two facility in 25 regions in the country.
- About 11/22 (50%) big point of entry i.e. Airport of Dar es Salaam, Kilimanjaro, Namanga etc have been provided with screening gadgets for temperature monitoring as one of the important signal for Viral Hemorrhagic fever including Ebola.

- Twelve entry points (26%) were assessed for International Health Regulations (IHR) core capacity and action plan developed for strengthening core capacities for designation as the requirement of IHR 2005.

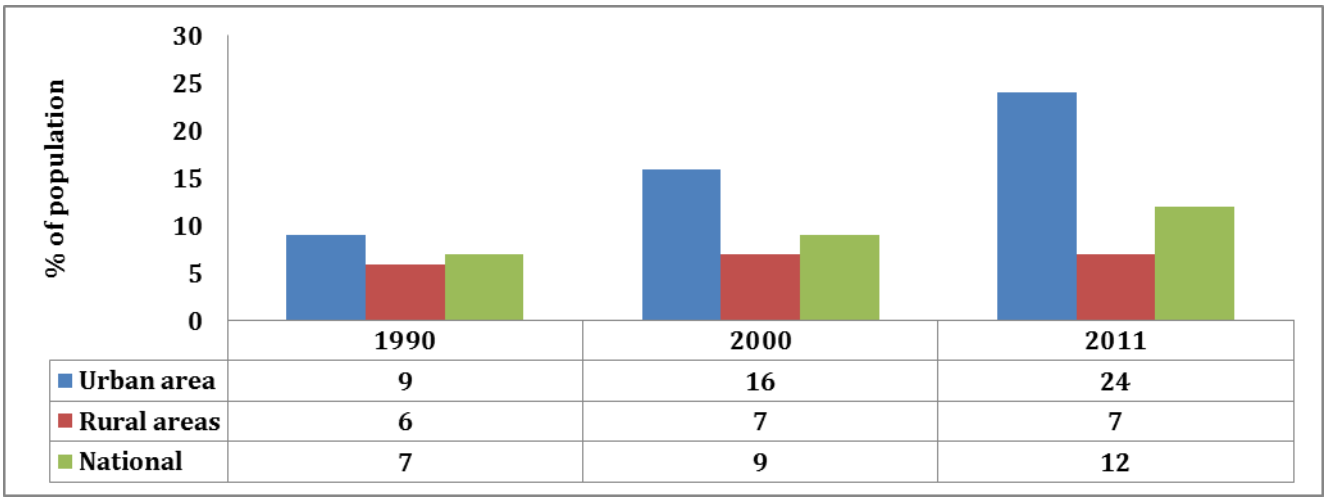
Other performance indicators

- Number of international travellers screened for international notifiable diseases e.g. yellow fever. Thirteen points of entry (27%) have necessary yellow fever equipment and supplies and therefore execute vaccination services. About 120,000 travellers have been screened and an average of 30,000 vaccinated for yellow fever were given to travellers.
- Number of highway bus stops provided with Water, Sanitation and Hygiene (WASH) facilities increased to 40 by 2019
- Number of transport hubs provided with WASH facilities increased to 840 by 2019
- proportion of households with water treatment and safe storage facilities increased to 25% by 2019

Trends in achieving the indicators

Access to improved sanitation facilities internationally, the WHO/ UNICEF Joint Monitoring Programme (JMP) monitors progress on improved sanitation. The trend on use of improved sanitation and hygiene facilities from 1990 to 2011 is shown in the figure below:-

Figure 3.20: Percentage of population that use improved sanitation facilities from 1990 to 2011 in Tanzania Mainland



	1990	2000	2011
Urban area	9	16	24
Rural areas	6	7	7
National	7	9	12

Source: JMP Progress on sanitation and drinking water, 2013 Updates

With the implementation of National Sanitation Campaign (NSC) a significant increase in the number of households with improved sanitation facilities is expected. The campaign aims at increasing an additional 1.68 million households and 812 schools that use

improved toilets, hand washing with soap and maintain general environmental cleanliness in both urban and rural by 2015. Implementation of the campaign up to June 2015 resulted into construction of 876,707 improved toilets and installation of 540,593 hand-washing facilities outside the toilets. Also 1,189 primary schools have rehabilitated their toilets facilities to meet the minimum standards of 1:40 and 1:50 for girls and boys respectively. With regards to provision of WASH services in health facilities, transport hub and high ways the implementation has not yet started. The actual implementation is expected to start in July 2016 when second phase of the National Sanitation Campaign starts.

Challenges

- Late disbursement of funds that support National Sanitation Campaign to promote Hygiene and Sanitation and Household and in primary schools.
- It has been a steady decrease in elimination of open defecation because of difficulty behaviour change in the community t
- Inadequate allocation of financial resource for the waste management in urban city authorities
- Inadequate knowledge on climate change and impact in health among workers in health sectors
- The port of entry are facing the shortage of staff, inadequate budget allocation, equipment and supplies that has results in inadequate service and missing the target.

Recommendation

- Reduces bureaucracy in release of funds to fast tract the implementation of Hygiene and Sanitation
- Increase allocation of funds for adequate management of wastes in Urban Local Authorities
- Involvement of Private sector to undertake waste management services
- To raise awareness on impact of Climate Change to Health Sector among policy makers at all levels

Way forward

Conduct national wide review and planning, supportive supervision and monitoring in all Regions and Districts to monitor trends on sanitation and hygine promotion, waste management at urban cities and improments of hygine and sanitation in primary schools and the intergretiuon of occupational health services into primary health care facilities.

CHAPTER 4: HEALTH SYSTEMS STRENGTHENING

4.1 Health Financing

The Tanzania health care system is financed through various sources, including; taxation, external funding by development partners, insurance and pre-payment schemes, and out-of-pocket (OOP) payments in the form of user fees. This multitude of different sources of funding has resulted in a fragmented financing picture, which the Government is intending to rationalize through articulation of a medium term Health Financing Strategy which aims at ensuring both access to quality services and financial protection for household, as we strive for Universal Health Coverage.

HSSP III Indicators

- Per capita government spending on health services
- Proportion of the population enrolled in the Community Health Fund

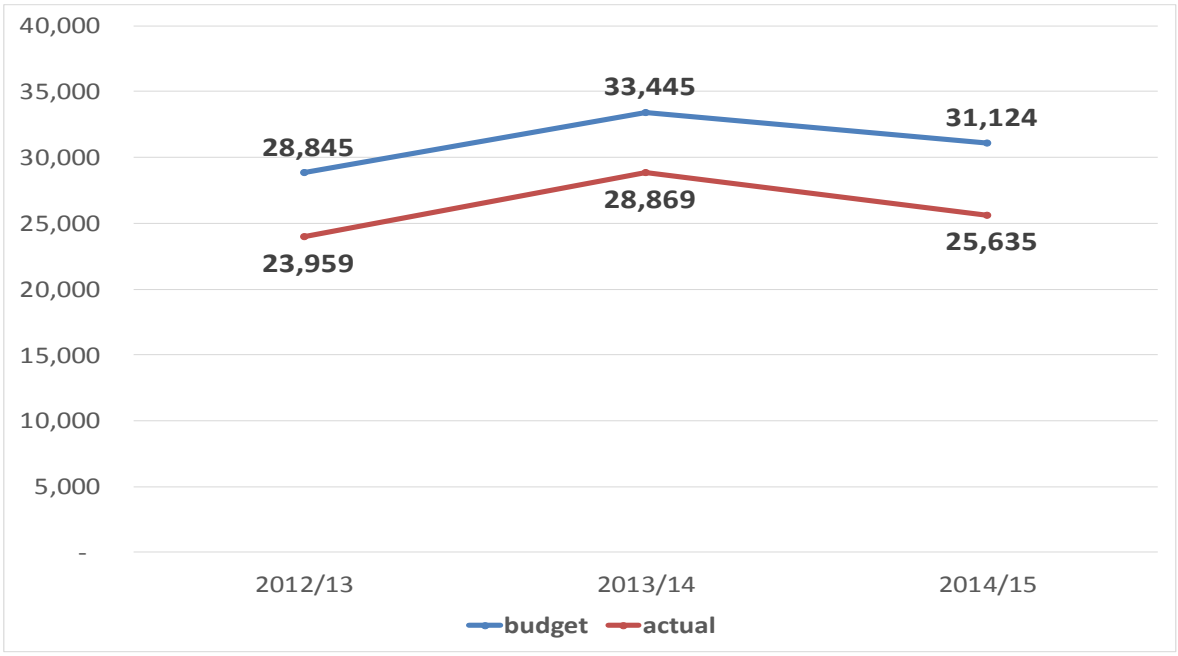
Baseline and targets

- Per capita government spending on health services (baseline TZS 13,193 in 2008, target TZS 52,800)
- Proportion of the population enrolled in the Community Health Fund (baseline 9% in 2008; target 30% by 2015)

Progress

The graph below shows per capita government spending on health services over the past three financial years. As shown, the nominal per capita budget on health increased slightly from TZS 28,845 in FY2012/13 to TZS 31,124 in FY 2014/15, an increase of almost 8%. However, there was a fall of almost 7% over FY2013/14. Actual spending per capita rose by 7% over the period, but fell by 11% year-on-year to 2014/15. In each year, the level of spending was 14-18% lower than budgeted, and in real terms, ie taking account of inflation, the level of per capita spending is substantially lower, at TZS 13,038 in 2001 prices.

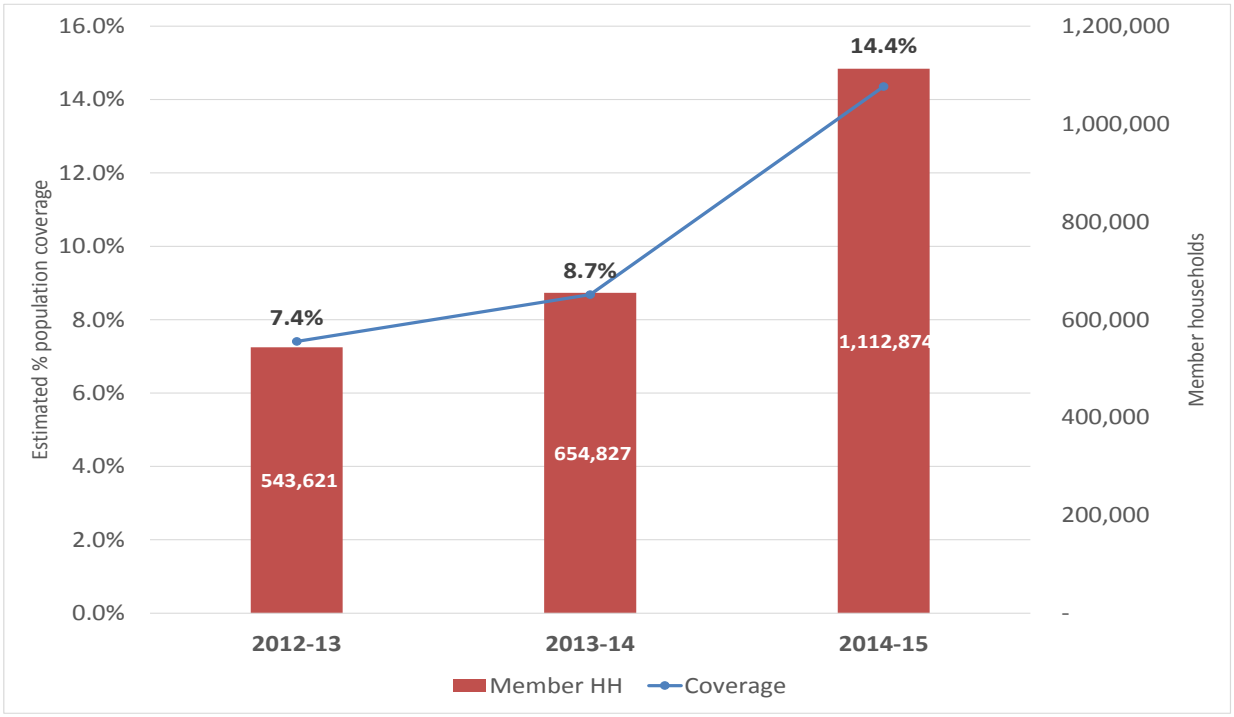
Figure 4.1: Per capita public spending on health, FY 2012/13 – 2014/15



Source: Draft FY2014/15 PER data

The second HSSP III indicator on health financing measures financial protection, in terms of the proportion of the population enrolled in the Community Health Fund. Figure 28 below shows the three year trend for the indicator.

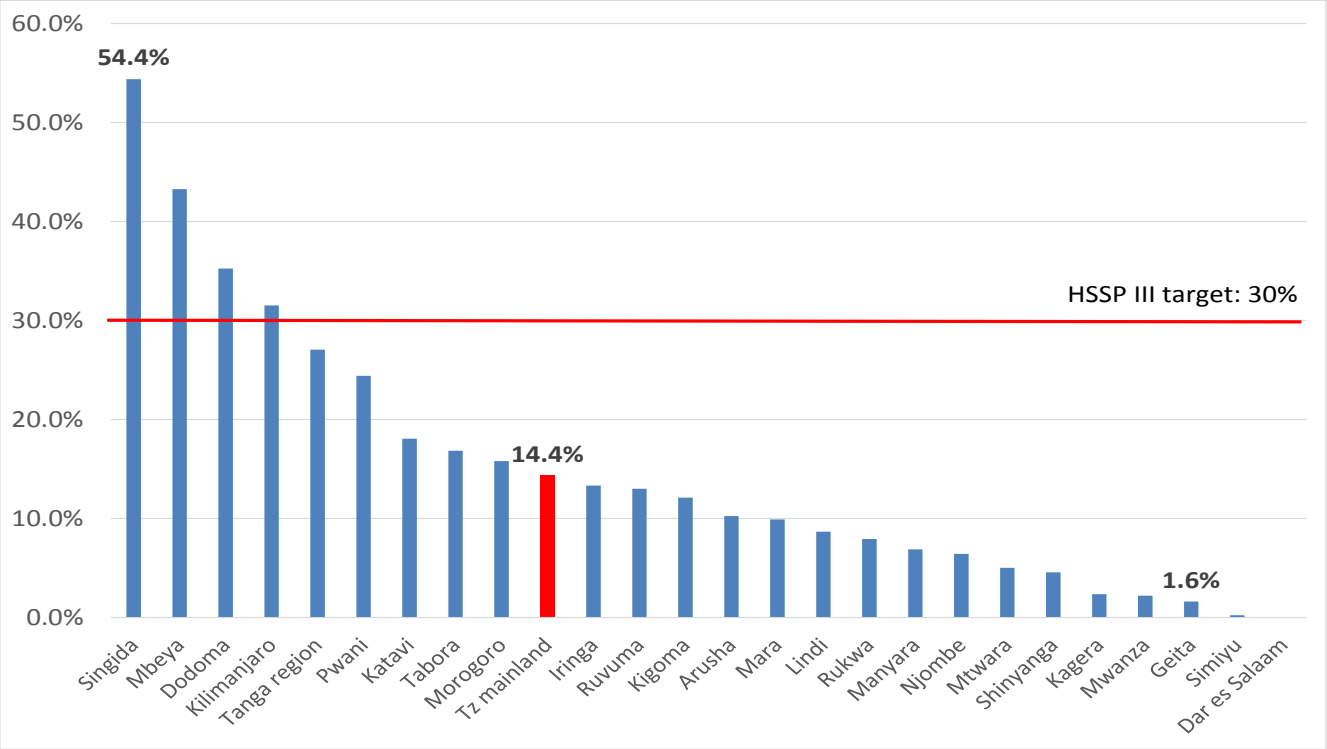
Figure 4.2: CHF coverage, 2012/13 – 2014/15



Source: NHIF data on CHF membership; population estimates based on Census 2012

Figure 28 shows that estimated[2] CHF coverage has picked up substantially in FY 2014/15, reaching 14.4% of the population. This represents an increase of 65% over the previous year in terms of population coverage, and a slightly higher rise in the number of member households (70%), and for the first time takes the estimated coverage above the HSSP III baseline. As in earlier years, this increase is largely driven by growth in a few selected regions, including Dodoma, Lindi, Manyara, and Mara.

Figure 4.3: Regional CHF coverage, 2014/15



For the first time, four regions have attained the national HSSP III target of 30% coverage. Estimated coverage remains highest in Singida region, which is notable for the lack of external support, while the other three regions all benefit from ongoing externally-funded project support from which it is hoped that the transition to a Single National Health Insurance will ultimately benefit. Coverage is lowest in Dar es Salaam, at zero, as the Tiba kwa Kadi intended for urban areas has not yet taken off.

Other areas of Performance

Health Financing Strategy:

Work on the Health Financing Strategy (HFS) progressed significantly during FY 201415, and is now submitted Government approval process. The strategy is intended to set the country on the path to universal health coverage. The objective is to improve access to

[2] NHIF data records member households and assumes 6 members per household, hence use of the term "estimated coverage" in relation to population.

services by removing financial barriers to care at the time of use, especially for poor people and those in rural and remote areas, and to ensure that sufficient resources exist to enable health care providers to deliver a basic package of high-quality health care services. As noted above, the main thrust is the establishment of a Single National Health Insurance mechanism, covering both formal and informal sectors, and with government subsidy for those unable to contribute themselves.

Limitation/Challenges

- Data timeliness, completeness and consistency continue to be a challenge in reporting health spending, both for government and complementary sources
- The lack of a consistent definition of government health spending results in multiple values of a single indicator in circulation,
- The health sector continues to receive a share of the total government resource envelope lower than pledged in Abuja, and that is needed to deliver HSSP III targets

Way forward

- Obtain approval for the Health Financing Strategy to guide effective resource mobilization from various sources and allocation
- Build on successful pilots for CHF/informal sector health insurance in order to maintain the momentum and further expand coverage
- Demonstrate efficiency gains and value for money with existing public funding in order to strengthen MOHSW case for a higher share of the national budget

4.2 Human resources for health

Human Resources for Health (HRH) briefly mean the health workers including supporting staff who deals with the provision of health and health related services. The minimum number of health workers required providing services in all dispensaries, health centers and hospitals. According to the new staffing level guideline (MOHSW 2014) the Human Resources for Health required to operate the existing 5,913 dispensaries, 711 Health Centres and 254 hospitals are 145,454.

Goals

The main goal of Human Resources for Health is to produce the human resources for deployment in the health sector, the main goal is to ensure that, all health facilities and institutions have the right number of health workers, with the right cadre having the right

skills mix at the right place, in the right time doing the right thing in quality health service provision to the population.

Indicators

The HRH indicators shows the density of health workers per population in a specified geographical/ catchment area, This indicators shows the status of the available workforce and their distribution within the country, the status and the quality of health training institutions are indicated by the level of the accreditation of the institutions.

Mostly used HRH indicators are: -

- The number of health workers (Specific cadre) per 10,000 population (E.g. 1 MD per 10,000 WHO recommendation)
- The number of Health Training Institution with full accreditation (Recommended 75% annually)

Table 4.1: HRH-population ratios for selected cadres, by region

Region	Assistant Medical Officer	Medical Doctor	Medical Laboratory Staff	Nurse/Nurse Midwives	Nursing Officer	Pharmaceutical staff	Total	Population Estimates 2014	Assistant Medical Officer	Medical Doctor	Medical Laboratory Staff	Nurse/Nurse Midwives	Nursing Officer	Pharmaceutical staff	Total Density
Arusha	108	133	167	1,288	73	49	1,818	1,806,946	0.60	0.74	0.92	7.13	0.40	0.27	10.06
Dar Es Salaam	239	293	320	2,054	340	119	3,365	4,980,560	1.32	1.62	1.77	11.37	1.88	0.66	18.62
Dodoma	81	103	134	1,027	66	33	1,444	2,187,959	0.45	0.57	0.74	5.68	0.37	0.18	7.99
Geita	35	18	91	476	7	21	648	1,850,180	0.19	0.10	0.50	2.63	0.04	0.12	3.59
Iringa	61	61	114	796	26	24	1,082	966,617	0.34	0.34	0.63	4.41	0.14	0.13	5.99
Kagera	84	41	95	1,286	56	22	1,584	2,647,538	0.46	0.23	0.53	7.12	0.31	0.12	8.77
Katavi	18	13	15	169	6	9	230	609,139	0.10	0.07	0.08	0.94	0.03	0.05	1.27
Kigoma	74	26	88	770	23	18	999	2,251,231	0.41	0.14	0.49	4.26	0.13	0.10	5.53
Kilimanjaro	137	91	88	1,428	69	45	1,858	1,708,905	0.76	0.50	0.49	7.90	0.38	0.25	10.28

Region	Assistant Medical Officer	Medical Doctor	Medical Laboratory Staff	Nurse/Nurse Midwives	Nursing Officer	Pharmaceutical staff	Total	Population Estimates 2014	Assistant Medical Officer	Medical Doctor	Medical Laboratory Staff	Nurse/Nurse Midwives	Nursing Officer	Pharmaceutical staff	Total Density
Lindi	57	30	37	588	5	14	731	883,802	0.32	0.17	0.20	3.25	0.03	0.08	4.05
Manyara	64	61	84	964	58	25	1,256	1,535,377	0.35	0.34	0.46	5.33	0.32	0.14	6.95
Mara	50	39	85	936	39	28	1,177	1,847,562	0.28	0.22	0.47	5.18	0.22	0.15	6.51
Mbeya	123	76	140	1,720	27	49	2,135	2,865,955	0.68	0.42	0.77	9.52	0.15	0.27	11.82
Morogoro	130	85	84	1,245	152	25	1,721	2,344,505	0.72	0.47	0.46	6.89	0.84	0.14	9.52
Mtwara	50	40	45	759	15	12	921	1,307,892	0.28	0.22	0.25	4.20	0.08	0.07	5.10
Mwanza	60	62	95	1,199	33	45	1,494	2,973,164	0.33	0.34	0.53	6.64	0.18	0.25	8.27
Njombe	31	31	35	921	15	28	1,061	715,319	0.17	0.17	0.19	5.10	0.08	0.15	5.87
Pwani	97	112	61	851	108	38	1,267	1,155,891	0.54	0.62	0.34	4.71	0.60	0.21	7.01
Rukwa	33	25	24	486	15	9	592	1,083,058	0.18	0.14	0.13	2.69	0.08	0.05	3.28
Ruvuma	63	48	99	1,049	37	20	1,316	1,447,204	0.35	0.27	0.55	5.81	0.20	0.11	7.28
Shinyanga	46	41	74	828	12	10	1,011	1,610,822	0.25	0.23	0.41	4.58	0.07	0.06	5.60
Simiyu	24	21	54	446	6	15	566	1,654,106	0.13	0.12	0.30	2.47	0.03	0.08	3.13
Singida	54	30	108	726	42	12	972	1,447,397	0.30	0.17	0.60	4.02	0.23	0.07	5.38
Tabora	52	27	76	782	9	15	961	2,454,534	0.29	0.15	0.42	4.33	0.05	0.08	5.32
Tanga	111	69	73	1,165	25	29	1,472	2,155,175	0.61	0.38	0.40	6.45	0.14	0.16	8.15

Source: HRHIS 2014

Table 4.2: HRH-population ratios, selected cadres, baseline, targets and progress status

Performance Indicator	Baseline (2008)	2011/12	2012/13	2013/14	2014/15	Target	Comment
Number of Medical Officers (MO) per 10,000 population	0.4	0.46	0.51	0.48	0.34	0.38	From 2014/15 onwards Medical Specialists were excluded hence density decreased from 0.48 to 0.34 per 10k
Number of Assistant Medical Officers (AMO) per 10,000 population	0.3	0.39	0.41	0.38	0.40	0.42	
Number of AMOs/MOs per 10,000 population	0.7	0.85	0.92	0.86	0.74	0.80	From 2014/15 onwards Medical Specialists were excluded hence density decreased from 0.86 to 0.74 per 10k
Number of All Nurses per 10,000 population	2.6	4.77	4.97	5.05	5.42	5.60	Increase in nursing graduates has increased number of nurses in the facilities
Number of Pharmaceutical Staff per 10,000 population	0.15	0.23	0.29	0.15	0.15	1.11	
Number of Health Laboratory Staff per 10,000 population	0.27	0.21	0.26	0.27	0.49	T.b.d	

The table above shows the trend of Human resource indicators from 2008 baseline to 2014. There is drop out of health workers to population ratio from year to year except for nurses whereby has been an increase from 2.6 in 2008 to 5.42 in 2014. A proxy for the

quality of health training (institutions) measures the proportion of Health Training Institutions with full accreditation, whereby the numerator is the number of institutions with full accreditation and the denominator is the total number of training institutions.

Table 4.3: Progress with Health training institution accreditation

Performance Indicator	Baseline (2008)	2013/14	2014/15	Target (2015)
Number of training institutions	116	121	138	179
Health training institutions with Registration/Accreditation	1	27	116	All

Challenges

Human Resources for Health faces some challenges, some of the challenges are: -

- **Inadequate Human Resources for Health**

  The actual number of health workers available, including staff from Social Welfare and Health Training Institutions is 70, 244 while the actual requirement is 145,454. This means there is shortage of 75,210 health workers. Therefore the current staffing level is only 48% of the actual requirements. On the part of social welfare, a total of 357 social workers are available in the country while the requirement is 1,340 this is 26.6% of the total requirement (Source: HRHIS, 2014/15)

- **Low production of human resources as compared to rapid population increase**.

  Since 2008 the MoHSW have not managed to fill all the recruitment permits given by POPSM due to low production of medical graduates from the health training colleges. The ministry fills between 64% and 83% of the recruitment permits provided annually. See the table below;-

Table 4.4: Showing recruitment permits Vs number of Health personnel posted

Sn.	Year	Approved Post	Posted	% Posted
1	2007/08	6,437	4,812	74.80%
2	2008/09	5,241	3,010	57.40%
3	2009/10	6,247	4,090	65.50%
4	2010/11	7,471	5,687	76.10%
5	2011/12	9,391	7,028	74.80%
6	2012/13	8,602	5,702	66.30%
7	2013/14	11,221	7,677	68.40%
	Total	**52,967**	**38,066**	**71.87%**

- **Inadequate funds allocated for HRH training**

Student's enrolment and outputs in health training institutions have been increasing for several years now in order to meet national and international commitments on HRH; this expansion in terms of capacity for enrolment and outputs should go simultaneously with an increase funds allocation to these health training institutions. However, there is no significant increase budget allocation to the directorate to meet this demands.

Table 4.5: Shows funds allocated Vs Disbursements for DHR

Year	2012/13	2013/14	2014/15
Approved budget for the directorate of Human Resource for Health	24,331,455,500	23,139,914,776	23,193,045,916
Amount Received for training	5,200,950,000	5,208,204,016	6,043,448,596
Percentage of the Approved budget Received	21.38%	22.51%	26.06%

- Shortage of tutors/lectures for health and social welfare training institutions also Inadequate health training or learning material for students
- Lack of appropriate Infrastructure to support increase in enrolment and training of students.
- Recruitment and retention of health workers in service delivery facilities and training institutions

Recommendations

- The Ministry should increase funds for HRH which includes funds for training of pre- service and in-service students
- The Ministry should allocate more funds for HRH development and HRH retention
- The Ministry should rehabilitate the training institutions and increase more staff to accommodate increase in students enrolment

Way Forward

- The Ministry and Local government Authorities should design local incentives to attract and retain health workers
- The Ministry and Local government Authorities should redistribute the available HRH fairly by considering the workload
- The Ministry should facilitate the full accreditation of the Health Training institutions

- The government should facilitate the private sector to invest in health training

4.3 Medicines

The Ministry of Health and Social Welfare (MOHSW) oversees implementation of the National Medicines Policy (NMP) through the Pharmaceutical Services Unit (PSU). The NMP's goal is to ensure the availability of and equitable access to quality, safe, and efficacious essential medicines for all Tanzanians, through selection, procurement, production, storage, inventory control, distribution, quality assurance, and rational use.

Key performance indicator

The key performance indicator in the HSSP III and for CCHPs is the availability of ten tracer medicines and health supplies at the health facilities.

Definition of the Key performance indicator

Facilities with all ten-tracer medicines in stock over the total number of eligible (facilities which are allowed to shock a particular medicine) facilities

Target

The set target for 2015 is 80% of health facilities to have all ten-tracer medicines.

Figure 4.4: Showing all facilities having entire package of tracer medicines (10/10) in 2014 by region

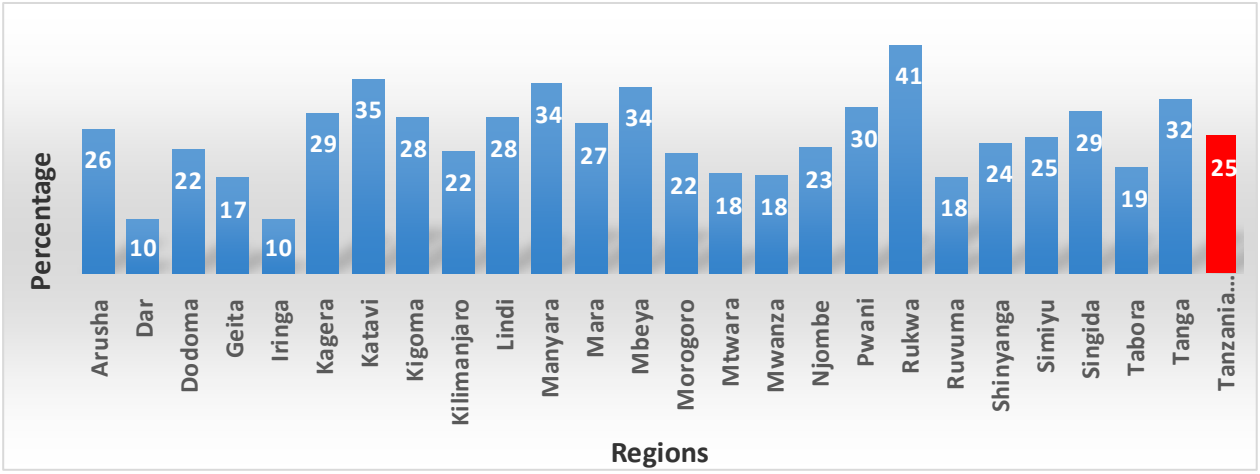
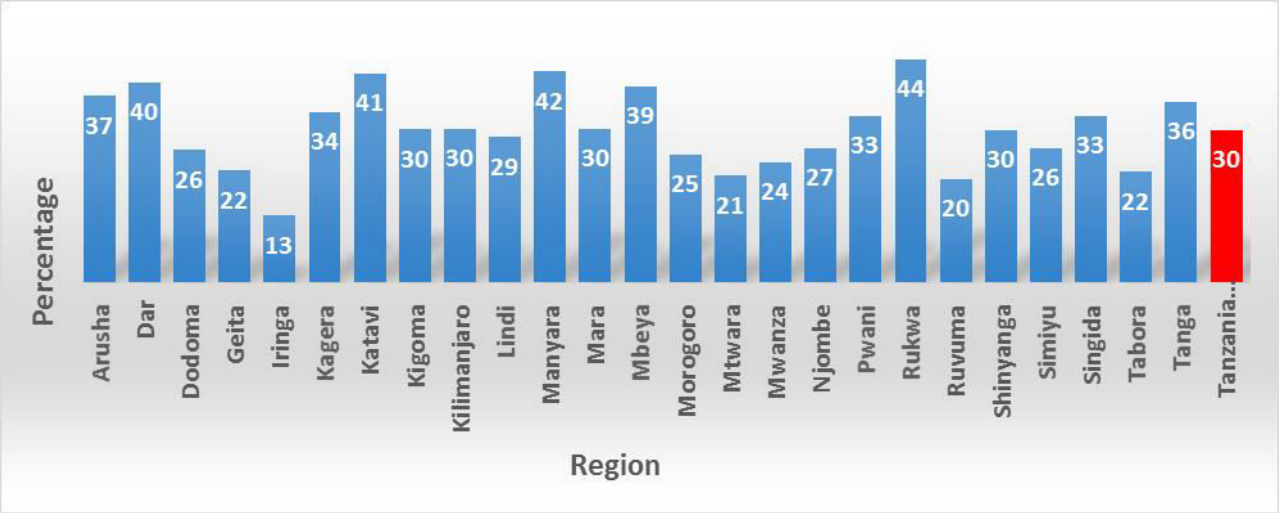


Figure 4.5: Showing public facilities having the entire package of tracer medicines (10/10) in 2014 by region



An analysis of the percentage of health facilities in Tanzania Mainland reporting continuous availability of *all* tracer medicines (10/10 or zero tolerance for stock out of tracers), showed that;-

- Only 25 % of all facilities and 30% of public facilities complies with this standard.
- For all the facilities, 12 regions fall below the national average and 13 are above national average
- For public facilities, 11 regions fall below the national average and 14 regions are above national average.
- Dar es salaam region shows good performance for public facilities (40%) while for all facilities it is least performing region with only 10%. This show that most private facilities in Dar es Salam do not comply with this standard.
- The best performing regions are Rukwa, Manyara and Katavi while Iringa is the least performing region; this is for both public and all facilities.

To complement the HMIS data, survey data from the quarterly PMI end-use assessments[3]-conducted from Q1 through Q4 of 2014/15 - are reported in table below for selected health commodities. Data on availability of 11 specific commodities on the day of survey were extracted from the assessments of 26-28 commodities in four quarterly surveys from July 2014 through April 2015. It should be noted that this proxy indicator,

percentage of health facilities with availability of an indicator commodity on the day of the survey, is not directly comparable with the HMIS tracer medicine indicator.

- Items with average high availability (≥ 80%) were Artemether Lumefantrine (ALu) antimalarial 1x6 tabs (84%), injection contraceptives (Depo-Provera; 81%), malaria Rapid Test Diagnostic (mRDT; 83%) and Oxytocin injection (80%).
- Items with average low availability (<67%) were Misoprostol (9%) and Albendazole tabs (59%).
- On average, an indicator commodity was available on the day of survey at 70% of the health facilities sampled (n=210) in 2014/15,

Table 4.6: Percent of health facilities with specific health commodities on the day of survey

Year	**2013/14**	**2013/14**	**2013/14**	**2013/14**	**2013/14**	**2012/13**	**2011/12**
Quarter	**Q1**	**Q2**	**Q3**	**Q4**	**MEAN**	**MEAN**	**MEAN**
Month	**July-14**	**Oct-14**	**Jan-15**	**Apr-15**			
ALU 1X6 TABS	88	87	79	83	84		
ALU 4X6 TABS	81	77	74	83	79		
AMOXYCILLIN CAPS	62	63	64	78	67		
ORS SACHETS	73	74	78	85	78		
INJ CONTRACEPTIVE	89	76	76	83	81		
ALBENDAZOLE TABS	37	47	76	74	59		
COTRIMOXAZOLE TABS	78	71	65	84	75		
DEXTROSE 5% INFUSION	82	79	74	73	77		
MALARIA RDT	81	89	79	83	83		
OXYTOCIN INJECTION	78	75	75	91	80		
MISOPROSTOL TABS	14	5	5	12	9		
11 ITEMS (MEAN)	69	68	68	75	70		
11 ITEMS (MIN)	14	5	5	12	9		
11 ITEMS (MAX)	89	89	79	91	87		
# of HF sampled	215	225	200	200	**210**		
# of districts sampled	18	12	16	17	16		

Table 4.7: Disbursements to MSD in FY2014/15

SNO	MONTH	GOT	HBF	TOTAL ALOCATION
ALLOCATION		**60,000,000,000**	**16,598,490,641**	**76,598,490,641**
1	Jul-14	8,000,000,000	0	
2	Aug-14	5,000,000,000		
3	Sep-14			
4	Oct-14		8,000,000,000	
5	Nov-14			
6	Dec-14			
7	Jan-15	2,500,000,000		
8	Feb-15			
9	Mar-15	3,000,000,000		
10	Apr-15		2,500,000,000	
11	May-15	2,117,026,082		
12	Jun-15		6,098,490,641	
TOTAL		**20,617,026,082**	**16,598,490,641**	**37,215,516,723**
% DISBURSEMENT		**34.4**	**100**	**49**

The disbursed funds are used to procure essential and other hospital consumables

Challenges

- The government source (GOT) disbursed 34.4% of the amount it pledged while from Health Basket Fund (HBF) disbursement was 100%.
- The disbursement of funds for medicines and supplies is less than pledged in budget allocation from GOT.
- Erratic disbursement affects commodity availability, especially in primary healthcare facilities.
- Only 25 % of all facilities and 30% of public facilities complies with this standard

- Private health facilities do not comply with the standards.
- Different capacities in management at council level result in wide variation with about more than 70% of councils are below the standard of 10/10 for availability.

Recommendations

- Timely disbursement of allocated funds for procurement of medicines and medical supplies.
- Refresher trainings and On Job Training (OJT) on inventory management in both public and private health facilities
- Rollout of toolkit to disseminate best practices on availability, governance and accountability of health commodities at council level.

Conclusion

Implementation of the Pharmaceutical Sector Action Plan 2014-2020 (PSAP 2020) will address the above challenges through system strengthening in HSSP III. The electronic logistics management and information system (eLMIS) will provide comprehensive and accurate data, bringing efficiencies and enabling managers to improve availability of medicines and health commodities. Strengthening CHMT in medicines auditing and governance will enhance medicines availability and access medicines at service delivery points.

4.4 Health infrastructure

The growth of health care infrastructure is guided by the PHDSP 2007-17 (known as MMAM) with the following objectives:

- Rehabilitating health facilities
- Upgrading of Health Facilities, “Establish facilities at primary level to ensure equity and access of quality health care

According to the 2007 Health Policy, the following targets were set to achieve the PHSDP goals:

- At least one Dispensary for the Village
- One Health Centre per Ward
- One Hospital per District.

Progress

Table below shows the trends in the number of health facilities at different service delivery levels by region for the period 2010 to 2015 and narration for the respective achievements given here below.

Between 2010 and 2015 the following progress has been made:

- The number of village health facilities has increased from 5400 to 5960
- The number of ward health facilities has increased from 620 to 716
- The number of district health facilities has increased from 240 to 257

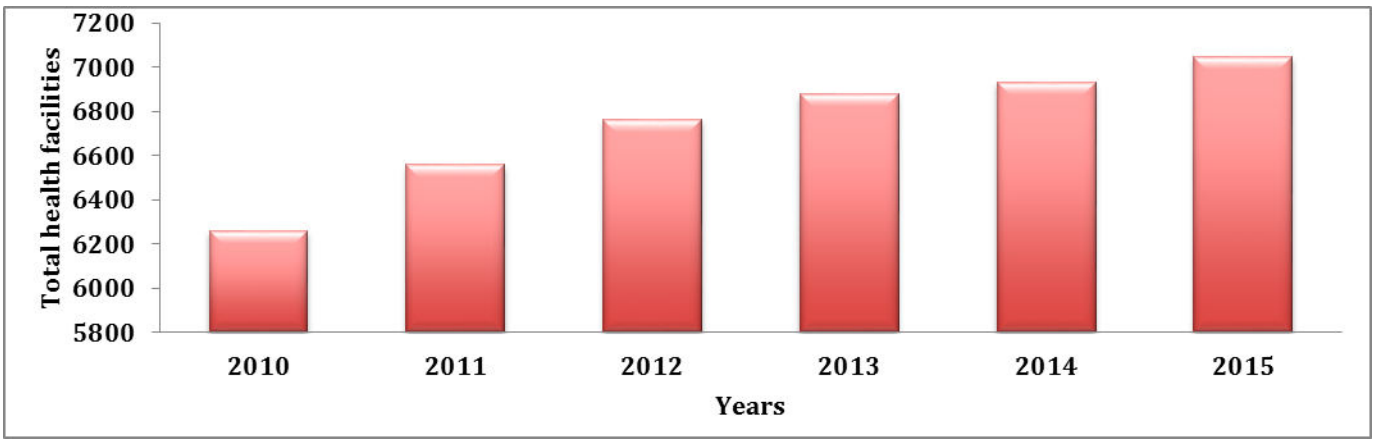
Table 4.8: Distribution of Health Facilities by type and ownership by region in Tanzania Mainland in 2015

Regions	Dispensary					Health Centre					Hospital					Total					*Clinics	Grand Total
	Govt	FBOs	Parasitatal	Private	Total	Govt	FBOs	Parastal	Private	Total	Govt	FBOs	Parastal	Private	Total	Govt	FBOs	Parastal	Private	Total		
Arusha	157	46	7	78	288	27	7	0	12	46	8	5	0	1	14	192	58	7	91	348	5	353
DSM	107	23	13	246	389	4	9	4	21	38	11	3	1	20	35	122	35	18	287	462	53	515
Dodoma	274	25	3	15	317	30	6	1	1	38	5	1	1	1	8	309	32	5	17	363	1	364
Geita	93	16	1	20	130	18	1	0	2	21	4	0	0	0	4	115	17	1	22	155	2	157
Iringa	151	38	1	14	204	17	4	1	3	25	4	1	0	2	7	172	43	2	19	236	2	238
Kagera	212	26	4	13	255	21	9	0	1	31	5	6	3	0	14	238	41	7	14	300	3	303
Katavi	48	5	0	6	59	10	3	0	0	14	2	0	0	0	2	60	8	0	6	74	0	74
Kigoma	193	16	4	9	222	23	4	0	1	28	4	2	0	0	6	220	22	4	10	256	0	256
K'njaro	200	88	6	41	335	28	10	1	2	41	11	5	4	0	20	239	103	11	43	396	1	397
Lindi	177	6	0	3	186	16	1	0	0	17	6	3	0	0	9	199	10	0	3	212	0	212
Manyara	124	17	1	15	157	15	6	0	0	21	7	1	0	0	8	146	24	1	15	186	2	188
Mara	172	24	5	21	222	27	8	1	3	39	4	4	1	1	10	203	36	7	25	271	5	276
Mbeya	304	29	10	32	375	24	9	0	4	37	9	8	1	2	20	337	46	11	38	432	17	449
Morogoro	229	49	8	32	318	30	10	2	2	44	6	5	2	0	13	265	64	12	34	375	2	377
Mtwara	161	13	11	10	195	15	3	0	3	21	4	1	0	0	5	180	17	11	13	221	0	221
Mwanza	224	17	12	51	304	29	7	1	8	45	7	5	0	4	16	260	29	13	63	365	7	372
Njombe	173	22	2	6	203	10	10	0	1	20	4	5	1	1	11	187	37	3	8	235	0	235
Pwani	205	21	6	21	253	18	4	0	3	25	5	1	1	0	7	228	26	7	24	285	3	288
Rukwa	160	12	3	9	184	13	8	0	0	21	1	2	0	0	3	174	22	3	9	208	0	208
Ruvuma	191	33	0	9	233	21	7	0	0	28	4	7	0	0	11	216	47	0	9	272	3	275
Shinyanga	137	15	2	19	173	15	3	0	6	24	2	1	0	1	4	154	19	2	26	201	2	203
Simiyu	157	14	1	10	182	12	1	0	0	13	3	0	0	0	3	172	15	1	10	198	0	198
Singida	160	22	2	2	186	15	1	0	0	16	3	6	0	0	9	178	29	2	2	211	2	213
Tabora	236	30	1	6	273	17	4	0	2	23	4	3	0	0	7	257	37	1	8	303	3	306
Tanga	257	19	13	28	317	29	6	1	4	40	6	4	0	1	11	292	29	14	33	368	4	372
National	4502	626	116	716	5960	484	141	12	79	716	129	79	15	34	257	5115	846	143	829	6933	117	7050

Table 4.9: Trend of Health facilities 2010-July 2015

Year	Hospitals	Health centers	Dispensaries	Total	Cumulative Increase
2010	240	620	5400	6260	
2011	249	653	5657	6559	299
2012	249	693	5822	6764	504
2013	254	711	5913	6878	618
2014	257	716	5960	6933	673
July 2015	257	716	6077	7050	790

Figure 4.6: Showing cumulative increase (trend) of health facilities 2010-July 2015



Challenges

- There is low coverage of health services especially at dispensaries and health centre levels compared with the remaining period towards the 2017 PHSDP target.
- There is a shortfall of 4 regional hospitals and 30 District Hospitals against targets, this is mostly for the newly established regions and councils.

Recommendations

In order to achieve PHSDP targets adequate resources should be allocated to facilitate health infrastructure development. This can be achieved by Government comittment and political willingness, with support from all stackholders.

4.5 Monitoring and Evaluation (M&E)

The M&E Section has completed national rollout of the MTUHA tools to all health facilities both public and non – public. Training and rollout of DHIS2 have successfully been done to all 25 RHMTs and 163 CHMTs country wide whereby 4 members from each RHMTs and CHMTs received training, further more introduction of use of DHIS2 to regional and district/council hospitals has also successfully been done currently data entry is done at hospital levels. Integration of vertical Programs such as HIV/AIDS, TB, Malaria and PMTCT to DHIS2 warehouse has been implemented successfully. The M&E Section has managed to develop DHIS2 web portal where semi processed health data can be accessed without a need for the password at ***http://hmisportal.moh.go.tz*** again the M&E working with ICT has introduced the Master facility list of Health facility registry which is available at ***http://hfrportal.ehealth.go.tz*** furthermore the M&E working with the e-Gov through Open Government Partnership (OGP) has posted key health indicators on the e-Gov website through ***http://Opendata.go.tz*** the M&E is working hard to ensure that data is collected analyzed and generated timely and posted to the web portal timely in order to meet the high demand for health data.

In future the M&E is looking to invest on Data Quality Assessment (DQA) focusing to support councils and facilities to improve data quality at all levels. Introduction of Annual Health Sector Performance Profile at regional and district/council levels. Strengthening of CHMTs and RHMTs on health data analysis, interpretation, dissemination and use. Capacity building on M&E to RMTTs and CHMTs and further training on DHIS2 in order to ensure that all RHMTs and CHMTs has capacity to utilize the system. Finally the M&E is looking to work with Local and International M&E Technical Assistants, implementing partners and funding partners for strengthen the performance of M&E Section.

CHAPTER 5: SUMMARY OF PROGRESS AGAINST MILESTONES

Area	TC SWAp MILESTONE 2014/15	Action plan	Indicator / Suggestions	TWG Update

Area	TC SWAp MILESTONE 2014/15	Action plan	Indicator / Suggestions	TWG Update
1. (DQA) Quality improvement	Step-Wise Certification towards Accreditation (SWCA) of health facilities together with required investments for quality improvement implemented, scaled up from one region to two regions by June 2015.	1) Develop/adapt standards for SWCA. 2) Conduct sensitization meeting to members of RHMT, CHMTs and MO-I/C of Council Hospital in one region. 3) Training of SWCA facilitators/surveyors. 4) Baseline assessment and development of Quality Improvement Plans (QIPs) for Council Hospitals, including mechanisms for mobilizing resources for QI (in places where no Council Hospitals, Urban Health Centres will be assessed). 5) Scale up baseline assessment and development of QIPs to other health facilities. 6) Develop capacity of MoHSW in terms of tools (including database) and capacity to coordinate the SCWA-process. 7) Scale up to another region, plus additional “test region” for integration / synergy with other QI related 8) Interventions (RBF, eTIQH).	1)Approved standards for SWCA in place. 2)Sensitization meeting conducted. 3)Number of Facilitators/Surveyors trained as assessors for SWCA. 4)Number of health facilities assessed (baseline assessment). 5)Number of staff from MoHSW trained on assessment, report evaluation and approval. 6)Report of implementation of SWCA by other stakeholders (NSSF-SHIB, APHFTA, JWTZ and KNCU) in place.	SWCA has been scaled up to Iringa and Njombe regions in March and April 2015 respectively. (So far it has scaled up to five (05) regions namely Pwani, Dodoma, Mwanza, Iringa and Njombe). A total of: 12 health facilities (Iringa 05 and Njombe 07) had baseline assessment; 16 RHMT Members (Iringa 10 and Njombe 06) were trained; and 24 CHMT/HF-MT members (Iringa 10 and Njombe 14) were trained.

Area	TC SWAp MILESTONE 2014/15	Action plan	Indicator / Suggestions	TWG Update
2a (TWG 11) Commodities and medicines	LGA good practices and approaches in management and governance of medicines mapped, documented and disseminated.	a) MOHSW to roll out through LMU/PSS a self-assessment and interventions planning toolkit to 10 Councils. b) MOHSW to provide technical support through LMU/PSS to Council-led self-assessments and interventions, using eLMIS to develop benchmarks, and measure performance against agreed norms and standards on medicines management and governance.	a) Number of councils conducted self-assessment and interventions. b) Proportion of HFs in 'intervention council' and number/proportion of councils 'certified' to agreed performance standard using eLMIS reports.	• Implementation of Toolkit for replicating commodity management best practices, governance and financing in health facilities was well understood and accepted by District Authorities. • Rollout started in July 2014, already covered 6 councils (Mkuranga, Kyela, Same, Singida DC, Kigoma MC and Serengeti). The next councils to be covered are Busega DC-Geita, Chato DC-Simiyu, and Sengerema DC-Mwanza. • Implementation is a highly engaging process, expected to be through in September 2015. Success depends on council willingness to change and adopt the proposed interventions. • Additional rollout will need budgeting in the 2015/16 CCHPs. • eLMIS was rolled out to 170 councils (All councils in Tanzania mainland) • Supply Chain staff from 170 councils were trained in using the system • Executive officers (DED, DMO, DC) were sensitized and provided with access to use eLMIS for informed decision making • One Hundred Seventy councils have started reporting by eLMIS All councils can access supply chain reports from eLMIS. Performance monitoring using eLMIS is the next step.

Area	TC SWAp MILESTONE 2014/15	Action plan	Indicator / Suggestions	TWG Update
2b (TWG 11) Commodities and medicines	Improved transparency and accountability for resources allocated for medicines, to ensure at least 80% availability at health facilities and access by the community	a) Councils to publicise information on revenue collection and funds allocated for medicines (including CHF and other complementary funding), and numbers of insured members served at HFs, in line with 'open government'. b) Councils to promote regular performance assessment and audit of HF recordkeeping and medicines utilization by CHMT with routine reporting to CHSB. HFs to displayed medicines received from MSD to their notice boards.	a) Number/proportions of health facilities displayed specified information, timely, on a quarterly basis, measured in intervention councils. b) CHMT activity reports and Indicator reports on Council performance measured in intervention councils; number and proportion of councils having continuous availability of more than 8 tracer medicines on average, based on DHIS2 reporting	Noted there is no means of verifying the indicators for a) and b). a) A number of current initiatives will promote transparency and accountability for revenue and medicines allocation: MSD publishing allocations in newspaper; use of Epicor at LGA level; fiscal decentralization and operation of facility bank accounts under BRN and RBF (scored in the star rating of facilities, rewarded in the RBF scorecards); extension of the CHF electronic registration system from Dodoma to 2 more regions. b) PSU has completed a tracking study and a medicines utilization study, findings yet to be disseminated to Councils, together with tools for audit, tracking, and performance indicators. BRN commodities work-stream plans for improved recordkeeping and inventory management through 5SKaizen-TQM. LMU notes there is a challenge on verifying the actual issue of medicines to clients due to low use of dispensing registers. Average number of tracer medicines available increased from 7.7 in mid-2014 to 8.5 by end of 2014. LMU • In future it will be possible to capture Data on HFs that have displayed medicine received from MSD by LMU through supportive supervision. The question could be included in the ILS gateway (SMS initiatives) • Reports on proportion of councils having continuous availability of more • than 8 tracer medicines is available as are per ILS gateway and eLMIS as PSU has no access to DHIS2

Area	TC SWAp MILESTONE 2014/15	Action plan	Indicator / Suggestions	TWG Update
2c DPP Commodities and medicines	Outstanding issues of debt at MSD resolved by January 2015.	a) Continuous discussion with MoF to set funds for debt reduction b) Establish budget line under development for government contribution /payment of MSD for handling externally financed / vertical programme health commodities, and incremental costs for direct delivery	a) MoF has set aside funds towards payment of the MDS debt. b) Setting earmarked funds in the MTEF for direct delivery and distribution of medicines to health facilities c) Setting earmarked funds in the MTEF for MSD handling medicines, health commodities for Vertical programme	a) Until 30th June 2012 a total amount of shillings 40.1 billion was verified as MSD debt. The Government developed a plan to pay the MSD debt and by 31st December, 2014 a total of Tanzania shillings 30.729 billion was paid. The office of Internal Auditor General is working with MoHSW to verify the current MSD debt which is estimated to be Tanzania shillings 106 billion (By April 2015). High-level Steering Committee and Global Fund supported independent study to resolve the structural issues around MSD debt. Progress on b) and c) is pending final budget process and approval FY 2015/16.

Area	TC SWAp MILESTONE 2014/15	Action plan	Indicator / Suggestions	TWG Update
3a (TWG 1) Governance & Accountability	Timeliness and quality of CCHP and RHMT and RRHMT implementation and planning reports improved in order to improve flow of funds	a) Summary analysis of plans and implementation reports for CCHP 2013/2014 submitted by December 2014 b) Summary analysis of plans and implementation reports for RHMT 2013/2014 submitted by December 2014 c) Summary analysis of CHOPs plans and reports of RRHMT submitted by December 2014 d) RHMTs provide technical and managerial assistance to CHMTs from September 2014 e) Provide continuous mentoring to CHMTs and RHMTs by central level on preparation of CCHPs plans and CCHP progress reports by September 2014 f) Developing a web-based PlanRep Health micro, Meso and Macro by June 2015 g) Link with DHIS and HRHIS, Epicor and other relevant database systems by December 2015.	a) Summary analysis of plans and implementation reports for CCHP 2013/2014 reports in place. b) Summary analysis of plans and implementation reports for RHMT 2013/2014 reports in place c) Summary analysis of CHOPs plans and reports of RRHMT submitted in time. d) Plan of Action of *RHMT* to provide Technical Assistance to CHMTs on planning and progress report writing available by December 2014 e) Continuous mentoring to CHMTs and RHMTs by central level available.	a). Summary analysis of plans and implementation reports for CCHP were prepared and shared at all levels. b).Summary and Analysis of RHMT plans was presented in November 2014 at the Technical Review Meeting c).17 CHOPs were submitted out of 25 by end of June 2014. Out of them, 10 were submitted before 31st March, 2014. Only 3 RRHMT had submitted quality implementation reports. These are Kigoma, Arusha and Kilimanjaro. All RRHMT had not been trained on reporting procedures due to limitations of funds. Currently the Unit in collaboration with Regional Referral Hospital Management Project (RRHMP) is planning to revise the planning and reporting guideline to make it user friendly as there were complaints it is too complex. d).RHMT reports in place and was circulated to different stakeholders. Reporting format need to be reviewed. Each RHMT produce reports on supportive supervision conducted to the Regional Referral Hospital and Council Health Management Teams on quarterly basis. e).Regional Management Supportive Supervision from RHMT to RRH and CHMT were developed and are in use. The tools follow implementation of CHOP and CCHP. Mentoring and Coaching on CCHP/PlanRep continuously provided to RHMT and CHMTs through visiting, emails and phones communication.

Area	TC SWAp MILESTONE 2014/15	Action plan	Indicator / Suggestions	TWG Update
			f) PlanRep Health micro, Meso and Meso developed by June 2015 g) PlanRep3Health linked with DHIS and HRHIS, Epicor and other relevant database systems by December 2015	f&g) Consultants demonstrated the initial draft of the system to the Project Management Team on 1st of June 2015. The following areas were still being developed, integration of Health Facility register (HFR), harmonization of funders between Epicor and PlanRep, Physical implementation, assessment criteria, and export of CCHP from the Web-based PlanRep to the existing PlanRep3. However, other areas, which are still pending that, require the Ministry and other stakeholders contributions are: revised list of performance indicators, new developments according the HSSP4/ BRN, Revised MKUKUTA, revised. Other important systems for integration are Epicor, Lawson, DHIS, HRHIS, eLMIS etc. These areas will need more time. The consultant (will share the draft initial system by the TWG1 on 24th June 2015.

Area	TC SWAp MILESTONE 2014/15	Action plan	Indicator / Suggestions	TWG Update
3b (OGP) Governance-Open data	To establish a strong open data system that include health sector data	1) Establish and publish Health Facility Master List 2) Establish and publish data on Tanzania health Portal.	1) Health Facility master list available online 2) Health Portal established	1). Health facility Master list of health facilities with special information (e.g. type, ownership Location, operation and registration status) accomplished and online through ***http://dhis.moh.go.tz/portal*** 2). District Health Information System (DHIS2) portal established with key health indicators is available through ***http://dhis.moh.go.tz/portal*** 3). Open Government Partnership (OGP) portal established with selected health indicators posted through ***http://Opendata.go.tz***

Area	TC SWAp MILESTONE 2014/15	Action plan	Indicator / Suggestions	TWG Update
4a (TWG 2) Equity	Improved ratio of nurse-midwives to population in the ten most understaffed councils by June 2015	1) Identify the ten most understaffed councils (HRHIS) by February 2015 2) Decide on interventions to correct the understaffing. 3) Implement the interventions before March	1) Understaffed councils identified. 2) Interventions decided.	In 2014/15 there were 9 Regions identified during BRN Lab. with their lower level health facilities that had acute HRH shortage to provide health services. In these 9 regions, there were 135 district, town and municipal councils. About 10 councils were identified as understaffed councils, which were below a national average ratio of 7.74/10,000 population - a third of the WHO recommended level of 22.8/10,000. These were Meatu with a shortage of 251, Buhigwe(254), Igunga(273), Nkasi(278), Kalambo(295), Karagwe(311), Nzega(318), Sumbawanga(330), Manyoni(337) and Ngara District Councils(379). Ministry of Health and Social Welfare with development partners and through a program of Big Results Now, developed in October 2014, has come up with a comprehensive strategy to ensure there is a 100% balance of distribution of health workforce at all levels, specifically at Primary health care level in the country by 2017/18. To implement this comprehensive strategy, the Ministry has begun to address the 9 regions, which have acute shortage of HRH. In collaboration with the President's Office Public Service Management, for the period of 2014/15 more graduated students will be employed directly to these 9 regions (Geita, Katavi, Kagera, Rukwa, Kigoma, Simiyu, Singida, Shinyanga and Tabora).

Area	TC SWAp MILESTONE 2014/15	Action plan	Indicator / Suggestions	TWG Update
4b (TWG 3) Equity	Proposed health-financing options that ensure waivers and exemption mechanisms are accommodated effectively through the draft health financing strategy by June 2015.	1) HFS commissioned report on Inclusion of the poor 2) Agree on preferred health insurance market option (ISC) 3) Explore implications for exemptions and waivers 4) Select appropriate option for ensuring inclusion of poor and priority population groups/diseases 5) Determine cost implications of "exemptions and waivers" 6) Identify appropriate funding mechanisms and budget accordingly	1) Final report on inclusion of the Poor available 2) Included in draft Health Financing Strategy document 3) Covered in report on Inclusion of the Poor 4) Outlined in draft Health Financing Strategy 5) Included in draft Health Financing Strategy 6) Funding integrated into budget in line with other HFS developments	1. Report available 2. Draft HFS includes clear proposals for Single National Health Insurer 3. Implications clearly spelled out in draft HFS 4. Proposal for exemptions and waivers included – through plans for identification of the poor for fully subsidized access to Minimum Benefit Package under SNHI. MBP covers the priority diseases/conditions. Cost implications of subsidized MBP included as integral part of costing of HFS 5. Awaiting approval of HFS for more detailed budgeting and incorporation into MTEF/CCHPs etc
5a TWG13&2) Community participation in health	Community health policy guideline and strategy are disseminated	1) National Community Health policy guideline 2014 disseminated by December 2014 2) National strategy 2014 – 2020 for community health disseminated by June 2014	1) National Community Health Policy guideline 2014 disseminated 2) National Strategy for Community Health developed – costing underway	1) The guideline was disseminated at national level and all districts of Mbeya, Iringa, Njombe and Simiyu 2) The cost strategic plan completed and submitted for signature.

Area	TC SWAp MILESTONE 2014/15	Action plan	Indicator / Suggestions	TWG Update
5b TWG13&2) Community participation in health	CHWs are included in the HRH strategies 2014 and Staffing level of MOHSW 2014 – 2020 by June 2015.	1. Review draft staffing level of MOHSW 2014 - 2019 to include CHWs 2. Review draft HRH strategy 2014 - 2019 to include CHWs	1) Staffing level of MOHSW 2014 - 2019 has addressed CHWs 2) HRH strategy has addressed CHWs	1). The achievement on this strategy includes revision of the staffing levels guideline and HRH Strategic Plan of 2014-2019; so far the Staffing Levels has been endorsement by Permanent Secretaries of MoHSW and POPSM and CHWs cadre has been reflected in the staffing norms. 2). The task of updating HRH Strategic Plan 2014-2019 has already been done and approved for endorsement. The CHWs cadre has been accommodated in the Plan.

Area	TC SWAp MILESTONE 2014/15	Action plan	Indicator / Suggestions	TWG Update
5c TWG13&2) Community participation in health	Curriculum for training of Community health workers is completed by December 2014	1) Training need assessment conducted by July 2014 2) Curriculum developed by September 2014 3) Dissemination for stakeholders comments, by December 2014 4) Submission to NACTE for approval by November 2014 5) Capacity assessment of training institutions by December 2014 6) Printing and dissemination to training institutions by December 2014 7) Training of Community health workers by January 2015	1) Training need assessment conducted 2) Curriculum developed 3) Dissemination workshop 4) Curriculum submission to NACTE 5) Capacity of training institutions asses 6) Copies of curriculum printed and disseminated 7) community health workers trained	1) Training need assessment conducted in X training institutions 2) Curriculum developed 3) Curriculum shared and comments gathered 4) Curriculum fine-tuned based on comments gathered thereafter submitted to NACTE 5) Capacity of 122 training institution assessed and plan for report dissemination is underway
6a (TWG 1) Performance Management	All RHMTs submit Regional Management Supportive Supervision (RMSS) Results quarterly	1) Prepare schedule for submission 2) On site follow up 3) Conduct Annual RHMT monitoring meeting 4) Remind them	Attached RMMS quarterly reports with RMSS implementation status Reports on number of on-site follow up conducted Reports on Annual RHMT monitoring meeting	RMSS reports are being attached to quarterly reports. Annual monitoring meeting was conducted in the fourth week of June 2015.

Area	TC SWAp MILESTONE 2014/15	Action plan	Indicator / Suggestions	TWG Update
6b (TWG 1) Performance Management	RHMT conduct at least 80% of planned RMSS to councils and regional referral hospital	1) Conduct biannual supportive supervision.	1) SS Report 2) RHMT Annual Performance results	SS reports in place. RHMT Annual Performance results to be ready by August 2015.

Area	TC SWAp MILESTONE 2014/15	Action plan	Indicator / Suggestions	TWG Update
7 (TWG 4) PPP	Functionality of national, regional and council level public-private for a strengthened by 2015 to ensure joint; planning, supportive supervision, reporting, monitoring, accreditation system; and PPP pipeline in place	Institutionalize Public-Private health dialogue fora at national, regional and council levels and advocate for joint planning, reporting, M&E by June 2015. a) Review, disseminate and orientate private sector umbrella organizations, RHMT and CHMTs in joint supportive supervision guideline (in collaboration with Quality Assurance Department) by June 2015. b) Build capacity of the Private sector to participate in the accreditation process, using National Quality Assurance Standards, (in collaboration with Quality Assurance Department) by June 2015. c) Establish a pipeline for PPP health projects according to national health priorities (Special focus on MNCH), monitor release of funds for PPP projects and follow-up of PPP implementation, by June 2015.	a) -60% of regions (15 regions) and 50% (84 councils) of councils having institutionalized PP health fora -75% (126)of council CCHPs developed with participation of the private sector and are including private sector activities in the CCHP -50% (17) of regional referral hospitals and Referral Hospitals at Regional Level develop annual CHOPs (with public and private sector participation) b) -Joint supportive supervision guideline (public and private) reviewed, disseminated and being used by at least 50% of RHMTs and their CHMTs (including private sector umbrella organizations) c) Functional accreditation system in place in public and private health facilities , involving private sector umbrella organizations d) pipeline for PPP health projects established and release of funds monitored annually	a) -100% of the target (15) regions are now conducting annual meetings with private sector, 62% (52 councils) of the target (84) councils conducted PP Health forum meetings -93% (117 CCHPs) out of the target 126 CCHPs developed with participation of private sector. -100% (17 RRHs) of the target (17) regional referral hospitals developed CHOPS including private sector b) –Plans for reviewing supportive supervision guidelines developed in collaboration with DHQA and awaiting release of funds to implement c) Public and private health facilities to be accredited using Star Rating system under BRN with private sector involvement d) Consultancy undertaken to support identification of PPP pipeline projects and final report being used to inform planning for 2015-2016 operational plans.

Area	TC SWAp MILESTONE 2014/15	Action plan	Indicator / Suggestions	TWG Update
8a (TWG 5) Maternal, Newborn and Child Health	Advocate for an increased funding allocations in the 2015/16 CCHPs in line with the delivery of the costed "One Plan" for MNCH.	a) One Plan be costed using the One Health tool by Jan 2015 b) Stakeholders advocacy meeting by March 2015 c) Capacity building to Regions and districts to plan for MNCH interventions in their CCHPs to align with One Plan d) Review of CCHPs to determine councils that have budget for Maternal, Newborn and Child Health Service delivery in line with the delivery of the costed "One Plan" for MNCH by May 2015. e) Follow up the policy process by the MNCH TWG from February to July 2015.	70% of Councils have costed One Plan for MNCH interventions in their CCHP by 2016	a) One Plan was costed using the One Health tool as planned, Stakeholders meeting conducted and His Excellency President of URT did the launch in May 2015. b) Capacity building to regions and districts to plan for MNCH interventions in their CCHPs to align with One Plan has been completed 23 regions. c) Review of CCHPs to determine councils that has budget for Maternal, Newborn and Child Health Service delivery in line with the delivery of the costed "One Plan" for MNCH by May 2015 was done and all Councils have budget for MNCH for various activities depending on 3 major Sharpened Plan priority interventions. d) The policy process for Sharpened One Plan is continuing in those regions that have aligned their plans by the MNCH TWG members.

Area	TC SWAp MILESTONE 2014/15	Action plan	Indicator / Suggestions	TWG Update
9b (TWG 5) Maternal, Newborn and Child Health	Increase communities' uptake of essential maternal, newborn and child health services (focusing on antenatal attendance, postnatal care, facility deliveries, immunization, adolescent reproductive health and family planning services).	1) Communities mobilized to attend ANC using CHWs and mobile phone sms notification from February 2015. 2) Communities mobilized to delivery in Health facility using CHWs and mobile phone sms notification from February 2015. 3) All Health facilities to provide EmONC signal functions as a measure of quality improvement from April 2015. 4) Institute REC/RED strategy in poor performing regions 5) Provide FP outreach services 6) Provide community based FP using CBDAs 7) Communities mobilized to attend PNC for mothers and newborns using CHWs and mobile phone sms notification 8) Training of health care providers on provision of youth friendly health services	1) 90% of pregnant women making 4 or more antenatal care service visits. 2) 80% of pregnant women who delivered in a health facility providing BMONC or CEOMNC services 3) 80% of pregnant women who received skilled attendance at birth during delivery in a health 4) 90% of children aged 12 to 23 months fully immunized 5) 60% contribution of new FP clients by community based FP CBDAs. 6) Percentage of mothers receiving postnatal care services within 48 hours after delivery. 7) Percentage of newborn children receiving postnatal care services within 48 hours after delivery. 8) 80% of RCH health facilities providing youth friendly services.	1) Community mobilization to attend ANC, deliver in Health Facilities and attend PNC using CHWs and mobile sms has not yet started since alignment process with BRN interventions was required. CHWs baseline assessment has begun in Simiyu in May 2015 region to be followed up by Mwanza region in Lake Zone. 2) Baseline assessment for EmONC signal functions as a measure of quality improvement has started in May 2015 in all Lake and Western Regions to be able to determine gaps that require improvement for the provision of quality services. 3) REC/RED strategy has been institutionalized in 5 Regions (Iringa, Njombe, Simiyu, Kagera and Tabora. 4) FP outreach services have been provided in 68 districts in collaboration with partners. 5) Community based FP using CBDAs has not been provided as the guidelines were being reviewed to incorporate new update 6) Training of 60 health care providers on provision of youth friendly services has been conducted in Dar es Salaam with support from MDH.

Area	TC SWAp MILESTONE 2014/15	Action plan	Indicator / Suggestions	TWG Update
10. TWG 9-Social Welfare/Social Protection	Operationalization of the National Costed Plan of Action for the Most Vulnerable Children (NCPA II -2013-2017) by June 2015	1. Finalization of the Communication Strategy for National Costed Plan of Action for the Most Vulnerable Children (NCPA-II 2013-2017) by June 2015. 2. Develop the National Monitoring and Evaluation Plan for National Costed Plan of Action for the Most Vulnerable Children (NCPA-II 2013-2017) by June 2015. 3. Conduct the Capacity Assessment for Department of Social Welfare to implement the National Monitoring and Evaluation Plan for the National Costed Plan of Action for the Most Vulnerable Children (NCPA-II 2013-2017) by June 2015.	**1.** Communication Strategy for the National Costed Plan of Action for the Most Vulnerable Children (NCPA-II 2013-2017) in place **2.** MVC National monitoring and Evaluation Plan for NCPA-II 2013-2017 in place. **3.** Capacity Assessment for Department of Social Welfare to implement the Monitoring and Evaluation Plan for the National Costed Plan of Action for the Most Vulnerable Children (NCPA-II 2013-2017) conducted	• Draft Communication Strategy for the National Costed Plan of Action for the Most Vulnerable Children (NCPA-II 2013-2017) has been developed. • The National Monitoring and Evaluation Plan for the National Costed Plan of Action for the Most Vulnerable Children (NCPA-II 2013-2017) has been developed • Capacity Assessment for Department of Social Welfare to implement the Monitoring and Evaluation Plan for the National Costed Plan of Action for the Most Vulnerable Children (NCPA-II 2013-2017) has been conducted

Area	TC SWAp MILESTONE 2014/15	Action plan	Indicator / Suggestions	TWG Update
11. TWG 12-Sanitation, Hygiene, Environmental Health Management & Climate Change	Leverage high level political commitment towards improved coordination between relevant MDAs and partners in support of progress towards MDGs 4,5,6, and 7	Develop and finalize Sanitation and Hygiene Strategy (i) Engage a consultant for drafting the document (ii) Conduct stakeholders meetings to review the zero draft, (iii) Finalize the zero draft for review by the ministerial management and approved by Dec 2012 (iv) Print 3000 copies and (v) Disseminate the final document.	Printed Strategic plan	• Plans to develop and print Strategic plan are underway however stakeholders strongly suggest that, it will be substantial if the MoHSW facilitate finalization of the National Sanitation Policy. • The TWG has mapped and created a database of stakeholders working in the area of sanitation and Hygiene • Under implementation of the National Sanitation Campaign (NSC) for the first two quarters, 167,097 households have improved toilets among which 122,274 have installed hand-washing facilities. Distinct performance was observed in 62 councils, which have achieved over 75% of their targets. Up to 31st December 2014 the overall performance was 81% with outstanding performance recorded in Mpanda TC, Njombe DC, Lushoto DC, Makete and Mpanda DC.

Area	TC SWAp MILESTONE 2014/15	Action plan	Indicator / Suggestions	TWG Update
12. (TWG 10) Information Systems	Timely reporting of HMIS health service data including HRH, HIV/AIDS, TB and Malaria are channelled through DHIS2-MTUHA database by districts and facilities for production of Health Sector Performance Profile, CCHP indicators, GBS and Health Statistical Tables and Figures.	1) Produce key reports and indicators that measure Health Sector performance 2) Integrate HRH, HIV/AIDS, TB, Malaria and PMTCT into DHIS2-MTUHA reporting system. 3) Mechanism for timely reporting of the newly introduced revised MTUHA tools from health facilities through DHIS2 enhanced 4) Introduce use of DHIS2 to regional and district/councils hospitals	1) Key health indicators used to track health performance produced by July 2015 2) Improved monthly DHIS2 data reporting from health facilities 3) Introduced use of DHIS2 to regional and district/council hospitals.	• Annual National Health Sector performance profile, and GBS indicators produced by July 2015 • At least 80% of the 163 councils submit monthly/quarterly/annual through DHIS2 • At least 5 staff from each regional hospitals and district/councils hospitals received training and introduced use of DHIS2

CHAPTER 6: GOVERNANCE, MANAGEMENT AND LEADERSHIP

6.1 District level

On an annual basis Local Government Authorities (LGAs) through their health technical teams; Council Health Management Teams (CHMTs) prepare Comprehensive Council Health Plans (CCHPs) using the CCHP guidelines and the Planning and Reporting (PlanRep) tools. Preparation of CCHPs is normally guided by National health policy, Strategies, guidelines, and according available resources. These guidelines ensure linkage of the CCHP targets to the relevant strategies and plans that focuses on provision of equitable quality health and social welfare services which are well supported, cost effective and gender sensitive with priorities developed according to the National Essential Health Care Interventions Package of Tanzania (NEHCIP – TZ) and client satisfaction. All public and private health and Social welfare stakeholders are involved in the preparation of CCHP. The CCHPs reflect the essential interventions based on local priority areas and burden of disease, activities and respective yearly budget as financed from all available sources.

In addition, preparation of 2014/15 CCHPs received guidance from the HSSP III, Midterm Review report and the HSSP IV priorities especially the Big Result Now (BRN) initiative.

The council plans and budget, and are monitored by a set of 20 indicators. The MOHSW in collaboration with the PMO-RALG assesses the annual CCHPs from LGA for quality assurance in line with national guidelines on planning and prepares a consolidated report for all CCHPs.

Findings of the assessment for 2014/2015

The 2014/2015 report is based on the assessment of the Comprehensive Council Health Plans (CCHPs) from 162 Local Government Authorities. This report was collated by the PlanRep3 Health Macro following receipt of the analyzed reports from the regions using the PlanRep3 Health Meso.

Performance of Councils

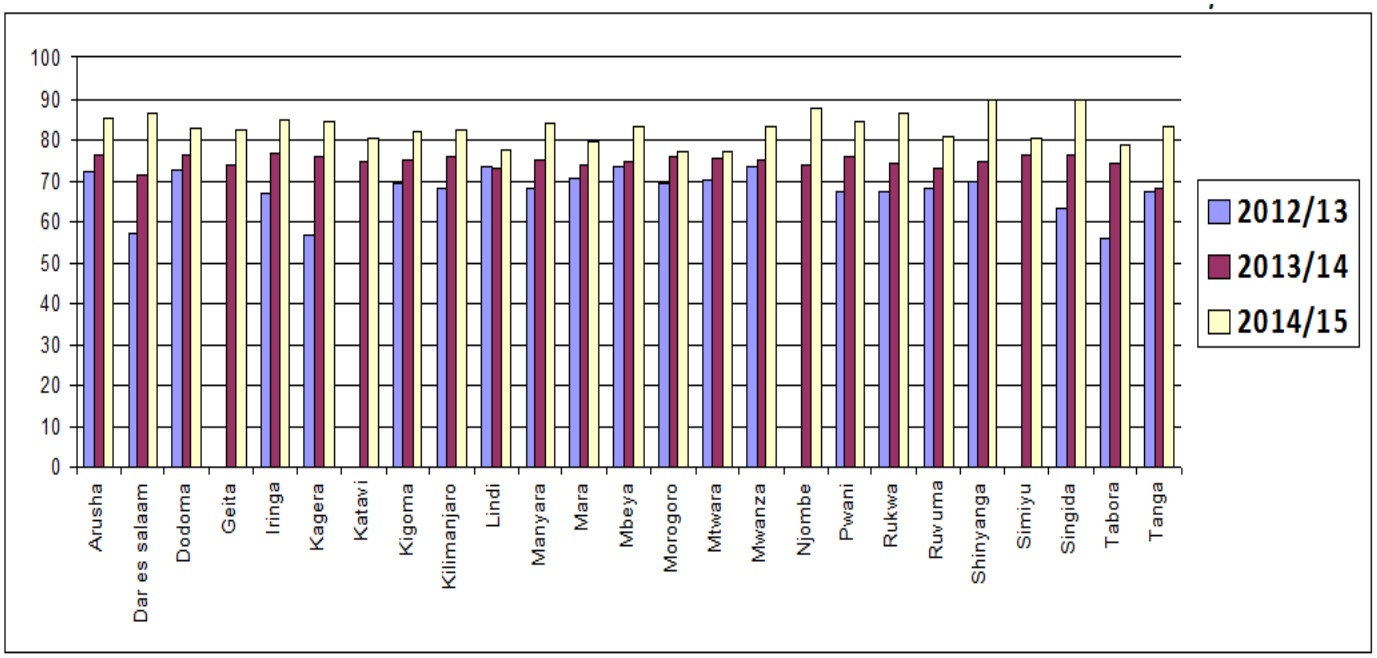
- Only 20% of the councils were recommended for funding in the first assessment round compared to 31% in the previous year.
- In 2014/15 only three assessment rounds were required, compared with four rounds during the previous year,
- Only 14% of councils achieved scores of 90% or above and some council scored as low as 25% in the first round.
- Substantial follow-up with Councils was provided by RHMTs following their intensive training on CCHP/PlanRep3 (micro and Meso).

- Members of the CHMTs (2-3 and RHMTs (2-3) worked with the central team in Dodoma on the identified weaknesses, comments and observations provided by the central level after the first assessment.
- Both the RHMT members and CHMTs received coaching and mentoring and thereby improved their performance scores.
  On second assessment 91% of councils were recommended for funding, and eventually all councils qualified after the third round

Table 6.1: Assessment results showing the status of the council performance in all three rounds 2014/2015

Assessment	Number of councils assessed	Recommended for funding	% recommended for funding	Not recommended
1st Assessment round	162	33	20%	129
2nd Assessment round	129	117	91%	12
3rd Assessment round	12	12	100%	0

Figure 6.1: CCHP performance by region showing the trend over the past 3 years 2012/2013 - 2014/15



- Overall, there were some improvements in compliance with the guidance at the micro level in 2014/2015 as compared with previous years.
- The largest improvements were observed in Singida, Shinyanga, Dar es Salaam, Kagera, Njombe and Iringa regions.
- Kagera region, despite not attending the supportive sessions with central level in Dodoma, and, communicating solely via email, succeeded in improving their performance considerably

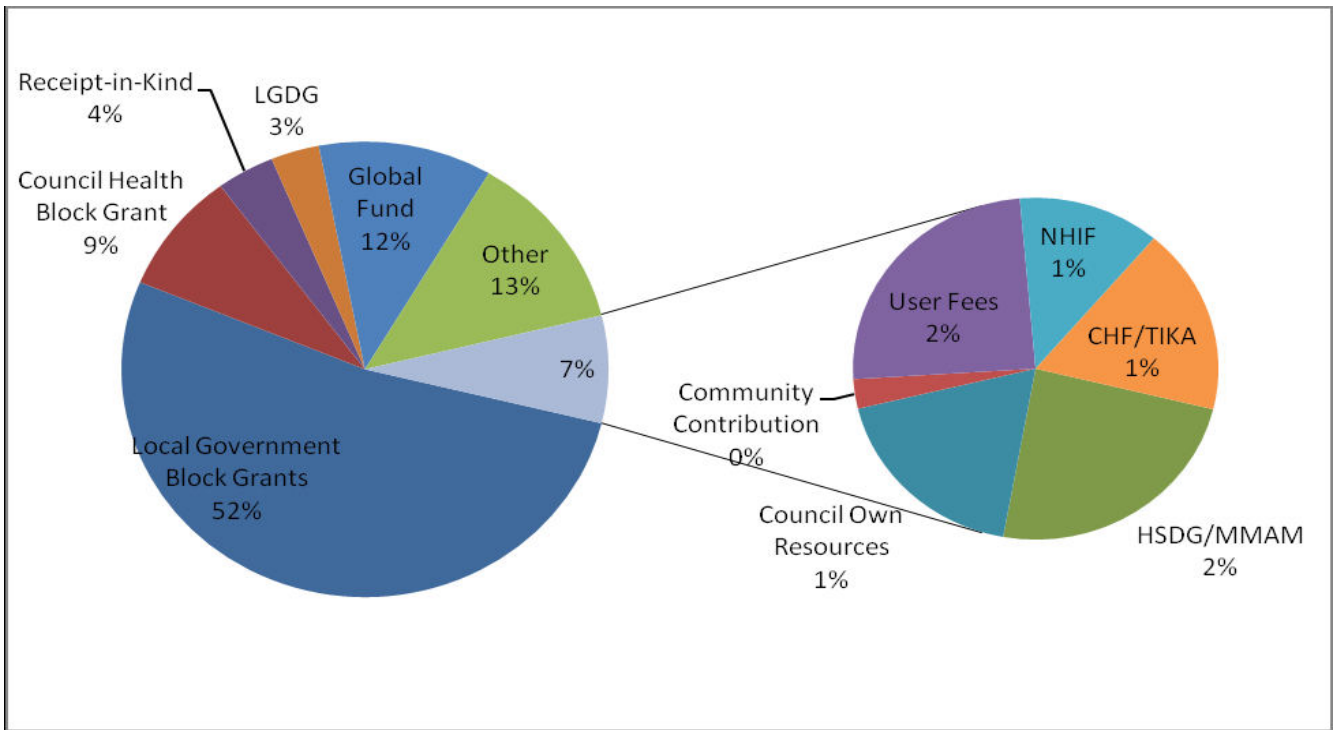
Sources of funds for CCHP

In 2014/2015 a total of TShs 899,372,123,253 was budgeted by 162 councils. Most of the funds for CCHP activities came from local government grants (52%), followed by Global Fund (12%), other sources (13%) and council health block grant (9%)

User fee, NHIF and CHF/TIKA accounted for only 4% of Councils' funds, probably due to the following reasons;

- Low collections due to low contributions as a result of too much exemptions (since public facilities are the only alternative for poor patients
- Low CHF enrollment and increased tendencies of members to drop out.
- Some facilities might not be performing well yet, as far as NHIF is concerned.
- Pilferage of collected funds according to SIKIKAs report presented at the JAHSR – TRM Meeting in November 2014.

Figure 6.2: Shows sources of funds for CCHP activities



In the figure above Global Fund is clearly mentioned as a funding source. Some known development partners such as UNFPA, UNICEF, PEPFER, USAID, IMA, Tunajali, World vision, EGPAF, Meda, JHPIEGO, NTD, Plan International are not indicated since their budgets are outside the council account.

Distribution wise, non-specific delivery support (interventions that fall outside of the essential health interventions package) received 54% of the allocated funds, followed by essential health interventions (32%) and lastly interventions that were not addressing the burden of disease (14%).

Table 6.2: Total health funds allocated per priority area

Priority Intervention Area	TZS	Share
Strengthen Human Resources for Health Management Capacity for	472,312,464,761	52.52%
improved health services delivery		
Communicable Disease Control	105,796,171,754	11.76%
Maternal, Newborn and Child Health	87,867,248,278	9.77%
Medicines, medical equipment, medical and diagnostic supplies	77,364,686,032	8.60%
management system		
Construction, rehabilitation and planned preventive maintenance at all	61,573,399,669	6.85%
Levels		
Strengthen organizational structures and institutional management at all levels	55,700,365,011	6.19%
Non-communicable disease control	16,748,468,202	1.86%
Treatment and care of other common diseases of local priority within the Council	7,762,162,768	0.86%
Environmental Health and Sanitation	6,832,937,244	0.76%
Emergency preparedness and response	2,515,511,097	0.28%
Health Promotion	2,658,532,601	0.30%
Strengthening Social Welfare and Social Protection Service	1,673,945,191	0.19%
Traditional Medicine and Alternative Healing	566,230,644	0.06%
Total	**899,372,123,252**	**100%**

Table 6.2 above shows the allocation of funds per priority area (totaling 472,312,464,761 Tshs), with the largest share of funds (52%) was allocated for strengthening human resource, followed by improved service delivery (11.76%). The same table shows the allocation to mother, newborn and child health to be less than 10% and non-communicable diseases to be less than 2%. Funds allocated for environmental sanitation accounted for less than 0.8%, while emergency preparedness received less than 0.3%.

Table 6.3: Resources allocation share to Essential Interventions 2014/2015

Intervention	TZS	Share
Integrated Logistics System	75,820,609,065	27%
Malaria	46,352,776,382	16%
Provision of ARVs	27,122,613,792	10%
Maternal conditions	26,923,576,794	9%
Childhood Immunizable Diseases	26,235,888,830	9%
Childhood Illnesses	22,481,448,131	8%
STI, HIV/AIDS	16,610,031,634	6%
Injury Care	13,393,193,177	5%
Newborn conditions	10,279,315,059	4%
TB disease	9,872,499,510	3%
Neglected Tropical Disease	5,075,711,293	2%
Provision of essential TB drugs	3,355,930,527	1%
Others (non communicable diseases)	1,837,944,906	1%
Total	285,361,539,100	100%

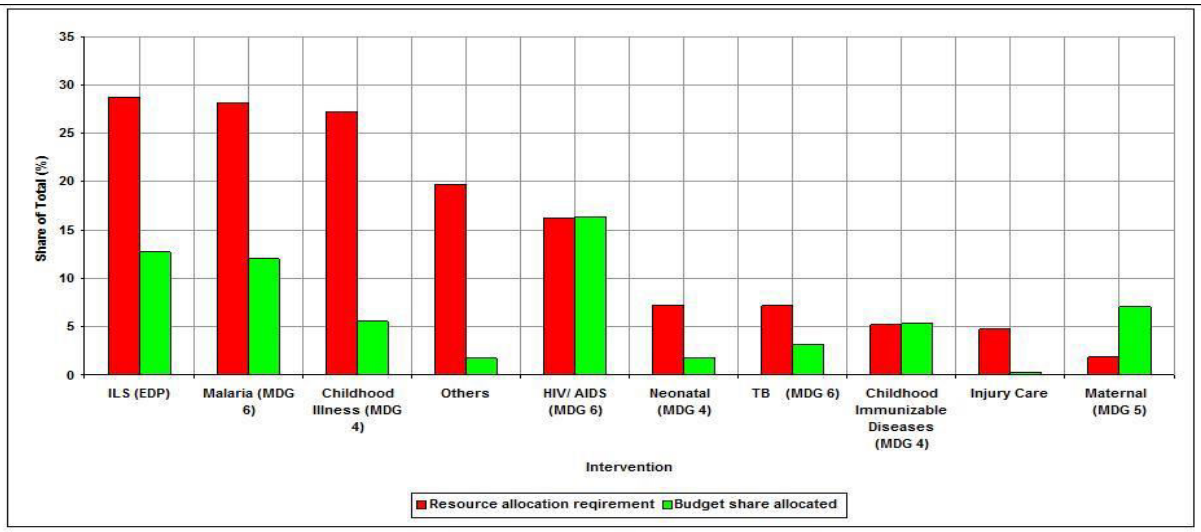
Table 6.3 shows the allocation of funds to essential interventions (totaling 285,361,539,100 Tshs), with largest percentage (27%) spent on integrated logistics systems, followed by malaria (16%), and provision of ARVs (10%). Newborn conditions, TB, and non-communicable diseases, each received less than 4%.

Table 6.4: Resources allocation share to non-specific delivery support 2014/2015 (excluding PE)

Interventions	TZS	Share
Council Health Service Board	3,900,367,059	11%
Preventive Maintenance Plan	3,991,792,598	12%
Supportive Supervision	6,416,594,513	19%
HMIS	3,684,584,298	11%
Public and private collaboration	834,371,121	2%
HRH Management System (excl. PE)	13,705,522,867	40%
Other Support	2,150,568,835	6%
Total	34,683,801,291	100%

Table above shows the **allocation to non-specific delivery support (totaling** 34,683,801,291), with the largest share allocated for HRH management system (40%). The HMIS was allocated 11%, while private and private collaboration received 2%.

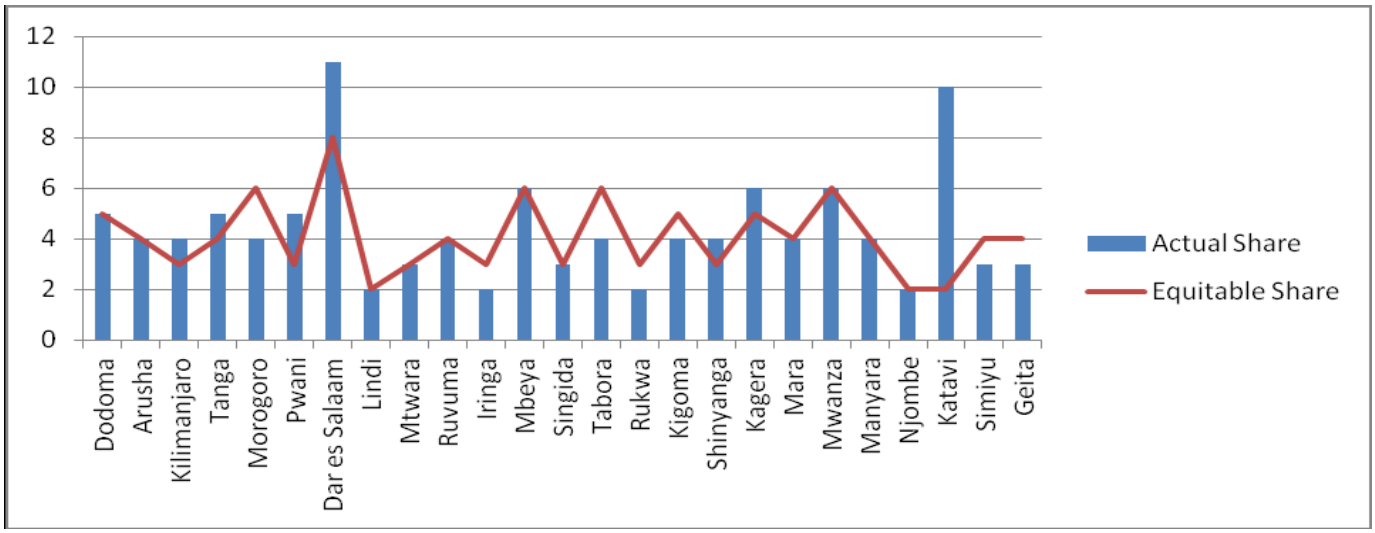
Figure 6.3: Resource allocation requirement Vs Expenditure Shares allocated 2014/15



It is important to note that requirement based on BOD do not tally with budget allocation shares for majority of the diseases. The only diseases with budget allocation that matches the burden of disease were HIV/AIDS and childhood immunizable diseases, while maternal conditions were given a budget that was twice the burden of disease.

Distribution of Funds by Region

Figure 6.4: Actual Allocation of Health Block Grant v. proxy indication of equitable distribution



The figure above indicates that not all regions are receiving the same level of support from donors. While it is not necessary that donor resources should be distributed equally across regions, as some regions are more underserved than others. However, the sector could benefit from a mapping of donor resources to limit potential duplication and overlap.

6.1.1 Reporting

The CCHP Performance 2014/2015 report covered 162 CCHPs, which were assessed three times. This is unlike 2013/2014, which had up to 4th rounds of assessment. In 2014/2015, 33 councils (20%) received favorable assessment report during the first round. Of the 129 CCHPs that were reassessed in round 2, 117 (91%) were recommended for funding. In 3rd round the remaining 12 CCHP were re –assessed and all passed and were recommended for funding. This achievement was due to the motivation and commitment of the RHMTs after being trained on CCHP planning guidelines/PlanRep Micro and PlanRep3 Health Meso.

6.1.2 Implementation capacity

Implementation capacity is measured as the number of activities implemented as a proportion of those approved by respective councils. Results are usually categorized as shown in Table 30 below.

Table 6.5: Implementation of approved activities by Councils FY 2011/12 to FY 2013/14

Planning Category	Categories	% of councils FY2011/12 (95)	% of councils FY2012/13 (115)	% of councils FY2013/14 (121)
Fully implemented	80% and above	41%	51%	77 (64%)
Partial implementation	60% to 79%	34%	25%	29 (24%)
Poor Implementation	40% to 59%	16%	12%	11 (9%)
Under-implementation	Below 40%	9%	12%	4 (3%)

In 2013/2014, 88% of councils had either fully or partially implemented planned activities. Full implementation rose to 54% in FY2013/14 from 51% in FY2012/13. This improvement was seen in each region. The improvement could be attributed by council's efforts to address issues related with: delays in release of fund; procurement process; poor communication within the councils; poor planning of activities, and shortages of skilled health providers and transport.

6.1.3 Supervision

For FY2014/15, 157 councils provided the necessary information included in the analysis (Table 31). The table shows a decline in the quality of supervision in 2014/2015, with 54% of the LGAs achieved the highest level of supervision, down from 64% in 2012/13. A total of 80% of health facilities were visited over the course of the year, implying that a full one-fifth had no supervision in twelve months.

Table 6.6: CHMT performance in relation to supervision, FY 2014/15

Criteria	Status	% of councils		
		2012/13 (123)	2013/14 (158)	2014/15 (157)
75% and above	Standard supervision route	64% (76)	52% (82)	54% (84)
50% - 75%	Moderate supervision route (below standard)	30% (38)	29% (46)	30% (47)
Below 50%	Poor supervision route	8% (9)	19% (30)	16% (26)

6.1.4 Outreach supervision

Table 6.7: Trend of Outreach performance services FY 2012/13 – FY 2013/14 – FY2014/15

Criteria	Status	% of councils		
		2012/13	2013/14	2014/2015
75% and above	Standard outreach supervision route	81% (96)	72% (113)	73%(114)
50% - 75%	Moderate outreach supervision route (below standard)	15% (17)	19% (29)	17% (27)
Below 50%	Poor supervision route	4% (5)	9% (14)	10% (15)
TOTAL COUNCILS				**156**

The table shows a decline in outreach services, from 81% in 2012/13 to 73: in 2014/15. The reasons given HMIS TRAINING MANUAL VERSION 3 AUG 2012 included shortage of qualified health staff at the facility level, competing priorities of CHMTs, lack of team spirit and commitment, lack and/or poor transport facilities such as vehicles, and impassable roads during rain seasons etc.

Challenges

- CHMTs do not have the necessary skills to prepare CCHPs and to use PlanRep3, particularly newly recruited members.
- Health budget is driven by HRH costs –there is less OC to address other issues
- Distribution of centrally administered resources is not equitable
- Insufficient resources to adequately address the BoD

- Preventive health services do not receive adequate resources

Recommendations

- Capacity building to the RHMTs and CHMTs on planning and reporting skills – introduce regional champions –those who perform best in trainings.
- Provide continuous capacity building for Central level (MOHSW and PMO-RALG) – broaden the team at MoHSW that can access and utilize PlanRep
- MOHSW, in collaboration with PMORALG, to compile the suggestions for systems improvement from the LGAs and incorporate proposed suggestions to update PlanRep3 Micro (Health Sector), PlanRep3 Health Meso and PlanRep3 Health Macro –and upcoming PlanRep4 web base
- PlanRep4 to be web-based, and linkage with EPICOR, DHIS2 and other data bases systems to be ensured (mutual export and import of data)
- Collaboration between MoHSW/PMO-RALG and POPSM to be strengthened
- All activities to be part of the CCHP to avoid duplication and cost effective way of utilizing the shortage human resources for health at the Council level.

6.2 Progress with the RBF re-design

Updates on PAY FOR PERFORMANCE (P4P)

Tanzania is in the progress of achieving Millennium Development Goal (MDG) 4 and 5, i.e. reducing maternal deaths by 75% by 2015, which has been slower than expected, as in many Sub Saharan African countries. The Ministry is implementing P4P pilot in Pwani by support from World Bank in the transition period of cycle 7, 8 and 9 beginning Jan 2014 which has ended in June 2015 while waiting the rollout of RBF system in the country.

Summary of key achievements for P4P include;

- Under the mentioned period, the unit did the data verification for cycle 7 to all eligible facilities in Pwani region and currently the payment of incentives to staff and investment to facilities have been processed and circle 8 and 9 verification will be conducted in coming months from October 2015.

6.3 Regional level

In FY2014/15, key achievements to strengthen the regional management level included; Training of RRHMT from 23 Hospitals (5 each) on newly introduced check list and Monitoring Sheet (RMSS) used by RHMTs to supervise RR Hospitals. The training focused on enabling the participants to understand how supervisions will be conducted using the new tools. Participants from all 25 regions finished the training whereby five members from each group were trained. Achievement was 100%; As a result supervision rate from RHMT to RRHMT and CHMT in 2014/15 increased to as follows in a table below

Table 6.8: Supervision rate from RHMT to RRHMT and CHMT in 2014/15

	FY 2012/13	FY2013/14	FY2014/15
RMSS-Council	86%	62%	87%
RMSS-Hospital	52%	60%	75%

Summary Analysis of annual plans and reports

All RHMTs prepared the RHMT Annual Plans. The plans were assessed by RHSU in collaboration with other departments and results presented to the June 2015 basket financing committee. All plans were recommended for funding and the BFC approved them (100%).

Table 6.9: Timely Submission of RHMT plans

	FY2013/14	FY201415	FY2015/2016
Timely submission of RHMT plans	76%	98%	98%
Quality of plans (70% or over)	88%	92%	95%

6.4 Regional and referral hospital level

During FY2014/15, the following activities were carried out under the Hospital Reform section:

Orientation of Regional Referral Hospital Management Teams and Hospital Advisory Boards On roles and Functions Of those boards Advisory.

RHMT, RRHMT and HAB members from eight regions that had not been trained were trained on Roles and responsibilities of HAB, Discussions on the link of HAB and management teams were clearly elaborated.

In June 2015, RHMT annual monitoring meeting was conducted and all twenty-five regions were represented.

During the meeting five best practices were selected by all participants and shared, which included;

- Improving maternal and child health at Rukwa,
- Improving CHF enrolment in Kibaha District Council in Pwani
- Improving HMIS Data Collection at Council level in Iringa region,
- Construction of Walkways at Regional referral hospital in Mbeya
- Monitoring Availability of Essential Medicines at Health Facilities in Shinyanga

6.5 Central level

The Ministry prepared Standard Treatment guidelines and the honorable Minister of Health and Social Welfare at the JAHSR Policy Meeting launched the National Essential Medicines List (STG+NEMLIT) in November 2013.

Various guidelines for quality improvements were finalized and introduced, including:

- National Health and Social Welfare Quality Improvement Strategic Plan: 2013-2018;
- National Guidelines on Use of Safe Care Standards for Dispensaries, Health Centers and Hospitals at District level;
- National Guidelines for Post-Exposure Prophylaxis Services for Occupational and Non – Occupational Exposures to blood and other body fluids;
- External Verification and Recognition Guidelines for health care quality improvement programs has been finalized and signed for use.

6.6 Social Welfare

Progress during FY 2014/15;

- There is a significant increase in the number of social welfare officers at LGAs; at least every council has one Social Welfare Officer.
- The department continues to provide support to most vulnerable children through the National In the course of its implementation the Department has managed to establish/strengthen Child Protection systems at LGA Level and manage to establish child protection teams in 32 councils.
- Currently a total number of 815 technical officers have been trained on child protection issues.
- For the reporting period the department received a total of 104 applications for foster care placements and adoptions.
- A total of 83 children were placed under foster care placement and a total of 21 children were fostered by adoptive parents, the children's homes which were registered found during the mapping of social welfare services in the country were 289, where 33.3% are officially registered.

6.7 Public Private Partnership

The TWG PPP oversees the progress of Strategy 6 of the just ended HSSP III dealing with Public Private Partnership. Its composition includes representatives from Faith Based Organizations (CSSC, BAKWATA), Private Health Providers (APHFTA), Development Partners (DANIDA, USAID, GIZ, and UNICEF), Government (MOHSW, PMO RALG), Health Professionals (TPHA) and Civil Society. Additional public and private partners are invited to participate as and when necessary at the TWG. The MOHSW PPP Coordinator chairs the TWG and Deputy Chair is the TPHA (private sector) representative. The TWG planned to meet monthly and managed to meet eight times as TWG and two times for ad-hoc meetings since July 2014. The TWG PPP collaborates with other TWGs and taskforces, including TC SWAp.

Main achievements towards HSSP PPP Strategies since the JAHSR 2014

a. To ensure conducive policy and legal environment to facilitate PPP operations

- ✓ New PPP Strategic Plan 2015-2020 drafted, with DANIDA and GIZ support, waiting official launching of HSSP IV to be completed and approved, developed in line with HSSP IV development process.
- ✓ PPP health and social welfare communication strategy developed and awaiting printing and dissemination.
- ✓ Mapping of social welfare services by public and private providers carried out and final report presented to Senior Management April 2015. Report informed increased allocation of resources for Social Welfare Services under 2015/2016 MTEF Budget.
- ✓ Quarterly meetings of the Public Private Health Forum Executive Board held
- ✓ Terms of Reference developed for consultancy to develop plan to operationalize the PPHF resource center, consultants contracted through Danida support and consultancy currently underway, to be completed by mid-December.
- ✓ Training conducted for 70 participants (MOHSW PPP contact persons, PMO RALG, Regional PPP focal persons, Regional health secretaries, training included identification of potential PPP pipeline projects, done in February 2015.

b. *To ensure effective management and operational framework for PPP*

- ✓ Service Agreement template of 2007 reviewed May 2015, as part of PPP support for BRN, draft to be presented to Senior Management for approval.
- ✓ Guidelines for completing the Service Agreement template were developed in Kiswahili with support from Pharm Access, also to be presented to Senior Management for approval.

- ✓ Review of joint supportive supervision guidelines done in collaboration with Directorate of Quality Health Assurance awaits approval and printing
- ✓ Schedule for monitoring PPP implementation in 25 Regions developed and actual monitoring will be conducted in November 2015
- ✓ Capacity building on PPP conducted to MOHSW officials including PPP-subunit, MSD, APHFTA supported by DANIDA, Ministry of Finance and the World Bank

c. *To enhance PPP in the provision of health and social welfare services*

- ✓ To date 89 Service Agreements have been signed, this includes 23 SAs with health centers and dispensaries. Both APHFTA and CSSC currently providing support to selected LGAs to develop Service Agreements with private sector partners.
- ✓ Following the approval of a pre-feasibility study on the local manufacturing of IV Fluids, Syrups, Gauze, Cotton-wool and syringes the Ministry of Finance have approved (September 2015) funding to carry-out full feasibility study
- ✓ Consultancy to identify national wide health PPP projects and a pipeline conducted. First mover projects will be programmed in 2015-2016 implementation plans.
- ✓ Syndication meeting held with private sector providers as an initial step in the process to engage the private sector to enter into agreements with LGAs to operate health facilities manned by medical attendants. A pre-feasibility is currently being undertaken with support through Pharm Access.

Major challenges and constraints

The timely release of funds continues to be a major constrain to implementation of activities. DANIDA HSPS IV programme support ended in June 2015, with no corresponding replacement of funding through the MOHSW MTEF budget, this will result in a significant reduction in activities in the coming year.

Way forward

- Finalize PPP strategic plan for 2015-2020 and disseminate to stakeholders
- Print and disseminate MOHSW PPP Communication Strategy and IEC materials, Service Agreement template and SA guideline, Joint Supportive Supervision guideline
- Complete health and social welfare PPP database and develop projects in PPP pipeline
- Continue to track and monitor PPPs in health and social welfare sector
- Continue PPP advocacy and dissemination of PPP and related documents

CHAPTER 7: DISCUSSION AND CONCLUSIONS

This report summarizes the performance of the health sector for the period 2014/2015 and is also showing progress, since baseline, towards the 2015 set targets. The release of the Health Sector Performance Profile Report 2014/2015 has come at critical time and when the millennium development goals have come to an end, in June 2015.

Evidently progress towards achieving the MDG goals has been uneven, as some of the indicators remain off-track, in particular those related to maternal, newborn and child health and to reproductive health. The report has outlined several challenges that hinder this progress, which include severe shortage of skilled human resources and supplies of medicines and health products, leading to insufficient quality of health services. In certain geographical areas, populations still live far away from health services. The report note that the allocation of funding to the health sector has been insufficient, especially the contribution from the government. The actual funds received in FY2013/14 were substantially lower than budgeted, only just over half and there was a considerable delay in releasing them.

These issues need to be resolved to enable universal access to quality health services by all Tanzanians, especially those who are the most vulnerable. The latter group includes children under five years of age, pregnant mothers, and the marginalized populations. Some recommendations have been made to some of the challenges that have been identified, which can form evidence-based foundation in decision making and planning, going forward.

Fortunately the country is due to embark on the Health Sector Strategic Plan IV 2015 – 2020 (HSSP IV) that intends to prioritise interventions based on available resources and define realistic targets for the health and social welfare sector. At the same time, the United Nations has recently released a set of Sustainable Development Goals (SDGs) as successors to the Millennium Development Goals (MDGs) that provided important input to the planning process of this HSSP IV. Fortunately, the achievement of SDGs and the unfinished business of the MDGs have been considered in formulating HSSP IV. The health and social welfare sector programme of Big Results Now (BRN) 2015 - 2018, along with the Tanzania Development Vision 2025 (Vision 2025) are providing direction and philosophy for long-term development.

What is needed is recommitting ourselves to the full realization of all the MDGs, particularly those that are off-track, by providing focussed and scaled-up assistance to complete the unfinished achievements, particularly in reaching the most vulnerable rural communities. We should also create awareness on non-communicable as well as the neglected tropical diseases, which increasingly affect the quality of life of our people.

Conclusion

The health status of the population is slowly improving and life expectancy is increasing. However, the overall service utilization has not reached the required level and the country does not yet have the capacity for an adequate response to health issues. The country needs to implement the HSSP IV more vigorously than it did during the HSSP III era. Fortunately, HSSP IV contains a solid M&E framework. Based on this, the Joint Annual Health Sector Review (JAHSR) will have the necessary inputs for strategic decisions for improvement on the performance of the health and social welfare sector in Tanzania.