United Republic of Tanzania

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

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

Thematic Report

HEALTH SERVICES and INFRASTRUCTURE

October 2019

Recommended Citation: MOHCDGEC. 2019, Mid Term Review of the Health Sector Strategic Plan IV 2015 – 2020, HEALTH SERVICES and INFRASTRUCTURE, Technical Report, Ministry of Health, Community Development, Gender, Elderly and Children.

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

Thematic Report

HEALTH SERVICES and INFRASTRUCTURE

Dr. Elihuruma Nangawe and Dr. Zacharia Berege

Table of Contents

List of tables

List of figures

Abbreviations

ADDO	Accredited Drug Dispensing Outlets
AMTSL	Active Management of Third Stage of Labour
APHTA	Association of Private Hospitals in Tanzania
ART	Anti-Retro Viral Therapy
CBHP	Community Based Health Program
CHMT	Council Health Management Team
CCHP	Council Comprehensive Health Plan
CSSC	Christian Social Services Commission
DHFF	Direct Health Facility Financing
DHIS2	District Health Information System2
DPT-HPV-HepB	Diptheria Pertusis and Tetanus- Human Papilloma Virus-Hepatitis B.
FEFO	First Entry First Out
FFARS	Facility Financial Accounting and Reporting System
GAVI	Global Alliance for Vaccines and Immunization
GBV	Gender Based Violence
GOT-HOMIS	Government of Tanzania Hospital Management Information System
HBB	Helping Babies Breath
HFGC	Health Facility Governing Committee
IPC	Infection Prevention and Control
MMAM	Mpango wa Maendeleo ya Afya ya Msingi (PHCDP)
MNAP	National Multisectoral Nutrition Plan
MDA	Mass Drug Administration
MDR-TB	Multi Drug Resistance –Tuberculosis
NACTE	National Accreditation Body for Technical Education
NCD	Non- Communicable Diseases
NTD	Neglected Tropical Diseases
PEP	Post Exposure Prophylaxis
PLA	Participatory Learning and Action
PMTCT	Prevention of Maternal to Child HIV Transmission
PMO	Prime Minister's Office
PPH	Post Partum Hemorrhage
PRINMAT	Private Nurse Midwives Association of Tanzania
REC	Reaching Every Child
RMNCAH	Reproductive, Maternal, Neonatal, Child and Adolescent Health
RHMT	Regional Health Management Team
RRH	Regional Referral Hospital
SAM	Social Accountability Monitoring
SARA	Service Availability and Readiness Assessment
SBCC	Social Behavioral Change Communication
SOPs	Standard Operational Procedures
SWASH	School Water, Sanitation and Hygiene Program
TASAF	Tanzania Social Action Fund
THIS	Tanzania Health Impact Survey
TMA	Tanzania Meteorological Authority
VAC	Violence Against Children
VEO	Village Executive Officer
VCT	Voluntary Counseling and Testing
WDC	Ward Development Committee

1 Introduction

The Health Sector Strategic Plan IV (HSSP IV) is a cross cutting document for Tanzania health sector from July 2015 to June 2020. The overall objective of HSSP IV is to reach all households with quality essential health and social welfare services, meeting, as much as possible, the expectations of the population, adhering to objective quality standards, and applying evidence-informed interventions through efficient channels of service delivery.
Thematic entry point:
The Mid Term Review (MTR) of HSSP IV started with a kick off meeting in March 2019 informed by an Inception Report shared earlier by the Team Leader and members of the MTR Core team. The main objective of the MTR is to review, analyze, and document progress, challenges, and lessons learned from the first three years of HSSP IV implementation. Recommendations from HSSP IV MTR will suggest improvements to the final period of HSSP IV implementation and inform the design and formulation of the Health Policy and Health Policy Implementation Strategy, as well as the formulation of HSSP V. This report presents findings of the Service coverage and Quality of services thematic area that was handled by two Consultants. The report is organized around... sub-themes in which achievements or progress made, challenges, lessons and way forward are presented**.** It concludes with a set of recommendations some of which are intended as agenda for consideration in either health policy, implementation strategy or for formulating in HSSP V.

1.1 Methodology

The process of reviewing the Service coverage and Quality of health services component began with a literature review that included studying survey reports, program plans and progress reports, documentation and studies from relevant Technical Working Groups as well as analytical work that was available at the early stages and updated during the process of review. This was supported using further insights from field visits to pre-selected regions and districts where interviews were conducted at Council (CHMT), Health Centers, Dispensaries and Community levels. Focus Group Discussions were held with women attending RMNCH clinics and an equity study was undertaken sourcing information from community members. Data collection tools were developed and discussed at a workshop prior to field testing. Findings from the field visits were discussed at a national level workshop followed by thematic analysis and report writing.

Strategic Direction	Specific issue
Quality Assurance: The primary focus will be on quality in order to improve outcomes of health care and social welfare services and to enhance trust within the population and other stakeholders in the quality of the sector's services. A series of measures will make the quality of health care visible, more acceptable to users, and safer for both clients and health workers. Transparency in official processes and	Certification towards Accreditation, Star rating Clients' Charter Pay for Performance

decision-making, as well as value, for money will attract investments in the sector.	
Council Health Services: Council Health Services will constitute the backbone of the health services. These services will provide the National Essential Health Care Intervention Package (NEHCIP-Tz) while guaranteeing quality (3-star rating) and transparency (social accountability). Increased trust will sensitise the population to enrol in the Single National Health Insurance and take part in management of Council Health Services the necessity for international referral	***5.3.1 National Essential Health Care Intervention Package*** ***5.3.2 District Health Services*** Integrated and evidence-based health planning and decision making at LGAs Decentralisation of financial management to the facility level Partnership with Private Providers
Secondary and Tertiary Services	***5.3.4 Regional Referral Hospitals*** Electronic medical records and e-health expansion SOPs, clinical audits and mentoring Leadership, planning and resource management capacity **5.3.5 Zonal and National Level, including International referral**
Health Promotion: Strategic Investment in health promotion interventions that give emphasis to multi-sectoral approaches in addressing the preventable causes of disease, disability and premature deaths in all population groups throughout the course of life.	*The MOHCDGEC will:* ensure better coordination of advocacy, social and behavioural change communication across different initiatives, programmes and interventions. provide national standards and guidelines for designing, development and delivery, monitoring and evaluation of health communication interventions. establish a national resources centre for health communication, which will produce and archive integrated health promotion packages, which include paper, audio-visual and e-health materials. ensure effective active community engagement in the design, planning, implementation monitoring and evaluation of health promotion intervention through the implementation of a Community Health Strategy. oversee capacity building for and professionalisation of CHWs to plan, implement, monitor and evaluate health promotion interventions at the community level. invest in the National School Health Program for better health and education outcomes. The MOHCDGEC will oversee the revision of the Food and Nutrition Policy of 1992, develop its implementation strategy (2015/1616 – 2025/26) and develop and implement a National Nutrition Action Plan for 2015 – 2020 based on the outcomes of the National Nutrition Survey 2014.

Nutrition: The health sector, in collaboration with partners, will accelerate nutrition interventions, with emphasis on pregnancy stage and the two first years of life (1000 days).	MOHCDGEC and MDAs will review and update guidelines to address maternal and infants and young child feeding, management of acute malnutrition, control of micronutrient deficiencies and healthy eating and lifestyle issues as needed. A pool of nutrition professionals is sustained through skill based in-service and pre-service training programs integrated in existing curricula. The health and social welfare sector will promote appropriate maternal, infant and young child feeding practices in households and in communities and will advocate towards reducing food insecurity among households. More attention will be paid to strengthening compliance to exclusive breast feeding and infant and young child feeding practices, and promoting hygiene and sanitation practices. Strategies for control of micronutrient deficiencies will be integrated in the Community Health Programme. Routine provision of nutrition counselling and essential vitamins and micronutrients to pregnant and lactating women and children under the age of five-years will be strengthened. Children with nutrition disorders will be identified, investigated for underlying diseases, and, when necessary, treated or referred for nutrition rehabilitation and family support. The MOHCDGEC will ensure regular provision of nutrients for supplementation, fortification and promote dietary intervention for control of micronutrient deficiencies.
Communicable Diseases: The health system will maintain the high level of performance of Disease Control Programmes; reduce morbidity and mortality caused by infectious diseases while increasing efficiency through improved integration of activities	rough campaigns, the MOHCDGEC will intensify awareness creation and public sensitisation on life-style related illnesses Disease Control Programmes, e.g., malaria, tuberculosis and HIV/AIDS require specific knowledge and skills in some areas, e.g., vector control, contact tracing, diagnostics and treatment regimes. In other areas, common knowledge on health promotion, disease prevention, laboratory diagnostics or supervision, monitoring and evaluation is applicable.
Non Communicable Diseases: The country will focus on community-based prevention, health promotion, screening and early treatment as well as rehabilitation. Activities will be integrated in	***Non Communicable Diseases***

health services and not as new vertical programme	e.g Mental Health and Substance Abuse Disorders, Cancer, Oral Health, Diabetes, Hypertension, Sickle Cell Disease
Inter-sectoral Collaboration for Health. Strategic Direction: The health sector will advocate for inter-sectoral action and actively engage in partnerships in addressing the Social Determinants of Health including implementation of the approach **Emergency Preparedness and Response.** The MOHCDGEC (in collaboration with other MDAs) will put systems and structures in place to be able to respond immediately to health related epidemics and crises, at relevant levels, using modern means of communication to ensure global health security**.**	***Intersectoral Collaboration:*** Intersectoral action and active engagement in partnerships to address the Social Determinants of Health including implementation of the approach in the following areas Water and Sanitation Occupational Health General and Health Care Waste Management Port Health Road Safety ***Emergency Preparedness and Response:*** *The MOHCDGEC (in collaboration with other MDAs) will put systems and structures in place to be able to respond immediately to health related epidemics and crises, using modern means of communication to ensure global health security*
Social Welfare service delivery. Social welfare will be further decentralised and become a fully–fledged department in the LGAs. Health channels will be used to reach communities and vulnerable groups for sensitization and referral to organizations providing social welfare support.	***Social Wellfare Service delivery*** 5.7.1 General 5.7.2 Policies and Strategies 5.7.3 Vulnerable groups *5.7.3.1 Services to People with Disabilities* *5.7.3.2 Family, Child Welfare and Early Childhood Development* *5.7.3.3 Services for the Older People* *5.7.4 Juvenile Justice* *5.7.4.1 Corrective Treatment* *5.7.4.2 Rehabilitative Youth Services* *5.7.5 Accountability mechanisms for child protection*
Regional Referral Level: Regional Referral Hospitals will serve as centres of medical excellence and referral in the Regions, and as the hubs for technical innovation to be disseminated to lower levels	***6.3.1 Infrastructure*** *Construction and rehabilitation of health facilities:* Construction of nearly 800 dispensaries, 35 health centres, 9 district hospitals and 4 regional hospitals by 2020 Rehabilitation of around 5,800 health facilities (around 70% of all facilities) will undergo maintenance works. Health facilities in selected regions will be refurbished, upgraded, electrified and furnished with a safe water supply, in order to provide BEmONC or CEmONC services.

	Oversight on Health Infrastructure; Public and Private, Quality and maintenance at all levels (icl. MMAM), Staff houses ***6.3.2 Maintenance and replacement of equipment*** Guidelines and standard operating procedures for infrastructure maintenance (including waste disposal and water supply) and rehabilitation, for maintenance of equipment as well as for means of transport available in CHMTs and hospitals; developed or revised to increase efficiency and quality Zonal workshops provide on-demand services to CHMTs and health facilities in maintenance of equipment. ***6.3.3 Transport and Ambulance Services*** Mechanism for emergency medical services at all levels, including guidelines and protocols Private sector engaged in transport services for health. Streamlined mechanism for ambulance specification, registration and management.

Table 1 HSSP IV Health Strategic Directions and specific issues

2 Strategic Directions and Specific issues Findings

2.1 Strategic Direction 1

2.1.1 Quality Assurance

The Sector has evidence to show it focused on quality and made some progress (refer annex 1 a for details), at some facilities very significant progress, majority made moderate efforts and gains and a few were relatively slow to gain momentum in improving quality of services. Nevertheless, expanded scope and understanding of the various agents and beneficiaries calls for extending, deepening and sustaining what is already going on for countrywide coverage. Extending and optimizing application of committed leadership, as well as advocacy to encourage the proliferation of quality inclined leaders appears to be an approach that bears success but has so far not been given deserving attention. Disciplined compliance to SOPs is a behaviour that requires consistent daily follow up routine to influence practice positively.

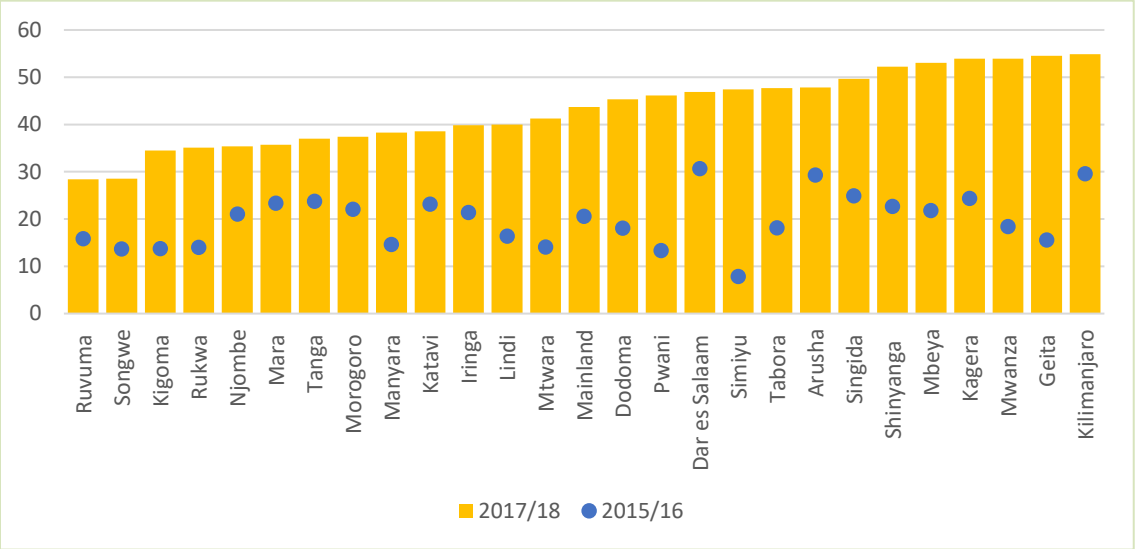


Figure 1:Star rating assessment scores by region 2015/16 and 2017/18 (100% = 4 stars)

2.1.2 Specific issues

Star rating

PHC facilities started with a very challenging low level of baseline ratings (Only 2% met three stars or more and 34% scored zero). One and a half years after the initial assessments marked improvements were recorded with 19% of facilities assessed scoring 3 stars and above; only 4% were at zero stars status[1].

[1] MOHCDGEC 2017. Report of the National Baseline 2015-2016 Final HN 2017 06 23.pdf

Facilities that scored 1 star at baseline were 51%: two years down the line facilities rated 1 star and above were 94%[2], quite a remarkable increase.
All star rating data are electronically captured in DHIS2.
Some facilities have matriculated to self-assessment level, a low cost and sustainably effective measure.
Quality assessments extended to Regional Referral Hospitals and services better appreciated by Clients where SOPs are followed consistently and clinical meetings reflect seriously on quality of care issues (refer to the following text box on drivers of quality).

Text box: Drivers of Quality Improvement:

+ Staff craving for excellence-RBF
+ Inter-dept competitions-RBF
+ Interfacility competition
+ Councilors constituencies competing
+ Members of Parliament competing
+ Intrafacility self-assessments
+ QI a standing agenda at all clinical meetings
+ Client's Charter optimization (Accountability ideal)
+ SOPs increasingly consulted
+ CPED seminars weekly
+ Star rating-based QI Planning

Caution: The first two drivers have short term gains but in medium to long term there are system-wide damages and hence demerits of RBF also known as PBF[3] should be taken seriously.

Besides star rating, **Standard Operational Procedures and Protocols** were also observed in all facilities visited including guidelines for Malaria, HIV, TB and STI testing, BeMONC, AMTSL, IPC, PEP, ECCLAMPSIA, PPH, HBB and ANC. SOP were also observed during interview including SOPs for Artesunate Injection Administration, Testing and Treatment of HIV and Malaria, 5S-Kaizen, Rapid Testing and SOPs for Lab Diagnostics. Disciplined compliance to the SOPs is the behavioral element that should be in hot pursuit in day to day management of service delivery.

Certification towards Accreditation

In the Health Sector's Quality Improvement work a link was conceptualized between the 'Star Rating' effort and movement of health facilities towards Certification and Accreditation. It was agreed that health facilities that attain a score of 3 stars and above qualify for certification and upon reaching 5 stars they qualify for accreditation. APHTA, CSSC and PRINMAT have been at the forefront together with some public facilities in pursuit of Certification towards Accreditation with encouraging support from the Safe Care initiative made progress as follows:-

[2] MOHCDGEC 2018. National QI Star Rating 2017-2018 reassessment X-cel scores
[3] Elisabeth Paul et al. Performance- Based Financing in low-income and middle-income countries: Isn't it time for a re-think? BMJ Global Health Analysis.

SAFE CARE LEVELS[4]	2015	2016	2017	2018
Level 1	68	137	191	144
Level 2	35	75	106	150
Level 3	0	44	92	140
Level 4	0	7	25	46
Level 5	0	0	0	4
Total	**103**	**263**	**414**	**484**

Table 2 Safe care certification to accreditation scores 2015-2018

The total Safe Care enrolled facilities multiplied almost five times the baseline number by 2018 and the number that fulfilled certification level 2 and above rose from 34% in 2015 to 70% in 2018. As more facilities realize the benefits of moving in this line, objectivity and compliance to recognized standards shall establish a positive impact on quality and influence staff towards better performance.

Clients Charter

Health facilities visited featured the placement of signage and public display of telephone numbers of key officers of the facility, as well as having suggestion boxes at key points: These constitute concrete examples evidencing implementation of the Clients' Charter beyond simply displaying it. Complaints handling mechanisms are supported by capture of complaints in earmarked registers. Community voice is been registered in operating routines of health facilities through various channels (suggestion boxes, telephone calls or sms, whatsapp, or direct face to face encounters). The FGDs conducted during field visits as well as key informant interviews detected some beneficiaries concerns on rude language by female staff in contrast to male colleagues. The message on rights and obligations contained in the Clients' Charter has not yet been applied more practically as a tool for dialogue amongst providers and between providers and beneficiaries such that the charter is learned and understood by all parties. It is encouraging that the Clients' Service Charter has been reviewed and a more elaborate document produced to guide facilities in adapting it. But unfortunately in this revised charter the right to be heard and the responsibility to communicate effectively are not elaborated and the right to be respected appears among providers but not among the clients being served.

Pay for Performance

Linking results based financing (RBF) and insurance payments to quality of service using star rating as a proxy was designed to accelerate quality improvement and have a positive influence on clients. Staff was motivated where this has been applied (refer for instance Kakonko in Kigoma) and de-motivated (refer to Lindi plea where no RBF resources were disbursed). While this has positive motivation against performance in the short term, it is not hard to foresee negative system-wide effects (dependency syndrome) in the longer term horizon when donor funds are no longer available for this purpose. The Human Resource limitations related to quality of services would seemingly be in the HR shortages but the evidence does not seem to back this. For instance Ligula, Sekou Toure, Bukoba, Shinyanga, and Manyara RRHs had staff shortages but still managed to score satisfactorily on quality. Lack of a system of tracking medical errors is encountered in many facilities. Generally the 2017 assessment found RRH in-patients are treated according to up to date standard treatment guidelines, injection safety procedures are adhered to, over 80% of the hospitals are stocked with all 30 tracer medicines and dispensing points are staffed by a qualified pharmaceutical cadre. However only 2 RRH have well-functioning equipped

[4] See annex 2 for detailed elaboration of Safe Care Levels

ICU with their staff trained on critical care; 2/3 of RRH do not have well established emergency, ICU, CSSD service units.

2.2 Strategic Direction 2 District Health Services

Evidence-based planning of Local Councils health services has matured (in 2016/17 good performance on technical reports stood at 75% of 105 Councils, while poor performance on technical and financial reports stood at 23%). In 2017/18 the number of Councils assessed increased to 184 with 77.5 % passing at first round and 91.8% at second round. Councils implementation assessments improved from 63% to 80% in 2016/17 and 91.8% in 2017/2018.

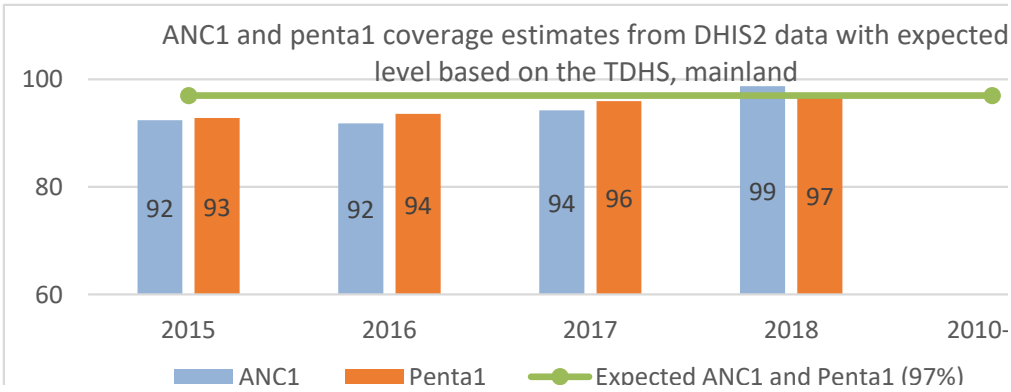
HSSP IV TARGETS & INDICATORS

Indicator	Baseline (Year)	Target 2020	Achievement	Comments
Maternal mortality per 100,000 live births	556 (TDHS 2015-16)	192		No progress in the past decade; no new population-based data
Maternal deaths per 1000 deliveries in health facilities		-		Recent data from DHIS not available
ANC: first visit before 12 weeks of pregnancy	24% (TDHS 2015/16)	60%	14% (DHIS 2015) 28% (DHIS 2018)	Modest increase but still well-off target
ANC at least 4 visits among pregnant women	51% (TDHS 2015/16)	80%	62% (TMIS 2017) 64% (DHIS 2018)	Steady increase from 2014- 2017 followed by dramatic increase in 2017-2018. Target of 2020 may be too far
IPT 2	35% (TDHS 2015/16)	90%	87% (DHIS 2018)	Major increase, target likely to be met
Institutional delivery rate	63% (TDHS 2015/16)	80%	80 % (DHIS 2018)	Steep increase between 2017 to 2018 DHIS. Target of 2020 may be met
Skilled Birth Attendants use during childbirth	64% (TDHS 2015-16) 60% (DHIS, 2015)	80%	76 % (DHIS 2018)	A dramatic increase between 2017 and 2018; 2020 goal near
Postnatal care within 48 hours (women)	34% (TDHS 2015-16)	80%	65% (DHIS, 2018)	Rapid increase in PNC use; 2020 target within reach
Postnatal care within 48 hours (Newborns)	43% (TDHS 2015-16)	80%	64.9% (DHIS, 2018)	Rapid increase in PNC use; 2020 target within reach
C- Section Rate	6 % (TDHS 2015/16) 5.9 % (DHIS, 2015)	5-15 %	7.3% (DHIS, 2018)	2020 goal has been met, but many women still lack CS access
Emergency Obstetrics Services: facilities that can provide EMOC (%)	25% (2015)	70%	15% Health centre; 81% Hospitals (2017 SARA)	Achieved in hospitals but not in health centres

Table 3 Indicators HSSP IV (source analytical report)

By virtue of 2017/2018 CCHP Report a total of 2510 health facilities including staff houses have been planned for construction and rehabilitation (for more details see infrastructure section 4.1). Preparation of CCHPs continued to be guided by National; Health policy, Strategies, guidelines and the scope of the available resource envelop. Preparation of 2017/18 CCHPs in particular received guidance from the HSSP III Midterm Review report and the HSSP IV priorities especially the Big Result Now (BRN)

initiative including also putting emphasis on the Sustainable Development Goals with special attention on measures towards attainment of Universal Health Coverage.
The National Essential Health Care Intervention Package (NEHCIP-Tz) has continued to serve as the basis for CCH Plans. Using the NBS projections to estimate the number of pregnant women and the number of infants eligible for immunization, the national coverage in 2018 for first ANC visit is and for first pentavalent dose vaccination is close to what we expect on the basis of the TDHS 2010 and 2015/16.[5]



Source: Ties Boerma 2019. Draft Analytical Report preliminary version and WHO 2019. GAVI proposal based on routine EPI data.

Figure 2 ANC and vaccination coverage

Social Accountability has been given impetus through utilization of the Clients' Charter and SAM reports dissemination at districts and beyond. The community voice that is facilitated by the Clients' Charter, SAM reports, as well as specific advocacy activities, have enhanced health insurance enrolment. Efforts to expand health insurance coverage are ongoing with a target goal of reaching Universal Health Coverage. HFGCs also facilitate giving and receiving feedback between Health Care providers and the community they represent even though to a limited extent.
Health facilities are now directly funded through DHFF and this enables them to engage fast in executing their operational plans besides the self-confidence it has bestowed on health facility managers. The GOT-HOMIS has also facilitated revenue collection at Hospitals; at lower level health facilities FFARS enables regular monitoring by the CHMTs.
Of high priority within Council Health Planning is maternal health overall and maternal mortality reduction which has remained high and critical unfinished agenda of the MDGs. The surveys and census suggest that maternal mortality did not decline and remains within the range of 4 to 6 per 1,000 live births.

Male involvement in RCH services has improved testing of HIV and syphilis as well as birth preparedness and compliance to iron supplements such as FEFO which is critical for fetal growth. *On Family Planning, the DHIS data by method (including community-based distribution) show a strong increase in contraceptive use, especially in 2018. The number of women receiving implants increased rapidly (nationally, based on an increase in 81% of district councils), and it became the most important method. IUCD use was the only other method that also increased.*

CEmONC services were commonly found in hospitals (81 percent) than in health centers, with 53 out 59 hospitals in the sample providing the service. A summary CCHP Analysis 2017-2018 report (page 30)

[5] The modest increase in ANC1 and penta1 over time may be due to improved reporting in DHIS2 or overestimation of the target population in 2015-2016. Source: Ties Boerma et al, Analytical Report 2019

shows non-availability of CEmONC services in 79% of Public Health (see illustration in following pie chart – figure 2) and raised an alarm on this.

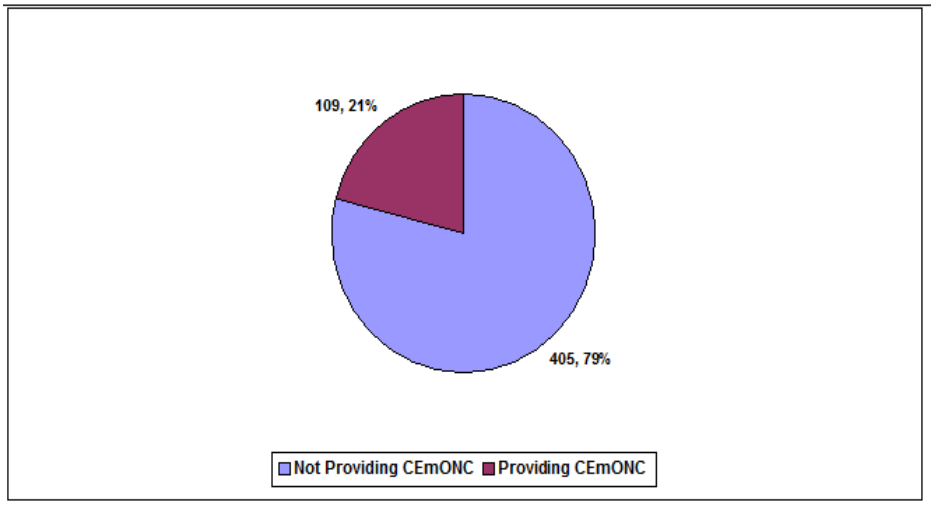


Figure 3 Health centres proving CEmONC services Vs Not providing CEmNOC Services

Major reasons behind this situation are infrastructure shortfalls, lack of anaesthesiologists, and absence of clean and safe water.

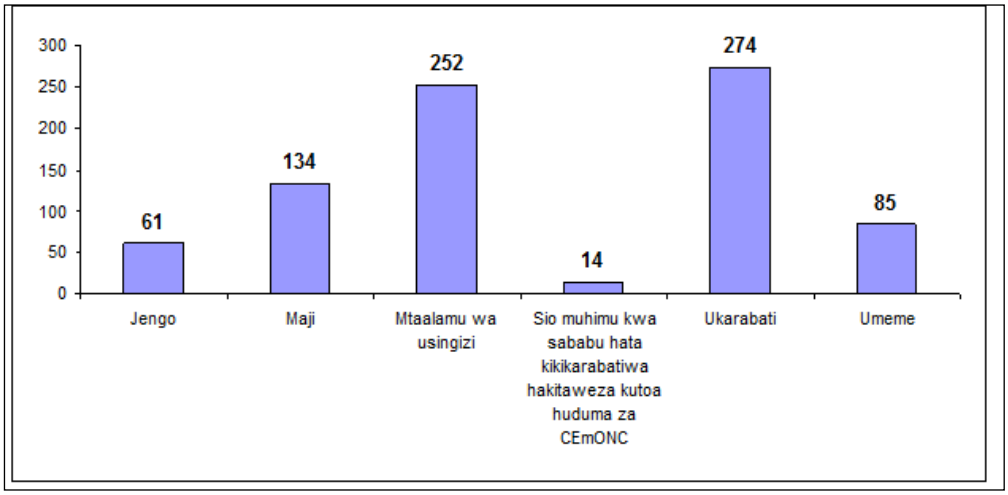


Figure 4 Reasons for Health centers not providing CEmONC Services

More over a 10 years retrospective study conducted in 2016[6] and published this year revealed that hospital-based maternal mortality ratio increased from 40.24 (2006) to 57.94/100000 births in 2015. Of the 1,987 deaths, 83.8% were due to direct causes and 16.2% were due to indirect causes. Major direct causes were eclampsia (34.0%), obstetric haemorrhage (24.6%) and maternal sepsis (16.7%). Anaemia (14.9%) and cardiovascular disorders (14.0%) were the main indirect causes. Causes of maternal deaths were highly related; being attributed to up to three direct causes (0.12%). Cardiovascular disorders and

[6] Veneranda M. Bwana et al 2019. Patterns and causes of hospital maternal mortality in Tanzania: A 10-year retrospective analysis. https://doi.org/10.1371/journal.pone.0214807

anaemia had strong linkage with haemorrhage. While there was a decline in the number of deaths due to eclampsia and abortion, those due to haemorrhage and cardiovascular disorders increased during the period.

However with the ongoing construction and rehabilitation, Health Centres are expected to increase significantly and hence CEmONC practice shall be enhanced subject to signal functions being fully attended. Blood supply safety was available in 72 percent of health facilities providing CEmOC services, whereas less than half (46 percent) of the CEmOC facilities had blood supply sufficiency. Incompleteness in Signal Functions of CEmONC negatively affects CEmONC coverage. BEmONC competency of health staff at first line health facilities is low due to limited practical training sessions. According to the WB Development Indicators for Tanzania the country performs 484 surgical procedures per 100,000 population per year. The Non-Obstetrical Surgical Procedures accounted for 40-60% of all surgical Procedures. Attendance to less complicated surgical procedures for primary level should therefore be considered when the NEHCIP is updated. But making safe blood available along with ensuring all signal functions for CemONC are assured must continue to be the line of focus.

From the SARA conducted in 2017, basic amenities domain was the highest with a mean score of 82 out of 100 while essential medicines scored the lowest with a mean score of 38 out of 100. Overall service availability in terms of health facilities and core health worker's density per 10,000 populations is still below the required standards (Tanzania is among the countries with a critical shortage of health service providers – i.e doctors, nurses and midwives[7]). Only one third (32 percent) of health facilities across the 26 districts had all the basic items required. The general service readiness (GSR) though has improved from 42 percent in 2012 to 57 percent in 2017.

Although availability of tracer medicines is gauged at a national average over 96% across regions[8], essential medicines that were **less** likely to be found in-stock in the (SARA) districts were Fluoxetine tablets (1 percent), Carbamazepine (3 percent), Beclometasone inhaler (3 percent), Haloperidol tablets (3 percent), Enalapril or alternative ACE inhibitor (6 percent). The most common essential medicines found in health facilities across the SARA districts were ORS (90 percent), Amoxicillin tablets (89 percent), Oxytocin injection (83 percent), Ceftriaxone (79 percent) and Magnesium Sulphate injectable (73 percent). Regional visits also found tracer medicines to be available but beyond the tracer items, anti-diabetes and anti-hypertension medicines were consistently lacking in primary health facilities. Therapeutic Committees are in place in hospitals that were visited: However availability of medicines may be due to factors beyond their reach to manage. A more elaborate look based on deeper reflection of SARA 2017 information[9] showed availability of specific items for all programs revealed major deficiencies.

Availability of the four antigens ranged from 85 percent for pneumococcal vaccine to 89 percent for both measles and rotavirus and 90 percent for DPT-HB+HepB vaccine across the SARA districts. Routine immunization in rural health facilities was higher than in urban - 87 percent compared to 78 percent respectively. Immunization coverage trends between 2016 and 2017 show over 95% (annexed Figure 2) , a high level sustained in 2018 (refer DHIS 2, WHO/UNICEF reports and GAVI proposal 2018), thanks to the REC strategy.

The CHMTs play a role of registration of food premises, ADDO stores and monitoring compliance to regulations, as well as implementing fore-casting and quantification of required medicines.

[7] www.who.int/ World Health Report 2006 updates

[8] MoHCDGEC, 2019. Analytical Report to inform the Health Sector Strategic Plan IV (HSSPIV) 2015/16 – 2019/2020 page 83.

[9] MoHCDGEC, 2019. Analytical Report to inform the Health Sector Strategic Plan IV (HSSPIV) 2015/16 – 2019/2020 page 83.

2.3 Strategic Direction 3 Regional referral hospitals

Establishing electronic medical records is a good development in Regional Hospitals that have initiated this activity. This paves the way to introduce e-health into health service delivery. RRHs that have been slow to implement this program have an opportunity to learn from peers who have gone ahead with it, so that they may fast track its establishment. The RRHs are able to conduct planning and decision making using electronically generated data even though at times there are difficulties in ensuring data completeness, correctness and network stability.
Internal procedures to optimize use of SOPs, supportive supervision, and mentoring, have enhanced management practices as evidenced by sound clinical audits, clean records due to adherence to financial management discipline and human resource performance enhancement.
The recent decision of moving the RRH to be directly under the MOHCDGEC instead of PORALG, may have slowed the speed of creating the desired changes because even the PAYMENT VOTE will change and the systems will have to be realigned to MOHCDGEC procedures with due emphasis to enhance capacity for diagnostics, management and rehabilitation needs of referred patients. Short falls in equipment and infrastructure rehabilitation (section 4.1) require phased planning (refer to Dodoma RRH, Mwananyamala RRH examples) and resourcing to meet maintenance and planned preventive maintenance, an area often overlooked or accorded low priority at planning stages.
Management of referred cases has been proceeding smoothly but sometimes performance is negatively affected by late referral or mismanagement that took place at primary care level.

Muhimbili National Hospital and Mloganzila Hospital, the Zonal Referral Hospitals and the Specialized Hospitals (MOI, JKCI, ORCI, Kibong'oto) and also the Benjamin Mkapa Hospital in Dodoma have been handling referral patients according to the range of available expertise. The quality of services focused in these high level institutions need to be reviewed and/or studied in depth, considering the complexity of their internal processes and operational realities. But to enable the lower levels to utilize the referral services both efficiently and effectively the secondary and tertiary institutions have to put into effect training that assures competency of their graduates, and hence they need to be self-sufficient in availability of the relevant specialities. The RRHs play a role in offering practical training for some primary health cadres (Clinical Officers, Nurses) who have to have vital competencies in running RMNCAH services. For this reason a full complement of RMNCAH services has to **be re-established** at the RRHs.

2.4 Strategic Direction Health Promotion

The Health Promotion Section developed a Health Promotion Policy Guideline and Strategy and other guidelines on specific areas for Health promotion such as CBHP guide and implementation design in 2017 (further elaborated below).

Through this section the Ministry ensured better coordination of advocacy, social and behavioural change communication across different initiatives, programmes and interventions by dedicating a Technical Working Group and inviting collaboration of programs having SBCC type interventions. Standard Operating Procedures for SBCC, a policy guide and strategy for SBCC were also developed. A Community Based Health Promotion Risk communication Strategy, rumour tracking tool and community messages mapping tool were also developed. Currently SBCC expertise is attained through collaborating with Implementing Partners' support. Through intense collaboration with the District Health Services TWG the SBCC intent shall attain closer monitoring of its operational aspects within the CCHP process

for countrywide coverage. Within the CCHP guideline Health Promotion is outlined in pages 33, 41 and 85 (2011 version of CCHP guide).

A health communication resources centre is in place with an Audio-visual studio, printing unit, Social media accounts, and a Health Promotion Digital Platform engaging social and mass media to reach the public with educative and correctional messages more efficiently (e.g the CHWs SoS Whatsapp) and with effective interaction in the population. A well managed and well structured SBCC approach should be applied to counter the negative misconceptions and traditional beliefs and practices such as narrated in text box hereunder:

Belief that complications in pregnancy and child birth are associated with witchcraft (Tanga)

Early booking affected by aversion to being known to be pregnant early during pregnancy – afraid that the pregnancy will be be-witched.

Misconceptions about Family Planning (in Lindi): Male dominance, perceived negative side effects of some FP methods; Male permission needed to engage in FP (at most FGDs)

Past negative delivery experiences hindering PNC attendance,

During the period the Health Sector embarked on formulating a comprehensive approach to Community Based Health guided by three main documents that conferred a programmatic approach: First is the National Community Based Health Care Program (CBHP) Policy Guidelines developed in 2014 provided context for the program, outlined its vision and components, and delineated a framework through which the program should be organized and implemented. The other key program document is the National Costed CBHP Strategic Plan (2015-2020) which built upon the Policy Guidelines to further define program priorities and objectives, including specific strategies for management and coordination; formalizing CHWs; strengthening institutional capacity, resource mobilization and management, and advocacy; and promoting gender equity, human rights, and sustainability.
Finally, the National Community Based Health Programme - Implementation Design which covers scope, coordination, governance, implementation, rollout, and monitoring and evaluation: This was finalized in 2017. Effective community engagement was a key running methodical theme and approach to advance health promotion interventions through the formulated policy guide, the strategy and the implementation design. Close consultations with PO-RALG have been ongoing regarding implementation and resource implications of formalized CHWs. MOHCDGEC leadership collaboration with PO-PSM, NACTE, Development Partners and NGOs on this community engagement initiative has been exemplary in terms of consultations in favor of integration and critical considerations on sustainability. A number of DPs and NGOs have moved into supporting training and performance of CHWs in the country (Ireland Aid, UNICEF, THET, AMREF, BMAF, Solida-Med, D-Tree etc). Wage bill implications of this program have been the center of attention and debate on options for moving forward. At the time of this review the government is advancing going forward with shorter duration (three months) trained volunteers, three per hamlet selected by own community but has not closed the door for debating how to sustain the longer duration formalized CHWs.

Through effective use of the School Health Program the opportunity of reaching adolescents and youths in school to address sensitive issues in this target group such as SRH related, gender in health, GBV etc, is calling for more vigorous activism. Practical examples uncovered during the field visits include health facility dedication of Saturdays for Adolescent SRH including family planning (refer 3.9 below Chemba district visit community work). So far SH Program efforts are focused on strengthening coordination multilevel in three engaged sectors, i.e PO-RALG (LGAs), Ministry of Education and Vocational Training, and Ministry of Health Community Development Gender Elderly and Children. A national School Health Policy guideline and strategy are reported to have been completed in 2018. Interventions include HP Vaccination for Cervical Cancer prevention, health screening, sanitary pads hygienic use education on use and disposal, advocating Health Promoting Schools through (a) health clubs (b) sports with education (c) health rooms renovation, integrated training guide (content School nutrition, value and life skills, WASH, child protection rights and gender issues, school adolescent health, psychosocial counseling). Currently a School Health Training manual is being written to teach students on CD, NCDs, Life skills and Reproductive Health.

2.5 Strategic Direction Nutrition

Malnutrition is a significant problem in this country given the fact that 34 percent or 3.3million children under 5years suffer from chronic malnutrition(stunting or low height-for-age), while 5 percent suffer from acute malnutrition (wasting) and 58 percent or 5.6million suffer from anemia (2015–16 DHS-MIS). At the other extreme, 4 percent of children under five are overweight. Obesity is significantly higher among women (15% compared to 2.5%) and overweight prevalence standing at 37% in women compared to 15% in men[10]. In women of reproductive age 28% were found to be overweight/ obese by 2015.
The MOHCDGEC through the TFNC and Nutrition Stakeholders managed to attain the revision of the Food and Nutrition Policy of 1992, developed its implementation strategy (2015/2016 – 2025/26). From the strategy and outcomes of the National Nutrition Survey 2014 a National Multisectoral Nutrition Action Plan-NMNAP (2015 – 2020)[11] was developed involving high level sector managers drawing on the leadership of the Prime Minister. The NMNAP was rolled out for implementation countrywide and across key sectors.

Graphical illustration of LGA spending on Nutrition:

[10] National STEPS survey 2012.
[11] National Multisectoral Nutrition Action Plan (NMNAP 2015-2020)

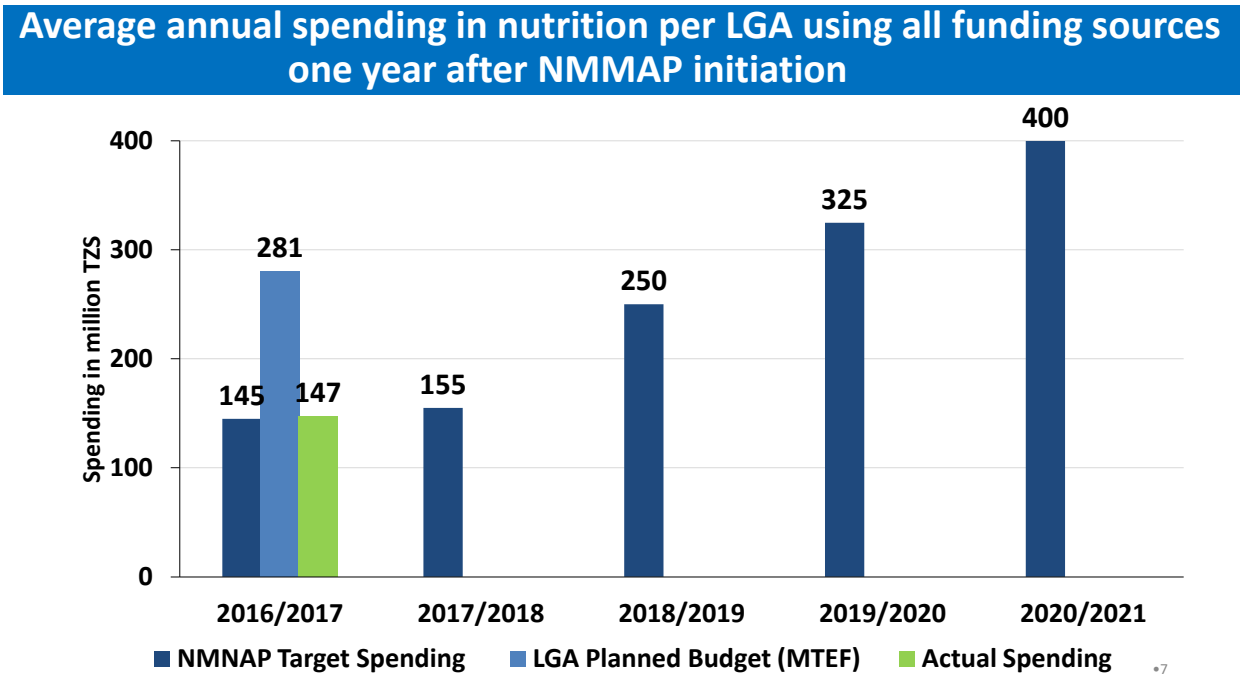


Figure 5 Annual spending on nutrition projects

The NMNAP target average spending per LGA for 2016/17 using all types of funding sources had been exceeded. However only 52% of LGA 2016/17 MTEF planned budget was spent. LGA spending is mainly directed to MIYCAN, Micronutrients and Governance activities. IMAM activities are poorly funded. Nutrition Information System is mainly funded through TFNC. Taking the planned activities into operation seems to be at initial stages at Regional and District levels. Nutrition sensitive interventions in Health Sector are poorly reported in routine data system.

Growth monitoring and mothers counseling on key nutrition interventions including provision of supplements (Vit A, iron, folate, zinc), exclusive breastfeeding, supplementary feeding, screening of diseases and early treatment of illness, constitute routine measures at RMNCAH clinics; but the malnutrition figures (especially the chronic form) suggest limited effectiveness of the nutrition advice given to mothers.

Field visits revealed the NMNAP was being addressed in terms of putting in place Regional Action Plans consequently followed by District plans, all of which are multisectoral, but a critical gap is noticeable at Ward level. It was encouraging to observe in a district that stunting intervention campaign in villages in collaboration with CONSENUT was going on with male involvement to balance labor distribution per day, a measure which was bound to free mother's time for child feeding; first 1000 days focus includes engagement of men.

The SBCC strategy[12] embraces a top-down mode of intervention design and implementation; notably absent is the use of Participatory Learning and Action approach to attain local ownership of the nutrition agenda and hence be more focused on local problem-solving.

[12] URT 2013. National Nutrition Social Behavior Change and Communication Strategy July 2013-June 2018.

2.6 Communicable, Non Communicable diseases and Neglected Tropical Diseases

A few initial observations from the Analytical Report 2015-2018[13]:

- Upper respiratory tract infections (URI), acute diarrhoea and pneumonia (non-severe) ranked as top 3 of the leading causes of under-five OPD attendance in 2014
- URI, UTI and pneumonia were the leading causes of OPD in 2018.
- Among the 5 and older individuals, the three leading causes of OPD attendance were URI, UTI and hypertension.
- The number of hypertension cases in >5 individuals increased by 152% from 2014 to 2018.
- The leading cause of deaths are certain infectious and parasitic diseases. However, the contribution of this group to total death has declined from 61.5% in 2014 to 41.3% in 2018.

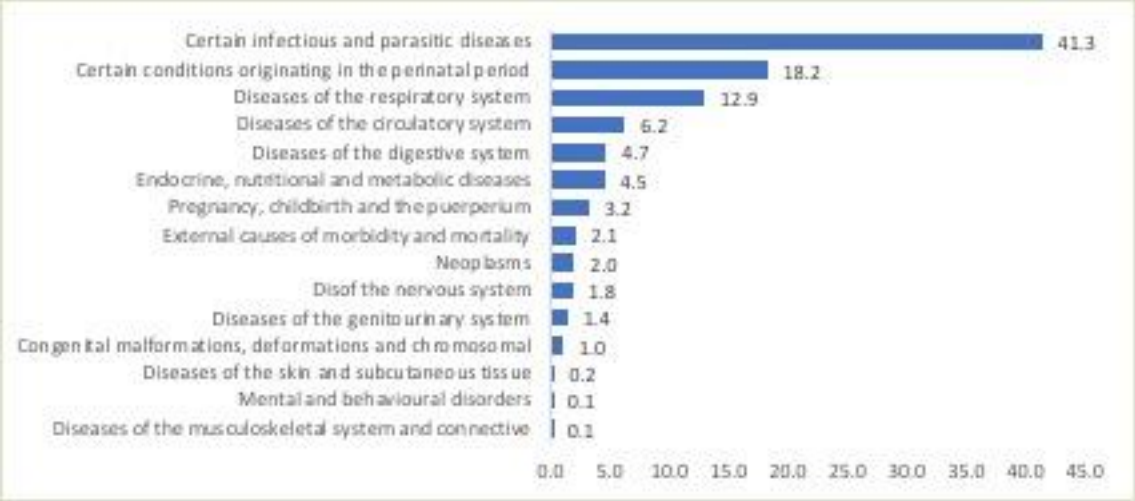


Figure 6 Distribution by percentage of main causes of death, 2018 (source: DHIS2)

2.6.1 Communicable Diseases

There is substantial progress in dealing with HIV/AIDS and TB. Electronic information is obtained and kept. The TWO programmes are well integrated and services are offered under the same roof. These programmes have well built M&E systems with varying percentages of new detected (for TB &HIV) and cure rates (for TB). However TB notification in some areas is as low as 53%.

- TB case detection rates are well below target (50%). TB notification rates declined until 2015, but increased since from 128 to 140. This is not necessarily due to an increase in TB cases but could be due to better case detection.
- TB treatment success rates are as high as 90% and the target has been achieved.

Regional field reports have shown that there are appearances of MDR that have been successfully handled by the Kibongoto TB Centre of Excellence.

[13] MOHCDGEC 2019. Analytical Report to inform the Health Sector Strategic Plan IV (HSSPIV) 2015/16 – 2019/2020 page 17.

The Compulsory TB vaccination move in the underfives which has been well sustained has given positive impact in the control of the disease.
The DOT treatment programme and outreach services assist follow up of defaulters using Community Health Workers.
HIV/AIDS problem on the other hand is still a big challenge. The National prevalence rate at 2016/17 was 4.7% compared to the 2012 levels of 5.1%[14]. From the Analytical Report[15]

- HIV prevalence is gradually declining among young people, indicating reduced HIV incidence, but young women 15-24 still have a considerably higher prevalence than young men (2.2% and 0.7% respectively).
- PMTCT interventions are almost universally accessible, utilization rates are high and PMTCT coverage rates were over 90% during HSSP IV, reaching the target, resulting in a decline in HIV positive infants.
- There has been an increase in access (facilities providing ART services), utilization (increase of number of clients accessing HIV care) and coverage of ART for people living with HIV. ART coverage increased in all regions, with nearly half of all persons living with HIV on ART early 2015, even though late initiation of ART and loss to follow up are still major challenges.
- Several indicators show increasing program outputs, such as proportion of persons who know their HIV status, male circumcision rates.

HSSP IV TARGETS & INDICATORS

Indicator	Baseline (Year)	Target 2020	Achievement	Comments
HIV prevalence among 15-24 years	15-19: 1.0% 20-24: 3.2% (THMIS 2012)	0.8% and 2.4% by 2017 (NACP)	0.7% and 2.2% (THIS 2016/17)	Targets achieved
HIV positive women receiving ART for PMTCT	65% (NACP, 2012)	90% by 2017 (NACP)	99% (2018)	Target achieved
ART Coverage among eligible persons living with HIV infection (under 5, 5+, by sex)	*65% (adults)* *25% (children)*	*95% (adults)* *80% (children)*	75% (all ages) (NACP, 2018) 47% (children (2018)	Eligibility criteria changed during HSSP IV, now based on all people living with HIV

The Continuum of care and the innovations made of self testing countercheck, coupled by the intensified efforts in provision of ART, Behaviour Change Communication and Health Education assist in the various interventions of the HIV /AIDS problem. Number of males circumcised almost doubled during 2015-2018 from 484,174 in 2015 to 885,657 in 2018.
There was more attention for key vulnerable populations, with more than 2,291,061 clients were cumulatively enrolled in KVP services by December 2018. Other interventions, PITC, VVT, PMTCT, Blood safety together with modern diagnostic techniques practiced in the HFs and the communities, are important contributory measures in controlling the disease where steady progress is noted. However,

[14] Tanzania HIV and Malaria Indicator Surveys (THMIS) 2016/17 and 2011/12
[15] Ties Boerma, 2019. Analytical Report on HSSP IV indicators from various data sources (work in progress).

stigma and discrimination are still a major concern to HIV/AIDS interventions as well as MDR TB. The Tanzania HIV Impact Survey (THIS)[16], revealed new information as follows:

- HIV prevalence and incidence estimates indicate a stabilizing HIV epidemic in Tanzania.
- Tanzania has made considerable progress towards the 90-90-90 goals, particularly in linkage to and retention in HIV treatment as demonstrated by the 2nd and 3rd 90 targets (91 and 88 percent, respectively). **The 90 percent of all PLHIV knowing their HIV status is still low (52.2%).**
- The goal of ending the AIDS epidemic in Tanzania by 2030 is attainable through improvement in targeted HIV testing, in men and women.
- Annual incidence of HIV among adults aged 15 to 64 years in Tanzania is 0.29 percent (0.40 percent among females and 0.17 percent among males). This corresponds to approximately 81,000 new cases of HIV annually among adults aged 15 to 64 years in Tanzania.
- Prevalence of HIV among adults aged 15 to 64 years in Tanzania is 5.0 percent (6.5 percent among females and 3.5 percent among males). This corresponds to approximately 1.4 million people living with HIV (PLHIV) ages 15 to 64 years in Tanzania.
- Prevalence of viral load suppression (VLS) among HIV-positive adults aged 15 to 64 years in Tanzania is 52.0 percent (57.5 percent among females and 41.2 percent among males).
- The disparity in HIV prevalence between males and females is most pronounced among younger adults, with women in age groups 15 to 19, 20 to 24, 25 to29, 30 to 34 and 35 to 39 all having prevalence more than double that of males in the same age groups

In general more focus and engagement of young girls and vulnerability among females is an urgent call given the current state of HIV vis a vis the goal to end it. But the system has to be vigilant in monitoring resistance to ARVs given abuses that may occur as the drugs are reportedly used by Hepatitis sufferers.

Malaria situation: Survey and facility data indicate a significant decline in malaria incidence, prevalence and mortality, which appears to have started well before HSSP IV. The main target of parasite prevalence among children 6-59 months below 1% is still far off (7.3% in 2017).
Malaria diagnostic practices in health facilities improved greatly and 99% of reported cases are now lab-confirmed.
The coverage of the key preventive interventions of ITN use IPT2 were still far from the targets. The percent of under0fives and pregnant mothers sleeping under treated mosquito nets even dropped to just over 50% by 2017, while IPT2 increased to just 50%, and both are still well-off the 80% targets.

HSSP IV TARGETS & INDICATORS

Indicator	Baseline (Year)	Target 2020	Achievement	Comments
Prevalence of malaria parasitemia (6-59 months)	18% (2008 THMIS) 9% (2012 THMIS)	<1% (NMCP)	15% (TDHS 2015/16) 7.3% (TMIS 2017)	Modest decline to 7.3% in 2017
Percent of all malaria cases that are lab confirmed	64% (2014 HMIS)	95% (NMCP)	99% (DHIS 2018)	Target achieved
Children with febrile illness who received a diagnostic test for malaria	25% (THMIS, 2012)	80%	43.4% (TMIS 2017)	Progress, but still far from 2020 target

[16] URT 2017. Tanzania HIV impact survey 2016-2017.

Mothers who received 2 doses of IPT for malaria during last pregnancy (%)	33% for 2 doses (THMIS 2012) 34% (HMIS 2014)	80%	55.1% (TMIS 2017)	Increase during 2012-2017 but still well-off target
Vulnerable groups (pregnant women 15-49 years of age, children under 5) sleeping under an ITN the previous night (%)	72% children 75% pregnant women (THMIS 2012)	80% for both populations	50.8% (children) 51.1% (PW) (TMIS 2017)	Decline since peak in 2011/12, and far from target

Data sources: Data for the malaria indicators were obtained from national surveys in 2012, 2015/16 and 2017. All surveys include collection of serum for malaria parasite testing. DHIS data were used to assess the diagnostic practices in OPD.

The recurrence of Cholera outbreaks attests to a need for intensified efforts to improve personal hygiene, water and food hygiene as well as sanitary disposal of excreta. Case fatality rate has been above the target of 'below one' indicating weakness in case management.

2.6.2 Non-Communicable Diseases

According to WHO[17] The global prevalence of diabetes* among adults over 18 years of age has risen from 4.7% in 1980 to 8.5% in 2014 (1). Diabetes prevalence has been rising more rapidly in middle- and low-income countries. Diabetes is a major cause of blindness, kidney failure, heart attacks, stroke and lower limb amputation. In 2016, an estimated 1.6 million deaths were directly caused by diabetes. Another 2.2 million deaths were attributable to high blood glucose in 2012**. Almost half of all deaths attributable to high blood glucose occur before the age of 70 years. WHO estimates that diabetes was the seventh leading cause of death in 2016.

NCDs constitute an increasing number of OPD and IPD attendances in the country. Main findings from the Analytical Study show:

- There is a dramatic increase in obesity (and overweight) in Tanzania, as shown by data from women 15-49 years where obesity prevalence increased from 6% to 10% in just 5 years.
- Obesity and overweight are increasing everywhere in mainland Tanzania, but by 2015/16 obesity was three times higher among urban women than rural women (18% and 6% respectively), and 10 times higher among the wealthiest women compared to the poorest quintile women (21% and 2% respectively).
- There are no new data to assess trends in hypertension or raised blood glucose but the 2012 STEPS did establish that both risk factors are common among men and women 25-64 years.

[17] https://www.who.int/news-room/fact-sheets/detail/diabetes

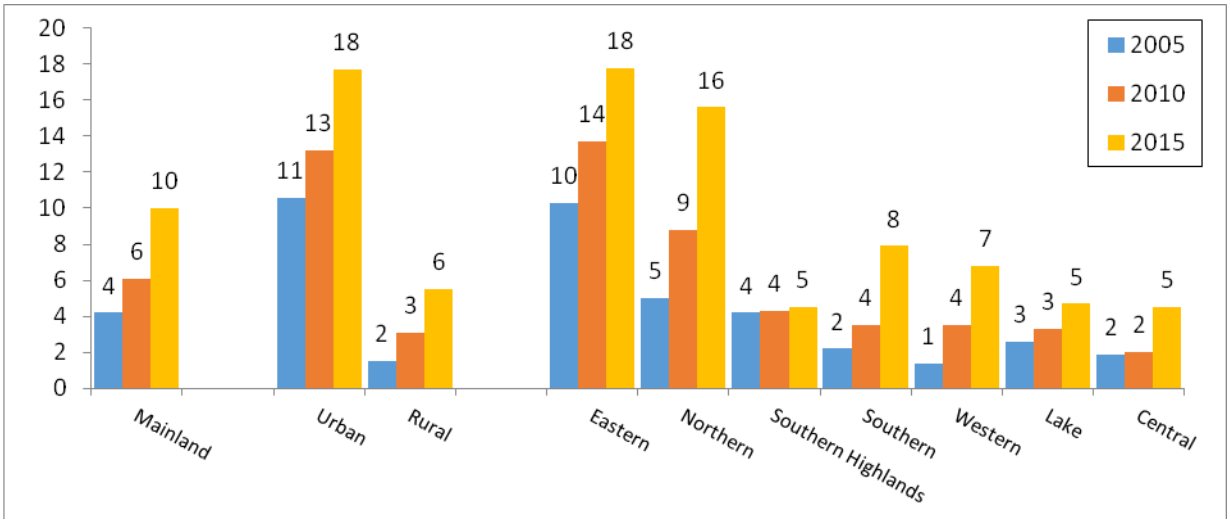


Figure 7 Obesit among women 15 -49 yrs by residence TDHS 2004/05, 2010, 2015/16

Overweight and Obesity are major risk factors for a number of Chronic Diseases including Diabetes Cardiovascular disease and Cancers—Source STEPS Survey 2012 (women and men25-64years and DHS Surveys ,since 2000 (included body mass index for women 15- years used to assess the trend. Hypertension is an important risk factor in CVA.

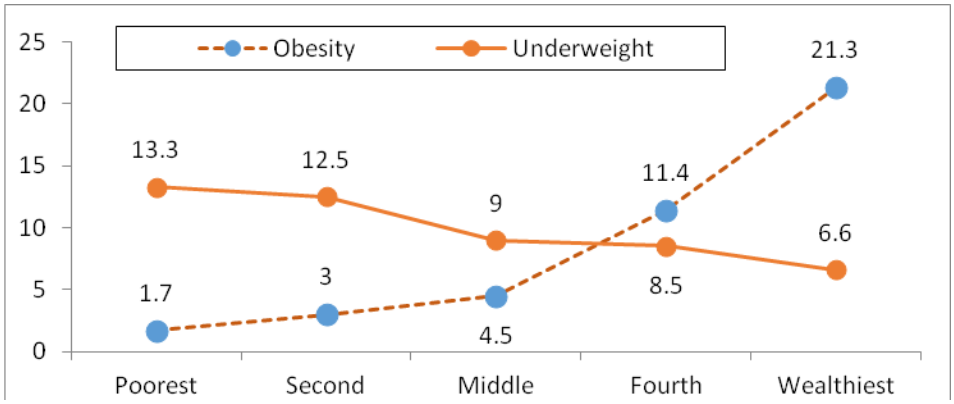


Figure 8 Underweight and obesity by wealth quintile: women 15-49 yrs (%), TDHS 2015/2016

The percent of women who were underweight (BMI below 18.5) shows 13.3% of women who were underweight in the poorest quintile and 6.6% of women underweight in the richest quintile.
Cancer: Reports of the Regional field visits have shown that Cancer screening is conducted in many Health Facilities and referral is given for further investigations at tertiary level Institutions that can handle these problems. However, many of them report for care when the diseases are at advanced stages.
The NCDs strategic plan is available with the aim of deploying preventive measures like change of lifestyle. Nutrition, regular physical exercise as initiated by Her Excellency the Vice President of Tanzania. A booklet for general public education on NCDs has been produced by the Tanzania Non-Communicable Disease Alliance (TANCDA) and currently been utilized as resource material as well as distributed at events that address NCDs.

The increase of budget of Pharmaceuticals and Supplies to the Health Facilities will make some changes to the availability of NCD medications (particularly Diabetes Mellitus and Hypertension) considering the need for these services to be available even below the Hospital level.

2.6.3 Neglected Tropical Diseases

These are a group of infectious viral, bacterial and parasitic diseases which are highly endemic in tropical and subtropical regions disproportionately affecting developing Countries. HSSP IV maps the agenda for NTDs in section 5.4.4.4 (page 47).
In Tanzania the prevalence is not exactly known but there are about 5000 people who require at least some Antibiotic Therapy and treatment for Trachoma. There are also more than 6000 people who also require some kind of preventive measures and about 4000 people who require treatment for Onchocerciasis. Lymphatic filariasis is becoming a pronounced problem not only across the Coastal belt as it was formerly claimed, but also seen in quite a number of places in Tanzania. Trachoma is predominant in Dodoma: Along with Schistosomiasis which is more common in poor sanitation areas with water infested by snails that facilitate the transmission cycle of the disease, the fecal oral transmitted Helminths also constitute widespread prevalence in many parts of the country. The public is regularly educated on the causative factors and preventive measures including giving Mass Drug Administration (MDA) to primary school children and the community at large (village, ward) at least yearly through the agency of Facility Health workers and Community Drug Distributers (Community Health Workers). Collaboration with Ministry of Education is keeping the program reach quite effective. The MDA activity is usually accompanied by Vitamin A supplementation. All these efforts have resulted into a decline in the prevalence of Trachoma from 2014 to 2018, with the number of endemic trachoma districts reduced from sixty to eight[18]. Moreover, in the same study there is also an indication of a decline in MDA coverage from 2013 to 2016 with a significantly improved overall coverage to above 80%.
The same report gives

- The number of lymphatic filariasis endemic districts has declined from 119 districts in 2013 to 24 districts in 2018. Since 2013 lymphatic filariasis coverage has been above the threshold (range was 70% to 84%).
- Onchocerciasis MDA coverage has improved over the years to 100% in 2018.
- Schistosomiasis MDA using Praziquantel applied in all 185 councils steadily increased from 2013 to 2018.
- Soil transmitted helminths MDA coverage using Albendazole during 2014-2018 was higher than 74%.

However, more research is mandatory in order to obtain the magnitude of the problem, the patho-physiology and immunogenicity of these diseases that are a public health concern.

2.7 Intersectoral collaboration

Functional thematic work is on course with the following progress

HIV committees (National, District)
are in place and functional– focusing on reaching 90, 90, 90 targets and clamping down on transmission with special attention to high risk groups. The challenge of increasing new infections and rising prevalence was at hand due to entrenched stigma, denial and discrimination of PLHIV, limitations in the

[18] Ties Boerma et al 2019. Analytical Report of progress on HSSP IV indicators based on various data sources.

span and reach of education and advocacy activities where cultural norms, traditions and some spiritual orientations contradicted interventions targeted at promoting safe sex practices. Reaching vulnerable population groups (adolescents and youth) and persons at greater risk of getting infected or transmitting the virus (key populations, truck drivers, injecting drug users) prevailed as a challenge for a considerable period before effective reach could be designed and get implemented more rigorously. The Tanzania HIV Impact Survey (THIS)19, a household-based national survey, was conducted between October 2016 and August 2017 to measure the status of Tanzania's national HIV response. THIS offered HIV counseling and testing with return of results, and collected information about household and individual characteristics, and uptake of HIV care and treatment services. THIS survey was the first in Tanzania to measure national HIV incidence and viral load suppression.

Nutrition

Nutrition committees (National, District, Ward) – Stunting (chronic malnutrition) is attributed to a combination of factors, including maternal malnutrition, inadequate infant feeding practices, low quality of health care, and poor hygiene. Poverty, malnutrition, diseases and inequality are intricately linked, and if not addressed are often transferred from one generation to the next[20]. Thus effectively addressing the challenge of malnutrition may help interrupt the vicious cycle of malnutrition-disease-poverty-inequality now and future generations if a multisectoral approach is applied effectively. At Ward level however, nutrition interventions are still viewed as belonging to health (CHWS driven) and there is less assimilation as multisectoral. This should not be surprising as stunting awareness has been observed to be less at sub-districts (Wards and Villages) compared to higher levels. Nutrition strategy MTR observed at ward level, involvement of health sector is insufficient. Health facilities have curative approach: detection of malnutrition, but do not actively work on prevention (apart from some health talks). Insufficient intersectoral collaboration at grass root level is what is manifest. Refer to section 3.5 above for more details.

Health Security and International Health Regulations

Health Security and International Health Regulations (National) - Tanzania, was the first country globally to volunteer to do a Joint External Evaluation (JEE) and the first to use the recommendations for priority actions from the JEE to develop a National Action Plan for Health Security (NAPHS) that was launched at a Parliamentary session in September 2018. Tanzania developed the NAPHS through a nationwide consultative and participatory process. The Government of Tanzania through the Office of the Prime Minister (PMO), the MoH-CDGEC, the Ministry of Agriculture, Livestock and Fisheries, the Vice President's Office—Environment, the Ministry of Defense National Service and the Ministry of Home Affairs coordinated the planning with technical guidance from WHO; this way priorities to be included in a 5 year NAPHS were identified.

Environmental health and WASH

Environmental health - Through the Tanzania Urban Resilience Program (TURP) launched in 2017 there is now support to national and local governments in strengthening management of urban climate risk, which has commenced with work around urban flood basins. The Msimbazi flood plain in Dar-es-Salaam is a concrete example with a well-documented process and inclusive approaches.
Still in environmental health the focus of Disease Control and Prevention (Cholera), Water supply and sanitation, Hygiene promotion has continued in LGAs with best practices in Moshi Municipality. The

[19] URT 2017. Tanzania HIV impact survey 2016-2017.
[20] URT, PMO 2016. National Multisectoral Nutrition Action Plan (NMNAP) page 11.

draft National Environmental Health, Hygiene and Sanitation Strategy (NEHHSAS) 2007-2016 does not appear to have been updated since it expired. Its main components included:

- Disease Control and Prevention
- Water supply and sanitation
- Hygiene promotion.

As far as Cholera is concerned a classical issue is at hand for multisectoral collaboration to have in place effective control and prevention of future occurrences. Examining the Prevention and Control of Cholera Guidelines (2011) multisectoral committees are clearly recommended to be established multilevel. Glaringly missing in the guidance is representation of media, an important link for public education en mass. On sanitation the Open Defecation Free (ODF) environment was advocated throughout the country with impressive results in some regions.

In areas covered during field visits, integrated WASH plans inclusive of all districts developed and implemented models for community-operated and maintained rural water supply (tested and scaled-up). MDAs, LGAs and CSOs were trained in policy analysis and strategic planning, monitoring and local accountability, school heads trained in education leadership, management and administration, whole school development approach, and gender and disability issues. Health facilities (private) had own multi sectoral plans typically involving education, water, agriculture, Lands and Local Government.

National Health Adaptation to Climate Change

The Tanzania Health National Adaptation Plan (HNAP) a comprehensive document to guide the country towards a health system that is more resilient to climate change and a sustainable and healthy future for the Tanzanian people has been developed based on a Vulnerability and Adaptation assessment conducted in 2015-16. The MOHCDGEC has been advocating for policies protecting and advancing health and social welfare, e.g.in reduction of point-source environmental pollution, building resilient interventions for the reduction of harmful effects of climate change, improve road safety, protection from the double burden of non-communicable diseases and communicable diseases through promotion of healthier lifestyles, safety of consumer goods and food products.

Tanzania is already experiencing the effects of climate change on health and these effects are likely to become more pronounced in the future. The Tanzania Vulnerability and Adaptation (V&A) assessment, conducted in 2015-2016, highlighted four key health adaptation priorities for the country:

- Vector-borne diseases: malaria, dengue, plague, rift valley fever, lymphatic filariasis, human Africa trypanosomiasis, onchocerciasis
- Nutrition: stunting, wasting
- Water-related diseases: diarrhoea, dysentery, cholera, schistosomiasis, typhoid and trachoma
- Disasters: floods and droughts frequency

A multisectoral team comprising of Vice President's Office–Division of Environment, President's Office–Regional Administration and Local Government, Ministry of Finance and Economic Affairs, Ministry of Water and Irrigation, Tanzania Meteorological Agency, Muhimbili University of Health and Allied Sciences, University of Dar es Salaam, Sokoine University of Agriculture, Regional Secretariats and Local Government Authorities contributed to development of this Health- National Adaptation Plan (HNAP)[21]. The Tanzania HNAP is a comprehensive document to guide the country towards a health system that is more resilient to climate change and a sustainable and healthy future for the Tanzanian people. It should constitute a key guiding reference to formulation of a successor HSSP. Creating linkages with the already multisectoral One Health approach which has been ongoing, shall benefit particularly in

[21] MOHCDGEC, 2018. Health-National Adaptation Plan to Climate Change in Tanzania 2018-2023

addressing anti-microbial resistance emerging among the anthropozoonotic diseases and abusive tendencies dispensing medicines without prescriptions at local pharmacies.

2.8 Emergency preparedness, epidemics, Accidents and Injuries

In most high-income countries disaster preparedness and response are well prepared pre-disaster, with a clear action plan established by a team representing multiple sectors[22]. In Tanzania an assessment of preparedness of Regional Hospitals[23] found 80% of the Hospitals without a plan. 92% of hospitals reported experiencing a disaster in the past 5 years; with the top three being large motor vehicle accidents 22 (87%), floods 7 (26%) and infectious disease outbreaks 6 (22%) such as Cholera, Plague, Rift Valley Fever etc. Multisectoral collaboration and action is vital in the top three causes of disasters. One is compelled to inquire if the same situation prevails in District Hospitals. Poor surge capacity as a marker of ability to deliver emergency care in a disaster situation is not available and this leads to frustration and fatigue resulting into bad outcomes.
However, according to this MTR field visit reports, protocols and guidelines are available in 50% of hospitals and only about 1/3 of dispensaries are reported to have some adequate materials and supplies to deal with Emergencies. Hospitals lack Emergency Medical Departments that are well equipped (even with basic ones), to sufficiently handle emergencies. There are no trained Emergency Medical Physicians and no fire alarms. In the National and Zonal Referral hospitals there are some efforts of establishing such departments. During the field visits many hospitals (60%) reported to have some means of communication (cellular phones) and transport –ambulances or any vehicle that can serve for transportation purposes. Since no one can predict an Emergency, we should always have a preparedness plan that can allow fast and appropriate interventions.

Emergency preparedness guidelines and initiative has recently been launched by the Government with World Bank support. The initiative has involved a number of key sectors (Home Affairs, PORALG, Health, Tourism sector, Red Cross/ Red Crescent, Communications and Transport and other key sectors). Within this collaborative framework Road Traffic Accidents shall be handled more efficiently. A pre hospital component, capacity building, community providers (1st Aiders), emergency ambulances at accident prone areas/locations, rescue vans, orientation of surrounding communities, VHF radios linked vehicles and health facilities are reported to be on board to get the kick off on track. Health facilities in accident prone areas will have restructuring for organized Emergency Medicine Departments (EMDs). Marine and air components shall be forthcoming given a positive go ahead from the government.
At role out the following are lined up for action: Paramedics cadre curriculum ready and hence training can commence, as well as plans for EMDs infrastructure to be implemented at respective targeted health facilities.

2.9 Social Welfare

A Social Welfare strategy 2011-2016 saw organization of its financing under vote 53 of the government budget: It witnessed intensified efforts to achieve a substantial number of planned activities despite getting (spending) about 55% of approved budget for the year. The focus continued to be orphans,

[22] Centers for Disease Control and Prevention. Predicting Casualty Severity and Hospital Capacity. USA: Centers for Disease Control and Prevention; 2003.
[23] Koka et al. BMC Health Services Research (2018) 18:835https://doi.org/10.1186/s12913-018-3609-5. Disaster preparedness and response capacity of regional hospitals in Tanzania: a descriptive cross-sectional study.

vulnerable children, elderly and persons with disability with gender sensitivity following a community participatory approach.
For the FY 2015/16, the Ministry implemented a number of key priority areas including: Women Empowerment as per "Agenda 2063-the Africa we want"; fight against gender based violence as well as preventing child violence and abuse; operationalizing monitoring and evaluation framework; conducting survey and acquiring land title deeds for FDCs and CDTIs; construction and rehabilitation of buildings and infrastructures in FDCs and CDTIs; and debts payments for the staff, contractors and suppliers.
On aggregate the community health work led under Social Welfare, as narrated by CHMT members utilizes the agency of CHWs (reaching every child with immunization services, gender address in measures against stunting, 'special day' for FP to adolescents, "MTAKUWA" Committees to track uncover and act against GBV, VAC, Child trafficking, "Komandoos" to keep vigil on at risk pregnancies and avert maternal deaths etc) and it is genuine testimony that there is a focussed community involvement in some districts that is making significant extension of service delivery to communities and their households leading to a valuable contribution to health gains. Social Welfare Officers, where available at lower levels, have been active in tackling GBV, VAC, Orphans and disability issues.
Capacity issues: While popularity of the courses offered at CDTIs and FDCs was wavering judging from peaks and falls of student enrolment it is encouraging that Local Government Councils continued to employ Community Development Officers in order to facilitate implementation of Community Development Programs and Projects: Up to March, 2016 a total of 2,832 Community Development Officers were employed by Regional Secretariats, Municipal and District Councils. At ward level a total of 1,332 Community Development Officers were employed against the requirement of 3,957resulting to a gap of 2,625 of Community Development Officers equivalent to 66.3 per cent of the requirement. This indicates the challenge at hand was still enormous in 2016 but not insurmountable if steady progress was maintained thereafter. Performance accountability for these employees should be used as a tool to argue for continuation of measures to address the existing gaps.
Comparatively, Vocational Training however seemed to be doing better gauging from their increase in enrolment (increased from13,974 in 2014/15 to 19,144 in 2015/16).
The Department of Social Welfare in collaboration with relevant MDAs, UN Agencies, Development Partners and Stakeholders developed a National Costed Plan of Action (NPA II) for Most Vulnerable Children (MVC) 2013-2017, aimed at enhancing their well-being through preventing and /or reducing the incidences of risks and impacts of shocks and protect their rights.
Going forward it is reasonable to monitor how much progress in made on empowerment of the marginalized and disadvantaged population including a look at how many are accessing bank loans (Tanzanian Women's Bank) and the growing number of credit centres to show rate of growth in entrepreneurship: Document good practices such as Matamba village in Makete Njombe which has organized income generating activities (Vegetable garden, managing hostels) and (through FEMA) runs an Orphanage and day care centre for children, all as measures to reduce poverty. In other words the Social Welfare operational agenda is basically hinged on working practically across sectors particularly at Wards and Village/Hamlets level.

JUVENILE JUSTICE

The main targets were to Scale up Community –Based Prevention and Reintegration programmes in order to prevent Juvenile offences and Promote alternative measures to justice proceedings against children in Conflict with Law and Risk of offending

MOHCDGEC, to provide services to children detained in various retention homes and in addition the Government will remove Retention Homes and Approved Schools to ensure more resources and **training** materials are in place.
In addition to this, the target:

- Remove or Lessen the Conflict in Law
- Establish more juvenile Courts
- The best of the child to be protected

Best Practice

The Community Rehabilitation Programme at Kigamboni for Children in Conflict with the LAW (that started as a pilot project based at Kigamboni Cultural Center) has become a very successful one by converting itself from Formal Juvenile Justice to a Rehabilitation Programme. Eight children who are well reformed have begun an ACROBATIC cultural group that is doing so well that it has been invited to Germany to conduct country tours and also do some Voluntary work for a period of one year. The group drew its participants from street children who have now found a niche in community entertainment and education (enter-educate) in the course of transforming their lives.

Progress Made

Before the implementation of HSSPIV, (2014/2015), there were only three (3) juvenile Courts-Kisutu,Kisarawe and one in Mbeya.
In (2016-GN 7/12/2016), the Chief Justice designated all Primary Courts in Tanzania Mainland to be Juvenile Courts, making the total number of courts to be 132.
This was then followed by the demand to train Court Officers/Personnel (Magistrates, Social Welfare Officers and Probing Actors-Police, State Attorney and Advocates, who facilitate the investigation processes and learn how to handle Juvenile cases and see that Detention is the last resort measure to children.
Training has so far been done in the following regions (Forty participants were selected per Zone as planned by the Judiciary):
Njombe,Mbeya, Simiyu, Iringa, Dodoma, Tabora ,Kigoma Singida, Coast, Mwanza, Morogoro, Kilimanjaro, Dar as salaam, Tanga and Arusha.Training is yet to be done in Ruvuma, Katavi, Rukwa, Lindi, Mtwara,Kagera and Manyara.

Corrective Treatment and Rehabilitation

Currently the Government has five (5) Retention Homes and One Approved School in Mbeya.
Social Welfare Department targets to have NO more Retention Homes in order to be more responsive to juvenile rights and attain community participation which contributes to re-integration in society.
Activities done in the Homes;

a. Couselling(Unasihishi)
b. Educational services-reading, learning Mathematics.Health and Environmental Care and Sanitation,Nutrition and Learning Life skills and Religious Studies and cultural events
c. Recreational Activities including Various games, Acrobatic games,Dancing and Singing
d. Vocational Training –Handcraft, gardening and horticulture ,Poultry farming and income generating activities

Social Welfare also want to merge Corrective Therapy and Rehabilitation Programme(CRP),where the Leprosarium based at Turiani, Morogoro has been moved to the Town Centre(Funga funga) and is

merged with the Juvenile Corrective Programme. The Nyabange Centre in Musoma,Mara will be moved to Bukumbi Mwanza.This will give room to establish more Corrective Homes.
There are plans to merge programmes on Violence Against Children with Violence Against Women(VA/WC)

Achievements

a. A decrease in the Number of cases handled in accordance with the Law of the Juvenile Imprisonment from **1440 (2013**/14), to **403** (2016/17)
b. A Five Year Strategic Development Reform programme of Child Justice is under review
c. The Social Welfare Department has now established Non-Residential Retention Homes having begun working with Families and Communities in the field of Rehabilitation. This has resulted in diverting more than 1000 children from Retention homes to Rehabilitation Centres.
d. The Number of Rehabilitation Homes has increased from two (2) to ten(10) –These homes are in the following districts-Mbeya Urban and City ,Iringa, Mbarali ,Hai, Kasulu DC and TC, Kigamboni (show-case),and Temeke.
e. These Non-Residential Rehabilitation Homes have caused a decline of the number of Reoffending Juveniles to only 400.

Accountability Mechanisms and CHILD Protection

This is a challenging area and NOT much has been accomplished as planned. There are two Permanent Secretaries and the Social Welfare Officers have to be answerable to TWO official focal points at the Operational Level: The District Social Welfare Officer reports to the Director of Health Social Welfare and Nutrition of PO-RALG ,and at the same time the same Officer has to conduct activities that are Supervised by the Regional Social Welfare Officer who reports to the RMO. The Regional Social Welfare Officer is not a member of the RHMT. This calls for clear guidance on performance accountability based on mutually agreed lines of reporting.

3 Cross Cutting Issues Findings

3.1 Infrastructure, equipment and Quality

PHCDP (MMAM) was the main government document guiding infrastructure development. It set out a program to establish a Health Centre in every Ward, a Dispensary in every village and a District Hospital in every Council. For all 12,545 villages to have a dispensary, and all 4,220 Wards to have a Health Centre and for each Council to have a Hospital by 2018 government had made the following achievements: 53% of villages had dispensaries out of which 38% were public and 15% private or faith based organizations, and 16% of Wards had Health Centres of which 12% were public and 4% were private or faith based organizations. Moreover, there were 70 Councils with Hospitals out of 184 Councils (38%). Between 2015 and 2018, three hundred and four Health Centres were rehabilitated or constructed. In addition the construction of 67District Hospitals started in January 2019. The financial implications of getting on top of MMAM target coverage are substantial and require phased medium to long term scheduling to facilitate resource mobilization.

According to DHIS there were 11,251 health facilities which translates into 2.1 facilities per 10,000 population for the Mainland. The majority of these facilities were dispensaries (refer to following table)

Facility type	Number	Percent	Density per 100,000 population
Hospitals	295	2.6	0.6
Health Centers	796	7.1	1.5
Dispensaries	6,874	61.1	13.1
Private	1,961	17.4	3.7
FBO	1,002	8.9	1.9
Other facilities	323	2.9	0.6
Total facilities Mainland	11,251	100	21.4
Population 2018	52,619,314		

Table 4 Underweight and obesity by wealth quintile: women 15-49 yrs (%), TDHS 2015/2016

While there was an important effort to rehabilitate Health Centres it is encouraging that there was attention to increase facilities providing CEmONC services as well as health workers to provide the services in these facilities. CEmONC services are provided at Hospitals and some Health Centres although at the latter the services are constrained by inadequacy of anaesthetic services and blood transfusion services.

Star rating and striving for fulfilling criteria for certification – to accreditation are insufficient considerations for assuring quality service delivery if health care providers are overburdened, ill-supervised, sub-optimally motivated or unavailable for assuring humane service provision. However taking note of Analytical report findings on Human Resource density and Health Facility density per population and comparing that to star rating scores improvement, there is no direct correlation since some facilities with low HR complement have marked improvements in star rating gains (e.g Geita, Sekou Toure, Simiyu, Ligula); In contrast Njombe with the best ratios of HR and Facility density had lower than expected star rating improvement recorded. This calls for in-depth studies to reveal explanations for the differences in quality improvements.

Within a crisis of HRH practical measures have to be initiated and sustained. PORALG has shared that they have introduced individual staff reporting on work performed daily to enable tracking individual outputs against daily health facility workload as a way to understand the outcry on human resources shortages against establishment prescription. This personalized measure has made immediate positive contributions to HRH management at facilities where this has been introduced (according to information from PO-RALG Health).

The need to have personnel with personal calling and dedication to serve in health care, requires a revisit of enrolments procedures as prior measure for entry in training courses for health, so that humane handling of patients (a quality sensitive driver) gets re-established in health facilities. However, quality measures require a more holistic approach since the various measures complement each other. Handling staff issues without a look at the environment where they work can be counterproductive. A study on WASH status at sampled health facilities in 2016 revealed 60.4% of facilities had no piped water supply, 34% had irregular water supply while 12.5% obtain water only seasonally: In the surveyed Health Care Facilities 44% of consultation rooms and 42% of delivery rooms had no functional hand washing facilities. With only 33.5% of respondents in the survey having been informed about essential hygiene behaviours upon arriving at the health facility, it is not surprising that water samples from health facilities in all district councils surveyed were contaminated with E. coli and other microbes[24].

Best practice: High frequency low dose refresher routines have helped staff remember steps on newborns resuscitation. The next step planned to organize reminders on eclampsia management every Wednesday [Dodoma RRH]. These sessions reduce panicking amongst staff as they acquire confidence to perform life saving procedures. Such an approach can be extended to other areas for maintenance of optimal professional practice.

The recent move to establish District Hospitals within an area where a private hospital exists has to be looked at in a manner that considers the current scarcity of resources and budget constraints within the health sector.

The long established formal communication mechanisms between the Government and FBOs as well as Government recognition of APHTA activities are exemplary avenues that nurture prosperity, harmony in pursuit of the common agenda for policy compliance in complementary roles under the PPP arrangement.

Capital and infrastructure development and rehabilitation of the private institutions is the responsibility of the owners of the facilities. However, the private sector also participates in the overall rehabilitation of facilities in order to improve the quality of care within the spirit of partnership. These Private institutions are also part of the referral system where patients obtain expert care at higher levels even if they originate from the private sector. Moreover, graduates from the Private sector are also absorbed and recognized by the Government when they request to get engaged in the public sector.

[24] Malebo, H et al 2016. Water, sanitation and hygiene situation in Health Care Facilities in Mainland Tanzania and Way forward. NIMR, MOHCDGEC, MUHAS, UDSM, UNICEF.

3.2 Equity

According to the Household Budget Survey 2016/17 *the daily cost of the food poverty line is TZS 858 per adult equivalent.* From the focus group discussions the fact that clients have to go to purchase medicines from private pharmacies was a registered concern throughout; this could be an indicator on economic access problems felt on the ground. Adolescent girls face greatest disadvantage due to their inability to pay for services or access insurance: Their economic dependency on parents leaves them in powerlessness when they are faced with needs for health care. Disabled persons were reported to have neither government support nor reliable community support; where missionaries/philanthropists are found they get sympathy and attention from them.

Services relevant aspects from Equity Study:

- Inequality in stunting
- Inequality in distribution of health care facilities and health workers – more in urban areas than rural areas.
- People prefer friendly tone of voice, openness for questions and good explanations of health care workers.
- Fees for transfer(fuel, rental of bodaboda/car/boat) is too high for many to pay.
- Stock out of medicines is a frequent occurrence.
- Many facilities test for Malaria and HIV; there are no other tests or examinations.

The risk pooling introduced through insurance is equity beneficial but those unable to afford insurance premiums have to suffer the negative effects of user fees. When insurance cards are nearly expiring, some providers turn away clients without providing them with service for fear that insurance custodians may not refund their bills in case such bills are on the high side. Progress in establishing the Single National Health Insurance to enable Universal Health Coverage has been slow to come by despite common knowledge that it is beneficial to attainment of equity to health services access.

3.3 Gender

Mainstreaming gender has been the focus in the health sector for some years now. Concrete programmatic interventions include male involvement in RMNCAH clinics, male involvement in HIV status testing, and partner involvement in STI management. GBV and VAC cases are increasingly encountered but the reporting system and management of the incidents is riddled with shortfalls, in favor of culprits to the disadvantage of victims.

Some facilities have established gender focal point desks to handle gender violence victims but still needy in terms of coverage and legally sound operating procedures. Initiatives handling gender interventions at districts and sub-district are mainly NGO driven. Tapping on the local NGOs experience in constructive male involvement is still limited in terms of making systems wide impacts.

Gender mainstreaming, gender equality, gender equity covered in HSSP IV were not backed up by articulation of the socio-cultural context of gender norms, relations and division of labour and therefore these elements shall require more attention in future programs: Specifically there will be a need to strategize managers' providers' and community sensitization on gender mainstreaming and how to address this as a forerunner or hand in hand with programmatic interventions.

3.4 Public Private Partnership

In the Health delivery system, the Pyramidal structure as indicated by the Health Policy has also included the Private sector as an important contributor to the provision of Health services in Tanzania. The Private sector is working hand in hand with the Government from the grass root level to the National level. The secondary and tertiary level institutions (both public and private not for profit) are monitored and directly supported by the MOHCDGEC, while primary level health facilities are monitored and supported by the Local Authorities through a Devolved and Decentralized system. The Central Ministry issues Policies and Guidelines for all institutions providing health care and have to conform to the given standards and norms irrespective of ownership status.

The District Designated Hospitals that serve as District Hospitals in some LGAs that do not have public Hospitals, closely collaborate with the Government to give the desired services to the Public through the **Service Level Agreements.** Through the Service Agreements FBO health facilities have also been undertaking service delivery tasks such as RMNCAH, HIV/AIDS (CTC and prevention), TB and Leprosy, Malaria interventions as well as collaboration in epidemics and health promotion overall.

With the introduction of DHFF to public service delivery facilities, FBO arrangement of service delivery via Service Agreements needs to be re-visited in order to ensure they are included in the DHFF. However the excellent PPP arrangement is negatively affected by sloth in responding to CAG report queries needing response.

4 Strategic Objectives

*The overall objective of HSSP IV: To **reach all households with essential health and social welfare services**, meeting as much as possible expectations of the population and objective quality standards, applying evidence-based, efficient channels of service delivery.*

Strategic objective	*Reflection*
1) The health and social services sector will achieve **objectively measurable quality improvement of primary health care services**, delivering a package of essential services in communities and health facilities.	The CCHP process is all about primary health care services countrywide, based the essential health care package both at health facility and at communities. The CCHP process has matured to the level of decentralization to health facilities. Tracking compliance to quality standards has initiated the use of star rating in an objective way. A Minimum Benefit Package for the Single National Health Insurance has been conceptualized awaiting high level decision to put it into practice. Guidance to strengthen emergency preparedness and response to disasters has been given but not yet taken up to its full extent. The development of a stepwise certification and accreditation system and linkage of quality to performance and insurance payments is on course with positive stimulus to practising health facilities but focus on patient care as a core element still needs attention. Despite prevailing staff shortages, in-house retention and continuing professional development through on-job training measures optimize existing resources.

	Performance management and regular clinical and departmental meetings and seminars as well death and clinical audits have been enhancing accountability. Direct facility delivery and signing off medicines and supplies received by HFGC involvement has made a mark in improving availability of medicines despite erratic shortage of some. Compliance to the guidance on involving HFGCs is sometimes not followed due to individual traits. Measures to curb maternal mortality and neonatal mortality are on course through CEmONC and BEmONC application countrywide, with priority to underserved and hard to reach areas. Gains made in combating Communicable Diseases have reached a stage of demanding sustenance measures. Increasing attention to NCDs and NTDs, particularly the prevention and control measures are at various stages of implementation. Impressive progress on under fives and infant mortality attributed to a number of measures is reason enough to keep high immunization coverage sustained, continue emphasis on IMCI, close gaps in malnutrition perpetuating factors, and keep an eye on supplements and protection of child rights within the context of managing the first 1000 days of life. Measures already on course to integrate Social Welfare and Health Services shall be intensified to a higher level for the benefit of vulnerable groups, persons with disability and at risk groups. *This objective is therefore on a trail towards successful delivery.*
2) The health and social welfare sector will improve **equitable access** to services in the country by focusing on geographic areas with higher disease burdens and by focusing on vulnerable groups in the population with higher risks.	At formulation of Big Results Now (BRN) the regions with higher load of morbidity and mortality, as well as access challenges were prioritized and facilitated for immediate term interventions while the health sector went ahead to ensure availability of a dispensary in every Village and a health center in every Ward (MMAM target), thus paving the way for attaining geographical equity. Application of epidemiological analysis is increasing in the sector given the deliberate targeting of under-served populations and vulnerable groups, and responding to high priority health needs like Maternal Health, Neonatal survival, HIV, Malaria, TB and more recently the growing problem of NCDs. Increased attention to gender equity is evidence in concrete measures, such as focus on prevention of HIV amongst adolescent girls and their access to family planning services on special days and addressing violence against women in manner that includes community leaders in intervention and disputes settlement. Working closely with Social Welfare on these issues as well as aspects on applying the Waivers and Exemptions policy moulds the effort towards a more systematic approach going forward. Public education to popularize social health insurance and its cost-effectiveness is ongoing. Deepening engagement of Social Welfare and work around vulnerable and at risk groups including GBV, VAC, orphans and vulnerable children as well as articulating how to move forward with older people issues shall require intensified attention in HSSP V. *This objective is on the other hand also on a trail towards successful delivery.*

3) The health and social welfare sector will achieve **active community partnership** through intensified interactions with the population for improvement of health and social wellbeing.	Tanzania has a lot of experience with community participation in development and health shall not be an exception. Successful functional literacy campaigns such as "Mtu ni Afya", "Chakula ni Uhai", community based self reliance initiatives of the 1970s and 1980s conferred ground breaking experience with participatory approach. Extending the already practiced "O&OD" method that came at the close of the 1990s and beginning of 2000 decade, and infusing this with "Participatory Learning and Action" approach shall intensify interactions with the population. CHWs are trained to apply these methods since the commencement of HSSP IV. This objective therefore stands to be attained if the community health agenda shall continue to receive the intense attention it deserves and experience of TASAF in community engagement is harnessed going forward. A system of social accountability has been put in place to strengthen bottom-up planning, transparent reporting to Boards and Committees. The health and social welfare sector is engaging with the population in modern interactive communication via e-health (Whatsapp groups) to establish partnerships. Methods and approaches to attain participation, involvement and empowerment are known, time tested and reliable: they just need to be applied on a wider scale. *This objective is making progress but more could be achieved faster; accelerating the pace needs to be emphasized in HSSP V.*
5) To **address the social determinants of health, the health and social welfare sector will collaborate with other sectors, and advocate for the inclusion of health promoting** and health protecting measures in other sectors' policies and strategies.	A good number of health themes cut across key sectors to be delivered for the benefit of the general population (refer to sections 3.7 and 3.9 above). Nutrition and Food safety, WASH, School Health, HIV/AIDS, International Health Regulations, Epidemics preparedness, Road Traffic Accidents, Mental Health conditions, Anthropozoonoses, all call for multidisciplinary approach. Significant chunks of work have been laid out promoting Health in other sector policies and strategies, ranging from multisectoral plans to health promotive and health protective implementation measures. Inter-ministerial meetings of Permanent Secretaries and Local Government Councils already provide platforms that are usually optimized for the intersectoral health agendas. The SWAP process has continued to be sustained. Multisectoral engagement in HIV/AIDs has visibility from National right into LGA levels. School Health has been sustained and emphasized for the benefit of students and Adolescent age group. Action planning on nutrition issues has been emerging as a concrete approach. WASH interventions have been accepted and understood especially where Open Defecation eradication campaigns were engaged in and Urban authorities seriousness in enforcement of environmental health measures. Epidemics and emergency preparedness including traffic injuries have started to benefit from collaboration across key sectors. Information is yet to be shared on progress made on *Juvenile Justice issues, Corrective Treatment, Rehabilitative Youth Services, and Accountability mechanisms for child protection* where legal sector engagement and National Education and Culture institutions would play a critical role. *The work on this objective has taken root and moving fairly effectively at national level but actual tangible performance at districts and in particular the*

	sub-district level calls for intensified focus and action in the immediate to medium as well as the long term. Prioritizing the ward, village/hamlet and household practices shall be necessary in HSSP V.

Table 5 Reflection on actions in favour of achieving the HSSP IV Strategic Objectives

5 SWOC Analysis

Strengths	**Weaknesses**
The Ministry's interest and commitment to excel in quality of service and its coverage and availability of partners back-up including the complementary role of PPP. Favorable policy environment putting in place a DxD approach with accountability and control procedures, clear policy guidelines and strategies, clear SOPs CCHPs now including Health Facility Plans captured electronically and resourced via DHFF. A positive move to rehabilitate health facilities and significant increase of health centers Compliance to CHF and NHIF requirements making revenue available to meet critical service delivery needs. Team work enhanced by ward rounds, clinical meetings and mentoring during supportive supervision. Planned Specialist outreach to primary health facilities. Increasing use of evidence based approach in planning and management such as Maternal Death Audits, Neonatal Death Audits and feedback. Faster retrieval of records with increased use of electronic recording and reporting systems. Impressive levels of immunization coverage noted in three consecutive years.	Management and organization of health care with good governance and accountability of facilities are weak links in the quality chain[25]. Harmonization and coordination within the Sector's quality improvement drive, and insufficient internalization of the critical links between Accountability, Transparency and Governance to the quality improvement work. Ward Development Committees utilization for many disease prevention interventions including health promotion has until now not fully optimized the local resource base (business community, FBOs, NGOs, Social Clubs, schools and influential individuals). Insufficient optimization of Ward level structure for WASH measures and interventions against stunting. Some health facilities run by Health Attendants due to delays in absorption of skilled personnel. Erratic availability or insufficiency in organization and placement of vital supplies and equipment at working stations; inadequate tools and equipment at various levels of service delivery. Sub-optimal utilization of Health Boards and HFGCs Weak waivers and exemption mechanism to care for vulnerable groups and the elderly; patients not getting the services they require on timely basis due to managerial shortfalls. Interrupted support to FBO run RMNCAH clinics that came with introduction of the positive DHFF measure.
Opportunities	**Challenges**
e-Health strategy and electronic medical records potential for keeping quality practices consistent and feasibility of performance audit. The multitude of SOPs and guidelines could be compiled into one or two Working Manuals so that these are more readily accessible to practitioners. Social Services Committee of Parliament and at LGAs facilitate sector plans resourcing.	Establishing disciplined compliance to SOPs in day to day practice. Effective and efficient management of service delivery through unmotivated, overburdened health professionals available at 30-50% capacity. Limited understanding of "Service Delivery" considering variance and convergence of understanding between stakeholders (DPs,

[25] MOHCDGEC 2017. Report of the National Baseline 2015-2016 Final_HN 2017 06 23.pdf

Existence of health Development Partners and global financing institutions (UN, W Bank, Global Fund, GAVI) as well as local business community. Emerging experience with application of Health Insurance. Inclusion of older persons care and attention to vulnerable groups in the health policy	Managers, health service providers and beneficiaries). Data completeness, analysis capacity, and utilization in reporting affecting timeliness of disbursements. Fragmentation of health financing sources continues as path towards Single National Health Insurance remains uncertain. Creating a shared view and committing to action the measures to fulfill the rights and obligations of health care providers and beneficiaries, as per intention of the Client's Service Charter. A cohesive Social Behavioural Change Communication initiative that caters for various programmatic SBCC needs has been hampered by bottlenecks to the principle of Alignment and Harmonization already adopted by the country. Sloth in progress of establishing the Single National Health Insurance to enable Universal Health Coverage.

6 Recommendations.

6.1 Immediate term

National Essential Health Care Interventions Package

The Health Sector Stakeholders should agree on a timeline to update the National Essential Health Care Interventions Package (NEHCIP-Tz) in light of recent developments such as Cervical Cancer immunization, Male circumcision, Self HIV Testing, MDR TB and Gene X-pert detection of TB, epidemiological transition to NCDs and the need to attend neglected areas such as Oral Health, Ophthalmic Conditions, and Mental Health.

- In HSSP V prioritize NCDs detection, treatment and prevention including SBCC measures
- Extend the gains made in integration of the treatment aspect of major Communicable Diseases (ATM) to benefit prevention measures through an integrated single SBCC adapted multilevel and ensuring the already designed Community Based Health Program is put into effective implementation at all LGAs.

Maternal Mortality

Health Stakeholders should prioritise studying factors responsible for perpetuation of Maternal Mortality and use the evidence to devise effective interventions. However the obvious systems gaps cannot and should not wait for studies: Examples in point here include;

MOHCDGEC and PORALG to jointly develop a guide that shall address continuous gap filling to address shortage of midwives in remote areas and the timely application of this guide be regularly monitored by management,

In order to ensure RMNCAH competency of staff deployed at primary care facilities, the RMNCAH program should immediately consult with MOHCDGEC Senior Management on the dire need to re-establish RMNCAH clinic services at RRHs (to offer practical sessions to students from nearby Health Training Institutions).
All primary health facilities should embark on measures to improve compliance to BEmONC and CEmONC signal functions taking advantage of the DHFF arrangement. LGAs should address gaps of Human Resources by recruiting and deploying Nurse Midwives and Doctors where they are missing. An expedited arrangement to train and deploy Anesthesia competent cadre at all Health Centers in need should be actioned by the DHR in MOHCDGEC.

Measures to improve and assure quality of health services:
Quality systems

Health Management Teams should take advantage of DHFF to oblige all facilities to strive for qualification to be certified as a consequence of applying SOPs and service management principles in a rigorous manner; and hence be able to track the path towards eventual accreditation.

Quality Assurance Directorate /department should update the existing Quality of Care indicators to ensure all key service delivery areas are covered and shall meet accreditation requirements as well as monitor care of patients.

Health Services Quality Improvement Teams should ensure that the newly revised Clients' Service Charter is put into application such that it facilitates accountability to local authorities in addition to serving health facility staff and their clients.

Staff capabilities for quality

Health Services Managers should strengthen the OPRAS such that staff are obliged to record and account for their daily performances to respective management levels taking key lessons from the practical application of daily performance monitoring already ongoing in PORALG- Health.

Health Services Managers should optimize existing staff and utilization of extension agents such as CHWs and CHVs by setting right and managing rigorously the performance incentives and accountability for tasks performance including balancing workload so that waiting time and client turn-around time gain efficiency.

Human Resource Managers should strengthen the CPD function to improve on its management including tracking on competencies transfer.

Patient rights

The Quality Assurance Department should improve the Clients' charter functionality by ensuring it is used as a tool for dialogue amongst providers and between providers and beneficiaries, by including an addendum to the newly revised Charter that patients/ clients should be respected and listened to effectively.

Health Managers should make patient rights, client satisfaction and gender sensitive approach a standing agenda addressed routinely at HFGC, CHB and all Hospital Boards to enhance awareness creation.

To support Health Facilities and the public to realize human rights, the Health Promotion Section should translate selected sections of newly revised Clients' Service Charter into artistic educational posters that shall break the 'hidden silence' on patients' rights and obligations and care providers' rights and duties.

Health facility managers should place orders for the posters (referred to in (c) above and ensure they are put to effective use, so that the fear surrounding communication with and among clients on rights, obligations and duties is averted for mutual benefits.

Health financing, economics and equity

Establish Development Dialogue fora multilevel where appeals for increased investments beyond the current per capita spend shall be discussed and clarity on the **economic dividend of health** shall be elaborated using well researched papers. Engage Health Economists to calculate the economic returns of investing in health, to propose strengthening of **cost cutting** and **cost saving** measures within the health system.

Put in place innovative financial resource mobilization schemes such as a **Trust fund** (that includes the private sector) to pay insurers of care costs of the elderly not covered by any insurance, compassionate fund invested in profitable stock exchange with a proportion earmarked to cover MNCAH costs of care.

Specifically

a) Undertake wide public education on benefits of, and advocacy to get increased coverage of health insurance schemes using multiple channels of communication.

b) Oblige insurers to improve efficiency of their re-imbursements to health care facilities.

c) To facilitate the proposal to ensure health insurance guarantees Universal Health Services Coverage devise community solidarity funds (e.g voluntary contributions, appeals to business enterprises) to pay insurers on health care costs incurred by low income earners and those without regular income sources.

Persons with disability and the vulnerable

Organize **persons with disabilities for gainful productive employment** (self employment or deliberate policy to give them preferential treatment in labor market) that will enable them to acquire health insurance.
Management should deepen intra-departmental consultations among Health, Social Welfare, and Community Development in order to reap gains in the area of equity of access to health services. The DSW and CD, in close consultation and collaboration with DCS and DPS should develop a cohesive national program to cover vulnerable groups, like people with disabilities, older people, and adolescents in terms of access to health services, disease prevention and address to specific disabilities.

Public Private Partnership
The MOHCDGEC should hold consultation with PO-RALG and FBO Umbrella organizations to review the functionality of Service Agreements in light of putting into practice the DHFF initiative and address accountability issues.

Emergency services and response

The Government's multisectoral initiative on Emergency Preparedness and Response is a solid entity that deserves going forward in the phases foreseen as provided in its guideline: Creation of Emergency Medicine Departments and capacity for handling emergencies at health facilities in accident prone areas should be an immediate term priority, the commendable point of departure being to establish a highly disciplined cadre for running the system including:

a. Appeal to private businesses to invest in ambulance venture focused on providing services to and from Health Centres throughout the country.
b. Train and post cadres trained in handling emergencies in Ambulances in order to initiate life saving measures instantly and in the course of transfer to definitive treatment facility.
c. As part of emergency preparedness undertake mock-drills periodically to keep staff aptitude and preparedness alive.
d. Establish a drone system to respond to SOS calls for supply of blood and other emergency medicines according to feasibility.

Medicines and supplies

While the tracer medicines are reported to be in stock, complaints about other medicines out of stock have been a consistent finding. Considering the epidemiological transition the Medicines and Supplies TWG, in close consultation with MSD, should be tasked to update the medicines stock indicator (Tracer Medicines) and expand the list as an immediate task, so that medicines and supplies system meets service delivery needs multilevel. In addition the TWG should consult and draw on technical positions (e.g from WHO, CDC) on monitoring and managing anti-microbial resistance to medicines.

6.2 Immediate to Medium Term

Professional Councils and quality of practice

Professional Councils should be directed by the CMO and CNO to examine ethics of practice among respective cadres and determine effective correctional measures.
An indicator to track quality of patient care should be developed by the QA Unit and be one of the measures to strengthen care provided by clinicians and nurses. In the course of addressing the ethics issues deliberate on and put in place measures to counter stigma and discrimination effectively.
In collaboration with PO-RALG the Health Sector top management should continue the QA measures already in momentum to consolidate gains and move facilities further in star rates attained, enhanced quality practices subsequently enabling certification towards accreditation. In this manner the Health Insurance framework shall be optimized for benefits to all parties.

6.3 Medium Term (HSSP V agenda)

Social Welfare intensification

Consolidate and strengthen the initiated Social Welfare activities (more capacity, finish the review, enhance juvenile rehabilitation) and give more attention to child protection in HSSP V.

Community linkage, involvement and empowerment

Consolidate gains made in decentralization to health facilities such that the Facility to Community linkage is infused with methods and availed tools that **enable local problem-solving** and attainment of genuine community participation focused on **advancing the continuum of care** and generating practical solutions to encountered health problems (increasing application of PLA methods and tools at grassroots level) i.e promoting the application of public health measures at households, villages/hamlets and wards. This is recommended as an elaboration of details to take forward the appeal by PORALG – Health to put into a pragmatic footing the call for involving the Ward Governance, Village and Hamlet governance structures in bottom-up participatory planning of preventive health interventions, assurance of quality of primary health services using the route of performance-based incentives to agents.
Undertake a national initiative on community empowerment that includes addressing social determinants of health by requiring health agents at community level to apply the participatory methods referred to in the CBHP, under supportive supervision of Health Promotion activists, including taking lessons from TASAF and documented lessons and best practices.

Programs sustainability

While continuing with programs integration in district councils plans and operations, the impressive levels of immunization attained and high ART coverage were due to well designed strategies and effective partnerships: Learning from the GAVI and Global Funds support should inform the creation of sustainability measures with respect to the immunization and ART coverage levels attained. The MOHCDGEC should bring this up as a standing agenda for SWAP and DPG-H deliberations in order to advise government on the most practical way forward.

Nutrition

District Nutrition Officers should work with Community Development Officers and Social Welfare agents at District and **especially the sub district level** (Wards, Villages, Hamlets, Households) to foster population problem-based planning and intervention that addresses local nutrition issues such as stunting and the emerging obesity. The approach should be guided by the National Multisectoral Nutrition Action Plan.

GBV and VAC

Building on existing initiatives tackling GBV and VAC, the RMNCAH program management should review and propose strengthening the reporting system, screening, and response procedures for health facility practices including referrals, to benefit victims; and take necessary steps to channel available resources to expand use of drop-in centres at LGA areas.

Expand the scope of community based programs to address social and cultural factors related to GBV and VAC with attention to capacity development for CHW/V, CDO, SW Focal Persons, male sensitization and involvement, plus supporting innovative community initiatives (such as Chemba District “MTAKUWA Committees”, “UTURO example using Kommandoos” from Mbarali, “Couples Connect” approach applied at Shinyanga, Mtwara etc and others as identified).

Integrated SBCC

SWAP partners should foster Alignment and Harmonization of SBCC ventures in favour of One integrated SBCC initiative that caters for all programs with its close monitoring for impact in the population. In addition to SBCC for AIDS, TB, Malaria and Nutrition, diseases of public health concern such as NTDs, which are very common and chronic entities, should be prioritized in integrated SBCC informed by operational research, and intervened through MDA and continuing mass education on prevention measures.

Schools in emergency preparedness

MOHCDGEC should engage with Education Sector colleagues to get firm commitment to attain teaching of emergency preparedness as a topic of health science in schools curricula (primary, secondary, training colleges and Universities).

Rehabilitation and geriatrics

Rehabilitation medicine including physiotherapy should gradually be extended beyond current levels to cover all regional and district hospitals, including initiating a process of establishing geriatrics departments and capabilities in all hospitals in the country: The DCS should be the focal point for this.

Infrastructure

In the interest of consolidating gains in equity of access (geographical) the nation should continue to pursue full realization of MMAM targets by continuing the PO-RALG initiative to construct 350 Primary Health Facilities where needs are greatest using “force account” approach that conferred a speed that is both efficient and cost-effective; and hence should also feature in HSSP V.

6.4 Medium to Long Term

Healthy Ageing and active ageing

In light of the rising burden of NCDs and its higher toll among the elderly, the demographic dividend currently points at the need to establish geriatrics discipline amongst health cadres and concurrent national program on healthy ageing/active ageing to keep costs of care at lower level. The MOHCDGEC should work out a system to attain geriatrics care expertise within the ranks of the health system and how the health needs of Older People can be met in a costs conscious, cost-effective manner supported by disease prevention advantages of healthy ageing.

Maternity waiting homes

Within the CCHP framework, the responsible focal person for District Health at PO-RALG should continue to advise Councils to establish CEmONC competent facilities at hard to reach areas, together with Maternity Waiting Homes through appealing to local business community for resources, in order to address the distances and geographical inaccessibility issues especially for pregnancies detected to be at

risk. This measure should be appreciated as a further extension of the currently efficiently executed infrastructure and rehabilitation effort aiming at expanding the number of Health Centres in the country.

Health campaigns and their impact

Research Institutions should evaluate the impact of health campaigns approach in order to popularise and intensify the elements that enabled success as well as synthesise elements to be sustained to assure continuity of the measures and continuation of gains. Examples here include the Environmental Sanitation (WASH) campaign, the Road Safety campaign, the control of Mosquitoes and other disease vectors campaign and so on. Results from the studies should inform how to improve current status of WASH in health facilities and schools, improvements in road safety, and clamping down on Malaria and Dengue etc.

Using evidence in Health Systems Strengthening

Stakeholders in Health, Community Development, Gender, Elderly and Children should invest in health systems research picking year by year research priorities according to the most affected HSS building block; aimed at documenting the level of strengthening attained and further steps needed for improving it to optimal functioning so that within the next 6 to 8 years all the building blocks have been studied and solid evidence is in place that informs the HSS measures at country.

Electronics and Health Services improvements

Best practice examples on electronic medical records, e-medicine and e-health should be shared wider for example through peer learning approach such that the benefits to service delivery and coverage of services shall be increasingly harnessed.

Administration in Health Management

Administration procedures in day to day management practices should be streamlined to enhance efficiency and effectiveness in the Sector.

7 References

1. Alexander K. Rowe et al. 2005. How can we achieve and maintain high-quality performance of health workers in low resource settings? A review. Lancet 2005;366:1026-35

2. Bonaventura C. T. Mpondo, Daniel W. Gunda, and Semvua B. Kilonzo: 2017. HIV Epidemic in Tanzania: The Possible Role of the Key Populations. Hindawi AIDS Research and Treatment, Volume 2017, Article ID 7089150, 7 pages https://doi.org/10.1155/2017/7089150

3. URT, NAOT. Ripoti Kuu ya Mwaka ya Mdhibiti na Mkaguzi Mkuu wa Hesabu za Serikali Juu ya Taarifa za Fedha kwa mwaka wa fedha 2017-2018. Mamlaka za Serikali za Mitaa.

4. Centers for Disease Control and Prevention. Predicting Casualty Severity and Hospital Capacity. USA: Centers for Disease Control and Prevention; 2003.

5. Council Report 2 of the National Star Rating baseline 2015-2016 Annex 2 final_HN 2017 06 23

6. Department of Social Welfare et al. National Costed Plan of Action (NPA II) for Most Vulnerable Children (MVC) 2013-2017

7. Expanded Program on Immunization Comprehensive Review 2015.

8. Hotez PJ. Empowering women and improving female reproductive health through control of neglected tropical diseases. PLoS Negl Trop Dis 2009; 3: e559. doi:10.1371/journal.pntd.0000559PMID:19936248

9. Hotez PJ, Kamath A. Neglected tropical diseases in sub-Saharan Africa: review of their prevalence, distribution, and disease burden. PLoS Negl Trop Dis. 2009; 3: e412. doi:10.1371/journal.pntd.0000412PMID:19707588

10. https://www.dropbox.com/preview/HSSP%20IV%20ANALYSIS_ntlp26032019UPDATED.pptx?role=work

11. Koka et al. BMC Health Services Research (2018) 18:835https://doi.org/10.1186/s12913-018-3609-5. Disaster preparedness and response capacity of regional hospitals in Tanzania: a descriptive cross-sectional study.

12. Malebo, H et al 2016. Water, sanitation and hygiene situation in Health Care Facilities in Mainland Tanzania and Way forward. NIMR, MOHCDGEC, MUHAS, UDSM, UNICEF.

13. Maternal and Child Survival Program (MCSP) Tanzania Country Summary report, March 2017

14. Mghamba JM, Talisuna AO, Suryantoro L ,et al. Developing a multisectoral National Action Plan for Health Security (NAPHS) to implement the International Health Regulations (IHR 2005) in Tanzania.BMJ Glob Health2018;3:e000600. doi:10.1136/bmjgh-2017-000600

15. MOHCDGEC 2018. Three Regions Analysis: Star Rating Repeat Assessments 2017.

16. MOHCDGEC 2015. National Costed Community Based Health Program Strategic Plan (2015-2020)

17. MOHCDGEC 2017. National Community Based Health Program Implementation Design.

18. MOHCDGEC, 2018. Health-National Adaptation Plan to Climate Change in Tanzania 2018-2023

19. MOHCDGEC 2017. Report of the National Baseline 2015-2016 Final HN 2017 06 23.pdf

20. MOHCDGEC 2018. National QI Star Rating 2017-2018 reassessment X-cel scores

21. MoHCDGEC, 2017. Roadmap towards Accreditation of Health Facilities in Tanzania. (Draft)

22. MoHCDGEC, 2019. Analytical Report to inform the Health Sector Strategic Plan IV (HSSPIV) 2015/16 – 2019/2020.

23. MOHCDGEC et al 2016. Tanzania Demographic and Health Survey and Malaria Indicator Survey 2015/2016

24. MOHSW 2014. National Community Based Health Care Program (CBHP) Policy Guidelines

25. MOHSW 2015. National Health Promotion Guidelines

26. MOHSW.. The National Essential Health Care Intervention Package (NEHCIP-Tz)

27. Mwangombe, Mary et al. Perceptions of Diabetes care provision among health providers in rural Tanzania: A qualitative study. Health Policy and Planning, 32, 2017,418-429.

28. National Steps Survey 2012

29. Paul, E et al 2017. Performance-based financing in low-income and middle-income countries: Isn't it time for a rethink? BMJ Global Health. http://gh.bmj.com/

30. Primary Health Care Performance Initiative (PHCPI) in https://improvingphc.org/measuring-phc

31. PO RALG, MOHCDGEC 2019. Summary Analysis of Council Comprehensive Health Plans (CCHPs) 2017-2018.

32. Service Availability and Readiness Assessment 2017

33. Stephen Turner et al 2018. Evaluation of the Bringing Nutrition to Scale Project in Iringa, Mbeya and Njombe Regions. Makoro Food Economy Group. Oxford U.K

34. Tanzania HIV and Malaria Indicator Surveys (THMIS) 2016/17 and 2011/12

35. Ties Boerma et al. Analytical Performance Report on HSSP IV indicators (draft).

36. Uchangiaji wa Damu katika Tawala za Mikoa na Serikali za Mitaa 2019. Sourced from Dodoma RRH June 2019.

37. URT, MOHCDGEC &WHO 2017. A report from mid-term review of national malaria control strategic plan 2014—2020 in mainland Tanzania.

38. URT 2007. Mpango wa Maendeleo ya Afya ya Msingi (MMAM) 2007-2017.

39. URT MOHCDGEC & PO-RALG 2017. Direct Health Facility Financing Guide.

40. URT 2017. Tanzania HIV impact survey 2016-2017.

41. URT 2013. National Nutrition Social Behavior Change and Communication Strategy July 2013-June 2018.

42. URT, PMO 2016. National Multisectoral Nutrition Action Plan-NMNAP. From Evidence to Policy to Action (July 2016 – June2021).

43. URT, W Bank, Dfid 2017. Tanzania Urban Resilience Program (TURP) 2018 Report.

44. Veneranda M. Bwana et al 2019. Patterns and causes of hospital maternal mortality in Tanzania: A 10-year retrospective analysis. https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0214807

45. www.who.int/ World Health Report 2006 updates

46. www.lancet.com/lancet vol 6 November 2018

Ministry of Health, Community Development, Gender, Elderly and Children
Government City - Mtumba Area,
P. O. Box 743
40478 Dodoma