THE UNITED REPUBLIC OF TANZANIA
MINISTRY OF HEALTH
AND

PRESIDENT'S OFFICE, REGIONAL ADMINISTRATION AND LOCAL GOVERNMENT

THE PRIMARY HEALTH SERVICES IMPLEMENTATION DEVELOPMENT STRATEGY (PHSIDS)

(*MKAKATI WA UTEKELEZAJI WA MAENDELEO WA AFYA YA MSINGI*) 2022 -2032

DECEMBER, 2022

Contents

List of Tables

ACRONYMS

AIDS	Acquired Immune deficiency Syndrome
ART	Anti- Retroviral Therapy
ASRH	Adolescent Sexual Reproductive Health
ATF	AIDS Trust Fund
BOD	Burden of Disease
CCHP	Comprehensive Council Health Plan
CHF	Community Health Fund
CHMT	Council Health Management Team
CHR	Child Mortality Rate
CHSB	Council Health Services Board
CMO	Chief Medical Officer
CPD	Continue Professional Development
CPR	Contraceptive Prevalence Rate
DHIR	District Health Infrastructure Rehabilitation
DHS	Demographic Health Survey
DFID	Department for International Development
DOT	Direct Observed Treatment
DUHP	Dar es Salaam Urban Health Project
DPs	Development Partners
EHIP	Essential Health Interventions Package
EMD	Emergency Medical Department
EmOC	Emergency Obstetric Care
ENA	Essential Nutrition Actions
ENT	Ear, Nose and Throat
EPI	Extended Programme on Immunization
EPZ	Export Processing Zone
ERP	Economic Recovery Programme
ESAF	Economic Structural Adjustment Facility
ESAP	Economic and Social Action Programme
ETAT	Emergency Triage Assessment and Treatment
FANC	Focused Ante-natal care
FP	Family Planning
FPMS	Financial Planning and Management System
GDP	Gross Domestic Product
GNP	Gross National Product
GOT	Government of Tanzania
GOTHOMIS	Government Hospital Management Information System
HBS	Household Budget Survey
HC	Health Centre
HE	Health Education
HIS	Health Information System

HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HRD	Human Resources Development
HSR	Health Sector Reforms
HRHIS	Human Resources Health Information System
ICB	International Competitive Bidding
iCHF	Improved Community Fund
ICU	Infection Control Unit
IDA	International Development Agency (World Bank)
IEC	Information Education and Communication
ILO	International Labour Organization
IMCI	Integrated Management of Childhood Illnesses
IMR	Infant Mortality Rates
IPPF	International Planned Parenthood Federation
IRS	Indoor Residual Spray
IRP	Integrated Roads Programme
IRTAP	Industrial Restructuring and Trade Adjustment
IVD	Immunization and Vaccine Development
JAS	Joint Assistance Strategy
JRF	Joint Rehabilitation Fund
KMC	Kangaroo Mother Care
LC	Local Competition
LGA	Local Government Authority
LFCP	Lymphatic Filariasis Control Programme
LLINs	Long Life Insecticide Nets
MCH	Maternal and Child Health
MCHA	Maternal and Child Health Aides
MDG	Millennium Development Goals
MIS	Management Information System
MKUKUTA	Mkakati wa Kukuza Uchumi na Kupunguza Umaskini Tanzania
MMAM	Mpango wa Maendeleo wa Afya ya Msingi
MNH	Muhimbili National Hospital
MNR	Maternal Mortality Rates
MOF	Ministry of Finance
MOHSW	Ministry of Health and Social Welfare
MPDE	Methodology for Project Design and Evaluation
MRC	Mass Replacement Campaign
MRTH	Muhimbili Research and Teaching Hospital
MUCHS	Muhimbili University College of Health
NACP	National AIDS Control Programme
NACTE	National Accreditation Council of Tanzania Examination
NDP	National Drug Policy
NGO	Non - Governmental Organization
NIDA	National Identification Authority
NIMR	National Institute for Medical Research
NORAD	Norwegian Agency for Development Cooperation

NSGRP	National Programme for Economic Growth and Poverty Reduction (MKUKUTA)
NTDs	Neglected Tropical Diseases
OBYS	Obstetrics and Gynaecology
OPD	Out patients Department
PAC	Post Abortal Care
PCR	Project Completion Report
PER	Public Expenditure Review
PFP	Policy Framework Paper
PHC	Primary Health Care
PHLHIV	People Living with Human Immunodeficiency Virus
PHN	Public Health Nurse
PHSDP	Primary Health Services Development Programme
PHSIDS	Primary Health Services Implementation Development Strategy
PIU	Project Implementation Unit
PMO-RALG	Prime Minister's Office, Regional Administration and Local Government
PO-RALG	President's Office Regional Administration and Local Government
PMTC	Prevention of Material to Child Transmission of HIV
POA	Programme of Work
PPB	Patients per Bed
PSMGG	Public Service Management Good Governance
PVS	Prime Vendor System
RHMT	Regional Health Management Teams
RMAs	Rural Medical Aides
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent health
RPFB	Rolling Plan and Forward Budget
RS	Regional Secretariat
SCD	Sickle Cell Disease
SOPs	Standard Operation Procedures
STI	Sexual Transmitted Infections
SWAp	Sector Wide Approach
TA	Technical Assistance
TACAIDS	Tanzania Commission for AIDS
TAF	Technical Assistance Fund
TB	Tuberculosis
TBA	Traditional Birth Attendant
TCU	Tanzania Commission for Universities
TFR	Total Fertility Rate
TMDA	Tanzania Medicines and Medical Devices Authority
TRCHS	Tanzania Reproductive and Child Health Survey
TRHS	Three Region Health Study
TIIS	Training Institutes Information Systems
TSH	Tanzanian Shillings
TT2	Tetanus Toxoid 2
WISN	Workload Indicators for Staffing Needs

FOREWARD

This Primary Health Services Implementation Development Strategy denoted in *Swahili Mkakati wa utekelezaji wa Maendeleo ya Afya ya Msingi* document highlights the national effort towards the attainment of Universal Health Coverage (UHC). It contains most of the strategies which are relevant for implementation of health interventions which are key to our health development. Most of the strategic plans, policies and guidelines for health development are addressed by this Program document and then synchronized to create the needed synergy among the different approaches. Health is one of the key sectors in the development of a country.

The various interventions involve provision of resources, buildings, medicines and equipment which make it possible for implementation of specific interventions to desired goals through disease control, treatment and sustained surveillance. Monitoring and evaluation should inform the overall achievement, areas required to be rectified and any deviations which we need to avoid. It is with this understanding that we take monitoring and evaluation very seriously and should be allocated enough resources to be done accurately and inform accordingly and the results taken seriously.

Finally we take this opportunity to urge the responsible authorities to ensure that this Programme document is available to all beneficiaries and other stakeholders so as to provide the opportunity and ability for every concerned individual to gauge the progress for the period this document is supposed to guide us towards the achievement of Universal Health Coverage.

Prof. Abel N. Makubi
PERMANENT SECRETARY,
Ministry of Health.

Prof. Riziki S. Shemdoe
PERMANENT SECRETARY,
President's Office Regional Administration and Local Government

ACKNOWLEDGMENT

The development of The Primary Health Service Implementation Development Strategy (PHSIDS) is a long process which involved consultations with stakeholders, detailed understanding of the different policy documents, strategic documents and guidelines. PHSIDS brings together all these documents for easy reference. The Ministry of Health (MOH) and the President's Office - Regional Administration and Local Government (PORALG) appreciate technical and financial support that facilitated the development of the document.

Specific acknowledgement is extended to the Ministry Officials from MOH, PO-RALG for spearheading and facilitating the development of this guideline. Appreciation is extended to Mr. Edward Mmbaga - Director of Policy and Planning, Mr. Lusajo Ndagile-Assistant Director of Policy and Planning (MoH), Dr. Catherine Joachim- Head of Health Sector Coordination and Dr. Ntuli A. Kapologwe-Director of Health, Social Welfare and Nutrition Services (PO-RALG). In the same vein, appreciation is extended to Dr. Paul Chaote - Assistant Director of Health Services (PO-RALG), Dr. Yusuph S. Sonda, Ally Kananika, Mr. Raymond Kiwesa, Dr. Salum Bakari, Sarah Hussein, Joyce Kalamule and Stephen Kitinya, for the coordination and provision of technical inputs during the whole process of developing this guideline.

Specific acknowledgement is extended to MOH National Programme Managers who provided their inputs and their Strategic Plans, these include Health Policy, HSSP V, Malaria, HSHSP, TB/L, NCDs, One Plan III, HRH, NTD, HCW, Traditional and Alternative Medicines, Nutrition Multi - sectoral Plan, DHSWNS, STG & NEMLIT 6th Edition, Draft Tanzania Quality Improvement Strategic Framework in HealthCare, Strategic Implementation Plan for PORALG Health, Social Welfare and Nutrition Services Division and the Annual Health Sector performance reports.

Appreciation is further extended to all stakeholders specifically the Regional and District Medical Officers, Medical Officer and Health Facility in-charges, Health Secretaries, Council Health Service Board members to mention a few, who were contacted and provided their inputs during the development of this document.

Special thanks goes to the Consultants: Dr. Anna Nswilla, Dr. Adeline Kimambo and Dr. Peter Kilima who tirelessly reviewed relevant policies and technical guidelines and strategic plans and provided the link between this document and other documents whose intention is to guide the country in the implementation of primary health care.

The Ministries acknowledges the financial assistance provided by Global Fund support for successful development of this PHSIDS.

Prof. Tumaini J. Nagu
Chief Medical Officer

EXECUTIVE SUMMARY

The Primary Health Service Implementation Development Strategy (PHSIDS) is intended to guide the Country in fulfilling her noble goal of providing quality and equitable health services to its citizens as strategy towards achieving Universal Health Coverage (UHC). Since independence in 1961, the Government has consistently focused its development strategies on combating ignorance, diseases, and poverty. Quality health services delivery is one of the major contributor to fighting diseases as well as improving the quality of lives of the people leading to improving country's economic development.

Since 2005, Tanzania's gross domestic product (GDP) annual growth rate averaged 7%, which was in line with poverty reduction strategy target of 6%–8% per annum. GDP stands at 6.7percent by 2018 in Mainland Tanzania. Poverty varied across geographic areas, with rural areas worse off than urban.

During the last decade, Tanzania made major progress in health sector leading to a continuous increase in life expectancy for Tanzanian at birth 66.08 in 2022: Female 68; Males 66)[1].
Contrary to this positive trend, there no reduction on infectious diseases; and the burden of Non Communicable (NCDs) is increasing and risk factors for NCDs are on the rise.
On a positive note, services for pregnant and childbearing women, and neonates have improved considerably during HSSP IV implementation period[2]. Further reduction of neonatal and child mortality rates is needed for achieving the SDG targets.

There have been improvement on other disease too. Malaria deaths in all age groups have decreased by 67 percent from 6,311 in 2015 to 2,079 in 2019/20. There were 2,079 deaths for year 2019, among which under five deaths were 957 (46 percent).

In 2017, HIV prevalence was 4.7% in general population. The prevalence of HIV among young people aged 15-19 years was 1.3% among girls, and 0.8% among boys.

On Feb 22, 2022, a new push for the control of HIV/AIDS was initiated by

[1] Chart and table of Tanzania life expectancy from 1950 to 2022. United Nations projections.

[2] URT: Ministry of Health ; HSSP implementation through the years 2015-2020

the signing of an MOU between TACAIDS and the Tanzania Private Sector Foundation (TPSF), whereby TPSF will work more closely with TACAIDS in AIDS /HIV control effort.

Tuberculosis has continued to be among the main causes of death in the country. During 2019/20, 92 percent of TB patients were treated and recovered compared to 90 percent who were treated and recovered in 2014/15. HIV testing for TB patients has reached 99 percent in 2019/20, up from 93 percent in 2014/15.

Tanzanian's under-five mortality rate is declining at an encouraging rate, followed by infant mortality rate. Under-five mortality rate has decline from 76 per 1,000 live births in 2015/2016 to 50 per 1,000 live birth in 2019/20. The number of pregnant women giving birth at health facilities increase from 64 percent in 2015/16 to 83 percent in 2019/20.

The burden on NCD is increasing and risk factors for NCDs are on the rise. Access to health care is not yet equitable, and quality health services are not provided in every ward. The increase in health infrastructure during the implementation of the fourth Health Sector Strategic Plan (HSSP IV 2015-2020) has not gone hand in hand with the increase in human resources for health. While the number of health professionals and the capacity for training has increased, the shortage of health workers is at all levels of health care, with Human resources in the health shortage estimated at 52 per cent of the actual need.

To achieve health for all, the government has developed a number of enabling policies. Enabling policies are both national and international commitments like National Vision 2025, National Five Year Development Plan 2021-2026, Sustainable Development Goals (SDG) 2016-2030, East African Community, Southern African Development Community, and National Health Policy 2020, Health Sector Strategic Plan, and Policy Paper on Local Government Reform. The process of developing this Strategy applied a review of a mix of methodologies and strategies within these documents.

The Strategy aims at empowering all levels of government and communities; involving them in health services provision. Despite the construction of health care facilities, some citizens still have to travel long distances to access services. Currently, in order to ensure that health services reach all the people, the government is focusing on strengthening district/Council health services to ensure easy access to health services by all.
The community has continued to participate in the construction of health facilities and management of health care delivery through Health Facility Governing Committees. There indications that the country is moving in the

right direction, and therefore it is worthy to accelerate in the same direction.

Outbreaks of endemic diseases like measles, and new diseases like Coronavirus disease 2019 (COVID-19) threaten the well-being of population. There is still inequitable access to health care for several groups in the population, especially the most vulnerable and marginalized communities due to social cultural, epidemiological, and geographical and terrain variations.

Treatment and disposal of medical waste is still insufficient in many of the health facilities (from primary to tertiary level), although guidelines are in place. Improvement is necessary for environmental reasons but also for reduction of risk of spreading diseases.
As a response, the Ministry has developed this PHSIDS, which is focusing on catalyzing government, community and individual efforts towards accelerating provision of quality primary health care services to all Tanzanians by 2032.

The PHSIDS have components. Some of these components and targets intended to be achieved during the lifetime of the program are shown in the Annex 2.

Monitoring and evaluation of the programme is another important component of the programme. There will be a continuous and regular monitoring of the programme punctuated by a mid-term and end-term evaluation.

1. BACKGROUND INFORMATION

1.1 Introduction

Disease conditions have direct impact on socio - economic development of nations. Differentials in health conditions explain a substantial part of the difference in growth rates between countries. Tropical regions are hindered in development relative to temperate regions, probably because of higher disease burdens and limitations on agricultural productivity[3]. Since independence in 1961, the Government has consistently focused its development strategies on combating ignorance, diseases, and poverty[4]. Quality health services delivery is one of the major contributor to fighting diseases as well as improving the quality of lives of the majority of people. Delivery of quality Primary Health Care requires good information on country's geographical features, administrative structures, current population characteristics, socioeconomic situation, health status, organization and management of health services and the current health care services and health status in the country.

1.2 Geographical Features

The United Republic of Tanzanian (URT) is a union between Tanganyika and Zanzibar, which was formed in April 1964. It lies between the latitudes 1^{o}S and 12^{0}S and longitudes 30^{0} East and 40^{0} East. It is the largest country in East Africa, occupying an area of about 945,087 sq. Km. The country shares borders with eight countries, namely: Kenya and Uganda to the North: Rwanda, Burundi and Democratic Republic of Congo to the west, Zambia, Malawi and Mozambique to the South. The Indian Ocean forms eastern border. There are two seasons of rainfall – long rains from March to May and short rains from November to January. The vastness of the country poses great challenges to physical positioning and accessibility of health facilities. Disease pattern to some extent is influenced by seasonal variations.

1.3 Administrative Structure

Tanzania Mainland is divided into 26 administrative regions and 139 districts with 184 Councils. Each district is divided into 4 – 5 divisions, which in turn are composed of 3 – 4 wards and each ward has 5 – 7 villages. There are a total of 43,956 Wards divided into 12,318 villages[5]. Management of government

[3] Gallup, Sachs, and Mellinger (1999)

[4] Maendeleo Dialogue, Democracy in Tanzania, Issue VI January 2010

[5] Amri ya mgawanyo wa maeneo ya Utawala katika Serikali za Mitaa (Mamlaka za Miji na Wilaya) (marekebisho) ya mwaka 2020 NA TANGAZO LA SERIKALI NA 74A la tarehe 31/1/2020 na TANGAZO LA SERIKALI NA 498A la tarehe 29/6/2020

activities within districts are through Local Government Authorities (LGAs). The Council is the most important administrative and implementation authority for public services as it is close to the people. For this reason, the Ministry of Health (MOH) has assumed the role of policy formulation whereas the Presidents' Office Regional Administration and Local Government (PORALG), through the LGAs delivers health services in line with established national and international standards. Local Government Authorities at Council level has been playing a key role in the implementation of this programme in an effort to attain Universal Health Coverage (UHC).

1.4 Population characteristics

The total population of mainland Tanzania in 2021 is projected at 57,724,380 with a population growth rate of 2.7%, and an average of 5.1 household members[6]. The rapid population growth has an impact on the available resources, especially on public expenditures including health.

The annual population growth rate, according to the 2012 Population and Household Census, is 3.1 percent. Total Fertility Rate (TFR) stands at 4.5 per woman indicating a decline as compared to 2007 (6.3) population projection Census. The population is relatively young, with 46 percent of the total population under 15 years of age. The average household size is 4.9 inhabitants. The population density was 63.58 people per sq. Km in 2018. Higher population clusters occur in the northern half of the country and along the eastern coast. The population of Tanzania has continued to be predominantly rural despite the increase in proportion of urban residents over time, from 6 percent in 1967 to 30 per cent in 2016. The increasing population exerts a massive pressure to the provision of primary health services.

1.5 Socio economic information

Since 2005, Tanzania's gross domestic product (GDP) annual growth rate averaged 7%, which was in line with poverty reduction strategy target of 6%–8% per annum. GDP grew 6.7percent from 2013 to 2018 in Mainland Tanzania. The percentage shares of GDP at current prices (after adjustments of taxes on products) by sectoral contribution include agriculture and mining (30.7%), industry and construction (29.1%), and services (40.2%)[7] . The incidence of income poverty (i.e., basic needs and food poverty) did not decline significantly. Out of every 100 Tanzanians, 36 were poor in 2000–2001 compared to 34 in 2007 and 22.8 in 2011-2012 (Household Budget Survey 2012). Income poverty varied

[6] Source: NBS: National population projection February 2018

[7] National Bureau of Statistics. https://www.nbs.go.tz/index.php/en/tanzania-in-figures/422-tanzania-in-figures-2018. Accessed March 05th 2020.

across geographic areas, with rural areas worse off than urban. Tanzania was classified by the United Nations (UN) as a lower middle-income country with the Gross National Income (GNI) per capita of US$1,080 in 2020.[8] About 26.4percent of Tanzanians live below the national poverty line. The primary education net enrolment rate was 94.2 percent, and the adult literacy rate was at 79 percent in 2018. According to the National Bureau of Statistics[9], the national labour force has grown from 22.3 million people in 2014 to 24.3 million people in 2018.

1.6 Health Status

1.6.1 Situation in the health sector

During the last decade, Tanzania made major progress in health sector leading to a continuous increase in life expectancy for Tanzanian at birth. In particular, Tanzania was successful in reduction of neonatal and child mortality, as well as childhood malnutrition. Mortality due to major communicable diseases including HIV, tuberculosis (TB) and Malaria, is decreasing. Contrary to this positive trend reduction of infectious diseases, the burden of Non Communicable (NCDs) is increasing and risk factors for NCDs are on the rise. Services for pregnant and childbearing women, and neonates have improved considerably during HSSP IV implementation period. But further reduction of neonatal and child mortality rates is needed for achieving the SDG targets. Adolescent childbearing remains persistently high. Fertility and unmet need for family planning are still high despite positive trends.

In the last decade the number of health facilities nearly doubled, and availability of medicines improved substantially. Despite the increase in training outputs, shortages of human resources for health remains high, around 50% of the actual need. Information technology and information systems have improved across the board in Tanzania, Making the health sector ready for the 21st century. Domestic funding for health has doubled in the last decade, also through improving access to health insurance schemes, but falls short of creating access to quality care for all. Governance of health sector was strengthened through decentralization by devolution, with more responsibilities for communities in planning and accountability. Some new development in society pose new challenges to the Tanzanian health sector: First the demographic and epidemiological transitions lead to more ageing population and hence more NCDs. Industrialization and urbanization demand new types of services for the urban poor. Climate change may lead to more extreme weather conditions than

[8] World Bank. https://data.worldbank.org/country/tanzania. Accessed 27th March, 2020.

[9] Ibid

experienced in the past, with an epidemiological impact. Globalization in trade and human travel leads to new spread of diseases, like recently experienced with COVID - 19. On a positive note; information and communication technology offers new opportunities ranging from electronic medical records, to online supervision, training and health education.

Despite all these developments, access to health care is not yet equitable and quality health services are not yet provided in every ward. The increase in health infrastructure has not gone hand in hand with increase in human resources for health. While provision of medicines has improved, adequate diagnostic equipment and treatment remains unavailable for some conditions. Health care financing has improved and more domestic sources of funding have become available, though the increase of resources is not keeping pace with inflation and population growth. The health financing strategy was not implemented, and the population covered by health insurance stays below expectations.

1.6.2 Burden of Disease of some selected diseases/conditions

Malaria Incidence: malaria deaths in all age groups have decreased by 67 percent from 6,311 in 2015 to 2,079 in 2019/20. Out of 2,079 deaths for year 2019, under five 957 deaths (46 percent)[10]. The confirmed cases of Malaria have been registered to increase from 2015 to 2019 due to constant availability of diagnostic facilities especially malaria Rapid Diagnostic Tests (mRDTs). The introduction of Service and Data Quality improvement (MSDOI) package has also increased the performance of the health facilities on malaria indicators.

Prevalence of HIV: It is estimated that around 1.4 million people were infected with HIV in the country in Tanzania by 2017. HIV prevalence of 4.7% in general population. The prevalence of HIV among young people aged 15-19 years was 1% (1.3% among girls, and 0.8% among boys). Furthermore, the percentage of women aged 20-24 infected with HIV is higher (4.4%) than that of men (1.7%) in the same age group[11].

On Feb 22, 2022, a new push for the control of HIV/AIDS was initiated by the signing of an MOU between TACAIDS and the Tanzania Private Sector Foundation (TPSF), whereby TPSF will work more closely with TACAIDS in AIDS /HIV control effort.

Tuberculosis incidence: Tuberculosis has continued to be among the top causes of death in the country. During 2019/20, 92 percent of TB patients were treated

[10] National Five Year Development Plan III 2021/22- 2025/26

[11] TACAIDS 2018

and recovered compared to 90 percent who were treated and recovered in 2014/15. In addition participatory TB and AIDS services have improved and HIV testing for TB patients has reached 99 percent in 2019/20, up from 93 percent in 2014/15[12].

Maternal mortality, neonatal mortality and under-five mortality: Tanzanian's under-five mortality rate is declining at an encouraging rate, followed by infant mortality rate. This is due to improvements made in the health services delivery across the country. Under-five mortality rate has decline from 76 per 1,000 live births in 2015/2016 to 50 per 1,000 live births in 2019/20. Maternal mortality rates (MMRs) in Tanzania have remained unacceptably high at around 500 per 100,000 live births13. More efforts and innovations are needed to initiate a clear downward trend in MMRs in Tanzania.

Tanzania has continued to be one of the leading countries in Africa in vaccinating children under one year. In 2019/20, 98 percent of all children under one year old were vaccinated (Penta3 vaccine) compared to 82 percent in 2015/16, thus exceeding the 90 percent target set by the world health organization (WHO). Also, during 2019/20, 81 percent of all pregnant women made four (4) or more visits at antenatal clinics compared to 39 percent in 2015/16 implying that more pregnant women receive quality care and advice on safe birth control methods. The number of pregnant women giving birth at health facilities increased from 64 percent in 2015/16 to 83 percent in 2019/20.

Population dynamics: The total fertility rate (TFR) was recorded at 4.9 births per reproductive woman in 2019, a decline from 5.2 births per woman recorded in 2016. However, it is worthy to take note that some regions in the country have high TFR more than national average. One of the consequences of the high FTR amidst rapidly declining mortality is that Tanzania's population grows at relatively high pace, and heavily youthful, with children between 0-14 years old constituting about 44 percent of the total population. In 2020, the age dependency ratio in Tanzania was 85.9 percent[14]. This meant that there were around 86 people aged 0-14 years and 65 years and older per 100 working-age population (aged 15-64 years). The ratio declined from 90 percent in 2000, indicating a reduced burden for the working-age population.

Stunting and wasting Prevalence: Tanzania National Nutrition Strategy has continued to guide nutrition issues, aimed at reducing all forms of malnutrition.

12 National Five Year Development Plan III 2021/22- 2025/26

13 Policy brief 40424 | October 2018

14 Julia Faria, Research expert covering Angola, Kenya & Tanzania

The nutrition situation among children under five years has improved, underweight has decreased from 13 percent in 2014/15 to 10 percent in 2019/20 while children born underweight at less than 2.5 kg has also declined from 6.5 percent in 2019/20. Prevalence of stunting among children under 5 years (0–59 months) has decreased from 42% in 2010 to 32% in 2016. Whereas the Prevalence of underweight among children under 5 years (0–59 months) also decrease from 16% in 2010 to 14% in 2016[15].

1.7 Status of Primary Health Care

Primary health care (PHC) addresses the majority of a person's health needs throughout their lifetime. PHC is an all-inclusive approach that includes health promotion, disease prevention, treatment, rehabilitation and palliative care. It is made of a number of dispensaries, health centres and District hospitals at the district level. Currently the health facilities for both public and private include 6,937 dispensaries, 930 health centres and 312 hospitals distributed throughout the country. The dispensaries and health centres that are at a centre of primary health care facilities were planned to serve an average population of 10,000 and 50,000 respectively. However, with increasing population and slow pace of construction primary health facilities coupled with shortage of human resources for health and inadequate medical equipment, the average population served by each dispensary and health centres is more than the planned population, overstretching the effective functioning of the current primary health care facilities. The geographical accessibility of the current primary health facilities is improving though, there is great variation due to land terrain and lack of reliable transport.

1.8 The coverage of Health Insurance Schemes

The National Health Insurance Fund (NHIF) adopted by the government is a vehicle for accessing quality health services for all. The government has continued to provide quality and affordable health services in the country to every citizen. The government is constructing health facilities with accordance to set criteria of targeting areas with the diseases, areas with large population , and poor accessibility of health services due to geographical location. The number of health facilities have increased from 6,871 in 2015/16 to 8,458 in 2021. Also the Government has continued to reduce the gap of Human Resources for Health from 86,152 in 2015/16 to 102,469 in 2021 equal to 46.78 perecnt of the required health care workers. In addition, the Government has increased the budget for medicines, medical supplies and medical equipment from 30.0 billion in FY 2015/16 to 230.0 billion in FY 2020/21. Strenghtened ICT systems together

[15] DHS 2010 and DHS 2015-2016

with supervision of health services in order to reach the goal of Health for all.

Financing health services

Health services are financed through many sources including Central Government, User fees, Development Partners (DPs) and Health Insurances. According to the available data from the National Health Accounts (NHA) total expenditure of health sector was 5.42 trillion Tanzanian Shillings in FY 2019/20, contributed by the following: the Government 1.2 trillion (22%), DPs TZS.1.8 trillion (34%), user fees TZS. 1.7 trillion (32%) and Health insurance funds TZS. 653.0 billion (12%.

Introduction of the Prepayment schemes/ Cost sharing system.

Since independence, the Government has been providing free health services to her people. The objective of this was to ensure provision of quality health services to all Citizens. However, due to increase in costs of provision of health services and increase of the population which didn't much with the increase in economy of the country, the implementation of providing free health services was no longer possible due to many challenged as a result many alternative strategies were sought. In 1990 the Government developed the Health Policy and in 1993 introduced cost sharing for health services starting with user fees together with an introduction of Exemption policy.

In 1996, the Government started implementation of pre-payment schemes by introducing Community Health Funds (CHF) as a pilot in Igunga DC, Tabora region. After successful results, the Government in 2001 formulated the CHF Law and the scheme was implemented in all councils in the country under the supervision of the LGAs whereby each LGA formulated a CHF By Law. Unfortunately the By Law had no mandatory provision for joining the CHF scheme by all people which rendered the scheme un-functional. In 2018, it was reviewed and changed to improved Health insurance fund (iCHF). For 20 years up to December 2021, the Scheme had enrolled only six percent (6%) out of the total population 57,179,654 expected to be enrolled in the CHF scheme.

In 1999 the Government prepared the National Health Insurance Fund (NHIF) Legislation for Public Servants. The Legislation was mandatory to all Public Servants to join the fund. In 2012 and 2015, the Government made an amendments to the National Health Insurance Fund Legislation (Cap 395) to include Employees from Government Agencies and Companies in the Public Servants groups and allowed other different groups to enrol in the National Health Insurance Fund. By December 2021, beneficiaries of the NHIF were 4,450,451. Out of these beneficiaries 3,007,373 were Public Servants, 1,443,078 different groups from private non - formal sector. The Public Servant members'

enrolment was 99 percent of the target because it was mandatory.

By December 2021, the total beneficiaries of health insurance funds were 8,567,486 (15.3%) of the total population approximately 57,724,380 people, according to the National Bureau of Statistics (NBS). Out of these beneficiaries 4,450,451 (8%) were from NHIF, 3,327,415 (6%) beneficiaries from CHF, 229,960 (0.3%) beneficiaries enrolled into the National Social Security Fund (NSSF) and Social Health Insurance Benefits (SHIB)) were 55,660 (1%) of all enrolment was from Private health insurances (AAR, Resolution, Jubilee, Strategis, Britam and Bima Mkononi).

The Government is in the process of developing the Health Insurance Legislation which will make it mandatory to every citizen to be insured for implementation of the Universal Health Coverage (UHC) in the context of Health for All. Citizens will be able to join any Health Insurance Scheme either NHF, iCHF, Private Companies Health Insurance schemes etc.

Implementation of the Health Insurance for all Act /Legislation, expects to increase membership from 8,594,455 to 18,063,379 (29%) of the total population in 2023. This number is expected to continue increasing up to 27,326,377 (42%) of all population by 2025 and reach 52,434,299 (70%) of all population by 2030.

After the legislative is in place, contributions from NHIF members is expected to increase from TZs 1.86 trillion by 2023 to TZs. 3.08 trillion (2025). This increase is expected to reach at TZs. 7.35 trillion in 2030. At the same time the Fund expenditure will also increase from TZs 1.53 trillion in 2023 to TZs. 2.62 trillion by 2025 will continue increasing up to TZs. 6.33 trillion in 2030.[16]

2 POLICY CONTEXT

The government has developed a number of enabling policies and environment as an effort to strengthen the health services in the country. Enabling policies are both national and international commitments like National Vision 2025, National Five Year Development Plan 2021-2026, Sustainable Development Goals (SDG) 2016-2030 and National Health Policy 2020, Health Sector Strategic Plan, and Policy Paper on Local Government Reform.

[16] **JMT: Wizara ya Afya: Andiko la Mapendekezo ya kuboresha Mfumo wa Bima ya Afya Kiambatisho Na 2; June 2022**

2.1 The process of developing Primary Health Services Implementation Development Strategy

The process of developing/reviewing the Primary Health Service Implementation Development Strategy 2022-2032 (PHSIDS) applied a mix of methodologies.

The process involved reviewing available midterm reports, guidelines and sector strategic plans. The objectives of the review was to identify lessons for improving the formulation of the PHSIDS.

The review also assessed progress made in implementing agreed international and regional commitments addressed in the Health Sector Strategic Plan (Health Systems/ Disease Health National Strategic Plans). a) Literature review: the preparation of this PHSIDS involved a comprehensive review of various documents. Documents reviewed include:
The fifth Health Sector Strategic Plan (HSSP V) 2021- 2026, the Mid-Term Review of the HSSP IV in October 2019 formulated recommendations, Joint Annual Health Sector Policy Meeting in November 2019 formulated priorities for HSSP V, The National Health Policy 2007, the Draft Final Health Policy 2020 and Policy Implementation Strategy 2020 – 2030, Policy Guideline for Community Based Health Services, The Tanzania Development Vision 2025 (TDV 2025)[17], National Malaria Strategic Plan 2020/2021- 2025/2026 (*"Transitioning to Malaria Elimination in phases"*), National Tuberculosis and Leprosy Strategic Plan VI 2020 -2025 *("Impactful Innovative Strategies towards Ending TB and Leprosy Suffering and Burden"*), Strategic master Plan for the Neglected Tropical Diseases Control Program July 2021- June 2026 (*"Sustain Gains for Control and Elimination of NTDs"),* National Strategic Plan for Prevention and Control of Non – Communicable Diseases 2021- 2026 (*" Leaving No One Behind"),* Health Sector HIV Strategic Plan V 2021-2026, Tanzania Immunization Strategy 2021-2025, National Plan for Reproductive, Maternal, Newborn, Child and Adolescent Health & Nutrition 2021/2022 - 2025/2026 One Plan III, National Multisectoral Nutrition Action Plan 2021/2022 – 2025/2026, National Traditional and Alternative Medicines Strategic Plan 2026/2017- 2020/2021, Primary Health Services Development Programme – MMAM 2007-2017, Mid-tern Review Report of Primary Health Services Development Programme – MMAM 2018, Human Resources for Health Strategic Plan July 2021- June 2026, The third Five Years' Development Plan 2021/22 – 2025/26 (FYDP III), National Essential Health Care Intervention

[17] United Republic of Tanzania, Ministry of Health, Community Development, Gender, Elderly and Children. 2017. National health policy – 2017. Dar-es-Salaam. United Republic of Tanzania

Package – Tanzania (NEHCIP- Tz) (2013), Standard Treatment Guidelines and National Essential Medicines List for Tanzania Mainland Six Edition 2021, The Election Manifesto 2020 - 2025, Draft Tanzania Quality Improvement Strategic Framework in HealthCare 2021-2026, Strategic Implementation Plan for PORALG Health, Social Welfare and Nutrition Services Division 2021-2026, Annual Health Sector Performance reports, PORALG Health Sector facilities Rehabilitation and Construction implementation reports, National Health Workforce Volunteering Guidelines, National Guideline for Emergency Care Services in Health Facilities: First Edition April 2019, The Intensive Care Services guideline June 2022, Comprehensive Council Health Planning Guidelines 5th Edition 2020 and 4th Edition guidelines.

b) Consultation was employed whereby, stakeholders consulted at different levels of developing the PHSIDS 2022 - 2032, Technical health sector experts from Ministry of Health, PORALG, Regions, Councils, including Council Health services Board members, Health facility teams from Dispensary and Health centers to ensure consistency and accuracy of information and data throughout the initial drafting of the PHSIDS focusing on enhancing ownership and Published journal articles on primary health care development in Tanzania.

2.2 The Tanzania Development Vision 2025 (TDV 2025)[18]

Provides direction and a philosophy for long term development. By 2025, the country desires to achieve a high quality of livelihood for its citizens, peace, stability, unity, good governance, a well-educated society and a competitive economy capable of producing sustainable growth and shared benefits by 2025 The TDV 2025 recognizes health as one of the priority sectors contributing to a high- quality livelihood for all Tanzanians.

In the Tanzania Development Vision 2025 the main objective is achievement of high quality livelihood for all Tanzanians. This is expected to be attained through strategies, which will ensure realization of the following health services goals: -

1. Access to quality primary health care for all;
2. Access to quality reproductive health service for all individuals of appropriate ages;
3. Reduction in infant and maternal mortality rates by three quarters of current levels;

[18] United Republic of Tanzania, Ministry of Health, Community Development, Gender, Elderly and Children. 2017. National health policy – 2017. Dar-es-Salaam. United Republic of Tanzania

4. Universal access to clean and safe water;
5. Life expectancy comparable to the level attained by typical middle-income countries;
6. Food self-sufficiency and food security;
7. Gender equality and empowerment of women in all health parameters;
8. Encourage the participation of community in the delivery of health services.

In line with Government Development Vision 2025 goals, the Ministry of Health and PORALG is expected to contribute towards the improvement of health status and life expectancy of the people of Tanzania. This can partly be achieved through good health policies and effective implementation of public health interventions.

2.3 The Sustainable Development Goals – 2016 – 2030

The Sustainable Development Goals (SDGs)[19] constitute a global post 2015 development agenda with a vision focusing on values of equity, sustainability, peace and security and the elimination of poverty. The 17 goals are balanced between development and protection of the human environment and social development and equity. Goal number three seeks to ensure health and well-being for all, at every stage of life. The Goal addresses all major health priorities, including reproductive, maternal and child health; communicable, non-communicable and environmental diseases; universal health coverage; and access to safe, effective, quality and affordable medicines and vaccines. These interventions are on -going and will be accelerated through the implementation of the PHSIDS.

The majority of the poor and specifically the rural poor suffer from the above and other preventable conditions. The Ministry will continue to advocate for an increase in resource allocation to address cost effective interventions, while at the same time join hands with other stakeholders, the communities and development partners to reorient the services to be more responsive to the needs of the population, and specifically targeting the indigent and vulnerable groups. PORALG, as main implementer, will continue to be innovative by identifying ways of collecting own source revenue to bridge gaps in the implementation of health intervention.

[19] United Nation Department of Economic and Social Affairs. 2015. Sustainable development goals. https://sustainabledevelopment:Un.org/topics/sustainabledevelopmentgoals

2.4 East African Community

In order to promote the achievement of the objectives in respect to cooperation in identified priority health activities in the region as set out in Article 118 of the Treaty for the establishment of the East African Community (EAC), five standing Technical Working Groups responsible for handling detailed health matters are operational. These are:

- Medicines and food Safety, EAC medicines Registration Harmonization Project, aiming at an integrated registration, saving costs, and increasing access to affordable quality medicines.
- Control and prevention of Sexually Transmitted Infections (STIs), HIV and AIDS: Enhance regional harmonization of policies and best practices and develop a regional response on evidence based interventions.
- Control and Prevention of Communicable and Non-Communicable Diseases: Enhance collaboration in the East African Public Health Laboratory Network, in the East African Integrated Disease Surveillance Network and improve Pandemic Preparedness in East Africa.
- Health Research, Policy and Health Systems Development: Monitor policies and practices, especially in the area of human resource management, mobility of health workers and human resources development.
- Reproductive, Child, Adolescent Health and Nutrition: Investing in adolescent health and capacity building and sharing experiences in scaling up mother and childhood interventions, and creating political leverage for better health services.

2.5 Southern African Development Community (SADC)

Protocol on health: Acknowledging that a healthy population is a prerequisite for sustainable human development and increased productivity, the SADC Protocol on Health promotes cooperation among Member States on key health issues. It recognizes that this cooperation is essential for the control of communicable and non-communicable diseases and for addressing common health concerns, including emergency health services, disaster management, and bulk purchasing of essential medicines. *Regional Indicative Strategic Development Plan*: integrates health as a priority within the context of Social and Human Development, Poverty and Food Security. In particular, the current HIV/ AIDS pandemic is woven into the entire plan as an issue that influences most factors of development in the region. For this reason, HIV/AIDS is also addressed as a stand-alone cross-cutting issue.

High morbidity and mortality rates, low nutrition status, poor healthcare infrastructure and services, poor living conditions present major challenges to development in Southern Africa. Increasing rates

of communicable and non-communicable Diseases are compounding the problem. In addition, an inadequate understanding of the gender dimension and inadequate resources for improving health present further challenges. *Pharmaceuticals:* SADC is committed to improving sustainable availability and access to affordable, quality, safe, efficacious essential medicines, including African traditional medicines

2.6 Agenda 2063: The African We Want (African Union)

Agenda 2063 of the African Union (AU) which is Africa's blueprint and master plan for transforming the continent into the global powerhouse of the future. It is the continent's strategic framework born out of realization by African leaders that there is a need to focus and prioritize African's agenda from the struggle against apartheid and colonialism to commitment to support Africa's new path for attaining inclusive and sustainable economic growth and development[20].

2.7 The National Five Year Development Plan 2021/22 – 2025/26

Human Resource development: The health sector is a key to human resource development. The sector includes infrastructure, professionals, medical equipment and supplies, reagents, medicines, curative and preventive care, and health insurance. Therefore, this plan seeks to strengthen health management systems, service availability and delivery. FYDPIII also gives priority to the evolution and management of quality challenges in health services.

Key interventions include:

1) Construction and rehabilitate health facilities;
2) Ensure availability of medicines, medical supplies, reagents, vaccines and medical equipment;
3) Promote and increase scope, as well as coverage of health schemes;
4) Strengthen specialized services in all zonal, specialized and national referral hospitals;
5) Improve traditional health services/ alternative medicines;
6) Promote and support establishment of vaccines, medicines and medical equipment manufacturing industries;
7) Promote and support private sector investment in health commodity supply chain;
8) Design and establish proper logistics and storage of medical commodities;
9) Strengthen public health rapid response teams; and

[20] https://au.int/en/agenda2063/overview

10) Improve Emergency Medical Services (EMS).

Table 1: The indicator and targets for the Health Sector [21]

Indicator	Target	
	2019/20	2025/26
Infant Mortality Rate per 1,000 births	36	30
Under five Mortality Rate per 1,000 births	50	40
Births attended by a skilled health worker (%)	80	85
Maternal Mortality Rate per 100,000	220	180
Life Expectancy (Years)	66	68
National HIV prevalence rate (%)	4.7	3.1
Health Expenditure, Public (% of Govt. Expenditure)	10	12.2
Source: FYDP III 2021/22-2025/26		

2.8 National Health Policy 2020 (Draft)

The National Health Policy aims at implementing national and international commitments. These are summarized through policy vision, mission, objectives and strategies. The Health Policy vision is to have a healthy and prosperous society that contributes fully to the development of individuals, their communities and the national. The mission is to provide sustainable health services of acceptable quality standards for all citizens without financial constraints, based on geographical and gender equity. The main objective of the health policy is to increase the life expectancy and quality of life of citizens by reducing deaths, diseases and disabilities, especially among those most at risk, by establishing a health care system that meets the needs of all citizens. Both the vision and mission of the health policy supports the attainment of the PHSDP 2022 - 2032 objectives and targets.

2.9 Health Policy Implementation Strategy 2020 -2030 (Draft)

Health Policy Implementation Strategy 2020-2030 elaborates all elements of the policy, and is fully integrated into this strategic plan. The Policy Implementation Strategy objectives are organized into nine areas including: preventive services, medical services, quality of care, training, regulatory and research services, human resources for health care delivery, the private sector, international cooperation, funding for health care and cross-border issues.

[21] Fiver Year development Plan III 2021/22-2025/26

2.10 Health Sector Strategic Plan V[22] 2021/22 – 2025/26

The Ministry of Health, PORALG in collaboration with all stakeholders has been providing health services within the framework of Health Sector strategic Plan. The Health Sector Strategic Plan has identified three outcomes and impact of health services:

1) Universal health coverage. This covers three aspects:

i) Accessibility of essential health service for all;

ii) Quality of essential services; and

iii) Financial risk protection.

2) Preparedness and proper response to epidemics and emergencies or disasters is in the context of the global health security agenda and covers areas of:

i) Epidemics, especially new epidemics as a result of globalization;

ii) Antimicrobial resistance, and

iii) Disasters with health impact.

3) A healthier population: Better health, increase of life expectancy requires interventions beyond the mandate of the health sector and therefore, asks for introducing health related matters in all policies and multi-sectoral collaboration at all levels.

2.11 The Public Service Reform

The Programme aims at transforming the public service into a service that has the capacity, systems and culture for continuous improvements of services. The main issues on which the Strategy focuses on mitigating the weak capacity of the public services and poor delivery of public services. In order to implement the aims of the public reform, each sector is executing sectoral reforms in line with public reform. This includes provision of adequate and skilled staff in health facilities which is one of the priorities of PHSIDS.

2.12 Health Sector Reforms

Health sector reform aims at improving the health sector for provision of quality health services for communities. Health sector reforms is a sustainable process of fundamental change in national health policy and institutional arrangement that are evidence based. Health and Development Partners (DPs) agreed to pursue a sector-wide approach (SWAp). The SWAp facilitates coordination and collaboration among stakeholders within the health sector.

[22] United Republic of Tanzania, Ministry of Health, Community Development, Gender, Elderly and Children. 2021. Health sector strategic plan – July 2021 – June 2025 (HSSP V)

It aims to create synergies and reduce transaction costs through coordinating financing, planning and monitoring of all health interventions, on and off-budget, in line with the policy framework. The SWAp contribute to the achievement of targets for the National Development Vision 2025 National Health Policy, Health Sector Strategic Plan and Sectoral operational Plans. Stakeholders include the MOH, PO-RALG, PO-PSMGG, MOFP, NGOs and civil society, private sector, and development partners, including UN Agencies, active in health. They work under the Development Cooperation Framework (DCF). Under the DCF the Health Sector Working Group (HSWG) promote a sector wide approach (SWAp) to health. The Common Management Arrangements was established to manage the processes for the Health Sector Strategic Plan.

Other health reforms which facilitate decentralization up to the community includes the User's committees such as Health Facility Governing Committees (HFGCs) are some of the popular mechanisms used to represent communities and civil societies in holding service providers to account, the Fiscal decentralization through different arrangements such as Direct Health Facility Financing (DHFF (2017/2018, Prime Vendor Systems (PVS) 2018/2019 to supplement availability of medicines in case of out of stock from Medical Stores Department (MSD), improved Community Health Funds (iCHF), 2017/2018 and introduction of EMD, ICU services in 2021/2022.

2.13 Local Government Reform Policy

Tanzanian Government has decentralized most of its functions through Decentralization by Devolution (D by D). In this context, the PORALG provides the interface between Local Government Authorities (LGAs) and line ministries. At the central level, the MoH is responsible for policy formulation, resource mobilization, technical guidance, monitoring, and evaluation of guidelines implementation and manages international partnerships. While the PO-RALG is responsible for the management and administration of Regional and Council health services, LGAs are responsible for health service delivery within their Councils.

The local government reform denotes devolution of powers and establishment of a holistic local government system, to achieve a democratic and autonomous institution. Within this context, primary health services are also managed and administered by Local Government Authorities. The PHSDP which aims at strengthening PHC Services has been and will continue to be implemented within the Local Government Reform context.

The implementation of MMAM requires political support at all levels.

2.14 CCM Election Manifesto 2020 - 2025

The Health Sector Development Program for the last fifteen (15) years made achievement for the ruling Party and for the next ten 10 years will facilitate the attainment of commitments and targets proclaimed by the ruling Party, Election Manifesto 2020 in the health sector as follows;

- Reduction of Infant Mortality Rate from 25 to 15 per 1000 live births by year 2030.
- Reduction of under-fives deaths from 67 to 38 per 1000 live births by year 2030.
- Reduction of Maternal Mortality Rate from 556 to 232 per 100,000 live births by year 2030.
- Increase coverage of births attended by skilled attendants from 76% to 85% by year 2030.
- Impactful innovative strategies towards TB and Leprosy suffering and Burden.
- Strengthen the HIV/AIDS prevention and control initiatives.
- Ensure all health facilities are well equipped.

2.15 Policy Guidelines for Community Based Health Services

The government has re-introduced the use of voluntary community based health workers to complement the critical shortage of human resource for health in Tanzania and contribute to expanding access to quality health intervention for better health outcome while strengthening community health systems[23]. The overall objective is to create sustainable and functional national community services for improving health and social wellbeing of all communities with a focus of those most at risk to be more responsive to the needs of the people.

[23] United Republic of Tanzania, Ministry of Health, Community Development, Gender, Elderly and Children.2020. Policy guidelines for community based health services – towards sustainable community health and social welfare services, leaving no one behind. Dar-es-Salaam, United Republic of Tanzania, March 2020

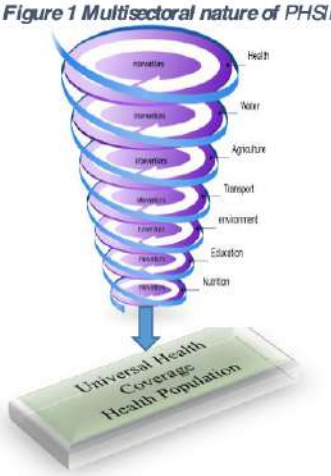
3 THE PRIMARY HEALTH SERVICE IMPLEMENTATION DEVELOPMENT STRATEGY (PHSIDS)

3.1 The Programme concept and rationale

The aim of the Programme and government commitments is to ensure the delivery of fair, equitable and quality health services to the community. The programme aims at empowering and involving communities in health services provision to contribute towards the attainment of quality health services for all.

It is important to know that the PHSIDS involves multiple sectors whose interventions contribute to the health of the community (see Figure 1). The Community should be made aware of the prevailing disease conditions, both communicable and non- communicable, and other related sectorial services and be ready to contribute for health interventions in kind. The government has made some effort to increase access to health services by building new health care facilities in underserved areas.

Figure 1 Multisectoral nature of PHSIDS



Despite the construction of health care facilities, some citizens still have to travel long distances to access services. The biggest problem is inadequate coverage of the health system to deal with the health service needs of all people in the country. This problem is due to poor infrastructure especially in rural areas. Uneven distribution of health services also contributes to inequity in accessing health. This is contrary to the government main focus which is to ensure that health services reach all Tanzanians irrespective of where they live.

Currently, in order to ensure that health services reach all the people, the government is focusing on strengthening District/Council health services to ensure easy access to health services by all. The Health Sector Strategic Plan provides guidance in implementation and for monitoring and evaluating the health sector targets and achievements over the stated timeframe.

3.2 Progress in Health System Strengthening

Primary Health Care: Tanzania made an effort to expand the concept of primary health care and to provide timely, sustainable and accessible health

care to all citizens, including ensuring that every village has a clinic and every ward has a health centre. The first Primary Health Services Development Programme (PHSDP or MMAM) was implemented 2007-2017 to facilitate achievement of this goal. The MMAM assessment, conducted in 2018, showed an increase in the number of healthcare facilities and the availability of staff, medication and equipment at these facilities. The number of healthcare facilities has increased from 5,253 in 2007 to 7, 879 in 2022[24]. The total number of public health care facilities has increased from 3,421 to 5,062 in the same period. A substantial number of public health facilities were constructed between 2017 and 2020.

The community has continued to participate in the construction of health facilities and management of health care delivery through Health Facility Governing Committees and formulation and participation through construction committees. These committees have been continuously supported to give them the capacity to monitor the quality of services. Community Health Volunteers involvement has also played a major role in increasing utilization of health services including encouraging pregnant women to attend clinics and deliver at health care facilities and taking part in vaccination campaign

The expected rapid decline in maternal and neonatal mortality has not happened. Although improvements have been noted, the targets of the MDGs have not yet been met. Regional differences have to be addressed further, with attention for urban poor. There continues to be a large number of children with malnutrition.

Outbreaks of endemic diseases like measles, and new diseases like Coronavirus disease 2019 (COVID-19) threaten the well-being of population. Epidemic and disaster control is still insufficient, especially operationalization of standard operating procedures at grass root requires strengthening.

Treatment of medical waste is still insufficient in many of the health facilities (from primary to tertiary level), although guidelines are in place. Improvement is necessary for environmental reasons but also for reduction of risk of spreading diseases.
The Ministry of Health is dedicated to ensure equitable, quality and accessible health services. This calls for deliberate effort to formulate new health policies and subsequent plans to facilitate achievement of the desired health services. As a response, the Ministry has developed a Primary Health Services

[24] Source HFR February 2022

Implementation Development Strategy 2022 -2032 (PHSIDS 2022), which is focusing on catalyzing improvement in access to health services at all, levels.

3.3 Objectives of the Programme

3.3.1 *Overall objective*

To accelerate and sustain provision of quality primary health care services to all Tanzanians by 2032

3.3.2 *Specific Objectives*

a. To construct and rehabilitate health facilities and staff houses at primary level to ensure equity and access to quality health care to all Tanzanians by 2032.

b. To complete construction of buildings at health facilities to meet the required number as per MOH standards by 2032.

c. To rehabilitate and construct MOH training institutions to ensure quality and adequate availability of skilled Human resources for Health by 2032.

d. To fast track capacity building, orientation and Continuing Profession Development for health workers to meet the needs of the primary health facilities by 2032.

e. To strengthen and maintain human resource database by 2032

f. To provide standardized medical equipment, instruments, pharmaceuticals and sundries to all primary health facilities to ensure optimal performance by 2032.

g. To Strengthen and sustain that referral system is operational by 2032.

h. To increase financial allocation to the sector with a view to attain the Abuja Call of 15% of the annual budget by 2032

i. To ensure availability and provision of equitable, quality and accessible Primary health care services which are condition (RMNCAHS) and other diseases specific conditions (e.g. TB, NCD, HIV/AIDS etc.) by 2032

j. To have evidence-based decision making through use of findings from implementation/operation research by 2032.

3.4 Programme Components

The PHSIDS comprises components which will contribute to the attainment of the above objectives. The components are as follows:-

- Human Resources for Health
- Council Health Services (Infrastructure, Pharmaceuticals and Supplies, Equipment, Transport, Furniture and Plants, Staff houses)
- Primary health care essential intervention packages
    - Maternal, Newborn, Child and Adolescent Health
    - Malaria
    - HIV/AIDS
    - Tuberculosis and Leprosy
    - Neglected Tropical diseases
    - Non Communicable
    - Mental Health Services
    - Oral health services
    - Eye health care services
    - Laboratory and Imaging services
    - Social welfare services
    - Emergencies and epidemics
    - Environmental Health Services
    - Health Promotion and Education
    - Nutrition
    - Traditional Medicines
    - Nursing Services
- Public Private Partnership
- Advocacy and health promotion
- Institutional Arrangements
- Sustainable and resilient Health Care Financing and social protection.
- ICT and Monitoring and Evaluation

4 SITUATION ANALYSIS OF COMPONENTS

4.1 Country's Health Systems Framework

The health services focus on is implementation of the new health policy, and in the international context of the SDGs, especially SDG 3. (*'Ensure healthy lives and promote well-being for all at all ages'*). Nine global targets have been formulated, and each country specifies its own targets, based on the present situation and the ambition of the country.

Box1: Sustainable Development Goal (SDG) 3 targets

SDG 3 Global targets
3.1 By 2032, reduce the global maternal mortality ratio to less than 70 per 100,000 live births.
3.2 By 2032, end preventable deaths of newborns and children under 5 years of age, aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births
3.3 By 2032, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases
3.4 By 2032, reduce by one-third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being.
3.5 Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol
3.6 By 2032, halve the number of global deaths and injuries from road traffic accidents
3.7 By 2032, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.
3.8 By 2032 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality, and affordable essential medicines and vaccines for all.
3.9 By 2032, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water, and soil pollution and contamination

SDG 3 is health-specific, but nearly all other sixteen SDGs have a health impact. The framework for the health sector in Tanzania is related to the achievement of the SDGs and structured according to impact - processes based on building blocks.

4.1.1 *Outcomes and impact of health service during Health Sector Strategic implementation for Society and individuals.*

Universal health coverage: UHC is about ensuring that people have access to the health care they need without suffering financial hardship and covers three aspects:

- Accessibility of essential service for all (including geographical, financial, and socio-cultural).
- Quality of essential services (including expanding coverage of essential package health interventions, quality, and acceptability for better outcomes).
- Financial risk protection (especially for the poor and vulnerable groups)

Preparedness and proper response to epidemics and emergencies or disasters:

In the context of the global health security agenda, this covers the areas of:

- Epidemics, particularly new epidemics due to globalisation
- Antimicrobial resistance, and prudent use of medicines
- Disasters with health impact, e.g. as results of climate (drought, flooding, high temperatures) or as results of urbanization (road traffic accidents, pollution).

A healthier population means better health, and increased life expectancy require interventions beyond the mandate of the health sector and therefore, requires Health in All Policies (HiAP) and multi-sectoral collaboration at all levels. The increase in NCDs in particular demands and integrated approach with all aspects. Equity is very much related to determinants of health, especially in those aspects that are not directly related to UHC, e.g. cultural factors, gender and health literacy.

4.1.2 *Service delivery process: people centered care.*

The process of service delivery (ranging from grassroots level, health promotion to tertiary level, curative care requires the following supporting strategies:

Community strategies aims: at empowering individuals to make effective

decisions about their own health and to enable communities to become actively engaged in co-producing healthy environments.

Strengthening governance: requires a participatory approach to policy formulation, decision making, and performance evaluation at all levels of the health system, from policymaking to the clinical intervention level.

Reorienting health care: requires a shift from inpatient to outpatient and ambulatory care, and from curative to preventive care. It requires investment in holistic and comprehensive care, including health promotion and ill-health prevention strategies that support people's health and well-being. It also respects gender and cultural preferences in the design and delivery of health services. A new package of essential health interventions (minimum package) is needed.

Coordination across sectors encompasses inter- sectoral action at the community level to address the social determinants of health and optimize use of scarce resources, including, at times, through partnerships with the private sector.

Creating and enabling environment encompasses all processes that support service delivery. In the HSSP V, strengthening ***planning, monitoring and evaluation*** are particularly important to ensure that goals are met in a decentralized context. The other building blocks, which have more to do with inputs are relevant as well.

Health care financing is a crucial element in the process of service delivery and needs inclusion of all relevant sources of funding. Attention will be paid to increasing domestic health financing and expanding strategic purchasing in the sector. Building blocks, inputs into the health system.

4.1.3 *The building blocks represent inputs and processes to make the health system work.*

The building blocks are the key elements in formulated health systems framework that describes health systems in terms of seven building blocks. These comprise:

- National and subnational service delivery systems which facilitate efficient management of inputs for delivery of health services to users,
- Governance and organisational structures,
- Human resources for Health(including planning, management, and HR development),
- Medicines commodities and supplies essential for diagnosis and treatment,
- Health care financing,

- Infrastructures buildings, equipment, and transport,
- Monitoring and evaluation and ICT infrastructure (previously not indicated separately but essential backbone for modern health care).

4.2 Human Resources for Health (HRH)

The government of Tanzania is committed to the equitable delivery of quality health services through strengthening health systems to better respond to health needs.

Severe shortage of skilled human resources for health primarily affects the quality of health service delivery, the attainment of universal health coverage and achievement of the desirable health outcomes. Countrywide, the human resources for health shortage disproportionately affects rural areas where over 70% of population lives. The allocation of Medical Doctors are a reversal of the true situation: Seventy-four (74) percent of Medical Doctors are located in urban areas (MOHCDGEC- HRHIS 2018). So there is the real overall shortage human resource for health which is further made worse by the actual allocation which does not respond to the real need.

The number of healthcare workers has increased from 29,063 (35.32% of the demand) in 2006/07 to 102,919 (52% of the demand) in 2019. Despite the success so far in addressing the critical shortage of health workforce through increased HRH production, recruitment and improved retention of available workforce, the human resources shortage is further exacerbated by an increased disease burden attributed by simultaneous increase in infectious as well as non-communicable diseases (double burden of disease).

4.2.1 *Health Workforce requirement:*

Needs versus staff Availability.

Despite the implementation of strategic options set during the BRN lab 2014 such as prioritized allocation of employment permits to regions with critical shortage, strengthened central guidance on HRH planning in terms of production and recruitment plan and conversion of permits to increase ability to recruit critical cadres; available HRH is 48% of the required staff. This was caused by employment freeze and construction of new facilities. The total human resources for health requirement is 208,595 for 7,397 health facilities, according to government computations and based on the available data. The total health workforce was 95,827 by December 2018. In 2017, the total workforce was 90,873, an increase of more than 5% in one year. According to the HSSP IV Analytical report there were 34,120 core health professionals in 2018. This includes the number of core health professionals from the 184 councils (75.0% of the total), the regional referral hospitals (15.6%) and the zonal and national referral hospitals (the remaining 9.4% of health workers).

Table 2 Needs versus Staff Availability in 2019

Facility level	HRH required	HRH available	shortage	Percent available	Shortage percent
Dispensary	99,060	30,625	68,435	31%	69%
Health Centre	32,487	17,954	14,533	55%	45%
District Hospital	21,600	17,443	4,157	81%	19%
Other Hospitals	26,400	11,243	15,157	43%	57%
Regional Hospital	14,226	11,373	2,853	80%	20%
National, Zonal, Specialized and Referral Hospital	14,509	10,349	4,160	71%	29%
Health Training Inst.	1,321	697	624	53%	47%
Grand Total	**209,603**	**99,684**	**109,919**	**48%**	**52.%**

Source Human Resources for Health Strategy 2021-2026

From table 2 out of the total 209,603 human resources for health required only 99,684 are available, this is a shortage of 109,919 (52.4%).

On the other hand, majority of health workforce who graduate from various training institutions are not sufficiently absorbed into the government employment, private sector and faith based organizations due to limited government budget and few opportunities in the private sector and faith based facilities as a result of limited financial capacity. Among the strategic issues critical to the success of the PHSIDS is to have in place the required number of motivated, qualified and skill mix staff in the right place at the right time. This facilitates not only access to health services but also the quality of health services provided.

To address some of these challenges, on May 2019, the Ministry of Health and health implementing partners, including CSOs, convened a meeting that spear-headed a new dialogue on HRH. A multi sectoral High level meeting on HRH was conducted in November 2019. Among the key resolutions was to establish a mechanisms for health graduates to volunteer in facilities that have critical shortage of HRH. The initiative aimed partly to address the HRH challenges at the same time provide opportunity for short term on job training for newly qualified professionals.

The Government and private sector have continued to invest in training

programmes in health. As of 2020 there were 463 public and private colleges offering (para) medical training. One of the aims of the PHSDP implemented from 2007 to 2017, was to increase student enrolment in health facilities in the country. Achievements in the area include an increase in eligible students in health colleges from 6,450 in 2007/08 to 18,539 in 2018/19. In ensuring that these colleges provide quality education, they have been evaluated for quality and have been fully accredited by the National Accreditation Council of Technical Education (NACTE). In addition, on-the-job training is provided to health workers to enhance their skills and effectiveness. Increasing e-learning is offered to health workers for continuing professional development (CPD). There is need to synchronize among the many different organizations providing CPD in order to have a clear overview how many health workers receive training.

The Human Resources for Health Strategic Plan 2014-2019, implemented six objectives on production, recruitment, retention, performance management, information and planning for HRH. Significant gains were achieved in the previous strategy in terms of meeting production targets and addressing the critical challenge of ensuring that at least all facilities have one trained provider.

However, the pace at which the shortage of HRH was reduced is low and create an extra burden for operations of the newly constructed and upgraded health facilities for delivery of quality health services. Recruitment of healthcare workers has remained to be lower compared to production. Still there are cadres with critical shortage and their enrollment remains lower or related academic programs do not exist at all.

In addition, despite of achievements in enrollment, the training institutions still have serious shortage of tutors some of which are inadequately updated with new development in teaching methods and the infrastructures are inadequate and some are dilapidated. The same is also true for teaching labs.

There has been chronic under-investment in training and recruitment of health workers. This was compounded by difficulties in deploying health workers to rural, remote and underserved areas. Despite significant progress made in addressing rural-urban divide, there is a need to boost political will and mobilize resources for the workforce agenda as part of broader efforts to strengthen and adequately finance health system in Tanzania. The implementation of the previous plan was guided by the development of HRH recruitment and production plans whose implementation was unacceptably low. The investment in the previous strategy was lower than was expected.

4.2.2 *Human resource Planning*

Planning of human resources is still largely an administrative process, rather

than based on actual needs, and actual service provision. Experience with workload-based planning is available but needs to be institutionalized all over the country. Evidence based HRH planning system is critical to guide HRH production, recruitment, distribution, retention and management in order to address existing health workforce policy dilemma of mismatches between need, supply, and demand. This should go hand in hand with improvement in information systems as well as promotion of HRH data use for decision making. Deployment of trained health workers and retention has not been successful for bridging the gaps between demand and supply. New types of employment must be sought to which will lead to demand driven absorption of trained staff.

4.2.3 *Human Resources Training and Development*

The PHSDP 2007-2017, Human Resources for Health component was implemented through the Human Resources for Health Strategic Plans whereby, more emphasis was placed on the production of middle level cadres and increasing supply of medical doctors whose production was also low compared to the future needs by then. The focus was to increase enrolment of students in order to reach production targets of 15,000 HRH by 2020. In academic year 2017/2018, a total of 17,370 students were enrolled that increased to 18,539 in academic year 2018/2019. This achievement is attributed to government support to training such as joint public and private sector focused attention to the production of middle level cadre.

Private providers have been engaged in training for various levels of certification. This arrangement has had positive contribution in achievements realized to date. Quality management of training is exercised right from selection of students where NACTE manage the selection. Supervision visits to the private providers' institutions conducted by Ministry of Health found limitations in achieving the required numbers of specialists and the few critical cadres for primary care services delivery such as lab technicians, radiology and pharmaceutical middle level cadres whose outputs are low. Also there are claims that such arrangements somehow jeopardizes the quality of training[25].

Competencies of human resources are not sufficient to deal with new technical development, in diagnostic and therapeutic areas, or with ICT.

New training courses will be developed in midwifery, specialized nursing, and dentistry. Fellowship programs to increase production of medical specialists and super-specialists will be introduced. Training capacity needs to be increased in fields of pharmacy, laboratory and Anaesthesia. The

[25] Sirili, Frumence et al. 2019

Government will continue to oversee and coordinate the training of human resources for health. The MOH will take the lead in preparing curricula and will oversee training courses in public and private health colleges, to ensure the quality of training and to the link between training and practice in healthcare.

The Quality of training will address education systems in a holistic manner right from curriculum design, selection of trainees, skill development and examination systems. It will focus on policies, people, infrastructure, processes and materials. The Ministry of Health will ensure the availability of trainers, equipment, adequate infrastructure, accommodation and food in all government health colleges. As a priority, infrastructure, including ICT, learning and teaching materials and skills laboratories will be improved. Quality assurance of the training system will be put in place, to ensure that the workforce produced have the required core competencies.

The accreditation system for health training institutes will be strengthened. To achieve this, Government will work closely with the Ministry of Education and other related agencies, and stakeholders in the private sector. The MOH will establish a legal framework for the operation of public health training colleges.

Professional councils continued to focus on which competencies are relevant to various cadres and raising importance of CPD in managing licensing of the professionals. The Tanzania Nursing and Midwifery Council (TNMC) demonstrated proactive efforts in promoting CPD as compared to other councils.

Further innovative solutions to address Continuing Professional Development are important. The Ministry will enhance the provision of on-the-job training for all health care workers using ICT and expand e-learning for local health workers on demand as part of the planned CPD approaches.

The Professional Councils have different systems for assessing, registering, managing and coordinating various disciplines. There is need to develop consistent strategy for improving and maintaining quality of trained health staff to address the quickly changing pathologies and therapies.

The MoH manages training institutions through eight (8) Zonal Health Resources Centres (ZHRC). The training institutions are responsible for provision of pre-services and continuing professional development (CPD), training, research on health issues and consultancy services to the MOH, Local Government authorities, Development Partners, NGOs and Private sector. The justification to train and develop workers is enshrined in the following facts:

1. Leadership for managers

2. The increasing burden of disease as a result of HIV/AIDS, NCDs and expanding health worker's roles and new forms of service provision.
3. Political commitment to establish health facility in every village which translate to additional skilled health workers.
4. Presence of tremendous community enthusiasm and expectations for health improvement.
5. Realization and commitment to address critical HRH shortage in the Health sector.
6. Increase and maintain the supply and production of human resources,
7. The need to maintain standards and quality.

4.2.4 *Human Resource Management*

There are multiple players in the management of human resources for health sector. It is a shared responsibility undertaken by MoH, Local Government Authorities and the private sector who are employers under the facilitation of PO - PSMGG. The Ministry of Finance is the financier. The MoH is the technical Ministry responsible for developing policy and guidelines as well as ensuring standards in health care delivery at all levels. Having multiple players in the management of human resource for health has contributed to inefficiency in some practices including development, recruitment, deployment and retention processes. With regards to promotions, the public service procedures tend to treat employees uniformly but without consideration of the special needs of unique sectors, such as health. Recruitment and promotions for public servants are the responsibility of PO - PSMGG. Due to this administrative arrangement the processing of transfers and promotions is cumbersome hence creating delays. Delays in re-categorization of staff after they have gone for further training are also common complaints.

The government has identified HRH as a priority area and is fully committed for its improvement. A number of initiatives are currently being undertaken by the MoH to address the HRH crisis. Improving Human Resource Management (HRM) has the purpose of ensuring that staff get timely orientation, understand what they are supposed to do, get timely feedback, feel valued and respected, and have opportunities to learn and grow on the job. Appropriate mechanism for staff appraisal, internal supervision and effective, job allocation are important to enhance productivity and optimal utilization of available health workforce.

4.2.5 *Recruitment and Deployment*

The health sector has also suffered from under investment in health infrastructures including staff housing, provision of water, basic communication, transport and working tools and materials. The hardships in most remote areas and hard to reach is a great challenge to retain qualified staff in adequate numbers.

Human resources for health is an enabler to many service delivery priorities, and therefore increased absorption of health workforce to reduce the HRH shortage is mandatory. The government will expand use of workload indicator for staffing needs -Prioritization and Optimization Analysis allocating health workers according to need. Innovations and alternative hiring arrangements (including use of private sector) will be formalized and supported. Application of innovative strategies will be allowed, such as allowing facilities to hire staff using local arrangements or devising mechanism that will enable interns to serve for longer periods. Special arrangements for staffing newly constructed facilities will be considered. Community based Health Workers will be deployed in villages and hamlets to extend health promotion, health education, disease prevention and rehabilitation in the community.

Priority for employment permits and funding for HRH positions will be given to completed health facilities, regions with low HRH per population ratio and tutors for health training institutions. Budget will be allocated for redistribution of HRH within Councils to avoid inequalities between health facilities. Guidelines for non-financial incentives and policy for volunteers in the health sector has been developed and should be disseminated, advocated and implemented. The MOH will develop a strategy to improve execution capacity and oversight for managing results effectively, efficiently with high sense of individual and institutional accountability at all levels.

4.2.6 *Human resources for Health Retention*

The HRH crisis in the health sector is attributed to various related causes; lack of retention strategies being one of them. Socio-economic disparities and other work environment challenges have been factors that put off professionals and thereby affecting their retention, particularly in the rural areas.

Incentive package and innovative retention strategy need to be developed by each Council that will take into account the need to improve performance and management. The PHSIDS seeks to encourage improved retention of health staff particularly in hard to reach districts using innovative retention strategy. The use of attractive differential incentive packages is advocated.

The improvements in government salaries in the previous years, continue to attract staff from NGOs and private sector to join public services. Attracting staff to rural areas have not been a challenge as it was previously reported. However, the challenge has been to retain the skilled staff in rural areas after they have been employed and enrolled into the public services. Frequent public sector requests for transfers and for further training has been one of the mechanisms that create staff mobility from underserved regions. On the other hand, following implementation of WISN and POA it has been very difficult for the government to redistribute staff from areas with high numbers to areas with critical shortage due to challenges of financing the transfers.

Motivation starts when the employee feels that the employer honors the obligations on timely manner. Delays in payment of leave allowances, uniform allowance, on call and extra duty allowances due to financial deficit is a common complaint. However, there are continuing complaints for shortages of staff housing and inadequacy of housing allowances.

4.3 Nursing and Midwifery Services

Nursing and Midwifery Services continues to be one among important pillar within health system and important in attaining Universal Health Coverage for quality health care. It is estimated that 60% of HRH are nurses and midwives assuming roles of about 80% of health services due to critical shortage of other important health cadres. The government of Tanzania aimed in investing in this important cadre as one of the strategies in improving quality of care by strengthening its governance and establishment of specific Division at Ministry of Health to oversee provision of quality care. According to HRHIS, currently the health system comprises of 25,139 nurses and midwives who are engaged in rendering health services, this is equal to 43% of the requirements. On the other hand, the country has about 64,274 nurses and midwives according to TNMC database who are eligible in providing health services at different levels. Although Tanzania is implementing competency based curricular for the pre-service training, the competencies of the most graduates are still insufficient in meeting standards and public demands.

Tanzania aims at having effective and safe nursing and midwifery services that meet standards and requirements at all levels, in the public and private sectors. The sector will have adequate staff, effective guidelines and standard operating procedures, and a functional reporting system as well as institutionalize nursing and midwifery audit. Nursing and midwifery should first and foremost meet the community needs. Training and ensuring the adequate numbers of nurses and midwives in health care facilities is an

important priority for the coming years. Government will expand the scope of nursing and midwifery services to meet the demand for specialized health care services. Specialist nursing training at Nurses and Midwives Colleges will be initiated. The recently adopted "respectful maternity care" will be expanded to all services in the health sector and the government will improve respectful patient-centred care, to treat patients with dignity, respect and ethics both in maternal and child health and all other care. The health sector will continue to build the capacity of nurses and midwives in the management and operation of health care facilities, and the health information system will improve to include the information needed to manage nursing and midwifery services at all levels.

4.4 Council Health Services

Generally, the quality of health services in Tanzania, despite remarkable improvements over the years since the advent of health sector reforms in the early 1990s, is still unsatisfactory. For a long time, the performance of the health sector has been negatively affected by limited resources which have led to an unsatisfactory quality of health care provision at all levels. The reforms are aimed at enhancing the effectiveness and efficiency in the provision of health services in line with the health sector policy of ensuring accessibility to quality health care services by all Tanzanians.

Despite the construction of health care facilities, some citizens still have to travel long distances to access services. There is still inequitable access to health care for several groups in the population, due to epidemiological and geographical factors. Not all regions have adequate referral systems for patients in need. At the same time, due to changes in road- and transportation systems, mobility of people has increased in many regions. The health sector has to embark in smart planning based on actual utilization of service, for expansion of infrastructure as well as staffing to run the facilities. Equipment, e.g. in imaging, is still inadequate in most of the hospitals. There is no system of preventive maintenance of critical infrastructure in health services and training colleges, leading to dilapidated structures. On the other hand, decentralized funding enables institutions to generate income, and take maintenance in their own hands.

Changing demographics and epidemiological transition: Population growth will remain above 3% in the coming five years. Tanzania will have over 67 million inhabitants by 2025. Tanzania will in the coming years remain a country with the majority of people below the age of 25 (over 42 million). The demand for RMNCAH, and health services in general, will therefore continue to increase. However, ageing will be more and more common, with changing demands for health services. Life expectancy at birth will increase to 66.2 years

for men and 71.3 years for women in 2025. Deaths due to non-communicable diseases in Tanzania are just below 50% and will reach well over a 50% in the coming years. As the population ages, people with disabilities will increase and will need institutional palliative care. This requires new services, new skills of health workers, new approaches in medical care, including home based care.

Industrialization and urbanization also affects health services; in the coming decade Tanzania will experience the moment when more than 50% of the population will live in urban areas, as a result of the economic development with more and more jobs in industries and services. This will have an impact on the demographics and environment of the country, exposing more people to occupational hazards, pollution and road traffic accidents. There will be more demand for health services in urban areas. At this moment in time health indicators of the urban poor are not better than those of rural poor. In urban areas, the majority of health services are provided by private providers.

Urbanization and industrialization will require new approaches in healthcare delivery, and new joint ventures, and new relations between government and private providers. It will be important to work with other sectors on health in all policies, to protect and improve health of urban dwellers, manage water supply and sanitation, and maintain a healthy environment.

Climate change affects the normal seasons in Tanzania, with longer spells of drought in some parts of the country, or heavy rainfall and flooding in other parts of the country. The average temperature in Tanzania is increasing by 3 centigrade Celsius by 2100. This may lead to disasters with medical impact, e.g. depleting food supplies or pollution. There may be permanent damage to the environment, leading to increase in disease carrying insects and rodents, with spread of zoonotic diseases. Awareness building on environmental conservation, handling climate changes is needed, and staff needs to be prepared for new challenges in healthcare. The MOH has to collaborate closely with other ministries, across sectors, with non-state actors and Development Partners on short-term and long-term measures.

Under funding of the health sector has undermined the health infrastructure across the country. With the above challenges more resources are required for the health sector to be prepared and able to cope with the situations. The inputs to the sector in terms of equipment supplies, transport and communication remain insufficient.

Local Government Councils, especially rural ones, have benefited from a redistribution of health allocations through a more equitable pro poor

Resource Allocation Formula in recurrent funding for health care. Also the setup of capital investment and health infrastructure development funds are steps in the right direction, though certainly not enough to cover deficits. This is most noticeable at primary care and district hospital level, and especially in all aspects of obstetric and surgical care.

This special focus on district health services is of particular importance to Tanzania in the context of the government's policy of decentralization by devolution and the commitment to reaching the goals under the Health Sector Strategic plan, Five Year Development Plan III and SDGs within the overall Government Vision 2025.

4.4.1 *Access to quality health services*

The Government will ensure availability of essential primary health care services with acceptable quality standards throughout the country with respect to geographical, population, gender, disability and burden of disease. All new health facilities will be equipped including staff housing and staffed to meet the minimum standards.

The government will institutionalize preventive maintenance to ensure well maintained and functioning infrastructure and equipment. Waste management infrastructure will be improved and maintained in all health facilities as per stipulated standards. The Government will strengthen cooperation with private health sector in health care delivery, through service agreements and promote private health sector investments in priority areas. The Government will strengthen community and stakeholder engagement to participate in infrastructure development and maintenance.

In order for the health facilities to provide the required services, the Government will strengthen the system for competence-based service delivery by health care workers through improving pre-service training, continuous professional development and mentorship system in clinical settings and by using Telemedicine. Also, the government will improve nursing and midwifery care to improve quality of services at all levels and provision of respectful and compassionate care that entails (1) Respectful nursing and midwifery care (2) ethics and compassionate care and (3) gender integration and responsiveness.

In order to ensure that all health facilities provide quality, safer and efficient services the government will enhance clinical audit and supervision mechanisms to improve quality of care in line with the established guidelines and appropriate training for better services. The Government will strengthen

cooperation with the private health sector in health care delivery to jointly implement these initiatives.

The Government will reinforce the referral system from community to national level. MOH will rationalize the referral system guidelines and a National Ambulance Service will be established to facilitate quick transportation of patients to and from accident sites, community (residences) and health facilities. The government will implement the Universal health coverage which is about ensuring that people have access to health care they need without suffering financial hardship and covers three areas on *accessibility of essential services for all* -- including geographical, financial and social cultural; *quality of essential services* including – expanding coverage of essential package health intervention, quality and acceptability for better outcome of health services; financial risk protection especially for the poor and vulnerable groups.

4.4.2 *Package of health services*

The National Essential Healthcare Interventions Package (NEHCIP-TZ will be revisited in the context of the creation of the mandatory health insurance scheme as envisaged in the Health Financing Strategy and will serve as the basis for providing care at various levels.

4.4.3 *Health Services at Primary Health Care level*

Government will build the capacity of communities and grass-root health workers to deliver community-based and home-based care. Government will equip health facilities managed by LGAs to facilitate the provision of equitable primary health services throughout the country. A special area of concern is healthcare in urban areas. There is need for strategic partnerships between governmental and private providers (including private pharmacies) and functioning health insurance schemes to improve access to healthcare for the urban poor.

4.4.4 *Quality of HealthCare Services*

The health sector will focus on improving quality of care through health systems level improvements. The health sector aims to provide people-centred care. Quality improvement (QI) approaches will be incorporated in facilities. Clinical audits as well as nursing and midwifery audits will be institutionalized. Quality Improvement Teams (QITs) will continue their work in Regions and Councils. Capacity building in the area of quality of care and compassionate care will be provided.

The health sector will continue establishing an accreditation system. The "Star" rating will be strengthened, with self-assessment tools, and web-based

tools. Health care facilities (public and private) that have reached five-star will receive official certification. Government will harmonize registers, licenses and accreditation systems, for public and private health care. The Patient Charter will be promoted countrywide, and follow-up on adherence to the guidelines will be part of the support to health facilities. It will enhance accountability of the health services. Community engagement to discuss issues concerning quality of care will be encouraged through the Health Facility Governing Committees.

4.4.5 *Distances to health facilities and long queues*

Patients/Clients at health facilities often experience long distances and queues. Despite the fact that urban residents have greater access to health services in terms of distance to a health facility and the number of essential health prevention measures available compared to rural residents (the so-called "urban advantage"), higher health service coverage in cities has not been translated into improved health outcomes in a number of areas. The problem is largely attributed to the shortage of staff. On the other hand some facilities serve a very large population, facilities being far from settlements, limited equipment, shortage of medicines and other supplies. There is still inequitable access to health care for several groups in the population, due to epidemiological and geographical factors. Not all regions have adequate referral systems for patients in need. In some areas there are physical barriers to an existing facility though it may be within 5 kilometers of a population centre. Geographical barriers include rivers, bad roads, valleys and mountains. There are many examples of non-functioning facilities scattered in the districts.

4.4.6 *Diagnostic Services*

Effective and up-to-date diagnostic services, with equipment, supplies and consumables, will be created to support a functional referral systems for health services. All Primary health facilities should have the diagnostic capacity for laboratory and radiology, medical imaging where applicable to enable provision of services according to the requirement of package of essential health service per level. Government will strengthen the system of standardized procurement, preventive maintenance and repair of health care equipment.

Safe Blood Transfusion, Effective and sustainable system for the collection, care and distribution of safe blood will be strengthened in order to ensure uninterrupted supply of safe blood in the country.

4.4.7 *Medical Supplies and Equipment*

The government has continued to strengthen access to medicines, equipment,

medical, medical supplies, laboratory equipment and quality reagents. Through the Medical Stores (MSD), the system for the importation and distribution of medicines, supplies, laboratory, equipment and reagents to public health facilities at all levels has been improved.

4.4.8 *Medical and supply system,*

The budget for medicines, equipment, medical supplies, laboratory equipment and reagents, has increased from shillings 31 billion in 2015/16 to 269 billion in 2018/19. The health sector aims to guarantee access to affordable quality medical supplies and equipment, to meet the country's requirements for service delivery at all levels. The health sector will improve the present procurement and delivery systems to reduce the cost and increase availability of medicines and supplies. The Government will continue to promote the use by all health programmes and other entities providing commodities of a single/uniform system for bottom-up system of quantification and distribution system for commodities. With regards to quality of medicines, the ministry will enhance the use of TMDA Apps and tools to improve monitoring of quality and safety of medicines. Government will improve the post-marketing surveillance system (quality of medicines in the market). The Government will strengthen the availability of medicines and health commodities, medical devices and supplies, to cover the needs according to the NEHCIP-TZ.

The prime vendor system at regional level will be reviewed and strengthened. Interventions to reduce antimicrobial resistance including to stimulate optimal prescription of medicines will be expanded in coverage and range of antimicrobials monitored. Rational use of medicines will be mainstreamed in supply chain interventions. The MOH have reviewed and disseminate standard treatment guidelines and essential medicine list based on evidence. It will ensure that all institutions will have (electronic) versions of guidelines and that health workers have the skills to apply these guidelines, protocols and SOPs properly. Government will train and deploy health staff for pharmaceutical services.

Government will strengthen domestic pharmaceutical manufacturing, as well as research and development. It will continue to create an enabling environment for pharmaceutical and pharmaceutical production in the country that meet international standards for domestic and export use. The Government will reinforce financial and stock management accountability at public health facilities and improve oversight and regulation in both public and private health facilities.

4.4.9 *Medicines, Health products and supplies*

Although availability of medicines, medical supplies, Laboratory equipment and reagents has increased, it still does not meet the health care requirements, especially at primary hospitals, regional referral hospitals, special hospitals and national hospital. For covering the National Essential Health Care Intervention Package in Tanzania many more types of medicines are needed, especially to address NCDs. Efficiency in supplies of medicines has improved, but further steps of strengthening the supply chain are needed, in logistics and in storage of medicines. Alignment by different programmes is needed as well as improvements in quality of medicines, quality control and rationalization of prescription and increase of efficiency

4.4.10 *Irregular availability of Medicines*

The "out of stock" phenomenon of essential medicines and supplies is a main factor that hamper access" of services at health facilities. Considerably, challenges in provision of access to health services including long distances to health facilities, inadequate and unaffordable transport systems and continuous limited quality of care.

In the light of the above critical parameters that amply justify this intervention programme, the ultimate goal is inevitably the strengthening of district health services so as to make them more effective and sustainable.

Given our natural barriers, communication systems, roads and the poverty line, there is a need of putting a health care facility in each village disregarding the concept of 5,000 people to qualify for a dispensary. The services should ultimately be accessible to the whole Tanzanian population with a focus on rural areas and particularly those most at risk.

4.4.11 *Essential medicines and medical supplies*

Availability of appropriate and affordable medicines, medical supplies and equipment is necessary for the provision of health services. The items have a special importance because they save lives, improve health of patients, promote trust of patients to the health delivery system and enhance participation and ownership of the services. Most of deaths and causes of sufferings and disabilities can be prevented, treated or alleviated with essential medicines, medical supplies and equipment.

Provision of health services in Tanzania faces a number of challenges, most notably the inequity in access to essential medicines and related supplies. This has undesirable on quality of care. Availability of medicines, medical supplies and equipment in health facilities is one of the factors that make patients to

visit them for services. Therefore, it is important to maintain uninterrupted supply of these items in the health facilities at all times.

Expenditure on medicines, medical supplies and equipment in Tanzania is second only to personal emolument. The expenditure represents more than a third of the health budget. Since the budget is generally limited, the country has experienced a disproportion between the needs and allocated budget for the purchase of medicines and medical supplies.

4.4.12 *Medical products, technologies and related supplies*

The changes in the health sector budget from TZS 31 Billion in 2015/2016 to TZS 270 in 2020/2021 has led to increased availability of medicines from 35per cent to 90 per cent (DHS2). The interventions that have been implemented to facilitate availability of tracer medicines include:

i. Prime Vendor System to supplement availability of medicines in case of out of stock from the Medical Stores Department (MSD);
ii. Redesigned Logistic System to facilitate request and supply of medicines in an organized frequency, specifically doing it monthly for all health facilities;
iii. Strengthening Medicine Audit in health facilities;
iv. Coordination and implementation of the Impact Team Approach; [26]
v. Coordination and implementation of the "Bottom up Quantification;
vi. Preparation of role and responsibility of key actors in the supply chain system and key performance indicators for supply chain system[27] and
vii. Establishment of the Compounding Unit in each of the council hospitals.

The Health Sector Strategic Plan Five (2021 – 2026)[28] and high-level political will by the ruling party (2021 – 2025)[29] set high targets (>95%) for improving the availability of essential health commodities at all levels.

4.4.13 *Transportation*

The PHSIDS recognizes the importance of transport and transportation in relation to availability and accessibility of quality primary health care. Transport is important for achieving good RMNCH. In fact, 38% of women encounter long distances to health facility and lack of transport as a major barrier for accessing health services[30]. Finally, transport is important for

[26] URT: MoH, 'Data Management and Usage for Health Commodities Supply Chain Improvement (IMPACT Approach Manual), 2020

[27] URT: MoH, 'Guideline for Health Supply Chain Roles and Responsibilities', 2019

[28] URT: MoH, 'Health Sector Strategic Plan V (2021 - 2026), 2021

[29] CCM Election Manifesto 2020-2025, August 2020

[30] URT: Primary Health Service Development Program 2007-2017

ensuring that very sick patients can be referred to the next level. Transport is also important for ensuring availability of medicines and equipment at the Health facility level.

Transport management is a system or logistics platform that allows users to manage and optimize the daily operations of their transport fleets. It is the Government's policy to provide district and regional transport and vehicle replacement. In the early useful life of the vehicle, 5 years, the maintenance costs are very low due to simple repairs. The cost escalations start from the fourth year and hence become uneconomical to operate and also a burden to the users and in most cases the users put a plan for replacement when it is at this state.

The responsibility for transport at the lower level of the health sector is with PO-RALG while the MoH is responsible for the policy and standard setting. Currently the relevant transport documents and guidelines are more than 15 years old and not updated. In fact, the last relevant transport documents reviewed are 1998 and 2003 (a Transport Management Manual). According to these documents the purpose of transport was: 1) distribution of medical supplies and equipment, 2) movement of officers, 3) movement of patients which would contribute to an effective and efficient referral system from community to tertiary level, and last 4) transportation of medical specimen and laboratory services. This purpose has not changed. The 2020 Comprehensive Council Health Planning (CCHP) guidelines defined a transport management system as, an effective process of planning, distribution controlling, directing and monitoring of transport in terms of fuel, maintenance, services and route scheduling[31]. Its primary function is to plan and execute the physical movements of people and goods. Due to development in the health sector the needs have now changed. Previously transport was used for routine distribution of health commodities. Currently distribution is managed through a different mechanism, whereby delivery of health commodities (medicine and medical supplies) procured from MSD is direct to health facilities. However; the Council may utilize transport services to deliver to health facilities medicine and health commodities supplied out of MSD (Prime vendor). The Council may also utilize services of private provider of health commodities contracted at the respective regional level. The sector is keen to reduce the burden of disease including maternal mortality, HIV/AIDS, TB, NCD etc. and in this regard it recommends strengthening the referral systems by including the budget for maintaining ambulance and transportation of samples such as CD4, sputum, DBS in the health facility

[31] URT: Comprehensive Council Health Planning Guidelines 5th Edition 2020; 5.1. 5 Page 50

plans and CCHP by using various sources of fund. It also prescribes that maximum of 20% of HBF be used for transport (fuel, maintenance of vehicles). Means of transport are vehicles, motorcycles, bicycles and boats[32]. The documents define how the transport cost must be calculated and monitored and sustained. But the documents have remained silent on transport standards for different levels of the health sector.

In 1999 when the D by D policy came into force, the PO-RALG started to develop five (5) years transport policies. The primary objectives of these policies were to provide an adequate minimum level of access to social and economic services for the citizens of Tanzania. It was also a policy requirement to strengthening institutions to implement PPPs in transport infrastructure; and to deliver safe and environmentally sustainable transport infrastructure and services; and finally, to attain gender and cross-cutting benefits in accordance with national expectations[33]. The PHSIDS document states that it is the Government's policy to provide district and regional transport and vehicle replacement. The recent data available due to the importance of transport for referral of patients and supervision of health services, the Government has allocated part of COVID- 19 funds distributed by the President of the United Republic of Tanzania Her Excellency Samia Suluhu Hassan, to procure 316 ambulances for primary Health care facilities in the councils to be used for referral of patients and 212 vehicles for supervision and distribution of health commodities in 26 regions and 184 councils.[34]
These vehicles will need to be serviced regularly and replaced after a period of five years, according to the utilization, therefore the Councils to continue setting aside/allocating fund for service and repair, fuel and vehicle replacement.

In order to have sufficient funds for vehicle replacement the Councils will require setting up depreciation/retention accounts and for councils to be disciplined in ensuring that the equivalent annual depreciation cost of running a vehicle is deposited into these accounts. The large sums involved in setting up of such accounts will also focus a council's awareness on the need to only operate sufficient vehicles to meet the operational demands of the individual departments. Adapting good transport management systems will enable councils to identify those vehicles that are superfluous to

[32] Comprehensive Council Health Planning Guidelines 4th Edition 2011 page 82
[33](https://www.afdb.org/fileadmin/uploads/afdb/Documents/Project-and-Operations/Tanzania_-_Transport_Sector_Review.pdf).

[34] Taarifa kwa Umma kuhusu utekelezaji wa Mpango wa Maendeleo kwa Ustawi wa Taifa na Mapambano dhidi ya UVIKO -19. Ofisi ya Rais, Tawala za Mikoa na Mamlaka ya Serikali za Mitaa October 2021

requirements which can be disposed of and the financial savings, both capital and operational, redirected into other development programmes.

4.4.14 *Communication System*

In order to strengthen the referral system from the dispensary to the health centre, there is a need of placing an ambulance and a motorcycle in each health centre and, radio call system to facilitate the inter-facility communication in each district as a means to strengthen the referral system and sharing of experience. Installation of appropriate communication equipment (internet, electricity, email, and radio call system) and emergency transportation means to facilities will facilitate provision of community interventions such as outreach service, educational campaigns, and establishing community emergency preparedness mechanism.

There is inadequate transportation at health facilities and in communities in general specifically there are insufficient vehicles to provide administrative, supervisory or logistical support for the Districts. The situation is even worse in regard to the transportation of patients, the sick and injured, when Ambulances are used for administrative and logistical functions which is not the rational use of such vehicles.

4.4.15 *Healthcare Financing*

The budget allocated to the health sector does not meet the real needs of health care. The per capita health expenditure in TZS slightly decreased from TZS 102,905 (USD 45.2) in 2018 to TZS 93,433 (USD 40.5) in 2020. This is well below international benchmarks for provision of essential health care estimated to be USD 86 per capita per year[35]. This is further aggravated by population growth, epidemiological changes, and increased number of infectious and non-communicable diseases. The existence of separate public funds for the formal sector (National Health Insurance Fund) and the informal sector (Community Health Fund) with different levels of contribution results in inequitable access to care, and inefficiencies due to duplication of administrative costs. The level of contribution to the Community Health Fund does not meet the cost of services, and many people remain without health insurance. This result, either in failure to seek care when needed, or high levels of out-of-pocket spending, which is estimated to have contributed 24% of total health spending in 2017/18. The introduction of universal health insurance, with increased government subsidy for those who cannot afford to pay for membership, is therefore an important strategy in the move towards

[35] URT: MOH , National Health Accounts 2020

achieving Universal Health Coverage (UHC).

Thus the government will review and update the Health Financing Strategy to be in line with the current situation and priorities. Government will work with stakeholders to expand the scope of health insurance. Government will mobilise citizens to join health insurance schemes to ensure that every citizen has access to health care without financial constraints. The government in collaboration with stakeholders will develop a resource mobilisation plan, monitoring and evaluation. Government will continue to strengthen planning, budgeting, execution, monitoring and evaluation. Partners in the health sector will continue improving the efficiency in the use of available resources, for example through strategic purchasing and harmonization of funds flow. Partners will increasingly align with GOT public financial management systems.

4.4.16 *Information and Communication Technology (ICT)*

Among the objectives of the Health Policy 2007 version 2022[36] is to improve health services through strengthening information and communication technologies (ICT) usage.

ICT is having a major impact on society, globally. In Tanzania with rapidly expanding mobile technology and coverage with high speed internet, most of the population will have access to internet services. This offers new opportunities for communication with citizens in general. The health sector must ensure that citizens get access to correct information online. More and more data communication are taking place in the health sector, and new applications ranging from tele-consultation to remote diagnostics, are being introduced. The health workers should be capacitated to manage the new ICT solutions.

The important domains in ICT include information management and reporting (both in administration and in service provision); support to medical decision-making processes; e-learning for health workers and for communicating information to the general public. The Ministry of Health is developing sustainable ICT systems in all these domains, and has defined regulations of interoperability and harmonization of systems. Through Open Distance e-Learning, ICT will facilitate in more cost effective way orienting newly recruited staff.

The Government will establish a Centre for Digital Health. Furthermore, the Government will continue to coordinate, harmonize and manage the use of

[36] National Health Policy 2007 updated to Health Policy 2020

ICT systems in the health sector. The health sector will continue to expand ICT to the grassroots level of health services through mobile technology. Capacity building for users of ICT systems will take place, from grassroots to top management level, both through pre-service and in-service training, and where possible through Open Distance e-Learning. Government will ensure that at local level ICT experts will be deployed for management of infrastructure and capacity building of staff.

The Government will also expand use of Electronic Medical Record system in all health facilities from primary health care level to national referral hospitals that seamlessly interact and exchange information with the national HMIS. The HMIS central data warehouse will be maintained and there will be improved availability and accessibility of data through visualization on dashboards, and other tools for better use of information in decision-making. Government will establish a legal framework for protecting the security of data, privacy and confidentiality of patients. There will be regulations for the use of personal data for management and research.

Medical Technology: Scientific and technological advances in the provision of medical and surgical services offer new opportunities. Use of artificial intelligence, data science, robots, and other technology will reach all levels of hospital: national, regional and district hospitals. There is a growing and increasing demand for the use of genetic sciences, medical biology and applications in medicine. Personalized medicine, based on genetic profiles, will become more normal. New technology may be costly, but at the same time save costs, when integrated well into the health system.

4.4.17 *Telemedicine*

Information and Communication technologies (ICT) are transforming the lives of Tanzanians and, indeed, individuals across the world in education, health, and governance. The Tanzanian Ministry of Health leadership has recognized the potential of ICT to support and transform the individuals across the world in education, health, and governance. The Tanzanian Ministry of Health leadership has recognized the potential of ICT to support and transform the delivery of quality healthcare services with a mandate to adopt and effectively use ICT throughout the health sector. eHealth is the commonly applied term for the application of ICT in the health sector. This commitment of the Government is stipulated in the National eHealth Strategy of July 2013 – June 2018 within the Strategic Objective 9 (SO9) which reads *"Establish telehealth services to enable electronic delivery of quality health care to individuals in remote areas lacking needed expertise"*. The term telehealth is used in this context interchangeably with Telemedicine. This was translated by the

guidance of the National Telemedicine Framework into the health system environment and suggested strategic initiatives for its practical implementation over the next five years.

Definition of Telemedicine

The World Health Organization (WHO) define Telemedicine as follows:
"The delivery of health care services, where distance is a critical factor, by all health care professionals using information and communication technologies for the exchange of valid information for diagnosis, treatment and prevention of disease and injuries, research and evaluation, and for the continuing education of health care providers, all in the interests of advancing the health of individuals and their communities"[37].

In practical terms and related to the Telemedicine Framework and Master Plan, Telemedicine is a means of ensuring that correct health information is provided in a timely manner, where it is needed and to whom it is needed, in a secure, electronic form for the purpose of improving the quality and efficiency of healthcare delivery and disease prevention. The primary goal of Telemedicine is the improvement of clinical practice and the health of patients but continuous medical education is implicitly contained in Telemedicine as all exchange and discussion of clinical questions and expertise results in learning. The Tanzanian eHealth strategy contains have a separate strategic objective which states that enable healthcare workers to have access to continuous professional development through e- learning and digital resources specifically dealing with the use of ICT for professional education and learning[38]. The Health research is an additional benefit which may result but is not the primary goal of Telemedicine. It is also noteworthy that the definition refers to health care providers as the main actors and patients are the beneficiaries. Consumer health informatics to support individuals in health decision making are therefore excluded from the definition of Telemedicine.

4.4.18 Health Information Systems

The health information system is a comprehensive and integrated structure that collects, stores, analyses, and disseminates health and health-related data and information for monitoring and evaluating the performance of health interventions.

The Monitoring and Evaluation Strengthening Initiative (MESI) (2010-2015) operational plan aimed at bringing together M&E stakeholders to modernize

[37] Global Observatory eHealth series. 2. Telemedicine: Opportunity and development in Members State> report in the second Global Health Survey on eHealth 2009. s1..: WHO, 2010. ISBN 978 92 4 156414 4.

[38] URT, MOHSW. Tanzania National eHealth Strategy July 2013 – June 2018. 2013

and strengthen all aspects of M&E within the Health Sector. GOT is committed to improving the application of digital health technologies in order to facilitate attainment of her overall objective of delivering high-quality health services to all citizens. A minority of health facilities make use of the GOT Hospital Management Information System (GOTHoMIS) application as electronic medical record system and data aggregation tool. Expansion is a priority for PO-RALG and MOH.

Major achievements included comprehensive revisions of data collection tools, upgrading the Health Management Information System (HMIS) to a partially computerized system through the use of the DHIS2 software, and consolidation of some vertical programme data into the main HMIS e.g., HIV, TB & leprosy, malaria and reproductive and child health services. Data flow from health facilities to higher levels through DHIS2 is currently more than 90 percent. The government is now investing efforts in Data Quality Assessment (DQA) and data use through implementation of the National Data Quality Guideline (2016) and Data Dissemination and Use Strategy (2015-2020). According to a recent Internal Auditor General report, data quality has improved from 45 percent (2016) to 92 percent (2019).

Digital technologies potentially play a fundamental role in facilitating timely availability of high-quality health information for provision of better-quality health care services, and thus digital health solutions should respond to clients' needs through user-centred design to ensure responsive, resilient, and inclusive health systems. The Government developed and implemented the National eHealth Strategy 2013–2018 to accelerate the health system transformation by enabling timely information access and supporting health care administrative, financial, and clinical operations to enhance decision-making.

Introduction of GOTHoMIS was an example of improved electronic medical records, combined with data aggregation. By the end of 2018, 55 percent of the 17 strategic objectives in the National Digital Health Strategy (2013 – 2018) were achieved. This has led to improvements in quality of health services delivery, revenue collection and management, human resource management, supply chain management of health commodities, health information management, and planning and decision making at different levels of the health system.

The National Digital Health Strategy 2019–2024 was developed and launched in 2019. The strategy is in line with the Tanzania Development Vision 2025 and the draft Health Policy 2020 and aims to facilitate the realization of Government priorities to achieve UHC. The digital strategy will be taken into

consideration in guiding the HSSP V digital health initiatives aiming at improving health outcomes and achieve UHC.

The situation of the health information system in the LGAs is improving. Although majority of the facilities are still using paper based health information system (MTUHA), a good number of facilities are already using electronic health information management systems. The GOTHoMIS is already functional in about 1,161 health facilities by 2021 (see table 2).

Table 3: **Health facilities with GOTHoMIS**

SN	Type of health facility	Facilities offering services	Health facilities with GOTHoMIS
1	Regional Referral Hospitals	26	12
2	Council Hospitals	131	98
3	Designated Council Hospitals	40	19
4	Health Centers	625	411
5	Dispensaries	5,325	621
TOTAL			**1161**

The registration of health facilities is done through the HFR system. By 2021, all the LGAs are registered in the system and it is possible to see all the registered facilities (private and public facilities).

4.4.19 Infrastructure

The Government is committed to improving the health of all Tanzanians and increase life expectancy by providing quality health services that meet the needs of the population. To achieve this, the Government is guided mainly by two principal documents, the Health Policy and the Health Sector Strategic Plan. The Health Policy sets a framework of the government commitment for the health sector. The policy provides guidance for several programs and strategies that are developed to plan realistic targets, prioritize evidence-based interventions and efficient use of available resources. On the other hand, the Health Sector Strategic Plan (s) (HSSP) provides guidance in monitoring and evaluating the health sector targets and achievements over the stated timeframe. For the year 2019 – 2020, the health sector was guided by Health Sector Strategic Plan IV (HSSP IV 2015 -2020).

Table 4: **Summary of Primary Health Facility Coverage (Public) 2020**

SN	Level	Type of health facility	Total health facility required	Total health facility available	Percentage of Coverage HFs	Percentage of CHSB/ HFGC
1	Councils	Hospitals	184	147	80%	100
2	Wards	Health Centres	3,956	648	16%	100
3	Villages	Dispensaries	12,318	5144	42%	100

Distribution of health facilities in 2022 indicates that, dispensaries had constituted 86.6 percent of all health facilities of which Government owned nearly three quarters (73.5 percent) of them. Irrespective of the facilities ownership, there is a deficit of dispensaries by half (56.6 percent), health centres by three quarters (76.5 percent) and District Hospital by 20 percent in year 2022.

Access to health care services is one of the significant factors that contributes to a healthy population. Development and upgrading of health infrastructure is an important step in the journey towards achieving Universal Health Coverage (UHC).

4.4.20 Health infrastructure network

The infrastructure is part of the primary health care services network encompasses dispensaries, health centres and district hospitals. The Health Services Delivery System in Tanzania consists of a network of facilities, which assume a pyramidal Structure starting from a Dispensary, Health Centre through the District and the Regional Hospitals to the Referral Hospitals.

In principle the referral system is designed for the dispensary to refer patients to health centres and for the health centres in turn to refer patients into hospitals. Unfortunately this system is not functioning as intended. A number of factors contribute to this situation, among others, under funding, weak management arrangements, inadequate staff and difficulties in transport and communication.

The 2007 Health Policy recognize the importance of accessible and sustainable Primary Health Care services for all citizens through provision of dispensary in every village, a health centre in every ward and, a hospital in every district. However, with the given country size, population and, the geographical barriers, the health services are not easily accessible to all.

The Health Policy, Health Sector Strategic Plans (HSSP IV, 2021-2026), Primary Health Service Development Program (, 2007 - 2017) and the ruling Political Party Manifesto (Ilani ya Chama Cha Mapinduzi, 2020), all give emphasize on bringing health services closer to where the communities live. Ninety percent (90%) of the Tanzania population now lives within five (5) kilometers from a health facility while ten percent (10%) live within ten (10) kilometers from a health facility[39] (MOHSW 2006; HSA). However, more facilities are still required to serve areas with geographical barriers for the sick and pregnant women.

4.4.21 *The status of Health facilities in the Country*

Health services are provided by both public and non-public facilities. The status of Health sector development programme (HSDP) 2007/2017 directed to improve Health infrastructure network whereby in every village there should be a dispensary and every ward to have a Health centre, every district Council to have a Council Hospital and in every region having a Regional Referral Hospital. Out of 518 Health centres, 115 (22.2%)[40] were providing Comprehensive Emergency Obstetric and Neonatal Care. Definitely massive improvement of Health services in the Country requires involvement of all partners who are available, local and international.

Due shortage of health facilities, patients walk far to seek health services which causes problems to people. At least every Council has more than three health centres compared to what the situation was in 2007 [41] where there was only one Health centre used to serve 15 wards, some district Councils had no any health centre. The situation caused many patients to walk far to seek quality health services. In some incidences, they walked more than 100 kilometers, and sometimes the services were of poor quality. This caused many people to remain at home or visiting Traditional Healers. In this situation the referral system is un-functional and many un-necessary deaths may occur. The government priority in the health sector is to improve access to quality primary health care to the rural communities and hence reduce un-necessary deaths especially maternal death.

[39] MOHSW 2006; Health Sector Assessment (HSA).

[40] PORALG Comprehensive Rehabilitation Plan Oct. 2017

[41] PORALG Rehabilitation and Construction Implementation report 2021

Table 5: *Distribution of Health Facilities per Region 2022*

Region	Dispensary	District Hospital	Health Center	Hospital at District Level	Hospital at Regional Level	Hospital at Zonal Level	National Hospital	National Super Specialized Hospital	Regional Referral Hospital	Zonal Referral Hospital	Grand Total
Arusha Region	312	8	61	7	3	1			1		393
Dar es Salaam Re	510	3	63	35	13	5	1	4	3	1	638
Dodoma Region	381	6	46	5		1		1	1	1	442
Geita Region	163	4	33	5					1	1	207
Iringa Region	236	5	34	4					1		280
Kagera Region	283	4	39	12					1		339
Katavi Region	82	3	16						1		102
Kigoma Region	240	7	39	3	1				1		291
Kilimanjaro Reg	347	4	50	14		1		1	1		418
Lindi Region	228	5	25	4					1		263
Manyara Region	191	5	29	3	2				1		231
Mara Region	255	8	50	8					1		322
Mbeya Region	308	8	31	10	1				1	1	360
Morogoro Reg	392	6	58	9	2				1		468
Mtwara Region	231	6	32		1				1		271
Mwanza Region	327	8	51	14	2	2			1		405
Njombe Region	265	7	35	8					1		316
Pwani Region	332	9	46	2					1		390
Rukwa Region	204	3	26	2					1		236
Ruvuma Region	296	5	36	6	1				1		345
Shinyanga Region	223	4	32	3					1		263
Simiyu Region	207	6	18	2					1		234
Singida Region	216	4	21	5	1				1		248
Songwe Region	199	3	19	4							225
Tabora Region	300	6	29	7					1		343
Tanga Region	367	7	43	9					1		427
Grand Total	**7095**	**144**	**962**	**181**	**27**	**10**	**1**	**6**	**27**	**4**	**8457**

The construction of health care facilities (Public), recorded an increase of the primary health care facilities from 5,572 in 2007 to 8,457 in 2022. This included the increase in dispensary from 4,930 (2007) to 7,095 (2022), Health centre from 565 (2007) to 962 (2022) and Council Hospitals from 77 (2007) to 144 in 2022. Table 5 shows the overall distribution of health facilities in the country by level of care per region. Out of the total facilities 7,095 (83.9 percent) are dispensaries; 962 (11percent) are Health Centres; 144 are District Hospitals (out of 184 Councils), in addition there are 181 hospitals at District level; 27

Hospitals at Regional level; 10 Hospitals at Zonal Level; 1 National Hospital; 6 National Super Specialization Hospitals. Despite the government commitments in increasing the number of health facilities in the country, health facilities across the country remains unevenly distributed. As the results, more health facilities are required to increase access of health services to population. The Government to reduce the gap shall strengthen existing health facilities to attain its optimal operational capacity including completion and equipping of unfinished health facilities across geographical location.

Table 6: **Total registered Health facilities Public and Private Feb. 2022**

Health Facilities Summary as of April,2022								
Region	**Health Centres**	**Dispensaries**	**Clinics**	**Hospitals**	**Health Labs**	**Public**	**Private**	**Total**
Arusha Region	61	312	43	20	57	243	250	493
Dar es Salaam Reg	63	510	365	65	180	176	1,013	1189
Dodoma Region	46	381	29	15	48	364	156	520
Geita Region	33	163	6	11	45	167	100	267
Iringa Region	34	236	19	10	12	205	106	311
Kagera Region	39	283	9	17	14	270	97	367
Katavi Region	16	82	0	4	7	86	24	110
Kigoma Region	39	240	1	12	29	240	82	322
Kilimanjaro Region	50	347	28	21	8	258	200	458
Lindi Region	25	228	5	10	9	248	29	277
Manyara Region	29	191	8	11	8	181	67	248
Mara Region	50	255	8	17	32	252	117	369
Mbeya Region	31	308	37	21	20	274	154	428
Morogoro Region	58	392	31	18	82	326	258	584
Mtwara Region	32	231	10	8	12	215	80	295
Mwanza Region	51	327	43	27	138	310	294	604
Njombe Region	35	265	8	16	14	255	84	339
Pwani Region	46	332	11	12	52	303	155	458
Rukwa Region	26	204	1	6	3	203	39	242
Ruvuma Region	36	296	13	13	26	280	104	384
Shinyanga Region	32	223	16	8	21	193	107	300
Simiyu	18	207	3	9	9	202	46	248
Singida	21	216	8	11	27	209	75	284
Songwe	19	199	3	7	2	187	44	231
Tabora	29	300	13	14	41	283	113	396
Tanga	43	367	25	17	26	357	123	480
Total	**962**	**7,095**	**743**	**400**	**922**	**6287**	**3917**	**10,204**

The total number of health facilities registered by the Ministry of Health were 10,204 (Public 6,287 and Private 3,917) by April 2022. The facilities are owned by Public, Faith Based Organization (FBOs) and Private Health facilities. These includes 962 Health centres compred to 3,956 Wards, 7,095 Dispensaries compared to 12,318 Villages, 144 Council hospitals compared to 184 Councils according to the Health Policy 2007. Facilities complementing the Public facilities from FBOs and Private include Hospitals at the district and Zonal level, Health Centres, Dispensaries, Clinics and Health Labs making a total of 10,204 registered health facilities. Depite this increase, the target has not been reached. Furthermore, some of the available Health facilities infrastructures are inadequate compared to the required standards. Also there is the challenge of shortage of financial resources, Human Resources for Health and other health commodities (Medical equipment, Medicines, medical supplies and Diagnostic supplies). Therefore, according to the Health Policy 2007 updated to version 2022 there is still a need and priority of implementation of PHSDP in order to increase the number of health facilities[42] and the quality of services offered therein. In 2021/22, a total of 80 EMDs and 28 ICUs have been constructed in Council hospitals.

One of the goals of 2007 – 2017 was to reduce maternal death from 578/100,000 to 175/100,000. However, this goal was not achieved since the Tanzania Demographic Health Survey (TDHIS, 2015/2016) showed Maternal Death to be 556/100,000 this is far short of the desired single digit number of maternal death.

Maternal Mortality Ratio (MMR) in Tanzania has been stagnant at 454 and 556 per 100,000 live births in 2010 and 2015, which is far from SDG targets: 292 by 2020, and 140 by 2030. HSSP IV/One Plan II (2020) maternal mortality target was 195/100,000, the achievement up to 2020 is 250/100,000. The target for HSSP V is 100/100,000 (2025) MOH projection[43]. Annually 8,200 pregnant women die due to maternal reasons. Main causes of maternal deaths are "three delays": i) **Delay** in seeking care (demand side); ii) Delay in reaching care - access to health services in rural and remote areas due to long distance, poor infrastructure, shortage of qualified health human resource and lack/inadequate availability of appropriate medicines, medical supplies and medical/Laboratory equipment; and iii) Delay in receiving quality care as providers adhered to only 30.4 percent of the clinical guidelines for managing maternal and neonatal complications.

[42] Health Policy 2007 updated to version 2022

[43] National Plan for Reproductive, Maternal, Newborn, Child and Adolescent Health & Nutrition (2021/2022- 2025/2026

4.4.22 Guidelines for rehabilitation and construction[44]

The Government has provided the guideline to construct a new health facility using public funds. Rehabilitation of the available existing dispensaries, health centre and Council hospitals and staff houses according to standards recommended by MOH. Health Facility plans should be updated by MOH to accommodate necessary rooms to provide quality health services including CEmONC services. Emphasis has been placed on completion of unfinished infrastructures for health facilities constructed by Communities. The health facility should not be upgraded from original functional built dispensary to Health Centre, or Health centre to Council hospital. Also construction of new Dispensaries, Health Centers and Council hospital including staff houses for retention of health care workers should be a mandatory where there is a great need for primary health care services, especially where populations have poor access to health services due to long distance and geographical variation where patients have to walk to access health services *(hard to reach areas)*.

The Government provided the circular for Councils during construction of health facilities to use Force Account method as guided by Financial and Procurement regulation Act No. 17 of 2013. This method has proved to be cost effective in the following aspects:

i) Low cost for Rehabilitation since building materials are bought at the lowest price possible without compromising the quality. Priority is given to technicians residing within the community after fulfilling the selection criteria.
ii) Ensures community participation and ownership since community representatives also participates in special committees to oversee the project.
iii) Regions and Councils are responsible for the oversight, consultation and supervision.

Health facilities should be constructed at locations which promotes easy access to services for the intended communities. It has been observed that many Councils do not follow this principle, instead they have constructed health facilities in locations which do benefit the majority of the community. The PORALG provided the criteria used for selection of areas for construction of a new health facility. The selection should be done by the technical teams using the criteria set by the Health Policy of constructing a dispensary in every village, Health centre in every ward and a district hospital at each district. The whole process of allocating a place for the construction of a new health facility are detailed in the following sections.

[44] Mwongozo wa kuchagua maeneo ya ujenzi wa Zahanati, Vituo vya Afya na Hospitali za Halmashauri , Ofisi ya Rais, Tawala za Mikoa na Serikali za Mitaa, Katibu Mkuu Prof. Riziki S. Shemdoe uliotolewa tarehe 23 Septemba 2021.

4.4.23 Construction of new Dispensary and Health centre

Things to observe during construction of new dispensaries and health centres are listed below. It is important that these facts are followed:

i. Together with the Health Sector Development Programme instructions, construction will depend on the Council Budget allocated for construction. Amount allocated should be within the cost of building a new dispensary/health centre. Insufficient budget leads to failure in completion of construction and hence ending up with many unfished or uncompleted buildings which will take long time to be completed.

ii. The process of constructing a dispensary using community contribution, the process will be as follows:
   a. The Village Chairperson will forward the community request of constructing a dispensary to the VEO,
   b. The VEO will forward the community request to the WEO,
   c. The WEO present the request to the Council Director,
   d. The Council Director will see to it that they have a budget for the requested facility and that the criteria for building a new facility, distance from the available health facility is justified; population to be served (at least 5,000) and/or difficult access present facility. If all these criteria apply the Council Director will instruct the technical team to inspect the areas proposed by the Village for construction of a Dispensary.

iii. Process of constructing a Health Centre by Community contribution will be as follows:
   a. The WEO will forward the request of constructing a health centre using Community contribution to the Council Director
   b. The Council Director, will take into consideration the available budget, distance from the available health centre,
   c. Population to be served not less than 10,000 or hard to reach area, Council Director will instruct the technical team to inspect the areas proposed by the Ward for construction of a Health centre. The District Medical Officer will submit the inspection report of the areas proposed for construction of a dispensary/Health centre to the Council Management Team for discussion and action to be taken, then the report to be presented to the Finance, Administration and Planning Committee by the Council Director which then will be tabled to the Full Council for approval.

iv. The Full Council will review area selected for construction according to the criteria directed/provided by the PORALG.

v. The Executive Council Director (ECD) will submit report to the Regional Secretary for the area proposed for construction of a Dispensary or Health Centre.

vi. Construction of the Dispensary and Health Centre will be according to the new updated Drawings approved by the Ministry of Health. The Councils will prepare the "Site Plan" and secure the Title Deed and building permit before construction start.

vii. Construction of a dispensary/ health centre the Council Director will inform the Regional Secretary who will instruct the Regional Health Management Team (RHMT) to perform inspection of the Completed Dispensary/Health Centre, after the team satisfied with all the criteria, then finally will write a letter to the Permanent Secretary Ministry of Health requesting registration of the Dispensary/Health Centre.

4.4.24 Construction of a Council Hospital

i. All Councils are required to set areas for constructing a Council Hospital when preparing Council "Master Plan". The space of the area will be in accordance with "The Urban Planning (Planning space Standards) Regulations, 2018.

ii. Councils without "Master Plan" will be required to select/set the area for construction of a Council Hospital, The Council Director will appoint the Technical Team, which will advise the appropriate area for construction of Council Hospital, which is not less than thirty (30) acres and submit the report to the Council Management Team for discussion and action for decision making.

iii. The Council Director will submit the report on the area proposed for construction of a Council Hospital to the Regional Secretary who also will instruct the Regional Health Management Team (RHMT) to perform inspection of the proposed area to consider if meets the criteria provided by the PORALG.

iv. The Regional Secretary will write a letter to the Council Director regarding the area proposed/selected/recommended for construction of a Council Hospital.

v. The Council Director will submit the report on the area selected for construction of Council Hospital to the relevant Council Meetings then finally to the Regional Consultative Committee (RCC) for approval ready for construction implementation.

4.4.25 Criteria for selecting areas for construction of Dispensaries

i. The areas to be selected must have the population not less than 5,000 except areas will geographical challenges which include: Islands, Ireland, hard to reach areas during rainy seasons, areas farthest not less than 100 kilometers from the nearest health facility.
ii. Areas for constructing a Dispensary should not be less than five (5) Acres. The area should include staff houses and other buildings. The staff houses should be self-contained for safety reasons.
iii. The area selected should be easily reached/ accessible by all Villages which does not have a Dispensary.
iv. The area for construction of a dispensary should not be closer to another health facility providing healthcare services (Dispensary, Health Centre or Hospital) the distance should be not less than five (5) kilometers.
v. The Decision for which area to be given priority for construction of a dispensary the Village during selection should adhere to population and difficulty to reach/ hard to reach by the villages available in the Ward.
vi. The area selected for construction of a dispensary should be owned officially by village and the Title Deed should be prepared.
vii. The Dispensary should have a fence for security of facility property including equipment, surrounding and privacy of the patients and their properties and implement human rights.
viii. Perform Landscaping of the environment and plant trees, flowers. Garden.

4.4.26 Criteria for selecting areas construction of a Health Centre

i. The Ward, where the Health Centre to construct should have a population not less than 10,000.
ii. The Health Centre is for providing referral services from all Dispensaries in the Ward/catchment area. Therefore, the area selected must be easily accessible/ reached by all villages.
iii. Areas selected for construction of a Health Centre should not be less than fifteen (15) Acres. The area should include staff houses and other buildings. The staff houses should be self-contained for safety reasons.
iv. The area for construction of a Health centre should not be closer to another health facility providing healthcare services (Dispensary, Health Centre or Hospital) the distance should be not less than five (5) kilometers.
v. The Decision for which Ward be given priority during selection of the

area for construction of a Health centre should adhere the population (the Health center caters a population from 10,000 to 50,000) to the Wards available in the Division. The Ward which is the head quarter of the Division will be given the priority if there is no hospital built in that Ward.

vi. The area selected for construction should be owned officially by Ward and the Title Deed should be prepare.

vii. The Health Centre should have a fence for security of facility property including equipment, surrounding and privacy of the patients and their properties and implement human rights.

viii. Perform Landscaping of the environment and plant trees, flowers. Garden.

4.4.27 Criteria for selecting areas construction of a Council Hospital

i. The Council hospital is to provide referral services and those services not available at the Health centre level. The Council hospital will have the capacity to admit patients from 61 to 150 and provide health care services to the population from 200,000 to 500,000 (Basic standards for Health Facilities, Vol. 3; Hospital. at level 1 2017)[45]

ii. The Council is to have only one Council Hospital, only where deems necessary to have another Hospital the decision shall be agreed by the Regional Secretariat and approved by PORALG.

iii. The area for construction of a Council hospital should be not less than thirty three (33) acres. This area include construction of staff houses the remaining for construction of other buildings for other services evolved. The staff houses should be self-contained for safety reasons. For urban areas where land is challenge, the size of the area will depend with the innovation in design of high rise buildings. The Council will submit the request to PORALG before acquire the permit to start construction.

iv. The area selected for construction of a Council hospital should be easily reached/accessible by all Wards in that Council, in order to provide referral services from those Wards.

v. The Council hospital will not be constructed in any Ward for the reason that the Ward has fewer health facilities, but will be based on the

[45] Basic standards for Health Facilities, Vol. 3; Hospital. at level 1 2017.

easiness of accessibility by all Wards in the Council.

vi. The area for construction of a Council hospital should not be closer to another health facility providing healthcare services (Dispensary, Health Centre or Hospital) the distance should be not less than five (5) kilometers.
vii. Where it is possible, it's advised the hospital can be constructed near to the Council Head quarter in order to facilitate administrative functions for the District Medical Offices together with financial services.
viii. The area selected for construction should be owned officially by Council and the Title Deed should be prepare.
ix. The Council hospital should have a fence for security of facility property including equipment, surrounding and privacy of the patients and their properties and implement human rights.
x. Perfor: Landscaping of the environment and plant trees, flowers. Garden.

Table 7: **Status of Public Primary Health Facilities at different levels 2021/2022**

Level	Total	Type of Health Facility	Requirement	Operating	Completion Stage	New being constructed	Total
Villages	12,318	Dispensaries	12,318	5,144 (42%)	**564**	555	6,203(50 %)
Wards	3,956	Health Centres	3,956	648 (16%)		303	942 (23%)
Councils	184	District Hospitals	184	144 (79.9%)	**102***	28	170 ((92%)
Councils		Hospital at District level		3	**2**		
Total			**16,458**	**5,939**	**666**	**886**	**7,315(44 %)**

Source: *PORALG Report presented to Members of Permanent Administration Parliamentary Committee on February 5th, 2022.*

Out of 147 District Council Hospitals/Hospital at District level operating 102 are to be completed construction, but they are providing services catering for out-patients (OPD) and some surgical services. Reasons not all construction work (Wards) completed and also challenges related to scarcity of Anesthesia Personnel and equipment (only 390 are available among the 620 required). By 2015 there was 77 Council hospitals. The council hospitals have been increased to 102 by 2021. Due to financial constraints, the Government construct Council hospitals in phases, started construction of 67 Council hospitals in 2018/2019 in Councils without any hospital whether Public or Designated hospital, and continue to rehabilitate the existing district/Council hospitals. Construction started by

building seven priority buildings out of 31 buildings including three important areas Septic & Soak-way pit (30 - 90 USERS), external work and Local area networks planned. The buildings included Administration, Maternity ward, OPD, Laboratory, Radiology, Pharmacy and Laundry. The 67 hospitals among the 102 that are under construction have started providing outpatient services[46] and one hospital is already offering basic surgical services. In 2020/21, while the previous phases the process is ongoing, 28 other new Council hospitals are being constructed. Despite the achievements made since 2015 in terms of the physical infrastructure (dispensaries, health centres and council hospitals), there is a need for further strengthening to ensure proper functioning of the PHC facilities.

The aim of the Government is to improve the access, quality and efficiency of district based health services by strengthening the planning and management capacity of decentralized district health and administrative system, through construction, rehabilitation, extension and provision of equipment and furniture for the health facilities rendering the primary health service. This programme aims to help in achieving this goal and guide future health facility development.

A well-designed and constructed health facility shall consist of the following basic components:

- Buildings,
- Roads and drainage
- Walkways, parking and landscaping
- Security fences and lighting
- Water supply
- Sewerage system
- Solid waste management/incinerator
- Power supply

4.4.28 Water Supply

Reliable water supply is essential for improved hygiene and provision of health services. The principle sources of water supply are surface and ground or sub-soil water. Most of the dispensaries and health centre do not have reliable water supply and in most cases where water exist the system has deteriorated beyond repair. Most of the district hospitals are connected to piped supply of the urban water and sewerage systems. However it is prudent to supplement the piped water supply with sub-surface water from shallow wells and/or boreholes. Rainwater harvesting with water reservoirs is highly recommended in places where the other sources are not available.

In the context of this programme it is assumed that all dispensaries and health centres situated in rural settings do not have reliable water supply. It is suggested that all these facilities be provided with this essential amenity. The

[46] URT: PORALG Strategic implementation Plan – Health, Social Welfare and Nutrition Services Division (2021-2026)

introduction of safe water supply in these facilities will eventually benefit both facility and the communities.

4.4.29 *Electricity Supply*

A sufficient and constant supply of electricity is indispensable for the economic development of countries. This applies to all areas of a modern economy, beginning with the production sector and including transportation and the service sector all the way down to private households.

The health sector is a big beneficially of electricity supply in terms of ensuring good working environment and sterility. The safety of most hospital equipment and surgical services depends largely on constant supply of electricity.

In Tanzania, apart from the numerous cuts we have gained excellent coverage of electric supply. Still there is need for the two sectors (Health and Energy) to work closely to ensure adequate coverage. Seventy-eight percent (78.4%) of the total population have access to the grid electricity while households connected are 37.7%[47]. The households electrified by solar photovoltaic technology are 30.4%.

4.4.30 *Dispensaries*

A standard dispensary consists of out-patient-department, maternal and child health services, toilets and a minimum of two staff quarters. The current situation with dispensaries as by April 30, 2022 is as follows:

Total number of villages 12,318

Total number of existing dispensaries 5,145

Total number of hospitals 147

Total number of villages without dispensaries 7,173

Total number of dispensaries with BEmONC coverage: 51%[48] Target 70%

Total Health Centres with BEmONC coverage is 415: 64%[49] Target 100%

Note: A village with a health centre does not need a dispensary which entails that the total number of dispensaries required is (12,318 -7,821) = 4,497

It has been established that more than 50%[50] of the dispensaries are in bad state of repair. PORALG, with assistance from the Development Partners is currently rehabilitating 25% PHC facilities in Tanzania with the remaining 25% of the

[47] Rural Energy Agency April 2020

[48] (SARA, 2020);

[49] (SARA, 2020)

[50] The percentage has been arrived at in the Rehabilitation Needs Assessment Study by PMO-RALG

existing health facilities in poor state, which need to be rehabilitated under this programme, is 1170 dispensaries.

Although rehabilitation is taking place, most of the existing dispensaries are operating without a space for maternal and child health services. Approximately 70%[51] of the dispensaries lack this necessary element of the facility.
Staff houses form an integral part of the dispensary, however in most cases these have been neglected during the construction of these units and where they exist are in a very bad state of repair. It is assumed that 80%[52] of the dispensaries lack modest staff houses the provision of which will give impetus to the health service delivery.

4.4.31 *Health Centres*

A standard health centre consists of out-patient-department, maternal and child health services, 24 beds medical ward for female and male, obstetrics theatre, diagnostic services, mortuary, surf-burner (improvised incinerator), kitchen, store, and a minimum of 10 staff quarters 2 out of them being grade 'A staff quarters'.
The current data status of the Health infrastructures is as follows:

- Total number of wards: 3,950
- Total number of existing Health Centres: = 639
- Total number of Health Centres required: = 3,317
- Total number of available Health Centres (operating + under construction and completed=1,009
- Total number of available Staff houses : = 7,947
- Total number of available dispensary (operating + under construction and completed =6,301)
- Total number of available Councils Hospitals (operating + under construction =190)
- Total number of available current operating Council Hospitals 147, Health Centres 648 and 5,145 Dispensaries as per April 30, 2022)
- Total number of available Health Centres providing CEmONC=415
- Total number of available ambulances 423
- Total number of available Health facilities (Public-LGAs) with GOTHoMIS=1,129 as per April 30, 2022.

Staff houses and fencing of the health facilities form an integral part of the Health Centre, Council Hospital and Dispensary. However, in some cases these have not been given the required credence during the construction of these units and where they exist are in a very bad state of repair. It is assumed that 30% of the health centres lack adequate and suitable staff houses and 60% of the existing

[51] From the Three Regions Health Study
[52] From the Situation Analysis Report for preparation of Standard Guidelines and Drawings by PMO-RALG

staff houses are in bad state of repair. The provision of staff houses is a fundamental necessity and will give the required impetus to the health service delivery.

4.4.32 *District Hospitals*

District hospitals are an integral part of the PHC system forming the apex of a system of dispensaries and health centres. District and other level I hospitals are either owned by the government or voluntary institutions. A few private hospitals now exist but mostly in urban areas. Government district hospitals are the responsibility of Local Authorities, funded through the President's Office Regional Administration and Local Government.

4.4.33 *Referral System*

In the context of the Tanzania health system, the planned referral system is basically non-functional due to a number of reasons:

i. Critical shortage of the core human resources for health from the dispensaries, upward to health centres to district hospitals to deliver core services at those levels to reduce unnecessary referrals due to lack of required skills;
ii. Inadequate or inability to complete diagnostic checkup at dispensaries and district hospitals;
iii. Lack of transportation and communication facilities to operationalize organized referrals and feedback processes from the lower levels to the district hospitals and higher up the referral chain;
iv. Irregular supply of essential drugs necessary at levels of the health delivery system to minimize unnecessary referrals,
v. Lack of communication, between various health service providers within districts and regions to maximize utilization of existing skills and facilities, particularly in private facilities, towards promoting horizontal referral of patients

This situation leads to self-referrals and by pass of the referral system by patients, unnecessary referrals by unskilled staff at the various levels of the health care delivery system. This undermines the users' trust and credibility of the sector.

For the purposes of the PHSIDS, innovative approaches will be introduced to ensure timely and a smooth referral system while maximizing on locally available facilities and skills within districts and regions. A revamped referral system will ensure continuity of care- putting patients in the right hands for care.

4.5 Situation analysis - Health Services Delivery

Evidence from the evaluation of the National Health Policy 2007 Implementation, MMAM review report 2018, Mid Term Review of Health Sector Strategic Plan V (HSSP IV) 2020-2025 and the Annual Health Sector Performance Profile Report July 2020 shows that, during the last decade, Tanzania made major progress in the health sector leading to a continued increase in life expectancy at birth as a result of reduced mortality and morbidity. The national census in 2012 determined that the life expectancy had increased from 51 years in 2002 to 62 years by 2012 which is projected to have increased to 65.5 years by 2019 (NBS - Tanzania in Figure 2019). In particular, this increase was contributed by the success in reducing newborn and child mortality, childhood malnutrition and in the battle against major communicable diseases including HIV, Tuberculosis (TB) and malaria. Under-five child mortality has decreased from 81 per 1000 live births in 2015 to 67 per 1000 live births in 2019, while during the same period, infant mortality rate and neonatal mortality rate have only slightly decreased from 45 and 26 to 25 and 43 per 1000 live births, respectively. However, there is some evidence of the increasing burden of non-communicable diseases (NCDs), an inevitable trend as the battle against infectious diseases is successful and risk factors for NCDs are on the rise. With regard to equity, there are persistent inequalities between urban and rural populations, the poorest and richest households and between regions for almost all indicators.

During the period 2015–2018 many positive developments were seen in terms of expanding programme coverage for family planning with modern methods, antenatal, delivery and postnatal care, prevention of mother to child transmission (PMTCT) and HIV treatment. The improvements occurred in almost all regions and were particularly strong in most focus regions, which received additional funding for improving performance. The quality of care appears to have improved considerably, according to the star rating assessment in all regions. The above mentioned progress is partly attributed to improvement in availability, access and quality of health service delivery at all levels.

The number of health facilities has increased from 5,253 in 2007 to 8,179 in 2022[53], of which the major increase was in the number of primary health care facilities (dispensaries, health centres and district hospitals) constructed by the public and private sectors.

Despite the significant progress in the health sector, many of the HSSP IV targets have not been met. Neonatal and child mortality rates have not declined enough to stay on course of achieving the Sustainable Development Goals indicators. In particular, urban children need greater attention.

[53] Source HFR February 2022

Adolescent childbearing remains persistently high and a source of concern, even though maternal and newborn health care coverage is the same for adolescent and older mothers. Fertility and unmet need for family planning are still high in spite of positive trends. Several indicators suggest that maternal and newborn care in health facilities can be improved greatly, and in general the quality of care should continue to be a priority. The coverage of malaria and TB interventions needs to increase to make a greater impact on disease control. Access to improved drinking water sources and sanitary facilities has improved but still far from targets, especially in the rural population.

4.5.1 *Reproductive, Maternal, Newborns, Child and Adolescent Health (RMNCAH) Services.*

Maternal, newborn and child health care are key components of National Package of Essential Reproductive and Child Health Interventions focusing on improving quality of life of women, adolescents and children. The major elements of the package include antenatal care, care during childbirth, Emergency Obstetric Care (EmOC), Newborn care, postpartum care, and Childcare. The provision of RMNCAH services has continued to be a priority in the past decade. Improvement of RMNCAH services has enabled many Women, Adolescent and Children to easily access health services with equity. This is demonstrated by the service utilization along the continuum of care which is supposed to be high in Antenatal fourth visits, institution delivery, postnatal, immunization and family planning services. Health facilities providing RMNCAH services have increased from 3,369 in 2007 to 7,268 in 2019. The majority (82.7%) of all health facilities in 2019 were providing delivery services for pregnant women. The number of pregnant women delivering with skilled birth attendance has increased from 51% in 2015 to 79% in 2019.[54] The number of health facilities providing comprehensive Emergency Obstetric and Newborn Care (CEmONC) services has also increased.

Fertility in Tanzania declined from 5.2 to 4.9 children per woman according to TMIS 2017, surpassing the target of 5.0 for 2020. Modern contraceptive use continued to increase, as measured by couple years of protection, even though there is still considerable unmet need. Implants became the most popular method, overtaking hormonal injections.

During 2015–2018 there were major increases in the coverage of antenatal, delivery and postnatal care. The ANC 4 or more visits increased from 37% to 61%, institutional delivery care from 65% to 77% and postnatal visits within 2

[54] URT: MOH, Annual Health Performance Profile Report 2020.

days after delivery from 42% to 66%. The DHIS2 data showed 2018 improvements in coverage of anaemia testing (61% of pregnant women), syphilis testing (61%), intermittent preventive treatment of malaria in pregnancy (IPT) 2 coverage (80%), deworming with mebendazole (88%), HIV testing (99%) and caesarean (C)-section rates. However, several other indicators suggest that the quality of care did not improve across the board. These include treatment for syphilis and neonatal care (kangaroo mother care, neonatal resuscitation). DHIS2 indicate that stillbirth rates, and low birth weight rates (from 5.5% to 5.0% among health facility live births declined during 2015–18.

Adolescent birth rate remains high, and not declining. Youth friendly services are integrated in 63% of existing RCH platforms across the country. Major gaps affecting delivery of adolescent health include inadequate infrastructure for adolescent reproductive health services; inadequate integration of adolescent interventions into CCHPs; sociocultural taboos hindering efforts to reduce teenage pregnancy.

4.5.2 *Immunization and Vaccines Development*

Immunization coverage levels among infants remained high with 9 out of 10 children receiving the recommended vaccines.

The scope of the IVD program has expanded beyond the initial focus on infant under one-year (0-11 months), with this development, the current goal of the program is to contribute to the reduction of morbidity, mortality and disability due to Vaccines Preventable Diseases through provision of high-quality immunization services in in the country. The country is on steady track to achieve the Decade of Vaccines universal goals. In 2020, a total of 2,152,759 children under one year were vaccinated (DTP3), which is a drop of 8,338 compared to children vaccinated in 2019.

There was suboptimal coverage for OPV3 vaccination (74 percent) compared to other vaccine antigens administered under one year of age. This may be partly contributed to instants stock outs of Vaccines. BCG and TT2 performance were above the targeted coverage.

4.6 Control of Communicable disease

4.6.1 *The National AIDS Control*

Tanzania is one of the highest HIV burdened countries in Africa. Although the prevalence of HIV among people aged 15-49 years has declined progressively from 7% in 2003/2004 to 5.1% in 2011/2012 and 4.7% in 2016/2017[55], about 1.7 million people are living with HIV (PLHIV), which

[55] National Bureau of Statistics, 'Tanzania HIV Impact Survey (THIS) 2016-2017', December 2018.

places Tanzania among the top five countries with the highest number of PLHIV in Africa

However, the Tanzania and Global HIV responses have yielded significant results in reducing new HIV infections, AIDS-related morbidities, and mortalities. It is evident that we now have both the tools and the means to prevent every new HIV infection and every single HIV -related death.

However, new HIV infections and HIV-related deaths still occur due to inequalities in access to care and barriers related to gender and human rights barriers. Thus, the global society, through the Joint United Nations Program on HIV/AIDS (UNAIDS) Global AIDS Strategy 2021 – 2026, calls for a response that will empower communities to eliminate inequalities and end AIDS.

The Government adopted and committed to fast-track the UNAIDS 90-90-90 targets by 2020 which was later upgraded to 95-95-95 by 2023 to end the epidemic by 2030. In order to achieve these targets, the Government has developed the Health Sector HIV and AIDS Strategic Plan 2017/2022 (HSHSP-IV) to provide guidance on strategic priorities in HIV and AIDS prevention, care, treatment and support services and to accelerate achievement of selected SDGs.

On average Tanzanian has made good progress in attaining three 90s indicators especially the last two 90s. However, there are regional variations with only Mbeya and Kagera regions having achieved the set targets before year 2020. On the other hand, with an estimated 1,600,000 people living with HIV in 2019, new HIV infections have decreased from 65,000 in year 2017 to 53,000 in year 2019 (NMSF) and AIDS-related deaths have decreased from 30,000 annually in 2017 to 24,000 annually (NMSF).

By December 2019, a total of 1.28 million (79%) knew their HIV status and had been enrolled in antiretroviral therapy (ART) care and treatment services. Among them 1.27 (99%) million were already on ART while 91% had attained viral suppression.

Tanzania has made notable progress towards epidemic control. Based on 2020 UNAIDS estimates, 84% of People Living with HIV (PLHIV) knew their status; among them, 97% were on Antiretroviral Therapy (ART), and among those on ART, 95% had attained viral suppression.

Despite this progress, some populations, such as Key and Vulnerable Populations (KVP), men, children, adolescents, and young people, are being left behind. Thus, in the past 10 years, we have only been able to

reduce new HIV infections by 38%%, which falls short of the goal of reducing new HIV infections by 85%.

Elimination of mother to child transmission of HIV is on track with PMTCT service coverage having increased from 93% of primary health care (PHC) facilities in 2010 to 97% in 2019 and provision of antiretroviral (ARV) for PMTCT among pregnant women increasing from 59% in 2010 to 98% in 2019. However, more efforts are needed to reach the 2025 target of below 2% for mother to child transmission of HIV in exposed infants, despite a reduction from 26% in 2010 to 9.4% in 2019 (Mid -Term review of HSHSP IV)

4.6.2 *Malaria Control*

The vision of the new strategy is that, Tanzania becomes a society where malaria is no longer a threat to the health of its citizens regardless of gender, religious or socio-economic status. The mission is to ensure that, Tanzanians have universal access to malaria interventions through effective and sustainable collaborative efforts with partners at all levels.

Despite the decrease of malaria incidence in the country, the climatic conditions remain favourable for transmission throughout the year. Almost 96 percent of the country is a high transmission risk area with reported malaria incidence is more than one per 1000 population, whereby only 4 percent is a low transmission risk with reported malaria incidence of less than one per 1000 population.

Hospital admissions due to Malaria have decreased by 30.3% from 264,879 in 2016 to 184,674 admissions in 2020. Also, there was a declining malaria admission based on clinical diagnosis since 2016 to 2020. The overall slight declining malaria admission might be attributed to the adherence to malaria case management guidelines and wide coverage of SBC and Advocacy on early health seeking behaviour among the community members.

Mortality trends; there is a decline in Malaria death rate per 100,000 population from 8.2 (2016) to 3.9 (2020). Also, indicates that, number of Malaria deaths in all age groups have decreased by 50% from 4,884 (2016) to 2,460 (2020).
The decline trend was attributed by the decrease in both Malaria prevalence and incidence as a result of Malaria interventions undertaken in the country.
The antimalarial medicines dispensing ratio; the ratio of antimalarial medicines dispensing ratio against confirmed malaria diagnosis indicates how well anti-malarial medicines dispensed are managed by health facilities in comparison to the number of confirmed cases diagnosed.

In 2020, Tanzania's dispensing ratio of ALu was 1:2. This means that more medicines were dispensed than the cases diagnosed. The observed variance might be due to improper documentation of malaria commodities.
The recommended actions to improve this situation are to enhance availability of malaria testing and recommended antimalarial at all levels of health care delivery and ensure improved quality of services offered to malaria patients; to strengthen the capacity of regional and district teams to conduct data quality assessment and strengthening the health information regarding data quality and use; to improve awareness to community members on appropriate use of vector and curative interventions of malaria including Mass Replacement Campaign (MRC) and LLINs care and repair; improve resources mobilisation to support effective implementation of malaria interventions.

Malaria Program performance: The percentage of households population with access to an LLIN within their household increased from a baseline of 39% to 65% in 2017 with the coverage higher in more wealthy population and in urban areas in 2020, (MPR 2020). IRS coverage at 3.7% (2017 MIS) was far below the set target of 25% to be achieved by 2020, average testing rate of children under the age of 5 years with fever who had a malaria test the same or next day after onset of a disease was increased to 43.1% in 2017 from 35.9% in 2015 and 24.9 in 2012 and percentage of children under age 5 with fever who were treated with recommended antimalarial the same or next day following the onset of fever dropped from 30% in 2015 to 25.2% in 2017.

The Test rate is lower in rural areas and low wealth quintile population, compared to the level of urban areas and higher wealth quintiles. Information available on Bio-larviciding was on procurement efforts and nothing on technical operation issues to reflect field implementation achievements and challenges. MPR 2020 also showed that malaria vector control accounts for 50% - 60% of the annual malaria budget while malaria case management accounts for 20%-30%.

The MPR 2020 report recommended to explore innovative multiple distribution channels to ensure national average LLIN access reach 80%, improve access to malaria testing and treatment beyond health facilities to adequately reach social-economic disadvantaged community (rural & low wealth quintile) and develop national framework and indicators for routine monitoring implementation of Bio-larviciding in the councils.

The supportive strategies are: commodities and logistics management; social behavior change & advocacy, and leadership, partnership and resource mobilization. Each strategy has a uniform outline which consist of strategic objective, strategic approach and service delivery mechanism. The impact indicators measure strategic objectives, while outcome indicators measure strategic approaches and output indicators measure deliverables of the service delivery mechanism.

Malaria morbidity and mortality: between 2016 and 2020 the average annual malaria morbidity recorded in health facilities has been fluctuating between 100 and 125 per 1000 population, from approximately 250-300 per 1000 in high-malaria risk regions and less than 15 per 1000 in low malaria transmission risk regions. The population-based mortality shows approximately 50% reduction in infant, child and under 5 mortalities from 1999 to 2016 (TDHS). Health facility-based indicators 56 show more than 50% reduction in mortality between 2016 and 2020 with very large variations between high and low malaria risk regions. Routine mortality indicators in DHIS2 are also showing progressive reduction on malaria deaths and its large heterogeneity.

The 2002- 2007 national malaria Strategic plan: The goal of the 2002–2007 National Malaria Strategy was "to reduce mortality and morbidity due to malaria in all 20 regions of the country by 25% by 2007 and by 50% by 2010" through the delivery of four strategic approaches: (1) improved malaria case management, (2) vector control through the use of ITNs, (3) Control of malaria in pregnancy and (4) malaria epidemic prevention and control.
Stock of ACTs: The stock out rate of ALu decreased from decreased from 2.5% (2015) to 1.6% (2017) and rose again to 2.3% (2019), HMIS/DHIS2.
Stock out rate of mRDT declined from above 4.5% in 2015 to below 2% by 2019, this is probably due to proper quantification of malaria commodities at health facilities as well as effective supervision and mentorship.
The malaria commodities reporting rate for the period of 2019 was 99.4%. According to the surveillance monitoring and evaluation for routine data all health facilities (100%) reported malaria OPD indicators, the target was achieved due to timely submission of the HMIS monthly summary forms and entry into the DHIS2 system. However, issues on data quality is still a challenge and some data are not obtained routinely for complete malaria indicators.

[56] Mboera LEG, Rumisha SF, Lyimo EP, Chiduo MG, Mangu CD, Mremi IR, et al. (2018) Cause-specific mortality patterns among hospital deaths in Tanzania, 2006-2015. PLoS ONE 13(10): e0205833. https://doi.org/10.1371/journal.pone.0205833

Malaria knowledge: Malaria knowledge, the targeted 8 (100%) malaria epidemiological bulletins were developed and disseminated to malaria stakeholders and stakeholders.
Epidemiology prevention: Proportion of malaria epidemics detected and responded within two weeks from the onset. No malaria epidemics was detected through established threshold, although the system was not functioning as expected.

Surveillance system for malaria elimination: Proportion of councils within the "very low" transmission stratum that established appropriate surveillance system. Establishment of surveillance system for malaria elimination was in process for 36 councils in very low malaria transmission stratum.

4.6.3 Tuberculosis and Leprosy

4.6.3.1 Tuberculosis

TB and Leprosy have continued to be public health importance diseases in the country. The Government of the United Republic of Tanzania has made significant progress towards attaining the ambitious mission of ending TB and of eliminating leprosy.

TB has remained a public health importance disease in the country. TB incidences decreased from 170,000 in 2014 to 142,000 in 2018 and TB case notifications increased from 65,000 in 2015 to 75,000 in 2018 during the previous NSP V. This trend in the reduction of TB burden makes Tanzania among a few countries that on track towards achieving the global End TB strategy year 2020 milestones.

Likewise, Tanzania has observed a gradual but progressive reduction of the burden of leprosy in the last five years, with 2,457 notified cases in 2015 and 1,607 in 2019. The country attained the global target of leprosy elimination ten years ago; however, one of the 17 countries notified more than 1,000 leprosy cases per year.

4.6.3.2 TB Mortality and Incidence

There has been a significant downward trend in TB mortality from 56/100,000 in 2015 to 40/100,000 population in 201. TB mortality among HIV negative and HIV positive TB cases decreased by 28 and 38 percent, respectively. TB deaths decreased from 30,000 in 2015 to 22,000 in 2018. Likewise, there was a steady decline in TB incidence rates from 305/100,000 in 2015 to 253/100,000

in 2018. The 4 percent annual reduction in TB incidence rate corresponds to the observed increase in case notifications and a decrease in the number and proportion of missed TB cases from around 113,002 (65%) in 2015 down to 59,776 (43%) in 2019. Tanzania is on track to achieving the End-TB 2020 milestones of a 35 percent reduction in the total number of TB deaths and a 20 percent reduction in TB incidence rate compared with the levels, which prevailed in 2015.

4.6.3.3 TB trends notifications

TB notification of all forms, new and relapses were 60,895 in 2015, and this gradually increased to 81,208 in 2019. The increase corresponds to 18 percent, decreasing trends in the estimated TB incidences. These changes could be the outcome of multiple initiatives including the introduction and rollout of program quality improvement approaches in health facilities since 2016 and implementation of community TB initiatives to search the missing people with TB.

The age and sex distribution in TB notification shows that, the age group of 25-44 years has the highest notification in both males and females. Males continue to be more affected than females with a ratio of 1:1.5. There is a high notification rate for adults over 65 years of age indicating not only the increased risk of TB in the elderly population but also increased ability of health care workers to identify cases in the older generation.

The case notification rate (CNR) has improved ranging from 128 in 2015 to 145 in 2019. However, there is a constant disparity of trend observed in particular geographically areas. The east and central regions reported high CNR, while the western part of the south and the lake zone has consistently been registering low CNR compared to the neighbouring areas and councils.

4.6.3.4 Treatment outcomes for Drug Susceptible TB

The country has maintained a high treatment success rate at over 90 percent, and in 2018, the treatment success rate was at its highest at 92 percent. Treatment outcomes show a decrease in the deaths among the notified cases from 6 percent in 2015 to 4 percent in 2018. Although the desired treatment outcomes are improving, a decrease in the cure rate from 34 percent in 2015 to 32 percent has been noted for year 2018.

4.6.3.5 *Multi- drug Resistant Tuberculosis*

According to the second TB drug resistance survey (2018), the prevalence of Multi-Drug Resistant Tuberculosis (MDR-TB) was 0.97 percent among new cases and 12 percent among re-treatment cases. Notification of drug-resistant cases increased from 178 cases in 2015 to 534 cases in 2019. The improvements are mainly due to increased systematic TB screening at most outlets and coverage of molecular diagnostics, GeneXpert machines from 65 in 2015 to 238 in 2019.

The treatment success rate of MDR-TB cases has been improving from 76 percent in 2014 to 83 percent for cases notified in 2017. This improvement has partly resulted from improved care and support services. The decentralization of the MDR-TB services has contributed significantly to these good outcomes.

4.6.3.6 *Collaborative TB-HIV*

TB/HIV collaborative activities have been implemented since 2006 and thus testing for HIV among TB patients, and active screening for TB among HIV patients have been scaled-up countrywide. Between 2013 and 2019, there was a rising trend of coverage for HIV testing, registration for HIV care, and the starting of ART. Since 2017, 99 percent of TB patients tested for HIV, this was an increase of 93 percent from 2015. Furthermore, 99 percent of co-infected patients began ART. ART uptake increased from 85 percent in 2015 to 99 percent in 2019. On the other hand, the proportion of TB patients who are co-infected with HIV has decreased over time, from 39 percent in 2012 to 24 percent in 2019.

The proportion of PLHIV screened for TB seemed to decrease from its peak of 91 percent in 2017 to 84 percent in 2019. The (HSHSP IV) 2017–2022 recommend that 82 percent of clients on care should be initiated on TPT by 2019. Although not achieved then, TPT enrolment and completion generally increased from 10 percent in 2016 to 69 percent by June 2019.

4.6.3.7 *Childhood TB*

TB disease in children is a public health problem of particular significance because it is a marker for recent transmission of TB. It is difficult to estimate the "correct" proportion of childhood cases, but experts believe it should be

around 15-20 percent in countries with high TB burden such as Tanzania. The proportion of paediatric TB cases in all TB notifications increased from 9.5 percent in 2015 to 15 percent in 2019. The ratio of 0-4 to 5-15 has been at 1.3 for the past four years, which is below the ideal ratio of 1.5-3.0.

Furthermore, data for 2017, 2018, and 2019 indicated a higher treatment success rate compared to all other age groups at 95.3 percent. However, cure rates are low at 14.6 percent and the co-infected children had a higher (8.3%) death rate than was the case in 2015 to 34 percent in 2019.

4.6.1 Leprosy

4.6.1.1 Leprosy prevalence

Leprosy is a neglected tropical disease, which causes more physical deformities than other infectious diseases. Even though Tanzania attained global target of leprosy elimination, the country is still among those notifying more than 1,000 cases per year. In 2019, leprosy registered prevalence rate was 0.3/10,000 population down from 0.4/10,000 in 2015. At the national level, the Leprosy prevalence rate has remained below 1 case per 10, 000 population since 2006. However, 19 districts councils of the Mainland and 2 districts from Zanzibar reported the prevalence rates of the above threshold of 1 case per 10,000 population in 2019.

4.6.1.2 Leprosy detection

In the past five years, a significant decrease in newly notified leprosy cases of 31 percent was recorded from 2,297 in 2015 to 1,593 in 2020. The 2019 data show that, 70 percent of all the newly notified cases come from 9 regions of Morogoro, Dar es Salaam, Lindi, Tanga, Rukwa, Mtwara, Mwanza, Pwani, Dodoma, and the Island of Unguja. The prevalence detection ratio has remained around 1 since the year 2006 suggesting that MDT units continue removing from the registers all the patients completing their MDT treatment course in time. The upward changes in the proportion of MB cases and the decline in the percentage of the children notified among the newly leprosy cases across the regions suggest the reduction in the incidences of the disease in the country with reduced disease transmission. However, there are many variations across regions with some reporting up to 20 percent of the children cases. Grade 2 disability among the new leprosy cases shows a gradual decrease, which has remained slightly above 10 percent. The aim was to lower

the grade 2 disability to less than 8 percent by 2020

4.7 Health Promotion and Education

The coverage of Primary Health Care services is still unacceptably low. Health and health related problems are unlimited as reflected by high Burden of Diseases (BOD) for both communicable and non-communicable diseases while resources are limited. Health seeking behaviour is poor, thus leading to high morbidity and mortality of diseases. In collaboration with other sectors and private partners, community awareness on health and health literacy will be strengthened, leading to behaviours that improve nutrition, healthy lifestyles and health seeking behaviour. Vulnerable groups in particular will be supported.

Communities should be aware of their health, health risks and environmental factors influencing health. Issues of life style, physical and psychological hazards and pollution due to industrialization, urbanization and climate change. The health sector will enhance the provision of community health education to motivate people to improve their health literacy, empowering them to take decisions about health and wellbeing. The health sector will undertake awareness campaigns and will engage with communities and other sector ministries in improving health in the environment and the workplace. The MOH will continue to strengthen the partnership between the health and education sector. Government will continue implementing the National School Health Strategic Plan (2018 - 2023). School health guidelines will be developed to include issues related to sanitation, nutrition, child safety, health screening and vaccinations.

These guidelines will take into consideration the school health programmes as implemented in the immediate post-independence era where health workers from nearby health facilities or health programmes used to visit schools and colleges to conduct screening of various diseases among school children. Government will design special programmes for out-of-school youths to improve their health and wellbeing.

The health sector is striving to improve accessibility and quality care for the public. Social mobilisation and public awareness is a critical step in the success of the programme. Health Education and Health Promotion will enhance delivery of Primary health services to the community focusing on community awareness and health literacy that will result in improved health of the population. Health education and promotion will:

i. Strengthen prevention of communicable and non-communicable diseases;
ii. Increase community awareness, life style, and health seeking behaviour;

iii. Increase community involvement, social mobilisation and participation in health services

4.8 Nutrition

The incidence of under nutrition is high although there has been considerable improvement recently. The percent of stunted children has dropped from 42% to 31% between 2015 and 2018. Better progress has also been recorded for underweight which has fallen from 16% to 12% during the same period. Despite this progress, Councils and community levels response and action for nutrition has remained weak. The underlying causes of malnutrition can be grouped into three factors: food security, caring capacity and access to essential services like health, education, safe water, sanitation and hygiene. The primary source of the food supply is local production which is estimated to account for about 95 per cent of food availability in the country. The aggregate national food availability in the country has a critical balance between productions and needs[57].

Both under nutrition and over nutrition will be tackled, not only at individual level through empowerment, but also at society level, with measures that increase access to safe food for nutrition. Where needed, the health sector will provide medical services for malnutrition.

Government and its partners will enhance healthy nutrition to prevent underweight as well as overweight, and where necessary issue regulations in regard to sugar and salt in processed food and beverages. The government will implement a common risk factor approach to promote healthier dietary consumption for prevention of non-communicable diseases. The Government will promote the availability of essential nutrients in the community in partnership with other ministries and with the private sector. Food for nutrition will be the guiding principle. Government will ensure that public and private industries have a system for adding nutrients to processed foods, for example iodine and vitamins. The Government will set standards for ingredients. Government will address quality of nutrients in urban environments, e.g. through quality standards for fast food, or for retail outlets.

The care of children, pregnant and lactating women, the elderly and those suffering from diseases including AIDS and tuberculosis is important towards improving nutrition in those population groups. Recent surveys show that inadequate access to safe water and sanitation and poor hygiene practices increase the burden of infectious diseases and lead to growth retardation and stunting[58]. The health sector will enhance education and

[57] Tanzania Comprehensive Food Security and Nutrition Assessment Report 2017

[58] Tanzania Comprehensive Food Security and Nutrition Assessment Report 2017

awareness to the community on the importance of good nutrition in vulnerable groups like women, children, elderly, and people with disabilities. In particular, women of childbearing age have to know the importance of good nutrition from pre-pregnancy to breastfeeding. Nutrition imbalances in vitamins and essential nutrients will be addressed. Government will build the capacity for nutritional services at Regional and Council levels. The health sector will continue to strengthen coordination of nutrition and research services at all levels.

4.9 Non Communicable Diseases

4.9.1 Chronic Diseases

The burden of diseases due to Non Communicable Diseases (NCDs) are rapidly increasing and now contribute nearly 50% causes of death in Tanzania. Changes in lifestyle have led to an increase of NCDs including feeding/nutrition (overweight, cardiovascular disease and diabetes), environmental factors, air and noise pollution (cancers, mental health), work related and family life stress (mental conditions) and travel and work (road traffic and occupational injuries). The present status of chronic non-communicable diseases and their risk factors cannot be left unattended as they already contribute significant proportion of the national morbidity and mortality burden and are a significant cause of premature deaths and disability.

The health sector will elaborate and implement strategic efforts to address the increased emerging trends of overweight and obesity among all age groups, to reduce the burden of chronic diseases, including mental conditions and morbidity and mortality due to accidents.

The health sector will engage with communities and promote participation in NCD prevention and control. The government will strengthen intersectoral collaboration in prevention and control of NCD and their co-morbidities as some interventions are needed outside the health side (e.g. ban on smoking, food processing, sugar, salt and fat content of fast food, road infrastructure conducive to exercises, cycling and walking, pro-health taxes etc.).

All health care facilities will provide screening services for non-communicable diseases and their co-morbidities as part of the initial screening for all new clients. Health facilities will be enabled to provide treatment for NCDs and their co-morbidities, according to their levels. The health facilities will use the experiences and structures built up by vertical programmes, to reach communities and provide integrated care.

The lessons learned from COVID-19 show that people with chronic diseases are much more susceptible to suffer from complications of infectious diseases.

There is a strong linkage between NCDs and social determinants for health. Government will have to address the determinants of health in order to reduce NCDs. Health in All Policies is therefore important, as many NCDs are caused by factors in society that are beyond the mandate of the health sector and require strong inter-sectoral collaboration to prevent or address them. This including addressing co-morbidities where NCDs are increasing in chronic communicable diseases such as HIV. Lessons learned from HIV prevention and control could be applied to NCDs.

Government will continue to strengthen the research into prevention and control of non-communicable diseases and its co morbidities. The findings of the research will be used to develop appropriate strategies and interventions to prevent and control non-communicable diseases. Government will ensure availability of skilled HR in the area of NCDs and their co-morbidities. MOH will ensure use of technology in the management of NCDs and their co-morbidities. Monitoring of NCDs through the HMIS will be improved.

4.9.2 *Mental Health, Addiction and Substance Abuse*

The availability and management of mental health services in communities and health care facilities at all levels, is a priority. First the country needs to adapt a multi-sectoral approach including adequate health workers with mental health training at all levels including primary health care to meet the needs of mental health services and psychological counselling. Secondly, counselling and therapy needs to be embedded in the regular health services. Outpatient services and ambulatory services will be established in health facilities. At primary healthcare level, screening, recognizing, treatment and referral will be the main target. Medicines for psychiatric disorders will be made available at PHC levels[59] .

The health sector will strengthen prevention, treatment and rehabilitation services for victims of substance abuse and addiction. This will be integrated in general health services. Government, in collaboration with the private sector, will support establishment and maintenance of treatment and rehabilitation centres for mental health and substance abuse in each region. Improved education, and where needed control of addictive substances will take place.

4.9.3 *Oral Health*

Improvement of access to quality oral health services is an important priority. In collaboration with stakeholders, the Government will continue to increase

[59] URT Ministry of Health, Community Development, Gender, Elderly and children: Standard Treatment Guidelines and National Essential Medicines List for Tanzania Mainland sixth Edition 2021

access to high quality oral health services and will focus on strengthening the delivery of preventive services through school based oral health programmes and facility level oral health education, continue to strengthen oral health services provision at all levels of health care facilities in order to improve access and increase utilisation. The Government will improve Infrastructure, increase skilled staff, dental equipment and related health commodities needed for provision of oral health services. The referral system will be improved, the referral system will be improved, to ensure continuity of services.

4.9.4 *Eye Care*

The Ministry is currently implementing a third Eye Health Strategic Plan (2018 – 2022) which focuses on reduction of blindness and visual impairment by strengthening the delivery of Primary Eye Health services at the community, primary schools and primary health care levels, in line with sustaining the advancement in the secondary and tertiary eye health services. With the increase in the global burden of NCDs, prevention of blindness to people living with diabetes is a new priority. Screening for glaucoma will be strengthened to detect the disease in early treatable stage.

Furthermore, screening and treatment of refractive errors (People centered eye care, increase in cataract surgical rate and refractive error correction rate, 2030 Insight, World Vision Report) Human Resource for eye health is among the main pillars in the prevention of blindness and visual impairment.

4.9.5 *Ear Nose Throat Care*

Currently there is limited access to specialized services for ear, nose and throat (ENT) care, mostly in referral hospitals. Especially with ageing, there will be more complaints of deafness. Through public private collaboration more services will be made available in Tanzania and increase the capacity to detect defects early enough to institute prevention.

4.9.6 *Sickle Cell Disease*

Globally, there estimated 300,000 births with sickle cell disease (SCD) each year. Tanzania is the fourth country in the world with the highest birth prevalence of SCD individuals, after Nigeria, Democratic Republic of Congo and India. Both the highest prevalence and highest mortality of SCD is found in Africa. In order to address this burden, there is a need to design and implement a comprehensive national newborn screening to identify patients, and development of holistic SCD care programs to provide therapeutics and education for families and children with SCD[60] and those genetic carriers for

[60] The global burden of sickle cell disease in children under five years of age: a systematic review and

SCD.

In Tanzania significant progress has been made in raising awareness of sickle cell disease (SCD). SCD is part of the Tanzanian National Strategic Plan for Prevention and Control of Non-Communicable Diseases 2021-2026. However current SCD services do not have a country-wide coverage. Current capacity to diagnose SCD exists only in tertiary facilities. More investment is needed to expand the diagnostic and the service delivery to the lower-level health facilities. Areas of focus should include strengthening preventive services at the community level including new-born screening and genetic counselling and testing. Research on innovations of increasing awareness on prevention and curative interventions for SCD should be explored. There is need to be more innovative in developing interventions against this preventable genetically propelled disease. Deliberate education to the youth on the genetics leading to the condition should be provided to allow them to make an informed choice when they reach a stage of selecting partners (wife or husband) and if possible encourage screening before marriage.

4.9.7 Cancers

Cancers (malignant tumors or neoplasms) represent a large group of diseases that can affect any part of the body. Cancers are characterized by rapid creation of abnormal cells that are invasive and grow beyond their usual boundaries. Cancer cells can spread to other organs/parts of the body – a process metastasis. Widespread metastases being the primary cause of death from cancer[61]. Globally, cancer is a leading cause of death, accounting for nearly 10 million deaths in 2020, or nearly one in six deaths. The most common cancers are breast, lung, colon and rectum and prostate cancers. Around one-third of deaths from cancer are due to tobacco use, high body mass index, alcohol consumption, low fruit and vegetable intake, and lack of physical activity. Cancer-causing infections, such as human papillomavirus (HPV) and hepatitis, are responsible for approximately 30% of cancer cases in low- and lower-middle-income countries[62]. The good thing is that cancers can be cured if detected early and treated effectively thus calling not only for preventive activities but also screening for early detection.

There has been a consistent and a significant rise in cancer in Tanzania. The International Agency for Research on Cancer (IARC) estimates that there are

Meta-analysis; Elizabeth Wastnedge et all. The Usher Institute for Population Health Sciences and Informatics, University of Edinburgh, Scotland, UK

[61] de Martel C, Georges D, Bray F, Ferlay J, Clifford GM. Global burden of cancer attributable to infections in 2018: a worldwide incidence analysis. Lancet Glob Health. 2020;8(2):e180-e190.

[62] Ferlay J, Ervik M, Lam F, Colombet M, Mery L, Piñeros M, et al. Global Cancer Observatory: Cancer Today. Lyon: International Agency for Research on Cancer; 2020 (https://gco.iarc.fr/today, accessed February 2021)

42,060 new cases of cancer per year in Tanzania, with a high mortality rate of 28,610 deaths per year, showing that many patients are diagnosed at advanced stages[63].

Currently in Tanzania, The Ocean Road Cancer Institute (ORCI) is the only specialized facility for cancer treatment. Tanzania is experiencing rising cancer incidence and mortality [4] and is increasing the number of cancer treatment centres. Of 40,464 new cases in 2020, the leading cancers were cervical (25%), breast (10%) and prostate (9%)[64]

4.10 Neglected Tropical Diseases.

Neglected Tropical Diseases (NTD) are communicable disease linked with poverty and prevalent in areas with poor sanitation, inadequate safe water supply and substandard housing conditions. These includes Schistosomiasis, soil-transmitted Helminthes, Lymphatic Filariasis, Onchocerciasis and Trachoma which are endemic in many areas as well as Zoonotic diseases such as Human African Trypanosomiasis (HAT), Rabies, Tick borne Relapsing fevers, Plague, Echinococcosis (hydatid), Taeniasis (cysticercosis) and Brucellosis with a large part of the population being at risk of co-infection with two or more of these diseases[65].

Neglected Tropical Diseases (NTDs the government in collaboration with partners will continue to) fight specific diseases, such as elephantiasis, hydrocele and trachoma, through mass drug administration (MDA), environmental interventions, case morbidity management.

Tanzania is endemic with lymphatic filariasis (lf), onchocerciasis, trachoma, schistosomiasis (SCH) and soil-transmitted helminthes (STH) – All five are preventable by chemotherapy through MDA. In Tanzania we have reached a geographical MDA coverage of 100% countrywide from 2016. MDA is provided in all endemic district councils on annual basis. Lymphatic filariasis, onchocerciasis and trachoma are targeted for elimination, thus, striving to reach the criteria to stop MDA implementation across all endemic councils. All targets for preventive chemotherapy treatment were met in 2018 while in 2019 only two targets (for onchocerciasis and trachoma) were met. The reason for not meeting these targets was lack of funding to support some of the MDA activities[66]. Efforts should be maintained for implementing MDA and morbidity management

One Health Approach to be advocated and strengthened in addressing the

---

[63] Aleesha Adatia, MD, MMed; Cancer in My Community: The Barriers to Cancer Care in Tanzania;

[64] Cancer statistics in Tanzania 2021 April 2020

[65] URT, MOH, Strategic Master plan for Neglected Tropical Disease Control Program July2021 – June 2026, Tanzania Mainland: " Sustain the Gains for control and Elimination of NTDs"

[66] URT. MOHCDGE, Annual Health Sector Performance Profile 2020 November, 2021:

zoonotic diseases (disease which affect both human as well as animals). One Health is a concept that recognizes the interconnection between people, animals and their shared environment. A growing human population creates a need for more land for habitat and economic activities, increases the importance of interactions with animals in human lives, climate change and movement of people, animals, and animal products across boundaries, and has led to more opportunities for diseases to pass between animals and people.

Zoonotic diseases that exist or pose a potential risk in Tanzania include Rabies, Salmonellosis, Human African Trypanosomiasis, Anthrax, Brucellosis to mention a few. Collaborative efforts human and animal scientists will be developed in conjunction with government ministries and agencies to ensure functional multidisciplinary/ intersectoral approach such as control of chronic diseases, zoonotic and non-communicable diseases[67].

4.11 Epidemics and Disaster Preparedness and Response

The Government will create a resilient and robust health and community system with sufficient capacity to prepare, detect, prevent, respond to and recover from health epidemics, emergencies and disasters. Government will continue to strengthen public health security by enhancing specialist systems and capabilities in preventing, preparing for, responding to and recovering from emergencies and disasters at all levels. The government will continue to integrate psychosocial and mental health care responses within the grand plan for preparing for, responding to, and recovering from disasters.

Risk communication and community engagement are crucial factors in prevention of epidemics and disasters, covering basic understanding of hygiene, medical hazards, and threats to health. National legislation, policy, and adequate financing are will be put in place to improve and strengthen prevention of health epidemics, emergencies, and disasters, alongside strategies for coordination, communication, behaviour change and advocacy through a multi-sectoral approach. All outbreaks and health events in the country will be monitored through a system of surveillance and reported to the World Health Organization in accordance with international health regulations (IHR 2005). Government will ensure the availability of the necessary equipment, medicines, and infrastructures to provide emergency services and post-emergency services and address the health effects of various disasters. Government will build the capacity of health care providers at all levels to deal with the effects of various disasters. All levels in the health system will develop "All hazard" Emergency Preparedness and Response

[67] Health Sector Strategic Plan July 2021 – June 2026 (HSSP V) Leaving No One Behind: Ministry of Health, Community Development, Gender, Elderly and Children.

(EPR) Plans and hazard-specific plans that will guide implementation during emergencies.

4.12 Water, Sanitation, Hygiene and Food Safety

Water, sanitation and hygiene (WASH) is one of the strategies to improve community health. SDG 6 envisions universal, sustainable, and equitable access to safe drinking water, sanitation and hygiene, as well as the elimination of open defecation by 2030. The provision of safe water, improved sanitation and adequate hygiene is key towards prevention of the majority of communicable diseases. Also waste collection, especially proper disposal of medical waste, is an area of attention for the health sector[68]. The government will ensure that public health care facilities are provided with adequate sanitation and hygiene services both in rural as well as urban areas. The Government will strengthen the management of Environmental Hygiene Laws and supervise the implementation of sanitation in school buildings, public institutions and at community level. Government will promote the availability of school health services including the essential infrastructure for improved hygiene and use of toilets. The government will enhance preparedness by putting in place guidelines and procedures supported by appropriate legislation and enhancement of community involvement.

4.12.1 Waste Management

The government will ensure that health facilities set an example and meet the standards for safe environment which can be emulated by the communities. Other waste management interventions outside of health facilities will be organized by LGAs to meet legal requirements for optimal sanitary standards. This can be achieved initiating and maintaining close collaboration with the National Environmental Management Council will be encouraged.

Health Care waste in health facilities. Although several isolated attempts have been made to improve the situation in some of the medical institutions, the management of health – care waste (HCW) in Tanzania remains below the minimum international standards, resulting in significant risks to health – care workers patients, community and the environment. Consequently, the hygienic conditions linked to the handling and disposal of HCW cannot guarantee a satisfactory control of nosocomial infections within the Health care facilities (HCFs). The backstopping and monitoring capacities of the Central Regional and District Authorities to support medical institutions remains limited. Furthermore the legal framework is not sufficiently

[68] URT: MOHCDGEC: National Strategic Plan for HealthCare Waste management 2018 –2022, January 2018.

developed and what exists is not properly enforced. As a result, the direct and indirect costs resulting from this situation are difficult to estimate but are certainly significant.

A standardized health- care waste management system must therefore be developed for the country. Additionally, our health – care facilities must be provided with appropriate equipment to implement safer procedures. The differentiation of health – care waste streams within the medical institutions of Tanzania must also be progressively upgraded taking into consideration the Tanzanian context. The Government has already formulated the National Healthcare Waste Management Policy Guidelines and Standards to more broadly prevent and control infections and improve hygiene in health facilities

4.12.2 WASH in Health Facilities

WASH facilities particularly hand hygiene practices may reduce infectious disease transmission in healthcare facilities (HFs) by 50% and forms effective measure against contagious diseases such as COVID-19. The NSC under P4R focus on construction and rehabilitation of WASH infrastructure in 1500 HF's by 2025. By December, 2020, a total of 754 (92.7%) of the planned 813 HFs were rehabilitated to install water supply infrastructure such as connections to water supply system, hand washing points and improved toilets. The programme also supports rehabilitation of labour wards to install sanitation and hygiene facilities, also construction and rehabilitation of incinerators.

4.12.3 Occupational Health and Safety

Occupational hazards are likely to increase with industrialization. Inspections and law enforcement are required in workplaces and production areas. Workers in most workplaces are at high risk of exposure to occupational hazards such as poisonous substances such as chemicals, fumes, dusts and radioactive materials that may lead to occupational health problems and diseases.

The government in collaboration with partners will ensure the safety of workers by strengthen awareness of occupations hazards, integration of occupational health services into primary health services, development of regulations and as well as enforcement of laws and regulations governing occupational health services.

4.12.4 Public Health and threats management at border points of Entry

The government in collaboration with partners will strengthen the border health security at all point of entries in order to prevent and control the international spread of diseases and provide public health response in ways

that will minimize the public health risks and avoid unnecessary interference with international traffic and trade. The government will expand port health services and ensure that by 2025 at least 70% of the major points of entry have core capacity developed to meet national and international standards and are able to provide access to appropriate medical services, including diagnostic facilities to allow prompt assessment and care of ill travelers.

4.12.5 Prevention of Importation of Communicable Diseases at Points of Entry (PoE)

PoE are potential routes for transmission of communicable diseases including those with capacity of causing large outbreaks and pandemics such as COVID 19. Tanzania have 55 Port of Entries, 28 International PoE served under MoH and 27 domestic PoE supervised by LGAs, these including Airports, and harbours and ground crossing. Public health measures at these PoE should include screening, isolation and quarantine of the travelers as per International Health Regulations, 2005 and Public Health Act, 2009. From 31 March to 26 May, 2020 a total of 416,641 travelers both international and local were screened in Tanzania whereby 37,927 (9.1%) were international majority of whom were truck drivers. Among the International travelers 4,147 were quarantined[69].

4.13 Public Private Partnership

The growing demand for health care services posed by evolution of emerging and re-emerging diseases has put more pressure on the health care delivery system in terms of increased need for extra resources and expertise. Government will continue to engage the private sector to increase access to health care in the country and to protect the rights of specific groups. All private health care facilities are monitored to ensure compliance with existing contracts and guidelines.

Government will harmonize the quality management systems of health care between the public and the private sector. There will be one single registration and accreditation system for health facilities, providing certification for healthcare services.

The private sector is crucial for health service delivery, both in rural areas where not-for-profit providers are active and in urban areas where commercial providers provide the majority of health services. Government will continue to engage the private sector to increase access to health care in the country and to protect the rights of specific groups.

Private providers are providing healthcare in accordance with existing

[69] **Source: EHS Reports,2020**

contracts and guidelines. All private health care facilities are monitored to ensure compliance with existing contracts and guidelines. All private health care facilities are monitored to ensure compliance with existing contracts and guidelines. While reporting of private health facilities through DHIS has continued to improve, the Government will strengthen the monitoring of private sector performance.

Government will harmonize the quality management systems of health care between the public and the private sector. There will be one single registration and accreditation system for health facilities, providing certification for healthcare services. This will create a level playing field for public and private health systems.

Government will engage with the private sector in programmes for control of communicable diseases e.g. HIV and malaria, and for reduction of risk factors for non-communicable diseases. Government will continue to create an enabling environment for joint ventures and investments in the health sector, especially in domestic production of medicines and consumables.

This Programme will take into account the already existing initiatives geared towards promoting and sustaining Public Private Partnerships in health service provision. Strengthening the health infrastructure network through constructing new ones, repair and rehabilitation works and provision of noncore services is to be done by the private sector. The government will put increased effort on district health services and further consolidate involvement of the various stakeholders at that level while continuing to maintain its fundamental role of ensuring provision of quality health services to all citizens.

4.14 Traditional and Alternative Medicine.

The government will continue to strengthen the framework for managing research and the provision of natural or alternative therapies. Government will facilitate the establishment of traditional and alternative health facilities, manufacturing facilities, and strengthen supervision for safety, quality and efficacy of remedies used in traditional and alternative medicine.

The MOH will coordinate the integration of traditional medicine and modern medicine. The government will stimulate studies to demonstrate scientific evidence of the efficacy, safety and quality of traditional medicine and traditional medicine therapies.

The Government will strengthen traditional medicine research system as well as the relationship with modern medicine. Government will create an enabling environment for the integration of traditional and alternative, and modern medicine by establishing duo traditional and modern health care

facilities. It will strengthen collaboration with other sectors to preserve environment and medicinal resources which are used in traditional and alternative medicine.

In order to support research and provision traditional and alternative medicine, the Government will improve the system to identify and compiling traditional medicine practice, traditional medicine prescriptions and other natural resources that are used for natural remedies and alternative therapies. Public research and academic institutions will be encouraged to solicit private funding for research studies as it is currently done by private institutions such as Ifakara Health Institute, REPOA or ESRF that do not receive any funding from the GOT for staff and running costs but sustain their research activities through research grants only.

The Government will facilitate the establishment of traditional and alternative health facilities, manufacturing facilities and strengthen supervision for safety, quality and efficacy of remedies used in traditional and alternative medicine.

They will identify areas with herbs and other natural resources that are used in traditional herbal and alternative medicine for preservation. It will strengthen the process of processing raw materials according to international standards of quality and safety for domestic and overseas use. Eventually the fledgling pharmaceutical industry can expand while meeting standards of safety, quality and effectiveness of herbal remedies and alternative therapies.

4.15 Advocacy

Advocacy is a communication process geared at instilling knowledge and influencing behaviour towards a specific desired change. People act, adopt new practices and form new life habits because of information/messages that make them understand how they can benefit. Thus, effective advocacy creates sense of understanding and desire to do something for an intended benefit-in this case health outcome. Targets for advocacy should be carefully chosen in order to maximize the impact of the advocated phenomenon. PHSIDS is encourages strategic thinking in issues selected for advocacy and the appropriate target community.

4.16 Institutional Arrangement

The implementation of the PHSIDS will be at all levels from National to Villages with each level having its own roles and responsibilities. This will also include modalities of implementation, feedback systems, supervision, monitoring and evaluation. The existing administration hierarchy will be used in the whole process of implementation. The following are the roles and responsibilities of different levels;

4.16.1 Ministry of Health

The Ministry of Health is responsible for:

a. formulating policy guidelines and strategies for implementation of the program;
b. taking the lead in resource mobilization for the successful implementation of the program;
c. Supporting Regional Secretariat to build capacity of LGAs in the implementation of the program;
d. Monitoring , Reviewing and evaluating the program implementation in collaboration PORALG and other stakeholders;
e. Overall coordination of program activities by ensuring quality and adherence to guidelines and regulations.

4.16.2 President's Office - Regional Administration and Local Government

The president's Office Regional Administration and Local Government (PORALG) will be the main actor in the implementation of health intervention in line with the guidelines and policy stipulated by the Ministry of Health. PORALG will be responsible for coordinating, facilitating and managing the implementation of the strategic plan through local government authorities at council, ward, village and community levels. PO-RALG, through the Regional Secretariat (RS), the Regional Administrative Secretary, oversees the office of the Regional Medical Officer, responsible for implementing various health interventions, overseeing the implementation and ensuring the quality of services provided. Local Government Councils have a Council Health Management Team under the Executive Council, which is responsible for providing health services through the preparation and implementation of council-level integrated health plans, plans for primary healthcare facilities, and community-level health plans for each ward and village.

The coordination of the program activities will be done by Regional Secretariat (RHMT) under the Regional Secretary. The Council Level (CHMT) will be responsible for planning of activities, monitor the procurement process in line with the program implementation plan, and oversee the construction and rehabilitation of health facilities and other technical issues. The Technical Team will report the implementation status to the Council Management Team and Council Health Service Board which is under the Council Director.

Furthermore, construction work supported by the Communities to address access and distance for addressing the provision of health services, to avoid unfished health facilities constructed by the Community the LGAs will advise

the Community to adhere to the following factors areas where there is *big population, poor access* to health services due to long distance and *geographical constraints (hard to reach areas)* construction and rehabilitation of the health facility to include staff houses for retention and fencing the facility areas. Construction is being supervised by Council and Regional Engineer with the District/CHMT/ Regional Medical Officers/RHMT.

Construction will use Force Account, Local technicians available in the Council/district, who have capacity will be used. Regions and Councils will be responsible for oversight, consultation and supervision.

Each facility will form three standing Committees to oversee the project as follows:

i. Construction committee, which is responsible for day-to-day construction activities;
ii. Procurement committee, which is responsible for procurement of all building materials and
iii. Reception Committee, which is responsible for receiving, assessing, storing and issuing of building materials to construction committee.

The selected committees are composed of a mix of technical personnel (Procurement, Engineers, Architects, Quantity surveyors, Land officers, Health personnel), and members from the community including Councilors who are the Chairpersons of Ward Development Committees (WDCs).

The role of PO-RALG is to oversee the proper functioning of the Council hospitals, health centres, dispensaries and community level health services. More specifically PO-RALG will be responsible for ensuring that LGAs prepare plans and budget for the programme, resource allocation to Regional Secretariat and LGAs level. The Ministry will also supervise the implementation of the programme at LGAs level. PORALG will collaborate with the MoH in implementation of the programme.

4.16.3 Regional Level

The Regional Secretariat (RS) through RHMT will provide technical and advisory support to the LGAs in order to ensure proper implementation of the programme. More over the RS will ensure that the programme is incorporated in the facility plans consolidated in the CCHP and budget as well as supervising programme implementation. The RS should create a conducive environment for the implementation of the programme.

4.16.4 Local Government Level.

The Local Government Authorities level (Councils) will be responsible for the management, implementation, recruitment and position of technical support

to the lower level health facilities. They are also required to ensure that the programme is incorporated into the facility plans and CCHP, ensure community participation and other stakeholders in the programme. Furthermore LGAs will submit both technical and physical implementation reports on regular basis maintain data bank and create awareness on health status to the community.

4.16.5 Ward Level

The Ward through the Ward Development committee (WDC) will be responsible for allocating land for the construction of a Health Centre and also supervise PHSIDS implementation at their respective areas of jurisdiction. This will include coordination of PHSIDS activities at village level. The WDC will also work hand in hand with village Government in mobilizing communities to contribute voluntary labour and materials for the programme. Moreover, the WDC will be responsible for compiling financial and technical reports from lower levels with respect to the accepted format and submit to the Council.

4.16.6 Village Level.

The Village Government will be responsible for allocating land for the construction of a dispensary. Other duties include community mobilization for the program in terms of voluntary labour and materials, plan and implement PHSIDS 2022 - 2032, to create a conducive environment for the implementation of the programme and attractive working conditions for the health staff, safety in terms of buildings, medical supplies and medicines and overall supervision of the programme.

The programme will enhance and strengthen community involvement and participation in planning and implementation of prioritized interventions. To ensure sustainability and create sense of ownership of the investment, the community will participate in the management of health facilities through Council Health Service Board (CHSBs) and Health Facility Governing Committees (HFGC) at Health facility level.

4.17 Role and responsibilities of Council Health Services Board and Health facility Governing Committees

4.17.1 Council Health Services Board

Through an instrument for establishing Council Health Services Board, the Community will continue to be involved in the management of health services and overseeing implementation of health development plans in the Council. The Council Health Services Board will oversee implementation of health services within their area of jurisdiction. Council Health Management Teams (CHMTs) is a technical arm to the board and it's the one charged with responsibilities of day to day management of health services in the district. The Board will work hand in hand with the council in mobilizing and managing all resources for the successful implementation of the PHSIDS.

4.17.2 *Health Facility Governing Committees*

In every Council, there are health facility governing committees at all levels of health care provision. The communities are involved and participate in management of health services. With respect to the PHSIDS the health facility governing committees will be responsible for the following: Mobilizing resources for the implementation of the PHSIDS at local level, mobilizing communities to contribute in terms of voluntary labour and materials, to give feedback to the communities on the status of implementation, and to ensure safety and conducive working environment for health workers.

4.17.3 *Leadership and Governance*

The Government has established systems and instruments for the registration, management and coordination of health services in both public and private health sub-sectors. However, coordination of health services at all levels remains a challenge for effective partnership between state and non-state actors. Further introduction of quality assurance systems and health care financing programmes will enhance individual and institutional accountability. There is poor community involvement and engagement in the implementation of various health interventions. While the provision of health education and information is improving, the capacity and support to the community system and programs is limited. Through decentralised health services and financing, small progress has been made to establish governance structures and financing modalities, but social accountability is still weak and needs further development of community health management systems. Although some diseases originate from sectors other than health, there is poor involvement of other sectors in disease management strategies. To address the social determinants of health (SDH), the health sector needs to collaborate with the other sectors, both at national and decentralised levels.

- Construction of new health facilities should consider peripheral, hard to reach geographical location,
- population size and where there is no alterative facility for partnerships;
- Enhance partnership agreement in all places where there is existing private owned health facilities rather than committing huge amount of resources to construct new one for effective and efficient utilization of public resources, while considering involving Community participation during decision making through Health Facility Governing Committees, to avoid Community constructing their own health facility, while observing the available health facility its capacity.

4.17.4 Decentralized Management

Government will maintain the framework for planning service delivery, financial management and information delivery at health care facilities. Capacity building of health facility teams, boards and committees at all levels of health is necessary, to achieve better `community participation.

Councils Health Boards, Hospital Management Boards, Health Facility Management Committees oversee the management of health care facilities in accordance with current guidelines. The Government will update the guidelines and procedures for involving citizens in decision-making on access, provision, operation and ownership of health care facilities.

4.17.5 Governance of Health facilities

The health sector will ensure good governance in the provision of health services at all levels, with accountability, transparency and ethical standards. Government will enhance social responsibility in health care. Therefore, government will strengthen multi-agency management to build better relationships and transparency. Capacity building of Council Boards, Hospital Boards and Health Facility Management Committees is necessary to achieve this. In this context there will be education and whistle blowing system to health care providers and the general public to stop the practices of lobbying, claiming, giving and receiving bribes. There will be a transparent system to file complaints. The government will improve governance and leadership capacities in health care delivery systems at all levels. It will build capacity to all management staff on managerial and financial and evidence based planning through data use management.

4.17.6 Government at the Community Level

Harmonization and alignment of health and development related community structures is important, with Health Facility Management Committees, village health committees, Ward Development Committees and other

community-based structures operating in the same domain. The links with Local Government Authorities should be reinforced, and community activities should become part of the bottom-up planning system. Capacity building of members of community committees will be improved and mobile technology will be availed to the committees in management and monitoring tasks.

It is also important to link with professionals, volunteers and extension workers e.g. Community Development Officers, Social Workers, Agriculture Extension Workers, teachers. Improved functioning of community structures will enhance community accountability for programmes and services. The primary healthcare committees will be revived, better linked to Health Facility Governing Committees (HFGCs) and Council Health Services Boards. District and Regional PHC will input to the District and Regional Consultative Councils. The community health workers will be housed at the Village Government Offices, reporting to Village Executive Officer and linked to health facilities at the respective area.

4.17.7 Gender and equity

The health sector delivers health care based on human rights, gender and specific needs. Everyone in Tanzania should receive health care services without discrimination on the basis of any gender, race, colour, religion, political ideology and social status. All health issues addressed will include gender equality and rights of vulnerable groups. The Government will stimulate awareness raising and competency development among health staff at all levels, to include gender issues in health services and policies, also in pre-graduate training. The health sector will enhance gender equality in decision making within various organs of the health sector, such as Boards and Committees, including community organizations. Representation in these organs will aim for equal representation of women. Special interest groups of vulnerable should also be represented. The policies in health will all pay attention to gender and equity. In the new Universal Health Insurance (UHI) scheme, there will be special attention to gender issues and protection of vulnerable groups, to guarantee universal access.

4.17.8 Intersectoral Collaboration

Implementing the PHSIDS, the MOH in collaboration with PORALG will collaborate with other ministries, institutions, religious organizations, social organisations, the private sector, and DPs. Many health issues require the

cooperation of various sectors. Achieving SDG3 (health) requires interventions in water, education, agriculture, nutrition, livestock, fisheries, environment, natural resources, and sports. This will involve infrastructure, legislation, financial resources, and communication. Intersectoral collaboration will take place at all levels, from national level to community level. Cross-cutting issues that have been prioritized in the Health Policy of 2020 include emergency and disaster response services, HIV/AIDS, good governance, corruption, the environment, human rights, gender and the social determinants of health.

4.17.9 Public Private Partnership.

The Ministry in collaboration with PORALG is partnering with sector, NGOs and DPs in ensuring access to health care in the country through the SWAp for health. The PPP dialogue must be reinforced at lower levels. It is necessary to engage in a meaningful collaboration with the private sector, e.g., through placement contracts or service level agreements. Joint actions in planning, supportive supervision, service agreements, provision of training for private providers, councils, regions or national ministries, departments and agencies are necessary. A special point of attention is collaboration in the urban areas, where private providers dominate health service provision.

4.18 Health Care Financing

In Tanzania health system is financed by multiple sources which include domestic tax, grants from development partners, health insurance funds and out of pocket health spending/ user fees. The share of total government expenditure allocated for health expenditure was mantained at 8% in 2016/17 an 2017/8 before decreasing to 6% and 5% in 2018/19 and 2019/20 respectively. The level of out of pocket health spending as proportion of total health expenditure has increased from 22% in 2016/17 to 31% in 2019/20, meanwhile, health insurance coverage decreased from 33% in 2017/18 to 14.7% in 2019/2020.

Generally, most of the health financing indicators have not performed to reach desirable level. There have been fluctuations of all indictors in across observed period. The summary is shown in Table 8.

Table 8: Key Health Financing Performance Indicators[70]

[70] Source: URT: MOH National Heath Account, 2020

Key Indicators	2015/16	2017/18	2018/19	2019/20	Bench Mark
Total Health Expenditure (Billions)	4,294	5,577	4,868	5,385	NA
Per-capita Health Spending ($)	45	47	39	42	86
Share of Government Health Expenditure to General Government Expenditure	8%	8%	6%	5%	15%
Share of Domestic Resources Total Health Expenditure	59%	66%	73%	67%	86%
Health Insurance Coverage	19%	25%	33%	14.70%	50%
Share of Out of Pocket Health Spending to Total Health Spending	22%	28%	33%	31%	22%

Source: National Heath Account, 2020

From the summary table above, details are provided on the performance indicators and their policy implication.

4.18.1 Total Health Expenditure and Per Capital Health Expenditure

Total health expenditures (THE) has been fluctuating from Tshs 4.3 trillion 2015/16 to Tshs 5.5 trillion in 2017/8, it dwindled to 4.9 trillion in 2018/9 before picking up to 5.4 trillion in 2019/20. The trend is associated with the decrease of funds from development partners and government funds which together they have been key sources of health sector financing. Similarly, there has been fluctuations in per capita spending where it raised from 42 to 47 in 2015/16 to 2017/18 dollars and then down to 39 dollars in 208/19 before rebounding up to 42 dollars in 2019/20. Percapita health spending is far from 86 dollars which is considered as substaintial level of spending for a country to attain universal health coverage. Low performance in per capita health spending can be improved by increasing the amount of resources allocated for health sector as well as controlling the rate of population growth.

4.18.2 Key National Health Accounts (2020) Findings

i. Government spending on health as a population of total government expenditure increased from 7.8 percent in 2018 to 8.8 percent in 2020.
ii. The government is the principal financing scheme managing about half of the sector funds.
iii. Hospitals consumed the largest share of Total Health Expenditure (THE);
iv. There is a significant increase in expenditure on medicines and medical goods; infectious diseases continue to account for the largest share of THE in terms of expenditure analysis by diseases and its approximated to 34 in 2020;
v. Expenditure on Non-Communicable Disease (NCD) increase by 62 percent between 2017 and 2020 which raised its share in total disease

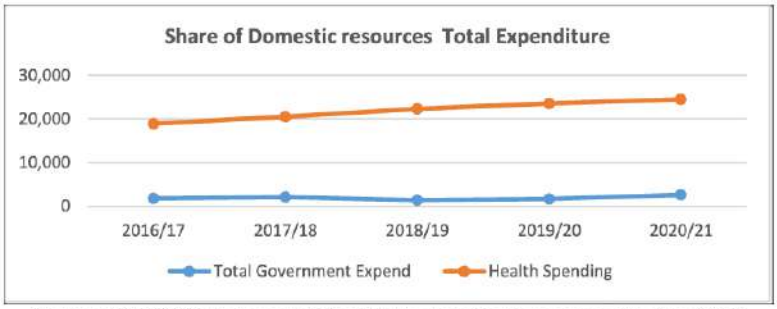
expenditure from 11% to 14% and

vi. Expenditure on Malaria increase by 15% between year 2017 and 2020.

4.18.3 Share of General government expenditure to health care expenditure.

The share of total government expenditure allocated for health expenditure was mantained at 8% in 2016/17 and 2017/8 before decreasing to 6% and 5% in 2018/19 and 2019/20 respectively (figure 8.2). The decrease is associated with increased focus of the goverment spending on flagship infrastructure development project which have been taking signficant share of government budget in the reporting period as well as slow down in economic growth from 9.7 to 5.7 in 2015/16 and 2019/20 respectively(URT, Budget Excution Report 2021). However, it is expected that, the implementation of universal health Insurance Act will raise the share of public resources allocated in health expenditure.

Figure 2: **Share of Domestic Resources Total Health Expenditure**[71]



Source: PER 2020/ Annual Health Sector Performance Profile 2020 November, 2021

The share of domestic resources total health expenditure stands at 66 percent on avarage between 2015/16 and 2019/20. The domestic sources of health sepnding includes; government expenditure, out of pocket, social and private insurance and health benefits spent by employees. Although the rate of domestic expending in health sector has been increasing on avarage, it is still bellow 84% threshold level of domestic spending recommended for the health sector to be immuned from vulnerability to external shocks associated with reduction or suden decrease in development partners' support – see Figure 1.

4.18.4 Out of Pocket Health Spending and Health Insurance Coverage

The level of out of pocket health spending as proportion of total health expenditure has increased from 22% in 2016/17 to 31% in 2019/20, meanwhile,

[71] URT, MOHCDGEC: Annual Health Sector Performance Profile 2020 November, 2021

health insurance coverage decreased from 33% in 2017/18 to 14.7% 2019/2020. These results imply that, more households are increasingly exposed to catastrophic and impoverished health spending. It is necessary to increase public resources allocated for health care services as well fast tracking the preparation of mandatory health insurance in order to increase health insurance coverage and reduce risks associated with out of pocket health spending.
Intervention and achievements:

i. allocation of fund for subsidizing the poor,
ii. Establishment of benefit package by NHIF that provide a window for people from private sector.
iii. Rolling out of improved Community Health Fund in all 26 Regions,

The government to fast track finalization of Health Insurance Bill and increase the share of domestic resource for health financing.

5 Monitoring and Evaluation

The Primary Health Services Development Program aims to inform the progress and performance assessment of the second and it's associated National Strategic and operational plans. Monitoring and evaluation ensures effective and efficient implementation of plan of action and the sustainability of the intended outputs and outcomes.

Monitoring will involve tracking the progress of the plan of action, while evaluation will be a critical and objective appraisal of the overall implementation of at all levels.
On the other hand, the Health Sector Strategic Plans (s) (HSSP) provides guidance in monitoring and evaluation of health sector targets and achievements over the stated timeframe. For the purpose of informing progress in implementation of the program, evaluation of the program will be done after every five years.

6 Component Objectives and Strategies

The Government is committed to improve health of all Tanzanians and increase life expectancy by providing quality health services that meet the needs of the population. To achieve this, the Government is guided mainly by two principal documents, the Health Policy and the Health Sector Strategic Plans. The Health Policy sets a framework of the government commitment for the health sector. The policy provides guidance for several programs and strategies that are developed to plan realistic targets, prioritize evidence-based interventions and efficient use of available resources.

6.1 Human resources for Health

Human resources is undeniably the essential resources for the implementation

of any program. The same for the health sector, that this is crucial resources which will only need to be supported by other resources to deliver what is required. The government strongly recognize that performance and quality of services delivered by a system are highly dependent on the knowledge, skills, and motivation of health workers responsible for delivering the respective health services (WHO, 2000). It has thus remained committed to ensure that the health systems at all levels has the standard required size of competent health workface with skill mix capable to provide equitable, high-quality healthcare services by addressing critical challenges including distribution of the healthcare workforce, workforce training, and migration of health workers.

Political will is important component in addressing HRH issues. The Human Resources for Health Strategic Plan 2021-2026 is prepared while the older problems identified the previous strategy still persist. Shortages, skill-mix imbalances, mal-distribution, poor working conditions, a skewed gender distribution, limited availability of health workforce data – all these persist, with an ageing workforce making the matter worse especially health training institutions. In 2014-2019 HRHSP implementations, it was learnt that there is need for forging strategic links and collaboration with other sectors in order to strengthen the content of the strategic plan and implementation of the strategy. The government also envision that its capacity alone is inadequate to address the HRH shortage.

6.1.1 Objectives of Human Resources for Health.

Thematic area: HRH Information for Decision Making and Planning

- Strengthen the HRH planning in MOH functional mandates and in decentralize setting of health service delivery by 2032

Thematic area: Human resource Production:

- Improve availability of qualified and competent human resources at all levels to adequately correspond with current and future health sector needs 2032.

Thematic area: Human resource distribution and management

- Improve the recruitment, deployment and retention of health workers through the use of context specific sound intervention to ensure equitable (need based) distribution of health work force at all levels of the health sector by 2032.

Thematic area: Human Resource for health healthy workplace and facilities

- Improve working environment, living conditions and facilities for HRH

by 2032.

Thematic area: HRH strategic Financing

- Strengthen mobilization of HRH financing from government, local based community stakeholders such as WDC, business companies (corporate social responsibility resource mobilization) and development partners locally and internally to adequately implement HRH interventions by 2032

6.1.2 *Strategies*

Key result area: Availability and Utilization of HRH Information for Planning and performance management

- Improve the existing HRHIS, TIIS and WISN to generate information for HRH planning including attrition rates, demand for HRH, supply of HRH, needed skills, distribution of staff and staff undergoing training.
- Improve and Integrate HRHIS and TIIS into existing information and reporting systems DHIS2, HFR, NIDA, GOTHoMIS, POPSMGG, NACTE, TCU, Professional Councils and other systems
- Improved staff audit to generate quality and reflective HRH issues through introduction and effective implementation of spot-checks for HRH Data at all levels
- Strengthen analytical capacity and utilization of HRH data at all levels

Key result area: Capacity for HRH planning

- Enhance HRH Planning tools for Health Workforce Planning at national, regional, Council and facility levels
- Improved training programs to strengthen HRH planning across the sector
- Enhance implementation and quality assurance of HRH capacity building programs
- Improve the scheme of service for HRH to commensurate with new demands of the time.
- Enhance implementation of HRH strategy at all levels.

Key result area: Pre- services development

- Increased students' enrolment with deliberate focus on cadres with decreased supply and rare in the market.
- Strengthen Health Training Institution to provide Training on rare cadres e.g. Dental, anaesthesia, Physiotherapy, Ophthalmology Strengthen linkage between MOH, PORALG (Demand side) and training institutions (supply side)

- Strengthen linkage between Professional Councils and Regulatory Bodies (NACTE,TCU)
- Expand opportunities for specialists (including rare specialization) training under conventional system
- Explore further specialization opportunities through the use of fellowship programs on specialized training
- Enhance effective application of competence based curriculum in training institutions
- Improve health curriculum to accommodate new and emerging health challenges.
- Enhance competences and scope of practices of health professionals which will guide training Institution to prepare Curriculum according to the required needs.
- Improve capacity of tutors, clinical instructors and lecturer in health training institutions in knowledge, skills and appropriate application of competence based curriculum.
- Improved tutor student ratio in HTIs to commensurate with national and international standards.

Key result area: On Job HRH Development

- Enhance in-service and continuous education program in response actual HRH and heath sector need
- Improve continuous education through revisions of existing tools and procedures including accreditation and certification of the CPD providers
- Strengthen the application of National Continuous Professional Development Framework for Healthcare workers
- Strengthen monitoring and assessment of Continuous Professional Development (CPD) to enhance competencies
- Enhance the use of eHealth (telemedicine, e-learning etc.) in the provision of Continuous Professional Development (CPD)
- Intergrade the Continuous Professional Development (CPD) into OPRAS using existing system.
- Review existing community based practices (e.g. Uturo Model) to develop a generic model that is scalable countrywide to enhance the impact of community health.
- Strengthen HRH capacity in field epidemiology to enhance responses on outbreaks, preparedness, border health, and other public health emergencies including accidental injuries, occupational health, NCD like aflatoxicosis and food poisonings.

Key result area: HRH available at all levels with optimal skills mix

- Increase availability of competent qualified health workers at all health delivery points (health facilities) in accordance to actual demands and national standards.
- Enhance equitable distribution of HRH in line to the MOH guidelines and in relation to the context specific needs.
- Enhance volunteerism for increasing efficiency and cost cut in health service delivery through development of guidelines and tools.

Key result area: Community health

- Increased utilization of Community Health Workers by enhancing community awareness on community health services
- Enhance effective engagement of Community Health Workers through development of scheme and policy guidelines

Key result area: Distribution HRH managers use modern technics in making evidence based decisions for HRH distributions.

- Technology – Enhanced modern technology in distribution of HRH
- Development- use of evidence based decision making to enhance equitable distribution on HRH in the Public Sector.
- Improving PPP – Involve private health sector players in enhancing the availability development and deployment of HRH.

Key result area: Utilization HRH productivity is optimized through the use of strengthened performance Management systems

- Increase productivity of HRH to the optimal level through effective use of performance management tools like OPRAS and other performance review technics EG: 360 degrees' performance review methodology.

Key result area: Health Governance

- Improve utilization, productivity and accountability of health workers at all levels
- Decentralize modern supportive supervision skills to the primary health facilities level.
- Enhanced capacity of HRH Department, Planning, Leadership and coordination to enhance transparence and accountability.
- Enhance implementation of health policy and sustainable development goals by health training institutions
- Leadership and managerial skills imparted to all Heads of Units, sections, Departments and Directorates.

- Strengthen involvement of stakeholders in resource mobilization for support implementation of local incentives schemes.
- Enhance capacity of managers in hospitals, primary health facilities and other institutions on supportive supervision, innovative leadership and in developing customized local incentive packages for attraction and retention of staff.
- Improve capacity of Health Facilities Boards and Committees to facilitate management of health facilities and responsive health services to make them more responsive to the needs of customers.
- Improve capacity of RHMTs and CHMT on dissemination, supportive supervision and innovative leadership.
- Improve capacity of the Facility governing structures (HMT and HFGC) on managing and running health facilities.
- Strengthen Inter-ministerial coordination forums to share updates, challenges and strengths.
- Improve staff recruitment criteria to reduce limitations and increase teaching staff in health training Institutions and Universities.
- Enhance joint supportive supervision between MOHCDGE, NACTE,TCU and professional councils

Key result area: Working Environment

- Enhance availability of safety supplies, machines, tools and social protection to HRH in health facilities and health training institutions and universities.
- Enhance availability of medical equipment, supplies and other accessories necessary for delivery of quality health services in health facilities.
- Enhance availability of improved Infrastructure necessary for delivery of quality services in health facilities and health training institutions.

Key result area: Living Environment

- Improve living conditions of HRH in health facilities and health training institutions.

Key result area: Investment in HRH

- Enhance sustainable financing for HRH from government and development partners Strengthen HRH financing from government and development partners through the DHFF modality.

Key result area: Revenue Collection and Resources Mobilization

- Enhance revenue collection and Resources Mobilization through

innovative mechanism and rolling out for mandatory SNHI for sustainable financing of HRH
- Enhance volunteerism for increasing efficiency and cost cut in health service delivery
- Enhance solicitation of community contributions and corporate social responsibilities for construction of staff housing and maintenance.

Key result area: Financial accountability and Transparency
- Improve public health response and financial management through strengthening the Health Sector M & E including data quality, use and dissemination
- Improve financial management process in health care facilities to enhance revenue collection and efficient utilization of financial resources
- Strengthen facilities revenue collection and expenditures system.
- Strengthen financial accountability and HRH productivity in health facilities at all levels.

6.2 Council Health Services

Council Health Services is unique to the community because this is the type of services which is close to the community and efforts should be made to ensure the community realization that it is their responsibility to ensure the availability of quality services to them. If this understanding is common within the community it follows that the community will be able to contribute to the effort of ensuring the availability of quality services to them through their own efforts and contributions.

6.2.1 *Objectives*
- To rehabilitate and construct new 2,728 Dispensaries in villages without facilities and provided with medical equipment and 5,456 staff houses by 2032
- To construct 1,000 new Health Centres in strategic wards and equipped with 10,000 staff houses and medical equipment by 2032
- To strengthen 233 old Health Centres by constructing theatres and Providing them with necessary medical/surgical equipment and furniture by year 2032
- To complete 6 buildings (IPD, RCH, Admin, X-rays, Laundry, external toilets and Mortuary) to 739 Health Centers started rehabilitation and construction in 2017/2018 to a fully functional Health Centres with medical equipment, plant and furniture and Human resources by 2032
- To complete construction of all 31 buildings in 130 Council Hospitals

started in 2018/19 to a fully functional Council Hospitals with medical equipment, plant and furniture and Human resources by 2032

- To construct 1,300 staff houses for 130 new Council Hospitals and 600 staff houses for 60 old Hospitals by 2032
- To rehabilitate 60 old Councils Hospitals as per standards and equipped with essential medical equipment and furniture by 2032
- To construct and rehabilitate 18,719 staff houses to 7,500 existing facilities by 2032
- To facilitate availability of 2,199 new ambulance for Health Centers and Council Hospitals by 2032.
- To Strengthening organization system by providing 210 supervision and 210 distribution vehicles to 26 RS and 184 LGAs by 2032
- To strengthen outreach services by providing 7,727 motor cycles to Health Centers/Dispensaries in hard to reach areas by 2032.
- To facilitate construction and rehabilitation of 182 Social Welfare physical infrastructures in 182 LGAs by 2026
- To construct and rehabilitate 184 Health Care Technical Services (HCTSs) workshop facility in 184 Council Hospitals and equipped with essential equipment by 2032
- To scale up the number of Health Centers in LGAs that provides CEmONC services from 415 HCs to 2,009 HCs by 2032
- To install ICT system to 6,371 facilities lacking GoTHOMIS and make all 7,500 facility in full functional (190 hospitals, 1,009 Health Centers and 6,301 dispensaries to full functional by 2032
- To construct fence to 1,199 existing 190 Council Hospitals and 1,009 Health Centers by 2032
- To support availability of Title deeds to 7,500 facilities (190 Hospitals, 1,009 Health Centers and 6,301 Dispensaries in 184 Councils by 2032
- To provide equipment, medical/surgical equipment, furniture and plants in 11,228 health facilities by 2032
- To advocate and disseminate PHSDP new guideline to 184 LGAs and 26 RS to ensure 100% of Council Hospitals, Health Centres and Dispensaries are constructed and equipped with medical equipment, medicines, furniture, human resources, fence and titles deeds as per MoH standards by 2032
- To ensure availability of essential medicines, medical supplies and equipment in public primary health facilities at affordable cost
- To provide medicines and medical supplies for prevention and treatment of non – communicable and neglected tropical diseases.
- To promote efficient and effective management of medicines, medical supplies and equipment in primary health facilities
- To strengthen referral system from Dispensary to Council hospitals

- To provide anti-TB and anti-leprosy drugs in all eligible health facilities by2032.
- To train 776 social welfare staff on leadership and good governance (in phases) at regional and councils level by 2026.
- To orient 208 RHMTs, 1,472 CHMTs on customer care, code of conduct, professionalism, ethics and values in health, social welfare and nutrition services provision by 2022.
- To conduct on-the-job training to 60 DHSWNS, 208 RHMTs, 1,472 CHMTs and 21,000 HFGC team members on leadership and good governance by 2032.
- To support 740 staff to attend 10 days court protocols training to Social Welfare professionals and Juvenile court officials to 26 RSs and 184 LGAs by 2032
- To conduct advocacy and awareness on the existence of harmful traditional cultural practices to 182 people (RC, Religion Stakeholders, Influential, RSWO, RMO, RAS, and RPC) in 26 RSs by 2032

6.2.2 *Strategies*

- Deployment and recruitment of appropriate skilled personnel
- Ensure availability of medicines, supplies, equipment
- Rehabilitate existing health facilities to be able to provide additional services having additional rooms to ensure privacy construct new health facilities with necessary skilled health care providers.
- Provide mobile clinics for outreach services
- Ensure adequate allocation of budget for medicines and medical supplies in public primary health facilities to ensure constant availability of essential medicines, supplies and equipment at affordable cost.
- Improvement of delivery system and management for provision of medicines, supplies and equipment in public primary health facilities.
- Ensure availability of guidelines in primary health facilities to promote rational use of medicines, medical supplies and equipment
- Establishment of planning and standardized stock-control systems for medicines.
- Procurement and maintenance of vehicles and ambulances to all Council hospitals and health centres based on the standard guidelines of the Ministry of Health
- Construction, expansion, and rehabilitation of dispensaries in various sites based on the standard guidelines of the Ministry of Health

- Provision of equipment, furniture and plants to selected health centres and dispensaries
- Ensure adequate allocation of budget for medicines and medical supplies in public primary health facilities to ensure constant availability of essential medicines, supplies and equipment at affordable cost. By Strengthening the following:
    i. Redesigned Logistic System to facilitate request and supply of medicines in an organized frequency, specifically doing it monthly for all health facilities;
    ii. Strengthening Medicine Audit in health facilities;
    iii. Strengthen coordination and implementation of the Impact Team Approach;
    iv. Strengthen coordination and implementation of the "Bottom up Quantification";
    v. Preparation of role and responsibility of key actors in the supply chain system and key performance indicators for the supply chain system; and
    vi. Establishment of the Compounding Unit in each of the council hospitals.

6.3 Reproductive, Maternal, Newborn, Child and Adolescent Health

Reproductive, maternal, newborn and child health is an indicator of health services delivery in any given community. If you do not have time to assess the whole Health Sector then get a quick impression by looking at what the sector is doing in the area of reproductive, maternal, newborn, child and adolescent health. This area is very important and for the sector to make the required impact it should be afforded the greatest priority. Some of the indicators for this programme shown in 11.3.1 below:

6.3.1 Objectives/ Targets/ Impact indicators

- Maternal Mortality Ratio reduced from 250 per 100,000 live births to 100 per 100,000 live births by 2032.
- Neonatal Mortality Rate reduced from 20 per 1,000 live births to 15 per 1,000 live birth by 2032
- Still birth rate reduced from 16 per 1,000 total births to 12 per 1,000 births by 2032
- Under five Mortality Rate reduced from 50 per 1,000 live births to 38 per 1,000 live births by 2032
- Teenage pregnancies (among girls aged 15-19) reduced from 27% to 20% by 2032
- Mother - to- child transmission of HIV reduced from 8% to 2% by 2032

6.3.2 *Objectives*

- To create an enabling environment for provision and utilization of quality, equitable and accessible RMNCAH and nutrition services
- To strengthen the capacity of health systems for planning, management and service delivery of RMNCAH services.
- To increase access and utilization of quality RMNCAH services

6.3.3 *Strategies/ Interventions*

Policy leverage

- Develop, Review, or update and disseminate integrated RMNCAH and Nutrition guidelines, protocols, and SOPs
- Integrate RMNCAH and Nutrition skill-based interventions in professional training curriculum
- Strengthen scope of functions for skilled birth attendants to conduct life-saving procedures

6.3.4 *Leadership, governance and accountability*

- Strengthen coordination, governance and integrated planning for RMNCAH and Nutrition services at all levels
- Improve accountability for maternal, newborn and child mortality at all levels
- Strengthen inter-sectoral coordination and collaboration for RMNCAH and Nutrition interventions
- Establish an evidence- based system to inform RMNCAH and Nutrition financing.

6.3.4.1.1 *Improve services delivery*

- Strengthen systems of clinical audit and continuous quality improvement of RMNCAH services
- Strengthen delivery of essential and emergency RMNCAH interventions
- Strengthen integrated in-service training, supportive supervision, mentoring and CPD for RMNCAH programs
- Enhance/ improve basic infrastructures for RMNCAH Services.
- Adopt and scale up use of proven innovations in RMNCAH to improve service delivery

6.3.4.2 *Improve Human resources for health (HRH)*

- Support health training institutions to have enabling curriculum to produce graduates with basic core competencies in RMNCAH services
- Improve the number and core competences of health workers in provision of services including RMNCAH services
- Advocate for regular employment and equitable deployment of skilled personnel for health including RMNCAH Services
- Strengthen capacity of mentors to provide RMNCAH packages at national, regional and district levels
- Advocate for a continuous system that provides motivation and retention for HRH at levels.

6.3.4.3 *Improve RMNCAH commodity security*

- Strengthen pipeline for RMNCAH commodities and equipment
- Increase tracking of RMNCAH lifesaving commodities
- Improve coordination, collaboration and accountability of supply chain activities
- Strengthen capacity of health system at all levels to forecast and procure RMNCAH lifesaving commodities and equipment
- Strengthen mobilization of resources for RMNCAH commodities
- Advocate for Planned Preventive Maintenance of RMNCAH Equipment

6.3.4.4 *Improve Health management information system (HMIS)*

- Improve capacity for RMNCAH data use for planning, service provision and decision making at all levels
- Support generation of electronic RMNCAH data from all service delivery points
- Enhance monitoring, evaluation and operational research to strengthen knowledge management and evidence

6.3.4.5 *Improve Community systems for RMNCAH*

- Strengthen community systems and structures to deliver the integrated service package for RMNCAH
- Improve capacity of CHW to support RMNCAH service delivery

6.3.4.6 *Improve Research for RMNCAH Services*

- Support comprehensive RMNCAH operation research to provide data for decision-making

6.4 Malaria Control.

In the early 70s and 80s there was a tendency to think that malaria was uncontrollable. It was the number one cause of outpatient and a major killer particularly of children. It is only with the modern innovation, particularly the use of impregnated nets have brought a major impact in the control of malaria. This programme will guide further control interventions and ensue we continue to reduce the incidence of malaria.

6.4.1 Objectives

- Reduced transmission is expected to decrease the Annual Parasite Incidence (API) from an average of 122 per 1000 in 2019, to less than 30 per 1000 in 2032
- Reduced malaria burden in moderate to high risk strata, from 259 API per 1000 in 2019 to less than 60 Annual Parasite Incidence (API) per 1000 in 2032
- Maintain and further reduce transmission in low and very low prevalence in areas targeting elimination from 24 API per 1000 in 2019 to an average of less than 6 API per 1000 in 2032
- All eligible population will have access to LLIN (1.8 persons per net over a period of three years).
- The indoor walls of household structures of targeted areas in 61 councils will be sprayed
- All 184 councils will introduce bio larvicides according to their epidemiological and operational characteristics.
- At least 85% of the people infected with malaria parasites will receive appropriate diagnosis and treatment. At least 85% of vulnerable groups will be protected through preventive therapies.
- Increased number of councils with very low malaria transmission risk.
- Timely availability of safe and quality malaria commodities and supplies at the delivery points.
- 85% of parents/caretakers with children under five years old with in the last two weeks will be able seek advice o treatment.

6.4.2 Strategies

6.4.2.1 *Integrated Malaria Vector Control*

- Reduce malaria parasites transmission by maintaining
- Ensure universal access to LLINs according to malaria transmission settings (LLIN
- Consolidate and expand IRS in epidemiologically and operationally suitable areas (IRS)
- Implement appropriate, sustainable and quality Larval Source Management (larviciding, environmental management and biological control) interventions in suitable epidemiological and operational areas (LSM
- Provide a strategic framework for coordination and continuous assessment for the implementation of evidence-based Vector control innovations (Insecticide resistance Mitigation)

6.4.2.2 *Malaria Diagnosis, Treatment and Preventive therapies*

- To prevent the occurrence of mortality related to malaria infection through universal access to appropriate diagnosis and treatment and targeted provision of preventive therapies for vulnerable groups
- Provide universal access to appropriate quality and timely malaria diagnosis to all eligible (symptomatic and asymptomatic) people according to the guidelines ***(Malaria diagnosis***
- Provide universal access to appropriate, quality and timely treatment to all people with malaria ***(Malaria treatment)***
- Provide appropriate and effective services to reduce the risk of malaria infection and its complications among populations biologically and socioeconomic vulnerable to malaria ***(Malaria Preventive Therapies).***
- Deploy appropriate malaria case management and preventive therapies interventions in suitable epidemiological and operational areas, in the event of emergency situations, and in peculiar population groups to reduce the risk of severe morbidity and mortality ***(Malaria case management in special situations and special groups)***

6.4.2.3 *Surveillance, Monitoring and Evaluation*

- To provide timely and reliable information on malaria and its control needed to take appropriate actions in different transmission risk and ensure resources are used in the most cost-effective manner
- Strengthen comprehensive malaria surveillance and response for improved programmatic performance ***(Malaria Routine Health Facility Based Surveillance)***
- Strengthen malaria framework for collecting, processing and storing essential indictors from periodic service delivery and programmatic surveys ***(Malaria Programmatic and Transmission Surveillance)***

- Strengthen a comprehensive malaria strategic information system to generate knowledge for evidence-based planning and decision making at all levels ***(Malaria Strategic Information System)***

6.4.2.4 *Supportive strategies*

- Commodities and Logistics Management,
- Maintain timely availability of safe and quality malaria commodities and supplies at the delivery points.
- Promote partnership to ensure malaria commodities are available in all service delivery points in the right amount and when needed (Procurement and Supply Management)
- Promote partnership to ensure that all malaria commodities used at service delivery points are quality assured (quality assurance)
- Promote partnership to ensure that all malaria commodities used at service delivery points are safe (vigilance on safety)

6.4.2.5 *Social Behaviour change & Advocacy*

- To strengthen an enabling environment where individuals at risk from malaria are empowered to protect themselves and their families from malaria and seek proper and timely malaria-treatment
- Reinforce and update knowledge and practice amongst all community members about appropriate malaria prevention, testing and treatment, promote desired positive behaviors and social norms about healthy behaviours ***(Malaria Information Education and Communication)***
- Maintain high knowledge and improve good practices amongst vulnerable groups with elevated risk of malaria infection so that they are aware about their specific risk, prevention and treatment options available to them ***(Malaria vulnerability outreach)***.
- Encourage communities to utilize and implement community-based malaria control and elimination initiatives ***(Malaria Control Community Engagement)***
- Strengthen Public Private Partnership to maximize SBC efforts and ensure consistence in fight against malaria ***(Malaria Public Private Partnership)***
- Increase visibility for specific malaria campaigns to politicians, communities and general public so that malaria become a priority agenda at all levels ***(Malaria Advocacy).***

6.4.2.6 *Leadership, Partnership and Resources Mobilization*

- To strengthen efficient and effective coordination for implementation of malaria strategies through accountable partnership
- To provide effective leadership and governance for the

implementation of malaria control and elimination interventions at all levels ***(Leadership)***

- Raise the profile of malaria amongst policy and decision makers at all levels so that national, regional and district plans include appropriate interventions and sufficient budget to implement the malaria strategic plan ***(Policy and Resource Mobilization)***
- Promote harmonized multi-sectoral approach and cross-border initiative for malaria control and elimination ***(Cross Border and Multi-sectoral Collaboration).***

6.5 The National AIDS Control Programme

In 2018, 16 million people were living with HIV in Tanzania. This equates to an estimated HIV prevalence among adults of 4.6%. In the same year, 72,000 people were newly infected with HIV, and 24,000 people died from an AIDS-related illness[72]. Despite the numbers, Tanzania has done well to control the HIV epidemic over the last decade. Scaling up access to antiretroviral treatment (ART) has meant that between 2010 and 2018, the number of new infections declined by 13% and the number of people dying from an AIDS-related illness has halved[73]. Tanzania through this Programme will continue with the efforts to control HIV/AIDS through innovative strategies and advocate increased funding for the AIDS Trust Fund (ATF) to support implementation of AIDS/HIV interventions.

6.5.1 Objectives

- To reduce HIV infections by 85% from the 2010 baseline (110,000) by 2025.
- To reduce Mother to Child Transmission by the end of breastfeeding to ≤4% by 2025.
- To reduce AIDS related deaths by 80% from the 2010 baseline (64,000) by 2025.
- To reduce HIV related stigma to <5% from 2013 baseline of 28% for external stigma and 20.5% for internal stigma by 2025

6.5.2 Strategies

Reduction of New HIV Infection Logical Framework

- Strengthen IEC/SBCC Community - based distribution
- Target risk groups community- based distribution for self-Testing IQC, EQA, Post market Surveillance.
- Response with aggressive ART Treatment support for rapid viral

[72] UNAIDS info 2019

[73] ibid

suppression PrEP for HIV negative contacts.

- Recruit and maintain non-remuneration donors Mass campaign in targeted communities CQI
- Reduction of HIV Mortality Logical framework
- Decentralization of ART services to lower Health facilities,
- Meaningful engagement of private Health facilities in ART delivery
- Community ART Approaches,
- Peer support and Community ART refill,
- Establish Medicines resistance, surveillance and monitoring,
- Strengthen/implement HF DR early warning system.
- Scale up second and third line therapeutic network,
- TPT coverage for children and lower HFs,
- Procure and support CTX provision through local funding,
- Integrate and scale NDC and Mental Health Services in HIV clinics,
- Nutrition and economic support,
- Strengthen and scale biomarkers monitoring (Hematology, Biochemistry, etc.).
- Detect and management including pre-emptive treatment.

6.6 Tuberculosis and Leprosy

The National Tuberculosis and Leprosy Programme (NTLP) was launched by the Ministry of Health and Social Welfare in 1977 as a single combined programme for the two disease. Among international development partners include; centre for Disease Control and Prevention (CDC). The Global Fund, German TB and Leprosy Relief Association (GLRA) and World Health Organization (WHO) who are main financers of various Programme activities through different grants countrywide. There is some synergy between TB and HIV virus. In general TB is still a top ten cause of death among admitted patients and hence warrants special attention as Tanzania implements Primary Health Care.

6.6.1 Objectives

- To increase TB treatment coverage from 53% in 2018 to 90% by innovatively addressing barriers to access, utilization, and the needs of the key and vulnerable populations for TB carea and prevention services by 2032,
- To expand access of quality TB diagnostic services, including the adoption of new technologiesby 2025,
- To maintain proportion of children TB among the notified cases at 15% and increasing the ratio of ages '0-4':5-14 years from 1.3 in 2019 to 1.5 by 2032,

- To increase RR/MDR-TB cases detected and enrolled for treatment from 54% to 90% of theestimated TB cases among the notified by 2032,
  - To Strengthen the management of co-morbidities including Collaborative TB/HIV, TB/Diabetes,
  - To strengthen TB services to the population of miners and their families by 2032,
  - To reduce leprosy prevalence in all endemic councils by 2032,
  - To ensure availability of supportive systems and strengthened Program management for theimplementation of TB and Leprosy Services by 2032, and
  - To ensure implementation of evidence-based interventions and decision making through institutionalized efficient M&E system and coordination of researches by 2032.

6.6.2 *Strategies*

6.6.2.1 *Treatment of DS and DR-TB patients*

- Scale –up health facility-based active case finding using Quality Improvement (QI-TB) model for TB case detection.
- Engage formal CHCs and community TB actors to deliver community-based TB care including active case finding and contact investigation,
- Strengthen TB services in prisons and other congregate settings, Improve access to TB services among Elderly people

6.6.2.2 *Radiology Services*

- Enhance access to TB diagnosis services,
- Strengthen the supply chain management for TB laboratory commodities at all levels,
- Strengthen quality assurance (QA) across TB diagnostic network,
- Expand the coverage and utilization of phenotypic and genotypic Drug Susceptible Testing, and
- Expand the coverage and access to X-ray services, including digital X-ray.

6.6.2.3 *Children and Adolescent TB*

- Establish burden of TB disease among children and adolescents in different regions and districts
- Strengthen the engagement of all care providers in the health facilities and communities in identification and linkage of all children and adolescents to comprehensive TB services,
- Build capacity of healthcare workers to diagnose and manage

childhood tuberculosis, and
- Integrate TB services to the child and adolescent health services in the facilities and communities.

6.6.2.4 ***Programmatic Management of drug Resistant TB***
- Strengthen MDR-TB case management,
- Scale up and Strengthening of MDR-TB Decentralized sites,
- Strengthen system to support MDR-TB services, and
- Strengthen systematic surveillance of drug resistance TB

6.6.2.5 ***Management* of Co-morbidities including collaborative TB/HIV Services**
- Strengthen collaborative TB/HIV,
- Scale up collaborative TB/MD activities,
- Strengthen prevention of TB among at risk group, and
- TB and Tobacco Smoking cessation

6.6.2.6 ***TB in Mining***
- Increase access to TB services in artisanal mining sites,
- Scale up OHSC including capacity building to Healthcare workers and CSOs in the mining in the mining areas on TB and Occupational lung disease services;
- Sustain coordination mechanism of multisectoral approaches to address issues of TB in the mining sector.
- Scale up and strengthening cross border TB initiatives (CBI)

6.6.2.7 ***Leprosy Services***
- Strengthen targeted leprosy screening campaign in high endemic councils and hidden hotspots,
- Strengthen the Prevention of Disability services, including self-care interventions, and
- Scale –up of PEP in the remaining endemic councils.

6.6.2.8 ***Supportive Systems for TB and Leprosy Prevention Care and Treatment***
- Institutional capacity is built to:
  - improve human resource capacity, planning, and management for TB and Leprosy,
  - Strengthen coordination and management of the implementation of SP,
  - Mobilize resource and management of NSP
  - Ensure accountability of TB and leprosy Programme at all levels
- Build community linkages and coordination,
- Address the underlying social determinants and barriers to TB and

Leprosy services,

- Promote advocacy and communication for TB and leprosy control in the country,
- Strengthen TB care, treatment, and prevention services in the private health sector,
- Ensure uninterrupted supply of TB and Leprosy medicines, Lab commodities, and other supplies,

6.6.2.9 Monitoring, Evaluation, and Learning,

- Improve the TB surveillance system's ability to measure the burden of TB and Leprosy accurately,
- Improve the quality of TB and leprosy data,
- Monitor the implementation of NSP VI, Capacity building of data analysis and use at all levels,
- Implement TB and Leprosy Operational Research agenda,
- Strengthen Collaborate with TB and leprosy research stakeholders. Leprosy services.

6.7 Neglected Tropical Diseases.

The WHO has developed a Global NTD Roadmap 2012-2030. The roadmap calls for stronger accountability, intensified cross-cutting approaches, and a change in the operating model and culture, with more ownership being taken at the country level.

The WHO has identified five interventions that aims to combat NTDs.

- **Preventative chemotherapy and transmission control:** This intervention aims to make preventative medications widely available. In the case of leprosy, teams across the world are providing doses of an antibiotic called Rifampicin, which acts as a preventative treatment against leprosy.

- **Intensified diseases management (IDM):** This intervention is relevant to diseases for which we do not already have cost-effective control tools and where large-scale use of tools is limited. The aim is that intensified disease management will allow diseases to be easily managed within the primary health care system.

- **Vector ecology and management:** This intervention refers to the targeting of mosquitos, flies, ticks, bugs and other ' vectors' that allow NTDs to be transmitted.

- **Safe water, sanitation and hygiene:** Clean water and good hygiene are

important to the prevention, care, and management of all NTDs. The WHO has called for increased collective action on this area, increased collaboration between the NTD and WASH (Water, Sanitation, and Hygiene) sectors. The WHO has produced a specific WASH strategy to complement the new NTD roadmap.

- **Veterinary public health services: The** health of humans is often tied up with the health of animals and the local environment. Many NTDs are transmitted from animals to humans, so work needs to be done to break the chain of that transmission.

6.7.1 *Objectives*

- To reduce the burden of Neglected Tropical Diseases until they are no longer of public health significance at all levels by 2030.

Specific disease

- To maintain achieved Lymphatic Filariasis (LF) geographical coverage of 100% and therapeutic coverage 65% by 2032,
- To eliminate STH by treating 100% of at risk School Aged Children population by 2032.
- To eliminate of transmission Onchocerciasis through mass treatment by 2032
- To eliminate Schistosomiasis by mass treatment by 2032
- To eliminate blinding trachoma as a public health problem by through mass treatment and environmental modification 2032

6.7.2 *Strategies*

- MDA and Disease alleviation (surgeries and Lymphedema management, promotional of vector management and Health Promotion Behavioural change communication for transmission control and Health promotion,
- Environmental and hygiene improvement,
- face washing (SAFE)
- Conduct surveys.
- Strengthening school health programme in combating Schistosomiasis;
- Strengthen and expand Lymphatic Filariasis control program (LFCP) ,
- Strengthen and expand national Onchocerciasis control program, Continue with Disease specific assessment of 5

- PCTs Strengthening pharmaco – vigilance in NTD program
- Continue with MDAs, case Management, Water and Sanitation hygiene and improve coverage,
- Strengthen the use of Community based Health program in delivering NTD interventions.

6.8 Non Communicable Diseases

Globally there is evidence of growing burden of Non Communicable diseases (hypertension, diabetes and obesity) especially in developing countries including Tanzania. There are initiatives to control the burden of non-communicable diseases in the country. However there is need to focus more on primary prevention at population level targeting interventions to reduce exposure to tobacco, reduce alcohol intake, reduce salt intake, promote healthy diets and physical activity.

For the prevention and control of NCDs, there needs to be a continuum from primary to tertiary prevention and a scope of interventions from the community level up to the national level. Community-based interventions are needed targeting the risk factors for primary prevention.

Early identification of potential patients should be advocated and preventive and control majors made known by the community. For instance the community should be aware that a "Kitambi" (belly) is not an indication of worthy but that of ill-health. Hard facts about obesity, smoking, and excessive alcohol intake should be exposed to young students at primary and secondary level. In addition, secondary prevention measures are needed targeting those at high risk to ensure that they are identified early through a high risk targeted screening for early identification and appropriate care. Effective policies are needed to support these interventions.

6.8.1 Objectives

- To improve service provision for control and prevention of non-communicable diseases at primary levels of health care delivery.
- To reduce morbidity and mortality from NCD
- To introduce the knowledge about NCD to young Tanzanians in school.

6.8.2 Strategies

- Capacity building of health care providers at primary facility levels
- Community involvement in the control of NCDs using relevant IEC.
- Involvement of other stakeholders in the control and prevention of NCDs
- Include subjects on NCD in primary and Secondary Schools
- Strengthen NCD coordination at all levels
- Resource mobilization for NCDs strategy implementation
- Coordinate implementation of the NCD strategy at all levels
- Strengthen regulation/enforcement by assessing national regulatory and enforcement capacity for prevention and control of NCDs
- Advocate for good governances and implement anti-bribery policy
- Strengthen leadership for community empowerment for health promotion and prevention of NCDs
- Review, implement and monitor strategy on tobacco control
- Review, implement and monitor strategy on tobacco control
- Advocate for implementation and monitoring of strategy for promoting healthy diet for NCD prevention and control
- Advocate for implementation of updated early childhood and maternal nutrition strategies
- Implement, and monitor strategy for promoting physical activities
- Strengthen school health program to include NCDs prevention and health promotion activities.
- Advocate for health promoting environment by reducing exposure to indoor air pollution, and other environmental hazards.
- Establish integrated chronic care services at primary health care level and strengthen capacity of NCD care at secondary and tertiary levels.
- Ensure availability of high quality NCD risk factors, morbidity and mortality data reported by age, sex, locality and other demographic and social determinants is available and used for planning and monitoring of effectiveness of NCD interventions and country capacity according to national and global NCD monitoring framework.

6.9 Environmental Health and Sanitation

Environmental sanitation refers to the control of environmental factors that form links in disease transmission. This category includes solid waste management, water and wastewater treatment, industrial waste treatment and noise and pollution control. Sanitation refer to public health conditions related to clean drinking water and treatment and disposal of human excreta and sewage. Sanitation systems aim to protect human health by providing a clean environment that will stop the transmission of disease, especially through the fecal–oral route. Proper sanitation promotes health, improves the quality of the environment and thus, the quality of life in a community. Sanitation refers to the safe collection, transportation, treatment and disposal of human wastes. The health facilities with safe, integrated and efficient health care waste management system that is gender sensitive, sustainable established across the country.

6.9.1 Objectives

- Strengthen environmental Health, Sanitation and Hygiene services
- Raise awareness of communities on the dangers of lack of proper sanitation.
- Solicit Community participation in issues related to environmental Health and Sanitation.
- Disseminate Health Care Waste Management policies, Regulations, Guidelines and Standards at the Primary care level.

6.9.2 Strategies

- Capacity building for environmental officers at district and ward level
- Strengthen community participation in hygiene, sanitation and Health care waste management interventions.

6.10 Health Promotion and Education.

Health promotion is the process of enabling people to increase control over, and to improve, their health. It moves beyond a focus on individual behaviour towards a wide range of social and environmental interventions. World Health Organization's definition of health promotion is "enables people to increase control over their own health. It covers a wide range of social and environmental interventions that are designed to benefit and protect individual people's health and quality of life by addressing and preventing the root causes of ill health, not just focusing on treatment and cure." This program will aim at catching people to understand sanitation from their childhood. This may need inclusion of elements of health promotion in school program

6.10.1 Objectives

- To build capacity for communities and individuals to engage in health promotion and education activities at all levels including schools

6.10.2 Strategies

- Support all program components to enhance behaviour change for informed health choices and action.
- Promote advocacy for primary health care services and mobilize resources for the program Build capacity on Health promotion & education/communication to all stakeholders.
- Promote community involvement and participation in health activities promote health promotion in schools.

6.11 Nutrition

Nutrition is the study of nutrients in food, how the body uses them, and the relationship between diet, health and disease. Nutritionists use ideas from molecular biology, biochemistry, and genetics to understand how nutrients affect the human body. Nutrition is about eating a healthy and balanced diet. Food and drink provide the energy and nutrients you need to be healthy. Understanding these nutrition terms may make it easier for you to make better food choices. It defines the hard fact that 'we are what we eat'. If everyone would come to understand the fact that we are what we eat, then, everyone will understand why one would be careful to make what one is!

6.11.1 ***Objectives.***

- To build capacity for Nutrition intervention at Council and community levels by 2032
- To increase coverage of adequate, equitable and quality nutrition services at the community and facility levels.
- To strengthened multisectoral and private sector engagement for nutrition
- To enable environments (adequate policies and frameworks) that are supportive of adequate human and financial resources for nutrition
- To reducing under nutrition
- Reducing micronutrient deficiencies
- Reducing overweight and obesity
- To strengthen enabling environments

6.11.2 Strategies

- Recruitment of Nutrition focal person at all levels of health care.
- Innovatively design nutrition promotion materials for communities.
- Introduce the concept of nutrition and health in schools
- Strengthened nutrition commodity supply chain for service delivery

- Increased access to facility and community- based nutrition services for women, men, children and adolescents.
- Women, men, children and adolescents have increased nutrition knowledge.
- Women, men and adolescents empowered to make necessary nutrition decisions
- Women, men, children, and adolescents have increased consumption of safe nutrition and adequate foods
- Strengthen food supply chains that support functional food systems' activities
- Strengthen food environments that promote the consumption of safe and nutritious foods
- Collaboration and coordination amongst public and private sectors strengthened.

6.12 Traditional and Alternative Medicine

WHO has defined "traditional Medicine" as sum total of the knowledge, skills, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health, as well as in the prevention, diagnosis, improvement, or treatment of illnesses.

Traditional medicine refers to health practices, approaches, knowledge and beliefs incorporating plant, animal and mineral based medicines, spiritual therapies, manual techniques and exercises, applied singularly or in combination to treat, diagnose and prevent illnesses or maintain well-being. Alternative medicine is a term that describes medical treatments that are used instead of traditional (mainstream) therapies. Some people also refer to it as "integrative", or "complementary" medicine.

6.12.1 Objectives

- To support research in the whole area of traditional and alternative medicine
- To facilitate the provision of quality traditional and alternative medicine services to all people to enable them improve their wellbeing.
- To Promote (standardization and formulation of value added traditional Medicine products through the application of Traditional Model Research and development;
- To establish and strengthen registration of tradition of traditional health practitioners;
- To institute Quality assurance Programmes and Certification of Traditional Medicines Products in accordance with research results.

6.12.2 *Strategies*

- Promotion of the establishment of modern traditional medicine facilities.
- Promoting (standardization and formulation of value added traditional medicine products through the application of)Traditional Model Research and development
- Promoting Documentation of the traditional and alternative medicine Services
- Instituting Quality Assurance Programmes including certification of Traditional Medicine Products;
- Promoting local production and safe use of traditional and alternative Medicines according to evidence based approaches, ICE and advocacy of traditional and alternative medicine, Develop standard guidelines, monitoring and evaluation for traditional and alternative medicine.

6.13 Public Private Partnership:

Public private partnership (PPP) refers to an arrangement between the government and private sector, with the principal objective of providing public infrastructure, community facilities and other related services, is an old concept in Tanzania. The concept of PPP entails an arrangement between the public and private sector entities whereby the private entity renovates, constructs, operates, maintains, and/or manages a facility in whole or in part, in accordance with specified output specifications.

Most project requires an environmental impact assessment which is undertaken under Part VI of the Environmental Management Act[74]. Act provides the institutional framework for the implementation of public private partnership agreements between the public sector and private sector entities; to set rules, guidelines and procedures governing public private partnership procurement, development and implementation of public private partnerships and to provide for other related matters.

The Government will strengthen cooperation with private health sector in health care delivery. This included to enhance public private partnerships in the provision of health care services, in line with services agreements and existing guidelines, promotion of private health sector investments in the key priority areas of the health sector for public benefit and establishing a mechanisms for private health

[74] Public Private Partnership Act, 2010 (No. 18 of 2010) implemented by Public Private Partnership Regulations, 2011 (G.N. No.165 of 2011)

facilities to provide public health services to the community, either without payment, or at a reasonable cost.

6.13.1 Objectives

- To strengthen and promote private sector participation in the implementation of the PHSID Strategy.

6.13.2 Strategies

- The government will regularly review monitoring systems and jointly develop, with private providers, guidelines for monitoring of private health services.
- The government will promote and facilitate regular partnership meetings to strengthen and sustain public-private partnership initiatives as part of the implementation arrangements.

6.14 Advocacy for the PHSIDS

In the medical profession, activities related to ensuring access to care, navigating the system, mobilizing resources, addressing health inequities, influencing health policy and creating system change are known as health advocacy. The implementation of will require targeted advocacy in different service oriented sections, let it be construction, procurement or consumption. Advocacy will target government officials, stakeholders and potential organizations or individuals.

6.14.1 Objectives

- To advocate understanding of the PHSIDS to stakeholders at all levels.

6.14.2 Strategies:

- Awareness creation.
- Community involvement and participation.

6.15 Institutional Arrangement

Institutional arrangements of health systems and the incentives they set are increasingly recognized as critical to promote performance in the health sector. Looking at complex health system interventions from an institutional perspective may contribute to better understanding what are the paths and processes that lead to the results of such interventions. No one institution can implement the PHSIDS in its complexity and multispectral nature. Therefore there is great need for a good arrangement modality to involve many institutions and stakeholders.

The National Health Systems

The national health System is based on government structure. The MoH and PORALG are jointly responsible for the delivery of public health services. The MOH is responsible for policy formulation, development of guidelines to facilitate policy implementation, and M&E of policies and implementation guidelines. The MoH is also responsible for direct implementation of National, Zonal and Regional Referral hospitals.

The Regional Health Management Teams (RHMTs) interpret health policies and monitor their implementation in the Councils. The Regional Medical Officer (RMO) heads the RHMT and reports directly to MoH on issues related to medical management and to PO-RALG, through the Regional Administration Secretary (RAS), on issues related to administration and management.

The Council Health Management Team (CHMT) is responsible for Council health services, including Dispensaries, Health centers and Hospitals. The CHMT follows guidelines for planning and management of Council health Services, which are issued jointly by MoH and PO-RALG. The District Medical Officer (DMO) heads the CHMT and is in charge of all Council Health Services; is accountable to Council Executive Director on administrative and managerial matters; and reports to RMO on technical matters.

The Public health services are delivered through government, non-profit voluntary agencies and parastatal healthcare facilities.

Government will ensure the availability of Primary Health Care facilities with sufficient infrastructure and resources according to geographical, demographic and population needs. Evaluation of epidemiological and demographic factors will be a basis for assessing the needs for health care facilities.

Government will develop a new long-term investment plan for health care facilities based on these factors, aiming to cover all wards in the country. Government will maintain and renovate health care facilities according to the needs based on priority planning. Planned maintenance of buildings and equipment will be strengthened and operationalized.

Government will continue to mobilize and create an enabling environment for citizens to actively participate in the acquisition, ownership, utilization and management of health care services, including the construction and rehabilitation of health care facilities.

Government will build capacity of health care facilities to manage the waste (including medical waste) and sewage. Government will continue to put in place sanitation infrastructure in all government facilities in compliance with medical waste management guidelines, for all levels health care.

6.15.1 Objectives

- To strengthen the PHSIDS management and coordination capacity of MoH and PO-RALG
- Identify institutions which will add value in the implementation of the PHSIDS.
- Outline clear guidelines for setting up institutional arrangement for implementation of the PHSIDS components.

6.15.2 Strategies

- Put in place a coordination mechanism with clear terms of reference for the implementation of the PHSIDS within MoH and PORALG and other health interested instructions.

6.16 Health Care Financing.

Beginning with the Third health Sector Strategic Plan 2009 – 2015, the Government made a commitment to universal healthcare via social health insurance. Tanzania's health financing system is dominated by tax- and donor-funded health delivery, with a modest proportion of the population enrolled in social, community, or private health insurance.

The Components of the Health Financing System (HFS) include pooling the current risk pools into a mandatory Health insurance for all and will develop a minimum benefits package that will be available to all, while increasing efficiency through improved public financial management and choosing the most appropriate provided payment mechanisms[75].

The government will continue to strengthen planning, budgeting, execution, monitoring and evaluation. The management of public finances at all levels including reporting on expenditures in relation to outputs. Regular audit will be performed. Partners will align with GOT public financial management (PFM) systems.

[75] Health Financing Profile , TANZANIA, May 2016

6.16.1 Objectives

- To mobilize additional resources to supplement the Government's efforts for implementation of the programme.
- To allocate sufficient funds to support the PHSIDS implementation by Government, Development Partners, NGOs/CSOs, and Private Sector.
- To finalize arrangements for a Mandatory Health Insurance for all citizens.
- To allocate Government financial resources through DHFF at the Facility level.

6.16.2 Strategies

- Strengthen existing complimentary financing schemes such as NHIF, iCHF and private sector
- Mobilization of sufficient funding from within and without.
- Develop Legal Acts for Mandatory Health Insurance.
- Strengthen PlanRep and Facility Financing Accounting and Reporting as basis for financial management at facility level.

6.17 Programme Monitoring and Evaluation

Management. Monitoring and Evaluation (M&E) are techniques used to find out how well a health programme is achieving what it set out to do. M&E enables to see how effectively those objectives set for the programme are reached. The techniques of M&E is one way to measure success, but other measures of success may be just as important.

Monitoring refers to ongoing assessment of the progress. It is part of the routine programme management and ideally done by both programme and community members together. *Evaluation* refers to a systematic review of the programme outcomes and impact often at the end of a funding cycle. It often involves an outside evaluation team. It uses the record systems built into the programme.

One helpful way to distinguish between Monitoring and Evaluation is that monitoring asks the question 'Are we doing things right?', and evaluation asks 'Are we doing the right things?' If monitoring is carried out well, evaluation will be easier.

6.17.1 Objectives

- To continually monitor the programme implementation progress base on

set targets.

- To conduct mid and end of the programme evaluation and learn from the findings.

6.17.2 Strategies

- Creation of an institutionalized programme management structure at various levels with clearly set objectives.
- Strengthen the capacity of the central MoH/PORALG, RS/RHMTs and Council/CHMTs to undertake effective programme supervision of planned activities.
- Identify a credible team to perform programme evaluation and learn their findings and advice.

7 LOGICAL FRAMEWORK

7.1 Annual Activity Targets

The attached Annex 1, physical implementation summary shows the outputs.

7.2 Financial Outlays

The attached Annex 2, financial outlays shows the resource requirements.

7.3 Implementation Plan

The attached Annex 3, Implementation Plan for Primary Health service Implementation Development Strategy 2022 - 2032.

8 ANNEXES

8.1 Annex 1 ANNUAL ACTIVITY TARGETS BY COMPONENTS 2022 – 2032

8.1.1 COMPONENT: HUMAN RESOURCES FOR HEALTH

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
1. Strengthen the HRH planning in line with MOH functional mandates and in decentralized settings of health service delivery by 2032	Update HRHIS and TIIS systems to improve HRH data collection and generate quality information by 2024	Update HRHIS and TIIS systems to improve HRH data collection and generate quality information by 2026	Update HRHIS and TIIS systems to improve HRH data collection and generate quality information by 2028	Update HRHIS and TIIS systems to improve HRH data collection and generate quality information by 2030	Update HRHIS and TIIS systems to improve HRH data collection and generate quality information by 2032
	Link between HRHIS and TIIS into 2 (i.e., DHIS2 and GOTHoMIS) existing information and reporting systems by 2024	Link between HRHIS and TIIS into 2 (i.e., DHIS2 and GOTHoMIS) existing information and reporting systems by 2026	Link between HRHIS and TIIS into 2 (i.e., DHIS2 and GOTHoMIS) existing information and reporting systems by 2028	Link between HRHIS and TIIS into 2 (i.e., DHIS2 and GOTHoMIS) existing information and reporting systems by 2030	Link between HRHIS and TIIS into 2 (i.e., DHIS2 and GOTHoMIS) existing information and reporting systems by 2032
	Introduce spot-checks for HRH Data as means of staff audit for 184 councils and 26 RRH by 2024	Introduce spot-checks for HRH Data as means of staff audit for 184 councils and 26 RRH by 2026	Introduce spot-checks for HRH Data as means of staff audit for 184 councils and 26 RRH by 2028	Introduce spot-checks for HRH Data as means of staff audit for 184 councils and 26 RRH by 2030	Introduce spot-checks for HRH Data as means of staff audit for 184 councils and 26 RRH by 2032
	Build analytical capacity of HRH data for HCW from 184 councils and 26 from RRH by 2024	Build analytical capacity of HRH data for HCW from 184 councils and 26 from RRH by 2026	Build analytical capacity of HRH data for HCW from 184 councils and 26 from RRH by 2028	Build analytical capacity of HRH data for HCW from 184 councils and 26 from RRH by 2030	Build analytical capacity of HRH data for HCW from 184 councils and 26 from RRH by 2032

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
	50 health facility managers from 50 facilities in the country trained in operational research skills and vital population statistical data management by 2024	50 health facility managers from 50 facilities in the country trained in operational research skills and vital population statistical data management by 2026	50 health facility managers from 50 facilities in the country trained in operational research skills and vital population statistical data management by 2028	50 health facility managers from 50 facilities in the country trained in operational research skills and vital population statistical data management by 2030	50 health facility managers from 50 facilities in the country trained in operational research skills and vital population statistical data management by 2032
	Develop training programs (Health Sector Training Plan) required to strengthen HRH planning across the sector by 2024	Review training programs (Health Sector Training Plan) required to strengthen HRH planning across the sector by 2026	Review training programs (Health Sector Training Plan) required to strengthen HRH planning across the sector by 2028	Review training programs (Health Sector Training Plan) required to strengthen HRH planning across the sector by 2030	Review training programs (Health Sector Training Plan) required to strengthen HRH planning across the sector by 2032
	Develop HRH Planning tools (WISN online System) for Health Workforce Planning at 11 tertiary hospitals, 26 RRH and 5940 PHC facilities by 2024	Review HRH Planning tools (WISN online System) for Health Workforce Planning at 11 tertiary hospitals, 26 RRH and 5940 PHC facilities by 2026	Review HRH Planning tools (WISN online System) for Health Workforce Planning at 11 tertiary hospitals, 26 RRH and 5940 PHC facilities by 2028	Review HRH Planning tools (WISN online System) for Health Workforce Planning at 11 tertiary hospitals, 26 RRH and 5940 PHC facilities by 2028	Review HRH Planning tools (WISN online System) for Health Workforce Planning at 11 tertiary hospitals, 26 RRH and 5940 PHC facilities by 2028
	Develop advocacy strategy for implementation of HRH strategy by 2024	Disseminate and conduct stakeholders' meetings on data dissemination and use at 184 councils and 26 regions by 2026	Disseminate and conduct stakeholders' meetings on data dissemination and use at 184 councils and 26 regions by 2028	Disseminate and conduct stakeholders' meetings on data dissemination and use at 184 councils and 26 regions by 2030	Disseminate and conduct stakeholders' meetings on data dissemination and use at 184 councils and 26 regions by 2032
2. Improve availability of	Increase pre-service students' enrollment in	Increase pre-service students' enrollment	Increase pre-service students' enrollment	Increase pre-service students' enrollment	Increase pre-service students' enrollment in

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
qualified and competent human resources at all levels to adequately correspond with current and future health sector needs 2032	Health Training Institutions from 21,047 up to 23,247 by 2024	in Health Training Institutions from 25,447 by 2 up to 27,647 by 2026	in Health Training Institutions from 27,647 up to 29,847 by 2028	in Health Training Institutions from 29.847 up to 32,047 by 2030	Health Training Institutions from 32,047 up to 35,000 by 2030
	Produce rare cadres e.g., Dental, Anesthesia, Physiotherapy, Ophthalmology, Nutrition, Orthostetic, Radiographer, speech therapy etc. from 593 up to 759	Produce rare cadres e.g., Dental, Anesthesia, Physiotherapy, Ophthalmology, Nutrition, Orthostetic, Radiographer, speech therapy etc. from 759 up to 925	Produce of rare cadres e.g., Dental, Anesthesia, Physiotherapy, Ophthalmology, Nutrition, etc Orthostetic, Radiographer, speech therapy from 925 up to 1,091	Produce of rare cadres e.g., Dental, Anesthesia, Physiotherapy, Ophthalmology, Nutrition, Orthostetic, Radiographer, speech therapy etc. from 1,091 up to 1,257	Produce of rare cadres e.g., Dental, Anesthesia, Physiotherapy, Ophthalmology, Nutrition, Orthostetic, Radiographer, speech therapy etc from 1,257 up to 1423
	Conduct 2 Inter-ministerial and Health Training Institutions (HTIs) coordination meeting by 2024	Conduct 2 Inter-ministerial and Health Training Institutions (HTIs) coordination meeting by 2026	Conduct 2 Inter-ministerial and Health Training Institutions (HTIs) coordination meeting by 2028	Conduct 2 Inter-ministerial and Health Training Institutions (HTIs) coordination meeting by 2030	Conduct 2 Inter-ministerial and Health Training Institutions (HTIs) coordination meeting by 2032
	Conduct 1 joint meeting among Professional Councils and Education Regulatory Bodies (NACTE, TCU) by 2024	Conduct 1 joint meeting among Professional Councils and Education Regulatory Bodies (NACTE, TCU) by 2026	Conduct 1 joint meeting among Professional Councils and Education Regulatory Bodies (NACTE, TCU) by 2028	Conduct 1 joint meeting among Professional Councils and Education Regulatory Bodies (NACTE, TCU) by 2030	Conduct 1 joint meeting among Professional Councils and Education Regulatory Bodies (NACTE, TCU) by 2032
	Review 2 curricula to enhance HTIs to effectively apply competence based training by 2024	Review 2 curricula to enhance HTIs to effectively apply competence based training by 2026	Review 2 curricula to enhance HTIs to effectively apply competence based training by 2028	Review 2 curricula to enhance HTIs to effectively apply competence based training by 2030	Review 2 curricula to enhance HTIs to effectively apply competence based training by 2032
	Develop and review 3	Develop and review	Develop and review 3	Develop and review 3	Develop and review 3

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
	standardized teaching and learning materials by 2024	3 standardized teaching and learning materials by 2026	standardized teaching and learning materials by 2028	standardized teaching and learning materials by 2030	standardized teaching and learning materials by 2032
	Develop training package (curriculum & teaching materials) for certificate courses specialized on dhobi and mortuary attendant for health facilities by 2024	Develop training package (curriculum & teaching materials) for certificate courses specialized on dhobi and mortuary attendant for health facilities by 2026	Develop training package (curriculum & teaching materials) for certificate courses specialized on dhobi and mortuary attendant for health facilities by 2028	Develop training package (curriculum & teaching materials) for certificate courses specialized on dhobi and mortuary attendant for health facilities by 2030	Develop training package (curriculum & teaching materials) for certificate courses specialized on dhobi and mortuary attendant for health facilities by 2032
	Improve teaching and learning environment at all 44 Teaching Hospitals, skills & computer laboratories by 2024	Improve teaching and learning environment at all 44 Teaching Hospitals, skills & computer laboratories by 2026	Improve teaching and learning environment at all 44 Teaching Hospitals, skills & computer laboratories by 2028	Improve teaching and learning environment at all 44 Teaching Hospitals, skills & computer laboratories by 2030	Improve teaching and learning environment at all 44 Teaching Hospitals, skills & computer laboratories by 2032
	Capacity of 88 tutors, clinical instructors, and lecturers in health training institutions in knowledge, skills and appropriate application of competence-based curriculum improved by 2025	Capacity of 88 tutors, clinical instructors, and lecturers in health training institutions in knowledge, skills and appropriate application of competence-based curriculum improved by 2025	Capacity of 88 tutors, clinical instructors, and lecturers in health training institutions in knowledge, skills and appropriate application of competence-based curriculum improved by 2025	Capacity of 88 tutors, clinical instructors, and lecturers in health training institutions in knowledge, skills and appropriate application of competence-based curriculum improved by 2025	Capacity of 88 tutors, clinical instructors, and lecturers in health training institutions in knowledge, skills and appropriate application of competence-based curriculum improved by 2032
	3 new Health Training Institution campuses constructed by 2024	3 new Health Training Institution campuses constructed by 2026	3 new Health Training Institution campuses constructed by 2028	3 new Health Training Institution campuses constructed by 2030	3 new Health Training Institution campuses constructed by 2032

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
	5 Health Training Institutions renovated and rehabilitated	5 Health Training Institutions renovated and rehabilitated	5 Health Training Institutions renovated and rehabilitated	5 Health Training Institutions renovated and rehabilitated	5 Health Training Institutions renovated and rehabilitated
	2 incomplete buildings/projects completed by 2024	2 incomplete buildings/projects completed by 2026	2 incomplete buildings/projects completed by 2028	2 incomplete buildings/projects completed by 2030	2 incomplete buildings/projects completed by 2030
	Tutor student ratio in HTIs to commensurate with national and international standards improved from 1:20 to 1:8 by 2024	Tutor student ratio in HTIs to commensurate with national and international standards improved from 1:16 to 1:8 by 2026	Tutor student ratio in HTIs to commensurate with national and international standards improved from 1:13 to 1:8 by 2028	Tutor student ratio in HTIs to commensurate with national and international standards improved from 1:11 to 1:8 by 2030	Tutor student ratio in HTIs to commensurate with national and international standards improved 1:8 by 2032
	88 staff houses are constructed at all 44 Health Training Institutions by 2024	88 staff houses are constructed at all 44 Health Training Institutions by 2026	88 staff houses are constructed at all 44 Health Training Institutions by 2028	88 staff houses are constructed at all 44 Health Training Institutions by 2030	88 staff houses are constructed at all 44 Health Training Institutions by 2032
	All 44 Health Training Institutions provided with relevant learning materials and teaching aids	All 44 Health Training Institutions provided with relevant learning materials and teaching aids	All 44 Health Training Institutions provided with relevant learning materials and teaching aids	All 44 Health Training Institutions provided with relevant learning materials and teaching aids	All 44 Health Training Institutions provided with relevant learning materials and teaching aids
	Conduct short courses on teaching methodology to 150 newly recruited tutors	Conduct short courses on teaching methodology to 150 newly recruited tutors	Conduct short courses on teaching methodology to 150 newly recruited tutors	Conduct short courses on teaching methodology to 150 newly recruited tutors	Conduct short courses on teaching methodology to 150 newly recruited tutors
	Conduct short courses on implementation of competence-based curriculum training	Conduct short courses on implementation of competence-based	Conduct short courses on implementation of competence-based	Conduct short courses on implementation of competence-based	Conduct short courses on implementation of competence-based curriculum training

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
	(CBET) to 120 tutors	curriculum training (CBET) to 120 tutors	curriculum training (CBET) to 120 tutors	curriculum training (CBET) to 120 tutors	(CBET) to 120 tutors
	Sponsor 600 health care workers to pursue postgraduate specialties within and outside the country	Sponsor 600 health care workers to pursue postgraduate specialties within and outside the country	Sponsor 600 health care workers to pursue postgraduate specialties within and outside the country	Sponsor 600 health care workers to pursue postgraduate specialties within and outside the country	Sponsor 600 health care workers to pursue postgraduate specialties within and outside the country
	Provide accreditation and certification of 5 CPD providers by 2024	Provide accreditation and certification of 5 CPD providers by 2026	Provide accreditation and certification of 5 CPD providers by 2028	Provide accreditation and certification of 5 CPD providers by 2030	Provide accreditation and certification of 5 CPD providers by 2032
	Review the National CPD Framework for healthcare workers by 2024	Monitor and assess the application of National CPD Framework for healthcare workers to enhance competencies by 2026	Monitor and assess the application of National CPD Framework for healthcare workers to enhance competencies by 2028	Monitor and assess the application of National CPD Framework for healthcare workers to enhance competencies by 2030	Monitor and assess the application of National CPD Framework for healthcare workers to enhance competencies by 2032
	To evaluate the use of eHealth (telemedicine, e-learning, etc.) in the provision of Continuous Professional Development (CPD) enhanced	To evaluate the use of eHealth (telemedicine, e-learning, etc.) in the provision of Continuous Professional Development (CPD) enhanced	To evaluate the use of eHealth (telemedicine, e-learning, etc.) in the provision of Continuous Professional Development (CPD) enhanced	To evaluate the use of eHealth (telemedicine, e-learning, etc.) in the provision of Continuous Professional Development (CPD) enhanced	To evaluate the use of eHealth (telemedicine, e-learning, etc.) in the provision of Continuous Professional Development (CPD) enhanced
	Review existing community-based practices (e.g. Uturo Model) to develop a	Review existing community-based practices (e.g. Uturo Model) to develop a	Review existing community-based practices (e.g. Uturo Model) to develop a	Review existing community-based practices (e.g. Uturo Model) to develop a	Review existing community-based practices (e.g. Uturo Model) to develop a

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
	generic model that is scalable countrywide to enhance the impact of community health	generic model that is scalable countrywide to enhance the impact of community health	generic model that is scalable countrywide to enhance the impact of community health	generic model that is scalable countrywide to enhance the impact of community health	generic model that is scalable countrywide to enhance the impact of community health
3. Improve the recruitment, deployment and retention of health workers through the use of context specific sound interventions to ensure equitable (need based) distribution of health work force at all levels of the health sector by 2032	Recruit competent qualified health workers to work for 11 tertiary hospitals, 28 RRH and 5940 PHC from 102,469 up to 125,787 by 2024	Recruit competent qualified health workers to work for 11 tertiary hospitals, 28 RRH and 5940 PHC from 125,787 up to 149,105 by 2026	Recruit competent qualified health workers to work for 11 tertiary hospitals, 28 RRH and 5940 PHC from 149,105 up to 172,423 by 2028	Recruit competent qualified health workers to work for 11 tertiary hospitals, 28 RRH and 5940 PHC from 172,423 up to 195,741 by 2030	Recruit competent qualified health workers to work for 11 tertiary hospitals, 28 RRH and 5940 PHC from 195,741 up to 219,059 by 2032
	Employ Health Workforce by Volunteerism scheme at 11 tertiary hospitals, 28 RRH and 184 Councils from 0 up to 6,000 by 2024	Employ Health Workforce employed by Volunteerism scheme at 11 tertiary hospitals, 28 RRH and 184 Councils from 6,000 up to 12,000 by 2026	Employ Health Workforce employed by Volunteerism scheme at 11 tertiary hospitals, 28 RRH and 184 Councils from 12,000 up to 18,000 by 2028	Employ Health Workforce employed by Volunteerism scheme at 11 tertiary hospitals, 28 RRH and 184 Councils from 18,000 up to 24,000 by 2030	Employ Health Workforce employed by Volunteerism scheme at 11 tertiary hospitals, 28 RRH and 184 Councils from 2,000 up to 30,000 by 2032
	Conduct 2 meetings with professional bodies and councils to increase HRH productivity to the optimal level through effective use of performance tools by 2024	Conduct 2 meetings with professional bodies and councils to increase HRH productivity to the optimal level through effective use of performance tools by 2026	Conduct 2 meetings with professional bodies and councils to increase HRH productivity to the optimal level through effective use of performance tools by 2028	Conduct 2 meetings with professional bodies and councils to increase HRH productivity to the optimal level through effective use of performance tools by 2030	Conduct 2 meetings with professional bodies and councils to increase HRH productivity to the optimal level through effective use of performance tools by 2032
	Conduct 2 meetings with professional bodies and councils for improving utilization, productivity and	Conduct 2 meetings with professional bodies and councils for improving utilization,	Conduct 2 meetings with professional bodies and councils for improving utilization,	Conduct 2 meetings with professional bodies and councils for improving utilization,	Conduct 2 meetings with professional bodies and councils for improving utilization, productivity and

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
	accountability of HRH from National to the Council level (11 tertiary hospitals, 28 RRH and 184 Councils) by 2024	productivity and accountability of HRH from National to the Council level (11 tertiary hospitals, 28 RRH and 184 Councils) by 2026	productivity and accountability of HRH from National to the Council level (11 tertiary hospitals, 28 RRH and 184 Councils) by 2028	productivity and accountability of HRH from National to the Council level (11 tertiary hospitals, 28 RRH and 184 Councils) by 2030	accountability of HRH from National to the Council level (11 tertiary hospitals, 28 RRH and 184 Councils) by 2032
	Review and scale up Makole Model from 0 – 5 regions at 11 tertiary hospitals, 28 RRH and 184 Councils by 2024	Scale up Makole Model from 5 – 10 regions at 11 tertiary hospitals, 28 RRH and 184 Councils by 2026	Scale up Makole Model from 10 – 15 regions at 11 tertiary hospitals, 28 RRH and 184 Councils by 2028	Scale up Makole Model from 15 – 20 regions at 11 tertiary hospitals, 26 RRH and 184 Councils by 2030	Scale up Makole Model from 20 – 28 regions at 11 tertiary hospitals, 28 RRH and 184 Councils by 2028
	Develop capacity of managers in 15 RRHMT, 40 HMT and CHMT, 44 HTIs on supportive supervision, innovative leadership and in developing customized local incentive packages for attraction and retention of staff by 2024	Develop capacity of managers in 15 RRHMT, 40 HMT and CHMT, 44 HTIs on supportive supervision, innovative leadership and in developing customized local incentive packages for attraction and retention of staff by 2026	Develop capacity of managers in 15 RRHMT, 40 HMT and CHMT, 44 HTIs on supportive supervision, innovative leadership and in developing customized local incentive packages for attraction and retention of staff by 2028	Develop capacity of managers in 15 RRHMT, 40 HMT and CHMT, 44 HTIs on supportive supervision, innovative leadership and in developing customized local incentive packages for attraction and retention of staff by 2030	Develop capacity of managers in 15 RRHMT, 40 HMT and CHMT, 44 HTIs on supportive supervision, innovative leadership and in developing customized local incentive packages for attraction and retention of staff by 2032
4. Improve working environment, living conditions and facilities for HRH by 2032	Conduct meeting to enhance safety supplies, machines, tools and social protection to HRH in 11 tertiary hospitals, 28 RRH, 184 Councils, 44 HTIs and 5	Conduct meeting to enhance safety supplies, machines, tools and social protection to HRH in 11 tertiary hospitals, 28 RRH, 184	Conduct meeting to enhance safety supplies, machines, tools and social protection to HRH in 11 tertiary hospitals, 28 RRH, 184 Councils,	Conduct meeting to enhance safety supplies, machines, tools and social protection to HRH in 11 tertiary hospitals, 28 RRH, 184 Councils,	Conduct meeting to enhance safety supplies, machines, tools and social protection to HRH in 11 tertiary hospitals, 28 RRH, 184 Councils, 44 HTIs and 5

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
	universities 2024	Councils, 44 HTIs and 5 universities 2026	44 HTIs and 5 universities 2028	44 HTIs and 5 universities 2030	universities 2030
	Procure medical equipment, supplies and other accessories necessary for delivery of quality health services and training in 11 tertiary hospitals, 28 RRH, 184 Councils, 44 HTIs and 5 Universities by 2024	Procure medical equipment, supplies and other accessories necessary for delivery of quality health services in 11 tertiary hospitals, 28 RRH, 184 Councils, 44 HTIs and 5 Universities by 2026	Procure medical equipment, supplies and other accessories necessary for delivery of quality health services in 11 tertiary hospitals, 28 RRH, 184 Councils, 44 HTIs and 5 Universities by 2028	Procure medical equipment, supplies and other accessories necessary for delivery of quality health services in 11 tertiary hospitals, 28 RRH, 184 Councils, 44 HTIs and 5 Universities by 2030	Procure medical equipment, supplies and other accessories necessary for delivery of quality health services in 11 tertiary hospitals, 28 RRH, 184 Councils, 44 HTIs and 5 Universities by 2024
	Construct and rehabilitate infrastructure necessary for delivery of quality services and training in 11 tertiary hospitals, 28 RRH, 184 Councils, 44 HTIs and 5 by 2024	Construct and rehabilitate infrastructure necessary for delivery of quality services and training in 11 tertiary hospitals, 28 RRH, 184 Councils, 44 HTIs and 5 by 2024	Construct and rehabilitate infrastructure necessary for delivery of quality services and training in 11 tertiary hospitals, 28 RRH, 184 Councils, 44 HTIs and 5 by 2024	Construct and rehabilitate infrastructure necessary for delivery of quality services and training in 11 tertiary hospitals, 28 RRH, 184 Councils, 44 HTIs and 5 by 2024	Construct and rehabilitate infrastructure necessary for delivery of quality services and training in 11 tertiary hospitals, 28 RRH, 184 Councils, 44 HTIs and 5 by 2024
	Rehabilitate and renovate 44 houses to improve living conditions of HRH in HTIs by 2024	Rehabilitate and renovate 44 houses to improve living conditions of HRH in HTIs by 2026	Rehabilitate and renovate 44 houses to improve living conditions of HRH in HTIs by 2028	Rehabilitate and renovate 44 houses to improve living conditions of HRH in HTIs by 2030	Rehabilitate and renovate 44 houses to improve living conditions of HRH in HTIs by 2032

8.1.2 COMPONENT: DISTRICT HEALTH SERVICES

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
Construction and Completion of 2,682 hospital building to 130 council hospital as per standard by 2032	Increase operating council hospital from 147 to 190 through completion of 476 buildings by 2024	35 Council hospital with all required buildings by 2026	35 Council hospital with all required buildings by 2028	30 Council hospital with all required buildings by 2028	30 Council hospital with all required buildings by 2032
Rehabilitate 60 old councils hospitals and make function as per standard by 2032	Rehabilitate 20 old council hospitals by 2024	Rehabilitate 20 old council hospitals by 2026	Rehabilitate 20 old council hospitals by 2028		
Construct 1,900 staff house to 190 council hospitals by 2032	Construct 300 staff houses to 190 council hospitals by 2024	Construct 300 staff houses to 190 council hospitals by 2026	Construct 450 staff houses to 190 council hospitals by 2028	Construct 450 staff houses to 190 council hospitals by 2030	Construct 400 staff houses to 190 council hospitals by 2032
Construction of new 2,728 dispensaries and 5456 staff houses in Villages which do not have health facilities by 2032	544 Dispensaries constructed and 1088 staff houses by 2024	544 Dispensaries constructed and 1088 staff houses by 2026	544 Dispensaries constructed and 1088 staff houses by 2028	548 Dispensaries constructed and 1088 staff houses by 2030	548 Dispensaries constructed and 1088 staff houses by 2032
Construction of new 1,000 Health Centers and 10,000 staff houses at strategic Wards by 2032	200 Health Centers and 2000 staff houses constructed by 2024	200 Health Centers and 2000 staff houses constructed by 2026	200 Health Centers and 2000 staff houses constructed by 2028	200 Health Centers and 2000 staff houses constructed by 2030	200 Health Centers and 2000 staff houses constructed by 2032
Improve working environment by constructing 18,719 staff houses to 7, 500 available facilities (190 hospitals, 1,009 health centers and 6,301 dispensaries by 2032	3750 staff houses constructed by 2024	3750 staff houses constructed by 2026	3750 staff houses constructed by 2028	3750 staff houses constructed by 2030	3719 staff houses constructed by 2032

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
Completion 6 IPD, RCH, Administration, X-rays, Laundry, external toilets and Mortuary buildings to 739 Health Centers by 2032	120 Health facilities with all required building by 2024	169 Health facilities with all required building by 2024by 2026	150 Health facilities with all required building by 2024by 2028	150 Health facilities with all required building by 2024by 2030	150 Health facilities with all required building by 2024by 2032
Provide medical equipment to 7,500 existing facilities (190 hospitals, 1,009 health centers and 6,301 dispensaries by 2032	New Council hospital 99 equipped with CEmONC and other essential medical equipment from 99 to 130 by 2024	New Council hospital 31 equipped with CEmONC and other essential medical equipment by 2026	190 Council hospital equipped with all essential medical equipment by 2028	190 Council hospital equipped with all essential medical equipment by 2028	190 Council hospital equipped with all essential medical by 2032
	New 350 Health centers equipped with medical equipment by 2024	All health centres equipped with medical equipment by 2026	All health centers equipped with medical by 2028	All health centers equipped with medical by 2030	All health centers equipped with medical by 2032
	Dispensaries 800 equipped with medical equipment by 2024	Dispensaries 801 equipped with medical equipment by 2026	Dispensaries 1700 equipped with medical equipment by 2028	Dispensaries 1800 equipped with medical equipment by 2030	Dispensaries 1200 equipped with medical equipment by 2032
		Equip 50 biomedical centers to council hospitals by 2026	Equip 50 biomedical centers to council hospitals by 2028	Equip 50 biomedical centers to council hospitals by 2030	Equip 40 biomedical centers to council hospitals by 2032
Rehabilitate 233 old health centers to provides CEmONC services and equipped with essential equipment by 2032	80 old health centres provided with CEmONC facilities and equipment by 2024	80 old health centres provided with CEmONC facilities and equipment by 2026	73 old health centres provided with CEmONC facilities and equipment by 2028	All 233 equipped with medical equipment by 2030	All 233 equipped with medical equipment by 2032
Strengthening referral system by equipping council hospital and health centres with 1199 Ambulances by 2032	Increase availability functional ambulance from 423 to 739 by 2024 (316 ambulance secured through IMF	Increase availability functional ambulance from 739 to 939 by 2026	Increase availability functional ambulance from 939 to 1,119 by 2028	25% of Council hospitals and health centers replaced with (300 ambulances) ambulance by 2030	25% of Council hospitals and health centers replaced with (300 ambulances) ambulance by 2032

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
Strengthening organization system by providing transport to 26 RS and 184 LGAs 2032	Provide 210 supervision vehicles for 26 and 184 and 50 distribution vehicles by 2024	Provide 50 distribution vehicles to 50 councils by 2026	Provide 21 supervision vehicles and 50 distribution vehicles by 2028	Provide 150 supervision vehicles and 100 distribution vehicles by 2028	Provide 60 supervision vehicles and 80 distribution vehicles by 2028
Construction of fence to 1,199 facilities (190 council hospital and 1,009 health centers) by 2032	Advocate and disseminate PHSDP to 184 LGAs and 26 RS to ensure 50% of hospital and health centre constructed fences by 2024	80% of hospital and health centers constructed fence by 2026	100% of hospitals and health centers constructed fence by 2028	100% of hospitals and health centers constructed fence by 2030	100% of hospitals and health centers constructed fence by 2032
Facilitate availability of Title deeds to 7, 500 facilities (190 hospitals, 1,009 health centers and 6,301 dispensaries by 2032	Advocate and disseminate PHSDP to 184 LGAs and 26 RS to ensure 25% of health facilities secured title deed by 2024	50% of health facility secured title deed by 2026	100% of health facility secured title deed by 2028	100% of health facility secured title deed by 2030	100% of health facility secured title deed by 2032
Provide ICT system to 7, 500 facilities (190 hospitals, 1,009 health centers and 6,301 dispensaries to full functional by 2032	Increase availability of GOTHoMIS/Afya Care system from 1,129 to 1,879 facilities(hospital 50, health centres 350 and 400 dispensaries by 2024	Increase availability of GOTHoMIS/ Afya Care system from 1,879 to 2,779 facilities (hospital 52,health centers 248 and 600 dispensaries by 2026	Increase availability of GOTHoMIS/ Afya Care system from 2,779 to 3,779 facilities (1200 dispensaries by 2028	Increase availability of GOTHoMIS/ Afya Care system from 3,779 to 5,779 facilities (1,750 dispensaries by 2030	Increase availability of GOTHoMIS/Afya Care system from 5,779 to 7,500 facilities (1,721 dispensaries by 2032
	Completion of ICT system to 200 facilities by 2024	Completion of ICT system to 250 facilities by 2026	Completion of ICT system to 259 facilities by 2028	Completion of ICT system to 220 facilities by 2030	Completion of ICT system to 200 facilities by 2032
Strengthen capacity to Planning teams on Comprehensive Social Welfare Operation plans at all levels from 24% to	Capacity building on CCSWOP planning teams at all levels strengthened to 35%	Capacity building on CCSWOP planning teams at all levels strengthened to 50%	Capacity building on CCSWOP planning teams at all levels strengthened to 65%	Capacity building on CCSWOP planning teams at all levels strengthened to 80%	Capacity building on CCSWOP planning teams at all levels strengthened to 100%

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
100% by 2032	Strengthened Comprehensive Council Social welfare plans at all level by 40%	Improved Comprehensive Council Social welfare plans at all level by 50%	Improved Comprehensive Council Social welfare plans at all level by 60%	Improved Comprehensive Council Social welfare plans at all level by 70%	Improved Comprehensive Council Social welfare plans at all level by 80%
	Scrutinization and assessment of CCSWOP strengthened at all level (Council, Region and National) by 30%	Scrutinization and assessment of CCSWOP improved at all level (Council, Region and National) by 50%	Scrutinization and assessment of CCSWOP improved at all level (Council, Region and National) by 70%	Scrutinization and assessment of CCSWOP improved at all level (Council, Region and National) by 80%	Scrutinization and assessment of CCSWOP improved at all level (Council, Region and National) by 95%
Strengthens capacity of Child Protection committee teams in 95% at all levels by 2032	Capacity building to Child and women protection teams at all levels strengthened to 40%	Capacity building to Child and women protection teams at all levels strengthened to 60%	Capacity building to Child and women protection teams at all levels strengthened to 75%	Capacity building to Child and women protection teams at all levels strengthened to 85%	Capacity building to Child and women protection teams at all levels strengthened to 95%
Strengthens Child Protection services at all levels by 95% in 2032	Increased Child Protection data quality and use on District Case Monitoring System (DCMS) by 30%	Increased Child Protection data quality and use on District Case Monitoring System (DCMS) by 50%	Increased Child Protection data quality and use on District Case Monitoring System (DCMS) by 60%	Increased Child Protection data quality and use on District Case Monitoring System (DCMS) by 70%	Increased Child Protection data quality and use on District Case Monitoring System (DCMS) by 80%
	Engaging and recruiting of alternative care services e.g. fit person, foster care, rehabilitation and Safe home strengthened by 35%	Engaging and recruiting of alternative care services e.g. fit person, foster care, rehabilitation and Safe home strengthened by 50%	Engaging and recruiting of alternative care services e.g. fit person, foster care, rehabilitation and Safe home strengthened by 75%	Engaging and recruiting of alternative care services e.g. fit person, foster care, rehabilitation and Safe home strengthened by 85%	Engaging and recruiting of alternative care services e.g. fit person, foster care, rehabilitation and Safe home strengthened by 95%
Strengthen family conflict services at all levels by 95 by 2032	Reconciliation and affiliation case management strengthened by 40%	Reconciliation and affiliation case management strengthened by 50%	Reconciliation and affiliation case management strengthened by 70%	Reconciliation and affiliation case management strengthened by 80%	Reconciliation and affiliation case management strengthened by 95%

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
	Reconciliation and Affiliation and Case follow up improved by 40%	Reconciliation and Affiliation and Case follow up improved by 50%	Reconciliation and Affiliation and Case follow up improved by 70%	Reconciliation and Affiliation and Case follow up improved by 85%	Reconciliation and Affiliation and Case follow up improved by 95%
Strengthen child in conflict with the Law services at all levels by 2032	Child in conflict with the Law decreased from 80% to 75%	Child in conflict with the Law decreased from 75% to 65%	Child in conflict with the Law decreased from 65% to 55%	Child in conflict with the Law decreased from 55% to 45%	Child in conflict with the Law decreased from 45% to 35%
Strengthen GBV and VAC services at all levels by 2032	GBV and VAC cases received social welfare care and support services increased by 40%	GBV and VAC cases received social welfare care and support services increased by 50%	GBV and VAC cases received social welfare care and support services increased by 60%	GBV and VAC cases received social welfare care and support services increased by 70%	GBV and VAC cases received social welfare care and support services increased by 80%
	GBV and VAC incidences at all levels reduced from 85%-75%	GBV and VAC incidences at all levels reduced from 75%-65%	GBV and VAC incidences at all levels reduced from 65%-55%	GBV and VAC incidences at all levels reduced from 55%-45%	GBV and VAC incidences at all levels reduced from 45%-35%
Strengthening capacity of Elderly persons support and Care Councils at all levels in 95% by 2032	Capacity building of Elderly Councils at all levels strengthened to 35%	Capacity building of Elderly Councils at all levels strengthened to 55%	Capacity building of Elderly Councils at all levels strengthened to 75%	Capacity building of Elderly Councils at all levels strengthened to 85%	Capacity building of Elderly Councils at all levels strengthened to 95%
	At least 50% Elderly Identified and supported with social welfare services	At least 60% Elderly Identified and supported with social welfare services	At least 70% Elderly Identified and supported with social welfare services	At least 80% Elderly Identified and supported with social welfare services	At least 90% Elderly Identified and supported with social welfare services
	Elderly persons accessing care and support services increased to 40%	Elderly persons accessing care and support services increased to 60%	Elderly persons accessing care and support services increased to 75%	Elderly persons accessing care and support services increased to 80%	Elderly persons accessing care and support services increased to 95%
Strengthens Most Vulnerable Children services at all levels by 95% by 2032	Capacity building on use of MVC-MIS (data entry, analysis and use) among Social Welfare Officers at	Capacity building on use of MVC-MIS (data entry, analysis and use) among Social Welfare	Capacity building on use of MVC-MIS (data entry, analysis and use) among	Capacity building on use of MVC-MIS (data entry, analysis and use) among	Capacity building on use of MVC-MIS (data entry, analysis and use) among

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
	all level strengthen by 40%	Officers at all level strengthen by 60%	Social Welfare Officers at all level strengthen by 75%	Social Welfare Officers at all level strengthen by 85%	Social Welfare Officers at all level strengthen by 95%
	45% identified MVCs linked to Social Welfare services according to their needs	50% identified MVCs and linked to Social Welfare services according to their needs	70% identified MVCs and linked to Social Welfare services according to their needs	85% identified MVCs and linked to Social Welfare services according to their needs	95% identified MVCs and linked to Social Welfare services according to their needs
	Availability of working tools and facilities for Social welfare officers improved at all levels by 40%	Availability of working tools and facilities for Social welfare officers improved at all levels by 60%	Availability of working tools and facilities for Social welfare officers improved at all levels by 70%	Availability of working tools and facilities for Social welfare officers improved at all levels by 80%	Availability of working tools and facilities for Social welfare officers improved at all levels by 95%
	Improved MVC reunification system at all levels by 40%	Improved MVC reunification system at all levels by 60%	Improved MVC reunification system at all levels by 75%	Improved MVC reunification system at all levels by 85%	Improved MVC reunification system at all levels by 95%
	Capacity building to MVCs Care takers from MVC Institutions by 40%	Capacity building to MVCs Care takers from MVC Institutions by 40%	Capacity building to MVCs Care takers from MVC Institutions by 60%	Capacity building to MVCs Care takers from MVC Institutions by 80%	Capacity building to MVCs Care takers from MVC Institutions by 95%
Strengthens Under-five Birth registration system by 95% by 2032	Under-five birth registration system improved by 40%	Under-five birth registration system improved by 60%	Under-five birth registration system improved by 70%	Under-five birth registration system improved by 80%	Under-five birth registration system improved by 95%
	Increased Capacity of SWOs on Under five Birth registration system by 40%	Increased Capacity of SWOs on Under five Birth registration system by 60%	Increased Capacity of SWOs on Under five Birth registration system by 70%	Increased Capacity of SWOs on Under five Birth registration system by 80%	Increased Capacity of SWOs on Under five Birth registration system by 95%
	Elderly Persons supported with iCHF/NHIF Cards increased by 50%	Elderly Persons supported with iCHF/NHIF Cards increased by 60%	Elderly Persons supported with iCHF/NHIF Cards increased by 70%	Elderly Persons supported with iCHF/NHIF Cards increased by 85%	Elderly Persons supported with iCHF/NHIF Cards increased by 95%
Strengthen Care and services to people with	Capacity building to People with disabilities	Capacity building to People with disabilities	Capacity building to People with	Capacity building to People with	Capacity building to People with

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
disabilities by 95% by 2032	committee at all levels strengthened by 40%	committees at all levels strengthened by 50%	disabilities committees at all levels strengthened by 70%	disabilities committees at all levels strengthened by 80%	disabilities committees at all levels strengthened by 95%
	Attain 35% identified people with disabilities supported with social welfare care and services	Attain 50% identified people with disabilities supported with social welfare care and services	Attain 60% coverage identified people with disabilities supported with social welfare care and services	Attain 70% identified people with disabilities supported with social welfare care and services	Attain 80% coverage identified people with disabilities supported with social welfare care and services
Reduce incidences of Emergency that lead to high rates of mental health psychosocial problem (MHPSS) related issues in community to 95% by 2032	Survivors received mental health and psychological services increased from 20% 40%	Survivors received mental health and psychological services increased from 40% 50%	Survivors received mental health and psychological services increased from 50% 70%	Survivors received mental health and psychological services increased from 70% 80%	Survivors received mental health and psychological services increased from 80% 90%
Strengthen Social Welfare Referral and linkages to integrated Case management to 95% by 2032	Social Welfare referral and linkage improved at all levels by 35%	Social Welfare referral and linkage improved at all level by 50%	Social Welfare referral and linkage improved at all levels by 70%	Social Welfare referral and linkage improved at all levels by 85%	Social Welfare referral and linkage improved at all levels by 95%
Strengthens M&E for social welfare services at all level by 95% by 2032	Develop Social Welfare monitoring and evaluation framework and its implementation by 100% by	Update the Social Welfare monitoring and evaluation framework and its implementation by 100%	Update the Social Welfare monitoring and evaluation framework and its implementation by 100%	Update the Social Welfare monitoring and evaluation framework and its implementation by 100%	Update the Social Welfare monitoring and evaluation framework and its implementation by 100% by 2032
	Capacity Building of Social welfare M&E coordinators at regional and Council levels by 20%	Capacity Building of Social welfare M&E coordinators at regional and Council levels by 40%	Capacity Building of Social welfare M&E coordinators at regional and Council levels by 60%	Capacity Building of Social welfare M&E coordinators at regional and Council levels by 80%	Capacity Building of Social welfare M&E coordinators at regional and Council levels by 95%

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
	Working tools (Laptop, Desk top, Tablets) for social welfare M&E services strengthened at all levels by 30%	Working tools (Laptop, Desk top, Tablets) for social welfare M&E services for social welfare M&E strengthened at all levels by 40%	Working tools Laptop, Desk top, Tablets) for social welfare M&E services for social welfare M&E strengthened at all levels by 50%	Working tools (Laptop, Desk top, Tablets) for social welfare M&E services for social welfare M&E strengthened by 70%	Working tools (Laptop, Desk top, Tablets) for social welfare M&E services or social welfare M&E strengthened by 80%
Strengthens Social Welfare, community HIV / AIDS Service system by 2032	Capacity building to Social Welfare officers on HIV prevention at the community level improved at all levels by 35%	Capacity building to Social Welfare officers on HIV prevention at the community level improved at all levels by 45%	Capacity building to Social Welfare officers on HIV prevention at the community level improved at all levels by 60%	Capacity building to Social Welfare officers on HIV prevention at the community level improved at all levels by 75%	Capacity building to Social Welfare officers on HIV prevention at the community level improved at all levels by 85%
	Improved knowledge and skills on HIV and Reproductive Health among children's in Approved schools and retention homes by 30%	Improved knowledge and skills on HIV and Reproductive Health among children's in Approved schools and retention homes by 50%	Improved knowledge and skills on HIV and Reproductive Health among children's in Approved schools and retention homes by 65%	Improved knowledge and skills on HIV and Reproductive Health among children's in Approved schools and retention homes by 75%	Improved knowledge and skills on HIV and Reproductive Health among children's in Approved schools and retention homes by 85%

8.1.3 COMPONENT: NURSING AND MIDWIFERY SERVICES

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
1. Strengthen Mentorship and Coaching systems to health facilities to improve skills by 2032	Establish simulation laboratories for mentorship in 15 teaching hospitals by 2024	Establish simulation laboratories for mentorship in 15 teaching hospitals by 2026	Establish simulation laboratories for mentorship in 15 teaching hospitals by 2028	Establish simulation laboratories for mentorship in 15 teaching hospitals by 2030	Establish simulation laboratories for mentorship in 15 teaching hospitals by 2032
	Capacity building of 250 Clinical mentors to facilitate cascade mentorships in all levels by 2024	Capacity building of 250 Clinical mentors to facilitate cascade mentorships in all levels by 20226	Capacity building of 250 Clinical mentors to facilitate cascade mentorships in all levels by 20228	Capacity building of 250 Clinical mentors to facilitate cascade mentorships in all levels by 2030	Capacity building of 250 Clinical mentors to facilitate cascade mentorships in all levels by 2032
2. Improve Quality of Care and client experience	Institutionalize Customer care for Respectful and Compassionate Care in service delivery to all tertiary hospitals by 2024	Institutionalize Customer care for Respectful and Compassionate Care in service delivery to all council hospitals by 2026	Institutionalize Customer care for Respectful and Compassionate Care in service delivery to all health centers by 2028	Institutionalize Customer care for Respectful and Compassionate Care in service delivery to all dispensaries by 2030	Institutionalize Customer care for Respectful and Compassionate Care in service delivery to all dispensaries by 2030
	Build Capacity on nursing and midwifery audit to 60 hospitals by 2024	Build Capacity on nursing and midwifery audit to 60 hospitals by 2026	Build Capacity on nursing and midwifery audit to 60 hospitals by 2028	Build Capacity on nursing and midwifery audit to 60 hospitals by 2030	Build Capacity on nursing and midwifery audit to 60 hospitals by 2032
	Disseminate nursing and Midwifery SOPs and tools for the in-patient care to 150 health facilities by 2024	Disseminate nursing and Midwifery SOPs and tools for the in-patient care to 150 health facilities by 2026	Disseminate nursing and Midwifery SOPs and tools for the in-patient care to 150 health facilities by 2028	Disseminate nursing and Midwifery SOPs and tools for the in-patient care to 150 health facilities by 2030	Disseminate nursing and Midwifery SOPs and tools for the in-patient care to 150 health facilities by 2032
3. Strengthening Nursing and Midwifery	Build capacity of Nursing and Midwifery Leaders for tertiary	Build capacity of Nursing and Midwifery Leaders	Build capacity of Nursing and Midwifery Leaders	Build capacity of Nursing and Midwifery Leaders	Build capacity of Nursing and Midwifery Leaders for

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
Leadership and Management of health facilities by 2032	level by 2024	for regional level by 20226	for council level by 2028	for health centers by 2030	dispensaries by 2032
	Disseminate job descriptions for nurses and midwives to all levels by 2024	Monitor implementation of the job descriptions for nurses and midwives to all levels of service delivery by 2026	Monitor implementation of the job descriptions for nurses and midwives to all levels of service delivery by 2028	Monitor implementation of the job descriptions for nurses and midwives to all levels of service delivery by 2030	Monitor implementation of the job descriptions for nurses and midwives to all levels of service delivery by 2032
	Establish clinical attachment and mentorship system to 2000 newly employed nurses and midwives by 2024	Establish clinical attachment and mentorship system to 2000 newly employed nurses and midwives by 2026	Establish clinical attachment and mentorship system to 2000 newly employed nurses and midwives by 2028	Establish clinical attachment and mentorship system to 2000 newly employed nurses and midwives by 2030	Establish clinical attachment and mentorship system to 2000 newly employed nurses and midwives by 2032
4. Strengthen operational research and reporting of nursing and midwifery services by 2032	Capacity building of 150 nurses and midwives on operational research by 2024	Capacity building of 150 nurses and midwives on operational research by 2026	Capacity building of 150 nurses and midwives on operational research by 2028	Capacity building of 150 nurses and midwives on operational research by 2030	Capacity building of 150 nurses and midwives on operational research by 2032
	Develop 8 volumes of nursing and midwifery services bulletin by 2024	Develop 8 volumes of nursing and midwifery services bulletin by 2026	Develop 8 volumes of nursing and midwifery services bulletin by 2028	Develop 8 volumes of nursing and midwifery services bulletin by 2030	Develop 8 volumes of nursing and midwifery services bulletin by 2032
	Integrate nursing and midwifery indicators into DHIS 2 by 2024	Monitor and use reports of nursing and midwifery services from DHIS2 by 2026	Monitor and use reports of nursing and midwifery services from DHIS2 by 2028	Monitor and use reports of nursing and midwifery services from DHIS2 by 2030	Monitor and use reports of nursing and midwifery services from DHIS2 by 2032

8.1.4 COMPONENT: REPRODUCTIVE, MATERNAL, NEWBORN, CHILD AND ADOLESCENT HEALTH (RMNCH)

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
To create an enabling environment for provision and utilization of quality ,equitable and accessible RMNCAH and nutrition services	26 one stop centre established for provision of Gender based Violence in each region.	26 one stop centre established for provision of Gender based Violence in each region.	26 one stop centre established for provision of Gender based Violence in each region.	26 one stop centre established for provision of Gender based Violence in each region.	26 one stop centre established for provision of Gender based Violence in each region.
	100 of neonatal care Units to established at Regional Level and district level	100 of neonatal care Units to established at Regional Level and district level	40 of neonatal care Units to established at Regional Level and district level	40 of neonatal care Units to established at Regional Level and district level	40 of neonatal care Units to established at Regional Level and district level.
	Support all facilities to implement CEmONC signal functions for 24/7	Support all facilities to implement CEmONC signal functions for 24/7	Support all facilities to implement CEmONC signal functions for 24/7	Support all facilities to implement CEmONC signal functions for 24/7	Support all facilities to implement CEmONC signal functions for 24/7
	100 hospitals and Health Centres to establish Youth corner/room for provision of Adolescent and Youth Friendly service	100 hospitals and Health Centres to establish Youth corner/room for provision of Adolescent and Youth Friendly service	100 hospitals and Health Centres to establish Youth corner/room for provision of Adolescent and Youth Friendly service	100 hospitals and Health Centres to establish Youth corner/room for provision of Adolescent and Youth Friendly service	100 hospitals and Health Centres to establish Youth corner/room for provision of Adolescent and Youth Friendly service
	1,000 health workers trained from Health centres, districts and referral hospitals on safe anaesthesia and safe surgeries	1000 health workers trained from Health centres, districts and referral hospitals on safe anaesthesia and safe surgeries	1000 health workers trained from Health centres, districts and referral hospitals on safe anaesthesia and safe surgeries	1000 health workers trained from Health centres, districts and referral hospitals on safe anaesthesia and safe surgeries	1000 health workers trained from Health centres, districts and referral hospitals on safe anaesthesia and safe surgeries

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
To strengthen the capacity of Health system for planning, management and services delivery of RMNCAH services	1000 service providers supervised and mentored on ANC services to be conducted by the end of each year.	1000 service providers supervised and mentored on ANC services to be conducted by the end of each year.	1500 service providers supervised and mentored on ANC services to be conducted by the end of each year.	800 service providers supervised and mentored on ANC services to be conducted by the end of each year.	800 service providers supervised and mentored on ANC services to be conducted by the end of each year.
	Ensure availability and supply of ANC related commodities at all facility levels.	Ensure availability and supply of ANC related commodities at all facility levels.	Ensure availability and supply of ANC related commodities at all facility levels.	Ensure availability and supply of ANC related commodities at all facility levels.	Ensure availability and supply of ANC related commodities at all facility levels.
	184 council supervised and conduct trainees follow each year to ensure quality provision of Family planning services in 184 councils.	184 council to be supervised and conduct trainees follow each year to ensure quality provision of Family planning services in 184 councils.	184 council to be supervised and conduct trainees follow each year to ensure quality provision of Family planning services in 184 councils.	184 council to be supervised and conduct trainees follow each year to ensure quality provision of Family planning services in 184 councils.	184 council to be supervised and conduct trainees follow each year to ensure quality provision of Family planning services in 184 councils.
To increase access and utilization of quality RMNCAH services	1900 healthcare worker trained on comprehensive FP services provision to improve access and utilization of Long-acting contraceptive method.	1500 healthcare worker to be capacitated on comprehensive FP services provision.	1000 healthcare worker to be capacitated on comprehensive FP services provision.	1500 healthcare worker to be capacitated on comprehensive FP services provision.	500 healthcare workers to be capacitated on comprehensive FP services provision.
	1900 healthcare workers trained on Postpartum FP (2 per Health facility)	1500 healthcare workers trained on Postpartum FP (2 per Health Facility)	1000 healthcare workers trained on Postpartum FP (2per Health Facility)	500 healthcare workers trained on Postpartum FP (2per Health Facility)	500 healthcare workers trained on Postpartum FP (2 per Health Facility)
	1000 healthcare workers trained per Health facility on identified regions on provision of integrated ANC package	1000 healthcare workers trained per Health facility on identified regions on provision of integrated ANC package	1500 healthcare workers trained per Health facility on identified regions on provision of integrated ANC package	800 healthcare workers trained per Health facility on identified trained on provision of integrated ANC package	800 healthcare workers trained per Health facility on trained on provision of integrated ANC package

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
	962 health facilities to be trained on use of partograms to monitor progress of labour.	962 health facilities to be capacitated on use of partograms to monitor progress of labour.	962 health facilities to be capacitated on use of partograms to monitor progress of labour.	962 health facilities to be capacitated on use of partograms to monitor progress of labour.	962 health facilities to be capacitated on use of partograms to monitor progress of labour.
	4000 Healthcare providers trained from all Health Centers and Hospital for provision of Basic Emergency Obstetric and newborn care services (BEmONC)	4000 Healthcare providers from all Health Centers and Hospital to be capacities for provision of Basic Emergency Obstetric and newborn care services (BEmONC)	4000 Healthcare providers from all Health Centers and Hospitals to be trained for provision of Basic Emergency Obstetric and newborn care services (BEmONC)	4000 Healthcare providers from all Health Centres and Hospital to be trained for provision of Basic Emergency Obstetric and newborn care services (BEmONC)	4000 Healthcare providers all from Health Centres and Hospital to be trained for provision of Basic Emergency Obstetric and newborn care services (BEmONC)
	Sustain capacity for testing HIV, syphilis, haemoglobin, and urine for protein,	Sustain capacity for testing HIV, syphilis, haemoglobin, and urine for protein	Sustain capacity for testing HIV, syphilis, haemoglobin, and urine for protein	Sustain capacity for testing HIV, syphilis, haemoglobin, and urine for protein	Sustain capacity for testing HIV, syphilis, haemoglobin, and urine for protein
	50% of the community reached with HIV and RMNCAH integrated outreach services.	50% of the community reached with HIV and RMNCAH integrated outreach services.	50% of the community reached with HIV and RMNCAH integrated outreach services.	50% of the community reached with HIV and RMNCAH integrated outreach services.	50% of the community reached with HIV and RMNCAH integrated outreach services.
	50% of the community members sensitized for cervical cancer screening within the regions/districts	50% of the community members sensitized for cervical cancer screening within the regions/districts	50% of the community members sensitized for cervical cancer screening within the regions/districts	50% of the community members sensitized for cervical cancer screening within the regions/districts	50% of the community members has to be sensitized for cervical cancer screening within the regions/districts
	Build capacity to 16 technicians on repair and maintenance of treatment machine	Build capacity to 16 technicians on repair and maintenance of treatment machine	Build capacity to 16 technicians on repair and maintenance of treatment machine	Build capacity to 16 technicians on repair and maintenance of treatment machine	Build capacity to 16 technicians on repair and maintenance of treatment machine

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
	50% of the community informed and became aware on GBV/VAC issues in a region/district	50% of the community informed and became aware on GBV/VAC issues in a region/district	50% of the community informed and became aware on GBV/VAC issues in a region/district	50% of the community informed and became aware on GBV/VAC issues in a region/district	50% of the community informed and became aware on GBV/VAC issues in a region/district
	368 community Health workers on each region trained on provision of information and education on Gender based Violence and Violence against children	368 community Health workers on each region trained on provision of information and education on Gender based Violence and Violence against children	368 community Health workers on each region trained on provision of information and education on Gender based Violence and Violence against children	368 community Health workers on each region trained on provision of information and education on Gender based Violence and Violence against children	368 community Health workers on each region trained on provision of information and education on Gender based Violence and Violence against children
	400 Health Providers trained on provision of Gender Based Violence and Violence against Children.	400 Health Providers trained on provision of Gender Based Violence and Violence against Children.	400 Health Providers trained on provision of Gender Based Violence and Violence against Children.	400 Health Providers trained on provision of Gender Based Violence and Violence against Children.	400 Health Providers trained on provision of Gender Based Violence and Violence against Children.
	50% community Health workers on each region trained on newborn care through the RMNCAH community package	50% community Health workers on each region trained on newborn care through the RMNCAH community package	50% community Health workers on each region trained on newborn care through the RMNCAH community package	50% community Health workers on each region trained on newborn care through the RMNCAH community package	50% community Health workers on each region trained on newborn care through the RMNCAH community package
	400 of health workers trained on growth monitoring at facility level.	400 of health workers trained on growth monitoring at facility level.	400 of health workers trained on growth monitoring at facility level.	400 of health workers trained on growth monitoring at facility level.	400 of health workers trained on growth monitoring at facility level
	Regular campaigns to improve coverage in low performing regions for routine immunization to be conducted.	Regular campaigns to improve coverage in low performing regions for routine immunization to be conducted.	Regular campaigns to improve coverage in low performing regions for routine immunization to be conducted.	Regular campaigns to improve coverage in low performing regions for routine immunization to be conducted.	Regular campaigns to improve coverage in low performing regions for routine immunization to be conducted.

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
	400 community Health workers trained on immunization intervention within the community.	400 community Health workers trained on immunization intervention within the community.	400 community Health workers trained on immunization intervention within the community.	400 community Health workers trained on immunization intervention within the community.	400 community Health workers trained on immunization intervention within the community.
	500 health care workers trained on IMCI to detect malnutrition and respond appropriately by giving early referral for specialist care.	500 health care workers trained on IMCI to detect malnutrition and respond appropriately by giving early referral for specialist care	500 health care workers trained on IMCI to detect malnutrition and respond appropriately by giving early referral for specialist care	500 health care workers trained on IMCI to detect malnutrition and respond appropriately by giving early referral for specialist care	500 health care workers trained on IMCI to detect malnutrition and respond appropriately by giving early referral for specialist care
	368 community Health workers trained on management of malnutrition among children.	368 community Health workers trained management of malnutrition among children.	368 community Health workers trained management of malnutrition among children.	368 community Health workers trained management of malnutrition among children.	368 community Health workers trained management of malnutrition among children.
	Conduct community sensitization using media, IEC/BCC material and other platforms on the importance of using long life insecticide impregnated nets (LLIN)	Conduct community sensitization using media, IEC/BCC material and other platforms on the importance of using long life insecticide impregnated nets (LLIN)	Conduct community sensitization using media, IEC/BCC material and other platforms on the importance of using long life insecticide impregnated nets (LLIN)	Conduct community sensitization using media, IEC/BCC material and other platforms on the importance of using long life insecticide impregnated nets (LLIN)	Conduct community sensitization using media, IEC/BCC material and other platforms on the importance of using long life insecticide impregnated nets (LLIN)
	2,000,000 of LLINs to be Distribute LLIN via ANC to estimated pregnant women.	2,000,000 of LLINs to be Distribute LLIN via ANC to estimated pregnant women	2,000,000 of LLINs to be Distribute LLIN via ANC to estimated pregnant women	2,000,000 of LLINs to be Distribute LLIN via ANC to estimated pregnant women	2,000,000 of LLINs to be Distribute LLIN via ANC to estimated pregnant women.

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
	370 of health care trained on routinely assessment according to the developmental milestones at all levels.	370 of health care trained on routinely assessment according to the developmental milestones at all levels.	370 of health care trained on routinely assessment according to the developmental milestones at all levels.	370 of health care trained on routinely assessment according to the developmental milestones at all levels.	370 of health care trained on routinely assessment according to the developmental milestones at all levels.
	200 Health care workers trained on provision of Adolescent and Youth Friendly services at all levels.	200 Health care workers trained on provision of Adolescent and Youth Friendly services at all levels	200 Health care workers trained on provision of Adolescent and Youth Friendly services at all levels	200 Health care workers trained on provision of Adolescent and Youth Friendly services at all levels	200 Health care workers trained on provision of Adolescent and Youth Friendly services at all levels
	368 community Health workers trained provision for Information and Education on Adolescent &Youth Friendly services	368 community Health workers trained provision for Information and Education on Adolescent &Youth Friendly services	368 community Health workers trained provision for Information and Education on Adolescent &Youth Friendly services	368 community Health workers trained provision for Information and Education on Adolescent &Youth Friendly services	368 community Health workers trained provision for Information and Education on Adolescent &Youth Friendly services
To improve quality of care for RMNCAH services	100 health facility reached with supportive supervision visit to adolescent Friendly services at Hospital and Health Centres.	100 health facility reached with supportive supervision visit to adolescent Friendly services at Hospital and Health Centres.	100 health facility reached with supportive supervision visit to adolescent Friendly services at Hospital and Health Centres.	100 health facility reached with supportive supervision visit to adolescent Friendly services at Hospital and Health Centres.	100 health facility reached with supportive supervision visit to adolescent Friendly services at Hospital and Health Centres.
.	200,000 of HIV infected mothers at facility and in community visited for a follow up within a year.	200,000 of HIV infected mothers at facility and in community visited for a follow up within a year.	200,000 of HIV infected mothers at facility and in community visited for a follow up within a year.	200,000 of HIV infected mothers at facility and in community visited for a follow up within a year	200,000 of HIV infected mothers at facility and in community visited for a follow up within a year

8.1.5 COMPONENT: MALARIA CONTROL

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
Reduce malaria parasites transmission by maintaining recommended evidence-based vector control interventions according to the targeted malaria risk strata	A total of 11,256,662 LLINs will be issued to Tanzanians (average 1.8 people per LLIN in eligible areas and 10% buffer).	A total of 11,256,662 LLINs will be issued to Tanzanians (average 1.8 people per LLIN in eligible areas and 10% buffer).	A total of 11,256,662 LLINs will be issued to Tanzanians (average 1.8 people per LLIN in eligible areas and 10% buffer).	A total of 29,316,281 LLINs will be issued to Tanzanians (average 1.8 people per LLIN in eligible areas and 10% buffer).	A total of 29,316,281 LLINs will be issued to Tanzanians (average 1.8 people per LLIN in eligible areas and 10% buffer).
	1,023,333 LLINs will be distributed through targeted mass replacement campaign when required according to accessibility and epidemiological risk	1,023,333 LLINs will be distributed through targeted mass replacement campaign when required according to accessibility and epidemiological risk	1,130,117 LLINs will be distributed through targeted mass replacement campaign when required according to accessibility and epidemiological risk	1,130,117 LLINs will be distributed through targeted mass replacement campaign when required according to accessibility and epidemiological risk	1,130,117 LLINs will be distributed through targeted mass replacement campaign when required according to accessibility and epidemiological risk
	Distribute 4,502,574 LLINs through school net program (SNP) to keep up LLINs coverage in the general population	Distribute 4,502,574 LLINs through school net program (SNP) to keep up LLINs coverage in the general population	Distribute 4,630,136 LLINs through school net program (SNP) to keep up LLINs coverage in the general population	Distribute 4,630,136 LLINs through school net program (SNP) to keep up LLINs coverage in the general population	Distribute 4,630,136 LLINs through school net program (SNP) to keep up LLINs coverage in the general population
	Distribute 4,821,171 LLINs through RCH clinics to target biological vulnerable groups, infants and pregnant women, and to keep up net coverage in the general population	Distribute 4,821,171 LLINs through RCH clinics to target biological vulnerable groups, infants and pregnant women, and to keep up net coverage in the general population	Distribute 5,215,062 LLINs through RCH clinics to target biological vulnerable groups, infants and pregnant women, and to keep up net coverage in the general population	Distribute 5,215,062 LLINs through RCH clinics to target biological vulnerable groups, infants and pregnant women, and to keep up net coverage in the general population	Distribute 5,215,062 LLINs through RCH clinics to target biological vulnerable groups, infants and pregnant women, and to keep up net coverage in the general population

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
	A total of 909,585 LLINs will be distributed through alternative delivery system to special population groups and special situation	A total of 909,585 LLINs will be distributed through alternative delivery system to special population groups and special situation	A total of 1,455,973 LLINs will be distributed through alternative delivery system to special population groups and special situation	A total of 1,455,973 LLINs will be distributed through alternative delivery system to special population groups and special situation	A total of 1,455,973 LLINs will be distributed through alternative delivery system to special population groups and special situation
	Introduce and implement Policy and guidelines to regulate and encourage private sector selling LLINs focusing on net choices (colors, texture and shape) and annual increase of 1.5 million nets	Introduce and implement Policy and guidelines to regulate and encourage private sector selling LLINs focusing on net choices (colors, texture and shape) and annual increase of 1.5 million nets	Introduce and implement Policy and guidelines to regulate and encourage private sector selling LLINs focusing on net choices (colors, texture and shape) and annual increase of 1.5 million nets	Introduce and implement Policy and guidelines to regulate and encourage private sector selling LLINs focusing on net choices (colors, texture and shape) and annual increase of 1.5 million nets	Introduce and implement Policy and guidelines to regulate and encourage private sector selling LLINs focusing on net choices (colors, texture and shape) and annual increase of 1.5 million nets
	A total of 2,091,954 households in 61 high malaria risk councils of the country sprayed with recommended insecticide(s) during the past 12 months	A total of 2,091,954 households in 61 high malaria risk councils of the country sprayed with recommended insecticide(s) during the past 12 months	A total of 3,052,652 households in 61 high malaria risk councils of the country sprayed with recommended insecticide(s) during the past 12 months	A total of 3,052,652 households in 61 high malaria risk councils of the country sprayed with recommended insecticide(s) during the past 12 months	A total of 3,052,652 households in 61 high malaria risk councils of the country sprayed with recommended insecticide(s) during the past 12 months
	Application of focal IRS to cover a 33,000 house structures as a response to residual malaria transmission in the very low malaria risk councils targeting malaria elimination	Application of focal IRS to cover a 50,000 house structures as a response to residual malaria transmission in the very low malaria risk councils targeting	Application of focal IRS to cover a 75,000 house structures as a response to residual malaria transmission in the very low malaria risk councils targeting	Application of focal IRS to cover a 90,000 house structures as a response to residual malaria transmission in the very low malaria risk councils targeting	Application of focal IRS to cover a 100,000 house structures as a response to residual malaria transmission in the very low malaria risk councils targeting malaria

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
		malaria elimination	malaria elimination	malaria elimination	elimination
	A total of 98,362 mosquitoes breeding sites in all 184 councils are targeted to be treated with 840,601 liters of bio larvicides (Bti and Bs) per year	A total of 98,362 mosquitoes breeding sites in all 184 councils are targeted to be treated with 840,601 liters of bio larvicides (Bti and Bs) per year	A total of 98,362 mosquitoes breeding sites in all 184 councils are targeted to be treated with 840,601 liters of bio larvicides (Bti and Bs) per year	A total of 98,362 mosquitoes breeding sites in all 184 councils are targeted to be treated with 840,601 liters of bio larvicides (Bti and Bs) per year	A total of 98,362 mosquitoes breeding sites in all 184 councils are targeted to be treated with 840,601 liters of bio larvicides (Bti and Bs) per year
To prevent the occurrence of mortality related to malaria infection through universal access to appropriate diagnosis and treatment and targeted provision of preventive therapies for vulnerable groups	Perform 31,969,293 malaria tests with high-standard, accessible, affordable, equitable, and quality-assured services for people seeking treatment in the public health sector	Perform 31,969,293 malaria tests with high-standard, accessible, affordable, equitable, and quality-assured services for people seeking treatment in the public health sector	Perform 34,984,079 malaria tests with high-standard, accessible, affordable, equitable, and quality-assured services for people seeking treatment in the public health sector	Perform 34,984,079 malaria tests with high-standard, accessible, affordable, equitable, and quality-assured services for people seeking treatment in the public health sector	Perform 34,984,079 malaria tests with high-standard, accessible, affordable, equitable, and quality-assured services for people seeking treatment in the public health sector
	Annual assessment of over 8,000 health care facilities providing malaria RDT to verify the status of TAQC	Annual assessment of over 8,000 health care facilities providing malaria RDT to verify the status of TAQC	Annual assessment of over 8,000 health care facilities providing malaria RDT to verify the status of TAQC	Annual assessment of over 8,000 health care facilities providing malaria RDT to verify the status of TAQC	Annual assessment of over 8,000 health care facilities providing malaria RDT to verify the status of TAQC
	Biannual assessment of 600 public sector laboratory services for QAQC performances	Biannual assessment of 600 public sector laboratory services for QAQC performances	Biannual assessment of 600 public sector laboratory services for QAQC performances	Biannual assessment of 600 public sector laboratory services for QAQC performances	Biannual assessment of 600 public sector laboratory services for QAQC performances
	Provide 8,799,749 highly efficacious, accessible, affordable, equitable, and quality-assured antimalarial to patients seeking treatment in	Provide 8,799,749 highly efficacious, accessible, affordable, equitable, and quality-assured antimalarial to	Provide 9,022,823 highly efficacious, accessible, affordable, equitable, and quality-assured antimalarial to	Provide 9,022,823 highly efficacious, accessible, affordable, equitable, and quality-assured antimalarial to	Provide 9,022,823 highly efficacious, accessible, affordable, equitable, and quality-assured antimalarial to patients

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
	the public sector	patients seeking treatment in the public sector	patients seeking treatment in the public sector	patients seeking treatment in the public sector	seeking treatment in the public sector
	Provide 5,812,885 accessible, affordable, and quality-assured antimalarial to patients seeking treatment in the private sector	Provide 5,812,885 accessible, affordable, and quality-assured antimalarial to patients seeking treatment in the private sector	Provide 5,937,429 accessible, affordable, and quality-assured antimalarial to patients seeking treatment in the private sector	Provide 5,937,429 accessible, affordable, and quality-assured antimalarial to patients seeking treatment in the private sector	Provide 5,937,429 accessible, affordable, and quality-assured antimalarial to patients seeking treatment in the private sector
	281,030 severe malaria admitted patients will receive high-quality management services by skilled providers in public, private and community services	281,030 severe malaria admitted patients will receive high-quality management services by skilled providers in public, private and community services	254,799 severe malaria admitted patients will receive high-quality management services by skilled providers in public, private and community services	254,799 severe malaria admitted patients will receive high-quality management services by skilled providers in public, private and community services	254,799 severe malaria admitted patients will receive high-quality management services by skilled providers in public, private and community services
	Provide 2,382,475 doses of IPTp3+ and CPT for HIV positive pregnant women in health facilities in low, moderate and high transmission areas to reduce vulnerability in pregnancy	Provide 2,382,475 doses of IPTp3+ and CPT for HIV positive pregnant women in health facilities in low, moderate and high transmission areas to reduce vulnerability in pregnancy	Provide 2,574,659 doses of IPTp3+ and CPT for HIV positive pregnant women in health facilities in low, moderate and high transmission areas to reduce vulnerability in pregnancy	Provide 2,574,659 doses of IPTp3+ and CPT for HIV positive pregnant women in health facilities in low, moderate and high transmission areas to reduce vulnerability in pregnancy	Provide 2,574,659 doses of IPTp3+ and CPT for HIV positive pregnant women in health facilities in low, moderate and high transmission areas to reduce vulnerability in pregnancy
	Provide 2,397,466 of SP for IPTi during vaccination schedule during infancy in high malaria risk areas	Provide 2,397,466 of SP for IPTi during vaccination schedule during infancy in high malaria risk areas	Provide 2,566,673 of SP for IPTi during vaccination schedule during infancy in high malaria risk areas	Provide 2,566,673 of SP for IPTi during vaccination schedule during infancy in high malaria risk areas	Provide 2,566,673 of SP for IPTi during vaccination schedule during infancy in high malaria risk areas

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
	Introduce targeted 1,572,236 antimalarial preventive therapies to identified vulnerable groups within high malaria risk areas	Introduce targeted 1,572,236 antimalarial preventive therapies to identified vulnerable groups within high malaria risk areas	Introduce targeted 2,416,141 antimalarial preventive therapies to identified vulnerable groups within high malaria risk areas	Introduce targeted 2,416,141 antimalarial preventive therapies to identified vulnerable groups within high malaria risk areas	Introduce targeted 2,416,141 antimalarial preventive therapies to identified vulnerable groups within high malaria risk areas
	Passively detect 43,216 cases targeted for follow up, with 216,082 contacts actively tested of which 10,804 are expected to be positive for malaria parasites and treated with an ACT and additional primaquine annually	Passively detect 43,216 cases targeted for follow up, with 216,082 contacts actively tested of which 10,804 are expected to be positive for malaria parasites and treated with an ACT and additional primaquine annually	Passively detect 43,216 cases targeted for follow up, with 216,082 contacts actively tested of which 10,804 are expected to be positive for malaria parasites and treated with an ACT and additional primaquine annually	Passively detect 43,216 cases targeted for follow up, with 216,082 contacts actively tested of which 10,804 are expected to be positive for malaria parasites and treated with an ACT and additional primaquine annually	Passively detect 43,216 cases targeted for follow up, with 216,082 contacts actively tested of which 10,804 are expected to be positive for malaria parasites and treated with an ACT and additional primaquine annually
	170,692 people reached with MDA or TAT services targeted approaches for malaria risk mitigation and burden reduction through focal testing and treatment services and mass drug administration in suitable epidemiological and operational areas annually	170,692 people reached with MDA or TAT services targeted approaches for malaria risk mitigation and burden reduction through focal testing and treatment services and mass drug administration in suitable epidemiological and operational areas annually	170,692 people reached with MDA or TAT services targeted approaches for malaria risk mitigation and burden reduction through focal testing and treatment services and mass drug administration in suitable epidemiological and operational areas annually	170,692 people reached with MDA or TAT services targeted approaches for malaria risk mitigation and burden reduction through focal testing and treatment services and mass drug administration in suitable epidemiological and operational areas annually	170,692 people reached with MDA or TAT services targeted approaches for malaria risk mitigation and burden reduction through focal testing and treatment services and mass drug administration in suitable epidemiological and operational areas annually

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
To provide timely and reliable information on malaria and its control needed to take appropriate actions in different transmission risk and ensure resources are used in the most cost-effective manner	Achieve 22% of councils with very low malaria transmission risk from 20% in 2020	Achieve 25% of councils with very low malaria transmission risk from 20% in 2020	Achieve 35% of councils with very low malaria transmission risk from 20% in 2020	Achieve 50% of councils with very low malaria transmission risk from 20% in 2020	Achieve 75% of councils with very low malaria transmission risk from 20% in 2020
	75% of the health facilities score 75% and above performance on data quality according to MSDQI checklist compared to 65% in 2020	75% of the health facilities score 75% and above performance on data quality according to MSDQI checklist compared to 65% in 2020	85% of the health facilities score 75% and above performance on data quality according to MSDQI checklist compared to 65% in 2020	90% of the health facilities score 75% and above performance on data quality according to MSDQI checklist compared to 65% in 2020	95% of the health facilities score 75% and above performance on data quality according to MSDQI checklist compared to 65% in 2020
	Maintain 100% availability of periodic service delivery and programmatic surveys reports	Maintain 100% availability of periodic service delivery and programmatic surveys reports	Maintain 100% availability of periodic service delivery and programmatic surveys reports	Maintain 100% availability of periodic service delivery and programmatic surveys reports	Maintain 100% availability of periodic service delivery and programmatic surveys reports
	Continuous availability of uninterrupted interactive web-based system providing routine and non-routine malaria information	Continuous availability of uninterrupted interactive web-based system providing routine and non-routine malaria information	Continuous availability of uninterrupted interactive web-based system providing routine and non-routine malaria information	Continuous availability of uninterrupted interactive web-based system providing routine and non-routine malaria information	Continuous availability of uninterrupted interactive web-based system providing routine and non-routine malaria information
Maintain timely availability of safe and quality malaria commodities and supplies at the delivery points.	Procure 27,842,692 blisters of Alu for public and private HFs, vulnerable groups, refugees and special situation to treat uncomplicated malaria	Procure 31,920,165 blisters of Alu annually for public and private HFs, vulnerable groups, refugees and special situation to treat uncomplicated malaria	Procure 31,402,318 blisters of Alu annually for public and private HFs, vulnerable groups, refugees and special situation to treat uncomplicated malaria	Procure 31,402,318 blisters of Alu annually for public and private HFs, vulnerable groups, refugees and special situation to treat uncomplicated malaria	Procure 31,402,318 blisters of Alu annually for public and private HFs, vulnerable groups, refugees and special situation to treat uncomplicated malaria
	Procure 61,661,827 SP tablets for IPTp and IPTi	Procure 72,216,730 SP tablets for IPTp and	Procure 76,220,390 SP tablets for IPTp and	Procure 80,220,390 SP tablets for IPTp and	Procure 85,220,390 SP tablets for IPTp and IPTi

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
		IPTi	IPTi	IPTi	
	Procure 68,381,583 malaria rapid diagnostic tests for public health facilities, vulnerable and special groups, and active case detection	Procure 69,537,570 malaria rapid diagnostic tests for public health facilities, vulnerable and special groups, and active case detection	Procure 73,076,768 malaria rapid diagnostic tests for public health facilities, vulnerable and special groups, and active case detection	Procure 75,381,583 malaria rapid diagnostic tests for public health facilities, vulnerable and special groups, and active case detection	Procure 78,381,583 malaria rapid diagnostic tests for public health facilities, vulnerable and special groups, and active case detection
	Procure 3,118,176 Artesunate injectable vials for severe malaria treatment in the public health facilities	Procure 3,008,871 Artesunate injectable vials for severe malaria treatment in the public health facilities	Procure 2,892,320 Artesunate injectable vials for severe malaria treatment in the public health facilities	Procure 2,892,320 Artesunate injectable vials for severe malaria treatment in the public health facilities	Procure 2,892,320 Artesunate injectable vials for severe malaria treatment in the public health facilities
	Procure 11,256,662 of LLINs	Procure 11,256,662 of LLINs	Procure 12,431,288 of LINs	Procure 12,431,288 of LINs	Procure 12,431,288 of LINs
	Procure 737,712 liters of bio-larvicides (bacillus sphericus and bacillus turigiensis)	Procure 737,712 liters of bio-larvicides (bacillus sphericus and bacillus turigiensis)	Procure 737,713 liters of bio-larvicides (bacillus sphericus and bacillus turigiensis)	Procure 737,713 liters of bio-larvicides (bacillus sphericus and bacillus turigiensis)	Procure 737,713 liters of bio-larvicides (bacillus sphericus and bacillus turigiensis)
	Procure 1.1 million liters of Organophosphate and 0.99 million Kg of Neonicotinoid insecticides for insecticides resistance spraying (IRS)	Procure 1.1 million liters of Organophosphate and 0.99 million Kg of Neonicotinoid insecticides for insecticides resistance spraying (IRS)	Procure 2.13 million liters of Organophosphate and 1.97 million Kg of Neonicotinoid insecticides for insecticides resistance spraying (IRS)	Procure 2.13 million liters of Organophosphate and 1.97 million Kg of Neonicotinoid insecticides for insecticides resistance spraying (IRS)	Procure 2.13 million liters of Organophosphate and 1.97 million Kg of Neonicotinoid insecticides for insecticides resistance spraying (IRS)
	81% of parents/caretakers with children under five years old with fever in the last two weeks seek advice or treatment	81% of parents/caretakers with children under five years old with	85% of parents/caretakers with children under five years old with	By 2028, increase to 90% of parents/caretakers with children under five years old with	95% of parents/caretakers with children under five years old with fever in

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
	increased from 75% in 2017	fever in the last two weeks seek advice or treatment increased from 75% in 2017	fever in the last two weeks seek advice or treatment increased from 75% in 2017	fever in the last two weeks seek advice or treatment increased from 75% in 2017	the last two weeks seek advice or treatment increased from 75% in 2017
	80% of healthcare workers' capacity improved on effectively provision of accurate and relevant information to patients, pregnant women and caretakers of under-five on desired behaviors for malaria prevention and treatment	80% of healthcare workers' capacity improved on effectively provision of accurate and relevant information to patients, pregnant women and caretakers of under-five on desired behaviors for malaria prevention and treatment	85% of healthcare workers' capacity improved on effectively provision of accurate and relevant information to patients, pregnant women and caretakers of under-five on desired behaviors for malaria prevention and treatment	90% of healthcare workers' capacity improved on effectively provision of accurate and relevant information to patients, pregnant women and caretakers of under-five on desired behaviors for malaria prevention and treatment	95% of healthcare workers' capacity improved on effectively provision of accurate and relevant information to patients, pregnant women and caretakers of under-five on desired behaviors for malaria prevention and treatment
	60% of Community Health Workers' (CHWs) capacity increased to effectively provide accurate and relevant malaria information during their interaction with community members	60% of Community Health Workers' (CHWs) capacity increased to effectively provide accurate and relevant malaria information during their interaction with community members	80% of Community Health Workers' (CHWs) capacity increased to effectively provide accurate and relevant malaria information during their interaction with community members	85% of Community Health Workers' (CHWs) capacity increased to effectively provide accurate and relevant malaria information during their interaction with community members	90% of Community Health Workers' (CHWs) capacity increased to effectively provide accurate and relevant malaria information during their interaction with community members

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
	90% of women obtain knowledge on measures to avoid malaria from 87% in 2017 through build on pre-existing high knowledge, reinforce understanding of desired behaviors, and promote action using different approaches and channels e.g. mass media (radio, Television, print, social media) mid media, community mobilization/engagement, use of healthcare providers and malaria message delivery via school health programs	90% of women obtain knowledge on measures to avoid malaria from 87% in 2017 through build on pre-existing high knowledge, reinforce understanding of desired behaviors, and promote action using different approaches and channels e.g. mass media (radio, Television, print, social media) mid media, community mobilization/engagement, use of healthcare providers and malaria message delivery via school health programs	93% of women obtain knowledge on measures to avoid malaria from 87% in 2017 through build on pre-existing high knowledge, reinforce understanding of desired behaviors, and promote action using different approaches and channels e.g. mass media (radio, Television, print, social media) mid media, community mobilization/engagement, use of healthcare providers and malaria message delivery via school health programs	95% of women obtain knowledge on measures to avoid malaria from 87% in 2017 through build on pre-existing high knowledge, reinforce understanding of desired behaviors, and promote action using different approaches and channels e.g. mass media (radio, Television, print, social media) mid media, community mobilization/engagement, use of healthcare providers and malaria message delivery via school health programs	98% of women obtain knowledge on measures to avoid malaria from 87% in 2017 through build on pre-existing high knowledge, reinforce understanding of desired behaviors, and promote action using different approaches and channels e.g. mass media (radio, Television, print, social media) mid media, community mobilization/engagement, use of healthcare providers and malaria message delivery via school health programs
	94% of women aged 15 – 49 years are provided with malaria messages through relevant channels including healthcare providers and SBC outreach programs	94% of women aged 15 – 49 years are provided with malaria messages through relevant channels including healthcare providers and SBC outreach programs	95% of women aged 15 – 49 years are provided with malaria messages through relevant channels including healthcare providers and SBC outreach programs	98% of women aged 15 – 49 years are provided with malaria messages through relevant channels including healthcare providers and SBC outreach programs	100% of women aged 15 – 49 years are provided with malaria messages through relevant channels including healthcare providers and SBC outreach programs
	60% of communities encouraged to utilize and implement community-based malaria control and elimination	60% of communities encouraged to utilize and implement community-based	80% of communities encouraged to utilize and implement community-based	90% of communities encouraged to utilize and implement community-based	95% of communities encouraged to utilize and implement community-based

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
	initiatives	malaria control and elimination initiatives	malaria control and elimination initiatives	malaria control and elimination initiatives	malaria control and elimination initiatives
	40% of private sector companies engaged on investing in malaria (programmatic or financial) for domestic resource mobilization to close the existing funding gap in malaria	40% of private sector companies engaged on investing in malaria (programmatic or financial) for domestic resource mobilization to close the existing funding gap in malaria	50% of private sector companies engaged on investing in malaria (programmatic or financial) for domestic resource mobilization to close the existing funding gap in malaria	55% of private sector companies engaged on investing in malaria (programmatic or financial) for domestic resource mobilization to close the existing funding gap in malaria	60% of private sector companies engaged on investing in malaria (programmatic or financial) for domestic resource mobilization to close the existing funding gap in malaria
	86% of women aged 15 – 49 are reached with malaria campaign messages and materials via seeing or hearing	86% of women aged 15 – 49 are reached with malaria campaign messages and materials via seeing or hearing	88% of women aged 15 – 49 are reached with malaria campaign messages and materials via seeing or hearing	90% of women aged 15 – 49 are reached with malaria campaign messages and materials via seeing or hearing	90% of women aged 15 – 49 are reached with malaria campaign messages and materials via seeing or hearing
	75% of malaria control service delivery mechanisms implemented annually through mobilization of resources, including domestic funding, to sustain the realized achievements and successes gained via engagement with community increase from 63% in 2020	75% of malaria control service delivery mechanisms implemented annually through mobilization of resources, including domestic funding, to sustain the realized achievements and successes gained via engagement with community increase from 63% in 2020	90% of malaria control service delivery mechanisms implemented annually through mobilization of resources, including domestic funding, to sustain the realized achievements and successes gained via engagement with community increase from 63% in 2020	95% of malaria control service delivery mechanisms implemented annually through mobilization of resources, including domestic funding, to sustain the realized achievements and successes gained via engagement with community increase from 63% in 2020	Achieve 100% of malaria control service delivery mechanisms implemented annually through mobilization of resources, including domestic funding, to sustain the realized achievements and successes gained via engagement with community increase from 63% in 2020
	Conduct advocacy to policy and decision-makers to achieve 25% allocation of malaria	Conduct advocacy to policy and decision-makers to achieve 25%	Conduct advocacy to policy and decision-makers to achieve 50%	Conduct advocacy to policy and decision-makers to achieve 60%	Conduct advocacy to policy and decision-makers to achieve 75%

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
	interventions through domestic funding	allocation of malaria interventions through domestic funding	allocation of malaria interventions through domestic funding	allocation of malaria interventions through domestic funding	allocation of malaria interventions through domestic funding
	Cross-border and Multi sectoral action plan with clearly stipulated roles and responsibilities to end malaria developed	Cross-border and multi-sectoral action plan with clearly stipulated roles and responsibilities to end malaria disseminated.	Cross-border and Multi sectoral action plan implemented	Cross-border and Multi sectoral action plan implemented	Cross-border and Multi sectoral action plan implemented

8.1.6 COMPONENT: HIV & AIDS CONTROL

Objectives/Goa	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
To accelerate the reduction of new HIV infections and improve HIV treatment outcomes.	More than ninety-five percent (>95%) of people living with HIV are aware of their HIV status by 2022	More than ninety-five percent (>95%) of people living with HIV are aware of their HIV status by 2023	More than ninety-five percent (>95%) of people living with HIV are aware of their HIV status by 2024	More than ninety-five percent (>95%) of people living with HIV are aware of their HIV status by 2025	More than ninety-five percent (>95%) of people living with HIV are aware of their HIV status by 2026
Impact Area 1 **HIV case finding through differentiated HIV Testing Services**	Hundred Percent (100%) of All Newly Identified PLHIV (Irrespective of HTS Modality) are successfully Linked to HIV Care, Treatment, and Support Services	Hundred Percent (100%) of All Newly Identified PLHIV (Irrespective of HTS Modality) are successfully Linked to HIV Care, Treatment, and Support Services	Hundred Percent (100%) of All Newly Identified PLHIV (Irrespective of HTS Modality) are successfully Linked to HIV Care, Treatment, and Support Services	Hundred Percent (100%) of All Newly Identified PLHIV (Irrespective of HTS Modality) are successfully Linked to HIV Care, Treatment, and Support Services	Hundred Percent (100%) of All Newly Identified PLHIV (Irrespective of HTS Modality) are successfully Linked to HIV Care, Treatment, and Support Services
Impact Area 2: Elimination Of Mother to Child Transmission (MTCT) of New HIV	Reduce Mother to Child HIV Transmission by 4% by 2022() OFNFECTION	Reduce Mother to Child HIV Transmission by 4% by 2023(MTCT) OF NV	Reduce Mother to Child HIV Transmission by 4% by 2024(MTCT) OF NEW HIV	Reduce Mother to Child HIV Transmission by 4% by 2025MTCT) OF NEW HIV	Reduce Mother to Child HIV Transmission by 4% by 2026(MTCT) OF NEW HIV

Objectives/Goa	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
Infection	Over 95% of HIV exposed are tested for HIV within 2 months of age by 2022.	Over 95% of HIV exposed are tested for HIV within 2 months of age by 2023.	Over 95% of HIV exposed are tested for HIV within 2 months of age by 2024.	Over 95% of HIV exposed are tested for HIV within 2 months of age by 2025.	Over 95% of HIV exposed are tested for HIV within 2 months of age by 2026.
Impact Area: 3 **Reduction of New HIV Infections by 95% by 2032**	Ninety-Five Percent (95%) of Key & Vulnerable Population Saturated with A Minimum Package of Vulnerability-Tailored and Client-Cantered Combination Prevention Interventions by 2026	Ninety-Five Percent (95%) of Key & Vulnerable Population Saturated with A Minimum Package of Vulnerability-Tailored and Client-Cantered Combination Prevention Interventions by 2026	Ninety-Five Percent (95%) of Key & Vulnerable Population Saturated with A Minimum Package of Vulnerability-Tailored and Client-Cantered Combination Prevention Interventions by 2026	Ninety-Five Percent (95%) of Key & Vulnerable Population Saturated with A Minimum Package of Vulnerability-Tailored and Client-Cantered Combination Prevention Interventions by 2026	Ninety-Five Percent (95%) of Key & Vulnerable Population Saturated with A Minimum Package of Vulnerability-Tailored and Client-Cantered Combination Prevention Interventions by 2026
	Ninety-Five Percent (95%) of Vulnerable AGYW Saturated with a Minimum Package Evidence-Informed HIV Prevention Interventions by 2025	Ninety-Five Percent (95%) of Vulnerable AGYW Saturated with a Minimum Package Evidence-Informed HIV Prevention Interventions by 2025	Ninety-Five Percent (95%) of Vulnerable AGYW Saturated with a Minimum Package Evidence-Informed HIV Prevention Interventions by 2025	Ninety-Five Percent (95%) of Vulnerable AGYW Saturated with a Minimum Package Evidence-Informed HIV Prevention Interventions by 2025	Ninety-Five Percent (95%) of Vulnerable AGYW Saturated with a Minimum Package Evidence-Informed HIV Prevention Interventions by 2025
	Ninety-Five Percent (95%) of At-Risk General Population Saturated with a Minimum Package Evidence-Informed HIV Prevention Interventions by 2025	Ninety-Five Percent (95%) of At-Risk General Population Saturated with a Minimum Package Evidence-Informed HIV Prevention Interventions by 2025	Ninety-Five Percent (95%) of At-Risk General Population Saturated with a Minimum Package Evidence-Informed HIV Prevention Interventions by 2025	Ninety-Five Percent (95%) of At-Risk General Population Saturated with a Minimum Package Evidence-Informed HIV Prevention Interventions by 2025	Ninety-Five Percent (95%) of At-Risk General Population Saturated with a Minimum Package Evidence-Informed HIV Prevention Interventions by 2025

Objectives/Goa	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
	Ninety-Five Percent (95%) of Females and Males Engaging in Non-Cohabiting Non-Marital Sexual Relationship Reporting Condom Use at Last Sexual Intercourse by 2025	Ninety-Five Percent (95%) of Females and Males Engaging in Non-Cohabiting Non-Marital Sexual Relationship Reporting Condom Use at Last Sexual Intercourse by 2025	Ninety-Five Percent (95%) of Females and Males Engaging in Non-Cohabiting Non-Marital Sexual Relationship Reporting Condom Use at Last Sexual Intercourse by 2025	Ninety-Five Percent (95%) of Females and Males Engaging in Non-Cohabiting Non-Marital Sexual Relationship Reporting Condom Use at Last Sexual Intercourse by 2025	Ninety-Five Percent (95%) of Females and Males Engaging in Non-Cohabiting Non-Marital Sexual Relationship Reporting Condom Use at Last Sexual Intercourse by 2025
	95% of Eligible HIV Negative Populations Receiving HIV Pre-Exposure Prophylaxis (PrEP) by 2025	95% of Eligible HIV Negative Populations Receiving HIV Pre-Exposure Prophylaxis (PrEP) by 2025	95% of Eligible HIV Negative Populations Receiving HIV Pre-Exposure Prophylaxis (PrEP) by 2025	95% of Eligible HIV Negative Populations Receiving HIV Pre-Exposure Prophylaxis (PrEP) by 2025	95% of Eligible HIV Negative Populations Receiving HIV Pre-Exposure Prophylaxis (PrEP) by 2025
	Ninety-Five Percent (95%) Occupationally and Non-Occupationally Exposed HIV Negative Individuals Timely Received HIV Post-Exposure Prophylaxis (PEP) Services to by 2025	Ninety-Five Percent (95%) Occupationally and Non-Occupationally Exposed HIV Negative Individuals Timely Received HIV Post-Exposure Prophylaxis (PEP) Services to by 2025	Ninety-Five Percent (95%) Occupationally and Non-Occupationally Exposed HIV Negative Individuals Timely Received HIV Post-Exposure Prophylaxis (PEP) Services to by 2025	Ninety-Five Percent (95%) Occupationally and Non-Occupationally Exposed HIV Negative Individuals Timely Received HIV Post-Exposure Prophylaxis (PEP) Services to by 2025	Ninety-Five Percent (95%) Occupationally and Non-Occupationally Exposed HIV Negative Individuals Timely Received HIV Post-Exposure Prophylaxis (PEP) Services to by 2025
	Ninety per cent (90%) Male Circumcision rate attained in all regions by 2025	Ninety per cent (90%) Male Circumcision rate attained in all regions by 2025	Ninety per cent (90%) Male Circumcision rate attained in all regions by 2025	Ninety per cent (90%) Male Circumcision rate attained in all regions by 2025	Ninety per cent (90%) Male Circumcision rate attained in all regions by 2025
	Ninety-five (95%) of Syndromically At-Risk Population Syndromically Screened and Treated for STI by 2025	Ninety-five (95%) of Syndromically At-Risk Population Syndromically Screened and Treated for STI by 2025	Ninety-five (95%) of Syndromically At-Risk Population Syndromically Screened and Treated for STI by 2025	Ninety-five (95%) of Syndromically At-Risk Population Syndromically Screened and Treated for STI by 2025	Ninety-five (95%) of Syndromically At-Risk Population Syndromically Screened and Treated for STI by 2025

Objectives/Goa	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
	Hundred Percent (100%) of the donated blood and blood products screened for HIV, Syphilis, and other transfusion-transmitted infections TTIs (e.g., HBV & HCV) as per WHO quality assurance procedures 2025.	Hundred Percent (100%) of the donated blood and blood products screened for HIV, Syphilis, and other transfusion-transmitted infections TTIs (e.g., HBV & HCV) as per WHO quality assurance procedures 2025.	Hundred Percent (100%) of the donated blood and blood products screened for HIV, Syphilis, and other transfusion-transmitted infections TTIs (e.g., HBV & HCV) as per WHO quality assurance procedures 2025.	Hundred Percent (100%) of the donated blood and blood products screened for HIV, Syphilis, and other transfusion-transmitted infections TTIs (e.g., HBV & HCV) as per WHO quality assurance procedures 2025.	Hundred Percent (100%) of the donated blood and blood products screened for HIV, Syphilis, and other transfusion-transmitted infections TTIs (e.g., HBV & HCV) as per WHO quality assurance procedures 2025.
	Comprehensive Knowledge about HIV/AIDS Increased to 95% and Behaviour, Social and Cultural Norms Linked to High Risk of HIV Transmission Improved by 2025	Comprehensive Knowledge about HIV/AIDS Increased to 95% and Behaviour, Social and Cultural Norms Linked to High Risk of HIV Transmission Improved by 2025	Comprehensive Knowledge about HIV/AIDS Increased to 95% and Behavior, Social and Cultural Norms Linked to High Risk of HIV Transmission Improved by 2025	Comprehensive Knowledge about HIV/AIDS Increased to 95% and Behaviour, Social and Cultural Norms Linked to High Risk of HIV Transmission Improved by 2025	Comprehensive Knowledge about HIV/AIDS Increased to 95% and Behaviour, Social and Cultural Norms Linked to High Risk of HIV Transmission Improved by 2025
Impact Area 4: **HIV Care and Treatment Services improved by 2032**	By 2025, over 95% of PLHIV who know their HIV status, enrolled, and retained into ART	By 2025, over 95% of PLHIV who know their HIV status, enrolled, and retained into ART	By 2025, over 95% of PLHIV who know their HIV status, enrolled, and retained into ART	By 2025, over 95% of PLHIV who know their HIV status, enrolled, and retained into ART	By 2025, over 95% of PLHIV who know their HIV status, enrolled, and retained into ART
	Improved Quality of Care for PLHIV, including sustaining >95% Viral suppression among PLHIVs on ART from 2021 onwards	Improved Quality of Care for PLHIV, including sustaining >95% Viral suppression among PLHIVs on ART from 2021 onwards	Improved Quality of Care for PLHIV, including sustaining >95% Viral suppression among PLHIVs on ART from 2021 onwards	Improved Quality of Care for PLHIV, including sustaining >95% Viral suppression among PLHIVs on ART from 2021 onwards	Improved Quality of Care for PLHIV, including sustaining >95% Viral suppression among PLHIVs on ART from 2021 onwards

Objectives/Goa	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
	Over 95% of HIV positive children are enrolled and retained on ART, and over 95% are virally suppressed by 2025	Over 95% of HIV positive children are enrolled and retained on ART, and over 95% are virally suppressed by 2025	Over 95% of HIV positive children are enrolled and retained on ART, and over 95% are virally suppressed by 2025	Over 95% of HIV positive children are enrolled and retained on ART, and over 95% are virally suppressed by 2025	Over 95% of HIV positive children are enrolled and retained on ART, and over 95% are virally suppressed by 2025
	Over 95% of adolescents are enrolled and retained on ART, and over 95% are virally suppressed by 2025	Over 95% of adolescents are enrolled and retained on ART, and over 95% are virally suppressed by 2025	Over 95% of adolescents are enrolled and retained on ART, and over 95% are virally suppressed by 2025	Over 95% of adolescents are enrolled and retained on ART, and over 95% are virally suppressed by 2025	Over 95% of adolescents are enrolled and retained on ART, and over 95% are virally suppressed by 2025
	Over 95% of pregnant and breasting women are enrolled and retained in ART and over 95% are virally suppressed by 2022, onwards	Over 95% of pregnant and breasting women are enrolled and retained in ART and over 95% are virally suppressed by 2022, onwards	Over 95% of pregnant and breasting women are enrolled and retained in ART and over 95% are virally suppressed by 2022, onwards	Over 95% of pregnant and breasting women are enrolled and retained in ART and over 95% are virally suppressed by 2022, onwards	Over 95% of pregnant and breasting women are enrolled and retained in ART and over 95% are virally suppressed by 2022, onwards
	Over 90% of PLHIV received TB Preventive Therapy (TPT), and 95% of HIV/ TB co infected clients initiated and maintained on ART, all by 2025	Over 90% of PLHIV received TB Preventive Therapy (TPT), and 95% of HIV/ TB co infected clients initiated and maintained on ART, all by 2025	Over 90% of PLHIV received TB Preventive Therapy (TPT), and 95% of HIV/ TB co infected clients initiated and maintained on ART, all by 2025	Over 90% of PLHIV received TB Preventive Therapy (TPT), and 95% of HIV/ TB co infected clients initiated and maintained on ART, all by 2025	Over 90% of PLHIV received TB Preventive Therapy (TPT), and 95% of HIV/ TB co infected clients initiated and maintained on ART, all by 2025
	Ninety percent (90%) of PLHIV at risk linked to other integrated health services (NCDs, Cervical Cancer, Hepatitis, and STIs) by 2025	Ninety percent (90%) of PLHIV at risk linked to other integrated health services (NCDs, Cervical Cancer, Hepatitis, and STIs) by 2025	Ninety percent (90%) of PLHIV at risk linked to other integrated health services (NCDs, Cervical Cancer, Hepatitis, and STIs) by 2025	Ninety percent (90%) of PLHIV at risk linked to other integrated health services (NCDs, Cervical Cancer, Hepatitis, and STIs) by 2025	Ninety percent (90%) of PLHIV at risk linked to other integrated health services (NCDs, Cervical Cancer, Hepatitis, and STIs) by 2025

Objectives/Goa	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
Impact Area 5: **Resilient and Sustainable Systems by 2032**	Improved supply chain system that ensures 100% of HIV commodities are available in health facilities at all times	Improved supply chain system that ensures 100% of HIV commodities are available in health facilities at all times	Improved supply chain system that ensures 100% of HIV commodities are available in health facilities at all times	Improved supply chain system that ensures 100% of HIV commodities are available in health facilities at all times	Improved supply chain system that ensures 100% of HIV commodities are available in health facilities at all times
	All (100%) of HIV care and treatment facilities prescribed and dispensed ARVs and OIs according to national guidelines by 2025	All (100%) of HIV care and treatment facilities prescribed and dispensed ARVs and OIs according to national guidelines by 2025	All (100%) of HIV care and treatment facilities prescribed and dispensed ARVs and OIs according to national guidelines by 2025	All (100%) of HIV care and treatment facilities prescribed and dispensed ARVs and OIs according to national guidelines by 2025	All (100%) of HIV care and treatment facilities prescribed and dispensed ARVs and OIs according to national guidelines by 2025
	Minimal (<5%) report of expiries and wastage resulting from improved governance, leadership and accountability in supply chain management at all levels.	Minimal (<5%) report of expiries and wastage resulting from improved governance, leadership and accountability in supply chain management at all levels.	Minimal (<5%) report of expiries and wastage resulting from improved governance, leadership and accountability in supply chain management at all levels.	Minimal (<5%) report of expiries and wastage resulting from improved governance, leadership and accountability in supply chain management at all levels.	Minimal (<5%) report of expiries and wastage resulting from improved governance, leadership and accountability in supply chain management at all levels.
	Improved and resilient Quality Management System implemented at all POCT and laboratories to support HIV services at all health care levels by 2026	Improved and resilient Quality Management System implemented at all POCT and laboratories to support HIV services at all health care levels by 2026	Improved and resilient Quality Management System implemented at all POCT and laboratories to support HIV services at all health care levels by 2026	Improved and resilient Quality Management System implemented at all POCT and laboratories to support HIV services at all health care levels by 2026	Improved and resilient Quality Management System implemented at all POCT and laboratories to support HIV services at all health care levels by 2026

Objectives/Goa	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
	By 2022, 100% of health facilities complete and submit monthly reports on time.	By 2023, 100% of health facilities complete and submit monthly reports on time.	By 2024, 100% of health facilities complete and submit monthly reports on time.	By 2025, 100% of health facilities complete and submit monthly reports on time.	By 2026, 100% of health facilities complete and submit monthly reports on time.

8.1.7 COMPONENT: TUBERCULOSIS & LEPROSY CONTROL

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
To increase TB treatment coverage from 53% in 2018 to 90% in 2032by innovatively addressing barriers to access, utilization and the needs of the key and vulnerable populations for TB care and prevention services.	Review and update QI toolkit and training package (including management of KVP, most at-risk population, and Comorbidities) for health care workers	Introduce Active Case Finding (ACF) and QI model in newly constructed hospitals and health centers in all councils	Sensitize health Managers and facility teams on ACF using QI toolkit in newly constructed hospitals and health centers	Refresher training to TB Focal persons in newly constructed hospitals and health centers	Identify and capacitate 2 District TB mentors (HF TB champions) with mentorship and supportive supervisions skills in all councils.
	Sensitize prisons authorities to obtain their full support on TB control activities in all regions	Conduct systematic TB screening and management among remands and inmates in 189 councils (Train HCWs in prisons, screening)	Minor repairs of health facilities in prisons in selected regions and districts	Supervise and Monitor TB services in prisons in all regions	Support coordination to prison department to monitor and supervise TB services in the prison countrywide (Provide transport/car and other costs.
	100% of First line TB drugs will be Procured and Distributed	100% of First line TB drugs will be Procured and Distributed	100% of First line TB drugs will be Procured and Distributed	100% of First line TB drugs will be Procured and Distributed	100% of First line TB drugs will be Procured and Distributed

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
	Print and distribute community-Based TB. DR TB, TB/HIV guide, orientation package, CHV handbook, and M&E tools in all councils	Conduct orientation sessions among community TB service providers including CHWs and ex-TB patients on a new comprehensive community TB guideline in 186 councils	Support CHWs and Ex-TB Volunteers to implement community-based TB interventions and outreach services (including incentive & enablers	Support Motorcycle riders (BODABODA) for TB to transport sputum specimen from lower HFs to GeneXpert sites and bring back feedback results in all councils	Conduct yearly TB screening among traditional healers and their clients in all councils
To expand access to quality TB diagnostic services, including the adoption of new diagnostic technologies.	Develop and disseminate national TB Laboratory Strategic Plan	Provide bi-annual technical assistance to zonal TB laboratories	Perform periodic preventive maintenance, repair, and calibration for all TB laboratory equipment	Sensitize regional HCWs on the availability and use of TB diagnostic tests	Conduct refresher training in TB diagnostics GeneXpert users in 336 health facilities
	100% Procure and distribute TB laboratory equipment, commodities and supplies	100% Procure and distribute TB laboratory equipment, commodities and supplies	100% Procure and distribute TB laboratory equipment, commodities and supplies	100% Procure and distribute TB laboratory equipment, commodities and supplies	100% Procure and distribute TB laboratory equipment, commodities and supplies
	Procure at least 2 GeneXpert machines to each council in the country.	Connect, maintain and update GeneXpert machines to electronic information systems for example GX-alert and DHIS2- ETL	To support the linkage (interoperability) Gx Alert with electronic information systems. DHIS2/ETL, eSRS, GoTHOMIS etc)	Conduct Quarterly Supportive supervisions for AFB smear microscopy and GeneXpert sites	Conduct workshop with System provider consultant to upgrade GxAlert system
To increase RR/MDR-TB cases detected and	100% of Anti-tuberculosis second-line medicines are	100% of Anti-tuberculosis second-line medicines are	100% of Anti-tuberculosis second- line	100% of Anti-tuberculosis second- line medicines are Procured	100% of Anti-tuberculosis second- line medicines are Procured

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
enrolled for treatment from 54 percent to 90 percent of the estimated TB cases among the notified by 2025.	Procured	Procured	medicines are Procured		
	Train HCWs on Programmatic management of Drug Resistance TB (PMDT	Support TB coordinators and DOT providers to conduct contact investigation for all confirmed RR/MDR- TB cases	Conduct targeted Supportive supervisions and mentorship on MDR- TB management in all councils	To conduct follow up contacts investigations for MDR Patients on treatment across country	Conduct quarterly cohort review in 5 zones
	Procure 5 special MDR TB ambulances for zonal MDR TB initiating centres to strengthen and facilitate referral of MDR TB patients	Support referral and transportation of MDR-TB patients with special needs to and from the zonal treatment centers	To conduct assessment of health facilities capacity to provide MDR-TB services	To support 100 DOT providers to conduct contact investigation for all confirmed RR TB cases	To Support TB coordinators and DOT providers to conduct contact investigation for all confirmed RR/MDR-TB cases
To strengthen TB services to population of miners and their families by 2025.	Conduct sensitization meeting with mining owners, managers, unions, NGOs, CBOs and stakeholders	Conduct TB screening to mineworkers and surrounding communities in 40 councils	Conduct TB and TB/HIV outreach services using mobile van in 30 mining areas.	Develop digital technology platform to Monitor TB treatment adherence in mining communities	Orient mining owners, managers and stakeholders on updated dust control tool kit.
	Print and distribute IEC materials targeting cross border communities	Conduct orientation to MO i/c, Clinicians, DOT providers from health facilities on cross border TB initiatives to 60 councils	Training of the local CSOs to implement TB CBI to 30 councils	Support TB awareness campaigns and community mobilization to enhance health seeking behavior among border communities	Facilitate quarterly interfacilities cross border coordination meetings
To reduce leprosy prevalence in all endemic councils by 2025	Develop and distribute leprosy elimination interventions' package for endemic councils	Support councils to conduct targeted campaign in selected endemic area and	Conduct planning meeting for elimination activities in	Develop IEC materials for leprosy elimination activities in endemic districts	Training health workers on leprosy in districts with elimination activities

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
		hot spots	endemic districts		
	To Conduct visit to assess capability of rehabilitation centers	To facilitate transportation expenses and allowances for 200 patients who receive specialized rehabilitative care in 20 councils	Procure and distribute 400 special footwear and repair materials, prosthesis and other assistive devices for PALs	Procure and distribute 1000 special shoe making materials, Prostheses and other appliances.	To Develop training manual on self-care
	Develop PEP field manual and SOPs, data collection, monitoring checklist and reporting tools	Support training of HFs HW to scale up of household contact screening and PEP in endemic councils	Support 300 CHVs to conduct household contact screening and provision of SDR during scale up of targeted PEP in endemic councils	Support region and council technical officer to conduct SS and mentorship to HFs to implementing PEP	Sensitize community leaders, CHVs and PALs, committees, in endemic councils
	Develop Leprosy training and community advocacy/information packages for frontline health care providers and affected communities	Conduct leprosy training sessions to frontline care providers especially in 15 endemic councils	Conduct 2 consultative forums and strategic dialogues for resource mobilization	Support councils to conduct targeted campaigns in selected endemic area and hot spots	To train160 Journalists in community mobilization and advocacy activities for TB services
To ensure availability of supportive systems and strengthened Program management and coordination for the implementation of TB and Leprosy	To procure 5 motor vehicles and 200 motorcycles for central, regions and districts level	To maintain motor vehicles and motorcycle for programme coordination at all levels	To conduct supportive supervision at District level and health facilities level	To develop proposal for resource mobilization in all councils	
	Develop Strategic Plan and associated documents for	Support in cooperation of TB and leprosy	Conduct advocacy meetings with the local government	Review and develop NTLP annual plan (AP) and Plan of action (POA)	To Conduct Annual NTLP Meeting

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
Services by 2032	Tuberculosis and leprosy control	activities into CCHP and DHFF.	authorities		
	Support Parliamentary Standing Committee on HIV, TB and Drug Abuse activities	Support Parliamentary TB Caucus operation biannual operation forums	Advocate and Sensitize political leaders on TB and leprosy budget	Conduct sensitization meeting with newly selected councilors and parliamentarians on various key on TB control	Conduct orientation sessions to high level Religious leaders and TB caucus members on TB control
	To Conduct Sensitization meeting to owners of ADDOs, retail pharmacies and private laboratories on TB services in 10 regions	To Conduct orientation to ADDOs dispensers on TB symptoms, sputum collection and referral system	Procure and distribute cooler boxes to facilitate sputum samples storage from ADDOs and Traditional healers	Conduct quarterly supportive supervision and mentorship to regions with ADDOs and Traditional Healers engaged in TB case detection	To Facilitate referral and linkage between Ex TB Volunteers and ADDO dispensers and traditional healers in the country
To ensure implementation of evidence-based interventions and decision making through institutionalized efficient M&E system and coordination of research by 2032	To Integrate community and TPT monitoring tools with DHIS2-ETL system	To Conduct workshops to review and validate the upgrades in DHIS2-ETL	To Orient National, Regional and District TB and Leprosy Coordinators on the updated DHIS2-ETL	To Procure 500 computers and accessories for data management in DHIS2-ETL enrolment	To Develop video and audio tutorial on DHIS2-ETL use for coordinators and HCWs at all levels
	Revise and Print routine data management guidelines including quality assurance guidelines and checklist to accommodate DHIS2-ETL system	To Conduct routine data quality assessment to regions, districts and health facilities	To Conduct TB inventory study to measure TB under-reporting in all councils	To Conduct ToT training on data analysis and usage using the DHIS2-ETL dashboard	To Conduct data analysis and usage training to HCWs using DHIS2-ETL dashboard
	Disseminate the operational research agenda to national and subnational staff and	Training staff at central, regional and districts levels on research	To Support staff and graduate students to conduct operational	Conduct training to RTLCs & DTLCs on country specific research priorities based on	To Develop mechanisms, milestones and indictors for ongoing M&E of the

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
	other stakeholders	methodology	researches on TB and leprosy	current TB epidemic	implementation of the TB research plan in the country.

8.1.8 COMPONENT: NON COMMUNICABLE DISEASES

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
To capacitate NCD prevention and health promotion approaches targeting all modifiable risk factors (Alcohol, Tobacco, Nutrition physical inactivity and environmental) and other social determinant strengthened by 2032	Harmonizing and develop training material for all NCDs	Harmonizing and develop training material for all NCDs			
	Training 3,000 health care providers on NCD's	Training 3,000 health care providers on NCD's	Training 3,000 health care providers on NCD's	Training 3,000 health care providers on NCD's	Training 3,000 health care providers on NCD's
	Promote 20,000 Community awareness on modifiable risk factors	Promote 20,000 Community awareness on modifiable risk factors	Promote 20,000 Community awareness on modifiable risk factors	Promote 20,000 Community awareness on modifiable risk factors	Promote 20,000 Community awareness on modifiable risk factors
	Laws/bylaws enforcement	Laws/bylaws enforcement	Laws/bylaws enforcement	Laws/bylaws enforcement	Laws/bylaws enforcement
2.To Improve NCD services by strengthened infrastructure, Human resource for health, finance, Health delivery system, HMIS and Medicine and medical supplies by 2032	Integration of NCD's into 15 district hospitals with existing health system	Integration of NCD's into 15 district hospitals with existing health system	Integration of NCD's into 15 district hospitals with existing health system	Integration of NCD's into 15district hospitals with existing health system	Integration of NCD's into 15 district hospitals with existing health system
	Strengthened NCD's infrastructure, in to 15 district hospitals	Strengthened NCD's infrastructure, in to 15 district hospitals	Strengthened NCD's infrastructure, in to 15 district hospitals	Strengthened NCD's infrastructure, in to 15 district hospitals	Strengthened NCD's infrastructure, in to 15 district hospitals

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
	Strengthened health financing in to 15 district hospitals	Strengthened health financing in to 15 district hospitals	Strengthened health financing in to 15 district hospitals	Strengthened health financing in to 15 district hospitals	Strengthened health financing in to 15 district hospitals
	Strengthened NCD's health delivery System in to 15 district hospitals	Strengthened NCD's health delivery System in to 15 district hospitals	Strengthened NCD's health delivery System in to 15 district hospitals	Strengthened NCD's health delivery System in to 15 district hospitals	Strengthened NCD's health delivery System in to 15 district hospitals
	Strengthened supply chain of NCD's medicine and medical supplies in to 15 district hospitals	Strengthened supply chain of NCD's medicine and medical supplies in to 15 district hospitals	Strengthened supply chain of NCD's medicine and medical supplies in to 15 district hospitals	Strengthened supply chain of NCD's medicine and medical supplies in to 15 district hospitals	Strengthened supply chain of NCD's medicine and medical supplies in to 15 district hospitals
3.To Improve Mental Health services by strengthened infrastructure, Human resource for health, finance, Health delivery system, HMIS and Medicine and medical supplies by 2032	Strengthened Mental Health infrastructure in to 10 district hospitals	Strengthened Mental Health infrastructure in to 1 0 district hospitals	Strengthened Mental Health infrastructure in to 10 district hospitals	Strengthened Mental Health infrastructure in to 10 district hospitals	Strengthened Mental Health infrastructure in to 10 district hospitals
	Strengthened mental health financing in to 10 district hospitals	Strengthened mental health financing in to 10 district hospitals	Strengthened mental health financing in to 10 district hospitals	Strengthened mental health financing in to 10 district hospitals	Strengthened mental health financing in to 10 district hospitals
	Strengthened mental health delivery System in to 10 district hospitals	Strengthened mental health delivery System in to 10 district hospitals	Strengthened mental health delivery System in to 10 district hospitals	Strengthened mental health delivery System in to 10 district hospitals	Strengthened mental health delivery System in to 10 district hospitals
	Strengthened supply chain of mental health medicine and medical supplies in to 10 district hospitals	Strengthened supply chain of mental health medicine and medical supplies in to 10 district hospitals	Strengthened supply chain of mental health medicine and medical supplies in to 10 district hospitals	Strengthened supply chain of mental health medicine and medical supplies in to 10 district hospitals	Strengthened supply chain of mental health medicine and medical supplies in to 10 district hospitals

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
4. To review, 10 develop and disseminate strategic plan for Mental Health, SOPs, Guidelines and legal documents	Review and develop strategic plan and National Mental Health Policy Guideline	Review and develop National Alcohol Guideline and Standard Operating Procedure for Mental Health Policy	Review Mental Health Act No .21 of 2008 and regulation	Develop National Mental Health Guideline and Standard Operating Procedure	Review Alcohol Act and Tobacco Act
5.To enhance HMIS to accommodate NCD indicators by 2032	develop NCD's indicators and customize in DHIS and HMIS	develop NCD's indicators and customize in DHIS and HMIS	develop NCD's indicators and customize in DHIS and HMIS	develop NCD's indicators and customize in DHIS and HMIS	develop NCD's indicators and customize in DHIS and HMIS
	review and develop data collection tools and customize to the DHIS2 system	review and develop data collection tools and customize to the DHIS2 system	review and develop data collection tools and customize to the DHIS2 system	review and develop data collection tools and customize to the DHIS2 system	review and develop data collection tools and customize to the DHIS2 system

8.1.9 COMPONENT: ORAL HEALTH SERVICES

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
Improve availability of qualified and competent District Dental Officers from 21% to 100% by June 2025	Qualified DDOs (With Doctor of Dental Surgery Degree) increased from current 21 to 50 % by June 2023	Qualified DDOs (With Doctor of Dental Surgery Degree) increased from 50 % to 70% by June 2025	Qualified DDOs (With Doctor of Dental Surgery Degree) increased from 70 % to 80% by June 2026	Qualified DDOs (With Doctor of Dental Surgery Degree) increased from 80 % to 90% by June 2028	Qualified DDOs (With Doctor of Dental Surgery Degree) increased from 70 % to 100% by June 2032
Improve availability of qualified and competent oral health professionals in Primary Health Care from 25% to 100% by June 2032	Pre- service trainees of Dental therapist increased from 25% to 30% by June 2023	Pre- service trainees of Dental therapist increased from 30% to 50% by June 2025	Pre- service trainees of Dental therapist increased from 50%to 70% by June 2026	Pre- service trainees of Dental therapist increased from 70% to 90% by June 2028	Pre- service trainees of Dental therapist increased from 90% to 100% by June 2032
	103 Council Hospitals manned with Dental Surgeon to provide oral health services by June 2024	120 Council Hospitals manned with Dental Surgeon to provide oral health services by June 2026	150 Council Hospitals manned with Dental Surgeon to provide oral health services	170 Council Hospitals manned with Dental Surgeon to provide oral health services	184 Council Hospitals manned with Dental Surgeon to provide oral health services by June 2032

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
	103 Council Hospitals manned with Dental Therapist to provide oral health services by June 2024	120 Council Hospitals manned with Dental Therapist to provide oral health services by June 2026	150 Council Hospitals manned with Dental Therapist to provide oral health services by June 2024	170 Council Hospitals manned with Dental Therapist to provide oral health services by June 2024	184 Council Hospitals manned with Dental Therapist to provide oral health services by June 2024
	184 Strategic health centers manned with Dental therapist to provide oral health services by June 2023	184 Strategic health centers manned with Dental therapist to provide oral health services by June 2025	100 Strategic health centers manned with Dental therapist to provide oral health services by June 2027	100 Strategic health centers manned with Dental therapist to provide oral health services by June 2029	100 Strategic health centers manned with Dental therapist to provide oral health services by June 2031
			123 Strategic Dispensaries manned with Dental therapist to provide oral health services by June 2027	123 Strategic Dispensaries manned with Dental therapist to provide oral health services by June 2029	122 Strategic Dispensaries manned with Dental therapist to provide oral health services by June 2031
	Develop Curriculum for training of Dental Nurses	92 District hospitals practice four handed Dentistry by June 2026	92 District hospitals practice four handed Dentistry by June 2028	150 District hospitals practice four handed Dentistry by June 2028	184 District hospitals practice four handed Dentistry by June 2032
	Develop Mini Curriculum for the orientation of Non-Dental Clinician in Primary Health Care Facilities	5792 Clinician in Dispensaries and Health Centers oriented on diagnosis, pain alleviation and referral for oral diseases and conditions by June 2025	4792 Clinician in Dispensaries and Health Centers oriented on diagnosis, pain alleviation and referral for oral diseases and conditions	4792 Clinician in Dispensaries and Health Centers oriented on diagnosis, pain alleviation and referral for oral diseases and conditions	5792 Clinician in Dispensaries and Health Centers oriented on diagnosis, pain alleviation and referral for oral diseases and conditions
Appropriate and uninterrupted promotive, preventive, curative, rehabilitative	5 years Costed Oral Health Strategic plan 2022-2027 prepared by June 2023	Oral health policy guideline 2025-2030 prepared by June 2025	5 years Costed Oral Health Strategic plan 2028-2033 prepared by June 2028	Oral health policy guideline 2031-2036 prepared by June 2030	Orient Health care works on Oral health policy guideline 2032

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
and corrective quality oral health services in Primary health Care facilities provided by June 2032	Clinical and managerial Supportive supervision visit to 184 councils conducted quarterly per year	Clinical and managerial Supportive supervision visit to 184 councils conducted quarterly per year	Clinical and managerial Supportive supervision visit to 184 councils conducted quarterly per year	Clinical and managerial Supportive supervision visit to 184 councils conducted quarterly per year	Clinical and managerial Supportive supervision visit to 184 councils conducted quarterly per year
	Annual Regional Dental Officers meeting conducted every year	Annual Regional Dental Officers meeting conducted every year	Annual Regional Dental Officers meeting conducted every year	Annual Regional Dental Officers meeting conducted every year	Annual Regional Dental Officers meeting conducted every year
	184 Strategic Health Centres equipped with essential dental equipment in the provision of oral health care by June 2023	184 Strategic Health Centres equipped with essential dental equipment in the provision of oral health care by June 2025	100 Strategic Health Centres equipped with essential dental equipment in the provision of oral health care by June 2027	100 Strategic Health Centres equipped with essential dental equipment in the provision of oral health care by June 2029	100 Strategic Health Centres equipped with essential dental equipment in the provision of oral health care by June 3032
	103 Councils Hospitals equipped with essential dental equipment in the provision of oral health care by June 2024	27Councils Hospitals equipped with essential dental equipment in the provision of oral health care by June 2026	25 Councils Hospitals equipped with essential dental equipment in the provision of oral health care by June 2028	15 Councils Hospitals equipped with essential dental equipment in the provision of oral health care by June 2030	14 Councils Hospitals equipped with essential dental equipment in the provision of oral health care by June 2032
			123 Strategic Dispensaries equipped with essential dental equipment in the provision of oral health care by June 2027	123 Strategic Dispensaries equipped with essential dental equipment in the provision of oral health care by June 2029	120 Strategic Dispensaries equipped with essential dental equipment in the provision of oral health care by June 3032

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
	Planned preventive maintenance of Dental equipment in 184 Councils conducted	Planned preventive maintenance of Dental equipment in 184 Councils conducted	Planned preventive maintenance of Dental equipment in 184 Councils conducted	Planned preventive maintenance of Dental equipment in 184 Councils conducted	Planned preventive maintenance of Dental equipment in 184 Councils conducted
	Oral health commodities for Primary health care facilities in 184 Councils procured	Oral health commodities for Primary health care facilities in 184 Councils procured	Oral health commodities for Primary health care facilities in 184 Councils procured	Oral health commodities for Primary health care facilities in 184 Councils procured	Oral health commodities for Primary health care facilities in 184 Councils procured
	65 Dental building in Council Hospitals constructed by June 2024	65 Dental building in Council Hospitals constructed by June 2026	24 Dental building in Council Hospitals constructed by June 2028	15 Dental building in Council Hospitals constructed by June 2030	15 Dental building in Council Hospitals constructed by June 2032
	60 Dental building in District Hospitals renovated by June 2024				
Routine and appropriate oral health education and promotion in clinics, RCH clinics, ordinary primary schools, primary schools for children with special needs provided by June 2032	Guideline for the provision of oral health education to RCH clinics printed and disseminated to 50% of RCH staff in primary health care facilities by June 2024	Guideline for the provision of oral health education printed and disseminated to 50% of RCH staff in primary health care facilities by June 2026	Continue dissemination of the guideline	Continue dissemination of the guideline	Continue dissemination of the guideline
	Guideline for the provision of School Based Oral health education printed and disseminated to 50% of Primary School teachers by June 2024	Guideline for the provision of School Based Oral health education printed and disseminated to 50% of Primary School teachers by June 2026	Continue dissemination of the guideline	Continue dissemination of the guideline	Continue dissemination of the guideline
	Backstopping in the provision of routine School based and RCH	Backstopping in the provision of routine School based and RCH	Backstopping in the provision of routine School based and	Backstopping in the provision of routine School based and	Backstopping in the provision of routine School based and

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
	Oral Health Education program in 184 conducted by Councils Oral health personnel quarterly in each year	Oral Health Education program in 184 conducted by Councils Oral health personnel quarterly in each year	RCH Oral Health Education program in 184 conducted by RHMT and Councils Oral health personnel quarterly in each year	RCH Oral Health Education program in 184 conducted by RHMT and Councils Oral health personnel quarterly in each year	RCH Oral Health Education program in 184 conducted by RHMT and Councils Oral health personnel quarterly in each year

8.1.10 COMPONENT: NUTRITION SERVICES

Objective	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
1. To Strengthen nutrition commodities supply chain for service delivery (specialize nutritious foods, local production and anthropometric equipment's)	Conduct biannual stakeholders' (MSD, RCHS, MoH - NS and PSU, PO RALG) meetings to streamline procurement and distribution of nutrition commodities	Conduct biannual stakeholders' (MSD, RCHS, MoH - NS and PSU, PO RALG) meetings to streamline procurement and distribution of nutrition commodities	Conduct biannual stakeholders' (MSD, RCHS, MoH - NS and PSU, PO RALG) meetings to streamline procurement and distribution of nutrition commodities	Conduct biannual stakeholders' (MSD, RCHS, MoH - NS and PSU, PO RALG) meetings to streamline procurement and distribution of nutrition commodities	Conduct biannual stakeholders' (MSD, RCHS, MoH - NS and PSU, PO RALG) meetings to streamline procurement and distribution of nutrition commodities
	Conduct annual stakeholders meeting of 26 regions to assess the feasibility of producing the nutrition commodities and supplies	Establishment of Regional electrolyte compounding unit for local production of nutrition therapeutic milk	Scaling up of Regional electrolyte compounding unit for local production of nutrition therapeutic milk	Scaling up of Regional electrolyte compounding unit for local production of nutrition therapeutic milk	Scaling up of Regional electrolyte compounding unit for local production of nutrition therapeutic milk
	Develop/ review guidelines and standards for production of nutrition commodities and supplies	Develop/ review & disseminate guidelines and standards for production of nutrition commodities and supplies	Develop/ review & disseminate guidelines and standards for production of nutrition commodities	Develop/ review & disseminate guidelines and standards for production of nutrition commodities and supplies	Develop/ review & disseminate guidelines and standards for production of nutrition commodities

Objective	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
			and supplies		and supplies
	Conduct quarterly supportive supervision, mentorship and couching to health facilities to assess management of nutrition commodities and supplies	Conduct quarterly supportive supervision, mentorship and couching to health facilities to assess management of nutrition commodities and supplies	Conduct quarterly supportive supervision, mentorship and couching to health facilities to assess management of nutrition commodities and supplies	Conduct quarterly supportive supervision, mentorship and couching to health facilities to assess management of nutrition commodities and supplies	Conduct quarterly supportive supervision, mentorship and couching to health facilities to assess management of nutrition commodities and supplies
	To procure and distribute equipment and tools for nutrition assessment and Village Health and Nutrition Days (e.g., weighing scales, and height boards, MUAC, skin-fold callipers, bio-electrical impedance, in indirect calorimetry, Dexa machines	To procure and distribute equipment and tools for nutrition assessment and Village Health and Nutrition Days (e.g., weighing scales, and height boards, MUAC, skin-fold callipers, bio-electrical impedance, indirect calorimetry, Dexa machines	To procure and distribute equipment and tools for nutrition assessment and Village Health and Nutrition Days (e.g., weighing scales, and height boards, MUAC, skin-fold callipers, bio-electrical impedance, indirect calorimetric, Dexa machines	To procure and distribute equipment and tools for nutrition assessment and Village Health and Nutrition Days (e.g., weighing scales, and height boards, MUAC, skin-fold callipers, bio-electrical impedance, indirect calorimetry, Dexa machines	To procure and distribute equipment and tools for nutrition assessment and Village Health and Nutrition Days (e.g., weighing scales, and height boards, MUAC, skin-fold callipers, bio-electrical impedance, indirect calorimetry, Dexa machines
	To procure nutrition-related commodities (enteral and parenteral feeds, e.g., free amino acids IV, fatty acids IV) for management of DRNCDs and chronic disease	To procure nutrition-related commodities (enteral and parenteral feeds, e.g., free amino acids IV, fatty acids IV) for management of DRNCDs and chronic disease	To procure nutrition-related commodities (enteral and parenteral feeds, e.g., free amino acids IV, fatty acids IV) for management of DRNCDs and chronic disease	To procure nutrition-related commodities (enteral and parenteral feeds, e.g., free amino acids IV, fatty acids IV) for management of DRNCDs and chronic disease	To procure nutrition-related commodities (enteral and parenteral feeds, e.g., free amino acids IV, fatty acids IV) for management of DRNCDs and chronic disease
	To conduct advocacy meeting for inclusion of nutrition	To conduct advocacy meeting for inclusion of nutrition commodities	To conduct advocacy meeting for inclusion of nutrition	To conduct advocacy meeting for inclusion of nutrition commodities	To conduct advocacy meeting for inclusion of nutrition

Objective	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
	commodities into national health insurance scheme	into national health insurance scheme	commodities into national health insurance scheme	into national health insurance scheme	commodities into national health insurance scheme
	Procure annual stock and distribute micronutrient commodities – to health facilities and school programs	Procure annual stock and distribute micronutrient commodities – to health facilities and school programs	Procure annual stock and distribute micronutrient commodities – to health facilities and school programs	Procure annual stock and distribute micronutrient commodities – to health facilities and school programs	Procure annual stock and distribute micronutrient commodities – to health facilities and school programs
	Conduct stakeholders' meetings to advocate for local production of micronutrient, pre-mix, and supplements	Preparation for establishment of at least one industry for local production of Micro nutrition, premix and supplements	Establishment of industry for local production of Micro nutrition, premix and supplements	Establishment of industry for local production of Micro nutrition, premix and supplements	Establishment of industry for local production of Micro nutrition, premix and supplements
2. Strengthen nutrition technical capacity on the prevention and management of under nutrition, over nutrition & micronutrient deficiencies at	To conduct ToT on prevention and management of overweight and obesity (national and regional training	To conduct ToT on prevention and management of overweight and obesity (national and regional training	To conduct refresher ToT on prevention and management of overweight and obesity (national and regional training	To conduct refresher ToT on prevention and management of overweight and obesity (national and regional training	To conduct refresher ToT on prevention and management of overweight and obesity (national and regional training
	To develop guide/SOPs on nutritional management of DRNCDs and chronic diseases at facility level (working sessions and validation)	To disseminate guide/SOPs on nutritional management of DRNCDs and chronic diseases at facility level (working sessions and validation)	To disseminate guide/SOPs on nutritional management of DRNCDs and chronic diseases at facility level (working sessions and validation)	To assess implementation and review guide/SOPs on nutritional management of DRNCDs and chronic diseases at facility level (working sessions and validation)	To review guide/SOPs on nutritional management of DRNCDs and chronic diseases at facility level (working sessions and validation)

Objective	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
	To develop guide on screening and interpretation of overweight and obesity for Community Health Workers (CHWs	To disseminate guide on screening and interpretation of overweight and obesity for Community Health Workers (CHWs	To disseminate guide on screening and interpretation of overweight and obesity for Community Health Workers (CHWs	To assess implementation and review guide on screening and interpretation of overweight and obesity for Community Health Workers (CHWs	To review guide on screening and interpretation of overweight and obesity for Community Health Workers (CHWs
	To conduct stakeholders meeting on prevention of overweight and obesity at all levels	To conduct stakeholders meeting on prevention of overweight and obesity at all levels	To conduct stakeholders meeting on prevention of overweight and obesity at all levels	To conduct stakeholders meeting on prevention of overweight and obesity at all levels	To conduct stakeholders meeting on prevention of overweight and obesity at all levels
	Capacitate healthcare workforce on dietetics and clinical nutritionists	Capacitate healthcare workforce on dietetics and clinical nutritionists	Capacitate healthcare workforce on dietetics and clinical nutritionists	Capacitate healthcare workforce on dietetics and clinical nutritionists	Capacitate healthcare workforce on dietetics and clinical nutritionists
	Advocate for nutrition package and specific nutrition recommendations for prevention, early identification (diagnosis) and treatment of micronutrient deficiencies for different service delivery channels	Advocate for nutrition package and specific nutrition recommendations for prevention, early identification (diagnosis) and treatment of micronutrient deficiencies for different service delivery channels	Advocate for nutrition package and specific nutrition recommendations for prevention, early identification (diagnosis) and treatment of micronutrient deficiencies for different service delivery channels	Advocate for nutrition package and specific nutrition recommendations for prevention, early identification (diagnosis) and treatment of micronutrient deficiencies for different service delivery channels	Advocate for nutrition package and specific nutrition recommendations for prevention, early identification (diagnosis) and treatment of micronutrient deficiencies for different service delivery channels
	Review micronutrient guidelines and standards as appropriate	Disseminate micronutrient guidelines and standards as	Monitor implementation of micronutrient guidelines and	Assess implementation and review micronutrient guidelines and	Review micronutrient guidelines and standards as appropriate

Objective	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
		appropriate	standards as appropriate	standards as appropriate	
3. Enhance SBCC to create demand and increase the uptake of services by raising on the importance of nutrition services among women, men,	To design relevant localized approaches to promote appropriate nutrition behaviours (promotion materials) during the first three years	To design relevant localized approaches to promote appropriate nutrition behaviours (promotion materials) during the first three years			
	To facilitate quarterly implementation of nutrition SBCC activities at community level (media, traditional groups, community groups, FBOs interventions, etc.)	To facilitate quarterly implementation of nutrition SBCC activities at community level (media, traditional groups, community groups, FBOs interventions, etc.)	To facilitate quarterly implementation of nutrition SBCC activities at community level (media, traditional groups, community groups, FBOs interventions, etc.)	To facilitate quarterly implementation of nutrition SBCC activities at community level (media, traditional groups, community groups, FBOs interventions, etc.)	To facilitate quarterly implementation of nutrition SBCC activities at community level (media, traditional groups, community groups, FBOs interventions, etc.)
	To conduct advocacy meeting to CHMT/RHMT for screening for overweight and obesity into other existing health programs, e.g., TB, HIV as part of vital assessment in the health facilities	To conduct advocacy meeting to CHMT/RHMT for screening for overweight and obesity into other existing health programs, e.g., TB, HIV as part of vital assessment in the health facilities	To conduct advocacy meeting to CHMT/RHMT for screening for overweight and obesity into other existing health programs, e.g., TB, HIV as part of vital assessment in the health facilities	To conduct advocacy meeting to CHMT/RHMT for screening for overweight and obesity into other existing health programs, e.g., TB, HIV as part of vital assessment in the health facilities	To conduct advocacy meeting to CHMT/RHMT for screening for overweight and obesity into other existing health programs, e.g., TB, HIV as part of vital assessment in the health facilities
	To conduct advocacy meeting with employers to	To conduct advocacy meeting with employers to	To conduct advocacy meeting with employers to	To conduct advocacy meeting with employers to	To conduct advocacy meeting with employers to

Objective	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
	implement nutrition package at working place including prevention of overweight and obesity at the workplace	implement nutrition package at working place including prevention of overweight and obesity at the workplace	implement nutrition package at working place including prevention of overweight and obesity at the workplace	implement nutrition package at working place including prevention of overweight and obesity at the workplace	implement nutrition package at working place including prevention of overweight and obesity at the workplace
	To commemorate annual health lifestyle/ NCD week (cooking demonstrations, and bonanza on preparation and consumption of fruits and vegetables)	To commemorate annual health lifestyle/ NCD week (cooking demonstrations, and bonanza on preparation and consumption of fruits and vegetables)	To commemorate annual health lifestyle/ NCD week (cooking demonstrations, and bonanza on preparation and consumption of fruits and vegetables)	To commemorate annual health lifestyle/ NCD week (cooking demonstrations, and bonanza on preparation and consumption of fruits and vegetables)	To commemorate annual health lifestyle/ NCD week (cooking demonstrations, and bonanza on preparation and consumption of fruits and vegetables)
	To conduct sensitization meeting for policy makers, religious leaders and influential people on healthy lifestyles	To conduct sensitization meeting for policy makers, religious leaders and influential people on healthy lifestyles	To conduct sensitization meeting for policy makers, religious leaders and influential people on healthy lifestyles	To conduct sensitization meeting for policy makers, religious leaders and influential people on healthy lifestyles	To conduct sensitization meeting for policy makers, religious leaders and influential people on healthy lifestyles
	To conduct sensitization sessions for artists and celebrities on healthy lifestyles	To conduct sensitization sessions for artists and celebrities on healthy lifestyles	To conduct sensitization sessions for artists and celebrities on healthy lifestyles	To conduct sensitization sessions for artists and celebrities on healthy lifestyles	To conduct sensitization sessions for artists and celebrities on healthy lifestyles
	To develop/review messages on healthy lifestyles among social media houses and artists	To disseminate messages on healthy lifestyles among social media houses and artists	To disseminate messages on healthy lifestyles among social media houses and artists	To disseminate messages on healthy lifestyles among social media houses and artists	To disseminate messages on healthy lifestyles among social media houses and artists
	To conduct public	To conduct public	To conduct public	To conduct public	To conduct public

Objective	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
	awareness campaigns on healthy lifestyle at regional and national level	awareness campaigns on healthy lifestyle at regional and national level	awareness campaigns on healthy lifestyle at regional and national level	awareness campaigns on healthy lifestyle at regional and national level	awareness campaigns on healthy lifestyle at regional and national level
	Develop 'Nutrition Social and Behavior Change Communication Strategy' to address micronutrient deficiencies	Develop 'Nutrition Social and Behavior Change Communication Strategy' to address micronutrient deficiencies	Develop 'Nutrition Social and Behavior Change Communication Strategy' to address micronutrient deficiencies	Develop 'Nutrition Social and Behavior Change Communication Strategy' to address micronutrient deficiencies	Develop 'Nutrition Social and Behavior Change Communication Strategy' to address micronutrient deficiencies
	Develop national campaign by engaging with relevant ministries and organizations, e.g., Ministry of Information, Culture, Arts and Sports, and BASATA to create partnerships for effective BCC programmes	Develop national campaign by engaging with relevant ministries and organizations, e.g., Ministry of Information, Culture, Arts and Sports, and BASATA to create partnerships for effective BCC programmes	Develop national campaign by engaging with relevant ministries and organizations, e.g., Ministry of Information, Culture, Arts and Sports, and BASATA to create partnerships for effective BCC programmes	Develop national campaign by engaging with relevant ministries and organizations, e.g., Ministry of Information, Culture, Arts and Sports, and BASATA to create partnerships for effective BCC programmes	Develop national campaign by engaging with relevant ministries and organizations, e.g., Ministry of Information, Culture, Arts and Sports, and BASATA to create partnerships for effective BCC programmes
	To conduct national/regional school campaigns on nutrition and healthy lifestyle	To conduct national/regional school campaigns on nutrition and healthy lifestyle	To conduct national/regional school campaigns on nutrition and healthy lifestyle	To conduct national/regional school campaigns on nutrition and healthy lifestyle	To conduct national/regional school campaigns on nutrition and healthy lifestyle

Objective	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
4. Mainstreaming of nutrition services at workplace, schools, social protection schemes	To develop nutrition package for workplace interventions based on identified gaps	To disseminate nutrition package for workplace interventions based on identified gaps	To disseminate nutrition package for workplace interventions based on identified gaps	To disseminate nutrition package for workplace interventions based on identified gaps	To disseminate nutrition package for workplace interventions based on identified gaps
	To conduct training for health and nutrition teachers/ coordinators, and school committees on implementation of school feeding guidelines in primary and secondary schools	To conduct training for health and nutrition teachers/ coordinators, and school committees on implementation of school feeding guidelines in primary and secondary schools	To conduct training for health and nutrition teachers/ coordinators, and school committees on implementation of school feeding guidelines in primary and secondary schools	To conduct training for health and nutrition teachers/ coordinators, and school committees on implementation of school feeding guidelines in primary and secondary schools	To conduct training for health and nutrition teachers / coordinators, and school committees on implementation of school feeding guidelines in primary and secondary schools
	To develop guidelines for food vendors in and around the school environment	To disseminate guidelines for food vendors in and around the school environment	To disseminate guidelines for food vendors in and around the school environment	To asses implementation & review guidelines for food vendors in and around the school environment	To review guidelines for food vendors in and around the school environment
	Review and update existing training materials on nutrition education and counselling for children and adolescents	Review and update existing training materials on nutrition education and counselling for children and adolescents	Review and update existing training materials on nutrition education and counselling for children and adolescents	Review and update existing training materials on nutrition education and counselling for children and adolescents	Review and update existing training materials on nutrition education and counselling for children and adolescents
	Promote integration of nutrition agenda with implementation of nutrition sensitive interventions such as	Promote integration of nutrition agenda with implementation of nutrition sensitive interventions such as	Promote integration of nutrition agenda with implementation of nutrition sensitive interventions such as	Promote integration of nutrition agenda with implementation of nutrition sensitive interventions such as	Promote integration of nutrition agenda with implementation of nutrition sensitive interventions such as

Objective	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
	WASH, MHM and deworming campaigns at the schools by holding joint campaigns (development of IEC, training package, media seminar kit, and media seminar meetings) Airtime cost.	WASH, MHM and deworming campaigns at the schools by holding joint campaigns (development of IEC, training package, media seminar kit, and media seminar meetings) Airtime cost.	WASH, MHM and deworming campaigns at the schools by holding joint campaigns (development of IEC, training package, media seminar kit, and media seminar meetings) Airtime cost.	WASH, MHM and deworming campaigns at the schools by holding joint campaigns (development of IEC, training package, media seminar kit, and media seminar meetings) Airtime cost.	WASH, MHM and deworming campaigns at the schools by holding joint campaigns (development of IEC, training package, media seminar kit, and media seminar meetings) Airtime cost.
5. Enhance Nutrition monitoring and evaluation, surveillance and operational research.	Conduct bi - annual national Vitamin IT A supplementation in children (6-59 months) and deworming (12 to 59 months) campaigns including screening for nutrition status	Conduct bi- annual national Vitamin IT A supplementation in children (6-59 months) and deworming (12 to 59 months) campaigns including screening for Nutrition status	Conduct bi- annual national Vitamin A supplementation in children (6-59 months) and deworming (12 to 59 months) campaigns including screening for Nutrition Status	Conduct bi - annual National Vitamin IT A supplementation in children (6-59 months) and deworming (12 to 59 months) campaigns including screening for Nutrition Status	Conduct bi - annual National Vitamin IT A supplementation in children (6-59 months) and deworming (12 to 59 months) campaigns including screening for Nutrition Status
	Conduct support supervision of Vitamin A Supplementation	Conduct support supervision of Vitamin A Supplementation	Conduct support supervision of Vitamin A Supplementation	Conduct support supervision of Vitamin A Supplementation	Conduct support supervision of Vitamin A Supplementation
	Monitor micronutrient deficiencies through routine data collected in HMIS	Monitor micronutrient deficiencies through routine data collected in HMIS	Monitor micronutrient deficiencies through routine data collected in HMIS	Monitor micronutrient deficiencies through routine data collected in HMIS	Monitor micronutrient deficiencies through routine data collected in HMIS

8.1.11 COMPONENT: NEGLECTED TROPICAL DISEASES SERVICES

Objectives	Target Year 1-2	Target Year 4-5	Target Year 6-7	Target Year 7-8	Target Year 9-10
Strengthen Government Ownership, Advocacy, Coordination and Partnership	Strengthen country ownership and leadership through organizational structures at national and local government with dedicated funding	Prepare and launch a 5 years NTD Strategic plan and Sustainability plan for Neglected Tropical Diseases 2027-2032	Conduct advocacy meetings at all levels and asses the outcome of the sessions	Conduct advocacy meetings at all levels and asses the outcome of the sessions	Conduct advocacy meetings at all levels and asses the outcome of the sessions
Conduct activities that Promote	Annual Joint Planning Meeting conducted per year to foster partnership for NTDs at all levels per year	Annual Joint Planning Meeting conducted per year to foster partnership for NTDs at all levels per year	Annual Joint Planning Meeting conducted per year to foster partnership for NTDs at all levels per year	Annual Joint Planning Meeting conducted per year to foster partnership for NTDs at all levels per year	Annual Joint Planning Meeting conducted per year to foster partnership for NTDs at all levels per year
	Disease specific review and planning for each endemic disease district conducted annually	Disease specific review and planning for each endemic disease district conducted annually	Disease specific review and planning for each endemic disease district conducted annually	Disease specific review and planning for each endemic disease district conducted annually	Disease specific review and planning for each endemic disease district conducted annually
	Procurement of Vehicles, Motorbikes and Bicycles for the National Secretariat, Regional and District to support coordination of NTD Elimination	Procurement of Vehicles, Motorbikes and Bicycles for the National Secretariat, Regional and District to support coordination of NTD Elimination	Procurement of Vehicles, Motorbikes and Bicycles for the National Secretariat, Regional and District to support coordination of NTD Elimination	Procurement of Vehicles, Motorbikes and Bicycles for the National Secretariat, Regional and District to support coordination of NTD Elimination	Procurement of Vehicles, Motorbikes and Bicycles for the National Secretariat, Regional and District to support coordination of NTD Elimination
	Guide establishment of coordination mechanisms at regional and Councils levels	Guide establishment of coordination mechanisms at regional and	Guide establishment of coordination mechanisms at regional and Councils	Guide establishment of coordination mechanisms at regional and	Guide establishment of coordination mechanisms at regional and Councils levels

Objectives	Target Year 1-2	Target Year 4-5	Target Year 6-7	Target Year 7-8	Target Year 9-10
		Councils levels	levels	Councils levels	
	Promote improved communication and awareness at the Community level for a successful elimination of the endemic NTDs.	Promote improved communication and awareness at the community level for a successful elimination of the endemic NTDs.	Promote improved communication and awareness at the community level for a successful elimination of the endemic NTDs.	Promote improved communication and awareness at the community level for a successful elimination of the endemic NTDs.	Promote improved communication and awareness at the community level for a successful elimination of the endemic NTDs.
Enhance planning for results resources mobilization and financial sustainability	Support regions and districts to develop integrated annual plans and budgets for NTD control (CCHP)	Support regions and districts to develop integrated annual plans and budgets for NTD control (CCHP)	Support regions and districts to develop integrated annual plans and budgets for NTD control (CCHP)	Support regions and districts to develop integrated annual plans and budgets for NTD control (CCHP)	Support regions and districts to develop integrated annual plans and budgets for NTD control (CCHP)
	Develop and update national NTD guidelines and tools for operationalization of NTD interventions to 184 Councils.	Develop and update national NTD guidelines and tools for operationalization of NTD interventions to 184 councils	Develop and update national NTD guidelines and tools for operationalization of NTD interventions to 184 councils	Develop and update national NTD guidelines and tools for operationalization of NTD interventions to 184 councils	Develop and update national NTD guidelines and tools for operationalization of NTD interventions to 184 council
	Conduct activities to strengthen the integration and linkages of NTD programme and financial plans into sector-wide and national budgetary and financing mechanisms	Conduct activities to strengthen the integration and linkages of NTD programme and financial plans into sector-wide and national budgetary and financing mechanisms	Conduct activities to strengthen the integration and linkages of NTD programme and financial plans into sector-wide and national budgetary and financing mechanisms	Conduct activities to strengthen the integration and linkages of NTD programme and financial plans into sector-wide and national budgetary and financing mechanisms	Conduct activities to strengthen the integration and linkages of NTD programme and financial plans into sector-wide and national budgetary and financing mechanisms
Scale up access to interventions, treatment and system capacity	Conduct other NTD interventions such as Snakebite envenoming, Visceral Leishmaniasis,	Conduct other NTD interventions such as Snakebite envenoming, Visceral	Conduct other NTD interventions such as Snakebite envenoming, Visceral	Conduct other NTD interventions such as Snakebite envenoming, Visceral	Conduct other NTD interventions such as Snakebite envenoming, Visceral Leishmaniasis,

Objectives	Target Year 1-2	Target Year 4-5	Target Year 6-7	Target Year 7-8	Target Year 9-10
building	Podoconiosis etc	Leishmaniasis, Podoconiosis etc	Leishmaniasis, Podoconiosis etc	Leishmaniasis, Podoconiosis etc	Podoconiosis etc
	Conduct integrated case-management-based diseases interventions, including MMDP services for LF and Trachoma.	Conduct integrated case-management-based diseases interventions, including MMDP services for LF and Trachoma.	Conduct integrated case-management-based diseases interventions, including MMDP services for LF and Trachoma.	Conduct integrated case-management-based diseases interventions, including MMDP services for LF and Trachoma.	Conduct integrated case-management-based diseases interventions, including MMDP services for LF and Trachoma.
	Conduct NTD program activities with identified platforms with similar delivery strategies and interventions (MDAs), skin NTDs, Mortality management, SBCC, WASH etc) for integrated approaches across NTDs	Conduct NTD program activities with identified platforms with similar delivery strategies and interventions (MDAs), skin NTDs, Mortality management, SBCC, WASH etc) for integrated approaches across NTDs	Conduct NTD program activities with identified platforms with similar delivery strategies and interventions (MDAs), skin NTDs, Mortality management, SBCC, WASH etc) for integrated approaches across NTDs	Conduct NTD program activities with identified platforms with similar delivery strategies and interventions (MDAs), skin NTDs, Mortality management, SBCC, WASH etc) for integrated approaches across NTDs	Conduct NTD program activities with identified platforms with similar delivery strategies and interventions (MDAs), skin NTDs, Mortality management, SBCC, WASH etc) for integrated approaches across NTDs
	Conduct integrated vector management and WASH activities for targeted NTDs	Conduct integrated vector management and WASH activities for targeted NTDs	Conduct integrated vector management and WASH activities for targeted NTDs	Conduct integrated vector management and WASH activities for targeted NTDs	Conduct integrated vector management and WASH activities for targeted NTDs
	Conduct pharmaco-vigilance activities in NTD program and ensure timely effective supply chain management of quality-assured NTD Medicines and other products up to	Conduct pharmaco-vigilance activities in NTD program and ensure timely effective supply chain management of quality- assured NTD	Conduct pharmaco-vigilance activities in NTD program and ensure timely effective supply chain management of quality- assured NTD	Conduct pharmaco-vigilance activities in NTD program and ensure timely effective supply chain management of quality- assured NTD	Conduct pharmaco-vigilance activities in NTD program and ensure timely effective supply chain management of quality- assured NTD

Objectives	Target Year 1-2	Target Year 4-5	Target Year 6-7	Target Year 7-8	Target Year 9-10
	the last mile	Medicines and other products up to the last mile	Medicines and other products up to the last mile	Medicines and other products up to the last mile	Medicines and other products up to the last mile
	Conduct capacity building activities for NTD programme management and implementation & accelerate disease burden assessments and integrated mapping of NTDs	Conduct capacity building activities for NTD programme management and implementation & accelerate disease burden assessments and integrated mapping of NTDs	Conduct capacity building activities for NTD programme management and implementation & accelerate disease burden assessments and integrated mapping of NTDs	Conduct capacity building activities for NTD programme management and implementation & accelerate disease burden assessments and integrated mapping of NTDs	Conduct capacity building activities for NTD programme management and implementation & accelerate disease burden assessments and integrated mapping of NTDs
Enhance NTD monitoring and evaluation, surveillance and operational research	Conduct monitoring of national NTD programme performance and outcome	Conduct monitoring of national NTD programme performance and outcome	Conduct monitoring of national NTD programme performance and outcome	Conduct monitoring of national NTD programme performance and outcome	Conduct monitoring of national NTD programme performance and outcome
	Conduct surveillance of NTDs and response to epidemic prone NTDs	Conduct surveillance of NTDs and response to epidemic prone NTDs	Conduct surveillance of NTDs and response to epidemic prone NTDs	Conduct surveillance of NTDs and response to epidemic prone NTDs	Conduct surveillance of NTDs and response to epidemic prone NTDs
	Support operational research, documentation and evidence to guide innovative approaches to NTDs programmes interventions.	Support operational research, documentation and evidence to guide innovative approaches to NTDs programmes interventions.	Support operational research, documentation and evidence to guide innovative approaches to NTDs programmes interventions.	Support operational research, documentation and evidence to guide innovative approaches to NTDs programmes interventions.	Support operational research, documentation and evidence to guide innovative approaches to NTDs programmes interventions.

Objectives	Target Year 1-2	Target Year 4-5	Target Year 6-7	Target Year 7-8	Target Year 9-10
	Establish integrated data management system (Monitoring Information System, MIS, for NTDs and link NTD MIS with DHIS2) and support impact analysis of NTD in Tanzania as part of WHO Africa region and global NTD data Management system.	Establish integrated data management system (Monitoring Information System, MIS, for NTDs and link NTD MIS with DHIS2) and support impact analysis of NTD in Tanzania as part of WHO Africa region and global NTD data Management system	Establish integrated data management system (Monitoring Information System, MIS, for NTDs and link NTD MIS with DHIS2) and support impact analysis of NTD in Tanzania as part of WHO Africa region and global NTD data Management system	Establish integrated data management system (Monitoring Information System, MIS, for NTDs and link NTD MIS with DHIS2) and support impact analysis of NTD in Tanzania as part of WHO Africa region and global NTD data Management system	Establish integrated data management system (Monitoring Information System, MIS, for NTDs and link NTD MIS with DHIS2) and support impact analysis of NTD in Tanzania as part of WHO Africa region and global NTD data Management system
	Develop M and E framework for NTD Master Plan and Sustainability Plan 2021-2026	Conduct M and E of NTD Master Plan and Sustainability Plan Implementation	Develop M and E framework for NTD Master Plan and Sustainability plan for 2027-2032	Conduct M and E of NTD Master Plan and Sustainability Plan Implementation	Conduct M and E of NTD Master Plan and Sustainability Plan Implementation

8.1.12 COMPONENT: QUALITY IMPROVEMENT SERVICES

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
	Finalization of revised Tanzania Quality Improvement Framework (TQIF) and National QI Strategic Plan by June 2024.	Review the SRA tools for regional referral hospitals to suit the verification for zonal and national hospital by March 2026.	Conduct Star Rating assessment to primary healthcare facilities in 12 regions by March 2028.	Development of provider's and patient safety guidelines by June 2030.	Finalization and alignment to Continuing Professional Development (CPD) framework of National Generic QI Training Packages (Training Slides, Facilitator's Guide, and Participant's Manual) by June 2032.

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
Improve quality management systems and accountability.	Dissemination of revised Tanzania Quality Improvement Framework (TQIF) and National QI Strategic Plan by June 2024	Dissemination of SRA results to different stakeholders including MoH (Health Department) Management Meeting, PORLG and in TWG meetings by June 2026.	Conduct quality assessment to all Zonal and National level Hospitals and develop Quality Improvement Plans (QIPs) by June 2028.	Dissemination of Client Service Charter guide for health facilities to all stakeholders (CHMTs; RHMTs; Regional, zonal and national level hospitals; and umbrella organization – APHFTA, CSSC and BAKWATA) by June 2030.	Integration of QI training contents into E-Learning Platform by June 2032
	Dissemination of Complaint, Compliment Management Guidelines to all stakeholders (CHMTs; RHMTs; Regional, zonal and national level hospitals; and umbrella organization– APHFTA, CSSC and BAKWATA) by June 2032	Dissemination of Complaint, Compliment Management Guidelines to all stakeholders (CHMTs; RHMTs; Regional, zonal and national level hospitals; and umbrella organization– APHFTA, CSSC and BAKWATA) by June 2032	Dissemination of Complaint, Compliment Management Guidelines to all stakeholders (CHMTs; RHMTs; Regional, zonal and national level hospitals; and umbrella organization– APHFTA, CSSC and BAKWATA) by June 2032	Dissemination of Complaint, Compliment Management Guidelines to all stakeholders (CHMTs; RHMTs; Regional, zonal and national level hospitals; and umbrella organization– APHFTA, CSSC and BAKWATA) by June 2032	Dissemination of Complaint, Compliment Management Guidelines to all stakeholders (CHMTs; RHMTs; Regional, zonal and national level hospitals; and umbrella organization– APHFTA, CSSC and BAKWATA) by June 2032
Institute and monitor adherence to standards of care at different levels of health care delivery	Development of National IPC standards for National, Zonal, Specialized, Regional Referral Hospitals by June, 2024.	Develop and Printing of SOPs for IPC by June 2026	To conduct facilities internal assessment using IPC Standards implemented by June 2028	To conduct facilities internal assessment using IPC Standards implemented by June 2030. .	. To conduct facilities internal assessment using IPC Standards implemented by June 2032
	Printing of National IPC Standards by June 2024.	Disseminating the SOPs for IPC by June 2026			
	Dissemination of revised National IPC Standards for National, Zonal, Specialized, Regional Referral Hospitals by	Dissemination of revised National IPC Standards for Council Hospitals, Health Centers and Dispensaries by June 2026			

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
	June, 2024.				
	Dissemination of National IPC standards to all stakeholders by June 2024	CHMTs, RHMTs and National level team conduct external assessment using IPC Standards by June 2026.			
Coordination of implementation of Infection Prevention and Control activities in health services delivery by June 2032	Finalization of Protocol which will guide the HAIs surveillance by June 2024	Dissemination of HAIs Surveillance protocol to all stakeholders Train ICT officials from MoH and PORALG as part of knowledge transfer for sustainability and system maintenance by June 2032.by June 2026	Development of data base for PEP in DHIS2 by June 2028. .	Coordinate and conduct POCT sensitization meeting to remained 17 Regions: (Arusha, Iringa, Katavi, Kigoma, Manyara, Mara, Mbeya, Mtwara, Mwanza, Njombe, Rukwa, Ruvuma, Shinyanga, Simiyu, Songwe, Tabora, and Tanga) by June	Oversee the Implementation of POCT activities to eight regions namely: Mbeya, Songwe, Katavi, Morogoro, Pwani, Rukwa and Iringa
	Develop database for HAIs data by June 2024.		Printing of PEP Guideline, Registers and other PEP tools by June 2028	Conduct External Auditing to 1440 rapid HIV testing points in all regions by 2030.	Review and integration of SPRT checklist into Afya SS by June, 2032
	Printing the final version of HAIs Surveillance Protocol by June 2024.		Dissemination of PEP Guideline, Registers and other PEP tools to all stakeholders by June 2028.	Conduct Point of Care Testing [POCT] framework steering committee meetings	

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
Conduct Supportive Supervision to Health Facilities by 100% by 2026	Finalization of review of Supportive Supervision Guidelines by June 2024.	Deployment and dissemination of supervision digital system and capacity building for health workers on new practices for conducting supervision using digital system from national to facility level by June 2026.	Conduct resource mobilization activities with stakeholders for rollout of Afya SS by June 2028.	Conduct Supportive Supervision to Health Facilities	Conduct Supportive Supervision to Health Facilities
	Printing the revised SSG by June 2024	Identify indicators for Afya SS reports by departments, units and programs.	Conduct Supportive		
	Development of Job Aids and training martials for dissemination of digital supportive supervision system by June 2024.	Conduct baseline and re-assessment on implementation of supportive supervision using Afya SS to selected region as part of monitoring and evaluation by June 2026.	Supervision to Health Facilities		
	Train ICT officials from MoH and PORALG as part of knowledge transfer for sustainability and system maintenance by June 2024.				

8.1.13 COMMONENT: SUPPLY CHAIN OF HEALTH COMMODITIES SERVICES

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
Improve availability of health commodities from 84% to 95% by 2032	86% of health commodities are available	88% of health commodities are available	90% of health commodities are available	92% of health commodities are available	95% of health commodities are available

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
	To conduct medicine tracking/audit	To conduct medicine tracking/audit	To conduct medicine tracking/audit	To conduct medicine tracking/audit	To conduct medicine tracking/audit
	To strengthen Bottom up Qualification	To strengthen Bottom up Qualification	To strengthen Bottom up Qualification	To strengthen Bottom up Qualification	To strengthen Bottom up Qualification
	To disseminate and monitor implementation of health commodities revolving fund guidelines	To disseminate and monitor implementation of health commodities revolving fund guidelines	To disseminate and monitor implementation of health commodities revolving fund guidelines	To disseminate and monitor implementation of health commodities revolving fund guidelines	To disseminate and monitor implementation of health commodities revolving fund guidelines
	To establish system for monitoring performance of medicine and therapeutic committee to PHC 7327 health facilities	To establish system for monitoring performance of medicine and therapeutic committee to PHC 7327 health facilities	To establish system for monitoring performance of medicine and therapeutic committee to PHC 7327 health facilities	To establish system for monitoring performance of medicine and therapeutic committee to PHC 7327 health facilities	To establish system for monitoring performance of medicine and therapeutic committee to PHC 7327 health facilities
	To enforce implementation of health commodities revolving fund to PHC in 7327 public health facilities	To enforce implementation of health commodities revolving fund to PHC in 7327 public health facilities	To enforce implementation of health commodities revolving fund to PHC in 7327 public health facilities	To enforce implementation of health commodities revolving fund to PHC in 7327 public health facilities	To enforce implementation of health commodities revolving fund to PHC in 7327 public health facilities
	Monitoring adherence to generic during use of persecution in 7324 health facilities.	Monitoring adherence to generic during use of persecution in 7324 health facilities.	Monitoring adherence to generic during use of persecution in 7324 health facilities.	Monitoring adherence to generic during use of persecution in 7324 health facilities.	Monitoring adherence to generic during use of persecution in 7324 health facilities.

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
	To review and disseminate MTC guidelines to 7327 public health facilities.	To review and disseminate MTC guidelines to 7327 public health facilities.	To review and disseminate MTC guidelines to 7327 public health facilities.	To review and disseminate MTC guidelines to 7327 public health facilities.	To review and disseminate MTC guidelines to 7327 public health facilities.
	To monitor implementation of hospital formulary to 7327 health facilities	To monitor implementation of hospital formulary to 7327 health facilities	To monitor implementation of hospital formulary to 7327 health facilities	To monitor implementation of hospital formulary to 7327 health facilities	To monitor implementation of hospital formulary to 7327 health facilities.
Strengthened Inventory management system from 20% to 99.95% Primary Health Facilities by 2032	(20%) 1465 of the HF Inventory management system is strengthened	(40%)2930 of the HF Inventory management system are strengthened	(60%) 4395 of the HF Inventory management system are strengthened	(80%) 5860 of the HF Inventory management system are strengthened	(99.95%) 7325of the HF Inventory management system are strengthened
	To improve infrastructure for storage to 1465 health facilities.	To improve infrastructure for storage to 1465 health facilities.	To improve infrastructure for storage to 1465 health facilities.	To improve infrastructure for storage to 1465 health facilities.	To improve infrastructure for storage to 1465 health facilities.
	To strengthen supportive supervision of key staff managing health commodities to 1465 health facilities	To strengthen supportive supervision of key staff managing health commodities to 1465 health facilities	To strengthen supportive supervision of key staff managing health commodities to 1465 health facilities	To strengthen supportive supervision of key staff managing health commodities to 1465 health facilities	To strengthen supportive supervision of key staff managing health commodities to 1465 health facilities
	Increase budget for medicines, equipment, medical supplies, laboratory equipment and reagents from the overall health budget from 29% to 35% by 2032.	Increase budget for medicines, equipment, medical supplies, laboratory equipment and reagents from the overall health budget from 29% to 35% by 2032	Increase budget for medicines, equipment, medical supplies, laboratory equipment and reagents from the overall health budget from 29% to 35% by 2032	Increase budget for medicines, equipment, medical supplies, laboratory equipment and reagents from the overall health budget from 29% to 35% by 2032	Increase budget for medicines, equipment, medical supplies, laboratory equipment and reagents from the overall health budget from 29% to 35% by 2032

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
Increase budget for medicines, equipment, medical supplies, laboratory equipment and reagents from the overall health budget from 29% to 35% by 2032	29% (218,000,000,000) of overall health budget is allocated for medicines, equipment, medical supplies, laboratory equipment and reagents	30% (222,000,000,000) of overall health budget is allocated for medicines, equipment, medical supplies, laboratory equipment and reagents	32% (236,800,000,000) of overall health budget is allocated for medicines, equipment, medical supplies, laboratory equipment and reagents	34% (251,600,000,000) of overall health budget is allocated for medicines, equipment, medical supplies, laboratory equipment and reagents	35% (259,000,000,000) of overall health budget is allocated for medicines, equipment, medical supplies, laboratory equipment and reagents
	To conduct advocacy meeting for adequate budget allocation for paratheatrical	To conduct advocacy meeting for adequate budget allocation for paratheatrical	To conduct advocacy meeting for adequate budget allocation for paratheatrical	To conduct advocacy meeting for adequate budget allocation for paratheatrical	To conduct advocacy meeting for adequate budget allocation for paratheatrical
	To enforce implementation of health commodity revolving funds and disseminate HCFR guidelines to 7327 health facilities	To enforce implementation of health commodity revolving funds and disseminate HCFR guidelines to 7327 health facilities	To enforce implementation of health commodity revolving funds and disseminate HCFR guidelines to 7327 health facilities	To enforce implementation of health commodity revolving funds and disseminate HCFR guidelines to 7327 health facilities	To enforce implementation of health commodity revolving funds and disseminate HCFR guidelines to 7327 health facilities
Stimulate local production from 32 to 50 domestic pharmaceutical industries and reduce importation of medicines, supplies, medical supplies, laboratory equipment and reagents from 84% to 65% by 2032	Importation of medicines, supplies, medical supplies, laboratory equipment and reagents reduced to 85%	Importation of medicines, supplies, medical supplies, laboratory equipment and reagents reduced to 80%	Importation of medicines, supplies, medical supplies, laboratory equipment and reagents reduced to 75%	Importation of medicines, supplies, medical supplies, laboratory equipment and reagents reduced to 70%	Importation of medicines, supplies, medical supplies, laboratory equipment and reagents reduced to 65%
	To promote the establishment of domestic pharmaceutical industries	To promote the establishment of domestic pharmaceutical industries	To promote the establishment of domestic pharmaceutical industries	To promote the establishment of domestic pharmaceutical industries	To promote the establishment of domestic pharmaceutical industries

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
	To develop mechanism to allow for harmonization of policies and their reciprocity on domestic pharmaceutical manufacturing among EAC countries	To develop mechanism to allow for harmonization of policies and their reciprocity on domestic pharmaceutical manufacturing among EAC countries	To develop mechanism to allow for harmonization of policies and their reciprocity on domestic pharmaceutical manufacturing among EAC countries	To develop mechanism to allow for harmonization of policies and their reciprocity on domestic pharmaceutical manufacturing among EAC countries	To develop mechanism to allow for harmonization of policies and their reciprocity on domestic pharmaceutical manufacturing among EAC countries
Strengthening rational use of medicine by 90% of health facilities adhere to established national treatment protocols by June 2032	To undertake assessment on current prescribing and dispensing practices	To undertake assessment on current prescribing and dispensing practices	To undertake assessment on current prescribing and dispensing practices	To undertake assessment on current prescribing and dispensing practices	To undertake assessment on current prescribing and dispensing practices
	To train health care workers on prescribed antibiotics are as per aware categorization	To train health care workers on prescribed antibiotics are as per aware categorization	To train health care workers on prescribed antibiotics are as per aware categorization	To train health care workers on prescribed antibiotics are as per aware categorization	To train health care workers on prescribed antibiotics are as per aware categorization
	To enforce the use of STG/NEMLIT to all 7327 health facilities	To enforce the use of STG/NEMLIT to all 7327 health facilities	To enforce the use of STG/NEMLIT to all 7327 health facilities	To enforce the use of STG/NEMLIT to all 7327 health facilities	To enforce the use of STG/NEMLIT to all 7327 health facilities
	To monitor the implementation of good dispensing manual	To monitor the implementation of good dispensing manual	To monitor the implementation of good dispensing manual	To monitor the implementation of good dispensing manual	To monitor the implementation of good dispensing manual

8.1.14 COMPONENT: ENVIRONMENTAL HEALTH SERVICES

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
Strengthen capacity to 95% of Health Care workers at all levels on WASH by 2032	Capacity building on WASH strengthened to 35% of HCWs	Capacity building on WASH strengthened to 55% of HCWs	Capacity building on WASH strengthened to 65% of HCWs	Capacity building on WASH strengthened to 85% of HCWs	Capacity building on WASH strengthened to 95% of HCWs
Rehabilitation of existing WASH facilities in 3500 HCFs by 2032	Rehabilitation of water supply infrastructure, sanitation facilities and hand washing infrastructures in 600 HCFs	Rehabilitation of water supply infrastructure, sanitation facilities and hand washing infrastructures in 1,400 HCFs	Rehabilitation of water supply infrastructure, sanitation facilities and hand washing infrastructures in 2,200 HCFs	Rehabilitation of water supply infrastructure, sanitation facilities and hand washing infrastructures in 3,000 HCFs	Rehabilitation of water supply infrastructure, sanitation facilities and hand washing infrastructures in 3,500 HCFs
Construction of WASH facilities in 800,000 HCFs by 22032	Construction of water supply infrastructure, sanitation facilities and hand washing infrastructures in 1,500 HCFs	Construction of water supply infrastructure, sanitation facilities and hand washing infrastructures in 3,000 HCFs	Construction of water supply infrastructure, sanitation facilities and hand washing infrastructures in 4,700 HCFs	Construction of water supply infrastructure, sanitation facilities and hand washing infrastructures in 6,500 HCFs	Construction of water supply infrastructure, sanitation facilities and hand washing infrastructures in 8,000 HCFs
Strengthening hygiene practices in 95% of HCFs by 2032	Provision of adequate cleansing materials and materials in 35% of HCFs	Provision of adequate cleansing materials and materials in 45% of HCFs	Provision of adequate cleansing materials and materials in 65% of HCFs	Provision of adequate cleansing materials and materials in 85% of HCFs	Provision of adequate cleansing materials and materials in 95% of HCFs
	Hygiene promotion materials developed and disseminated into 35% of HCFs by 2032	Hygiene promotion materials developed and disseminated into 45% of HCFs by 2032	Hygiene promotion materials developed and disseminated into 65% of HCFs by 2032	Hygiene promotion materials developed and disseminated into 85% of HCFs by 2032	Hygiene promotion materials developed and disseminated into 95% of HCFs by 2032
Open defecation free status achieved and	Reaching 99% of open defecation free	maintaining 99.7% of open defecation free	maintaining 99.9% of open defecation free	maintaining 100% of open defecation free	maintaining 100% of open defecation free

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
access to safely managed sanitation increased to 65% by 2032	Attain 35% coverage of household safely managed sanitation and basic sanitation	Attain 40% coverage of household safely managed sanitation and basic sanitation	Attain 50% coverage of household safely managed sanitation and basic sanitation	Attain 60% coverage of household safely managed sanitation and basic sanitation	Attain 65% coverage of household safely managed sanitation and basic sanitation
To strengthen environmental Health, Sanitation and Hygiene services by 2032	Capacity building for environmental officers at Regional district and ward level by 10%	Capacity building for environmental officers at Regional district and ward level by 25%	Capacity building for environmental officers at Regional district and ward level by 50%	Capacity building for environmental officers at Regional district and ward level by 75%	Capacity building for environmental officers at Regional district and ward level by 90%
	Health and Sanitation cleanliness competition for ward level strengthened in all 60 LGAs	Health and Sanitation cleanliness competition for ward level strengthened in all 80 LGAs	Health and Sanitation cleanliness competition for ward level strengthened in all 100 LGAs	Health and Sanitation cleanliness competition for ward level strengthened in all 144 LGAs	Health and Sanitation cleanliness competition for ward level strengthened in all 184 LGAs
To strengthen Food Safety and Hygiene services by 2032	Increasing capacity building of Environmental Health Officers at Regional to Ward level on surveillance and investigation of foodborne illnesses by 10%	Increasing capacity building of Environmental Health Officers at Regional to Ward level on surveillance and investigation of foodborne illnesses by 30%	Increasing capacity building of Environmental Health Officers at Regional to Ward level on surveillance and investigation of foodborne illnesses by 50%	Increasing capacity building of Environmental Health Officers at Regional to Ward level on surveillance and investigation of foodborne illnesses by 70%	Increasing capacity building of Environmental Health Officers at Regional to Ward level on surveillance and investigation of foodborne illnesses by 90%
	Capacity building on implementation, monitoring and evaluation of Food Safety and Hygiene services strengthened in 37 Councils	Capacity building on implementation, monitoring and evaluation of Food Safety and Hygiene services strengthened in 74 Councils	Capacity building on implementation, monitoring and evaluation of Food Safety and Hygiene services strengthened in 111 Councils	Capacity building on implementation, monitoring and evaluation of Food Safety and Hygiene services strengthened in 148 Councils	Capacity building on implementation, monitoring and evaluation of Food Safety and Hygiene services strengthened in 184 Councils

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
To strengthen drinking water quality at point of use testing and monitoring at Regional and District levels by 2032	Capacity building to Environmental Health officers at Districts and Regions on drinking water quality testing and monitoring by 32%	Capacity building to Environmental Health officers at Districts and Regions on drinking water quality testing and monitoring by 48%	Capacity building to Environmental Health officers at Districts and Regions on drinking water quality testing and monitoring by 64%	Capacity building to Environmental Health officers at Districts and Regions on drinking water quality testing and monitoring by 80%	Capacity building to Environmental Health officers at Districts and Regions on drinking water quality testing and monitoring by 100%
Strengthen monitoring and evaluation and Research of environmental health services by 2032	Develop Environmental Health monitoring and evaluation system and its implementation by 100% by	Update the Environmental Health monitoring and evaluation system and its implementation by 100%	Update the Environmental Health monitoring and evaluation system and its implementation by 100%	Update the Environmental Health monitoring and evaluation system and its implementation by 100%	Update the Environmental Health monitoring and evaluation system and its implementation by 100% by 2032
	Increase number of Regions and Councils self-reporting environmental health interventions from 70-130	Increase number of Regions and Councils self-reporting environmental health interventions from 131-150	Increase number of Regions and Councils self-reporting environmental health interventions from 151-160	Increase number of Regions and Councils self-reporting environmental health interventions from 160-170	Increase number of Regions and Councils self-reporting environmental health interventions from 171-184 by 2032
	Improve environmental health data quality and information use from 50%-80%	Improve environmental health data quality and information use from 80%-85%	Improve environmental health data quality and information use from 85%-90%	Improve environmental health data quality and information use from 90%-95%	Improve environmental health data quality and information use from 95%-100% by 2032
	Upgrade the National Sanitation Monitoring Information system and data collection tools by 50%	Upgrade the National Sanitation Monitoring Information system and data collection tools by 50%	Upgrade the National Sanitation Monitoring Information system and data collection tools by 50%	Upgrade the National Sanitation Monitoring Information system and data collection tools by 50%	Upgrade the National Sanitation Monitoring Information system and data collection tools by 50% by 2032
	Conduct biannual assessment of environmental health	Conduct biannual assessment of environmental health	Conduct biannual assessment of environmental health	Conduct biannual assessment of environmental health	Conduct biannual assessment of environmental health

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
	programs including environmental health competitions	programs including environmental health competitions	programs including environmental health competitions	programs including environmental health competitions	programs including environmental health competitions by 2032
To strengthen safe health care practices at all levels of health care delivery services	To increase proper health care waste segregation practices at the point of Health care waste generation by 65%	To increase proper health care waste segregation practices at the point of Health care waste generation by 75%	To increase proper health care waste segregation practices at the point of Health care waste generation by 85%	To increase proper health care waste segregation practices at the point of Health care waste generation by 90%	To increase proper health care waste segregation practices at the point of Health care waste generation by 95%
	To increase availability of acceptable waste disposal facilities by 60% at point of health care deliver	To increase availability of acceptable waste disposal facilities by 65% at point of health care delivery	To increase availability of acceptable waste disposal facilities by 70% at point of health care delivery	To increase availability of acceptable waste disposal facilities by 80% at point of health care delivery	To increase availability of acceptable waste disposal facilities by 85% at point of health care delivery
	Increase the use of standard colour coded waste and bin liner at point of health care delivery increased by 68%	Increase the use of standard colour coded waste and bin liner at point of health care delivery increased by 70%	Increase the use of standard colour coded waste and bin liner at point of health care delivery increased by 75%	Increase the use of standard colour coded waste and bin liner at point of health care delivery increased by 85%	Increase the use of standard colour coded waste and bin liner at point of health care delivery increased by 95%
Prevention and control the importation of public health emergency of international concern at point of entry by 2032	Port health services cost sharing guidelines implemented to 20 point of entries	Port health services cost sharing guidelines implemented to 25 point of entries	Port health services cost sharing guidelines implemented to 35 point of entries	Port health services cost sharing guidelines implemented to 40 point of entries	Port health services cost sharing guidelines implemented to 54 point of entries
	Core capacities at PoE improved to meet at least 50% IHR requirements	Core capacities at PoE improved to meet at least 55% IHR requirements	Core capacities at PoE improved to meet at least 60% IHR requirements	Core capacities at PoE improved to meet at least 70% IHR requirements	Core capacities at PoE improved to meet at least 80% IHR requirements
To enhance advanced knowledge and technology for	50% of all PoE in the country attain demonstrated capacity as per	60% of all PoE in the country attain demonstrated capacity as per International	65% of all PoE in the country attain demonstrated capacity as per International	70% of all PoE in the country attain demonstrated capacity as per International	70% of all PoE in the country attain demonstrated capacity as per International

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
detection, analysis and timely response to public health threats at Points of Entry (PoE) by 2032	International Health Regulations of 2005	Health Regulations of 2005	Health Regulations of 2005	Health Regulations of 2005	Health Regulations of 2005
To strengthen and promote protection of the health and safety of the working population in formal and informal sectors by 2032	Develop at least 1 occupational exposure limits (OEL)	Develop at least 2 occupational exposure limits (OEL)	Develop at least 3 occupational exposure limits (OEL)	Develop at least 3 occupational exposure limits (OEL)	Develop at least 3 occupational exposure limits (OEL)
	Conduct workers OSH education to 3,000 through media and other means	Conduct workers OSH education to 5,000 through media and other means	Conduct workers OSH education to 8,000 through media and other means	Conduct workers OSH education to 10,000 through media and other means	Conduct workers OSH education to 12,000 through media and other means
	Conduct workplace evaluation in 50 health facilities using Health | Wise tool 2032	Conduct workplace evaluation in 40 health facilities using Health | Wise tool by 2032	Conduct workplace evaluation in 30 health facilities using Health | Wise tool by 2032	Conduct workplace evaluation in 20 health facilities using Health | Wise tool by 2032	Conduct workplace evaluation in 10 health facilities using Health | Wise tool by 2032
Disseminate HCWM policies, Regulations, Guidelines and standards by December, 2022	Dissemination of policies, guidelines, standards and regulations conducted to 35% of district councils	Dissemination of policies, guidelines, standards and regulations conducted to 75% of district councils	Dissemination of policies, guidelines, standards and regulations conducted to 90% of district councils	Dissemination of policies, guidelines, standards and regulations conducted to 100% of district councils	Dissemination of policies, guidelines, standards and regulations conducted to 35% of district councils
Improve infrastructure, equipment and supplies and disposal options for HCWM by June 2023	Renovate and construct new functional incinerators to 2000 HCFs	Renovate and construct new functional incinerators to 4000 HCFs	Renovate and construct new functional incinerators to 6000 HCFs	Renovate and construct new functional incinerators to 7000 HCFs	Renovate and construct new functional incinerators to 8000 HCFs
Enhance accessibility of equipment, supplies and materials for	Facilitate availability of Siller machines for Color coded bin liners	Facilitate availability of Siller machines for Color coded bin liners for 120	Facilitate availability of Siller machines for Color coded bin liners for 140	Facilitate availability of Siller machines for Color coded bin liners for 160	Facilitate availability of Siller machines for Color coded bin liners for 200

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
HCWM by December, 2032	for 80 RRH and district hospitals	RRH and district hospitals	RRH and district hospitals	RRH and district hospitals	RRH and district hospitals
	Facilitate availability of pair of standard color-coded waste bins for HCWM in Low performing HCFs to 2000	Facilitate availability of pair of standard color-coded waste bins for HCWM in Low performing HCFs to 3000	Facilitate availability of pair of standard color-coded waste bins for HCWM in Low performing HCFs to 4000	Facilitate availability of pair of standard color-coded waste bins for HCWM in Low performing HCFs to 4500	Facilitate availability of pair of standard color-coded waste bins for HCWM in Low performing HCFs to 5000
Capacitate HCFs on safe HCWM by 2032	Advocacy and sensitization conducted to 60% of HCFs to increase proper health care waste segregation practices at the point of Health care waste	Advocacy and sensitization conducted to 70% of HCFs to increase proper health care waste segregation practices at the point of Health care waste	Advocacy and sensitization conducted to 75% of HCFs to increase proper health care waste segregation practices at the point of Health care waste	Advocacy and sensitization conducted to 80% of HCFs increase proper health care waste segregation practices at the point of Health care waste	Advocacy and sensitization conducted to 90% of HCFs to increase proper health care waste segregation practices at the point of Health care waste
	Capacity building conducted to 60% of HCFs to facilitate availability of acceptable waste disposal facilities lower healthcare facilities	Capacity building conducted to 70% of HCFs to facilitate availability of acceptable waste disposal facilities lower healthcare facilities	Capacity building conducted to 75% of HCFs to facilitate availability of acceptable waste disposal facilities lower healthcare facilities	Capacity building conducted to 80% of HCFs to facilitate availability of acceptable waste disposal facilities lower healthcare facilities	Capacity building conducted to 90% of HCFs to facilitate availability of acceptable waste disposal facilities lower healthcare facilities

8.1.15 COMPONENT: EMERGENCY AND PREPARADNESS AND RESPONSE SERVICES

Main Objective;	Improve health and community systems with sufficient capacity to prepare for, detect, prevent, respond to and recover from health epidemics, emergencies and disasters by 2032				
Specific objective	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
Ensure availability of 90% of necessary equipment, medicines, and infrastructure to provide emergency	Procurement and installation of medical equipment 20% for emergency and critical care available at 11 National, Zonal and	Procurement and installation of medical equipment 30% for emergency and critical care available at 40 National, Zonal and	Procurement and installation of medical equipment 50% for emergency and critical care available at 132 National, Zonal and	Procurement and installation of medical equipment 70% for emergency and critical care available at 224 National, Zonal and	Procurement and installation of medical equipment 90% for emergency and critical care available at 1,224 National, Zonal and Specialized

Main Objective;	Improve health and community systems with sufficient capacity to prepare for, detect, prevent, respond to and recover from health epidemics, emergencies and disasters by 2032				
Specific objective	**Target Year 1-2**	**Target Year 3-4**	**Target Year 5-6**	**Target Year 7-8**	**Target Year 9-10**
services and post-emergency services and address the health effects of various disasters available at 1,224 National, Zonal and Specialized referral hospitals and all Council level hospitals and all health centres., . By year 2032	Specialized referral hospitals.	Specialized referral hospitals.	Specialized referral hospitals and half the Council level hospitals	Specialized referral hospitals and all the Council level hospitals	referral hospitals and all Council level hospitals and all health centres.
	Procure and stock essential medicines for infectious diseases	Procure and stock essential medicines for infectious diseases	Procure and stock essential medicines for infectious diseases	Procure and stock essential medicines for infectious diseases	Procure and stock essential medicines for infectious diseases
	Construction of Emergency Medical Departments at National Specialized, Zonal and Regional hospitals	Construction of Emergency Medical Departments at District hospitals (184 District Hospitals)	Construction of Emergency Medical Departments at District hospitals (184 District Hospitals)	Construction of Emergency Medical Departments at District hospitals (184 District Hospitals)	Construction of Emergency Medical Departments at at the highly congested Health centers located in either urban or rural areas (100 Health Centers)
	Advocate the training of at least three (3) emergency physicians (Post graduate studies) for each level to run the EMDs	Advocate the training of at least one (1) emergency physician (Post graduate studies) to run the EMDs	Advocate the training of at least one (13) emergency physician (Post graduate studies) to run the EMDs	Advocate the training of at least one (13) emergency physician (Post graduate studies) to run the EMDs	Advocate the training of at least three (3) MD on emergency care (In service training) to run the EMDs
	Advocate the training of at least three (3) critical care nurses (Diploma studies) for each level to run the ICUs	Advocate the training of at least two (2) critical care nurses (Diploma studies) to run the ICUs	Advocate the training of at least two (2) critical care nurses (Diploma studies) to run the ICUs	Advocate the training of at least two (2) critical care nurses (Diploma studies) to run the ICUs	Advocate the training of at least three (3) nurses per facility (In service or attachment studies) for emergency care
	Conduct observational survey/assessments to determine the quality of emergency and critical care at all levels on annual basis	Conduct observational survey/assessments to determine the quality of emergency and critical care at all levels on annual basis	Conduct observational survey/assessments to determine the quality of emergency and critical care at all levels on annual basis	Conduct observational survey/assessments to determine the quality of emergency and critical care at all levels on annual basis	Conduct observational survey/assessments to determine the quality of emergency and critical care at all levels on annual basis
To develop10 Plans and 6 (95%) Action guidelines dealing	Development of Influenza preparedness contingency plan	Development of Influenza preparedness	Development of Influenza preparedness contingency plan	Development of Influenza preparedness contingency plan	Update Influenza preparedness contingency plan

Main Objective;	Improve health and community systems with sufficient capacity to prepare for, detect, prevent, respond to and recover from health epidemics, emergencies and disasters by 2032				
Specific objective	**Target Year 1-2**	**Target Year 3-4**	**Target Year 5-6**	**Target Year 7-8**	**Target Year 9-10**
with 100% event specific with the effects such as the physical and psychological effects of various disasters at all levels.		contingency plan			
	Development/Updating the Ebola Virus Disease preparedness contingency plan	Development/Updating the Ebola Virus Disease preparedness contingency plan	Development/Updating the Ebola Virus Disease preparedness contingency plan	Development/Updating the Ebola Virus Disease preparedness contingency plan	Update the Ebola Virus Disease preparedness contingency plan
	Development/ Update the mass casualty guidelines	Development/ Update the mass casualty guidelines	Development/Update the mass casualty guidelines	Development/ Update the mass casualty guidelines	Update the mass casualty guidelines
	Update the COVID-19 Response Plan	Development of Cholera preparedness contingency plan	Development/Update of Cholera preparedness contingency plan	Development/Update of Cholera preparedness contingency plan	Update of Cholera preparedness contingency plan
	Update the COVID-19 Treatment Guidelines	Develop the Dengue Preparedness contingency plan	Develop/update the Dengue Preparedness contingency plan	Develop/update the Dengue Preparedness contingency plan	Update the Dengue Preparedness contingency plan
	Assessment of the health systems for the availability and use of preparedness and response plans/guidelines	Update the Dengue Treatment Guideline	Update the EVD treatment guidelines	Update the EVD treatment guidelines	Update the EVD treatment guidelines
		Assessment of the health systems for the availability and use of preparedness and response plans/guidelines	Update the cholera treatment guideline	Update the cholera treatment guideline	Update the cholera treatment guideline
	Development of Influenza preparedness contingency plan	Development of Influenza preparedness contingency plan	Development of Influenza preparedness contingency plan	Development of Influenza preparedness contingency plan	Update Influenza preparedness contingency plan
				Develop the Anthrax contingency plan	Develop the Anthrax contingency plan

Main Objective;	Improve health and community systems with sufficient capacity to prepare for, detect, prevent, respond to and recover from health epidemics, emergencies and disasters by 2032				
Specific objective	**Target Year 1-2**	**Target Year 3-4**	**Target Year 5-6**	**Target Year 7-8**	**Target Year 9-10**
				Assessment of the health systems for the availability and use of preparedness and response plans/guidelines	Assessment of the health systems for the availability and use of preparedness and response plans/guidelines
Capacitate 70% of health care providers at all levels to deal with the effects of various disasters by year 2032	Training of 10% health care workers at regional referral Hospitals to management infectious diseases e.g. Cholera, EVD, COVID-19, and keep their data base	Training of 30% health care workers at 100 District Hospitals to management infectious diseases e.g. Cholera, EVD, COVID-19, and keep their data base	Training of 40% health care workers at 100 District Hospitals (including private hospitals) to management infectious diseases e.g. Cholera, EVD, COVID-19, and keep their data base	Training of 50% health care workers at 50% 0f Health Centers and Dispensaries to management infectious diseases e.g. Cholera, EVD, COVID-19, and keep their data base	Training of 70% health care workers at 50% 0f Health Centers and Dispensaries to management infectious diseases e.g. Cholera, EVD, COVID-19, and keep their data base
	Onsite mentorship of health care workers at regional referral Hospitals to management infectious diseases e.g. Cholera, EVD, COVID-19, and keep their data base	Onsite mentorship of health care workers at regional referral Hospitals to management infectious diseases e.g. Cholera, EVD, COVID-19, and keep their data base	Onsite mentorship of health care workers at District Hospitals to management infectious diseases e.g. Cholera, EVD, COVID-19, and keep their data base	Onsite mentorship of health care workers at Health Centers and Dispensaries to management infectious diseases e.g. Cholera, EVD, COVID-19, and keep their data base	Onsite mentorship of health care workers at Health Centers and Dispensaries to management infectious diseases e.g. Cholera, EVD, COVID-19, and keep their data base
	Conduct annual assessment of capacity among healthcare workers to management infectious diseases	Conduct Facility based simulation exercises with health care workers at regional referral Hospitals to management infectious diseases e.g. Cholera, EVD, COVID-19, and keep their data base	Conduct Facility based simulation exercises with health care workers at District Hospitals to management infectious diseases e.g. Cholera, EVD, COVID-19, and keep their data base	Conduct Facility based simulation exercises with health care workers at Health Centers and Dispensaries to management infectious diseases e.g. Cholera, EVD, COVID-19, and keep their data base	Conduct Facility based simulation exercises with health care workers at Health Centers and Dispensaries to management infectious diseases e.g. Cholera, EVD, COVID-19, and keep their data base
		Conduct annual	Conduct annual	Conduct annual	Conduct annual

Main Objective;	Improve health and community systems with sufficient capacity to prepare for, detect, prevent, respond to and recover from health epidemics, emergencies and disasters by 2032				
Specific objective	**Target Year 1-2**	**Target Year 3-4**	**Target Year 5-6**	**Target Year 7-8**	**Target Year 9-10**
		assessment of capacity among healthcare workers to management infectious diseases	assessment of capacity among healthcare workers to management infectious diseases	assessment of capacity among healthcare workers to management infectious diseases	assessment of capacity among healthcare workers to management infectious diseases
Subnational level "all hazard" emergency preparedness and response plans that will guide implementation during emergencies for all 26 regions developed by 2032	Develop 5 regions subnational level "all hazard" emergency preparedness and response plans and hazard-specific plans that will guide implementation during emergencies at all levels	Develop 10 regions subnational level "all hazard" emergency preparedness and response plans and hazard-specific plans that will guide implementation during emergencies at all levels	Develop 15 regions subnational level "all hazard" emergency preparedness and response plans and hazard-specific plans that will guide implementation during emergencies at all levels	Develop 20 regions subnational level "all hazard" emergency preparedness and response plans and	Develop 26 regions subnational level "all hazard" emergency preparedness and response plans and hazard-specific plans that will guide implementation during emergencies at all levels
To conduct simulation exercises to enhance preparedness competence of the health workforce from national to subnational levels	One national level drills and simulation exercises conducted to enhance the competence of the health workforce.	One national level and at least 5 regional level drills and simulation exercises conducted to enhance the competence of the health workforce.	One national level and at least 10 regional level drills and simulation exercises conducted to enhance the competence of the health workforce.	One national level and at least 18 regional level drills and simulation exercises conducted to enhance the competence of the health workforce.	One national level and 26 regional level drills and simulation exercises conducted to enhance the competence of the health workforce.
To update A National Health and 26 Regional Health risk profiles by 2032	Conduct National wide risk profiling and vulnerability assessment and mapping	Conduct 10 Regional level risk profiling and vulnerability assessment and mapping	Conduct 10 regional level risk profiling and vulnerability assessment and mapping	Conduct 6 regional level risk profiling and vulnerability assessment and mapping	Review the risk National health risk profile
	Prepare a national health risk profile	Prepare a Regional health risk profile	Prepare a Regional health risk profile	Prepare a Regional health risk profile	Prepare a Regional health risk profile
To ensure 80% availability of	20% Annual budget based on the need	30% Annual budget based on the need	40% Annual budget based on the need versus annual	60% Annual budget based on the need	80% Annual budget based on the need versus annual

Main Objective;	Improve health and community systems with sufficient capacity to prepare for, detect, prevent, respond to and recover from health epidemics, emergencies and disasters by 2032				
Specific objective	**Target Year 1-2**	**Target Year 3-4**	**Target Year 5-6**	**Target Year 7-8**	**Target Year 9-10**
required finance for emergencies preparedness and response through the annual budget for sustainable system for timely financing of emergencies by 2032	versus annual budget allocated for sustainable system at all levels	versus annual budget allocated for sustainable system at all levels	budget allocated for sustainable system at all levels	versus annual budget allocated for sustainable system at all levels	budget allocated for sustainable system at all levels
	Conduct resource mobilization to various stakeholders via emergency specific response plans	Conduct resource mobilization to various stakeholders via emergency specific response plans	Conduct resource mobilization to various stakeholders	Conduct resource mobilization to various stakeholders via emergency specific response plans	Conduct resource mobilization to various stakeholders via emergency specific response plans
	Resource mobilization via proposals development and partners engagement	Resource mobilization via proposals development and partners engagement	Resource mobilization via proposals development and partners engagement	Resource mobilization via proposals development and partners engagement	Resource mobilization via proposals development and partners engagement
To establish and strengthen National and 26 Regional level Emergency Response Operations centers by year 2032	Pre establishment assessment of infrastructures and provide preparatory recommendations	Pre establishment assessment of infrastructures and provide preparatory recommendations	Pre establishment assessment of infrastructures and provide preparatory recommendations	Pre establishment assessment of infrastructures and provide preparatory recommendations	Pre establishment assessment of infrastructures and provide preparatory recommendations
	procurement of ICT and teleconference equipment	procurement of ICT and teleconference equipment	procurement of ICT and teleconference equipment	procurement of ICT and teleconference equipment	procurement of ICT and teleconference equipment
	Installation of the procurement equipment to the ready prepared rooms	Installation of the procurement equipment to the ready prepared rooms	Installation of the procurement equipment to the ready prepared rooms	Installation of the procurement equipment to the ready prepared rooms	Installation of the procurement equipment to the ready prepared rooms
	Equip each PHEOC with a monthly internet connection for at least 12 months	Equip each PHEOC with a monthly internet connection for at least 12 months	Equip each PHEOC with a monthly internet connection for at least 12 months	Equip each PHEOC with a monthly internet connection for at least 12 months	Equip each PHEOC with a monthly internet connection for at least 12 months
	Conduct training to the national teams on PHEOC establishment and operations	Conduct training to the national teams on PHEOC establishment and operations	Conduct training to the national teams on PHEOC establishment and operations	Conduct training to the national teams on PHEOC establishment and operations	Conduct training to the national teams on PHEOC establishment and operations

Main Objective;	Improve health and community systems with sufficient capacity to prepare for, detect, prevent, respond to and recover from health epidemics, emergencies and disasters by 2032				
Specific objective	**Target Year 1-2**	**Target Year 3-4**	**Target Year 5-6**	**Target Year 7-8**	**Target Year 9-10**
	Conduct post installation assessment for the PHEOC functionality	Conduct post installation assessment for the PHEOC functionality	Conduct post installation assessment for the PHEOC functionality	Conduct post installation assessment for the PHEOC functionality	Conduct post installation assessment for the PHEOC functionality
To establish and oversee efficient and effective emergency medical services in 26 regions to ensure timely provision of required services by 2032	To conduct facilities assessment in 3 regions along the highway in the target regions to determine the need for establishing an Emergency medical Services Post	To conduct facilities assessment in 5 regions (Dodoma, Iringa, Mbeya, Singida, Songwe) along the highway in the target regions to determine the need for establishing an Emergency medical Services Post	To conduct facilities assessment 5 regions (Tabora, Shinyanga, Mara, Simiyu& Mwanza) along the highway in the target regions to determine the need for establishing an Emergency medical Services Post	To conduct facilities assessment 7 regions (Geita, Kagera, Kigoma, Katavi, Rukwa, Arusha, Manyara) along the highway in the target regions to determine the need for establishing an Emergency medical Services Post	To conduct facilities assessment in 6 regions (Kilimanjaro, Tanga, Lindi, Mtwara, Ruvuma, Njombe) along the highway in the target regions to determine the need for establishing an Emergency medical Services Post
	Identification of health facilities to serve as EMS posts	Identification of health facilities to serve as EMS posts	Identification of health facilities to serve as EMS posts	Identification of health facilities to serve as EMS posts	Identification of health facilities to serve as EMS posts
	Renovate the identified healthcare facilities if need be	Renovate the identified healthcare facilities if need be	Renovate the identified healthcare facilities if need be	Renovate the identified healthcare facilities if need be	Renovate the identified healthcare facilities if need be
	Procure and install the medical equipment in the identified and renovated healthcare facilities for emergency care	Procure and install the medical equipment in the identified and renovated healthcare facilities for emergency care	Procure and install the medical equipment in the identified and renovated healthcare facilities for emergency care	Procure and install the medical equipment in the identified and renovated healthcare facilities for emergency care	Procure and install the medical equipment in the identified and renovated healthcare facilities for emergency care
	Identification of medical staff including ambulance drivers to be trained (At least 6 staff (DH) or 4 (HC)	Identification of medical staff including ambulance drivers to be trained (At least 6 staff (DH) or 4 (HC)	Identification of medical staff including ambulance drivers to be trained (At least 6 staff (DH) or 4 (HC)	Identification of medical staff including ambulance drivers to be trained (At least 6 staff (DH) or 4 (HC)	Identification of medical staff including ambulance drivers to be trained (At least 6 staff (DH) or 4 (HC)
	To conduct training of	To conduct training of	To conduct training of	To conduct training of	To conduct training of

Main Objective;	Improve health and community systems with sufficient capacity to prepare for, detect, prevent, respond to and recover from health epidemics, emergencies and disasters by 2032				
Specific objective	**Target Year 1-2**	**Target Year 3-4**	**Target Year 5-6**	**Target Year 7-8**	**Target Year 9-10**
	healthcare workers from all the identified facilities	healthcare workers from all the identified facilities	healthcare workers from all the identified facilities	healthcare workers from all the identified facilities	healthcare workers from all the identified facilities
	Procurement of Ambulances (Ratio 1:3 for Advanced versus Basic Life support Ambulances)	Procurement of Ambulances (Ratio 1:3 for Advanced versus Basic Life support Ambulances)	Procurement of Ambulances (Ratio 1:3 for Advanced versus Basic Life support Ambulances)	Procurement of Ambulances (Ratio 1:3 for Advanced versus Basic Life support Ambulances)	Procurement of Ambulances (Ratio 1:3 for Advanced versus Basic Life support Ambulances)
	Procurement and installation of EMS communication system	Procurement and installation of EMS communication system	Procurement and installation of EMS communication system	Procurement and installation of EMS communication system	Procurement and installation of EMS communication system
	procurement and distribution of communication radios for all the identified health facilities and Ambulances	procurement and distribution of communication radios for all the identified health facilities and Ambulances	procurement and distribution of communication radios for all the identified health facilities and Ambulances	procurement and distribution of communication radios for all the identified health facilities and Ambulances	procurement and distribution of communication radios for all the identified health facilities and Ambulances
	Procurement of Air Ambulances	Procurement of Air Ambulances	Procurement of Air Ambulances	Procurement of Air Ambulances	Procurement of Air Ambulances
	Procurement and commissioning of marine Ambulances to the identified water bodies	Procurement and commissioning of marine Ambulances to the identified water bodies	Procurement and commissioning of marine Ambulances to the identified water bodies	Procurement and commissioning of marine Ambulances to the identified water bodies	Procurement and commissioning of marine Ambulances to the identified water bodies
	Prepare the Emergency Medical Services operational framework	Prepare the Emergency Medical Services operational framework	Update the Emergency Medical Services operational framework	Monitor the implementation of the Emergency Medical Services operational framework	Monitor the implementation of the Emergency Medical Services operational framework
	To establish a national registry for all emergencies, major	To maintain a national registry for all emergencies, major	To maintain a national registry for all emergencies, major	To maintain a national registry for all emergencies, major	To maintain a national registry for all emergencies, major

Main Objective;	Improve health and community systems with sufficient capacity to prepare for, detect, prevent, respond to and recover from health epidemics, emergencies and disasters by 2032				
Specific objective	**Target Year 1-2**	**Target Year 3-4**	**Target Year 5-6**	**Target Year 7-8**	**Target Year 9-10**
	incidents and accidents	incidents and accidents	incidents and accidents	incidents and accidents	incidents and accidents
To develop and operationalize the program for provision of psychosocial support, gender mainstreaming and social protection services to affected individuals and effective restoration of essential health services at all levels. By 2032	To develop Mental Health and psychosocial support Basic guidelines and SOPs during emergencies	Printing of Mental health and Psychosocial support guidelines and SOPs before dissemination	Capacity building to key mental health and psychosocial support experts and disseminate Mental health and psychosocial guidelines and PFA guidelines at Subnational level	Conduct assessment, monitoring and evaluation to strategic facilities to determine the quality of services being provided (e.g., POE, Health Facilities etc.)	Conduct assessment, monitoring and evaluation to strategic facilities to determine the quality of services being provided (e.g., POE, Health Facilities etc.)
	To develop the Psychosocial first Aid guidelines	Dissemination of Mental health and psychosocial guidelines and PFA guidelines at Subnational level	Capacity Building of Social welfare officers at all levels for psychosocial support services during emergencies provision	Onsite assessment and mentorship on proper services provision	Onsite assessment and mentorship on proper services provision
	Printing of Mental health and Psychosocial support guidelines before dissemination	Capacity Building of Social welfare officers at all levels for psychosocial support services during emergencies provision	Onsite assessment and mentorship on proper services provision	Capacity building for secondary and primary schools on Mental Health and Psychosocial support	Conduct Impact assessment and reporting
	Develop the gridline for health care services for Vulnerable group	Disseminate the vulnerable group guideline	Orientation of health care workers on the guideline	Assess the health care services for vulnerable group	Conduct On job training for
	Gender equity and equality during the emergence	Strengthening and mainstreaming gender in programs from National level to Local Governments Authority (LGAs)	Capacity building for Mental health and Psychosocial support service provides that is from Health facilities, Point of Entry and at the Community	Monitoring the gender issues in Health facilities and at Point of Entry	Conduct Impact assessment on Gender
To carry out	Develop and review all	Disseminate all hazard	Disseminate all hazard	Disseminate all hazard	Assessment of the

Main Objective;	Improve health and community systems with sufficient capacity to prepare for, detect, prevent, respond to and recover from health epidemics, emergencies and disasters by 2032				
Specific objective	**Target Year 1-2**	**Target Year 3-4**	**Target Year 5-6**	**Target Year 7-8**	**Target Year 9-10**
comprehensive all hazard preparedness and response interventions at all levels	hazard Emergency Preparedness Guidelines	Emergency Preparedness Guidelines	Emergency Preparedness Guidelines	Emergency Preparedness Guidelines	availability of guidelines and SOPs for emergency preparedness and response at all levels
	National action plan for health security developed and updated	National action plan for health security disseminated to subnational levels	National action plan for health security disseminated to subnational levels	National action plan for health security disseminated to subnational levels	Assessment of the database of the response teams at all levels as per national and international guidelines recommendations
	To train and keep the database for national rapid response teams	To train and keep the database for regional rapid response teams	To train and keep the database for council rapid response teams	To train and keep the database for council rapid response teams	To identify and incorporate the key preparedness indicators into the DHIS2
	To participate in the cross border simulation exercises	To participate in the cross border simulation exercises	To participate in the cross border simulation exercises	To participate in the cross border simulation exercises	To participate in the cross border simulation exercises
	Conduct regular multisectoral meetings on matters related to emergencies preparedness and response at national level	Conduct regular multisectoral meetings on matters related to emergencies preparedness and response at both national and subnational levels	Conduct regular multisectoral meetings on matters related to emergencies preparedness and response at both national and subnational levels	Conduct regular multisectoral meetings on matters related to emergencies preparedness and response at both national and subnational levels	Conduct regular multisectoral meetings on matters related to emergencies preparedness and response at both national and subnational levels
	To conduct the national level simulation exercises	To conduct the regional level simulation exercises	To conduct the council level simulation exercises	To conduct the council level simulation exercises	To conduct the council level simulation exercises
	Conduct the national wide readiness assessment	Conduct the national wide readiness assessment	Conduct the national wide readiness assessment	Conduct the national wide readiness assessment	Conduct the national wide readiness assessment

8.1.16 COMPONENT: HEALTH PROMOTION AND EDUCATION SERVICES

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-82	Target Year 9-10
To Guide and harmonize health education and communication interventions	To develop guidelines and manuals for behavior change Communication (BCC), social mobilization and advocacy to guide SBCC interventions to all levels.	To conduct Training of Trainers (ToTs) to 50 national trainers on SBCC manual and tools.	To conduct orientation to 5 CHMT members from 100 councils on the SBCC manuals and tools.	To conduct orientation to 5 CHMT members from 86 councils on the SBCC manuals and tools.	To review the guidelines and manuals for behavior change Communication (BCC), social mobilization and advocacy to guide SBCC interventions to all levels.
To Strengthen health facility-based education	To develop Health Facility Based Education Standard Operating Procedures (SoP)	To print 10,000 copies of Health Facility Based Education SoP	To distribute Health Facility Based Education SoP to 10,000 facilities countrywide.		
	To Assess facility based health education status by conducting Mapping of Health Education Delivery Facilities to all Health Facilities.	To Equip 10,000 health facilities with job aids and audio visual materials (audio-video materials, TV, DVD players)	Conduct continuous monitoring and improve	Conduct continuous monitoring and improve	Conduct continuous monitoring and improve
To strengthen capacity of emergency health communication preparedness, response and resilience	Develop emergency preparedness and response communication guidelines and training manuals	Develop messages on emergencies which can be disseminated through different communication outlets	To support dissemination of the Emergency Health Communication by conducting orientation to 5 CHMT members from 100 Councils.	To disseminate messages through 5 National Radio/TV and 100 community radios for 12 month	To disseminate messages through 5 National Radio/TV and 100 community radios for 12 month

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-82	Target Year 9-10
To strengthen monitoring, evaluation and research component in the health promotion section	To review and update Health Promotion indicators at all levels.	To develop checklist/tool for Health promotion Data quality check and assessment.	To conduct annual data management and systems supportive supervision and data quality assessment.	To conduct annual data management and systems supportive supervision and data quality assessment.	To conduct annual data management and systems supportive supervision and data quality assessment.
To provide an enabling environment for Revitalizing implementation of Health Promotion at School level.	To print and distribute National School Health Program guidelines to all regions, councils and stakeholders	To develop, design and pretest school based IEC/SBCC materials for health issue for Primary, Secondary and Tertiary education.	To disseminate school based SBCC/IEC materials to 25% of all schools country wide.	To support dissemination school based SBCC/IEC materials to 50% of all schools country wide.	To assess availability status of NSHP guidelines and IEC/SBCC materials to schools.

8.1.17 COMPONENT: ADVOCACY OF PHSIDS

Objectives	**Target Year 1-2**	**Target Year 3-4**	**Target Year 5-6**	**Target Year 7-8**	**Target Year 9-10**
To advocate for mainstreaming of health and multi-sector response to social determinants of health	Conduct and document analysis of relevant policies, their impact on health and identify health issues that are rooted in different policies	To develop advocacy IEC/SBCC Materials based on the analysis findings.	To disseminate IEC/SBCC materials through 5 national TV and Radios for 12 months.	To disseminate IEC/SBCC materials through 5 national TV and Radios for 12 months.	To disseminate IEC/SBCC materials through 5 national TV and Radios for 12 months.
To advocate understanding of the PHSIDS to stakeholders at all levels	Create understanding and supportive environment for the PHSIDS to leaders and influential at all levels	Enhance active participation and ownership of the PHSIDS at community level	Advocate for implementation and supportive maintenance and sustainability of the PHSIDS	Advocate for implementation and supportive maintenance and sustainability of the PHSIDS	Advocate for implementation and supportive maintenance and sustainability of the PHSIDS
		To conduct orientation meetings to 500 CHMT Members on the revised the PHSIDS	To conduct orientation meetings to 430 CHMT Members on the revised the PHSIDS		

8.1.18 **COMPONENT:** *COMMUNITY HEALTH SYSTEM*

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
To strengthen management and coordination of the CBHP at all levels	To Conduct mapping and developing database of stakeholders supporting community based health services at all level	To update annually database of stakeholders supporting community based health services at all level	To update annually database of stakeholders supporting community based health services at all level	To update annually database of stakeholders supporting community based health services at all level	To update annually database of stakeholders supporting community based health services at all level
	To Support annual stakeholders meetings for Community based health services including 1 member from all 26 regions and member from 186 councils.	To Support annual stakeholders meetings for Community based health services including 1 member from all 26 regions and 1 member from 186 councils.	To Support annual stakeholders meetings for Community based health services including 1 member from all 26 regions and 1 member from 186 councils.	To Support annual stakeholders meetings for Community based health services including 1 member from all 26 regions and 1 member from 186 councils.	To Support annual stakeholders meetings for Community based health services including 1 member from all 26 regions and 1 member from 186 councils.
	To review guideline for supportive supervision, mentorship and coaching at Community level.	To conduct annual joint supportive supervision on CBH interventions at all levels using the developed supportive guideline	To conduct annual joint supportive supervision on CBH interventions at all levels using the developed supportive guideline	To review guideline for supportive supervision, mentorship and coaching at community level.	To conduct annual joint supportive supervision on CBH interventions at all levels using the developed supportive guideline
	Review the primary health care guideline (1990)	To support two (2) Primary Health Care Meetings annually at all levels	To support two (2) Primary Health Care Meetings annually at all levels	To support two (2) Primary Health Care Meetings annually at all levels	To support two (2) Primary Health Care Meetings annually at all levels
To strengthen CHW Cadre	To recruit and deploy CHWs at hamlet/Mtaa level based on the	To train and equip 10,000 CHWs by using standardize	To train and equip 10,000 CHWs by using the standardize	To train and equip 10,000 CHWs by using standardize training	To train and equip 10,000 CHWs by using standardize training

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
	National Operational Guideline for Community Based Health Services countrywide.	training Package and CHWs tool Kit.	training Package and CHWs tool Kit	Package and CHWs tool Kit.	Package and CHWs tool Kit.
	To develop Performance based incentive package for Community Health Workers	To facilitate incentives to at least 1 CHW from 16000 villages countrywide based on the Performance based incentive package.	To facilitate incentives to at least 1 CHW from 16000 villages countrywide based on the Performance based incentive package.	To facilitate incentives to at least 1 CHW from 16000 villages countrywide based on the Performance based incentive package.	To facilitate incentives to at least 1 CHW from 16000 villages countrywide based on the Performance based incentive package.
	To develop the training package and Supervision guide for CHWs supervisors at the Community level.	To support orientation of 2500 CHWs Supervisor (V/MEOs and Health Facility in charges)	To support orientation of 2500 CHWs Supervisor (V/MEOs and Health Facility in charges)	To support orientation of 2500 CHWs Supervisor (V/MEOs and Health Facility in charges)	To support orientation of 2500 CHWs Supervisor (V/MEOs and Health Facility in charges)
To strengthen community health systems through inclusive involvement and empowerment of communities by 2032	To review and disseminate Health Facility Governing Committees Guidelines	To facilitate HFGC meetings to 800 of all facilities countrywide	To facilitate HFGC meetings to 800 of all facilities countrywide	To facilitate HFGC meetings to 800 of all facilities countrywide	To facilitate HFGC meetings to 800 of all facilities countrywide
	To conduct orientation meetings to 2400 HFGC members on the revised HFGC guidelines	To conduct orientation meetings to 2400 HFGC members on the revised HFGC guidelines	To conduct orientation meetings to 2400 HFGC members on the revised HFGC guidelines	To conduct orientation meetings to 2400 HFGC members on the revised HFGC guidelines	To conduct orientation meetings to 2400 HFGC members on the revised HFGC guidelines
	Develop/adapt tools to facilitate community mobilization on health issues	To facilitate 2 Council Health Board Meetings annually to 100 councils	To facilitate 2 Council Health Board Meetings annually to 86 councils	To conduct assessment on the impact of community mobilization interventions on improving health indicators.	To review tools to facilitate community mobilization on health issues

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
	To conduct orientation meetings to 200 Council Health Services Board Members and Health facility Governing Committees on the revised Council Health Board Guideline.	To conduct orientation meetings to 400 Council Health Services Board Members and Health facility Governing Committees on the revised Council Health Board Guideline.	To conduct orientation meetings to 344 Council Health Services Board Members and Health facility Governing Committees on the revised Council Health Board Guideline.	To conduct orientation meetings to 300 Council Health Services Board Members and Health facility Governing Committees on the revised Council Health Board Guideline.	To conduct orientation meetings to 400 Council Health Services Board Members and Health facility Governing Committees on the revised Council Health Board Guideline.

8.1.19 COMPONENT: TRADITIONAL AND ALTERNATIVE MEDICINES SERVICES

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
To Improve quality of traditional and alternative medicine services through evidence-based research by June 2032	Capacitate 5 researchers to conduct research and development on traditional and alternative medicine	One traditional medicine related research conducted that will provide answers for improving quality traditional and alternative medicine	One traditional medicine related research conducted that will provide answers for improving quality traditional and alternative medicine	One traditional medicine related research conducted that will provide answers for improving quality traditional and alternative medicine	One traditional medicine related research conducted that will provide answers for improving quality traditional and alternative medicine
	Procurement of machines and reagents for 3 research institutions to conduct traditional research and analysis of rational medicine products	One traditional research and analysis of traditional medicine products conducted	Integration of traditional and modern medicine	Development of Traditional medicine marketing strategies	Integration of traditional and modern medicine
	Land acquisition, installment of machines for Establishment of 2 resource centers	Land acquisition for Establishment of one botanical garden	Land acquisition for Establishment of one botanical garden		
	Development of training manual and teaching curriculum for traditional	Training and orientation of 200 modern health	Training and orientation of 200 modern health	Training and orientation of 200 modern health	Training and orientation of 200 modern health practitioners on the

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
	practitioners and modern health practitioners	practitioners on the traditional medicine	practitioners on the traditional medicine	practitioners on the traditional medicine	traditional medicine
	Training and orientation of 200 traditional health practitioners trained on handling of patients, IPC, safe preparation of traditional medicine products, IPR, referral system	Training and orientation of 200 traditional health practitioners trained on handling of patients, IPC, safe preparation of traditional medicine products, IPR, referral system	Training and orientation of 200 traditional health practitioners trained on handling of patients, IPC, safe preparation of traditional medicine products, IPR, referral system	Training and orientation of 200 traditional health practitioners trained on handling of patients, IPC, safe preparation of traditional medicine products, IPR, referral system	Training and orientation of 200 traditional health practitioners trained on handling of patients, IPC, safe preparation of traditional medicine products, IPR, referral system
	26 Regional coordinators and 184 Council coordinators of traditional medicines trained on the safe use of traditional medicines	26 Regional coordinators and 184 Council coordinators of traditional medicines trained on the safe use of traditional medicines	26 Regional coordinators and 184 Council coordinators of traditional medicines trained on the safe use of traditional medicines	26 Regional coordinators and 184 Council coordinators of traditional medicines trained on the safe use of traditional medicines	26 Regional coordinators and 184 Council coordinators of traditional medicines trained on the safe use of traditional medicines
	Sensitization of THPs to increase registration of THPs from 31,064 to 45,000	Sensitization of THPs to increase registration of THPs from 45,000 to 55,000 By 2026	Sensitization of THPs to increase registration of THPs from 55,000 to 65,000 By 2028	Sensitization of THPs to increase registration from THPs 65,000 to 75,000 By 2030	Sensitization of THPs to increase registration from THPs 75,000 to 85,000 By 2032
	Sensitization of THPs to increase registration of traditional and alternative health facilities from 1,129 To 1329 By 2024	Sensitization of THPs to increase registration of traditional and alternative health facilities from 1,329 To 1529 By 2026	Sensitization of THPs to increase registration of traditional and alternative health facilities from 1,529 To 1729 By 2028	Sensitization of THPs to increase registration of traditional and alternative health facilities from 1,729 To 1929 By 2030	Sensitization of THPs to increase registration of traditional and alternative health facilities from 1,929 to 2129 By 2032
	Sensitization of Number of registered traditional medicines increased from 75 to 90 by 2024	Number of registered traditional medicines increased from 90 to 110 By 2026	Number of registered traditional medicines increased from 110 to 130 By 2028	Number of registered traditional medicines increased from 130 to 150 By 2030	Number of registered traditional medicines increased from 150 to 200 By 2032
	Develop Guidelines for	500 dispensaries oriented	500 dispensaries oriented	500 dispensaries	500 dispensaries oriented

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
	roles of VEOs and PHC in identification, data management of traditional medicine practice (, health statistics including number and cases attended by THPs) by 2024	and trained on referral systems and data management of cases attended by THPs by 2024	and trained on referral systems and data management of cases attended by THPs by 2026	oriented and trained on referral systems and data management of cases attended by THPs	and trained on referral systems and data management of cases attended by THPs

8.1.20 COMPONENT: HEALTH CARE FINANCING

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
	To review cost sharing guidelines that will provide guidance for implementation at lower level, including shift from block payment to fee for service 2024	Prepare mechanism for tracking of total PHC Budget by 2026	To conduct resource mobilization activities with stakeholders for support PHSIDS implementation by June 2028	To conduct resource mobilization activities with stakeholders for support PHSIDS implementation by June 2030	To conduct resource mobilization activities with stakeholders for support PHSIDS implementation by June 2032.
Allocation of sufficient funds to support PHSIDS implementation by Government, Development Partners, NGOs/CS Os, and Private Sector.	Dissemination of cost sharing guidelines to Stakeholders at National, Regional, Council and Facility levels by 2024	Conduct resource mobilization meetings with stakeholders for support PHSIDS implementation by June 2026.			

8.1.21 COMPONENT: INSTITUTIONAL ARRANGEMENT

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
To build the capacity of MOH and PO RALG in coordinating and managing PHSDP by establishing a Committee at all levels	Committees recruited/ established	4 Steering Committee Meeting and 12 Programme Review Meetings conducted	4 Steering Committee Meeting and 12 Programme Review Meetings conducted	4 Steering Committee Meeting and 12 Programme Review Meetings conducted	4 Steering Committee Meeting and 12 Programme Review Meetings and End of the Programme Evaluation conducted
To advocate understanding of the PHSIDS to stakeholders at all levels	Create understanding and supportive environment for the PHSIDS to leaders and influential at all levels	Enhance active participation and ownership of the PHSIDS at community level	Advocate for implementation and supportive maintenance and sustainability of the PHSIDS	Advocate for implementation and supportive maintenance and sustainability of the PHSIDS	Advocate for implementation and supportive maintenance and sustainability of the PHSIDS
	To conduct orientation meetings to decision making committees/boards at all levels on the revised the PHSIDS.	To conduct orientation meetings to decision making committees/ boards at all levels on the revised the PHSIDS	To conduct orientation meetings to decision making committees/ boards at all levels on the revised the PHSIDS.	To conduct orientation meetings to decision making committees/boards at all levels on the revised the PHSIDS.	To conduct orientation meetings to decision making committees/ boards at all levels on the revised the PHSIDS.

8.1.22 COMPONENT: LEADERSHIP AND GOVERNANCE

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
Have functioning National, Specialized, Zonal, Regional Referral Hospitals Boards, Council Health Service Boards (CHSB) and Health Facility Governing Committees for council hospitals,	Finalization of the Council Health Service Boards and Health Facility Governing Committees Guidelines by 2022	Training of the Council Health Service Boards and Health Facility Governing Committees members	Training of the Council Health Service Boards and Health Facility Governing Committees	Training of the Council Health Service Boards and Health Facility Governing Committees	To conduct Supportive Supervision to Regional, Council and Facility Levels on the functioning of the set governance structures
	Review the Hospital Boards and the	Conduct Supportive Supervision to	To conduct MID term Review of the of the set	To conduct Supportive Supervision to	

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
health centers and dispensaries.	Council Health Service Boards and Health Facility Governing Committees in all Public Health Facilities by 2024.	Regional, Council and Facility Levels on the functioning of the set governance structures	governance structures by 2026	Regional, Council and Facility Levels on the functioning of the set governance structures	
	Dissemination of the Council Health Service Boards and Health Facility Governing Committees of guidelines		To conduct supportive Supervision to Regional, Council and Facility Levels on the functioning of the set governance structures by 2026.		
Strengthen PHSIDS Implementation and institutional capacities for improved Health Services Management			To conduct MID term Review of the PHSIDS Implementation by 2026		To conduct End term Review of the PHSIDS Implementation by 2032

8.1.23 COMPONENT: PUBLIC-PRIVATE PARTNERSHIP

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
Strengthening cooperation with the private health sector in health care delivery.	To engage private sector to increase access to health care in the country and to protect the rights of specific groups.	To strengthen one single registration and accreditation system for all HFs	To harmonize the quality management systems of health care between the public and the private sector by 2026	To create enabling environment for joint ventures and/or private sector investments in the health sector, esp. in domestic production of medicines and consumables.	To stimulate and maintain PPP agreements at all levels
	To enhance involvement of other sectors in disease management strategies.	Disseminate one single registration and accreditation system to all stakeholders	To engage private sector in programmes for control of communicable diseases		

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
	To enhance collaboration with the other sectors, both at national & lower levels in order to address the social determinants of health (SDH)				
Enhance community involvement and engagement in the implementation of various health interventions.	To engage Community to volunteer for or donating to local health interventions/projects	To enhance social accountability for community health management systems.			

8.1.24 COMPONENT: INFORMATION TECHNOLIGY & COMMUNICATION

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
1. Strengthen Digital Health Governance framework to 450 regional HMT and 3128 CHMT to facilitate better coordination and implementation of digital health initiatives by 2032	Provide Digital Health Strategy (DHS) one day orientation to all 450 RHMT teams	Provide Digital Health Strategy (DHS) one day orientation to all 450 regional HMT	- Provide Digital Health Strategy (DHS) one day orientation to all 450 regional HMT	- Provide Digital Health Strategy (DHS) one day orientation to all 450 regional HMT	- Provide Digital Health Strategy (DHS) one day orientation to all 450 regional HMT
	-Provide one day orientation to 3128 Council Health Management Team	-Provide one day orientation to 3128 Council Health Management Team	-Provide one day orientation to 3128 Council Health Management Team	-Provide one day orientation to 3128 Council Health Management Team	-Provide one day orientation to 3128 Council Health Management Team
2.Improve ICT infrastructure to 28 Regional referral Hospital, 6681 Dispensaries, 498 Health	Install provisions for ICT infrastructure to support digital solution to 200 Health Center and 95 District Hospitals	Install provisions for ICT infrastructure to support digital solution in 200 Health Centre	Install provisions for ICT infrastructure to support digital solution in 98 Health Center	Continue improving ICT infrastructure to support digital solution in District Hospital and Health Centers	Continue improving ICT infrastructure to support digital solution in District Hospital and Health Centers

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
Centre and 95 District Hospital	Improve ICT infrastructure to 28 Regional referral Hospital	Improve ICT infrastructure to 28 Regional referral Hospital	Improve ICT infrastructure to 28 Regional referral Hospital	Improve ICT infrastructure to 28 Regional referral Hospital	Improve ICT infrastructure to 28 Regional referral Hospital
	Install provisions for ICT infrastructure to support digital solution to 1200 Dispensary	Install provisions for ICT infrastructure to support digital solution to 1200 Dispensary	Install provisions for ICT infrastructure to support digital solution to 1200 Dispensary	Install provisions for ICT infrastructure to support digital solution to 1510 Dispensary	Install provisions for ICT infrastructure to support digital solution to 1511 Dispensary
3.Availability of 84 RRH ICTO, 36 Zonal and Tertiary Hospital ICTO and 380 District Hospitals ICTO experts to facilitate technical support (2 ICTO in each District Hospital)	Recruit of 56 RRH ICTO and 9 Zonal and Tertiary Hospital ICT experts to facilitate technical support,	Recruit of 28 RRH ICTO and 18 Zonal and Tertiary Hospital ICT experts to facilitate technical support,	Recruit of 9 Zonal and Tertiary Hospital ICT experts to facilitate technical support		
	-Recruit 50 ICTO experts to facilitate technical support to District Hospital	- Recruit 50 ICTO experts to facilitate technical support to District Hospital	- Recruit 80 ICTO experts to facilitate technical support to District Hospital	- Recruit 100 ICTO experts to facilitate technical support to District Hospital	-Recruit 100 ICTO experts to facilitate technical support to District Hospital
4. Digitalize health services delivery in holistic manner and enhance information exchange through open standards to 6681 Dispensaries, 498 HC and 95 DH at all health facility level	- Digitalize health system and enhance information exchange to 95 District hospitals and 100 Health Centers	-Digitalize health system and enhance information exchange to 150 Health Centers	Digitalize health system and enhance information exchange to 150 Health Centers	Digitalize health system and enhance information exchange to 98 Health Centers	
	Digitalize health systems and enhance information exchange to 1200 dispensaries	Digitalize health systems and enhance information exchange in 1200 dispensaries	Digitalize health systems and enhance information exchange in 1200 dispensaries	Digitalize health systems and enhance information exchange in 1510 dispensaries	Digitalize health systems and enhance information exchange in 1511 dispensaries
	Identification of one digital system to be used in Community based health system by 2023	Implementation and improving Community based Digital system by 2024-25	Continue improving digital solution in community level	Use of digital solution in community level by 80%	Use of digital solution in community level by 90%

Objectives	Target Year 1-2	Target Year 3-4	Target Year 5-6	Target Year 7-8	Target Year 9-10
5.Improve data use at all levels by using Facility Supervision System to 450 regional HMT and 3128 CHMT	Sensitization the use of Supervision system to 450 regional HMT team and 3128 Council	-Provide three days training to 1608 CHMT	Provide three days training to 1515 CHMT	Continue Sensitization the use of Supervision system	Continue Sensitization the use of Supervision system
6.Use of telemedicine services	One day orientation to 450 RHMT and 3128 CHMT on telemedicine services -Identifies 368 health Centers which will be Telemedicine hub (2 HC in each council)	Install telemedicine infrastructure to 80 health centres	Install telemedicine infrastructure to 120 health centres	Install telemedicine infrastructure to 120 health centres	Install telemedicine infrastructure to 48 health centres
7.eLearning and knowledge management platforms for continuous professional development	Provide one day orientation on the use of eLearning platforms to 450 regional HMT team and 3128 CHMT -Develop and Upload training materials	-Develop and Upload training materials - Health professionals utilizing digital platforms for health professional development	Develop and Upload training materials - Health professionals utilizing digital platforms for health professional development	Develop and Upload training materials - Health professionals utilizing digital platforms for health professional development	Develop and Upload training materials - Health professionals utilizing digital platforms for health professional development
8. Adherence of all provided ICT Guidelines	One day Orientation in all ICT guidelines to 450 regional HMT and 3128 CHMT	One day Orientation in all ICT guidelines to 450 regional HMT and 3128 CHMT	One day Orientation in all ICT guidelines to 450 regional HMT and 3128 CHMT	One day Orientation in all ICT guidelines to 450 regional HMT and 3128 CHMT	One day Orientation in all ICT guidelines to 450 regional HMT and 3128 CHMT

8.1.25 COMPONENT: MONITORING AND EVALUATION

Objective	Target year 1-2	Target year 3-4	Target year 5-6	Target year 7-8	Target year 9-10
To monitor the programme implementation progress based on set targets	To conduct Ministerial M&E on development projects, programs and RRH performance in relation to collection,	To Conduct Technical inspection, Site Meeting and any of the General follow up and Monitoring of	To conduct supervision on IMF development project to all 28 RHH	To conduct Ministerial M&E on development projects, programs and RRH	To conduct Ministerial M&E on development projects, programs and RRH

Objective	Target year 1-2	Target year 3-4	Target year 5-6	Target year 7-8	Target year 9-10
	studying and analyses statistics needed in the implementation of policies and plans by June 2023	ongoing Construction Projects at respective 28 Regions by June 2025	Regions levels by June 2026	performance in relation to collection, studying and analyse statistics needed in the implementation of policies and plans by June 2028	performance in relation to collection, studying and analyse statistics needed in the implementation of policies and plans by June 2032
To conduct mid and end of the programme evaluation	To conduct assessment of quality of service deliveries through monitoring in all levels health Sector by June, 2023	To conduct research and evaluation in health Sector by June, 2024	To conduct research and evaluation in health Sector by June, 2026	To conduct research and evaluation in health Sector by June, 2028	To conduct research and evaluation in health Sector by June, 2032
To strengthen the capacity for implementing M&E at all levels	To conduct training on RHMIS Focal and DHMIS focal person to 26 regional and national levels by June 2023	To conduct Data Validation and Audit in all 26 regions to improve annual PHC services Performance as measured by the national balanced Score card by June 2025	To conduct Data Validation and Audit in all 26 regions to improve annual PHC services Performance as measured by the national balanced Score card by June 2027	To conduct Data Validation and Audit in all 26 regions to improve annual PHC services Performance as measured by the national balanced Score card by June 2028	To conduct Data Validation and Audit in all 26 regions to improve annual PHC services Performance as measured by the national balanced Score card by June 2032
Improved efficiency of HMIS and processes to meet all health sector M&E requirements	To capacitate MOH staffs in issues related to Data analysis and strategic plan by June, 2023	To conduct data quality check and supportive supervision at all levels by June, 2026	To capacitate MOH staffs in issues related to policy analysis and strategic plan by June, 2027	To capacitate MOH staffs in issues related to policy analysis and strategic plan by June, 2028	To provide training and capacity building to all new staff at all levels by June 2032
Strengthen accuracy, completeness, and timeliness of data	To procure computers, motor circles for 2 health district staff and 2 RHH staff to improve data quality, accuracy, timelines,	To conduct Data quality assessment to all RHH levels and District levels by June 2025 0658771972	To conduct Data quality assessment to all RHH levels and District levels by June 2027	To conduct Data quality assessment to all RHH levels and District levels by June 2028	To conduct Data quality assessment to all RHH levels and District levels by June 2032

Objective	Target year 1-2	Target year 3-4	Target year 5-6	Target year 7-8	Target year 9-10
	completeness and data submission by June 2023				
Strengthen capacity for data analysis, dissemination, and use for evidence-based decision making and accountability	To conduct Data dissemination, Data use and strengthening use of DHIS2, Dashboard and Web Portal to all levels by June 2023	To develop both Regional Health Profile and District Health Profile by June 2025	To conduct Data dissemination, Data use and strengthening use of DHIS2, Dashboard and Web Portal to all levels by June 2027	To conduct Data dissemination, Data use and strengthening use of DHIS2, Dashboard and Web Portal to all levels by June 2028	To conduct Data dissemination, Data use and strengthening use of DHIS2, Dashboard and Web Portal to all levels by June 2032

8.2 Annex 2 : FINANCIAL OUTLAY

COMPONENT	FINANCIAL OUTLAY					*All figures in '000'000 Tshs.*
	YEAR 1-2	YEAR 3-4	YEAR 5-6	YEAR 7-8	YEAR 9-10	TOTAL
HUMAN RESOURCES DEVELOPMENT & TRAINING	741,508.79	729,561.97	734,733.41	721,536.17	723,304.95	3,650,645.28
DISTRICT HEALTH SERVICES	1,767,139.45	1,774,029.15	1,708,546.37	1,623,44.55	1,586,517.84	8,459,675.34
NURSING AND MIDWIFREY SERVICES	12,381.82	12,131.82	12,131.82	12,131.82	12,131.82	60,909.10
MATERNAL, NEWBORN AND CHILD HEALTH	541,880.67	541,880.67	541,880.67	541,880.67	541,880.67	2,709,403.37
MALARIA CONTROL SERVICE	782,469.73	933,401.16	972,811.76	972,811.76	972,811.76	4,634,306.17
HIV AND AIDS CONTROL SERVICES	44,206.80	54,379.60	69,397.90	81,467.10	93,194.20	342,645.60
TUBERCULOSIS AND LEPROSY CONTROL	126,241.12	127,613.22	23,515.58	11,459.96	125,309.63	617,139.51
NON COMMUNICABLE DISEASES	11,749.72	11,749.72	11,516.62	11,516.62	11,516.62	58,055.30
ORAL HEALTH SERVICES	103,112.00	37,174.00	26,934.00	20,422.00	20,209.00	207,851.00
ENVIRONMENTAL HEALTH AND SANITATION	173,902.00	172,782.00	172,132.00	171,932.00	171,932.00	862,680.00
EMERGENCY PREPAREDNESS & RESPONSE	133,763.89	120,897.71	83,019.42	75,070.42	84,205.42	496,956.85

COMPONENT	FINANCIAL OUTLAY					*All figures in '000'000 Tshs.*
	YEAR 1-2	YEAR 3-4	YEAR 5-6	YEAR 7-8	YEAR 9-10	TOTAL
HEALTH PROMOTION AND EDUCATION	4,855.17	3,681.00	3,628.09	3,454.00	3,454.00	19,072.26
COMMUNITY HEALTH SYSTEM	57,363.62	56,427.72	56,318.22	56,151.72	56,016.72	282,278.00
NUTRITION SERVICE	31,348.73	30,703.24	31,125.61	31,620.77	31,870.40	156,668.76
RADITIONAL AND ALTERNATIVE MEDICINE	23,939.95	28, 793.76	24,812.74	20,421.29	20,134.19	97,237.11
HEALTH CARE FINANCING	5,601,100.00	2,940,500.00	6,162,900.00	6,400,400.00	6,800,400.00	27,905,300.00
NEGLECTED TROPICAL DISEASES (NTDs)	6,606.00	6,679.00	6,903.00	6,845.00	7,003.00	34,036.00
QUALITY	37,200.00	13,800.00	29,800.00	21,900.00	16,750.00	119,450.00
HEALTH SUPPLY AND LOGISTICS MANAGEMENT	45,116.67	54,679.71	66,136.68	79,997.04	96,796.42	342,726.53
PUBLIC PRIVATE PARTNERSHIP	2,700.00	2,200.00	3,250.00	2,450.00	2,200.00	12,800.00
ADVOCACY	3,012.00	2,752.00	2,752.00	2,752.00	2,752.00	14,020.00
INSTITUTIONAL	1,019.24	1,145.46	1,268.12	1,440.54	1,581.59	6,454.95
LEADERSHIP & GOVERNANCE	3,285.36	2,831.46	3,940.26	3,228.54	3,044.17	16,329.79
INFORMATION COMMUNICATION TECHNOLOGY	96,996.12	164,485.92	163,715.37	133,150.08	133,153.44	691,500.93
MONITORING AND EVALUATION	13,694.85	76,909.21	78,363.22	100,224.71	140,428.39	898,274.69
TOTAL	**12,124,140.15**	**9,637,248.79**	**12,691,390.63**	**9,587,264.21**	**11,658,598.23**	**61,128,634.18**

8.3 Annex 3 IMPLEMENTATION PLAN FOR PRIMARY HEALTH DEVELOPMENT PROGRAMME (PHSDP) 2022-2032

8.3.1 HUMAN RESOURCES DEVELOPMENT AND TRAINING

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget										*All figures in '000'000 Tshs*
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
1. Strengthen the HRH planning in line with MoH functional mandates and in decentralized settings of health service delivery by 2032	1.1 Update HRHIS and TIIS systems to improve HRH data collection and generate quality information by 2024	7,819.00	781.90	781.90	781.90	781.90	781.90	781.90	781.90	781.90	781.90	781.90	DHR, PARTNERS
	1.2 Link between HRHIS and TIIS into 2 (i.e., DHIS2 and GOTHOMIS) existing information and reporting systems by 2024	149.58	149.58	0	0	0	0	0	0	0	0	0	MOH, PORALG, PARTNERS
	1.3 Introduce spot-checks for HRH Data as means of staff audit for 185 councils and 26 RRH by 2024	1,418.60	141.86	141.86	141.86	141.86	141.86	141.86	141.86	141.86	141.86	141.86	MOH, PORALG, PARTNERS
	1.4 Build analytical capacity of HRH data for HCW from 185 councils and 26 from RRH	17,106.50	1,710.65	1,710.65	1,710.65	1,710.65	1,710.65	1,710.65	1,710.65	1,710.65	1,710.65	1,710.65	MOH, PORALG, PARTNERS
	1.5 Train 50 health facility managers from 50 facilities in the country on operational research skills and vital population statistical data management by	8,290.75	829.08	829.08	829.08	829.08	829.08	829.08	829.08	829.08	829.08	829.08	MOH, PORALG, PARTNERS
	1.6 Develop and review training programs (Health Sector Training Plan) required to strengthen HRH planning across the sector	3,498.00	349.80	349.80	349.80	349.80	349.80	349.80	349.80	349.80	349.80	349.80	MOH, PORALG, PARTNERS
	1.7 Develop and review HRH Planning tools (WISN online System) for Health Workforce Planning at 11 tertiary hospitals, 26 RRH and 5940 PHC facilities	1,804.00	180.40	180.40	180.40	180.40	180.40	180.40	180.40	180.40	180.40	180.40	MOH, PORALG, PARTNERS
	1.8 Develop and disseminate advocacy strategy for implementation of HRH strategy	1,249.40	124.94	124.94	124.94	124.94	124.94	124.94	124.94	124.94	124.94	124.94	MOH, PORALG, PARTNERS

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget										All figures in '000'000 Tshs
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
2 Improve availability of qualified and competent human resources at all levels to adequately correspond with current and future health sector needs 2032	2.1 Increase pre-service students' enrollment in Health Training Institutions	1,129.40	112.94	112.94	112.94	112.94	112.94	112.94	112.94	112.94	112.94	112.94	MOH, PORALG, PARTNERS
	2.2 Produce rare cadres e.g., Dental, Anesthesia, Physiotherapy, Ophthalmology, Nutrition, Orthostetic, Radiographer, speech therapy etc.	733.80	73.38	73.38	73.38	73.38	73.38	73.38	73.38	73.38	73.38	73.38	MOH, PORALG, PARTNERS
	2.3 Conduct Inter-ministerial and Health Training Institutions (HTIs) coordination meeting	465.60	46.56	46.56	46.56	46.56	46.56	46.56	46.56	46.56	46.56	46.56	MOH, PORALG, PARTNERS
	2.4 Conduct joint meeting among Professional Councils and Education Regulatory Bodies (NACTE, TCU)	126.10	12.61	12.61	12.61	12.61	12.61	12.61	12.61	12.61	12.61	12.61	MOH, PARTNERS
	2.5 Review 2 curricula annually to enhance HTIs to effectively apply competence based training	7,533.30	753.33	753.33	753.33	753.33	753.33	753.33	753.33	753.33	753.33	753.33	MOH, PORALG, PARTNERS
	2.6 Develop and review 3 standardized teaching and learning materials annually	12,387.00	1,238.70	1,238.70	1,238.70	1,238.70	1,238.70	1,238.70	1,238.70	1,238.70	1,238.70	1,238.70	MOH, PORALG, PARTNERS
	2.7 Develop training package (curriculum & teaching materials) for certificate courses specialized on dhobi and mortuary attendant for health facilities	1,651.60	412.90	412.90	412.90	412.90	0.00	0.00	0.00	0.00	0.00	0.00	MOH, PARTNERS
	2.8 Improve teaching and learning environment at all 44 Teaching Hospitals, skills & computer laboratories	10,587.92	5,293.96	0.00	0.00	0.00	0.00	5,293.96	0.00	0.00	0.00	0.00	MOH, PARTNERS
	2.9 Capacity of 88 tutors, clinical instructors, and lecturers in health training institutions in knowledge, skills and appropriate application of competence-based curriculum improved	1,064.25	106.43	106.43	106.43	106.43	106.43	106.43	106.43	106.43	106.43	106.43	MOH, PARTNERS

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget										All figures in '000'000 Tshs
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
	2.10 Construct 3 new Health Training Institution campuses annually	21,600.00	7,200.00	0.00	7,200.00	0.00	0.00	7,200.00	0.00	0.00	0.00	0.00	MOH
	2.11 Renovate and rehabilitate 5 Health Training Institutions renovated and rehabilitated annually	175,000.00	17,500.00	17,500.00	17,500.00	17,500.00	17,500.00	17,500.00	17,500.00	17,500.00	17,500.00	17,500.00	MOH
	2.12 Complete construction of 2 incomplete buildings/ projects completed annually	57,600.00	5,760.00	5,760.00	5,760.00	5,760.00	5,760.00	5,760.00	5,760.00	5,760.00	5,760.00	5,760.00	MOH
	2.13 Tutor student ratio in HTIs to commensurate with national and international standards improved	7,462.40	746.24	746.24	746.24	746.24	746.24	746.24	746.24	746.24	746.24	746.24	MOH, PARTNERS
	1.13 Construct 88 staff houses are at all 44 Health Training Institutions annually	2,550.00	255.00	255.00	255.00	255.00	255.00	255.00	255.00	255.00	255.00	255.00	MOH, PORALG, PARTNERS
	Procure and supply relevant learning materials and teaching aids at all 44 Health Training Institutions	58,000.00	5,800.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	MOH, PARTNERS
	Conduct short courses on teaching methodology to 150 newly recruited tutors yearly	13,622.34	1,362.23	1,362.23	1,362.23	1,362.23	1,362.23	1,362.23	1,362.23	1,362.23	1,362.23	1,362.23	MOH, PARTNERS
	Conduct short courses on implementation of competence-based curriculum training (CBET) to 120 tutors yearly	1,064.25	106.43	106.43	106.43	106.43	106.43	106.43	106.43	106.43	106.43	106.43	MOH, PARTNERS
	Sponsor 350 health care workers to pursue postgraduate specialties within and outside the country yearly	59,500.00	5,950.00	5,950.00	5,950.00	5,950.00	5,950.00	5,950.00	5,950.00	5,950.00	5,950.00	5,950.00	MOH
	Increase number of CPD course providers (through eLearning and face-to-face)	249.33	24.93	24.93	24.93	24.93	24.93	24.93	24.93	24.93	24.93	24.93	MOH, PARTNERS
	Review, monitor and assess the application of National CPD Framework for healthcare workers to enhance competencies	1,018.25	101.83	101.83	101.83	101.83	101.83	101.83	101.83	101.83	101.83	101.83	MOH, PARTNERS

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget										All figures in '000'000 Tshs
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
	To evaluate the use of eHealth (telemedicine, e-learning, etc.) in the provision of Continuous Professional Development (CPD) enhanced	1,317.40	131.74	131.74	131.74	131.74	131.74	131.74	131.74	131.74	131.74	131.74	MOH, PORALG, PARTNERS
	Review existing community-based practices (eg. Uturo Model) to develop a generic model that is scalable countrywide to enhance the impact of community health	177.24	17.72	17.72	17.72	17.72	17.72	17.72	17.72	17.72	17.72	17.72	MOH, PORALG, PARTNERS
3. Improve the recruitment, deployment and retention of health workers through the use of context specific sound interventions to ensure equitable (need based) distribution of health work force at all levels of the health sector by 2032	3.1 Recruit competent qualified health workers to work for 11 tertiary hospitals, 26 RRH and 5940 PHC	3,208,694.34	320,869.43	320,869.43	320,869.43	320,869.43	320,869.43	320,869.43	320,869.43	320,869.43	320,869.43	320,869.43	MOH, PORALG, PARTNERS
	3.2 Employ Health Workforce by Volunteerism scheme at 11 tertiary hospitals, 26 RRH and 184 Councils	621.39	62.14	62.14	62.14	62.14	62.14	62.14	62.14	62.14	62.14	62.14	MOH, PORALG, PARTNERS
	3.3 Conduct 2 meetings with professional bodies and councils to increase HRH productivity to the optimal level through effective use of performance tools yearly	180.40	18.04	18.04	18.04	18.04	18.04	18.04	18.04	18.04	18.04	18.04	MOH, PORALG, PARTNERS
	3.4 Conduct 2 meetings with professional bodies and councils for improving utilization, productivity and accountability of HRH from National to the Council level (11 tertiary hospitals, 26 RRH and 184 Councils) annually	126.10	12.61	12.61	12.61	12.61	12.61	12.61	12.61	12.61	12.61	12.61	MOH, PORALG, PARTNERS
	3.5 Review and scale up Makole Model from 0 – 5 regions at 11 tertiary hospitals, 26 RRH and 184 Councils annually	177.24	17.72	17.72	17.72	17.72	17.72	17.72	17.72	17.72	17.72	17.72	MOH, PORALG, PARTNERS
	3.6 Develop capacity of managers in 15 RRHMT, 40	541.29	54.13	54.13	54.13	54.13	54.13	54.13	54.13	54.13	54.13	54.13	MOH,

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget										*All figures in '000'000 Tshs*
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
	HMT and CHMT, 44 HTIs on supportive supervision, innovative leadership and in developing customized local incentive packages for attraction and retention of staff annually												PORALG, PARTNERS
4 Improve working environment, living conditions and facilities for HRH by 2032	4.1 Conduct meeting to enhance safety supplies, machines, tools and social protection to HRH in 11 tertiary hospitals, 26 RRH, 184 Councils, 44 HTIs and 5 universities	81.79	8.18	8.18	8.18	8.18	8.18	8.18	8.18	8.18	8.18	8.18	MOH, PORALG, PARTNERS
	4.2 Procure medical equipment, supplies and other accessories necessary for delivery of quality health services and training in 11 tertiary hospitals, 26 RRH, 184 Councils, 44 HTIs and 5 Universities	3,196.50	0.00	0.00	1,065.50	0.00	0.00	0.00	1,065.50	0.00	0.00	1,065.50	MOH, PORALG, PARTNERS
	4.3 Construct and rehabilitate infrastructure necessary for delivery of quality services and training in 11 tertiary hospitals, 26 RRH, 184 Councils, 44 HTIs and 5 Universities	5,306.34	0.00	1,768.78	0.00	0.00	1,768.78	0.00	0.00	0.00	0.00	1,768.78	MOH, PARTNERS
	4.4 Rehabilitate and renovate 44 houses to improve living conditions of HRH in HTIs	7,743.90	0.00	1,548.78	0.00	1,548.78	0.00	1,548.78	0.00	1,548.78	0.00	1,548.78	MOH, PARTNERS
SUB TOTAL HUMAN RESOURCES FOR HEALTH DEVELOPMENT		**3,702,845.28**	**378,317.39**	**363,191.40**	**368,139.34**	**361,422.62**	**361,229.72**	**373,503.68**	**360,526.44**	**361,009.72**	**359,460.95**	**363,844.00**	

8.3.2 DISTRICT HEALTH SERVICES

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget .										*All figures in '000'000 Tshs*
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
Construction, rehabilitation and completion of 3,927 primary health care facilities 190 Council Hospitals, 2,199 Health Centres and 2,728 Dispensaries by 2032	Construction of new 2,728 Dispensaries	723,474.70	72,135.31	72,135.31	72,135.31	72,135.31	72,135.31	72,135.31	72,665.71	72,665.71	72,665.71	72,665.71	PORALG, RS & LGAS, COMMUNITY
	Construction of new 1,000 Health Centres	913,461.30	91,346.13	91,346.13	91,346.13	91,346.13	91,346.13	91,346.13	91,346.13	91,346.13	91,346.13	91,346.13	PORALG, RS & LGAS, COMMUNITY
	Completion 6 buildings in 739 Health Centres	333,241.53	27,056.15	27,056.15	38,104.07	38,104.07	33,820.18	33,820.18	33,820.18	33,820.18	33,820.18	33,820.18	PORALG, RS & LGAS
	Construction of 476 building in 63 new Council Hospitals	108,000.00	50,400.00	50,400.00									PORALG, RS & LGAS
	Completion of 17 building in 130 new Council Hospitals	499,537.21			67,245.39	67,245.39	67,245.39	67,245.39	57,638.91	57,638.91	57,638.91	57,638.91	PORALG, RS & LGAS
	Rehabilitation of 60 old Council Hospitals	230,555.64	57,638.91	57,638.91	57,638.91	57,638.91							PORALG, RS & LGAS
	Construction of fence to 1,199 Council Hospitals and Health Centres	239,800.00	25,000.00	25,000.00	25,000.00	25,000.00	25,000.00	25,000.00	20,000.00	20,000.00	24,900.00	24,900.00	PORALG, RS & LGAS
To strengthen 233 health centers by constructing theatres and providing them with necessary medical equipment and furniture by year 2032	Construction of 233 theatre, maternity and lab building in old Health Centres	116,500.00	20,000.00	20,000.00	20,000.00	20,000.00	18,250.00	18,250.00					PORALG, RS & LGAS,
To improve working environments by Constructing and rehabilitation of 20,619 staff houses 11,228 primary health	Construction of 5,456 staff houses in 2,728 new Dispensaries	300,080.00	30,002.50	30,002.50	30,002.50	30,002.50	30,002.50	30,002.50	30,002.50	30,002.50	30,030.00	30,030.00	PORALG, RS & LGAS, PARTNERS
	Construction of 10,000 staff houses in 1,000 new Health Centres	550,000.00	55,000.00	55,000.00	55,000.00	55,000.00	55,000.00	55,000.00	55,000.00	55,000.00	55,000.00	55,000.00	PORALG, RS & LGAS

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget										*All figures in '000'000 Tshs*
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
care facilities 190 Council Hospitals, 2,009 Health Centres and 9,029 Dispensaries by 2032	Construction of 1,900 staff houses in 190 Council Hospitals	104,500.00	8,250.00	8,250.00	8,250.00	8,250.00	12,375.00	12,375.00	12,375.00	12,375.00	11,000.00	11,000.00	PORALG, RS&LGAS, PARTNERS
To strengthen referral, organization system and outreach services by providing 2,199 Ambulances, 771 supervision and distribution vehicles and 7,727 motorcycles in hard to reach facilities by 2032	Procure and distribute 420 supervision and 351 distribution vehicles to LGAs	69,390.00	11,700.00	11,700.00	2,250.00	2,250.00	3,195.00	3,195.00	11,250.00	11,250.00	6,300.00	6,300.00	PORALG& PARTNERS
	Procure and distribute 2,199 Ambulances to Council Hospitals and Health Centres	395,820.00	46,440.00	46,440.00	36,000.00	36,000.00	43,470.00	43,470.00	36,000.00	36,000.00	36,000.00	36,000.00	PORALG, LGAS & PARTNERS
	Procure and distribute 7,727 motorcycles to Health centres and Dispensaries with hard to reach setting	29,362.60	3,040.00	3,040.00	3,040.00	3,040.00	3,040.00	3,040.00	3,040.00	3,040.00	2,521.30	2,521.30	PORALG, LGAS & PARTNERS
To ensure availability of medical supplies and equipment to 11,228 in public primary health facilities at affordable cost by 2032	Supply and install medical equipment for CEMoNC services in new 130 Council Hospitals	117,910.00	44,896.50	44,896.50	14,058.50	14,058.50							PORALG, LGAS & PARTNERS
	Supply and install medical equipment to all 190 Council Hospitals	145,120.00					20,407.50	20,407.50	24,942.50	24,942.50	27,210.00	27,210.00	PORALG, LGAS & PARTNERS
	Supply and install medical equipment 1,000 new Health Centres	913,461.30	91,346.13	91,346.13	91,346.13	91,346.13	91,346.13	91,346.13	91,346.13	91,346.13	91,346.13	91,346.13	PORALG ,LGAS & PARTNERS
	Supply and install medical equipment 1,009 old Health Centres	921,682.45	91,346.13	91,346.13	116,009.58	116,009.58	100,480.74	100,480.74	77,644.21	77,644.21	75,390.56	75,390.56	PORALG, LGAS & PARTNERS
	Supply and install medical equipment 2,728 Dispensaries	136,400.00	13,600.00	13,600.00	13,600.00	13,600.00	13,600.00	13,600.00	13,700.00	13,700.00	13,700.00	13,700.00	PORALG ,LGAS & MOH, PARTNERS
	Supply and install		20,000.00	20,000.00					45,000.00	45,000.00	30,000.00	30,000.00	PORALG, MOH,

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget										All figures in '000'000 Tshs
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
	medical equipment 6,301 old Dispensaries	315,050.00			20,025.00	20,025.00	42,500.00	42,500.00					LGAS & PARTNERS
To strengthening digitalization of 7,500 primary health facilities by installing GoTHOMIS System by 2032	Supply and installing GoTHMOMIS in 6,371 facilities	222,985.00	14,000.00	14,000.00	15,750.00	15,750.00	21,000.00	21,000.00	30,625.00	30,625.00	30,117.50	30,117.50	PORALG, MOH, LGAS & PARTNERS
	Supply and complete installing GoTHMOMIS accessories in 1,129 facilities	22,580.00	2,000.00	2,000.00	2,500.00	2,500.00	2,590.00	2,590.00	2,200.00	2,200.00	2,000.00	2,000.00	PORALG, MOH LGAS & PARTNERS
To advocate and disseminate PHSDP 2022-2032 Guidelines to stakeholders	PHSDP disseminated to 6,300 from 184 LGA and 26RS	900.95	450.475	450.475									PORALG, RS, LGAS & PARTNERS
TOTAL DISTRICT HEALTH SERVICES		**8,432,157.67**	**878,773.22**	**878,773.22**	**882,426.52**	**882,426.52**	**849,928.88**	**849,928.88**	**811,721.27**	**811,721.27**	**793,258.92**	**793,258.92**	
Strengthen capacity to Planning teams on Comprehensive Social Welfare Operation plans at all levels from 24% to 100% by 2032	To conduct 5 days training on CCSWOP to 105 planning teams at LGAs by 2027	431.00	120.00	150.20	160.80	0.00	0.00						PORALG, RS, LGAS & PARTNERS
	To conduct Scrutinization and assessment workshop on CCSWOP at Regional and National level by 2027 (Region and National)	161.50	30.00	32.00	32.50	33.00	34.00						PORALG, RS, LGAS & PARTNERS
Strengthens capacity of Child Protection committee teams in 95% at all levels by 2032	To conduct training to Child and women protection teams at 184 Councils by 2027	670.00	130.00	132.00	135.00	136.00	137.00						PORALG, RS, LGAS & PARTNERS
	To conduct data review meeting on Child Protection data quality and use on District Case Monitoring System (DCMS) to 368	310.00	60.00	61.00	62.00	63.00	64.00						PORALG, RS, LGAS & PARTNERS

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget										All figures in '000'000 Tshs
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
	participants from all 184 LGAs												
	To conduct quarterly supportive supervision and mentorship activities for social welfare services information in 26 regions and 184 LGAs system MVC-MIS and DC-MIS in 26 regions and 184 LGAs by June 2025	623.00	124.00	124.00	124.00	125.00	126.00						PORALG, RS, LGAS & PARTNERS
	To Engage and recruit 200 alternative care services providers eg fit person, foster care, rehabilitation and Safe home caregivers from 100 LGAs by 2027	160.00	30.00	31.00	32.00	33.00	34.00						PORALG, RS, LGAS & PARTNERS
	To support LGAs to conduct 10 days family Reconciliation and affiliation case management and monitoring quarterly by 2027	225.00	45.00	45.00	45.00	45.00	45.00						PORALG, RS, LGAS & PARTNERS
	To conduct 5 days training on life skills and reproductive health to Child in conflict with the in 8 detention homes and 1 rehabilitation school by 2027	453.00	150.00	0.00	151.00	0.00	152.00						PORALG, RS, LGAS & PARTNERS
	To facilitate quarterly inclusive growth and reduce poverty, vulnerability and inequality by providing soft loans to vulnerable	3,000.00	600.00	600.00	600.00	600.00	600.00						PORALG, RS, LGAS & PARTNERS

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget										All figures in '000'000 Tshs
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
	groups at DHSN, RS &LGAs by June 2027												
	To conduct a three days workshop to at least 10 social welfare workers per council in dealing with gender issues in all in all LGAs by June 2027	948.00	315.00	316.00	0.00	317.00	0.00						PORALG, RS, LGAS & PARTNERS
	To develop and disseminate guidelines on identification of poor families and caregivers at the community for 10 days to all RS & LGAs by June 2027.	1,530.00	500.00	510.00	520.00	0.00	0.00						PORALG, RS, LGAS & PARTNERS
	To organize a gender mainstreaming stakeholders forum to share best practices and challenges experienced in RS and LGAs once a year by 2027	253.00	125.00	0.00	0.00	128.00	0.00						PORALG, RS, LGAS & PARTNERS
	To conduct Capacity building to 184 Elderly Councils at LGAs by 2027	685.00	135.00	136.00	137.00	138.00	139.00						PORALG, RS, LGAS & PARTNERS
	To facilitate Elderly persons identification and Health Insurance card provision to 200 elder persons from 100LGAs by 2027	767.00	150.00	152.00	154.00	155.00	156.00						PORALG, RS, LGAS & PARTNERS
	To facilitate on 5 days training to Social welfare officers from 184	411.00	80.00	80.00	82.00	83.00	86.00						PORALG, RS, LGAS & PARTNERS

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget										All figures in '000'000 Tshs
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
	LGAs on use of MVC-MIS (data entry, analysis and use) by 2027												
	To conduct quarterly supportive supervision on economic activities to MVC's and family household at the community in DHSN. RS & LGAs by June 2027	600.00	200.00	0.00	200.00	0.00	200.00						PORALG, RS, LGAS & PARTNERS
	To facilitate 184 LGAs to identify MVCs and link them to the Social Welfare services according to their needs by 2027	930.00	184.00	185.00	186.00	187.00	188.00						PORALG, RS, LGAS & PARTNERS
	To facilitate purchasing of working tools and facilities for Social welfare officers LGAs, ,RS and National levels by 2027	1,600.00	300.00	310.00	320.00	330.00	340.00						PORALG, RS, LGAS & PARTNERS
	To facilitate 184 LGAs on MVC reunification services by 2027	1,104.00	368.00	0.00	368.00	0.00	368.00						PORALG, RS, LGAS & PARTNERS
	To conduct training of 184 SWOs on Under five Birth registration system by 2027	4,630.00	900.00	910.00	930.00	940.00	950.00						PORALG, RS, LGAS & PARTNERS
	To conduct quarterly supportive Supervision to PWDs in 26 Regions and 184 LGAs	700.00	50.00	50.00	500.00	50.00	50.00						PORALG, RS, LGAS & PARTNERS
	To facilitate 5 PWDs from each Council (184) to attend commemoration days by 2027	883.20	220.80	0.00	220.80	0.00	441.60						PORALG, RS, LGAS & PARTNERS

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget										All figures in '000'000 Tshs
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
	To conduct training at least 2 teams of People with disabilities committees from 184 LGAs by 2027	210.00	40.00	41.00	42.00	43.00	44.00						PORALG, RS, LGAS & PARTNERS
	To facilitate 184 LGAs Social welfare offices to provide Mental health and psychosocial support services during emergencies by 2027	4,097.00	35.00	36.00	37.00	39.00	3,950.00						PORALG, RS, LGAS & PARTNERS
	To facilitate 20 Health facilities Social welfare Officers on referral and linkage services by 2027	82.00	20.00	20.00	20.00	20.00	2.00						PORALG, RS, LGAS & PARTNERS
	To Capacitate 190 Social welfare M&E coordinators at regional and Council levels on Social Welfare M&E services by 2027	144.00	120.00	0.00	12.00	0.00	12.00						PORALG, RS, LGAS & PARTNERS
	To purchase 200 Working tools (Laptop, Desk top, Tablets) for social welfare M&E services at RS,COUNCILS and PORALG by 2027	1,500.00	500.00	0.00	500.00	0.00	500.00						PORALG, RS, LGAS & PARTNERS
	To conduct 10 days training to 35 Social Welfare officers on HIV .prevention at the community level by 2027	350.00	70.00	70.00	70.00	70.00	70.00						PORALG, RS, LGAS & PARTNERS
SUBTOTAL SOCIAL WELFARE		27,457.70	5,601.80	3,991.20	5,641.10	3,535.00	8,688.60						
TOTAL DISTRICT HEALTH + SOCIAL WELFARE SERVICES		8,459,615.37	884,375.02	882,764.42	888,067.62	885,961.52	858,617.48	849,928.88	811,721.27	811,721.27	793,258.92	793,258.92	

8.3.3 NURSING AND MIDWIFERY SERVICES

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget										*All figures in '000'000 Tshs*
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
1. 1. Strengthen Mentorship and Coaching systems to health facilities to improve skills by 2032	1.1 Establish simulation laboratories for mentorship in 75 teaching hospitals by 2032	30,000.00	3,000.00	3,000.00	3,000.00	3,000.00	3,000.00	3,000.00	3,000.00	3,000.00	3,000.00	3,000.00	MOH, PORALG&PARTNERS
	1.2 Capacity building of 1,250 Clinical mentors to facilitate cascade mentorships in all levels by 2032	5,000.00	500.00	500.00	500.00	500.00	500.00	500.00	500.00	500.00	500.00	500.00	MOH, PORALG&PARTNERS
2. Improve Quality of Care and client experience by 2032	2.1 Institutionalize Customer care for Respectful and Compassionate Care in service delivery to all levels by 2032	17,281.00	1,728.10	1,728.10	1,728.10	1,728.10	1,728.10	1,728.10	1,728.10	1,728.10	1,728.10	1,728.10	MOH, PORALG, PARTNERS
	2.2 Build Capacity on nursing and midwifery audit to 186 hospitals by 2032	2,772.13	277.21	277.21	277.21	277.21	277.21	277.21	277.21	277.21	277.21	277.21	MOH, PORALG, PARTNERS
	2.3 Disseminate nursing and Midwifery SOPs and tools for the in-patient care to 7,200 health facilities by 2032	666.00	66.60	66.60	66.60	66.60	66.60	66.60	66.60	66.60	66.60	66.60	MOH, PORALG, PARTNERS
3. 3. Strengthening Nursing and Midwifery Leadership and Management of health facilities by 2032	3.1 Build capacity of Nursing and Midwifery Leaders for all levels by 2032	786.00	78.6	78.6	78.6	78.6	78.6	78.6	78.6	78.6	78.6	78.6	MOH, PORALG, PARTNERS
	3.2 Disseminate job descriptions for nurses and midwives to all levels by 2032	786.00	78.6	78.6	78.6	78.6	78.6	78.6	78.6	78.6	78.6	78.6	MOH, PORALG, PARTNERS
	3.3 Establish clinical attachment and mentorship system to 10,000 newly employed nurses and midwives by 2032	718.00	71.8	71.8	71.8	71.8	71.8	71.8	71.8	71.8	71.8	71.8	MOH, PORALG, PARTNERS

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget										All figures in '000'000 Tshs
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
4 4. Strengthen operational research and reporting of nursing and midwifery services by 2032	4.1 Capacity building of 750 nurses and midwives on operational research by 2032	2,250.00	225.0	225.0	225.0	225.0	225.0	225.0	225.0	225.0	225.0	225.0	MOH, PORALG, PARTNERS
	4.2 Develop 40 volumes of nursing and midwifery services bulletin by 2032	400.00	40	40	40	40	40	40	40	40	40	40	MOH, PORALG, PARTNERS
	4.3 Integrate nursing and midwifery indicators into DHIS 2 by 2032	250.00	250.0	0	0	0	0	0	0	0	0	0	MOH, PORALG, PARTNERS
SUB TOTAL HUMAN RESOURCES FOR HEALTH DEVELOPMENT		60,909.00	6,315.91	6,065.91	6,065.91	6,065.91	6,065.91	6,065.91	6,065.91	6,065.91	6,065.91	6,065.91	

8.3.4 REPRODUCTIVE, MATERNAL, NEWBORN, CHILD AND ADOLESCENT HEALTH

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget										All figures in '000'000 Tshs
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
To create an enabling environment for provision and utilization of quality ,equitable and accessible RMNCAH and nutrition services	26 one stop centre established/building for provision of Gender based Violence in each region.	5,000.00	500.00	500.00	500.00	500.00	500.00	500.00	500.00	500.00	500.00	500.00	MOH, PORALG, RS. LGAs, PARTNERS
	100 of neonatal care Units to established at Regional Level and district level	5,000.00	500.00	500.00	500.00	500.00	500.00	500.00	500.00	500.00	500.00	500.00	MOH, PORALG, RS. LGAs, PARTNERS
	Support all facilities to	3,075.41	307.54	307.54	307.54	307.54	307.54	307.54	307.54	307.54	307.54	307.54	MOH,

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget										*All figures in '000'000 Tshs*
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
	implement CEmONC signal functions for 24/7												PORALG, RS. LGAs, PARTNERS
	100 hospitals and Health Centres to establish Youth corner/room for provision of Adolescent and Youth Friendly service	3,500.00	350.00	350.00	350.00	350.00	350.00	350.00	350.00	350.00	350.00	350.00	MOH, PORALG, RS. LGAs, PARTNERS
To strengthen the capacity of Health system for planning management and services delivery of RMNCAH services	1000 health workers trained from Health centres, districts and referral hospitals on safe anaesthesia and safe surgeries	5,000.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	MOH, PORALG, RS. LGAs, PARTNERS
	1000 service providers supervised and mentored on ANC services to be conducted by the end of each year.	3,000.00	30.00	30.00	30.00	30.00	30.00	30.00	30.00	30.00	30.00	30.00	MOH, PORALG, RS. LGAs, PARTNERS
	Ensure availability and supply of ANC related commodities at all facility levels.	412.00	41.20	41.20	41.20	41.20	41.20	41.20	41.20	41.20	41.20	41.20	MOH, PORALG, RS. LGAs, PARTNERS
	184 council supervised and conduct trainees follow each year to ensure quality provision of Family planning services in 184 councils.	55,200.00	5,520.00	5,520.00	5,520.00	5,520.00	5,520.00	5,520.00	5,520.00	5,520.00	5,520.00	5,520.00	MOH, PORALG, RS. LGAs, PARTNERS
	500 healthcare worker trained on comprehensive FP services provision to improve access and utilization of Long-acting contraceptive method.	3,000.00	300	300	300	300	300	300	300	300	300	300	MOH, PORALG, RS. LGAs, PARTNERS
	1800 healthcare workers trained on Postpartum FP (2 per Health facility)	600.00	60	60	60	60	60	60	60	60	60	60	MOH, PORALG, RS. LGAs, PARTNERS
To increase access and utilization of quality RMNCAH services	500 service providers supervised and mentored on ANC services to be conducted by the end of each year.	500.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	MOH, PORALG, RS. LGAs, PARTNERS

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget										All figures in '000'000 Tshs
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
	1000 healthcare workers trained per Health facility on identified regions on provision of integrated ANC package	40,000.00	4,000.00	4,000.00	4,000.00	4,000.00	4,000.00	4,000.00	4,000.00	4,000.00	4,000.00	4,000.00	MOH, PORALG, RS. LGAs, PARTNERS
	960 health workers facilities to be trained on use of partographs to monitor progress of labour.	40,000.00	4,000.00	4,000.00	4,000.00	4,000.00	4,000.00	4,000.00	4,000.00	4,000.00	4,000.00	4,000.00	MOH, PORALG, RS. LGAs, PARTNERS
	500 Healthcare providers trained from all Health Centers and Hospital for provision of comprehensive Emergency Obstetric and newborn care services (CEmONC)	800.00	80.00	80.00	80.00	80.00	80.00	80.00	80.00	80.00	80.00	80.00	MOH, PORALG, RS. LGAs, PARTNERS
	Sustain capacity for full range of ANC services(testing HIV, syphilis, haemoglobin, and urine for protein)	2,112,015.96	211,201.60	211,201.60	211,201.60	211,201.60	211,201.60	211,201.60	211,201.60	211,201.60	211,201.60	211,201.60	MOH, PORALG, RS. LGAs, PARTNERS
	50% of the community reached with HIV and RMNCAH integrated outreach services.	64,400.00	6,440.00	6,440.00	6,440.00	6,440.00	6,440.00	6,440.00	6,440.00	6,440.00	6,440.00	6,440.00	MOH, PORALG, RS. LGAs, PARTNERS
	50% of the community members sensitized for cervical cancer screening within the regions/ districts	64,400.00	6,440.00	6,440.00	6,440.00	6,440.00	6,440.00	6,440.00	6,440.00	6,440.00	6,440.00	6,440.00	MOH, PORALG, RS. LGAs, PARTNERS
	Build capacity to 184 technicians on repair and maintenance of treatment machine	46,000.00	4,600.00	4,600.00	4,600.00	4,600.00	4,600.00	4,600.00	4,600.00	4,600.00	4,600.00	4,600.00	MOH, PORALG, RS. LGAs, PARTNERS
	50% of the community informed and became aware on GBV/VAC issues in a region/ district	46,000.00	4,600.00	4,600.00	4,600.00	4,600.00	4,600.00	4,600.00	4,600.00	4,600.00	4,600.00	4,600.00	MOH, PORALG, RS. LGAs, PARTNERS

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget										All figures in '000'000 Tshs
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
	368 community Health workers on each region trained on provision of information and education on Gender based Violence and Violence against children	20,000.00	2,000.00	2,000.00	2,000.00	2,000.00	2,000.00	2,000.00	2,000.00	2,000.00	2,000.00	2,000.00	MOH, PORALG, RS. LGAs, PARTNERS
	400 Health Providers trained on provision of Gender Based Violence and Violence against Children.	16,000.00	1,600.00	1,600.00	1,600.00	1,600.00	1,600.00	1,600.00	1,600.00	1,600.00	1,600.00	1,600.00	MOH, PORALG, RS. LGAs, PARTNERS
	200 community Health workers on each region trained on newborn care through the RMNCAH community package	8,000.00	2,000.00	2,000.00	2,000.00	2,000.00	2,000.00	2,000.00	2,000.00	2,000.00	2,000.00	2,000.00	MOH, PORALG, RS. LGAs, PARTNERS
	400 of health workers trained on growth monitoring at facility level.	32,000.00	3,200.00	3,200.00	3,200.00	3,200.00	3,200.00	3,200.00	3,200.00	3,200.00	3,200.00	3,200.00	MOH, PORALG, RS. LGAs, PARTNERS
	Regular campaigns to improve coverage in low performing regions for routine immunization to be conducted.	1,200.00	120.00	120.00	120.00	120.00	120.00	120.00	120.00	120.00	120.00	120.00	MOH, PORALG, RS. LGAs, PARTNERS
	400 community Health workers trained on immunization intervention within the community.	20,000.00	2,000.00	2,000.00	2,000.00	2,000.00	2,000.00	2,000.00	2,000.00	2,000.00	2,000.00	2,000.00	MOH, PORALG, RS. LGAs, PARTNERS
	500 health care workers trained on IMCI to detect malnutrition and respond appropriately by giving early referral for specialist care.	32,000.00	3,200.00	3,200.00	3,200.00	3,200.00	3,200.00	3,200.00	3,200.00	3,200.00	3,200.00	3,200.00	MOH, PORALG, RS. LGAs, PARTNERS
	368 community Health workers trained on management of malnutrition among children.	30,000.00	3,000.00	3,000.00	3,000.00	3,000.00	3,000.00	3,000.00	3,000.00	3,000.00	3,000.00	3,000.00	MOH, PORALG, RS. LGAs, PARTNERS
	Conduct community sensitization using media, IEC/BCC material and other platforms on the	6,000.00	60.00	60.00	60.00	60.00	60.00	60.00	60.00	60.00	60.00	60.00	MOH, PORALG, RS. LGAs, PARTNERS

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget										*All figures in '000'000 Tshs*
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
	importance of using long life insecticide impregnated nets (LLIN)												
	2,000,000 of LLINs to be Distribute LLIN via ANC to estimated pregnant women.	4,000.00	40.00	40.00	40.00	40.00	40.00	40.00	40.00	40.00	40.00	40.00	MOH, PORALG, RS. LGAs, PARTNERS
	370 of health care trained on routinely assessment according to the developmental milestones at all levels.	24,000.00	2,400.00	2,400.00	2,400.00	2,400.00	2,400.00	2,400.00	2,400.00	2,400.00	2,400.00	2,400.00	MOH, PORALG, RS. LGAs, PARTNERS
	300 Health care workers trained on provision of Adolescent and Youth Friendly services at all levels.	10,000.00	1,000.00	1,000.00	1,000.00	1,000.00	1,000.00	1,000.00	1,000.00	1,000.00	1,000.00	1,000.00	MOH, PORALG, RS. LGAs, PARTNERS
	368 community Health workers trained provision for Information and Education on Adolescent &Youth Friendly services	10,000.00	1,000.00	1,000.00	1,000.00	1,000.00	1,000.00	1,000.00	1,000.00	1,000.00	1,000.00	1,000.00	MOH, PORALG, RS. LGAs, PARTNERS
To improve quality of care for RMNCAH services	250 health facility reached with supportive supervision visit to adolescent Friendly services at Hospital and Health Centres.	500.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	MOH, PORALG, RS. LGAs, PARTNERS
	200,000 of HIV infected mothers at facility and in community visited for a follow up within a year.	2,000.00	200.00	200.00	200.00	200.00	200.00	200.00	200.00	200.00	200.00	200.00	MOH, PORALG, RS. LGAs, PARTNERS
SUB TOTAL RMNCHA		**2,713,603.37**	**270,940.34**	**270,940.34**	**270,940.34**	**270,940.34**	**270,940.34**	**270,940.34**	**270,940.34**	**270,940.34**	**270,940.34**	**270,940.34**	

8.3.5 MALARIA CONTROL SERVICES

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget All figures in '000'000 Tshs										
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
Reduce malaria parasites transmission by maintaining recommended evidence-based vector control interventions according to the targeted malaria risk strata	Integrated Malaria Vector Control	2,795,752.19	192,087.97	235,815.73	272,619.27	298,282.80	299,491.07	299,491.07	299,491.07	299,491.07	299,491.07	299,491.07	MOH, PORLAG, RS, LGAs, PARTNERS
To prevent the occurrence of mortality related to malaria infection through universal access to appropriate diagnosis and treatment and targeted provision of preventive therapies for vulnerable groups	Malaria Case Management	1,123,296.40	100,913.38	103,958.97	114,767.17	107,999.85	115,942.84	115,942.84	115,942.84	115,942.84	115,942.84	115,942.84	MOH, PORLAG, RS, LGAs, PARTNERS
Maintain timely availability of safe and quality malaria commodities and supplies at the delivery points.	Commodities and Logistic Management	32,597.46	3,789.14	3,413.34	3,505.83	3,127.02	3,127.02	3,127.02	3,127.02	3,127.02	3,127.02	3,127.02	MOH, PORLAG, RS, LGAs, PARTNERS
To provide timely and reliable information on malaria and its control needed to take appropriate actions in different transmission risk and ensure resources are used in the most cost-effective manner	Surveillance Monitoring & Evaluation	265,608.53	28,877.02	25,265.63	31,061.88	21,290.10	26,518.98	26,518.98	26,518.98	26,518.98	26,518.98	26,518.98	MOH, PORLAG, RS, LGAs, PARTNERS
	Social Behavioral Change and advocacy	123,215.09	14,149.18	14,443.64	12,909.07	12,974.02	11,456.53	11,456.53	11,456.53	11,456.53	11,456.53	11,456.53	MOH, PORLAG, RS, LGAs, PARTNERS
	Programme Management	293,836.51	30,163.46	29,592.26	30,944.18	23,919.97	29,869.44	29,869.44	29,869.44	29,869.44	29,869.44	29,869.44	MOH, PORLAG, RS, LGAs, PARTNERS
SUBTOTAL MALARIA CONTROL		**4,634,306.17**	**369,980.16**	**412,489.56**	**465,807.39**	**467,593.76**	**486,405.88**	**486,405.88**	**486,405.88**	**486,405.88**	**486,405.88**	**486,405.88**	

8.3.6 HIV AND AIDS CONTROL

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget										All figures in '000'000 Tshs
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
Implement Case identification programs to get up to 95% of PLHIV aware of their status by 2025 and elimination of new HIV infection by 2030	Self-Testing: Conduct bi-annual TWG meeting on HIVST	254.20	25.42	25.42	25.42	25.42	25.42	25.42	25.42	25.42	25.42	25.42	MOH, PORALG, PARTNERS
	Conduct Site Auditing of Non PEPFAR supported testing sites in six regions , 18 councils -Dodoma, Singida, Manyara, Mtwara, Kilimanjaro, & Arusha	483.40	48.34	48.34	48.34	48.34	48.34	48.34	48.34	48.34	48.34	48.34	MOH, PORALG, PARTNERS
To Implement programs to eliminate of Mother to Child Transmission (eMTCT) of New HIV Infection to less than 4% by 2026	Conduct biannual post training follow up visits to validate data from mother child cohort monitoring system in regions with poor performing non PEPFAR Sites (15 regions)	2532.00	253.20	253.20	253.20	253.20	253.20	253.20	253.20	253.20	253.20	253.20	MOH, PORALG, RSs, LGAs
	To conduct live radio and TV Programme for creating awareness on male involvement in PMTCT Services utilization	500.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	MOH, PARTNERS
	Conduct annual Zonal HVL/EID Data Review Meeting/Discuss Challenges and institute remedial actions for improving Coverage	1028.60	102.86	102.86	102.86	102.86	102.86	102.86	102.86	102.86	102.86	102.86	MOH, PORALG, PARTNERS
	Print and Disseminate PMTCT Annual Programme report in 5 zones	843.50	84.35	84.35	84.35	84.35	84.35	84.35	84.35	84.35	84.35	84.35	MOH, PORALG, PARTNERS
	Conduct workshop to prepare PMTCT Annual Program report	483.20	48.32	48.32	48.32	48.32	48.32	48.32	48.32	48.32	48.32	48.32	MOH, PORALG, RSs, LGAs, PARTNERS
	Conduct bi annual PMTCT TWG meetings	417.90	41.79	41.79	41.79	41.79	41.79	41.79	41.79	41.79	41.79	41.79	MOH. PARTNERS
	Conduct PMTCT Performance appraisal with RHMTs and CHMTs Using PMTCT score card and programme report in 10 Poor Preforming regions	2200.70	220.07	220.07	220.07	220.07	220.07	220.07	220.07	220.07	220.07	220.07	MOH, PORALG, PARTNERS
	Conduct Post Training follow up to Health facilities with health care workers recently trained on HIV/Syphilis Duo Testing in 10 regions	1018.00	101.80	101.80	101.80	101.80	101.80	101.80	101.80	101.80	101.80	101.80	MOH, PORALG, PARTNERS
To test over 95% of HIV exposed Infants within 2 months of age by 2026	Conduct Follow up of EID/POC Facilities to Abstract and Validate DNA PCR Data for analysis and Performance Assessment in 10 regions.	483.20	48.32	48.32	48.32	48.32	48.32	48.32	48.32	48.32	48.32	48.32	MOH, PORALG, PARTNERS
Implement programs to reduce New HIV infections by 85% by 2026	To review national guideline, Training package and Job Aid according to antimicrobial susceptibility results	2366.64	236.66	236.66	236.66	236.66	236.66	236.66	236.66	236.66	236.66	236.66	MOH, PORALG, RSs, LGAs, PARTNERS

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget										*All figures in '000'000 Tshs*
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
from 2010 baseline	To review national guideline, Training package and Job Aid according to antimicrobial susceptibility results	1281.79	128.18	128.18	128.18	128.18	128.18	128.18	128.18	128.18	128.18	128.18	MOH, PORALG, RSs, LGAs, PARTNERS
Conduct mass campaigns to reach 95% of females and males engaging in non-cohabiting non-marital sexual relationships reporting condom use at last sexual intercourse by 2026	Support task force to conduct quarterly meetings to oversee condom programming	198.80	19.88	19.88	19.88	19.88	19.88	19.88	19.88	19.88	19.88	19.88	MOH, PORALG, RSs, LGAs, PARTNERS
	Conduct one day meeting to validate the developed targeted condom promotion radio spots	140.75	14.08	14.08	14.08	14.08	14.08	14.08	14.08	14.08	14.08	14.08	MOH, PORALG, RSs, LGAs, PARTNERS
Implement the minimum package evidence-based HIV and AIDS combination prevention interventions in at least 95% of Vulnerable AGYW by 2026	AGYW&KVP: Orientation of CBHS TOTs on the developed orientation package on HIV risk reduction to the marginalized, under-served and key and vulnerable populations including AGYWs and PLHIVs	582.54	58.25	58.25	58.25	58.25	58.25	58.25	58.25	58.25	58.25	58.25	MOH, PORALG, RSs, LGAs, PARTNERS
	AGYW: Orientation of Artists and Celebrities on AGYW issues related to HIV, Early Pregnancies, keeping girls in school, HIV and AIDS Services utilization, Stigma a	146.20	14.62	14.62	14.62	14.62	14.62	14.62	14.62	14.62	14.62	14.62	MOH, PARTNERS
	AGYW: Conduct National Task Force Meeting for In school AGYW Interpersonal Communication	100.98	10.10	10.10	10.10	10.10	10.10	10.10	10.10	10.10	10.10	10.10	MOH, PORALG
	AGYW: Conduct Baseline Assessment and post event Evaluation to assess implementation of In School interpersonal Communication Events in Selected schools events.	246.20	24.62	24.62	24.62	24.62	24.62	24.62	24.62	24.62	24.62	24.62	MOH, PARTNERS
	AGYW: Support Government Officers to facilitate the National Launch and implementation of Interpersonal Communication Events in ten Regions (Tanga, Arusha, Dodoma, Singida, Morogoro, Mtwara, Iringa, Njombe, Mwanza, Geita and Mbeya)	969.80	96.98	96.98	96.98	96.98	96.98	96.98	96.98	96.98	96.98	96.98	MOH, PORALG, RSs, LGAs, PARTNERS
	AGYW: Develop, print and distribute bi-annual Magazine to documenting and share AGYW project progress and Successful stories to be disseminated among AGYW, IP's, MP's, Donors and other police makers.	672.10	67.21	67.21	67.21	67.21	67.21	67.21	67.21	67.21	67.21	67.21	MOH, PORALG, RSs, LGAs, PARTNERS
	AGYW: Engage Artists and Celebrities to Conduct In school SBCC Interpersonal Communication Events In 18 Districts of Morogoro, Dodoma, Singida, Tanga and Geita	10842.13	1084.21	1084.21	1084.21	1084.21	1084.21	1084.21	1084.21	1084.21	1084.21	1084.21	MOH, PORALG, RSs, LGAs, PARTNERS

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget									*All figures in '000'000 Tshs*
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
	AGYW: Media Coverage - National and Local Radio Stations, TV, Newspapers & Social Media (3 Months) during and after in School Interpersonal Communication Events	1158.20	117.10	115.50	115.50	115.50	115.50	117.10	115.50	115.50	115.50	115.50	MOH, PORALG, RSs, LGAs, PARTNERS
	AGYW: Conduct advocacy and dissemination meeting on the health sector response on implementation of Primary Prevention Coalition Objectives, 10 points roadmap, scorecard to members of parliament and the highest level of government leaders.	272.00	27.20	27.20	27.20	27.20	27.20	27.20	27.20	27.20	27.20	27.20	MOH, PORALG, PARTNERS
Implement the minimum package of vulnerability-tailored and client centred combination prevention intervention to reach 95% of the Key and vulnerable populations by 2026	KVP: Conduct TOT Training to 300 HCW on KP HIV friendly services in year one and two from 10 regions to increase up take of HIV services to KVP	2366.64	236.66	236.66	236.66	236.66	236.66	236.66	236.66	236.66	236.66	236.66	MOH, PORALG, PARTNERS
	To capacitate/equip school health coordinators, teachers on adolescent HIV services (package is available) aim at case identification, creating support environment in school that focuses on achievement of health, educational outcomes and stigma reduction in adolescent living with HIV in schools.	1258.32	125.83	125.83	125.83	125.83	125.83	125.83	125.83	125.83	125.83	125.83	MOH, PARTNERS
	Post training follow up and technical assistance of school health coordinators, teachers, and matrons to Ensure continuum of HIV care.	660.00	66.00	66.00	66.00	66.00	66.00	66.00	66.00	66.00	66.00	66.00	MOH, PORALG, RSs, LGAs, PARTNERS
	KVP: Orient Community Based HIV Service TOT on the revised community HIV service manual for KVPs	1003.50	100.35	100.35	100.35	100.35	100.35	100.35	100.35	100.35	100.35	100.35	MOH, PARTNERS
Implement ART programs to enroll 95% of HIV positive children on ART and supress over 95% of those by 2026	Conduct bi-annual pediatric and adolescent technical working groups to discuss ongoing implementation and provide technical guidance relating to pediatric and adolescent HIV services	161.34	16.13	16.13	16.13	16.13	16.13	16.13	16.13	16.13	16.13	16.13	MOH, PORALG, RSs, LGAs, PARTNERS
	Clinical attachment for HCWs(Clinician and Nurse providing Pediatric ART services) at centre of excellence for management of children living with HIV e.g. Baylor Mbeya and Mwanza Centre	401.32	40.13	40.13	40.13	40.13	40.13	40.13	40.13	40.13	40.13	40.13	MOH, PORALG,
Implement ART program to ensure that 90% of PLHIV on ART receive TPT and 95 of TB co-infected ART patients are sustained on ART by 2026	TPT: Bi-annual orientation of 33 TB/HIV ToTs on Active Drug Safety Monitoring of INH, 3HP and 3RH (TPT) in Collaboration with TMDA	719.48	71.65	72.02	72.02	72.02	72.02	71.65	72.02	72.02	72.02	72.02	MOH, PORALG, RSs, LGAs, PARTNERS
	TPT: RHMTs to conduct bi-annual Regional meetings on TPT (3HP,3RH and INH) Target setting to 80 districts councils and administrative districts in 12 GF supported regions	3632.66	363.27	363.27	363.27	363.27	363.27	363.27	363.27	363.27	363.27	363.27	MOH, PARTNERS

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget										*All figures in '000'000 Tshs*
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
	TPT: Annual orientation workshops to engage Association of Private Health Facilities in Tanzania (APHFTA) and Christian Social Services Commission (CSSC) & Private Health Facilities/ FBOs	445.50	44.55	44.55	44.55	44.55	44.55	44.55	44.55	44.55	44.55	44.55	MOH, PORALG, RSs, LGAs, PARTNERS
	TPT: Conduct Zonal refresher training to RHMTs on identification, Initiation and retention of Under Five years old Children Living With HIV(CLHIV) on TPT in 12 GF funded regions	546.32	54.63	54.63	54.63	54.63	54.63	54.63	54.63	54.63	54.63	54.63	MOH, PORALG, RSs, LGAs, PARTNERS
	TPT: Conduct regionals refresher training (Twice a year) to ART Nurses and DOT Nurses on identification, Initiation and retention of Under Five years old Children Living With HIV on TPT in high volume HF in 12 supported by GF	1167.02	116.70	116.70	116.70	116.70	116.70	116.70	116.70	116.70	116.70	116.70	MOH, PORALG, RSs, LGAs, PARTNERS
	TPT: Conduct Bi-annual Zonal orientation workshops targeting CTC Coordinators& ART Nurses working on Prison Health facilities to improve TPT	1006.78	100.68	100.68	100.68	100.68	100.68	100.68	100.68	100.68	100.68	100.68	MOH, PORALG, RSs, LGAs, PARTNERS
	TPT: Conduct on-job mentorship twice a year to six zones (each zone has 4-5 regions) to regional TB program and regional AIDS programs staffs at the Regional and District levels	466.30	46.63	46.63	46.63	46.63	46.63	46.63	46.63	46.63	46.63	46.63	MOH, PARTNERS
	TPT: Bi-annual MoH- Zonal meetings on TPT (3HP,3RH and INH) Target setting at the regional levels (Rotating per zonal)	1135.30	113.53	113.53	113.53	113.53	113.53	113.53	113.53	113.53	113.53	113.53	MOH, PORALG, RSs, LGAs, PARTNERS
	TPT: Conduct Bi-annual orientation workshops of DOT, ART Nurses & CTC coordinators of 12 Regional Referral Hospitals in 12 GF supported regions on TPT (INH,3HP and 3RH) provision in the context of SDM models	850.20	85.02	85.02	85.02	85.02	85.02	85.02	85.02	85.02	85.02	85.02	MOH, PORALG, RSs, LGAs, PARTNERS
	TPT: Bi-annual TPT drugs quantification and stock availability verification vs targeted clients at all councils in 10 GF supported regions (Participants from 10 MSD zones and selected 10 councils)	595.02	59.50	59.50	59.50	59.50	59.50	59.50	59.50	59.50	59.50	59.50	MOH, PORALG, RSs, LGAs, PARTNERS
Implement Adolescent program to enroll and retain and virally suppress 95% of them on ART by 2026	Health Facility visits to support effective implementation of HIV services through DSD models including data abstraction to assess progress over time in regions with high HIV prevalence and/or poor linkage, retention and viral suppression rate.	823.00	82.30	82.30	82.30	82.30	82.30	82.30	82.30	82.30	82.30	82.30	MOH, PORALG, RSs, LGAs, PARTNERS
Increase linkage to 90% to other integrated health related services ((NCDs, Cervical Cancer, Viral Hepatitis, and STIs) by	Increased coverage of quality and use of cervical cancer screening and treatment services (The investment will support procurement of 130 new Cryotherapy machines and accessories	10306.54	1030.65	1030.65	1030.65	1030.65	1030.65	1030.65	1030.65	1030.65	1030.65	1030.65	MOH, PARTNERS

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget .										All figures in '000'000 Tshs
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
2026	as per regional scale-up plan to increase access for WLHIV to be screened and treated for cervical cancer)												
Maintain Standards for prescription of drugs for OIs, including monitoring and reporting of adverse drug reactions (ADRs) in all facilities by 2026	National Guidelines for Management of HIV and AIDS revision as per changes in policies, WHO updates and/or evidence from local and international scientific findings.	785.70	78.57	78.57	78.57	78.57	78.57	78.57	78.57	78.57	78.57	78.57	MOH, PORALG, RSs, LGAs, PARTNERS
Implement Point of Care (POC) in all HIV testing points and laboratories to support HIV services at all health care levels by 2026.	To Orient RHMTs and regional IPs on the newly revised Health facility assessment tools in 26 regions.	783.68	78.37	78.37	78.37	78.37	78.37	78.37	78.37	78.37	78.37	78.37	MOH, PORALG, RSs, LGAs, PARTNERS
	To conduct bi- annual Advanced HIV Disease task force team meetings to discuss progress of implementation and advice the clinical subcommittee on implementation of Advanced HIV Diseases interventions.	368.96	36.90	36.90	36.90	36.90	36.90	36.90	36.90	36.90	36.90	36.90	MOH, PARTNERS
	Assessment and Accreditation of Health Facilities to provide ART services in collaboration with PORALG and R/CHMTs (government, faith based and private facilities in 12 regions)	475.00	47.50	47.50	47.50	47.50	47.50	47.50	47.50	47.50	47.50	47.50	MOH, PORALG, RSs, LGAs, PARTNERS
	To update the Comprehensive National Training Package for Management of HIV and AIDS according to the changes of the National Guidelines	369.85	36.99	36.99	36.99	36.99	36.99	36.99	36.99	36.99	36.99	36.99	MOH, PORALG, , PARTNERS
Observe improved governance, leadership and accountability in supply chain management at all levels to minimize (<5%) reported expiries and wastage	Conduct three days meeting to develop and make consensus on quantification assumptions for ARV OIs, STI,HIV Lab Commodities ,MAT,HIV Self-Test, NBTS, Condom, PrEP Commodities	344.25	34.43	34.43	34.43	34.43	34.43	34.43	34.43	34.43	34.43	34.43	MOH, PORALG, RSs, LGAs, PARTNERS
	Conduct demand Forecasting and Supply Planning on ARV & OIs ,STI, HIV Lab Commodities ,MAT,HIV Self-Test, NBTS, Condom, PrEP Commodities	1224.30	122.43	122.43	122.43	122.43	122.43	122.43	122.43	122.43	122.43	122.43	MOH, PORALG, RSs, LGAs, PARTNERS
	Conduct two days debriefing meeting on the Quantification of ARVs & OIs, STI, HIV Lab Commodities ,MAT,HIV Self-Test, NBTS, Condom, PrEP Commodities)	206.00	20.60	20.60	20.60	20.60	20.60	20.60	20.60	20.60	20.60	20.60	MOH, PORALG, RSs, LGAs, PARTNERS
	Conduct quantification review for ARVs & OIs and HIV Lab commodities	736.85	73.69	73.69	73.69	73.69	73.69	73.69	73.69	73.69	73.69	73.69	MOH, PORALG, RSs, LGAs, PARTNERS
Implement supply chain programs to ensure availability of HIV commodities by 100% in all facilities by 2026	Review of quantification data sources and preparation of data collection tools from sources (CTC Pharmacy Module, eLmis, Lab Info system, paper based)	219.80	21.98	21.98	21.98	21.98	21.98	21.98	21.98	21.98	21.98	21.98	MOH, PORALG, RSs, LGAs, PARTNERS
	Conduct data collection to establish the	957.90	95.79	95.79	95.79	95.79	95.79	95.79	95.79	95.79	95.79	95.79	MOH, PORALG,

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget										*All figures in '000'000 Tshs*
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
	distribution of ART patients by ARV regimens and laboratory service data in 9 regions for quantification exercises												RSs, LGAs, PARTNERS
	Data Cleaning, Validation and Analysis of the collected data of ARVs patients by regimen, laboratory commodities; and extracted consumption data from eLMIS	219.80	21.98	21.98	21.98	21.98	21.98	21.98	21.98	21.98	21.98	21.98	MOH, PORALG, RSs, LGAs, PARTNERS
Implement programs to identify 95% of all people living with HIV into care, treatment and support services by 2025,	Conduct HIV care and treatment clinical subcommittee meetings to discuss ongoing implementation and provide technical advice to the Ministry of Health relating to HIV care and treatment services	216.74	21.67	21.67	21.67	21.67	21.67	21.67	21.67	21.67	21.67	21.67	MOH, PARTNERS
To Coordinate and manage of national HIV disease control (NACP) programs	Support Office Expenses	4660.41	472.44	464.44	464.44	464.44	464.44	472.44	464.44	464.44	464.44	464.44	MOH, PORALG, RSs, LGAs, PARTNERS
	Office operations and Administrative costs (MOFP)	121.00	12.10	12.10	12.10	12.10	12.10	12.10	12.10	12.10	12.10	12.10	MOH, PORALG, RSs, LGAs, PARTNERS
	NACP: Preventive Maintenance for Computers with related accessories	87.60	8.76	8.76	8.76	8.76	8.76	8.76	8.76	8.76	8.76	8.76	MOH, PORALG, RSs, LGAs, PARTNERS
	NACP Website Hosting, Updating and Maintenance	250.00	25.00	25.00	25.00	25.00	25.00	25.00	25.00	25.00	25.00	25.00	MOH, PORALG, PARTNERS
	NACP LAN Services and Maintenance	250.00	25.00	25.00	25.00	25.00	25.00	25.00	25.00	25.00	25.00	25.00	MOH, PORALG, RSs, LGAs, PARTNERS
	Communication bundles for office telephones at NACP	31.68	3.17	3.17	3.17	3.17	3.17	3.17	3.17	3.17	3.17	3.17	MOH, , PARTNERS
	NACP: Procurement of Software Packages	109.91	10.99	10.99	10.99	10.99	10.99	10.99	10.99	10.99	10.99	10.99	MOH, PORALG, RSs, LGAs, PARTNERS
	Procurement of NACP-PMTCT office vehicles	5400.01	540.00	540.00	540.00	540.00	540.00	540.00	540.00	540.00	540.00	540.00	MOH, PORALG, , PARTNERS
	Support monthly airtime for administration and coordination (report tracking)	180.00	18.00	18.00	18.00	18.00	18.00	18.00	18.00	18.00	18.00	18.00	MOH, PORALG, RSs, LGAs, PARTNERS
	Conduct Annual NACP with RMOs, DMOs, RACCs, DACCs, RRCHCOs and DRCHCOs meeting to discuss status of implementation, review achievement of annual program targets, best practices and discuss challenges	2447.20	244.72	244.72	244.72	244.72	244.72	244.72	244.72	244.72	244.72	244.72	MOH, , PARTNERS
	Annual Program staff Team building retreat	1207.82	120.78	120.78	120.78	120.78	120.78	120.78	120.78	120.78	120.78	120.78	MOH, PORALG, RSs, LGAs, PARTNERS
	Support the Ministry, technical staff and GF coordination Team to attend bi-annual Oversight meeting	126.40	12.64	12.64	12.64	12.64	12.64	12.64	12.64	12.64	12.64	12.64	MOH, PARTNERS
	Conduct annual stock taking exercise to verify the physical verification of the quantities and condition of items and update the Inventory register	30.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	MOH, PORALG, RSs, LGAs, PARTNERS

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget .										All figures in '000'000 Tshs
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
	Conduct bi - annual Oversight visits to HIV Grant Implementers and Technical Partners	214.20	21.42	21.42	21.42	21.42	21.42	21.42	21.42	21.42	21.42	21.42	MOH, PORALG, RSs, LGAs, PARTNERS
	To conduct Annual HIV/AIDS zonal dissemination meetings on health sector policy, strategies and guidelines	813.50	81.35	81.35	81.35	81.35	81.35	81.35	81.35	81.35	81.35	81.35	
	Conduct Quarterly National HIV/AIDS Advisory (steering) committee meetings to oversee the national Health sector HIV/AIDS Response	282.40	35.30	26.48	26.48	26.48	26.48	35.30	26.48	26.48	26.48	26.48	MOH, PORALG, RSs, LGAs, PARTNERS
	Support RHMTs to perform bi-annual comprehensive supportive supervision to CHMTs (in selected priority regions)	265.12	26.51	26.51	26.51	26.51	26.51	26.51	26.51	26.51	26.51	26.51	MOH, PORALG, RSs, LGAs, PARTNERS
	Support Program staff to attend Local/International short courses	1008.24	100.82	100.82	100.82	100.82	100.82	100.82	100.82	100.82	100.82	100.82	MOH, PARTNERS
	Support technical staff from HIV grant implementers to attend technical meetings (local & international)	743.02	74.30	74.30	74.30	74.30	74.30	74.30	74.30	74.30	74.30	74.30	MOH, , PARTNERS

8.3.7 TUBERCULOSIS AND LEPROSY CONTROL

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget .										All figures in '000'000 Tshs
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
To increase TB treatment coverage from 53% in 2018 to 90% in 2025 by innovatively addressing barriers to access, utilization and the needs of the key and vulnerable populations for TB care and prevention services.	Review and update QI toolkit and training package (including management of KVP, most at-risk population, and Comorbidities) for health care workers	2,170.37	203.61	203.61	220.39	220.39	220.39	220.39	220.39	220.39	220.39	220.39	MOH, PORALG, PARTNERS
	Sensitize prisons authorities to obtain their full support on TB control activities in all regions	6,360.00	500.00	500.00	670.00	670.00	670.00	670.00	670.00	670.00	670.00	670.00	MOH, PORALG, PARTNERS
	Print and distribute community-Based TB. DR TB, TB/HIV guide, orientation package, CHV handbook, and M&E tools in all councils	4,537.71	272.38	272.38	294.83	294.83	567.21	567.21	567.21	567.21	567.21	567.21	MOH, PORALG, RSs, LGAs
	Introduce Active Case Finding (ACF) and QI model in newly constructed hospitals and health centers in all councils	22,761.57	1,868.08	1,943.55	1,982.42	2,022.07	2,062.51	3,878.63	4.30	3,000.00	3,000.00	3,000.00	MOH, PARTNERS
	Conduct systematic TB screening and management among remands and inmates in 189 councils (Train HCWs in prisons, screening)	24,270.16	2,268.00	2,359.63	2,406.82	2,406.82	2,504.06	2,406.82	2,454.96	2,454.96	2,504.06	2,504.06	MOH, PORALG, PARTNERS

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget										All figures in '000'000 Tshs
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
	100% of First line TB drugs will be Procured and Distributed	80,000.00	8,000.00	8,000.00	8,000.00	8,000.00	8,000.00	8,000.00	8,000.00	8,000.00	8,000.00	8,000.00	MOH, PORALG, PARTNERS
	Sensitize health Managers and facility teams on ACF using QI toolkit in newly constructed hospitals and health centers	5,282.18	499.21	499.21	499.21	540.36	551.16	499.21	551.16	551.16	540.36	551.16	MOH, PORALG, RSs, LGAs, PARTNERS
	Minor repairs of health facilities in prisons in selected regions and districts	2,148.80	200.00	208.08	212.24	212.24	220.82	220.82	216.49	216.49	220.82	220.82	MOH, PARTNERS
	Refresher training to TB Focal persons in newly constructed hospitals and health centers	2,343.38	221.57	230.52	235.13	239.83	244.63	221.57	230.52	235.13	239.83	244.63	MOH, PORALG, PARTNERS
	Supervise and Monitor TB services in prisons in all regions	7,908.21	754.10	754.10	800.00	800.00	800.00	800.00	800.00	800.00	800.00	800.00	MOH, PORALG, PARTNERS
	Support Motorcycle riders (BODABODA) for TB to transport sputum specimen from lower HFs to GeneXpert sites and bring back feedback results in all councils	7,887.98	855.81	701.62	715.65	926.36	744.56	855.81	701.62	715.65	926.36	744.56	MOH, PORALG, PARTNERS
	Identify and capacitate 2 District TB mentors (HF TB champions) with mentorship and supportive supervisions skills in all councils.	272.60	27.26	27.26	27.26	27.26	27.26	27.26	27.26	27.26	27.26	27.26	MOH, PORALG, RSs, LGAs, PARTNERS
	Support coordination to prison department to monitor and supervise TB services in the prison countrywide (Provide transport/car and other costs.	10,794.11	1,020.60	1,061.83	1,083.07	1,104.73	1,126.82	1,020.60	1,061.83	1,083.07	1,104.73	1,126.82	MOH, PORALG, RSs, LGAs, PARTNERS
	Conduct yearly TB screening among traditional healers and their clients in all councils	15,911.32	1,504.44	1,565.22	1,596.52	1,628.45	1,661.02	1,504.44	1,565.22	1,596.52	1,628.45	1,661.02	MOH, PORALG, RSs, LGAs, PARTNERS
To expand access to quality TB diagnostic services, including the adoption of new diagnostic technologies.	Develop and disseminate national TB Laboratory Strategic Plan	335.75	33.58	33.58	33.58	33.58	33.58	33.58	33.58	33.58	33.58	33.58	MOH, PORALG, RSs, LGAs, PARTNERS
	100% Procure and distribute TB laboratory equipment, commodities and supplies	178,796.44	16,905.48	17,588.46	17,940.23	18,299.03	18,665.01	16,905.48	17,588.46	17,940.23	18,299.03	18,665.01	MOH, PORALG, RSs, LGAs, PARTNERS
	Procure at least 2 GeneXpert machines to each council in the country.	21,618.74	2,161.87	2,161.87	2,161.87	2,161.87	2,161.87	2,161.87	2,161.87	2,161.87	2,161.87	2,161.87	MOH, PARTNERS
	Provide bi-annual technical assistance to zonal TB laboratories	304.60	28.80	29.96	30.56	31.17	31.80	28.80	29.96	30.56	31.17	31.80	MOH, PORALG

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget										All figures in '000'000 Tshs
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
	Connect, maintain and update GeneXpert machines to electronic information systems for example GX-alert and DHIS2- ETL	1,517.42	143.47	149.27	152.26	155.30	158.41	143.47	149.27	152.26	155.30	158.41	MOH, PARTNERS
	Perform periodic preventive maintenance, repair, and calibration for all TB laboratory equipment	3,113.65	294.40	306.29	312.42	318.67	325.04	294.40	306.29	312.42	318.67	325.04	MOH, PORALG, RSs, LGAs, PARTNERS
	To support the linkage (interoperability) Gx Alert with electronic information systems. DHIS2/ETL, eSRS, GoTHOMIS etc)	1,517.42	143.47	149.27	152.26	155.30	158.41	143.47	149.27	152.26	155.30	158.41	MOH, PORALG, RSs, LGAs, PARTNERS
	Sensitize regional HCWs on the availability and use of TB diagnostic tests	20,810.27	500.00	570.00	5,700.09	500.00	570.00	5,700.09	500.00	570.00	5,700.09	500.00	MOH, PORALG, RSs, LGAs, PARTNERS
	Conduct Quarterly Supportive supervisions for AFB smear microscopy and GeneXpert sites	3,594.16	352.30	366.53	352.30	366.53	352.30	366.53	352.30	366.53	352.30	366.53	MOH, PORALG, RSs, LGAs, PARTNERS
	Conduct refresher training in TB diagnostics GeneXpert users in 336 health facilities	3,172.87	300.00	312.12	318.36	324.73	331.22	300.00	312.12	318.36	324.73	331.22	MOH, PORALG, PARTNERS
	Conduct workshop with System provider consultant to upgrade GxAlert system	323.71	30.67	31.91	32.55	33.20	33.86	30.67	31.91	32.55	33.20	33.20	MOH, PORALG, PARTNERS
To increase RR/MDR-TB cases detected and enrolled for treatment from 54 percent to 90 percent of the estimated TB cases among the notified by 2025.	100% of Anti-tuberculosis second- line medicines are Procured	30,000.00	3,000.00	3,000.00	3,000.00	3,000.00	3,000.00	3,000.00	3,000.00	3,000.00	3,000.00	3,000.00	MOH, PARTNERS
	Train HCWs on Programmatic management of Drug Resistance TB (PMDT	1,761.37	166.54	173.27	176.73	180.27	183.87	166.54	173.27	176.73	180.27	183.87	MOH, PORALG, RSs, LGAs, PARTNERS
	Procure 5 special MDR TB ambulances for zonal MDR TB initiating centres to strengthen and facilitate referral of MDR TB patients	29,760.13	7,600.00	7,600.00	7,600.00	980.07	980.07	1,000.00	1,000.00	1,000.00	1,000.00	1,000.00	MOH, PARTNERS
	Support TB coordinators and DOT providers to conduct contact investigation for all confirmed RR/MDR- TB cases	2,792.13	264.00	274.67	280.16	285.76	291.48	264.00	274.67	280.16	285.76	291.48	MOH, PORALG, RSs, LGAs, PARTNERS
	Support referral and transportation of MDR-TB patients with special needs to and from the zonal treatment centers	1,665.76	157.50	163.86	167.14	170.48	173.89	157.50	163.86	167.14	170.48	173.89	MOH, PORALG,

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget .										All figures in '000'000 Tshs
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
	Conduct targeted Supportive supervisions and mentorship on MDR- TB management in all councils	1,289.46	121.92	126.85	129.38	131.97	134.61	121.92	126.85	129.38	131.97	134.61	MOH, PORALG, RSs, LGAs, PARTNERS
	To conduct assessment of health facilities capacity to provide MDR-TB services	2,792.13	264.00	274.67	280.16	285.76	291.48	264.00	274.67	280.16	285.76	291.48	MOH, PARTNERS
	To conduct follow up contacts investigations for MDR Patients on treatment across country	4,759.31	450.00	468.18	477.54	487.09	496.84	450.00	468.18	477.54	487.09	496.84	MOH, PORALG, RSs, LGAs, PARTNERS
	To support 100 DOT providers to conduct contact investigation for all confirmed RR TB cases	2,792.13	264.00	274.67	280.16	285.76	291.48	264.00	274.67	280.16	285.76	291.48	MOH, PARTNERS
	Conduct quarterly cohort review in 5 zones	3,888.67	367.68	382.53	390.18	397.99	405.95	367.68	382.53	390.18	397.99	405.95	MOH, PORALG, PARTNERS
To strengthen TB services to population of miners and their families by 2025. To reduce leprosy prevalence in all endemic councils by 2025	Conduct sensitization meeting with mining owners, managers, unions, NGOs, CBOs and stakeholders	856.50	85.65	85.65	85.65	85.65	85.65	85.65	85.65	85.65	85.65	85.65	MOH, PORALG, RSs, LGAs, PARTNERS
	Print and distribute IEC materials targeting cross	403.20	40.32	40.32	40.32	40.32	40.32	40.32	40.32	40.32	40.32	40.32	MOH, PARTNERS
	Conduct TB screening to mineworkers and surrounding communities in 40 councils	1,259.17	177.00	105.08	107.18	128.81	111.51	177.00	105.08	107.18	128.81	111.51	MOH, PORALG, RSs, LGAs, PARTNERS
	Conduct orientation to MO i/c, Clinicians, DOT providers from health facilities on cross border TB initiatives to 60 councils	703.40	70.34	70.34	70.34	70.34	70.34	70.34	70.34	70.34	70.34	70.34	MOH, PORALG, RSs, LGAs, PARTNERS
	Conduct TB and TB/HIV outreach services using mobile van in 30 mining areas.	1,929.11	182.40	189.77	193.56	197.44	201.38	182.40	189.77	193.56	197.44	201.38	MOH, PORALG, RSs, LGAs, PARTNERS
	Training of the local CSOs to implement TB CBI to 30 councils	793.95	79.40	79.40	79.40	79.40	79.40	79.40	79.40	79.40	79.40	79.40	MOH, PORALG, RSs, LGAs, PARTNERS
	Develop digital technology platform to Monitor TB treatment adherence in mining communities.	3,172.87	300.00	312.12	318.36	324.73	331.22	300.00	312.12	318.36	324.73	331.22	MOH, PARTNERS
	Support TB awareness campaigns and community mobilization to enhance health seeking behavior among border communities	916.33	86.64	90.14	91.94	93.78	95.66	86.64	90.14	91.94	93.78	95.66	MOH, PORALG, RSs, LGAs, PARTNERS

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget .										All figures in '000'000 Tshs
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
	Orient mining owners, managers and stakeholders on updated dust control tool kit.	1,608.95	160.90	160.90	160.90	160.90	160.90	160.90	160.90	160.90	160.90	160.90	MOH, PORALG, RSs, LGAs, PARTNERS
	Facilitate quarterly inter[1]facilities cross border coordination meetings	916.75	86.68	90.18	91.99	93.83	95.70	86.68	90.18	91.99	93.83	95.70	MOH, PARTNERS
	Develop and distribute leprosy elimination interventions' package for endemic councils	1,423.67	134.61	140.05	142.85	145.71	148.62	134.61	140.05	142.85	145.71	148.62	MOH, PORALG, RSs, LGAs, PARTNERS
	To Conduct visit to assess capability of rehabilitation centers	183.11	18.31	18.31	18.31	18.31	18.31	18.31	18.31	18.31	18.31	18.31	MOH, PORALG, , PARTNERS
	Develop PEP field manual and SOPs, data collection, monitoring checklist and reporting tools	393.40	39.34	39.34	39.34	39.34	39.34	39.34	39.34	39.34	39.34	39.34	MOH, PORALG, RSs, LGAs, PARTNERS
	Develop Leprosy training and community advocacy/information packages for frontline health care providers and affected communities	1,423.67	134.61	140.05	142.85	145.71	148.62	134.61	140.05	142.85	145.71	148.62	MOH, PORALG, RSs, LGAs, PARTNERS
	Support councils to conduct targeted campaign in selected endemic area and hot spots	3,391.17	320.64	333.59	340.27	347.07	354.01	320.64	333.59	340.27	347.07	354.01	MOH, PORALG, RSs, LGAs, PARTNERS
	To facilitate transportation expenses and allowances for 200 patients who receive specialized rehabilitative care in 20 councils	5,076.60	480.00	499.39	509.38	519.57	529.96	480.00	499.39	509.38	519.57	529.96	MOH, PORALG, RSs, LGAs, PARTNERS
	Support training of HFs HW to scale up of household contact screening and PEP in endemic councils	578.09	57.81	57.81	57.81	57.81	57.81	57.81	57.81	57.81	57.81	57.81	MOH, PORALG, RSs, LGAs, PARTNERS
	Conduct leprosy training sessions to frontline care providers especially in 15 endemic councils	437.40	43.74	43.74	43.74	43.74	43.74	43.74	43.74	43.74	43.74	43.74	MOH, PORALG, RSs, LGAs, PARTNERS
	Conduct planning meeting for elimination activities in endemic districts	713.30	71.33	71.33	71.33	71.33	71.33	71.33	71.33	71.33	71.33	71.33	MOH, PORALG, RSs, LGAs, PARTNERS
	Procure and distribute 400 special footwear and repair materials, prosthesis and other assistive devices for PALs	732.93	69.30	72.10	73.54	75.01	76.51	69.30	72.10	73.54	75.01	76.51	MOH, PARTNERS

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget										All figures in '000'000 Tshs
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
	Support 300 CHVs to conduct household contact screening and provision of SDR during scale up of targeted PEP in endemic councils	1,282.68	102.00	102.00	102.00	102.00	145.78	145.78	145.78	145.78	145.78	145.78	MOH, PORALG, RSs, LGAs, PARTNERS
	Develop IEC materials for leprosy elimination activities in endemic districts	537.40	53.74	53.74	53.74	53.74	53.74	53.74	53.74	53.74	53.74	53.74	MOH, PORALG, RSs, LGAs, PARTNERS
	Procure and distribute 1000 special shoe making materials, Prostheses and other appliances.	260.44	24.63	25.62	26.13	26.65	27.19	24.63	25.62	26.13	26.65	27.19	MOH, PORALG, RSs, LGAs, PARTNERS
	Support region and council technical officer to conduct SS and mentorship to HFs to implementing PEP	802.10	75.84	78.90	80.48	82.09	83.73	75.84	78.90	80.48	82.09	83.73	MOH, PORALG, PARTNERS
	Training health workers on leprosy in districts with elimination activities	825.30	82.53	82.53	82.53	82.53	82.53	82.53	82.53	82.53	82.53	82.53	MOH, PORALG, RSs, LGAs, PARTNERS
	To Develop training manual on self-care	437.40	43.74	43.74	43.74	43.74	43.74	43.74	43.74	43.74	43.74	43.74	MOH, , PARTNERS
	Sensitize community leaders, CHVs and PALs, committees, in endemic councils	720.56	68.13	70.88	72.30	73.75	75.22	68.13	70.88	72.30	73.75	75.22	MOH, PORALG, RSs, LGAs, PARTNERS
	Develop Leprosy training and community advocacy/information packages for frontline health care providers and affected communities	968.80	96.88	96.88	96.88	96.88	96.88	96.88	96.88	96.88	96.88	96.88	MOH, PORALG, , PARTNERS
	Conduct leprosy training sessions to frontline care providers especially in 15 endemic councils	4,530.86	428.40	445.71	454.62	463.71	472.99	428.40	445.71	454.62	463.71	472.99	MOH, PORALG, RSs, LGAs, PARTNERS
	Conduct 2 consultative forums and strategic dialogues for resource mobilization	2,068.68	375.17	159.93	163.13	166.39	169.72	375.17	159.93	163.13	166.39	169.72	MOH, , PARTNERS
	To train160 Journalists in community mobilization and advocacy activities for TB services	1,196.23	96.88	96.88	96.88	96.88	96.88	134.61	140.05	142.85	145.71	148.62	MOH, PORALG, RSs, LGAs, PARTNERS
To ensure availability of supportive systems and strengthened	To procure 5 motor vehicles and 200 motorcycles for central, regions and districts level	8,590.86	890.00	890.00	890.00	783.05	814.69	830.98	847.60	864.55	890.00	890.00	MOH, PARTNERS

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget										All figures in '000'000 Tshs
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
Program management and coordination for the Implementation of TB and Leprosy Services by 2025	To Conduct Sensitization meeting to owners of ADDOs, retail pharmacies and private laboratories on TB services in 10 regions	1,643.20	164.32	164.32	164.32	164.32	164.32	164.32	164.32	164.32	164.32	164.32	MOH, PORALG, RSs, LGAs, PARTNERS
	Develop Strategic Plan and associated documents for Tuberculosis and leprosy control	2,180.01	218.00	218.00	218.00	218.00	218.00	218.00	218.00	218.00	218.00	218.00	MOH, PORALG, RSs, LGAs, PARTNERS
	Support Parliamentary Standing Committee on HIV, TB and Drug Abuse activities	4,775.90	477.59	477.59	477.59	477.59	477.59	477.59	477.59	477.59	477.59	477.59	MOH, PARTNERS
	To maintain motor vehicles and motorcycle for programme coordination at all levels	444.20	42.00	43.70	44.57	45.46	46.37	42.00	43.70	44.57	45.46	46.37	MOH, RSs, LGAs,
	Support in cooperation of TB and leprosy activities into CCHP and DHFF.	2,977.42	281.52	292.89	298.75	304.73	310.82	281.52	292.89	298.75	304.73	310.82	MOH, PORALG, RSs, LGAs, PARTNERS
	Support Parliamentary TB Caucus operation biannual operation forums	1,320.00	132.00	132.00	132.00	132.00	132.00	132.00	132.00	132.00	132.00	132.00	MOH, PORALG, RSs, LGAs, PARTNERS
	To Conduct orientation to ADDOs dispensers on TB symptoms, sputum collection and referral system	5,232.20	523.22	523.22	523.22	523.22	523.22	523.22	523.22	523.22	523.22	523.22	MOH, PORALG, RSs, LGAs, PARTNERS
	To conduct supportive supervision at District level and health facilities level	1,731.97	163.76	170.38	173.78	177.26	180.80	163.76	170.38	173.78	177.26	180.80	MOH, PORALG, RSs, LGAs, PARTNERS
	Conduct advocacy meetings with the local government authorities	2,761.46	261.10	271.65	277.08	282.62	288.28	261.10	271.65	277.08	282.62	288.28	MOH, PORALG, RSs, LGAs, PARTNERS
	Advocate and Sensitize political leaders on TB and leprosy budget	225.80	21.35	22.21	22.66	23.11	23.57	21.35	22.21	22.66	23.11	23.57	MOH, PORALG, RSs, LGAs, PARTNERS
	Procure and distribute cooler boxes to facilitate sputum samples storage from ADDOs and Traditional healers	312.00	31.20	31.20	31.20	31.20	31.20	31.20	31.20	31.20	31.20	31.20	MOH, PORALG, RSs, LGAs, PARTNERS
	To develop proposal for resource mobilization in all councils	2,088.28	197.45	205.43	209.54	213.73	218.00	197.45	205.43	209.54	213.73	218.00	MOH, PORALG, RSs, LGAs, PARTNERS

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget										All figures in '000'000 Tshs
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
	Review and develop NTLP annual plan (AP) and Plan of action (POA)	487.25	46.07	47.93	48.89	49.87	50.87	46.07	47.93	48.89	49.87	50.87	MOH, PORALG, RSs, LGAs, PARTNERS
	Conduct sensitization meeting with newly selected councilors and parliamentarians on various key on TB control	6,085.40	608.54	608.54	608.54	608.54	608.54	608.54	608.54	608.54	608.54	608.54	MOH, PORALG, RSs, LGAs, PARTNERS
	Conduct quarterly supportive supervision and mentorship to regions with ADDOs and Traditional Healers engaged in TB case detection	1,731.97	163.76	170.38	173.78	177.26	180.80	163.76	170.38	173.78	177.26	180.80	MOH, PORALG, RSs, LGAs, PARTNERS
	To Conduct Annual NTLP Meeting	1,149.11	108.65	113.04	115.30	117.61	119.96	108.65	113.04	115.30	117.61	119.96	MOH, PORALG, RSs, LGAs, PARTNERS
	Conduct orientation sessions to high level Religious leaders and TB caucus members on TB control	4,775.90	477.59	477.59	477.59	477.59	477.59	477.59	477.59	477.59	477.59	477.59	MOH, PORALG, RSs, LGAs, PARTNERS
	To Facilitate referral and linkage between Ex TB Volunteers and ADDO dispensers and traditional healers in the country	3,375.78	766.80	223.48	227.95	232.51	237.16	766.80	223.48	227.95	232.51	237.16	MOH, PORALG, RSs, LGAs, PARTNERS
To ensure implementation of evidence-based interventions and decision making through institutionalized efficient M&E system and coordination of research by 2025.	To Integrate community and TPT monitoring tools with DHIS2-ETL system	2,594.00	259.40	259.40	259.40	259.40	259.40	259.40	259.40	259.40	259.40	259.40	MOH, PORALG, RSs, LGAs, PARTNERS
	Revise and Print routine data management guidelines including quality assurance guidelines and checklist to accommodate DHIS2-ETL system	644.75	64.48	64.48	64.48	64.48	64.48	64.48	64.48	64.48	64.48	64.48	MOH, PORALG, RSs, LGAs, PARTNERS
	Disseminate the operational research agenda to national and subnational staff and other stakeholders	456.50	45.65	45.65	45.65	45.65	45.65	45.65	45.65	45.65	45.65	45.65	MOH, PORALG, RSs, LGAs, PARTNERS
	To Conduct routine data quality assessment to regions, districts and health facilities	123.32	11.66	12.13	12.37	12.62	12.87	11.66	12.13	12.37	12.62	12.87	MOH, PORALG, RSs, LGAs, PARTNERS
	Training staff at central, regional and districts levels on research methodology	2,812.80	281.28	281.28	281.28	281.28	281.28	281.28	281.28	281.28	281.28	281.28	MOH, PORALG, PARTNERS

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget .									All figures in '000'000 Tshs
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
	To Conduct TB inventory study to measure TB under-reporting in all councils	696.73	69.67	69.67	69.67	69.67	69.67	69.67	69.67	69.67	69.67	69.67	MOH, PORALG, RSs, LGAs, PARTNERS
	To Support staff and graduate students to conduct operational researches on TB and leprosy	2,812.80	281.28	281.28	281.28	281.28	281.28	281.28	281.28	281.28	281.28	281.28	MOH, , PARTNERS
	To Conduct ToT training on data analysis and usage using the DHIS2-ETL dashboard	274.25	27.43	27.43	27.43	27.43	27.43	27.43	27.43	27.43	27.43	27.43	MOH, PORALG, RSs, LGAs, PARTNERS
	Conduct training to RTLCs & DTLCs on country specific research priorities based on current TB epidemic	355.00	35.50	35.50	35.50	35.50	35.50	35.50	35.50	35.50	35.50	35.50	MOH, PORALG, RSs, LGAs, PARTNERS
	To Conduct data analysis and usage training to HCWs using DHIS2-ETL dashboard	1,083.06	108.31	108.31	108.31	108.31	108.31	108.31	108.31	108.31	108.31	108.31	MOH, PORALG, RSs, LGAs, PARTNERS
	To Develop mechanisms, milestones and indictors for ongoing M&E of the implementation of the TB research plan in the country.	100.00	10.00	10.00	10.00	10.00	10.00	10.00	10.00	10.00	10.00	10.00	MOH, PORALG, RSs, LGAs, PARTNERS
	To Conduct workshops to review and validate the upgrades in DHIS2-ETL	508.10	50.81	50.81	50.81	50.81	50.81	50.81	50.81	50.81	50.81	50.81	MOH, PORALG, RSs, LGAs, PARTNERS
	To Orient National, Regional and District TB and Leprosy Coordinators on the updated DHIS2-ETL	1,003.00	100.30	100.30	100.30	100.30	100.30	100.30	100.30	100.30	100.30	100.30	MOH, PORALG, RSs, LGAs, PARTNERS
	To Procure 500 computers and accessories for data management in DHIS2-ETL enrolment	1,530.00	153.00	153.00	153.00	153.00	153.00	153.00	153.00	153.00	153.00	153.00	MOH, PORALG, RSs, LGAs, PARTNERS
	To Develop video and audio tutorial on DHIS2-ETL use for coordinators and HCWs at all levels	458.00	45.80	45.80	45.80	45.80	45.80	45.80	45.80	45.80	45.80	45.80	MOH, PORALG, RSs, LGAs, PARTNERS
SUBTOTAL TUBERCULOSI & LEPROSY CONTROL		**617,139.51**	**62,951.17**	**63,289.95**	**69,323.00**	**58,290.22**	**59,229.90**	**64,285.68**	**55,394.22**	**59,065.74**	**65,051.68**	**60,257.94**	

8.3.8 NON COMMUNICABLE DISEASES

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget										All figures in '000'000 Tshs
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
To capacitate NCD prevention and health promotion approaches targeting all modifiable risk factors (Alcohol, Tobacco, Nutrition physical inactivity and environmental) and other social determinant strengthened by 2032	Harmonizing and develop training material for all NCDs	468.00	116.55	116.55	116.55	116.55							MOH, PORALG, PARTNERS, RS, LGAs, COMMUNITY
	Training 3,000 health care providers on NCD's	3,990.00	398.58	398.58	398.58	398.58	398.58	398.58	398.58	398.58	398.58	398.58	MOH, PORALG, PARTNERS, RS, LGAs, COMMUNITY
	Promote 20,000 Community awareness on modifiable risk factors	1,580.00	158.00	158.00	158.00	158.00	158.00	158.00	158.00	158.00	158.00	158.00	MOH, PORALG, PARTNERS, RS, LGAs, COMMUNITY
	Laws/bylaws enforcement	890.00	89.00	89.00	89.00	89.00	89.00	89.00	89.00	89.00	89.00	89.00	MOH, PORALG, PARTNERS, RS, LGAs, COMMUNITY
To Improve NCD services by strengthened infrastructure, Human resource for health, finance, Health delivery system, HMIS and Medicine and medical supplies by 2032	Integration of NCD's into 78 district hospitals with existing health system	2,340.00	116.55	116.55	116.55	116.55							MOH, PORALG, PARTNERS, RS, LGAs, COMMUNITY
	Strengthened NCD's infrastructure, in to 78 district hospitals	6,788.65	678.9	678.9	678.9	678.9	678.9	678.9	678.9	678.9	678.9	678.9	MOH, PORALG, PARTNERS, RS, LGAs, COMMUNITY
	Strengthened health financing in to 78 district hospitals	9,000.00	900.00	900.00	900.00	900.00	900.00	900.00	900.00	900.00	900.00	900.00	MOH, PORALG, PARTNERS, RS, LGAs, COMMUNITY
	Strengthened NCD's health delivery System in to 78 district hospitals	2,350.00	235	235	235	235	235	235	235	235	235	235	MOH, PORALG, PARTNERS, RS, LGAs, COMMUNITY
	Strengthened supply chain of NCD's medicine and medical supplies in to 78 district hospitals	5,400.00	540.00	540.00	540.00	540.00	540.00	540.00	540.00	540.00	540.00	540.00	MOH, PORALG, PARTNERS, RS, LGAs, COMMUNITY
To improve Mental health Services by strengthened infrastructure, Human resource for health, finance, Health delivery system, HMIS and	Strengthened Mental Health infrastructure in to 78 district hospitals	6,788.65	678.87	678.87	678.87	678.87	678.87	678.87	678.87	678.87	678.87	678.87	MOH, PORALG, PARTNERS, RS, LGAs, COMMUNITY
	Strengthened mental health financing in to 78 district hospitals	4,800.00	480.00	480.00	480.00	480.00	480.00	480.00	480.00	480.00	480.00	480.00	MOH, PORALG, PARTNERS, RS, LGAs, COMMUNITY
	Strengthened mental	1,950.00	195.00	195.00	195.00	195.00	195.00	195.00	195.00	195.00	195.00	195.00	MOH, PORALG,

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget										All figures in '000'000 Tshs
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
Medicine and medical supplies by 2032	health delivery System in to 78 district hospitals												PARTNERS, RS, LGAs, COMMUNITY
	Strengthened supply chain of mental health medicine and medical supplies in to 78 district hospitals	6,000.00	600.00	600.00	600.00	600.00	600.00	600.00	600.00	600.00	600.00	600.00	MOH, PORALG, PARTNERS, RS, LGAs, COMMUNITY
To review, develop and disseminate strategic plan for Mental Health, SOPs, Guidelines and legal documents	develop and disseminate relevant documents	2,190.00	219.00	219.00	219.00	219.00	219.00	219.00	219.00	219.00	219.00	219.00	MOH, PORALG, PARTNERS, RS, LGAs, COMMUNITY
To enhance HMIS to accommodate NCD indicators by 2032	develop NCD's indicators and customize in DHIS and HMIS	1,190.00	119	119.00	119.00	119.00	119.00	119.00	119.00	119.00	119.00	119.00	MOH, PORALG, PARTNERS, RS, LGAs, COMMUNITY
	review and develop data collection tools and customize to the DHIS2 system	2,330.00	233.00	233.00	233.00	233.00	233.00	233.00	233.00	233.00	233.00	233.00	MOH, PORALG, PARTNERS, RS, LGAs, COMMUNITY
TOTAL NON COMMUNICABLE DISEASES		**58,055.30**	**5,874.86**	**5,874.86**	**5,874.86**	**5,874.86**	**5,758.31**	**5,758.31**	**5,758.31**	**5,758.31**	**5,758.31**	**5,758.31**	

8.3.9 ORAL HEALTH SERVICES

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget										All figures in '000'000 Tshs
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
Improve availability of qualified and competent District Dental Officers from 21% to 100% by June 2025	Deploy 146 DDOs (With Doctor of Dental Surgery Degree) by June 2023	2,593.00	888.00	888.00	817.00								**MoH, PORALG, LGAs, PARTNERS**
Improve availability of	Deploy 184 In-charges of Councils Hospitals	3,268.00			888.00	888.00	888.00	604.00					**PORALG, LGAs,**

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget										*All figures in '000'000 Tshs*
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
qualified and competent oral health professionals in Primary Health Care from 25% to 100% by June 2032	(With Doctor of Dental Surgery Degree qualification) by June 2032												**PARTNERS**
	Deploy 1139 Dental therapist for manning District Hospitals (103), Strategic Health Centres (668) and Strategic Dispensaries (368) by June 2032	9,300.00	913.00	980.00	980.00	980.00	980.00	980.00	980.00	980.00	980.00	547.00	**PORALG, LGAs, PARTNERS**
	Develop Curriculum for training of Dental Nurses	150.00	150.00										**MoH**
	Recruit 184 Dental Nurses foe manning Council Hospitals by June 2032	1,502.00		751.00	751.00								**PORALG, LGAs**
	Develop Mini Curriculum for the orientation of Non-Dental Clinician in Primary Health Care Facilities	150.00	150.00										**MoH**
	Orientation to 5792 Clinician in Dispensaries and Health Centers by DDOs on diagnosis, pain alleviation and referral for oral diseases and conditions by June 2025	1,200.00		600.00	600.00								**PORALG, LGAs, PARTNERS**
Appropriate and uninterrupted promotive, preventive, curative, rehabilitative and corrective quality oral health services in Primary health Care facilities provided by June 2032	Review, develop, and disseminate Oral Health Policy Guideline (Oral health policy guideline 2025-2030, Oral health policy guideline 2031-2036 prepared by June 2031) and Strategic Plans (5 years Costed Oral Health Strategic plan 2022-2027, 5 years Costed Oral Health Strategic plan 2028-2032)	880.00	220.00		220.00			220.00			220.00		**MoH**
	Conduct Clinical and									1,435.00			**RAS, PORALG**

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget										All figures in '000'000 Tshs
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
	managerial Supportive supervision visit to 184 councils quarterly per year	14,350.00	1,435.00	1,435.00	1,435.00	1,435.00	1,435.00	1,435.00	1,435.00		1,435.00	1,435.00	
	Conduct Annual Regional Dental Officers meeting every year	500.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	MoH, PORALG, PARTNERS
	Equip 668 Strategic Health Centres with essential dental equipment in the provision of oral health care by June 2032	32,064.00	8,832.00	8,832.00	4,800.00	4,800.00	4,800.00						MoH, PORALG, LGAs, PARTNERS
	Equip 103 Councils Hospitals with essential dental equipment in the provision of oral health care by June 2032	10,712.00	10,712.00										MoH, PORALG, PARTNERS
	Construct 130 Dental Buildings in District hospitals by June 2025	32,500.00	16,250.00	16,250.00									MoH, PORALG, LGAs, PARTNERS
	Rehabilitate 60 Dental units in 60 Councils by June 2025	15,000.00	7,500.00	7,500.00									MoH, PORALG, LGAs, PARTNERS
	Conduct Planned preventive maintenance of Dental equipment in 552 Primary health care facilities in 184 Councils	2,760.00	276.00	276.00	276.00	276.00	276.00	276.00	276.00	276.00	276.00	276.00	MoH, PORALG, LGAs, PARTNERS
	Procure Oral health commodities for 552 Primary health care facilities in 184 Councils by 2032	73,600.00	7,360.00	7,360.00	7,360.00	7,360.00	7,360.00	7,360.00	7,360.00	7,360.00	7,360.00	7,360.00	MoH, PORALG, LGAs, PARTNERS
Routine and appropriate oral health education and promotion in clinics, RCH	Print and distribute Guideline for the provision of oral health education to 5948 RCH clinics by June 2024	60.00	30.00	30.00									MoH, PORALG, LGAs, PARTNERS

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget										*All figures in '000'000 Tshs*
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
clinics, ordinary primary schools, primary schools for children with special needs, public and elderly provided by June 2032	Conduct dissemination of Guideline for the provision of oral health education to 11896 RCH staff by June 2024	2,356.00	589.00	589.00	589.00	589.00							MoH, PORALG, LGAs, PARTNERS
	Print and distribute Guideline for the provision of oral health education to 18546 Primary Schools by June 2024	186.00	93.00	93.00									MoH, PORALG, LGAs, PARTNERS
	Conduct dissemination of Guideline for the provision of oral health education to 18546 Primary School Teachers by June 2024	3,620.00	905.00	905.00	905.00	905.00							MoH, PORALG, LGAs, PARTNERS
	Conduct Supportive Supervision in the provision of routine School based and RCH Oral Health Education program in 184 Councils by DDOs biannual	1,100.00	110.00	110.00	110.00	110.00	110.00	110.00	110.00	110.00	110.00	110.00	MoH, PORALG, LGAs, PARTNERS
SUBTOTAL ORAL HEALTH		**207,851.00**	**56,463.00**	**46,649.00**	**19,781.00**	**17,393.00**	**15,899.00**	**11,035.00**	**10,211.00**	**10,211.00**	**10,431.00**	**9,778.00**	

8.3.10 NUTRITION SERVICES

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget										All figures in '000'000 Tshs
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
1. To Strengthen nutrition commodities supply chain for service delivery (specialize nutritious foods, local production and anthropometric equipment's)	Conduct biannual stakeholders' (MSD, RCHS, MoH - NS and PSU, PO RALG) meetings to streamline procurement and distribution of nutrition commodities	107.69	9.90	10.33	10.77	10.82	10.86	10.91	10.96	11.00	11.05	11.10	MOH, PORALG, PARTNERS
	Conduct annual stakeholders meeting of 26 regions to assess the feasibility of producing the nutrition commodities and supplies	1,145.82	407.00	80.70	81.04	81.38522	81.75	82.13	82.46	82.79	83.12	83.45	MOH, PORALG, RSs, LGAs
	Develop/ review guidelines and standards for production of nutrition commodities and supplies	221.99	85.99	42.90	43.09	-	-	-	-	50.00	-	-	MOH, PARTNERS
	Conduct quarterly supportive supervision, mentorship and couching to health facilities to assess management of nutrition commodities and supplies	2,864.08	342.88	246.45	257.05	268.10	279.63	291.65	292.82	293.99	295.17	296.35	MOH, PORALG, PARTNERS
	To procure and distribute equipment and tools for nutrition assessment and Village Health and Nutrition Days (e.g., weighing scales, and height boards, MUAC, skin-fold callipers, bio-electrical impedance, in indirect calorimetry, Dexa machines	1,148.97	100.55	104.87	109.38	114.08	118.99	118.99	119.50	120.01	121.05	121.57	MOH, PORALG, PARTNERS
	To procure nutrition-related commodities (enteral and parenteral feeds, e.g., free amino acids IV, fatty acids IV) for management of DRNCDs and chronic disease	2,414.31	201.09	209.13	217.50	226.20	235.25	244.66	254.44	264.62	275.21	286.21	MOH, PORALG, RSs, LGAs, PARTNERS
	To conduct advocacy meeting for inclusion of nutrition commodities into national health insurance scheme	310.67	27.15	28.32	29.54	30.81	32.13	32.27	32.41	32.55	32.69	32.83	MOH. PARTNERS
	Procure annual stock and distribute micronutrient commodities – to health facilities and school programs	123,229.95	12,086.42	12,138.39	12,190.59	12,243.01	12,295.65	12,348.52	12,401.62	12,454.95	12,508.50	12,562.29	MOH, PORALG, PARTNERS
	Conduct stakeholders' meetings to advocate for local production of micronutrient, pre-mix, and supplements	258.48	22.60	23.57	24.59	25.64	26.75	26.85	26.96	27.07	27.18	27.28	MOH, PORALG, PARTNERS
2. Strengthen	To conduct ToT on prevention and			101.01				115.10					MOH,

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget										All figures in '000'000 Tshs
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
nutrition technical capacity on the prevention and management of under nutrition, over nutrition & micronutrient deficiencies at	management of overweight and obesity (national and regional training	1,108.14	96.84		105.35	109.88	114.60		115.59	116.09	116.59	117.09	PORALG, PARTNERS
	To develop guide/SOPs on nutritional management of DRNCDs and chronic diseases at facility level (working sessions and validation)	837.61	73.20	76.35	79.63	83.05	86.63	87.00	87.37	87.75	88.13	88.51	MOH, PORALG, PARTNERS
	To develop guide on screening and interpretation of overweight and obesity for Community Health Workers (CHWs	258.61	59.30	61.85	-	-	-	-	-	67.28	70.18	-	MOH, PORALG, RSs, LGAs, PARTNERS
	To conduct stakeholders meeting on prevention of overweight and obesity at all levels	367.57	36.19	36.35	36.50	36.66	36.82	36.82	36.98	36.98	37.14	37.14	MOH, PORALG, RSs, LGAs, PARTNERS
	Capacitate healthcare workforce on dietetics and clinical nutritionists	2,758.46	270.55	271.71	272.88	274.06	275.23	276.42	277.61	278.80	280.00	281.20	MOH, PORALG, RSs, LGAs, PARTNERS
	Advocate for nutrition package and specific nutrition recommendations for prevention, early identification (diagnosis) and treatment of micronutrient deficiencies for different service delivery channels	3,527.09	345.94	347.43	348.92	350.42	351.93	353.44	354.96	356.49	358.02	359.56	MOH, PORALG, RSs, LGAs, PARTNERS
	Review micronutrient guidelines and standards as appropriate	85.99	42.90	0.00	-	-	-	43.09	-	-	-	-	MOH, PARTNERS
3. Enhance SBCC to create demand and increase the uptake of services by raising on the importance of nutrition services among women, men,	To design relevant localized approaches to promote appropriate nutrition behaviours (promotion materials) during the first three years	188.37	18.48	18.55	18.63	18.71	18.79	18.88	18.96	19.04	19.12	19.20	MOH, PORALG
	To facilitate quarterly implementation of nutrition SBCC activities at community level (media, traditional groups, community groups, FBOs interventions, etc.)	524.06	51.40	51.62	51.84	52.07	52.29	52.51	52.74	52.97	53.20	53.42	MOH, PARTNERS
	To conduct advocacy meeting to CHMT/RHMT for screening for overweight and obesity into other existing health programs, e.g., TB, HIV as part of vital assessment in the health facilities	1,730.73	169.75	170.48	171.21	171.95	172.69	173.43	174.18	174.93	175.68	176.43	MOH, PORALG, RSs, LGAs, PARTNERS
	To conduct advocacy meeting with employers to implement nutrition package at working place including	518.96	50.90	51.12	51.34	51.56	51.78	52.00	52.23	52.45	52.68	52.90	MOH, PORALG, RSs, LGAs,

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget										*All figures in '000'000 Tshs*
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
	prevention of overweight and obesity at the workplace												PARTNERS
	To commemorate annual health lifestyle/ NCD week (cooking demonstrations, and bonanza on preparation and consumption of fruits and vegetables)	871.74	85.50	85.87	86.24	86.61	86.98	87.35	87.73	88.11	88.49	88.87	MOH, PORALG, RSs, LGAs, PARTNERS
	To conduct sensitization meeting for policy makers, religious leaders and influential people on healthy lifestyles	171.29	16.80	16.87	16.94	17.02	17.09	17.16	17.24	17.31	17.39	17.46	MOH, PORALG, RSs, LGAs, PARTNERS
	To conduct sensitization sessions for artists and celebrities on healthy lifestyles	136.11	13.35	13.41	13.47	13.52	13.58	13.64	13.70	13.76	13.82	13.88	MOH, PORALG, PARTNERS
	To develop/review messages on healthy lifestyles among social media houses and artists	606.14	59.45	59.71	59.96	60.22	60.48	60.74	61.00	61.26	61.53	61.79	MOH, PORALG, PARTNERS
	To conduct public awareness campaigns on healthy lifestyle at regional and national level	5,262.58	516.15	518.37	520.60	522.84	525.09	527.35	529.62	531.89	534.18	536.48	MOH, PARTNERS
	Develop 'Nutrition Social and Behavior Change Communication Strategy' to address micronutrient deficiencies	124.27	62.00	62.27	-	-	-	-	-	-	-	-	MOH, PORALG, RSs, LGAs, PARTNERS
	Develop national campaign by engaging with relevant ministries and organizations, e.g., Ministry of Information, Culture, Arts and Sports, and BASATA to create partnerships for effective BCC programmes	150.69	14.78	14.84	14.91	14.97	15.04	15.10	15.17	15.23	15.30	15.36	MOH, PARTNERS
	To conduct national/regional school campaigns on nutrition and healthy lifestyle	1,857.66	182.20	182.98	183.77	184.56	185.35	186.15	186.95	187.76	188.56	189.37	MOH, PORALG, RSs, LGAs, PARTNERS
4. Mainstreaming of nutrition services at workplace, schools,	To develop nutrition package for workplace interventions based on identified gaps	123.97	-	61.85	-	-	-	-	62.12	-	-	-	MOH, PORALG,

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget										All figures in '000'000 Tshs
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
social protection schemes	To conduct training for health and nutrition teachers/ coordinators, and school committees on implementation of school feeding guidelines in primary and secondary schools	350.99	34.43	34.57	34.72	34.87	35.02	35.17	35.32	35.47	35.63	35.78	MOH, PORALG, RSs, LGAs, PARTNERS
	To develop guidelines for food vendors in and around the school environment	57.50	57.50	0.00	-	-	-	-	-	-	-	-	MOH, PARTNERS
	Review and update existing training materials on nutrition education and counselling for children and adolescents	145.67	37.49	108.18	-	-	-	-	-	-	-	-	MOH, PORALG, RSs, LGAs, PARTNERS
	Promote integration of nutrition agenda with implementation of nutrition sensitive interventions such as WASH, MHM and deworming campaigns at the schools by holding joint campaigns (development of IEC, training package, media seminar kit, and media seminar meetings) Airtime cost.	390.14	27.83	34.24	35.61	37.03	38.51	40.05	41.65	43.32	45.05	46.85	MOH, PORALG, RSs, LGAs, PARTNERS
5. Enhance Nutrition monitoring and evaluation, surveillance and operational research.	Conduct bi annual national Vitamin A supplementation in children (6-59 months) and deworming (12 to 59 months) campaigns including screening for nutrition status	219.63	18.30	19.09	19.91	20.73	21.55	22.37	23.19	24.01	24.83	25.65	MOH, PORALG, RSs, LGAs, PARTNERS
	Conduct support supervision of Vitamin A Supplementation	2,391.14	199.16	207.13	215.41	224.03	232.99	242.31	252.00	262.08	272.56	283.47	MOH, PORALG, RSs, LGAs, PARTNERS
	Monitor micronutrient deficiencies through routine data collected in HMIS	201.70	16.80	17.47	18.17	18.90	19.65	20.44	21.26	22.11	22.99	23.91	MOH, PARTNERS
SUBTOTAL NUTRITION SERVICES		156,668.76	15,840.76	15,507.97	15,319.55	15,383.69	15,493.10	15,632.51	15,738.71	15,882.06	15,924.99	15,945.41	

8.3.11 NEGLECTED TROPICAL DISEASES (NTD)

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget										All figures in '000'000 Tshs
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
Strengthen Government Ownership, Advocacy, Coordination and Partnership	Conduct activities that Promote and strengthen country ownership and leadership through organizational structures at national and local government with dedicated funding.	730.00	113.00	63.00	113.00	63.00	63.00	63.00	63.00	63.00	63.00	63.00	NTD Program Manager
	Prepare and launch a 5 years NTD Strategic plan and Sustainability plan for Neglected Tropical Diseases 2027-2032.	67.00	-	-	-	-	67.00	-	-	-	-	-	NTD Program Manager
	Conduct advocacy meetings at all levels and asses the outcome of the sessions.	2,500.00	245.00	245.00	245.00	245.00	245.00	245.00	245.00	245.00	270.00	270.00	NTD Program Manager
	Annual Joint Planning Meeting conducted per year to foster partnership for NTDs at all levels per year.	230.00	23.00	23.00	23.00	23.00	23.00	23.00	23.00	23.00	23.00	23.00	NTD Program Manager
	Disease specific review and planning for each endemic disease district conducted annually.	2,700.00	270.00	270.00	270.00	270.00	270.00	270.00	270.00	270.00	270.00	270.00	NTD Program Manager
	Procurement of Vehicles, Motorbikes and Bicycles for the National Secretariat, Regional and District to support coordination of NTD Elimination.	500.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	NTD Program Manager
	Guide establishment of coordination mechanisms at regional and Councils levels.	29.00	-	-	-	-	29.00	-	-	-	-	-	NTD Program Manager
	Promote improved communication and awareness at the community level for a successful elimination of the endemic NTDs.	180.00	18.00	18.00	18.00	18.00	18.00	18.00	18.00	18.00	18.00	18.00	NTD Program Manager
Enhance planning for results resources mobilization and financial	Support regions and districts to develop integrated annual plans and budgets for NTD control (CCHP)	300.00	30.00	30.00	30.00	30.00	30.00	30.00	30.00	30.00	30.00	30.00	NTD Program Manager
	Develop and update national		30.00	30.00	30.00	30.00	30.00		30.00				NTD Program

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget										All figures in '000'000 Tshs
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
sustainability	NTD guidelines and tools for operationalization of NTD interventions to 184 councils	300.00						30.00		30.00	30.00	30.00	Manager
	Conduct activities to Strengthen the integration and linkages of NTD programme and financial plans into sector-wide and national budgetary and financing mechanisms	1,515.00	30.00	57.00	84.00	111.00	138.00	165.00	192.00	219.00	246.00	273.00	NTD Program Manager
Scale up access to interventions, treatment and system capacity building. Enhance NTD monitoring and evaluation, surveillance and operational research.	Conduct other NTD interventions such as Snakebite envenoming, Visceral Leishmaniasis, Podoconiosis etc.	1,270.00	127.00	127.00	127.00	127.00	127.00	127.00	127.00	127.00	127.00	127.00	NTD Program Manager
	Conduct integrated case-management-based diseases interventions, including MMDP services for LF and Trachoma.	9,430.00	943.00	943.00	943.00	943.00	943.00	943.00	943.00	943.00	943.00	943.00	NTD Program Manager
	Conduct NTD Program activities with identified platforms with similar delivery strategies and interventions (MDAs, skin NTDs, Morbidity management, SBCC, WASH etc) for integrated approaches across NTDs.	230.00	23.00	23.00	23.00	23.00	23.00	23.00	23.00	23.00	23.00	23.00	NTD Program Manager
	Conduct integrated vector management and WASH activities for targeted NTDs.	6,780.00	678.00	678.00	678.00	678.00	678.00	678.00	678.00	678.00	678.00	678.00	NTD Program Manager
	Conduct pharmaco-vigilance activities in NTD program and ensure timely effective supply chain management of quality-assured NTD Medicines and other products up to the last mile.	2,110.00	211.00	211.00	211.00	211.00	211.00	211.00	211.00	211.00	211.00	211.00	NTD Program Manager
	Conduct capacity building activities for NTD programme management and implementation & accelerate disease burden assessments and integrated mapping of	1,010.00	101.00	101.00	101.00	101.00	101.00	101.00	101.00	101.00	101.00	101.00	NTD Program Manager

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget										All figures in '000'000 Tshs
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
	NTDs.												
	Conduct monitoring of national NTD programme performance and outcome.	450.00	45.00	45.00	45.00	45.00	45.00	45.00	45.00	45.00	45.00	45.00	NTD Program Manager
	Conduct surveillance of NTDs and response to epidemic prone NTDs.	450.00	45.00	45.00	45.00	45.00	45.00	45.00	45.00	45.00	45.00	45.00	NTD Program Manager
	Support operational research, documentation and evidence to guide innovative approaches to NTDs programmes interventions.	800.00	80.00	80.00	80.00	80.00	80.00	80.00	80.00	80.00	80.00	80.00	NTD Program Manager
	Establish integrated data management system (Monitoring Information System, MIS, for NTDs and link NTD MIS with DHIS2) and support impact analysis of NTD in Tanzania as part of WHO Africa region and global NTD data management system.	850.00	85.00	85.00	85.00	85.00	85.00	85.00	85.00	85.00	85.00	85.00	NTD Program Manager
	Develop M and E framework for NTD Master Plan and Sustainability Plan 2021-2026.	35.00	-	-	-	-	35.00	-	-	-	-	-	NTD Program Manager
	Conduct M and E of NTD Master Plan and Sustainability Plan Implementation.	1,500.00	150.00	150.00	150.00	150.00	150.00	150.00	150.00	150.00	150.00	150.00	NTD Program Manager
	Develop M and E framework for NTD Master Plan and Sustainability plan for 2027-2032.	70.00	35.00	-	-	-	35.00	-	-	-	-	-	NTD Program Manager
SUBTOTAL NEGLECTED TROPICAL DISEASES		**34,036.00**	**3,332.00**	**3,274.00**	**3,351.00**	**3,328.00**	**3,521.00**	**3,382.00**	**3,409.00**	**3,436.00**	**3,488.00**	**3,515.00**	

8.3.12 QUALITY HEALTH SERVICES

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget .										All figures in '000'000 Tshs
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
Improve quality management systems and accountability.	Finalization and dissemination of revised Tanzania Quality Improvement Framework (TQIF) and National QI Strategic Plan by June 2024.	600	200	0	0	0	0	200	0	0	0	200	HQAU
	Dissemination of revised Tanzania Quality Improvement Framework (TQIF) and National QI Strategic Plan by June 2024.	1,350	450	0	0	0	0	450	0	0	0	450	HQAU
	Review the SRA tools for regional referral hospitals to suit the verification for zonal and national hospital by March 2026.	900	300	0	0	0	0	300	0	0	0	300	HQAU
	Dissemination of SRA results to different stakeholders including MoHCDGEC (Health Department) Management Meeting, PORLG and in TWG meetings by June 2026.	1,350	450	0	0	0	0	450	0	0	0	450	HQAU
	Conduct Star Rating assessment to primary healthcare facilities in 12 regions by March 2028..	39,000	3,900	3,900	3,900	3,900	3,900	3,900	3,900	3,900	3,900	3,900	HQAU
	Conduct quality assessment to all Zonal and National level Hospitals and develop Quality Improvement Plans (QIPs) by June 2028.	4,000	400	400	400	400	400	400	400	400	400	400	HQAU
	Development of provider's and patient safety guidelines by June 2030.	1,000	200	200	0	0	0	200	200	0	0	200	HQAU
	Dissemination of Client Service Charter guide for health facilities to all stakeholders (CHMTs; RHMTs; Regional, zonal and national level hospitals; and umbrella organization – APHFTA, CSSC and BAKWATA) by June 2030.	900	300	0	0	0	0	300	0	0	0	300	HQAU
	Finalization and alignment to Continuing Professional Development (CPD) framework of National Generic QI Training Packages (Training Slides, Facilitator's Guide, and Participant's Manual) by June 2032.	1,000	250	250	0	0	0	250	0	0	0	250	HQAU

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget										All figures in '000'000 Tshs
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
	Integration of QI training contents into E-Learning Platform by June 2032.	1,500	150	150	150	150	150	150	150	150	150	150	HQAU
	Dissemination of Complaint, Compliment Management Guidelines to all stakeholders (CHMTs; RHMTs; Regional, zonal and national level hospitals; and umbrella organization – APHFTA, CSSC and BAKWATA) by June 2032.	900	300	0	0	0	0	300	0	0	0	300	HQAU
Institute and monitor adherence to standards of care at different levels of health care delivery	Development of National IPC standards for National, Zonal, Specialized, Regional Referral Hospitals by June, 2024.	500	50	50	50	50	50	50	50	50	50	50	HQAU
	Printing of National IPC Standards by June 2024.	400	200	200	0	0	0	0	0	0	0	0	HQAU
	Dissemination of revised National IPC Standards for National, Zonal, Specialized, Regional Referral Hospitals by June, 2024	6,000	3,000	0	0	0	0	3000	0	0	0	0	HQAU
	Dissemination of National IPC standards to all stakeholders by June 2024.	9,000	3000	0	0	0	0	3000	3000	0	0	0	HQAU
	Develop and Printing of SOPs for IPC by June 2026.	12,000	3000	3000	0	0	0	3000	3000	0	0	0	HQAU
	Disseminating the SOPs for IPC by June 2026	2,500	250	250	250	250	250	250	250	250	250	250	HQAU
	Dissemination of revised National IPC Standards for Council Hospitals, Health Centers and Dispensaries by June 2026.	6,000	3,000	0	0	0	0	3,000	0	0	0	0	HQAU
	CHMTs, RHMTs and National level team conduct external assessment using IPC Standards by June 2026.	4,000	400	400	400	400	400	400	400	400	400	400	HQAU
	To conduct facilities internal assessment using IPC Standards implemented by June 2028.	1,000	100	100	100	100	100	100	100	100	100	100	HQAU
Coordination of implementation of Infection Prevention and Control activities in health services	Finalization of Protocol which will guide the HAIs surveillance by June 2024.	1,000	200	0	0	0	0	200	200	200	200	0	HQAU
	Develop database for HAIs data by June 2024.	1,500	250	250	0	0	0	250	250	250	250	0	HQAU
	Printing the final version of HAIs Surveillance Protocol by June 2024.	400	200	200	0	0	0	0	0	0	0	0	HQAU

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget										All figures in '000'000 Tshs
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
delivery by June 2032	Dissemination of HAIs Surveillance protocol to all stakeholders Train ICT officials from MoH and PORALG as part of knowledge transfer for sustainability and system maintenance by June 2026	2,000	200	200	200	200	200	200	200	200	200	200	HQAU
	Development of data base for PEP in DHIS2 by June 2028.	1,500	250	250	0	0	0	250	250	250	250	0	HQAU
	Printing of PEP Guideline, Registers and other PEP tools by June 2028.	500	250	250	0	0	0	0	0	0	0	0	HQAU
	Dissemination of PEP Guideline, Registers and other PEP tools to all stakeholders by June 2028.	800	0	0	0	0	500	300	0	0	0	0	HQAU
	Coordinate and conduct POCT sensitization meeting to remained 17 Regions: (Arusha, Iringa, Katavi, Kigoma, Manyara, Mara, Mbeya, Mtwara, Mwanza, Njombe, Rukwa, Ruvuma, Shinyanga, Simiyu, Songwe, Tabora, and Tanga) by June 2030.	1,000	250	250	0	0	250	0	0	250	0	0	HQAU
	Conduct External Auditing to 1440 rapid HIV testing points in all regions by 2030.	3,000	300	300	300	300	300	300	300	300	300	300	HQAU
	Conduct Point of Care Testing [POCT] framework steering committee meetings	2,000	200	200	200	200	200	200	200	200	200	200	HQAU
	Oversee the Implementation of POCT activities to eight regions namely: Mbeya, Songwe, Katavi, Morogoro, Pwani, Rukwa and Iringa	500	250	250	0	0	0	0	0	0	0	0	HQAU
	Review and integration of SPRT checklist into Afya SS by June, 2032	600	200	200	0	0	0	0	200	0	0	0	HQAU
Conduct Supportive Supervision to Health Facilities by 100% by 2032	Finalization of review of Supportive Supervision Guidelines by June 2024.	400	200	200	0	0	0	0	0	0	0	0	HQAU
	Printing the revised SSG by June 2024.	750	250	250	0	0	0	0	0	250	0	0	HQAU
	Development of Job Aids and training martials for dissemination of digital supportive supervision system by June 2024.	500	50	50	50	50	50	50	50	50	50	50	HQAU
	Train ICT officials from MoHCDGEC and PORALG as part of knowledge transfer for sustainability and system maintenance by June 2024.	3,000	300	300	300	300	300	300	300	300	300	300	HQAU

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget										All figures in '000'000 Tshs
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
	Deployment and dissemination of supervision digital system and capacity building for health workers on new practices for conducting supervision using digital system from national to facility level by June 2026.	2,000	200	200	200	200	200	200	200	200	200	200	HQAU
	Identify indicators for AfyaSS reports by departments, units and programs by June 2026	500	250	250	0	0	0	0	0	0	0	0	HQAU
	Conduct baseline and re-assessment on implementation of supportive supervision using AfyaSS to selected region as part of monitoring and evaluation by June 2026.	600	200	200	200	0	0	0	0	0	0	0	HQAU
	Conduct resource mobilization meetings with stakeholders for rollout of AfyaSS by June 2028.	1,000	100	100	100	100	100	100	100	100	100	100	HQAU
	Conduct Supportive Supervision to Health Facilities	2,000	200	200	200	200	200	200	200	200	200	200	HQAU
SUB TOTAL HEALTH QUALITY ASSURANCE		**119,450**	**24,200**	**13,000**	**7,000**	**6,800**	**7,550**	**22,250**	**13,900**	**8,000**	**7,500**	**9,250**	

8.3.13 SUPPLY CHAIN MANAGEMENT SYSTEM

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget										All figures in '000'000 Tshs
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
Improve availability of health commodities from 84% to 95% by 2032	Increase budget for medicines, equipment, medical supplies, laboratory equipment and reagents from the overall health budget from 29% to 35% by 2032	3,506.23	220.00	242.00	266.20	292.82	322.10	354.31	389.74	428.72	471.59	518.75	MOH, PORALG, LGAs PARTNERS
	To facilitate clearing of health commodities	122,718.17	7,700.00	8,470.00	9,317.00	10,248.70	11,273.57	12,400.93	13,641.02	15,005.12	16,505.63	18,156.20	MOH, PORALG, LGAs PARTNERS
	To facilitate storage of health commodities	35,062.33	2,200.00	2,420.00	2,662.00	2,928.20	3,221.02	3,543.12	3,897.43	4,287.18	4,715.90	5,187.48	MOH, PORALG, LGAs PARTNERS
	To facilitate distribution of health commodities to public health facilities	157,780.50	9,900.00	10,890.00	11,979.00	13,176.90	14,494.59	15,944.05	17,538.45	19,292.30	21,221.53	23,343.68	MOH, PORALG, LGAs PARTNERS
	Improving quantification and												MOH,

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget										All figures in '000'000 Tshs
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
	forecast demand by building capacity to HCWs to 7,327 Health facilities	**1,241.07**	44.52	93.13	96.49	106.14	116.75	128.42	141.27	155.39	170.93	188.03	PORALG, LGAs PARTNERS
	To conduct medicine audit to 7327 Health facilities	**232.75**	17.81	31.04	16.08	17.69	19.46	21.40	23.54	25.90	28.49	31.34	MOH, PORALG, LGAs PARTNERS
	Conduct SS and mentorship to Prime vendors, Medicine procurement Units.	**1,912.49**	120.00	132.00	145.20	159.72	175.69	193.26	212.59	233.85	257.23	282.95	MOH, PORALG, LGAs PARTNERS
	Monitoring adherence to generic during use of prescription in 7324 health facilities.	**286.87**	18.00	19.80	21.78	23.96	26.35	28.99	31.89	35.08	38.58	42.44	MOH, PORALG, LGAs PARTNERS
	To disseminate and monitor implementation of health commodities revolving fund guidelines to PHC 7327 health facilities	**1,041.64**	44.52	77.61	80.41	88.45	97.29	107.02	117.72	129.50	142.44	156.69	MOH, PORALG, RSs LGAs PARTNERS
	To facilitate development of hospital formulary to 7327 health facilities.	**549.84**	34.50	37.95	41.75	45.92	50.51	55.56	61.12	67.23	73.95	81.35	MOH, PORALG, LGAs PARTNERS
	To establish system for monitoring performance of medicine and therapeutic committee to PHC 7327 health facilities	**817.79**	35.61	46.57	64.33	70.76	77.83	85.62	94.18	103.60	113.96	125.35	MOH, PORALG, LGAs PARTNERS
Strengthened Inventory management system from 0 to 7327 Primary Health Facilities by 2032	Improve infrastructure for storage at 7327 Health facilities	**4,781.23**	300.00	330.00	363.00	399.30	439.23	483.15	531.47	584.62	643.08	707.38	MOH, PORALG, LGAs PARTNERS
	Strengthen support supervision of key staff managing health commodities in 7327 health facilities	**1,539.56**	96.60	106.26	116.89	128.57	141.43	155.58	171.13	188.25	207.07	227.78	MOH, PORALG, LGAs PARTNERS
	finalization and printing of the inventory management guidelines and disseminate inventory management tools and guidelines to 7327 Health facilities	**5,074.79**	318.42	350.26	385.29	423.82	466.20	512.82	564.10	620.51	682.56	750.82	MOH, PORALG, LGAs PARTNERS
	To conduct advocacy meetings for adequate budget allocations for pharmaceuticals	**573.75**	36.00	39.60	43.56	47.92	52.71	57.98	63.78	70.15	77.17	84.89	MOH, PORALG, LGAs PARTNERS
	Enforce implementation of Health commodity revolving funds and disseminate HCFR guidelines to 7327 health facilities	**1,041.64**	44.52	77.61	80.41	88.45	97.29	107.02	117.72	129.50	142.44	156.69	MOH, PORALG, LGAs PARTNERS
	Dissemination of manual for	**876.56**											MOH,

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget										All figures in '000'000 Tshs
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
	health commodity resource allocation		55.00	60.50	66.55	73.21	80.53	88.58	97.44	107.18	117.90	129.69	PORALG, LGAs PARTNERS
	Disseminate and monitor implementation of Hospital Pharmacy guideline	97.68	16.00	17.60	19.36	21.30	23.43	-	-	-	-	-	MOH, PORALG, LGAs PARTNERS
	To facilitate development of Hospital formularies at 7327 health facilities	274.92	17.25	18.98	20.87	22.96	25.26	27.78	30.56	33.62	36.98	40.67	MOH, PORALG, LGAs PARTNERS
	Enforce generic prescribing and dispensing and establish regulatory measures to allow for generic substitution in both the public and private sectors	159.37	10.00	11.00	12.10	13.31	14.64	16.11	17.72	19.49	21.44	23.58	MOH, PORALG, LGAs PARTNERS
	Establish a mechanism that will enable MoH to coordinate and monitor the performance of MTCs	398.44	25.00	27.50	30.25	33.28	36.60	40.26	44.29	48.72	53.59	58.95	MOH, PORALG, LGAs PARTNERS
	Monitor the implementation of good dispensing manual	286.87	18.00	19.80	21.78	23.96	26.35	28.99	31.89	35.08	38.58	42.44	MOH, PORALG, LGAs PARTNERS
	To undertake assessment on current prescribing and dispensing practices	602.43	37.80	41.58	45.74	50.31	55.34	60.88	66.97	73.66	81.03	89.13	MOH, PORALG, LGAs PARTNERS
Strengthening rational use of medicine facilities by 2032	To enhance adherence to good dispensing manual	949.87	59.60	65.56	72.12	79.33	87.26	95.99	105.59	116.14	127.76	140.53	MOH, PORALG, LGAs PARTNERS
	Enforce the use of STG/ NEMLIT in the public sector and encourage the private sector to comply	159.37	10.00	11.00	12.10	13.31	14.64	16.11	17.72	19.49	21.44	23.58	MOH, PORALG, LGAs PARTNERS
	Periodic review and dissemination of MTCs meeting	314.09	19.71	21.68	23.85	26.23	28.85	31.74	34.91	38.41	42.25	46.47	MOH, PORALG, LGAs PARTNERS
	Establish an antimicrobial stewardship program	127.50	8.00	8.80	9.68	10.65	11.71	12.88	14.17	15.59	17.15	18.86	MOH, PORALG, LGAs PARTNERS
reduce Importation of medicines, supplies, laboratory equipment and reagents reduced from 85% to 65% by 2032	Promote the establishment of domestic pharmaceutical industries	318.75	20.00	22.00	24.20	26.62	29.28	32.21	35.43	38.97	42.87	47.16	MOH, PORALG, LGAs PARTNERS
SUBTOTAL SUPPLY CHAIN MANAGEMENT		342,726.53	21,426.84	23,689.83	26,037.96	28,641.75	31,505.93	34,630.75	38,093.83	41,903.21	46,093.53	50,702.89	

8.3.14 ENVIRONMENTAL HEALTH AND SANITATION

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget .										All figures in '000'000 Tshs
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
Strengthen capacity of 95% of Health Care workers on WASH by 2032	Training of HCW on WASH guidelines and IPC	5,000.00	500.00	500.00	500.00	500.00	500.00	500.00	500.00	500.00	500.00	500.00	MOH
	Review of guidelines and tools, dissemination of guidelines and tools	2,000.00	200.00	200.00	200.00	200.00	200.00	200.00	200.00	200.00	200.00	200.00	MOH
Rehabilitation of existing WASH facilities in 3500 HCFs by 2032	Conducting need assessment for HCFs	3,500.00	350.00	350.00	350.00	350.00	350.00	350.00	350.00	350.00	350.00	350.00	MOH, PORALG, RSs, LGAs
	Training of local mason	7,000.00	700.00	650.00	750.00	700.00	800.00	600.00	600.00	700.00	700.00	700.00	MOH, PORALG, RSs, LGAs
	Rehabilitation of water supply infrastructure, sanitation facilities, hand washing infrastructures, develop and implement O & M plan	250,000.00	25,000.00	25,000.00	25,000.00	25,000.00	25,000.00	25,000.00	25,000.00	25,000.00	25,000.00	25,000.00	MOH, PORALG, RSs, LGAs
Construction of WASH facilities in 800,000 HCFs by 2032	Training of HCWs and Health Facility Governing committees/Council Health Services Boards	4,000.00	400.00	400.00	400.00	400.00	400.00	400.00	400.00	400.00	400.00	400.00	MOH, PORALG, RSs, LGAs
	Construction of water supply infrastructure, sanitation facilities, hand washing infrastructures, develop and implement O & M plan	320,000.00	32,000.00	32,000.00	32,000.00	32,000.00	32,000.00	32,000.00	32,000.00	32,000.00	32,000.00	32,000.00	MOH, PORALG, RSs, LGAs
Strengthening hygiene practices in 95% of HCFs by 2032	Conduct needs assessment for cleansing materials and equipment	1,200.00	120.00	200.00	200.00	200.00	200.00	200.00	200.00	200.00	200.00	100.00	MOHSW
	Develop/review SOPs on use	1,080.00	108.00	108.00	108.00	108.00	108.00	108.00	108.00	108.00	108.00	108.00	RALG, RSs, LGAs, COMMUNITY
	Conduct supportive supervision and monitoring	2,000.00	200.00	200.00	200.00	200.00	200.00	200.00	200.00	200.00	200.00	200.00	MOHSW
	Design of messages for hygiene promotion, promotion of messages and communication	1,080.00	108.00	108.00	108.00	108.00	108.00	108.00	108.00	108.00	108.00	108.00	MOHSW

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget										*All figures in '000'000 Tshs*
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
	Training of HCWs , develop plans for hygiene promotion in HCFs	3,000.00	300.00	300.00	300.00	300.00	300.00	300.00	300.00	300.00	300.00	300.00	MOH, PORALG, RSs, LGAs
Open defecation free status achieved and access to safely managed sanitation increased to 65 by 2032	Conduct Behaviour Change Communication intervention to all 26 Regions of mainland Tanzania	100,000.00	10,000.00	10,000.00	10,000.00	10,000.00	10,000.00	10,000.00	10,000.00	10,000.00	10,000.00	10,000.00	MOH, PORALG, RSs, LGAs
	Conduct capacity building to Environmental Health Officers at Regional and Council levels on safely managed sanitation	5,000.00	500.00	500.00	500.00	500.00	500.00	500.00	500.00	500.00	500.00	500.00	MOH
	Develop, Review and disseminate Guidelines and Strategies related to sanitation and hygiene	2,100.00	300.00	200.00	200.00	200.00	200.00	200.00	200.00	200.00	200.00	200.00	MOH
To strengthen environmental Health, Sanitation and Hygiene services by 2032	Procurement of transport facilities (Vehicles for Regions and Councils), motorcycles for Wards at all 26 regions	100,000.00	10,000.00	10,000.00	10,000.00	10,000.00	10,000.00	10,000.00	10,000.00	10,000.00	10,000.00	10,000.00	MOH
To strengthen Food Safety and Hygiene services by 2032	Training of Environmental Health Officers from Regional towards level on implantation of surveillance and investigation of foodborne diseases	5,400.00	800.00	600.00	500.00	500.00	500.00	500.00	500.00	500.00	500.00	500.00	MOH
	Conduct technical monitoring, supportive supervisions and evaluation of food borne diseases surveillance data	2,000.00	200.00	200.00	200.00	200.00	200.00	200.00	200.00	200.00	200.00	200.00	MOH, PORALG
To strengthen drinking water quality at point of use testing and monitoring at Regional and District levels by 2032	Conduct trainings to EHOs to Regions and LGAs on effective testing and monitoring of drinking water safety at the point of use, on the use and maintenance of	5,000.00	500.00	500.00	500.00	500.00	500.00	500.00	500.00	500.00	500.00	500.00	MOH

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget										All figures in '000'000 Tshs
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
	Delagua Water testing and monitoring kits												
	To procure 98 Delagua water testing and monitoring testing kits for drinking water quality at the point of use.	5,000.00	500.00	500.00	500.00	500.00	500.00	500.00	500.00	500.00	500.00	500.00	MOH
	Promotion of low cost and effective technologies for household drinking water treatment	2,000.00	200.00	200.00	200.00	200.00	200.00	200.00	200.00	200.00	200.00	200.00	MOH, PORALG, RSs, LGAs
	Develop and disseminate relevant Guidelines and Strategies on drinking water safety	2,600.00	500.00	300.00	300.00	250.00	250.00	200.00	200.00	200.00	200.00	200.00	MOH
Strengthen monitoring and evaluation and Research of environmental health services by 2032	To upgrade NSMIS data base and its capacity to manage Environmental Health data	4,100.00	800.00	500.00	500.00	500.00	300.00	300.00	300.00	300.00	300.00	300.00	MOH
	To Prepare Monthly, Quarterly and Annual Environmental Health Reports and provide feedback to 26 regions	500.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	MOH, PORALG
	To conduct Quarterly EHS Data quality assessment (DQA) in 26 Regions	2,000.00	200.00	200.00	200.00	200.00	200.00	200.00	200.00	200.00	200.00	200.00	MOH, PORALG
	Conduct biannual assessment of environmental health programs including environmental health competitions	5,000.00	500.00	500.00	500.00	500.00	500.00	500.00	500.00	500.00	500.00	500.00	MOH, PORALG, RSs, LGAs
To strengthen menstrual Health and Hygiene at all levels by 2032	Development of National Menstrual Health and Hygiene Guidelines and its dissemination	2,600.00	500.00	300.00	300.00	250.00	250.00	200.00	200.00	200.00	200.00	200.00	MOH
	Carry out a comprehensive MHH Research to evaluate the MHH status in school and community	5,000.00	500.00	500.00	500.00	500.00	500.00	500.00	500.00	500.00	500.00	500.00	MOH, PORALG, RSs, LGAs
	Capacity building to	5,000.00	500.00	500.00	500.00	500.00	500.00	500.00	500.00	500.00	500.00	500.00	MOH,

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget .										All figures in '000'000 Tshs
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
	MHH coordinators in 184 Councils on Menstrual Health and Hygiene issues												PORALG, RSs, LGAs
	Conduct health education campaigns to schools and community	7,000.00	700.00	700.00	700.00	700.00	700.00	700.00	700.00	700.00	700.00	700.00	MOH, PORALG, RSs, LGAs
Increase access to improved sanitation and hand washing practices in public places by 2032	Conduct sensitization meetings on construction of sanitation and hygiene facilities for travelers with hygiene services for babies equipped with necessary facilities in bus stops and transport hubs	2,000.00	200.00	200.00	200.00	200.00	200.00	200.00	200.00	200.00	200.00	200.00	MOH, PORALG, RSs, LGAs
Strengthen capacity of 95% of Health Care workers on WASH by 2032	Training of HCW on WASH guidelines and IPC	5,000.00	500.00	500.00	500.00	500.00	500.00	500.00	500.00	500.00	500.00	500.00	MOH
	Review of guidelines and tools, dissemination of guidelines and tools	2,000.00	200.00	200.00	200.00	200.00	200.00	200.00	200.00	200.00	200.00	200.00	MOH
SUB TOTAL ENVIRONMENTAL HEALTH AND SANITATION		**862,160.00**	**87,436.00**	**86,466.00**	**86,466.00**	**86,316.00**	**86,216.00**	**85,916.00**	**85,916.00**	**86,016.00**	**86,016.00**	**85,916.00**	

8.3.15 EMERGENCY PREPARENESS AND RESPONSE (EPR)

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget .			All figures in '000'000 Tshs						All figures in '000'000 Tshs
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
1. Improve availability of necessary equipment, medicines, and infrastructure to provide emergency services and post-emergency services and address the health effects of various disasters by 2032	Procurement and installation of medical equipment for emergency and critical care by 2023	70,000.00	7,000.00	7,000.00	7,000.00	7,000.00	7,000.00	7,000.00	7,000.00	7,000.00	7,000.00	7,000.00	MOH (EPRU), PARTNERS, LGAs, PORALG
	Procure and stock essential medicines for infectious diseases for all levels	50,000.00	5,000.00	5,000.00	5,000.00	5,000.00	5,000.00	5,000.00	5,000.00	5,000.00	5,000.00	5,000.00	MOH (EPRU), PARTNERS, LGAs, PORALG
	To train three (3) emergency physicians (Post graduate studies) for each level to run the EMDs (National, Zonal, Specialized and Regional referral Hospitals) by 2026	1,440.00	360.00	360.00	360.00	360.00	0.00	0.00	0.00	0.00	0.00	0.00	MOH (EPRU), PARTNERS,
	Construction of Emergency Medical	24,000.00	8,000.00	8,000.00	8,000.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	MOH (EPRU),

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget .					All figures in '000'000 Tshs					*All figures in '000'000 Tshs*
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
	Departments at National Specialized, Zonal and Regional hospitals By March 2023												PARTNERS,
	To train three (3) critical care nurses (Diploma studies) for each level to run the ICUs (National, Zonal, Specialized and Regional referral Hospitals) by 2030	720.00	240.00	0.00	0.00	240.00	0.00	0.00	0.00	240.00	0.00	0.00	MOH (EPRU), PARTNERS,
	To Conduct observational survey/assessments to determine the quality of emergency and critical care at all levels on annual basis by 2032	1,000.00	0.00	200.00	0.00	200.00	0.00	200.00	0.00	200.00	0.00	200.00	MOH (EPRU), PARTNERS,
	Construction of Emergency Medical Departments at District hospitals (184 District Hospitals) by 2032	55,200.00	5,520.00	5,520.00	5,520.00	5,520.00	5,520.00	5,520.00	5,520.00	5,520.00	5,520.00	5,520.00	MOH (EPRU), PARTNERS, LGAs, PORALG, RS
	To training one (1) emergency physician (Post graduate studies) to run the EMDs at council level by 2030	2,760.00	276.00	276.00	276.00	276.00	276.00	276.00	276.00	276.00	276.00	276.00	MOH (EPRU), PARTNERS, LGAs, PORALG
	To train two (2) critical care nurses (Diploma studies) to run the ICUs at council level BY 2032	2,208.00	220.80	220.80	220.80	220.80	220.80	220.80	220.80	220.80	220.80	220.80	MOH (EPRU), PARTNERS, LGAs, PORALG
2. Enhance availability known public health events action guidelines for dealing with the effects such as the physical and psychological effects of various disasters at all levels by 2032	Development of Influenza preparedness contingency plan	150.00	100.00	50.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	MOH (EPRU), PARTNERS,
	Development/Updating the Ebola Virus Disease preparedness contingency plan	150.00	0.00	50.00	0.00	50.00	0.00	50.00	0.00	0.00	0.00	0.00	MOH (EPRU), PARTNERS,
	Development/Update the mass casualty guidelines	200.00	100.00	0.00	0.00	0.00	0.00	100.00	0.00	0.00	0.00	0.00	MOH (EPRU), PARTNERS,
	Update the COVID-19 Response Plan	160.00	80.00	80.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	MOH (EPRU), PARTNERS,
	Update the COVID-19 Treatment Guidelines	100.00	0.00	50.00	0.00	50.00	0.00	0.00	0.00	0.00	0.00	0.00	MOH (EPRU), PARTNERS,
	Assessment of the health systems for the availability and use of preparedness and response plans/guidelines	813.28	81.33	81.33	81.33	81.33	81.33	81.33	81.33	81.33	81.33	81.33	MOH (EPRU), PARTNERS, LGAs, PORALG
	Development of Cholera preparedness contingency plan	150.00	0.00	50.00	0.00	50.00	0.00	50.00	0.00	0.00	0.00	0.00	MOH (EPRU), PARTNERS, LGAs, PORALG
	Develop the Dengue Preparedness contingency plan	150.00	0.00	0.00	50.00	0.00	50.00	0.00	50.00	0.00	0.00	0.00	MOH (EPRU), PARTNERS, LGAs, PORALG
	Update the Dengue Treatment	100.00	0.00	0.00	50.00	0.00	0.00	50.00	0.00	0.00	0.00	0.00	MOH (EPRU),

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget .									All figures in '000'000 Tshs	*All figures in '000'000 Tshs*
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
	Guideline												PARTNERS,
	Update the EVD treatment guidelines	100.00	0.00	0.00	50.00	0.00	0.00	0.00	50.00	0.00	0.00	0.00	MOH (EPRU), PARTNERS,
	Update the cholera treatment guideline	150.00	0.00	0.00	50.00	0.00	0.00	50.00	0.00	0.00	50.00	0.00	MOH (EPRU), PARTNERS,
	Develop the Aflatoxicosis contingency plan	150.00	0.00	0.00	0.00	0.00	0.00	0.00	100.00	50.00	0.00	0.00	MOH (EPRU), PARTNERS, LGAs, PORALG
	Develop the Anthrax contingency plan	150.00	0.00	0.00	0.00	0.00	0.00	0.00	100.00	50.00	0.00	0.00	MOH (EPRU), PARTNERS, LGAs, PORALG
3. Capacitate health care providers at all levels to deal with the effects of various disasters	Training of health care workers at regional referral and district Hospitals to management infectious diseases eg Cholera, EVD, COVID-19, and keep their data base	22,996.80	2,299.68	2,299.68	2,299.68	2,299.68	2,299.68	2,299.68	2,299.68	2,299.68	2,299.68	2,299.68	MOH (EPRU), PARTNERS, LGAs, PORALG
	On site mentorship of health care workers at regional referral Hospitals to management infectious diseases e.g. Cholera, EVD, COVID-19, and keep their data base	16,640.00	1,664.00	1,664.00	1,664.00	1,664.00	1,664.00	1,664.00	1,664.00	1,664.00	1,664.00	1,664.00	MOH (EPRU), PARTNERS, LGAs, PORALG
	Conduct annual assessment of capacity among healthcare workers to management infectious diseases	8,320.00	832.00	832.00	832.00	832.00	832.00	832.00	832.00	832.00	832.00	832.00	MOH (EPRU), PARTNERS, LGAs, PORALG
	Conduct Facility based simulation exercises with health care workers at regional referral Hospitals to management infectious diseases e.g. Cholera, EVD, COVID-19, and keep their data base	5,600.00	1,400.00	0.00	0.00	1,400.00	0.00	0.00	0.00	1,400.00	0.00	1,400.00	MOH (EPRU)
	Conduct Facility based simulation exercises with health care workers at District Hospitals to management infectious diseases e.g. Cholera, EVD, COVID-19, and keep their data base	13,800.00	0.00	4,600.00	0.00	0.00	4,600.00	0.00	0.00	0.00	0.00	4,600.00	MOH (EPRU), PARTNERS, LGAs, PORALG
	Conduct Facility based simulation exercises with health care workers at Health Centers and Dispensaries to management infectious diseases e.g. Cholera, EVD, COVID-19, and keep their data base	15,135.00	0.00	0.00	5,045.00	0.00	0.00	5,045.00	0.00	0.00	5,045.00	0.00	MOH (EPRU), PARTNERS, LGAs, PORALG
4. Develop subnational level "all hazard" emergency	To develop a regional specific subnational level "all hazard" emergency preparedness and	2,400.00	240.00	240.00	240.00	240.00	240.00	240.00	240.00	240.00	240.00	240.00	MOH (EPRU), PARTNERS, LGAs, PORALG

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget .							All figures in '000'000 Tshs			All figures in '000'000 Tshs
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
preparedness and response plans that will guide implementation during emergencies for all 26 regions 2032	response plans												
5. To conduct the National and subnational level risk assessment which will include risk profiling and vulnerability assessment and mapping for all 26 regions	Conduct National wide risk assessment	1,080.00	360.00	360.00	360.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	MOH (EPRU)
	Prepare a national health risk profile	150.00	0.00	50.00	100.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	MOH (EPRU)
6. To improve availability/securing of finance for emergencies preparedness and response	Conduct resource mobilization to various stakeholders via emergency specific response plans	650.00	65.00	65.00	65.00	65.00	65.00	65.00	65.00	65.00	65.00	65.00	MOH (EPRU), PARTNERS, LGAs, PORALG
7. To establish and oversee the Emergency Response Operations centers at national and subnational level for 26 regions	Pre establishment assessment of infrastructures and provide preparatory recommendations	336.00	84.00	84.00	84.00	84.00	0.00	0.00	0.00	0.00	0.00	0.00	MOH (EPRU), PARTNERS, LGAs, PORALG
	procurement and installation of ICT and teleconference equipment	5,532.93	1,383.23	1,383.23	1,383.23	1,383.23	0.00	0.00	0.00	0.00	0.00	0.00	MOH (EPRU)
	Equip each PHEOC with a monthly internet connection for at least 12 months	56.00	14.00	14.00	14.00	14.00	0.00	0.00	0.00	0.00	0.00	0.00	MOH (EPRU)
	Conduct training to the national teams on PHEOC establishment and operations	2,800.00	700.00	700.00	700.00	700.00	0.00	0.00	0.00	0.00	0.00	0.00	MOH (EPRU)
	Conduct post installation assessment for the PHEOC functionality	336.00	0.00	84.00	84.00	84.00	84.00	0.00	0.00	0.00	0.00	0.00	MOH (EPRU)
8. To establish and oversee the efficient and effective emergency medical services to ensure timely provision of required services established in 26 regions	To conduct facilities assessment along the highway in the target regions to determine the need for establishing an Emergency medical Services Post	1,200.00	120.00	120.00	120.00	120.00	120.00	120.00	120.00	120.00	120.00	120.00	MOH (EPRU), PARTNERS, LGAs, PORALG
	Renovate the identified healthcare facilities if need be	45,000.00	4,500.00	4,500.00	4,500.00	4,500.00	4,500.00	4,500.00	4,500.00	4,500.00	4,500.00	4,500.00	MOH (EPRU), PARTNERS, LGAs, PORALG
	To conduct training of healthcare workers from all the identified facilities	7,200.00	720.00	720.00	720.00	720.00	720.00	720.00	720.00	720.00	720.00	720.00	MOH (EPRU), PARTNERS, LGAs, PORALG

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget .					All figures in '000'000 Tshs					*All figures in '000'000 Tshs*
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
	Procure and install the medical equipment in the identified and renovated healthcare facilities for emergency care	6,000.00	600.00	600.00	600.00	600.00	600.00	600.00	600.00	600.00	600.00	600.00	MOH (EPRU), PARTNERS, LGAs, PORALG
	Procurement of Ambulances (Ratio 1:3 for Advanced versus Basic Life support Ambulances)	54,000.00	5,400.00	5,400.00	5,400.00	5,400.00	5,400.00	5,400.00	5,400.00	5,400.00	5,400.00	5,400.00	MOH (EPRU), PARTNERS, LGAs, PORALG
	Procurement and distribution of communication radios for all the identified health facilities and Ambulances	364.00	36.40	36.40	36.40	36.40	36.40	36.40	36.40	36.40	36.40	36.40	MOH (EPRU), PARTNERS, LGAs, PORALG
	Procurement of Air Ambulances	36,502.20	12,167.40	12,167.40	12,167.40	0.00	0.00	0.00	0.00	0.00	0.00	0.00	MOH (EPRU), PARTNERS, LGAs, PORALG
	Procurement and commissioning of marine Ambulances to the identified water bodies	22,206.65	0.00	7,402.22	7,402.22	7,402.22	0.00	0.00	0.00	0.00	0.00	0.00	MOH (EPRU), PARTNERS, LGAs, PORALG
	Development of Emergency Medical Services operational framework	100.00	0.00	50.00	50.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	MOH (EPRU), PARTNERS, LGAs, PORALG
	To establish a national registry for all emergencies, major incidents and accidents	140.00	50.00	10.00	10.00	10.00	10.00	10.00	10.00	10.00	10.00	10.00	MOH (EPRU), PARTNERS, LGAs, PORALG
	Monitor the implementation of the Emergency Medical Services operational framework	1,000.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	MOH (EPRU), PARTNERS, LGAs, PORALG
9. To develop and operationalize the program for provision of psychosocial support, gender mainstreaming and social protection services to affected individuals and effective restoration of essential health services at all levels.	To develop the Mental Health and psychosocial support during emergencies guidelines	150.00	0.00	100.00	0.00	50.00	0.00	0.00	0.00	0.00	0.00	0.00	MOH (EPRU), PARTNERS, LGAs, PORALG
	To develop the Psychosocial first Aid guidelines	150.00	50.00	0.00	50.00	0.00	0.00	50.00	0.00	0.00	0.00	0.00	MOH (EPRU), PARTNERS, LGAs, PORALG
	Printing of Mental health and Psychosocial support guidelines before dissemination	120.00	0.00	40.00	0.00	40.00	0.00	0.00	40.00	0.00	0.00	0.00	MOH (EPRU), PARTNERS, LGAs, PORALG
	Dissemination of Mental health and psychosocial guidelines and PFA guidelines at national level	5,000.00	500.00	500.00	500.00	500.00	500.00	500.00	500.00	500.00	500.00	500.00	MOH (EPRU), PARTNERS, LGAs, PORALG
	Capacity Building of Social welfare officers at all levels for psychosocial support services during emergencies provision	2,400.00	240.00	240.00	240.00	240.00	240.00	240.00	240.00	240.00	240.00	240.00	MOH (EPRU), PARTNERS, LGAs, PORALG

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget .							All figures in '000'000 Tshs			*All figures in '000'000 Tshs*
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
	Onsite assessment and mentorship on proper services provision	1,200.00	120.00	120.00	120.00	120.00	120.00	120.00	120.00	120.00	120.00	120.00	MOH (EPRU),
	Observational surveys/assessments to strategic facilities to determine the quality of services being provided (e.g., POE, Health Facilities etc)	800.00	80.00	80.00	80.00	80.00	80.00	80.00	80.00	80.00	80.00	80.00	MOH (EPRU),
10. To carry out comprehensive all hazard preparedness and response interventions at all levels	To review All hazard Emergency Preparedness Guidelines	300.00	0.00	0.00	100.00	0.00	0.00	0.00	100.00	0.00	0.00	100.00	MOH (EPRU), PARTNERS,
	To update the National action plan for health security	360.00	120.00	0.00	0.00	0.00	120.00	0.00	0.00	0.00	120.00	0.00	EPRU
	To train and keep the database for national rapid response teams	2,600.00	260.00	260.00	260.00	260.00	260.00	260.00	260.00	260.00	260.00	260.00	EPRU
	To participate in the cross border simulation exercises	100.00	10.00	10.00	10.00	10.00	10.00	10.00	10.00	10.00	10.00	10.00	MOH (EPRU), LGAs, PORALG
	Conduct regular multisectoral meetings on matters related to emergencies preparedness and response at national level	600.00	60.00	60.00	60.00	60.00	60.00	60.00	60.00	60.00	60.00	60.00	MOH (EPRU), PARTNERS, LGAs, PORALG
	To conduct the national level simulation exercises	480.00	120.00	0.00	0.00	120.00	0.00	0.00	0.00	120.00	0.00	120.00	MOH (EPRU), PARTNERS,
	Conduct regular multisectoral meetings on matters related to emergencies preparedness and response at both national and subnational levels	1,800.00	180.00	180.00	180.00	180.00	180.00	180.00	180.00	180.00	180.00	180.00	MOH (EPRU), PARTNERS,
	Conduct the national wide readiness assessment	1,500.00	150.00	150.00	150.00	150.00	150.00	150.00	150.00	150.00	150.00	150.00	MOH (EPRU), PARTNERS,
SUB TOTAL EMERGENCY PREPAREDNESS & RESPONSE (EPR)		**496,956.85**	**61,603.84**	**72,160.05**	**72,385.05**	**48,512.65**	**41,139.21**	**41,880.21**	**36,725.21**	**38,345.21**	**41,500.21**	**42,705.21**	

8.3.16 HEALTH PROMOTION AND EDUCATION

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget .										*All figures in '000'000 Tshs*
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
To Guide and harmonize health education and communication interventions	To develop guidelines and manuals for behavior change communication (BCC), social mobilization and advocacy to guide SBCC interventions to all levels.	110.00	80.00	30.00									MoH, PO - RALG and Partners
	To conduct Training of Trainers (ToTs) to 50 national trainers on SBCC manual and tools.	132.26	44.09	44.09				44.09					MoH, PO - RALG and Partners
	To conduct orientation to 5 CHMT members from councils on the SBCC manuals and tools.	1,555.00	180.00	180.00	180.00	145.00	145.00	145.00	145.00	145.00	145.00	145.00	MoH, PO - RALG and Partners
	To review the guidelines and manuals for behavior change communication (BCC), social mobilization and advocacy to guide SBCC interventions to all levels.	570.00	30.00	80.00	80.00	80.00	80.00	80.00	80.00	30.00	30.00		MoH, PO - RALG and Partners
To Strengthen health facility-based education	To develop Health Facility Based Education Standard Operating Procedures (SoP) conduct orientation on the SoP	530.00	55.00	45.00	45.00	55.00	55.00	55.00	55.00	55.00	55.00	55.00	MoH, PO - RALG and Partners
	To print 10,000 copies of Health Facility Based Education SoP	70.00		70.00									MoH, PO - RALG and Partners
	To distribute Health Facility Based Education SoP to 10,000 facilities countrywide.	80.00	20.00	20.00	20.00	20.00							MoH, PO - RALG and Partners
	To Assess facility based health education status by conducting Mapping of Health Education Delivery Facilities to all Health Facilities.	45.00	45.00										MoH, PO - RALG and Partners
	To Equip 10,000 health facilities with job aids and audio visual materials	500.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	MoH, PO - RALG and Partners

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget										*All figures in '000'000 Tshs*
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
	(audio-video materials, TV, DVD players)												
	Conduct continuous monitoring and improve	200.00	20.00	20.00	20.00	20.00	20.00	20.00	20.00	20.00	20.00	20.00	MoH, PO - RALG and Partners
To advocate for mainstreaming of health and multi-sector response to social determinants of health	Conduct and document analysis of relevant policies, their impact on health and identify health issues that are rooted in different policies	560.00	56.00	56.00	56.00	56.00	56.00	56.00	56.00	56.00	56.00	56.00	MoH, PO - RALG and Partners
	To develop advocacy IEC/SBCC Materials based on the analysis findings.	133.00		133.00	.								MoH, PO - RALG and Partners
	To disseminate IEC/SBCC materials through 5 national TV and Radios for 12 months.	300.00	30.00	30.00	30.00	30.00	30.00	30.00	30.00	30.00	30.00	30.00	MoH, PO - RALG and Partners
To strengthen capacity of emergency health communication preparedness, response and resilience	Develop emergency preparedness and response communication guidelines and training manuals	101.00	76.00	25.00									MoH, PO - RALG and Partners
	Develop messages on emergencies which can be disseminated through different communication outlets	192.00		160.00	32.00								MoH, PO - RALG and Partners
	To support dissemination of the Emergency Health Communication by conducting orientation to 5 CHMT members from 100 Councils.	3,500.00	350.00	350.00	350.00	350.00	350.00	350.00	350.00	350.00	350.00	350.00	MoH, PO - RALG and Partners
	To disseminate messages through 5 National Radio/TV and 100 community radios for 12 month	3,000.00	300.00	300.00	300.00	300.00	300.00	300.00	300.00	300.00	300.00	300.00	MoH, PO - RALG and Partners
To strengthen monitoring, evaluation and research component in the health promotion	To review and update Health Promotion indicators at all levels.	110.00	55.00	55.00									MoH, PO - RALG and Partners
	To develop checklist/tool for Health promotion Data quality check and	54.00	27.00	27.00									MoH, PO - RALG and Partners

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget										*All figures in '000'000 Tshs*
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
section	assessment.												
	To conduct annual data management and systems supportive supervision and data quality assessment.	700.00	70.00	70.00	70.00	70.00	70.00	70.00	70.00	70.00	70.00	70.00	MoH, PO - RALG and Partners
To provide an enabling environment for revitalizing implementation of Health Promotion at School level.	To print, distribute and disseminated National School Health Program guidelines to all regions, councils and stakeholders	4,500.00	450.00	450.00	450.00	450.00	450.00	450.00	450.00	450.00	450.00	450.00	MoH, PO - RALG and Partners
	To develop, design and pretest school based IEC/SBCC materials for health issue for Primary, Secondary and Tertiary education.	270.00	200.00	70.00									MoH, PO - RALG and Partners
	To disseminate school based SBCC/IEC materials to 25% of all schools country wide.	760.00	76.00	76.00	76.00	76.00	76.00	76.00	76.00	76.00	76.00	76.00	MoH, PO - RALG and Partners
	To assess availability status of NSHP guidelines and IEC/SBCC materials to schools.	1,100.00	150.00	150.00	150.00	70.00	150.00	70.00	70.00	70.00	70.00	150.00	MoH, PO - RALG and Partners
SUBTOTAL HEALTH PROMOTION & EDUCATION		**19,072.26**	**2,364.09**	**2,491.09**	**1,909.00**	**1,772.00**	**1,832.00**	**1,796.09**	**1,752.00**	**1,702.00**	**1,702.00**	**1,752.00**	

8.3.17 ADVOCACY SERVICES FOR THE PHSIDS

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget .									All figures in '000'000 Tshs
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
To advocate for mainstreaming of health and multi-sector response to social determinants of health	Conduct, document and disseminate analysis of relevant policies, their impact on health and identify health issues that are rooted in different policies	660.00	50.00	50.00	70.00	70.00	70.00	70.00	70.00	70.00	70.00	70.00	MoH, PO - RALG and Partners
	To develop advocacy IEC/SBCC Materials based on the analysis findings.	200.00	120.00	80.00									MoH, PO - RALG and Partners
	To disseminate IEC/SBCC materials through 5 national TV and Radios for 12 months.	2,100.00	300.00	200.00	200.00	200.00	200.00	200.00	200.00	200.00	200.00	200.00	MoH, PO - RALG and Partners
To advocate understanding of PHSDP to stakeholders at all levels	Create understanding and supportive environment for MMAM to leaders and influential at all levels	1,500.00	150.00	150.00	150.00	150.00	150.00	150.00	150.00	150.00	150.00	150.00	MoH, PO - RALG and Partners
	To conduct orientation meetings to 430 Members of Parliament on the revised MMAM.	2,750.00	275.00	275.00	275.00	275.00	275.00	275.00	275.00	275.00	275.00	275.00	MoH, PO - RALG and Partners
	To conduct orientation meetings to 500 CHMT and CMTs Members on the revised MMAM.	2,800.00	280.00	280.00	280.00	280.00	280.00	280.00	280.00	280.00	280.00	280.00	MoH, PO - RALG and Partners
	To conduct orientation meetings to 430 Councilors and CHSBs, HFGCs and Communities Members on the revised MMAM.	2,750.00	275.00	275.00	275.00	275.00	275.00	275.00	275.00	275.00	275.00	275.00	MoH, PO - RALG and Partners
	Enhance active participation and ownership of MMAM at community level	760.00	76.00	76.00	76.00	76.00	76.00	76.00	76.00	76.00	76.00	76.00	MoH, PO - RALG and Partners
	Advocate for implementation and supportive maintenance and sustainability of MMAM	500.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	MoH, PO - RALG and Partners
SUBTOTAL ADVOCACY		**14,020.00**	**1,576.00**	**1,436.00**	**1,376.00**	**1,376.00**	**1,376.00**	**1,376.00**	**1,376.00**	**1,376.00**	**1,376.00**	**1,376.00**	

8.3.18 COMMUNITY HEALTH SYSTEMS

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget .										All figures in '000'000 Tshs
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
To strengthen management and coordination of the CBHP at all levels	To Conduct mapping and developing database of stakeholders supporting community based health services at all level	480.00	250.00	230.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	MoH, PO - RALG and Partners
	To update annually database of stakeholders supporting community based health services at all level	870.00	87.00	87.00	87.00	87.00	87.00	87.00	87.00	87.00	87.00	87.00	MoH, PO - RALG and Partners
	To Support annual stakeholders meetings for Community based health services including 1 member from all 26 regions and 1 member from 186 councils.	2,107.10	210.71	210.71	210.71	210.71	210.71	210.71	210.71	210.71	210.71	210.71	MoH, PO - RALG and Partners
	To review guideline for supportive supervision, mentorship and coaching at Community level.	270.00	90.00	45.00					90.00	45.00			MoH, PO - RALG and Partners
	To conduct annual joint supportive supervision on CBH interventions at all levels using the developed supportive guideline	1,156.50	115.65	115.65	115.65	115.65	115.65	115.65	115.65	115.65	115.65	115.65	MoH, PO - RALG and Partners
	Review the primary health care guideline (1990)	86.90	63.90	23.00									MoH, PO - RALG and Partners
	To support two (2) Primary Health Care Meetings annually at all levels	272.00			34.00	34.00	34.00	34.00	34.00	34.00	34.00	34.00	MoH, PO - RALG and Partners
To strengthen CHW Cadre	To recruit and deploy CHWs at hamlet/Mtaa level based on the National Operational Guideline for Community Based Health Services countrywide.	450.00	45.00	45.00	45.00	45.00	45.00	45.00	45.00	45.00	45.00	45.00	MoH, PO - RALG and Partners
	To train and equip 10,000 CHWs by using the standardized training Package and CHWs tool Kit.	59,365.00	5,936.50	5,936.50	5,936.50	5,936.50	5,936.50	5,936.50	5,936.50	5,936.50	5,936.50	5,936.50	MoH, PO - RALG and Partners
	To develop Performance based incentive package for Community Health Workers	1,200.00	120.00	120.00	120.00	120.00	120.00	120.00	120.00	120.00	120.00	120.00	MoH, PO - RALG and Partners

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget										All figures in '000'000 Tshs
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
	To support orientation of 2500 CHWs Supervisor (V/MEOs and Health Facility in charges)	5,625.00	562.50	562.50	562.50	562.50	562.50	562.50	562.50	562.50	562.50	562.50	MoH, PO - RALG and Partners
	To facilitate incentives to at least 1 CHW from 16000 villages countrywide based on the Performance based incentive package.	192,000.00	19,200.00	19,200.00	19,200.00	19,200.00	19,200.00	19,200.00	19,200.00	19,200.00	19,200.00	19,200.00	MoH, PO - RALG and Partners
To strengthen community health systems through inclusive involvement and empowerment of communities	To develop inclusive governing committees members to accommodate special positions (traditional health practitioners, teachers, people with disabilities etc)	386.00	98.00	32.00	32.00	32.00	32.00	32.00	32.00	32.00	32.00	32.00	MoH, PO - RALG and Partners
	Health facility governing committee/Board meetings conducted annually involving all members	6,500.00	650.00	650.00	650.00	650.00	650.00	650.00	650.00	650.00	650.00	650.00	MoH, PO - RALG and Partners
	To conduct orientation meetings to 2400 HFGC members on the revised HFGC guidelines	4,760.00	476.00	476.00	476.00	476.00	476.00	476.00	476.00	476.00	476.00	476.00	MoH, PO - RALG and Partners
	Develop/adapt tools to facilitate community mobilization on health issues	104.00	72.00	32.00									MoH, PO - RALG and Partners
	To conduct orientation meetings to 400 Council Health Board Members on the revised Council Health Board Guideline.	852.00		276.00	72.00	72.00	72.00	72.00	72.00	72.00	72.00	72.00	MoH, PO - RALG and Partners
	To conduct orientation meetings to 344 Council Health Board Members on the revised Council Health Board Guideline.	1,307.00	254.00	254.00	254.00	254.00	48.50	48.50	48.50	48.50	48.50	48.50	MoH, PO - RALG and Partners
	To facilitate 2 Council Health Board Meetings annually to 100 councils	786.50	48.50	48.50	48.50	48.50	48.50	350.00	48.50	48.50	48.50	48.50	MoH, PO - RALG and Partners
	Conduct 4 Primary Health Care Meetings annually at all levels	3,700.00	370.00	370.00	370.00	370.00	370.00	370.00	370.00	370.00	370.00	370.00	MoH, PO - RALG and Partners
	SUB TOTAL CHS	**282,278.00**	**28,649.76**	**28,713.86**	**28,213.86**	**28,213.86**	**28,008.36**	**28,309.86**	**28,098.36**	**28,053.36**	**28,008.36**	**28,008.36**	

8.3.19 TRADITIONAL MEDICINE AND ALTERNATIVE HEALING

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget										*All figures in '000'000 Tshs*
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
To facilitate the provision of quality traditional and alternative medicine services to all people to enable them improve their well being	To Capacitate 5 researchers to conduct research and development on traditional and alternative medicine	5,500.00	1,000.00	500.00	500.00	500.00	500.00	500.00	500.00	500.00	500.00	500.00	MOH/, PARTNERS
	To use ethno-botanical information to establish traditional medicine practice	3,000.00	500.00	-	500.00	-	500.00	500.00	-	500.00	-	500.00	MOH/, PARTNERS, SCIENTISTS
	To engage local clinical trialists to conduct traditional and alternative medicines clinical trials	1,361	212.90	287.10	-	-	-	-	-	287.10	287.10	287.10	MOH/, PARTNERS, SCIENTISTS
(standardization and formulation of value added traditional medicine products through the application of traditional	To capacity for pre[1]clinical studies for traditional and alternative medicines	10,068.00	1,068.00	-	1,000.00	1,000.00	1,000.00	1,000.00	1,000.00	1,000.00	1,000.00	1,000.00	MOH/, PARTNERS, SCIENTISTS
	To establish safety profile of traditional and alternative medicine practice and products	2,000.00	-	500.00	500.00	500.00	500.00	-	-	-	-	-	MOH/, PARTNERS, SCIENTISTS
To establish and strengthen registration of traditional health practitioners	To identify and integrate medicinal foods (Nutraceutical) as nutritional interventions for COVID -19	1,156.50	115.65	115.65	115.65	115.65	115.65	115.65	115.65	115.65	115.65	115.65	MOH/, PARTNERS, SCIENTISTS
To institute quality assurance programmes and certification of traditional medicine products	To promote the cultivation of medicinal plants	3,120.00	115.65	115.65	115.65	115.65	115.65	-	-	-	-	-	MOH/, PARTNERS, SCIENTISTS
	To promote agriculture and industrial development of traditional and alternative medicines	1,360.00	360.00	250.00	250.00	250.00	250.00	-	-	-	-	-	MOH/, PARTNERS, SCIENTISTS
	To establish agronomical requirements for cultivation of medicinal plants required in the manufacturing of traditional and	79,850,000	79,850,000	-	-	-	-	-	-	-	-	-	MOH/, PARTNERS, SCIENTISTS
	To train farmers on GACPs	215.05	215.05	-	-	-	-	-	-	-	-	-	MOH/, PARTNERS, SCIENTISTS
	To acquire 200 hectors of land in Dodoma and 125 acres	769											MOH/, PARTNERS, SCIENTISTS
	To construct and equip traditional medicine resource centre at Kisarawe	14,015	400	3,600	3,645	3,600	3,600						MOH/, PARTNERS, SCIENTISTS

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget										*All figures in '000'000 Tshs*
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
	To equip (human, equipment and supplies) the traditional medicine resource centre	11,590	1,600	1,100	1,100	1,100	1,115	1,115	1,115	1,115	1,115	1,115	MOH/, PARTNERS, SCIENTISTS
	To establish botanical garden in Dodoma	215.05	215.05							-	-	-	MOH/, PARTNERS, SCIENTISTS
	To Develop training module and teaching curriculum for traditional practitioners and modern health practitioners	98.30	98.30							-	-	-	MOH/, PARTNERS, SCIENTISTS
	To train 10% of traditional health practitioners on continuous Professional development	1,230.00	150.00	120.00	120.00	120.00	120.00	120.00	120.00	120.00	120.00	120.00	MOH/, PARTNERS, SCIENTISTS
	To train 26 Regional coordinators and 184 Council coordinators of traditional medicines on the safe use of traditional medicines	1,363.00	400.00	107.04	107.04	107.04	107.04	107.04	107.04	107.04	107.04	107.04	MOH/, PARTNERS, SCIENTISTS
	To train TOTs on awareness creation to all councils and region traditional and alternative medicine coordinators	19,203.81	1,600.00	4,400.95	4,400.95	4,400.95	4,400.95						MOH/, PARTNERS, SCIENTISTS
	To utilize ethno-botanical surveyed information to develop compendium/ pharmaco opioea on traditional medicine	500.00	500.00	-	-	-	-	-	-	-	-	-	MOH/, PARTNERS, SCIENTISTS
	To conduct sensitization and training of modern health practitioners	1,160.00	116.00	-	116.00	116.00	116.00	116.00	116.00	116.00	116.00	116.00	MOH/, PARTNERS, SCIENTISTS
	To set traditional medicine service model at the modern health facility	134.00	134.00	134.00	134.00	134.00	134.00	134.00	134.00	134.00	134.00	134.00	MOH/, PARTNERS, SCIENTISTS
	To develop capacity for biotechnological research scientists and procure consumables and reagents for bio - assays	3,500.00	350.00	350.00	350.00	350.00	350.00	350.00	350.00	350.00	350.00	350.00	MOH/, PARTNERS, SCIENTISTS
	To procure formulation materials, tableting machines, laboratory equipment (rotary evaporator, chiller and microbiological equipment	380	380	-	-	-	-	-	-	-	-	-	MOH/, PARTNERS, SCIENTISTS

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget										*All figures in '000'000 Tshs*
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
	To procure stability chamber for herbal pharmaceuticals stability test, laboratory spray drier, heavy duty -80°C freezer, inverted microscope and micro plate reader	150.00	150.00	-	-	-	-	-	-	-	-	-	MOH/, PARTNERS, SCIENTISTS
	To Sensitize and register THPs in 184 Councils,	9,681.50	1.50	1,200.00	1,060.00	1,060.00	1,060.00	1,060.00	1,060.00	1,060.00	1,060.00	1,060.00	MOH, PARTNERS, SCIENTISTS
	To facilitate registration of traditional medicines	1,048.50	104.85	104.85	104.85	104.85	104.85	104.85	104.85	104.85	104.85	104.85	MOH,, PORALG, RS, LGAs, PARTNERS, SCIENTISTS
	To facilitate registration of traditional medicine facilities	500.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	
	To develop guidelines to stipulate roles of VEOs and primary health care in identification, data management of traditional medicine practice (traditional healers, facilities, referrals, health statistics including number and cases attended by THPs)	87.90	87.90		-	-	-	-	-	-	-	-	MOH,, PORALG, RS, LGAs, PARTNERS, SCIENTISTS
	To train and orient 2574 dispensaries on referral systems and data management of cases attended by THPs	1,250.00	250.00	250.00	250.00	250.00	250.00						MOH,, PORALG, RS, LGAs, PARTNERS, SCIENTISTS
	To train and orient VEOs on their role and responsibilities in identification and registration of THPs	2,500.00	250.00	250.00	250.00	250.00	250.00	250.00	250.00	250.00	250.00	250.00	MOH,, PORALG, RS, LGAs, PARTNERS, SCIENTISTS
SUB TOTAL TRADITIONAL &ALTERNATIVE MEDICINE		97,237.11	**10,504.70**	**13,435.25**	**14,669.62**	**14,124.15**	**14,639.20**	**10,173.55**	**9,960.65**	**10,460.65**	**9,960.65**	**10,173.55**	

8.3.20 HEALTH CARE FINANCING

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget .										*All figures in '000'000 Tshs*
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
Allocation of sufficient funds to support PHSDP implementation by Government, Development Partners, NGOs/CSOs, and Private Sector.	To allocate sufficient funds to support PHSDP implementation by Government, Development Partners, NGOs/CSOs, and Private Sector.	24,460,000	2,800,000	2,800,000	2,940,000	2,940,000	3,080,000	3,080,000	3,200,000	3,200,000	3,400,000	3,400,000	MOH,, PORALG, RS, LGAs, PARTNERS
Review of cost sharing guidelines that will provide guidance for implementation at lower level, including shift from block payment to fee for service	Review of cost sharing guidelines that will provide guidance for implementation at lower level byb 2024	800.00		300.00	300.00	200.00	0.00	0.00	0.00	0.00	0.00	0.00	MOH,, PORALG, RS, LGAs, PARTNERS
Dissemination of cost sharing guidelines to Stakeholders at National, Regional, Council and Facility levels by 2025	To disseminate cost sharing guidelines to Stakeholders at National, Regional, Council and Facility levels by 2024	2,500.00	0.00	0.00	0.00	0.00	2,000.00	500.00	0.00	0.00	0.00	0.00	MOH,, PORALG, RS, LGAs, PARTNERS
Prepare mechanism for tracking of total PHC Budget by 2024	Prepare mechanism for tracking of total PHC Budget by 2026	400.00	200.00	200.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	MOH,, PORALG, RS, LGAs, PARTNERS
Resource mobilization for support PHSDP implementation conducted by June 2032.	Conduct resource mobilization meetings with stakeholders for support PHSDP implementation by June 2032.	2,000.00	200.00	200.00	200.00	200.00	200.00	200.00	200.00	200.00	200.00	200.00	MOH,, PORALG, RS, LGAs, PARTNERS
SUBTOTAL HEALTH CARE FINANCING		24,465,700	2,800,400	2,800,700	2,940,500	2,940,400	3,082,200	3,080,700	3,200,200	3,200,200	3,400,200	3,400,200	

8.3.21 INSTITUTIONAL ARRANGEMENT

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget										All figures in '000'000 Tshs
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
To strengthen PHSDP Management and Coordination capacity of MOH & PORALG	Conduct quarterly consultative and orientation meetings to TWG and Steering committees	1,965.78	145.88	175.11	175.6	185.36	191.21	195.12	216.56	220.48	228.28	232.18	MOH,, PORALG, RS, LGAs, PARTNERS
	Create understanding and supportive environment for MMAM to leaders and influential at all levels	1,423.39	106.87	113.88	115.31	120.19	140.54	146.39	155.78	165.72	176.27	182.44	MOH,, PORALG, RS, LGAs, COMMUNITIES, PARTNERS
To build the capacity of MOH and PO RALG in coordinating and managing PHSDP by establishing Committees at all levels	To conduct orientation meetings to decision making committees/boards at all levels on the revised and implementation of MMAM.	1,525.39	112.87	123.88	138.31	140.19	144.54	146.39	169.78	170.72	180.27	198.44	MOH,, PORALG, RS, LGAs, COMMUNITIES, PARTNERS
	Conduct meetings to implementers of MMAM at all levels	1,540.39	116.87	123.88	131.31	139.19	147.54	156.39	165.78	175.72	186.27	197.44	MOH,, PORALG, RS, LGAs, COMMUNITIES, PARTNERS
SUBTOTAL INSTITUTIONAL ARRANGEMENT		**6,454.95**	**482.49**	**536.75**	**560.53**	**584.93**	**623.83**	**644.29**	**707.90**	**732.64**	**771.09**	**810.50**	

8.3.22 LEADERSHIP AND GOVERNANCE

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget All figures in '000'000 Tshs										
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
Strengthening cooperation with the private health sector in health care delivery.	To engage private sector to increase access to health care in the country and to protect the rights of specific groups	1,000.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	MOH, PORALG, RS LGAs, COMMUNITY
	To enhance involvement of other sectors in disease management strategies	1,000.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	MOH, PORALG, RS LGAs, COMMUNITY

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget All figures in '000'000 Tshs										
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
	To enhance collaboration with the other sectors, both at national and decentralised levels in order to address the social determinants of health (SDH)	1,000.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	MOH, PORALG, RS LGAs, COMMUNITY
	To strengthen one single registration and accreditation system for all HFs	1,000.00	250.00	250.00	0.00	0.00	0.00	250.00	250.00	0.00	0.00	0.00	MOH, PORALG, RS LGAs, COMMUNITY
	Disseminate one single registration and accreditation system to all stakeholders	800.00	0.00	0.00	0.00	0.00	500.00	300.00	0.00	0.00	0.00	0.00	MOH, PORALG, RS LGAs, COMMUNITY
	To harmonize the quality management systems of health care between the public and the private sector	1,000.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	MOH, PORALG, RS LGAs, COMMUNITY
	To engage private sector in programmes for control of communicable diseases	1,000.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	MOH, PORALG, RS LGAs, COMMUNITY
	To create enabling environment for joint ventures and/or private sector investments in the health sector, especially in domestic production of medicines and consumables.	1,000.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	MOH, PORALG, RS LGAs, COMMUNITY
	To stimulate and maintain PPP agreements at all levels	1,000.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	MOH, PORALG, RS LGAs, COMMUNITY
Enhance community involvement and engagement in the implementation of various health interventions.	To engage Community to volunteer for or donating to local health interventions/projects	2,000.00	200.00	200.00	200.00	200.00	200.00	200.00	200.00	200.00	200.00	200.00	MOH, PORALG, RS LGAs, COMMUNITY
	To enhance social accountability for further development of community health management systems.	2,000.00	200.00	200.00	200.00	200.00	200.00	200.00	200.00	200.00	200.00	200.00	MOH, PORALG, RS LGAs, COMMUNITY
To strengthen PHSDP Management and Coordination capacity of MOH & PO-RALG	Conduct quarterly consultative and orientation meetings to TWG and Steering committee at all levels.	1,989.40	169.50	175.11	175.60	185.36	191.21	195.12	216.56	220.48	228.28	232.18	MOH, PORALG, RS LGAs, COMMUNITY
	Management and coordination of PHSDP at all levels	1,540.39	116.87	123.88	131.31	139.19	147.54	156.39	165.78	175.72	186.27	197.44	MOH, PORALG, RS LGAs, COMMUNITY
SUBTOTAL LEADERSHIP & GOVERNANCE		**16,329.79**	**1,636.37**	**1,648.99**	**1,406.91**	**1,424.55**	**1,938.75**	**2,001.51**	**1,732.34**	**1,496.20**	**1,514.55**	**1,529.62**	

8.3.23 PRIVATE AND PUBLIC PARTNESRSHIP (PPP)

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget										*All figures in '000'000 Tshs*
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
Strengthening cooperation with the private health sector in health care delivery by 2032	To engage private sector to increase access to health care in the country and to protect the rights of specific groups	1,000.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	MoH, PORALG, RS, LGAs, Partners
	To enhance involvement of other sectors in disease management strategies	1,000.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	MoH, PORALG, RS, LGAs, Partners
	To enhance collaboration with the other sectors, both at national and decentralised levels in order to address the social determinants of health (SDH)	1,000.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	MoH, PORALG, RS, LGAs, Partners
	To strengthen one single registration and accreditation system for all HFs	1,000.00	250.00	250.00	0.00	0.00	0.00	250.00	250.00	0.00	0.00	0.00	MoH, PORALG, RS, LGAs, Partners
	Disseminate one single registration and accreditation system to all stakeholders	800.00	0.00	0.00	0.00	0.00	500.00	300.00	0.00	0.00	0.00	0.00	MoH, PORALG, RS, LGAs, Partners
	To harmonize the quality management systems of health care between the public and the private sector by 2032	1,000.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	MoH, PORALG, RS, LGAs, Partners
	To engage private sector in programmes for control of communicable diseases	1,000.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	MoH, PORALG, RS, LGAs, Partners
	To create enabling environment for joint ventures and/or private sector investments in the health sector, especially in	1,000.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	MoH, PORALG, RS, LGAs, Partners

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget										All figures in '000'000 Tshs
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
	domestic production of medicines and consumables.												
	To stimulate and maintain PPP agreements at all levels	1,000.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	MoH, PORALG , RS, LGAs, Partners
Enhance community involvement and engagement in the implementation of various health interventions by 2032.	To engage Community to volunteer for or donating to local health interventions/ projects	2,000.00	200.00	200.00	200.00	200.00	200.00	200.00	200.00	200.00	200.00	200.00	MoH, PORALG , RS, LGAs, Partners
	To enhance social accountability for further development of community health management systems.	2,000.00	200.00	200.00	200.00	200.00	200.00	200.00	200.00	200.00	200.00	200.00	MoH, PORALG , RS, LGAs, Partners
SUB TOTAL PUBLIC PRIVATE PARTNERSHIP		**12,800.00**	**1,350.00**	**1,350.00**	**1,100.00**	**1,100.00**	**1,600.00**	**1,650.00**	**1,350.00**	**1,100.00**	**1,100.00**	**1,100.00**	

8.3.24 INFORMATION, COMMUNICATION AND TECHNOLOGY

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget										All figures in '000'000 Tshs
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
1. Strengthen Digital Health Governance framework to 450 regional HMT and 3128 CHMT	Provide Digital Health Strategy (DHS) one day orientation and Support Supervision & mentorship on implementation to all 450 RHMT teams	147.36		18.42		18.42	18.42	18.42	18.42	18.42	18.42	18.42	MoH, PORALG, RS, LGAs, PARTNERS
	Provide Digital Health Strategy (DHS) one day orientation and Support Supervision & mentorship on implementation to all 3128 CHMT teams	1,492.56		165.84	165.84	165.84	165.84	165.84	165.84	165.84	165.84	165.84	MoH, PORALG , RS, LGAs, PARTNERS
.Improve ICT infrastructure to 6681 Dispensaries, 498 Health	Improve ICT infrastructure to 6681 Dispensaries	572,433.93		63,603.77	63,603.77	63,603.77	63,603.77	63,603.77	63,603.77	63,603.77	63,603.77	63,603.77	MoH, PORALG , RS, LGAs, PARTNERS
	Improve ICT	2,000.60	200.06	200.06	200.06	200.06	200.06	200.06	200.06	200.06	200.06	200.06	MoH,

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget										All figures in '000'000 Tshs
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
Centre and 95 District Hospital	infrastructure to 28 Regional referral Hospital												PORALG , RS, LGAs, PARTNERS
	Improve ICT infrastructure to 498 Health Centre	65,018.85		13,003.77	13,003.77	13,003.77	13,003.77	13,003.77					MoH, PORALG , RS, LGAs, PARTNERS
	Improve ICT infrastructure to 95 District Hospital	7,983.77		7,983.77									MoH, PORALG , RS, LGAs, PARTNERS
.Availability of 84 RRH ICTO, 36 Zonal and Tertiary Hospital ICTO and 380 District Hospitals ICTO	Availability of 84 RRH ICTO	121.80		48.72		24.36		48.72					MoH, PORALG , RS, LGAs, PARTNERS
	Availability of 36 Zonal and Tertiary Hospital ICTO	31.32		7.83		15.66		7.83					MoH, PORALG , RS, LGAs, PARTNERS
	Availability of 380 District Hospitals ICTO	330.60		43.50		43.50		69.60		87.00		87.00	MoH, PORALG , RS, LGAs, Partners
Digitalize health services delivery in holistic manner and enhance information exchange through open standards to 6681 Dispensaries, 498 HC and 95 DH at all health facility level	Digitalize and enhance information exchange through open standards to 95	1,197.00		1,197.00		0.00		0.00		0.00		0.00	MoH, PORALG , RS, LGAs, PARTNERS
	Digitalize and enhance information exchange through open 498 Health Centers	5,019.84		2,016.00		2,016.00		987.84		0.00		0.00	MoH, PORALG , RS, LGAs, PARTNERS
	Digitalize health systems and enhance information exchange through open standards to 1200 dispensaries	34,342.56		8,064.00		8,064.00		8,064.00		5,073.60		5,076.96	MoH, PORALG , RS, LGAs, PARTNERS
	Identification of digital system to be used in Community based health system by 2022	66.50	13.30		13.30		13.30		13.30		13.30		MoH, PORALG , RS, LGAs, PARTNERS
SUB TOTAL ICT		**691,500.93**	**320.70**	**96,675.42**	**77,330.54**	**87,155.38**	**77,005.16**	**86,710.21**	**64,001.39**	**69,148.69**	**64,001.39**	**69,152.05**	

8.3.25 MONITORING AND EVALUATION

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget									All figures in '000'000 Tshs
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
1. To monitor the programme implementation progress based on set targets	To conduct Ministerial M&E on development projects, programs and RRH performance in relation to collection, studying and analyses statistics needed in the implementation of policies and plans by June 2032	92.10		18.42		18.42		18.42	0.00	18.42		18.42	MOH, PORALG , RS, LGAs, PARTNERS
2.To conduct mid and end of the programme evaluation	To conduct assessment of quality of service deliveries through monitoring in all levels health Sector by June, 2032	288,911.08		72.00		63,603.77		63,603.77		80,033.77		81,597.77	MOH PORALG , RS, LGAs, PARTNERS
3.To strengthen the capacity for implementing M&E at all levels BY 2032	To conduct training on RHMIS Focal and DHMIS focal person to 26 regional and national levels by June 2023	121.80		48.72		24.36		48.72					MOH, PORALG, PARTNERS
	To conduct Data Validation and Audit in all 26 regions to improve annual PHC services Performance as measured by the national balanced Score card by June 2025	31.32		7.83		15.66		7.83					MOH PORALG , RS,, PARTNERS
	To conduct Short course training on Data Analysis, Project management skills to M&E staff at national levels by June 2032	330.60		43.50		43.50		69.60		87.00		87.00	MOH, PORALG,
4. Improved efficiency of HMIS and processes to meet all health sector	To capacitate MOH staffs in issues related to Data analysis and strategic plan by June, 2032	1,197.00		1,197.00		0.00		0.00		0.00		0.00	MOH, PORALG, PARTNERS
	To conduct data quality	34,342.56		8,064.00		8,064.00		8,064.00		5,073.60		5,076.96	MOH, DHS, DPP,

OBJECTIVES	ACTIVITIES	BUDGET	Annual Budget										*All figures in '000'000 Tshs*
			YR 1	YR 2	YR 3	YR4	YR 5	YR 6	YR 7	YR 8	YR 9	YR 10	RESPONSIBLE
M&E requirements	check and supportive supervision at all levels by June, 2026												PORALG, PARTNERS
	To provide training and capacity building to all new staff at all levels by June 2032	5,019.84		2,016.00		2,016.00		987.84		0.00		0.00	MOH, PORALG, PARTNERS
5.Strengthen accuracy, completeness, and timeliness of data	To procure computers, motor circles for 2 health district staff and 2 RHH staff to improve data quality, accuracy, completeness and timelines of data submission by June 2023	776.34	107.34		343.80			325.20					MOH, PARTNERS
6.Strengthen capacity for data analysis, dissemination, and use for evidence-based decision making and accountability	To conduct Data dissemination, Data use and strengthening use of DHIS2, Dashboard and Web Portal to all levels by June 2023	331,037.80		107.58									MOH, PARTNERS
	To develop both Regional Health Profile and District Health Profile by June 2023	343.80	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	PORALG , RS, LGAs, PARTNERS
To determine progress made against the set objectives and targets of MMAM by 2032	Monitor, supervise and evaluate PHSDP implementation at all levels. 2032	78,690.13	972.57	1,039.89	1,255.21	1,524.49	2,080.36	3,157.48	5,351.72	9,660.20	18,207.16	35,441.08	MOH PORALG , RS, LGAs, PARTNERS
SUB TOTAL MONITORING AND EVALUATION		**898,274.69**	**1,079.91**	**12,614.94**	**1,599.01**	**75,310.20**	**2,080.36**	**76,282.86**	**5,351.72**	**94,872.99**	**18,207.16**	**898,274.69**	

References

Amri ya Mgawanyo wa Maeneo ya Utawala katika Serikali za Mitaa (Mamlaka za Miji na Wilaya) (marekebisho) ya mwaka 2020 na TANGAZO LA SERIKALI NA 74A la tarehe 31/1/2020 na TANGAZO LA SERIKALI NA 498A la tarehe 29/6/2020

Global Observatory for eHealth Series, 2, Telemedicine: opportunities and developments in Member States: report on the second global survey on eHealth 2009. s.l. : WHO, 2010. ISBN 978 92 4 156414 4

Jamhuri ya Muungano Tanzania, Ofisi ya Rais - Tawala za Mikoa na Serikali za Mitaa: Mwongozo wa kuchagua maeneo ya ujenzi wa Zahanati, Vituo vya Afya na Hospitali za Halmashauri, Ofisi ya Rais, Tawala za Mikoa na Serikali za Mitaa, Katibu Mkuu Prof. Riziki S. Shemdoe uliotolewa tarehe 23 Septemba 2021.

Jamhuri ya Muungano wa Tanzania; Wizara ya Afya: Andiko la Mapendekezo ya kuboresha Mfumo wa Bima ya Afya Kiambatisho Na 2; June 2022.

Marc Blunier, Reinhold Werlein: Swiss Centre for International Health: National telemedicine Framework and a Feasibility Study and implementation support for a Telemedicine Pilot Project at Muhimbili National Hospital in Tanzania: Framework and Master plan; Contract Ref. No.: RCIP TZ / 11 / 2013, 28.11.2013.

Papanicolas I, Rajan D, Kananikolas M, Soucat A, Figueras J, editors: Health Systems Performance Assessment: a framework for policy analysis. Geneva: World Health Organisation 2022; (Health Policy Series No 57).

Taarifa kwa Umma kuhusu utekelezaji wa Mpango wa Maendeleo kwa Ustawi wa Taifa na Mapambano dhidi ya UVIKO -19. Ofisi ya Rais, Tawala za Mikoa na Mamlaka ya Serikali za Mitaa October 2021.

Todd G, Nswilla A, Kisanga O, Mamdani M. The Role of Essential Health Benefits in the Delivery of Integrated Services: Learning from Practice in East and Southern Africa July 2017: A case study of Essential Health Benefits in Tanzania mainland: Regional Network for Equity in Health in East and Southern Africa Discussion Paper No. 109

URT: Ministry of Health and Presidents' Office Regional Administration and Local Government Authorities Comprehensive Council Health Planning Guidelines 5th Edition 2020; 5.1. 5 Page 50

URT, Ministry of Health (2020): National Health Accounts 2020

URT, Ministry of Health (2020). Annual Health Sector Performance Profile 2019.

URT, Ministry of Health (2019). Annual Health Sector Performance Profile 2018.

URT, Ministry of Health (2018). Report of the 19th Joint Annual Health Sector Technical Review Meeting.

URT, Ministry of Health (2021). Health Sector Strategic Plan V.

URT, Ministry of Health (2019). Mid-Term Review of the Health Sector Strategic Plan IV 2015-2020

URT, Ministry of Health (2019). Mid-Term Review of the Health Sector Strategic Plan IV 2015-2020-Thematic Report (Health Commodities).

URT, Ministry of Health (2021). Health Sector Strategic Plan V 2021-2026

URT, Ministry of Finance and Economic Affairs (2021). Economic Survey 2020

URT, Ministry of Health (2021), The fifth Health Sector Strategic Plan (HSSP V) 2021/2026,

URT, Ministry of Health (2021). The Mid-Term Review of the HSSP IV October 2019

URT, Ministry of Health (2022). The National Health Policy 2007,

URT, Ministry of Health (2021). The Draft Final Health Policy 2020 and Policy Implementation Strategy 2020 – 2030,

URT, Ministry of Health (2022). Policy Guideline for Community Based Health Services,

URT, The Tanzania Development Vision 2025 (TDV 2025),

URT, Ministry of Health (2021). National Malaria Strategic Plan 2020/2021-2025/2026 – ("Transitioning to Malaria Elimination in phases"),

URT, Ministry of Health (2022). National Tuberculosis and Leprosy Strategic Plan

VI 2020/2025 – ("Impactful Innovative Strategies towards Ending TB and Leprosy Suffering and Burden"),

URT, Ministry of Health (2022): Strategic master Plan for the Neglected Tropical Diseases Control Program July 2021- June 2026 – ("Sustain Gains for Control and Elimination of NTDs"),

URT, Ministry of Health (2022): National Strategic Plan for Prevention and Control of Non – Communicable Diseases 2021- 2026 –(" Leaving No One Behind"),

URT, Ministry of Health (2022): Health Sector HIV Strategic Plan V 2021-2026, Tanzania Immunization Strategy 2021-2025,

URT, Ministry of Health (2022): National Plan for Reproductive, Maternal, Newborn, Child and Adolescent Health & Nutrition 2021/2022- 2025/2026

URT, Ministry of Health (2022): One Plan III 2021,

URT, Ministry of Health (2022): National Multisectoral Nutrition Action Plan 2021/2022 – 2025/2026, National Traditional and Alternative Medicines Strategic Plan 2026/2017- 2020/2021,

URT, Ministry of Health (2007-2017): Primary Health Services Development Programme – MMAM 2007-2017,

URT, Ministry of Health (2018): Mid-tern Review Report of Primary Health Services Development Programme – MMAM 2018,

URT, Ministry of Health (2021): Human Resources for Health Strategic Plan July 2021- June 2026,

URT, The third Five Years' Development Plan 2021/22 – 2025/26 (FYDP III),

URT, Ministry of Health (2013): National Essential Health Care Intervention Package – Tanzania (NEHCIP- Tz) (2013),

URT, Ministry of Health (2021): Standard Treatment Guidelines and National Essential Medicines List for Tanzania Mainland Six Edition 2021,

The Election Manifesto 2020-2025,

URT, Ministry of Health (2021): Draft Tanzania Quality Improvement Strategic Framework in HealthCare 2021-2026,

URT, (2021): Strategic Implementation Plan for PORALG Health, Social Welfare and Nutrition Services Division 2021-2026,

URT, Ministry of Health (2019/20 & 2020/21): Annual Health Sector Performance reports,

URT, (2021): PORALG Health Sector facilities Rehabilitation and Construction implementation reports,

URT, Ministry of Health (2021): National Health Workforce Volunteering Guidelines.

URT, Ministry of Health: National Guideline for Emergency Care Services in Health Facilities: First Edition April 2019.

URT: Ministry of Health: The Intensive Care Services Guidelines June 2022.

URT: Ministry of Health & Presidents Office Regional Administration and Local Government: Comprehensive Council Health Planning Guidelines 4th Edition 2011 page 82
(https://www.afdb.org/fileadmin/uploads/afdb/Documents/Project-and-Operations/Tanzania_-_Transport_Sector_Review.pdf).

URT, MOHSW. Tanzania National eHealth Strategy July 2013 – June 2018. 2013