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Ministry of Health and Social Welfare

Mid Term Review of the Health Sector Strategic Plan III 2009-2015

Health Services

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Mid Term Review of the Health Sector Strategic Plan III 2009-2015

Health Services

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Acronyms

ACT	Artemisin-based Combination Therapy
AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante Natal Care
ART	Anti Retroviral Therapy
BCC	Behaviour Change Communication
CCHP	Comprehensive Council Health Plan
CBHC	Community-Based Health Care
CBMC	Community-Based Malaria Control
CDB	Community-Based Distribution
CFR	Case Fatality Rate
CHMT	Council Health Management Team
CHSB	Council Health Services Board
CHW	Community Health Worker
CSW	Commercial Sex Workers
CT	Care and Treatment
CTC	Care and Treatment Clinic
DH	District Hospital
DMO	District Medical Officer
DOTs	Directly Observed Treatments
eMTCT	Elimination of Mother to Child Transmission
FBOs	Faith Based Organisations
GBD	Global Burden of Disease
HBC	Home Based Care
HC	Health Centre
HF	Health Facility
HFGC	Health Facility Governing Council
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HRH	Human Resources for Health
HSSP III	Health Sector Strategic Plan III (2009-15)

HTC	HIV Testing and Counselling
ICAP	International Centre for AIDS Prevention (Columbia University, USA)
IEC	Information, Education and Communication
IDUs	Injecting Drug Users
IDWE	Infectious Disease Week Ending
IFC	International Finance Corporation
IHME	Institute of Health Metrics (University of Washington, USA)
IPD	In Patient Department
IPT	Intermittent Preventive Treatment
ITN	Insecticide Treated Nets
LLIN	Long-lasting Impregnated Nets
MDR-TB	Multi-drug-resistant TB
MIP	Malaria In Pregnancy
MOHSW	Ministry of Health and Social Welfare
MSM	Men who have sex with men
MTCT	Mother to Child Transmission
MTR	Mid Term Review (2013)
NACP	National AIDS Control Programme
NBTS	National Blood Transfusion Services
NCD	Non Communicable Disease
NGO	Non-Governmental Organization
NTBL	National TB & Leprosy Programme
NTD	Neglected Tropical Disease
OPD	Out Patient Department
PALs	People Affected by Leprosy
PEPFAR	President's Emergency Plan for AIDS Relief
PLHIV	People Living with HIV
PMO-RALG	Prime Minister's Officer – Regional Administration & Local Government
PMTCT	Prevention of Mother to Child Transmission
PPP	Public Private Partnership
QA	Quality Assurance
QI	Quality Improvement
RAS	Regional Administrative Secretary
RDT	Malaria Rapid Diagnostic Tests

RMO	Regional Medical Officer
RRHSB	Regional Referral Hospital Services Board
RRHMT	Regional Referral Hospital Management Team
RHMT	Regional Health Management Team
RTI	Reproductive Tract Infection
RS	Regional Secretariat
STI	Sexually Transmitted Infection
TB	Tuberculosis
THMIS	Tanzania HIV/AIDS and Malaria Indicator Survey
TQIF	Tanzania Quality Improvement Framework
TZNTDCP	Tanzania Neglected Tropical Diseases Control Programme
USAID	United States Agency for International Development
VHC	Village Health Committees
VCT	Voluntary Counselling and Testing
VHC	Village Health Committees
WDC	Ward Development Committee
WHC	Ward Health Committees
WHO	World Health Organization
XDR TB	Extensively Drug-Resistant TB

1. Introduction

This Health Services Specific Technical Report of the HSSP III Mid-Term Review summarises the main findings of health service delivery strengths and areas for improvement for consideration by the MOHSW and other stakeholders. Based on the assessments of district health services, referral hospital services, disease control and prevention generally as well as for more specific major communicable and non-communicable health strategies, we have made twenty recommendations. These are intended to be relatively specific for consideration by the MOHSW and partners for the remaining two years before the close of HSSP III (2009-15), and they are in line with the main debrief findings of the entire HSSP III MTR provided to the MOHSW. These findings and recommendations are based on a review of a wide range of key reference documents, of which the principal ones are included in the references section, key informant interviews with MOHSW, development partners and NGO colleagues as well as results of field visits to Lindi, Mbeya and Geita Regions. Where feasible we have identified strategic areas for consideration in preparation for HSSP IV (2016-21).

2. HSSP III Health Strategic Objectives and Expected Results

District Health Services Strategies

1. Increase accessibility to health services based on equity and gender balanced needs
2. Improve quality of health services

HSSP III planned to update the Tanzania Package of Essential Health Interventions. The MMAM continued as the major strategy for improving access and expansion of health services in underserved areas with one dispensary per village and one health centre per ward. Public Private Partnership (PPP) should be enhanced. Community based strategies would be used to create more ownership of health in the community. The integration of health and social welfare services was to create synergies.

The Tanzania Quality Improvement Framework (TQIF) should be operationalised, with the introduction of an accreditation system. Standards and protocols in service delivery were to be promoted and updated where necessary.

The district hospital together with other hospitals in the district should provide first level referral care, with functional referral system.

Management of District Health Services Strategies

3. Strengthen and decentralise management of District Health Services and harmonise MOHSW and PMO-RALG management procedures

Improvement of the management capacity of District Health Services and availability of human resources for health in the periphery are priorities in the HSSP III. The Councils should develop health strategic plans for the period 2009-2015, following the HSSP III and annual Comprehensive Council Health Plans (CCHP). Further decentralisation within the District Health Services should take place. Collaboration with the private sector should be strengthened through service agreements.

The Council Health Services Boards (CHSB) and Health Facility Committees were to be stimulated to take their responsibilities in planning and monitoring of the health services. CHMT supervision of health facilities could focus on coaching based on guidelines and standards, and evidence based medicine. The RHMTs should be given more responsibilities in supporting the District Health Services.

M&E of the District Health Services should be strengthened, using LGA and PMO-RALG procedures and systems. A combination of supportive supervision and performance based incentive systems should be rolled out in the coming years. Pay for performance (P4P) and Results Based Bonuses (RBB) would be introduced.

Referral Hospital Services Strategies

1. Increase access for patients in need of advanced medical care
2. Improve quality of clinical services in hospitals

Regional hospitals should be reformed and perform their referral role. The Hospital Reforms Programme would be taken forward. The Tanzania Quality Improvement Framework programme would be reinforced, with a Quality Assurance Unit in each referral hospital. Health workers should be

sensitised to follow available standard treatment guidelines. A hospital accreditation system will be put in place. The zonal referral structure should be endorsed and made operational. Regional hospitals should be involved in supervision of district hospitals.

Social welfare services in hospitals would be expanded. Emergency preparedness and response in hospitals should improve based on a national programme.

Referral Hospital Care Objectives

3. Improve management of the hospital s through implementation of Hospital Reform Programme
4. Strengthen hospital governance

Hospital management capacity building should continue in HSSP III. The hospital reforms programme would be fully implemented. National and Regional Hospital Boards would be created based on a sound legal framework.

Referral hospitals would be encouraged to introduce and maintain financial and accounting management software systems. The hospitals should develop strategic plans for the period 2009-2015, following the HSSP III and produce annual plans and budgets.

General Strategies for Disease Prevention and Control

1. Improve disease surveillance of communicable and non-communicable diseases
2. Enhance community participation in health promotion and disease prevention
3. Improve disease case management in health facilities through integrated disease control activities at health facility level
4. Improve home-based treatment and care

Improvement of District Health Services and hospital services should create better conditions for achieving targets in specific programmes. Guidelines and diagnostic capacity, drugs and supplies should be available at health facilities. Community involvement and home-based care programmes for chronically should increase.

HIV/AIDS Strategies

1. Maximise the health sector contribution to HIV prevention
2. Accelerate the access and utilisation of HIV/AIDS care and treatment services
3. Scale up integrated TB and HIV services
4. Scale up STI control

Programmes for prevention of mother to child transmission (PMTCT), for VTC and ART and blood safety should continue and be intensified where needed. Care and treatment for people living with HIV/AIDS would be improved. Improvement of STI services, e.g. in youth-friendly clinics and condom distribution was planned as well.

Malaria Strategies

1. Implement universal access to malaria interventions, through effective and sustainable collaborative efforts.

Tuberculosis and Leprosy Strategies

1. Expand and mainstreamDOTs strategy to the general health system and involve FBOs and NGOs in DOTs
2. Introduce and implement MDR/XDR –TB management
3. Leprosy elimination prevention of disabilities and social economic

The National Malaria Medium Term Strategic Plan (2008-2012) guided the activities in diagnosis, treatment and vector control. Implementation of Stop TB Strategy should continue. Management of Multi-Drug Resistant TB (MDRTB) should be improved. In leprosy control, efforts should be concerted on targeted leprosy elimination and prevention of disabilities. Health promotion, disease prevention and control, care and rehabilitation should be integrated further.

Neglected Tropical Diseases Strategies

1. Strengthen surveillance, prevention, diagnosis and treatment of neglected tropical diseases and other epidemic-prone diseases

Non-communicable Diseases Strategies

1. Reduce the burden of NCDs, mental disorders and substance abuse
2. Develop NCD MH & SA advocacy and sensitisation programmes

Environmental Health Strategies

1. Operationalise the Public Health Act (PHA) 2008, and health elements of the Environment Management Act (2008)

The Ministry should develop policies, guidelines and protocols for infectious diseases and NCDs. More capacities should be mobilised to implement the NCD programme. The emphasis will be on promotion of healthier lifestyles including nutrition and physical exercise, prevention and protection especially for mental disorders. In collaboration with social welfare programmes the care for the chronically ill and handicapped should improve.

The Public Health Bill and Environment Management Law provide guidance in future developments. The ministry should develop regulations based on these acts. Sanitation and hygiene measures should be promoted. More research should be carried out into the actual burden of diseases in Tanzania and into proper intervention strategies.

The Draft National Environmental Health, Hygiene and Sanitation Strategy, should be finalised and operationalised. Integration of service delivery and disease surveillance at the implementation level is important, offering comprehensive services to the population.

Emergency Health Strategies

1. Establish systems at al levels for immediate emergency response to health disasters and disasters with health problems

Capacity building should take place in emergency preparedness and response at all levels (awareness, training, guideline finalisation and dissemination, protocols for response, communications, etc.). An effective surveillance and information system for emergency preparedness and response (risk assessment and early warning system) should be created in coordination with other information systems in the sector (e.g. epidemiology) and in coordination with other sectors (e.g. meteorology).

3. Findings and Issues by Strategic Objective and Crosscutting Issues

3.1 District Health Services Strategies

3.1.1 Increase Accessibility to Health Services Based on Equity and Gender Balanced Needs

The 2007-17 Mpangowa Maendeleowa Afyaya Msingi (MMAM) or Primary Health Services Development Programme (PHSDP) is a major strategy in HSSP III to improve access and expand health services in underserved areas with the aim of one dispensary per village and one Health Centre per ward. Continued expansion of health facilities at ward and village level is taking place (see MTR specific report on Capital Investment). The number of health workers deployed nationally has increased since the beginning of HSSP III (MTR-AR 2013). However, financial accessibility of essential services has not been fully realized as envisaged in HSSP III. It is unlikely therefore that this strategy will be realized due to limited available budget within the HSSP III.

3.1.2 Improve Quality of Health Services, Including TQIF and Accreditation System

Attendance rates for OPD and reproductive health services are a good indicator of whether or not the population is satisfied with general health services. Tanzania has low general OPD and reproductive health service rates compared to other countries in the sub-Saharan region. General OPD attendance rates did not increase during 2009-2012 and remained at a low 0.7 visits per capita per year (MTR-AR 2013). Most other countries in the region have rates above 1.00. The HSSP III target 0.80 is not met.

This low attendance in OPD and areas of reproductive health is explained in part by the public not perceiving quality in parts of the health services. Where quality is seen as high, good attendance usually results. Findings from the Community Perspective Study also reflect dissatisfaction with quality of parts of the health services, some of which suggest that poor communities in rural and urban areas mistrust public health services and the health facility staff. The Study findings also suggest that many women do not accept reproductive health services because of the presence of non-qualified staff, being asked to provide their own delivery supplies, and being treated without respect.

Other recent studies on quality of care in health services corroborate these Community Perspective Study findings. Provider training, supervision and improving drug supply and equipment systems are central to improving quality of care (Plotkin et al, 2011).

Further, general capacity of health facilities to deliver health services, is reflected in the availability of basic amenities as found in the SARA 2008/9 and SARA 2012 surveys. The proportion of health facilities with three important service readiness amenities declined from 2008/9 to 2012: a regular power source, an improved water source and designated communication equipment (landline, cell or short wave radio).

Other factors, which indicate non-improvement of health service quality at the time of the MTR, are reflected in the conditions and associated performance for many health facility staff. As detailed in the

MTR Human Resources for Health specific report, variations in staff attitudes and performance are also affected by the availability of basic amenities, in addition to salary and incentives, support supervision, and availability of medicines, among others. A recent study documenting staffing levels and productivity in southern Tanzania (Manzi et al 2012) found inadequate staffing of health facilities, high levels of absenteeism and low productivity.

The Tanzania Quality Improvement Framework in Health Care (2011-16) is a comprehensive national reference document for Tanzania's health sector. Of its main elements, national Infection Prevention and Control (IPC) guidelines in particular and 5S-Continuous Quality Improvement/KAISEN training are the most referenced by district health managers when asked during the field visits. However, operationalization to date of the TQIF at Regional and Council level health facilities has been limited. While most of the five (5) District Hospitals seen during the MTR field visits did refer to TQIF training received in 2010-11 in collaboration with CHMTs and RHMTs, the review team were only able to confirm active Quality Improvement Teams (QITs) in 2 (40%) of these health facilities. A lack of ownership of QI initiatives at health facility level may also be reflected in weak QI features in the HMIS. Building on experience in disease specific programmes, the MOHSW is developing an accreditation system. Identification of assessment criteria, appropriate standards and re-categorization of health facilities are underway.

The draft national QI Strategic Plan is under review by the Health Services Quality Assurance Department of the MOHSW.

3.1.3 Strengthen and Decentralise Management of District Health Services and Harmonise MOHSW and PMO-RALG Management Procedures

All 132 Councils completed Comprehensive Council Health Plans (CCHP) in 2012/13 (MOHSW 2012d). Guidelines for the CCHPs have been revised and aligned with both the HSSP III and the National Essential Health Package (MTR-AR 2013). Annual CCHP preparation, with technical support from central MOHSW and RHMTs, is one of the most structured management actions at CHMT level. This also applies to the quarterly reporting requirements from CHMTs to RHMTs and then to both MOHSW and PMO-RALG at national level. However, some CHMTs were unclear on how they prioritise activities in their CCHPs, and a number reported planning without knowing a budget as a major challenge. Most CCHPs are only partially implemented each year due to lower than expected disbursements. District hospitals, health centres and dispensaries reported having only limited involvement in the CCHP decision-making process and did not receive feedback. Not all CHMTs met during the MTR field visits reported feeling empowered to set priorities as per local needs or to take autonomous management decisions. The effectiveness of decentralized management of district health services appears to the reduced by national directives, political interference and budget constraints.

Notwithstanding identified challenges in some RHMT knowledge levels of CCHPs (MOHSW, 2012c), the Districts visited reported that their RHMTs had provided beneficial quarterly supportive supervision as required in the previous year. In turn, CHMTs are providing (often monthly) supportive supervision to District health facilities but face challenges with funds shortages for fuel and insufficient vehicles. None of the CHMTs or District Hospital (DH) in-charges met, were aware of the national hospital reforms programme.

Community Involvement

While community involvement in CCHP planning per se was not confirmed during the MTR field visits, the most common community strategy activity referenced by CHMT, DH, HC and Dispensary teams was the presence of Health Facility Governing Committees (HFGCs). As was also found by Simon (2012), only half (approx.) of HFGCs met or discussed during the MTR field visits, appeared to be

functional and few have approved CCHPs or annual Hospital Plans to date. These findings were in line with the general conclusions from Ifakara Health Institute (2011a) that more training on their fundamental roles is needed for HFGCs. HFGCs will need to be clear about their terms of reference before communities can effectively use them to hold health facilities accountable for essential health services rendered.

As noted in the field visits, HFGCs, Council Health Services Boards and members from the general public often refer to the MOHSW as being responsible for delivering health services and have only a weak understanding of the decentralization by devolution (D by D) approach. A recent study (Frumence et al 2013) found a number of benefits of decentralization for district health officials including enhanced bottom-up planning, improved accountability of health workers to local community bodies, increased autonomy in local resource mobilization and a reduction of bureaucratic decision-making. However, they also found that community participation in local health services planning is lacking.

Community Perspectives Study consultations support this Frumence (2013) finding related to community participation. Despite protocols to encourage women's, younger people's and persons living with disabilities (PLWD) participation in local level committees and decision-making forums, this is still weak. Women, younger people and PLWDs feel they have no real part in improving service governance. They think they are not listened to and that they will not be chosen as representatives. They feel their issues and concerns are not taken seriously nor given weight in budgets.

3.2 Referral Hospital Services Strategies

3.2.1 Increase Access for Patients in Need of Advanced Medical Care

Strengthening the referral role of Regional Referral Hospitals (RRH) since the beginning of HSSP III has been challenged with respect to one necessary but insufficient condition: availability of key clinical staff. In regional visits, at least two RRHs were operating as district hospitals instead of their designated role as specialized referral facilities. For both RRHs visited, only one clinical specialist (a paediatrician in both instances) was present rather than the minimum of five. For those RRHs with similar staffing limitations, capacity to deliver one of their core functions, peer coaching and clinical mentoring within the region, will be constrained.

There appeared to be no clear referral guidelines in operation at the RRH or at the lower level District Hospitals within the Region visited. Further, coaching received on hospital planning or clinical service improvement, leaving aside the national Hospital Reforms Programme as a whole, was either unknown or only marginally referenced when raised for discussion with RRHMTs. Clearly, large opportunities exist in 2013/14 to improve hospital planning, management and quality of care at and for the 37 RRHs, particularly through the JICA-funded 2011-14 Capacity Development in Regional Health Management Phase 2 (RHM2) Project (JICA, 2013).

3.3 Improve Quality of Clinical Services in Hospitals Including TQIF and Accreditation System.

Beyond the large understaffing of specialists at some RRHs as outlined above, the current status of Regional Hospital exposure to TQIF, including accreditation, are virtually the same as those summarized above in the findings on the quality of District Health Services including TQIF and accreditation system. No RRH visited had a Quality Assurance Unit operational or planned, but one did have a Quality Improvement Team (QIT), which met on an ad hoc basis.

3.3.1 Improve Management of the Hospitals Through Implementation of Hospital Reforms Programme and Strengthen Hospital Governance

Development partners have been supporting implementation of hospital reforms in HSSP III in the areas of hospital management training, hospital management systems strengthening, institutional development and clinical quality improvement. Activities have taken place in all four areas of hospital reforms, including some experience with pilot testing in clusters of hospitals performance based management in the P4P approach. All regional hospitals have reportedly developed annual plans since 2011 but the MTR was not able to confirm how many have produced annual reports or capital investment plans.

However, the current Hospital Reform Programme has had limited impact to date with only a third of planned activities executed by the in 2010-12. This has been due in part to the challenge of Hospital Reform Unit staff levels and turnover in the Unit since 2009. One development partner ceased funding support to the Hospital Reform Programme in 2012 due these factors. Notwithstanding these constraints, this year the MOHSW has performed Regional Hospital inspections in 10 Regions with a focus on clinical and management/operational competencies.

In order to see the Hospital Reforms Programme re-activated for the remaining two years to 2015, the District Services & Referral Hospitals TWG could consider strengthened advocacy to address Hospital Reform Unit staffing constraints. In addition, the TWG can regularly (quarterly) track and review quarterly progress against the two HSSP III indicators relevant to hospital reform: i) proportion of hospitals with annual plan, annual report and with capital investment plan; and ii) proportion of hospitals with functional boards (MOHSW, 2009).

Regional Hospital Health Services Boards (RHHSB) are in place in a number of RRHs but their functionality need attention in the remaining HSSP period. For the two RRHs visited in the MTR, in one RHHSB had still not been legally established. For the other RRH, Board members reported being unclear whom the RHHSB was accountable to, i.e. MOHSW or PMO-RALG. Further, they were unaware of both the HSSP III and their own terms of reference as a RHHSB. Even though they had met "rarely" over the past year due to lack of previously available (GIZ funded) sitting allowances, they were still keen to contribute to regional hospital governance, subject to provision of basic training on their TORs and clarity on levels of accountability within the Region.

3.4 General Strategies for Disease Prevention and Control

3.4.1 Enhance Community Participation in Health Promotion and Disease Prevention

Village health committees (VHCs) are responsible for enhancing community participation in health promotion and disease prevention. A review of a sample of the CCHPs 2011 does not show adequate capacitating of the VHCs in terms of budget allocation, e.g. for training and meetings, even though these community based initiatives are given priority status as key areas for health promotion. The activities noted included: strengthening Community Based HMIS and disease surveillance; strengthening Health Facilities Governing Councils (HFGCs); activities for national environmental health day; communicable diseases control (e.g., Community Based Malaria Control [CBMC]); non communicable disease control: community-based iodinated salt monitoring; initiate task force groups on solid waste management; facilitate community participatory planning and management of community based water hygiene and sanitation project using PHAST (Participatory Hygiene And Sanitation Training); treatment of NTDs by mass medicine administration, traditional and alternative medicine by involving TBAs and traditional healers. The budget for community-based initiatives in the CCHPs is minimal and even absent in some of the CCHPs.

Health services do little to promote themselves to the general public through VHCs or otherwise. For example, while there is acknowledged considerable progress in immunization coverage, ITN distribution and HIV prevention, treatment and care, this positive information does not trickle through to communities. Citizens are often unaware of these achievements by government in essential health service delivery.

After adopting the Alma Ata Declaration, Tanzania recognized CHWs as a necessary strategy to increase access to comprehensive Primary Health Care (PHC). In the 1980s, Primary Health Care committees were set up at all levels: regional, district and village with one of their roles being to facilitate CHWs to work in the communities. Due to managerial problems the dropout rate was large. A range of programmes, various funded by CSOs and donors, has been implemented to date at community level. The MOHSW and developmental partners have reviewed the CHWs strategy and realized again its potential for increasing health services coverage in underserved areas. Various challenges have to be looked into in re initiating this important strategy like defining the role of PMORALG, MOHSW, Councils and Villages in their recruitment, training, remuneration and motivation. At present there are no guidelines on community involvement including the recruitment, retention and incentives for CHWs. However, in the forthcoming CBHC Programme, such CHW guidelines are understood to be included. This national reference for CHW coordination is timely because standardization of CHWs in terms of recruitment, training, utilisation and provision of incentives across the board is needed to improve efficiencies and effectiveness in this component of community health service delivery.

3.4.2 Improve disease Case Management in Health Facilities

Integrated disease control Programmes included in a sample of CCHPs are IMCI, HIV, STI, RCHS and PMCTC. Community IMCI intervention are included under priority area health promotion in some of the CCHPs. The activities under IMCI include training of Community Own Resource Persons (CORPs). According to the Tanzania Service Availability and Readiness Assessment (SARA) Study (MOHSW 2012b) malaria services, preventive and curative child health services, PMTCT and Sexually Transmitted Infection services are available in 75% or more of all health facilities in the sample while antiretroviral therapy for HIV was available in less than 30% of the facilities included in the study. TB and Leprosy management services are available at all the levels of health facilities. RCHS clinics visited during the fieldwork show evidence of integration with IMCI, PMCT and STI services. Thus provision of disease case management of the major diseases (malaria, STIs, TB and leprosy) are provided in an integrated manner in health facilities while ARV services have not been integrated in the majority of health facilities.

3.4.3 Improve Home-Based Treatment and Care

Community based health care interventions have been used over many years in Tanzania for distribution of contraceptive commodities, HIV and AIDS care and in RCHS. In relation to HIV/AIDS care and support since 2003, there has been a concerted effort to scale up care, support and treatment for HIV/AIDS by home-based care (HBC). About half of the districts in Tanzania have HBC HIV and AIDS services implemented by NGOs, FBOs and community organizations with support from several donors. HBC is a core service in HIV and AIDS care and treatment and is included in the National Multisectoral Strategic Framework on HIV and AIDS (NMSF 2008-2012) as well as in the Health Sector HIV/AIDS Strategic Plan III (2009-2015). Guidelines, curricula and monitoring tools are in place as part of standardization, harmonization and quality control; providers have been trained from health facilities, FBOs, private sector, and NGOs. The specific technical report on Social Welfare provides more information on home-based care.

Field visits to the regions during the MTR established that due to inadequate resources at the time of the year, outreach services had been terminated. In the health facilities visited there were very little or

no community based services being implemented. Where HBC activities are being implemented, it is through and by FBOs and donor-funded projects. There are many health projects where NGOs and CSOs are collaborating with communities to promote community participation in disease prevention. Various donor-supported and NGO implemented health projects, in collaboration with regional and district authorities, are being implemented in many areas in Tanzania utilizing varying types of Village Health Workers to raise awareness in communities and reach families with basic preventive and even curative services. The National Strategy for Growth and Reduction of Poverty states that CSOs will work closely with government ministries and local authorities to ensure that cross-cutting issues are included and implemented in sectoral and district plans. This offers an opportunity to increase participation of the NGOs and CSOs involvement at the community level. This is expected to be included in the forthcoming national Community-Based Health Care (CBHC) Programme that will be implemented and supported by the Councils and individual villages.

3.5 Disease Control Programmes

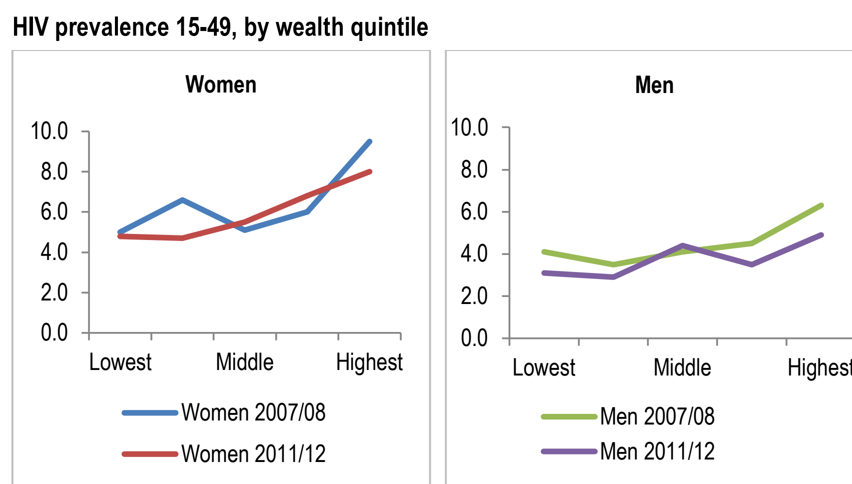
3.5.1 HIV/AIDS Strategies

MOHSW HIV strategies include maximising the health sector contribution to HIV prevention, accelerating access and utilisation of HIV care and treatment services, scaling up integration of TB and HIV services and scaling up of STI control.

3.5.2 Maximise the Health Sector Contribution to HIV Prevention

HIV prevalence continued to decrease during the implementation of the HSSP III, as shown in the figure below. HIV prevalence is higher in women than in men and higher in the highest wealth quintiles.

Figure 1 HIV prevalence trend Tanzania



Source: MTR-AR 2013

Regional differences in HIV prevalence narrowed since 2008. Iringa, Dar es Salaam, Mbeya and Ruvuma have about twice the national average rate (HMIS 2011/12). The regions of Manyara , Arusha and Singida had the lowest prevalence. Reduction in risky behavior was shown by increased condom use by non-marital and non-cohabitating partners (MTR- AR 2013).

Access to and coverage of PMTCT increased according to HSSP III targets. Testing and treatment is close to 80% of the target (MTR-AR 2013).

The SARA survey (MOHSW 2012b) indicates good access to services (92% of hospitals in the sample offered each of the service elements: counselling and testing, prophylactic treatment for both mother and newborn, counselling on infant feeding and family planning). Health facilities visited during the MTR fieldwork reported to be experiencing inadequate supply of Dry Blood Spot (DBS) test kits and HIV test kits. This is likely to reduce the proportion of pregnant women tested at ANC and the number of infants born to HIV positive mothers being diagnosed with HIV.

Data regarding specific HIV prevention interventions from 2009-13 in most cases reflect a positive trend:

- Male circumcision: in THMIS 2011/12, 72% of men reported that they had been circumcised, an increase from 67% reported in the 2007/08 THMIS; male circumcision is substantially higher among urban men than rural men (94%, 64%, respectively);
- Blood transfusion: the National Blood Transfusion Services (NBTS) collected and tested 110,000 units of blood in 2012, a 16% increase since 2010. Despite the increase hospitals reported to be very inadequately supplied with blood.
- Safety of injections: THMIS 2011/12 showed 98% of women and 97% of men who received an injection in the past 12 months reported that for their most recent injection, the syringe and needle were taken from a new, unopened package;
- Adolescent HIV prevention education: various CSOs and NGOs address early sex and unsafe sex practices by adolescents. Early sex experiences of teenagers are reducing as the table below shows.
- Vulnerable groups: the needs of CSWs, MSM, mobile workers, prisoners, IDUs are hardly addressed in the national HIV AIDS Programme.

Table 1 Teenage sex experience in Tanzania

	THMIS 2007/8 sex before age of 15	THMIS 2011/12 sex before age of 15	THMIS 2007/8 sex before age 18	THMIS 2011/12 sex before age 18
Women aged 15-24	11.4%	9%	59.8%	50%
Men youths aged 15-24	10%	10%	44.2%	43%

3.5.3 Accelerate the Access and Utilisation of HIV/AIDS Care and Treatment Services

ART coverage by 2011 was 65% of adults and 48% of children (MTR – AR – 2013). In accelerating access and utilisation of HIV and AIDS care and treatment services, the number of patients nearly doubled (MTR-AR 2013).

Treatment is initiated earlier and survival rates in the first year have improved among those who were initiated in 2010. Challenges include i) the small percentage of health facilities that offer ART and ii) high dropout rate.

3.5.4 Scale Up Integrated TB and HIV Services

In scaling up integrated TB and HIV services, in 2010, 80% of clients for HIV Testing and Counselling (HTC) services were self-referrals. The remaining 20% were referred from TB, STI, OPD IPD, and HBC clinics with TB clinics contributing only 1%. The HIV programme has put more emphasis on reducing the burden of TB in PLWHA by starting TB-HIV integrated services where patients with TB and HIV are managed for the two diseases in one clinic.

3.5.5 Scale Up STI Control

STIs are on the increase (MTR-AR 2013). The increase is due to increase in the number of patients suffering from genital discharge syndromes and to a lesser extent PID and VDRL/RPR positive cases However, this increase can also be due to better service delivery in terms of privacy, confidentiality and drugs availability. Findings in the SARA study (MOHSW, 2012b) show that health facilities are well supplied with the three drugs (metronidazole, ciproflaxin and injectable cetriaxone) for treatment of STIs.

In summary, HSSP III HIV/AIDS strategies for the period 2009-2013 are generally achieving the targets, particularly for utilisation of HIV/AIDS care and treatment services, with the queries regarding scaling up STI control.

3.5.6 Malaria Strategies

3.6 Implement Universal Access to Malaria Interventions

MOHSW malaria strategies for implementation of universal access include five interventions: malaria diagnosis and treatment, malaria prevention, BCC/IEC , intermittent preventive therapy (IPT) and Community Based Malaria Control.

3.6.1 Malaria Diagnosis and Treatment

Throughout the 3 years implementation of HSSP III there has been a large reduction of malaria prevalence in children under five years of age, as shown by decline in OPD malaria diagnosis. Malaria diagnosis in children under five years fell from 49% of all diagnosis in 2009 to 30% in 2012 (MTR-AR 2013).

Despite the decrease in malaria prevalence malaria is still the number one diagnosis in children under 5 in OPD and inpatients and is the leading cause of deaths in hospital, accounting for almost one third of the deaths in 2012 (MTR-AR 2013)

Malaria parasitemia as measured by RTD declined (THMIS 2007/8, 2011/12). The fall in parasitemia occurred in all zones. In the two surveys high malaria parasitemia was found in Lake, Western, Southern and Eastern zones, which could be targeted with selective effective malaria strategies, i.e. Insecticide Treated Nets (ITNs) and Indoor Residual Spraying (IRS) (MTR-AR 2013).

3.6.2 Intermittent Preventive Treatment (IPT)

The percentage of women who received two or more doses of SP with at least one dose received during an ANC visit has slowly increased: from 21% in the 2004-05 TDHS to 32% in the 2011-12 THMIS. However, preventive therapy with two doses of SP during pregnancy has remained low, with the poorest pregnant women having a coverage of only 25% (MTR-AR 2013). This is probably due to dropping follow-up attendance rates at ANC as well as late attendance.

3.6.3 Malaria Prevention

MOHSW malaria prevention includes ITN use, IRS, larviciding and environmental management methods. The use of mosquito nets by children under five and pregnant women has increased dramatically. Over 75% of the population is now using bed nets. BCC/IEC activities have resulted into awareness in the population. Among women and men, over 80% have heard of Hati Punguzo (THMIS 2011/120), the voucher programme for ITNs for pregnant women and infants.

There has been limited implementation of IRS. This intervention is not well accepted in the urban population claiming that it interferes with privacy. IRS has been implemented mainly in the Lake Zone and was associated with a 56% reduction in hospital admissions, and a 75% reduction in deaths attributable to malaria, based on data from a sentinel surveillance site in Muleba District.

MOHSW collaborates with development partners involved in malaria and in RCHS, the private sector and research institutions, to improve capacities of health workers. Training of health workers on the comprehensive package of reproductive health care includes malaria in pregnancy (MIP), syphilis in pregnancy, and management of anaemia and Prevention of Mother-to-Child Transmission of HIV /AIDS. MIP training is integrated into the Reproductive and Child Health training and the HIV and AIDS Programme.

In sum, HSSP III malaria strategies for the period 2009-2013 are generally achieving set targets, particularly for malaria diagnosis and treatment and ITNs with the exception of IRS and intermittent preventive treatment (IPT) during ANC visits.

3.7 Tuberculosis and Leprosy Strategies

3.7.1 Expand and mainstream DOTs strategy

Preliminary results of the national tuberculosis prevalence survey show that the prevalence of tuberculosis in the country is 295/100,000. TB is still a major burden in the country. Most of the progress of the programme has been attributed to the home-based DOT strategy where 78% of all TB cases are managed at home. Treatment success rate remains high at about 90% thus reaching the target of the Global Plan to Stop TB 2011 - 2015[1].

But the new TB prevalence survey (July 2013) reveals lower case detection rate than previously estimated. TB case detection rate is 75% of estimated cases. There has been a decline of TB case notifications (MTR-AR 2013).

A TB National Coordinating Body (NCB) that promotes coordination among NGOs, FBOs, CSOs engaged in TB control was formed in 2012. In 2012 NTBLP staff in collaboration with NGOs and FBOs developed national operational guidelines and a code of conduct for engaging CSOs and NGOs in TB control, as well as a Memorandum of Understanding and identified CSOs/NGOs with potential for collaborating in community-based DOTS. This is an example of successful Public Private Partnership in the health sector.

3.7.2 Introduce and implement MDR/XDR –TB management

MDR-TB case management was launched in 2009 at Kibong'oto National TB Hospital (KNTH). To date 155 MDR patients have been treated at KNTH with a cure rate of 73%. The national prevalence of drug resistance TB is still low. Despite the current low drug resistance in Tanzania, there is a need for continuous monitoring of resistance.

The main constraints affecting the national TB control efforts in Tanzania as at 2013 is the overall level of donor dependency. Most of the programme funds come from donors with the government covering mainly staff salaries and maintenance of physical facilities. In addition, there is only one MDR centre. The NTBLP has not set up other MDR centres in other Zones of the country (i.e. Southern and Lake Zones).

[1] The Stop TB Partnership's Global Plan to Stop TB 2011 - 2015 has set a target of smear-positive treatment success rate of 90%.

3.7.3 Leprosy elimination, prevention of disabilities and social economic rehabilitation

Overall, the prevalence of leprosy has showed a steady decline since 2002. However, in 2011 there were 26 districts from 9 regions with prevalence rates higher than 1 per 10,000 as shown in Annex B. Therefore, the HSSP III target for all districts to achieve the target of global leprosy elimination by 2015 is unlikely to be reached. At the end of 2011 (MOHSW NTBLP), a total of 2,561 people affected by leprosy (PALs) with disabilities were registered. There is a high disfigurement rate in leprosy patients (12%) because patients present and are diagnosed late when disfigurement has already started.

In sum, HSSP III TB and leprosy strategies for the period 2009-2013 are generally achieving targets, particularly for expansion and mainstreaming of DOTs strategy to the general health system and introducing and implementing MDR-TB management with the exception of leprosy elimination and prevention of disabilities.

3.8 Neglected Tropical Disease Strategies

3.8.1 Strengthen surveillance, prevention, diagnosis and treatment of neglected tropical diseases and other epidemic-prone diseases

A disease surveillance system is in place in all districts.[2], The HMIS reporting system has tools that facilitate disease surveillance. However, a significant challenge is that the OPD register is not always filled, especially when patients are seen by junior staff. Therefore, it is not possible to accurately review the occurrence and incidence of diseases. Integrated reporting is done through THMIS and IDS (Integrated Disease Surveillance).

In 2012, the Tanzania Neglected Tropical Diseases Control Programme (TZNTDCP) completed the five years Strategic Master Plan for 2012-2017. It targets seven NTDs: lymphatic filariasis, onchocerciasis, schistosomiasis, three soil-transmitted helminths (roundworm, hookworm, ringworm) and trachoma. The establishment of the M&E Unit at the TZNTDCP has been a key achievement.

In 2009 with the support of USAID and the African Programme for Onchocerciasis Control (APOC) started to implement an integrated approach of NTD control where Mass Drug Administration (MDA) activities are implemented in an integrated manner in 36 districts. In 2012 implementation of the TZNTDCP was up-scaled to 94 districts in 14 regions, with support from trained CHWs, schoolteachers and Community Drug Distributors (CDDs). Epidemiological surveys in Tanga in 2010 and Tukuyu in 2011 have indicated that the transmission of onchocerciasis has been interrupted after 10 years of Ivermectin distribution.

Schistosomiasis: implementation of schistosomiasis control programme has been facilitated by the presence of a guide: Helminth Control in School-aged Children and the presence of sentinel and spot check sites for monitoring the progress.

[2] Surveillance of polio, anthrax, blood diarrhoea, cholera, meningitis, human influenza, diarrhoea in less than 5 years old, kerato conjunctivitis, malaria, measles, neonatal tetanus, onchocerciasis, plague, pneumonia in less than 5 years, rabies/animal bites, smallpox, tick born fever, trachoma, trypanosomiasis, typhoid, viral hepatitis and yellow fever

TZNTDCP constraints in 2013 include i) CHWs and CDDs volunteer trainees are not motivated as they are not provided with allowances; and ii) a high level of donor dependency at both national and local levels3.

In sum, HSSP III NTD strategies for the period 2009-2013 are generally developing well particularly for strengthening surveillance and diagnosis and treatment.

3.8.2 Non-Communicable Diseases Strategies

1. **Reduce the burden of NCDs, mental disorders and substance abuse**
2. **Develop NCD MOHSW advocacy and sensitization programmes**

Non-communicable diseases are increasingly becoming more important in Tanzania as a cause of death and ill health.

Data from the Sentinel Panel of Districts, which include Sample Vital Registration with Verbal Autopsy (SAVVY) run by the Ifakara Health Institute shows that non communicable diseases are a cause of significant proportion of deaths in patients 5 years and older (MTR-AR-2013)

The MOHSW Non Communicable Diseases Surveillance Programme is monitoring trends in the major risk factors for chronic non-communicable diseases and foster and support an integrated approach to the reduction of such risk factors at population level. Injuries and accidents especially traffic accidents are a cause of mortality disabilities and ill health (MTR-AR 2013). The 2012 national population based survey (Mayige et al., 2012) shows high prevalence of NCD risk factors in Tanzania. In the general population knowledge about NCDs is still low. For example, according to THMIS (2011-12), 66% of women age 15-49 years reported having heard of cervical cancer. In a community survey in Rungwe District[i] there was high prevalence of NCD risk factors and inadequate knowledge of NCDs. The strategic objective to reduce the burden of NCDs, mental disorders and substance abuse by putting in place partnerships at all levels to raise awareness to stimulate healthier life styles, and early treatment, has not been achieved.

In sum, HSSP III NCD activities in the period 2009-2013 do not yield result yet.

3.9 Environmental Health Strategies

3.9.1 Operationalize the Public Health Act (PHA) 2009, and the Environment Management Act (2009)

In the period of two and a half years of HSSP III implementation, much has been achieved with respect to regulatory mechanisms for environmental health and sanitation. Regulations for sanitation and hygiene, sanitary fitments, plumbing and latrines and management of wastes and human remains have been developed to support enforcement of Public Health Act, 2009. Similarly, guidelines for solid waste management have been developed and rolled out nationally. Environmental health practitioners (EHP) that enforce compliance of the PHA and other public health related laws are being registered and given licenses by the Environmental Health Practitioner Registration Council to enforce the public health laws. About 1,485 EHPs have been registered.

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[3] TZNTDCP partners include WHO; USAID's ENVISION project; WHO African Programme for Onchocerciasis Control (APOC); Centre for Neglected Tropical Diseases, Liverpool School of Tropical Medicine (CNTD); Schistosomiasis Control Initiative (SCI) Imperial College, London; and Sight Savers International.

The MOHSW is working to establish a national environmental health and sanitation data management system. The Ministry has also signed memoranda of understanding with other parts of government, i.e., Ministry of Water (MOW), Ministry of Education and Vocational Training (MOEVT) and PMO-RALG, with regard to implementation of environmental sanitation issues. In addition, an intersectoral group for Environment Management was formed. The curriculum for certificate course in environmental health is being reviewed in the effort to address the EHP understaffing levels.

RHMTs visited during the MTR were generally aware of the Public Health Act and the Environmental Management Act. One district visited (Geita) inaugurated a three years sanitation campaign in which the Public Health Act will be used as a guiding tool in legal issues concerning sanitation and hygiene. However, most activities in districts for improvement of hygiene are dependent on NGOs and DPs (see Social Welfare Specific Report)

3.10 Emergency Health Strategies

3.10.1 Establish systems at al levels for immediate emergency response to health disasters and disasters with health problems

The MOHSW 2007 Emergency Operations Plan (EOP) is a well-structured and comprehensive national reference for health sector emergency preparedness and response. It is currently under review by the Health Emergency Preparedness & Response Unit (HEPRU) with a revised EOP expected in due course. This is timely as there are opportunities for strengthening the essential Standard Operation Procedures (SOPs) section to provide needed clarity on standardized nomenclature of various EPR teams, committees and plans at health facility level in particular[4].

Notwithstanding the reference strength of the 2007 EOP, the MTR found weak or no regular application of any SOPs at HFs at Regional, District, Health Centre and Dispensary levels. Budget provision for disease outbreak pharmaceuticals (especially for cholera outbreaks) was found in some CCHP budgets, but nothing else EPR-related, including staff training, hazard surveillance, and emergency logistics. Most health facilities visited had no active "emergency preparedness committee" but some did refer to "rapid response teams" usually lead by the HF head, DMO or RMO, which had been used on an ad hoc basis over the past three years mainly for suspected/confirmed cholera outbreaks.

3.11 Crosscutting Issues

3.11.1 Quality

The 2011 CCHP Guidelines are clear that all health centres and dispensaries should adhere to the Annual Health Plans template for their facilities during the annual CCHP planning sessions. However, this was not followed among those health facilities met during the MTR regional and district visits.

[4] Undifferentiated references to "*emergency response personnel teams*", "*emergency response committees*" and "*health facility EPRU*", all at health facility level, can be found in the 2007 EOP. Similarly, all Health Facility heads must ensure that they have "*Emergency Contingency Response plans*", or a *"Hospital Disaster Contingency Plan*", or a *"Hospital Emergency Contingency Plan"* or an *"Emergency Operations Plan*" which includes all SOPs – depending on which part of the 2007 EOP is being referenced. Standardised and consistently applied nomenclature for EPR committees, team and plans (at all levels but particularly at health facility level) is a necessary, but not sufficient, condition for successful new 2013/14 EOP operationalization and cascaded training down to health facility level.

Moreover, only some of the health facility health plans are presented to the respective HFGCs, and much less approved by this committee. Further, the MOHSW has clearly acknowledged the need to strengthen the quality of data entry into PlanRep3 (MOHSW, 2012c). Notwithstanding these concerns, CCHP preparation and reporting by CHMTs is an area of general strength in the quality of district health service planning (with support from RHMTs capacitated by the Tanzania-Japan Technical Cooperation in Capacity Development for Regional Referral Health Management or TC-RRHM[5] and RHM2[6]).

Straddling district and regional service delivery, are the recent hospital accreditation and hospital inspection initiatives from the MOHSW Health QA Directorate. As indicated above, hospital accreditation as part of TQIF is still under development as a major quality support initiative from the MOHSW. By approximately mid-2014, re-categorization of public health facilities, based on agreed accreditation standards, should be completed at national level, after which a rolled-out will be undertaken. Parallel to this, the MOHSW is also taking the lead with a programme of hospital inspections, which during this start-up year has covered ten Regions[7]. Given the resources required to support both of these initiatives, it would seem sensible for the MOHSW to explore ways to integrate the accreditation assessment (in part) with the hospital inspection visits, where applicable. If inspection visits were also seen as a method to accelerate full accreditation, recipient hospitals at all levels may adopt a more positive and proactive view for quality improvement purposes.

While the HSSP III has aimed for hospital boards to be created and then support regional hospital management capacity building, the latter at least appears to be some way off. All hospitals visited during the Regional visits for the MTR referred to their Boards, but, as has been indicated above, many Boards reportedly suffer from a lack of clarity on the their terms of reference and approximately only half have been functional over the past 2 years (i.e. meet more than twice a year). The Board members representing the community are volunteers who refer to a lack of motivation (e.g. sitting allowances).

With the support from the JICA-funded TC-RRHM & RHM2, all RHMTs have received considerable capacity development for improved supervision and support to health service providers. Improvement in provision of technical support and oversight from RHMTs to CHMTs has been validated during MTR field visits, with the latter referring to the frequency and benefit received from RHMT supportive supervision visits. Nonetheless, RHMT capacity to comprehensively assess CCHPs and annual reports (MOHSW/PMO-RALG, 2007), rather than this function being met centrally, is reported as a continuing concern by some TWG members.

RHMT supervisory support to RRHMTs was not observed during the MTR field visits. RHMT technical support visits to RRHMTs was either highly sporadic or not in place, possibly linked to the large overlap of membership between the two teams due to acknowledged shortages of senior clinical/technical staff at regional level and their physical proximity with both teams often working from and in the RRH.

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[5] 2008-11 TC-RRHM: aimed at strengthening the capacity of RHMT in the Tanzanian Health Systems through articulation of its roles and functions and developed Central Management Supportive Supervision (CMSS).

[6] 2011-14 RHM2 (Project for Capacity Development in Regional Health Management Phase 2) Outputs: 1) Management skills of RHMTs in supporting CHMTs and RRHMTs is improved; 2) Roles and functions of RHMT to support CHMTs and RRHMTs are institutionalized; 3) Guidelines and tools for RHMTs to perform their functions are improved; http://www.jica.go.jp/project/english/tanzania/009/outline/

[7] Over a three week period, nine health facilities are provided a non-punitive, comprehensive inspection (includes OPD, laboratory, medical staff, nursing staff, and accounting with a focus on competencies) per Region including the RRH, five District Hospitals, one health centre, one dispensary, one nursing training college and one medical assistant training college, according to the HQA Directorate, MOHSW.

3.11.2 Gender

District health services cross-cutting gender findings and issues include collaboration between social welfare officers and health staff, fee exemption mechanisms for fee paying for pregnant and delivering women, privacy and confidentiality for clients, gender balance in management and village committees. Very few social welfare officers were in found during the MTR field visit to selected Regions and Districts (as is detailed in the Social Welfare specific report). Therefore the potential for constructive collaboration to inform and address relevant gender issues at district level is limited. All district level health facilities visited confirmed that pregnant and delivering women are exempted from fees. Most health facilities complained of the need to improve confidentiality and privacy for girls and women and that these concerns have been central to recommendations to their CHMT for health facility infrastructure improvements. Gender balance in district health facility management as well as village committees did not appear to be a principal concern for health facility staff.

3.11.3 Equity

As found by Makawia et al (2010) public primary providers are the only health care providers who serve the poorest household in rural areas. MMAM aims at improving geographic equity, expanding the number of health centres and dispensaries to all areas with a priority to the most remote and underserved rural areas. However this programme is facing signifant budget and staffing constraints, as has been discussed in detail in the beginning of Section 3 above. The serious associated challenges in improving staffing levels of primary health care facilities in remote rural areas, as well as staff incentives for these cadres, are reviewed in detail in the HRH Specific Report.

Beyond equity considerations from a socio-economic and geographical perspective, the MOHSW's strategic commitment to the fundamentals of primary health care is evidenced in the forthcoming national Community-Based Health Care (CBHC) Programme. In part with respect to a recognized and developed cadre of Community Health Workers, the anticipated CBHC Programme should provide an additional platform for strengthened essential community health service provision for expanded consideration for HSSP IV.

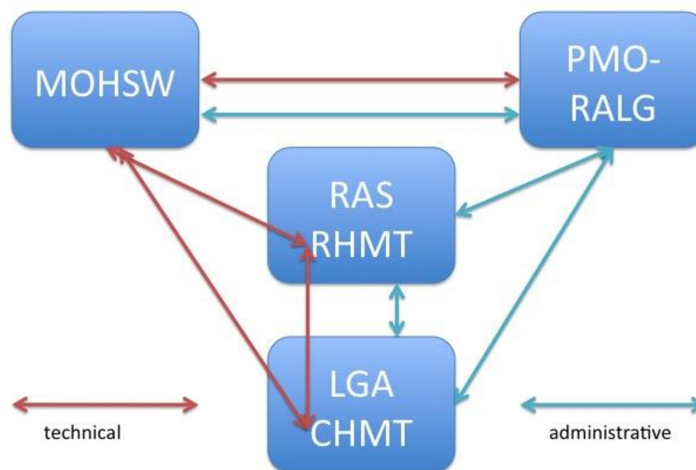
4. Governance

4.1 District Health Services Strategies

4.1.1 Strengthen and decentralise management of District Health Services and harmonise MOHSW and PMO-RALG management procedures

While the quality of RHMT assessment of CCHPs and annual reports may need attention as discussed above, planning procedures in support of annual CCHP preparation are working reasonably well over the past three years. The figure below illustrates central to Regional level reporting and technical supervisory relationships being mainly technical between the MOHSW and RHMT. The 2008 MOHSW and PMO-RALG jointly published document "Functions of the Regional Health Management System" has been cited as the main reference document to map out the decentralized management of central to regional to district to Council health facilities.

Figure 2 Structure of Health Service Governance at Three Levels



All health facilities visited from Dispensary up to Regional Referral Hospital appeared to be generally clear about who they were accountable to between the PMO-RALG administrative and financial elements at Council and Regional levels on the one hand and health technical and policy elements from the MOHSW on the other. As has been discussed above, some HFGCs and CHSBs reported the opposite.

4.1.2 Community involvement in health services HFGC and CHSB

Community involvement in HFGC and CHSB membership appears to be weak as half of the HFGCs are non-functional at LGA level (Simon, (2012)).

4.2 Referral Hospital Services Strategies

1. Strengthen hospital governance

Competent and informed Regional Referral Hospital governance is at risk at the moment due to many of the same factors as those affecting the non-functioning of many HFGCs and CHSBs. See Section 2 on Hospital governance above for a summary of findings.

4.3 PPP Strategies

4.3.1 Enhance PPP in the provision of health and nutrition services

According to the HSSP III, Public Private Partnership (PPP) can take a variety of forms with differing degrees of public and private sector responsibilities and risks. A number of key policy and guiding documents for the operationalization of Public Private Partnership (PPP) have been completed since 2009 including the MOHSW National PPP Policy (2009), the PPP Act (2010), PPP Regulations (2011), PPP Strategic Plan (2010-2015), Health and Social Welfare Sector PPP Policy Guideline (2012) and PPP Comprehensive Annual Operational Plan (2013/2014). Some experts interviewed argue that Tanzanian PPP activities in government are more geared towards productive sectors than towards social sectors, e.g. suitable for joint ventures in the energy sector. The PPP Technical Workgroup offers the platform for joint action, in which private (for profit) providers and Faith Based Organisations (FBOs) collaborate with government ministries and DPs. The TWG has produced guidelines for the CHMTs to develop Service Agreements (SAs), as well as guidelines for inclusion of PPP in CCHPs. The PPP TWG advocates for implementation of SAs, mobilizing additional funds to support SAs for service delivery, developing a PPP databank at MOHSW (for 2 zones initially), and supporting establishment of a regular Public Private Health Forum at national level, as well as in 50% of all regions.

Most of the private providers, especially the small clinics and ADDOs, are not part of an umbrella organisation and are difficult to reach. There is a genuine complaint by private providers, that there is no level playing field in the health sector, as the registration requirements for the private sector are different from the government sector. There is underreporting by private providers in HMIS, who fear that this health information will be used for tax purposes. This underreporting leads to incorrect health sector performance figures for the city of Dar es Salaam (MTR_AR 2013). As of now, there are 53 SAs signed between District Councils and FBO district hospitals or FBO health centres (of the 99 FBO health institutions). In general HBF funding is used for payment, but due to limited budgets, it is difficult to honour the SAs. There are no SAs with private (for-profit) providers, and – according to the PPP coordinator in the ministry – this is only possible when government is convinced that such contracts offer value for money. The MTR team concludes that there is still a high level of mistrust between government and private for profit sector in health. However, there are examples of informal public private collaboration "under the radar", e.g. vaccination activities, where the CHMT provides vaccines and needles, while private facilities provide labour. Also in disease control programmes public private collaboration exists, e.g. the ITN voucher scheme or ARV treatment. There are also contracts for maintenance of vehicles or equipment, or cleaning of hospitals, which can be considered PPP.

As mentioned in the section on Capital Investment (Paragraph 4.3) the number of private health facilities is not growing as fast as the number of public facilities, although MMAM envisaged that the private health sector would increase at the same pace. Private-for-profit facilities are still concentrated in urban areas and the FBOs are not expanding in view of reducing support from overseas. Dar es Salaam is one of the fastest growing cities in Africa, with 4.3 million people (NBS census 2012), where 70% of the health facilities is private. About 50% of the Tanzanian population now lives in urban areas, with a steep

increase due to economic growth. The contribution of the private sector to health service delivery will be more and more important in the HSSP IV period.

4.4 Vertical Programmes

4.4.1 Integration of vertical Programmes in health system

There have been evident efforts to integrate STI services and HIV services, MNCH and HIV services and TB and HIV services. Integration of RCHS and HIV services has taken various forms by integrating MNCH into HIV counselling and testing programmes, PMTCT services and care and treatment programmes and HIV testing, prevention, and counselling to existing MNCH services. Scope remains for strengthened linkages of two such services are by referring a client from one service to another in the same health facility. Since 2008, the HIV programme has been implementing TB/HIV prevention and management in line with the three WHO objectives for TB/HIV collaboration (3I's). HIV programme has put more emphasis on reducing the burden of TB in PLWHA by starting TBHIV integrated services where patients with TB and HIV are managed for the two diseases in one clinic visit.

While there has been integration of PMTCT and the MNCH services, integration of CTC services with PMCT, MNCH services and other hospital services is lagging behind. It was observed in some health facilities during field visits that there was inadequate sharing of resources between the CTC and PMTCT services (e.g., in periods of medical supply shortages, HIV test kits and CTC services were better supplied than those required for PMCT services).

4.4.2 Urban Health Services

Despite the fact that many health indicators show that urban dwellers are better off than their rural counterparts (MTR-AR 2013), many urban dwellers are worse off than their rural counterparts. The population of cities and towns in Tanzania is composed of people in all the wealth quintiles, the majority being in the lowest wealth quintiles. While the few in the highest wealth quintiles have higher incidences of NCDs, those in the lowest wealth quintiles suffer predominantly from communicable diseases, diseases related to poor nutrition, poverty, poor sanitation, air and environmental pollution. Taking Dar es Salaam as an example, the city is one of the regions with high HIV prevalence and one of its districts (Temeke) is one of the 26 districts in Tanzania with high incidence of leprosy. The fact that 70% of health facilities in the city are private facilities that share many constraints in the private sector including poor reporting, calls for strengthening of PPP initiatives. It is therefore recommended that the 2000 evaluation and recommendations of the Dar es Salaam Urban Health Project (Harpham T Few R., 2002) be reviewed and considered in developing sustainable urban health programmes in Tanzania

5. Crosscutting SWOC Analysis

The following is a summary of the main service delivery strengths, weaknesses, opportunities and challenges based on those presented and discussed at the 1 August 2013 HSSP III MTR debrief:

HSSP III Performance Criteria	Strengths	Weakness	Opportunities	Challenges
Access & coverage	Most major disease (HIV AIDS, malaria, TB leprosy, NTD)programme coverage improvements	Number of new HF constructed by the end of 2012 was less than planned	Political and community support in increasing accessibility	Financial resources and availability of qualified staff
Quality	Most national service delivery policies, standards, protocols, guidelines are well structured and in place (e.g. TQIF) Planned roll out & implementation of TQIF, incl. HF accreditation.	Weak rollout to Regional, District/Council levels & below Loss of momentum on 2009-10 training & rollout of TQIF & safety	Available experience of externally funded projects, which have accreditation system in place.	Limited financial resources for implementation
Efficiency & Sustainability	Monitoring efficiency: CCHPs & quarterly reporting well developed RHMT role clarified and capacity building for stronger technical supportive supervision to CHMTs	RHMT underutilization of their inputs regarding annual CCHP prep & report Duplication of systems PMO-RALG and MOHSW	PMO-RALG structures and systems further developed, increased improved automated reporting systems	Over-dependence on DPs and non-gov't structures; Financing major disease programmes by DPs likely to decrease 2013-15
Equity, Safety & Gender	Frameworks for increasing equity, safety and attention to gender issues in place	Translation of policy frameworks into effective implementation at Council/District, Ward, village levels	Lessons can be learned from FBO and NGO initiatives	Limited financial resources, which will hamper further implementation of MMAM.

6. Recommendations

Equity

- Prioritise MMAM implementation during the remainder of the HSSP III period against the opportunities and practical limits within the HRH Strategic Plan, the national Medicines Policy Implementation Strategy, the forthcoming Health Financing Strategy and the forthcoming national Community-Based Health Care (CBHC) Programme;

Quality

- Establish a dedicated task force for quality improvement (across the TWGs);
- Proceed with full operationalization and rollout of the TQIF, including an accreditation system, as per the 2013-18 QI Strategic Plan, once approved by the MOHSW;
- National Hospital Reform Task Force review the status of the current Hospital Reforms Programme to identify the top three barriers and ways forward to support operationalization at Zonal, Regional and District Hospital levels to 2015;
- District Services & Referral Hospitals TWG undertake quarterly tracking/progress review of the two HSSP III indicators relevant to hospital reform: i) proportion of hospitals with annual plan, annual report and with capital investment plan; and ii) proportion of hospitals with functional boards.
- Include in the current review of the MOHSW's 2007 Emergency Operating Plan (EOP) amendment of the standard operating procedures (SOPs) to include standardized and consistently applied nomenclature regarding key health EPR committees, teams and plans at all levels, but especially at HF level;
- Operationalize the expected new (2013/14) EOP to include training interventions to bring all key health staff at Regional and Council levels with EPR responsibilities to a common level of understanding and trained readiness for the most frequent and significant hazards (i.e. cholera outbreaks, MVAs);

Efficient Management

- Include, in capacity-building CHMTs, evidence-based priority setting mechanisms to strengthen annual CCHP preparation;
- Train CHSBs and HFGCs to better understand, and work according to, their terms of reference (regulations). Strengthening the capacity of HFGCs should include their review of annual facility health plans before these are then forwarded to the CHMT for approval;
- RHMTs, through the orientation and guidelines under development in the 2011-14 RHM2, support RRHMTs to ensure all produce hospital annual plans next year, i.e. 2014/15;
- MOHSW Health QA Directorate consider merging the planning and implementation of hospital accreditation and hospital inspection initiatives to capture logistical efficiencies;
- RHMT supervisory tools for RRHMT support be closely reviewed within the RHM2 programme between now and Oct 2014 to identify optimal lessons learned for application post JICA-support;

- Provide central planning and support for operationalizing PPP at regional and district level and support for service agreements;
- Review recommendations from the Tanzania Health Sector Assessment Study done in 2011 and use them to improve PPP especially in roll out to the regions and districts and in increasing the number of service agreements signed to improve access to essential health services;

Disease control programmes

- HIV/AIDS prevention, treatment and care interventions need to be formulated to target most at risk populations, i.e. CSWs, MSM, mobile workers, prisoners and IDUs. These groups are not adequately visible in the current national HIV AIDS Programme;
- Reproductive health services and HIV AIDS Programme collaborate in a programme that will increase men's attendance in ANC and VCT pregnant women attending early in ANC and ensure minimum of 4 visits during pregnancy in order to facilitate IPT;
- Intensify PMTC programme efforts in the five regions of Kigoma, Singida, Shinyanga, Mtwara and Mara that have coverage rates below 50% especially in three of these regions where coverage has been decreasing in 2009-2011;
- Initiate a community based follow-up and patient tracing system in all districts to ensure continuity of care for patients put on ART;
- Increase BCC/ICE on STIs especially on the most common STIs, their causes, treatment and prevention;
- Intensify selective malaria control strategies especially ITN and IRS in the regions and districts with high malaria prevalence rates particularly in the regions of Geita, Kigoma, Mwanza, Mara, Morogoro, Pwani, Lindi, Mtwara and Ruvuma.
- Encourage and increase participation of NGOs and CSOs involvement at the community level in health promotion.
- Utilise CHWs that are formally trained, supervised and employed by the health system in order to provide promotional and preventive health services in general.
- Complete finalization of the forthcoming national Community-Based Health Care (CBHC) Programme;
- Raise awareness on the high incidence of accidents and injuries and collaborate with the relevant sectors in prevention of accidents and injuries.
- Accelerate setting up of the National NCD programme that will be implemented at all levels at National, Regional, District and community levels with IEC to raise awareness on risk factors related to NCDs. It recommended implementing research studies on prevalence of NCDs in several districts to facilitate the development of evidence-based NCD interventions.
- Review the 2000 evaluation and recommendations of the Dar es Salaam Urban Health Project for consideration in developing sustainable urban health programmes in Tanzania

Annex A: People Consulted in Dar es Salaam 15 July – 1 Aug 2013

Name	Designation
Dr. Donan W. Mmbando	Acting CMO, MOHSW
Clavery P. Mpandana	Chief Nursing Officer, MOHSW
Dr. Anna Nswilla	District Health Services, MOHSW
Dr. Mohamed A. Mohamed	Director, Health Quality Assurance, MOHSW
Dr. Lymo	Programme Manager EPI, MOHSW
Sally Lake	Senior Adviser, HPPM, MOHSW
Andy O'Connell	Senior Adviser, PPP, MOHSW
Gene Peuse	Senior Public Private-Private Partnerships Advisor, USAID
Dr. Stephen Ayella	Health Programme Technical Advisor - Save the Children International (Tanzania)
Dr. Liz Tayler	Team Leader - Basic Services Team, DFID Tanzania
Dr. Nadia Hamel	Health Team Leader, CIDA-Tanzania
PPP Technical Working Group	
Mariam Ongara	MOHSW
Peter Maduki	CSSC Director
Adeline Kimambo	TPHA
Candida Moshiro	MUHAS
Andy O'Connell	MOHSW Advisor (PPP)
Gradelene Minja	DANIDA
Samuel Ogillo	APHFTA
Disease Specific Technical Working Group	
Dr Angela Ramadhani	NACP
Dr Alphoncine Hanai	NPO WHO
Leticia Rweyemamu	DPGH/WHO
Grace Saguti	NPO/DPC WHO
Blastus F. Njako	Ag Programme Manager NLTP
Dr Edward Kirumbi	Ag PM-NTD
EPR Technical Working Group	
Dr Faraja Msemwo	EPR Section
Renatus Mashauri	EPR Section
Mary Kitambi	EPR section
JanethHghamba	Epidemiology and Disease Control Section
MarcelinaMponela	PAS Emerging Infections (CDC)
JamilaHamidu	Nurse –Quality assurance

References

CIDA-Tanzania (2012). Health Programming in Tanzania 2010-16 (undated monograph)

Community Perspectives Study (2013)

DANIDA (2009). Health Sector Programme Support (2009-14)

Frumence et al (2013). Challenges to the implementation of health sector decentralization in Tanzania: experiences from Kongwa district council. Global Health Action. 2013;6:10

GIZ (2011). Tanzanian German Programme to Support to Health Programme Factsheet

Harpham T, Few R. (2002). The Dar es Salaam Urban Health Project, Tanzania: a multi-dimensional evaluation. J Public Health Med. 2002;24(2):112-9.

Ifakara Health Institute (2011). Health Facility Committees: Are they working? Spotlight Issue 7, 2011.

Ifakara Health Institute (2011). Sentinel Panel of Districts: a new platform for health monitoring and evaluation in Tanzania. Spotlight Issue 8, 2011.

Ifakara Health Institute (2012). Bridging the gap between health system and community to increase health facility delivery. Spotlight Issue 15, 2012.

Ifakara Health Institute (2012). Lessons from CHF reforms.Spotlight Issue X, 20XX.

Ifakara Health Institute (2013). Increased public and donor funding does not guarantee equity in out-of-pocket payments. Spotlight Issue 17, 2013.

IMPRINT (2011). Hospital Management Information Benchmark Project Tanzania – End of Project Evaluation

JICA (2013). Outline of the Project for Capacity Development in Regional Health Management Phase 2 (RHM2); available at: http://www.jica.go.jp/project/english/tanzania/009/outline/

Juma, D, Manongi, R (2009). Users' perceptions of outpatient quality of care in Kilosa District Hospital in Central Tanzania. Tanzania Journal of Health Research.

Kruk et al (2009). Women's Preferences for Place of Delivery in Rural Tanzania: A Population-Based Discrete Choice Experiment. American Journal of Public Health: September 2009, Vol. 99, No. 9, pp. 1666-1672.

Makawia, S. et al (2010). An assessment of the distribution of health service benefits in Tanzania (SHIELD Work Package 3 Report)

Manzi et al (2012). Human resources for health care delivery in Tanzania: a multifaceted problem. Human Resources for Health 2012, 10:3

Mayige et al (2012) www.who.int/chp/steps/UR_Tanzania_FactSheet_2012.pdf

MOHSW (2000). National Package of Essential Health Interventions in Tanzania

MOHSW (2003). Strategic Plan for Integration of Health Services in Tanzania

MOHSW (2004). National Infection Prevention and Control Guidelines in Tanzania

MOHSW (2005). Guideline for Reforming Hospitals at Regional and District Levels;

MOHSW (2007) Health Sector HIV and AIDS Strategic Plan (HSHSP) 2008-2012

MOHSW (2007a). The Health Sector Emergency Operations Plan (EOP)

MOHSW (2007b). Primary Health Services Development Programme – MMAM (2007-17)

MOHSW (2007c). The National Roadmap Strategic Plan To Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania 2008-15

MOHSW (2009) Health Sector Strategic Plan III July 2009 – June 2015

MOHSW (2011a). Tanzania Quality Improvement Framework in Health Care (2011-16)

MOHSW (2011b). Summary and Analysis of CCHPs 2011/12 & Progress Report

MOHSW (2011c). National AIDS Control Programme (2011) HIV/AIDS/STI Surveillance Report Number 22

MOHSW (2011d).National TB and Leprosy Programme Annual Report

MOHSW (2011e) National AIDS Control Programme (2011) HIV/AIDS/STI Surveillance Report Number 22.

MOHSW (2012a). Regional Health Management Phase 2 Project: Regional Health Management Newsletter. Issue No. 2, September 2012.

MOHSW (2012b). Tanzania Service Availability and Readiness Assessment (SARA) Final Report

MOHSW (2012c). A Summary Report of the Summary and Analysis of CCHPs 2012/13

MOHSW (2012d). National Standards Operating Procedures for Healthcare Waster Management in Tanzania

MOHSW (2012e). Summary and Analysis of CCHPs 2012-2013 (15.10.2012) – ppt.

MOHSW (2013). Regional Health Management Phase 2 Project: Regional Health Management Newsletter. Issue No. 3, April 2013.

MOHSW MTR-AR (2013) Mid term Analytical Review of the Health Sector Strategic Plan III 2009-2015

MOHSW/JAHSR (2010). 11th JAHSR Final Report

MOHSW/JAHSR (2011). 12th JAHSR Proceedings of the Technical Review

MOHSW/JAHSR (2012). SWAp Milestones (2012-13)

MOHSW/JAHSR (2012). Policy Meeting Report

MOHSW/JAHSR (2012). Report on the Technical Review Meeting (TRM) for the JAHSR

MOHSW/PMO-RALG (2007), CCHP Guideline

Mselle et al (2013). Why give birth in health facility? Users' and providers' accounts of poor quality of birth care in Tanzania. BMC Health Services Research 2013, 13:174

Muhimbili University of Health & Allied Sciences (2012). Assessment Study of the Service Agreement Tool and its implementation in TGPSH supported regions in Tanzania

National Institute for Medical Research (NIMRI) Community Survey for Chronic Diseases and Their Risk Behaviours, Health and Social Determinants in Rungwe District

OPM (2008). Review of Hospital Component of HSPS III

Penfold et al (2013). Staff experiences of providing maternity services in rural southern Tanzania – a focus on equipment, drug and supply issues. BMC Health Services Research 2013, 13:61

PharmAccess Foundation (2008). Report of a Study on the Regional Level Health Care Management Capacity on HIV/AIDS in Coast, Tanga and Arusha Regions

Plotkin et al (2011). Quality of care for prevention and management of common maternal and newborn complications. Report 2: Findings on labour, delivery and newborn care. USAID/MCHIP/Maisha.

PMO-RALG (2009). Local Government Reform Programme II (Decentralization By Devolution): Executive Summary July 2008 – June 2013

PMO-RALG (2009/10). Lindi District Council CCHP for 2009/10

PMO-RALG (2010/11). Lindi District Council CCHP for 2010/11

PMO-RALG (2010/11). Nchingwea CCHP for 2010/11

PMO-RALG (2011/12). Regional Health Management Team Annual Plan - Mbeya Region

PMO-RALG (2011/12). Regional Health Management Team Annual Plan - Lindi Region

PMO-RALG (2011/12). Lindi District Council CCHP for 2011/12

PMO-RALG (2011/12). Ruangwa District Council CCHP for 2011/12

PMO-RALG (2011/12). Geita District Council CCHP for 2011/12

Oliveira-Cruz et al (2003). Delivery of priority health services: searching for synergies within the vertical versus horizontal debate. Journal of International Development. 15(1):67-86.

PMO-RALG (2011/12). Bukombe District Council CCHP for 2011/12

PRINMAT (2000). Organizational Capacity Building and Management Support Concept Paper

Shayo, EH et al. (2012). Challenges for fair decision-making processes in the context of health care services: a qualitative assessment from Tanzania. Int. Journal for Equity in Health 2012, 11:30.

SIKIKA (2013). Report on the Availability of Essential Medicines, Medical Supplies and Bed Capacity in Hospitals in Tanzania Mainland

Simon, M (2012). In-depth analysis of quality of structure and functionality of CHSBs and HGCs

Tanzania National Bureau of Statistics and ICF Macro (2011) Tanzania Demographic and Health Survey (DHS) 2010

Tanzania Commission for AIDS (TACAIDS), Zanzibar AIDS Commission (ZAC), Tanzania National Bureau of Statistics (NBS) Macro International Inc. (2008) Tanzania HIV/AIDS and Malaria Indicator Survey 2007-08

Tanzania Commission for AIDS (TACAIDS), Zanzibar AIDS Commission (ZAC), TNZANIA National Bureau of Statistics (NBS) Macro International Inc. (2011). Tanzania HIV/AIDS and Malaria Indicator Survey 2011-12

Tanzania-Japan Technical Cooperation in Capacity Development for the Regional Referral Health Management (TC-RRHM) (2009). Regional Referral Health Management Newsletter, Vol 1, Issue 1, Feb 2009

Tanzania-Japan Technical Cooperation in Capacity Development for the Regional Referral Health Management (TC-RRHM) (2009). Progress Report, April 2009.

Tanzania-Japan Technical Cooperation in Capacity Development for the Regional Referral Health Management (TC-RRHM) (2009). Regional Referral Health Management Newsletter, Issue No. 2, Sept 2009.

UNDAP (2011) Health Sector Plan

UNICEF (2012). Tanzania Annual Report (2012)

UNICEF Tanzania (2007) One UN Pilot Programme: Tanzania – Strengthening National Disaster Preparedness and Response Capacity (2007-2008)

URT (2004). *The Environmental Management Act*

URT (2007). Agreement for the Provision of Health Services between the Government and the Service Providers

URT (2008). A Performance Audit Report on the Management of PHC: A Case Study of Health Centers

URT (2009). *The Public Health Act.*

URT/PO-PSM (2011). The Functions and Organizational Structure of the Regional Secretariats

URT/USAID/PEPFAR/IFC (2013). Tanzania Private Health Sector Assessment

USAID (2009). African PPP Units in Health

USAID/Abt Assoc (2011). Tanzania Health System Assessment 2010 Report

USAID/SHOPS (2013). Tanzania Private Health Sector Assessment

WHO (2010). Tanzania Country Cooperating Strategy (2010-15)

WHO (2012). Tanzania STEPS Survey Report

WHO (2013). STEPS Chronic Disease Risk Factors Surveillance www. Who.int/chp/steps

World Bank (2005).Trends & opportunities in Public-private Partnerships to Improve Health Service Delivery in Africa

World Bank (2011). Tanzania Basic Health Services Project PAD

World Bank/PPIAF (2012). PPP Reference Guide Vol. 1

WHO (2010) The Stop TB Partnership's Global Plan to Stop TB 2011 - 2015