REPORT OF THE
19TH JOINT ANNUAL HEALTH SECTOR
TECHNICAL REVIEW MEETING

Dodoma LAPF

14th -15th November 2018

MEETING OBJECTIVES

1. **To review the health sector performance for the previous years**
   - -Health Sector Performance profile
   - -RMOS/DMOs meeting report
   - -Joint field visit
   - -Other key informative priority presentations

2. **To review progress of implementation of previous years policy commitments**

3. To develop 2019/20 policy Recommendations

Chairpersons: Permanent Secretary, MoHCDGEC - Dr. Ulisubisya Mpoki
Co-Chair : Deputy Permanent Secretary- Health, PORALG - Dr. Zainab Chaula

Moderator: Ms. Khadija Kweka and Dr. Oberlin M. E.Kisanga

Participants: SWAp stakeholders; Representatives from MoHCDGEC, PORALG, VPOs, POPSMG, PMOs, Min.Agriculture, Fisheries, Min.of Water, Min.of Industry and Trade, MOL, Health Agencies, RHMT and CHMT representatives; Development Partners in health and Representatives from the Private Sector, NGOs, CSOs and the Academic/Research community.

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Key Messages from Discussions of 2018/19 Health sector Performance

Key Message 1: Service delivery has to focus beyond the facility in order to achieve effective population coverage- hence CHWs are critical in achieving this. Therefore for Tanzanian health systems to be effective there should be a right balance between curative and preventive service and thus GoT and partners have to find effective and sustainable ways of training and deploying CHWs

Key Message 2: DHFF mechanism is beyond fiscal decentralization. It paved a clear window of opportunity for meaningful community participation. It generated a link between health facilities and community leadership and stimulated the functionality of Health Facility Governing Committees. There is a clients express that there is an improvement in Quality of care

RC of Katavi Region participating with community in collecting sand for rehabilitation

Key Message 3: The investments approved have to have a holistic thinking or approach. All technocrats heading various sections have to ensure that efforts in various departments are integrated and are linked to generate meaningful output. For example infrasture development has to go hand in hand with staffing and equipping the facilities with equipment and supplies

Key message 4: Health service access will be enhanced if the population that is covered with health insurance increases and the health systems in Tanzania devise a pro-poor scheme to cover the poor Tanzanians. Fast tracking of health financing strategy finalization and ensuring that the finance bill is signed will move the country a step further towards achieving the UHC

Key Message 5: Mapping communicating and aligning the roles and responsibilities of supply chain actors is important for smooth operation of health service supply chain. The Availability of health commodities is crucial for a development of a responsive service delivery systems it is highly dependent much on the appropriate alignment of roles and functions of all actors along the supply chain.

Key message 6: Informed decisions will come from both routine M&E and implementation/operational research. The varied achievements between regions have lots of hidden issues to be unveiled. This will not be achieved through routine M&E. It is important for the health sector to define learning agenda for it to be responsive to dynamic health needs for population it serves

Key message 7: PPP is built under the umbrella of organisation learning and adaptability. Both public and private health facilities have create an environment of learning from each other and develop mechanisms that will enable them adapt to change for them to be able to provide quality services to all Tanzanians.

1. Introduction

The 19th JAHSTRM was conducted on 14th and 15th 2018 at LAPF in Dodoma. The meeting was attended by --- participants from various Ministries- (MOHCDDEC, PORALG, Water, Education, Environment, Agriculture, Communication and Infrastructure, Industry and Trade, Ministry of Finance and Planning), Development partners, CSOs/NGOs and representative of the private sector.

2. The Methodology

The 19th JAHSTRM was chaired by the Permanent Secretary MOHCDGEC and co-chaired by Deputy Permanent secretary –Health from PORALG. In this meeting several presentation were made which included plemanry questions and answers. In addition there were poster presentations which provided opportunities for participants to have more time to engage with presenters. This was done for the progress of 2018/20 policy commitments progress, star rating and ICT presentations. The generation of the recommendations was informed by the following

- The health sector performance for the previous years
- Updates of the progress of the previous year's policy commitments
- RMOS/DMOS resolutions
- Updates from the 11 Technical working groups
- Operational research updates on the awareness and implementation and waivers
- Key messages from the opening remarks
- Joint Field visits experiences and lessons

The welcome remarks was made by the Chair of the Health Services TWG number one on behalf of the Chief Medical Officer. Opening remarks were made by from CSOs/NGOs group, Private Sector, DPG-health and then PORALG-H. PS-MOHCDGEC provided the Opening Speech. The following are the highlights from the Opening Session remarks and opening speech-The speeches are annexed

Opening Remarks

The Chair of the Health Services TWG welcomed the Joint Annual Health Sector Technical Review meeting members on behalf of the Chief Medical Officer. She Confirmed that this is the First JAHSTRM to be held in Dodoma following the government shift from DSM to Dodoma for all government business activities. She narrated the Objectives of the meeting, the timetable and encouraged everybody to actively contribute both personal and institutional technical inputs to the Policy Recommendations. She hinted that the Policy meeting is planned for November 26th 2018

NGO/CSOs

These were delivered by the CSO representative. On behalf of more than 15 health sector NGOs and CSO group present in the meeting he thanked the MOHCDGE for continued recognition and invitation extended to them. He expresses his expectation of a substantial contribution from the Increased participation of all including the non-state actors in the development and Implementation of robust , focused, result oriented and feasible policy recommendation.

Private Sector

On behalf of the Private Sector (APHFTA,BAKWATA and CSSC) the CSSC representative appreciated the observed increasing availability of Health service Inputs including Trained HRH, funds for health Commodities, health facility construction and rehabilitation and improvement of data management. The Government was encouraged to finalise the National Health Policy and the Health Financing Strategy, as these are vital inputs in increasing accessibility of quality health care services as towards Universal Health Coverage. In the effort to Complement the Government, s effort to reach all households are reached with quality health services; to-date more than 190 health facilities (86 FBOs and 104 Private) signed Service Agreements with Local Governments. The private Sector expressed a plead to the government to respect and encourage Implementation of these Agreements and advocate for all Service Providers to have a fair play in the implementation of Single National health Insurance. The Private Health Sector requests the responsible Ministries to invite regulatory authorities to streamline relevant regulations so as to minimize the number of regulators visiting healthcare facilities, each charging high fees for unnecessary services

DPG-H Chair

The Health Development Partners (DPG-H) Chair commended the leadership of the MOHCDGEC and PORALG for managing the successful Health SWAp arrangement in Tanzania which provides for an opportunity to review and renew joint sector dedications to the collaboration and partnership and allowing to focus together on the important technical lessons and challenges that will require a coordinated attention over the coming year. She expressed the deep appreciation of the close partnership within the well-established swap mechanism which despite the 2018 being a busy year; a remarkable success addressing the 2018/19 policy commitments have been realized. These included; improved access to PHC services via posting of trained staff; 6,180 out of 8,000 new healthcare workers permits were allocated to Primary Health facilities alongside the renovation of health facilities especially the health centres with a priority of

improving CEmONC in an equitable manner. She expressed the clear need to consolidate the effort " Development partners believe that to be successful, this expansion also requires the development and implementation of Continuous Professional Development and task-sharing strategies, to ensure we are able to start safely providing the envisioned services at the newly developed CEmONC facilities"

She re-interated the need for a co-ordinated management of all the available human and financial resources to provide for the right balance ensuring Health promotion and curative services without forgeting the Power of health

promotionand Prevention " We also encourage everyone to pay close attention to the balance between scaling up curative services and putting in place community level efforts to prevent complications before they happen. CHWs can support pregnant girls and women to attend all of their ANC and PNC appointments, support access to family planning information and services and promote resting and good nutrition during pregnancy, potentially reducing some of the need for emergency obstetric care. CHWs can also help ensure high risk deliveries are identified and support girls and women and their families to seek the healthcare services they will need in a timely manner to ensure a positive outcome. CHWs are particularly important to reducing inequities in access to services, by bringing information, services and supplies to women and men in the communities where they live and work, rather than requiring them to visit distant or otherwise inaccessible facilities." DHFF implementation was appreciated from the practical evidenced during the Joint Field Visit and the need to maintaing the gains and strive for improved health outcomes included better Joint Public

Financial management and strengthening social protection . besides the increased access to and utilization of health services – in particular, the concerted effort to expand the health system's physical infrastructure and the referral system. Almost These desperately needed healthcare workers are now reporting to work, including to the 9 highest priority regions.

Remarks by the DPS- PORALG-Health

In her Opening remarks the DPS-PORALG who is also a Co-Chair of the JAHSTRM started by Welcoming all SWAp participants to the 19th JAHSRM which took place for the first time in Dodoma following the decision of the government to shift to Dodoma. She appreciated the joint support in implementing the last years Policy Commitment especially the DHFF where PORALG has invested a substantial co-ordination effort in ensuring planned renovation and equipping of 350 health facilities. 44 health facilities are in the final stage including posting of HRH and expecting Inauguration by the High level government and all involved stakeholder come November 28th 2018. She commended the joint accountability in the health sector performance improvement and recommended that the 2019/20 commitments strengthen the gains especially the decentralised PHC and Community health and involvement. A proper well designed Community health promotion, prevention and care services will streamline and complement the facility level curative services.

She ended by recommending regular reviews of progress in implementation of policy commitments progress and performance which are critical measures to determines the actions needed to implement and or adjust policy action

Opening speech by the PS-MOHCDGEC

The Permanent Secretary MOHCDGEC who is also the Chair of the Swap Technical Committee Officiated the 19th JAHSTR Meeting by requesting every participant to excel full Co-operation, active participation and make best use of time resource. He reiterated the power of the current health Swap collaboration in Tanzania by associating it with a number of achievements over the last years. He cited the falling malaria prevalence from 14.8% (2015) to 2015(2017), reduction in HIV prevalence from 7% (2004) to 4.7 (2018); on track towards reaching the 90-90-90 HIV/AIDS global targets; 69.2% of people living with HIV/AIDS are on care and 98.7% of those on care are on ARV. The progress to 97% coverage(Vs 90% WHO global target) of all the Vaccinations; made Tanzania receive the UN and Global Health Initiative organizations congratulations for reaching the target holding third position in WHO Afro Region after Zambia (99%) and Rwanda (98 %). Ongoing renovation of health centres moving Tanzania from 22% to 58% of available H/C to CEmONC friendly come 2020.Other cited achievements included the growing Specialised and Super specialised health services including Cardiac (JKCI), Renal and Cochlea implants in MNH, Bugando and BWM hospitals) leading to decreased referral abroad; March 2018 only 12 cardiac patients were referred compared to 43 patients in 2016/17. Despite the success stories a number of persistent challenges included; growing NCD and CD; especially frequent Cholera epidemics; In 2017, 4626 Cholera cases were reported in 17 regions with case fatality rate of 2%. Such health challenges cannot escape the need for well organised Community health Workers programme as majority are subject of serious health promotion and prevention. He ended his opening speech by denoting the power of joint health Swap without which Tanzania would not have been able to achieve the achieved and so recalling a continued and stronger collaboration in addressing the observed gap in previous commitments and the coming 2019/20 policy commitments

3.

The health Sector Performance

One of the objectives of this meeting was to take stock of progress in terms of burden of disease and interventions coverage. The presentation of performance focused on service delivery, human resources, health financing, infrastructure development, Health commodities and supply chain, star rating, DHFF implementation and field visit feedback

3.1. Service Delivery Progress

It was mentioned that DHS 2016 present an increase in MMR and stagnant progress on neonatal mortality while there is good progress in reducing infant's mortality. Malaria, neonatal asphyxia, pneumonia, neonatal septicaemia is the leading cause of deaths for under-fives. The 2015-16 TDHS-MIS found that the modern contraceptive methods prevalence rate was 27 % among all women aged 15 to 49 years; and 32 % among married women age 15 to 49 years. Only 46% of pregnant women achieve four ANC visit. Proportion of pregnant women who delivered in health facilities steadily increased from 60 % in 2015 to 61 % in 2016, and 66 % in 2017. More resources and efforts should be invested in maternal health interventions, especially on availability of skilled attendants and maternal health commodities for the 2020 target of 90% to be achieved. Coverage of Comprehensive Emergency Obstetric and Newborn Care (CEmONC) for health centres is planned from 12% to 50%; and for hospitals from 59% to 100%. Calling for combined efforts of reaching communities with appropriate awareness creation strategies at facility and through community based programs as well as mass media. Immunization coverage is high as 95% for Measles under one year and Penta3 under one year

The disease burden for age 5 and above despite HIV and AIDs being the leading cause of death, hypertension and heart failure are becoming amongst the top five cause of death calling for a strategic attention of the health sector to scale non-communicable diseases interventions to reach all population segments as it accounts for NCDs now accounts for about 27% of all deaths. HIV prevalence in young population seems to declining, as new infections are generally contained and PLHIV on treatment live longer.

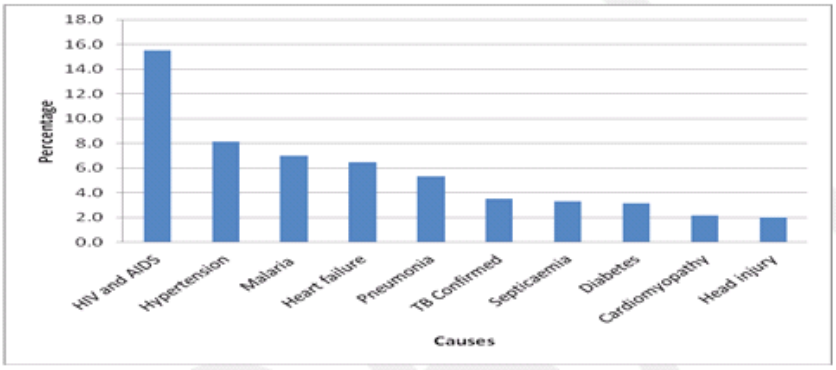


Figure 1: Top 10 causes of mortality for persons aged 5-years and above

With the Treat All (TEST AND TREAT) strategy in place, program seems to be covering well. Data indicates an increased uptake of in HIV testing services, although there may be double counts as the program is lacking unique way of identifying repeat tests. Current retention rates for patients on ART treatment are not satisfactory; as the program is notably losing significant number of clients to uncertain outcomes. There is considerable progress in achieving coverage of some TB interventions as highlighted below:

- TB treatment coverage has increased from 36% to 43%
- Preventive treatment of children aged < 5 years living in household contact of bacteriological confirmed TB cases increased from 7% to 34%
- The proportion of TB HIV positive patients on ART has increased from 83% to 95%

Some documented challenges in TB and Leprosy program include: Diagnosing the missing 57% TB cases 2% of cases outcomes were not evaluated and late of diagnosis of leprosy cases

3.2. Human Resource for Health

Availability of adequate and well-trained personnel is a key resource in planning, organizing, coordinating other resources for quality health services provision. The actual number of health workers required to deliver quality health services to reach all households is 197,932 while the available staff are 90,873, which is 46% of the total requirement. This means that the overall shortage of human resources for health stands at 54% which threatens the road towards UHC. Although there is an increase in numbers of Medical Officers, Pharmaceutical and Health Laboratory Staff and Nurses Per 10,000 population the HRH availability in the country is still below the national standard 7.2:10,000 and the WHO standards which is 23:10,000- Table 2. Regional disperities in terms of HRH availability continues to be a challenge. The 2017 HRH per 10, 000 population by regions shows that, Njombe, Kilimanjaro, Pwani and Dar Es Salaam are the leading regions compared to Geita, Tabora, Kigoma and Simiyu regions.

Table 1: Ratio of health staff available per 10.000 population

HSSP IV Indicators	Baseline-2008	Set Target 2017	Key achievements
Number of Medical Officers (MO)	0.34	0.67	0.53
Number of Assistant Medical Officers	0.31	0.41	0.44
Number of AMOs/MOs	0.65	1.08	0.97
Number of All Nurses	5.42	6.6	6.64
Number of Pharmaceutical Staff	0.211	0.287	0.281
Number of Health Laboratory Staff	0.75	0.889	0.797

What Could be done:

- Increase funds for HRH which includes funds for training of pre-service and in- service students
- Allocate more funds for HRH posting and retention
- Rehabilitate 18 Health Training Institutions and increase at least 53 tutors to accommodate the increase in student enrolment
- Put in place a modest HRH plan including designed local incentives to attract and retain health workers
- Expand, renovate health infrastructure including Staff houses.
- Equip Health Infrastructure with necessary equipment, tools and medical supplies
- Use **WISN** to redistribute the available HRH fairly by considering the workload
- Facilitate the full accreditation of **34** health training institutions

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

3.3. Health Care Financing

In 2007, the Government of Tanzania (GoT) adopted a Health Policy with the vision *"to improve the health and well-being of all Tanzanians with a focus on those most at risk […]"*. This vision remains valid as the GoT is committed to move towards Universal Health Coverage (UHC) by making sure that everybody has access to needed health services of high quality and is protected against financial risks that could arise as a result of paying of health care. As part of the Health Sector Strategic Plan IV , a decision was taken to develop a **Health Financing Strategy** to ensure that this vision is realized. The HFS has two objectives; To establish a single National Health Insurance scheme for all, which will ensure social protection to all Tanzanians and To improve payment method and strengthen Public Financial Management at all levels to ensure efficient use of resources- Table 2

Table 2: A summary of key achievements as per HSSP IV indicators

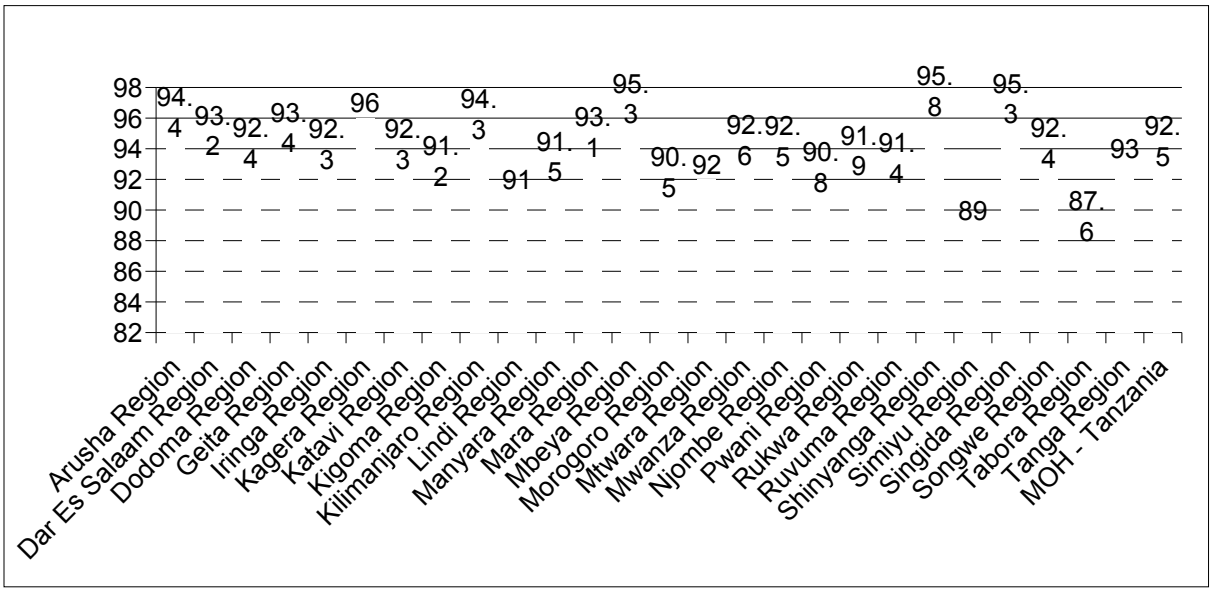
HSSP IV Indicators	Baseline- 2015	target by 2020	achievements by 2017
Share of total Government Expenditure allocated to Health	9.10%	13%	10%
Enrolment in social health insurance scheme	19%	70%	33%
Share of domestic resource in Health Insurance	29%	70%	37%
Proportion of population that has access to essential health services as outlined in standard MBP, by quintile (and also disaggregated by public and private providers	7%	50%	7%

The insurance coverage has remained almost the same between 2016 and 2017 where the coverage is at 33% of the population. In general User-fees in Tanzania is still a barrier to access health especially among the poor , Coverage of pre-payment schemes is low (8%) and I CHF is still Low roll (25%). It is recommended that government has to fast track the Single National Health Insurance Act which will ensure social protection to Tanzanian and increase the domestic finance for health care services while rolling out I-CHF as a short term measure.

3.4. Health Commodities,

MoHCDGEC oversees implementation of the National Medicines Policy (NMP) through the National Pharmaceutical Action Plan (NPAP) 2015-2020 with the aim of improving availability of essential

medicines and health commodities throughout the country. Availability of any of 30 tracer medicines, in most regions of the country was above 90% except Simiyu and Tabora Region.



With this achievement, there are challenges these include

- Insufficient and untimely disbursement of funds for procurement of essential medicines and health commodities from the treasury which erodes MSD capacity to procure.
- Growth of MSD Debt has been a challenging problem for sustainable supply of health commodities.
- Insufficient funds to conduct tracer medicines survey at health facility level

Important attention need to be given to:

- in the overall oversight on timeliness in managing MSD and Complementary private sector (Prime- vendor) supply to ensure constant on site availability
- Improving logistics information system to provide accuracy data feasibility
- Addressing the growth of debt by improvising the budget for debt repayment
- Roll out redesigned system to improve data visibility.

3.5 Health Information systems

The health and social welfare sector will embrace the rapid development of ICT for improving administrative processes, patient/client recording and communication. The MoHCDGEC will stimulate the development and guide interoperability of systems. The processes include planning, medical records, revenue collections, billing, diagnosis, reporting, and blood safety to mention few. ICT is also used for teaching, training and communication with professionals in the health sector. The National e-Health Steering Committee is providing the guide of the process, and the ICT Unit serve as Secretariat. The ICT Unit in collaboration with e-Government Agency (eGA) provides e-Health standards, rules, and protocols for eHealth implementation, information exchange and protection. It also coordinates management of existing and newly established systems within the health sector to eliminate silos and duplication of efforts. Current implementation of eHealth

solutions such as Electronic Medical Records, Health Information Systems (HIS), TeleHealth and mHealth services are the way to improve use of ICT in the health sector. Some of the relevant eHealth systems are managed by LGAs or PO-RALG and require close collaboration between ministries. The linked systems will constitute the National Health Information System. By 2018, the system will be fully functional.

Future improvements include:

- Implementation of Health Information Mediator enabling interoperability on prioritized use cases and enabling information exchange between the prioritized systems, support implementation of the Hospital Data Repository (HDR) to enable centralized data analysis and sharing of information from selected national hospitals.
- Implementing Tanzania Digital Health Roadmap.
- Scaling of existing initiatives such as Bata Information Data Initiative, deployment of EMR to Hospitals and Primary Health care, Provision of relevant training and capacity to resolve incomplete or untimely data reporting, inaccurate, duplicates, defaulters in a particular health services as well as improving data visibility to decision makers
- Finalize rollout of the eIDSR for the remaining two Regions by November.
- Implement and institutionalize data processing and monitoring protocols including establishment of help desk to support Health Information Exchange
- To expand HIE functionalities by Implementing additional modules representing new use cases into Health Information Mediator and Health Data Repository.
- Continue computerization of primary health care

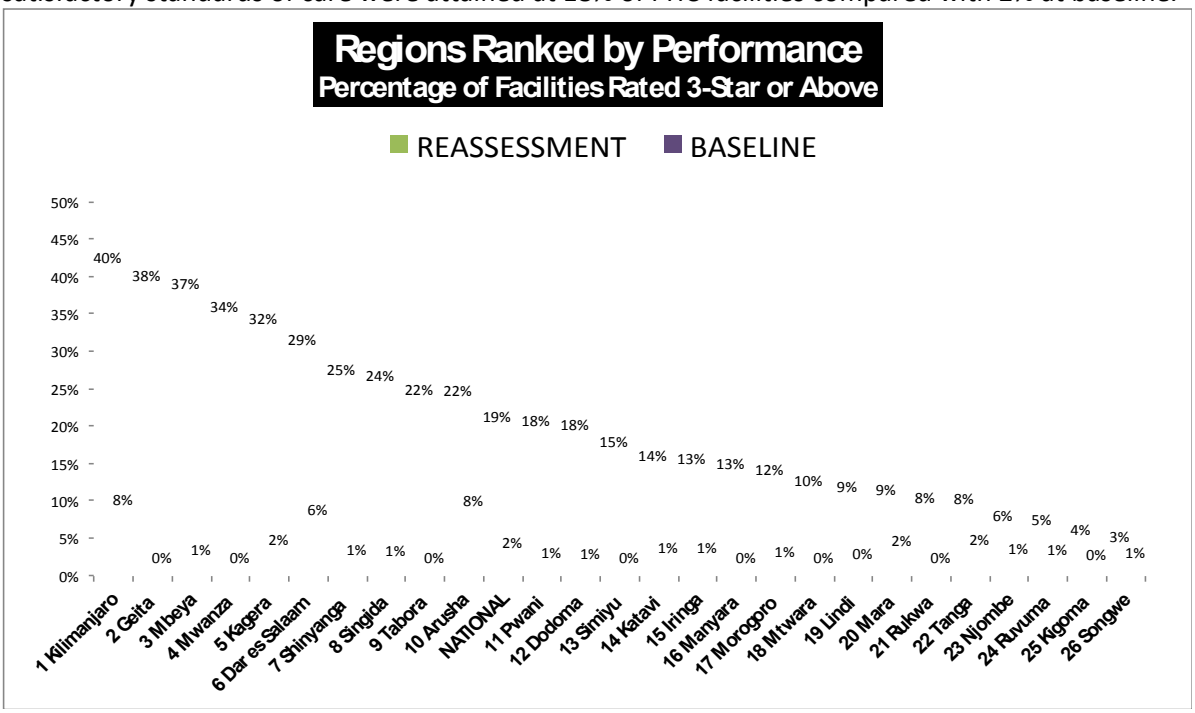
3.6.Leadership and Governance

Several activities were conducted

- Reviewed National Health Policy to provide for Single National Health Insurance and other key health sector reforms towards UHC in the final stage.
- Successful implementation of DHFF demand further governance reform; improved role re-definition ,CCHP guideline review and decentralised health SWAp Initiative.
- Decentralised H/Swap involving Mapping of all Stakeholders in the decentral health sector level and design a Complementary efficient decentral health SWAp Common Management Arrangement.
- HiAP framework kick-started to be followed by Refining joint Action plan towards Health in all policies.
- Establish an Accreditation system to encompass the Continuum of quality care at all levels and setting standards for the growing Specialised and Super specialised health services at the tertiary level

3.7 Health Facilities Performance

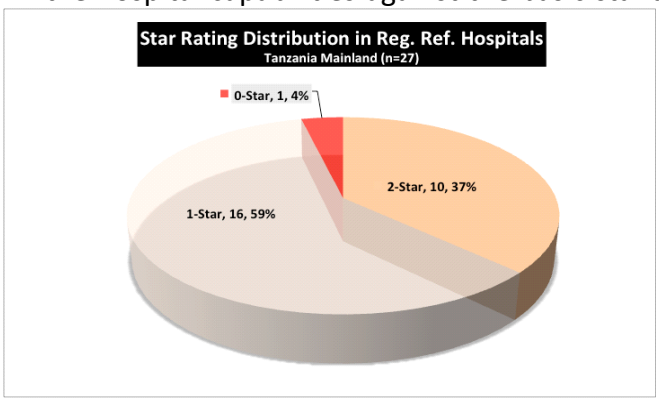
Significance changes have been realised with regards to facility performance all regions have moved from baseline ratings- Figure 2. Sub-standard facilities have reduced from 34% to 6% and satisfactory standards of care were attained at 18% of PHC facilities compared with 2% at baseline.



By 2018, 7000+ PHC facilities have had a repeat assessment after varying intervals of 12-24 months.

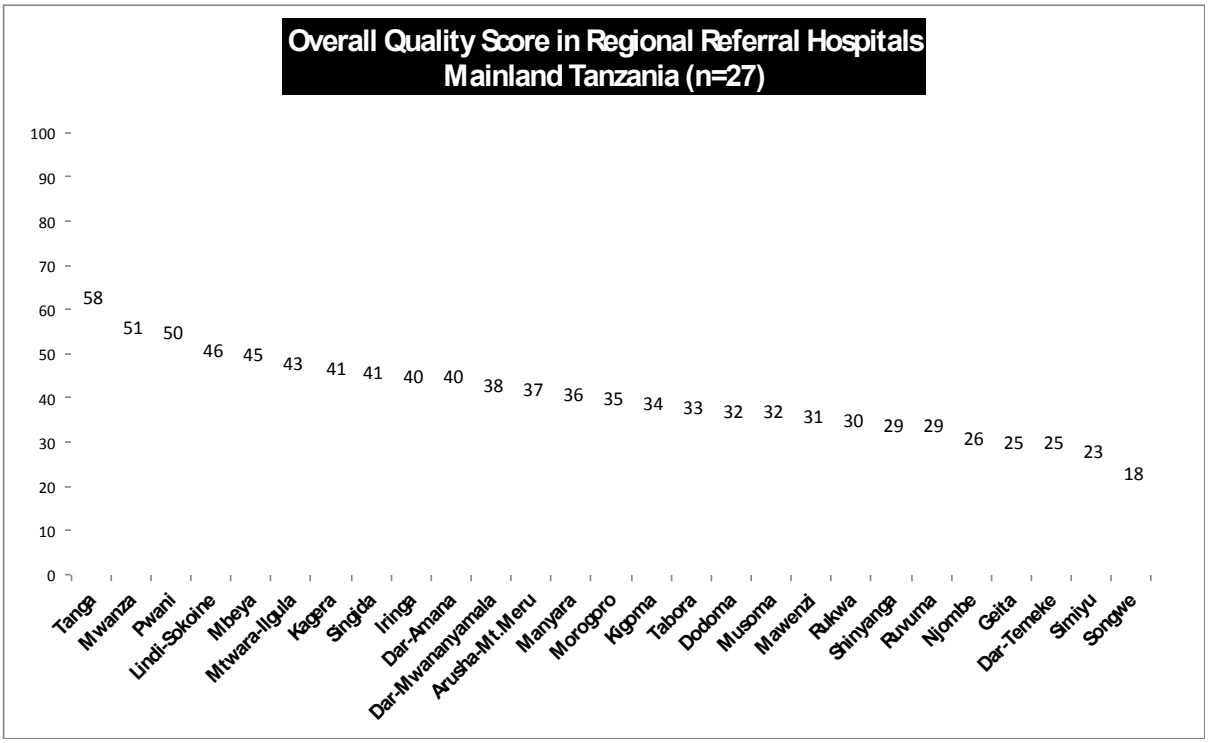
Results of the nationwide repeat assessments in 2017 and 2018 were shared at the DMO-RMO meeting in August 2018. The BRN and HSSP target for quality improvement to achieve a rating of three-star or above at 80% of primary health care facilities will require accelerated quality improvement (QI).

Following the assignment of **RRHs** to MOHCDGEC, a structured tool was developed to assess the hospital capabilities against the basic standards for RRH level using a structured tool in five domains: 1) Evidence-based leadership and management; 2) Patient and family rights and responsibilities; 3) Safe, conducive environment for patients and staff; 4) Competent and capable staff; and 5) Management of quality and patient safety.



Star rating results at baseline indicate much room for quality improvement.

The performance variation in overall score among the 27 regional referral hospitals; Tanga is highest performing (score 58);Songwe is lowest performing (score 18)
Giving a range of 40 points between min. and max



What next:

- Leverage resources for quality assessment and setting up improvement interventions in Referral Hospitals.
- Refining the Tool for Hospital Standards for Referral Hospitals after completion of assessment in Public RRHs-Assessments for all tertialry care facilties (including zonal and national hospitals)
  - Standards for specialised care hospitals to be developed: orthopaedic, psychiatry, cancer, cardiac etc
  - Accrediting the star rating tool with an international body (IsQUA); An accreditation body to be formed to oversee quality assessments and development of standards.
  - Working through the DUP - to harmonize the process of Supportive Supervision and develop a common online tool /platform that will allow data sharing across levels to improve efficiency: stakeholders have been consulted across all levels and field visits done to ascertain the supportive supervision process
  - Working on the process to adapt the WHO QoC Framework for Maternal and Child Health;Using this framework as a basis for the new TQIF and QI-Strategy

3.7 Health Infrastructure improvement

Tanzania mainland has has 4,420 Wards served by a total of 696; 513 (public) and 183 (private) Health Centres giving a health centre coverage of 16%. Out of the 513; only115 (22%) Health Centres provide CEmONC services. In the Financial Year 2017/2018 the Government and Development Partners have jointly mobilised funds for renovation of 350 health facilities including 247 out of the 513 Government Health Centres leaving behind 276 Health Centres. A total of **350** facilities have received funding for rehabilitation/construction for the period of October 2017 to October 2018, the distribution of funding is as follows; Rehabilitation of **8** hospitals -Rehabilitation of **247** HCs, Completing Seven **(7)** unfinished HCs - Construction **16** new HCs, Upgrading of **33** Dispensaries to HCs that provide CEmONC services and Rehabilitation of **31** Dispensaries - Finishing of **8** Dispensaries. The disbursement was in five phases and new architectural drawings which align with current standard and which are cost effective have already been developed- progress so far include:

kerege Facility Governing Commitee

- Phase I and II rehabilitation: Waiting for equipment to start CEmONC services to start.
- All other buildings; Laboratory, Labor Ward and staff house are in use for health care delivery.
- PO – RALG received permit in May 2018 for recruitment of 6,180 health workers of various Cadres.
- The permit aimed to cover the gap of 5,558 of Health workers needed for the 210 Health facilities under Rehabilitation, 6009 Health worker were successfully recruited.
- Additional staff for the phase IV and V rehabilitation are still needed
- Three kind of trainings, which will prepare clinicians and nurses to be ready for provision of CEmONC services are planned;
- Training for anaesthetic nurses, 200 staff are already at KCMC and Muhimbili attending the course.
- Three days Induction program for Emergence Obstetric Care
- Thee Month Clinical attachment for Clinicians who are excepted to perform CEmONC services.
- The estimated cost for accomplishing this task for facilities in phase I – III (210 facilities) is 5,597,321,000.00
- Medical Equipment for facilities in phase I and II have already started to being delivered.
- 3 out of 51 items of medical equipment for phase I facilities have already been delivered to respective facilities.
- 3 out of 63 items of phase II have been delivered, 1 item being partially delivered.
- The procurement for phase I and II facilities will be accomplished in January 2019.

- Councils are currently submitting list of needed medical equipment for facilities in phase III, IV and V.

4. 2019-2020 Policy Priority Recommendations

Preamble

The Ministry of Health, Community Development, Gender, Elderly and Children in collaboration with the President's Office – Regional Administration and Local Government, Development Partners and health sector stakeholders conducted the 19th Joint Annual Health Sector Technical Review. The Technical Review meeting was held in Dodoma at LAPF House on 14th and 15th November 2018. The objective of the meeting was to assess the health sector performance in the previous year and progress implementation of 2018/2019 policy commitments. This assessment enabled the identification of 2019/2020 policy recommendations to be presented in the 19th Joint Annual Health Sector Policy Meeting to be held on 26th November 2018.

The 2019/2020 policy recommendations are set to achieve the following three major intentions. First – ensure the resource allocated across the prioritized interventions results into tangible health outcomes towards Universal Health Coverage. The second intention is to accelerate a deliberate move towards the realization of a sustainable health services delivery systems by setting strategies that gradually and systematically build both institutional and financial sustainability in the health sector. The third intention is to position the health sector as a learning organization by promoting operational research in order to generate evidence that will inform health sector programming and policy formulation

With the three intentions mentioned above GoT 2019/2020 policy recommendations draw lessons from 2018/2019 and continues to prioritize majority of issues agreed upon in the previous year that were not fully implemented. The focus of the 2019/2020 policy recommendations is still aimed at addressing the high MMR -556/100000 live births (DHS 2016) and high neonatal death which is 28/1000 live births –ibid. The health sector considers addressing the MMR in a systemic focus will have a multiplier effect to variety of other problematic areas contributing to morbidity and mortality burden in the country- such as advancing health sector intentions in eradicating malaria, achieving the HIV/AIDS 90-90-90 goals and the reduction of TB infections. In order to address the morbidity and mortality burden, the GoT for 2019/2020 aims at promoting the capacity of the health systems to deliver services in terms of: a) HRH availability (Skilled and Community Health Workers), b) implementing appropriate strategies for in-service skill development through mentorship, coaching and training c)improving infrastructure, d) availability of health commodities e) Developing and implementing a pro-poor financing schemes f) improving health planning and governance f) promoting D-by-D by continuing to disburse funds to health facilities while strengthening the overall financial oversight and accountability. The 2019/2020 is made for 8 priority areas

i. Reproductive, Maternal, Newborn and Child Health
ii. Adolescent Health, Human Resources for Health
iii. Skilled and Community Health Workers
iv. Infrastructure Development and quality improvement
v. Health Care Financing
vi. Health Commodities
vii. Social Determinants of Health, Governance and Leadership and
viii. **Data Generation, Analysis, Communication and Use for decision making**

Priority 1: Reproductive, Maternal, Newborn and Child Health

The 2019/2020 policy recommendations for RMNCH will be focus on addressing drivers leading to poor achievement in RMNCH and adolescent health related indicators. This is because the global evidence indicates relationship between the quality, coverage, access and utilization of adolescent health services with the MMR and NMR burden. According to the Tanzania Demographic and Health Survey conducted in 2015/2016 showed that maternal mortality has remained persistently and unacceptably high at 556 per 100,000 live births in 2015/16. About 30% of women deliver at home, only 17% start ANC in week 12 and ANC four booking is only 46%. There is significant region variation between regions in variety of aspects calling for variation of strategies and need for community based strategies to improve coverage of interventions addressing MMR. Today, there are almost 12 million adolescents in Tanzania aged between 10 and 19 years – about 23 per cent of the population1. The number of adolescents in Tanzania is expected to increase to almost 30 million by 20502. In addition, about 13 per cent of the population is 20-24 years old. The Government shall work to ensure availability, improved access and coverage of EmONC services throughout Tanzania with a focus to strengthen BEmONC services and ensuring CEmONC old and new one are capacitated with necessary needed skilled human resource and medical equipment and use of innovation to reach rural population with specialized care. Enhance more active role of all levels care to provide enabling environment to reduce maternal and newborn mortality.

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The 2018/19 commitments focused on expanding the coverage of CEmONC and BEmONC service through infrastructure development, equipment, posting of qualified of human resources and training community health workers. The 2019/2020 recommendation therefore include

1.1: Continue scaling up CEmONC and BEmONC coverage and equity with a focus on priority areas and timely reaching rural population with specialized care.

- Provision of training, coaching and mentorship of health providers to be able to deliver quality BEmONC and CEmONC services

1.2. Improve New-born Care

Tanzania has met its MDG target of under-five mortality and infant mortality rates, but has not been able to achieve its target of reducing neonatal mortality rates. The target was to reduce Neonatal mortality rate to 19/1000 livebirths by 2015 but by end of 2015 the rate was 25/1000 livebirths. This death rate places Tanzania among the top five countries with the most newborn deaths in sub-Saharan Africa. Sepsis and pneumonia are the leading causes of neonatal deaths in Tanzania accounting for 32%

[1] NBS population projections from 2012 census.

[2] UNICEF, 2017. Generation 2030 Africa 2.0. Division of Data, Research and Policy, New York.

of the neonatal deaths. In order to reduce Neonatal deaths the following is recommended:Coaching and mentoring of health care workers on proper new-born care

- Equip health care facilities to perform new-born resuscitation and prevent Neonatal sepsis

- Compile Effective evidence based comprehensive newborn care including no baby left out and scale up to the entire country.
- Finalize guidelines for newborn care training package, disseminated and used for training

1.3: Scale up Comprehensive Family Planning Programme

Access to voluntary family planning improves the health and well-being of women and their children. Global evidence shows that a reduction in unintended pregnancies, combined with full care for all pregnant girls, women and newborns, would result in a 73 percent decrease in maternal deaths. Continue to scale-up a comprehensive FP programme, ensuring required commodities are available across the country are crucial to reduce the high unmet need for family planning.

Comprehensive and adolescent friendly services are also needed to reduce the current high rate of adolescent pregnancy. This would include SRH education and awareness, in coordination with the Ministry of Education.

Following are the recommended key actions:

Ensure that forecasted commodities are procured 100%
Ensure 80% of the primary health facilities have at least three modern methods of contraceptives.
Regional prioritization with more investment in 7 regions (Mwanza, Geita, Simiyu, Shinyanga, Katavi, Tabora and Kigoma) was the modern CPR is less than 20% and sustain gains in the remaining regions where the CPR is fairly high.
Increase expansion of PPFP marketing which has shown to 7% of CPR.
Scale up mobile community outreach program across the country for adolescents and adults.
Expand the package of FP services under CHW portfolio/service package, including to address gender/socio-cultural barriers.

1.4 Expanding coverage of Community based RMNCH services

- Intensify community based ART services for achieving critical coverage of pregnant women in order to reach last miles towards elimination of HIV mother to child transmission in Tanzania by 2020
- Intensify community based initiatives for RHMNCH (to increase facility ANC coverage (early booking and fourth visit immunization completion as well as postnatal attendance) including nutrition interventions

Priority 2: Adolescent Health

Today, there are almost 12 million adolescents in Tanzania aged between 10 and 19 years – about 23 per cent of the population3. The number of adolescents in Tanzania is expected to increase to almost 30 million by 20504. In addition, about 13 per cent of the population is 20-24 years old.

The success of reaching national scale-up of Option B+ in 2013-2014 resulted in significant reduction of HIV vertical transmission in 2015. However, despite the efforts, since 2016 data show that Tanzania has not been progressing towards elimination of HIV. The 2016-17 Tanzania HIV Impact Survey registered a very low viral load suppression in children 0-14 years old (18% only). In last 3 years the coverage with ARV treatment in this age group has been constantly around or below 50%.

The current health services provision concentrate on under-fives and childbearing age. There is no formal services package for above five and the teenage group. The 2015-16 Tanzania Demographic and Health Survey revealed that 27% of women between 15 and 19 have given birth which is 4 percentage point increase from TDHS 2010. Moreover, Tanzania has one of the highest adolescent birth rates in the world at 132 per 1,000 adolescent girls (aged 15 to 19). Adolescents and Young People (AYP) are the promise and a huge potential in terms of human capital for Tanzania's development. When adolescents and young people make the transition to adulthood in a safe, healthy, and empowered manner they are most likely to become active and productive citizens – making strong contributions to the economy and to society. This is exactly what Tanzania's VISION 2025 aims for and imperative for Tanzania becoming an industrialized and middle-income nation. The following are recommended

2.1 To enhance adolescent and young people health and wellbeing

In 2018, Ministry of Health led a cross-sectoral effort to develop National Accelerated Action and Investment Plan for Adolescent Health and Well-Being (NAAIA), through engagement with GoT ministries and agencies, DPs, civil society and adolescents. Funding and implementation of that plan is crucial to improve the health and well-being of adolescents and young people in Tanzania, therefore following actions were agreed:

- Finalize and disseminate NAAIA costed plan
- Develop an implementation plan including funding plan
- Finalize, disseminate and implement the National Standard for Quality Adolescent Friendly Reproductive Health Services (AFRHS)-in health facilities, schools and communities
- Establish the denominator and numerator for AFRHS facilities through National Assessment on availability of AFRHS
- Strengthen accountability for adolescent health, monitoring and evaluation including formation of coordinating body established for NAAI

Priority Area 3: Human Resources for Health: Skilled and Community Health Workers

Availability of adequate and well-trained personnel is a key resource in planning, organizing, coordinating other resources for quality health services provision. The actual number of health workers required to deliver quality health services to reach all households is 197,932 while the available staff are

[3] NBS population projections from 2012 census.

[4] UNICEF, 2017. Generation 2030 Africa 2.0. Division of Data, Research and Policy, New York.

90,873, which is 46% of the total requirement. This means that the overall shortage of human resources for health stands at 54% which threatens the road towards UHC. Although there is an increase in numbers of Medical Officers, Pharmaceutical and Health Laboratory Staff and Nurses Per 10,000 population; the HRH availability in the country is still below the national standard 7.2:10,000 and the WHO standards which is 23:10,000- Table 2. Regional disperities in terms of HRH availability continues to be a challenge. The 2017 HRH per 10, 000 population by regions shows that, Njombe, Kilimanjaro, Pwani and Dar Es Salaam are the leading regions compared to Geita, Tabora, Kigoma and Simiyu regions.

To achieve effective coverage of services a balance between scaling up curative services and putting in place community level efforts to prevent complications before they happen is important. CHWs can support pregnant girls and women to attend all of their ANC and PNC appointments, support access to family planning information and services and promote resting and good nutrition during pregnancy, potentially reducing some of the need for emergency obstetric care. CHWs can also help ensure high risk deliveries are identified and support girls and women and their families to seek the healthcare services they will need in a timely manner to ensure a positive outcome. CHWs are particularly important to reducing inequities in access to services, by bringing information, services and supplies to women and men in the communities where they live and work, rather than requiring them to visit distant or otherwise inaccessible facilities.Efforts are ongoing to train CHWs since 2015. Total number of CHWs required is 33,164 and currently there are 11924 CHWs who were trained. Apart from having gap in terms of numbers (29,164), the placement policy for CHWs during selection of trainees was not adhered. Currently a total of 4000 CHWS have been or are currently deployed through the support of partners in the span on 1 to 3 years. The 2019/20 recommendation include

3.1: Ensuring all facilities are manned by skilled personnel

To will continue to prioritize posting staff to those remaining 21 Facilities to cover the gap of those who could not report in 2018/19 permits

To ensure all facilities manned nurses are staffed receive clinicians

To ensure all CEmONC facilities have a minimum required staff. Given the government's efforts to improve infrastructure for RMNCAH, specifically emergency obstetric and new-born care (EmONC), continue to prioritize permits to ensure that all upgraded health centres have the full skilled staffing complement required with the appropriate skill mix.

To update and synchronize the HRH Strategy and Costed HRH Action Plan with infrastructure

To updated HRIS on quarterly basis

To advocate for HRH production, recruitment, development and retention budget increase

3.2: Investing in Improved Practice by essential HRH

Expand CPD & training to ensure the quality and safety of services (particularly CEmONC) to be offered at new & existing facilities – for example, anaesthetists, theatre management, nurse midwives –

3.3: Absorbing and scaling up CHWs

GoT appreciate the support provided by health partners in training and recruiting CHWs. It believes that to expand coverage of certain interventions as a country we need machinery that will reach populations with health needs at their own settings. It was agreed that feasible ways will be collectively devised to ensure that sustainable financing strategies to engage CHWs are devised to enhance the absorption of the currently employed CHWs and also continue to train and absorb new ones in a cost effective manner. The following are recommended

To Support deployment of CHW in 2019/2020

The government –MOH,MOFEA,PO-PSM to establish a feasible long term financing projection for the government to employ CHW- to guide deployment and production plan

Adhere to CHW policy by recruiting from communities they will serve.

Undertake mapping of current CHW production and distribution and map training institutions with capacity to deliver CHW training.

To finalize CHWs curriculum to ensure it consist comprehensive package of skills required for provision of basic preventive, promotive, rehabilitative and curative services

Priority Area 4: Health Infrastructure and Quality of Care

According to October 2017 PORALG PHC Infrastructure development appraisal report, and MOHCDGEC-HRH report Tanzania has 12,545 villages served by 6640 dispensaries (52% coverage) and 4,420 geographical wards served by 863 (19.5% coverage). Of these health centres , 518 are government owned and only 115 (22%) are CEmONC friendly. Following the 2018/19 policy commitments; a joint effort from Government and Development partners 247 Health Centres have received funds to support their rehabilitation and equipment to become CEmONC compliant leaving behind 271 Health Centres in a bad state of repair and not offering comprehensive services especially for pregnant women. Funds have been secured for rehabilitation and construction of 350 health facilities. To address geographical inequities, GoT to ensure that the construction of Health centres and upgrading of dispensaries to health centres is done at strategic locations where there is no such services. It is recommended that the ongoing efforts to improve infrastructure to continue in a phased manner that ensures new facilities are functional (staff, equipment, water, electricity). The following are recommended for 2019/2020

4.1 Improving coverage of Primary health care Infrastructure

- Finalize construction and rehabilitation of 303 health centres (rehabilitation of 247 existing health centres, construction of 23 health centres and upgrading of 33 dispensaries) **to ensure** facilities are functional and offering services.
- Construction of 67 District hospitals
- Undertake documentation of process, lessons of work done

4.2: Improving referral system and infrastructure

Following the move of ensuring the expansion of quality referral services at reginal, zonal and national level, GoT plans to expand access of specialized and super specialized services to all Tanzanians. This will be done through infrastructure and quality management improvements. The following is recommended

- Rehabilitation of 10 Regional hospitals and construction of 5 new RRHs
- Continue construction of Mtwara Zonal Referral hospital
- Upgrading of National specialized hospitals to provide super specialized services
- Finalization and dissemination of Referral Guideline

4.3 Continue with quality assessment and improvement

- Carry forward commitment to harmonize external hospital assessment tools
- Initiating Medical audit system starting with tertiary care hospitals
- Star rating assessment of all primary facilities (both public and private) with improved harmonized tool
- Star rating of Zonal, National and Specialized Care (both public and private) hospitals with regional standards for tertiary care.

Priority Area 5: Health Care Financing

About 25.8 percent of total health expenditure is accounted for out of pocket. This exposes the populations to catastrophic health expenditures. Despite the ongoing efforts to ensure the population has access to health insurance services through National Health Insurance Fund, Community Health Fund and other private health insurance schemes there is still a large proportion of population about 67% out of the insurance scheme. This due to the challenges in the existing insurance structure. On of the sustainable and comprehensive strategy to curb the challenges is putting in place Health Insurance Act with mandatory nature and having a Single National Health Insurance. However, this objective was not realized despite being part of the 2018/19 commitments as the bill was not passed. The move is expected to contribute in increasing percent contribution of the domestic financing for health and will as well protect Tanzania from financial hardship during the need of Health Care and in the end achieve Universal Health Coverage. The following is recommended

5.1: Finalization of finance strategy and fast tracking the pass of the bill

- MOHCDGEC to update and finalize the Health Financing Strategy, aligning it to the latest design and scale-up developments of ICHF and Direct Health Facility Financing. This is to ensure that it paves the way for mandatory health insurance for all Tanzania's and provides a roadmap for a strong, de-fragmented National Health Insurance System towards UHC.
- Advocacy for SNHI to different stakeholders and civil society to ensure understanding of the reforms and promote their uptake, including among decision makers (Parliamentarian, PS, Cabinet). **Parliamentarian to fast track the p**ass of the bill
- Disseminate information and educate communities to ensure understanding of the social health insurance reforms, their entitlements and how it benefits them and their families. (Sensitization for increased coverage)

5.2: Implementation of ICHF

- GoT and partners to continue supporting roll-out of the ICHF in the remaining regions **and ensure adequate budget lines** are dedicated to ensure timely availability and disbursements of matching funds and subsidies for the poor, which should be linked to the Social Protection Policy current under development.
- Develop the ICHF implementation manual

5.3: Sustaining DHFF

The first year of implementation of DHFF, has proven it has the potential to be an effective mechanism to improve health service delivery, ownership and engagement in the governance of health facility by the communities. However, it is important to first ensure that also other government grants are disbursed in the same way. It is recommended that

- Government to
- assesses the feasibility of disbursing OC and other GoT grants using DHFF mechanism
- GoT in collaboration with partners to develop DHFF M&E framework
- That ICHF allocations also follow the DHFF principle and formula.

5.4: Strengthening Public Financial Management

Public Financial Management can be more optimally implemented. The limited involvement of different stakeholders during the time of budget formulation can be improved. Better disbursement of approved budgets (disbursement is now about 60% of the approved budget) and budget reviews, monitoring and evaluation will be supported.

The following will be done:

- MOHCDGEC and PORALG share their draft annual health plans and budgets to all stakeholders before beginning a process of approval.
- MOHCDGEC and PORALG improve expenditures on the disbursed funds in a efficiency and cost effective manner, including adopting of strategic purchasing.
- MOF to ensure approved health budget is disbursed accordingly.
- ICHF allocation should follow DHFF

- Implement more efficient provider payment mechanism

Priority Area 6: Health Commodities

Despite improved availability of tracer items (up to over 90% in HFs) and increased budget allocation from about 30B in 2015 to over 270B in 2018/19; overall availability of health commodities could improve further. Currently, there is no end-to-end visibility of supply chain data/information, data quality is still a problem (latest DQA report indicated that data quality was xxx). In addition, over 90% of health commodities available in the country are imported. Lastly, as reported in the 2017 holistic supply chain review, stronger supply chain governance and accountability is needed. For MOHCDGEC improve availability and accessibility of quality health commodities in the country the following are recommended

- Improving end-to-end supply chain quality data visibility and use for decision making
- Strengthen supply chain governance and accountability for better oversight, coordination and management
- Promote domestic manufacturing of health commodities

Priority 7: Social Determinants of Health, Governance and Leadership

Not all health and health related problem are addressable by interventions with the health sector alone. In order to ensure that health issues (maternal Health, adolescent health, environmental management, early healthy nutrition, NCDs, clean and safe water, and other social determinants issues) are reflected in other sector policies.

7.1: Operationalize a health Multi-sectoral leadership and Governance Framework

Since the introduction of health sector reforms, multi-sectoral collaboration was set as one of the strategies to address health and related issues especially so at Primary Institutional and household level.

In line with 2018/19 policy Commitment; the MOHCDGEC and PMOs in a participatory and joint manner coordinated analysis of other Ministries and identified health and related opportunities. The following are therefore recommended for 2019/20

- Operationalize a Common Management Arrangement Framework for the identified health Opportunities between MOHCDGEC with all ministries.
- MOHCDGEC to create awareness of other ministries, NGOs, CSOs and the Private Sector of their engagement in health promotion and continuously inco-oporate health in their policies and strategies.

7.2: Institutionalize SWAp, Common Management Arrangement and Development Cooperation Framework

The effectiveness of Sector Wide Approach has been realized since the introduction of health sector reforms in 1998. The National level experience is highly appreciated by all Government and Co-operating Partners as With the implementation of DHFF the windows of opportunities are clear for expanding SWAp arrangements to lower levels. However, central guidance is needed for operationalising such arrangements at lower levels central guidance is needed. It therefore recommended that MOHCDGEC in collaboration with PORALG to:

- Develop and implement a decentralized SWAp Common Management arrangements including Guidelines at all levels".
- Mapp all decentralized Health and related Stakeholders (GOT, DPs, NGOs, Private Sector ,CSOs) and Set relevant Technical Working Groups in which local partners will engage in joint planning ,Implementation, Monitoring and evaluation at LGA level
- Conduct comprehensive HSSPIV MTR

7.3: Align roles and responsibilities of Governance structures with ongoing reforms

With the on-going reforms including introduction of the Direct Health Facility Financing (DHFF), the governing mechanisms need to be reviewed to ensure effective coordination and implementation of the reforms. It is recommended that:

> MOHCDGEC in collaboration with the PORALG to review roles and responsibilities of the Regional Health Management Teams (RHMTs), Council Health Management Teams (CHMTs) and all PHC Health Facility Governing Committees (HFGCs) to align with DHFF.

7.4: Strengthen TWGs Performance

The goal of the HSSP IV, 2015-2020 is "Reaching all households with quality health care". The SWAp Technical Working Groups (TWGs) have been working through development and implementation of Annual Action Plans to implement the HSSP IV objectives, however keeping to a regular meeting schedule has been challenging with some stakeholders in Dar and some in Dodoma. A need for accelerating progress towards achievement of the HSSP IV goal has been realized . It is therefore recommended that:

> MOHCDGEC, PORALG and SWAp partners will review the TWGs as part of the comprehensive review of the HSSP IV MTR, and consider aligning TWGs Plan of Action to 21 HSSP IV strategic objectives.
>
> Develop options to hold TWGs across Dar/Dodoma (VC)
>
> MOHCDGEC and PORALG to enhance a joint and representative Health Sector Reform and SWAp Co-ordination Secretariat

7.5: Learning agenda

As stated earlier the policy recommendations are set to create continuity of actions towards achieving indicators subscribed in HSP IV as well as enabling the achievement of health related SDG targets. In this notion, it has been realized that continuous learning is important to inform programming and policy formulation. It has been recommended that the learning agenda be identified in each thematic area and thus prioritized by TWGs. However, there should also be general learning agenda for issues that will need solutions that influence more than a single thematic group. It is recommended that the management of learning for HSS needs to be coordinated by the HSS unit under DPP. The following are the recommended learning question for 2019-2020

1. What kinds of Business process optimization processes are needed to at facility level to reduce number of forms are filled by nurses at dispensary level (– focusing on 17 forms to be filled in y nurses at dispensary)
2. Which potential options for active multisector engagement and collaboration exist to elevate health agenda in all relevant sectors
3. What locally viable options exist to enhance a pro-poor financing scheme?

Priority 8: Strengthening Data Generation, Analysis, Communication and Use for decision making

The MOHCDGEC in collaboration with PORALG and other health stakeholders is committed to strengthen data collection in the health facilities and ensure data collected is of better quality, reliable and is used at all levels for planning and decision making. Since the introduction of DHIS2 software in year 2013, the web based database, Monthly Summary Reporting (MSR) of data from health facilities has improved significantly from zero (0) monthly reporting rate before DHIS2 to over 95% monthly reporting rate after DHIS2, for data coming from over 8,000 health facilities both government and non-government countrywide while data quality has improved from unknown level before use of DHIS2 up to 75% in year 2017 after introduction of DHIS2. (according to the national verification conducted by the Audit Internal General (AIG)). The fore said success prompt the Health Sector to focus on generation of desegregated data, analyze, disseminate and use the following are recommended to

8.1: Improve Maternal and Perinatal Death Surveillance and Response (MPDSR) by scaling up Village Vital Registration, Harmonizing and integrating all vital statistics registration systems (including maternal death reporting) and aligning them to national CRVS Strategy and collecting data on maternal and perinatal deaths, infant deaths and U5 deaths to provide real-time information and inform policy.

8.2. Strengthen use of disaggregated data for decision making

- Introduce and strengthen the electronic data collections at facility levels aiming to get rid of the hard
- copy paper based systems
- Strengthen data storage repository (Health Information Mediator -HIM and MUNGANO Gateway) in order to facilitate data exchange among health data collection software
- Improve ICT infrastructure at all levels to enable data sharing through interoperability

8.3 Improve data quality management, dissemination and use

- Introduce DHIS2 health web portal and score cards to facilitate accessibility and use of data at all levels

5.

Annexes