United Republic of Tanzania

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

Health Sector Strategic Plan

July 2021 – June 2026

(HSSP V)

Leaving No One Behind

Foreword

On 1st July, 2020, the World Bank declared that Tanzania has been categorised Tanzania as a lower middle-income country (LMIC) after achieving economic and human development consistent with a middle-income status. This goal was achieved five years ahead of the country's schedule of 2025 as indicated in the Tanzania Development Vision 2025. The government's investment in the health sector has contributed to attainment of the LMIC status by improving the health and the health status of Tanzanians. The key attributes contributing to this achievement include the discipline in financial expenditure, the prevailing peace and tranquillity, reinforcement of leadership ethics, implementation of flagship projects and investment in human development which are the hallmarks of the Sixth phase Government under Her Excellency Samia Suluhu Hassan, the President of the United Republic of Tanzania.

The report of the Mid-Term Review (MTR) of Health Sector Strategic Plan Four and the Annual Health Sector Performance Report of July 2020 highlight the achievements made in the health sector during the first five years of implementing Sustainable Development Goals (SDG). The gaps identified have informed the development of the fifth Health Sector Strategic Plan 2021-2026 (HSSP V) which aims to achieve the targets for the last five years of TDV2025 and the second five years of SDGs. The health sector interventions in the HSSP V are also guided by the ruling party election manifesto and the third Five Year Development Plan 2021/22 – 2025/26.

In implementing the HSSP V, Tanzania will continue strengthening health systems in order to sustain achievements made in improving reproductive, maternal, newborn, children and adolescent health as well as results attained in control of communicable and non-communicable diseases. Government will improve the response to epidemics and disasters. Also, the government will strengthen leadership, governance and accountability in the sector in order to safeguard these achievements.

Local Government Authorities (LGAs) have a critical role to play in order to reach all communities, all people, providing services and solutions to the health needs of the population. The health sector commits itself to apply community- and facility-based interventions inspired and guided by locally generated evidence and globally proven best practices. Increased capacity of the President's Office Regional Administration and Local Government (PO-RALG) will continue to play a major role of coordination and support to LGAs in implementation of health sector policies and guidelines towards achieving the goals of HSSP V.

Achievements in the health sector cannot be reached and sustained without participation of central ministries, Ministry of Finance and Planning (MOFP) and President's Office – Public Service Management and Good Governance (PO-PSMGG) and other sectoral ministries including but not limited to those responsible for water, agriculture, livestock, fisheries, infrastructure, ICT and others that have impact in the health sector. Cross-sector collaboration will be enhanced under the guidance of the Prime Minister's Office to ensure that the Health in All Policies (HiAP) approach is effectively implemented.

The Government will establish systems and mechanisms to ensure increased accountability of all health sector stakeholders at all levels towards achieving the goals of HSSP V. The Ministry of Health Community Development, Gender, Elderly and Children (MOHCDGEC) will develop an accountability

framework for all health sector stakeholders to be included in the Common Management Arrangements for implementing HSSP V.

Tanzania continues to have a strong Sector-Wide Approach (SWAp) providing an avenue for policy and technical dialogue among all key stakeholders of the health sector. The SWAp structure will be further decentralised to regional and council levels to ensure that inputs from local council and regional stakeholders are always recognised and taken on board during the Joint Annual Health Sector Review (JAHSR) –Technical Review and Policy Meetings.

It is my expectation that HSSP V will guide all players in the health sector including all departments and agencies of the health sector, all councils and departments at PO-RALG, MOFP, POPSMGG and all ministries, departments and agencies in allocating financial, material and human resources for the health sector and inter-sectoral roles that have a health impact. I believe that the HSSP V will also guide health sector Development Partners and other stakeholders including non-state actors as they support and complement the Government's role to bring health and development to people and communities, Leaving No one Behind.

Dr Dorothy O. Gwajima (MP),
Minister of Health, Community Development, Gender, Elderly and Children

Acknowledgement

The development of the HSSP V was a participatory process that began with the completion of the MTR of HSSP IV that was presented to the 20th Joint Annual Health Sector Review (JAHSR 2019).

The process was led and guided by the Senior Management of MOHCDGEC chaired by the Permanent Secretary. The role of my predecessors Dr Zainab Chaula and Prof Mabula Mchembe in kick-starting the process is underscored and appreciated. Most of all, I would like to recognize and applaud the excellent coordination by Mr Edward Mbanga, the Director of Policy and Planning whose performance was that of the conductor of an orchestra involving diverse players across the spectrum of the multiple internal and external stakeholders of the sector. While each of the stakeholders had their vested interest at heart, he ensured that all contributed to the vision of the country and mission of the sector. In the same breath, I would like to recognise and thank the entire senior management team of the MOHCDGEC for their active engagement throughout the formulation of HSSP V.

Participation of representatives of health facilities, Council and Regional Health Management Teams (CHMTs and RHMTs), PO-RALG, POPSMGG, MOFP, other ministries, departments and agencies and non-state actors (including civil society and private sector) enhances ownership of this document by ensuring that it contains strategies and interventions that are adequate and relevant to the prevailing situation and actual needs of people and communities.

The Development Partners supporting the health sector (DPG-H) led by the DPG-H Troika and the Health Basket Fund (HBF) partners continues to provide technical and financial support to the sector including the support for conducting the mid-term review of HSSP IV and the development of this strategic guidance document.

The MOHCDGEC established a core team involving development partners and lead consultants under the leadership of the Head of the Health Sector Resource Secretariat (HSRS). The Core team acted as cement holding together all pieces contributing to the development and finalization of HSSP V. I would like to recognise and acknowledge efforts made in this regard by Dr Catherine Joachim, (Head of HSRS), Dr Jaap Koot (Lead consultant HSSP V), Dr. Yahya Ipuge (National Consultant HSSP V), Dr Ties Boerma (M&E Lead), Prof Daudi Simba (M&E National Consultant), Harun Mahundi (M&E National Consultant), Rachel Sanders (Costing Lead), Prof Sia Msuya (Consultant RMNCAH), Dr Mary Mayige (Consultant NCD), Prof Henry Mollel (Consultant HRH), Sally Lake (Advisor, PO-RALG and Costing Team), Dr Rutasha Dadi (Canada DFATD), Maximillian Mapunda (WHO) and Dr Thomas Fedjo Tefoyet (WHO). I extend my sincere thanks to technical experts from all Technical Working Groups listed in Annex 1 for their valuable inputs to the formulation of this strategy.

I would like to thank the Health Sector Basket Partners, WHO, UNAIDS and USAID for their financial support that has been instrumental in facilitating the entire development process.

The entire leadership of the Ministry of Health, Community Development, Gender, Elderly and Children will ensure that this HSSP V is used at all levels to guide the sector in planning, monitoring and evaluation of the progress towards universal health coverage, leaving no one behind.

Prof Abel N. Makubi,
Permanent Secretary

Table of content

Foreword ii
Acknowledgement iv
Table of content v
Acronyms/Abbreviations viii
Key messages xi
1 Chapter 1: Introduction 1
1.1 The formulation process of HSSP V 1
1.2 Health in Tanzania's national development agenda 2
1.2.1 Tanzania Development Vision 2025 2
1.2.2 Third Five Years' Development Plan 2021/22-2025/26 (FYDP III) 3
1.3 National Health Policy and Policy Implementation Strategy 4
1.3.1 National Health Policy (NHP) 2007 4
1.3.2 Draft National Health Policy 2020 4
1.3.3 Draft Health Policy Implementation Strategy 2020 - 2030 5
1.4 Tanzania's legal framework guiding the health sector 6
1.5 Sustainable Development Goals (SDGs): Global and regional health focus 8
2 Chapter 2: Situation Analysis 10
2.1 Health Status of the Population in Tanzania 10
2.2 Status of Progress in Health Service Delivery and Utilisation 12
2.3 Status of Progress in Health System Strengthening 16
3 Chapter 3: Emerging Strategic Priorities 20
3.1 Emerging strategic priority issues from the situation analysis 20
3.2 Unfinished Business from HSSP IV 21
4 Chapter 4: Country's Health System Framework 24
4.1 Strategic Mission and Vision 24
4.2 Conceptual Framework 24
4.3 Principles and Values 26
4.3.1 Equity 26
4.3.2 Gender 27
4.3.3 Health in All Policies to address social determinants of health 27
5 Chapter 5: Strategic Outcomes 28
5.1 Strategic Priorities in Provision of Health Services 28
5.1.1 Community Health Systems 28
5.1.2 Health Education 28
5.1.3 Nutrition 29
5.1.4 Environmental Health 29
5.1.5 Reproductive Maternal Neonatal Child and Adolescent Health 30
5.1.6 Communicable Diseases 32
5.1.7 Epidemics and Disaster Preparedness and Response 34
5.1.8 Non-Communicable Diseases 37
5.1.9 Social Determinants of Health 39
5.2 Strategic Priorities in Organisation of Health Services 39
5.2.1 Package of Health Services 39
5.2.2 Essential Health Services at Primary, Secondary and Tertiary Levels 40
5.2.3 Traditional and Alternative Medicine 41
5.2.4 Rehabilitative and Palliative Care 42
5.3 Strategic Priorities in Health System Performance 42

5.3.1 Expanding Access to Health Services (UHC1) 42
5.3.2 Improving Quality of Health care Services 43
5.3.3 Diagnostic Services 44
5.3.4 Safe Blood Transfusion 44
5.3.5 Public Health Laboratories 44
5.4 Strategic priorities in Health System Investments and Functioning 45
5.4.1 Human Resources for Health 45
5.4.2 Nursing and Midwifery Services 46
5.4.3 Medicines and Supply Systems 47
5.4.4 Infrastructure 48
5.4.5 Information and Communication Technology 48
5.4.6 Health Research and Development 49
5.4.7 Public Private Partnership 49
5.4.8 Financial Resources 50
6 Chapter 6: Institutional Framework for Implementation 52
6.1 Management framework 52
6.1.1 Decentralised Management 52
6.1.2 MOHCDGEC 52
6.1.3 PO-RALG 52
6.1.4 Governance of Health Facilities 53
6.1.5 Governance at Community Level 53
6.1.6 Gender and Equity 53
6.1.7 Urban health care 54
6.2 Partnership framework 54
6.2.1 Intersectoral Collaboration 54
6.2.2 Public Private Partnership 54
6.2.3 International Collaboration 54
6.3 Governance framework 55
6.4 Alignment of Subsector Health and Disease Specific Strategies 57
7 Chapter 7: Costing 59
7.1 Resource Needs 59
7.1.1 Methodology 59
7.1.2 Total Resource Needs 59
7.1.3 Costs of health services and health systems 61
7.2 Health impact of the plan 62
7.3 Resources available 63
8 Chapter 8: Monitoring and Evaluation 66
8.1 Introduction 66
8.2 Integrated M&E system 66
8.3 Technical framework 67
8.4 Indicator selection 68
8.5 Indexes 70
8.6 Data sources 70
8.7 Capacity, roles and responsibilities 71
8.8 Country mechanisms for review and action 72
ANNEX 1: LIST OF TECHNICAL EXPERTS 74
ANNEX 2 INDICATORS 78

List of tables

Table 1 Public health legislation 6
Table 2 Health professional legislation 6
Table 3 Health financing legislation 7
Table 4 Rights and social protection legislation 7
Table 5 Legislation concerning institutions 8
Table 6 Selected indicators for the urban poor in Tanzania 12
Table 7 Coverage of Government health facilities in 2019 18
Table 8 HSSP V costs (TZS billions) by programme and health system component 61
Table 9 Measurement of indicators 70

List of figures

Figure 1 OneHealth Tool structure 59
Figure 2 Costs of health services and systems 60
Figure 3 NCD Healthy Life Years Gained in Tanzania, in Disability-Adjusted Life Years (DALYs) 63
Figure 4 Resource envelope estimates 64
Figure 5 Resource envelope and resource need estimates 65
Figure 6 Areas of M&E 67
Figure 7 HSSP V M&E framework for selection of indicators 68
Figure 8 Indicators for HSSP V 69

Acronyms/Abbreviations

ADDO	Accredited Drug Distribution Outlet
AIDS	Acquired Immuno-Deficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral (medicines)
CCHP	Comprehensive Council Health Plan
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CHMT	Council Health Management Teams
CHSB	Council Health Services Board
CHW	Community Health Worker
COSECSA	College of Surgeons of East, Central and Southern Africa
COVID-19	Coronavirus disease
CPD	Continuing Professional Development
DCF	Development Cooperation Framework
DHIS2	District Health Information Software 2
DMO	District Medical Officer
DP	Development Partner
DPG-H	Development Partners Group Health
DQA	Data Quality Assessment
EAC	East African Community
ECSACON	East, Central and southern African College of Nursing
ENT	Ear Nose Throat
FEFOL	Ferrous sulphate/Folic Acid
FP	Family Planning
FYDP III	Five Years' Development Plan III (2021 – 2026)
Gavi	The Vaccine Alliance
GBV	Gender Based Violence
GDP	Gross Domestic Product
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
GOT	Government of Tanzania
GOTHoMIS	Government of Tanzania Hospital Management Information System
HBF	Health Basket Fund
HFGC	Health Facility Governing Committee
HiAP	Health in All Policies
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HPV	Human Papilloma Virus
HR	Human Resources
HRH	Human Resources for Health
HRHIS	Human Resources for Health Information System
HSHSP	Health Sector HIV/AIDS Strategic Plan
HSR	Health Sector Reforms
HSRS	Health Sector Resource Secretariat
HSSP	Health Sector Strategic Plan
HSSP II	Health Sector Strategic Plan II (2003 – 2008)
HSSP III	Health Sector Strategic Plan III (2009 – 2015)
HSSP IV	Health Sector Strategic Plan IV (2015 – 2020)
HSSP V	Health Sector Strategic Plan V (2021 – 2026)
HTI	Health Training Institutions
ICC	Interagency Coordinating Committee
iCHF	improved Community Health Fund
ICT	Information Communication Technology

IDSR	Integrated Disease Surveillance and Response
IHI	Ifakara Health Institute
IHR	International Health Regulations
IPT	intermittent Presumptive Treatment
ITN	Insecticide Treated Nets
JAHSR	Joint Annual Health Sector Review
JFV	Joint Field Visits
LGA	Local Government Authority
LMIC	Lower Middle-Income Country
M&E	Monitoring and Evaluation
MDA	Mass Drug Administration
MDR TB	Multi Drug Resistant Tuberculosis
MMAM	Mpango wa Maendeleo ya Afya ya Msingi (Primary Health Care Development Plan)
MOFP	Ministry of Finance and Planning
MOHCDGEC	Ministry of Health Community Development Gender Elderly and Children
MSD	Medical Stores Department
MTR	Mid-Term Review
NACP	National AIDS Control Programme
NACTE	National Accreditation Council for Technical Education
NBS	National Bureau of Statistics
NCD	Non-Communicable diseases
NEHCIP-TZ	National Essential Health Care Interventions Package Tanzania
NGO	Non-Governmental Organization
NHA	National Health Accounts
NHIF	National Health Insurance Fund
NHP	National Health Policy
NIMR	National Institute for Medical Research
NMCP	National Malaria Control Programme
NMSF	National Multisectoral Framework for HIV & AIDS
NTD	Neglected Tropical Diseases
NTLP	National Tuberculosis and Leprosy Programme
OOP	Out of pocket
OPD	Outpatient department
PER	Public Expenditure Review
PHC	Primary Health Care
POA	Plan of Action
PO-RALG	President's Office – Regional Administration & Local Government
POW	Programme of Work
PMTCT	Prevention of Mother to Child Transmission
PO-PSMGG	President's Office – Public Service Management & Good Governance
PPP	Public Private Partnership
QA	Quality Assurance
QI	Quality Improvement
RHMT	Regional Health Management Team
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
RMO	Regional Medical Officer
RRH	Regional Referral Hospital
SADC	Southern African Development Community
SARA	Service Availability and Readiness Assessment
SAVVY	Sample Vital registration with Verbal Autopsy
SDG	Sustainable Development Goal
SDH	Social Determinants of Health
SHA	System of Health Accounts
SMART	Specific Measurable Assignable Realistic Time-boud

STEPS	WHO STEPwise approach to Surveillance for Chronic Diseases
STI	Sexually Transmitted Infection
SWAp	Sector-Wide Approach
TASAF	Tanzania Social Action Fund
TB	Tuberculosis
tBD	To be determined
TBS	Tanzania Bureau of Standards
TDHS	Tanzania Demographic and Health Survey
TDV2025	Tanzania Development Vision 2025
TFNC	Tanzania Food and Nutrition Centre
TMDA	Tanzania Medicines & Medical Devices Authority
TMIS	Tanzania Malaria Indicator Survey
TNCM	Tanzania National Coordination Mechanism
TWG	Technical Working Group
TZS	Tanzania shillings
UHC	Universal Health Coverage
UHI	Universal Health Insurance
UNAIDS	Joint United Nations Programme on HIV and AIDS
USD	United States dollars
VHC	Village Health Committee
WASH	Water, Sanitation and Hygiene
WDC	Ward Development Committee
WHO	World Health Organization
WISN-POA	Workload Indicator of Staffing Needs – Prioritization and Optimization Analysis
WRA	Women of Reproductive Age

Key messages

Section 1: Introduction and background

Policy context

The formulation of HSSP V is part of a long tradition of formulating health sector strategic plans (HSSPs) which started in 1999. The development of this fifth Health Sector Strategic Plan (HSSP V) was a participatory process guided by the Ministry of Health, Community Development, Gender, Elderly and Children (MOHCDGEC).

Tanzania Development Vision 2025 (Vision 2025) provides the direction and philosophy for long-term development. By 2025, Tanzania wants to achieve a high quality of livelihood for its citizens, peace, stability and unity, good governance, a well-educated and learned society and a competitive economy capable of producing sustainable growth and shared benefits. The Five-Year Development Plan sets as one of the targets to improve quality of life and human wellbeing. The health sector is guided by the National Health Policy 2007, while a new policy is being drafted. Innovation in healthcare is the ambition of the new policy. A draft policy implementation strategy has been formulated to facilitate the operationalisation of the policy.

The United Republic of Tanzania endorses the achievement of the sustainable development goals (SDGs). Achievement of SDG 3, health and wellbeing, as well as other SDGs with an impact on health are central in this HSSP V. At the same time Tanzania is committed to achievement of Agenda 2063 of the African Union, with improvement of health of the population, and achievement health goals of the East African Community in transborder collaboration. Tanzania collaborates in the Southern African Development Community in the protocol on health to improve provision of essential medicines, to strengthen collaboration in disease control and disaster management.

Situation in the health sector

During the last decade, Tanzania made major progress in the health sector leading to a continued increase in life expectancy for Tanzanians at birth. In particular, Tanzania was successful in reducing neonatal and child mortality, as well as childhood malnutrition. Mortality due to major communicable diseases including HIV, tuberculosis (TB) and malaria, is decreasing. But there are still pockets of neglected tropical diseases with high morbidity. Contrary to this positive trend in reduction of infectious diseases, the burden of non-communicable diseases (NCDs) is increasing and risk factors for NCDs are on the rise.

Services for pregnant and childbearing women, and neonates have improved considerably in the HSSP IV period. But further reduction of neonatal and child mortality rates is needed for achieving the SDG targets. Urban children in particular need more attention. Adolescent childbearing remains persistently high. Fertility and unmet need for family planning are still high despite positive trends. Regarding equity, there are persistent inequalities between urban and rural populations, the poorest and richest households, and between regions.

In the last decade the number of health facilities nearly doubled, and availability of medicines improved substantially. Despite the increase in training outputs, shortages of human resources in health remain high, around 50% of the actual need. Information technology and information systems have improved across the board in Tanzania, making the health sector ready for the 21st century. Domestic funding for health has doubled in the last decade, also through improving access to health insurance schemes, but falls short of creating access to quality care for all. Governance of the health sector was strengthened through decentralisation by devolution, with more responsibilities for communities in planning and accountability.

Emerging strategic priorities

The developments in society pose new challenges to the Tanzanian health sector. First of all the demographic and epidemiological transitions lead to more ageing population and more NCDs. Industrialisation and urbanisation demand new types of services for the urban poor. Climate change may lead to more extreme weather conditions than experienced in the past, with an epidemiological impact. Globalisation in trade and human travel leads to new spread of diseases, like recently experienced with COVID-19. More positively, information and communication technology offers new opportunities, ranging from electronic medical records, to telemedicine and online supervision, training and health education.

Unfinished busines of HSSP IV

Not all service delivery targets of HSSP IV have been met in relation to improvement of health status of the population, e.g. in maternal and neonatal health, or adolescent health.

Access to health care is not yet equitable, and quality health services are not yet provided in every ward. The increase in health infrastructure has not gone hand in hand with the increase in human resources for health. While provision of medicines has improved, adequate diagnostic equipment and treatment remains unavailable for some conditions.

Healthcare financing has improved and more domestic sources have funding have become available, but increase of resources is not keeping pace with inflation and population growth. The health financing strategy was not implemented, and the population covered by health insurance stays below expectations.

Governance was strengthened, but parallel processes of management remain common for disease control programmes, and intersectoral collaboration has not reached the periphery.

Section 2: Strategic directions

Mission and Vision

The vision of HSSP V is to have a healthy and prosperous society that contributes fully to the development of individuals and the nation. As its mission, the health sector will provide sustainable health services with standards that are acceptable to all citizens without financial constraints, based on geographical and gender equity.

Framework for HSSP V

At the outcome level HSSP V aims at moving to universal health coverage for the population of Tanzania, to be achieved in 2030. The health sector will be able to prevent or respond adequately to emergencies and disasters. The HSSP V will lead to better health of the population by addressing social determinants of health and tackling all types of inequities in health.

People-centred service delivery will guide the processes in the health sector, with empowerment of citizens to contribute to health in the community, improved governance and accountability, as well as increased focus on primary and community health. Better coordination with all sectors that contribute to population health, will be achieved.

In terms of inputs for service delivery, the building blocks for health will be reinforced: infrastructure and medical supplies, human resources for health, health information systems, governance and healthcare financing. Coherence between strengthening the building blocks to achieve maximum effect will be crucial in the HSSP V period.

HSSP V will promote gender equality not only in service delivery for the population, but also in governance and human resource development and management.

Strategic outcomes in health service delivery

Community health: HSSP V aims for improved health of the population through community empowerment and engagement through responsive community health systems. The community-based health service strategy will be implemented and community health workers and volunteers will be embedded in an integrated system aiming at health and wellbeing.
Health education: in collaboration with other sectors and private partners, community awareness on health and health literacy will be strengthened, leading to behaviours that improve nutrition, healthy lifestyles and health seeking behaviour. Vulnerable groups in particular will be supported.
Nutrition: both undernutrition and overnutrition will be tackled, not only at individual level through empowerment, but also at society level, with measures that increase access to safe food for nutrition. Where needed, the health sector will provide medical services for malnutrition.
Environmental health: is becoming increasingly important at home with safe housing, safe water and safe food, protection against pollution and hazardous products. Health at the workplace also requires more protection against industrial risks, like noise, toxic products, and injuries. In environmental health cross-border collaboration is imperative, as well as working with international agencies.
Maternal health and neonatal: requires better adherence to existing quality standards and procedures in antenatal and delivery care and better timely referral, if needed.
Child health: Successful vaccination and prevention programmes will continue, as well as integrated management of childhood illnesses, while more attention will be given to urban poor.
Adolescents: Considerable improvement of adolescent-friendly health services is required, including reproductive health and rights. More attention is needed for out-of-school adolescents and their health needs.
Female cancers: There will be gradual introduction of cervical and breast cancer screening.
Infectious diseases: The health sector will achieve reduced morbidity and mortality due to communicable diseases through preventive measures, early detection and early treatment for communicable diseases of public health importance. In the coming years it is important to broaden the perspective of communicable diseases control beyond malaria, HIV and tuberculosis. Upcoming epidemics threaten the country. Government will continue to enhance health promotion and prevention in an integrated manner. It is important to target vulnerable groups, e.g. adolescent girls, drug users, and prisoners. It is important to keep vaccination coverages high, both for traditional and new vaccines.
Neglected tropical diseases: The government in collaboration with partners will continue to fight specific diseases, such as elephantiasis, hydrocele and trachomatous trichiasis, through mass drug administration, environmental interventions, case and co-morbidities management.
Zoonotic Diseases: These will become more important with climate change and increasing land use and will be tackled through intersectoral collaboration using the One Health approach.
Non-communicable diseases (NCDs): The health sector aims to reduce morbidity and mortality from NCD. Increased attention is necessary due to the increase in life expectancy, nutrition, and changes in lifestyle. Healthy ageing will be promoted. Government will stimulate preventive measures addressing lifestyle-related and mental health risk factors, as well as environmental factors. Where necessary, legislation and regulations will be put in place to reduce exposure to risk factors. There will be early detection of chronic diseases through screening and early treatment of non-communicable conditions of public health importance. Mental health services will be expanded to council level, alongside support to reduce addiction and substance abuse. Where needed, rehabilitation services will be put in place. Oral health, eye care and ear nose throat services will be stepped up to meet the increasing needs of the population.

Social determinants of health: These will be addressed across all diseases, as the poorest suffer most from all health conditions and have the least access to health services. Action will be through policies and strategies, financial support for insurance schemes, as well as grassroots interventions to increase access to care.

Strategic Outcomes in Epidemics and Disaster Preparedness and Response

Government will create a resilient and robust health and community system with sufficient capacity to prepare, detect, prevent, respond, and recover from health epidemics, emergencies, and disasters.

Risk communication and community engagement are crucial factors in prevention of epidemics and disasters, covering basic understanding of hygiene, medical hazards, and threats to health. National legislation, policy, and adequate financing will be put in place for prevention, alongside strategies for coordination, communication, behaviour change and advocacy through a multi-sectoral approach.

All outbreaks and health events in the country will be monitored through a system of surveillance and reported to the World Health Organization in accordance with international health regulations.

Government will ensure the availability of the necessary equipment, medicines, and infrastructures to provide emergency services and post-emergency services and address the health effects of various disasters. Government will build the capacity of health care providers at all levels to deal with the effects of various disasters. All levels in the health system will develop "All hazard" Emergency Preparedness and Response Plans and hazard-specific plans that will guide implementation during emergencies.

Strategic Outcomes in Organisation of Health Services

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

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

Specialised Health Services at Regional level: Government will strengthen the provision of health services at public regional referral hospitals (RRH) by improving the infrastructure, equipment and staffing by specialist health care professionals in these hospitals. The RRHs are envisaged to become a hub for innovation of healthcare in the regions.

Specialised and Super-specialised Health Services at Zonal, Specialised and National Hospitals: Government will continue to strengthen both specialised and super-specialised medical services to meet international standards.

Referral Systems: Government will improve gatekeeping and referral so that referral hospitals at regional, zonal, specialist and national level focus on provision of specialist and super-specialist services not available at PHC level. More efficient use of available capacity will be stimulated.

Rehabilitative Care: The health sector will better identify people with disabilities and their needs. The health sector will put in place various social care interventions tailored to specific needs.

Palliative Care: Government will, in collaboration with NGOs, develop expertise in palliative care and expand outpatient care and outreach services for home-based care.

Traditional and Alternative Medicine: The government will continue to strengthen the framework for managing research and the provision of natural or alternative therapies. Government will facilitate the establishment of traditional and alternative health facilities, manufacturing facilities, and

strengthen supervision for safety, quality and efficacy of remedies used in traditional and alternative medicine.

Strategic Outcomes in Health System Performance

Access to Health Services: The Government will ensure availability of essential primary health care services with acceptable quality standards throughout the country with respect to geographical, population, gender, disability, and burden of disease. All new health facilities will be equipped and staffed to meet minimum standards. The government will institutionalise preventive maintenance to ensure well-maintained and functioning infrastructure and equipment. Government will strengthen cooperation with the private health sector in health care delivery, through service agreements and promotion of private health sector investments in priority areas.

Quality of Healthcare Services: The health sector will focus on improving quality of care through health system-level improvements. The health sector aims to provide people-centred care. Quality improvement approaches will be incorporated in facilities. Clinical audits as well as nursing and midwifery audits will be institutionalised. Quality improvement teams will continue their work in regions and councils. The health sector will establish an accreditation system. The Star rating will be strengthened, with self-assessment and web-based tools. Government will harmonise registers, licenses, and accreditation systems, for public and private health care. The Patient Charter will be promoted countrywide, and follow-up on adherence to the guidelines will be part of the support to health facilities.

Diagnostic Services: Effective and up-to-date diagnostic services, with equipment, supplies and consumables, will be created to support a functional referral system for health services. Government will maintain external quality assurance and accreditation systems for laboratory services.

Safe Blood Transfusion: Effective and sustainable systems for the collection, processing, and distribution of safe blood will be strengthened in order to ensure uninterrupted supply of safe blood nationwide.

Public Health Laboratories: The core functions of public health laboratories will be strengthened, including disease prevention, control and surveillance, reference and specialised testing, environmental health and protection testing, food safety testing, laboratory regulations and policy development. Participation in the East African Public Health Laboratory Networking Project will continue.

Strategic Outcomes in Health System Investments and Functioning

Human Resources for Health (HRH): The government will continue to oversee and coordinate the training of human resources for health. The MOHCDGEC will take the lead in preparing curricula and will oversee training courses in public and private health colleges, to enhance both the quality of training and the link between training and practice in healthcare. New training courses will be developed. Quality of training will address education systems in a holistic manner right from curriculum design, selection of trainees, skills development, and examination systems. Government will work closely together with the Ministry of Education, other agencies and stakeholders in the private sector.

Data-driven and evidence-based HRH planning systems will be reinforced to encourage matches between need, supply, and demand. This will go hand in hand with improvement in human resources for health information systems as well as promotion of HRH data use for decision-making. The government will expand use of Workload Indicator of Staffing Needs – Prioritisation and Optimisation Analysis allocating health workers where they are most needed. Placement of staff according to workload and patient needs will be introduced in place of fixed establishments. Appropriate mechanisms for staff performance appraisal, internal supervision and effective job allocation will be introduced to enhance productivity and optimal utilisation of available health workforce. Government will introduce a mechanism to measure individual productivity in relation to assigned tasks, possibly

with automated tools. Government will expand the scope of nursing and midwifery services, to meet the demand for specialised health care services. Specialist nursing training at Nurses and Midwives Colleges will be initiated. Government will improve respectful and compassionate patient-centred care, to treat patients with dignity, respect, and ethics.

Medicines and Supply Systems: The health sector will improve the present procurement and delivery systems to reduce the cost and increase availability of medicines and supplies. Government will step up audits of medical commodities to ensure adherence to quality value-for-money standards. The MOHCDGEC will review and disseminate standard treatment guidelines and an essential medicines list based on evidence. Government will strengthen domestic pharmaceutical manufacturing, as well as research and development.

Infrastructure: Government will develop a new long-term investment plan for health care facilities, aiming to cover all 1,845 wards in the country. Government will maintain and renovate health facilities according to needs based on priority planning. Planned preventive maintenance of buildings and equipment will be strengthened.

Information and Communication Technology (ICT): Government is developing sustainable ICT systems in the domains of data management, processing and reporting, medical decision-making and e-learning for health workers. It has defined regulations for interoperability and harmonisation of systems. The government has developed a national investment plan to guide all partners in ICT development, and will establish a Centre for Digital Health. Government will establish a legal framework for protecting the security of data, privacy, and confidentiality of patients. There will be regulations for the use of personal data for management and research.

Health Research and Development: The ministry will improve the coordination of clinical and public health research conducted in the health sector. The National Institute for Medical Research, on behalf of the MOHCDGEC, will coordinate the national health research agenda and translation of research evidence to inform policy and practice.

Public Private Partnership: Government will continue to engage the private sector to increase access to health care in the country and to protect the rights of specific groups. All private health care facilities are monitored to ensure compliance with existing contracts and guidelines. Government will harmonise the quality management systems of health care between the public and the private sector. There will be one single registration and accreditation system for health facilities, providing certification for healthcare services.

Financial Resources: The government will continue to increase domestic funding in the health sector budget with a view to meeting high priority needs in line with the overall country's priorities. Government will review and update the Health Financing Strategy to be in line with the current situation and priorities. Government will work with stakeholders to expand the scope of health insurance. Government will mobilise citizens to join health insurance schemes to ensure that every citizen has access to health care without financial constraints. The government will provide further regulations regarding the gatekeeper system, reimbursements of claims, with clarification on eligibility, automation, and maximum period for reimbursement, to guarantee continuity of care.

Resource mapping is a first step in harmonisation and alignment, and equitable coverage over the country, of financial contributions from within and outside government. The government will strengthen capacities for and improve timeliness of routine Public Expenditure Reviews, National Health Accounts, supplemented by occasional Public Expenditure Tracking Studies. The government in collaboration with stakeholders will develop a resource mobilisation plan, monitoring and evaluation.

Government will continue to strengthen planning, budgeting, execution, monitoring and evaluation. Partners in the health sector will continue improving the efficiency of use of available resources, for example through strategic purchasing and harmonisation of funds flow. Partners will increasingly align with GOT public financial management systems.

Section 3: Implementation Arrangements

Institutional Framework for Implementation

Decentralised Management: Government will maintain the framework for bottom-up planning, service delivery, financial management, and information delivery at health care facilities. Councils Health Service Boards (CHSB), Hospital Management Boards, and Health Facility Governing Committees oversee the management of health care facilities in accordance with the guidelines.
MOHCDGEC: The Ministry will prepare policies, guidelines, laws, and regulations to enable the implementation of HSSP V. The M&E framework of the strategic plan guides the performance assessment of the health sector and informs measures to be taken for proper implementation.
PO-RALG: is responsible for coordinating, facilitating, and managing the implementation of the strategic plan through local government authorities (LGAs) at council, ward, village and community levels. LGAs are responsible for managing and providing primary health care services.
Governance of Health Facilities: Government will strengthen multi-agency management to build better relationships and transparency, through CHSBs, hospital boards, and health facility management committees.
Governance at Community Level: Harmonisation and alignment of health and development-related community structures will be achieved, with health facility management committees, Village Health Committees, Ward Development Committees and other community-based structures operating in the same domain. The links with LGA will be reinforced.
Urban healthcare: New health zones will be developed, starting in Dar es Salaam, to establish an integrated approach to address specific challenges in healthcare for the urban poor.

Partnership framework

Intersectoral Collaboration: In implementing this strategy, the MOHCDGEC will collaborate with other ministries, institutions, religious organisations, social organisations, the private sector, and development partners. This collaboration will be intensified at decentralised levels during HSSP V.
Public Private Partnership: The PPP dialogue will be reinforced at lower levels, through placement contracts or service level agreements. A single accreditation system in the health sector will create a level playing field for all actors.
International Collaboration Government will collaborate with various countries and international organisations on matters of health that are of global and national interest. Government will coordinate with development partners on health sector plans that focus on national priorities.

Governance framework

Strengthening SWAp: The SWAp dialogue structure will re-affirm the guiding principles of the Development Cooperation Framework of fostering national ownership, alignment to national priorities, use of country systems, and strengthening accountability. MOHCDGEC will align the SWAp Technical Working Group formation to the six health system building blocks, and decentralise SWAp structures to regional and district level. Government will create more transparency in off-budget funding in the health sector, in collaboration with partners.
Strengthening accountability and leadership: MOHCDGEC and PO-RALG will continue developing leadership performance management tools and assessment.
Gender and Equity: The MOHCDGEC will stimulate awareness-raising and competency development among health staff at all levels, to include gender issues in health services and policies, also in pre-graduate training. The health sector will enhance gender equality in decision making bodies.

Alignment of Subsector Health and Disease Specific Strategies

Increasingly, subsector strategies will be aligned to HSSP V by timeframe and strategic direction. The goals and strategic objectives will be linked to HSSP V and implementation arrangements will use SWAp structures. The M&E plans, impact and outcome indicators will be in line with HSSP V.

Costing of HSSP V

The total costs of implementing the HSSP V under the moderate scenario are expected to rise from TZS 8 trillion to TZS 11 trillion over the course of the plan, with a total five-year cost of TZS 47 trillion shillings. This expansion is due to several factors, including the addition of new services, expansion of coverage of existing services, population growth, and the disease burden. However, the moderate scenario does not include all advanced medical and technical options that could be implemented right now. This scenario implies a cost per capita of nearly TZS 133,000 in 2021, rising to TZS 159,000 by 2025 (USD 58 and USD 69 respectively). Approximately 51% of the HSSP V financing requirement is related to health services, and another 49% is related to health system costs. Health service costs are driven by NCDs, infectious disease, and RMNCAH. The financial resource requirements for systems are greatest for HRH and for infrastructure.

Health impact of the plan The HSSP V is anticipated to save more than 200,000 additional lives by expanding services beyond current levels. More than 400,000 DALYs are averted by the additional services offered as part of the HSSP V.

Resources available for HSSP V

Under the baseline scenario, assuming continuation of past trends without additional resource mobilisation, the resources available for health programs would rise from TZS 8 trillion in 2021 to TZS 10.8 trillion by 2025. Under an assumption of increasing UHI coverage, we could anticipate TZS 9.9 trillion for health spending in 2023, increasing to TZS 12.1 trillion by 2025.
The costs for implementing the primary HSSP V scenario are consistent with the expected resource envelope under baseline assumptions. If more resources become available through UHI by 2023, essential interventions could also be scaled up more aggressively.

Monitoring and Evaluation

The M&E plan addresses the strategic priorities of HSSP V, One Plan III, NCD and HRH strategic plans and provides an integrated system and framework for M&E of all health programmes (HSSP V). The M&E plan presents a technical results framework for the selection of indicators and targets and specifies country mechanisms for data collection, analysis, review and remedial action.
With the overall goal of improving health and well-being for all at all ages (SDG3) the overall framework of HSSP V is defined at three levels (outcomes, outputs or process and inputs). Indicators have been selected according to the SMART criteria.
From July 2021 to June 2026, health systems performance and coverage indicators for HSSP V, One Plan III, HRH and NCD plans will be monitored annually at the national level, as was done in the previous plans. The MOHCDGEC has developed a monitoring and evaluation strategic framework (MESF 2019-2024) that specifies the roles of the different data sources. This includes the key data sources including routine health management information system (clinical and administrative), surveillance, civil registration and vital statistics, and population-based surveys. In addition, the MESF 2019-2024 specifies the approaches and resources for information systems integration and ICT infrastructure in support of the M&E system.
Results from annual and mid-term reviews are incorporated into decision-making, including resource allocation and financial disbursement to programmes and subnational levels, through the mechanisms used by government and funding partners.

Section One: Introduction and Background

1 Chapter 1: Introduction

1.1 The formulation process of HSSP V

The formulation of HSSP V is part of a long tradition of formulating health sector strategic plans (HSSPs) which started in 1999 with the development of the three-year Programme of Work 1999-2001. However, the origins can be traced back further to 1993 when Proposals for Health Sector Reforms were developed in response to findings of a review that showed that health outcome and impact indicators including life expectancy, infant and child health, maternal health and other health indicators had remained poor despite the efforts of the Government to implement the National Health Policy (NHP) since the post-independence era. Implementation of the Health Sector Reforms (HSR) led to the development of the health sector Programme of Work (POW) 1999-2001 and Plan of Action 1999/2000 (POA) as a precursor of the health sector strategic plans that would follow in subsequent years. The HSR also informed the review of the NHP 1990 that was completed in 2007, moving from "free" health policy to introduction of cost-sharing and pre-paid health schemes. Also, with the development of the POW 1999 -2001, development partners (DPs) supporting the health sector agreed to join the Government of Tanzania (GOT) to adopt a Sector-Wide Approach to planning (SWAp) in the health sector. This involved aligning their financial and technical support to the government priorities outlined in the POW. Some of the partners went further to establish a pooled funding mechanism known as the Health Basket Fund (HBF) to channel their financial support to the sector. The HBF partners have continued to use this modality to support the health sector throughout the subsequent strategic plans. In subsequent years, the POW was replaced by the five-year health sector strategic plans (HSSP) including HSSP II (2003 – 2008), HSSP III (2009 – 2015) and the just ended HSSP IV (2015-2020). The health sector strategic plans are guided by the Tanzania Development Vision 2025 (TDV2025) as well as the UN global development targets including the Millennium Development Goals 2015 and Sustainable Development Goals 2030 (SDGs).

The methodology of formulation of these plans has always been participatory, linked to the SWAp. Technical Working Groups (TWG) have always had a strong input into the formulation. The Decentralisation by Devolution process in Tanzania has brought the President's Office – Regional Administration and Local Government (PO-RALG) on board as an important contributor to the planning process.

Over the past 22 years, the process has matured. The first two HSSPs did not have a budget or resource envelope incorporated. With these elements included the MOHCDGEC was much better equipped to mobilise funds for improvement of service delivery. Also, monitoring and evaluation (M&E) has developed strongly, with a comprehensive set of indicators and targets, which allow for rigorous assessment of performance of the health sector.

In the beginning of SWAp annual external evaluations were common, with strong inputs from Development Partners. Starting with HSSP III, these were replaced by Mid-Term Reviews, with increasing contributions from consultants, universities and research institutions in Tanzania.

Throughout the formulation of all HSSPs, the Health Sector Resource Secretariat in the MOHCDGEC Department of Policy and Planning has played a pivotal role in the process, ensuring that the HSSPs were central in the planning of disease control programmes, plans for World Bank, Global Fund, or other Development Partners.

The formulation of this fifth Health Sector Strategic Plan (HSSP V) was a participatory process guided by MOHCDGEC. The closing conference of the Mid-Term Review of the HSSP IV in October 2019 formulated recommendations, while the Joint Annual Health Sector Policy Meeting in November 2019 formulated priorities for HSSP V. The NHP 2007, the Draft Health Policy 2020 and Policy Implementation Strategy 2020 - 2030 provided the reference for planning the HSSP V.

The formulation took place in three phases: a brainstorming phase; a formulation phase (including budgeting and the development of a Monitoring & Evaluation framework), and a validation phase. In the second and third phases, taskforces around thematic areas discussed the drafts, provided inputs to the plan, and advised on the implementation modalities. In the third phase verification of priorities against government policies, harmonisation of strategic plans and alignment of resource envelopes and M&E strategies took place.

The formulation of HSSP V took place simultaneously with the formulation of One Plan III (the strategic plan for delivering services for reproductive, maternal, neonatal, child and adolescent health), the Strategic Plan for prevention and control of Non-Communicable Diseases (NCDs), and the Human Resources for Health (HRH) Strategic Plan, all for the period July 2021 – June 2026. One Plan III is a continuation of One Plan II, which expired in June 2020. The NCD plan replaces the NCD Action Plan 2013 – 2020. The HRH plan follows up on the HRH strategy 2014 – 2019.

The MOHCDGEC has many other strategic plans in operations and most of these need to be updated to be in line with the guidance and aspirations expressed in this strategic plan. During the process of formulation of HSSP V, all these strategic plans have been identified and mapped according to the following criteria:

1. Timeframe of strategic plan in relation to HSSP IV/HSSP V
2. Linkage of goals and strategic objectives to HSSP IV/HSSP V
3. Alignment of subsector strategies with national and international planning guidance documents (Tanzania Development Vision 2025, NHP, SDG, Universal Health Coverage, WHO Global Health Strategy etc)
4. Implementation arrangements taking into consideration the SWAp structures
5. Financing or costing of strategic plan included in costing of HSSP IV/HSSP V
6. Governance structures
7. M&E plan, impact and outcome indicators in line with HSSP IV/HSSP V

1.2 Health in Tanzania's national development agenda

1.2.1 Tanzania Development Vision 2025

Tanzania Development Vision 2025 (Vision 2025) is a document providing direction and a philosophy for long-term development. By 2025, Tanzania wants to achieve a high quality of livelihood for its citizens, peace, stability and unity, good governance, a well-educated and learned society and a competitive economy capable of producing sustainable growth and shared benefits by 2025.

The Vision 2025 document identifies health as one of the priority sectors contributing to a higher-quality livelihood for all Tanzanians. This will be attained through strategies, which will ensure realisation of the following health service goals:

- Access to quality primary health care for all;
- Access to quality reproductive health services for all individuals of appropriate ages;
- Reduction in infant and maternal mortality rates by three-quarters of levels in 1998;

- Universal access to clean and safe water and sanitation;
- Life expectancy comparable to the level attained by typical middle-income countries;
- Food self-sufficiency and food security; and
- Gender equality and empowerment of women in all health parameters.

1.2.2 Third Five Years' Development Plan 2021/22-2025/26 (FYDP III)

The third Five Years' Development Plan 2021/22 – 2025/26 (FYDP III) sets as one of the targets to improve quality of life and human wellbeing.

During implementation of FYDP II, emphasis was on strengthening the health service delivery system with service delivery geared towards improving the health of mothers and children; addressing commonly prevalent illnesses such as malaria, HIV/AIDS and NCDs which are major causes of deaths as well as addressing the human resource crisis which constrains provision of adequate health care.

The overall priorities in health of the FYDP III are arranged into four broad outcomes:

- ***Outcome 1****. To transform Tanzania into a manufacturing hub of East Africa*
- ***Outcome 2:*** *To improve competitiveness (business environment, markets, human capital, innovation), i.e., focus on improving the competitiveness in all*
- ***Outcome 3****: To facilitate export-oriented growth (regional, global trade and global value chain), including focusing on new markets*
- ***Outcome 4.*** *To promote Human Development (education, life expectancy, per capita income)*

The health sector priorities in each of the four broad outcomes of FYDP III are the following:

I. Improvement in curative services through availability of medicines, medical equipment, reagents and other health commodities, and the treatment of communicable and non-communicable diseases such as cancer, heart disease, and diabetes for Tanzanian citizens.
II. Improvement in preventive services through sensitisation of communities on communicable diseases (CD) such as tuberculosis (TB), malaria, HIV/AIDS, viral hepatitis, neglected tropical diseases (NTDs), COVID-19, as well as NCDs, and the strengthening of prevention programmes. The improvement of maternal health services will contribute to prevention of mortality and morbidity.
III. Improvement in the collection of funds for health commodities through health insurance schemes.
IV. Improvement in the engagement of private sector, non-governmental organisations (NGOs) and DPs in improving access to health care in the country. Create an enabling environment for the private sector investment in the sector, in industrial medicine, production of medicine equipment, health commodities, etc.
V. Improving emergency and disaster responses to reduce risk or death related to emergencies/ disasters.
VI. Strengthening Information and Communication Technologies (ICT) usage to improve health and support services including telemedicine and financial management.
VII. Improvement of research and development in health services to establish and strengthen research mechanisms on domestic pharmaceutical manufacturing that meet international standards for domestic and export use.
VIII. Increased availability of health professionals by increasing enrolment and through the renovation, expansion and improvement of health training institutions (HTI).
IX. Strengthening the availability of safe blood and other blood products by establishing an effective and sustainable system for the collection, care and distribution of safe blood in the country and completing construction of regional satellite blood banks in five regions (Kigoma, Mara, Mwanza, Simiyu, and Geita).

X. Strengthening of referral system (amongst other measures involving non-governmental providers) by health services delivery in 28 regional referral hospitals, 125 in District Councils and dispensaries and health centres, as well as construction of zonal hospitals in 7 zones and other zones which have no zonal referral hospitals.

XI. Strengthening specialised and super-specialised services to meet international standards and creating an enabling environment for super-specialists from abroad to work in our country in order to transfer knowledge to our local experts; and

XII. Strengthening traditional and alternative medicine by conducting comprehensive research on traditional medicine to generate enough evidence from traditional health practitioners about their indigenous ways of managing diseases.;

1.3 National Health Policy and Policy Implementation Strategy

1.3.1 National Health Policy (NHP) 2007

Vision of the health policy

To have a healthy and prosperous society that contributes fully to the development of individuals, communities and the nation.

Mission of the health policy

Providing essential health services with geographical equity, acceptable quality standards that are affordable and sustainable.

Main objective of the health policy

Improve health and health status of all Tanzanians with a focus on those most at risk by establishing a health service delivery system that meets the needs of citizens and increase the life expectancy and quality of life of citizens.

Specific objectives

1. Reduce morbidity and mortality in order to increase the lifespan of all Tanzanians by providing quality health care.
2. Ensure that basic health services are available and accessible to all.
3. Prevent and control communicable and non- communicable diseases.
4. Sensitise the citizens about preventable diseases.
5. Create awareness to citizens on responsibility for caring for their own health, that of their families and society at large.
6. Improve partnership between public sector, private sector, religious institutions, civil society and community in provision of health services.
7. Plan, train, and increase the number of competent health staff.
8. Identify and maintain the infrastructure and medical equipment; and
9. Review and evaluate health policy, guidelines, laws and standards for provision of health services.

1.3.2 Draft National Health Policy 2020

The Government is in the process of reviewing and updating the NHP 2007. The drafts of the National Health Policy 2020 and Policy Implementation Strategy 2020-2030 are at an advanced stage.

Vision of the health policy
To have a healthy and prosperous society that contributes fully to the development of individuals, their communities and the nation.

Mission of the health policy
Providing sustainable health services of acceptable quality standards for all citizens without financial constraints, based on geographical and gender equity.

Main objective of the health policy
Increase the life expectancy and quality of life of citizens by reducing deaths, disease and disabilities, especially among those most at risk, by establishing a health care system that meets the needs of all citizens.

Specific objectives
1. Decrease morbidity and mortality by improving quality health care that addresses the needs of special groups, especially pregnant women, neonates, infants and children under five years of age and ensure survival, thriving, and flourishing of women, children, and adolescents.
2. Decrease the incidence of communicable and non-communicable diseases, especially those caused by poor hygiene and environmental health, nutrition, environmental degradation, climate change, environmental and chemical disasters.
3. Guarantee the availability of essential primary health care services with acceptable quality standards throughout the country with respect to geographical, population and disease prevalence.
4. Increase access to national and international professional services that use the latest technology to reach more citizens, using a national and international referral system.
5. Have an effective system of funding for health care that will ensure that every citizen has access to health care without incurring catastrophic expenditure or failing to meet other essential needs.
6. Have a society that understands various health issues and is responsible for caring for their own health, that of their families, elderly and society at large.
7. Increase efficiency in the delivery, management and monitoring of health care utilising ICT.
8. Have effective health care by ensuring the availability of adequate health professionals, financial resources, infrastructure, medicines, equipment and medical supplies that meet the requirements of primary health care, referral and specialty health care according to the needs of the level.
9. Enable the availability of safe and sustainable alternative treatments offered in conjunction with formal health care.
10. Improve cooperation with the private health sector and the various sectors in health care delivery.
11. Reinforce the referral system from community to national level.

1.3.3 Draft Health Policy Implementation Strategy 2020 - 2030

The Health Policy Implementation Strategy (HPIS) elaborates all elements of the policy, and is fully integrated into this strategic plan. The HPIS has 34 goals that include measures to achieve the ultimate goal. The objectives are organised into nine areas including: preventive services (5), medical services (8), quality of care (1), training (1) regulatory and research services (2), human resources for health care delivery (4), the private sector (1), international cooperation (1), funding for health care and cross-border issues (5). HPIS contains a total of 97 statements describing the Policy's commitment to

various areas of health care delivery. The implementation strategies are clearly defined for each purpose and indicate the targets, timeframes and resources required.

1.4 Tanzania's legal framework guiding the health sector

The MOHCDGEC is mandated to prepare for Government health and social welfare legislation and policies, as well as oversee their implementation through sector-wide monitoring and evaluation. The Ministry and its departments and agencies develop health policy and policy guidelines, strategies, work plans, guidelines and other documents elaborating the policy documents and legislation and referral service delivery at regional, zonal, and national levels. PO-RALG translates policies and strategies and oversees implementation of social and primary health services, delivered by Local Government Authorities (LGAs). The MOHCDGEC sees to it that all Tanzanians access quality health and social welfare services.

The existing health and social welfare sector legislation is mainly divided into public health, practice and establishment of professional councils, health care financing, protection and rights of vulnerable groups, and establishment of government institutions as presented below:

i. Public Health legislation which is for the control of epidemics, infectious diseases and environmental health protection.

Table 1 Public health legislation

Public Health Legislation	Summary
Public Health Act, No 21, 2009	An Act to provide for the promotion, preservation and maintenance of public health with a view to ensuring the provisions of comprehensive, functional and sustainable public health services to the general public and to provide for other related matters.
The Public Health Sewerage and Drainage Act, Cap 336	An Act to make better provision for the preservation of public health by means of sewerage, drainage and sanitation.
The Accident and Occupational Diseases (Notification) Act, Cap 330	An Act to provide for the notification of accidents and occupational diseases
The Tsetse Fly (Control) Act, Cap 100	An Act to provide for regulating traffic to and from areas infested with tsetse flies

ii. Health professional legislation which governs the practice and conduct of health professions and professionals such as doctors, dental practitioners, pharmacists, nurses, and allied health personnel.

Table 2 Health professional legislation

Health Professional Legislation	Summary
The Medical, Dental and Allied Health Professionals Act, 2017	An Act provides for the regulation of medical, dental and allied health professionals and for establishment of Medical Council of Tanganyika and other related matters.
The Nursing and Midwifery Act, 2010	An Act makes provision for protection, promotion and preservation of the public health, safety, and welfare through regulation and control of nursing and midwifery education and practice.
The Chemist Professionals Act, 2016	An Act provides for establishment of Chemist Council and provide the powers for management and regulation of professional chemists.

Health Professional Legislation	Summary
The Optometry Act, NO 12, 2007	An Act to make provisions for promotion, control and regulation of optometry practice, to establish the Optometry Practice Council and to provide for related matters.
The Traditional and Alternative Medicine Act, Cap 244	An Act to make provisions for promotion, control and regulation of traditional and alternative medicines practice, to establish the Traditional and Alternative Health Practice Council and to provide for related matters.
The Medical Radiology and Imaging Professionals Act NO 21, 2017	An Act to establish the Medical Radiology and Imaging Professionals' Council and to provide for its functions and management; to provide for regulation and control of medical radiology and imaging professionals and for related matters.
The Environment Health Practitioners (Registration) Act NO 21, 2017	An Act to establish the Environment Health Council and to provide practice of environment health professionals and for related matters.
The Health Laboratory Practitioners Act, No 22, 2007	Regulation and registration of health laboratory practitioners
The Pharmacy Act, 2011	An Act to establish the Pharmacy Council and to provide for the functions, management of the Council; to provide for regulation and control of the pharmacy profession and practice and to provide for other related matters.

iii. Health financing legislation, which seeks to provide a health financing mechanism with the aim of furthering government efforts to finance health services in the country towards universal health coverage.

Table 3 Health financing legislation

Health financing	
National Health Insurance Fund Act, CAP 395 Revised Edition 2015	This Edition of the National Health Insurance Fund Act, Chapter 395, incorporates all amendments made up to and including 31st December 2015 and is printed under the authority of section 4 of the Laws Revised Act, Chapter 4.
The Community Health Fund Act, Cap 409	An Act to provide for the mechanism of establishment of Community Health Fund and to provide for the constitution of the management organs, and the administration of the Fund and other related matters.

iv. Legislation, which guarantees the rights and social protection of vulnerable groups who are unable to pay for health services like pregnant women, persons with disabilities, children, the elderly, destitute, etc. which the Minister responsible for social welfare is empowered to make Regulations for the better implementation of the law.

Table 4 Rights and social protection legislation

Rights and social protection of vulnerable groups	
The Industrial Consumer Chemicals (Management and Control), Act, Cap 182	An Act to provide for the management and control of the production, importation, transportation, exportation, storage, dealing, and disposal of chemicals and for matters connected therewith.
The Tobacco Products (Regulation) Act, Cap 121	An Act to regulate the manufacture, labelling, distribution sale, use, promotion of tobacco products, smoking in specified areas and matters connected thereto.
The Tanzania Medicines & Medical Devices Act, 2019	An Act to provide for the efficient and comprehensive regulation and control of medicines, medical devices, herbal drugs and diagnostics

v. Legislation, which establishes autonomous health and social welfare institutions for a particular need, such as National Institute for Medical Research (NIMR), national and special hospitals, Institute of Social Work, etc.;

Table 5 Legislation concerning institutions

The Government Chemist Laboratory Authority Act, 2016
National Institute for Medical Research Act 23, Cap 59, 1979
The Muhimbili National Hospital Act, Cap 150
The Muhimbili Orthopaedic Institute Act, Cap 97
The Tanzania Food and Nutrition Centre, Act, Cap 109
The Jakaya Kikwete Cardiac Institute (Establishment Instrument) GN.454 of 2015
Benjamin Mkapa Hospital (Establishment) GN 453 of 2015
The Tanzania Commission of AIDS Act, Cap 379
The Medical Store Department Act, Cap 70
The Ocean Road Cancer Institute Act, Cap 86

These laws and its regulations need to be effectively implemented in order to accomplish the intended objectives of their enactment. Furthermore, due to a number of socio- economic changes, policy and political changes, enactment and review of the existing health and social welfare legislations is an on-going undertaking.

1.5 Sustainable Development Goals (SDGs): Global and regional health focus

SDGs

The United Republic of Tanzania embraces the achievement of high quality and sustainable human development for her citizens. This is engraved in the country's Constitution and in her long-term development visions. There is a strong nation-wide partnership and commitment to implementation, monitoring, tracking and reporting SDGs, backed by a strong political will, collective ownership, integrated planning, and supportive legal frameworks. A "whole-of-society" approach has been adopted, and a robust national SDG coordination and monitoring framework is being developed, supported by national statistical offices.

According to the voluntary national review of SDGs in Tanzania in 2019, the country is doing reasonably well in achieving goals 2, 3, 4, 5, 6, 8, 10, 16. Goals 7, 9, 11, 12 are likely to be achieved with stepped-up efforts. Goals 1, 13, 14, 15 17 will need significant local efforts and international support to achieve.

The main challenges in implementing the SDGs revolve around data constraints for some indicators and insufficient technical and financial resources to tackle all hurdles that inhibit the implementation of SDGs. Solving these challenges entails: forging new partnerships for mobilising innovative sources of financing; capacity building in resource mobilisation and data management; strengthening national statistical capacity; and support for building appropriate technological capability (diffusion of new technologies, linking generators and users of innovations, and providing technology-based equipment for reporting on the environment). The solutions proposed are also tackled in this strategic plan.

Agenda 2063: The Africa We Want (African Union)

Agenda 2063 is Africa's blueprint and master plan for transforming the continent into the global powerhouse of the future. It is the continent's strategic framework that aims to deliver on its goal for inclusive and sustainable development and is a concrete manifestation of the pan-African drive for unity, self-determination, freedom, progress and collective prosperity pursued under Pan-Africanism and African Renaissance.

Improvements in health and wellbeing belong to the transformational outcomes:

- Incidence of hunger, especially amongst women and youth will only be 20% of 2013 levels.
- Malnutrition, maternal, child and neo-natal deaths as of 2013 would be reduced by half;
- Access to anti-retroviral medicines will be automatic and proportion of deaths attributable to HIV/AIDS and malaria would have been halved.
- Nine out of ten persons will have access to safe drinking water and sanitation; electricity supply and internet connectivity will be up by 50% and cities will be recycling at least 50% of the waste they generate.

East African Community (EAC)

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

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

Southern African Development Community (SADC)

Protocol on Health: Acknowledging that a healthy population is a prerequisite for sustainable human development and increased productivity, the SADC Protocol on Health promotes cooperation among Member States on key health issues. It recognises that this cooperation is essential for the control of communicable and non-communicable diseases and for addressing common health concerns, including emergency health services, disaster management, and bulk purchasing of essential medicines.

Regional Indicative Strategic Development Plan: integrates health as a priority within the context of Social and Human Development, Poverty and Food Security. In particular, the current HIV and AIDS pandemic is woven into the entire plan as an issue that influences most factors of development in the region. For this reason, HIV and AIDS is also addressed as a stand-alone cross-cutting Issue.

High morbidity and mortality rates, low nutrition status, poor health care infrastructure and services, poor living conditions present major challenges to development in Southern Africa. Increasing rates of communicable and non-communicable diseases are compounding the problem. In addition, an inadequate understanding of the gender dimension and inadequate resources for improving health present further challenges.

Pharmaceuticals: SADC is committed to improving sustainable availability and access to affordable, quality, safe, efficacious essential medicines, including African traditional medicines.

2 Chapter 2: Situation Analysis

2.1 Health Status of the Population in Tanzania

Evidence from the Evaluation of the National Health Policy 2007 Implementation, Mid-Term Review of Health Sector Strategic Plan 2015 - 2020 (HSSP IV) and the Annual Health Sector Performance Profile Report July 2020 shows that, during the last decade, Tanzania made major progress in the health sector leading to a continued increase in life expectancy for Tanzanians at birth as a result of reduced mortality and morbidity. The national census in 2012 determined that the life expectancy had increased from 51 years in 2002 to 62 years by 2012 which is projected to have increased to 65.5 years by 2019 (NBS - Tanzania in Figures 2019). In particular, this increase was contributed by the success in reducing newborn and child mortality, childhood malnutrition and in the battle against major communicable diseases including HIV, TB and malaria. Under-five child mortality has decreased from 81 per 1000 live births in 2015 to 67 per 1000 live births in 2019 while during the same period, infant mortality rate and neonatal mortality rate have only slightly decreased from 45 and 26 to 25 and 43 per 1000 live births respectively.

However, there is some evidence of the increasing burden of non-communicable diseases (NCDs), an inevitable trend as the battle against infectious diseases is successful and risk factors for NCDs are on the rise. Regarding equity, there are persistent inequalities between urban and rural populations, the poorest and richest households, and between regions, for almost all indicators.
During the period 2015–2018 many positive developments were seen in terms of expanding programme coverage for family planning with modern methods, antenatal, delivery and postnatal care, prevention of mother to child transmission (PMTCT) and HIV treatment. The improvements occurred in almost all regions and were particularly strong in certain regions of focus, which received additional funding for improving performance. The quality of care appears to have improved considerably, according to the star rating assessment in all regions.

The above-mentioned progress is partly attributed to improvement in availability, access and quality of health service delivery at all levels. The number of health facilities has increased from 5,253 in 2007 to 8,446 in 2019, of which the major increase was in the number of primary health care facilities (dispensaries, health centres and district hospitals) constructed by the public and private sectors. In addition, the increase in availability of specialized and super-specialised services in the country has reduced the number of patients referred abroad for treatment from 347 in 2008 to 45 in 2019.

Despite the significant progress in the health sector, many of the HSSP IV targets have not been met. Neonatal and child mortality rates have not declined enough to stay on course to achieve the SDG targets. Children in urban areas, in particular, need greater attention. Adolescent childbearing remains persistently high and a source of concern, even though maternal and newborn health care coverage is the same for adolescent and older mothers. Fertility and unmet need for family planning are still high despite positive trends. Several indicators suggest that maternal and newborn care in health facilities can be improved greatly, and in general the quality of care should continue to be a priority. The coverage of malaria and TB interventions needs to increase to make a greater impact on disease control. Access to improved drinking water sources and sanitary facilities has improved, but is still far from targets, especially in the rural population.

Population growth, Urbanisation and Health Outcomes

Tanzania has made significant strides in improving the health of its population, which has resulted in an increase in average life expectancy. However, these improvements have been seen disproportionately in rural areas, where life expectancy has increased by 13 years, compared with a three-year increase in urban areas. For example, urban populations in Tanzania have higher under-5 mortality and maternal mortality than rural areas, and studies indicate that urban populations are at an increased risk for specific health risks including cholera, diabetes and road traffic accidents.

Tanzania's urban population increased from 6 per cent of the total population in 1967 to 30 per cent in 2012. This growth has mostly been seen in the largest cities with Dar es Salaam having been quoted as being the fastest-growing urban area in Sub-Saharan Africa, on track to become a 'megacity' inhabited by more than 10 million residents by 2025. The consequences of this high population growth combined with lack of education and job opportunities in rural areas lead disadvantaged youths to urban drift. A significant proportion of the migrant populations from rural to urban areas are youths.

Despite the fact that urban residents have greater access to health services in terms of distance to a health facility and the number of essential health prevention measures available compared to rural residents (the so-called "urban advantage"), higher health service coverage in cities has not been translated into improved health outcomes in a number of areas including nutritional status of Women in the Reproductive Age (WRA), use of Family Planning (FP), anaemia in WRA and low birth weight. HIV/AIDS is also significantly higher for urban females. More than other groups, adolescent girls epitomize the apparent HIV and AIDS urban paradox. Throughout sub-Saharan Africa, HIV and AIDS has hit women and young people hardest. Adolescent girls are especially vulnerable. A risky urban environment interplays with gender and age to compound the adolescent girls' vulnerability.

Health of urban poor in Dar es Salaam

As discussed before, the city is unique because of population density, larger and faster-growing population, a greater proportion of young people, greater concentration of wealthy but also greater inequalities, higher levels of unemployment, a unique governance structure, and closer to a number of services. Dar es Salaam is home to about five million people, with a population growth in Dar es Salaam of 7 percent, more than twice the national growth rate of three percent. The city is younger; 66 percent of the city population is aged between 15 and 64 years as compared to 52 percent national average with highest WRA 62% against 51% national average. Consequently, Dar es Salaam has less (31%) of the population between 0 and 14 years compared to 44 percent of Tanzania Mainland. Dar es Salaam is a city of migrant community from upcountry. This number of inhabitants' growth is barely controlled by the authorities. Population concentration is within the Central Business Centre.

Although it is considered that there are no slums in Tanzania, Dar es Salaam has areas in Kigogo, Buguruni, along Msimbazi Valley, Tandale, Manzese, Mbagala, Vingunguti, and Temeke that are very densely populated, and effectively share the characteristics of slums. Evidence from similar scenarios by Ifakara Health Institute (IHI) and the Institute of Health Equity (2016), the work of Calas et al (2006) and the 2015 NBS analysis of Census 2012 data showed a need to re-look on urban and densely populated areas. Specifically, several studies including the midterm review of the Health Sector Strategic Plan IV revealed poor health outcomes in urban areas particularly Dar es Salaam.

Table 6 Selected indicators for the urban poor in Tanzania

Themes	Indicator	Urban	Rural	Slums –Tanzania
General population	Life expectancy (years)	60	62	44-46
	HIV/AIDS (%)	7.2	4.3	-
	Unimproved latrines (%)	21	73	83
	No latrines (%)	2	13	14
Child health and nutrition	U5 mortality/1000 live birth	71.2	65.9	97
	Low birth weight (%)	9.1	5.8	-
	Low birth weight (%)	9.1	5.8	-
	Stunting (%)	24.7	37.8	46-56
	Diarrhoea (%)	14.1	11	60
	Prelacteal feeds (%)	12	14.5	91
Maternal health	Maternal mortality (rate)	432	336	-
	Overweight (%)	42	21	-

Source: TDHS, IHI, and other studies

Health Facility Distribution in Dar es Salaam

Out of 572 health facilities located in Dar es Salaam, 42 are hospitals, 48 health centres, and 423 dispensaries. The 2014-2015 Service Provision Assessment showed the rapidly increasing population is placing pressure on social services including reproductive, maternal, newborn, child and adolescent health services (RMNCAH). For example, in contrast to the national proportion of almost 70 percent public facilities ownership against 30 percent non-public, in Dar es Salaam 111 of the 572 health facilities (19%) were recorded as government leaving more than 80 percent as private. These statistics imply that although health facilities are relatively easily accessible geographically in Dar es Salaam, the city health system is largely private-oriented thus making financial access to health care difficult among poor households.

Although urban dwellers have easy access to health care services, not all health outcomes are better in urban areas and for all urban inhabitants. City life seems to be 'healthy' for high-income groups. The poorest are not equally consuming health services in urban settings. In addition, because of increased population pressure mismatch with the health system development, there is evidence of poor performance of key health indicators. For example, although Dar es Salaam is considered to have more educated and better-off communities and a closer network of health facilities; the region does not appear to be the leading one in term of RMNCAH services. The poor performance may be attributed to the size of population served against allocated health services delivery management system.

2.2 Status of Progress in Health Service Delivery and Utilisation

Reproductive, Maternal, Newborn, Child and Adolescent Health services

The provision of RMNCAH services has continued to be a priority in the past decade. Health facilities providing RMNCAH services have increased from 3,369 in 2007 to 7,268 in 2019. The majority (82.7%) of all health facilities in 2019 were providing childbirth services for pregnant women. The number of pregnant women delivering with skilled birth attendance has increased from 51% in 2015 to 79% in 2019. The number of health facilities providing comprehensive emergency obstetric and newborn care (CEmONC) services has increased, but still only around 22% of health centres provide the full package.

Fertility in Tanzania has declined from 5.2 to 4.9 children per woman according to TMIS 2017, surpassing the target of 5.0 for 2020. Modern contraceptive use continued to increase during HSSP IV,

as measured by couple years of protection, even though there is still considerable unmet need. Implants became the most popular method, overtaking hormonal injections (Depo Provera).

During 2015–2018 there were major increases in the coverage of antenatal, delivery and postnatal care: The proportion of women attending 4 or more antenatal visits increased from 37% to 61%, institutional delivery care from 65% to 77% and postnatal visits within 2 days after delivery from 42% to 66%. The 2018 DHIS2 data showed improvements in coverage of anaemia testing (61% of pregnant women), syphilis testing (61%), coverage of intermittent preventive treatment (IPT) of malaria in pregnancy (IPT2) (80%), deworming with mebendazole (88%), HIV testing (99%) and C-section rates. DHIS2 data also indicate declines in stillbirth rates, including fresh or intra-partum stillbirth rates (from 6.4 to 5.0 per 1000 health facility births), and low birthweight rates (from 5.5% to 5.0% among health facility live births) in the period 2015 – 2018. However, several other indicators suggest that the quality of care did not improve across the board. These include treatment for syphilis and neonatal care (kangaroo mother care, neonatal resuscitation).

The adolescent birth rate remains high and is not declining. Youth friendly services are integrated in 63% of existing reproductive and child health platforms across the country. Major gaps affecting delivery of adolescent health include inadequate infrastructure for adolescent reproductive health services, inadequate integration of adolescent interventions into Comprehensive Council Health Plans (CCHPs), and sociocultural taboos hindering efforts to reduce teenage pregnancy.

Immunisation coverage levels among infants remained high with 9 out of 10 children receiving the recommended vaccines. Three-quarters of the regions had an increase in Penta-3 coverage during HSSP IV, but there were still 8 regions with Penta-3 coverage below 85%. Five regions accounted for 50% of all infants not receiving Penta-3.

Control of communicable diseases

HIV/AIDS: The Government adopted and committed to fast-track the UNAIDS 90-90-90 targets by 2020 which was later upgraded to 95-95-95 by 2023 to end the epidemic by 2030. In order to achieve these targets, the Government has developed the Health Sector HIV and AIDS Strategic Plan 2017/2022 (HSHSP-IV) to provide guidance on strategic priorities in HIV and AIDS prevention, care, treatment and support services and to accelerate achievement of selected SDGs. On average Tanzanian has made good progress in attaining three 90s indicators especially the last two 90s. However, there are regional variations with only Mbeya and Kagera regions having achieved the set targets before year 2020. On the other hand, with an estimated 1,600,000 people living with HIV in 2019, new HIV infections have decreased from 65,000 in year 2017 to 53,000 in year 2019 (NMSF) and AIDS-related deaths have decreased from 30,000 annually in 2017 to 24,000 annually (NMSF). By December 2019, a total of 1.28 million (79%) knew their HIV status and had been enrolled in anti-retroviral therapy (ART) care and treatment services. Among them 1.27 (99%) million were already on ART while 91% had attained viral suppression. Elimination of mother to child transmission of HIV is on track with PMTCT service coverage having increased from 93% of primary health care (PHC) facilities in 2010 to 97% in 2019 and provision of antiretrovirals (ARV) for PMTCT among pregnant women increasing from 59% in 2010 to 98% in 2019. However, more efforts are needed to reach the 2025 target of below 2% for mother to child transmission of HIV in exposed infants, despite a reduction from 26% in 2010 to 9.4% in 2019 (Mid-Term Review of HSHSP IV).

Tuberculosis and Leprosy Control: The government is in the final year of implementing its fifth TB and leprosy Strategic Plan (2015 -2020) with goals to reduce the TB incidence rate by 20% and the number of TB deaths by 35% by 2020. In this reporting period, TB treatment coverage (previously known as case detection rate) increased from 36% in 2014 to 59% in 2019. The 2019 treatment coverage is 82%,

slightly above the national 2020 target. The TB treatment success rate has reached 92% for cases notified in 2018, which is within the 2020 target. The treatment coverage in 2018 was 53% and far from the 2020 target of 72%. The improvement of treatment coverage has been a result of increased notification and declining TB incidence. There was a significant increase of TB case notification rates from 128 per 100,000 population in 2015 to 144 per 100,000 population in 2019. The increase is due largely to interventions implemented during this period, which included quality improvement in TB management in health facilities, community sensitization, and referral of presumptive TB cases and TB specimen transportation to the nearest TB diagnostic facility. The percentage of people with TB who were tested for HIV was 88% in 2015 and increased to 99% in 2019. The proportion of HIV positive TB cases among the notified declined from 36% in 2015 to 24% in 2019. The detection and enrolment into treatment for RR/multi-drug resistant TB have improved significantly from 123 to 518 patients in 2019.

Malaria: The government is implementing a 5-year National Malaria Strategic Plan (MSP) 2021 – 2025. The aim is to reduce transmission by vector control, improve diagnosis and treatment, and enhance surveillance. This plan stratifies malaria interventions in line with transmission burden to strategically adjust available investments for achieving reduction of the burden in high transmission settings and to advance towards malaria elimination in very low transmission areas. The performance of population-based indicators included in the HSSP IV is still low despite great efforts made by the government to ensure availability of Long-Lasting Insecticide Treated Nets and Sulphadoxine-Pyrimethamine in the health facilities for prevention of malaria among pregnant women. The introduction of the malaria dashboard within DHIS2 and roll-out of Malaria Service and Data Quality Improvement package has increased performance of the indicators. In addition, community awareness raising through social behaviour change and advocacy has been performed to increase use of these interventions. Despite the decrease of malaria incidence in the country, the climatic conditions remain favourable for transmission throughout the year. Almost 96 percent of the country is a high transmission risk area with reported malaria incidence at more than one per 1000 population, whereby only 4 percent is a low transmission risk with reported malaria incidence of less than one per 1000 population.

Notifiable diseases: Integrated Disease Surveillance and Response (IDSR) emphasized early detection, reporting and timely response to all events. The IDRS programme at all levels was critical for proper data collection that monitored the trend of diseases and enhanced timely response of epidemic prone diseases. The IDRS was implemented as part of compliance with the International Health Regulations (IHR)

There are a total of 15 notifiable diseases and events that are closely followed up by IDSR in Tanzania, the performance of which is measured by two key attributes, e.g., timeliness and completeness. In 2014, Tanzania started using mobile technology, known as electronic IDSR to enhance early reporting of diseases and events. This system is linked to DHIS2, improving reporting and sharing information among stakeholders. In 2019, a total of 424 cases of cholera were reported in 16 regions. This was a sharp reduction (90.9%) of cholera cases reported when compared with cases reported previous year (4,708). Most reported cases were from Tanga, Dar es Salaam, Arusha, Kigoma, Manyara and Songwe regions. A total of 6,817 confirmed cases of Dengue Fever were reported in 2019 from 12 regions in the country, an increase of 98.1% when compared to the previous year when 128 cases were reported. Regions with the most reported cases were Dar es Salaam, Tanga, Pwani and Morogoro.

Neglected tropical diseases (NTD): Tanzania is endemic with five Preventive Chemotherapy Neglected Tropical Diseases namely lymphatic filariasis, onchocerciasis, trachoma, schistosomiasis (SCH) and

soil-transmitted helminths (STH). Preventive chemotherapy against NTDs through mass drug administration (MDA) reached a geographical coverage of 100% countrywide from 2016. MDA is provided in all endemic district councils. Lymphatic filariasis, onchocerciasis and trachoma are targeted for elimination, i.e. efforts are aimed at reaching the criteria to stop MDA implementation across all endemic councils. All targets for preventive chemotherapy treatment were met in 2018 while in 2019 only two targets (for onchocerciasis and trachoma) were met. The reason for not meeting these targets was lack of funding to support some of the mass drug administration activities.

Control of non-communicable diseases

Non-communicable diseases (NCD) such as cardiovascular diseases, diabetes, cancer, chronic respiratory diseases, injuries and mental health now contribute about a third of all deaths in the country and are a source of an increasing disability in Tanzania.

It is estimated that there was an increase of NCDs deaths from 27% in 2010 to 33% in 2016. Available NCD data are derived from the last STEPS survey conducted in 2012. It is not yet possible to interpret recent trends in NCDs. Government is planning to conduct another STEPS survey in 2021.

Hospital data show that NCDs are increasing yearly. There was a dramatic increase in the number of NCD cases in 2019, compared to 2017 and 2018. The mortality was mainly caused by the four major risk factors (tobacco use, alcohol use, physical inactivity, and unhealthy diet). There was also a rise in the burden of injuries caused by other factors including road traffic accidents, snake bites and burn cases from 2017 to 2019.

Nutrition

Nutrition services/interventions aim at improving nutrition status of children, adolescents, women and men in Tanzania to have a better nourished population leading to healthier and more productive lives that contribute to economic growth and sustainable development. Low birth weight (LBW) has remained a public health concern in many developing countries, whereby poor nutrition status both before and during pregnancy is recognized as an important cause. In Tanzania, there is a slight improvement in this indicator, with a decrease in newborns with birth weight less than 2.5 kg from 6.2% in 2017 to 5.7 % in 2018 and 5.6% in 2019. There is a great variation in the proportion of newborns with LBW at regional level. In 2019, Lindi region had the highest proportion (11.8%) of low birth weight among newborns followed by Mtwara (10.2%) and Dar es Salaam Region (10%). Among the 26 regions, 11 regions had higher percentage of LBW above the national level. These include five regions from southern highlands (Mbeya, Iringa, Ruvuma, Songwe and Iringa) which are also the major food basket of the country. In addition to LBW, they also have higher rates of other forms of malnutrition. Women who are underweight and anaemic during pregnancy are more likely to have stunted children, perpetuating the inter-generational transmission of stunting. Use of iron and folic acid supplements is associated with a reduced risk of iron deficiency and anaemia in pregnant women, and reduction of neural tube defects in newborns. There has been an increase in the provision of Ferrous/Folic Acid (FEFOL) among pregnant women at antenatal care (ANC) facilities from 42.9% in 2017 to 84% in 2019. However, this does not measure the daily consumption of FEFOL by pregnant women. Data show that the percentage of pregnant women with anaemia on first ANC visit has remained the same i.e. 1.9% in 2017 and 2% in 2019. However, there are large regional variations.

To capitalize optimal growth and development, especially during the first 1000 days of life, infants should be breastfed within one hour of birth coupled with other relevant infant and young child feeding practises. There has been a gradual increase in the proportion of newborns breastfed within one hour from 87.6% in 2017 to 90.1% in 2018 and 91.0% in 2019. HSSP IV set a target to attain 80% by end of year 2020, but due an increase in proportion of facility deliveries and good progress of other nutrition and related interventions this target has been surpassed. There was a remarkable decrease in the trend of children 0 – 59 months who are underweight, from 14% in 2017 to 10.2% in 2019.

While stunting is still a major public health problem in Tanzania, the proportion of stunting among children under 5 years of age has decreased from 44.3% in 2007 to 31.8% in 2019.

2.3 Status of Progress in Health System Strengthening

Health Infrastructure

Primary Health Care: Tanzania made an effort to expand the concept of primary health care and to provide timely, sustainable and accessible health care to all citizens, including ensuring that every village has a clinic, and every ward has a health centre. The Primary Health Services Development Programme (better known as MMAM in Kiswahili) was implemented during 2007-17 to facilitate achievement of this goal. The number of health facilities increased from 5,253 in 2007 to 8,665 in 2020, while the total number of public health facilities increased from 3,421 to 5,122 in the same period.

The community has continued to be involved in the construction and management of health care facilities through Health Facility Governing Committees (HFGC). These committees have been continuously supported to give them the ability to monitor the quality of services. Community Health Volunteer involvement has also played a major role in increasing utilisation of health services including encouraging pregnant women to attend clinics and deliver at health care facilities.

Specialised and Super-specialised services: In the area of medical treatment Government made an effort to strengthen the health care delivery system, referral system, access to specialists and equipment to improve health care that is accurate, safe and sustainable. Clinical and specialist care services have been enhanced at regional referral hospitals (RRH), national hospital and specialised hospitals for obstetrics, TB, heart, mental health, and cancer. Currently the country has developed the capacity to provide cardiovascular services, kidney transplants and various implants. In addition, RRH, specialised hospitals and national hospitals have been provided with the expertise, equipment and technology to provide specialised diagnostic and treatment services including genetics, blood purification for kidney problems and cancer treatment. In addition, 26 RRH are providing integrated epidemiological services and their specialists have been trained on how to manage these diseases.

Medicines and Equipment

The government has continued to strengthen access to medicines, equipment, medical supplies, laboratory equipment and quality reagents. Through the Medical Stores Department (MSD), the system for the importation and distribution of medicines, medical supplies, laboratory equipment and reagents to public health facilities at all levels has been improved, by expanding and building warehouses at regional hospitals and regional centres as well as purchasing dispensing vehicles and supplies. Health facilities still buy large quantities of medicines from private vendors as MSD does not always have sufficient stocks, e.g., for NCDs. The budget for medicines, equipment, medical supplies, laboratory equipment and reagents, has increased from TZS 31 billion in 2015/16 to TZS 269 billion in 2018/19. In the private sector, the government has continued to strengthen access and availability to medicines and equipment through the Tanzania Medicines and Medical Devices Authority (TMDA) which is the body responsible for registering and regulating private medicines and equipment suppliers. The TMDA website has listed 1,526 private medicines and equipment suppliers with the numbers still growing. The government has continued to stimulate local production through providing tax exemptions for raw materials and pharmaceutical packages, compiling a specific list of medicines to be purchased from local manufacturers. In addition, 13 pharmaceutical manufacturing companies

were registered by the end of 2018. Still 85 percent of medicines, supplies, medical supplies, laboratory equipment and reagents are imported.

Human Resources for Health

The number of health care workers has increased from 29,063 in 2006/07 to 102,919 in 2019. The human resources for health (HRH) shortfall is currently estimated at 52 percent of the actual need, while the number of health professionals per 10,000 people has increased from 15.7 in 2010 to 17.2 in 2020. The system of allocating staff based on the workload and demand for health care services has been initiated, to ensure that there is a balance between need for services and numbers of staff to provide those services. However, due to recruitment problems, in remote facilities there remains a shortage of staff.

The Government and the private sector have continued to invest in training programmes in health. As of 2020 there were 463 public and private colleges offering (para)medical training. One of the aims of MMAM, implemented 2007-17, was to increase student enrolment in health facilities in the country. Achievements in the area include an increase in eligible students in health colleges from 6,450 in 2007/08 to 18,539 in 2018/19. In ensuring that these colleges provide quality education, they have been evaluated for quality and have been fully accredited by the National Accreditation Council of Technical Education (NACTE). In addition, on-the-job training is provided to health workers to enhance their skills and effectiveness. Increasingly e-learning is offered to health workers for continuing professional development (CPD). Due to the many different CPD providers, there is no clear overview how many health workers receive training.

Health care Financing

The 2007 Health Policy aimed to continue increasing the health sector budget, in order to improve access to services. MOHCDGEC Public Expenditure Review data show that the Government health sector budget increased from TZS 577 billion in 2007/08 to TZS 2.8 trillion in 2020/21 in nominal terms. However, during the period of HSSP IV, taking account of population growth and inflation, this represents a fall of 5% in the real per capita budget from TZS 44,549 in 2015/16 to TZS 42,147 in 2020/21. In US dollars, this equates to a 20% fall from USD 22.44 to USD 18.05, remaining well below the USD 86 – 112 deemed necessary to reach Universal Health Coverage (UHC).

Total health care expenditure from all sources, including development partner funding outside the Treasury system and out-of-pocket (OOP) spending, increased from TZS 4.29 trillion in 2015/16 to TZS 6.54 trillion in 2017/18. Recent draft National Health Accounts (NHA) data indicate that the Government through its domestic revenue contributed 40 percent of total expenditure in 2017/18, up from 34% in 2015/16; development partners 29%, down from 36%; and OOP 24%, up from 22% in 2015/16. The contribution from health insurance has remained broadly stable at around 7%.

The improved Community Health Fund (iCHF) has created a reliable source of income for health facilities, and a trustworthy basis for patients' confidence in the health system.

Health Information Systems

The health information system is a comprehensive and integrated structure that collects, stores, analyses, and disseminates health and health-related data and information for monitoring and evaluating the performance of health interventions. The Monitoring and Evaluation Strengthening Initiative (MESI) (2010-2015) operational plan aimed at bringing together M&E stakeholders to modernise and strengthen all aspects of M&E within the Health Sector. GOT is committed to improving the application of digital health technologies in order to facilitate attainment of her overall objective of delivering high-quality health services to all citizens. A minority of health facilities make use of the GOT Hospital Management Information System (GOTHoMIS) application as electronic medical record system and data aggregation tool. Expansion is a priority for PO-RALG and MOHCDGEC.

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

Digital technologies potentially play a fundamental role in facilitating timely availability of high-quality health information for provision of better-quality health care services, and thus digital health solutions should respond to clients' needs through user-centred design to ensure responsive, resilient, and inclusive health systems. The Government developed and implemented the National eHealth Strategy 2013–2018 to accelerate the health system transformation by enabling timely information access and supporting health care administrative, financial, and clinical operations to enhance decision-making. Introduction of GOTHoMIS was an example of improved electronic medical records, combined with data aggregation. By the end of 2018, 55 percent of the 17 strategic objectives in the National Digital Health Strategy (2013 – 2018) were achieved. This has led to improvements in quality of health services delivery, revenue collection and management, human resource management, supply chain management of health commodities, health information management, and planning and decision making at different levels of the health system.

The National Digital Health Strategy 2019–2024 was developed and launched in 2019. The strategy is in line with the Tanzania Development Vision 2025 and the draft Health Policy 2020 and aims to facilitate the realisation of Government priorities to achieve UHC. The digital strategy will be taken into consideration in guiding the HSSP V digital health initiatives aiming at improving health outcomes and achieve UHC.

Leadership and Governance

The Health Policy (2007) requires each region to have a RRH, each council to have a hospital, each ward a health centre and each village a dispensary. Currently, there are 6 cities, 20 municipalities, 22 town councils and 137 district councils. In addition, there are 3,956 wards and 12,319 villages.
Nearly all functioning public health facilities have hospital boards, a Council Health Services Board (CHSB) or HFGC for health centres and dispensaries. In addition, there are 21 RRHs with functional advisory boards.

By 2019, Government had established governing structures in 100% of health facilities at the regional level, 65.8% of at the Council level, 23.0% at the Wards and 58.8% at the Villages.

Table 7 Coverage of Government health facilities in 2019

SN	Level of Administration	Level of Service	Total number health facility required	Number of health facility available	Percentage of Board or Governing Committees
1	Region	Referral Hospital	28	28	100.0
2	Councils	Hospital	184	121	65.8
3	Wards	Health Centre	3,956	910	23.0
4	Villages	Dispensaries	12,319	7242	58.8

All 26 health regions are administratively and technically supervised by Regional Health Management teams (RHMT) while 184 councils are supervised by Council Health Management Teams (CHMT). The Regional Medical Officer (RMO) and District Medical Officer (DMO), respectively, head the RHMT and the CHMT.

In the HSSP IV period, decentralisation has been taken a step further by measures like the Direct Health Facility Financing, giving more responsibility to health facilities to direct financial resources to local priorities. Also, the procurement of medicines and supplies by facilities was improved. Bottom-up planning of the CCHPs has strengthened priority-setting geared toward local needs of the population.

All government allocations and expenditures are subjected to auditing, internally as well as externally. Procurement of services is advertised publicly in compliance with procurement law and procedures are subjected to auditing by the Public Procurement Regulatory Authority (PPRA).

3 Chapter 3: Emerging Strategic Priorities

3.1 Emerging strategic priority issues from the situation analysis

Changing demographics and epidemiological transition

Population growth will remain above 3% in the coming five years. Tanzania will have over 67 million inhabitants in 2025. Tanzania will in the coming years remain a country with the majority of people below the age of 25 (over 42 million). The demand for RMNCAH, and health services in general, will therefore continue to increase. However, ageing will be more and more common, with changing demands for health services. Life expectancy at birth will increase to 66.2 years for men and 71.3 years for women in 2025. Deaths due to NCDs in Tanzania are just below 50% and will reach a percentage over 50% in the coming years. There will be more people with chronic diseases, more people with multi-morbidity, more people with non-communicable diseases. More older people with disabilities will need institutional care; more people will need palliative care. This requires new services, new skills of health workers, new approaches in medical care, including home-based care.

Industrialisation and urbanisation

In the coming decade Tanzania will experience the moment when more than 50% of the population will live in urban areas, due to economic development with more and more jobs in industries and services. This will have an impact on the demographics and environment of the country, exposing more people to occupational hazards, pollution, and road traffic accidents. There will be more demand for health services in urban areas. At this moment in time health indicators of the urban poor are not always better than those of rural poor. In urban areas, most health services are provided by private providers. Urbanisation and industrialisation will require new approaches in health care delivery, new joint ventures, and new relations between governmental and private providers.

It will be important to work with other sectors on health-in-all-policies, to protect and improve health of urban dwellers, manage water supply and sanitation, and maintain a healthy environment.

Climate change

Climate change affects the normal seasons in Tanzania, with longer spells of drought in some parts of the country, or heavy rainfall and flooding in other parts of the country. The average temperature in Tanzania is predicted to increase by 3 centigrade Celsius by 2100. This may lead to disasters with medical impact, e.g., depleting food supplies or pollution. There may be permanent damage to the environment, leading to pests, e.g., disease-carrying insects or rodents, resulting in spread of zoonoses. Awareness building on environmental conservation and handling climate changes is needed, and staff need to be prepared for new challenges in health care.

The MOHCDGEC will collaborate closely with other ministries, across sectors, with non-state actors and Development Partners on short-term and long-term measures.

Globalisation

Increasing mobility of people around the globe has increased the speed of spreading of diseases, as shown by the recent experiences with COVID-19, Ebola and Zika. This requires increased risk assessment, surveillance, and epidemic preparedness. Globalisation of trade brings opportunities and challenges of products that are brought into the country, especially medicines, pesticides, and chemical products, requiring cross-border cooperation in control of hazardous goods and products.

Information and communication technology

In the coming years, ICT will have a major impact on society, globally and in Tanzania. With rapidly expanding mobile technology and coverage with high-speed internet, most of the population will have access to internet and services. This offers new opportunities for communication with citizens in general, patients in particular, and above all for communication within the health sector. The health sector must ensure that citizens get access to correct information online. More and more data communication is taking place in the health sector, and new applications ranging from teleconsultation to remote diagnostics are being introduced. Growth of ICT *per se* is not an issue, but it must be regulated growth, which contributes to achieving the strategic objectives, cuts out duplication, and enhances interoperability. Health workers should be capacitated to manage the new ICT solutions. New cadres should be incorporated into the health services.

Medical technology

Scientific and technological advances in the provision of medical and surgical services offer new opportunities, and increasing patient demands. Use of artificial intelligence, data mining, robots, and other technology will not only reach the highest level of hospital but also regional and district hospitals. There is a growing and increasing demand for the use of genetic sciences, medical biology and applications in medicine. Personalised medicine, based on genetic profiles, will become more normal.

New technology may be costly, but at the same time save costs, when integrated well into the health services.

3.2 Unfinished Business from HSSP IV

Service delivery

In service delivery not all targets of HSSP IV have been met, as explained in chapter 2. This asks for incorporation of reformulated goals in the HSSP V.

The expected rapid decline in maternal and neonatal mortality has not materialised. Although improvements have been noted, the targets of the Millennium Development Goals have not yet been met. Regional differences must be addressed further, with attention for urban poor.

There continue to be many children with malnutrition. Although the percentage is decreasing, in absolute numbers malnutrition is increasing. At the same time, the number of overweight people is increasing. Intersectoral collaboration has been strengthened to achieve the goals.

Low rates of HIV testing are seen, especially for some groups including men and young people. High prevalence of HIV among young women shows their vulnerability and requires more adolescent-friendly health services. The detection of TB is still behind the requirements for elimination of the disease. Better case finding and diagnostics are required to start early treatment.

Malaria prevention is insufficient, and the fear for new explosion of malaria is real, as was shown in neighbouring countries. Vector control is a high priority in the coming years.

Continued outbreaks of endemic diseases like measles, and new diseases like COVID-19 threaten the population. Epidemic and disaster control is still insufficient, especially operationalisation of standard operating procedures at grass root requires strengthening.

Infrastructure and equipment

Despite the construction of health care facilities, some citizens must travel long distances to access services. There is still inequitable access to health care for several groups in the population, due to epidemiological and geographical factors. Not all regions have adequate referral systems for patients in need. At the same time, due to changes in road and transportation systems, mobility of people has

increased in many regions. The health sector must embark on smart planning based on actual utilisation of service, for expansion of infrastructure as well as staffing to run the facilities.
Equipment, e.g., in imaging, is still inadequate in most of the hospitals. There is no system of preventive maintenance of critical infrastructure in health services and training colleges, leading to dilapidated structures. On the other hand, decentralised funding enables institutions to generate income, and take maintenance in their own hands.
Treatment of medical waste is still insufficient in many of the health facilities (from primary to tertiary level), although guidelines are in place. Improvement is necessary for environmental reasons but also for reduction of risk of spreading diseases.

Human Resources for Health
Planning of HRH is still largely an administrative process, rather than based on actual needs, and actual service provision. Experience with workload-based planning is available but needs to be institutionalised all over the country. There is a shortage of health workers to meet the needs at all levels of health care, while the capacity for training has increased for many health professionals. Deployment of trained health workers and retention has not been favourable for bridging the gaps between demand and supply. New types of employment contracts can lead to higher absorption of trained staff.
Competencies of human resources are not sufficient to deal with new technical development, in diagnostic and therapeutic areas, or with ICT. Improvement of pre-service training and in-service training is required for better implementation of innovation. At the same time there is variation in productivity, not only dependent on human factors, but also on availability of infrastructure, medicines and supplies.
The Professional Councils have different systems for assessing, registering, managing and coordinating various disciplines. There is no consistent strategy for improving and maintaining quality of trained health staff in a time with quickly changing pathologies and therapies.

Medicines, health products and supplies
Although availability of medicines, medical supplies, laboratory equipment and reagents has increased, it still does not meet the health care requirements, especially at hospitals of all levels and specialities. For covering the National Essential Health Care Intervention Package in Tanzania (NEHCIP-TZ) many more types of medicines are needed, especially to address NCDs.
Efficiency in the supply of medicines has improved, but further steps to strengthen the supply chain are needed, in logistics and in storage of medicines. Alignment by different programmes is needed. Improvements in quality of medicines and quality control, as well as rationalisation of prescriptions and further increases in efficiency are still needed. Expiry of medicines should be cut to a minimum by using modern technology of procurement and logistics.

Health Management Information Systems
The HMIS has been strengthened, data quality has improved and is more timely and more reliable. Unintegrated parallel health information systems remain a challenge but initial steps towards systems interoperability are underway. New opportunities like electronic medical records are under development, but they are not yet sufficiently interfacing with the standard health information systems.

Health care Financing
The budget allocated to the health sector does not meet the real needs of health care due to the fact that it is well below international benchmarks for provision of essential health care, which propose that domestic general government spending on health should be around 5% of Gross Domestic Product (GDP) or between USD 86 and 112 per capita per year. This is further aggravated by

population growth, epidemiological changes, increased number of infectious and non-communicable diseases. HSSP IV projected funding did not materialise in full, hampering implementation.

The existence of separate public health insurance funds for the formal sector (through the National Health Insurance Fund, NHIF) and the informal sector (iCHF) with different levels of contribution results in some inefficiency. The level of contribution to the iCHF does not currently meet the cost of services patients have to receive, while NHIF funding is skewed towards higher level referral facilities and the private sector. Many people remain outside the health insurance system, so they are not sure how to get health care when they need it without the financial constraints. The introduction of a universal health insurance scheme, as envisaged in the 2015 Health Financing Strategy, therefore is very important.

Governance and Leadership

The Government has established systems and instruments for the registration, management and coordination of health services in both public and private health sub-sectors. However, coordination of health services at all levels remains a challenge for effective partnership between state and non-state actors. Further introduction of quality assurance systems and health care financing programmes will enhance individual and institutional accountability.

There is poor community involvement and engagement in the implementation of various health interventions. While the provision of health education and information is improving, the capacity and support to the community system and programs is limited. Through decentralised health services and financing, small progress has been made to establish governance structures and financing modalities, but social accountability is still weak and needs further development of community health management systems.

Although some diseases originate from sectors other than health, there is poor involvement of other sectors in disease management strategies. To address the social determinants of health (SDH), the health sector needs to collaborate with the other sectors, both at national and decentralised levels.

Section Two: Strategic Directions

4 Chapter 4: Country's Health System Framework

4.1 Strategic Mission and Vision

Vision
To have a healthy and prosperous society that contributes fully to the development of individuals and the nation.

Mission
Providing sustainable health services with standards that are acceptable to all citizens without financial constraints, based on geographical and gender equity.

4.2 Conceptual Framework

The health services focus on implementation of the new health policy, and in the international context of the SDGs, especially SDG 3: *Ensure healthy lives and promote well-being for all at all ages*. Nine global targets have been formulated, and each country specifies its own targets, based on the present situation and the ambition of the country. In the section on M&E, targets for Tanzania are reflected.

SDG 3 global targets
3.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births
3.2 By 2030, end preventable deaths of newborns and children under 5 years of age, aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births
3.3 By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases
3.4 By 2030, reduce by one-third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being
3.5 Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol
3.6 By 2030, halve the number of global deaths and injuries from road traffic accidents
3.7 By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes
3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality, and affordable essential medicines and vaccines for all
3.9 By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water, and soil pollution and contamination

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

a. ***Outcomes and impact of health service during HSSP V implementation for society and individuals***

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

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

Preparedness and proper response to epidemics and emergencies or disasters: In the context of the global health security agenda, this covers the areas of:

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

A healthier population: Better health, and increased life expectancy require interventions beyond the mandate of the health sector and therefore requires HiAP and multisectoral collaboration at all levels. The increase in NCDs in particular demands an integrated approach with all sectors.
Equity is very much related to determinants of health, especially in those aspects that are not directly related to UHC, e.g., cultural factors, gender, and health literacy.

b. ***Service delivery processes: people centred care***

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

1. Community strategies aim at **empowering individuals** to make effective decisions about their own health and to enable communities to become actively engaged in co-producing healthy environments.
2. **Strengthening governance** requires a participatory approach to policy formulation, decision-making, and performance evaluation at all levels of the health system, from policymaking to the clinical intervention level.
3. **Reorienting health care** requires a shift from inpatient to outpatient and ambulatory care, and from curative to preventive care. It requires investment in holistic and comprehensive care, including health promotion and ill-health prevention strategies that support people's health and well-being. It also respects gender and cultural preferences in the design and delivery of health services. A new package of essential health interventions (minimum package) is needed.
4. **Coordination** across sectors encompasses intersectoral action at the community level to address the SDH and optimize use of scarce resources, including, at times, through partnerships with the private sector.
5. **Creating an enabling environment** encompasses all processes that support service delivery. In the HSSP V, strengthening ***planning, monitoring and evaluation*** are particularly important to ensure that goals are met in a decentralised context. The other building blocks, which have more to do with inputs are relevant as well. ***Health care financing*** is a crucial element in the process of service delivery and needs inclusion of all relevant sources of funding. Attention will be paid to increasing domestic health financing and expanding strategic purchasing in the sector.

c. ***Building blocks, inputs into the health system***

The building blocks represent inputs and processes to make the health system work. The building blocks were the key elements in formulation of HSSP IV and continue to be crucial for HSSP V. These comprise:

- National and subnational service delivery systems which facilitate efficient management of inputs for delivery of health services to users
- Governance and organisational structures
- Human Resources for Health (including planning, management, and HR development)
- Medicines, commodities and supplies essential for diagnosis and treatment
- Health care financing
- Infrastructure, buildings, equipment, and transport
- Monitoring and evaluation and ICT infrastructure (previously not indicated separately but essential backbone for modern health care).

4.3 Principles and Values

4.3.1 Equity

HSSP V aims to improve the health of vulnerable groups

Health insurance schemes will cover the poor and vulnerable groups through government subsidyin the envisaged unified health insurance.

Health education will enhance economic empowerment (in grassroot development activities) to enable poor people to access nutrition, sanitation and health services. Health education and support will be directed to priority groups, especially adolescent females who remain vulnerable to HIV. Reviving the school health programme and moving services beyond health facilities (closer to communities) will enhance reaching of vulnerable groups. The health sector will adapt existing best practices from programmes' interventions that reach such groups. Health information systems will monitor how vulnerable groups benefit from service delivery.

HSSP V will address geographic, socio-economic inequities

Government will address issues of geographic and socio-economic inequities, through improving the targeting of public subsidies. This will reduce inefficiencies and overlaps by increasing private sector contribution to health markets, ultimately increasing access to and use of health products and services in an equitable and sustainable manner.

The hotspot areas (such as villages, wards, councils, or regions) will be monitored to determine specific needs within a specific area, and to provide inputs for adequate priority setting (as has been done in the HSSP IV period).

Decentralised financing will facilitate sustainable, alternative options for ensuring health worker availability. Fully functional primary health care including community health workers will enable access of services for vulnerable groups in a more effective and efficient way based on the burden of disease, geographical barriers and population. The health sector will strengthen referral system and guarantee access for the vulnerable. This includes strengthening the gatekeeper function within public health insurance schemes, and ensuring subsidised health insurance coverage for the poorest in society.

4.3.2 Gender

HSSP V will enhance gender equality in the health sector

Guidelines and strategies will straight away integrate gender equality component e.g., training and service provision documents. Health promotion and health education will **a**ddress social values and norms within the community on gender issues and promote gender equity at grassroot level.

Local Government Authorities will empower and strengthen more balanced gender participation within grassroot committees to enable them in identifying and mitigating gender issues from the community.

The MOHCDGEC will enforce the incorporation of gender issues at all levels of implementation of health interventions e.g., CCHP, Star rating assessment, and health insurance schemes.

4.3.3 Health in All Policies to address social determinants of health

The HSSP V will enhance a "whole of government" approach for health through collaboration with other sectors that have an impact on the health of the population.

The main areas that have an impact on the SDH are water and sanitation, nutrition and food safety (incl. sugar, salt, smoking, and alcohol), education and training, environment (including climate change), occupational conditions, social protection and community development, infrastructure, housing and road security.

Activities for collaboration with other sectors will reinforce the national SWAp and take forward relevant actions, creating a platform to include the participation of all other sectors, also at the level of a decentralised SWAp at regional and council level. LGAs will create exchange platforms at ward and community levels.

5 Chapter 5: Strategic Outcomes

5.1 Strategic Priorities in Provision of Health Services

5.1.1 Community Health Systems

STRATEGIC OUTCOMES - COMMUNITY HEALTH:
Improved health of the population through community empowerment and engagement through responsive community health systems

The focus of the HSSP V is to empower communities in a gender responsive and culturally sensitive manner, to improve their own health, especially for vulnerable groups. HSSP V will focus on enabling stronger and better-equipped structures for community health. The MOHCDGEC has updated the Policy Guidelines for Community-Based Health Services (CBHS) and has developed operational guidelines to guide their implementation. The guidelines emphasise community-based management and participation of groups within communities in the prevention and control of communicable and non-communicable diseases and promotion of environmental health. In the HSSP V period the revised strategy will be rolled out. Volunteer community health workers (CHW) will operate at village and hamlet levels, providing better alignment with community development and social welfare services. These CHWs will work closely with peer groups that address specific needs for young and adolescent boys or girls, people living with HIV and other communicable diseases, people living with disabilities of chronic diseases, and the elderly. Self-help and self-management in families is an important strategy in disease prevention and control. The CHWs will be incentivised through performance-based payment modalities. Experiences from successful community health programmes will be learned and best practices will be scaled up nationwide. Community engagement platforms established for specific disease programmes such as HIV and TB care could be utilized to support dissemination of accurate information on other health issues, e.g., COVID-19. It is important to strengthen the referral system from CHW and other volunteers to primary health facilities to enhance continuity of care.

Government will strengthen public-private partnerships (PPP) to address the health effects of commercial and business activities, including climate change and air pollution. The health sector will contribute to improve monitoring systems and the capacity of community groups to use data for priority setting at community level. This will lead to improved governance at community level, including strengthened advocacy and representation in governing bodies.

5.1.2 Health Education

STRATEGIC OUTCOMES - HEALTH EDUCATION:
Improved health of the population through community awareness and health literacy

Communities should be aware of their health, health risks and environmental factors influencing health. Issues of lifestyle, physical and psychological hazards, and pollution due to industrialisation, urbanisation and climate change will communicated through different channels. The health sector will enhance the provision of community health education to motivate people to improve their health literacy, empowering them to take decisions about health and wellbeing. The health sector will undertake awareness campaigns and will engage with communities and other sector ministries in improving health in the environment and the workplace.

The MOHCDGEC will continue to strengthen the partnership between the health and education sector. Government will continue implementing the National School Health Strategic Plan (2018 - 2023). School health guidelines will be developed to include topics related to sanitation, nutrition, child safety, health screening and vaccinations. These guidelines will take into consideration the school health programmes as implemented in the immediate post-independence era where health workers from nearby health facilities or health programmes used to visit schools and colleges to conduct screening of various diseases among school children. Government will design special programmes for out-of-school youths to improve their health and wellbeing, as described in One Plan III.

5.1.3 Nutrition

STRATEGIC OUTCOME - NUTRITION:
Improved nutritional status of the population, both in terms of reducing under- and over-nutrition

Government and its partners will enhance healthy nutrition to prevent under-weight as well as over-weight and, where necessary, issue regulations regarding sugar and salt in processed food and beverages. The government will implement a common risk factor approach to promote healthier dietary consumption for prevention of NCDs. The government will promote the availability of essential nutrients in the community in partnership with other ministries and with the private sector. Food for nutrition will be the guiding principle. Government will ensure that public and private industries have a system for adding nutrients to processed foods, for example iodine and vitamins. The government will set standards for ingredients. Government will address the quality of nutrients in urban environments, e.g., through quality standards for fast food, or for retail outlets.
The health sector will enhance education to and awareness of the community on the importance of good nutrition in vulnerable groups like women, children, elderly, and people with disabilities. In particular, women of childbearing age must know the importance of good nutrition from pre-pregnancy to breastfeeding. Improvement of feeding frequency beyond breast feeding i.e. during the age period between two years and five years will be promoted in order to reduce chronic malnutrition (stunting). Nutritional imbalances in vitamins and essential nutrients will be addressed. Government will build the capacity for nutritional services at regional and council levels. The health sector will continue to strengthen coordination of nutrition and research services at all levels.

5.1.4 Environmental Health

STRATEGIC OUTCOME - ENVIRONMENTAL HEALTH:
Reduction of morbidity and mortality due to environmental health risks associated with physical, chemical, biological and behavioural factors.

Water, Sanitation, Hygiene and Food Safety
The provision of safe water, improved sanitation, and adequate hygiene (WASH) is key in prevention of the majority of communicable diseases prevalent in the country. The government in collaboration with partners will improve access to sanitary facilities through implementation of a National Sanitation and Hygiene Campaign. The government will ensure that public health care facilities are provided with adequate sanitation and hygiene services, both in rural as well as urban areas. Waste collection, especially proper disposal of medical waste, is also an area of attention for the health sector. Furthermore, the government will ensure food safety by strengthening the monitoring systems for food quality and safety. Government will strengthen the management of environmental hygiene laws and supervise the implementation of sanitation in school buildings, public institutions and at

community level. Government will promote the availability of school health services including the essential infrastructure for improved hygiene and use of toilets.
Increasingly, the health sector is at risk of climate-sensitive diseases. Climate change-related water quality is the main concern in the health sector as people suffer from water-related diseases. The government will increase preparedness capacity at council level to respond to climate change-related health events and impacts through adaptation and resilient mechanisms.

Occupational Health and Safety and Occupational health
Occupational hazards are likely to increase with industrialisation. Inspections and law enforcement are required in workplaces and production areas. Workers in most workplaces are at high risk of exposure to occupational hazards that may lead to health problems. Such occupational health problems include injuries, permanent disability or even death due to accidents, infectious diseases such as hepatitis and HIV/AIDS, and chronic ailments resulting from exposure to poisonous substances such as chemicals, fumes, dusts and radioactive materials. The government in collaboration with partners will ensure the safety of workers by strengthening awareness of occupational hazards, integration of occupational health services into primary health services, development of regulations and as well as enforcement of laws and regulations governing occupational health services.

Public health events and threats management at Points of Entry.
The government in collaboration with partners will strengthen border health security at all points of entry in order to prevent and control the international spread of diseases and will provide a public health response in ways that will minimise public health risks and avoid unnecessary interference with international traffic and trade. This will involve strengthening country capacity to prevent, rapidly detect, and respond to public health threats and emergencies at points of entry and in the border districts. Furthermore, the government will establish a mechanism to control importation and exportation of diseases through uncontrolled and porous borders. The government will expand port health services and ensure that by 2025 at least 70% of the 20 major points of entry have core capacity developed to meet national and international standards and are able to provide access to appropriate medical services, including diagnostic facilities to allow prompt assessment and care of ill travellers.

Waste Management
The government will ensure that health facilities meet the standards for safe health care waste management which is an integral part of a national health care system. Management of chemical substances is important, to reduce chemical pollution in health facilities. MOHCDGEC will ensure that the developed guidelines are adhered to. Other waste management interventions outside health facilities will be organised by LGAs to meet legal requirements for optimal sanitary standards. To this end, close collaboration with the National Environmental Management Council will be encouraged.

5.1.5 Reproductive Maternal Neonatal Child and Adolescent Health

STRATEGIC OUTCOMES - RMNCAH:
Improved maternal, newborn, child and adolescent wellbeing through equitable availability of and access to health and nutrition services leading to reduced morbidity and mortality due to maternal, neonatal and childhood illnesses and reproductive health-related conditions.

The government and its partners will implement the strategy of *survive, thrive and transform. Survive* aims at reducing morbidity and mortality of women, children, and adolescents. *Thrive* aims improving health and resilience of target groups. *Transform* aims at making changes in society and the health sector to enable progress in the two other areas.

Specific plans are laid down in One Plan III, which was developed simultaneously with HSSP V. More than in One Plan II the focus will be on people-centred health services.
The focus of RMNCAH activities in HSSP V is on:

1. Enhanced multisectoral coordination of nutrition through improved food security and feeding practices to enable children, adolescents, and the community at large to thrive.
2. Improved availability and access of sexual and reproductive health services for young people to reduce teenage pregnancy, thus keeping girls in school, and the provision of life schools to transform life.
3. Improved quality of care in reproductive, maternal, newborn, child and adolescent health to ensure maternal and child survival.

Government will continue to strengthen reproductive health services at all health care facilities and engage with women, men, youths, and people with disabilities, in order to improve geographical and financial accessibility, and increase utilisation. The health sector will improve infrastructure, and increase skilled staff, medicines and equipment needed for RMNCAH. The referral system will be improved, to ensure continuity of service.
The primary health care providers and community health volunteers will continue to sensitise and educate the community on the importance of maternal and child health, and reproductive health for all groups including young people. The issue of gender-based violence (GBV) and violence against children will be brought into community health programmes.

Maternal health
Improvement of access to quality health services is an important priority. In collaboration with stakeholders, the government will continue to increase access to high quality emergency obstetric and neonatal care and will increase focus on key instruments during delivery and immediate post-natal phase which save lives e.g., partogram, APGAR score, neonatal screening and resuscitation, early breastfeeding, and postpartum care. Elimination of mother-to-child transmission of HIV will continue to be a top government priority.

Child health
The health sector will continue to provide vaccination services to children and adolescents to avoid vaccine-preventable diseases. Growth monitoring and nutritional advice will be made available and where needed rehabilitation services will be offered. Through health education, health of children will be promoted.

Adolescent health
In collaboration with stakeholders, the government will expand youth-friendly services, not solely by improving infrastructure and supplies. Through CPD, the MOHCDGEC will reorient health staff on compassionate care, patient charter and rights of adolescents. This will be attained by supporting the implementation of priorities identified in the National Agenda to Accelerate Investment for Adolescent Health and Wellbeing (NAIA) (2019 – 2022) and the National School Health Strategic Plan (2018 - 2023). The two plans mainly prioritise school-age and adolescent health, education, child protection, equity, gender, and inclusiveness, WASH, nutrition, HIV and AIDS. The use of private sector platforms such as Accredited Drug Distribution Outlets (ADDOs) offer unique opportunities for reaching adolescents with services such as contraceptives. These platforms are an important point of contact with the health system for adolescents and youths. Young people's affinity to ADDOs is due to their proximity to their homes and other gathering points such as educational institutions.

Family planning
The National Family Planning Costed Implementation Plan (NFCIP II) identifies increased access to and use of contraceptives among young people as one of the four strategic priorities that will contribute towards achieving the overall modern contraceptive prevalence rate goal. Government and partners will improve access to family planning. Participation of males in RMNCAH is important to enhance gender equity.

Female cancers
Government and partners will increase awareness and access to cervical cancer screening for all women and will expand breast cancer screening services. The Government will improve access to screening and treatment services for NCDs and their co-morbidities during pregnancy and the postnatal period. Government will increase coverage of the vaccination for human papilloma virus (HPV) among adolescent girls.

Partnerships
In the training curricula there will be more attention to requirements of RMNCAH services, especially using modern technologies and working with new equipment.
The government will strengthen its stewardship capacity as a way to improve overall sustainability in the health sector. The government will continue to support partnerships with the private sector encouraging equity and resource allocation and prioritizing RMNCAH interventions to achieve quality and equity goals (according to the needs). Government will enter into service agreements with private providers to expand access to maternal and childcare and will improve adherence to quality standards.

5.1.6 Communicable Diseases

STRATEGIC OUTCOME - INFECTIOUS DISEASE CONTROL
Reduced morbidity and mortality due to communicable diseases as a result of preventive measures, early detection and early treatment for communicable diseases of public health importance. Broadened perspective of communicable diseases control beyond malaria, HIV and tuberculosis.

Control of Priority Communicable Diseases
The health sector will continue to provide health education on the prevention of communicable diseases. This should lead to increasing public awareness of the prevention, management, and control of communicable diseases. People should be more aware in particular of the pathways of spreading communicable diseases and their own contributions to such spread.

The health sector will continue with strategies to control communicable diseases of public health importance, especially HIV-AIDS, hepatitis, malaria, and TB. The existing disease-specific strategic plans will be reviewed and updated in line with this HSSP V. Increasing integration of services will help to enhance outputs and impact, e.g., linking HIV and cervical cancer screening, linking TB and HIV treatment.

Government will continue to enhance health promotion and prevention of HIV/AIDS. It will facilitate adaptation and implementation at scale of proven, effective, context-specific and culturally appropriate HIV prevention strategies, including a prevention package that includes comprehensive condom programming, prevention and early treatment of sexually transmitted infections, structural interventions targeting most at risk populations, economic empowerment, comprehensive sexuality education and behavioural change interventions targeting in and out of school adolescents and young boys and girls, and targeted counselling and testing, so that more people know their HIV status,

especially those left behind. People living with HIV/AIDS will receive affordable, effective, and sustainable antiretroviral treatment and care to reduce onward HIV transmission, provision of treatment of opportunistic infections and prevention to eliminate HIV-related morbidities. Reduction of mother-to-child transmission remains a priority. The government will ensure that ARV treatment is safe and acceptable by safeguarding patient safety, strengthening ARV pharmacovigilance, while vigorously monitoring patient ART adherence and viral suppression.

The government will improve its tracing of missing people with TB, expand the use of new diagnostic technologies to improve case detection, disease surveillance, and maintain high treatment rates. The government will expand use of GeneXpert to improve case detection.
Government will enhance identification and management of antimicrobial resistance and appropriate treatment of resistant TB cases and TB/HIV co-infections.

The government will continue to guide the implementation of interventions for viral hepatitis control in public and private institutions as well as increasing awareness in the community. Preventive measures to halt transmission of viral hepatitis within the population will be strengthened. This includes provision of hepatitis B vaccination to those most at risk and the general population.

Government will continue to implement effective malaria control interventions including larviciding, use of insecticide-treated mosquito nets, residual indoor spraying (in endemic areas) and case management using malaria rapid diagnostic tests (MRDT) and artemisinin combination therapy. Surveillance of malaria transmission and insecticide resistance will be strengthened.

Prevention and Control of other Communicable Diseases
In the light of new epidemics, strengthening systems for the diagnosis and management of disease outbreaks will take place as well as management of health-related events, e.g., in disasters. Health facilities will receive tools for diagnosis and management of outbreaks and public health events.
The government will ensure availability of vaccination services for the control of vaccine-preventable communicable diseases. Government is committed to keeping vaccination coverage high for young children and will increase the amount of local funds allocated to cover vaccination services. The package of vaccination services will increase, to include TB, poliomyelitis, measles, rubella, whooping cough, tetanus, influenza, and hepatitis. Government will make vaccines available for specific groups in society to prevent a variety of diseases including HPV in girls, hepatitis, rabies, and yellow fever. All girls under the age of 14 are given HPV vaccine to prevent cervical cancer.
The government will strengthen systems (including public health laboratory networks) and capabilities and will promote cooperation with different countries in order to prevent cross-border spreading of diseases. Government will develop joint strategies and protocols in collaboration with neighbouring countries.

Neglected Tropical Diseases (NTDs)
The government in collaboration with partners will continue to fight specific diseases, such as elephantiasis, hydrocele and trachomatous trichiasis, through mass drug application, environmental interventions, and case and co-morbidities management. The government will continue to implement various interventions to eradicate previously neglected tropical diseases and will enhance access to and supply of medicines. The government will strengthen the health promotion and education component for the prevention of neglected tropical diseases (NTD) and increase uptake of treatment interventions.

One Health Approach for Zoonotic Diseases

The health of people is closely connected to the health of animals and the shared environment. A collaborative, multi-sectoral, and trans-disciplinary approach is required to achieve optimal health outcomes. One Health is a concept that recognises the interconnection between people, animals, plants, and their shared environment. A growing human population creates a need for more land for habitat and economic activities, increases the importance of interactions with animals in human lives, climate change and movement of people, animals, and animal products across boundaries, and has led to more opportunities for diseases to pass from animals to people (zoonoses).

These changes have led to the increased spread of existing zoonotic diseases and emergence of new ones. Zoonotic diseases that exist or pose a potential risk in Tanzania include rabies, salmonellosis, human African trypanosomiasis, anthrax, brucellosis, Lyme disease, ringworm, Rift Valley fever, Ebola virus disease and COVID-19.

The health sector will engage veterinary professionals and animal scientists to jointly control zoonoses. A joint strategy for zoonoses prevention and control will be updated in conjunction with government ministries and agencies. One Health issues also include addressing AMR, food safety and other health threats shared by people, animals, and the environment. The One Health approach can also be applied in other conditions that require a multidisciplinary, intersectoral approach such as control of chronic diseases and non-communicable diseases.

5.1.7 Epidemics and Disaster Preparedness and Response

STRATEGIC OUTCOME - EPIDEMICS AND DISASTER CONTROL
A resilient and robust health and community system with sufficient capacity to prepare for, detect, prevent, respond to and recover from health epidemics, emergencies and disasters.

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

Risk communication and community engagement are crucial factors in prevention of epidemics and disasters, with basic understanding of hygiene, medical hazards, and threats to health. In order to improve and strengthen prevention of health epidemics, emergencies, and disasters, it is important to make sure that national legislation, policy, and adequate financing are in place for prevention, alongside strategies for coordination, communication, behaviour change and advocacy through a multi-sectoral approach. Government will invest in sensitisation and awareness-raising of disasters that can occur in society, their impact and how to manage them. There will be a toll-free information line for questions from the public. Government will use social media and other communication channels to inform the public.

Antimicrobial resistance is a threat to society and is linked closely to misuse of antibiotics in the health, agricultural and fisheries sectors, either due to inappropriate prescription, illegal medicines, or due to patient/user related factors of inadequate dosage. The government will update strategies to slow the development and spread of AMR.

It is important to ensure health security of the Tanzanian community by enhancing implementation of a laboratory biosafety and biosecurity regimen to prevent unintentional exposure to pathogens and toxins. The government will sustain national immunisation delivery systems and strengthened regulatory mechanisms for new vaccines, in alignment with national and international standards for emergencies and disasters. The government through multi-sectoral approach will put strict preventive measures on the prevention of epidemics and disasters from zoonotic disease, food safety and water, sanitation and hygiene.

The MOHCDGEC will work closely together with the police and other agencies to increase road safety and prevent accidents. It will establish ambulance services along major highways as part of a comprehensive national ambulance service. Opportunities will be sought to finance this from the motor vehicle insurance system. The government through MoHCDGEC will ensure availability of safe blood to save lives during emergencies. There is also need to prevent occupational hazards during emergencies and disasters.

All outbreaks and health events in the country will be monitored and reported to the World Health Organization in accordance with international health regulations (IHR 2005).

Prepare

Government will ensure the availability of the necessary equipment, medicines, and infrastructure to provide emergency services and post-emergency services and address the health effects of various disasters. Government will continue developing specific action guidelines for dealing with the effects such as the physical and psychological effects of various disasters at all levels. Government will build the capacity of health care providers at all levels to deal with the effects of various disasters. All levels of the health system will develop “all hazard” emergency preparedness and response plans and hazard-specific plans that will guide implementation during emergencies. These plans will build an effective, efficient, and well-coordinated health sector “all hazard” response system that will lead to reduction of morbidity and disability. These plans will be implemented through multi-sectoral and multi-disciplinary coordination systems at all levels. The government will ensure a sustainable system for timely financing of emergencies. To ensure better preparedness, drills and simulation exercises will be conducted to enhance the competence of the health workforce. Also, the ministry will establish mechanisms for risk assessment which will include risk profiling and vulnerability assessment and mapping. Emergencies demand special attention from the health system, and as a result regular health services can suffer. Lessons learned from Ebola and COVID-19 show that even more people can suffer from this “collateral damage” than from the emergency itself. The emergency response therefore includes maintaining regular services as much as possible, in reproductive and child health and in disease control programmes. Strategies for continuity of care in times of emergency will therefore be developed.

Detect

In order to enhance effective country capacity in detection and tracking of health epidemics, emergencies, and disasters, a modern point of care and capacity will be established, and national laboratory systems will be strengthened. MOHCDGEC will maintain a functioning real-time surveillance system for detection of potential events of public health importance at all levels as well as a well-functioning framework for reporting /public information on detected potential events. The country will ensure there is an adequately skilled, multidisciplinary public health workforce in regions and councils. Points of entry (ports and border posts) are very important to detect potential public health events, therefore surveillance will be strengthened and maintained.

Response

In responding to health epidemics, emergencies and disasters, the capacity of the health system and community will be enhanced through establishing and strengthening Emergency Response Operations Centres at all levels. Government will strengthen and maintain linkages of public health and security authorities. There will be a functioning system for receiving and sending medical countermeasures and personnel during emergencies. Effective and timely risk communication and community engagement during emergencies will be of high priority. In addition, MOHCDGEC will establish efficient and effective emergency medical services to ensure timely provision of required services. Government will also improve case management of patients, while observing infection prevention and control precautions. In responding to emergencies and disasters that require blood transfusion, all levels of health systems will be required to facilitate and support the availability of safe blood and blood products to meet the increased needs during such events.

Recovery

The restoration of health systems and communities from a public health event/disaster will be enhanced through provision of psychosocial support and social protection services to affected individuals and effective restoration of essential health services. The government will establish a mechanism for facilitating compensation for affected communities within the recommended time under legal frameworks. The ministry will ensure comprehensive post-event impact assessments are conducted on time.

Linkages

A monitoring system that will include all stakeholders during disaster management will be maintained through the establishment of a multisectoral coordination framework that will strengthen linkages between different sectors. This system will advocate continuity of essential health services during the whole cycle of epidemic management. This will be achieved through engagement of non-government stakeholders by enhancing PPP/private sub-sector involvement during any emergency.

Management

A national disaster coordination centre exists, and an additional regional coordination centre will be established. There will be a national register for recording emergencies, major incidents and the victims and types of trauma. In epidemics close collaboration with other sectors is needed. Government will continue to expand the disaster management committees to peripheral levels, up to the council, village or neighbourhood level to ensure adequate response at all levels.

Emerging and Re-Emerging Diseases.

Emerging diseases are a global threat to human existence. Every country is exposed to the potential emergence of infectious diseases. Factors such as changes in ecology, climate and human demographics play different roles in a complex mechanism contributing to the occurrence of infectious diseases. Examples of diseases which have newly emerged in Tanzania are HIV/ AIDS (1980's), Rift Valley fever (2007), influenza A H1N1 (2009), dengue fever (2010), multi-drug resistant TB (2007 – 2010) and COVID-19 (2020 – 2021). Important aspects of control in case of outbreaks are surveillance, preparedness and early response. The Public Health Emergency Operations Centre is a key stakeholder spearheading the country's response and preparedness for emerging and re-emerging diseases.

5.1.8 Non-Communicable Diseases

STRATEGIC OUTCOME – NCD
Reduced morbidity and mortality due to non-communicable diseases as a result of preventive measures addressing risk factors, early detection and treatment and rehabilitation of non-communicable conditions of public health importance. Increased attention due to increase in life expectancy, nutrition and changes in lifestyle.

Chronic Diseases
There is a strong linkage between NCDs and social determinants for health. NCDs are rapidly increasing and now contribute nearly 50% to causes of death in Tanzania. Changes in lifestyle have led to an increase of NCDs due to feeding/nutrition (overweight, cardiovascular disease and diabetes), environmental factors, air and noise pollution (cancers, mental health, chronic obstructive pulmonary diseases), work-related and family life stress (mental conditions) and travel and work (road traffic and occupational injuries).

The government and partners will enhance cross-sector collaboration, similar to the One Health approach in addressing zoonotic diseases, in order to decrease morbidity and mortality due to NCDs. The health sector will elaborate and implement strategic efforts to address the increased emerging trends of overweight and obesity among all age groups, to reduce the burden of chronic diseases, including mental conditions, and morbidity and mortality due to accidents. The health sector will engage with communities and promote participation in NCD prevention and control. The MOHCDGEC will promote inclusion of NCD elements including prevention and screening in the revised community health strategy and the related curriculum for community health volunteers/workers.

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

All health care facilities will provide screening services for NCDs and their co-morbidities as part of the initial screening for all new clients. Health facilities will be enabled to provide treatment for NCDs and their co-morbidities, according to their levels. Facilities will use the experiences and structures built up by vertical programmes to reach communities and provide integrated care. The lessons learned from COVID-19 show that people with chronic diseases are much more susceptible to suffer from complications of infectious diseases. Continued integration is therefore logical.
Government must address the SDH to reduce NCDs. HiAP is therefore important, as many NCDs are caused by factors in society that are beyond the mandate of the health sector and require strong inter-sectoral collaboration to prevent or address them. Co-morbidities between NCDs and communicable diseases have to be addressed. Lessons learned from HIV prevention and control could be applied to NCDs and vice versa.

Government will continue to strengthen research into prevention and control of non-communicable diseases and co-morbidities. Research findings will be used to develop appropriate strategies and interventions to prevent and control NCDs. Government will build the capacity of HRH in the area of NCDs and their co-morbidities and will ensure the use of technology in their management. Monitoring of NCDs through the HMIS will be improved.

Mental Health, Addiction and Substance Abuse

The availability and management of mental health services in communities and health care facilities at all levels is a priority. First, the country needs adequate health workers with mental health speciality at all levels (including PHC level) to meet demand for mental health services and psychological counselling. Secondly, counselling and therapy needs to be embedded in regular health services. Outpatient and ambulatory services will be established in health facilities. At PHC level, screening, recognising and referral will be the main target, while at higher levels treatment and rehabilitation services will be provided. Medicines for psychiatric disorders will be made available at appropriate levels of health care.

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

Ageing

Ageing of the population will require a paradigm shift in health care. The ageing body and mind asks for a completely different mindset of health care workers. The concept of healthy ageing will be introduced, aiming at active participation of the elderly population in society and maintaining productivity, health, and well-being. For older, sick people the concept of geriatrics will be developed, combining knowledge about multi-morbidity with knowledge about frailty and palliative care. Special care will be developed for geriatric patients. Training in these areas will be part of medical and paramedical curriculums. The MOHCDGEC will work together with NGOs already active in this field.

Oral Health

Improvement in access to quality oral health services is an important priority. In collaboration with stakeholders, the government will continue to increase access to high quality oral health services and will focus on strengthening the delivery of preventive services through school-based oral health programmes and facility-level oral health education, continue to strengthen oral health service provision at all levels of facilities in order to improve access and increase utilisation. The government will improve infrastructure, increase skilled staff, dental equipment and related health commodities needed for provision of oral health services. The referral system will be improved, to ensure continuity of service.

Eye Care

The Ministry is currently implementing a third Eye Health Strategic Plan (2018 – 2022) which focuses on reduction of blindness and visual impairment by strengthening the delivery of primary eye health services at community and PHC level, in line with sustaining the advancement in the secondary and tertiary eye health services.

With the increase in the global burden of NCDs, prevention of blindness for people living with diabetes is a new priority. Human resources for eye health is among the main pillars in the prevention of blindness and visual impairment.

Ear Nose and Throat Care

Currently there is limited access to specialised services for ear, nose, and throat (ENT) care, mostly delivered in referral hospitals. The ageing population will result in more complaints of deafness. Through public private collaboration more services will be made available in Tanzania.

5.1.9 Social Determinants of Health

STRATEGIC OUTCOME – SDH
Improved health, health equity, and wellbeing of the population irrespective of socio-economic status, gender, geographical and cultural diversity.

Policy and Practice
Social determinants of health are the conditions in which people are born, grow, live, work and age. They include factors like socioeconomic status, education, neighbourhood and physical environment, employment, and social support networks, as well as access to health care. These circumstances are shaped by the distribution of money, power, and resources at global, national and local levels; hence the key problem is inequity in terms of socio-economic, gender and racial dimensions. While addressing inequity is a matter of human rights and development of the society, health is a crucial element in improving equity.
Social determinants influence morbidity and mortality due to all diseases, both communicable and non-communicable. Therefore, plans for control of HIV, malaria and TB include actions to improve equity and address socio-economic factors. Also, the NCD plan focuses on increasing equity. In health care financing equity is addressed by safeguarding access to universal health insurance for the poorest and most vulnerable groups.
Socio-cultural and economic situations lead to clustering of problems, e.g., HIV and substance abuse, malnutrition, risky sexual behaviour. There will be an increasingly integrated approach, linking health to welfare and social protection.
Levels of education and health literacy are important determinants of health. More collaboration between the health sector and the education sector is therefore relevant in achieving equity in health. Policies in health will include more focus on vulnerable groups and improving equity. Legal advice on how to avoid discrimination and exclusion will be provided.

Inter-Sectoral Collaboration in Addressing Social Determinants of Health
Since most SDH are beyond the mandate of the health sector, inter-sectoral collaboration is essential to address these and to achieve equity. Tanzania has embarked on increasing cross-sector collaboration through the HiAP approach. Government will reduce geographical inequity (regions with poorer health indicators or districts with poorer performance), poverty-related inequities (urban and rural poor) and gender-related inequities (GBV and poor access for adolescents, out of school youths). Therefore, it will introduce a system of decentralised priority-setting, in which weaker regions and councils will receive additional resources to address equity and gender issues.

5.2 Strategic Priorities in Organisation of Health Services

STRATEGIC OUTCOME - ORGANISING HEALTH SERVICES
Improved organisation of the health facilities, with adequate referral

5.2.1 Package of Health Services

The NEHCIP-TZ will be revisited in the context of the creation of mandatory health insurance as envisaged in the Health Financing Strategy and will serve as the basis for providing care at various levels. The NEHCIP-TZ will have three explicit packages with standards of care defined for: PHC (dispensary, health centre and council hospital) level; secondary level (regional referral hospital); and tertiary level (zonal, specialized, and national referral hospitals). The packages will impact on the

training curriculum, provision of medicines and supplies, health care equipment, diagnostic services etc. They will also serve as a guide for entitlements of patients in the context of health insurance.

5.2.2 Essential Health Services at Primary, Secondary and Tertiary Levels

Health Services at PHC level

The health sector will provide a wide range of health services, to meet the needs of citizens at all levels. Government will build the capacity of communities to deliver community-based and home-based care. Interaction between community health care and primary health services is important to achieve better health. HFGC, CHWs and other stakeholders will be involved in strengthening community health.

Government will equip health facilities managed by LGAs to facilitate the provision of equitable primary health services throughout the country. In addition to the ongoing efforts to strengthen, improve, and sustain primary health care, the government will improve referral services by developing essential health packages and standards of care for each level of the health system.

A special area of concern is health care in urban areas. Due to rapid growth of cities, services do not keep pace with the needs of the population, particularly in high-density areas. Most health care is provided by private providers (ranging from private practices to private hospitals).
There is need for strategic partnerships between governmental and private providers (including private pharmacies) and functioning health insurance schemes to improve access to health care for urban poor.

Specialised Health Services at Regional level

The regional referral hospitals provide specialist services in all regions. The government will strengthen the provision of health services at public RRH by improving the infrastructure, equipment and staffing by specialist health care professionals in these hospitals. The government will establish infrastructure and systems that enable regional referral hospitals to use new technologies in the provision of medical services and applied research. Where appropriate, government will work in partnership with the private sector, including faith-based organisations, to increase the level of access to RRH services. The government will establish operational procedures for RRH (public) and the management of public and private referral hospitals, to achieve functional (public and private) referral services. RRH staff capacity will be built in the use of modern technology and diagnostics. RRHs are envisaged as future hubs for innovation of health care in the regions, and for training health professionals in various fields (certificate level and diploma), and providing internship training for physicians and other degree graduates.

Specialised and Super-specialised Health Services at Zonal, Specialised and National Hospitals

Government will continue to strengthen both specialised and super-specialised medical services to meet international standards. The scope and quality of specialised and super-specialised services will be expanded in all zonal, specialised, and national hospitals. This will continue to eliminate need for referrals abroad, while at the same time introducing medical tourism to Tanzania as more patients from other countries continue to seek specialized medical care in Tanzania.

Government will strengthen relationships with institutions in other countries to improve access to quality services. Government will provide opportunities for local professionals to learn from other countries. The health sector aims at strengthening and expanding provision of specialized and super-specialized services like organ transplant and device implants that in the past required patients to be referred abroad.

Referral Systems

The government will improve gatekeeping and referral so that hospitals at regional, zonal, specialist and national level can focus on provision of specialist and super-specialist services not available at PHC level. In some referral hospitals, where inevitable, special units or departments may be designated to provide some element of lower levels of care within their premises. These will be equipped, staffed and funded appropriately. The government will conduct a hospital bed census in public and private facilities to determine what proportion of patients actually need to be in a referral facility, rather than a more cost-effective primary level facility closer to their area of residence. This information will inform the national health services masterplan that will guide a balanced and evidence-based expansion of health facilities at all levels. Given limited resources, it will always be more cost-effective to strengthen PHC to ensure equitable access to health services. More efficient use of available capacity will be stimulated.

5.2.3 Traditional and Alternative Medicine

STRATEGIC OUTCOME – TRADITIONAL AND ALTERNATIVE MEDICINE
Improved integration of evidence-based traditional and alternative medicine in health services for the people

The government will continue to strengthen the framework for managing research and the provision of natural or alternative therapies. The MOHCDGEC will coordinate the integration of traditional medicine and modern medicine. The government will stimulate studies to demonstrate scientific evidence of the efficacy, safety and quality of traditional medicine and traditional therapies. The Government will strengthen the traditional medicine research system as well as the relationship with modern medicine. Government will create an enabling environment for the integration of traditional, alternative, and modern medicine by establishing dual traditional and modern health care facilities. It will strengthen collaboration with other sectors to preserve the environment and medicinal resources which are used in traditional and alternative medicine.

In order to support research on and provision of traditional and alternative medicine, the government will improve the system to identify and compile traditional medicine practice, traditional medicine prescriptions, and other natural resources that are used for natural remedies and alternative therapies. Public research and academic institutions will be encouraged to solicit private funding for research studies as currently done by private institutions such as IHI, REPOA or the Economic and Social Research Foundation that do not receive any funding from the GOT for staff and running costs but rather sustain their research activities through research grants only. NIMR, as the MOHCDGEC research arm, will continue to receive funds from the Government and from external partners to ensure proper design and implementation of traditional medicine research.

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

5.2.4 Rehabilitative and Palliative Care

STRATEGIC OUTCOME - REHABILITATION AND PALLIATIVE CARE
Reduced the consequences of physical, mental and social disabilities and chronic pain enabling the affected people to live a normal life with or without

Rehabilitative Care
The health sector will better identify people with disabilities, their needs, and the types of physical, social and mental rehabilitation interventions that can be provided at various levels. The health sector will put in place various social care interventions tailored to specific needs. Government will work closely with NGOs offering services for disabilities.
The government will strengthen medical and counselling services for people with severe pain due to disability and chronic disease. Access to specialists, medications, and equipment will increasingly be available according to needs.

Palliative Care
Access to quality palliative care services at PHC facilities and through home-based care is important in caring for terminally ill patients or people with severe pain due to disability and chronic disease. Government will develop expertise in palliative care, expand outpatient care and outreach services for home-based care, and ensure access to all palliative care needs including pain relief medicines (especially oral morphine), counselling, and psychosocial support for home-based care.

The health sector will build capacity for community and home-based caregivers to be able to provide relevant home-based care for older people and to link patients needing palliative care to health facilities. Government will strengthen partnerships between health providers, both public and private, and traditional and alternative, to address palliative care. Government will ensure palliative care is accommodated in the curricula of all medical and allied health training institutions.

5.3 Strategic Priorities in Health System Performance

5.3.1 Expanding Access to Health Services (UHC1)

STRATEGIC OUTCOME - UHC1
Geographical, social-cultural and financial barriers in accessing quality and people-centred basic health services for all people are being addressed.

The government will ensure availability of essential PHC services with acceptable quality standards throughout the country with respect to geographical, population, gender, disability, and burden of disease. This includes interventions to avail infrastructure (including staff housing) and equipment for health facilities to facilitate equitable access for all, including people with special needs. Existing structures and equipment will be maintained or renovated to be functional and efficient. A long-term investment plan for construction of new health facilities at all levels will be developed, based on realistic health requirements, in order to ensure that there is equitable and sustainable distribution of health services which satisfy citizens' needs. All new health facilities will be equipped to meet minimum standards. The government will institutionalize preventive maintenance to ensure well-maintained and functioning infrastructure and equipment. Waste management infrastructure will be improved and maintained in all health facilities as per stipulated standards. The government will strengthen community and stakeholder engagement to participate in infrastructure development and maintenance.

For health facilities to be able provide the required services, government will strengthen the system for competence-based service delivery through improving pre-service training, CPD, and a mentorship system in clinical settings. The government will also improve nursing and midwifery care to improve quality at all levels and the provision of respectful and compassionate care, that entails: (1) respectful nursing and midwifery care; (2) ethics and compassionate care; and (3) gender integration and responsiveness (birth companionship, male involvement). In order to ensure that all health facilities provide quality, safe and efficient services, the government will enhance clinical audit and supervision mechanisms in line with established guidelines.

The government will strengthen cooperation with the private health sector in health care delivery. This includes strategies to enhance PPP in the provision of health services, in line with service agreements and existing guidelines, promotion of private health sector investments in the key priority areas of the health sector for public benefit and establishing a mechanism for private health facilities to provide public health emergency health services to the community, either without payment, or at a reasonable cost.

The government will reinforce the referral system from community to national level. During the implementation of HSSP V, the guidelines for referral will be rationalised, and a national ambulance service will be established, in collaboration with private providers, to facilitate quick transportation of patients to and from accident sites, community (residences) and health facilities.

5.3.2 Improving Quality of Health care Services

STRATEGIC OUTCOME – QUALITY OF CARE
Ensure availability of quality of essential health care services and interventions.

Quality of Care

The health sector will focus on improving quality of care through system-wide improvements. The health sector aims to provide people-centred care. The government in collaboration with stakeholders will focus on integrating, sharpening, synergising and intensifying efforts to improve the quality of care, starting with root causes of poor quality at the health systems level (human resources, equipment, supplies, infrastructure, etc.). The MOHCDGEC will facilitate an agreement on the joint quality improvement approach to be used in the sector, and the harmonisation of all quality tools developed by programmes, departments, NGOs and others. The MOHCDGEC will also guide the exploration of new approaches to large-scale improvement in quality including selection of the game-changers that should be adopted or adapted for use throughout the health sector.

Furthermore, to address the root causes of poor-quality care, small scale quality improvement (QI) approaches that target the behaviour of providers or patients will be incorporated in facilities. Clinical audits as well as nursing and midwifery audits will be institutionalised. QI Teams will continue their work in regions and councils. Where needed, further capacity building in quality of care and compassionate care will be provided.

The health sector will continue with the establishment of an accreditation system. The Star-rating will be strengthened, with self-assessment and web-based tools. Health facilities (public and private) that have reached five stars will receive official certification. Government will harmonise registers, licenses, and accreditation systems, for public and private health care.

Government will put in place the accreditation system for public and private health care facilities including clinics, pharmacies and independent laboratories which will be managed by a single independent sectoral accreditation board.

The Patient Charter will be promoted countrywide, and follow-up on adherence to the guidelines will be part of the support to health facilities, thereby enhancing accountability. Patient/client satisfaction surveys will be institutionalized in the health sector. Community engagement to discuss issues concerning quality of care will be arranged through the HFGCs. Community and social accountability mechanisms will be enhanced. Accessibility of services for people with a physical challenge will be improved.

5.3.3 Diagnostic Services

Effective and up-to-date diagnostic services, with equipment, supplies and consumables, are essential to support a functional referral system for health services. All health facilities should have the diagnostic capacity appropriate to their level of care (for laboratory, radiology, and medical imaging) to enable provision of services according to the requirements of the essential package per level. The government will ensure that a functional external quality assurance scheme and accreditation systems for laboratory services are maintained, and also for radiology and medical imaging standards for safety. Use of new mobile technology, ICT and artificial intelligence will be promoted to increase access to quality diagnostic services whereby patients attending health facilities that may not have the equipment or staff are served through telemedicine.
Government will strengthen the system of standardised procurement, preventive maintenance, and repair of health care equipment. Regional and zonal maintenance centres will be charged with this role. MSD will enter into maintenance contracts with suppliers of equipment. The introduction of managed equipment services will ensure uninterrupted functionality of health care equipment including laboratory, radiology and medical imaging in a cost-effective manner.

5.3.4 Safe Blood Transfusion

The MOHCDGEC will continue to encourage voluntary non-remunerated blood donation through active engagement of the community. Effective and sustainable systems for the collection, processing, and distribution of safe blood in the country will be strengthened in order to ensure uninterrupted supply of safe blood nationwide. The MOHCDGEC will continue to strengthen infrastructure for blood transfusion safety throughout the country and increase resources for collection, testing, processing, storage, distribution and utilization of safe blood.
The government will establish a legal framework to protect the rights and safety of blood donors, health care providers, and blood recipients through creation of a Blood Safety Act.

5.3.5 Public Health Laboratories

Public health laboratories (PHL) focus on diseases and the health status of population groups. Tanzania has created a national network of public health laboratories (at the national PHL Mabibo in Dar es Salaam, St Benedict's Hospital in Ndanda, and Kibong'oto Infectious Disease Hospital in Kilimanjaro region) and isolation centres located in strategic places throughout the country. They perform limited diagnostic testing, reference testing, and disease surveillance. They also provide emergency response support, perform applied research, and provide training for laboratory personnel. The core functions of PHL include disease prevention, control and surveillance, reference and specialised testing, environmental health and protection testing, food safety testing, laboratory regulations and policy

development. Public health laboratories participate in the East African Public Health Laboratory Networking project. The government will continue to strengthen and expand the national PHL system by establishing a new facility in Dodoma, and will also expand isolation centres and ensure all zonal and national level laboratories have international accreditation while regional and district level laboratories have at least 3-star rating according to the World Health Organisation (WHO) system towards accreditation.

5.4 Strategic priorities in Health System Investments and Functioning

5.4.1 Human Resources for Health

STRATEGIC OUTCOME - HRH:
Competent health workforce with adequate and updated competencies in adequate numbers available.

The health sector needs adequate staff with the necessary skills and expertise to provide quality services, and to run health facilities at all levels. Far-reaching reforms in the HRH area are needed, to meet the demand for the health services.

Human resource development
The Government will continue to oversee and coordinate the training of HRH. The MOHCDGEC will take the lead in preparing curricula and will oversee training courses in public and private health colleges, to enhance the quality of training and to enhance the link between training and practice in health care. New training courses will be developed in midwifery, specialised nursing and dentistry. Fellowship programs to increase production of medical specialists and super-specialists will be introduced. Training capacity needs to be increased in the fields of pharmacy and laboratory.
Quality of training will address education systems in a holistic manner right from curriculum design, selection of trainees, skill development and examination systems. It will focus policies, people, infrastructure, processes, and materials. Government will ensure the availability of trainers, equipment, adequate infrastructure, accommodation, and food in all government health colleges. As a priority, infrastructure, including ICT, learning and teaching materials and skills labs will be improved. Quality assurance of the training system will be enhanced, to ensure that the workforce produced are of acceptable quality and that they have the required core competencies. The accreditation system for health training institutes will be strengthened. Government will work closely together with the Ministry of Education, other agencies and stakeholders in the private sector. The MOHCDGEC will establish a legal framework for the operation of public health training colleges. Fast tracking the approval of COSESCA and ECSACON models for training specialised courses is critical.

Further innovative solutions to address CPD are important. Government will enhance the provision of on-the-job training for all health care workers using ICT. Government will expand e-learning for local health workers on demand as part of the planned CPD approach. The MOHCDGEC will improve and harmonise systems for recording, registration, licensing, and CPD. Government will introduce certification for health care professionals.
The MOHCDGEC will amend legislation to align or integrate the various governing and professional bodies. The country will have one system for registration, identification, licensing, and certification for health professionals and training colleges. MOHCDGEC will promote ethics of practice in all professions.

Human Resource Planning

A data-driven and evidence-based HRH planning system is critical to guide HRH production, recruitment, distribution, retention, and management to address the health workforce challenge of mismatches between need, supply, and demand. This will go hand in hand with improvement in HRH information systems as well as promotion of HRH data use for decision making.

Deployment

As HRH represent an enabler to many service delivery priorities, increased absorption of trained health workers to reduce the HRH shortage is essential. The government will expand use of Workload Indicator of Staffing Needs – Prioritisation and Optimisation Analysis (WISN-POA), allocating health workers where they are most needed. Strategies to address labour mobility between private and public facilities will be prioritised. Innovations and alternative hiring arrangements (including use of the private sector) will be formalised and supported. Application of innovative strategies will be facilitated, such as allowing facilities to hire and retain staff using local arrangements or devising mechanisms that will enable interns to serve for longer periods. Special arrangements for staffing newly constructed facilities will be considered. CHWs will be deployed in villages and hamlets (vitongoji) to extend health promotion, health education, disease prevention, and rehabilitation within the community.

Placement of staff according to workload and patient needs will be used in preference to fixed establishments. Priority for employment permits and funding for HRH positions will be given to completed health facilities, regions with a low HRH per population ratio and tutors for HTI. Budget will be allocated for redistribution of HRH within LGAs with huge inequalities between health facilities. Guidelines for non-financial incentives and a policy for volunteers in the health sector will be developed.

Government will work on adoption and scaling up of innovative retention schemes. Guidelines for use of volunteers in the health sector will be developed.

Appropriate mechanisms for staff performance appraisal, internal supervision and effective job allocation are important to enhance productivity and ensure optimal utilisation of the available health workforce. Government will introduce a mechanism to measure individual productivity in relation to assigned tasks, possibly with automated tools.

Strengthened management and leadership of HRH is needed. The MOHCDGEC will develop a strategy to improve execution capacity and oversight for managing results effectively and efficiently with a high sense of individual and institutional accountability at all levels.

5.4.2 Nursing and Midwifery Services

STRATEGIC OUTCOME - NURSING MIDWIFERY SERVICES:
A nursing and midwifery cadre that is able to provide quality and compassionate patient-centred care available.

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

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

5.4.3 Medicines and Supply Systems

STRATEGIC OUTCOME - MEDICINES AND SUPPLIES:
Sufficient medicines and medical products available in all health facilities. Wastage and misuse of medicines and medical products is reduced.

Medicines
The health sector aims to guarantee access to affordable, quality medical supplies and equipment, to meet the country's requirements for service delivery at all levels. The health sector will improve existing procurement and delivery systems to reduce the cost and increase availability of medicines and supplies. Government will step up audits of medical commodities to ensure adherence to standards for quality and value-for-money. The government will continue to promote the use of a single/uniform system for bottom-up quantification and distribution for commodities by all health programmes and entities, under the leadership of the Chief Pharmacist at MOHCDGEC and support technically by MSD. At national level, government will unify entities that now perform these tasks autonomously. Regarding the quality of medicines, MOHCDGEC will enhance the use of TMDA apps and tools to improve monitoring of both quality and safety of medicines. Government will improve the post-marketing surveillance system (quality of drugs in the market).

The government will strengthen the availability of medicines and health commodities, medical devices and supplies, to cover the needs according to the NEHCIP-TZ. The prime vendor system at regional level will be reviewed and strengthened. Interventions to reduce AMR, including optimal prescription of medicines, will be expanded in the coverage and range of antimicrobials monitored. Rational use of medicines will be mainstreamed in supply chain interventions. The MOHCDGEC will review and disseminate standard treatment guidelines and the essential medicine list based on evidence. It will ensure that all institutions will have (electronic) versions of guidelines and that health workers have the skills to correctly apply these guidelines, protocols and standard operating procedures. Therapeutic committees in health facilities will oversee this. Government will train and deploy health staff for pharmaceutical services.
Government will strengthen domestic pharmaceutical manufacturing, as well as research and development. It will continue to create an enabling environment for pharmaceutical production in the country that meets international standards for domestic and export use. The government will reinforce financial and stock management accountability at public health facilities, and improve oversight and regulation in both public and private health facilities .

Diagnostics
Government will establish one single committee at national level for quantification of all commodities and supplies, together with standardisation of equipment, consumables, and maintenance for all essential equipment. The health sector will expand the use of managed equipment services for procurement of diagnostic and other health care equipment.

5.4.4 Infrastructure

STRATEGIC OUTCOME - INFRASTRUCTURE:
A network of health facilities is in place that guarantees equitable access to essential health services for the whole population.

Government will ensure the availability of PHC facilities with sufficient infrastructure and resources according to geographical, demographic and population needs. Evaluation of epidemiological and demographic factors will be a basis for assessing the need for health facilities. Government will develop a new long-term investment plan for health facilities based on these factors, with the aim of covering all 1,845 wards in the country. Government will maintain and renovate health facilities according to needs, based on priority planning. The system of planned preventive maintenance of buildings and equipment will be strengthened.

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

Government will ensure that all regions have a public RRH, supplemented as needed by upgraded faith-based or private referral hospitals, that serve as functional referral centres for PHC facilities.
Government will build capacity of health facilities to manage waste (including medical waste) and sewage. Government will continue to put in place sanitation infrastructure in all government facilities in compliance with medical waste management guidelines, for all levels from PHC to national level.

5.4.5 Information and Communication Technology

STRATEGIC OUTCOME - ICT:
An interoperable ICT system in place, that meets international standards of communication, data storage and exchange of information, and that facilitates delivery of quality services to the population.

Information and Communication Technology (ICT) contributes to increasing productivity, efficiency, and quality of health care in the country. ICT is used in four domains in health: for data management, processing and reporting (both in administration and in service provision); for support to medical decision-making processes; for e-learning for health workers; and for communication and information of the general public. Government is developing sustainable ICT systems in all four domains and has defined regulations governing interoperability and harmonisation of systems. The government has developed a national investment plan to guide all partners in ICT development. Government will establish a Centre for Digital Health.
Government will continue to coordinate, harmonise, and manage the use of ICT systems in the health sector. The sector will continue to expand ICT to the grassroots level through mobile technology. Capacity building for users of ICT systems will take place, from grassroots to top management, both through pre-service and in-service training, and where possible through e-learning/mobile learning.

Government will ensure that ICT experts will be deployed at the local level for management of infrastructure and capacity building of staff.

Government and stakeholders will select a few essential apps that are really game changers in health care from the 180+ apps currently available in the country and will ensure that those apps will be available to all health workers (both the technical solutions and training). The government will also expand the use of electronic medical records systems, including back-up systems, that seamlessly interact and exchange information with the national HMIS, in all health facilities from PHC to national hospital level. The HMIS central data warehouse will be maintained and availability and accessibility of data will be improved through visualisation in dashboards, drill down features, and other tools for better use of information in decision-making. Government will establish a legal framework for protecting the security of data, privacy, and confidentiality of patients. There will be regulations for the use of personal data for management and research.

5.4.6 Health Research and Development

STRATEGIC OUTCOME - RESEARCH:
A vibrant research community in place, that can provide relevant and ethically sound inputs for evidence-based policy-making

The health sector needs to base its policies on evidence, and therefore needs a strong academic and research community, especially in the areas of public health, health systems, health policy, financing, food and nutrition, preventive services, medical and rehabilitation services. Research should be linked to the needs of the health sector. MOHCDGEC will improve the coordination of clinical and public health research conducted in the health sector. The NIMR, on behalf of the MOHCDGEC, will coordinate the national health research agenda and translation of research evidence to inform policy and practice. The ministry will enhance the use of the findings of studies conducted in Tanzania and other countries for developing health strategies and programmes. The ministry will collaborate with National Bureau of Statistics (NBS) to coordinate and manage the results of surveys and to process the findings of health surveys in the country. MOHCDGEC will continue to promote and stimulate health research that will result in industrial development, including pharmaceutical, medical, and translational products, improve health systems functioning, and foster behavioural change for disease management and control.

The government will continue to strengthen the framework for research and use of research findings to guide development in the health sector. Innovations will be taken on board through improvement of knowledge translation in research organisations.

5.4.7 Public Private Partnership

STRATEGIC OUTCOME - PPP:
A committed private sector in health in place, that contributes to improvement of health of the population in Tanzania, based on the principles of level playing field operations and mutual support in relation to the Governmental services

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

accordance with existing contracts and guidelines. All private health care facilities are monitored to ensure compliance with existing contracts and guidelines. While reporting of private health facilities through DHIS2 has continued to improve, the government will strengthen the monitoring of private sector performance.

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Government will harmonise the quality management systems of health care between the public and the private sector. There will be one single registration and accreditation system for health facilities, providing certification for health care services. This will create a level playing field for public and private health systems. Government will engage with the private sector in programmes for control of communicable diseases, e.g., HIV and malaria, and for reduction of risk factors for non-communicable diseases.

Government will continue to create an enabling environment for joint ventures and investments in the health sector, especially in domestic production of medicines and consumables. PPP agreements will be stimulated and maintained at all levels, from council to national level.

5.4.8 Financial Resources

STRATEGIC OUTCOME - FINANCIAL RESOURCES
Implementation of a health financing strategy, which maximises equitable access to quality health services for all, provides financial protection against ill health, and promotes strategic purchasing. All citizens are protected from catastrophic health expenditure

Tanzania has been recognised as a lower middle-income country and this status will lead to a change in the nature of external funding. The government will carefully plan the "transition" within this five-year period so that the health sector is not negatively impacted by a reduction in external financing or change of modality from grant aid and soft loans to commercial loans and trade. The government will continue to increase domestic funding in the health sector budget with a view to meeting high priority needs in line with the overall country's goals. Government will review and update the Health Financing Strategy to be in line with the current situation and priorities.

Health insurance

Government will work with stakeholders to expand the scope of health insurance. Government will mobilise citizens to join health insurance schemes to ensure that every citizen has access to health care without financial constraints at the time of service use. For people who do not have formal employment, the iCHF benefit package includes critical primary health care interventions such as treatment for severe acute malnutrition and transport or maternity waiting home. Innovative methods of payment for iCHF (e.g., through labour or in-kind) will be investigated.

NHIF is gradually expanding its services to cover people with informal employment. Following the introduction of mandatory insurance once the Bill currently under development is passed, work will initially focus on strengthening and expanding coverage under the existing schemes. Subsequent study will chart the way forward to increase pooling under one Universal Health Insurance (UHI) scheme, subsuming both iCHF and NHIF. Government will establish a mechanism to identify those in need of health services, identify vulnerable groups, such as children, pregnant women, people with chronic diseases, and elderly, and ensure that they are incorporated in the insurance schemes. The proxy-means testing approach used by the Tanzania Social Action Fund (TASAF) will be explored for use as a mechanism for identification of those unable to pay for health services who will progressively be supported by the government to access health insurance cover.

It is important to strengthen the payment system for health care providers, in order to improve service delivery in public and private health care facilities. A costing exercise will be undertaken to determine

the actual cost of providing various health interventions in health facilities at different levels, in public and private health facilities. The government will provide further regulations regarding the gatekeeper system, reimbursements of claims, with clarification on eligibility, automation, and maximum period for reimbursement, to guarantee continuity of care (e.g., replacement of medicines given to insured clients). The expansion of public health insurance schemes will increase the extent of strategic purchasing of services from health care providers whereby payments are based on services used rather than inputs.

Government will explore innovative taxation and other financing mechanisms (pro-health taxes, airline levies etc) to enhance funding for health. Government will stimulate corporate social responsibility in financing health activities.

Financial support to the health sector

Resource mapping is a first step in harmonisation and alignment, and equitable coverage over the country of financial contributions from within and outside government. The government will strengthen capacities for and improve timeliness of routine Public Expenditure Reviews and National Health Accounts, supplemented by occasional Public Expenditure Tracking Studies. The government in collaboration with stakeholders will develop a resource mobilisation plan, monitoring and evaluation. The GOT will revise and expand the Wadau portal developed by PO-RALG to all levels to record budget, activities and financial contributions from DPs, NGOs and community-based organisations (financed by DPs), private sector, philanthropies or social enterprises. At community level more control by LGA structures will be made possible, to enhance alignment of external support. Government will insist that DPs contribute to a shared health plan and have transparent sources of funding for health care including a system for monitoring of D-Funds.

Financial management

Government will continue to strengthen planning, budgeting, execution, M&E throughout the health system. Increased attention will be given to management of public finances at all levels, including reporting on expenditures in relation to outputs. Regular audits will be undertaken. The partners in the health sector will continue improving the efficient use of available resources, for example through strategic purchasing and harmonisation of funds flows. Partners will increasingly align with GOT public financial management systems. PlanRep and the Facility Financing Accounting and Reporting System will be used as the basis for financial management at facility level. Complete and timely disbursement and use of funds is critical to maintain continuity of service provision. The government will explore and address bottlenecks that lead to delayed disbursement by GOT and DPs.

Section Three:
Implementation Arrangements

6 Chapter 6: Institutional Framework for Implementation

6.1 Management framework

STRATEGIC OUTCOME - MANAGEMENT
A management framework in place, to implement Government's policies regarding decentralised management of health services.

6.1.1 Decentralised Management

Government will maintain the framework for planning, service delivery, financial management and information delivery at health facilities. Capacity building of facility management teams, boards and committees at all levels of the health sector is needed in order to achieve better community participation.
Councils Health Service Boards, Hospital Management Boards, and HFGC oversee the management of health care facilities in accordance with the guidelines. The government will update guidelines and procedures for involving citizens in decision-making, transparency, and accountability on access, provision, operation and ownership of health care facilities.

6.1.2 MOHCDGEC

Implementation of the HSSP V will be overseen by MOHCDGEC in accordance with the political and technical mandate. The ministry will prepare policies, guidelines, laws and regulations to enable the implementation of strategic plan. The M&E framework of the strategic plan guides performance assessment of the health sector, and measures to be taken for proper implementation. The MOHCDGEC is responsible for short- and medium-term plans such as the Medium-Term Expenditure Framework of central government and CCHPs for local government.
The Ministry is responsible for resource mobilisation and monitoring, evaluation, and research. Regarding the provision of health services, MOHCDGEC is responsible for providing referral services through RRH, zonal referral hospitals, specialized hospitals, and the national hospital(s). MOHCDGEC has institutions and authorities that perform various health functions to meet its goals of enhancing and improving health coverage so everyone in the country can access required health services without suffering financial hardship.

6.1.3 PO-RALG

The President's Office - Regional Administration and Local Government is responsible for coordinating, facilitating, and managing the implementation of the strategic plan through local government authorities at council, ward, village, and community levels. PO-RALG prepares the guidelines, regulations, and frameworks to facilitate the implementation of the strategic plan and to provide PHC. PO-RALG, through the Regional Administrative Secretariats, oversees the office of the RMO, responsible for empowering local governments to deliver health interventions, overseeing such

implementation, and ensuring the quality of services provided. Under the Executive Director of the council, LGAs have a CHMT responsible for managing and providing health services through the preparation and implementation of CCHPs, plans for PHC facilities, and community-level health plans for each ward and village.

6.1.4 Governance of Health Facilities

The health sector will ensure good governance in the provision of health services at all levels, with accountability, transparency, and ethical standards. Government will enhance social responsibility and protection of rights in health care. Government will therefore strengthen multi-agency management to build better relationships and transparency. Capacity building of council boards, hospital boards and HFGCs is necessary to achieve this. In this context there will be continuing education to health providers and the public to stop the practices of lobbying, claiming, giving and receiving bribes. There will be a transparent system for filing and follow-up complaints.
The government will Improve governance and leadership capacities in health care delivery systems at all levels. It will build capacity of all management staff on technical, managerial, financial and evidence-based planning and management.

6.1.5 Governance at Community Level

Harmonisation and alignment of health- and development-related community structures is important, with health facility management committees, Village Health Committees (VHC), Ward Development Committees (WDC), and other community-based structures operating in the same domain. The links with LGAs should be reinforced, and community activities should become part of the bottom-up planning system. Capacity building of community committee members will be improved, and mobile technology availed to the committees in management and monitoring tasks. It is also important to link with professionals, volunteers, and extension workers e.g. Community Development Officers, social workers, agriculture extension workers, teachers. Improved functioning of community structures will enhance community accountability for programmes and services.
The PHC committees will be revived, better linked to HFGCs, CHSBs, and Hospital Management Boards. District and regional PHC committees will input to the district and regional Consultative Councils. The CHWs will be housed at the village government offices, reporting to village executive officer and linked to health facilities in their respective areas.

6.1.6 Gender and Equity

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

6.1.7 Urban health care

The relatively poor health status of urban dwellers calls for redefinition and reprogramming of services in cities and townships. It is proposed that the health sector to recognise Dar es Salaam as a specific health zone. This approach has been adopted by other government administrative entities (e.g. police, Tanzania Revenue Authority and TANESCO). In this case the three municipalities are designated as health sector regions in line with population distribution and deploy additional HRH to the management system (i.e. RHMTs and CHMTs). The health sector will work with other sectors (notably land and NBS) to project and plan for future health facility expansion to meet health care demands. Future studies and surveys should provide disaggregated data according to these health sector regions in Dar es Salaam.

6.2 Partnership framework

STRATEGIC OUTCOME PARTNERSHIP
A partnership framework in place, enabling inputs from all relevant stakeholders in improving health of the population.

Society as a whole has a major interest in the implementation of the Health Policy as they are the key actors responsible for the use of health care as well as participating in contributing to the acquisition and management of its operations.

6.2.1 Intersectoral Collaboration

In implementing this strategy, the MOHCDGEC will collaborate with other ministries, institutions, religious organisations, social organisations, the private sector, and DPs. Many health issues require the cooperation of various sectors. Achieving SDG3 (health) requires interventions in water, agriculture, livestock and fisheries, nutrition, education, environment, natural resources, and sports. This will involve infrastructure, legislation, financial resources, and communication. Intersectoral collaboration will take place at all levels, from national level to community level. Cross-cutting issues that have been prioritised in the Health Policy of 2020 include emergency and disaster response services, HIV/AIDS, good governance, corruption, the environment, human rights, gender and the social determinants of health.

6.2.2 Public Private Partnership

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

6.2.3 International Collaboration

Government will collaborate with various countries and international organisations on matters of health that are of global and national interest. It will form and implement joint plans for improving and developing health care in the country and responding to emergencies and disasters.

The government will strengthen national ownership and government leadership in programming and cooperation. Government will promote mutual accountability in international collaboration. Government will coordinate with DPs on health sector plans that focus on national priorities.

6.3 Governance framework

STRATEGIC OUTCOME - GOVERNANCE
A functioning governance structure in place, aligned with government policies, such as decentralisation by devolution, social accountability, and health in all policies. Collaboration between government, non-state actors and development partners will be geared to facilitating effective actions at the intervention level.

From the Mid-Term Review (MTR) of HSSP IV it transpired that too many important issues of promotive, (protective), preventive, curative, rehabilitative, and palliative care are not adequately addressed, because linkages between departments, e.g., curative, preventive, pharmaceutical services, are not strong enough. There is also a need to strengthen the linkages and mandates of the national level institutions including Tanzania Food and Nutrition Centre (TFNC), Tanzania Bureau of Standards (TBS), and TMDA. It is therefore necessary to create crosscutting taskforces for key areas, in which the institutions, departments, sections and units work together to solve issues that are strongly interlinked. The task forces will have a strong mandate to take actions forward, but because of their ties to departments make sure that interactions between vertical and horizontal structures remain adequate.

Strengthening SWAp

The health sector SWAp dialogue structure is guided by the Development Cooperation Framework (DCF) July 2017 that takes into consideration the changes in development cooperation arising from the emergence of new and non-traditional development assistance providers, increased diversification of sources of finance, and the shift from aid effectiveness to development (trade and investment) effectiveness. Moreover, the recent classification of Tanzania as a lower middle-income country (LMIC) will require the country to increase domestic resource mobilization and gradually reduce donor dependence. The SWAp dialogue structure will therefore re-affirm the guiding principles of the DCF of fostering national ownership, alignment to national priorities, use of country systems, and strengthening accountability.

Although the health sector in Tanzania has functional SWAp structures, they require some revival especially in the functioning of the TWGs, further investment in inclusion of relevant stakeholders, and decentralization to sub-national levels through:

- Alignment of the SWAp TWG formation to the health system approach (6 health system building blocks) rather than disease or health interventions
- Trickling of SWAp structures to regional and district level (led by RMOs/RHMTs and DMOs/CHMTs)
- Ensure community health systems are reflected vividly under the SWAp
- Ensure integration, alignment, and harmonisation of existing vertical dialogue structures such as the Interagency Coordinating Committee (ICC) for Gavi-supported immunization activities and Tanzania National Coordinating Mechanism (TNCM) for Global Fund (GFATM)-supported HIV, TB, and malaria interventions.

National level

The focus of the SWAp will be on strategic issues in line with HSSP V, less on operational activities, which are either the mandate of MOHCDGEC or PO-RALG (in collaboration with operational partners). Therefore, mandates of structures at national level will be redefined, especially for TWGs. It is necessary to create TWGs that follow the dialogue structure of the taskforces within MOHCDGEC, reducing the number, and broadening the scope of work of TWGs. The terms of reference of annual Joint Field Visits (JFV) and the agenda of the Joint Annual Health Sector Review Technical Review Meeting and Policy Meeting will be expanded to include issues addressed in the ICC and TNCM. Gavi, GFATM and the Global Financing Facility will be required to send high level representation to the JVF and the Technical Review and Policy Meetings of the JAHSR. The HSRS will be strengthened to give it an internal communication mandate and capability to coordinate all stakeholders supporting the health sector.

Sub-national level

The MOHCDGEC will decentralise SWAp structure by creating TWGs at regional and council levels. It will define mandates for partner coordination structures for sub-national SWAp and describe the interaction between levels. This will both improve follow-up of HSSP V intentions, ensuring that things get done, and also reduce overlap. Communication needs between SWAp levels (and between SWAp structures at same level) will be defined. In addition, an electronic resource centre for exchange of confidential information will be created. MOHCDGEC will make use of the PO-RALG initiative http://hssrc.tamisemi.go.tz for public information concerning health sector initiatives.

Strengthening accountability and leadership

MOHCDGEC and PO-RALG will capacitate RMOs, DMOS and health managers at all levels with managerial and leadership skills to improve health service delivery performance and quality through decentralised, evidence-based decision making. PO-RALG will continue developing leadership performance management tools and assessment.

Strengthen governance in communities

MOHCDGEC and PO-RALG will review governance and stewardship structures and procedures at community level by mapping structures such as HFGCs, VHCs, WDCs, and WASH committees etc. If necessary, their mandates will be redefined to ensure that gender equality measures are implemented, and to make them work in a harmonised and equitable way. Community development and social welfare officers will be included in the governance structures. CHWs or volunteers with focus on specific programmes e.g., nutrition and HIV or malaria, will be incorporated. The exercise will ensure that more integration between the different cadres is achieved.

Sector resource mapping of NGOs, faith-based organisations and private sector

Resource mapping will show where the overlaps and gaps are between financial and technical contributions by stakeholders. The resource mapping aims at more equitable distribution of such support programmes over the country (or, if necessary, within councils).

6.4 Alignment of Subsector Health and Disease Specific Strategies

STRATEGIC OUTCOME
To have subsector strategic plans for health and disease specific programs that are aligned with the guidance and aspirations expressed in HSSP V so that joint efforts to uplift the health of Tanzania's population are stimulated and coordinated

In order to ensure that the guidance and aspirations expressed in the HSSP V are adhered to, all subsector strategies should be aligned to HSSP V by timeframe and strategic direction. The One Plan III, NCD, and the HRH Strategies were developed in tandem with HSSP V. The alignment applied the following criteria:

1 Timeframe of strategic plan in relation to HSSP V
2 Linkage of goals and strategic objectives to HSSP V
3 Alignment of subsector strategies with national and international planning guidance documents (Tanzania Development Vision 2025, National Health Policy, SDG, UHC, WHO Global Health Strategy etc)
4 Implementation arrangements using SWAp structures
5 Strategic plan included in costing of HSSP V
6 Governance structures
7 M&E plan, impact and outcome indicators in line with HSSP V

The following plans will be reviewed for further alignment:

1. Health Sector HIV and AIDS strategic plan 2018 – 2022
2. National Malaria Control Strategy 2020 – 2025
3. National Strategic Plan for TB and Leprosy Control Programme 2015 – 2020
4. National Action Plan for Health Security
5. Tanzania Quality Improvement Framework 2020 – 2025
6. National Pharmaceutical Action Plan 2015 – 2020
7. Tanzania National Strategic Plan for the control of Hepatitis

General recommendations for alignment

1. Synchronize time frames of implementation

In total, 7 out 8 plans are not implemented parallel to the HSSP that served as a guidance for the document. Plans that are approaching the end of their timeframe, i.e. have less than two years remaining, will be reviewed before the end of 2021 and a new strategy will be developed for the period 2021-2026. Strategies that have been implemented for two years or less will be reviewed and their time period extended to 2026.

2. Include financing strategies

In most strategic plans, the estimated costs and financing have not been incorporated. There is a tendency to give a brief overview of possible donors, but sources of income per strategy are left out. Thus, to enhance the reliability of future subsector plans and improve alignment with HSSP V, the finance strategies of subsector plans will be included.

3. SWAp structures alignment

The Sector-Wide Approach has been used by all plans. Committees to coordinate and manage SWAp are formed using the governance structures outlined in HSSP. However, the coordinating structures of SWAp in the subsector plans are largely parallel with HSSP. Government structures will be used to facilitate coordination and collaboration among stakeholders.

4. M&E alignment

All plans emphasize the importance of M&E systems. Nevertheless, the alignment of the subsector plans with national data collection and managements systems is not optimal. There is too much parallel M&E, burdening health workers. All programmes will use a single planning cycle and integrate in one single M&E system.

5. Accessibility of plans and reference to operational plans

In general, accessibility of the strategic subsector plans is very low. The MOHCDGEC will create a platform where policy plans are gathered and made accessible to the wider public. Moreover, this platform will enhance future alignment of plans by providing direct access to other strategic subsector plans.

7 Chapter 7: Costing

In order to guide target setting and implementation of the HSSP V, estimates of the costs of the various components are needed. This section provides details on the estimated costs, health impact, fiscal space and funding gap.

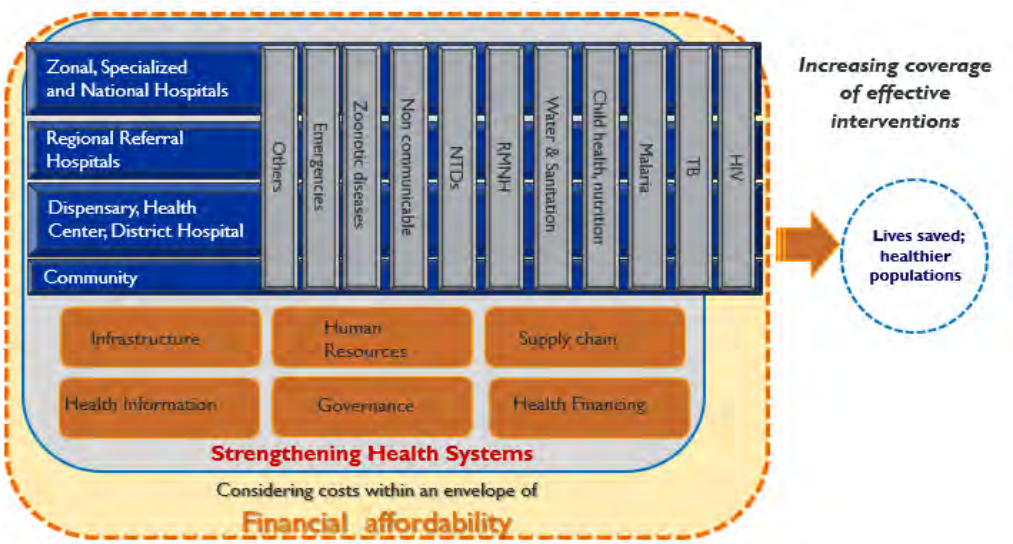
7.1 Resource Needs

7.1.1 Methodology

The estimates of resource needs were calculated using the OneHealth Tool, which is a model designed for medium to long term strategic planning for the health sector. It estimates the costs of health programmes, including service delivery and above-service delivery costs (e.g. programme-specific management, training, and supervision costs), as well as the resource requirements for the health system (represented by the health system building blocks of infrastructure, human resources for health, logistics, health information systems, health financing, and governance. The costing platform is linked to a series of impact models in order to estimate the health impact of scaling up coverage of key interventions, and to reflect the implications of preventive care on curative care needs, and synergies between services. Target populations for services are estimated based on these interactive impact models, which ensures the reflected savings of preventive care and public health interventions on curative care costs.

Figure 1 shows the structure of the OneHealth Tool, adapted to the Tanzania context.

Figure 1 OneHealth Tool structure



7.1.2 Total Resource Needs

In calculating the resource needs of HSSP V, three scenarios were analysed, with the moderate scenario being the primary focus scenario presented in these results unless otherwise noted.

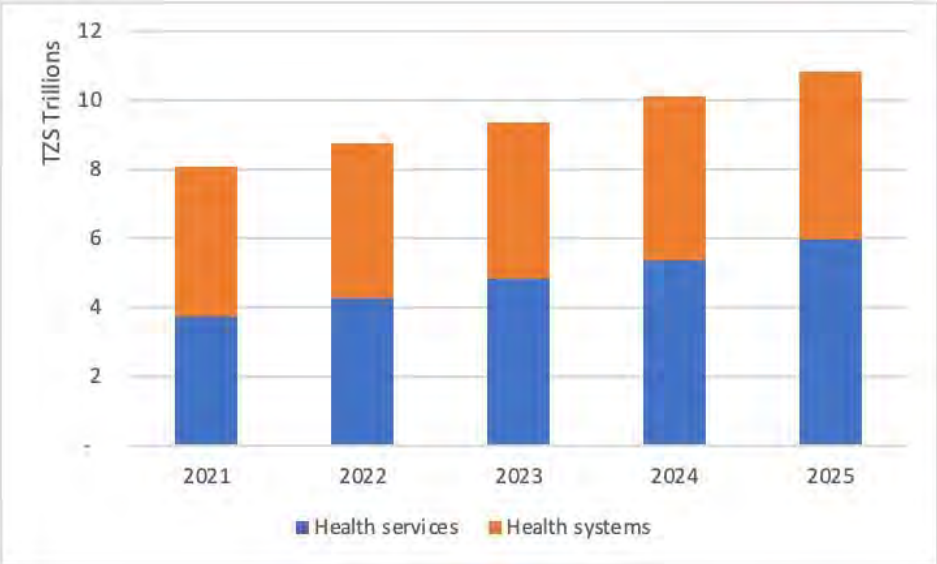
- Status quo: This scenario implies maintenance of current coverage of services and health system components. While all plans are to expand access and utilization of health services,

this scenario serves both as a useful counterfactual to examine additional costs and health gains, as well as an understanding of how much resources would be required simply to maintain current coverage as the population grows and inflation is applied.

- Moderate: This scenario includes full expansion to the targets set by the different health programme areas for vital interventions, partial scale-up for essential interventions, and maintenance of interventions deemed nice to have[1]. It is the primary scenario for purposes of HSSP V resource needs analysis, as it reflects a streamlined package of services designated for expansion and can be accommodated by the most likely resource envelope scenario.
- Ambitious: The ambitious scenario represents full expansion of vital and essential services contemplated by the various health areas and is relevant for consideration if UHI or innovative financing options allow for further investment.

As seen in Figure 3, the total costs of implementing the HSSP V under the moderate scenario are expected to rise from 8 trillion shillings to 11 trillion shillings over the course of the plan, with a total five-year cost of 47 trillion shillings. This expansion is due to several factors, including the addition of new services, expansion of coverage of existing services, population growth, and the disease burden. This implies a cost per capita of nearly TZS 133,000 in 2021, rising to TZS 159,000 by 2025 (USD 58 and USD 69 respectively).

Figure 2 Costs of health services and systems



The costs by programme area and health system component are shown in Table 8 below. Approximately 51% of the HSSP V financing requirement is related to health services, and another 49% is related to health system costs.

[1] The "Vital, Essential, Nice to have" classification was used as in HSSP IV, with categories based on expert view of each intervention according to a combination of criteria including burden of disease, cost-effectiveness, equity, political acceptability, and impact on the poorest.

Table 8 HSSP V costs (TZS billions) by programme and health system component

	2021	2022	2023	2024	2025	Total
Maternal/newborn and reproductive health (including FP)	289.82	305.58	321.90	332.74	348.01	1,598.06
Child health	189.84	210.28	216.25	206.72	203.24	1,026.32
Immunization	121.26	123.91	122.93	114.08	112.10	594.29
Adolescent health	17.01	14.13	15.10	13.03	12.97	72.24
Nutrition	113.00	117.66	124.05	125.41	129.61	609.72
Environmental Health and Sanitation	26.68	27.48	28.31	29.16	30.03	141.66
Malaria	155.53	155.09	181.49	174.27	189.27	855.65
TB	67.78	66.58	67.89	75.50	78.41	356.17
HIV/AIDS	688.04	736.17	785.54	832.72	878.85	3,921.31
NCD	953.62	1,183.49	1,380.08	1,625.64	1,870.04	7,012.87
MNS	74.39	88.56	103.81	120.66	138.91	526.33
NTD	218.03	244.79	273.57	304.52	337.80	1,378.70
Other communicable	177.48	195.53	214.31	208.06	219.72	1,015.09
Oral care	277.69	426.80	584.58	750.13	922.93	2,962.13
Ophthalmology	96.35	115.78	133.61	154.73	175.96	676.43
Orthopaedics	10.03	12.37	14.93	17.72	20.74	75.79
ENT	45.81	54.32	63.60	73.70	84.66	322.10
TAM	68.04	70.08	72.18	74.35	76.58	361.21
Health Promotion	48.62	53.11	57.95	63.15	68.73	291.56
Emergency Preparedness	76.55	49.16	49.41	50.21	51.74	277.06
Quality Assurance (QA)	3.02	4.72	4.96	5.83	5.77	24.30
HR	1,213.32	1,330.11	1,453.68	1,585.87	1,730.78	7,313.76
Infrastructure	2,330.96	2,331.09	2,201.61	2,220.39	2,155.43	11,239.48
Logistics	172.53	177.88	183.46	189.15	194.98	918.01
HMIS	15.49	16.41	16.17	14.34	14.57	76.99
Financing	198.07	224.55	253.99	287.70	323.78	1,288.10
Governance	415.58	428.05	440.89	454.12	467.74	2,206.39
Total	8,064.53	8,763.70	9,366.27	10,103.88	10,843.35	47,141.72

7.1.3 Costs of health services and health systems

As seen in the previous table, the costs of the health service delivery areas and programs is anticipated to increase from TZS 3.7 trillion to TZS 6 trillion by 2025, with a total five-year cost of TZS 24 trillion. These costs are driven by NCDs, infectious disease, and RMNCAH. Commodity costs, exclusive of logistics (procurement and supply chain management and other costs) represent around 86% of the requirement for health services, with the remainder needed for service delivery costs.

The five-year cost of the health system component totals TZS 23 trillion, with costs increasing from TZS 4 trillion in 2021 to nearly TZS 5 trillion by 2025. The financial resource requirements are greatest for HRH and for infrastructure (maintenance and construction), comprising 81% of the health system cost (and 40% of the HSSP V overall). By the end of the HSSP V, there will be an estimated more than

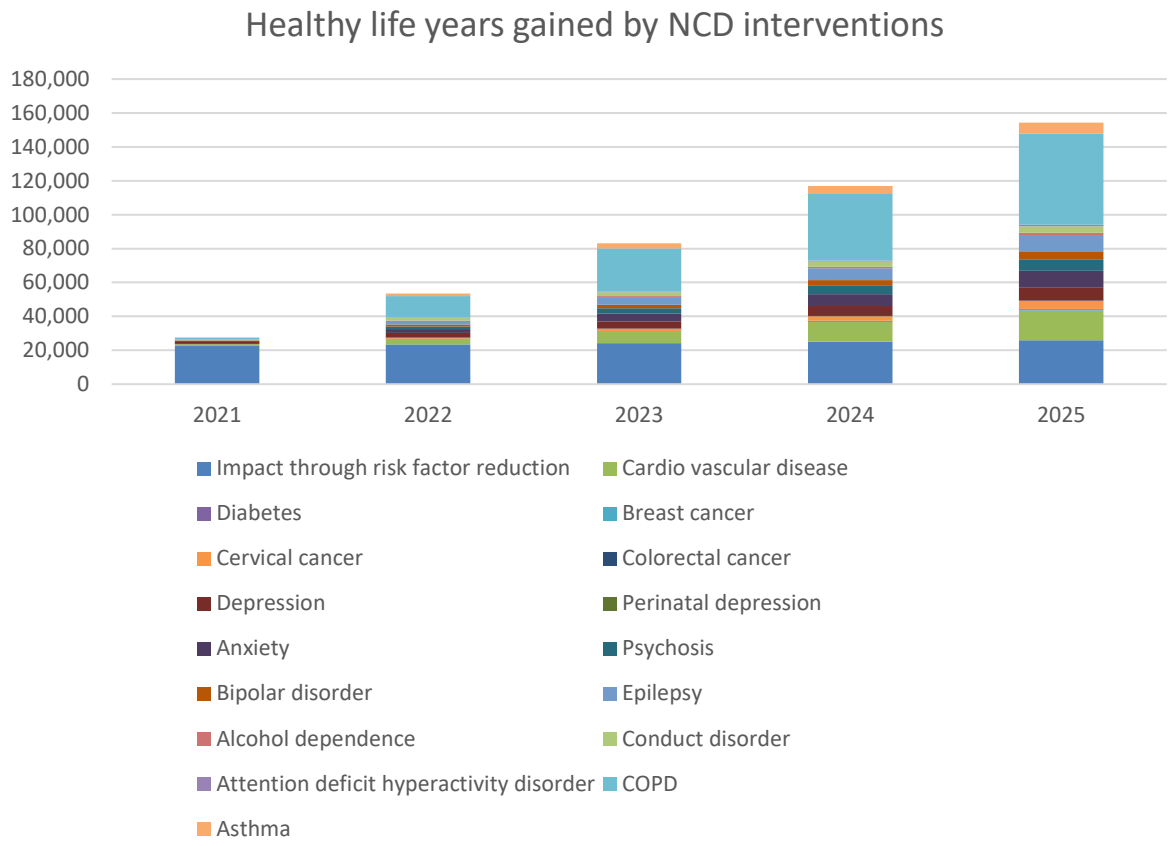
117,000 health service providers, an 21% increase over the estimated 97,000 at baseline. The human resources estimate also includes on call costs, a previously under-resourced component of care. Infrastructure costs are primarily driven by operating costs for existing facilities, but also reflect an expansion of nearly 1,500 dispensaries, nearly 250 health centres, and 35 district hospitals, reflecting a construction and new equipment and furniture cost of TZS 2 trillion over the five years of the plan.

The remaining health system components represent about 10% of the total HSSP V costs. Logistics costs capture MSD's operating costs, which cover the procurement and supply chain management costs in-country, as well as the cost of commodity wastage, freight, clearance, and quality assurance (note: MSD's working capital is not included in the costing). Governance includes management and governance activity costs for multiple government actors across different levels of the health system (e.g., MOHCDGEC, PO-RALG, RHMTs, and CHMTs).

7.2 Health impact of the plan

The impact models available in the OneHealth Tool to model the impact of the HSSP V can measure the effect on conditions, including the high burden areas of neonatal disorders, HIV/AIDS, lower respiratory infections, stroke, TB, ischaemic heart disease, malaria, diarrhoea, and diabetes. The HSSP V is anticipated to save more than 200,000 additional lives by expanding services beyond current levels. Child health drives mortality reductions most (nearly 125,000 deaths averted), followed by TB (33,000), NCD (27,000), maternal health (18,000) and HIV (4,000)
This is driven by increases in coverage of preventive and curative care services for children, continued improvement of the ART program, and expansion of the NCD prevention and treatment package. The health of the population is also being improved. For example, more than 400,000 DALYs are averted by the additional services offered as part of the HSSP V).

Figure 3 NCD Healthy Life Years Gained in Tanzania, in Disability-Adjusted Life Years (DALYs)



7.3 Resources available

The resource envelope was estimated using the WHO MacroHealth Tool. As the name indicates, this tool takes a primarily macroeconomic approach, assessing the amount of funds at the macro-level that are likely to be available for health from various sources over the upcoming years. It works by varying macroeconomic, public finance and health expenditure variables. Scenarios were developed to represent the following possible paths:

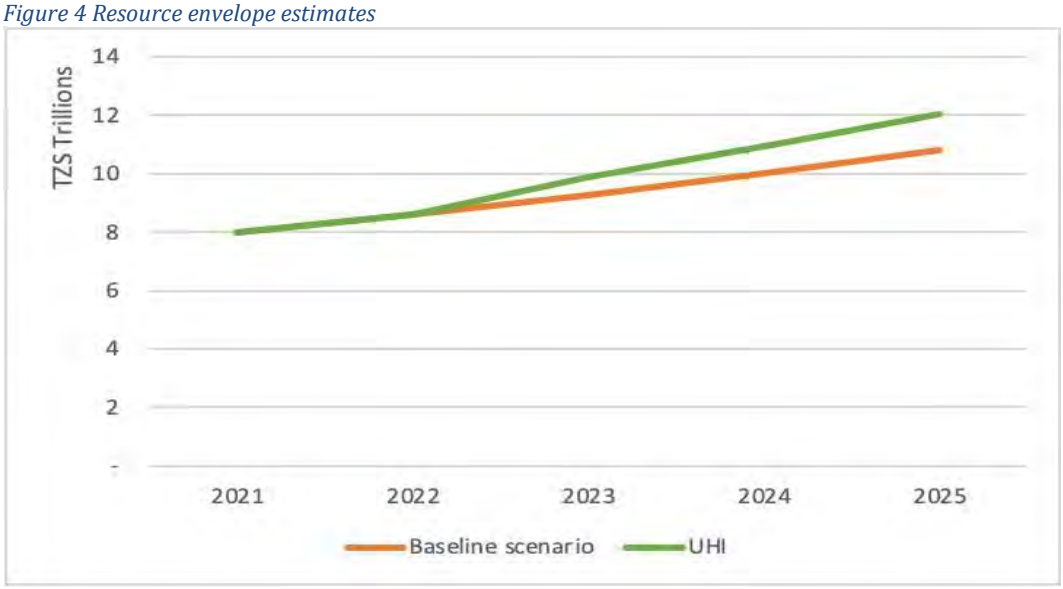
- A baseline, or conservative estimate of funds which would be available. This represents a scenario that considers past trends as predictive of future funds from government, health insurance, households, etc. Estimates use government data sources [2], together with assumptions that domestic public health spending keeps pace with GDP growth, while external sources fall slightly.
- An UHI scenario, where the components of the planned UHI scale up their coverage.

Figure 4 shows the anticipated funding available for each year of the plan, dependent on the coverage of UHI. Under the baseline scenario, assuming continuation of past trends, the resources available for

[2] Macro data from 2019/20 Budget Execution Report, and Health expenditure data from draft 2017/18 NHA data (including out-of-pocket data from Household Budget Survey data 2017/18). Domestic health spending sources were inflated, based on past trends, to the base year of 2019/20. More details of the methodology can be found in the companion volume on the HSSP V costing.

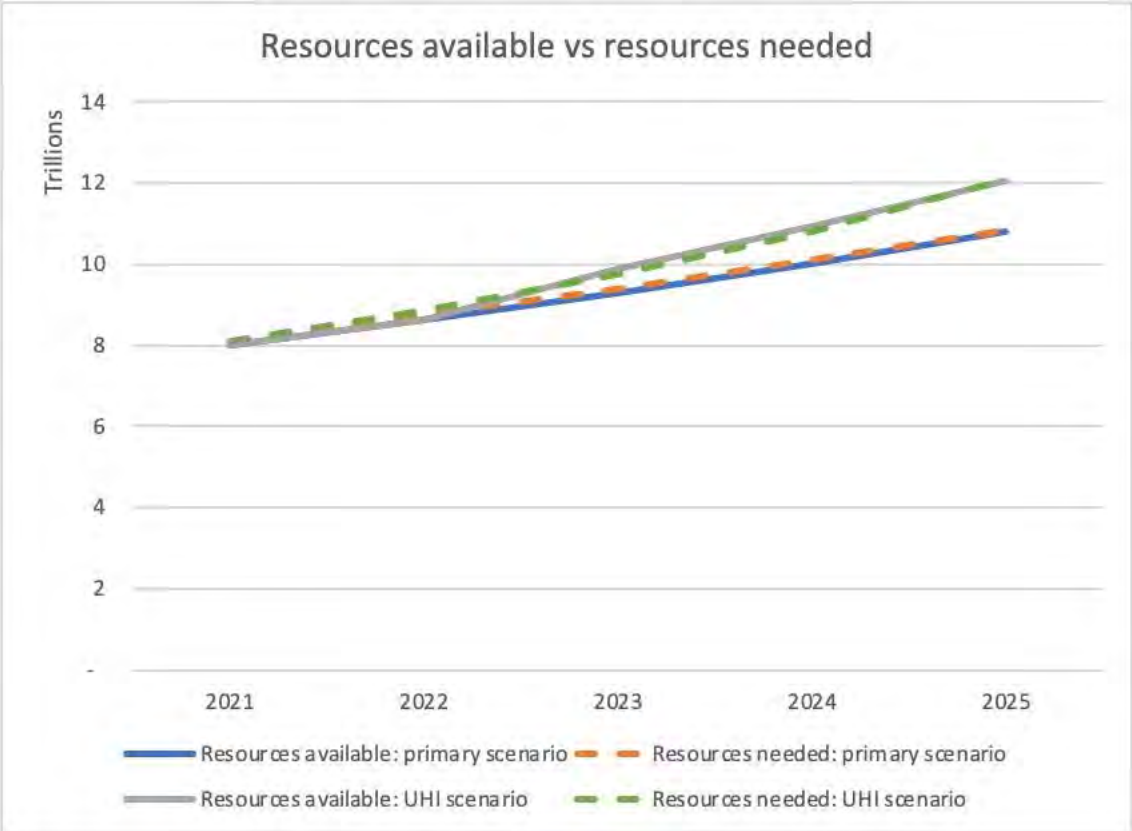
health programs would rise from TZS 8 trillion in 2021 to TZS 10.8 trillion by 2025. Under an assumption of increasing UHI coverage, we could anticipate TZS 9.9 trillion for health spending in 2023, increasing to TZS 12.1 trillion by 2025.

Figure 4 Resource envelope estimates



As seen in Figure 5, the costs for implementing the primary HSSP V scenario are consistent with the expected resource envelope under baseline assumptions. This scenario includes full scaleup of interventions categorized as vital, partial scaleup of interventions deemed essential, and maintenance of current coverage of interventions categorized as "nice to have". If more resources become available through UHI, essential interventions could also be scaled up more aggressively, with a price tag which would exceed the baseline resource envelope, but still within one which incorporates UHI and/or innovative financing. Under these assumptions, UHI coverage begins to scaleup up in 2023, allowing an expansion of coverage to full scale for those interventions categorized as essential and partial scaleup for nice to have interventions.

Figure 5 Resource envelope and resource need estimates



While based on available data, it should be noted that there remains uncertainty regarding these estimates, particularly in respect of scaling up UHI, and it is recommended that the resource envelope be reviewed before the expected Mid-Term Review of HSSP V.

8 Chapter 8: Monitoring and Evaluation

8.1 Introduction

The health sector M&E system aims to inform the progress and performance assessment of the HSSP V and its affiliated plans. Regular and systematic tracking of progress of implementation of priority interventions of the sector plan is essential to assess performance of the sector and local governments and adjust accordingly. The M&E system should provide timely and accurate information to government and partners in order to inform performance reviews, policy discussions and periodic revisions to the national strategic and operational plans.

The M&E plan for HSSP V builds upon the recommendations of the HSSP IV Mid-Term Review and aims to formulate a comprehensive and integrated M&E framework for HSSP V, One Plan III for RMNCAH, HRH strategic plan and NCD strategic plan. The M&E plan will also consider existing M&E plans and practices of other major health sector programs in Tanzania to maximize harmonization and alignment and take into account monitoring practices in other sectors where relevant.

This Plan describes the M&E framework, indicators, processes, sources of data, methods, and tools that the sector will use to collect, compile, report and use data, and provide feedback as part of the national health sector M&E mechanisms. It documents what needs to be monitored and how this will be done and specifies the roles and responsibilities of key actors in the monitoring process. It also outlines how and when the different types of studies and evaluations will need to be conducted by the health sector.

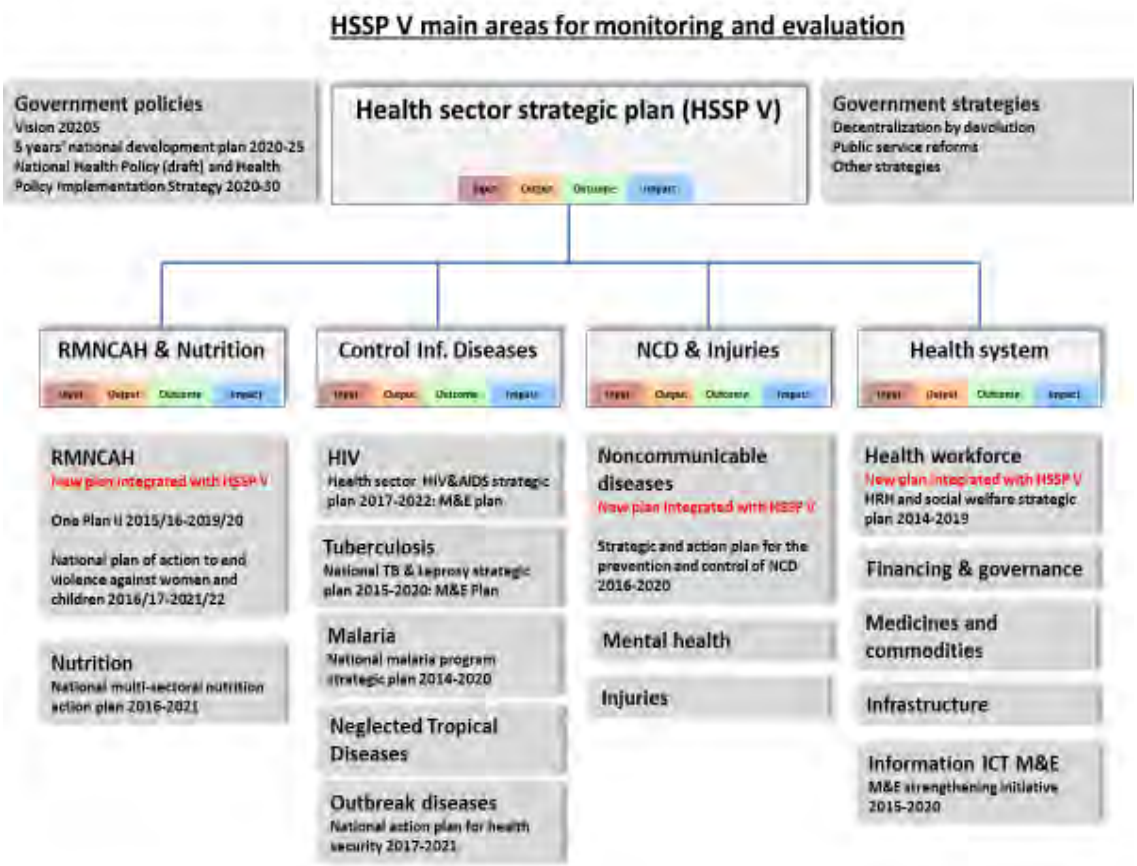
The M&E plan will:

- Address the strategic priorities of HSSP V, One Plan III, NCD and HRH
- Provide an integrated system and framework for M&E of all health programs (HSSP V)
- Present technical results framework for the selection of indicators and targets
- Link with M&E strategic framework
- Specify country mechanisms for data collection, analysis, review and remedial action

8.2 Integrated M&E system

HSSP V is at the apex of multiple other disease-specific plans. Therefore, the monitoring plans and practices, as well as indicators need to be aligned. HSSP V includes the main indicators of the different programme-specific M&E plans. The programme-specific M&E plans often have additional indicators and targets. The formulation of HSSP V indicators and targets needs to take the different plans into account. Figure 6 shows the different components of the HSSP V results framework as well as the link between the RMNCAH, HRH and NCD strategic plans. The programmes have been divided according to the classification used by WHO for the UHC index: RMNCAH & nutrition, control of infectious diseases, NCD and injuries, and health systems. The selection of indicators and targets for HSSP V and for the related plans will take into consideration the practices in the preceding and concurrent health plans.

Figure 6 Areas of M&E



From July 2021 to June 2026, health systems performance and coverage indicators for HSSP V, One Plan III, HRH and NCD strategic plans will be monitored annually at the national level, as was done in the previous plans. The indicators will be derived from multiple sources, and delivered to multiple consumers, at a frequency and in a format that meets the monitoring requirements of individual consumers. Some indicators will be monitored on a more frequent basis, such as a monthly or quarterly basis, at all levels of the health system – from facilities and councils to national and international levels.

8.3 Technical framework

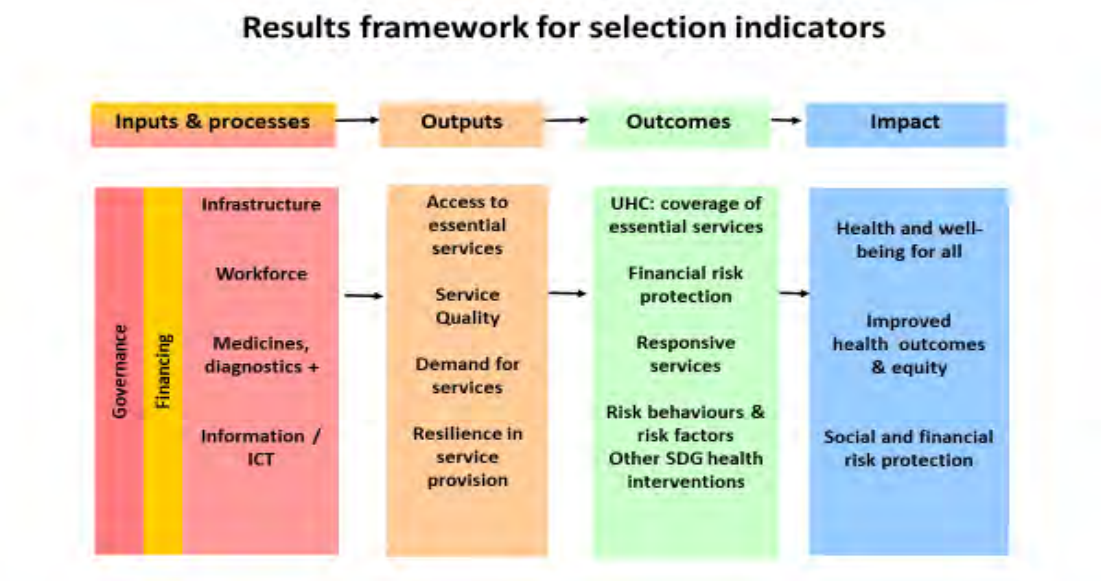
With the overall goal of improving health and well-being for all at all ages (SDG3) the overall framework of HSSP V is defined at three levels (outcomes, outputs or process and inputs), combining three WHO frameworks in strengthening health systems. The HSSP V framework can be adapted and presented as an input-output-outcome-impact results framework. Such a results framework is particularly useful for UHC and PHC monitoring, as it can be used to translate the framework into a core set of indicators and targets that are monitored on a regular basis. It can also be used to monitor progress of One Plan III, HRH and NCD strategic plans.

Figure 7 presents the results framework which includes:

- Inputs & processes: derived from the WHO building blocks for health systems which are used in HSSP V. The government can invest in building blocks to bring about changes in the outputs.
- Outputs: access, quality and safety of services, resilience in service provision and increased demand are the results of inputs and essential to get the desired improvements in outcomes and health impact

- Outcomes: coverage of interventions and health behaviours that have a direct impact on health and wellbeing. When possible, coverage with quality indicators is used.
- Impact: mortality and health status and wellbeing measures, as well as social and financial protection related to use of health services.
- Equity cuts across the different levels of the results framework. In line with the national health strategies, the emphasis is on reducing inequalities between populations. Therefore, improved equity in access, quality, coverage, and health status measures is part of the results framework.

Figure 7 HSSP V M&E framework for selection of indicators



The same results framework will be used to go deeper and select indicators for performance monitoring of the integrated plans: One Plan III, HRH and NCD Strategic plan.

8.4 Indicator selection

The following core principles were used to select indicators (using the SMART criteria and adding dimensions relevant to HSSP V and related plans):

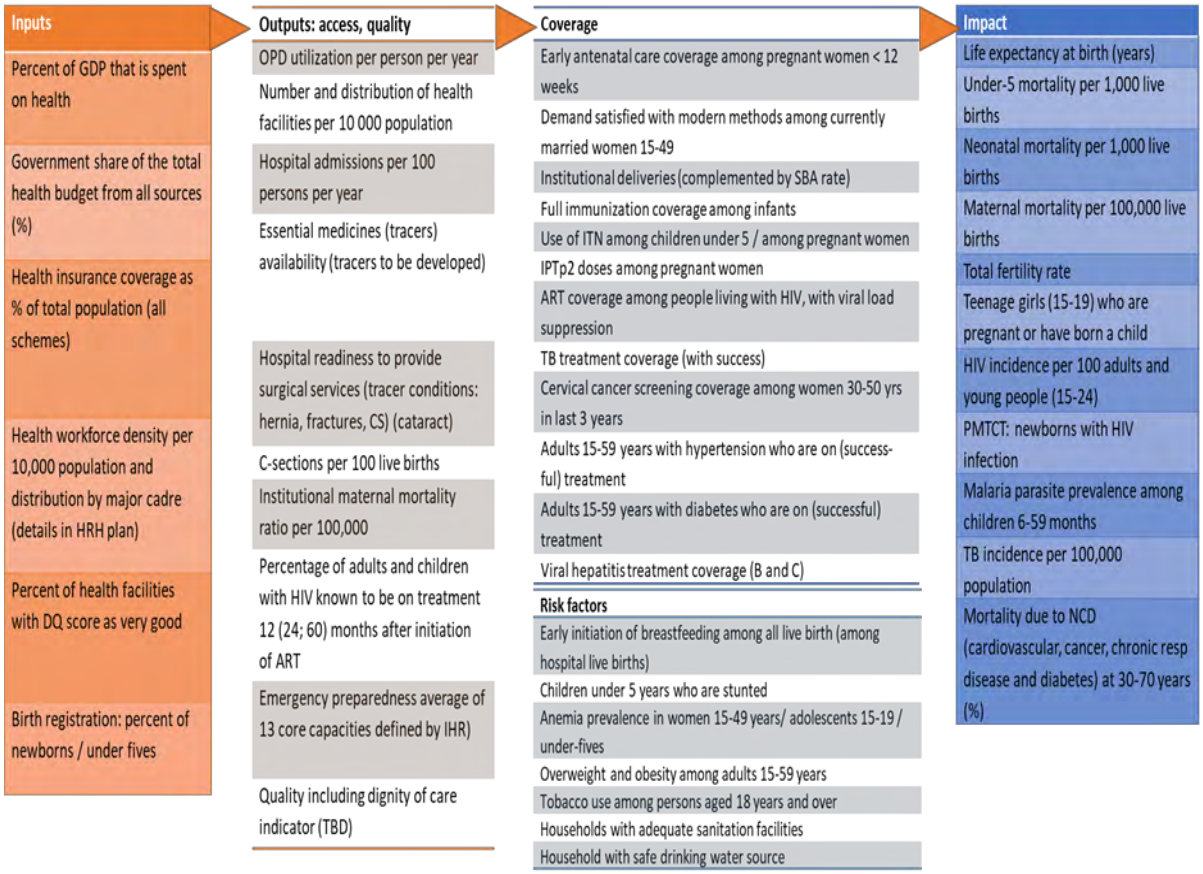
1. Specific: well-defined, clear and unambiguous – based on the use of international standards for the definition and measurement methods. The WHO list of 100 core health indicators provides guidance for the majority of indicators.
2. Measurable: the indicator should be measurable with specific criteria. For instance, the target population for the indicator needs to be clearly measurable. The disaggregation criteria need to be specified.
3. Achievable: this refers to targets. Ideally, each indicator has a baseline target, annual or midterm target and an endline target. In practice, this is not always feasible as baseline data are not available at the time of the formulation of a plan (for instance a Tanzania Demographic and Health Survey (TDHS) 2021 would provide baseline information for many indicators).
4. Realistic: this pertain to both the indicator selection – change can be expected based on the implementation of HSSP V – and to the target.
5. Timely: this is particularly relevant for process indicators which can change rapidly. Outcome and especially impact indicators take longer to show change.

6. Disaggregation: preference will be given to indicators that allow for meaningful disaggregation, and some indicators should have targets that are equity-specific (e.g., a target for the poorest)
7. Quality of care: wherever feasible the indicator should include a quality-of-care dimension
8. Other sector information: health is affected by many factors (and vice versa). The aim of the HSSP V M&E plan is not to include all those indicators but include only those with a direct bearing on health (e.g., water and sanitation).

The accompanying spreadsheet is derived from a review of the WHO 100 core health indicators and a review of the usefulness of indicators as part of previous plans such as HSSP IV and One Plan II. For each indicator reflections on how an appropriate baseline or target can be selected are given. For many indicators, the results of the national TDHS 2021 will be necessary to set appropriate baselines and targets for the end of the five-year plans.

Based on this analysis, a list of less than 50 indicators is proposed for HSSP V, following the grouping of indicators in the results framework in Figure 7 and summarised in Figure 8. For the ultimate set of HSSP V indicators baselines and targets will be set, and it will be encouraged to present disaggregated data where feasible. There is also a proposal for an additional five equity indicators which will be used to set specific targets for reduction in equalities that are monitored on a regular basis. The full list of indicators with baselines and targets is shown in Annex 2.

Figure 8 Indicators for HSSP V



8.5 Indexes

Summary measures or indexes are useful way to capture general progress and assess inequalities at national and subnational levels. WHO has proposed several measures to capture progress towards UHC service coverage targets. One possible measure is largely based on modelling using preventable mortality by cause. Other indexes are strongly dependent on survey data, and it would be difficult to disaggregate to the local level.
Ideally, a summary measure is derived from the routine data as this allows more local use, or at least a mixture of routine data and survey data. A proposed service coverage index for UHC could be addressing four main areas in line with the WHO proposals – RMNCAH, control of infectious diseases, NCD control and health systems strengthening. A minimum set of indicators could include (can be expanded):

Table 9 Measurement of indicators

Group	Indicators	Measurement issues
RMNCAH	Family planning coverage (demand satisfied among married women)	Can be estimated from DHIS2 data on users of modern contraception
	Institutional delivery coverage (or ANC4)	DHIS2 data (supported by TDHS when available)
	Immunization coverage (three doses of pentavalent vaccine or full coverage)	DHIS2 data (supported by surveys)
Infectious diseases	Coverage of ART among adults and children	DHIS2 by district, will need estimation of HIV prevalence to assess need
	TB treatment coverage	DHIS2 data on notification rates and treatment success; will need some modelling
	Malaria IPT2/3 coverage	DHIS2 data, supported by surveys
NCD	Prevalence / treatment coverage for hypertension	Will require further work to assess whether it can be derived from DHIS2 data
	Prevalence / treatment coverage for diabetes	Ditto
	Cervical cancer screening coverage	DHIS 2
Health system	Health workforce density / core health professionals	HRHIS
	Outpatient and inpatient service utilization per 100 population	DHIS2, as indicator of service access
	Emergency obstetric and newborn care access per 10,000 pregnant women	DHIS2, facility surveys

8.6 Data sources

The MOHCDGEC has developed a monitoring and evaluation strategic framework (MESF 2019-2024) that specifies the roles of the different data sources.[3] This includes the key data sources: routine health management information system (clinical and administrative), surveillance of diseases and risk factors, surveillance of vital events (SAVVY) and civil registration and vital statistics, and population-based surveys. In addition, the MESF 2019-2024 specifies the approaches and resources for information systems integration and ICT infrastructure in support of the M&E system.

[3] Ministry of Health, Community Development, Gender, Equity and Children. Monitoring and evaluation strategic framework (MESF 2019-2024). Dodoma. May 2019.

The HSSP IV MTR highly recommended greater interoperability and rationalization of information systems. The DHIS2 is an important source of annual coverage tracking, especially at the regional and possibly the council level. This data source must be strengthened, the core of information systems, and automation should be taken to grassroots level. The HMIS should become the basis for evidence-based planning and management from the lowest level to the top level in the health sector. Score cards, dashboards etc could help to bring a culture change. Regional differentiation of priorities based on information systems should be part of the data-for-decision-making approach, whereby data are frequently analysed and summarized for management. The HSSP IV MTR also recommends that ICT not be technology-driven, but rather content driven, and therefore needs more inputs from end-users. Simple systems that respond to needs of health workers and clients are needed.
GOTHoMIS could become a viable system for electronic medical records but cannot replace management information systems and reporting and accounting systems. Apps that are used in the health sector should be licensed to ensure interoperability and user-friendliness. Capacity building is very important, both in using the systems, as in using the data generated for management. Adequate ICT staffing at all levels is required to keep systems going.

Household surveys are the most important source to track national progress in health status indicators, behavioural indicators and disaggregated coverage data by socioeconomic and demographic stratifiers. The TDHS 2021 will provide critical baseline information and baseline and endline targets may have to be adjusted once the results are out. The TDHS provides baseline information for most indicators as generally the information collected is retrospective (e.g., mortality, coverage of interventions). The subsequent TDHS 2026 will provide significant information about health outcomes and impact of HSSP V. An intermediate survey should be considered if major changes are expected. Such a survey may be limited to some of the priority areas of the national health plans. Other sources of data are also critical. A regular National Health Accounts exercise using SHA 2011 will be critical to track expenditures. The Human Resources for Health Information System (HRHIS) and the Training Information System (TIS) should be integrated with DHIS2 and annual updates on the health workforce stocks, stock flows, deployment and distribution are essential, with disaggregation by council. Regular monitoring of medicine and commodity availability at the peripheral levels of the health system is required. Councils need to monitor health facilities and staffing, including the private sector. Furthermore, a system of verification of the quality of the reported health facility data in DHIS2 is needed, as quality cannot be taken for granted and adjustments may be needed.

Exchange of data among PlanRep, FFARS, HMIS and Epicor would facilitate review of sub annual incremental accomplishments and expenses. PO-RALG will facilitate in addressing the interoperability feature. Regardless of the complexity of assembling the data, the process outlined above for monitoring health systems performance applies here: define indicators and sources, assemble the required data, and then build the presentation options.

8.7 Capacity, roles and responsibilities

Existing capacity to support M&E

M&E and ICT units in the MOHCDGEC already have considerable capacity to build and maintain systems both for annual monitoring of overall health systems performance and for sub-annual monitoring of HSSP V, One Plan III, HRH and NCD strategic plan implementation progress. The HMIS collects, processes, and presents facility-based service delivery data. It is implemented on the DHIS2 software platform since 2014 which involves web-based collection, processing and communication system for health facility data. The HMIS already incorporates data sent from another independent information system, HRHIS, and also includes the RMNCAH dashboard. Oher data sources needed for

the monitoring of the four plans should be interoperable with the DHIS2 platform which allow exchange of data and analyses in both directions.
In theory it might be possible to incorporate both HSSP V, One Plan III, HRH and NCD SP M&E output/outcome and process indicators into the HMIS system. In addition, to facility-based information, the M&E system will need population-based data captured at community, such as the Sentinel Panel of Districts (SPD), or at irregular intervals from surveys, such as TDHS. Technology considerations also suggest that the M&E system should be an independent system developed on the DHIS2 platform.

Monitoring health systems performance
Many of the indicators for annual health systems performance monitoring were used during monitoring of HSSP IV, and it is desirable to keep the four HSSP health systems performance indicator sets as close as possible to each other so that time trends can be followed during the period of performance. Furthermore, integration and data exchange with other health programs plans such as HIV, malaria and TB will be essential.
It will be essential to select a set of indicators according to specific criteria. These should be tracers as the number of indicators needs to remain manageable and high level. The DHIS2 supports data dictionaries and indicator definition for the indicators that are derived from health facility data. The facility-based data required can be easily imported from the HMIS, but ample attention needs to be paid to data quality (of numerators and denominators).

8.8 Country mechanisms for review and action

Regular progress and performance reviews should evaluate performance using service or programme output and outcome indicators. Mid-term and end-of-plan reviews should be more extensive and also cover impact indicators.

The health sector carries out three types of monitoring which address different stages in the results chain, namely: (i) Financial implementation monitoring addresses whether or not budgets have been released and spent in line with allocations; (ii) Physical implementation monitoring addresses whether activities have taken place in line with targets; and (iii) Outputs, outcome and impact monitoring trace whether or not results are occurring amongst the target population.

The annual review will be conducted in the last quarter of every calendar year and is focused on the indicators and targets specified in annual operational plans. These are mainly input, process and output indicators. If available, coverage indicators are also used, derived from the HMIS data.

The MTR is conducted halfway through implementation of the HSSP V, that is at the end of year 3 - 2023. It covers all the targets mentioned in the strategy, including targets for outcome and impact indicators, and also takes contextual changes into account. The mid-term review should coincide with the third annual review. The results are used to adjust national priorities and objectives.

The final review involves a comprehensive analysis of progress and performance for the whole period of the national plans. The final review builds upon the annual and mid-term reviews, but also brings in results of specific research and of prospective evaluation that should be built in from the beginning. Different issues may be addressed with varying levels of depth or rigour during reviews, depending on the needs of the country.

The national reviews will be inclusive. The stakeholders that should be included in any joint review mechanism include key MOHCDGEC staff and departments, representatives of subnational teams, other key ministries (e.g., PO-RALG, finance, planning), global partners, non-state implementing partners such as civil society organisations and the private sector. Council level review and the associated reporting will precede the national reviews and be an important input, especially for the annual reviews.

Explicit, transparent performance ratings of programs, regions and councils will be done when appropriate. These should be based on an initial country review of performance as part of the health review process. These include explanations of deviations between results and targets, including catch-up plans, supported by guidance on the ratings and how they are adjusted by contextual factors.

Links between programme-specific reviews and the general health sector review

There are systematic linkages between health sector reviews, disease- and programme-specific reviews, as well as global reporting. Detailed programme-specific reviews should be linked to the overall health sector review and contribute to it. Ideally a programme-specific review should be conducted prior to or at the same time as the overall health sector review and help inform the content of the health sector review in relation to that specific programme area. It is important that the specific programme reviews involve staff and researchers not involved in the programme itself to obtain an objective view of progress.

Global reporting requirements should primarily be based on ongoing country processes of data generation, compilation, analysis, synthesis, communication and use for decision-making. This requires harmonization and minimization of global reporting requirements and increased coordination between "vertical" disease programmes and "horizontal" health systems actions.
The M&E component of the national plans should serve as the basis for all M&E. The aim is to minimize transaction costs for countries and global partners, reduce fragmentation and duplication, and jointly strengthen national health information systems, while meeting global standards.

Decision-making processes for remedial action and financial disbursement

There are processes by which related corrective measures can be taken and translated into action
Results from reviews are incorporated into decision-making, including resource allocation and financial disbursement. The results from progress and performance analyses will be formally incorporated into future decision-making, through the following mechanisms used by government and funding partners to make resource allocation decisions and financial disbursements to programmes and subnational levels. A multi-stakeholder M&E or a financial management committee meets regularly to review progress, identify constraints and bottlenecks, and advise on ways to reduce them.

The M&E component should describe multi-stakeholder mechanisms to provide routine feedback on performance to subnational and non-state providers. Just as it is important to take stock and review performance at a national level, so it is important to provide feedback on performance to subnational levels and implementers. Feedback loops, where information flows to central levels and back to those providing the information in the first place, have been shown to give a number of benefits. First, performance feedback can help local managers, supervisors, and implementers to consider what their own strengths and weaknesses are, and where they need to be making more of an effort. Second, for those collecting the information, seeing how that data are used, and how it can assist their own work and the work of their colleagues, helps motivate them to improve the quality of the information they provide.

ANNEX 1: LIST OF TECHNICAL EXPERTS

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

N/A	NAME	POSITION
	DIRECTORATE OF POLICY AND PLANNING	
1	Edward N. Mbanga	Director of Policy and Planning
2	Lusajo Ndagille	Assistant Director of Policy and Planning
3	Tumainiel Macha	Assistant Director of Monitoring and Evaluation
4	Francis Mbuya	Head of Building and Infrastructures Development Unit
5	Dr. Catherine Joachim	Head of Health Sector Resources Secretariat
6	Claud Kumalija	Head of Health Management Information Systems
7	Levina Kimaro	Health Basket Fund Coordinator
8	Juliana Mawalla	District Health Services Coordinator
9	Raynold John	Regional Health Services Coordinator
10	Edwin Mathew	SWAp TWG Coordinator
11	Stephen Kitinya	Former SWAp Coordinator
12	Isack Kaneno	Secretariat Health Administrator
13	Joyce Kalamule	Administration and Logistics
14	Ferdinand Ngesha	Economist
	DIRECTORATE OF PREVENTIVE SERVICES	
15	Dr. Leonard Subi	Director of Preventive Services
16	Dr. Janeth Mghamba	Former Assistant Director Epidemiology
17	Dr. Khalid Massa	Assistant Director Environmental Health Services
18	Dr. Ahmad Makuwani	Assistant Director Reproductive Health and Child Services
19	Dr. Amabelga Kasangala	Ag Assistant Director Health Promotion
20	Dr Azma Simba	Ag, Assistant Director Epidemiology
	DIRECTORATE OF MIDWIFERY AND NURSING SERVICES	
21	Ziada Sellah	Director of Midwifery and Nursing Services
22	Saturine Manangwa	Assistant Director of Midwifery and Nursing Services (Quality)
23	Ligmas Koyo	Assistant Director of Midwifery and Nursing Services
	DIRECTORATE OF ADMNISTRATION AND HUMAN RESOURCES MANAGEMENT	
24	Deodatha Makani	Director of Administration and Human Resources Management
25	Wilson Nyamanga	Assistant Director Administration
26	Dany Temba	Assistant Director Human Resources Management -Hospitals
27	Grace Seshui	Assistant Director Human Resources Management -Head Quarters
	DIRECTORATE OF HUMAN RESOURCES DEVELOPMENT	
28	Dr. Saitore Laizer	Director of Human Resources Development
29	Martin Mapunda	Assistant Director Human Resources Development (Planning)
30	Dr. Fadhili Lyimo	

		Assistant Director Human Resources Development (Training)
DIRECTORATE OF CURATIVE SERVICES		
31	Dr. Vivian T. Wonanji	Ag. Director of Curative Services
32	Dr. Paulo Mhame	Assistant Director Traditional and Alternative Medicine
33	Dr.James Kiologwe	Assistant Director Non-Communicable Diseases
34	Dr Caroline Damian	Assistant Director Regional Referral Hospitals
CHIEF PHARMACIST		
35	Daudi Msasi	Chief Pharmacist
DIRECTORATE OF EMERGENCY PREPAREDNESS AND RESPONSE		
36	Dr. Elias Kwesi	Director of Emergency Preparedness and Response
CHIEF ACCOUNTANT		
37	Hellen Mwakipunda	Chief Accountant
DIRECTORATE OF PROCUREMENT MANAGEMENT		
38	Bw. Peter Mabale	Director of Procurement Management
GOVERNMENT COMMUNICATION UNIT		
39	Catherine Sungura	Ag. Head of Government Communication Unit
DIRECTORATE OF LEGAL SERVICES		
40	Luvinga Merick	Director of Legal Services
CHIEF INTERNAL AUDITOR		
41	Grayson Kisava	Ag. Chief Internal Auditor
DIRECTORATE OF HEALTH QUALITY ASSURANCE		
42	Dr. Eliudi Eliakimu	Director of Health Quality Assurance

President's Office – Regional Administration and Local Government

S/N	NAME	POSITION
1	Dr. Ntuli Kapologwe	Director of Health Nutrition , Social Welfare and Nutrition
2	Dr. Paul Chaote	Assistant Director of Health Services
3	Rasheed Maftah	Assistant Director of Social Welfare
4	Dr Bakari Salum	Health Basket Fund Coordinator
5	Raymond Kiwesa	Coordinator Direct Health Facility Financing
6	Dr James Kengia	Regional Coordinator/Researcher Coordinator

Development Partner Group Health DPG H

S/N	NAME	ORGANIZATION
1	Pascal Kanyinyi	GIZ
2	Maximillian Mapunda,	WHO
3	Dr Fedjo Tefoyet	WHO
4	Andrew William	IOM
5	Milly Kayongo	USAID
6	Otilia Scutelniciuc	UNAIDS
7	Dr. Christian Pfleiderer	P4H
8	Dr. Grace Saguti	WHO

9	Dr. Peter Nyella	Embassy of Ireland
10	Elizabeth Williams	USAID
11	Dr. Christine Musanhu	WHO
12	Erneus Kajiji	Env specialist, Canada
13	Dr. Neema Kileo	WHO
14	Dr. Alphoncina Nanai	WHO
15	Kim Mwamelo	Embassy of Ireland
16	Paschal Wilbroad, USAID	USAID
17	Dorice Nydibalema	GE Specialist , Canada
18	Mariam Johari	GIZ
19	Dr. Nemes Iriya	WHO
20	Defa Wane	USAID
21	Stefan Paquett	Canada
22	Rose Shija	WHO
23	Godfrey Nyomby	USAID
24	Meaghan Byers	Canada
25	Prof. Gasper Munishi	SDC
26	Hiltruda Temba	PEPFAR
27	Mariam Ally	WB
28	Dr. Baltazar Ngoli	GIZ
29	Dr Ritha Njau	WHO
30	Jumanne Mbilao	UNPFA
31	Chiho Suzuki	WB
32	Gradeline Minja	Embassy of Denmark
33	Konrad Fenderich	GIZ
34	Irene Mwoga	Former WHO

NON STATE ACTORS

	Name	**Organization**
1	Peter Bujari MD	Health Promotion Tanzania
2	Kennedy Godwin	Tanzania Network of Women Living with HIV and AIDS (TNW+)
3	Emmanuel Carl	Pharm Access
4	Kuki Tarimo	Health Policy Plus
5	Gaddy Chuwa	BMF
6	Msafiri Swai	Intrahealth
7	Benedicto Luvanda	TAYOA
8	Dr Godfrey kway	CSSC
9	Michael Mhando	Centre for Public health, Law and Social Economic Rights and Advocacy (CENTA)
10	Rose Olotu	Tanzania Council of People Living with HIV and AIDS (NACOPHA)
11	Flavina Ngole	T-MARC Tanzania
12	Alex Margery	Tanzania National Network of People with HIV - TANEPHA
13	John Fulli	JHPIEGO
14	Dr Sisty Joseph Moshi	THPS
15	Mr. Josiah Otege	AMREF

16	Philomena Marjani	DSW
17	Gilbert Mateshi	CHAI
18	Rahim Nasser	TAYARH Coalition
19	Isihaka Mwandalima	PATHFINDER INTERNATIONAL
20	Dr. Ramadhani Mlange	Engender Health
21	Atuswege Mwangomale	SIKIKA

ANNEX 2 INDICATORS

Indicators proposed for HSSP V: Impact – coverage – risk factors – system outputs – system inputs / considerations

		HSSP IV		HSSP V					
	Indicator	**Target/2020 (HSSP IV)**	**Achievement 2020 / latest**	**Baseline 2020**	**Target 2025**	**Data Sources**	**Equity**	**Strengths**	**Limitations**
	Impact								
1	**Life expectancy at birth (years)**	59/62 (M/F)	66.0 years: 63.6 (male)/68.3 (female) years, NBS projections)	66.0 years: 63.6 (male)/68.3 (female) years, NBS projections)	68.0 years (both sexes)	Census 2022, surveys 2021 & 2026	Male/Female	Good overall indicator of mortality at all ages	Depends on availability child and adult mortality data
2	**Under-5 mortality per 1,000 live births**	54 per 1,000	50 (UN IGME projection 2019.5)	67 per 1,000 (TDHS 2016); 50 per 1,000 UN estimate (2019.5)	38 per 1,000 live births (to reach SDG target 2030)	Surveys 2021 & 2026; census 2022	SES, Urban-Rural, regions	SDG target 3.2	Can only be measured with national surveys
3	**Neonatal mortality per 1,000 live births**	19 per 1,000	25 per 1,000 (TDHS 2016); 20 per 1,000 LB (UN IGME) for 2019	25 per 1,000 live births (TDHS 2021); 20 per 1,000 UN IGME projection, 2019)	15 per 1,000 live births (to reach SDG target 2030)	Surveys 2021 & 2026	SES, Urban-Rural, regions	SDG target 3.2	Can only be measured with national surveys
4	**Maternal mortality per 100,000 live births (see also institutional MMR indicator)**	192/100,000	No data available for population level	556 per 100,000 TDHS 2016 (for 2010-2017 (UN MMEIG 2017 524)	232/100,000 (to reach SDG target 2030 - <140 (70))	Surveys 2021 & 2026; MDSR		Indicator of priority for HSSP V and One Plan III	Difficult to measure at population level
5	**Total fertility rate**	5.0	4.9 (TMIS 2017)	4.9 (TMIS 2018)	4.2 (based on AARR 2.3% / year)	Surveys 2021 & 2026	SES, urban-rural, region, education	Robust indicator	Measured only in national surveys, is for 3 years before survey
6	**Teenage girls (15-19) who are pregnant or have born a child**	20% (born a child, did not include current pregnancy)	27% pregnant or had birth (TDHS 2015/16)	27% pregnant or had birth (TDHS 2015/16)	<20%	Surveys 2021 & 2026	SES, urban-rural, region	Robust indicator, measures current situation	Measured only in national surveys

		HSSP IV		HSSP V					
	Indicator	**Target/2020 (HSSP IV)**	**Achievement 2020 / latest**	**Baseline 2020**	**Target 2025**	**Data Sources**	**Equity**	**Strengths**	**Limitations**
7	**HIV incidence per 100 adults and young people (15-24)**	Indicator was HIV prevalence 15-24	HIV prevalence 15-24: 0.6% (Male) and 2.4% (Female) (THIS 2016/17)	Incidence 15-24 per 1000 PY: 15-24: 0.07 (F:0.14/M:0.00) (THIS 2016/17)	50% reduction in incidence: 0.03 per 1,000 per 1,000 person years	Surveys with HIV incidence testing	Age; sex	SDG target 3.3 (elimination by 2030)	Measured only in HIV surveys, large sample size required
8	**PMTCT: newborns with HIV infection**	3% at end of exposure period	7.9% at end of exposure period (UNAIDS, 2020)	7.9% (UNAIDS, 2020)	3%	UN estimates and programme data	Region, SES, urban- rural	Robust indicator with strong program data	UN estimates
9	**Malaria parasite prevalence among children 6-59 months**	<1% (NMCP)	7.5% (TMIS 2017)	15% (TDHS 2015/16); 7.5% (TMIS 2017)	<3.5% (NMCP, 2021-2025)	Surveys with testing: TDHS 2021/ 2026; TMIS	Region, urban-rural, SES	Proxy for SDG target 3.3 (elimination by 2030) Trend data available	Measured only in surveys with testing
10	**TB incidence per 100,000 population**	231 / 100,000 population	237	273 per 100,000 population (WHO est., 2019)	162 per 100,000)	DHIS2 TB prevalence survey	Region; council	SDG Target 3.3. (elimination by 2030)	Modelling needed using case notification rates
11	**Mortality due to NCD (cardiovascular, cancer, chronic respiratory disease and diabetes) at 30-70 years (%)**	There was no target as indicator was not included	18% (WHO estimate, 2016)	18% (WHO estimate, 2016)	reduction by 10%	All available mortality data; DHIS2 data on causes of death	Only national estimate	SDG target 3.6 (reduction 4 lead NCDs)	Modelling to obtain mortality as no population data by cause of death available
	COVERAGE								
1	**Early antenatal care coverage among pregnant women< 12 weeks**	60%	27% (DHIS2 2018)	27% (DHIS2 2018)	60%	DHIS2 – annual TDHS 2021 & 2026	Councils (at least 50% of councils > 80%)	Measured in surveys and in DHIS2	Data quality a challenge
2	**Demand satisfied with modern methods among currently married women 15-49**	45%	53% (TDHS 2015/16)	53% (TDHS 2015/16)	62% (based on AARC 2010-2016 1.5%)	TDHS 2021 & 2026 DHIS (users, CYP)	SES; urban rural; regions	Good indicator, contraceptives use can be	Coverage measured only in surveys

		HSSP IV		HSSP V					
	Indicator	**Target/2020 (HSSP IV)**	**Achievement 2020 / latest**	**Baseline 2020**	**Target 2025**	**Data Sources**	**Equity**	**Strengths**	**Limitations**
								used as proxy for trends	
3	**Institutional deliveries (complemented by SBA rate)**	80%	76% (DHIS2 2018)	76% (DHIS 2018) Poorest 41%	85% **At least 75% of councils with >** 75% coverage **Poorest households > 75% coverage**	DHIS2; TDHS 2021 & 2026	Councils; SES; urban rural; regions	Measured in surveys and in DHIS2; robust indicator	private sector reporting
4	**Full immunization coverage among infants**	>90%	91% (DHIS2 2018);	88%(TDHS 2015/16) 75% (TDHS 2016)	>90% **At least 80% of councils with penta3 coverage > 90%**	DHIS2; TDHS	Councils; SES; urban rural; regions	DHIS2 and surveys	Some DHIS2 data issues with full coverage
5	**Use of ITN among children under 5 / among pregnant women**	80% / 80%	56% (MIS 2017) 51% (MIS 2017)	56% (TMIS 17) 51% (TMIS 2017)	80%	TDHS & TMIS	SES; urban rural; regions	Well measured in surveys	National surveys only
6	**IPTp2 doses among pregnant women**	80%	56% (TMIS 2017) 79% (DHIS2 2018)	56% (TMIS 2017) 79% (DHIS2, 2015)	85%	TDHS; DHIS; TMIS	SES; urban rural; regions	Measured in surveys and DHIS2	Quality of DHIS2 reports
7	**ART coverage among people living with HIV, with viral load suppression**	95%	94% (NACP 2020)	94% (NACP, 2020)	95%	NACP;	SES; urban rural; regions	DHIS2 based estimates; HIV surveys	Difficulties in estimating the denominator (people in need)

		HSSP IV		HSSP V					
	Indicator	**Target/2020 (HSSP IV)**	**Achievement 2020 / latest**	**Baseline 2020**	**Target 2025**	**Data Sources**	**Equity**	**Strengths**	**Limitations**
8	**TB treatment coverage (with success)**	72%	59% (2019)	59% (2019) (notification rate: 138 per 100,000 (2018)	90%	DHIS2; NTLP; WHO estimates (global report)	Regions	Based on TB case detection rate times TB treatment success rate	Case detection rate with TB incidence based on model with notification rate
9	**Cervical cancer screening coverage among women 30-50 yrs. in last 3 years**	60%	16% (DHIS2, 2018)	16% (DHIS2, 2018, 5 years) Facility readiness 18% (SARA 2020)	60%	DHIS2; TDHS 2021/2026		NCD indicator of coverage	
10	**Adults 15-59 years with hypertension who are on (successful) treatment**	< 5%	7.3% on treatment (3.1% successful)	7.3% (2012) Treatment readiness cardio-vascular 44% (SARA 2020)	>25%	STEPS TDHS 2021/26	Urban - rural	Surveys, with BP and treatment questions	Not possible to get from DHIS2
11	**Adults 15-59 years with diabetes who are on (successful) treatment**	<5 % among adults	9.1% (2012)	9.1% among adults (2012); 45% facility treatment readiness (SARA 2020)	>25%	STEPS TDHS 2021/26	Urban - rural	Surveys, with blood sugar / HbA1c and treatment questions	Not possible to get from DHIS
12	**Viral hepatitis treatment coverage (B and C)**	Not an indicator in HSSP IV	Not an indicator	5% (for each)	50% (for each)	Program data	Region	Part of SDG 3.3	Needs population survey for denominators
13	**Prevalence of blindness**	No baseline	2.8%	2.8%	1%	Survey (Rapid Assessment of Avoidable	Region	SDG connection	Dependent on special survey

	Indicator	HSSP IV		HSSP V		Data Sources	Equity	Strengths	Limitations
		Target/2020 (HSSP IV)	Achievement 2020 / latest	Baseline 2020	Target 2025				
						blindness – RAAB)			
	Risk factors								
1	**Early initiation of breastfeeding among all newborn children**	90%	54% (TNNS 2018)	54%(TNNS 2018)	65% (AARC 2%)	TDHS 2021 & 2026; TNNS	SES; urban rural; regions	Good indicator in surveys	Cannot be obtained from DHIS2 for all women
2	**Children under 5 years who are stunted**	34% (TDHS 2016); 35% (TNNS, 2014)	32%	32% (TNNS,2018)	20% **Equity: all regions below 25% stunting**	TDHS; TNNS	SES, region, urban rural	Surveys, objective	No annual data
3	**Anaemia prevalence in women 15-49 years/ adolescents 15-19 / under-fives**	<20%	58% (6-59 months) 45% (15-49 yrs.) 47% (15-19 yrs.) (TDHS 2016)	58% (6-59 months) 45% (15-49 yrs.) 47% (15-19 yrs.) (TDHS 2016)	25% reduction for all groups	TDHS, TNNS	SES, region, urban rural	Long term indicator of women's health	No annual data from DHIS2
4	**Overweight and obesity among adults 15-59 years**	29.7% over-weight/obese; 9.7% obese (TNNS 2014, women 15-49)	31.7% women 15-49 overweight (TNNS 2018); 11.5% obesity	31.7% women 15-49 overweight (TNNS 2018); 11.5% obesity	No increase	TDHS, TNNS	SES, region, urban rural	Good NCD indicator, transition	Depends on surveys
5	**Tobacco use among persons aged 18 years and over**	No specific target	14% men 15-59; 1% women 15-49 (TDHS 2016)	14% men 15-59; 1% women 15-49 (TDHS 2016)	30% relative reduction	TDHS	SES, region, urban--rural	Good NCD risk indicator, mostly men, surveys	Depends on survey
6	**Households with adequate sanitation facilities**	24% (TMIS 2017)	24% TMIS 2017	24% TMIS 2017	>50%	TDHS, SES surveys, program	SES, region, urban rural	Surveys(TMIS)	No DHIS2 data for annual monitoring

		HSSP IV		HSSP V					
	Indicator	**Target/2020 (HSSP IV)**	**Achievement 2020 / latest**	**Baseline 2020**	**Target 2025**	**Data Sources**	**Equity**	**Strengths**	**Limitations**
7	**Household with safe drinking water source**	60.4% (TMIS 2017) 59% (TDHS 2015/16)	60% (TMIS 2017)	60% (TMIS 2017)	>80%	TDHS, surveys	SES, region, urban rural	Surveys	No DHIS2 data

		HSSP IV		HSSP V					
	Indicator	**Target/2020 (HSSP IV)**	**Achievement 2020 / latest**	**Baseline 2020**	**Target 2025**	**Data Sources**	**Equity**	**Strengths**	**Limitations**
	Health system outputs including access and quality								
1	**OPD utilization per person per year**	At least 1 visit per person per year	0.85 (DHIS2, 2018)	0.85	1.20	DHIS2	Region, Council	Measured in DHIS2 in facilities (and surveys)	Includes revisits, no preventive care visits
2	**Number and distribution of health facilities per 10,000 population**	Increase PHC facilities	2.1 / 10,000 population (DHIS2, 2018)	2.1 / 10,000 population (DHIS2, 2018)	2.5	DHIS2	Region	Annual reporting, available in Master facility list	Private sector facilities under-reported
3	**Hospital admissions per 100 persons per year**	No target put	3.2 (DHIS2)	3.2 (AARC was -0.2%)	4.2	DHIS2	Type; Region/ Council	Measured in DHIS2 (and surveys)	Maternity included
4	**Essential medicines (tracers) availability**	>95%	96% (DHIS2, 2018)	Depends on selected package	>95%	DHIS2/ SARA for quality control	Type; Region/ Council. Rural vs urban (SARA)	Monthly monitoring possible	List of meds may change
5	**Percent of hospitals providing essential /comprehensive surgical services with**	>75%	5% (all items) (SARA 2017)	5% (SARA 2017)	>75%	SARA	Region/ Council. Rural vs urban (SARA)	Good indicator of surgical, needs facility survey	Very few facilities have all

	tracer items on the day of the assessment								
6	**C-sections per 100 live births**	5-10%	5.9% (TDHS 2016) 8.0% (DHIS 2018)	8.0%	10% Equity: all regions have at least 8% C-section rates	DHIS2 and TDHS	Region, urban rural, SES, parity	Measure low access to emergency services (CS rates < 10%)	Under- and overuse may go together, obscuring coverage of need
7	**Institutional maternal mortality ratio per 100,000**	No specific target HSSP IV	DHIS2 incomplete	160-200 (MOH review 2009-2012)	< 100 per 100,000 live births	DHIS2 - MDSR	Region/ Council. rural vs urban	Measure of quality and safety of care	accurate reporting by facilities
8	**Percentage of adults and children with HIV known to be on treatment 12 (24; 60) months after initiation of ART**	90%	Adults:82% Children: 86% (NACP)	Adults:82% Children: 86% (NACP)	90% (for both adults and children)	Program reporting	Sex; Age; region	HIV program quality indicator, obtained from electronic record system	Follow up challenges
9	**Emergency preparedness average of 13 core capacities defined by IHR)**	No indicator	No indicator in HSSP IV	Level 3 (average)	Level 5 (score of 80% and above)	External assessment	National	Part of UHC index	Self-assessment
10	**Quality of care: primary health facilities with 3 stars (% of all facilities)**	80% (2017/18; MoH)	21% (MoHCDGEC 2018)	21%	80%	Star rating assessment report	Public, private, regions	Possibly star rating assessment or SARA (readiness)	Depends on facility assessments

		HSSP IV		HSSP V					
	Indicator	**Target/2020 (HSSP IV)**	**Achievement 2020 / latest**	**Baseline 2020**	**Target 2025**	**Data Sources**	**Equity**	**Strengths**	**Limitations**
	Health system inputs								
1	**Domestic General Government Health Expenditure (GGHE-D) as percentage of Gross Domestic Product (GDP)**	No target	2.6% (2017/18)	2.6%	5%	GGHE-D, PER, annual reviews; NHA	National	Focus on domestic financing	No distribution
2	**Government share of the total health budget from all sources (%)**	10%	9%	9%	12%	PER, annual reviews; NHA; WHO estimates	National	Domestic financing	National only
3	**Health insurance coverage as % of total population (all schemes)**	>25% (no specific target)	9% (TDHS 2016)	14%	58% (HSSP V)	Surveys; insurance programs	Urban – rural; SES	If catastrophic expenses data available it should be used as well	community schemes harder to get data
4	**Health workforce density per 10,000 population and distribution by major cadre (details in HRH plan)**	7/10,000 nurses	6 per 10,000 nurses (2018 HRHIS) 0.8 per 10,000 doctors/ AMO/CO	6 per 10,000 nurses (2018 HRHIS) 0.8 per 10,000 doctors/ AMO/CO	Increase by 25% (HRH program input needed)	Annual data from HRHIS / PO-RALG **% of councils with HRH above threshold**	Region, Council, HF type	Other cadres in HRH plan	private sector missing; no trend data available
5	**Data accuracy for tracer indicators (Data agreement between source and report documents)**	43%	81% (DHIS 2019)	81% (DHIS2 2019)	85% (all indicators)	DHIS2 / Data Quality Assessment	All levels	Data collection and reporting through	Availability of data requires conducting DQA

								HMIS/ DHIS2)	
6	**Birth registration: percent of newborns / under fives**	No target	26% - under-5s (TDHS 2016)	26% - under-5s (TDHS 2016)	90%	RITA, surveys	All levels	Data from TDHS and birth registration system	Baseline data are limited to under-fives, need infants