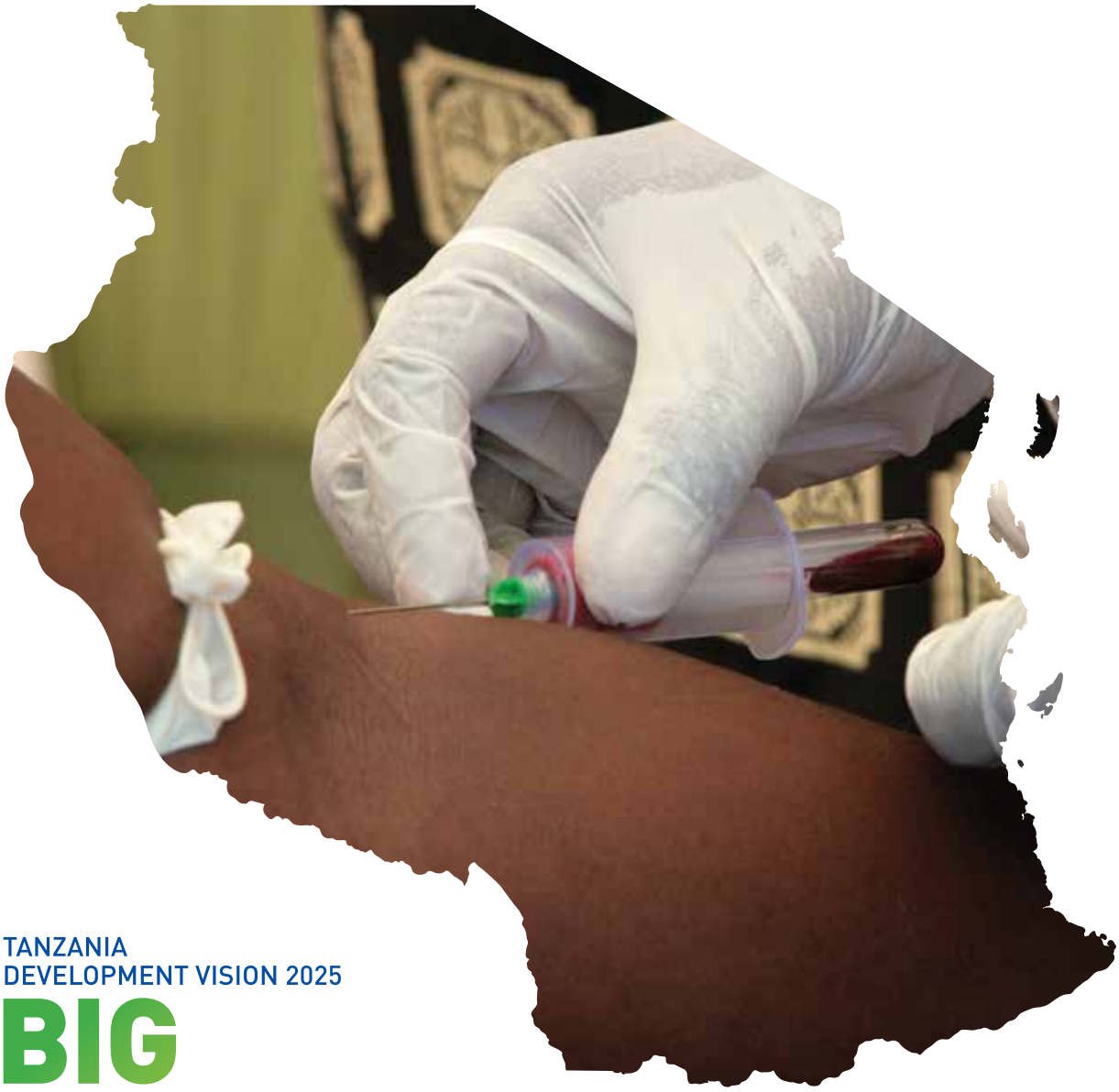
NATIONAL KEY RESULT AREA

HEALTHCARE

2015/16 - 2017/18



TANZANIA
DEVELOPMENT VISION 2025

BIG RESULTS NOW!

ROADMAP

The 8-Steps of *Big Results Now!* Delivery Methodology is a holistic transformation approach that is designed to focus on delivering implementation of specific goals within a stipulated delivery timeline. The Methodology comprises a highly adaptable set of tools that enables proactive tracking, monitoring and problem solving across the implementation structure. Together, these eight steps establish a developmental transformation framework that underscores inclusiveness, transparency and accountability.

The *Big Results Now!* Roadmap is an official publication by the Government of Tanzania that formally captures the President's mandate to transform Tanzania's public service delivery by adopting the 8-Steps of BRN Delivery Methodology. When embarking on a transformation programme, it is important to identify priority areas to ensure focus as well as enable effective deployment of resources and implementation within a specific time frame.

The Cabinet selected the priority sectors based on the highest relative impact of projected number of beneficiaries, on quality of life as well as the feasibility of achieving measurable impact within a relatively short timeframe. These priority sectors, also known as the National Key Result Areas (NKRAs), aim to bring Tanzania closer towards realising the Tanzania Development Vision 2025.

This NKRA Roadmap publication serves as a comprehensive reference material for all implementing ministries, departments and agencies. It provides an in-depth understanding behind the rationale and prioritisation of issues to be addressed within the sector as well as a detailed action plan with clear accountability and targets to be achieved within the committed time frame.

NATIONAL KEY RESULT AREA
HEALTHCARE

CONTENT

GLOSSARY

ANC	Antenatal Care
BEmONC	Basic Emergency Obstetric and Newborn Care
BRN	Big Results Now!
CCHP	Comprehensive Council Health Plan
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CHF	Community Health Fund
CHMT	Council Health Management Team
CHSB	Council Health Service Board
CHW	Community Health Workers
CPR	Cardiopulmonary resuscitation
CSC	Community Score Card
DED	District Executive Director
DHS	Demographic and Health Survey
DP	Development Partner
eLMIS	Electronic Logistics Management Information System
FGC	Facility Governing Committee
FSI	Facility Selection Index
HFGC	Health Facility Governing Committee
HMIS	Health Management Information System
HRH	Human Resources for Health
HSSP	Health Sector Strategic Plan
KPI	Key Performance Indicator
LGA	Local Government Authority
M&E	Monitoring and Evaluation
MDU	Ministerial Delivery Unit
MMR	Maternal Mortality Ratio
MOHSW	Ministry of Health and Social Welfare
MP	Member of Parliament
MSD	Medical Stores Department
MTC	Medicines Therapeutics Committee
NGO	Non-Governmental Organisation
NHIF	National Health Insurance Fund
NKRA	National Key Result Area
NMR	Newborn Mortality Rate
OPD	Outpatient Department
OPRAS	Open Performance Review and Assessment System
PDB	President's Delivery Bureau
PNC	Postnatal Care
POPSM	President's Office - Public Service Management
PPP	Public Private Partnerships
RHMT	Regional Health Management Team
RMNCH	Reproductive, Maternal, Neonatal and Child Health
SARA	Service Availability and Readiness Assessment
TDV25	Tanzania Development Vision 2025
TFDA	Tanzania Food and Drugs Authority
TIKA	Tiba Kwa Kadi
TQM	Total Quality Management
USAID	United States Agency for International Development
WHO	World Health Organisation
WISN	Workload Indicator for Staffing Needs

MINISTER'S MESSAGE

The Healthcare NKRA (National Key Results Area) is the 13th development roadmap under the Tanzanian Government's Big Results Now! (BRN) programme that aims to accelerate realisation of the goals under Tanzania's Development Vision 2025 (TDV25). In this case, the Healthcare NKRA aims to accelerate movement towards the vision's target of access to quality primary health care for all.

Through six weeks of consultation with more than 100 stakeholders, the Ministry of Health & Social Welfare was able to prioritise the Government's initiatives in the healthcare sector. The process also led to the identification of new initiatives to support and accelerate the transformation of the country's healthcare services. These initiatives are categorised into four Focus Areas:

1. **Human Resources for Health:** The country needs more trained medical personnel, distributed more equitably, to help roll out health services, particularly in rural areas.

2. **Healthcare facilities:** Tanzanians should have quality healthcare at all primary healthcare facilities to keep up with the growing needs of its population.

3. **Healthcare Commodities:** Tanzanians should have access to essential and specialised medicines and services.

4. **Reproductive and Child Health:** The provision of comprehensive reproductive and child healthcare services to the five regions with the worst reproductive, maternal, neonatal and child healthcare (RMNCH) services.

The Healthcare NKRA Lab identified 22 initiatives within these Focus Areas, all of which are described in this roadmap. These initiatives are designed to enhance many of the Government's current healthcare programmes and provide the sector with practical but challenging targets that are expected to have a significant impact on the country's overall development.

The objective of this BRN Healthcare Roadmap is to share these plans with Tanzanians and to communicate why these plans are important, how they will be implemented and what they aim to achieve. We have identified specific, measurable targets that will help us gauge our progress and ensure accountability. The proposed projects are expected to catalyse improvements in specific areas of the healthcare sector and bring about lasting impacts.

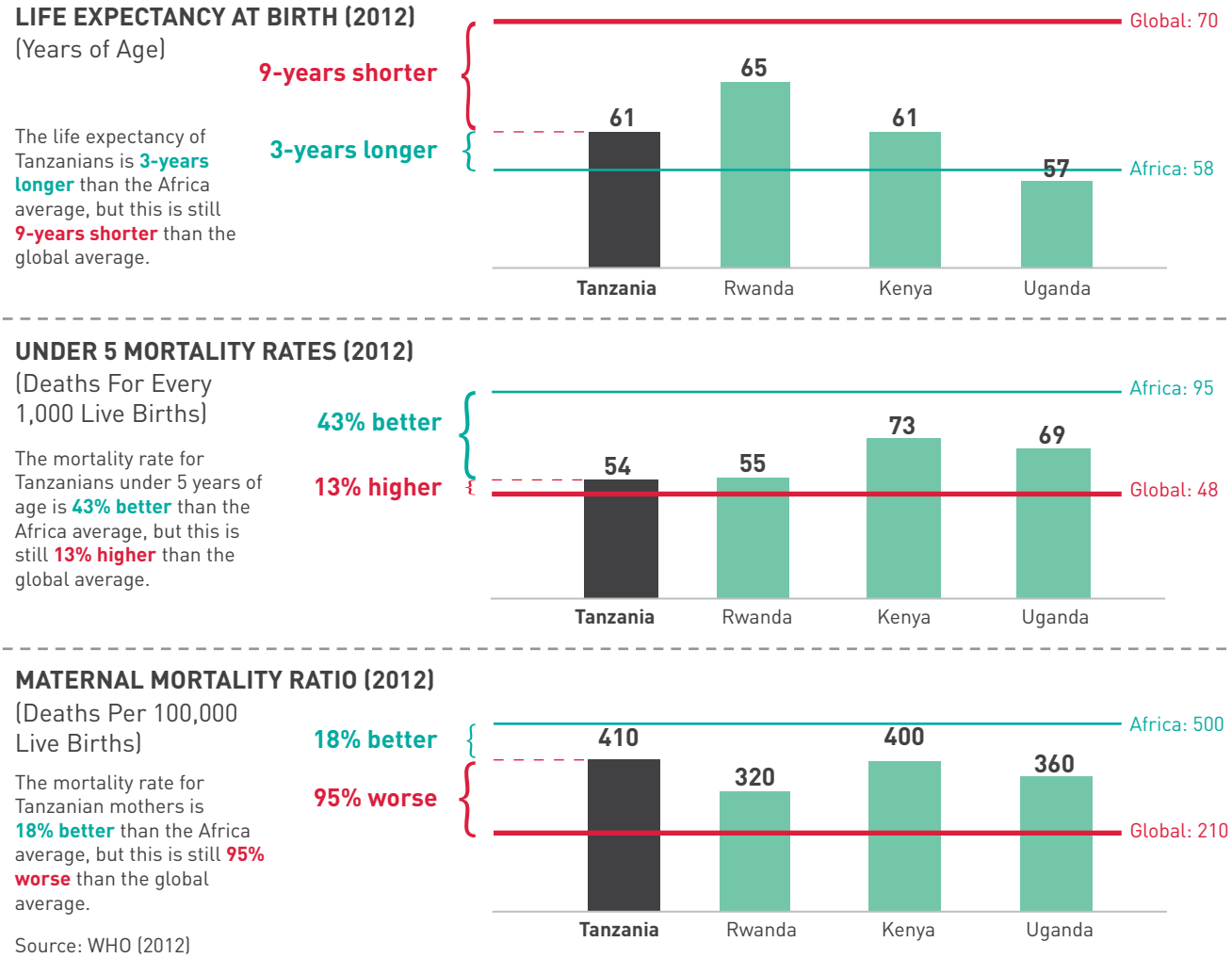
The Ministry of Health and Social Welfare is committed to doing its part in delivering the targets in this Roadmap and monitoring the implementation of the plans proposed. To transform Tanzania's healthcare system, the Government will require the support and expertise of the public and private sectors as well as all the country's citizens.

To succeed, we must work together. I look forward to leading this effort and invite you to join hands with us as we embark on this transformational journey.

Hon. Dr Seif Rashid (MP)
Minister of Health and Social Welfare

INTRODUCTION

FIGURE 1 | Tanzania's healthcare performance in East Africa



A country's healthcare sector is one of its most fundamental drivers of success. A healthy population is productive, innovative and content. This helps the country compete effectively in a globalised economy.

The Tanzanian Development Vision 2025 (TDV25) made the country's healthcare sector one of its top priorities to ensure a higher quality of living for all Tanzanians. TDV25 aims to ensure that all Tanzanians have access to quality comprehensive healthcare.

In addition to TDV25, the Government has also developed various strategies and plans to enhance the country's healthcare services. These plans aim to significantly improve disease prevention and control, healthcare facilities' infrastructure and service delivery, and the availability of skilled human resources for healthcare. Many of the country's Development Partners have also introduced healthcare programmes focused on combating diseases and improving mother and child health.

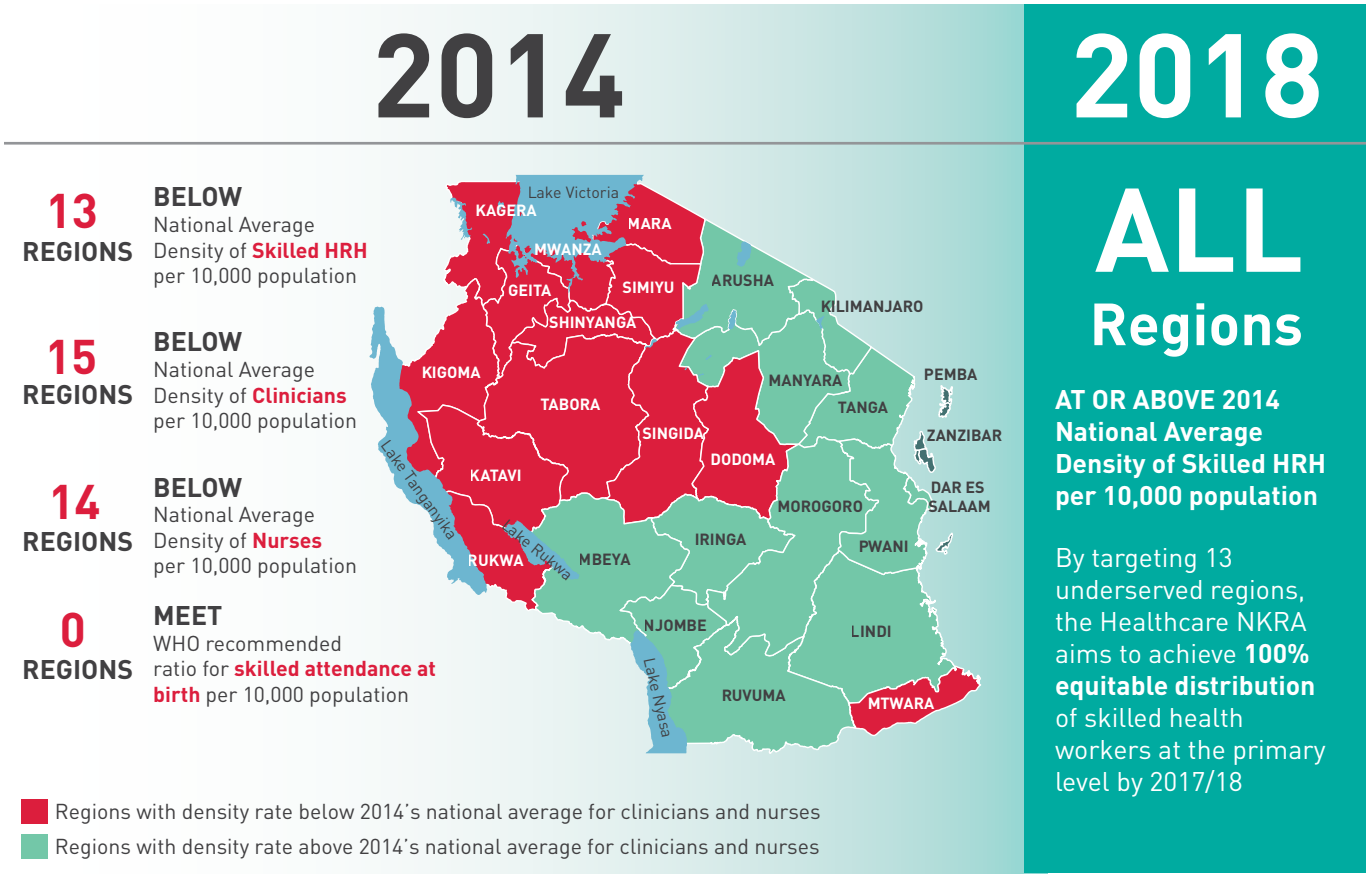
The aim of all these programmes is to reduce the country's morbidity and mortality rates and improve the quality of life for Tanzanians.

The overall health of Tanzania's population has improved significantly in recent years as a result of these Government programmes but more remains to be done.

At 61 years, life expectancy in Tanzania is currently 3-years higher than the African average (58 years), although this is still below the global average of 70 years[1] (as at 2012). The country's infant mortality rate is still uncomfortably high at 54 deaths per 1,000 live births, which is about 13% more than the global average (48 deaths for every 1,000 live births). Tanzania's maternal mortality ratio of 410 deaths for every 100,000 live births is more than 95% higher than the global average of 210, although still relatively low compared to other African countries (about 500 deaths for every 100,000 live births).

1 World Bank; CIA World Factbook (2014 est.)

FIGURE 2 | Density of clinicians and nurses per 10,000 population



There are a number of reasons why Tanzania's healthcare sector has failed to meet these challenges. One of the most significant is the unequal distribution of healthcare professionals and facilities throughout the country (Figure 2). Tanzania's healthcare workforce and facilities are highly concentrated in the country's Eastern Zones, whereas the more densely populated Lake and Western Zones suffer from a severe shortage in healthcare facilities, workers and commodities. Regardless, healthcare performance remains poor even in areas with more health workers. More than half of the country's health workers are regularly absent from work.

Another major reason why the country has had a hard time raising its healthcare standards is the broken supply chain of healthcare commodities. The incidence of high pilferage robs patients of life-saving medicines, medical dispensation devices and other important medical supplies. The losses incurred from these thefts erode the availability of funds to procure further supplies, thus exacerbating the shortage of supplies and denying millions of Tanzanians access to basic healthcare services. The timeliness of disbursing budget allocations is also a factor.

The BRN Healthcare NKRA is part of the Government's overall *Big Results Now!* national transformation programme and aims to accelerate the pace of improvement in the country's healthcare sector. It widens the scope of ownership by encouraging the private sector and civil society to work together to raise the country's healthcare standards through local and external partnerships. Twelve other NKRAs are being implemented throughout the country.

The Ministry is also in the process of developing the Health Sector Strategic Plan IV (HSSP IV 2015-2020). The BRN Healthcare will complement this effort and others by the Ministry to improve Tanzania's health indicators and ensure equitable service delivery in the country.

The aspirational targets of the BRN Healthcare NKRA are ambitious, such as ensuring 100% stock availability of critical healthcare commodities and ensuring that 100% of facilities have access to skilled healthcare workers. Over 100 initiatives were proposed during the BRN Healthcare Lab. These were later prioritised into 22 key initiatives and enablers to be implemented over the next three years. These initiatives have been categorised into three Focus Areas, while the challenge of Reproductive and Child Health has been made a Special Focus Area. These initiatives are described in detail in Section 4 "NKRA INITIATIVES", including their objectives, key players and the major activities that they will involve.

FOCUS AREA	CURRENT SITUATION	TARGET OUTCOMES (BY 2018)
Human Resources for Health (HRH) Distribution	• Tanzania's ratio for health workers per 1,000 population is about 4 times lower than WHO's recommended ratio (0.57 versus 2.30). It is worse in 13 regions that are under the National Averages for Density of Clinicians and Nurses. • Inequalities in the distribution of skill mix • 554 Dispensaries across the country without Skilled Health Workers	100% balanced distribution of Skilled Health Workers at the primary level
Healthcare Commodities	• Funding gap of around TZS 120bn for procurement of essential medicines • Low order fulfilment rate (35%) • Pilferages of commodities are rampant • Actors along supply chain are not monitored	100% stock availability of essential medicines
Performance Management	• 81% of Healthcare facilities suffer poor sanitation system • Incidence of corruption is as high as 69% • More than 50% of health workers are absent or late during work hours • 92.7% of health facilities have no means of safe disposal of biohazard waste • 84% of health facilities lack adequate infrastructure or services to serve the privacy of patients.	80% of primary healthcare facilities to be rated 3-Stars and above by a new facilities assessment and rating mechanism that will be introduced
Reproductive, Maternal, Neonatal and Child Health (RMNCH)	• Low annual reduction rate for maternal mortality ratio and newborn mortality rate compared to countries with a similar economic demographic (e.g. Bangladesh, Vietnam, etc.) • Only 25% of Healthcare facilities are able to provide all 7 signal functions required for BEmONC	20% reduction in maternal mortality ratio and newborn mortality rate in 5 regions

CASE FOR CHANGE

The Government's Health Sector Strategic Plans (HSSPs) have had varying degrees of success over the years. About 50% of the indicators identified in HSSP III (launched in 2010) saw considerable improvements between 2009 and 2012 and are on track to meet the Government's targets by 2015. However, about one quarter (27.5%) of the indicators saw no improvements due to lack of capacity and manpower, while a further 22.5% of the indicators actually declined because of lack of facilities, commodities, poor awareness and insufficient nutrition. Tanzania's healthcare sector faces multiple issues and challenges in upgrading its facilities and infrastructure, improving service delivery standards, human resources and funding. There are wide gaps in expectations pertaining to gender, location, training and affordability. The country's healthcare workforce presents a particularly challenging problem – it is currently characterised by inadequate expertise, negative attitudes, poor professional conduct, lack of accountability and inadequate mechanisms for administering rewards and consequences. The healthcare commodities supply chain is also riddled with inefficiencies in planning, coordination and tracking that result in stock shortages and millions of shillings in losses.

To overcome these challenges, more than 100 leaders in Tanzania's healthcare industry were consulted for one week in August to set the strategic direction of the country's healthcare sector. The leaders then met at the Healthcare NKRA Lab for six weeks from September to October 2014 to reach a collective agreement on the initiatives to be pursued under BRN.

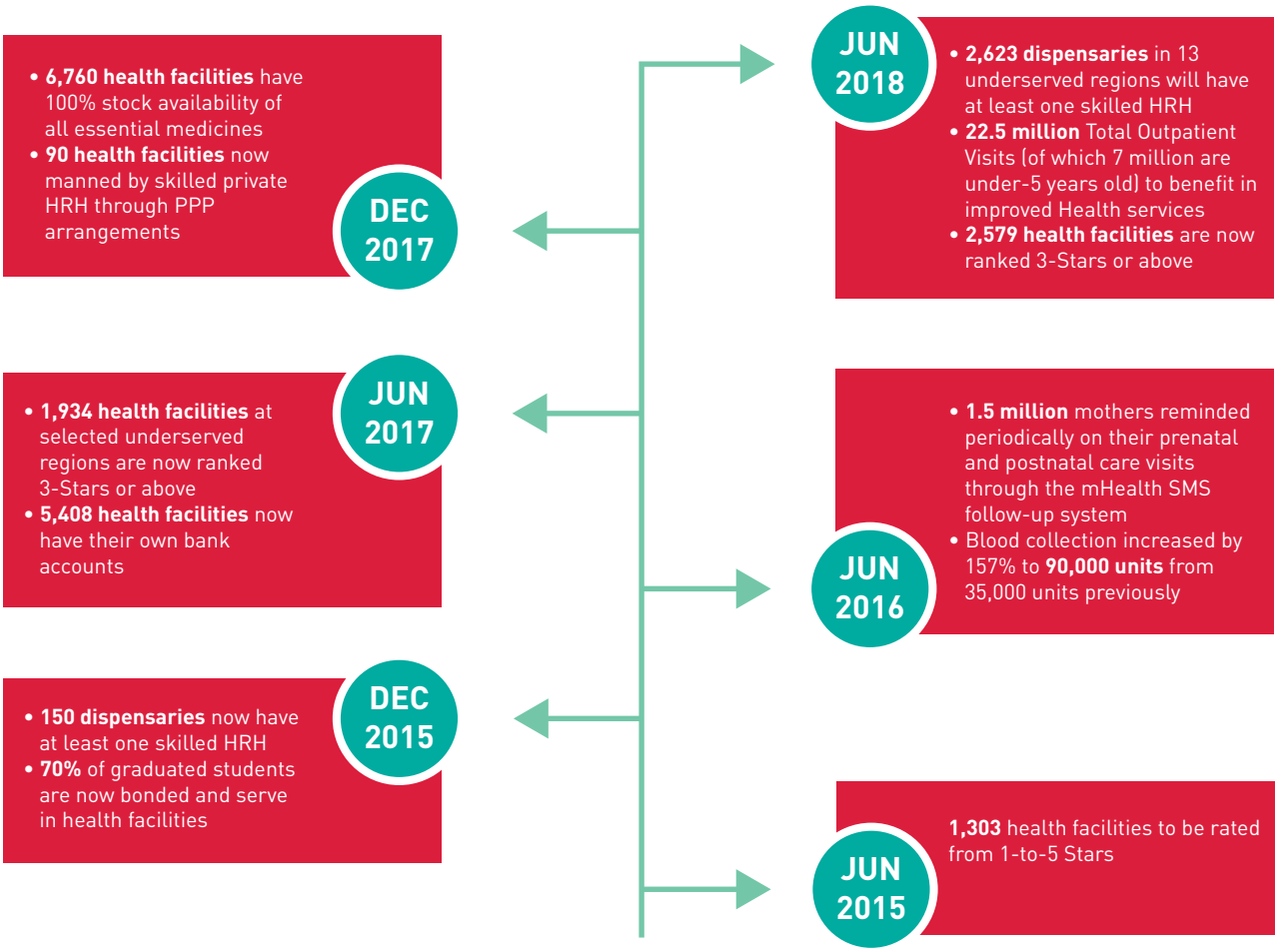
FIGURE 3 | Healthcare NKRA roadmap, 2015-2018

80% of primary health facilities to be rated 3-Stars and above

100% balanced distribution of Skilled Health Workers at primary level

100% stock availability of essential medicines

20% reduction in maternal mortality ratio & newborn mortality rate in 5 regions



INITIATIVES

HEALTHY TANZANIANS

HUMAN RESOURCES FOR HEALTH	HEALTHCARE FACILITIES	HEALTH COMMODITIES
Prioritise the allocation of employment permits to regions with critical shortage of skilled HRH	Implement a Healthcare Facility Star Rating System	Improve governance, accountability and sense of ownership in the health commodities supply chain
Provide skilled HRH through PPP/Private Sector engagement	Implement fiscal decentralisation by devolution from council level to healthcare facility level	Strengthen management of MSD working capital for sustainable availability of medicines and medical supplies
Redistribute healthcare workers within regions		Engage the private sector to complement MSD in the procurement and distribution of health commodities
Optimise the pool of new recruits	Improve social accountability	Introduce the use of SMS to report on stock-outs and quality of health services
Synchronise the recruitment process at the central level		Scale up 5S-KAIZEN-TQM initiatives for inventory management
Empower LGAs in Human Resource Management	Introduce the use of performance targets and contracts	Introduce ICT mobile application platforms for lower-level facilities

REPRODUCTIVE, MATERNAL, NEONATAL AND CHILD HEALTHCARE (RMNCH)

Provide Comprehensive Emergency Obstetric and Newborn Care (CEmONC) at hospitals and expand the services to strategically-selected health centres	Mobilise Community Health Workers to improve RMNCH services	Establish regional satellite blood bank facilities to support CEmONC operations
Improve primary healthcare facilities to provide RMNCH and Basic Emergency Obstetric and Newborn Care (BEmONC) services	Enhance awareness and outreach through mHealth (SMS) and Maternal CHW applications through PPP	Develop integrated 360° mass media campaign that can be multi sponsored through PPP

1 DISTRIBUTION OF HUMAN RESOURCES FOR HEALTH (HRH)

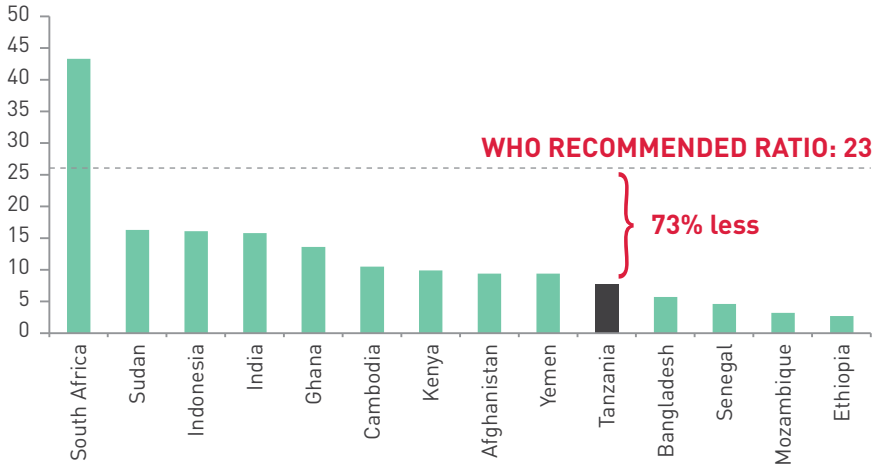
TOPLINE KPIs

- 100% of regions attain the 2014 baseline national average density of skilled HRH per 10,000 of population
- 90% of employment permits for HRH utilised
- 100% reduction in the number of facilities without skilled HRH nationwide

Tanzania is facing severe imbalances and shortages in the availability of HRH. The deficit across all cadres is 52%, severely compromising the country's ability to provide quality health services[1]. The ratio of Tanzania's skilled health workers to its inhabitants is 0.57 per 1,000 population, far behind many other countries around the world and well below the minimum recommended by the World Health Organisation (23 workers per 10,000 population). In addition, 554 healthcare facilities are not functional because they do not have a single skilled health worker. A total of 135 (24%) of these facilities are located in the nine regions that suffer a critical shortage of HRH[2].

Data from the Ministry of Health and Social Welfare also indicates that the distribution of skilled health professionals relative to population in 15 of the 25 regions in Mainland Tanzania is below the national average of 2.8 (clinicians) and 5.3 (nurses) per 10,000 population respectively (Figure 6). Tanzania's eastern and coastal regions enjoy the highest density of health professionals, while the western and north-western regions have the lowest (1.06 clinicians and 1.59 nurses per 10,000 population). Kilimanjaro, Dar es Salaam and Mwanza have three quarters of all skilled HRH in the country[3], and 74% of general physicians are found in urban areas with a doctor-population ratio that is 17 times higher than that of rural areas.

FIGURE 5 | Density of HRH and skilled health professionals per 10,000 population, 2010



The root cause of the uneven distribution is the lack of central HRH planning and varying capacity of Council and Regional Administrations to plan and attract skilled HRH. This, together with a lengthy recruitment process at the central level, aggravates the situation.

This focus area covers the creation of a universal distribution mechanism and will streamline recruitment and supply processes. The Government will develop an implementation plan for rolling out the initiatives on a national scale, which will include incentives to sustain health worker distribution and keep workers motivated. Regions that face a shortage of critical-skilled HRH will be prioritised in the allocation of both recruitment permits and funding.

The Government will also negotiate Public Private Partnerships (PPP) with the private sector that will allow Government healthcare facilities to "borrow" skilled health workers from private healthcare providers until new civil HRH workers are engaged. This will help Government healthcare facilities meet the needs of people in the short term until the other initiatives of BRN Healthcare bear fruit.

Overall HRH distribution within and between Local Government Authorities (LGAs) will also be reinforced to ensure a more balanced distribution of HRH workers throughout the country.

1 *Ministry of Health and Social Welfare*
2 *HMIS 2014*
3 *HRH Profile 2014*

Initiatives

1. PRIORITISE THE ALLOCATION OF EMPLOYMENT PERMITS TO REGIONS WITH A CRITICAL SHORTAGE OF SKILLED HRH

The current HRH planning process is complex and weak. It relies on Local Government Authorities (LGAs) to identify their HRH needs and submit them to the President's Office - Public Service Management (POPSM) for approval. There is no national planning of HRH distribution. The criteria used in honouring HRH requests does not take into account the existing distribution of skilled HRH workforce in the country or where HRH shortages are most critical.

This initiative aims to resolve inequalities in the distribution of skilled healthcare workers and improve the HRH planning process at the Central Level. In Phase 1 (Jan 2015 – June 2015), the nine regions that have been identified as having severe shortages of HRH workers will be prioritised for the use of employment permits. The HRH planning and recruitment process will be synchronised across the country and LGAs will be empowered to drive their own recruitment and retention programmes. Phase II of this initiative (July 2015 – June 2018) will also focus on prioritisation of regions with severe HRH deficits and reinforcing the bonding policy that ties HRH workers to their designated work locations.

2. PROVIDE SKILLED HRH THROUGH PPP/PRIVATE SECTOR ENGAGEMENT

The suboptimal HRH management in the public sector leads to failure to exploit opportunities to partner with other stakeholders to operate healthcare facilities. There are currently 498 public-owned dispensaries nationwide without skilled HRH.

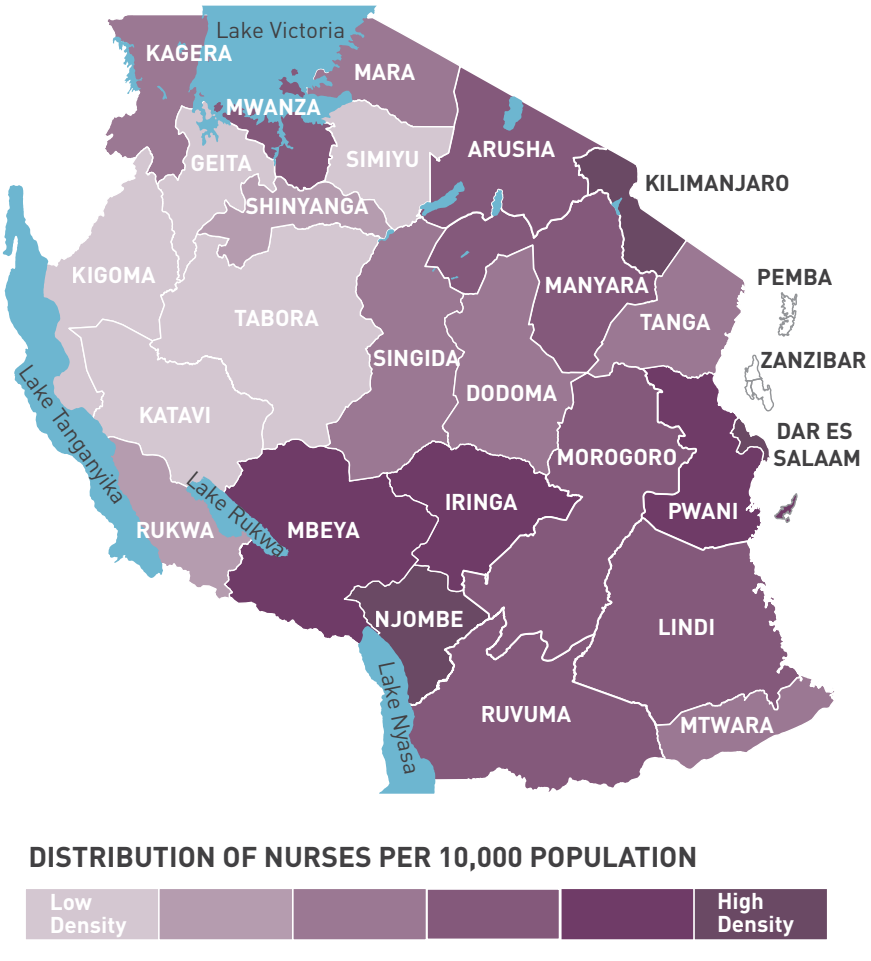
Bridging this gap through new hires will take time. To meet the country's short-term needs, it will be necessary to tap into available capacity within the private sector. In Phase 1 of this initiative (Jan 2015 – June 2015), the Government will seek Public Private Partnerships (PPPs) with experienced private healthcare providers that will be invited to manage Government-owned dispensaries in regions with critical shortages. It is expected that 45 facilities will utilise private HRH annually. This interim measure will ensure that Tanzanians will have access to quality healthcare while the Government works on longer-term solutions through other healthcare initiatives that will provide the country with a steady supply of skilled HRH in the future.

In Phase 2 (July 2015 – June 2018), Government-employed HRH will be redistributed to critical regions and take up posts in 45 privately-supported Government dispensaries.

3. REDISTRIBUTE HRH WORKERS WITHIN REGIONS

There are marked imbalances in the distribution of HRH among regions and between Local Government Authorities (LGAs) within the same region. For instance, there are more than 20 nurses in a Health Centre in Namtumbo DC, while a dispensary eight kilometres away does not have any nurses. It is estimated

FIGURE 6 | Distribution of nurses per 10,000 population



that over 70% of districts have similar imbalances.

These inequalities can be reduced by redistributing the HRH among facilities and LGAs within 16 regions in Tanzania. The Government will use the Workload Indicator for Staffing Needs (WISN) methodology recommended by the World Health Organisation to assess workload pressure and determine how many skilled workers are needed for each facility. Phase I of this initiative (2015/16) will tackle the Mwanza, Mtwara, Mara, Dodoma, Manyara, Ruvuma, Lindi and Tanga regions, while Phase 2 (2016/17) will see redistribution of HRH within the Morogoro, Arusha, Mbeya, Dar es Salaam, Pwani, Iringa, Njombe and Kilimanjaro regions. These redistribution exercises will include incentive plans to sustain health workers' distribution and ensure that skilled HRH are distributed equitably, providing access to healthcare for all.

4. OPTIMISE THE POOL OF NEW RECRUITS

Over the past three years, the Government has spent TZS 13 billion funding the education of students pursuing medical and nursing degrees. In principle, these students have a contractual obligation to serve the country's health sector for at least five years upon graduation as a condition of their financing agreement, whether in the private sector or in public facilities. However, this rule is rarely enforced. The movement of these students is not tracked and their whereabouts upon graduation are unknown.

The first part of the initiative will be to reinforce the bonding obligation amongst graduating students. Bonding agreements will be revised, with bond durations being longer for students who receive grants instead of loans. Every year in university funded by the Government will require a year of service in a public healthcare facility unless the Government grants an exemption.

The second part of this initiative will focus on implementing compulsory attachments for privately-educated clinicians and nurses. Fresh graduates (clinicians and nurses) shall be required to work in primary healthcare in mostly rural areas for two years as a pre-condition for professional registration. After completing the two-year attachment, and subject to having met all the other conditions for registration, they will receive their full professional registration and be given the choice to either continue working in the public sector or to move into the private sector. The cadres that will be covered by this include nurses, clinical assistants, assistant medical officers and doctors.

5. SYNCHRONISE THE RECRUITMENT PROCESS AT THE CENTRAL LEVEL

Healthcare workers complete training between July and August every year. Employment permits are released during the second and third quarter of each financial year (i.e. October – March). This

FIGURE 7 | Challenges through the annual HRH Planning and Process

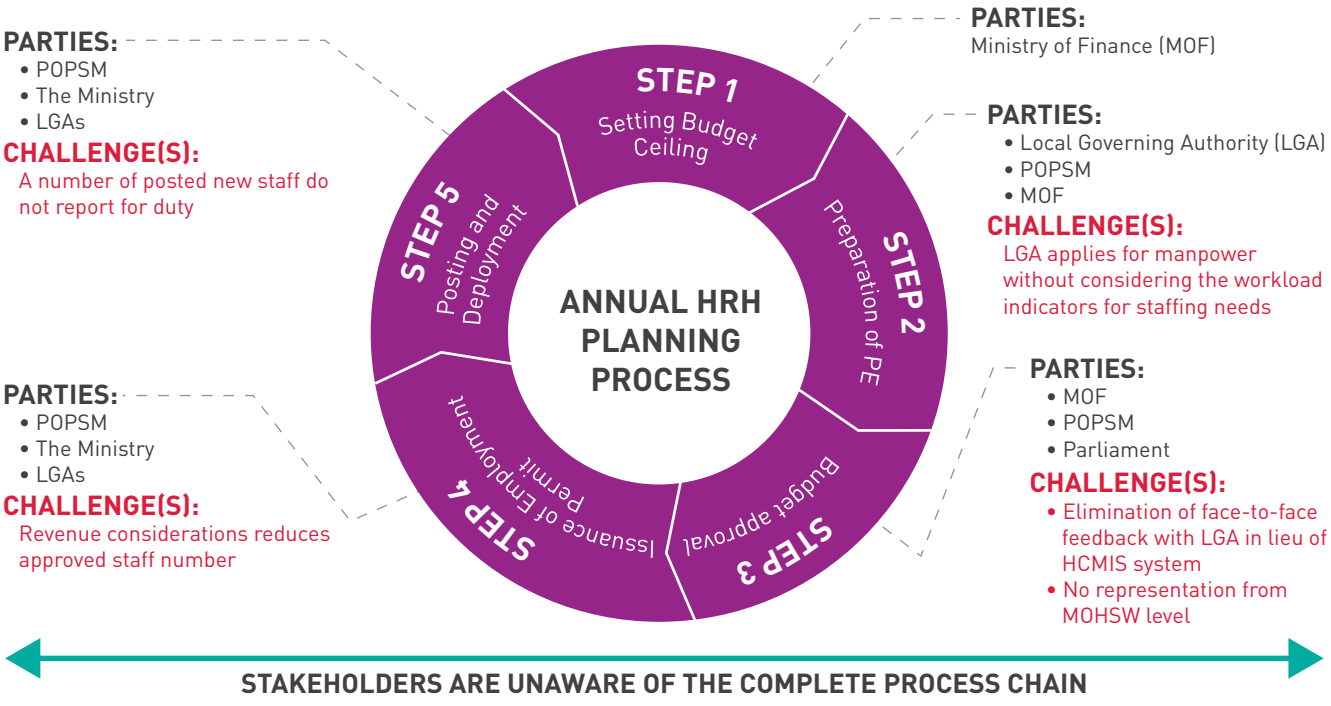
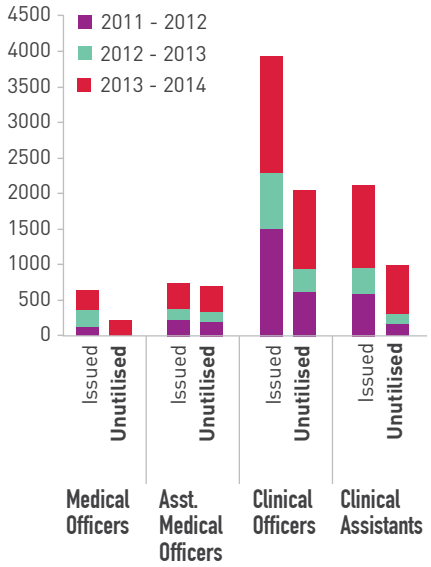


FIGURE 8 | Utilisation of employment permits in the healthcare sector, 2011-2014



means that there is a gap of two to eight months between the time the students graduate in January and the time they may start work. While waiting, these graduates often take up alternative employment at other institutions, including in nonmedical fields, making them unavailable for employment when the permits are finally issued. In 2013/14, only 50% of employment permits issued were utilised despite favourable numbers of graduates that year. This situation is untenable as it depletes the country's HRH capacity and creates further imbalances between rural and urban areas.

The objective of this initiative will be to ensure that middle-level skilled healthcare workers receive their posting within one month of graduation. Graduate doctors and nurses will be deployed for postings within two months of graduation.

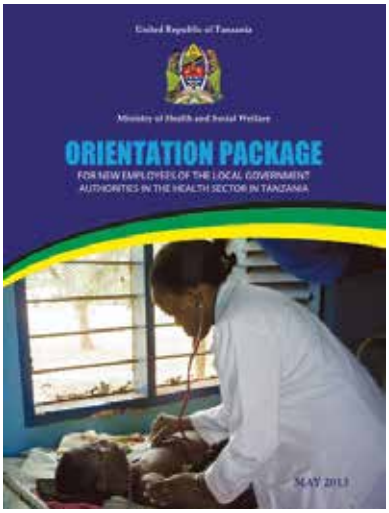
6. EMPOWER LGAs IN HUMAN RESOURCE MANAGEMENT

The performance of Council Health Management Teams (CHMTs) depends on the capacity of the District and LGA leadership and focus on healthcare issues. LGAs play a crucial role in the overall management of HRH, including workforce planning, recruitment, retention, employee incentives and performance management.

Current rules require all HRH employers to conduct orientation and induction programmes within six months of recruitment. However, this requirement is largely ignored by LGAs, mostly due to enforcement and financial constraints. Lack of financial resources has also caused LGAs to use funds intended for subsistence allowances for other expenses, thus delaying the disbursement of these allowances to newly-hired HRH staff.

New HRH recruits lack orientation and induction into their working environments and roles. Most rural areas facing a shortage of HRH also have inadequate measures to attract and retain staff. The Pay and Incentives Policy (2010) developed by the central Government is not actively implemented due to the high associated costs.

The Government believes that LGAs are in the best position to decide what incentives and orientation programmes work best within their respective regions. This initiative therefore seeks to provide LGAs with the necessary tools, skills and resources for them to manage HRH within their respective regions in a more effective manner. The Government will institutionalise the systematic orientation and induction of all newly recruited HRH at the LGA level to ensure better retention. The Government will also develop guidelines for offering incentives and will disseminate them to LGAs to help them establish their own incentive systems, after which the incentives will be mainstreamed in their Comprehensive Council Health Plan (CCHP) for funding. In addition, the subsistence allowance budget will be ring-fenced to ensure that newly recruited HRH receive their allowances



immediately upon reporting to their work stations.

LGAs will also benefit from coaching and mentoring programmes to address human resource management gaps within the Councils. These programmes will be led primarily by the Regional Health Management Teams (RHMTs).

The Government believes that LGAs should decide what incentives and orientation programmes will work best

2 HEALTHCARE FACILITIES

TOPLINE KPIs

- 80% of healthcare facilities to be rated at least 3-Stars in selected regions by 2017/18
- 100% of healthcare facilities to have their own bank accounts by 2017/18
- Healthcare facilities to achieve customer satisfaction scores of 75% and above by 2017/18

It is estimated that about 50% of Tanzania's primary healthcare facilities require urgent major rehabilitation or complete reconstruction. A survey of 1,297 healthcare facilities in 27 sample districts also found that approximately 80% of respondents' healthcare facilities have poor biohazard waste management and sanitation systems. These issues are compounded by the inadequate use of data to plan and improve service delivery and the absence of performance indicators to ensure the quality of services.

These challenges are partly due to the limited autonomy of lower level healthcare facilities, where the sources of funding are often unreliable. About 80% of primary level healthcare facilities rely on LGAs to manage their funds as a large number of these facilities do not have bank accounts and have no direct control of or access to the funds allocated to them. As a result, large amounts of funds are retained at LGAs instead of being spent on improvements in healthcare facilities.

Initiatives under this focus area will raise the quality of healthcare facilities and service delivery in the country, implementing a star rating system for all primary healthcare facilities in the country with the aim of motivating service providers to enhance the quality of their services and score at least 75% on customer satisfaction performance targets. By 2017/18, it is hoped that at least 80% of the country's primary healthcare facilities will be rated 3-Stars or above.

Healthcare facilities will be reassessed each year with the aim of raising their overall rating to 3-Stars or above by 2017/18

Initiatives

1. IMPLEMENT A HEALTHCARE FACILITY STAR RATING SYSTEM

The poor quality of service reported in primary healthcare facilities can only be improved if the cause of the incompetence can be identified. Like other service providers, healthcare facilities should be monitored and benchmarked against specific industry standards so that their performances can be measured and compared against those of their peers.

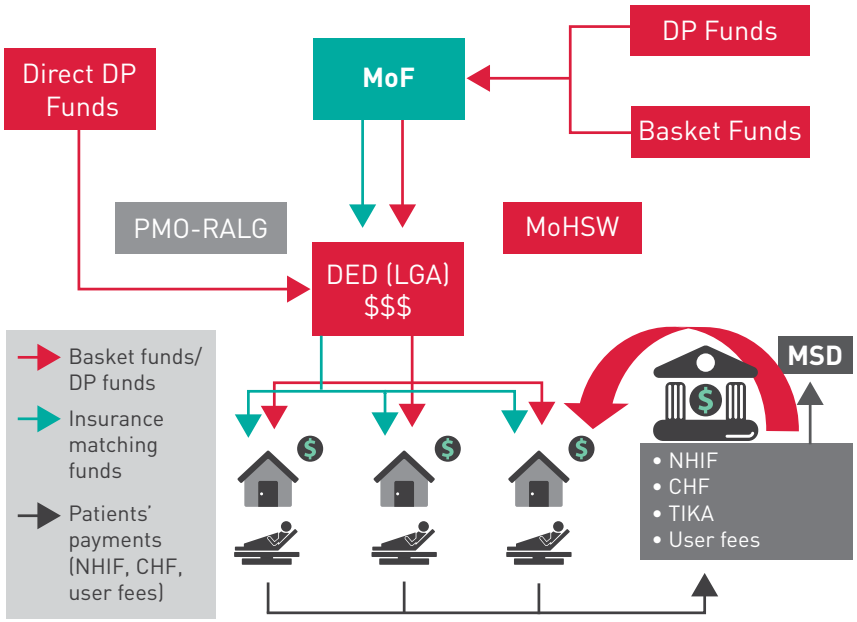
This initiative seeks to assess the relative performance of each primary healthcare facility in the country and develop a national health services accreditation system for Tanzania's healthcare sector. Baseline data will be gathered from the initial round of assessments of all facilities at the primary level (beginning in January 2015), after which phased assessment will take place starting with district facilities followed by health centres and dispensaries.

After the first assessment in 2015, each facility will be given an initial rating on a scale of 1-to-5 Stars. The assessing team will at the same time develop a facility improvement plan and incorporate it into the annual health facility plan and budget. The facility plan and budget will be consolidated by the CHMT to be incorporated in the Comprehensive Council Health Plan (CCHP). Thereafter, healthcare facilities will be reassessed each year with the aim of raising their overall rating to 3-Stars or above by 2017/18.

2. IMPLEMENT FISCAL DECENTRALISATION BY DEVOLUTION FROM COUNCIL LEVEL TO HEALTHCARE FACILITY LEVEL

Most primary healthcare facilities currently do not manage their own funds. Instead, their revenues (collected from users) and development funds (allocated by the central Government) are administered at the Council (LGA) level. Managing expenditures at healthcare facilities involves going through the Council, making the process more complicated than it needs to be. In addition, Councils often use the funds for matters unrelated to the healthcare

FIGURE 9 | Current flow of funds through the healthcare sector



It is vital that the public takes a more active role in ensuring good governance in health service delivery

facilities' needs. Healthcare facilities are therefore unable to solve local issues independently or innovate effectively. There is also no culture of using data for decision making and planning in most healthcare facilities.

Healthcare facilities (with the oversight of the Health Facility Governance Committee - HFGC) should be accountable for collecting revenues (including claims for National Health Insurance Fund - NHIF; membership of Community Health Fund - CHF; or Tiba Kwa Kadi - TIKA, user fees) and undertaking their own financial planning and budgeting. This initiative aims to empower healthcare facilities and user communities to plan and manage their own revenues by giving them authority over facility bank accounts. Government allocations of block grants, council own-source funds and basket funds will also be disbursed directly to these accounts to be used for delivery of health services to the community.

3. IMPROVE SOCIAL ACCOUNTABILITY

Healthcare facilities rarely monitor how they impact the communities around them. Communities seldom hold facility managers accountable for their services as they have a limited understanding of their rights or roles as customers and patients. This discourages healthcare facilities from making improvements that might otherwise raise the standard of healthcare services provided to the communities.

It is vital that the public takes a more active role in ensuring good governance in health service delivery. Communities should be invited to participate in the planning and monitoring of health facilities through mechanisms.

This initiative will implement a healthcare facility Community Score Card (CSC) as a tool monitoring the performance of healthcare service providers and measuring their impact on their immediate communities.

4. INTRODUCE THE USE OF PERFORMANCE TARGETS AND CONTRACTS

Healthcare client service charters are currently only available at the Council level. Most HRH employees and customers are not aware of the contents of these charters, leaving the healthcare system open to misinterpretation and subsequently abuse. This has inadvertently led to absenteeism, patient abuse, corruption and favouritism. Staff and facility recognition and reward systems are not implemented to scale, and current performance assessment tools are unable to address performance indicators and targets in a holistic manner.

This initiative will inspire healthcare facilities to leverage on client service charters to ensure greater compliance to current regulations and procedures. This will make healthcare facilities more accountable by linking their performance targets with the performance contracts of their staff through the Open Performance Review and Assessment System (OPRAS).

3 HEALTHCARE COMMODITIES

TOPLINE KPI

- 100% of healthcare facilities to always have 10 essential medicines in stock by 2017/18
- 100% of items ordered are received by health facilities within 14 days

Structural issues in Tanzania's procurement systems are causing commodity stock-outs all over the country. Pilferages across the supply chain bleed the system of valuable resources.

Nonetheless, some regions in Tanzania perform better than others despite facing tough challenges. The inventory management practices in these regions are supported by effective Local Government Authorities (LGAs), which helps to ensure that their healthcare facilities have adequate commodities.

This focus area will improve supply chain management by engaging the private sector to complement the activities of the Medical Stores Department (MSD). The process of ordering, delivery and consumption will be tracked to maintain optimum stock levels. End-to-end inventory management at healthcare facilities will also be improved.

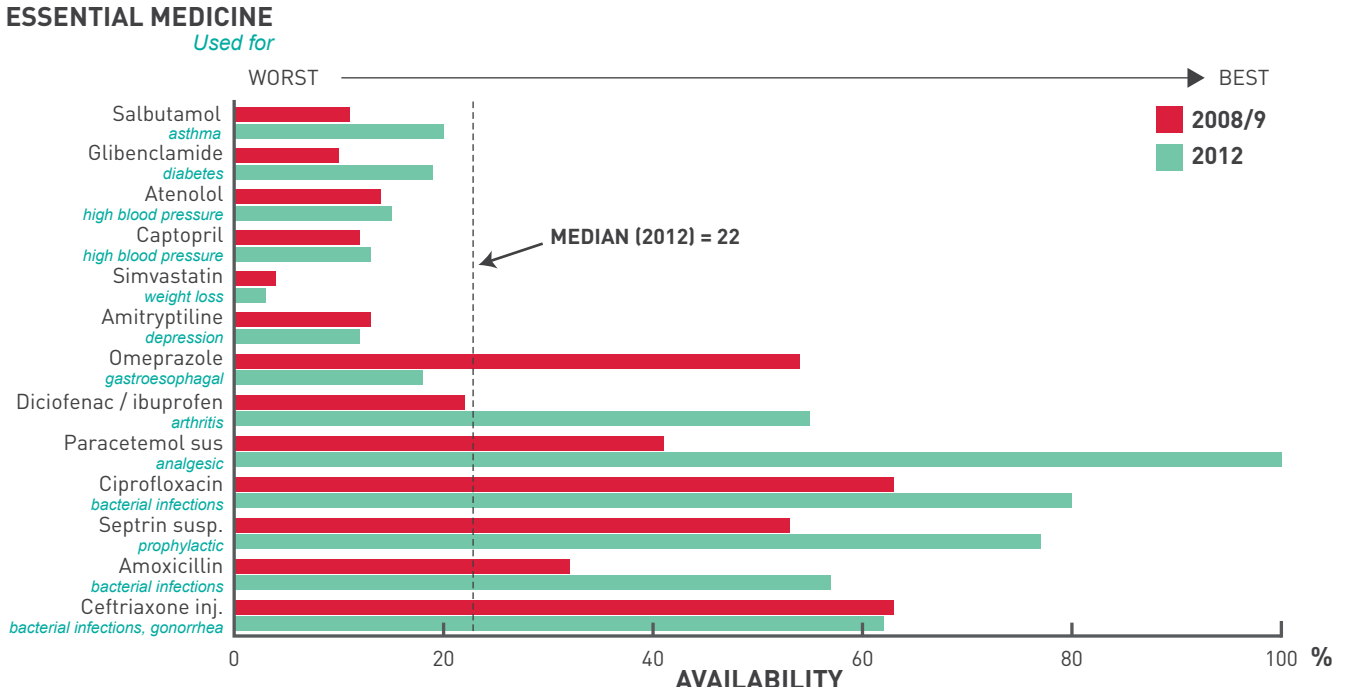
In Phase 1 (Jan 2015 – June 2015), a Donation Checklist will be introduced to coordinate vertical programmes and vendors will be appointed to complement the MSD. Cost sharing guidelines will also be updated and shared with LGAs.

In Phase 2 (July 2015 – June 2018), the Government will roll-out mobile apps to manage inventory at primary healthcare facilities and implement quality improvement interventions. The Government will also outsource diagnostic and similar specialised services at secondary and tertiary public healthcare facilities. The MSD will be restructured into an autonomous entity and Commodity Management Toolkits will be distributed to all Councils.

In Phase 3 (July 2018 onwards), the Government will initiate agreements with domestic manufacturers to produce six identified tracer medicines.

Structural issues in procurement systems are causing commodity stock-outs nationwide

FIGURE 10 | Availability of WHO tracer medicines (non-expired) on the day of visit (%)



Initiatives

1. IMPROVE GOVERNANCE, ACCOUNTABILITY AND SENSE OF OWNERSHIP IN THE HEALTH COMMODITIES SUPPLY CHAIN

There is a pressing need to stop health commodity pilferages in Tanzania. According to the Tanzania Food and Drugs Authority (TFDA), 37 premises were discovered to be in possession of illegally possessed Government medicines between September 2011 and May 2014. Of these cases, 25 were prosecuted while 12 were issued with warnings. Rigorous quarterly facility audits are necessary to monitor and inspect commodity stocks to ensure that facilities are held accountable for losses.

This initiative will first create internal and external controls to address pilferage by improving commodities tracking mechanisms, involving communities and NGOs in pilferage prevention and taking action on unethical practices. Secondly, the focus will then shift to improving the management of supply chain actors and orienting commodity-related stakeholders. The Ministry will provide stakeholders with commodity management guidelines and tools. The Government will also introduce a performance-based reward framework at all levels to enhance the functionality of Council Health Service Boards (CHSBs), Facility Governing Committees (FGCs) and Medicines Therapeutics Committees (MTCs).

2. STRENGTHEN MANAGEMENT OF MSD WORKING CAPITAL FOR SUSTAINABLE AVAILABILITY OF MEDICINES AND MEDICAL SUPPLIES

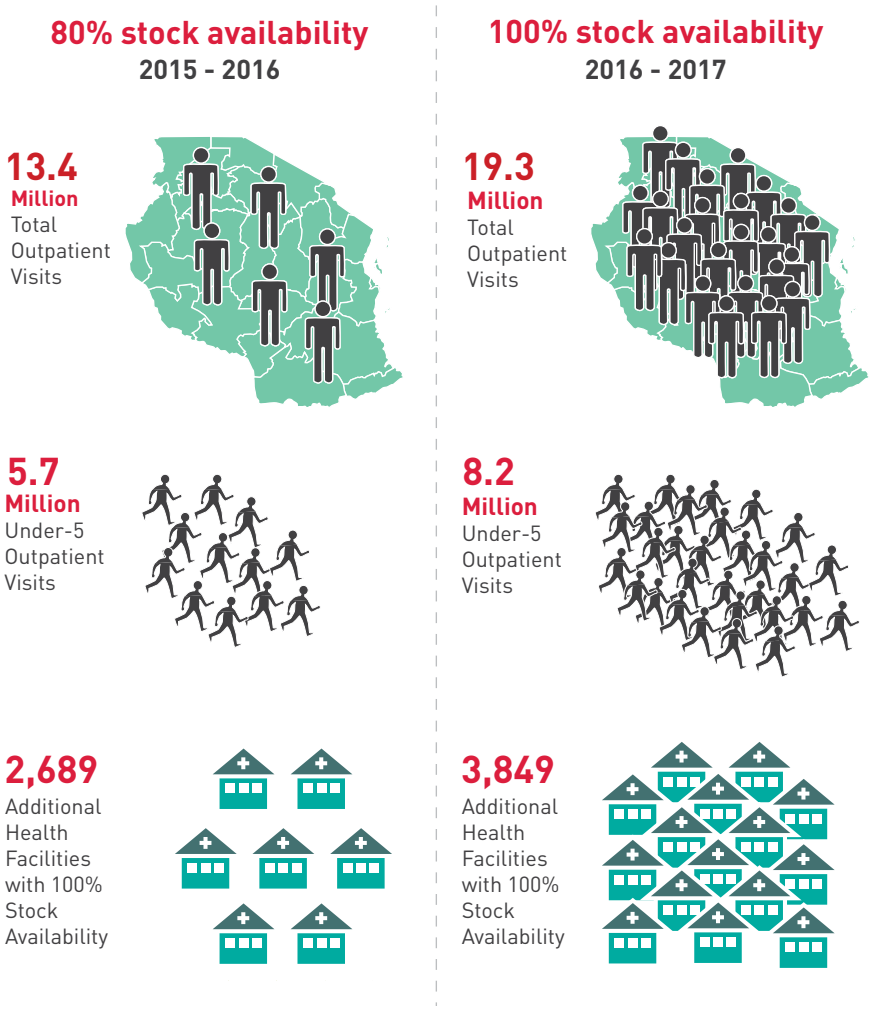
The working capital of the Medical Stores Department (MSD) has steadily declined due to its growing debt. The procurement of healthcare commodities has been erratic and unsustainable due to inadequate funds. Empowering the MSD to operate as a commercial entity provides the organisation with more autonomy to make decisions as well as the authority to borrow funds to ease its cash flow and ensure that it is able to sustain its procurement activities.

This initiative will restore MSD's working capital and make it self-sustainable by repaying its debt and frontloading funds to improve the management of vertical programme commodities.

The MSD will embark on a comprehensive cost reduction programme. This will involve optimising delivery routes, improving management efficiency, engaging in PPP with a concerted effort in specialised medical consumables and equipment and implementing a bulk procurement strategy. The services rendered

This initiative will restore MSD's working capital and make it self-sustainable

FIGURE 11 | Target growth of availability of healthcare commodities at facilities



will be paid promptly through options such as Delivery Duty Paid Contracts to avoid cash flow problems and the long-term accumulation of debt. On top of that, the provision of diagnostic services at the tertiary and secondary levels will be outsourced directly from the private sector on behalf of the health facilities, freeing up the supply of diagnostic commodities from MSD to enable it to focus on essential medicines for primary healthcare facilities.

3. ENGAGE THE PRIVATE SECTOR TO COMPLEMENT MSD IN THE PROCUREMENT AND DISTRIBUTION OF HEALTH COMMODITIES

MSD currently outsources about 40% of its transportation requirements to distribute healthcare commodities from the main distribution centre to zonal stores. This transfers the complexity of managing a transportation fleet to specialist private logistics companies and reduces the operational cost of MSD. The same model can be deployed to distribute commodities from zonal stores to healthcare facilities.

MSD has currently engaged 16 prime vendors from all its 9 zones for direct delivery of health commodities. However, only Dar es Salaam uses these services. This initiative seeks to deploy direct delivery services to all MSD zones across the country and to fast-track MSD direct delivery by outsourcing distribution services to the private sector. MSD direct delivery has significantly improved the availability of medicines at healthcare facilities.

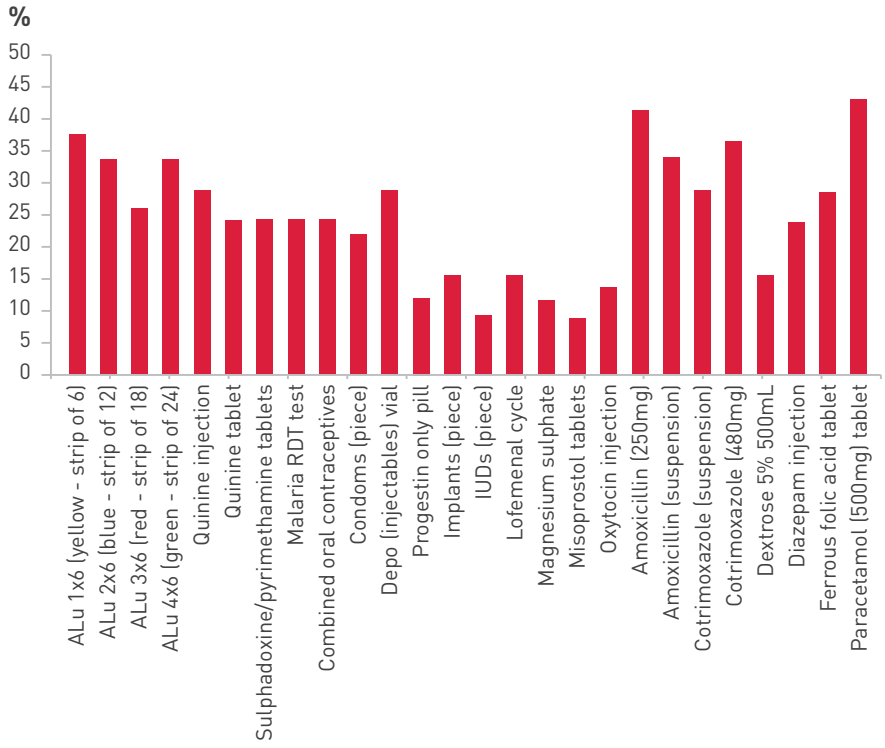
MSD also serves as the sole supplier of healthcare commodities to all public healthcare facilities at primary, secondary and tertiary levels. The private sector will provide some services at the secondary and tertiary levels through medium to long term contracts whereby the Government pays for services based on usage. In this case, MSD will be relieved of the financing and logistical burden associated with services provided by the private sector. The proposed initiative is to engage private sector service providers for qualifying services so that MSD concentrates on those services not amenable to private sector participation. The respective facilities will enter into PPP arrangements to deliver medical services like diagnostics, dialysis, and cardiac catheterisation so as to ease the pressure of funds and specialist management on the Government. On top of that, only 20% of the health commodities consumables are locally produced, despite there being a number of major local manufacturers operating in Tanzania. This high dependency on imports can be reversed by scaling up the domestic manufacturing industry to produce health commodities for local consumption with potential for exports in the future. The biggest challenge would be to provide an enabling environment in order to allow the manufacturing industry to scale up efficiently and economically.

4. INTRODUCE ICT MOBILE APPLICATION PLATFORMS FOR LOWER-LEVEL FACILITIES

Inaccurate consumption data from healthcare facilities has directly impacted the Ministry's ability to forecast its future requirements for healthcare commodities. The tools and practices used at most healthcare facilities are inadequate for the needs of modern planning. A study by The Ministry and USAID found that less than 50% of all healthcare facilities in Tanzania have updated stock cards, thus distorting the true quantities they have in stock and limiting their abilities to correctly estimate their orders for new supplies.

This initiative will shift healthcare facilities away from paper-based communication and data management tools to ICT mobile app platforms that will integrate with existing information systems such as the e-Logistics

FIGURE 12 | Percentage of facilities with up-to-date stock cards against medicine (source: end-use verification)



Management Information System (eLMIS). This will improve accuracy, planning and forecasting and ensure the timely order-and-delivery of new supplies. Healthcare service providers shall be trained on the use of these platforms. The Logistics Management Units at Central and Zonal levels will collaborate with RHMT/CHMT in developing the support in the planning and ordering process. All district hospitals and nearby facilities will will be using the system for ordering and managing commodities.

5. INTRODUCE THE USE OF SHORT MESSAGING SYSTEM (SMS) TO REPORT ON STOCK-OUTS AND QUALITY OF HEALTH SERVICES

Stock-outs frequently deny Tanzanians of much-needed relief from their illnesses and health issues as well as medical intervention. In addition, there is currently no mechanism for customers to channel complaints of frequent stock-outs to authorities.

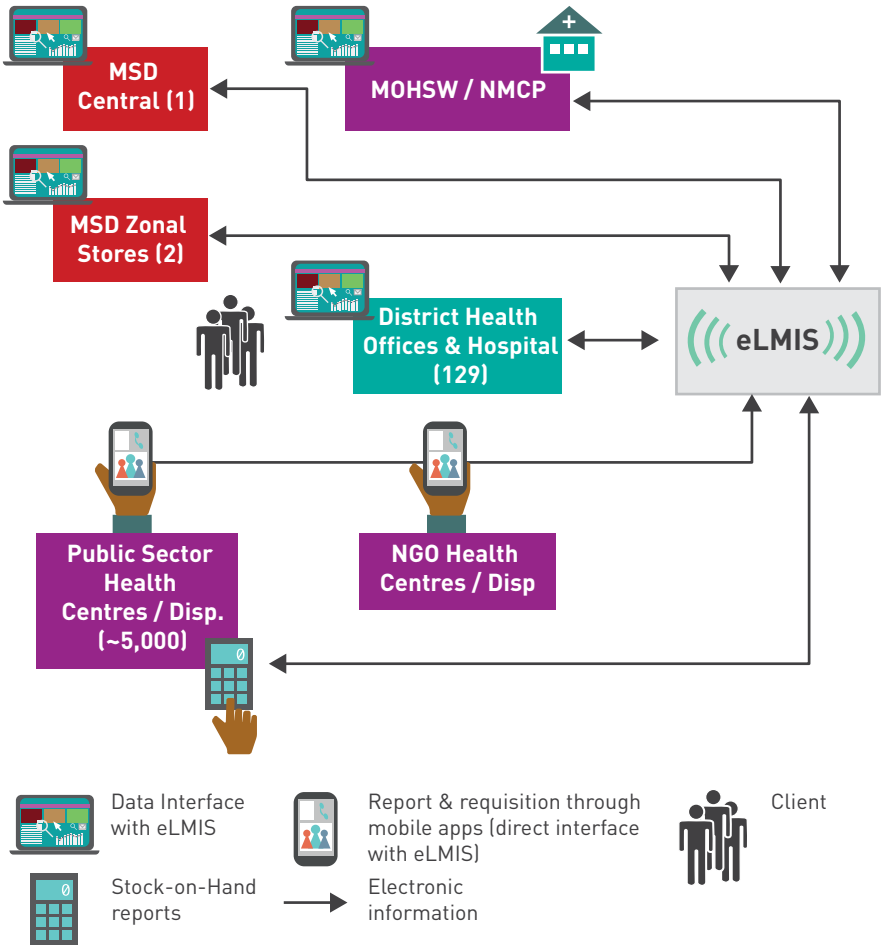
This initiative will provide users with a safe and convenient channel (SMS/text messages) to report stock-outs and to provide feedback on the health services they receive.

6. SCALE UP 5S-KAIZEN-TQM INITIATIVES FOR INVENTORY MANAGEMENT

Poor record-keeping at lower-level healthcare facilities has led to inaccurate reports and orders at the MSD resulting in poor procurement plans, forecasts and quantifications. This contributes to stock-outs as it leads to understocking or overstocking of healthcare commodities. Record-keeping tools are also not consistently available at the lower-level healthcare facilities, with some using paper-based systems while others have no system at all.

Introducing the 5S-KAIZEN-TQM methodology at lower level facilities will help staff to improve their inventory management, record-keeping, reporting, ordering and storage. The methodology will be introduced to facilities at the district and facility level, supported by training, coaching and mentoring to orient HRH employees on the benefits of 5S-KAIZEN-TQM and how to use it effectively. The Government will conduct quarterly audits/stock takes on medical commodities and promote the rational use of medicine in primary healthcare facilities. Expired healthcare commodities must be disposed of, and storage facilities will be refurbished to meet required standards for medical supplies.

FIGURE 13 | Information flow in Tanzania's health sector with eLMIS



The 5S-KAIZEN-TQM methodology will help staff at lower-level facilities to improve inventory management, record-keeping, reporting, ordering and storage

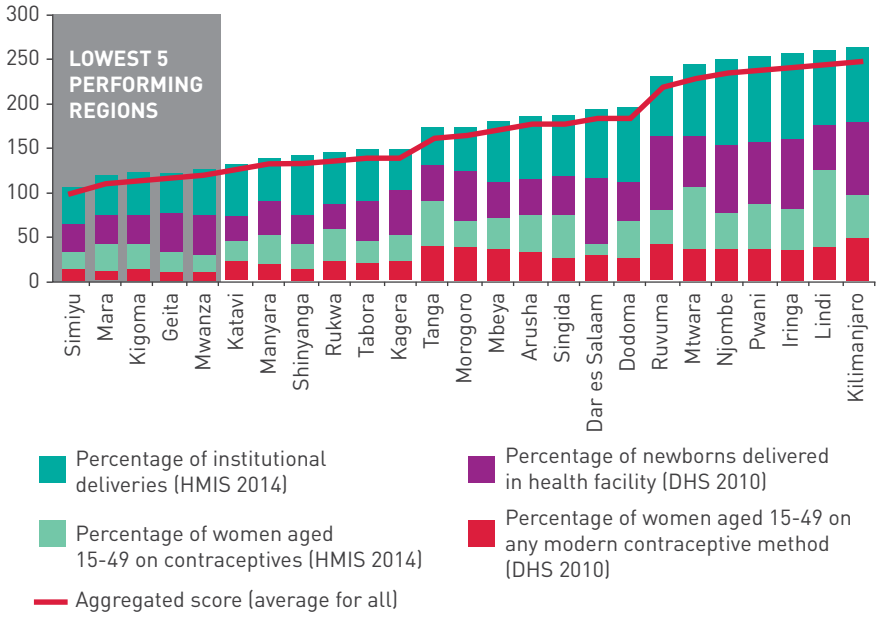
4 REPRODUCTIVE, MATERNAL, NEONATAL AND CHILD HEALTH (RMNCH)

TOPLINE KPI

- 70% availability of proper pre-pregnancy care and consultation by 2017/18
- 80% of pregnant women receive adequate neonatal care by 2017/18
- 80% of labours and deliveries receive proper obstetric care by 2017/18
- 80% of newborns receive proper medical care by 2017/18

The Government has initiated efforts in Maternal, Neonatal, and Child Healthcare (MNCH) through the One Plan 2008 and enhanced it with the Sharpened One Plan 2014 to bring the country nearer to the Millennium Development Goals. Efforts in reducing unwanted pregnancy and adolescent pregnancy through family planning have also yielded results. However, the annual reduction rate for the maternal mortality ratio (MMR) and newborn mortality rate (NMR) of 3.2% per annum is insufficient when compared with other countries such as Botswana, Bangladesh, Vietnam, Guinea and Egypt that have annual reduction rates between 5% and 6%.

FIGURE 14 | Comparison of the performance of regions in family planning and institutional delivery



High-impact interventions to complement the existing Government programmes are urgently required to accelerate the rate of improvement. Focus Area 4: Reproductive, Maternal, Neonatal and Child Health (RMNCH) will focus on improving RMNCH interventions in the five most underserved regions in Tanzania (Mara, Simiyu, Mwanza, Geita and Kigoma). This will be done by improving the quality of selected dispensaries and health centres, with selected health facilities to be upgraded to provide Basic Emergency Obstetric and Newborn Care (BEmONC) services and Comprehensive Emergency Obstetric and Newborn Care (CEmONC) services. This is especially important in strategically located health centres which function as satellite sites that support surrounding areas. The implementation aims to have all CEmONC facilities supported by regional blood bank facilities.

The implementation team will look at leveraging existing budgets and plans within these five regions by first conducting a quick ground assessment on both the service quality of health centres and dispensaries and their capabilities to provide BEmONC and CEmONC services. Enablers such as community health workers, information and communications technology and the mass media will be used to reach out to the community.

Initiatives

1. PROVIDE CEmONC AT HOSPITALS AND EXPAND TO STRATEGICALLY SELECTED HEALTH CENTRES WHICH WILL SERVE AS SATELLITE SITES

75-80% of maternal deaths occur during pregnancy and childbirth due to haemorrhage, obstructed labour, infection, unsafe abortions and other complications. These deaths can be averted by providing CEmONC at easy-to-reach facilities that are well staffed and equipped.

CEmONC services should cover all seven signal functions of BEmONC, caesarean section and blood transfusion services. To function at their best, CEmONC facilities should be manned by at least eight skilled health workers including surgeons, theatre nurses, midwives and anaesthetists. This initiative will ensure that CEmONC services are provided at hospitals and upgrade existing healthcare facilities to serve as satellite CEmONC sites in five underserved regions in northwest Tanzania. These efforts will increase the percentages of institutional deliveries, skilled birth attendants, antenatal care (ANC) visits and postnatal care (PNC) as well as encourage the use of contraception.

2. IMPROVE PRIMARY HEALTH CARE FACILITIES TO PROVIDE RMNCH AND BEmONC SERVICES

When properly staffed and supplied, one CEmONC facility can support up to four BEmONC facilities. For a facility to be considered a BEmONC, it must meet strict criteria of equipment, cleanliness, manpower and supplies.

Six criteria have been identified for facilities to upgrade to BEmONC, with additional evaluations on delivery complications as well as assessments on the health facility itself. The assessment covers the facility's referral system, the availability of medical equipment on the premises and essential medical equipment for RMNCH services.

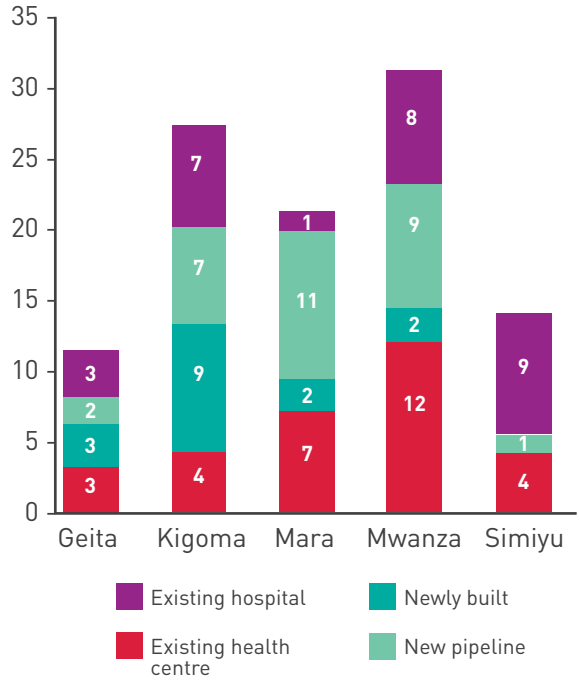
3. MOBILISE COMMUNITY HEALTH WORKERS TO IMPROVE RMNCH SERVICES

Cultural barriers and misinformation within communities frequently prevent Tanzanian women, girls and their families

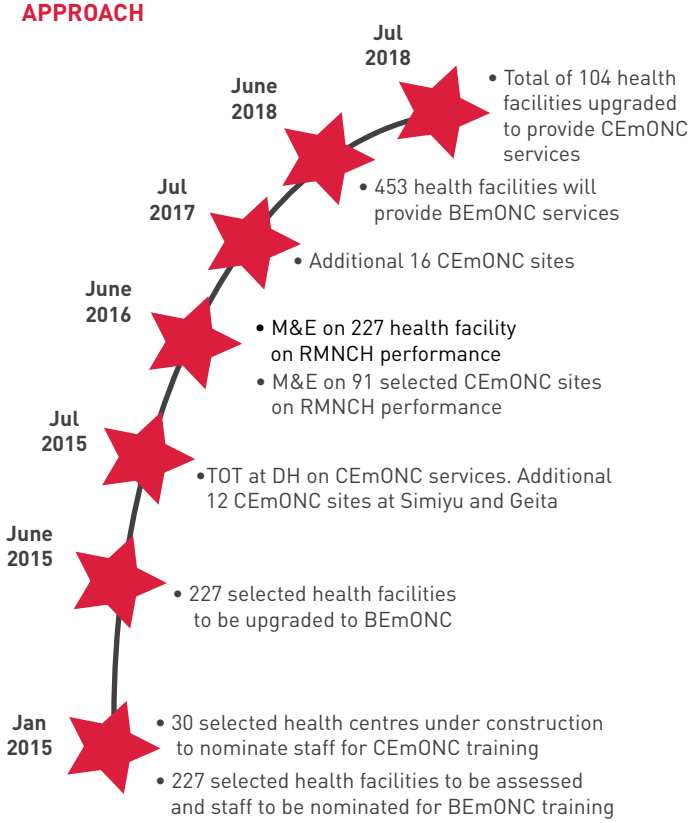
FIGURE 15 | Upgrading CEmONC satellite facilities in five regions

ANALYSIS

Health centres that meet the Facility Selection Index (FSI) requirements shall be strategically selected as CEmONC sites to support the surrounding BEmONC sites and dispensaries.



APPROACH



from utilising RMNCH services. This initiative will seek to mobilise over 10,000 community health workers (CHWs) to provide health promotional services and to improve visits to healthcare facilities. A case study in Simiyu found that a three-week training programme increased the percentages of birth by skilled birth attendants by 9% and increased full antenatal care (of four visits) by 25%. Under this initiative, 5,150 CHWs will be trained annually until 2017.

Performance-based incentives will be introduced to further boost CHWs' roles in improving the utilisation rate of RMNCH and other healthcare services by the community members.

4. ENHANCE AWARENESS AND OUTREACH THROUGH mHEALTH (SMS) AND MATERNAL CHW APP THROUGH PUBLIC PRIVATE PARTNERSHIPS (PPPs)

The usual health facility interfaces (front offices and desk counters) may not be suitable for patients to communicate key issues about their health concerns, including RMNCH. More feasible strategies for communication are necessary to improve the uptake of RMNCH and raise awareness about the Government's healthcare programmes.

Mobile phones are ubiquitous in Tanzania, with connectivity available in most parts of the country. Even those households unequipped with mobile phones are able to take advantage of mobile communications through friends or neighbours due to the everpresent nature of the devices. This initiative will seek to roll out mHealth (SMS) and the Maternal CHW App (Smartphones) to provide Tanzanians with an alternative interface for communicating about RMNCH issues.

5. ESTABLISH REGIONAL SATELLITE BLOOD BANK FACILITIES TO SUPPORT CEmONC

It is crucial that the country be able to give patients rapid access to adequate and safe blood for transfusion. Blood is vital for conducting caesarean sections and blood transfusions, which are two key components of CEmONC services. It is estimated that up to 26% of maternal deaths in sub-Saharan Africa are directly related to insufficient blood. This initiative will establish six Zonal Blood Transfusion Centres in Tanzania to cater to the blood needs of the whole country.

6. DEVELOP INTEGRATED 360-DEGREE MASS MEDIA CAMPAIGN THAT CAN BE MULTI-SPONSORED THROUGH PUBLIC PRIVATE PARTNERSHIPS (PPPs)

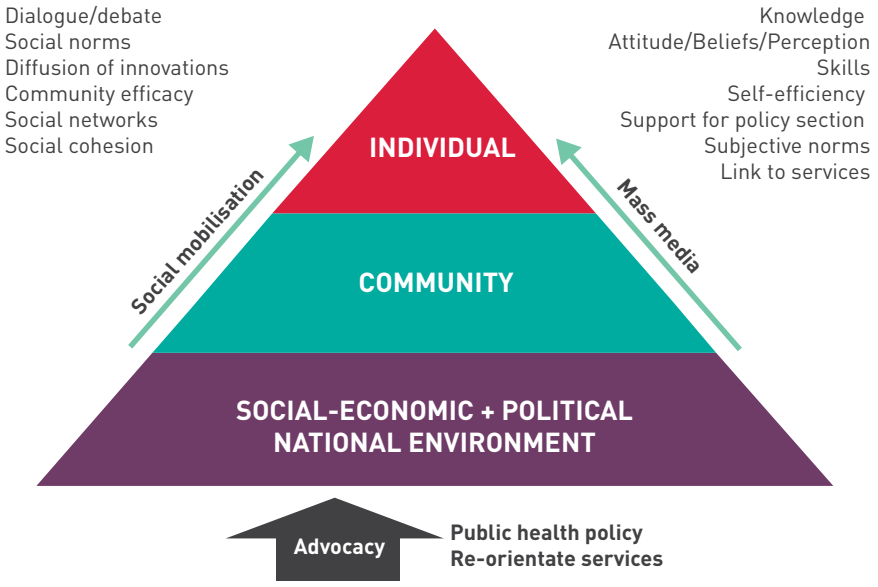
The current level of awareness on pregnancy danger signs and other RMNCH issues among Tanzanians is low. Myths, socio-cultural issues and misconceptions make people reluctant to accept RMNCH services. A lack of involvement from community members (for example, in donating blood) also deters RMNCH awareness and safety.

Mass media campaigns are the most effective way of encouraging health-conscious behaviours

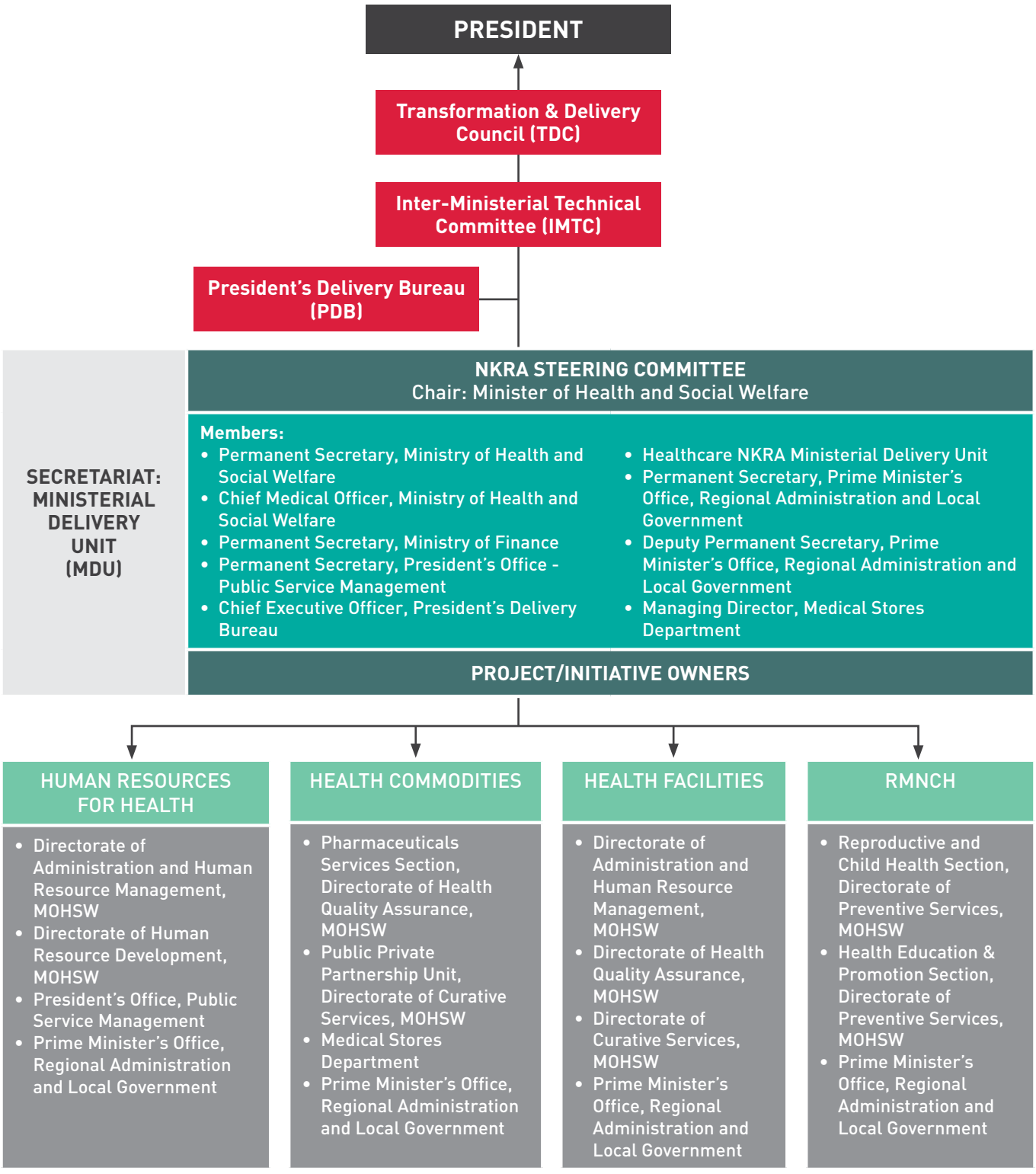
Mass media campaigns are the most cost effective and scalable way of encouraging health-conscious behaviours.

This initiative will develop and implement an integrated, 360-degree mass media campaign that will be sponsored through Public Private Partnerships (PPPs). It will be focused and executed in five underserved regions to increase awareness and the eventual uptake of RMNCH services in family planning, ante-natal care (ANC), institutional delivery, postnatal care (PNC) and access to safe blood.

FIGURE 16 | Strategic interventions through social mobilisation and mass media



GOVERNANCE STRUCTURE



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