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TANZANIA

USAID/TANZANIA HEALTH SYSTEMS STRENGTHENING STRATEGY

2013 – 2018

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USAID/TANZANIA HEALTH SYSTEMS STRENGTHENING (HSS) STRATEGY

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Executive Summary

Health system challenges in Tanzania are impeding the achievement of national development goals and consequently those relating to USAID's programs on Maternal and Child Health (MCH), Malaria, HIV/AIDS, Tuberculosis (TB), and Family Planning (FP). These challenges include, but are not limited to, the shortage of health care workers, health commodity stock outs, and insufficient financing. If such systems issues are not addressed, USAID's health programs on will not yield nor sustain desired results. Furthermore, while Tanzania has the potential to achieve 'middle-income' country status¹, without significant improvements in health care the country faces the risk of overwhelming an already-fragile social service system and eroding future economic gains.

Health Systems Strengthening (HSS) focuses on ensuring that improvements in the health care system are sustained after donor support ends, and that there is institutionalized capacity for ongoing improvement.² Guided by the United States Government (USG)/Tanzania Global Health Initiative (GHI), host country health policies and the Mission's first formally integrated HSS team, this HSS Strategy will shape USAID/Tanzania's HSS portfolio and influence Mission health activities over the next 5 years (2013-2018).

USAID/Tanzania's HSS strategy articulates a direction for the often ill-defined, poorly understood, and nebulous concept of systems strengthening. This document serves to clarify the concept, justify its purpose within USAID/Tanzania's programming, and provide a tangible direction to the implementation of HSS interventions to deliver results.

At its core, USAID/Tanzania's HSS Strategy aims to support the stewardship of the URT to lead HSS efforts and will work closely to coordinate and leverage systems strengthening interventions supported by other USG agencies, donor partners and national stakeholders. The premise being that only collectively, significant health systems change will be possible.

Beginning with USAID/Tanzania's HSS vision, this Strategy aims to *support the United Republic of Tanzania (URT) to develop a self-reliant health system (across the public and private sector) that is responsive to the health needs of Tanzanians*. This will be achieved by 1) strengthening financial protection, 2) improving access to and quality of service delivery, and 3) ensuring population coverage, particularly for the poor, vulnerable and underserved. To do so, USAID/Tanzania will target the following results:³

- Increased, effective, and efficient domestic **financing** for health
- Expanded and strengthened **human resources for health**
- Enhanced mechanisms for **governance** and accountability
- Strengthened and streamlined health **information** systems and **data use**.

¹ As articulated in The Tanzania Development Vision 2025

² Reference: Don de Savigny and Taghreed Adam, Eds. Systems Thinking for Health Systems Strengthening. Geneva: Alliance for Health Policy and Systems Research and World Health Organization, 2009.

³ Note, private sector and supply chain issues will be addressed within each of these four areas. Service delivery strengthening will be coordinated largely through the facilities and community-based services team within the health office.

Informed by consultations with the broader USG, host country, and implementing partner stakeholders, this Strategy articulates several major changes/shifts to USAID programming for health systems strengthening. Firstly, the Mission's HSS activities will call for a more integrated response across the World Health Organization (WHO) health system 'building blocks' (i.e. service delivery, health workforce, information, commodities, financing, leadership and governance) as opposed to the previously 'silo-ed' approach where activities relating to each 'building block' were largely distinct and separate from those of other blocks. Secondly, the HSS portfolio will increasingly prioritize long-term sustainable 'strengthening' interventions (e.g., helping the URT to forecast and budget its commodity needs) over stop-gap/'support' measures (e.g. direct USAID procurement of commodities).⁴ Thirdly, the Mission will shift away from a fragmented approach to HSS that is guided by the mandates of individual streams of earmarked programs (e.g., the President's Emergency Plan for AIDS Relief (PEPFAR), the Presidential Malaria Initiative (PMI), and MCH). Instead, the Mission will leverage these multiple funding sources to support a more strategic and purposeful HSS portfolio that helps address the major weaknesses in Tanzania's health system.

Another major change to USAID's HSS programming will be the added emphasis on monitoring and evaluation of HSS activities. This will serve to inform programming directions and document outcomes relevant to both the overall health care system as well as to specific priority areas. For example, an activity focusing on financial management strengthening at the district level should document whether strengthening the quality of district councils audits results in increased central level funding allocations to the councils (as per URT policy to reward councils with clean audits), and whether this in turn translates into greater council spending on health as well as its priority areas, such as malaria, MCH, FP, and HIV/AIDS. While HSS typically involves long-term interventions, it will still be important to monitor and ensure that HSS programming has an effect on priority areas within a reasonable period of time. Therefore, both near- and long-term tracking of HSS program outcomes will be important.

Finally, in recognition that many of the bottlenecks to strengthening Tanzania's healthcare system lie outside of the health sector,⁵ this Strategy calls for greater leveraging, partnering, and liaising with a variety of stakeholders, including those whose primary mandate may not be health (such as the Ministry of Finance, the President's Office- Public Service Management, Prime Minister's Office-Regional Administration and Local Governments). Internally, this will mean greater linkages with other critical Offices within the USAID/Tanzania Mission. For example, HSS interventions may entail partnering with USAID's Democracy, Human Rights and Governance (DRG) Office to 1) link with the National Audit Office and Public Procurement Regulatory Authority to strengthen financial management and procurement transparency at the Local Government Authority (LGA) level – *supply side*, and 2) to build civil society capacity to demand transparency in the budgeting and execution of health care programs at the LGA level – *demand side*.

By making these shifts, USAID/Tanzania aims to be more effective and holistic in its support of the URT to sustainably improve the performance of the country's health system.

⁴ 'Support' activities focus on "filling gaps to produce better short term outcomes." This concept is further articulated in the following paper: Chee G., N Pielemeier, A Lion, C Connor. 2012. 'Why differentiating between health system support and health system strengthening is needed?' *International Journal of Health Planning and Management*

⁵ For example, financial disbursement delays in health are symptomatic of broader government-wide public financial management challenges.

I. Tanzania's Health System Context

A health system consists of all organizations, people and actions whose primary intent is to promote, restore and/or maintain health.⁶ It can be conceived of as having six key 'building blocks', namely finance, human resources for health (HRH), governance, information, service delivery, and supply chain (World Health Organization, 2000).

Tanzania's health system is complex and pluralistic. It is comprised of public, private, and donor stakeholders operating at several different levels including national, regional, district, and community levels. According to the latest National Health Accounts (NHA) report (2009/10), 8.2% of the GDP is invested in health care and 6.5% of government expenditure is spent on health, well below the Abuja Target of 15%. Donor dependency for health care financing typifies Tanzania's health system. Indeed, NHA findings show that donors contribute a sizeable 40% of total health expenditures (THE), followed by the private sector (largely household out-of-pocket spending) at 34%, and lastly the government at 26%. Of the total spent on health care, HIV/AIDS programs account for a sizeable 27%, malaria for 19%, reproductive health for 18%. Expenditures on child health services, which cut across the HIV/AIDS and malaria programs as well as other general health spending, accounted for 9% of THE.

Findings from the 2010 *Tanzania Health Systems Assessment* show that the country's health system has had mixed performance during the past decade. On a positive note, several significant improvements have been realized:

- Proportion of births in health facilities has risen;
- Improved coordination of the health system through the SWAp structure;
- Clear guidelines and tools exist for proper planning at the LGA level (otherwise referred to as the 'district' level);
- Various initiatives are under way to strengthen financial management at this level; and
- HRH management is a high priority with the personnel emolument⁷ budgets also increasing in recent years.

In terms of challenges to achieving national health goals, these include limitations in healthcare infrastructure, poor healthcare worker coverage, procurement bottlenecks, and the challenges of managing a health system that is in the process of decentralization. The ongoing process of Decentralization by Devolution (D by D) adds a layer of complexity that stretches the managerial ability of staff to coordinate across different ministries and fulfill their roles within the Ministry of Health and Social Welfare (MOHSW) and Prime Minister's Office-Regional Administration and Local Government (PMO-RALG) structures. Overall health system implementation is often weak, arising in part from poor communication between the different levels of the system, lack of leadership and management skills and the imbalances between well-resourced vertical programs (e.g., HIV/AIDS) and the rest of the health system.

⁶ This is an expanded version of the definition given in the *World Health Report 2000 Health systems: improving Performance. And Everybody's business: strengthening health systems to improve health outcomes: WHO's framework for action. WHO, 2007.*

⁷ Emolument: profit made from employment, salary, fees etc. Kernerman English Multilingual Dictionary © 2006-2013

The path towards Universal Health Coverage (UHC) is considerable.⁸ As stated by the World Health Organization, achieving UHC requires a strong, efficient, well-run health system; a system for financing health services; access to essential medicines and technologies; and sufficient capacity of well-trained and motivated health workers. Along these lines, the Tanzanian health system needs considerable improvement as articulated in the *2010 Health Systems' Assessment*. Furthermore, adequate financial access to health care is wanting - with households paying more for health care (directly to health providers) than the URT and with only 15% of the population with some form of health insurance coverage. Supply chain challenges are numerous such as stock-outs, vertical systems for different products, and inadequate financing for commodities to accommodate a population increasingly facing a dual disease burden (of infectious as well as chronic diseases). Finally, health worker shortages across all cadres are widely recognized; in 2011, there was a deficit of 48% skilled health staff in the public and faith based facilities.

II. USAID Rationale for Strengthening the Health System

HSS can mean different things to different stakeholders. To some, it implies nebulous programming where results are typically not forthcoming or realized only in the distant future. This document aims to portray a more tangible HSS concept that addresses such concerns. It also aims to articulate a systems strengthening direction within USAID/Tanzania's health program.

Health systems strengthening (HSS), as referred to by the USAID Mission, means ensuring that any improvement in Tanzania's health system must be sustainable after donor support ends, and that there is institutionalized capacity for ongoing improvement.⁹ In doing so, the country increasingly relies on its own financial resources and has the human resource and institutional capacity to sustain and improve health services for all its citizens.

Why is it important that USAID/Tanzania support such efforts? Simply put, HSS exemplifies USAID's fundamental operating principles for development, namely:

1) *To Achieve Broader URT Development Goals:* USAID/Tanzania is committed to helping the country fulfill its potential to achieve 'middle-income' country status based on its economic growth rate (averaging 7% per annum) and relatively stable political environment. However, without significant improvements in governance, health, and health care systems, Tanzania faces the risk of overwhelming an already-fragile social service system and eroding future economic gains. In addition, the achievement of its health-related Millennium Development Goals is dependent in large part on urgent improvements in the performance of its' health system.

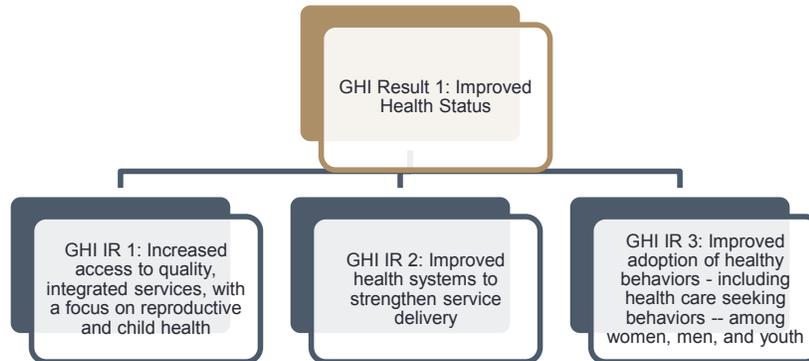
2) *To Align with USG Priorities:* Health systems strengthening is a central tenet of the USG's Global Health Initiative (GHI) within which all U.S. agencies work together to support the strengthening of the country's national health system. As shown in Figure 1 below, an improved

⁸ Universal Health Coverage aims "to ensure that all people obtain the health services they need without suffering financial hardship when paying for them." WHO (http://www.who.int/universal_health_coverage/en/)

⁹ Reference: Don de Savigny and Taghreed Adam, Eds. *Systems Thinking for Health Systems Strengthening*. Geneva: Alliance for Health Policy and Systems Research and World Health Organization, 2009.

health system is one of three intermediate results; the other results are related to increased access to quality integrated services and improved healthy behaviors.

Figure 1: GHI Results Framework



Furthermore, the HSS strategy incorporates principles and goals of PEPFAR, PMI, Stop TB, and the broader USG initiatives for ‘A Promise Renewed’ to end preventable maternal and child deaths and achievement of an ‘AIDS-Free Generation’. The HSS strategy will contribute to these higher level outcomes by assisting Tanzania to accelerate coverage of high impact interventions, while simultaneously building a strong health system which can sustainably provide positive health impact across health programs for HIV/AIDS, malaria, family planning, maternal and child health and tuberculosis.

3) *To Achieve USAID Goals:* If the underlying systems issues of staffing shortages, commodity stock outs, and inadequate financing are not addressed, USAID’s health programs – such as HIV/AIDS, TB, and Malaria-- will not yield nor sustain desired results. USAID HSS support is critical for the success of its disease-specific targets and lays the foundation upon which Tanzania can *end preventable child and maternal deaths* and bring about an *AIDS-free generation* – both of which are the overall health goals of the Agency.

4) *To Implement USAID Approaches:* HSS supports the Agency’s *Local Solutions* reform efforts by supporting and working through local institutions and actors. The premise is that donor resources should flow directly through local institutions, providing them capacity building support and experience to foster a robust health sector with decreasing need over time for predominantly external support, financial and technical. To do so, USAID seeks the most effective, efficient and financially sound means of using local systems. It should be noted that the public sector alone is unlikely to meet all national health goals; as such, USAID is committed to strengthening and facilitating partnerships with public, private and civil society organizations.

5) *To Leverage USAID/Tanzania’s Core Competencies:* To strengthen the health sector, it is important to address issues beyond the health sector; for example, to increase the URT budget for health, it becomes critical to understand the broader macroeconomic context of the country and motivations of the Ministry of Finance. With USAID’s multisectoral office structure, the Agency is well poised to implement true HSS interventions through the concerted efforts of its various offices. Also, as part of the larger USAID health community, USAID/Tanzania can leverage

USAID/Washington’s Office of Health Systems and the Health Systems Network of colleagues around the world. USAID/Tanzania can also leverage USAID’s global role as a member of Providing For Health (P4H), Harmonizing for Health in Africa (HHA), the Health Metrics Network, the Global Fund and GAVI, as well as the Agency’s close collaborative ties with WHO and the World Bank in HSS.

III. Development Process of USAID/Tanzania’s HSS Strategy

USAID/ Tanzania’s HSS interventions alone will not/cannot bring about a strengthened national health system. These efforts must be coordinated closely with those of the host government, donor partners, and other stakeholders.

As such, the development of USAID/Tanzania’s HSS strategy was informed by priority issues identified through USAID stakeholder meetings and the HSS Workshop held with USAID/Tanzania Health Office March, 2013. Subsequent stakeholder meetings were also held with the MOHSW and donor representatives to identify HSS priorities. The proposed results and approach are based on outcomes of those discussions and recommendations from the key national health sector documents including the *Health Sector Strategic Plan (HSSP) III 2009-2015*, the *National Health Systems Assessment (2010)*, *2009/10 National Health Accounts* (published in 2012), *Private Health Sector Assessment (2013)*, and *Strategic Review of the National Supply Chain System for Commodities (2013)*.

At its core, USAID/Tanzania’s HSS portfolio aims to support the stewardship of the URT to lead HSS efforts and will work closely to coordinate and leverage systems strengthening interventions supported by other USG agencies, donor partners and national stakeholders. The premise being that only collectively, significant health systems change will be possible.

The sections that follow articulate the HSS strategy’s results framework, including illustrative interventions, followed by a narrative describing the major shifts and principles needed to achieve those results.

IV. USAID/Tanzania Health Systems Strengthening Results Framework

Vision and Overview

USAID/Tanzania’s HSS results framework is shown in Figure 2.

The strategic vision is to help foster a ‘*self-reliant health system (across public and private sectors) that is responsive to the health needs of Tanzanians.*’ As stated earlier, this means ensuring that

any improvement in Tanzania’s health system must be sustainable after donor support ends, and that there is institutionalized capacity for ongoing improvement.¹⁰

Achievement of this vision will require 1) strengthening financial protection, 2) improving delivery, access to and quality of services/care, and 3) ensuring population coverage, particularly for the poor, vulnerable and underserved. To do so, USAID/Tanzania will focus its programmatic support on achieve the following four results:

- Increased, effective, and efficient domestic **financing** for health
- Expanded and strengthened **human resources for health**
- Enhanced mechanisms for **governance** and accountability
- Strengthened and streamlined health **information** systems and **data use**.

The hypothesis is that when implemented in concert with one another, the combined effect of the four results will jointly affect financial protection, access to services/care, and widen population coverage—which in turn will move the country closer towards USAID’s HSS vision.

Implicit in the HSS strategy is the inclusion of support for improved commodities and logistics systems and maximizing the potential of the private sector in health care. Both supply chain and private sector strengthening necessitate inputs into all four of the above-mentioned results.

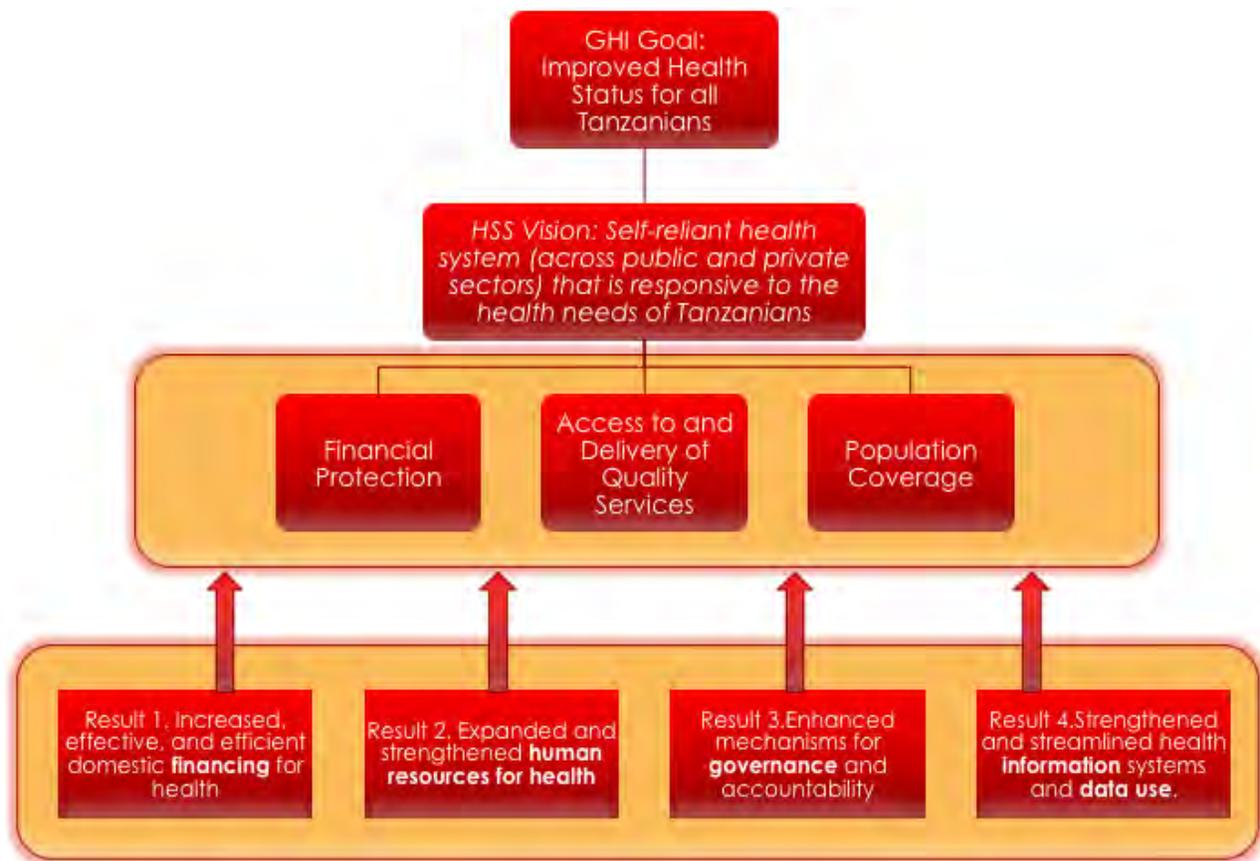
It should be noted that systems integration and linkages at the service delivery level (both facility and community) are not profiled in the HSS results framework, largely as this issue falls under the purview of the other two GHI intermediate results – that of facility and community services. That said, service delivery strengthening, linkages, and strategic integration is a health office-wide concern being addressed in accordance with the GHI strategy.

Critical assumptions for achieving such results and vision are as follows:

1. URT will continue to experience economic growth rates that can potentially be leveraged to sustainably finance healthcare;
2. URT will enhance its commitment to healthcare;
3. URT possesses political will to implement a comprehensive health financing strategy;
4. URT continues to invest in attracting and retaining a skilled health workforce;
5. URT and stakeholders desire an integrated health information system;
6. URT values a pluralistic healthcare system and one that is increasingly decentralized;
7. Political will exists to expand private sector involvement in the health sector; and
8. MOHSW continues to implement interventions to address identified supply chain gaps.

¹⁰ Reference: Don de Savigny and Taghreed Adam, Eds. Systems Thinking for Health Systems Strengthening. Geneva: Alliance for Health Policy and Systems Research and World Health Organization, 2009.

FIGURE 2: USAID Tanzania HSS Results Framework



The following sections flush out the background¹¹ and illustrative interventions to achieve each HSS result. While each result is listed separately for ease of presentation, the intent is to pursue each result in concert with other interventions in an integrated manner across the WHO building blocks.

RESULT 1: Increased, effective, and efficient domestic financing for health

Background

Tanzania's financing of health care is heavily dependent on donors, followed by the private sector – largely household out-of-pocket spending, which increased by 60% since the 2005/6 NHA survey. As a result, the Government is a minority partner in financing health care. In recent years,

¹¹ Background sections for each result are derived from a variety of national documents including *Tanzania Health Systems Assessment 2010*, *Tanzania Private Sector Assessment 2010*, *Tanzania National Health Accounts 2010*, *Tanzania Supply Chain System Review 2013*, and the *Health Sector Strategic Plan III 2009-2015*.

health sector basket funding has decreased significantly. Major issues and gaps relating to health care financing can be summarized as follows:

- Health financing is dependent on donors
- Total government expenditures on health is relatively low
- Financial protection is low and fragmented
- Health sector sets exemptions policies without reimbursements
- There are delays and inefficiencies in resource flows and low budget execution
- Inadequate resourcing for commodities and supply chain systems
- Private for-profit sector is not well integrated into health financing arrangements

The dependency on donor financing is unsustainable. Tanzania has an opportunity to capitalize on its steady economic growth to invest more in health. If Tanzania acts now, increased domestic spending can be channeled through effective health financing arrangements that mobilize, pool and allocate resources to ensure optimal and equitable health impact.

Achieving Result 1

The country has a critical window of opportunity to address financing challenges, namely the soon to be developed National Health Care Financing Strategy that aims to identify domestic and sustainable options for financing. This financing strategy will articulate approaches for a number of critical topics, including the expansion of risk-pooling mechanisms, defining a costed minimum benefits package for the country, the way forward on performance based financing, strengthening the involvement of the private sector, ensuring financial access for the poor, and generating local revenue for health. In continued partnership with the P4H Donor Partners group and in support of the Inter-ministerial Steering Committee and the Health Care Financing TWG, USAID/Tanzania will provide assistance to the development, finalization and implementation of the upcoming national health care financing strategy – particularly innovative financing and payment approaches to increase equitable access to and sustainability of quality service programs.

Seeking financial solutions will require the engagement of both the public and private sectors. On the latter, USAID will seek to maximize long-term private sector involvement in the health system (whether or not through formal partnerships). Development of USAID supported PPPs will target the alignment of such partnerships to programmatic priorities.

In addition, USAID/Tanzania will continue support for strengthening financial management processes at the LGA level along with the institutionalization of resource tracking and implementation of costing analyses.

Illustrative Program Interventions to Achieve Result 1:

- Support development and implementation of a comprehensive and sustainable national health care financing strategy; this may include the following efforts --
 - Strengthen needs-based resource allocation
 - Inform and technically support national performance-based financing strategies
 - Support reforms for rationalized and functional insurance and exemption programs towards universal health coverage.
 - Define/update essential health service package to be financed by URT
 - Support reforms to budget for community health component
 - Support improved financing and resource allocation processes for commodity procurement and supply chain systems.
 - Support sustainable involvement of private sector e.g. through private health insurance, employer involvement in risk-pooling mechanisms, and contracting out with private sector for essential service coverage
 - Advocate for increased URT budget for health through USG policy dialogue
- Strengthen LGA financial management processes and mechanisms for accountability with respect to revenue generation, fund allocation to health, collection, budget formulation and execution
- Support utilization and institutionalization of NHAs for improved decision-making
- Support costing and financial analyses for critical program areas such as HRH, commodities and supply chain systems, and high impact interventions for priority program areas

RESULT 2 – Human Resources for Health Strengthened and Expanded

Background

The health sector is facing a serious human resources for health (HRH) crisis that is negatively affecting the ability of the sector to deliver quality health services. There is an estimated 0.52 health care workers per 1,000 population, which is well below the WHO benchmark of 2.28 per 1,000 population (to reach 80% health coverage). HRH shortages exist at all levels and are more severe in rural districts. The shortage is made more critical by the pressure placed on the health care system due to HIV/AIDS, malaria, TB and population increase. Reasons for HRH shortages are complex and varied. They include low output of qualified staff, mal-distribution, poor remuneration, poor infrastructure, lack of attractive retention schemes, and migration to other countries after training, and inter-sectoral movement and/or retraining in other disciplines.

Tanzania's nationwide HRH shortage is even more extreme within the private health sector. As a result of the 2006 MOHSW decision to raise the salaries of all public health sector employees, significant numbers of health personnel left the private health sector for better pay and benefits available in the public sector. This exodus of qualified personnel from the private health sector, high turnover, and lower private sector salaries have contributed to the widespread perception that the providers remaining in the private health sector are not well qualified. With fewer private providers, there is added pressure on the public health care system to provide services to even those who would otherwise be able to pay. Exacerbating this situation that staff in private facilities are unable to participate in public sector continuing medical education and in-service trainings.

Without the opportunity to learn new skills or become oriented to national health priorities, private sector personnel are disconnected from the public health sector and their skills are not being leveraged in addressing key public health challenges.

Major issues and gaps relating to human resources for health can be summarized as follows:

- The health labor market does not produce the types, number and distribution of health workers needed to meet demand.
- Low enrollment of students coming from rural areas in pre-service training institutions—impacts retention.
- Tanzania does not mobilize a national community health workforce to protect community health.
- URT has difficulty attracting health human resources to underserved areas.
- Local governments run district health services but rely on central government for recruitment.
- Health workers are unmotivated and not highly productive.
- Staffing norms for each facility type are identical irrespective of workload.
- HRH planning does not take into account private facilities or personnel.
- Supply chain systems are understaffed, with poor capacity and low retention.
- Lack of access to in-service training opportunities for private health sector providers.
- Weak supportive supervision practices.

It is widely acknowledged that by not addressing the HRH challenge systemically and in a concerted manner, the success and sustainability of USAID's programs in HIV/AIDS, Malaria, TB, and MCH will not be viable.

Achieving Result 2

USAID/Tanzania will work with the URT to support the implementation of the upcoming National HRH Strategic plan and address the severe shortage and inequitable distribution of health workers essential for effective service delivery – both in the public and private sector. Critical elements include continuing to advocate for and guide inter-ministerial coordination (between MOHSW, PO-PSM, and PMO-RALG) focusing on identifying and implementing best practices in strengthening recruitment and distribution processes.

USAID's portfolio on HRH has traditionally focused on the development of health training institution infrastructures and investment in HRH production. While this focus remains important, going forward the Mission's HSS portfolio will increasingly target the strengthening of HRH recruitment, distribution and retention systems at the national and LGA levels. HRH production activities will concentrate on institutionalizing previous investments in pre-service training. In addition, USAID will continue to provide technical assistance for training cadres that contribute to improving reproductive, maternal and child health services. This will include assistance in workforce planning for community-based workers.

Furthermore, attention will be paid to strengthening the management capacity of healthcare managers like the District Medical Officers while advocating for the introduction of new administrative level cadres that do not require clinical training. These cadres can help improve data management, laboratory and commodity services and reduce the administrative burden of those providing clinical services.

For supply chain, USAID will strengthen management and planning challenges through the provision of technical support for also provide technical assistance in quantification, procurement, warehouse management, distribution, route optimization, data collection and management systems and security.

Finally, the HSS unit will assess USG's direct 'support' for health care workers and propose, in collaboration with interagency and host-country counterparts, a long-term transition plan for domestic absorption of such activities.

Illustrative Program Interventions to Achieve Result 2:

- Work to address the mismatch between production and recruitment (e.g., for doctors) in the HRH labor market
- Support approaches (as per the HRH strategic plan) for rationalized HRH production, retention and recruitment plan
- Promote the development, as guided by HRH strategic plan, of an incentive scheme for underserved areas
- Implement strategies for recruitment and retention of staff for supply chain systems
- Support the informed delineation and formalization of task shifting and task sharing practices
- Support the incorporation of the community workforce cadre into the health system
- Strengthen HRH management and administration skills through scaled and sustainable approach
- Partner with business associations and management institutions
- Utilize public and private sector HRH for service coverage and skills building
- Address supply chain system HRH requirements for capacity and staff sufficiency
- Leverage current technologies for improved services
- Include the private health sector in training opportunities and HRH planning exercises
- Leverage private medical training institutions particularly for production of mid-level certificate and diploma workers
- Develop transition plans for USAID-supported health care workers (ongoing and future)

RESULT 3 – Governance and Response Mechanisms Enhanced

Background

Critical to a well-functioning health system is the extent to which government responds to public and civil society needs, preferences, and demands; answers citizens' complaints or requests for information; and incorporates community-level opinions into policy. In Tanzania, there is an added layer of complexity—that of the national Decentralization by Devolution (D by D) policy; this policy has not been entirely implemented within the health sector. With the large exception of supply chain and human resources for health, other aspects of health care have been decentralized. Simply put, the MOHSW oversees technical aspects of regional and LGA activities, and PMO-RALG oversees administrative aspects. Within the government structure, councils are in charge of managing and delivering public services to their constituents, including health care.

Tanzania's health sector faces many critical governance challenges. For example, there is weak

coordination and communication between the central and decentralized levels. This is compounded by the implementation of multiple programs and initiatives that may compete for limited staff resources at district and facility level. Also, while national policies may be in place, they often are not distributed widely in a timely manner or accompanied later with guiding principles and procedures. Lastly, LGAs are not typically held accountable to the public for spending within the health sector. This is mainly because the public is often not aware of the money that should be allocated to health care at the community level. Many public or stakeholder complaints/issues get lost within the system and/or are not handled, and therefore, many health sector managers do not feel accountable to the public. This problem is exacerbated by HR constraints. There is not enough qualified staff to receive and manage input or to promote awareness of the appropriate feedback structures.

With respect to governance issues across the public and private sectors, Tanzania lacks national standards for facility, accreditation and quality assurance; moreover, the MOHSW has historically applied licensing standards differently across public and private sectors. The creation of structures that facilitate public-private dialogue, currently underway, will result in forums within which issues of mutual interest and concern between the public and private health sectors can be raised.

Major issues and gaps relating to governance can be summarized as follows:

- Accountability for staff roles and responsibilities a challenge
- Coordination between ministries is limited
- Limited mechanisms for feedback from lower to upper levels
- Regional teams need more access to information from central and community levels
- Multiple insurance schemes need better coordination
- Community Health Management Teams (CHMTs) often do not translate health data into health plans with appropriate prioritization of activities based on health needs.
- Functioning of governing bodies such as Council Health Service Boards can be strengthened
- Unclear processes for appeal of regulatory violations
- Limited government ownership and accountability for commodity and supply chain systems
- Inconsistent application of rules and regulations between public and private sectors
- Poor accountability impacts service quality and availability

Strengthened governance, and the leadership and management that underpin it, is essential for effective USAID program implementation at all levels.

Achieving Result 3

The Mission will work to support the URT's stewardship and policy implementation over the health sector in alignment with USAID's Government-to-Government (G2G) strategies and URT-Sector Wide Approach (SWAp) structure. In addition, the Mission will provide continued support to regional, district, and local government authorities to ensure that essential health services are prioritized and budgeted according to risk factors and burden of disease, and integrated for more cost-effective service delivery. USAID/Tanzania will also support the strengthening of leadership capacity and skills of local government authorities to promote decentralization, and strengthen

coordination between central, regional, and district levels as well as between public and private sector. Further focus will be placed on fiscal and social accountability measures at the local government level and through engagement of civil society and private sector in alignment with USAID's *Local Solutions* initiative. Outside of the public sector, the portfolio will also include organizational development support to civil society and private sector stakeholders.

Finally, the USG will support high level advocacy aimed at improving MOHSW and Ministry of Finance supply-chain budget planning, program funding allocation formulation, and timely commodities fund disbursement. Advocacy and support for improved regulatory oversight of the quality of drugs in Tanzania is also being pursued through work with the Tanzania Food & Drug Authority.

Illustrative Program Interventions to Achieve Result 3:

- Support critical policy change, reforms, and development, particularly at the decentralized level
- Develop forums for public-private dialogue on health sector-wide issues
- Utilize USAID's "Local Solutions" and G2G strategies to strengthen program performance and build local capacity
- Patient advocacy: Establish patient recourse mechanisms and increase awareness of rights
- Integrate vertical program commodities processes and systems, including budgeting, procurement forecasting, quantification, regulation, ordering and delivery, to create a highly cost-effective system.
- Conduct informed policy analyses and advocacy efforts (e.g., aimed at improving MOHSW and Ministry of Finance (MOF) supply chain budget planning, program funding allocation formulation and timely commodities fund disbursement)
- Support effective systems for PMO-RALG oversight of LGAs
- Use approach to LGA capacity building that has low transaction costs and low management burden
- Strengthen accountability measures (both social and financial) in line with national pay for performance approaches
- Provide organizational development support to CSOs and private sector NGO and health providers
- Provide technical support to develop district specific approaches to improve management and governance of health services using policy guidelines
- Support LGA in partnership with MOHSW to develop a comprehensive supply chain master plan
- Support LGAs directly through host country government mechanisms, such as the health sector basket to the greatest extent possible.

RESULT 4 – Health Information Systems and Data Use Strengthened

Background

The GOT places great importance on the functioning of the HIS and this is reflected in the new HSSP III (2009-2015). A national health management information system (HMIS) within Tanzania was fully rolled out to all regions in 1997. Since the introduction of this HMIS (the MTUHA system), there have been no comprehensive revisions. The expansion of reportable conditions and the advent of vertical programs with their own demands for data have rendered the HMIS inadequate, resulting in multiple and duplicative data collection and reporting subsystems. With the current scarcity of staff and other resources, these subsystems have rendered the MTUHA even more unresponsive to the information needs of the MOHSW and captured data is not only inaccurate but also incomplete and reported late.

A comprehensive modernization and strengthening of all aspects of monitoring and evaluation within the MOHSW is underway. This new project includes strengthening the HMIS to improve data collection, reporting, and use for decision making at all levels of the health system. It aims to integrate and harmonize all the existing (more than 10) subsystems, which have been created in an attempt to respond to the deficiencies of the main HMIS.

From the private sector side, providers do provide various weekly, monthly, and quarterly reports to LGAs, but this has been identified as a key area requiring strengthening. The private sector cites the lack of supportive supervision on data reporting from LGAs, inadequate supply of data collection tools and registers, and minimal training of their personnel on data collection standards and requirements are negatively impacting the quality of surveillance and routine reporting to public health authorities. In addition, lack of reports back from the public sector on disease surveillance and data trends, contributes to the frustration felt by private health sector personnel and limits their incentive to comply with data reporting requirements.

Major issues and gaps relating to information systems and data use can be summarized as follows:

- Policy on data flow and information use
- Need for harmonized collection, processing, and reporting of health information
- Separate and vertical data reporting formats complicate planning and budgeting, including for services, HRH and supply chain systems
- Weak links between data collected and information required to support decision making
- Inadequate feedback mechanisms/loops between higher and lower levels
- Inconsistent data use and reporting practices for commodity and supply chain systems
- Weak data reporting from private health sector and report back from MOHSW

While donor programs tend to be data 'hungry', the proliferation of donor supported information systems, in the absence of host country systems, undermines country ownership, management, and use of data to inform national policy dialogue. It becomes important to shift support to host country systems in a manner that is manageable and useful for local policymakers.

Achieving Result 4

A cornerstone of USAID health programming has been its reliance on collecting and verifying data for Washington reporting purposes, planning purposes, and to inform advocacy needs. Going forward, USAID will expand this focus to strengthen host country (both public and private) data collection, processing, reporting, and use for decision making at all levels of the health system. Specifically, the Mission will support implementation of the URT's monitoring and evaluation (M&E) strategies as well as improved integration and effectiveness of M&E systems for data use. This in turn will improve data quality.

For example, USAID will support the URT to strategically integrate, harmonize and/or link existing subsystems. In some instances, this may necessitate a gradual phasing-out of certain information systems (even if previously supported by USAID) if they are found to be duplicative, weak, and/or not a significant contributor to the overall national health information system architecture. Beginning with those information systems currently supported by USAID, the Agency will support efforts to improve interoperability/linkages/harmonization within the national health information system design. This will also include the development of user-friendly interfaces to promote data utilization (for both routine information systems and studies) at all levels for planning, forecasting and programming. As such, this may include linking systems that report on health care utilization to those dealing with financial management, planning, human resource and performance management information systems, and public supply chain management systems. USAID/Tanzania will collaborate closely with CDC on an interagency basis to implement USG supported HMIS programs and activities, and will engage in supporting PEPFAR's Open Data HIS initiative for greater transparency and information use.

M&E activities also aim to build capacity of National Bureau of Statistics (NBS) to minimize reliance on international technical assistance in conducting national census and surveys. As such, direct G2G support is envisioned for the National Bureau of Statistics (NBS) along with the articulation of clear milestones on how ICF MACRO will be relinquishing its technical assistance responsibilities to NBS.

Illustrative Program Interventions to Achieve Result 4:

- Support interoperability and linkages of prioritized systems
- Invest in flexible/adaptable platforms
- Design user-friendly interface for increased data utilization
- Assess current USAID supported system functionality and conduct gap analysis
- Support URT efforts to promote costed-plan of action; one that is financially sustainable
- Develop and implement change management strategy that improves the use of data for decision making
- Expert technical pre-evaluation of system proposed for scale-up
- Capacity building for technical teams to ensure standards and compliance
- Use training and supervision to strengthen use of data by CHMTs
- Develop appropriate incentives for timely collection/compilation of health data
- Determine next steps for iHRIS
- Support Open HIS through PEPFAR Initiative
- Include private providers in training on data collection tools, requirements and standards
- Design and implement the electronic Logistics Management Information Systems (e-LMIS) for all health commodities to improve access, management and use of data for decision-making, further contributing to commodities security.
- Develop routine standard commodity and supply reports that can be shared with stakeholders

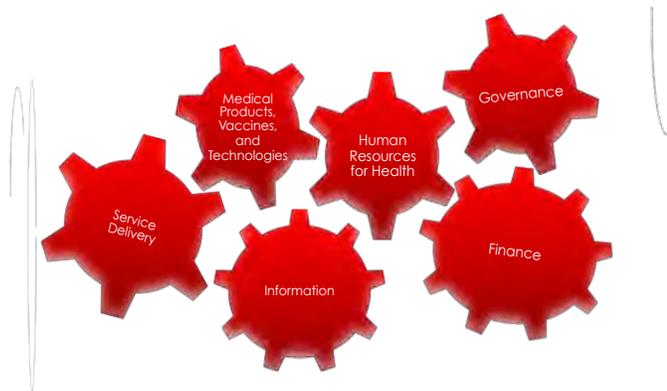
USAID/Tanzania will support a continuing evolution of indicators and tools to support the generation of quality evidence emphasizing the use of data at all levels, including for HSS. USAID/Tanzania will also contribute to supporting planning and implementation of national surveys such as the Demographic Health Survey and Service Provision Assessment.

V. Approach to Achieving HSS Results

To achieve the above HSS results, USAID will continue to work, coordinate, and leverage HSS efforts within the broader USG, the URT, other donor partners, private sector, and civil society stakeholders. Nonetheless, this Strategy does call for several major shifts in USAID’s HSS programming:

1. **Implement a more integrated response across the World Health Organization (WHO) health system ‘building blocks’** (Service delivery, Health workforce, Information, Commodities, Financing, Leadership and governance) as opposed to the previous ‘silo-ed’ approach where each ‘building block’s’ activities were largely distinct and separate from those of other blocks. As opposed to blocks, one way of envisioning the need for a concerted approach is that each HSS ‘block’ represents a gear in a complex machine – and all gears need to work in concert to operate the machine (see figure 3). This is important because previously for example, HRH activities did not necessarily connect to health care financing activities and vice versa. So without a thorough understanding of the cost of the future workforce, the health care financing strategy will fall short; similarly, without understanding the recommended pay for performance strategies in the health care financing strategy, the HRH strategy may propose approaches that will not be financed. As stated by WHO, “While the building blocks provide a useful way of clarifying essential functions, the challenges facing countries rarely manifest themselves in this way. Rather, they require a more integrated response that recognizes the inter-dependence of each part of the health system.”¹²

FIGURE 3: The ‘Blocks’ Need to Work Together



¹² WHO. 2007. *Everybody business: strengthening health systems to improve health outcomes: WHO’s framework for action.*

2. **Increasingly prioritize long-term sustainable systems strengthening interventions over stop-gap/ “support” measures.**¹³ Simply put *Supporting* focuses on filling gaps to produce better short-term outcomes. *Strengthening* is about making the system function better in the long term. USAID/Tanzania recognizes that the lack of adequate resources for health in a low income country like Tanzania impacts the number of available service sites, adequacy of infrastructure, availability and maintenance of health care and diagnostic equipment, and resources for supplies and other maintenance requirements. It is however critical to distinguish infrastructure investments, refurbishments and coverage of recurrent costs, from true systems strengthening objectives that address broader resourcing of health programs, efficiency and effectiveness of system functions, reliability and service quality, and long-term sustainability. For example, it is expected that USAID would continue to finance and procure commodities (as ‘inputs’/support) for the health system while at the same time providing technical assistance to the URT (for true ‘systems’ strengthening) to increase domestic financing (through the implementation of the country’s first national health financing strategy) along with strengthening supply chain system efficiencies and forecasting abilities (to minimize the need for costly emergency procurements). Over time, it is anticipated that the need for USAID to directly procure commodities would decrease. While both ‘support’ and ‘strengthening’ approaches need to co-exist in the interim and near future, the HSS portfolio will increasingly focus on targeted and ‘true’ strengthening activities over the long-term.

TABLE 1: Examples of USAID ‘Support’ Versus ‘Strengthening’ Activities

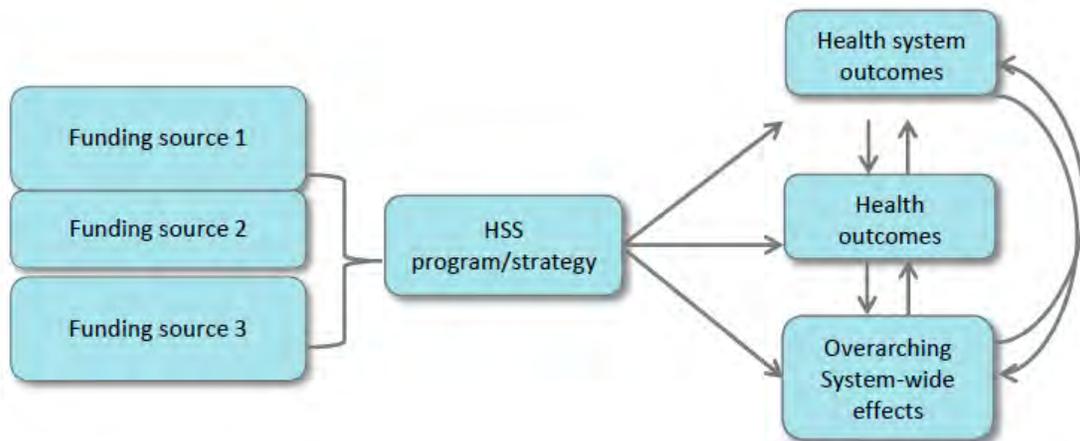
“Support” Activities	Corresponding USAID “Strengthening” Activities
Pharmaceutical and commodity procurement	TA for quantification, forecasting, pooled procurement, and implementation of healthcare financing strategy
Building staff housing in remote areas	TA to URT to ensure budget line item and appropriate maintenance of housing. TA to URT to incorporate staff housing as an attractive benefit to recruit and retain healthcare workers
Construction of MSD warehouses	TA for strengthening warehouse systems management and operational capacity (including human capacity and enhanced systems operations)
Procure equipment for public healthcare facilities and training institutions	Provide support to institutions to plan and mobilize resources to procure future equipment supplies (e.g., development of equipment database), account for depreciation

3. **Shift away from a fragmented approach to HSS that is guided by the mandates of individual streams of earmarked programs (e.g., PEPFAR, PMI, MNCH).** Instead, the

¹³ *Chee G., N Pielemeier, A Lion, C Connor. 2012. Why differentiating between health system support and health system strengthening is needed? *International Journal for Health Planning and Management*

Mission will leverage these multiple funding sources to support a more strategic and purposeful HSS portfolio that helps address the major weaknesses in Tanzania’s health system. This includes a reorientation to a broader integrated focus across priority programs (such as PEPFAR, PMI, TB, etc.) to achieve a more lasting systems impact. Figure 4 shows how various program element-specific funding sources (HIV, FP, MCH and Malaria) can be combined to invest in HSS for improved health system outcomes, improved health indicators and system-wide effects.

FIGURE 4: Pathway and Linkages between Funding Sources and HSS Program, and Program Outcomes and Effects



Source: HS20/20

4. **Emphasize the need for monitoring and evaluation of HSS activities.** This will serve to inform programming directions and document outcomes relevant to both the overall health care system as well as to specific priority areas. For example, an activity focusing on financial management strengthening at the district level should document whether strengthening the quality of district councils audits results in increased central level funding allocations to the councils (as per URT policy for councils with clean audits), and whether this in turn translates into greater council spending on health as well as its priority areas, such as malaria, maternal child health, family planning, and HIV/AIDS. While challenging given that HSS is typically a long-term intervention, it will be important to monitor and ensure that HSS programming have an effect on priority areas within a reasonable period of time.

5. **Recognize the multi-sectoral nature of health and leverage, partner, and liaise with a variety of stakeholders, including those whose primary mandate is not health** (such as the Ministry of Finance, the President’s Office- Public Service Management, etc.). Internally, this will entail greater linkages with other critical Offices within the USAID Mission. For example, HSS interventions may entail partnering with USAID’s Democracy, Human Rights, and Governance Office to 1) link with the National Audit Office and Public Procurement Regulatory Authority to strengthen financial management and procurement transparency at the Local Government Authority (LGA) level – *supply side*, and 2) to build

civil society capacity to demand transparency in the budgeting and execution of health care programs at the LGA level – *demand side*. Another example would be for USAID/Tanzania will work with Embassy and Mission leadership to interject adequate government health financing into the bilateral policy dialogue.

The HSSP III notes that “the health sector has to work in partnership with all government institutions that are responsible for services that have impact on health.” The HSS Strategy will operationalize that important principle. Both within USAID and in relationship to URT institutions, the Strategy endorses greater dialogue with other stakeholders in other sectors whose primary mandate is not health. This means, for example, seeking opportunities to work more closely with USAID’s Feed the Future office, the Ministry of Agriculture, Food Security and Cooperatives, and the Agriculture Council of Tanzania. The interface between health and agriculture on improving nutrition is obvious and could be pursued. It is important to identify such partners to operationalize a more expansive oriented HSS Strategy.

By making these shifts, USAID/Tanzania aims to be more effective and holistic in its support of the URT to sustainably improve the performance of the country’s health system.

VI. Managing for Results and Performance Monitoring and Measurement

In keeping with the USG/GHI HSS targets along with GHI’S layout of results, Table 3 below articulates USAID/Tanzania’s logical framework for its HSS strategy.

In reviewing the table, recall the Mission’s Development Hypothesis for HSS: *If a self-reliant health system with improved and sustained performance across public and private sectors is strengthened, then Tanzania’s national health and development goals of improving health status will be achieved and maintained.*

Table 3: USAID/Tanzania Logical Framework for HSS Strategy

***Baselines for these indicators are in the national surveys, and the targets are consistent with host country goals. Note that the indicators listed in this are illustrative and not exhaustive. Where feasible, efforts will be made to align indicators with those articulated in national strategic plans.*

	Narrative Summary	Objectively verifiable indicators	Means of Verification	Important Assumptions
Goal	Improved health status for all Tanzanians.	<ul style="list-style-type: none"> • Maternal mortality rate (per 100,000 live births) • Under-five mortality rate (per 1000 live births) 	<ul style="list-style-type: none"> • TDHS (every five years) • THMIS (every five years but occurs at the midpoint between TDHS studies) 	
Project Purpose/Objective	IR 2.2 Improved health systems to strengthen service delivery	<ul style="list-style-type: none"> • Domestic investment (public and private) on health as a percentage of total health expenditures. • Number of service agreements and PPPs between government (national, regional, LGA levels) and for-profit and not-for-profit stakeholders • Number of healthcare workers by cadre, per 10,000 population • Percent of URT unit(s) demonstrating use of data for planning, managing, or budgeting, • Proportion of facilities graduating from the supply chain mentoring program. 	<ul style="list-style-type: none"> • Annual Public Expenditure Review • Biennial National Health Accounts • Baseline, mid-term and end-evaluations of current and upcoming HSS Strategic Plan • LGA HSS Impact evaluation • Quarterly supply chain mentoring program reports 	<p>Human Resources: Scale up of health workers remains a high priority for the URT</p> <p>Health Information: Continued URT commitment to improve HMIS system and use of data; It is possible to make health information sub-systems interoperable. Expected improvements in connectivity will permit improved information transfer in country.</p> <p>Governance: Political will remains to foster a pluralistic healthcare system and implement Devolution by Decentralization</p> <p>Finance: Economic growth rate remains steady</p>
	Output 1. Human Resources for Health Strengthened and Expanded	<ol style="list-style-type: none"> 1. Health workers density ratio per 10,000 inhabitants. (Medical Officer + Assistant Medical Officer + Clinical Officer + Registered Nurse + Enrolled Nurse X 10,000 / Total population in the country in year x). 2. Vacancy Rate: Number of LGAs with vacant positions as per the approved establishment list (current filled positions / total approved positions). 3. Gap in the distribution of HRH between urban and rural areas (density of HRH for rural areas / density of HRH for urban areas). 4. Government expenditure on HRH as a proportion of recurrent general government expenditure on health. 	<ul style="list-style-type: none"> • Human Resource Information System (HRIS) • Human Resources for Health Information System (HRHIS) • Human Capital Management Information System (HCMIS) • Annual Comprehensive Council Health Plan (CCHP) analysis • Annual Public Expenditure Review • Biennial National Health Accounts 	

	Output 2. Health Information Systems and Data Use Strengthened	<ol style="list-style-type: none"> 1. Number of vertical programs whose indicators/information systems are linked/ incorporated into an integrated health information system 2. Number of district councils using integrated HMIS indicators to develop annual CCHPs 3. Number and type of capacity building activities related to data use, supported by USG assistance 4. Supply chain eLMIS system compliance reporting at 85% 	<ul style="list-style-type: none"> • Health Information System inventory • DHIS roll-out M&E reports • Annual CCHP reports • Program monitoring reports • Data Quality Assurance Reports • Quarterly ELMIS rollout dashboard report 	
	Output-3. Governance and Response Mechanisms Enhanced	<ol style="list-style-type: none"> 1. Percentage of districts receiving a clean overall financial audit reports 2. Percentage of all districts submitting plans that exceed CCHP assessment criteria 3. Number of LGAs that meet defined standard of good management of health services 4. Number of CCHPs developed with civil society private sector participation 5. Number of civil society organizations engaged in health advocacy and accountability interventions 6. CSO sustainability index 7. Institutional strengthening index (TBD) 8. Percentage of facilities with usable stock between minimum and maximum levels. 9. Number of Logistics Management Unit (LMU) reports available for decision maker use 	<ul style="list-style-type: none"> • Client/public opinion survey reports • Annual CCHP reports • PPP technical working group's reports • LGA HSS Impact evaluation Government budget and expenditure records • Annual USAID Civil Society Organization Sustainability Index (CSOSI) report • LMU reports (real-time) 	
	Output-4. Domestic Financing for Health in Tanzania Increased, Effective and Efficient	<ol style="list-style-type: none"> 1. Private sector spending as a percentage of THE 2. Public investment spending as a percentage of THE 3. Household out-of-pocket spending as a percentage of THE (income quintile level) 4. Percentage of population that is covered by insurance 5. Percentage increase in approved URT commodities budget. 6. Percentage of the approved budget credited to health facility accounts on time (per quarter) 7. Percentage of the approved budget released per quarter (MOF to MOHSW) 8. Percentage of the approved budget released per quarter (MOHSW to MSD) 	<ul style="list-style-type: none"> • TDHS that includes health expenditure module • Annual Public Expenditure Reports • Biennial National Health Accounts • Insurance market surveys • Government budget execution reports 	

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