附　属　資　料

①　協議議事録（Minutes of Meeting）

②　要請書

③　JICA「タ」事務所調査結果－1999年度在外プロジェクト形成調査報告書
（Situational Analysis for Project Formulation Study in Strengthening of District Health Management in Morogoro Region/Final Report）

④　HSR-POW（The Health Sector Reform Programme of Work）

⑤　モロゴロでのワークショップ報告

⑥　地方自治省による地方分権説明資料
（Status of the Implementation of the Local Government Reform Programme）

⑦　他ドナー資料
⑦－１　GTZ
⑦－２　TEHIP
⑦－３　SDC

① 協議議事録 (Minutes of Meeting)

THE MINUTES OF MEETING
BETWEEN THE JAPANESE PRELIMINARY STUDY TEAM
AND THE AUTHORITIES CONCERNED
OF THE GOVERNMENT OF THE UNITED REPUBLIC OF TANZANIA
ON THE JAPANESE TECHNICAL COOPERATION PROJECT
FOR STRENGTHENING DISTRICT HEALTH SERVICES
IN MOROGORO REGION

The Japanese Preliminary Study Team organized by Japan International Cooperation Agency and headed by Dr. Akira ENDO (hereinafter referred to as "the Team") visited the United Republic of Tanzania from November 30 to December 7, 1999, for the purpose of conducting a study regarding the request for Japanese technical cooperation for Project for Strengthening District Health Services in Morogoro Region (hereinafter referred to as "the Project").

During its stay in the United Republic of Tanzania, the Team exchanged views and had a series of discussions with the authorities concerned of the United Republic of Tanzania.

As a result of the discussions, both sides agreed upon the matters in the attached document hereto.

Dar es Salaam, December 7, 1999

Dr. Akira ENDO
Leader
Japanese Preliminary Study Team
Japan International Cooperation Agency

Dr. Gabriel L.UPUNDA
Chief Medical Officer
Ministry of Health
United Republic of Tanzania

Dr. Ferdinand FUPI
Regional Medical Officer
Morogoro Region
United Republic of Tanzania

The Attached Document

1. Title of the Project

Project for Strengthening District Health Services in Morogoro Region

2. Beneficiaries of the Project

Health management staff and health service providers in Morogoro Region, including the Regional Health Management Team (RHMT), the District Health Management Teams (DHMTs) and the Eastern Zonal Training Center (EZTC), are intended to be the direct and immediate beneficiaries; the population in Morogoro Region would be the direct beneficiaries in the long term.

The Project covers all the five Districts of Morogoro Region, namely, Kilombero, Kilosa, Morogoro Rural, Morogoro Urban and Ulanga.

3. Overall Goal of the Project

To reduce the burden of diseases and improve the health status of the people in Morogoro Region.

4. Purpose of the Project

To strengthen essential health service delivery by increasing the capacity of the RHMT and DHMTs.

5. Output of the Project

(1) The planning, execution and monitoring capacity of the DHMTs is strengthened.

(2) The supervisory skills of the RHMT are upgraded.

(3) The management systems of human resources, financial resources,

and health information, equipment, facilities and commodities (including drugs, medical articles of consumption, and office supplies) are improved.

6. Duration of the Project

The duration of the Project will be five years. The exact commencement/termination dates of the Project will be specified in the Record of Discussions (R/D), which will be signed by the authorities concerned of the Government of the United Republic of Tanzania and the Japanese Implementation Study Team.

7. Administration of the Project

(1) The Ministry of Health of the Government of the United Republic of Tanzania bears overall responsibility for the successful implementation of the Project.

(2) The Regional Administrative Secretary, RHMT and DHMTs are responsible for executing the activities of the Project.

(3) A Joint Coordinating Committee is to be established (the specifics of which will be laid out in the R/D), to ensure better communication among relevant authorities and smooth implementation of the Project. Potential participants are Chief Medical Officer, the representatives from the Directorate of Health Resource Development and PHC Secretariat of the Ministry of Health, the representative from Regional Secretariat, the Regional Medical Officer and the District Medical Officers of Morogoro Region, and the Japanese side.

8. Measures to be taken by the Tanzanian Side

(1) To assign an adequate number of suitably qualified personnel

necessary (counterparts of Japanese experts) to be in charge of implementation of the Project activities

(2) To provide working facilities, land, office space, privileges/exemptions for the Japanese experts and other basic utilities (such as water, telephone, and electricity) at its own expense

(3) To execute, at its own expense, prompt custom clearance, transport, installation and maintenance of equipment to be provided by Japan for the Project

(4) To ensure financial/institutional sustainability of the various activities of the Project during and after the implementation of the Project

9. Input from Japanese Side

(1) Dispatch of Japanese experts in relevant fields and a coordinator for the Project

(2) Provision of training opportunities in Japan for Tanzanian counterparts

(3) Provision of equipment necessary for the technical cooperation activities of the Project

10. Remarks

(1) With the presence of Regional Administrative Secretary, Regional Medical Officer, and representative of Ministry of Health, the Team and the staff of RHMT, DHMTs and EZTC, a two-day workshop was convened concerning the Health Sector Reform (HSR) . As a result of exchange of the views, the participants reached the following conclusions;

(i) Main objective of the HSR is to transfer the authority of health planning, execution and evaluation from Ministry of Health to District level.

(ii) In order to promote the HSR, it is necessary that the attitude and the way of thinking of people concerned should be changed.

(iii) In the formulation and implementation of the Project, the initiatives and actions of District level is absolutely indispensable to accomplish the objective of the Project.

Although the representatives from five Districts shared several problems in common, such as lack of suitable skilled and experienced human resources, transport and communication tools, and urgent need of capacity development through training, it was revealed that the features and needs of each District differ among each other. Therefore, the participants also agreed of the necessity of detailed situational analysis of each District, as the first step of the Project activities.

(2) The team visited to observe the activities of the Morogoro Regional Hospital, Kimamba Health Center (in Kilosa District) and the Mlali Dispensary (in Morogoro rural District) . The observation was that the efforts of health care workers for better service should be well recognized. Considering the reason why the health indicators are sub-optimal, the Team has reached the recommendation that sufficient attention should be given to preventive/promotive activities, especially health education and community participation. The rationale behind is that the people themselves are to protect their own health, and not Ministry of Health nor health workers, whose mandate is to facilitate the people to manage healthier lifestyle by themselves. This recommendation is in concordance with the HSR and Local Government Reform.

(3) Short-term Japanese expert (s) will be dispatched to formulate the Project Design Matrix before the dispatch of the Japanese Implementation Study Team to sign the R/D of the Project.

② 要請書

THE UNITED REPUBLIC OF TANZANIA

MINISTRY OF FINANCE

Telegrams: "TREASURY", DAR ES SALAAM.
Tel.: 111174/6, Fax: 110326, Telex: 41329.
(All Official communications should be addressed to the Permanent Secretary to the Treasury and NOT to individuals).

P.O. Box 9111,
DAR ES SALAAM.

In reply please quote:
Ref. No. TYC/E/450/11

2nd September, 1999

Embassy of Japan,
P.O. Box 2577,
DAR ES SALAAM.

RE: APPLICATION FOR PROJECT – TYPE TECHNICAL COOPERATION FOR STRENGTHENING DISTRICT HEALTH SERVICES IN MOROGORO REGION

Kindly refer to the above mentioned subject.

The Government of the United Republic of Tanzania places great emphasis on the appropriate Health Service delivery on the principle of quality and equity since independence. However, due to economic hardship the nation has faced for the past decades, the provision of such services has been made extremely difficult.

It is due to this fact that we request the Government of Japan to support the strengthening of District Health Services in Morogoro Region.

Details of the said project are contained in the attached project proposal.

We thank you for your co-operation.

Yours faithfully.

MNgingite

M. Ngingite (Mrs)
for; PERMANENT SECRETARY

c.c. The Resident Representative,
JICA
P.O. Box 9450,
DAR ES SALAAM

c.c. Permanent Secretary,
Ministry of Health,
DAR ES SALAAM. Attn. Dr. G. Mliga

PROPOSAL
FOR THE PROJECT-TYPE TECHNICAL COOPERATION

FOR THE

STRENGTHENING DISTRICT HEALTH SERVICES
IN MOROGOROREGION

TO THE GOVERNMENT OF JAPAN

AUGUST 1999

THE MINISTRY OF HEALTH
UNITED REPUBLIC OF TANZANIA

1. BACKGROUND

The Ministry of Health has placed greater emphasis on the appropriate health service delivery based on the principle of quality and equity since independence. Health facilities have been established throughout the nation and human resources have been trained to perform adequate services to the population. Nevertheless, due to economic hardship that the nation has faced for the past decades has made the provision of such services extremely difficult. The Ministry has been engaged in a series of sector reforms since 1994 for the effort to rehabilitate and revitalize sustainable health services.

In March 1999, the Health Sector Programme of Works for July 1999 – June 2002 was formulated, within the framework of sector wide approach where the government and partners consolidate their efforts for effective utilization of resources to improve services and restructuring of health system.

One of the most significant changes envisaged in the newly started Programme is decentralization and strengthening of district capacity to implement health services, including planning and financial management. The districts now are not only providing day-to-day services to the patients at health facilities, but also are required to plan their activities based on the information and evidence, such as specific burden of diseases.

Even in the past, various types of training programmes have been organized and district health service providers have been exposed to various tasks and different training skills. In connection to the Health Sector Reform, The Ministry of Health has already developed training modules for the District Health Management Teams (DHMT) and national Trainers of Training (TOTs) have been trained. The training of DHMTs on their responsibilities in the new POW has begun in several regions and the rest will follow in due course. However, it is considered extremely important for the districts to be given on-going follow-up to their work since many of the responsibilities are rather new to them, and acquisition of in-depth understanding and skills towards them will not be done over-night.

The health personnel at Regional level health service Regional Health Management Teams (RHMT) will also play a critical role in district health services. They are the long arms of the Ministry of Health at the regional level, and they are expected to guide, supervise and assure quality of services to the district level. They are also expected to liaise with the Ministry of Health on the issues, which affect the performance of district personnel and obtain necessary advice and/or solicit support in policy.

The Government of Tanzania has submitted a proposal for support to in-country Training Course project to the Government of Japan, for the purpose of facilitating nation-wide training of DHMT and RHMT to orient and build their capacity with new skills to enable take up new responsibilities, thus making the health sector reform transition smooth.

At the same time, proposed Project-type Technical Cooperation project in Morogoro is aimed at strengthening the district health services by providing on-going in-service capacity building of district as well as regional health personnel in the region of Morogoro. This type of move will increase their ability to perform in line with the sector programme effectively.

2. OBJECTIVE

The overall objective of this project is to improve health status of people in Morogoro through strengthening essential health service delivery by increasing the capacity of RHMT and DHMT.

3. STRATEGY

(1) Strengthening of DHMT in management and implementation capacity to ensure efficient district health services delivery

(2) Strengthening of RHMT in providing technical and managerial supervision to DHMT, and improving communication between RHMT and the MOH headquarters.
(3) Strengthening the capacity of the Eastern Zonal Training Center in Morogoro.
(4) Assisting upgrading skills of health service providers through training in target area in accordance with regional and/or district health plans.
(5) Rehabilitating physical capacity of health facilities to meet expected health services demands of patients
(6) Ensure functioning referral system in Morogoro
(7) Sharing of experience to other districts and regions in search for good practice

4. EXPECTED OUTPUT

(1) Burden of disease in Morogoro to be reduced
(2) Health service delivery to be improved
(3) Planning and monitoring capacity of the DHMT to be strengthened
(4) Supervisory skills of RHMT to be upgraded
(5) Management of Human Resources, Financial Resources, Information, Equipment, Facilities and commodities to be improved

5. BENEFICIARIES

The most direct and immediate beneficiaries of the project shall be the health management staff and health service providers in Morogoro. The population of Morogoro (approx. 1,671,589 in year 2000) will also be the direct beneficiaries. The positive experience of this project will be shared with other regions in the country.

6. IMPLEMENTING AGENCY

The Ministry of Health is responsible for overall coordination and supervision of the project. The Directorate of Human Resources and PHC Secretariat shall jointly monitor and advice on the development and performance of the project.

7. PROJECT COUNTERPART

The Regional Health Management Team of Morogoro, headed by the Regional Medical Officer, will be the primary project counterpart to the Japanese Team. The project, however, maintains direct contact with the District Health Management Teams where appropriate and necessary.

8. OTHER PARTICIPANTS

In Morogoro, Regional Administrative Secretary, Regional Planner, District Councils, District Health Boards, service providers at health facilities, Zonal Training Center in Morogoro and other relevant authorities which play various roles in the district health shall also be a part of the project participants. In addition, all partners (donors, NGOs, private organizations) working towards the same principle are also to be informed and invited to collaborate. The project will also liaise with JICA Health Cooperation Planning Advisor to the Ministry of Health.

9. PROJECT ACTIVITIES

(1) Strengthening of DHMT in management and implementation capacity of district health services

- With RHMT and DHMTs review the responsibilities and capacity of DHMT in planning, monitoring, supervision, human resources, financial and stores management, HMIS, drugs and supplies indent system.
- Identify gaps and weak areas in individual DHMT's capacity to implement the above tasks.
- Ensure all districts in Morogoro to be able to formulate District Health Plans as expected. Apart from the national level training for DHMTs (i.e. 4-week classroom training session), continuous support and follow-up will be provided in order to digest and utilize what are stipulated in the modules.
- Ensure activities planned to be carried out under the Health Sector

Programme of Action (or any other critical national workplans) to be incorporated in the District Health Plans with realistic implementation modalities.

- Ensure project activities assisted by various partners are well coordinated in the District plans as well as its implementation, including resource management.
- Facilitate establishment and/or strengthening of District Health Boards in each district, in line with Health Sector Reform plans.
- Outline general and specific capacity building strategies for each DHMT systematically according to individual DHMT's needs.
- Based on the above point, develop plan of action for capacity building for DHMTs.
- Review the national indicators for district performance in HSR and add relevant local indicators as necessary.
- Establishing objective supervision and monitoring system of health facilities.
- Strengthening of capacities in the areas such as below ("tools" to facilitate these activities piloted under Tanzania Essential Health Intervention Project (TEHIP) should be referred):
  a. Computer skills
  b. E-mail and other relevant communication skills
  c. District accounting system
  d. Financial planning and budgeting methodology
  e. Team building, delegation, problem solving
  f. Identification skills of weakness in financial and administrative systems
  g. Development of a quarterly technical and financial reporting formats for distribution to all donors/stakeholders.
  h. Development and piloting of a community labour approach to health facilities rehabilitation whereby planning/construction responsibility is given to the communities with backup support and procurement from the district.
  i. Inventory and procurement skills for drugs and supplies.

(2) Strengthening of RHMT in providing technical and managerial supervision to DHMT, and improving communication between RHMT and the MOH

headquarters.

- The RHMT and Regional Planning Officer to review the functions and responsibilities of RHMT in HSR in general and in decentralization and strengthening of district health services in particular.
- Review the functions and responsibilities of DHMTs, roles of DHBs and District Councils in decentralized district health services.
- Outline strategies for provision of technical and managerial supervision of health services in the districts including advisory role to DHBs and District Councils.
- Assess the capacity of the RHMT to carry out its functions. Define the role of RHMT as a team, and for individual members of the team in specific areas. Establish clear job description of RHMT and its individual members and have it officiated by the MOH. The function and authority of RHMT should be advocated and well understood by the Regional and district authorities, District Health Boards, DHMTs and any other partners in health.
- Prepare plan of action, including targets and performance indicators for RHMT
- Establish objective supervision, monitoring system and coordination mechanisms of district health services in the region.
- Develop schedule and format of regular liaison with MOH and feed back to districts.
- Organize regular experience sharing forums for all DHMTs in the region.
- Strengthening collection and analysis of district data e.g. INDENT, financial accounts, performance indicators, etc.
- Establish management and logistics system for the RHMT.
- Strengthening provision and coordination of training activities undertaken at regional and district level.

(3) Strengthening the capacity of the Eastern Zonal Training Center in Morogoro.

- Review the roles and responsibilities of the training center in capacity building for regional and district health management teams.
- Ensure the roles and functions of Zonal Training Center is well advocated

and followed with respect to Health Sector Reform.

- Identify relevant areas for ongoing support and monitoring of the DHMTs after the initial classroom training sessions.
- Assess institutional capacity and needs of the center to effectively carry out the above functions.
- Outline strategies for building up the necessary capacity for the center to undertake the above functions.
- Develop capacity building calendar for the zone.
- Develop mechanism and institutionalize "good practice" obtained through past projects, especially those which targeted for the capacity building of DHMTs such as that of TEHIP, GTZ, Swiss Development Cooperation, Irish Aid, and etc.
- Strengthen communication between the Eastern Center and other Zonal Training Centers in the country, especially those that are advanced in their capacity such as CEDHA (Arusha) and the Iringa Primary Health Care Institute. The curricula within all training centers need to be addressed and coordinated. Experience gained directly at the centers' level as well as through the projects implemented in their respective zones should be shared and used to improve the training contents/activities.
- Explore opportunities to utilize distant learning techniques to supplement and follow-up classroom training courses.

(4) Establish and/or strengthen partnership with Regional, District and any other local authorities in the health sector development.

- Review the existing status of collaboration among Regional Authority, District Councils, District Health Boards, community level health authorities.
- Strengthen the functioning of each authority according to health sector reform and Health Sector Plan of Works.
- Establish a mechanism for all concerned parties to participate in the health sector development activities, including its liaison with the central government.

(5) Assisting upgrading skills of health service providers through training in

target area in accordance with regional and/or district health plans.

- With RHMT, DHMTs, Zonal Training Center staff and relevant specialists, assess training needs for health service providers in each district and hospitals in relation to essential health services.
- Identify relevant training manuals for health workers prepared by MOH, AMREF, etc. for specific topics for use during training and at the health facilities.
- Identify priority areas in accordance with individual district health plans.
- Study available cost-effective health intervention package and explore possibilities to implement/strengthen such interventions (e.g. Integrated Management of Childhood Illnesses, Tuberculosis Directly Observed Treatment short-course, Sexually Transmitted Diseases Syndromic Management, Insecticide Treated Nets through social marketing, etc). Associated training needs for such interventions will be identified and supported.
- Procure or prepare training materials
- Develop training calendar for each district including supervision, on-the-job training and practical demonstrations.
- Assist DHMTs to design monitoring system for performance of health workers.

(6) Rehabilitating physical capacity of health facilities to perform expected services

- With DHMTs, District Planning Officer and Regional/District Engineer, identify priority areas for rehabilitation and maintenance of physical structures and equipment in the district.
- Outline rehabilitation needs; buildings, equipment and human resources.
- Develop short and long-term physical rehabilitation strategies including establishment of capacity for care and maintenance of equipment in each district and recruitment and training of local technicians.
- Agree on roles and contributions from the participating parties; the community, district council, MOH and donor(s). The ownership of those facilities by the local authorities and/or communities is strongly encouraged

for sustainability and effective utilization.

- Draw up plans of action for implementation
- Design monitoring system for impact of the rehabilitation and maintenance on the health care delivery system
- Identification of realistic and effective power sources to run each health facilities for provision of essential health services. Provision of training on the use of identified power source and associated equipment is also required

(7) Ensure sustainable functioning referral system in Morogoro

- With RHMT, DHMTs, District Planning Officer and relevant NGOs, assess the performance of the existing health infrastructure in the district and identify strengths and weakness in the referral system.
- Identify priority needs; skilled human resources, working facilities and equipment, and communication for functioning referral system.
- Outline strategies for improvement and institutionalization of referral system in the delivery of health care services from community, dispensary, health center and hospital.
- Establish referral guidelines and follow up the implementation.
- Identify training needs for case management (clinical and nursing) at various levels of health care for specific priority conditions and provide appropriate training.
- Design monitoring mechanism and follow up of functioning referral system and its impact on reduction of case mortality.

(8) Sharing of experience to other districts and regions in search for good practice

- Share experience and lessons learnt between districts in the region.
- Organize experience sharing visits to districts with functioning referral system
- Provide opportunities for visits from other districts
- Document experiences and share with MOH and other districts, RMOs meetings and in scientific conferences.
- Share experience with donors and other partners through JICA Health Planning Advisor to MOH, Donor Committee of Health Sector POW/POA and

any other occasions.

10. REQUESTED JAPANESE INPUTS

(1) Long-term Japanese Experts:

1. Chief Advisor (Health Management)
2. Health Planning
3. Health Management Information System / Health Statistics

(2) Short-term Japanese Experts

1. Management of Equipment Maintenance
2. Monitoring and Evaluation
3. Case management/Referral system
4. Strengthening of continuous education in health
5. Inventory Control

(3) Equipment

1. Office equipment
2. Vehicles
3. Training equipment and materials
4. Basic equipment for Primary Health Care facilities

(4) Training in Japan

1. District / Community Health Services
2. Health planning /financing
3. Equipment Maintenance
4. Case management/Referral system
5. Inventory Control/Supply management

11. GOVERNMENT INPUTS

(1) Human Resources (Remuneration and Other costs)
(2) Provision of development grant for health services

(3) Other necessary supports and inputs from central level

(4) Project office space at the Morogoro Regional Hospital

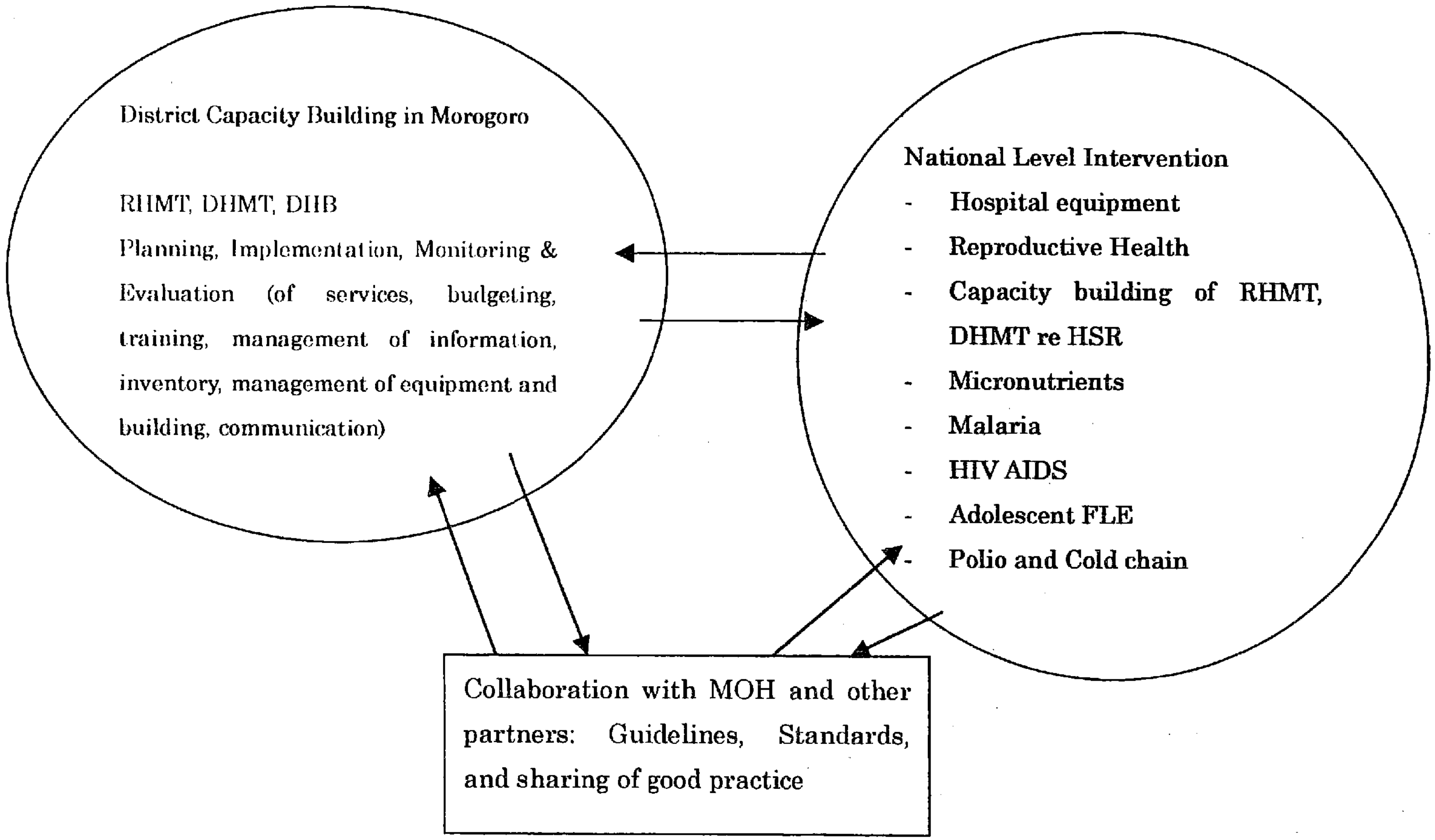
12. IMPLEMETNATION SCHEDULE

The project is requested to begin in the year 2000 for the duration of 5 years.

13. JAPANESE ASSISTANCE RELATED TO THIS PROJECT

- Provision of Reproductive Health Commodity project (with UNFPA and UMATI) in Morogoro rural (on-going since FY 1997)
- In-country Training Course for Malaria Control (on-going)
- Health Cooperation Planning Advisor to Ministry of Health (on-going)
- Proposed – In-country Training Course for DHMT and RHMT
- Will-be-proposed – Rehabilitation of Regional and District Hospitals
- Will-be-proposed – Provision of Safe Motherhood Equipment (with UNICEF)

Image of Japan's Cooperation Strategy



③ JICA「タ」事務所調査結果－1999年度在外プロジェクト形成調査報告書
(Situational Analysis for Project Formulation Study in Strengthening of District Health Management in Morogoro Region/Final Report)

SITUATIONAL ANALYSIS

FOR

PROJECT FORMULATION STUDY

IN

STRENGTHENING OF

DISTRICT HEALTH MANAGEMENT

IN

MOROGORO REGION

FINAL REPORT

Japanese International Cooperation Agency
Dar es Salaam
August 1999

Table of contents

No	Topic	Page
	Abbreviations	
	Executive summary	1
1.	Summary of Major Findings	3
1.1.	Physical infrastructure	3.
1.2.	Equipment	3
1.3.	Human Resources	3
1.4.	Financial Resources	4
1.5.	Transport	5
1.6.	District Health Management Teams	5
1.7.	District Health Plans	5
1.8.	Supervision and Monitoring	6
1.9.	Health Management Information System	6
1.10	Quality of Care	7
1.11.	Communication	7
1.12.	Equity and Accessibility	7
2.	Concerns regarding Health Sector Reform	7
3.	Proposed role of RHMT in strengthening district health services	8
4.	Proposed areas for JICA support in Strengthening Management of District Health Services in Morogoro region	9
4.1.	Strengthening the capacity of DHMT in management and implementation of district health services	9
4.2.	Strengthening of RHMT iin providinf technical and managerial supervision to DHMT, and improving communication between RHMT and MOH	10
4.3.	Strengthening the capacity of Eastern Zone Training Centre in Morogoro	10
4.4.	Assist upgrading skills of health service providers through training in in target areas in accordance with regional and/or district health plans	11
4.5.	Rehabilitating physical capacity of health facilities to perform expected services	11
4.6.	Ensure functioning referral system inn Morogoro	12
4.7.	Sharing experience with other districts and regions in search for good practice	13
5.	Morogoro Urban District	14
6.	Morogoro Regional Hospital	15
7	Morogoro Rural District	18
8.	Kilosa District	24
9.	Kilombero District	28
10	Ulanga/Mahenge District	32

Annexes. List of people consulted

Review of available resources (Manpower & equipment Morogoro Rural)

Questionnaire

Abbreviations

ADO	Assistant Dental Officer
AIDS	Acquired Immunodeficiency Syndrome
AMMP	Adult Morbidity and Mortality Project
AMO	Assistant Medical Officer
ANO	Assistant Nursing Officer
AMREF	African Medical Research Foundation
AO	Anaesthetic Officer
CA	Clinical Assistant
CBHC	Community Based Health Care
CBR	Crude Birth Rate
CDR	Crude Death Rate
CO	Clinical Officer
CSPD	Child Survival, Protection and Development
DA	District Accountant
DACC	District AIDS Control Coordinator
DANIDA	Danish International Development Agency
DCCO	District Cold Chain Coordinator
DCDO	District Community Development Officer
DDH	Designated District Hospital
DED	District Executive Director
DFID	Department for International Development
DHB	District Health Boards
DHMT	District Health Management Team
DHO	District Health Officer
DHS	District Health Secretary
DMO	District Medical Officer
DMCHC	District Maternal and Child Health Coordinator
DNO	District Nursing Officer
DPLO	District Planning Officer
DTLC	District Tuberculosis and Leprosy Coordinator
EDP	Essential Drugs Programme
EPI	Expanded Programme on Immunisation
FAMS	Financial and Administrative Management System
HC	Health Centre
HMIS	Health Management Information System.
HSPS	Health Sector Programme Support
HSR	Health Sector Reforms
IC	Ifakara Centre
IDM	Institute of Development Management
IDRC	International Development Research Centre
IMCI	Integrated Management of Childhood Diseases

JICA	Japanese International Cooperation Agency
KDC	Kilosa District Council
MCH	Maternal and Child Health
MCHA	Maternal and Child Health Aide
MO	Medical Officer
MOH	Ministry of Health
MRALG	Ministry of Regional Administration and Local Government
MSD	Medicacl Stores Department
NGO	Non-Governmental Organisation
NM	Nurse Midwife
PHC	Primary Health Care
PHN	Public Health Nurse
RHMT	Regional Health Management Team
RMO	Regional Medical Officer
SDC	Swiss Development Cooperation
STD	Sexually Ttransmitted Diseases
TBA	Traditional Birth Attendants
TEHIP	Tanzania Essential Health Interventions Project
TH	Traditional Healer
UNICEF	United Nations Children Fund
URTI	Upper Respiratory Tract Infection
VA	Voluntary Agency
VHW	Village Health Worker

EXECUTIVE SUMMARY

Situational analysis of district health services in Morogoro region was carried out from mid July to mid August 1999 as part of Project formulation study in strengthening of District Health Services in the region. Apart from data collection, the study involved interviews and discussions with Regional and District Authorities, Regional and District Health Management Teams and relevant individuals. The assignment was financed by JICA.

In general, the quality of health services in the districts in Morogoro region is poor. It is characterised by lack of planning and management capacity at all levels, poor physical state of most of the health facilities, lack of essential equipment, acute shortage of trained staff with all districts operating with less than fifty percent of the recommended establishment. There is no established system for supervision, monitoring, coordination and support of the health care system. Health management information system is weak and sketchy and hardly followed up by either DHMTs or RHMT. The referral system has not been functioning for many years due to various factors including lack of resources, interest and support. Lack of transport and telecommunication facilities, low motivation among health personnel, low quality of health care and weak health infrastructure in general have contributed to the collapse of the referral system.

However, despite the many problems, the infrastructure with the relatively good network of health facilities still exists albeit functioning poorly. Health care services are being provided in all the health facilities. Some health staff have remained relatively well motivated and dedicated despite the harsh working environment. Managerial and technical support is lacking at all levels, creating a climate of uncertainty, unaccountability and demotivation. This is particularly serious for districts like Kilosa and Morogoro Urban whose DHMTs are weak the performance of the DHMT is relatively good and quality of care is better. The performance of the DHMT in Morogoro Rural is relatively good and quality of care is better probably due to reasonably adequate financial resources and close monitoring by TEHIP. With closer monitoring and support the performance of DHMT in Kilombero district could be even better. The team can afford to spend at least one day at each health facility conducting comprehensive and objective supervision and on-the-job training quarterly given the few public health facilities and lack of government district hospital.

All districts are already implementing some components of the health sector reforms.
These include cost sharing, health management information system, central transport management system, cash based accounting system and drug indent system.

Unfortunately members of regional and district health management teams and other health workers are not well informed of the reforms. As a result there is a climate of uncertainty and/or misinformation regarding the reforms and their implications on the administration of health services generally. Serious concern was expressed in the following areas:

* That the health care system will most likely suffer and deteriorate further given the current poor state of the health infrastructure and the weak management and financial capacity of the district councils.

* The health infrastructure needs serious and well coordinated short and long term institutional capacity building to revitalise the system

* The role, responsibility and mandate of the Regional Health Management Teams (RHMTs) in supporting the decentralised district health services. This is not clearly defined in the structure and plan of action of health sector reform.

* There is urgent need to recruit trained staff without waiting for the reforms. The acute shortage of trained staff particularly nurses and MCHAs and failure to even fill vacant posts is demoralizing. It will take some time before the District councils think of recruitment.

* The composition, competence and mandate of the proposed District Health Board vis a vis the District Council to effectively direct the management of the health services

* The need to clearly define the technical and administrative roles and responsibilities of MOH and MRALG at all levels and clear communication and coordination mechanisms HSR

* The capacity of some DHMTs to effectively manage the decentralised district health services as some are very weak. All DHMTs will definitely need much support in planning and management. Classroom orientation in planning and management will not be enough. What is even more important is the continued process of support and capacity building, establishment and institutionalising management support systems and overall improvement of the quality of health care delivery system.

Areas where JICA intervention would be cost effective in strengthening the management of district health services are outlined below:

⇒ **Strengthen the capacity of DHMTs in planning, management and implementation of district health services**

⇒ **Capacity building for RHMT to provide effective technical and managerial support to the districts and improve communication and liaison with MOH**

⇒ **Establishment of the capacity and system for rehabilitation and maintenance of physical structures and hospital equipment**

⇒ **Management Support to all DHMTs in the region particularly Morogoro Urban and Kilosa Districts**

⇒ **Installation of Radio Communication network to improve the referral system**

⇒ **Assist in upgrading skills of health service providers**

⇒ **Support to Eastern Zone Continuing Education Centre in Morogoro.**

1. SUMMARY OF MAJOR FINDINGS

1.1. Physical Infrastructure

Apart from Morogoro regional hospital and St. Francis designated district hospital Ifakara which looks new after major rehabilitation and reconstruction with support from Swiss Development Cooperation (SDC) the physical state of most of the public hospitals and peripheral health facilities in all the districts in Morogoro region is poor. Most of the buildings are very old and crumbling and there is no programme for major rehabilitation and maintenance. Mahenge and Kilosa hospital buildings are in pathetic condition. They have had some renovation done by Irish Aid but they need major rehabilitation and reconstruction. In all the districts (except Morogoro Urban), initiatives have been taken to rehabilitate some peripheral health facilities with support from donors, district councils and local communities. In some cases the communities have taken ownership and responsibility for maintenance of the health facilities.

1.2. Equipment

Apart from St Francis Designated District Hospital in Ifakara which is relatively well equipped, there is shortage of essential equipment in most of the health facilities. Due to financial constraints there has not been planned procurement of new equipment for many years. The situation is worsened by the lack of a system and capacity to maintain and repair the equipment like microscopes, beds, sterilizers, Xray, furniture etc. As result in every hospital there are piles of non-functioning equipment most of which could be repaired and put back to use. In Kilosa hospital 5 microscopes are out of order, some simply because the bulb burnt out. While other districts have received some equipment from donors the situation is serious Morogoro Urban district which lack most of the basic equipment in all the health facilities. The actual needs for equipment for the government hospitals in the region has been compiled and submitted to MOH.

1.3. Human Resources

The human resources situation in all the districts is very serious. There is acute shortage of trained staff in all health facilities. The shortage was worsened by the retrenchment exercise in 1995 and since then there has not been any new recruitment or replacement of staff that have retired, died or transferred. The districts and regional hospital are operating with less than fifty percent of the recommended establishment. In Morogoro Rural, there are only 345 out of the recommended 842 with a deficit of 498 workers. This deficit including critical cadres like 134 Nurses, 28 MCHAs and 56 Clinical Officers. There are only 85 Nurses (45%) out of the recommended 189 in the five government hospitals in the region with a deficit of 104; hence patients in the wards and health facilities are sometimes left under the care of auxiliaries. Most of the trained workers particularly in peripheral health facilities lack the necessary clinical and nursing experience due to lack of close supervision and on the job training. Provision of health care by the poorly trained and low-salaried staff and auxiliaries has very much compromised the quality of health care.

1.4. Financial resources

With the exception of Morogoro Urban and Kilombero which enjoy substantial external support, the other districts and regional hospital are experiencing serious financial constraints for recurrent and development activities. Apart from staff salaries, the government hospitals in Morogoro, Kilosa and Mahenge receive very limited disbursements from central government for patients diet and hospital supplies only. For example Mahenge hospital receives about Tshs 400,000/= monthly for patient diet and hospital supplies.

Cost sharing has been introduced in all the hospitals and the revenue generated is used to fund some of the necessary activities. Mahenge hospital for example realises an average of about Tshs 5 million annually from cost sharing. Kilosa and Morogoro regional hospitals realised Ths 8 million and Tshs 40 million respectively in 1998 from cost sharing. Each hospital has established a system for exemption for those that cannot pay. It appears that some clarification is needed in the newly introduced system of capitalisation particularly where a patient undergoing major operation is charged 1000/= under the cost sharing system, while the items from the drug store used for the operation far exceed 7000/= which have to be accounted for under the capitalisation system.

Funds for the primary health care facilities under local government are disbursed through the district councils. Apart from staff salaries, the funds under other charges are pooled pooled with other sectors' funds in the district council and controlled by the District Executive Director. The DMOs have hardly any control over 'other charges' funds in health.

Morogoro Rural and Kilombero districts receive substantial financial support from TEHIP and SDC respectively for primary health care and community based health care activities. The budget for Morogoro Rural district for 1999/2000 stands about Tshs 1.500 million 46% of which is contributed by IDRC for the TEHIP project. A 75% is from external sources; donors and NGOs. Kilombero district budget for 1999/2000 has external support of Tshs 170 million from SDC.

Kilosa and Mahenge districts have support from Irish Aid health services under the health and water component in the districts' integrated development programmes. About a third of the health support is for the district hospitals and the remaining two thirds for peripheral health facilities and community based activities. But until the time of this assignment at the end of July 1999, no funds had been released by Irish Aid.

There are several area based health related activities undertaken by various non-governmental organisations in the districts whose financial contributions have not being quantified or included in the existing district health budgets.

Communities in Morogoro Rural and Kilombero districts are being involved more and more in health administration, funding and maintenance of health facilities.

1. 5. Transport

All districts have at least two running vehicles under the central transport management system for distribution of drugs and supplies and supervision. This system has very much facilitated and ensured regular distribution of drugs and vaccines to the peripheral health facilities. Funds for maintenance and fuel of the vehicles are provided by the MOH under the DANIDA supported Health Sector Programme Support (HSPS). However, the government hospitals of Morogoro, Kilosa and Mahenge have no transport for hospital related activities. Morogoro regional hospital which handles many emergencies and casualties from road accidents needs ambulance.

1.6. District Health Management Teams

All district have district health management teams. However the capacity, organisation and teamwork vary from district to district. Morogoro Rural, Kilombero and Mahenge have functioning DHMTs. They have even co-opted other members into their teams for better understanding and improved management. Morogoro Rural, Kilombero and Mahenge have regular DHMT meetings. However, the dates of their meetings, problems identified and planned actions are not recorded in the HMIS file for consistency and follow up.
The DHMT in Morogoro Rural is well organised, dynamic and with good team work. It has a tight schedule of supervision of health facilities. It was felt that close monitoring by TEHIP, adequate resources and good leadership influenced the good performance of the DHMT. Morogoro Urban and Kilosa districts have very weak DHMTs. The absence of Medical Officer of Health in Morogoro Urban district is very much evident as the services are more oriented towards sanitation and legislation and lack the overall vision of health services in the district

The competence of some members of the DHMT is a matter of great concern as some are not adequately educated, qualified or experienced to effectively contribute to health development in the district. Some are probably untrainable. Managerial capacity of most of the DHMT members is very much limited. Most of them lack planning and management skills. Only the DMOs of Morogoro Rural, Kilosa and Mahenge have public health background.

1.7. District Health Plans

Preparation of district health plans has not been of interest to DHMTs because plans did not matter nor influence budgetary allocations from the government. In fact it has been regarded as waste of time. Secondly, development of district health plans needs skills which all the DHMTs lack.

Out of the five districts only Morogoro Rural and Kilombero districts have district health plans. These are funded by IDRC and SDC respectively. Apart from financial support the DHMTs were also assisted in formulation of the plans. All the DHMTs admit that they do not have the capacity to formulate meaningful district health plans without external support.
The plans have been developed within the context of primary health care including community involvement and ownership of health facilities in target areas. Kilosa and Mahenge do not have

district health plans. They have activities within the district integrated development projects. Mahenge is currently in the process of developing its district health plan with assistance from the Zonal Continuing Education Training centre in Morogoro.

1.8. Supervision and Monitoring

Lack of established mechanism for supervision, monitoring, coordination and support in at all levels in the health care system is major weakness as health workers and managers feel uncertain, unaccountable and demotivated and quality a of care is compromised.
It was observed that communication between the RHMT and MOH is functionally weak and ad hoc. There is no system and format of regular reporting to MOH.

The introduction of central transport system was aimed towards ensuring regular distribution of drugs, supplies and supervision. However, supervision according to the route schedule is hardly adhered. Supervisors join in on ad hoc basis, and supervision exercise is casual, ineffective as it lacks seriousness and objectivity. Some supervisors complain that the time allowed is in the route schedule is inadequate for any meaningful supervision. Supervisors from national and regional level appear to lack managerial authority as they do not seem to assist the DHMTs in solving problems or make follow up. 'They come, they hear, they see, they go! No action'.

The region does not have a regional plan of action for supervision and mechanism for monitoring the district health services. There is no follow up of the HMIS district indicators by the DHMT and RHMT. The indicators were meant to reflect the performance of health services at all levels, problems encountered and actions to be taken.
Members of the RHMT have not been involved in the district planning exercises; hence they do not feel very confident in supervising the districts in relation to their district health plans.

The DHMT in Kilombero has the opportunity to improve considerably the quality of health care in the district by concentrating on supervision. Members of the team can spend at least one day at each health facility conducting comprehensive and objective supervision and on-the-job training in every quarter given the few public health facilities and lack of government district hospital.

1.9. Health Management Information System

Health management information system in all the districts and region is weak. Health facility reports are delayed, incomplete and inaccurate. Compilation and processing is poor at district and regional levels. With the weak HMIS at district levels the information at national level is likely to be fragmented, inaccurate and unreliable.

With the exception Kilombero where processing of the first quarter 1999 has started, no processing has been done in the other districts. Processing of the limited data for 1998 was done for demonstration during DHMTs orientation in the use of HMIS data for planning, decision making and supervision earlier this year. The district indicators are not up to date and not used. Performance in HMIS was poor even in Morogoro Rural where there is close supervision and contact with health facility workers most probably due to overwhelming demands by the several projects in the district.

1.10. Quality of care

All members of the regional and district health management teams were concerned about the deterioration of the quality of health care, both in the hospitals and in the peripheral health facilities. There are several reasons for this particularly lack of close supervision and on the job training as some of the trained health workers have limited clinical knowledge and skills, and feel unaccountable.

1.11. Communication

Morogoro region is easily accessible by road and rail from Dar es Salaam. It also has an airstrip for small aircraft. There is relatively good road network between the regional and district headquarters. However, the road network within the district can be difficult or impassable during the rainy season particularly in the remote areas. There are long distances between dispensaries and health centres and hospitals. Apart from the densely populated mountainous area of Uluguru mountains, most areas are sparsely populated thereby limiting accessibility to health care.

Telecommunication network is poorly developed. Only Morogoro town has adequate telephone and fax facilities. Telecommunication services in the districts' administrative headquarters is very poor and it is very difficult to communicate to Kilosa. Kilombero and Mahenge by phone from Morogoro and vice versa. Communication with the peripheral health facilities is very difficult as there are no telecommunication facilities in the rural areas and no regular transport facilities. Some remote health facilities are accessible with difficulty and inaccessible during rainy season. Most of the Mission facilities and projects resort to radio network for communication.

1.12. Equity and Accessibility

By numbers there is equitable distribution of health facilities in all the districts in the region. However, some communities live in remote areas where communication is difficult due to the landscape; mountains, rivers marshy land. Health services are provided free in the primary health care facilities. In some pilot villages initiatives have been taken to involve the community in the administration and funding the health facilities. System of exemption has been established in all the hospitals for those who cannot pay.

2. CONCERNS REGARDING HEALTH SECTOR REFORMS

2.1. The apparent lack of clear definition of the role and mandate of the RHMT in the HSR in general and district health services in particular is very unfortunate and may have serious consequences in the HSR implementation process. This has created general climate of uncertainty and/or misinformation among the health workers regarding HSR and its implications on the administration of health services generally. Serious concern was expressed in the following areas:

⇒ the role, responsibility and mandate of the Regional Health Management Teams (RHMTs) in supporting the decentralised district health services. This is not clearly defined in the structure and plan of action of health sector reform.

⇒ that the health care system will most likely suffer and deteriorate further given the current poor state of the health infrastructure in general and the weak management and financial capacity of the district councils.

⇒ the health infrastructure needs serious and well coordinated short and long term institutional capacity building efforts to revitalise the system

⇒ There is urgent need to recruit trained staff without waiting for the reforms. The acute shortage of trained staff particularly nurses and MCHAs and failure to even fill vacant posts is demoralizing. It will take some time before the District councils think of recruitment.

⇒ the composition, competence and mandate of the proposed District Health Board vis a vis the District Council to effectively direct the management of the district health services

⇒ the need to clearly define the technical and administrative roles and responsibilities of MOH and MRALG at all levels and clear communication and coordination mechanisms HSR

⇒ the capacity of some DHMTs to effectively manage the decentralised district health services as some are very weak. All DHMTs will definitely need much support in planning and management. Classroom orientation in planning and management will not be enough. What is even more important is the continued process of support and capacity building, establishment and institutionalising management support systems and overall improvement of the quality of health care delivery system.

⇒ Regarding District Designated Hospitals, who will be the responsible government representative to sign the agreements; MOH or DED

3. PROPOSED ROLE OF RHMT IN STRENGTHENING DISTRICT HEALTH SERVICES

3.1 The RHMTs are supposed to be the long arm of MOH in ensuring that health policies are followed, standards and quality of health care services are adhered to and that districts receive the necessary managerial and technical support. Therefore that role and mandate has to made quite clear.

3.2. There has to be close liaison between RHMT.and MOH regarding the overall health situation in the districts and the evolution of the decentralization process. RHMTs should provide early warning signals to MOH regarding ensuing major problems. It is also hoped that MOH will have a focal person or unit with strong mechanism to monitor the district health services and give feedback to RHMT and districts.

3.3. The districts need close supervision, monitoring and coordination. RHMT should be given both the necessary skills and resources to undertake those functions. Some districts have very weak DHMTs that will need close and sustained technical and managerial support

3.4. The RHMT will support the districts to improve the referral system, human resources development, quality of health services and management of disease outbreaks.

3.5. The proposed District Health Boards (and District councils) will need advice from RHMT on health administration matters.

3.6. The RHMT is the appropriate body to advise the regional secretariat on the health situation in the districts.

3.7. In order to facilitate coordination, any communication to and from districts and MOH should be copied to the RHMT.

3.8. RHMT should facilitate coordination of the DHMTs in the region to share experiences, update them on new developments and have common vision of the critical health development issues.

3.9. Develop proper and objective supervision guidelines and indicators for monitoring district health services and reporting format to MOH.

3.10. Identify areas for further health systems research

3.11. Process HMIS and provide feed back to the districts accordingly

4. Proposed areas for JICA support in Strengthening Management of District Health Services in Morogoro region

Strategy 1 Strengthening of the capacity of DHMT in management and implementation of district health services.

4.1.1. With RHMT and DHMTs review the responsibilities and capacity of DHMT in planning, monitoring, supervision, human resources, financial and stores management, HMIS, drugs and supplies indent system. Review managerial and technical capacity in the development and implementation of promotive, preventive and community based activities in the district.

4.1.2. Identify gaps and weak areas in individual DHMT's capacity to implement the above tasks.

4.1.3. Outline general and specific capacity building strategies for each DHMT systematically according to individual DHMT's needs

4.1.4. Based on 4.1.3. develop plan of action for capacity building for DHMTs

4.1.5. Review the national indicators for district performance in HSR and add relevant local indicators as necessary.

4.1.6. Establish objective supervision and monitoring system of health facilities .

4.1.7. Outline strategies for improvement of the human resources and recruitment of trained personnel according to priorities.

4.1.8. Develop systematic training scheme for relevant service providers in basic management skills and essential health packages.

Strategy 2. Strengthening of RHMT in providing technical and managerial supervision to DHMT, and improving communication between RHMT and MOH.

Activities:

4.2.1. With RHMT and Regional Planning Officer review the functions and responsibilities of RHMT in HSR in general and in decentralisation and strengthening of district health services in particular.

4.2.2. Review the functions and responsibilities of DHMTs, roles of DHB and District Councils in decentralized district health services.

4.2.3. Outline strategies for provision of technical and managerial supervision of health services in the districts including advisory role to DHB and District Councils.

4.2.4. Assess the capacity of the RHMT to carry out its functions. Define the role for RHMT as a team, and for individual members of the team in specific areas.

4.2.5. Prepare plan of action, including targets and performance indicators for RHMT

4.2.6. Establish objective supervision, monitoring system and coordination mechanisms of district health services in the region

4.2.7. Develop schedule and format of regular liaison with MOH and feed back to districts.

4.2.8. Organise regular experience sharing forums for all DHMTs in the region

4.2.9. Establish management and logistics system for the RHMT

Strategy 3. Strengthening the capacity of Eastern Zone Training Centre in Morogoro

4.3.1. Review the roles and responsibilities of the centre in capacity building for regional and district health management teams

4.3.2. Identify relevant areas for ongoing support and monitoring of DHMTs after the initial classroom training sessions

4.3.3. Assess institutional capacity and needs of the centre to effectively carry out the above functions

4.3.4. Outline strategies for building up the necessary capacity for the centre to undertake the above functions, including procurement of equipment, stationery and installation of hard and software.

4.3.5. Develop capacity building calendar for RHMT and DHMTs in the zone; in and out of classroom.

4.3.8. Develop systematic training scheme for relevant service providers in basic management skills and essential health packages.

4.3.9. Review and update the district health management training modules and methodology.

Strategy 4. Assist upgrading skills of health service providers through training in target areas in accordance with regional and/or district health plans.

4.4.1. With RHMT, DHMT, Training Centre Staff and relevant specialists, assess training needs for health service providers in each district and hospitals in relation to essential health services.

4..4.2. Identify relevant training manuals and guidelines for health workers prepared by MOH, AMREF, etc for specific topics for use during training and at the health facility

4.4.3. Identify priority areas in accordance with individual district health plans.

4.4.4. Procure or prepare training manuals

4.4.5. Develop training calendar for each district including supervision, on-the-job training and practical demonstrations. .

4.4.6. Assist DHMTs to design monitoring system for performance of health workers.

Strategy 5. Rehabilitating physical capacity of health facilities to perform expected services

4.5.1. With DHMTs and District Planning Officer, identify priority areas for rehabilitation and maintenance of physical structures and equipment in the district

4.5.2. Outline rehabilitation needs; buildings, equipment and human resources

4.5.3. Develop short and long term physical rehabilitation strategies including establishment of capacity for care and maintenance of equipment in each district and recruitment and training of local technicians.

4.5.4. Agree on roles and contributions from the participating parties; the community, district council, MOH and donor/s.

4.5.5. Draw up plan of action for implementation

4.5.6 Design monitoring system for impact of the rehabilitation and maintenance on the health care delivery system.

Strategy 6. Ensure functioning referral system in Morogoro

4.6.1. With RHMT, DHMT, District Planning Officer and relevant NGOs assess the performance of the existing health infrastructure in the district and identify strengths and weaknesses in the referral system.

4.6.2. Identify priority needs; human resources skills, working facilities and equipment, and communication for functioning referral system

4.6.3. Outline strategies for improvement and institutionalisation of referral system in the delivery of health care services from community, dispensary, health centre and hospital

4.6.4. Identify capacity building needs at all levels and training needs for case management (clinical and nursing) at various levels of health care for specific priority conditions and provide appropriate training. .

4.6.5. Design monitoring mechanism and follow up of functioning referral system, and its impact on reduction of case mortality.

Strategy 7. Sharing of experience with other districts and regions in search for good practice.

4.7.1. Share experience and lessons learnt between districts in the region

4.7.2. Organise experience sharing visits to districts with functioning referral system

4.7.3. Provide opportunities for visits from other districts

4.7.4. Document experiences and share with MOH and other districts, RMOs meetings and in scientific conferences.

5. MOROGORO URBAN DISTRICT.

Morogoro town is located 180 km east of Dar es salaam along the Tanzania – Zambia highway. It has an area of 260 sq km and population of 233,000.
Administratively it is divided into One division and 19 wards.

It has total of 46 health facilities:

3	Hosps	(2 Govt 1 institutional)
10	HCs	(3 Govt 7 private / parastatal)
33	Dispensaries	(4 Govt ,15 NGOs, 14 Private.)

Health facility : population ratio 1 : 5000.

Municipal health management team

Currently the team is composed of the following:
A J Baguma, Senior Municipal Health Officer,
R Mbena, Clinical Officer,
I Mhagama, Ag DMCHCo
Mary Nzoa, Nursing Officer 11
L A Kinigu H O
BF Moshi, HO, DAC/HMIS/Infectious disease

The DHMT is very weak in overall health planning and management. It lacks the general vision of the health development in the district which has large population living outside the town area of the municipality. Health management information was very scanty. Reportedly the DHMT meets twice monthly – minutes kept and followed up. There is no district health plan. The DHMT is more concerned with environmental sanitation and enforcement of health by- laws. Serious health issues like the hyperendemicity of malaria and endemicity of typhoid in the municipality did not feature in the list of major health problems. Clinical services are under the supervision of a clinical officer. For long time the municipality has not had the services of a Medical Officer for Health. The Municipal director is aware of the weakness in the health department and is trying hard to recruit a Medical officer of Health, which is a funded position.

Major health problems.

High Infant Mortality
High Maternal Mortality
Low Immunization Coverage
Poor Environmental sanitation
Dilapidated health facilities; Mafiga HC, Kingoluwira dispensary, Uhuru HC,
Lack of basic equipment
Lack of transport for supervision
Poor HMIS reports, and Lack of tetanus toxoid

Health programmes

Apart from the national health programmes and UNICEF supported CSPD which is being implemented in 11 of the 19 wards, there are no special programmes in the municipality. The municipality is one of the world bank supported Urban Sector Rehabilitation Programme which among other things the municipality will be provided with Refuse disposal trucks and sewage cesspit emptier.

Supervision

Supervision is reportedly carried all according to the route schedule. No records were available of supervision reports nor problems identified and actions taken. HMIS is very poor reportedly due to lack of reports from private health facilities which are the majority. Supervision by RHMT is irregular and ineffective.

People met:

Mr Baruti, Municipal Director
Mrs Mwangamila, Mun. Education Officer, Acting Municipal Director.

A J Baguma, Senior Municipal Health Officer,
R Mbena, Clinical Officer,
I Mhagama, Ag DMCHCo
Mary Nzoa, Nursing Officer I I
L A Kinigu H O
BF Moshi, HO, DAC/HMIS/Infectious disease

6. MOROGORO REGIONAL HOSPITAL

The hospital is located in Morogoro town. It has a capacity for 330 beds.
The following institutions are situated within the hospital compound thereby facilitating easy communication:

- DMOs Office (Morogoro Rural)
- MCH clinic,
- PHN Training Centre,
- Eastern Zone Continuing Education Centre
- National Distance Learning Centre

The hospital is the referral hospital in the region and provides six speciality services:
Surgery, Obstetrics and gynaecology, Paediatrics, Internal medicine, Ophthalmology, Dental services. It also provides physiotherapy services.

Recently with SDC support the hospital had major rehabilitation and reconstruction with complete new outpatients and consulting buildings.
However, according to the master plan the rehabilitation is not complete as the administration block is yet to be constructed.

The hospitals is having serious shortage of trained human resources. Shortage is more serious in the nursing cadre. Out of the required establishment of 110 nurses there are only 47 available with a shortage of 63 nurses. This has serious implications on the quality of patient care where total of 14,229 patients were admitted in 1998, and 31,980 were seen at the outpatients.

The hospital is also constrained with inadequate operational funds. Only limited amounts are disbursed for patient diet and hospital supplies. In 1998, the hospital realised almost 40 million shillings from cost sharing.

With support from Irish Aid, the hospital received some equipment recently. However as will be seen from the Situational Survey of Hospitals the hospital still lacks lots of equipment.

Concerns regarding HSR

The apparent lack of definition of the role and mandate of the RHMT in the HSR in general and district health services in particular is very unfortunate and may have serious consequences in the HSR implementation process.

The RHMTs are supposed to be the long arm of MOH. Therefore that role and mandate has to made clear. There has to be close liaison between RHMT and MOH regarding the evolution of the decentralization process. It is also hoped that MOH will have the necessary strong mechanism to monitor the process and give feedback to RHMT.

The districts need close supervision, monitoring and coordination. RHMT should be given both the necessary skills and resources to undertake those functions. Some districts have very weak DHMTs that will need lots of technical and managerial support

The proposed District Health Boards (and District councils) will need advice from RHMT on health administration matters.

The RHMT is the appropriate body to advise the regional secretariat on the health situation in the districts.

In order to facilitate coordination, any communication to and from districts and MOH should be copied to the RHMT.

People met:

Mr. Mwakiluma	Regional Administrative Officer,
Dr F Fupi	Regional Medical Officer
Mr M Sanki	Regional Health Secretary
Mr Minja	Regional Cold Chain Operator
Mrs Wapalila	Regional MCH Coordinator
Mr Kakai	Acting Regional Health Officer,
Dr Mrema	Regional Dental Surgeon
Mrs A Gutapaka	Regional Nursing Officer,
Mr Mulokozi	Acting Pharmacist

7. MOROGORO RURAL

1. District Profile

1.1 Geography

Morogoro Rural District is situated about 180 km east of Dar es Salaam, along the Dar es Salaam - Zambia highway. It covers an area of 19,250 sq.km. The district has an annual rainfall of 800–2200mm.

1.2 Physical features

The district is divided into three geographical zones: Mountainous/Highland zone – which covers Uluguru mountains with an altitude of 1200-2000m above sea level. This area is densely populated. It is fertile and suitable for production of maize, beans, coffee, cardamom, vegetables and Mediterranean types of fruits. It covers about 25% of the district area. Semi mountainous / Lowland zone. This occupies about 20% of the district area with an altitude of 800 – 1200m. above sea level. It is suitable for production of maize, cassava, sorghum, cotton, sunflower and sisal. Savanna zone. This covers about 55% of the district area, with an altitude of 600 – 800m above sea level and is suitable for production of maize, paddy, cassava, sugarcane, cotton and sisal. Substantial part of this area is occupied by the famous Selous game reserve. There are four rivers: Mgeta, Ruvu, Wami and Mkindo.

1.3 Communication System

The district is easily accessible by road, the main Dar-Zambia and Dodoma – Dar es Salaam trunk roads. It also accessible by the Central Railway line and Tanzania Zambia Railway. The feeder road network within the district can be rough and difficult during the rainy seasons. There are telephone services in some of the most of the trading centres in the district, with few radio call facilities. Only about 1% of the population has electricity.

1.4 Administrative structure

The district is divided into 10 divisions, 42 wards and 222 registered villages. The headquarters of the district is located in Morogoro town. Main tribes are Waluguru, Wakutu and Wazigua:

1.5 Demographic data

Total population: 536,108; (253,043 males and 283,065 females).

Children under 1 year :	21,444
Children under 5 years:	107,222
Women aged 15 – 49:	107,222
Population density:	28 persons per sq. km.
Average Household size:	5

1.6 **Vital Statistics**

Demographic fact	District Rate /Ratio	National Rate/Ratios
Annual Growth Rate	2%	2.8%
Crude Birth Rate	46 / 1000	46 / 1000
Crude Death Rate	22 / 1000	15 / 1000
General Fertility Rate	222 / 1000	222 / 1000
Total Fertility Rate	6.59	6.7
Infant Mortality Rate	145 / 1000	115 / 1000
Under 5 Mortality rate	245 / 1000	191 / 1000
Maternal mortality Rate	977 / 100,000 live births	529 / 100,000 live births
Life Expectancy at birth	Females 48	50
	Males 45	47

Source: Health Statistical abstract, 1997. MOH.

1.7 **Socio – Economic Status**

Agriculture and diary keep are the main economic activities in the district. Most of the population is are engaged in peasant farming, main crops being maize, beans, vegetables, fruits, cassava, sorghum, paddy, cardamon, cotton, sunflower, sisal and sugar cane.

2. District Health Profile

2.1. District Health Administration.

The office of the District Medical Officer (DMO) is situated in Morogoro Town, within the compound of the Regional Hospital. The DMOs is fairly will equipped with three computers photocopy, telephone and five serviceable vehicles.

The District Health Management Team (DHMT) includes:

1. District Medical Officer (DMO)
2. District Health Officer (DHO)
3. District Nursing Officer (DNO)
4. District MCH Coordinator (DMCHO)
5. District Cold Chain Coordinator (DCCO)
6. District TB & Leprosy Coordinator (DTLC)
7. District AIDS Control Coordinator (DACC)
8. District Mental Health Coord./HMS

The team appears to be well coordinated, motivated and effective. There is strong teamwork and every member of the team is well conversant with the district health situation, roles and responsibilities. Apart from the DMO – who is a graduate Medical Officer, the other members of the team are qualified and experienced health officers, nursing officer and clinical officers. For planning purposes, district planning officer (DPLO), district accountant (DA) and district community development officers (DCDO) are co-opted into the team as and when necessary. The DHMT meets weekly and the 'extended' DHMT meets monthly. The team has developed own comprehensive and integrated supervision checklist.

2.2 District Health Facilities

The district has a fairly good network of health facilities.
It has a total of 96 health facilities; 3 hospitals, 7 health centres and 88 dispensaries.
One hospital, seven health centre and 58 dispensaries are public, and the others are owned by religious organisation, parastatal/institutions and private.
The are also some 157 Village Health Posts, most of which are not functioning.

2.3 District Health Personnel

The district has serious shortage of skilled and support staff. Out of the recommended total of 842, there are only 345 (41%) in service, with a deficit of 498. The shortage includes all categories of trained staff but particularly nurses and MCHAs. .

2.4. Financial Resources

The district has admirable budget of Tsh. 1,480,878,657/= for the current fiscal year.
46% of the total budget is contributed by IDRC through the TEHIP project. The sources are as follows:

Local Govt (salaries, essential drugs, maintenance)	Tshs	371,238,008/=(25%)
Central Govt (EPI, STD, TB&L, Malaria, salaries)	Tshs	159,626,185/=(11%)
HSPS/MOH (EPI, Supervision,)	Tshs	114,524,894/=(8%)
Donors (IMCI, EPI, Malaria, SMI, STD, Drugs, supervision H/F equipment and maintenance, transport)	Tshs	767,429,570/=(52%)
Community contribution	Tshs	7,200,000/=
Cost recovery	Tshs	58,860,000/= (4%)

The DMO operates the AMMP account. The other funds are operated by the DED in which the DMO is a signatory. Other charges funds are pooled in Ac No 6. in the DEDs office.

2.4. Transport

The DHMT has five serviceable vehicles. Six out of the seven health centres have vehicles. The clinical officer i/c of the health centres and supervisors are provided with motorbikes for supervision and follow-up of reports

2.5. Supervision and Monitoring

The DHMT has a well formulated district health plan with detailed system of supervision, training and monitoring the various project activities and appears to be in full control. Interventions in the health plan include: Malaria control, integrated management of childhood illnesses, safe motherhood initiatives and syndromic management of STDs.
The district is also implementing and integrating the national health programmes including EPI, EDP/Indent, Reproductive and Child Health, TB and leprosy control, NACP, NSHP, Mental Health, Oral Health, Nutrient supplementation and Eye services. There are some area based projects including the Adult Morbidity and Mortality project (AMMP) and Integrated Deworming Programme are implemented in selected wards.

The health centres are given the responsibility to supervise, monitor and support the health facilities in the catchment area. The communities in some villages are involved in the administration and rehabilitation of health facilities and cost tracking.

However, despite the close supervision and contact with health service providers there is delay in receiving and processing health facility reports. Due to this delay, the DHMT has not been able to review district indicators and follow up ensuing problems accordingly.

2.6 Major Health Problems

The District Health Planning Team has identified seven major health problems in the district. The problems are more or less similar to the problems in other districts in Tanzania.

Major Health Problems

Rank	Health Problem
1	High Prevalence of Malaria
2	High underfive mortality
3	High maternal mortality
4	Insufficient supportive supervision in monitoring
5	Dilapidated health facilities
6	High incidence of HIV/AIDS/STDs
7	Inability to track cost of Essential Health Services

Top ten outpatient diagnoses – HMIS 1997.

Rank	Diagnosis	Total Number of cases	% of Total Reported cases
1.	Malaria	185,550	47.6
2.	ARI	90,900	23.3
3.	Diarrhoea Diseases	30,554	7.9
4.	Intestinal worms	25,745	6.6
5.	Major surgical conditions	16,775	4.3
6.	Eye infections	15,539	4.0
7.	Skin infections	15,409	4.0
8.	GDS / GUD	3,955	1.0
9.	PID	3,132	0.8
10.	PEM	1,833	0.5

2.8 Basic Medical Equipment and Furniture for Health Facilities:

According to the current budget over 226 million shillings was spent to procure some essential equipment for the primary health care facilities in the district. However, there is still serious shortage of essential equipment in the health facilities.

3 Constraints in Implementation

Serious shortage of staff
Unplanned activities from vertical programme
Delay in getting financial disbursements from DED and Acc. No. 6
Lack of transparency in NGO resources
Poor communication within the district due to its large geographical area
Lack of capacity in maintenance of equipment

4. Sustainability

This is a big challenge. More than 60% of the budget is from external sources.
TEHIP and AMMP activities are research interventions that have time limit and not necessarily replicable. However, some aspects that can be sustained are:

- Planning skills according to available resources and priorities that the DHMT has acquired
- Community ownership of the health facilities
- Improved clinical management skills among the health facility workers
- The continued use of ITNS.

5. Lessons learnt

Teamwork and good leadership are necessary. Involve other supporting staff members in the planning and implementation. Involve District Planning Officer (DPLO), District Accountant (DA), Community Development Officers (CDO) and other officers from relevant sectors. Involve communities through participatory Rural appraisal approach to identify community needs.

6 Weakness

Too much project oriented and externally funded which is not sustainable.
Poor performance on routine activities like HMTS etc
RHMT not involved in monitoring and quality assurance
Lack of Managerial / administrative powers over human and financial resources
Lack of forum for sharing experience with other DHMTs in the region

People met

1.	Mr. J. Gille	DED
2.	Dr. H. Machibya	DMO
3.	Mr. J. Teggo	N.O. (HMIS)
4.	Mr. L. Mbombwe	DHO
5.	Mr. P. Nkulila	CO/DACC
6.	Ms. C. Maro	DMCHCO
7.	Mr. Y. Sulley	HO / DCCO
8.	Mr. S. Njau	CO / DTLC
9.	Mrs. W. Mattee	DNO

8. KILOSA DISTRICT

1. District profile

1.2. Geography

Kilosa is 96 km west of Morogoro town. It has an area of 14249 sq. km and population of 437,690 (1997). The district headquarters in situated in Kilosa, town which appears to have seen the better days of the economy. Its easily accessible by road and by the central railway line from Dar es salaam and from Dodoma. The road network within the district is relatively poorly developed, and some areas are accessible with difficulty particularly during the rainy season.
At an altitude of 550 to 2200m above sea level, the district enjoys an annual rainfall between 800 to 1600 mm.

The town plus other trading centres like Mikumi, Kimamba, Dumila, and villages Msowero and Mvumi have electricity from the national grid. That are also postal and telephone services.

Administratively, the district is divided into 9 division, 36 wards and 136 villages.

The main ethnic groups are Wakaguru, Wavidunda and Wasagara. There also substantial number of Wamasai and Watindiga pastoralists have moved into the district.

1.2. Economic activities:

Agriculture is the most important activity which is carried out by about 78% of the population. Other activities include livestock, fishing and employment in industrial activities in the sugar and sisal plantations. The crops include maize, paddy, cotton, sisal, sugarcane, about 50% of the population have easy access to clean water from bore holes, shallow wells, and gravity fed systems. Wami and Great Ruaha rivers traverse through the district and the famous Mikumi National Park is within the district.

1.3. Basic data

Annual growth	2.6%
Infant Mortality Rate	112 per 1000 live births
Life expectancy at birth	46 years
Crude Death Rate	13.6
Fertility Rate	6.8
Persons per household	5.4
Male Female ratio	96.100
Population density (average)	24 inhabitants per 1 sq.km.

4. Health profile

4.1. Health facilities

The district has a total of 70 health facilities

2 hospitals (1 Govt. 150 beds, 1 mission 100 beds)
7 Health centres (5 Govt. 1 Mission, 1 private total 90 beds)
61 Dispensaries (42 Govt, 6 Mission, 9 para, 4 private)
53 of the health facilities provide MCH services. There are also some 90 Village Health Posts, 71% of which have trained Village Health workers.

4.2. The District Health Management Team

The DMOs office is located at the District Hospital and has no communication system – No telephone/fax. It is expected that with support from Irish Aid a computer/printer will be installed in the DMOs officer soon.

The DHMT consists of the following; DMO, DHO, DNO, DMCHCO, DCCO, ADO, DHS currently attending Adv. Dip course in Health Administration at IDM
It is comparatively weak team. Some members lack the necessary managerial experience There are no regular DHMT meetings. The DHMT has not had the necessary managerial and technical support from the RHMT. It does not have a comprehensive district health plan. Some interventions are contained in the health and water component of the district integrated development project supported largely by Irish Aid. About one third of the health component is directed towards the district hospital and two thirds towards primary health care facilities and community based health activities.

4.3. Supervision and Monitoring

There is no established system for supervision and monitoring of the health facilities in the district. In most cases the transport officer/DCCO distributes drugs and vaccines without supervisors.
Health management information system is weak, characterised by delayed, inaccurate and incomplete reports from health facilities, and no processing has been done at the district.
The DHMT has not received much managerial nor technical support from higher levels.

4.4. Health personnel

The district is experiencing serious shortage of trained health staff of all categories both at the district hospital and primary health care facilities particularly Trained Nurses, Public Health Nurses, MCHAs, Pharmaceutical and Laboratory Technicians. The performance of the available trained staff and auxiliaries could be improved by close supervision, in service training and constant monitoring

4.5. Health problems:

Health problems that were identified on the planning process of the Kilosa District Development Project include:

1. Long distances between households and health facilities.
2. High treatment / consultation rates including transport costs to health facility.
3. Weak health management capacity of health staff, including lack of supervisory and HMIS skills.
4. Poor quality and quantity of health personnel, lack of trained staff, 50% of deliveries done by untrained staff.
5. Poor conditions of health facilities.
6. Low level of community participation.

Top 10 OPD attendances:

	< 5	> 5
1.	Malaria	Malaria
2.	URTI	URTI
3.	Diarrhoea	Pneumonia
4.	Pheumonia	Diarrhoea
5.	Skin Diseases	Skin Diseases
6.	Eye Diseases	Accidents / Burns
7.	Intestinal worms	Intestinal worms
8.	Accidents/Burns	Eye Diseases
9.	Anaemia	Anaemia
10.	Ear diseases	Gonorrhea.

4.6. Financial resources

Information regarding the financial situation is sketchy as the responsible person could not be contacted during the assignment. However, as in other districts funds for hospital staff salaries, diet and supplies are obtained from the District Administrative Secretary. Funds for transport maintenance and distribution of drugs and supplies are operated by DMO and DED in the HSPS account.

Funds for local government staff and other charges for peripheral health facilities are disbursed through the DEDs office. The actual health sector contribution from Irish Aid could not be determined. However, as shown below, a total of Tshs 2526.5 million was budgeted for Health and Water component for this fiscal year but was yet to be released.

Community	Tshs.	43.3 million
KDC	Tshs.	108.9 million
Central Govt	Tshs.	51.1 million
Donors	Tshs.	2324.2 million

The donors include Irish Aid, UNICEF, World Bank, SNV, Royal Dutch Embassy, JICA and religious organisations.

The health and water component of the Kilosa integrated development project aims at increasing access to and utilization of appropriate and improved health services and water. The specific objectives are:

- Improved management and delivery of health services,
- Improved competence of health staff,
- Improved and expanded CBHC services
- Improved and expanded health infrastructure
- Improved access to clean and safe water for households
- Improved control of communicable and vector borne diseases

Issues / Concerns

Hospital needs not adequately considered in donor funded projects
The composition and mandate of the proposed DHB
The DHMTs lack of the capacity for planning and management
Lack of equipment and capacity for maintenance
Shortage of trained staff

People met:

Mr BBB Manento	Acting DED
Dr N Chiduo MD	DMO
Mr A Mkunda	DNO
Mr D Mazengo	DHO
Mrs Msigala,	DMCHC
Mr Kesyy	DCCO
Dr Chuwa	ADO

(Mr Makalamila DHS was away attending a course Adv. dip in Health Administration)

9. KILOMBERO DISTRICT

1. District Profile

1.1. Geography

Ifakara, the administrative headquarters of the district lies about 420 kms by car South West of Dar es Salaam at an altitude of 250 meters above sea level in the fertile valley of Kilombero river below the Udzungwa mountains. It has an area of 14918 sq km most of which is lowland.

Administratively the district in divided into 5 divisions, 19 wards, and 50 villages and has a population of about 260,000. Ifakara is easily accessible by road from Mikumi and by TAZARA train from Dar es salaam. An airstrip allows light aircraft throughout the year.
Communication by road within the district can be difficult particularly during the rainy season when some areas are inaccessible.

Only about 10. 5% of the total area is used for agriculture activities. Main occupation includes peasant farming, fishing and pastorals. Main crops are paddy, maize, cassava, cotton and sugar cane.

There are many sub ethnic groups the main ones being Wandamba, Wapogoro, Wambunga, and Wabenanamanga.

2. Health Profile

2.1. Health facilities

There are 2 hospitals : St Francis DDH: 370 beds.
Kilombero sugar Co (private)
3 health centres :Mangula (Govt), Mlimba (Govt), Kikopa (private)
34 dispensaries: 13 Govt, 7 V.A, 7 Institutional / parastatal and 7 private

Out of the 39 health facilities, 21 and 27 provide MCH and Family planning services respectively. 13 health facilities provide Diarrhoea Treatment Corner

2.2. Community Health

The community health situation in the district is generally poor. There is high prevalence of communicable diseases, poor environmental sanitation, inadequate availability of food and safe water. Diseases like malaria, diarrhoea, respiratory infections, intestinal worms and schistosomiasis are common. Cholera epidemics are not uncommon. Even in Ifakara town unsafe water supply and poor sanitation are some of the major challenges facing the district administration.

2.3. Human resources

As shown below Kilombero district is experiencing serious shortage of staff, particularly MCHA, PHN, NM, NA and dental auxiliaries.

Cadre	Recommended	Present	Deficit/Surplus
M O	1	1	0
AMO	3	0	- 3
C O	18	13	-5
Dental Assist	3	0	-3
C A	18	23	+5
N O	6	4	-2
N M	20	10	-10
N A	29	12	-17
PHN	18	3	-15
Dental Aux	16	0	-16

2.3. Financial Resources.

The DHMT has a working budget of Tshs 181 million out of which 170 million is disbursed by SDC. The funds from SDC and HSPS (DANIDA) are pooled into account No 1340 and operated by the DHMT. Funds for local government health workers and other charges are channelled through the District Council.
Total of Tshs 2,200,092/= was received from HSPS/MOH for distribution of drugs, supplies, supervision and kerosene and operated by the DHMT.
Communities in the community based health projects are getting more involved in the management of the health facilities including establishment of community health funds.

Irish Aid contributed Tshs 6.5 million for the completion of Chisano dispensary and MCH clinic at Chita.

2.4. Transport.

The district has four serviceable vehicles for supervision of primary health care facilities and community based health services.

2.5. District health management team.

The DHMT is composed of DMO, DHS, DNO, DCCO, DMCHCo, DACC, DTLC and EDPCo. The team meets regularly weekly and the extended DHMT which includes members from the training institutions, Ifakara Centre and SFDDH monthly.
Most of the DHMT members have received some training in health planning and management, assisted in the formulation of the district health plan.

2.6. District Health Plan

The district has a well detailed district health support plan which is oriented towards primary health care development with strong emphasis on community involvement in the administration and ownership of the health services. There are several area based health related projects in the district. These include UNICEF supported CSPD, Plan International, MUAJAK, Ifakara Centre (malaria control) and Religious health services.

2.6. Supervision and Monitoring

The DHMT has a schedule of supervision according to the route schedule and according the execution of the district health support plan of operation. There is no record of supervision visits, problems identified and steps taken. performance in health management information system is much better than other districts in the region. Entries for the second quarter of 1999 were being made. Given the relatively few number of public health facilities in the district the DHMT could intensify supervision and spend whole day at each health facility conducting comprehensive and objective supervision at least four times a year. This would very much improve the quality of care.

2.8. Attendances

Total out patient attendance s 1998: 297 197.

Total inpatients:	Mlimba HC:	1886.
	Mangula HC:	1074.
	Total	2960.

Top Ten diagnoses in outpatients 1998

1.	Malaria	87,969
2.	Diarrhoea	37,791
3.	URTI	21,230
4.	Worms infestation	14,791
5.	Anaemia	7,892
6.	Skin diseases	4,237
7.	Eye diseases	3,007
8.	Gonorrhea	1,962
9.	Ear discharges	
10.	Accident	

2.8. Constraints

Shortage of trained staff

Lack of staff houses

Lack of funds for allowances travelling and outreach activities.

3. Concern regarding HSR

Concern regarding the capacity of the district health boards and district councils to effectively manage the district health services given the previous experience in the management of funds of the funds for primary health facilities.

The role and mandate of RHMT and MOH in the decentralized district health services and the need for strong supervision and monitoring system at MOH and RHMT levels.

4. St Francis Designated District Hospital

This hospital owned by the Roman Catholic church Mahenge Diocese, has been designated district hospital since 1976 and is the referral hospital in Kilombero district with a capacity of 371 beds. Although it is a district hospital it bed capacity is that of regional hospital. It used to provide speciality services, but now with staff constraints it is operating just like other districts hospital, save for the better equipment and facilities. With support from SDC the hospital has recently undergone major rehabilitation and reconstruction.

The hospital is experiencing serious shortage of staff currently with deficit of 157 workers of all categories. The budget for 1998 stood at Tshs 583.4 million; 36% of which was contributed by MOH for staff salaries and other running costs, and 39.2% by SDC. 13% was revenue from cost sharing. The hospital is now experiencing financial constraints after suspension of financial support from SDC.

People met:

Mr A N M Sayille	District Executive Director
Dr F Lwilla	District MedicalOfficer
Mr C Kakwaya	District Health Secretary
Mrs E Mtyangiri	District Nursing Officer
Mrs G Lubomba	District MCH Coordinator
Dr P Kibatala	Medical Director, SFDDH Ifakara
Fr Achilles Ndege	Hospital Administrator, SFDDH Ifakara
Mr Henriko Kafwenji	Personnel Officer, SFDDH, Ifakara

10. ULANGA MAHENGE DISTRICT

1. Health profile

1.1. Geography

Ulanga district is 300 kms south of Morogoro town. The town and the hospital are about a century old ever since the early days of German rule in the then Tanganyika.

About 75 % the district's total area of 24,560 sq km is covered by forests and game reserve notably the famous Selous Game reserve .

Administratively the district is divided into 5 divisions, 24 wards and 65 village with a population of 186, 373 (1998)

Health Profile :

Health facilities:	2	hospitals;	Mahenge district hospital	120 beds
			Lugalo Lutheran hospital	90 beds
	3	health centres :	Mtimbira	30 beds
			Lupiro	20 beds
			Mwaya	12 beds
	30	dispensaries:	16 Govt. 14 VA	

Most of the health facilities in the district hospital all very old and dilapidated.
The hospital buildings are in a pathetic situation; they are old and virtually crumbling and there are no plans for major rehabilitation and reconstruction. Recently some limited renovation has been carried out with Irish Aid support. It has shortage of trained staff and basic equipment.

Attendances at Mahenge district Hospital 1998).

Outpatients	New attendances	15,078
	Reattendances	33,793
Total		48, 871
Admissions		3, 703
Major operations		98
Deliveries		923
Caesarean section		33

Top Ten diagnoses.

Under five		Five and above	
1	Malaria	1	Malaria.
2	URTI	2	URTI.
3	Pneumonia	3	Worm infection.
4	Anaemia	4	Diarrhoea.
5	Worm infection	5	Surgical conditions.
6	Nutritional disorders	6	Skin diseases.
7	Diarrhoea	7	Dental conditions.
8	Skin diseases	8	Anaemia.
9	Surgical conditions	9	Nutritional disorders

Human Resources.

The district has serious shortage of trained health staff and particularly of Nurses and MCHAs – as reflected below.

Cadre	Recommended	Present	Deficit/Surplus
M O	3	2	-1
A M O	3	2	-1
A O	1	0	-1
C O	28	23	-5
C A	21	22	+1
N O	19	5	-14
ANO/Nurse B	70	14	-56
MCHA	60	17	-43
Pharm. Techn	2	5	+3
Lab Techn	2	1	-1
Radiographer	1	1	0
H O	10	6	-4

Transport:

Hospital has one serviceable vehicle. The only two vehicles available are the pooled vehicles for distribution of drugs and supplies and supervision of peripheral health facilities

Financial resources.

The district has serious financial constraints both for the hospital and peripheral health facilities. Apart from the regular staff salaries the hospital receives the following :

1) Tshs 250,000 and 150, 000 / = from MOH for hospital diet and hospital supplies respectively which is very inadequate.

2) Tshs 2.5 million quarterly from HSPS / MOH for transport maintenance distribution of drugs and supplies and supervision of the PHC facilities.

3) Average of about Tshs 5 million per year from cost sharing

The accounts are audited regularly by both internal and external auditors.
The DMO does not have control over A/C no 6 –2006 – for peripheral health facilities. Apart from the staff salaries the DMO does not have control over other charges funds that is pooled and operated by DED .

However the DHMT would like some clarification regarding capitalization system .
Under cost sharing a patient is charged Tshs 1000/= for major operation but the cost of items issued from drug store could be more than 6000/= which should be accounted for.

Health Programmes

Under the Irish Aid supported district integrated development programme there is a budget of Tshs 317.3/= for health interventions in the district for three years:
Community based health care, TBAs, VHWs, Traditional healers and School health.
Support for Primary health care facilities: training of service providers, operational research, supervision and rehabilitation of dispensaries and health centre.
Establish appropriate data collection and reporting system, and train staff at all levels to compile and analyse data. .
Rehabilitate and provide some equipment for the district hospital.
Provide support for hospital administration and DHMT for supervision.

Health Sector Reform

The following HSR components are being implemented in the district:

FAMS - the cash based expenditure system for deposit accounts like a/c No 1006-HSPS.
Cost sharing - about Tshs 5 million is obtained annually and a system of exemption for those who cannot pay is in place.
Drug indent system is the operational although there are some delays in receiving consignments from MSD or orders from health centres.
Capitalization scheme has been introduced
Central transport management system is operational . However it is felt that the system is more for distribution of supplies as it does not give enough time for supervision activities .
HMIS – is being implemented but lacks the necessary supervision and on the job training. Processing for the two quarters in 1999 has not been done.

Constraints

Lack of managerial skills
Hospital has no transport for hospital services

Serious shortage of trained staff. In most cases the wards and health facilities are run by untrained nurse auxiliaries.
Old and dilapidated health facilities and Shortage of basic equipment
Poor and declining quality of care due to lack of trained staff and working facilities.
Some of the trained staff do not have enough clinical and managerial experience.
Long delay and uncertainty regarding the disbursement of funds from Irish Aid for planned and approved activities.

Concerns regarding the HSR

What is the role and mandate of RHMT in HSR

What will be the role of MOH in decentralised district health services. It was felt that the MOH (and RHMT) must retain some authority over districts particularly relating to quality of care, quality of health staff and maintenance of minimum standards of health services. There is fear that there will be further deterioration of the already poor health infrastructure.

MOH must establish strong and effective mechanism for supervision and monitoring of health services. Up to now supervisors have not been effective. They do not have authority over the system. 'They come, they see, they hear, and they go. No action!'

What will be the role, composition and mandate of DHBs versus District Councils.
Will the boards have the final decision on health administrative matters.

Some DHMTs are too weak to plan and manage district health services. They will need support not only in training but in having adequately trained and competent DHMT members. Quality will depend on level education

People met:	Mr Magoti	District Treasurer /Acting DED
	Mr N E Kisaka	District Human Resources Officer
Extended DHMT:	Dr. Mbena MD,	DMO
	Dr Likasi	AMO i/c Hospital
	Dr Kidunda	AMO
	Dr Kibasa	AMO
	Ms Msowoya	NO i/c
	Mrs Mpangile	DMCHCo
	Mr S. Mweta	DCCO
	Mr Mbumbumbu	Ag DHO
	Mr Chitalula	DACC
	Dr Omari	ADO
	Mr Zacharia	Pharm. Tech
	Mr R Egugu	Radiographer
	Mr Mwiyola	NO
	Mr Lyozia	Lab. Tech
	Mr Moshi	Hosp Accountant

List of Persons Consulted

1.	Mr E Manumbu	Director of Planning, Ministry of Health
2.	Dr Mliga	Director of Training, Ministry of Health
3.	Dr S M Egwaga	Acting Director of Preventive Health Services MOH
4.	Dr Mwakilasa	Head Continuing education MOH
5.	Dr Helmut Goergen	District Health Support Project - GTZ
6.	Dr Obelin Kisanga	District Health Support Project - GTZ
7.	Mr Arnold Buluba	Senior Programme Officer "Health" SDC
8.	Dr H Kasale	Country Project Coordinator, TEHIP
9.	Ms Kazuko Hashimoto	Health Cooperation Planning Advisor MOH

Regional Administration Morogoro

Mr. Mwakiluma	Regional Administrative Officer,

Regional Hospital

Dr F Fupi	Regional Medical Officer
Mr M Sanki	Regional Health Secretary
Mr Minja	Regional Cold Chain Operator
Mrs Wapalila	Regional MCH Coordinator
Mr Kakai	Acting Regional Health Officer,
Dr Mrema	Regional Dental Surgeon
Mrs A Gutapaka	Regional Nursing Officer,
Mr Mulokozi	Acting Pharmacist

Morogoro Urban District

Mr Baruti,	Municipal Director
Mrs Mwangamila.	Acting Municipal Director
A J Baguma,	Senior Municipal Health Officer,
R Mbena,	Clinical Officer,
I Mhagama,	Ag DMCHCo
Mary Nzoa,	Nursing Officer 11
L A Kinigu	H O
BF Moshi,	HO, DAC/HMIS/Infectious disease

Morogoro Rural District

Mr J Gille	District Executive Director
Dr H Machibya	District Medical Officer
Mr J Teggo	N O (HMIS)
Mr L Mbombwe	District Health Officer
Mr P Nkulila	CO/DACC
Ms C Maro	District MCH Coordinator
Mr Y Sulley	HO/DCCO
Mr S Njau	CO/DTLC

Mrs W Mattee	District Nursing Officer

Kilosa District

Mr B B E Manento,	Acting District Executive Director
Dr N Chiduo,	District Medical Officer
Mr A Mkunda	District Nursing Officer
Mr D Mazengo	District Health Officer
Mrs Msigala	District MCH Coordinator
Mr Kessy	DCCO
Dr Chuwa	Assistant Dental Officer

Kilombero District

Mr A N M Sayille	District Executive Director
Dr F Lwilla	District MedicalOfficer
Mr C Kakwaya	District Health Secretary
Mrs E Mtyangiri	District Nursing Officer
Mrs G Lubomba	District MCH Coordinator
Dr P Kibatala	Medical Director, SFDDH Ifakara
Fr Achilles Ndege	Hospital Administrator, SFDDH Ifakara
Mr Henriko Kafwenji	Personnel Officer, SFDDH, Ifakara

Ulanga Mahenge District

Mr Magoti	District Treasurer /Acting DED
Mr N E Kisaka	District Human Resources Officer
Dr. Mbena MD.	District Medical Officer
Dr Likasi	AMO i/c Hospital
Dr Kidunda	AMO
Dr Kibasa	AMO
Ms Msowoya	Nursing Officer i/c
Mrs Mpangile	District MCH Coordinator
Mr S. Mweta	DCCO
Mr Mbumbumbu	Ag DHO
Mr Chitalula	DACC
Dr Omari	ADO
Mr Zacharia	Pharm. Tech
Mr R Egugu	Radiographer
Mr Mwiyola	NO
Mr Lyozia	Lab. Tech
Mr Moshi	Hosp Accountant

3.0 REVIEW OF AVAILABLE RESOURCES

`3.1 Manpower

CADRE		AVAILABLE	REQUIREMENT	DEFICIT
1.	Medical officer	1	2	1
2.	AMO	1		6
3.	C.O	24	80	56
4.	C.A	59	75	16
5.	Nursing officer	3	3	-
6.	Nurse Midwife/TN	9	72	63
7.	PHNA	2	8	6
8.	PHN B	5	70	65
9.	MCHA	50	78	28
10.	Medical Attendant	134	160	26
11.	Dental Attendant	6	66	60
12.	Dental Technician	0	6	6
13.	Lab Technician	0	6	6
14.	Lab Attendant	12	70	58
15.	Health officer	7	15	8
16.	Health Assistant	20	42	22
17.	Medical Recorder	4	6	2
18.	Driver (Afya)	6	7	1
19.	Watchmen	2	52	50
20.	Dhobi	0	6	6
21.	Cooks	0	12	12
	TOTAL	**345**	**843**	**498**

3.2 Materials

BASIC MEDICAL EQUIPMENTS AND FURNITURE FOR HEALTH FACILITIES

	ITEM	PRESENT	DEFICIT
1.	Office chairs	240	300
2.	Office Tables	120	180
3.	Large benclies	48	192
4.	Small Beiches	108	200
5.	Drip stand	24	96
6.	Screen four folds	3	117
7.	Examinnation Couch	63	69
8.	Sphyginomenometer	80	160
9.	Stethoscope	60	180
10.	Hurvicane Lamp	20	128
11.	Hand washing basin	40	180
12.	Large medicine Copboard	40	20
13.	Sterillzer/stove 4 burner	50	70
14.	Inatciament tray ss Large	28	92
15.	Kidney dish Large ss	60	300
16.	Kidney dish medium ss	50	310
17.	Gallpot	60	300
18.	Jar forceps with cheatle forceps	50	130
19.	Hospital bed (white)	146	172
20.	Delivery bed	40	26
21.	Matress foam	57	261
22.	Small table for hyection	0	60
23.	Wheinghing scale Adult	22	80
24.	Viginal Speculum Large	30	90
25.	Vaginal Speculum medicine	25	95
26.	Vaginal Speculum Small	20	100
27.	Sponge holding forceps	20	160

28.	Scissors	140	240
29.	Infant weinghing scale	58	20
30.	Arteny forceps	72	288
31.	Koches forceps Curred	250	50
32.	Episiotony Scissors	50	130
33.	Hand torch	0	120
34.	Patient Lockers	0	90
35.	Bed sheets	50	1222
36.	Blankets	0	1272
37.	Pillows with pillow cases	0	318

STRENGTHENING DISTRICT HEALTH MANAGEMENT IN MOROGORO REGION

QUESTIONNAIRE FOR SITUATIONAL ANALYSIS

1. General Information

Name of District.. Date ....

General District profile including current Population estimates

2. District Health Profile

2.1. DHMT Composition /Qualification

Name/Designation/Qualification	Year Trained Plan &Mgmt	Others specify
i).		
ii)...		
iii)...		
iv)...		
v)...		

2.2. Profile of Health Facilities (HMIS: District Processing File: Table D.1)

2.3. District Summary Staff Report (HMIS: District Processing File: Form D001)

2.4. Transport

2.4. Transport	**Number of serviceable vehicles at DMOs Office**	
	Number of serviceable vehicles at Health Centres	

2.5. Communication: DMOs Office: Telephone Fax Email Radio call

Health Centres: Telephone Fax Email Radio call

3. District Health Planning

District Health Plan for 1999/2000

3.1. Available [Yes] [No]

Available and followed [Yes] [No]

If not followed state reasons

3.2. **What are the priorities in the District Health Plan** ....
....
....
....
....

3.3.1. **What are the priorities based on** [HMIS] [OTHER]

3.3.2. **Estimated budget for the District Health Plan** [Tshs]

Sources:

3.3.3. Is the budget adequate? [Yes] [No]

Reasons

3.4. **Top Ten Disease in the District:** (HMIS Regional Print Out/Selected)

Under Five Years	Five years and above
....	....
....	....
....	....
....	....
....	....
....	....
....	....
....	....
....	....
....	....

Does the plan provide for:

3.5. **Physical Equity and Accessibility:**

3.5.1 Estimated percentage of population within 5 km of Public HF in rural areas [ ]

3.5.2. Estimated percentage of population within 5 km of ANY HF in rural areas [ ]

3.5.3. Estimated percentage of population that cannot pay for health services in urban areas [ ]

3.6. Are there Guidelines for exemption for the poor in public health facilities [Yes] [No]

3.7 **Gender Sensitivity.**

Utilization of MCH services in the district (HMIS District Indicators).

Are there other MCH related activities in the district [Yes] [No]

If yes: Outline briefly the objectives and coverage

3.8. **Quality of Health Service**: Are there plans and guidelines to monitor and improve the quality of health care [Yes] [No]

3.9. Community based health services: Outline

3.10 Is Plan of Equipment Maintenance available [Yes] [No]

3.11. Proportion of Health Facility Buildings to be rehabilitated this fiscal year [ ]

3.12. DHMT's capacity to provide adequate support services [Satisfac] [Fair] [Poor]

[Personnel] [Transport] [Drugs] [Supplies] [Funds] [Schedule]

4. Regarding partner projects in the district

Name of partner project.. Funded by ....
Managed by .... Project period 19 ...... to ....

4.1. Projects main Objective ....

4.2. Project budget

Tshs

4.3. Is it included in the District Health Plan

Yes	No

4.4. Management Experiences from the project implementation

4.5. Suggestions for improvement

5. **HMIS: District Processing File 1998 & 1999**

5.1. District Quarterly Report (Quarter 2 Apr. - June 1999) Use HMIS Form D004.

Comments: Part 1: Management and Supervision

Part 2: Commodity Days Out of Stock

Part 3: Commodity Stock Balance at end of quarter

Part 4: Cold Chain Check

Part 5: Drug Kit Arrival

Part 6: Community data

Part 7: Attendances and Other Information

5.2. Part 8: District Quarterly Indicators .

5.3. Part 11: Actions planned to improve performance and other comments

5.4. District Indicators for !998

Comment on DHMT performance

6. **Managerial issues**

6.1. What are the common problems faced by the DHMT

6.2. **Does the DMO have powers over health personnel in the district regarding :**

Recruitment	Yes	No
Location / Transfers	Yes	No
Supervision / Monitoring	Yes	No
Promotion/Disciplinary action	Yes	No
In-service Training	Yes	No

7. **Regarding Health Sector Reform**

5.1. Is the DHMT aware of the HSR Yes No

5.2. Elements of HSR already being implemented at the district: (Tick)

HMIS TMIS FAMS Drug Indent System User Charges

Community Health Fund National Health Insurance

5.3. What is the role of DHMT in HSR

5.4. Does the DHMT have the capacity to implement HSR

Strengths:		Weaknesses:	
	1.......................................		1..
	2.......................................		2. ....
	3.......................................		3 ....
	4.......................................		4..
	5.......................................		5..

TABLE D1.1: LIST OF HEALTH FACILITIES AND THEIR CODES

Year _____ Page___

Health Facility Name	Code	Loc Gov HF or Gov Hosp?	Has service area?
District DMO Office	*000*	*not applicable*	*not applicable*
Number of Yes's	XXXXX		

DISTRICT SUMMARY STAFF REPORT (D001)

Category ↓ HF codes→										
Medical Doctors										
Specialist Doctors										
Dental Surgeons										
Specialist Dental Surgeons										
Pharmacists										
Chemists										
Assistant Medical Officer										
Assistant Dental Officer										
Medical Assistant										
Dental Assistant										
Rural Medical Aides										
Nursing Officers										
Nurse Tutors										
Trained Nurses /Nurse Midwives /Public Health Nurse B										
MCH Aides										
Medical Laboratory Technicians										
Radiographers										
Dental Technicians										
Optometry Technicians										
Orthopaedic Technicians										
Physiotherapists										
Chemical Laboratory Techn										
Health Officers										
Medical Records Officers										
Pharmaceutical Technicians										
Launderers										
Catering Officers										
Health Secretaries										
Mortuary Attendants										
Medical Attendants										
All others										
Total staff										

TABLE D1.4: RECORD OF HF SUPERVISION VISITS Year ______ Page ___

HF Code	Visit 1	Visit 2	Visit 3	Visit 4	Visit 5	Visit 6	Visit 7	Visit 8

TABLE D1.5: RECORD OF REGIONAL SUPERVISION VISITS

Date	Names of RHMT present	Summary of problems and suggestions for improvement

TABLE D2.1: RECORD OF ESSENTIAL EQUIPMENT

Year _______ Page___

Essential Equipment List

Number of Health Facilities expected to report _______

HF Code	Enter number of functional:											
	Adult Scale	Baby scale	Baby trousers	BP mach.	Deliv Kit	Feto-scope	Fridge	IUCD kit	Steri-lizer	Stetho-scope	Reusable Syringe	Therm-ometer

TABLE D2.2: RECORD OF OTHER EQUIPMENT

Year ______ Page ___

Other Equipment of interest to the district

Number of Health Facilities expected to report ______

HF Code	Enter number of functional:											

TABLE D2.3: RECORD OF EQUIPMENT BREAKDOWN

Year ______ Page ____

See instructions.

HF Code	Date Received	Description of Equipment and Problem	Date Resolved	Ess'l Eqpt?	If essential, fixed within 1 mth?

UNITED REPUBLIC OF TANZANIA
DISTRICT QUARTERLY REPORT (D004)

Ministry of Health

District ______________________________ Code ________

Quarter Number ____ Year ______

Part 1: Management and Supervision

	Dates of District Health Management Team Meetings during quarter
	Dates of RHMT supervision visits to the district during quarter
	Dates of meetings with District Health Board / District PHC Committee during quarter
	Number of health facilities (from Table D1.1)
	Number of Loc Gov HF and Gov Hospitals (from Table D1.1)
	Number of health facilities with service area (from Table D1.1)

Part 2: Commodity Days Out of Stock (from Table D4.2)

	Number Health Facility Reports

	Commodities O/S total
	Any stock out total

	Amoxycilline tablets
	Benzylbenzoate- emulsion
	Benzylpenicilline- injection
	Chloroquine- tablets
	Chloroquine- injection
	Chloroquine- syrup
	Co-trimoxazole- suspension
	Co-trimoxazole -tablets

	Doxycycline- tablets
	Ergometrine -injection
	Fe (2+)/folic acid tablets
	Lidocaine- injection
	Mebendazole -tablets
	Metronidazole-tablets
	Oral Rehydration Salt sachet
	Oxytetracycline eye ointment

	Paracetamol- tablets
	Procaine Penicillin fortified- vial
	Water for injection
	Examination gloves
	Povidone iodine solution
	Silk suture
	Surgical gloves disposable sterile
	Syringe resusable

Part 3: Commodity Stock Balance at End of Quarter (from Table D4.4)

	Aminoplylline - injection
	Benzylbenzoate- emulsion
	Chloroquine- syrup
	Chlorpromazine -injection

	Ephedrine (HCL)- tablets
	Oral Rehydration Salt sachet
	Phenytoin- tablets
	Vitamin A- capsules or tablets

Part 3: Specific Attendance Figures (from Table D5.4)

	Number Health Facility reports

Outpatient	
	OPD Attendances <5 year
	OPD Attendances 5+ years
	DTC attendances
	DTC attendances - with dehydration

Outpatient	
	OPD Referrals to other HFs
	OPD Re-attendances (from 1999)
	OPD Persons Attending
	Dental Clinic - caries diagnosed
	Dental Clinic - caries filled

	Family Planning total acceptors
Family Planning Current Users	
	Using Oral Pills
	Using Injection
	Using IUCD
	Using Condoms
	Using Foaming Tablets
	Using Diaphragm
	Using Natural Methods
	Using All Other Methods
	Total Current Users

MCH Services	
	ANC clients
	ANC Client Revisits
	ANC Clients with a Previous LB
	ANC Clients last LB died
	Postnatal Clients

Part 4: Tuberculosis Treatment (from Table D5.14)

	Smear positive TB cases in a cohort completing treatment with outcomes 'Failure' or 'Out of Control' or 'Transfer Out'

	Smear positive TB cases in a cohort initiating treatment

Part 5: Physical Structures and Equipment Maintenance

	F003 reports received (Table D2.4)
	Number HFs ranked in high or good condition (Table D2.4)
	Number HFs ranked in fair condition (Table D2.4)
	Number HFs ranked in poor condition (Table D2.4)

	F006 reports received (Table D2.5)
	No HFs reporting rehabilitation (Table D2.5)
	Equipment breakdown reports (Table D2.3)
	Equipment fixed within one month (Table D2.3)

Part 6: **Maternity Services** (from Table D5.8)

Born Before Arrival	Deliveries at health facility				Total Deliveries BBA and HF	Abortive Outcomes
	Normal	Vacuum	Caesarian Section	All other		

Mother Information				
Post-Partum Haemorrg	Retained Placenta	3rd Degree Tear	Other Complications	Deaths

Singleton Birth Information						
Live births	Live Birth Weights		Still Births		Live Births Died	
	No. Weighed	No. <2.5 kg	Macerated	Fresh	<24 hours	24+ hours

Multiple Birth Information				
Live birth	Total Still births		Live births died	
	Macerated	Fresh	<24 hours	24+ hours

Part 7: Special Services (from Table D5.10)

Major surgeries	Minor surgeries	Sterilizations		Blood transfusions		Number of X-rays
		Male	Female	Patients	Units	

Part 8: Laboratory Services (from Table D5.10)

Blood Smears	Haemo-globin	Syphilis	Blood Glucose	Stool Examination	Urine Examination	Sputum	Skin Smear	All other tests

Part 9: Results of Blood Donor Tests for HIV (from Table D5.10)

Ages 15-19				Ages 20-24				Ages 25 & older			
Male		Female		Male		Female		Male		Female	
+ve	Total	+ve	Total	+ve	Total	+ve	Total	+ve	Total	+ve	Total

Part 9: Special Information Collected in the District (from Table D4.8)

Enter District Value	Enter description as given by the DHMT

Part 10: District TB and Leprosy Information (from DTBL Officer)

Newly registered TB cases during the quarter	
	Number who were smear positive
	Total number

Newly registered Leprosy cases during the quarter	
	With unknown disability
	With WHO grade 1 or 2 disability
	Total number

Part 11: Actions planned to improve performance and other comments

Name of DMO ______________________ Signature ____________________________

Date of report ______________________

- -

(Regional use below)

Date received	
Date processed	

④ HSR-POW (The Health Sector Reform Programme of Work)

THE UNITED REPUBLIC OF TANZANIA
MINISTRY OF HEALTH
DAR ES SALAAM

THE HEALTH SECTOR REFORM PROGRAMME OF WORK

July 1999 - June 2002

June, 1999

1. INTRODUCTION

1.1 Background

The Government of Tanzania has always been committed to providing Tanzanians with equitable access and utilisation of health services. The first strategic Health Plan which was developed three years after independence and later revised after the Arusha Declaration (1967) emphasised the need for expansion of health facilities in the rural areas. The increase in health facilities corresponded with the policy of self-sufficiency in trained manpower. The Plan placed more emphasis on the role of the Government as the sole provider of health services, whereas the role of the private sector was greatly discouraged and restricted as it was seen to undermine the efforts to make health services equitable.

An equitable geographical distribution of health service infrastructure was to a greater extent achieved. However, because of the economic problems of the 1980s, the Government was not able to meet the recurrent expenditure for these services.

To address these problems, MoH appraised the health sector performance with the intention of revising strategies to improve quality of health services and increase equity in accessibility and utilisation. This appraisal culminated in the report: "Proposals for Health Reform", MoH, December 1994.

1.2 The Reform Vision

The health vision is **to improve the health and well being of all Tanzanians, with a focus on those at most risk and to encourage the health system to be more responsive to the needs of the people.**

Specific objectives of the health policy are to:

i) Reduce infant and maternal morbidity and mortality and increase life expectancy through the provision of adequate and equitable maternal and child health services, promotion of adequate nutrition , control of communicable diseases and treatment of common conditions:

ii) Ensure that health services are available and accessible to all in both urban and rural areas;

iii) Move towards self sufficiency in manpower by training all the cadres needed to implement health reforms;

iv) Sensitize the community on common preventive health problems and improve the capabilities at all levels of society to assess, analyze problems and to design appropriate action through genuine community involvement;

v) Promote awareness in government and the community at large that health problems can only be adequately solved through multi-sectoral cooperation. Such sectors are education, agriculture, water and sanitation, community development, women organizations, political parties, and non-government organizations with the ministry of health taking a leading role;

vi) Create awareness through family health promotion that the responsibility for ones health, rests squarely with the able bodied individual. Able-bodied individuals will there fore be expected to pay fees when they access health services unless they fall in the exemption categories;

vii) Public private mix will be promoted in the delivery of health services.

The Proposal for Health Reform was turned into the "Strategic Health Plan for 1995-1998", (HSR Group, February 1995). In October 1995, the Government and donors held a joint mission to appraise the Proposals and Strategic Plan for Health Reform, and to evolve options and actions for reform. The result was that they agreed to develop the "Action Plan for 1996-1999" (May 1996), specifying the expected outputs, inputs and activities to be implemented. Implementation of the Reform Plans started in July, 1996.

In the beginning of 1997, it was decided to broaden the scope of the Reform Plans in view of the on-going trends to develop a sector-wide improvement programme (SIP). The SIP approach addresses all areas in the health sector, including those already identified in the Health Reform and ensures that donor funds are used for agreed priorities and aid is delivered in a more effective and efficient manner using common implementation arrangements.

The "Health Sector Programme of Work (POW) for July 1999 – June 2002" is designed to implement Tanzania's health policy, building on the earlier Health Reform proposals and plans. It must therefore be stressed that it is not a new plan but rather a framework plan that broadens the scope of earlier plans within the Sector Wide Approach (SWAP).

The health sector programme of work for 1999/2002 entails a detailed unified HSR (POA) plan of action and costings for 1999/2000 and a programme of work for the other two years. The health sector programme of work has been written on eleven subtopics. These include:

1. Situation analysis which touches on status of health services in Tanzania and justifications for health sector reforms.

2. Health sector objectives and targets to be attained by each level of health system.

3. District health services which dwell on issues of organization and management, key principles of service provision, referral system, quality care, provision of essential drugs, supplies and equipment, cost effective essential clinical and public health packages, intersectoral collaboration and community involvement.

4. Secondary and Tertiary hospital service whose key components are organization and management, key principles of service provision, hospital institutional development and non for profit hospitals.

5. Role of the ministry of health, key management and administrative issues, policy development, reorganization of Ministry of Health, integration of vertical programmes, necessary legislation in view of Health Sector Reforms, advocacy of health sector reform, research and development and strengthening the health sector statutory regulatory bodies.

6. Human resource development, capacity building, formal in service training, technical assistance.

7. Central support system, personnel management, drug and supplies management and medical equipment management, physical infrastructure management, transport management and communication.

8. Health care financing, government funding via Ministry of Health, Prime Minister's office and Local Government.

9. Public Private Mix, developing new ways of promoting private sector participation, contracting out of services, required legislation, professional associations and traditional and alternative medicine.

10. Ministry of Health and donor relationship, Sector Wide Approach, Donor Co-ordination, joint funding, Ministry of Health Donors meeting and review and evaluation.

11. Resource envelope for financing the three year plan.

1.3 Purpose of Document

The purpose of this document is five-fold. First, it seeks to up-date the situation analysis presented in the December 1994 Proposal for Health Sector Reform (HSR). Second, it reviews the status of implementation of the HSR since its start. Third, it tries to specify the challenges still facing the health sector. Fourth, it seeks to establish - within a development framework - a coherent set of objectives and quantifiable targets for the health sector over the next three years i.e. 1999/2000-2001/02. Fifth, within an articulated set of strategies to address priority concerns about the health sector, a realistic resource envelope is identified from both public, semi-public and private sources within Tanzania, and externally (i.e. through donor support), to finance a POW. Intended resource allocation shifts are also quantified.

It is important to emphasise that this document is NOT a three year plan in the traditional sense of a plan. Rather, it is a reiteration of objectives, policies and priorities developed over several years, which are translated into a three year time frame of strategies (including their key components) and 'enveloped' in finite resource assumptions. In short: this document is intended to guide the preparation of one year plans and budgets by all the various units in the health sector and not to subvert that exercise through a process of over-centralised planning and control, insensitive to the most pressing needs of local communities, households and individuals throughout Tanzania.

1.4 Structure of Document

The POW document is structured as follows: Chapter 2 presents an update of the situation analysis presented in the Health Reform Document, followed by the status of implementation and the challeenges that continue to face the health sector.

Chapter 3 discusses the overall goals and objectives in line with the National Health Policy. Furthermore the objectives and targets are defined for the POW. This chapter also defines the priorities and quality improvement needed for the selection of strategies and key components.

Chapter 4 translates the priorities into a set of eight strategies, each of which is presented in terms of the purpose and concerns it addresses, the key components of the strategy and the work that is expected to be achieved within the three years. Finally the performance indicators by which progress in implementation can be monitored and evaluated at both local and national levels are presented.

Chapters 5 and 6 address the resource requirements and availability, and the resource shifts expected over the three years' period, in line with policy intentions for the health sector, and in line with extending coverage, improving quality and securing efficiency gains in the health sector. Specifically, a resource envelope is provided for all three years, on both development and recurrent expenditures. Chapter 6 takes this resource envelope, itself developed on a set of macro-economic and sector-specific assumptions made explicit in the model, to reflect the predicted shift of resources over the three year period towards priority services and priority needs. In line with policy intentions, shifts in the balance of resource allocation are sought in favour of district services and of non-salary recurrent growth.

To translate this Programme into action, particular attention has been directed to the institutional framework, the links between health development and overall social development, human resource implications, and the need for strengthened efforts on evidence-based, cost-effective interventions on the delivery of services. Chapter 7, the Conclusion, reiterates the need and the opportunity to involve all stakeholders in the process of translating goals and objectives into strategies, and then into plans and budgets, to ensure that targets for the start of the next millennium are achieved.

2. SITUATION ANALYSIS

2.1 Context of Health Sector Reform

2.1.1 Trends

Equity in health care and training of the relevant health personnel to deliver basic health services were important components of the health policy adopted after independence. The health facility picture explains the health system which has been built on the principles of equity in access and self-reliance. This observation is reflected by an actual 93% of the population living within 10 km of a health facility and about 72% within 5 kms of public health services (MOH, 1978)1. As a result of this policy, a number of achievements have been realised; such as:

a) A significant increase in the number of health facilities between 1961 and 1996. The number of hospitals increased from 98 to 224, health centres from 22 to 344 and Dispensaries from 875 to 4276. The ownership of these facilities is shown below (Table 1);

b) An almost tenfold increase in the number of trained health personnel of different cadres;

c) An increase in life expectancy from 45 years (male) and 47 years (female) in 1967 to 49 and 51 years respectively in 1988.

d) A drop in the infant mortality rate from 162/1000 live births in 1967 to 98/1000 live births in 1995 and a crude death rate from 23/1000 to 15/1000 (1992)2;

e) A completed immunisation coverage of children under one of 60% by (1996)3;

Table 1: Health facilities and type of ownership

Facility	Number by ownership				
	Government	Voluntary	Parastatal	Private	Totals
Hospital	81	81	17	45	224
Health centres	284	43	6	11	344
Dispensaries	2512	724	260	780	4276
Totals	2877	848	283	836	4844

Source: Health Statistics Abstract, MoH Dar es Salaam 1997

The distribution of health facilities per population (population estimate 1995) are the following:

Table 2: Distribution of health facilities per population

Total population	29,264.815
Number of health facilities	4,844
Estimated population per health facility	6,041
Number of health facilities per 10,000 population	1.7

Source: Health Statistics Abstract, MoH Dar es Salaam 1997

1 *Tanzania Health Inventory (1978)*
2 *Demographic health survey, 1992*
3 *Demographic health survey, 1992*

In spite of the expansion of the infrastructure of health services and achievements in improved health status, the morbidity pattern has not changed significantly. Many of the current common health problems such as malaria, diarrhoeas, acute respiratory disease, vaccine preventable diseases, malnutrition, as well as reproductive health problems are preventable or easily treatable with primary health care interventions. However, it is not possible to solve all these problems unless intersectoral collaboration with other related ministries is strengthened, in such sectors as agriculture, education and water.

Recently, Tanzania has been experiencing a series of events which have a bearing directly or indirectly on the health care system. The on-going political, economic and social reforms have contributed to the need for a review of the health care delivery system. The decline in the health service delivery system has been apparent. Recent studies on the performance of the health sector are full of examples of ineffective policy implementation initiatives such as dependence on donor funding for basic programmes, poor distribution of staff, inadequate supplies (particularly drugs), poor management, lack of supervision and lack of motivation, and the growing gap in knowledge between the community and public health providers. These problems have been witnessed both in rural and urban areas.

The Government has realised these shortcomings and corrective measures are being taken. The problems identified can be summarised into four main categories: ideological, organisational, managerial and financial. While it is convenient to categorise these central issues into groups, the relationships among the categories should not be ignored.

2.1.2 Ideological Issues

Prior to HSR it was the Government's responsibility to provide health services to all its citizens. With the onset of reforms it is the task of every Tanzanian to take an active part in disease prevention and health promotion. Health services are now partially paid for directly by the consumers, as user charges have already been introduced in referral, regional and district hospitals. As for the health centres and dispensaries, preparations are still underway.

To cope with the increasing needs of health care delivery systems, the government has adopted a policy of complementation rather than confrontation with the private sector. As a result, private practice has been legalised since 1991 to flourish alongside the public sector. However, regulation of private practice has not been properly undertaken.

2.1.3 Organisational Issues

The Role of the Government

Hitherto the government has been the main provider of health services to the country. Given the present economic climate, it has for some time been realised that it is no longer possible for the Government to be the sole provider of health services. The role of the Government is therefore in the process of changing. The role as provider will be reduced and the role as facilitator strengthened, including monitoring and regulatory functions.

Distribution of Health Facilities

The distribution of health facilities has a heavy rural emphasis because more than 70% of the population live there. Plans for the establishment of health facilities have in the past taken into consideration the facility/population ratio, but with time this has in some areas been seriously overtaken by the high population growth (rate).

The Referral System

The health system and especially the Government's referral system, from dispensary to consultant hospital, assumes a pyramidal pattern of a referral system recommended by health planners (e.g. in *Better Health in Africa*, 1993). If the system had functioned as originally intended, access to health services in rural areas would have improved considerably especially in areas that are unlikely to have large numbers of private providers. Unfortunately, several sections of the referral system are not functioning as intended, largely because of consistent under-funding, weak management support systems, and poor communications (roads and telecommunication). This situation has resulted in the following:

a) Levels of care and services available in one type of facility often cannot be distinguished from those of a facility at a lower level. Health centres are operating like dispensaries; and most regional hospitals perform like district hospitals but at a higher cost;

b) Patients who are willing and able to find a way up the referral system, are not barred from bypassing a lower level. This is often done in search of higher quality services;

c) Inadequate and costly transport have led to a situation whereby patients treated at referral hospitals often come from areas immediately surrounding the facility.

Human resources

One of the objectives of the Arusha Declaration was to create self-sufficiency in human resource. Deliberate efforts were made to create a health human resource base that was self-sufficing. In 1995, the total number of medical doctors were 1,264, trained nurses were 26,023, and allied health professionals were 15,482.

The Relationship between the Central and the Local Government

Devolution of authority to regional, district, and local authorities can increase the health system's responsiveness to local conditions and needs. Ideally, decentralisation promotes the development of health services by taking advantage of the locally available resources and placing more emphasis on the needs of the community.

In Tanzania, the Government's administrative structure has since independence been decentralised to the village level hence bringing the decision making process closer to the people. Likewise, the health care delivery system has been decentralised to match the administrative structure.

At the Central level, the MoH has been responsible for policy formulation and development of guidelines to facilitate the implementation of the national health policy. The Regions have interpreted national policies and overseen the implementation in the districts and the Districts have been responsible for implementation. However, a number of factors have rendered the decentralised health system to be less effective, such as:

(a) The Central level still retains most of the authority, some of which would be necessary to facilitate implementation at the district level. Vertical programmes are planned at the Central level with very little participation (if any at all) of the implementers.

(b) The concept of decentralisation is not yet well understood. However, strengthening the:

i) Regional Health Management Teams (RHMTs);
ii) District Health Management Teams (DHMT);

iii) District Health Boards and Facility Health Boards;
iv) Joint accounts under the Financial System (FS); and comprehensive district health plans, aim at empowering the districts in decision making.

The Dual Responsibility of Health Services at District Level

The present health services delivery system at district level has a dual responsibility. While the District Medical Officers? office and district hospitals are under the Regional Administration, all other services are under the Local Government. This creates problems of accountability.

2.1.4 Managerial Issues

Conceptual Framework

Health care management structures have been established on the basis of the existing Government administrative structures. In 1972, when the Government adopted a deconcentration[1] approach of decentralisation, the management of health care was split into two levels: the national level under the MoH, responsible for the management of consultant and specialised hospitals, paramedical training institutions, and national health programmes; and the regional level under the regional administration, responsible for the administration and management of regional and district health services. The management of health services was further split in 1982 when the Government decided to adopt devolution4 as another form of decentralisation, through the re-introduction of Local Governments. Local Governments were entrusted with the administration of health facilities below hospital level with a few cases where hospitals are managed by the City Councils (the three district hospitals in Dar es Salaam).

Health Sector Planning

It is expected that most of the 113 districts will have produced comprehensive district health plans, using the MoH District Health Planning Guidelines at the end of this fiscal year. These guidelines have recently been streamlined and simplified to make them more "user-friendly" for the districts.

Co-ordination of Health Services

There are two basic mechanisms that have been established to co-ordinate the activities of the various actors5 that provide health care services, namely: Primary Health Care Committees and Regional/District Management Committees. However, PHC Committees meet seldom6 and Management Committees are undermined by vertical programmes whose operations by-pass regional and district administrative structures. The current co-ordination system is therefore seriously fragmented.

Management Support Systems

All the district management personnel have been trained in the Health Management Information System (HMIS) aiming at improving the quality of information and the availability of vital statistics.

Reliable transport is in place in the districts as all the vehicles from vertical programmes have been integrated and converted into a two vehicle operation: one vehicle for supervision and the other for distribution of drugs and supplies.

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4 *Devolution refers to creating or strengthening sub-national levels of government which are substantially* independent of the national levels with respect to a defined set of *functions.*

5 *The various actors include: The Ministry of Health, the Prime Minister's Office, Local Government, NGOs, Traditional Healers and private practitioners.*

6 *Problems affecting Primary Health Care Committees in Iringa rural district, 1991, unpublished.*

National supervision guidelines have been developed which will be used to oversee all health activities at the district level.

Capacity Building

The physical expansion of health services has taken place hand in hand with training of human resources. However, the training has not achieved the goal of creating an effectively managed health service7. Training is often biased towards individual programme needs rather than general health service and management needs, and towards knowledge rather than skills development.

Management of Vertical Programmes

The implementation of vertical programmes - e.g. HIV/AIDS control, MCH/FP, TB/Leprosy, EPI and others B have resulted in duplication of functions such as in-service training and supplies as well as a serious lack of co-ordination. Some donors prefer to operate such programmes directly with the regions and districts without the overall co-ordination of MoH. The final outcome is an uneven distribution of health care services, resulting in the absence of integrated planning, implementation, monitoring and evaluation. However, progress has been made in integrating the vertical programmes - e.g. HIV/AIDS/STD, TB/Leprosy, and EPI.

Staff morale

The majority of health staff are very poorly motivated. This is partly due to:

a) The absence of co-ordination between programmes which makes many decisions on staff development fragmented;

b) Staff promotion being administered by different authorities (central MOH, local Government, mission NGOs, etc.) that rarely take into account individual performance;

c) Inadequate or often unavailable working tools and equipment;

d) Uncertain housing that, when available, is often very badly maintained;

e) Salaries that cannot meet the basic needs.

Quality Assurance

There has been little effort to ensure that the health care provided is of good quality.8 With the general increase in public expectations for quality health care in all spheres, particularly where the public is required to contribute towards the cost of the service, the need to focus on quality assurance in the health reform is therefore very obvious. The quality of care public and private organizations is of major concern to MoH and it should ensure quality in both the public and private service delivery units. The present mechanism of monitoring the quality in the public as well as private sector is very weak.

2.1.5 Financial issues

Financing of the health sector has been the overall problem since the beginning of the 1980s. Lack of financial resources has resulted into problems of low staff morale due to low wages, drug shortages, lack

7 *The Health Sector Reform, Appraisal Mission, Ministry of Health, 1993.*

8 *A study on the Prescribing habits of Primary Health Care Facilities in Kilombero District, Lucy Gilson, 1992.*

of equipment and supplies, and the overall detoriation of the infrastructure. Another problems has been that a districts budget depends on the number of health units. This has meant that there was an incentive

to build many health units even though they were poorly staffed, inadequately equipped and under-supplied. A third problem has been the dependency on donor funding, on which preventive programmes have been more or less been fully dependent. A fourth problem has been that the financing sources were not diversified before 1993 with the introduction of cost sharing schemes in hospitals. Finally the lack of a uniform, global, functioning financial management system has caused major problems for MoH and the donors.

2.1.6 Public/Private Mix

The private sector provides 40% of the health care delivery points in the country. The MoH has already started to give the private sector a more effective role in health care delivery to complement the public health efforts. In order to have a proper public/private mix, appropriate laws and systems have to be instituted.

The issue of equity will probably not be improved with more private sector involvement and so the public sector will therefore remain central in the MoH's provision of health services.

2.1.7 Population and Health Issues

The natural rate of population increase (NRI) for Tanzania is 2.8% according to 1988 census. The Total Fertility Rate (TFR) is high at 5.6 children per woman in 1994 although it has dropped from 6.3 in 1991. The contraceptive prevalence rate (CPR) has doubled from 5.9% for modern methods between 1991/92 (Tanzania Demographic and Health Survey - TDHS) to 11.3% in 1994 (1994 Tanzania Knowledge, Attitudes and Practices Survey - TKAPS). This rise has resulted from the increased access to injections, condoms and pills, as well as more limited use of longer term (NORPLANT, IUCD) and permanent methods (VSC). In 1994 the public sector was the source of supply for 74.2% of women using modern contraception.of women using modern contraception and the private sector (religious organisations facility, private hospitals/clinics, Pharmacy/medical store, CBD workers) accounted for 17.7%.

Tanzania established its population policy in 1992. The policy aims at providing quality life to the people. Its emphasis is on regulating the population growth rate, hence population quality by improving the health and welfare of the women and children. It also provides guidelines to strengthen the process of integrating population activities and implementing national social economic plans so that they are more accurate and efficient. To achieve this the government has developed population programmes in close collaboration with non-governmental programmes.

2.1.8 Food and Nutrition Activities

Though some child nutritional issues show positive signs in Tanzania (e.g. nearly 90% of mothers initiate breast-feeding within 1st day of birth), other indicators (Tanzania Demographic and Health Survey 1996) show persisting levels of under-nutrition which have shown no improvement over the past 5 years. Almost 20% of children under 5 are severely stunted indicating chronic malnutrition and/or infectious disease (below minus 3 standard deviations height-for-age from the median reference population) and 7% of under 5s are at least moderately wasted (below minus 2 standard deviations height-for-weight) indicating acute malnutrition or illness. Over 30% of under 5s are underweight using the composite index weight-for-age. Over 10% of those newborns weighed are below 2.5 kg (low birth-weight) and almost 10% of non-pregnant women showed acute malnutrition based on Body Mass Index (BMI).

The TFNC (Tanzania Food and Nutrition Centre) is the agency which is responsible for identifying health issues in relation to food and nutrition in the country. TFNC in collaboration with other sectors will direct National Nutrition goals towards:

a) Reduction of malnutrition
b) Prevention of low birth weight
c) Reduction of high maternal mortality
d) Reduction of anaemia and
e) Elimination of micro-nutrient deficiencies.

2.1.9 Research

Most of the research on health issues, both operational and bio-medical, are not related to the needs of the health system. It has often been orchestrated by interested parties from outside or by academic institutions for their own purpose. In order to cope with the problem, the Government needs to strengthen the existing health research institutions, i.e. the National Institute of Medical Research, Tanzania Food and Nutrition Centre, and the Health Systems Research Unit at the MoH by providing them with adequate resources to carry out and monitor appropriate research. A Health Research Users Trust Fund has been established which helps the MoH to secure research resources.

2.1.10 Legal Aspects

The Professional and Public Health Acts have been reviewed and found to be basically appropriate. However, some amendments need to be made so that they cope with the changing political, social and economic atmosphere prevailing in the country. The major problem has been the weakness in the implementation of these Acts. Penalties need to be upgraded to match the current value of the Tanzanian currency. Likewise prison sentences for public health offences should be a deterrent nature. In order to improve implementation, MOH has gazetted the private hospitals (standards guidelines for health facilities) regulations 1997.

2.2 Status of Implementation of Health Sector Reforms

The Proposal for HSR was published in December 1994. The proposal was divided between ideological, organisational, management and financial reforms. In the following the proposed reform is presented along with the status of implementation.

HEALTH REFORM PROPOSAL	*STATUS OF IMPLEMENTATION*
2.2.1 Ideological Reform The Government is to be more of a facilitator than the main provider of health services	This is one of the cornerstones of the Health Reform. The process is on-going.
The private for-profit sector will be encouraged to take a more active role than it used to do.	Private Medical Practice Legalised in 1991.
2.2.2 Organisational Reforms	
Administrative structures Support to community-based health care activities should be encouraged since they benefit the majority of the population and represent the actual implementation of Primary Health Care	Scheme for community health fund established in Igunga District andhas rolled on to Nzega, Singida, Iramba, Hanang, Songea Rural and Songea Urban Districts.
Functional review of MoH undertaken and implemented.	Proposals have been prepared by Ministry of Health and submitted to Civil Service Commission for approval
MoH aim at making the professional councils such as the Medical Council, Nurses Council, etc. autonomous	Under discussion - no final decision has yet been taken.
MoH to concentrate on developing policy, guidelines, regulations and setting standards	This is one of the cornerstones of the Health Reform. The process is on-going.
District Health Boards District Health Boards and Hospital Boards to be established.	District Health Boards have been established in Igunga and Kagera districts and efforts are directed to establish more boards in Rufiji and Morogoro Rural districts. DHBs in six districts in Tanga Region have been established. The existing Local Government Act is used as the mechanism for the establishment.
Refinement of the referral health system Health centres to be continued to run as they are while studying whether they should be turned into dispensaries or hospitals	Still under consideration
Existing referral system reinforced.	Transport is not the single answer to a better referral system. Better communication methods and systems must also be put in place. No firm decision has yet been taken.
Introduction of by-pass fees introduced	Not yet introduced
Roles and functions of dispensaries and health centres in urban settings redefined.	Not yet defined
2.2.3 Managerial Reforms *Dual responsibilities for district health services management* Management of district health services and the district hospitals transferred to Local Government;	Draft proposal for the relationship between and the role of different levels submitted to the Civil Service Commission

The post as District Medical Officer (DMO) to be advertised and recruitment based on merit.	Expected to take place with the introduction of the DHBs
The DMOs should preferably have a diploma or university degree in public health (MPH).	The proposed one-year MPH course at the University of Dar es Salaam in collaboration with the University of Heidelberg is underway. Senate has approved the curriculum and is expected to begin in October 1999. Currently students continue to be sent abroad in small numbers.
The post of DMO should have a scheme of service.	Being discussed. No decision has yet been taken.
The post of regional medical officer continues to be filled through MoH appointments and qualifications biased towards public health.	This is implemented
Financial Management Funds for district health services deposited in Account no. 6 and the DMO given the authority over this account.	Account no. 6 has not solved the problem. A special account will therefore be set-up under the DHB with the DMO given the authority to sign.
All transactions transparent and audited regularly.	The Financial System being developed should solve this problem
Accounting officers encouraged not to re-allocate resources. More realistic budgets developed.	The Financial System being developed should solve this problem. The Financial System being developed should solve this problem.

Human Resource Management	
Monetary incentives provided to staff working in areas with high work load.	Under discussion with Civil Service Commission.
Instructional courses in promotion, increments and disciplinary actions revived for civil servants in health management positions.	Will be included as part of the District management training.
Responsibilities given to District authorities to promote to the scales that are presently under the authority of the Civil Service and/or Local Government Commissions.	This authority will be transferred to the DHBs.
Remuneration of staff in the public health sector are competitive with the private sector.	This authority will be transferred to the DHBs.
The Government to analyse tasks that are carried out in the delivery of health services in order to provide appropriate manpower mixes.	Proposals presented to Civil Service Commission.
Centre for Education Development in Health Arusha (CEDHA), Institute of Primary Health Care and the four other Zonal Continuing Education Centres to develop training programmes for District Health Management Teams (DHMT) in health planning and Management.	Training material being developed. Testing will start in the near future.

Remuneration of staff in the public health sector are competitive with the private sector;	This authority will be given as part of the DHBs.
The Government to analyse tasks that are carried out in the delivery of health services in order to provide appropriate manpower mixes;	Proposals presented to Civil Service Commission.
Centre for Education Development in Health Arusha (CEDHA), Institute of Primary Health Care and the four other Zonal Continuing Education Centres to develop training programmes for District Health Management Teams (DHMT) in health planning and management.	Training material being developed. Testing will start in the near future.
2.2.4 Financial Reforms *Sources of financing* Diversification of sources of health financing continued. Health insurance established;	The government has introduced the cost sharing scheme in 1993. It covers the referral hospitals, regional and district hospitals. In Dar es Salaam cost-sharing has been introduced in some health centres and dispensaries. In Igunga District, cost sharing was introduced when the Community Health Fund was launched in 1996. The government is in the process of introducing a Health Insurance scheme as another source of financing health services.
Revenue from earmarked taxes considered;	Discussed as one option among many.
Allocation of public expenditure More emphasis put into financing of cost-effective services with greater impact on health status of the communities.	Work on-going as part of the development of essential packages. Components of essential health packages such as IMCI are being tested in Morogoro Rural and Rufiji.
Budget allocations to the health sector based on population patterns, income distribution and utilisation of health services.	MOH tries to adhere to the formula but difficult with present budget constraints where money is not released according to plan.
2.2.5 Public/private mix reforms Existing legislation on private practice amended;	Already amended.
The Government rehabilitates and consolidates existing health facilities over new facilities;	Being implemented.
New health facilities only to be built when a feasibility analysis proves need and after consultation with ministerial, regional and district level officers;	Being implemented but difficulties continue with community initiatives.
Investment in health facilities directed towards helping vulnerable groups;	Being implement.

Remuneration packages reviewed in the public health sector;	Being pursued as part of the Civil Service reform.
Cost of training to be recovered from individual benefits for health staff that decide not to remain in the public service;	Tuition fees have been introduced instead.
Training of different health cadres liberalised.	Private health training schools established but not yet regulated or inspected by MoH.
2.2.6 Research reforms Existing health research institutions strengthened to carry out and monitor appropriate research;	Under discussion
Health research fund within the MoH to be established.	The Health Research Users Trust Fund has been established as an independent body.
2.2.7 Nutrition and Population Reforms The Government's role in Nutrition and Population issues emphasised;	TFNCs role strengthened. Nutrition policy developed.
Intersectoral avenues to be promoted for Family Planning. District Health Teams shall ensure that their PHC Committees discuss Family Planning and develop strategies and plans for implementation;	MOH encourage districts to include national priorities like family planning in planning
The Government to invest more in population programmes through an intersectoral approach.	Reproductive health policy developed by MOH.
2.2.8 Revision of the Health Policy The National Health Policy revised to be in conformity with health reforms:	The National Health Policy has been revised. Health Services are no longer free of charge. Additions to the policy include user-charges, community health fund and insurance scheme. Private medical practice has been re-introduced.

2.3 Continuing Challenges of the Health System

In spite of the on-going health reforms, the following issues continue to be challenges for the health care system:

Limited Access to Health Care

80% of the total population are within one hour walk to the health facility and the remaining 20% have limited **physical access**. Certain geographic factors may prevent some parts of the population to get to the health facility easily for example: rivers; mountains; floods; huge forests; seasons e.g. heavy rainy season.

Where the health reforms advocate cost recovery or cost sharing, some people lack financial access and a large proportion of the population cannot afford even the little that is requested in cost sharing.

Inadequate service provision and quality

There is inadequate funding of health services due to the inefficient allocation of resources because of the lack of planning capacity at all levels (though reform is emphasising capacity building with major emphasis on district level); the general deterioration of the country's economy; as well a less funds from donor community (donor fatigue). This underfunding leads to:

a) Poor maintenance or no maintenance of the infrastructure
b) Inadequate supplies including drugs and equipment
c) Little supervision due to transport problems and lack of subsistance allowance
d) Lack of on-the-job training and continued education
e) Poor motivation
f) Poor quality of services

Deterioration of the health conditions of the population

In spite of some improvements, there remains the existence of:

a) High maternal mortality rates
b) High child and infant mortality rates
c) Poor sanitation and water supply
d) Recurrent epidemics e.g. cholera, malaria
f) General increase of prevalence of infectious diseases e.g. dysentery, meningitis,
g) HIV\AIDS and plague.

Poor community, intersectoral and private sector linkages

External relationships continue to be a problem with:

a) Inadequate community involvement, in decision making concerning their health;
b) Poor community participation in contribution towards health;
c) Limited linkage with other sectors;
d) Until recently, the private sector was completely neglected.

Limited linkages to Civil Service Reforms, Local Government Reforms and Macro-economic Reforms

There appears to be lack of synchronisation between the Health Reforms, Local Government Reforms and Civil Service Reforms despite the fact that they are interrelated.

3. HEALTH SECTOR OBJECTIVES AND TARGETS

3.1 Objectives

The overall objective of the health policy in Tanzania is to improve the health and well-being of all Tanzanians with a focus on those most at risk, and to encourage the health system to be more responsive to the needs of the people. Success in achieving this objective will require adequate solutions to the systematic problems that currently affect the delivery of health care. In the medium term, a firm foundation must be built for the improvement in the quality of health care as well as for increasing access to health facilities. There is also a critical need for the effective implementation of measures that will help establish a broad enabling environment for health. These measures must take into account factors that are external to the health system, such as cultural attitudes and the health seeking behaviour, physical environment in which the population lives, which have an important bearing on health outcomes.

The specific objectives of the health policy are to:

1. Reduce infant and maternal morbidity and mortality and increase life expectancy through the provision of adequate and equitable maternal and child health services, promotion of adequate nutrition, control of communicable diseases and treatment of common conditions;
2. Ensure that health services are available and accessible to all in urban and rural areas;
3. Move towards self sufficiency in manpower by training all the cadres required at all levels from village to national levels;
4. Sensitise the community on common preventable health problems and improve the capabilities at all levels of society to assess, analyse problems and to design appropriate action through genuine community involvement;
5. Promote awareness in Government and the community at large that health problems can only be adequately solved through multi-sectoral co-operation. Such sectors are education, agriculture, water and sanitation, community development, women's organisations, political parties and non-Governmental organisations with the MOH taking the lead;
6. Create awareness through family health promotion that the responsibility for ones' health rests squarely with the able-bodied individual as an integral part of the family.

MoH, following the thrust of the on-going health reforms, will take the process forward in the POW with the following underlying objectives (immediate objectives):

1. Improve access, quality and efficiency of primary health (district level) services.
2. Strengthen and reorient secondary and tertiary service delivery in support of primary health care.
3. Improve capacity for policy development and analysis, development of guidelines for national implementation, performance monitoring and evaluation, and legislation and regulation of service delivery and health professionals.
4. Implement a human resource programme to train adequate numbers of health staff to manage the services (primary, secondary and tertiary).

5. Strengthen the national support systems for personnel management, drugs and supplies, medical equipment and physical infrastructure management, transport management and communications.

6. Increase the financing sources and improve financial management
7. Promote private sector involvement in the delivery of health services.
8. Within the sector-wide approach, develop and implement a system for donor in involvement, co-ordination, monitoring and evaluation.

3.2 Targets

The targets for measuring the impact of the Programme of Work are detailed below. Source for the data to measure these vary, and have different methodological implications: the Tanzanian Demographic and Health Survey, conducted at 5 year intervals, reflects some information such as infant and under-5 mortality based on the 5 year period preceding the survey; MTUHA gives other information such as under 2 mortality which is currently based on incomplete returns and which may be subject to non-representative changes in view of the incomplete data; the MMR is not known accurately in the country, and may in fact go up as more high risk women present to the health system: e.g. previously "invisible" deaths become more visible; definitions of supervised delivery, ANC protection against tetanus, and completed immunisation vary so 2 different data source have been cited; case fatality rates are from MTUHA and have aggregated data from different causes of the diseases mentioned.

Outcome Indicators – Targets for Programme Impact

Aspect	Indicator	Current Situation	Target	Means of verification	Comments
1. Health status	IMR	88		TDHS Census	Useful for comparison between locations and over time, requires large population surveys, e.g., national census or DHS
	U5MR	137		TDHS	As above
	U2MR	93		HMIS	As above
	MMR	529		TDHS Other (various)	As above , but harder to validate. Most of the available data is institution-based, but many, if not most, of the deliveries andmaternal deaths do not occur in health units.
	Life expectancy - Male - Female	 49 51		Census	Difficult to gather and usually done only as part of a very large survey, such as a national census or DHS
2. Nutrition	% U5 severely stunted	17.8		TDHS	Stunting is the prevalent from of malnutrition in Tanzania; it is cumulative, and indicates chronic undernutrition. It is a good measure of household well-being; it can also be assessed on relatively small samples for specific locales.
	% U5 wasted	17.2		TDHS	This indicator is a measure of acute starvation, and can be due to illness (e.g. diarrhoea), or short-term underfeeding (e.g., in a natural disaster with population displacement). Wasting is generally resolvable with proper/adequate feeding, and is not cumulative. As such, it is a useful measure in emergency situations, but not so valuable for monitoring development programme impact.

3. **Fertility**	**CPR (modern)**	16%		TDHS	Contraceptive prevalence rate is a proxy indicator, based on the reported uptake of modern contraceptives. It has many limitations, including that it does not reveal whether the contraceptives are eing used properly/adequately (or whether,in fact, they are used at all for many of the methods). Monitoring birth intervals is a much better measure of actual fertility behaviour. Frequently intervals is a much better measure of actual fertility behaviour. Frequently tendss to gather and present information only about women (and too often, only about 'married' women), ignoring men, adolescents and single mothers.
	TFR	5.8		TDHS	Total fertility rate is another large population-based figure, and very slow to change, making it poor for assessing attributable programme impacts. Whileit gives some information about pregnancies that are too many, it does not identify patterns of pregnancies that are too early (adolesscentrs), too close together (birth spacing), or too late (mothers beyond the age of 35-40).
4. **Preventive health services**	Malaria prevention - % of homes with bed nets among all homes (especially in endemic areas)	Await Situation Analysis			
	AIDS prevention – HIV sentinel surveillance as % of seropositivity among pregnant women	36% - Urban 44% - Rural 40% Overall		HIV surveillance data	
	Tuberculosis – Proportion of newly diagnosed TB patient who completed the DOTs regimen			HMIS	

	% pregnant women receiving 4 or more ANC checks.	69.5%			May want to look at timing of attendance during the ANC period; place of delivery/trained attendant or not and link ANC attendance to delivery conditions.
	% of children under 1 year receiving DPTP 3	85%			
5. Clinical health services	Inpatient case fatality rate from malaria, as %	19.7			Assumes record-keeping sufficient to tract cases of malaria. It can miss deaths from malaria that occur outside the health unit after having come in for treatment, or generate misleading figures if the patienthas been treated in more that one unit for the same episode (e.g. public and private facilities).
	Proportion of caesarean operations, asactual number over expected number			Hospital HMIS	
6. Management and Equity	Proportion of population within 5 kilometers of a designated health unit	72%		DHMT inventory and mapping	
	Number of prescribing health units within 10km of another unit, by district and ownership	Await situation analysis		DHMT inventory and mapping	

Assumptions:

% enrolment of girls in secondary schools would change from 17.8% (1977) to 18% (2001)

% female literacy would change from 65.4% (1997) to 68% (2001)

% households with safe water from 48% (1997) to 52% (2001)

% households with access to sanitary facilities from 64% (1997) to 68% (2001).

In addition to the impact indicators above, there are a number of Performance Indicators which were developed for the one year POA which appear in that document.

3.3 Priorities for Health Interventions and Quality Assurance

3.3.1 Essential Health Package

The Ministry of Health Policy has stated that the Tanzanian basic health package will cover the following:

(i) Reproductive and Child Health Services
- Maternal conditions
  - ANC
  - Obstetric care
  - Post- Natal Care
  - Gynaecology, STD/HIV
- Family Planning
- IMCI (e.g. Malaria, ARI, CDD etc)
- Perinatal Care
- Immunisation
- Nutritional deficiencies

(ii) Communicable Disease Control
- Malaria
- TB/Leprosy
- STD/HIV/AIDS
- Epidemics (e.g. Cholera, Meningitis)

(iii) Non- Communicable Disease Control
- Cardiovascular diseases
- Diabetes
- Neoplasms
- Injuries/Trauma
- Mental Health
- Anaemia & Nutritional Deficiencies

(iv) Treatment of other common disease/local priorities within the district eg. Eye diseases, Oral Health,

(v) Community Health Promotion/Disease Prevention
- IEC
- Water, hygiene and sanitation.

This package will be incorporated into district health plans to enable the districts to utilise properly the meagre resources available.

3.3.2 Quality Assurance

The need to focus on ensuring quality assurance is obvious. The major concern lies with the quality of health care provided in public health facilities and in the increasing number of health units owned by private practitioners or organisations. Good quality of care will be achieved by ensuring proper training in quality assurance and in appropriate supervisory, monitoring and evaluating tools. Standards of health care will also be developed along with reinforcing mechanisms for complying with them.

4. STRATEGIES

Major changes are occurring in the way that health services are organised and financed as "Health Sector Reforms" are being placed high on the agenda of many Governments and donor agencies. The WHO has defined HSR as "a sustained process of fundamental change in policy and institutional arrangements, guided by Government, designed to improve the functioning and performance of the health sector and ultimately the health status of the population". In practice it is a review of responsibilities and mechanisms of health care provision leading to integrated service delivery with transfer of authority for implementation to local authorities.
The reform process is associated with two main themes: First, the development of a more rational use of resources by establishing priorities according to the burden of disease and cost-effective interventions; and second, addressing the organisation of health services and the managerial capacity to effectively finance and deliver health care.

Accordingly, the objective of Tanzanian HSR is to improve the health and well-being of all Tanzanians, especially the indigent and the most vulnerable, and to make health services accessible, sustainable and efficient. Therefore, the strategy for HSR will be holistic. All aspects of the health sector will be affected by the reforms, from administration and management of the health network (i.e. Central, Region, District and Local establishments) to the clinical facilities and preventive services and the health training institutions. The Central Government, Local Government, donors, the NGOs, communities, and private practitioners will all be involved as the focus shifts from disease specific programmes to a comprehensive sector approach.

In order to meet the challenges of providing health services within a HSR agenda, eight interlinked strategies are envisioned:

Strategy 1: concerns itself with the provision of accessible, quality, well-supported cost-effective district health services with clear, priorities and essential clinical and public health packages which are organised at the decentralised level.

Strategy 2: provides back-up secondary and tertiary level referral hospital services to support primary health care;

Strategy 3: redefines the role of the central MOH as a facilitator of health services, providing policy leadership and a normative and standard-setting role;

Strategy 4: addresses the challenges of human resource development to ensure well-trained and motivated staff, deployed at the appropriate health service level;

Strategy 5: ensures the required central support systems such as personnel, accounting and auditing. supplies, equipment, physical infrastructure, transportation and communication.

Strategy 6: ensures health care financing which is sustainable, involves both public and private funds as well as donor resources, and explores a broader mix of options such as health insurance, community-cost-sharing as well as user fees.

Strategy 7: addresses the appropriate mix of public and private health care services.

Strategy 8: restructures the relationship between MOH and the donors.

The assumptions behind these strategies are that:

More resources will be injected into the system and existing resources used more efficiently: Government allocations to the health sector will increase; donor funds will be seen as additive to Goverment allocations; Government disbursement systems will improve; financial management systems will improve; existing resources will be used more efficiently.

Resources will be distributed more equitably: Realignment of financial and human resources from tertiary and secondary health services to primary health services (district health systems); upgrading of existing health facilities; expansion of access in underserved areas.

Priorities, objectives and standards will be clearly defined and monitored: Priorities will be clearly defined at each level within an overall policy framework; standards will be developed; performance indicators will be agreed upon and systems for monitoring put in place.

Managers at institutional and district level will have greater authority in the allocation and use of available resources: Institutional reforms will aim at producing a sound organisational framework; clear lines of responsibility and control will be developed; global budgets introduced; some aspects of condition of service and staff incentives will be decided locally; contracting with the private sector will be encouraged.

Staff will be better motivated through improvements in working conditions: Incentives in various forms will be provided; staff development programmes will be put in place.

Drugs and essential supplies will be available as required: The existing system (supply driven) will be replace with an indent system (demand driven).

STRATEGY 1: DISTRICT HEALTH SERVICES

A. Concerns and purpose

Strengthening district health services to address key public health concerns is an important priority for the Government. The concerns are that: physical access in some areas is still a problem; financial access is a growing problem. Gender access is increasing, however, valunerable groups such as women and the poor may lack cash or have the time for opportunity cost of using health facilities with long waiting time. Hence the overall purpose of this strategy is to further strengthen district capacity to improve the coverage and quality of health care, and to provide it in a efficient and effective manner.

B. Current Status

In March 1996 cabinet approved the role of the district health boards for executive authority over district health. Funds for managing health services were in account No 6 at the district level. Currently basic health facilities are available within 5 km. of most of the population.
National priority programmes (MCH/FP, TB/ Leprosy, Malaria etc.) are in the process of being integrated at the district level. Under the technical leadership at national and regional levels, basic health packages are being developed and some components of health package are being tested in a few districts.

The kit system has at least ensured some drug availability in the health centres and dispensaries but it has a number of weaknesses. The indent system and capitation of regional hospitals are being piloted. Shift to an indent system to cover all districts is planned.

The referral system is not functioning as expected. It is common to find consumers by passing one level of service to another. The health centres in most districts operate like dispensaries.
Transport and radio communication to support referrals is non existent in most districts.

Health personnel at district level. currently lack management skills, to effectively manage a number of activities and responsibilities that will be decentralised to the district level by the centre.

PHC intersectoral committees rarely meet. Individual ministries plan their activities separately without consideration of needs from other ministries

Very little progress has been made to promote public/private mix.

Communities have been involved in setting up and participate in village / community health committees, activities such as mobilisation of children for NIDs. Communities also participate in identifying TBAs and CBDs.

C. Key Components

Decentralisation to the district

District Health Boards (DHBs) will be established starting with 35 districts in first year in conformity with local government reforms, then 35 during second year and the remainder in third year. These Boards will be charged with responsibilities to make overall policy decisions for district health services. The district hospital will have its own Hospital Board (HB) under the overall guidance of the DHB. The HB will have responsibility for final decisions in administration and management of the district hospital. The District Medical Officer (DMO) is the accountable officer with full responsibility and control of funds and resources to run the district health services.

The DHMTs will be further strengthened in health management so that the DHBs will have a well trained And strong executive hand for efficient and cost-effective management of health resources. The Zonal Continuous Education Centres will train the DHMTs and orient the DHBs in district health services and systems and in administration and financial management. The DHMTs managerial capacity, priority setting processes, and accountability, should all be improved in order to encourage donors to move from supporting disease specific vertical programmes, towards supporting comprehensive health plans. Joint funding mechanisms for donor and Government funds will be set up at all levels.

The remainder of the districts that will not yet have been decentralized will continue to provide health services according to approved district health plans. These districts will be implement their plans using grants from the central government, as well as funds from projects for some of the districts.

All districts will implement some health sector reforms components such as implementation of HMIS, national transport syste, drug indent system drug indent system, cost recovery initiatives such as user fees, national health insurance and community health fund.

Cost-effective essential clinical and public health packages

A fairly limited number of priority health problems accounts for the majority of deaths in Tanzania. In addition to the vaccine preventable deaths in children and the other common causes of childhood mortality such as ARIs and diarrhoea; malaria accounts for 25% of total mortality in all ages (MOH 1996); maternal deaths account for 6-7% of deaths; and 5% of deaths are due to TB.

Despite the close correlation between budget allocation and the the burden of disease, money has not always been targeted towards the most cost effective interventions within those diseases. it is therefore imperative that a package of both public health measures and clinical service which are highly cost-effective and help to resolve major health problems are identified. Ideally the services delivered in the package should meet the following criteria: I) address major health problems; ii) have a significant impact on the health status, iii) address prevention as well as curative; iv) be cost effective; v) improve equity; and vi) respond to the demands of the population. The Tanzania basic health package proposal in section 3.3.1 is expected to meet these criteria.

Definition of services provided at each type of facility/Referral System

Under the 4 consultant hospitals and 17 regional hospitals, there are 60 district hospitals providing back-up to lower health units. The district hospital serves an average population of 250,000 people. At the divisional level below the district there are 302 health centres each serving between 50-80,000 people. These are staffed by a Clinical Officer (CO), Assistant Clinical Officer (ACO), Health Assistants (HA), Public Health Nurses, Nurse Midwives, Laboratory Assistant and Maternal Child Health Aides. The health centres provide both preventive and clinical services and serve as training centres for Village Health Workers (VHW) and Traditional Birth Attendants (TBAs). At the ward level, there are about 3,500 dispensaries each serving between 6-8,000 pople or 3-5 villages. Staff at the dispensaries including the Rural Medical Aide (RMA) are potentially capable of training, supervising and supporting VHWs and TBAs, as well as Community-Based Distributors of contraceptives. About 1000 villages have VHWs who are engaged in promotive activities such as disease control, as well as simple treatment of common illnesses.

Referral system

In theory, the referral system is well organised but in reality the management of the systems has often failed the community. It is common to find consumers by-passing one level of service to another. The most affected level is the health centre which in most cases fails to serve as a referral centre for dispensaries. Further, levels of care and services available in one type of facility often cannot be distinguished from those at a lower level e.g. health centres are operating like dispensaries and most regional hospitals operate like district hospitals but at a higher cost. There is a worry that some clnicians do not refer in time; this problem might be taken up by the quality assurance system with the introduction of some form of peer review not only of the system but also of the actual patients.

An important pre-requisite for an effective system is a functional communication and transportation system between the lower and higher levels. At present the status of telephone or radio communication between the lower and higher levels i.e. dispensaries/health centre and the district hospital is pactically non existent. Many referred cases to the higher level especially the district hospital could be better managed at the level below if a reliable telephone/radio communication and transport system existed. Feedback from higher to lower levels does often not take place.

Strengthening of the dispensaries and health centres diagnostic capacity could reduce referrals if simple and effective diagnostic tests are made available together with the required training. In the urban setting, specific strategies will be needed to define the referral health system, characterised by high population density, short distances and easy accessibility. The DSM Urban Project has experience with this.

Relationship with the regional level

Most implementation will be at the district level while overall monitoring and supervision will be carried out at the regional level. The present structure where lower level programme co-ordinators are supervised by and reporting directly to programme supervisors or managers at higher (regional and national) levels and thus bypassing the DMO/DHMT will be discouraged. It is the responsibility of the DMO and DHMT to ensure that this is implemented while ensuring that prompt response and feedback is provided to health facilities and reports to the regional and national level are not delayed. When moving to the integrated structure where clear roles and responsibilities are defined and developed, it must be assured that the staff has the capacity to maintain the quality at all levels

Sustainability and community involvement

The community must be involved in taking care of their own health. Participation of the community in decision making must therefore go beyond the DHBs. Community based health activities will therefore be encouraged. One way of doing this is through developing community health plans as known as in Igunga District.

The community in the district are a very rich labour resource which may create community activities related to health. Generally the question of development of a sustainable health services depends on how the community is sensitised, supported and motivated to develop a sense/feeling of ownership of the health services, the health infrastructure, and a transparent relationship and trust between health providers and community members.

Key principles of service provision

The health sector refers to the totality of policies, programs, institutions and actors that provide health care and organised efforts to treat and prevent disease. Thus, among other things, reformed district health services should address key principles of service provision including:

(a) Equity
(b) Efficiency
(c) Cost-effectiveness
(d) Clear priorities
(e) Gender sensitivity

Equity in health services is frequently promoted as a means of achieving income redistribution or poverty alleviation. The specific form these services should take, however, depends on the goals and alternative policy options available as well as the political factors which made health services an acceptable option for this purpose in the first place. There are other meanings of the term "equity" but here we focus on the income dimension.

Much depends on what exactly is to be transferred to the poor and what policies are available to do so. The most effective way in the sense of there being the least leakage of benefits to the non-poor, is to target the use of services to the poor alone. If this is feasible, then it does not matter what goods are used for the purpose as long as poor people value and use it and the non-poor can be excluded. Examples are food, housing, cash grants or health care. Usually, this degree of targeting is not feasible due to information constraints on the part of government officials exacerbated by the incentives to pass oneself off as being poor. Therefore more indirect approaches are required.

The main forms of indirect targeting are geographic and variable pricing. Health care as a whole may be a candidate for subsidy or within health this may be specific to types of diseases, drugs, etc. Another possibility for transferring resources is to provide a fixed amount of services or cash per person. However, what is important is that the use be "infra-marginal", i.e. everyone or at least the poor actually uses at least as much as offered. An alternative would be to emphasise those diseases, treatment, etc. which place the largest burden (financial, productivity loss, household stress) on the poor. This could include many of the infectious diseases but it could also include treatments for diseases whose treatments may not be cost-effective in the clinical sense, but have significant impact on poverty when they hit the poor.

The District Health Planning Guidelines, can be viewed as a national health policy instrument, to check and guarantee equitable distribution of the health resources in districts, depending on the district health priorities, size of the population and its geographical distribution. The districts therefore must be supported to build their capacity to recognise, categorise, and range population groups by: i) socio-economic status, ii) age, iii) gender and iv) place of residence.

Efficiency: HSR have the potential to have a positive impact on allocative efficiency through the reallocation of the additional resources generated, and on operational efficiency through directly financing district health services. Allocative efficiency can be looked at in terms of the districts' capacity and capability to develop realistic and practical district health plans with clearly set priorities, and well defined cost-effective interventions.

UNICEF's child survival interventions during the 1980s were based on **cost-effective** analysis and were successfully implemented. The use of cost effectiveness analysis in prioritising interventions is one example of the way in which information can improve policy and health outcomes.

Clear priorities. The district health services must clearly define its health priorities. With the meagre health resources made available to district, the DHMTs have to build the capacity to use these resources wisely against competing community health needs. The achievement of clearly defined priorities will be achieved if the DHMTs have the capability and capacity to assess community health needs (e.g. through the use of the HMIS) and maximise the use of the community representative (through the DHBs and other health committees). DHMTs must also involve the NGOs and the private health providers in the formulation of the district health plans to further consolidate the districts' health priorities.

Gender issues are increasingly becoming of great concern across different strata of the communities. Gender sensitivity must be clearly observable at the district level. The health problems which particularly affect women and children like high maternal mortality and infant mortality due to childhood diseases must be reflected in the district healthh plan and health services. However, the health sector alone cannot deal with such health problems. The DHMTs must therefore sensitise and encourage multi-sectoral activities by involving other sectors like Education, Water and Sanitation, Agriculture, Legislators and Local Government in the formulation of gender sensitive issues and the promotion of a healthier environment.

Quality care and assurance

Quality of care is the degree to which health services are available, affordable, accessible and acceptable to individuals, families and communities and which are capable of producing and sustaining the desired impact on death, disease, disability, discomfort and dissatisfaction. In practice, while the health care provider may be most concerned about the effectiveness of a technical procedure in making an impact on the health of his/her patients, the patient may be primarily concerned about how much the service costs, how quickly he/she receives the service, and how well the patient gets in a given length of time. Generally the quality of health care is influenced by personnel capabilities, availability of equipment, drugs and supplies, infrastructure, and the general attitude of both the health provider and the consumer. At present, the quality of health care is low due to inadequate diagnostic equipment and supplies, poor infrastructure and working environment and poorly motivated staff.

MoH will provide guidelines and help in the formulation of a quality assurance system that will be used in all health facility and throughout the country. The zonal training educentres, in capacity building of the DHMTs (and RHMTs) in effective leadership in quality care and assurance leadership.

Provision of essential drugs, supplies, and equipment

Physical proximity of health care facilities is the beginning of effective health care coverage. However, a facility that is near people's homes will have little value if it lacks essential drugs, supplies and equipment. Drugs offer a simple cost effective solution to many health problems provided they are available, accessible, affordable and properly used. From the household perspective, the availability of drugs is one of the most visible symbols of quality of care. For the health provider a regular supply of drugs, supplies and equipment is a fundamental component of a well functioning health system.

A major bottleneck in the provision of essential drugs, supplies and equipment to health facilities at all levels, has been the persistent problem of inadequate budgetary allocation for these items although a significant proportion of the health budget is used to cover and supplies. However in the area of essential drugs, as a result of inefficiencies and waste, far more is being spent than necessary which falsely reinforces the view that the answer to drug shortage is always more money. Great effects are likely to be achieved through more effective use of existing resources, and rational and effective supply management.

In the present drug kit system, where drugs are supplied on a regular basis, there are periods during the course of a month, when most of the essential drugs are not in stock. Experience has shown that clients attend in more numbers shortly after the arrival of the kit to collect the family drug stock for fear that there are not enough when they need them. Thus creating an artificial "drug shortage period" during the latter part of the month until the arrival of the next monthly drug kit. In response to the dclining availability of public resources for financing drugs, the adoption of community managed drug revolving funds can help assure sustainability of supplies. The introduction of the indent system should have a marked effect on this problem.

Intersectoral collaboration

Provision of health services to the population should not be viewed as the enclave of the public health sector. Other sector such as water, agriculture and environment management make significant contributions to health of a community. HSR aim to strengthen collaboration with other sectors, local Government, NGOs, voluntary agencies, private sector in the following areas:

Advocacy for health within other sectors and the general population: inclusion of health issues on the agenda of other sectors meetings, workshops and seminars; investigating possible inputs from local community groups.

Promotion and strengthening integrated planning, implementation, monitoring and evaluation: Developing and implementing institutional arrangements for integrated intersectoral planning for health interventions with community participation where appropriate; co-sponsor of projects with significant health benefits; serving on joint review, monitoring and evaluation teams; strengthening the exchange of infomation among different sectors.

Provision of complementary activities such as-day care centres, school health programmes: Support the community in setting up day care centres; regularly provide inputs to schools on health matters.

Providing incentives for intersectoral collaboration: Incentives for participation in intersectoral meetings; support for research into appropriate mechanism for collaboration; inclusion of intersectoral collaboration as a criterion for performance evaluation.

D. Plans for 1999 - 2002

Objective: Improve access, quality and efficiency of primary health (district) health services

SPECIFIC OBJECTIVES	ACTIVITY	OUTPUTS	INDICATORS	MEANS OF VERIFICATION	RESP. UNIT PERSON
Devolve and decentralise	Conduct situation analysis to assess needs, in districts where intensified health sector reforms will be initiated.	Health needs in target districts identified	Number of target districts that have identified health needs	Situation analysis report	DHMTs MOH/MOLG
	Establish DHBs and HBs in target districts	Guidelines for selection and composition of DHB and HBs made available DHBs and HBs established in target districts	Number of DHBs and HBs established	Gazette order review of DHBs minutes. Training reports	DPP MOLG
	Orient DHBs and HBs on their roles and function	DHBs and HBs oriented	Number of DHBs/HBs oriented		MOH/MOLG
	Adapt and implement guidelines for promoting public private mix	Improved working relationship between public and private health providers	Number of target district with guidelines on public private mix	Improved working relationship public/ private	DPP DHMT
	Strengthen District Health Management Teams capacity in planning, budgeting, supervision, drugs and medical supplies management, monitoring and evaluation	DHMTs in target districts trained in planning, budgeting, supervision, drugs and medical supplies management, monitoring and evaluation	Number of DHMTs trained in planning, monitoring, evaluation and supervision	Number of DHMTs training. Availability of comprehensive district plans	DHR
	Orient district administration on their role in HSR and SWAp.	District administrators in target districts oriented	Number of district administrators oriented	Orientation workshop report	DPP LGRT

	Establish mechanism to ensure transparent and accountable management of financial resources	Transparent accounting system that meets expectations of partners established Special joint accounts in target districts	Presence of accounting system that satisfies partners Number of districts with joint account	Audited financial reports transparency Joint accounts statement of accounts	LGRT DHB
	Broaden and improve health finance options	Broad financing options in use	Proportion of funds raised from other sources	Financial reports	DHB DPP
	Establishment of exemption modalities to protect the poor and vulnerable groups	Exemption modalities in place	Number of individual exempted	Exemption records	DHB
Provide cost effective essential clinical and public packages	Develop capacity of DHMT to select prioritise cost and implement the district health package	Essential health packages implemented at all level district	Number of target districts implementing essential health packages.	District health plans and implementation reports	DHR
	Ensure availability of essential drugs, medical supplies and essential equipments at facilty levels according to health packages needs	Essential drugs. medical supplies and essential equipment available according to health packages provided by each facility.	Status of drugs and medical supplies in primary health facilities	Drug and Essential medical equipment returns	MSD
	Strengthen and monitor operation of indent system in target districts	Indent system institutionalised in target districts.	Number of districts operation indent system	Indent system monitoring reports	MSD
	Conduct supervision according to national supervision guidelines	Supervision carried out according to national guidelines	Number of health facilities supervised	Supervision reports	DHMTs
	DHMTs norms and standards applied in order to promote and monitor provision of quality health care in the districts	Norms and standards adhered to in health service delivery	Improved case management	Case management returns	DHMTS

Strengthen referral system	Undertake communication needs assessment provide radio phones, transport and or other communication links between district hospital, health centres and dispensaries to facilitate referrals	Radio communication and transport provided	Number of health facilities linked with communication or ambulance	Referral transport and communication review	DPH DHB
	Strengthen strategically located hospitals to provide referral health services to primary level facilities in the district	Referral system working	Decongested out patient departments at hospitals	Out patient returns	DHS
	Develop and introduce higher user fees for clients who by pass the referral system	By pass fees affected	Number of referral hospitals that have affected by pass fees	Referral register returns/ register on clients paying by pass fees	HBs
	Strengthen strategically selected health centres that will provide needed referral support to dispensaries	Strategically located health centres in target districts identified and strengthened	Number of strategically located health centres strengthened	HMIS returns	DHMT DCLG
	Down grade the rest of health centres to dispensaries	Rest of health centres relegated to dispensaries	Number of health centres relegated	DBH	DPP DHB
Improve Human Resources performance	Assess human resources required to support implementation of health packages	Staff gaps identified and filed	Number of vacant positions filled	Personnel record/staff records	DHMTs
		Staff training needs identified	Number of staff trained according to needs	Training records	RHMT
	Provide training to fill gaps in knowledge and skills	Job descriptions for staff available at all levels of health care systems	Number of staff with updated job descriptions	Staff inventories in district health facilities, personnel records	DHMT

STRATEGY 2: SECONDARY AND TERTIARY HOSPITAL SERVICES

A. Concerns and Purpose

The referral system, as outlined under Strategy 1, assumes a pyramidal pattern of referral from dispensaries to national referral hospitals. Curative health services are provided in three levels. District level primary health care services (Level I) consist of services provided by dispensaries, health centres and the district hospital. Level II referral hospitals are code named as Regional hospitals. These offer more specialised services and act as secondary referral health facilities for the districts. Level II hospitals serve a catchment population of about 1,000,000 people. In addition to services offered by Level I District Hospitals, Level II hospitals offer more specialised services in medicine, psychiatry, oral health, surgery, child health, obstetrics and gynaecology. At present there are such hospitals in 17 regions of mainland Tanzania (except Mbeya, Pwani and Dar es Salaam). Mbeya region is in the process of constructing a new regional hospital.

Highly specialised medical and health care services are provided at Level III (tertiary) referral hospitals. They also offer both formal and in-service training to different medical cadres and conduct research activities. At present, level III referral services are provided by four referral hospitals at Muhimbili Medical Centre (MMC) in Dar es Salaam, Bugando Medical Centre (BMC) in Mwanza, Kilimanjaro Christian Medical Centre (KCMC) in Moshi and Mbeya Referral Hospital (MRH) in Mbeya. Dodoma and Mtwara are earmarked for the next tertiary hospitals. In addition there are national hospitals which provide specialised services in psychiatry (Mirembe Hospital/Isanga Institution in Dodoma) and tuberculosis (Kibong'oto Hospital in Kilimanjaro Region).
Public hospitals, through the referral system, provide the backbone of increasing levels of curative care in support of primary and district health services. The expansion of the number of these hospitals has major budgetary consequences. Although level II and level III referral hospitals consume a high proportion of the health budget, the quality and availability of their services, the efficiency and effectiveness of their management and the access of the poor and vulnerable to hospital care are seriously compromised. Basic essential medical equipment, drugs and supplies are often not available. Many of these hospitals are faced with shortages of specialists. In addition, they also provide a large measure of primary health care services in addition to specialist services, which often leads to overcrowding and ineffective use of available resources. The physical superstructure has also suffered (with many of the facilities in a serious state of disrepair) due to under-funding and lack of maintenance.

Large public hospitals, especially referral institutions, are multi-faceted, complicated organisations which are difficult to run well - not only in Tanzania but everywhere in the world. Often they are inefficient and expensive, their contribution to public health is quite limited and they serve only a small proportion of the population, favouring those with higher than average incomes, usually in urban areas.

Tanzania has remained strongly committed over the past two decades to strengthening Primary Health Care (PHC) and district health systems -- reinforced by studies indicating that PHC was much more cost-effective than hospital care. The main strategy towards hospitals has been to try cutting the large share of the health budget that they received. However political and other constraints have prevented a reduction in the size or number of hospitals, so funding cuts have mainly effected maintenance, equipment, supplies, and other non-staff costs. As a result, the share of health resources for PHC did not increase substantially (and currently stands at about 52% of the recurrent health budget[1]), but the quality and efficiency of hospital care has dropped. The failure to shift resources and the decline in

1 World Bank PER Team Tanzanian Public Expenditure Review in the Health Sector, p.14

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hospital care can also be attributed to the limited analysis or systematic planning of hospital services, and the lack of major initiatives to improve their performance.

B. Current Status

Majority of hospitals offering level II and level III services operate under direct government supervision except for Muhimbili Medical Centre which has a semi autonomous Board of Trustees. Bugando Medical Centre and Kilimanjaro Christian Medical Centre are autonomous in that they have independent Boards. The remaining tertiary and specialised hospitals Mbeya Referral Hospital, Mirembe Hospital/Isanga Institution and Kibong'oto Hospital are governed by boards indirectly managed by the Ministry of Health. Also, Management Committees under direct government financing and supervision administer all level II (regional) hospitals. These hospitals are in a currently in a critical situation with deteriorating standards, services, facilities and capacityas examplified by:

(i) A continuing drop in the standards and availability of hospital care, so that a virtual collapse in public referral hospital services has become a real possibility, particularly with the rapid loss of skilled medical and nursing capacity to the private sector.

(ii) The decline in public hospital services has the greatest effect on. The poor and disadvantaged, are increasingly getting no care, or setting very poor care, or experiencing crippling financial burdens when they fall ill.

(iii) Deepening public disillusionment, discontent and dissatisfaction with *all* government health services, because its perceptions are strongly influenced by the quality and availability of hospital care.

The three major reasons for these difficulties with hospital services are financial constraints, deteriorated infrastructure and, in particular, under-management.
These conditions have made it extremely difficult for hospital managers and staff to work effectively. The fact that many of them are still struggling to provide good services and often succeeding despite the difficult circumstances, is a strong indication of their perseverance and dedication.

C. Key Components

Reform of Hospitals Services

The Health Sector Reform Programme of Work intends to transform curative services particularly at referral and regional hospitals, with the aim of achieving devolved and decentralised management authority, broadened hospital financing, strengthened management performance improvement in resources and infrastructure by concentrating on proving referral health services and living of some of the primary level curative health functions currently being undertaken.

MMC has been chosen as the first priority for reform, so that reform at secondary and tertiary hospitals will be built on its experience, successes and mistakes. In addition the lessons over the past two years of MOI and ORCI in piloting many changes will be valuable for the other hospitals and the reform process itself.

The roles of national specialised hospitals needs to be revised. Also, a comprehensive reform is required in almost all referral hospitals encompassing reforms in management of decentralised health care financing, public-private-mix of service delivery, organisation and structure of public health services, health research and preparation of health packages to be provided by each health facility.
The objectives for hospital reform will be to:

- Ensure the quality, accessibility and availability of essential hospital care

- Establish the equity, efficiency, affordability and financial viability of referral and regional hospitals
- Strengthen the referral system, so there are effective referral and regional hospitals to back up and support other health services, and health sector resources are used appropriately
- Keep the hospitals' share of the health budget from increasing, and if possible reduce it somewhat.
- Base future hospital development in the country on well-formulated strategic plans
- Deligate primary curative health services to the district
- Introduce by pass fees in order to strengthen compliance to referral.

To achieve these objectives it will be necessary to transform referral and regional hospitals into well-managed, efficient and effective institutions by reforming: almost all hospital services; the systems, procedures and structures of management; and the approach and attitudes of managers and staff.

Strengthen MoH Capacity to oversee Hospital Reforms

By the end of the reforms the Ministry should have ceased instructing, controlling and supervising most aspects of hospital management. Instead, it should establish goals, targets and policies for the hospital services that it wants provided.

Strengthening of hospital management

(i) *Separation of responsibilities:* between those paying for hospital services (i.e. the Ministry of Health and other customers) and those delivering services (i.e. the hospitals). The Ministry will thus exercise its influence over hospitals mainly through the process of payment for services.

(ii) *Clarity:* each hospital will have a *framework document* clearly describing its role, service aims, objectives and how its performance will be measured. It will also specify the responsibilities and accountability of hospital boards, executive directors and the Ministry of Health.

(iii) *Management self-sufficiency:* reformed hospitals will still remain subject to government policies and priorities, but their Boards and Executive Directors will have maximum control over their resources, with no interference from the centre of government.

(iv) *Modern management practice:* by using strategic and business planning, commercial style financial management and independent external auditing, hospitals will know the real costs of their services and be able to manage on the basis of resource consumption rather than just cash

(v) *Customer satisfaction and quality care:* hospitals will focus on their patients and other customers, find out what they need and check that they are being satisfied. "Customer satisfaction" will be one of their performance measures

(vi) *Continuous improvement:* each reformed hospital will have Key Performance Targets, and achievements will be published to provide transparency and enhance accountability.

(vii) *Freedoms and flexibilities:* to operate in a business-like way hospital boards and managers need to be freed from many current rules and regulations, so they would normally be given freedom over such areas as recruitment, appointment and management of staff; posts and conditions of service; financial authority; choice of suppliers: purchasing and contracting; and acquisition and disposal of assets, especially land and buildings

(viii) *Financial viability*: more effective income-generating measures will be introduced at hospitals to increase financial self-sufficiency, but with safeguards to ensure equitable access for poor people to essential care and cross-subsidisation of services for them with income from private patients and other sources

(ix) *Internal Devolution*: strengthening the management of divisions, departments and other service units within a hospital by increasing their authority over resources and their accountability for performance and outputs; establishing cost-centre budgeting and accounting; and creating single lines of authority.

Strengthening of national health services

(i) *Linkage*: Hospital Reform will complement and reinforce the other elements of Health Sector Reform by: strengthening the referral system; developing better back-up services and technical support for district and primary care; increasing hospital collaboration with training institutions to improve the number, capacity and skills of health workers; and building support for appropriate research in areas of priority health needs

(ii) *Financial restraint*:: keeping the hospitals' share of the government's health budget from increasing — and if possible reducing it somewhat

(iii) *Strategic management*: introducing the "eyes on, hands off" approach at national level, so the Ministry of Health can watch what is going on at a strategic level but not get involved with the day-to day operations of hospitals

(iv) *Focus on national hospital priorities*: developing a national capacity to plan the equitable distribution of hospital resources and services; to establish policies and guidelines to ensure equity, accessibility and accountability to stakeholders; to develop output and performance targets for hospital services based on national needs and available resources; to monitor and assess hospitals' achievements of their targets; and to allocate funding according to service delivery needs and hospital performance and outputs.

Strengthening Referral system

The referral system, from levels I to level II health facilities assumes a pyramidal pattern. The poor state of health services has led to collapse of the referral system and led to by-passing one level of service to another.

Strengthening of health service delivery will go hand in hand with strengthening of the referral system. It is envisaged that level II and level III hospitals will operate out-patient departments for **referral cases only**. These hospitals may operate fast-track (high cost) out patient services for customers by-passing lower facilities. In major urban centres it may be necessary to identify and strengthen level I health facilities, which will have the mandate to refer cases to higher level facilities.

D. PLANS FOR IMPLEMENTATION OF HOSPITAL REFORM

Year 1 Reform of Muhimbili Medical Centre, situational analysis in District and Regional Hospitals based in 35 districts and situational analysis for Mbeya Referral Hospital.

Year 2 Strengthen capacity of district and regional hospitals based in first 35 disticts to provide referral, and situational analysis in the next 35 districts.

Year 3 Strengthen capacity in the second 35 districts, Mbeya Referral Hospital and situational analysis in the remaining districts

Year 4 Strengthen capacity in the remaining districts

Year 5 Evaluate the implementation of Hospital Reforms.

D. PLANS

LEVEL 2 AND LEVEL 3 HOSPITAL SERVICES

Objective: **Improve the management, quality of services, efficiency and financial viability in level 2 and level 3 hospitals that support primary level services, teaching and research.**

SPECIFIC OBJECTIVES	ACTIVITIES	OUTPUTS	INDICATORS	MEANS OF VERIFICATION	RESPONSIBLE UNIT/PERSON
Effectively plan and manage the reform process in individual hospitals at all levels	Conduct situation analysis in level 2 and level 3 hospitals including financial inability training needs for capacity Building	• Situation analyses of all specialised, referral and regional hospitals		• Analysis reports	DHS
	Form a hospital reform committee in each hospital	• Hospital reform committees operational		• Annual hospital reports	DHS
	Review lessons learnt in pilot reforms of MOI, ORCI and other hospitals and apply as appropriate	• Review results presented		• Review reports	DHS
	Prepare and implement change management stakeholder Consultation plans	• Change management stakeholder consultation plans		• Workshop reports and documents • Progress evaluation reports	DHS DHS
	Prepare and implement a strategic plan for each hospital	• Hospital strategic plans prepared and implemented		• Hospital strategic plans • Progress reports	DHS DHS
	Prepare tools for monitoring reform process for each hospital and implement	• Monitoring tools for the reform developed and		• Evaluation report • Monitoring reports	DHS DHS

SPECIFIC OBJECTIVES	ACTIVITIES	OUTPUTS	INDICATORS	MEANS OF VERIFICATION	RESPONSIBLE UNIT/PERSON
		implemented			
	Proved support for models in support of Hospital Reforms (at MOI, ORCI and other hospitals)	• Models for hospital reforms researched and tested			DHS
Improve management of level 2 and level 3 hospitals	Appoint or reconstitute and Orient new Board, Executive Management Team	• Hospital Boards, Executive Management Team appointed		• Progress report	PS DHS
	Progressively revise the organisation structure of the hospitals	• New organisation structure Prepared		• Organogram	DHS
	Establish on-going change Management process				
	Devolve authority and accountability to lower levels of management	• Authority and accountability devolved to departments/units		• Organization structure/reports	Boards ED MO i/c
	Develop management information systems and link to performance targets, outputs and unit costs	• MIS in all hospitals		• Annual report	
	Institute on-going process of management capacity building and institutional development	• Human Resource Development plans developed		• Plans	Boards ED/MO i/c
	Establish new procedures & systems to ensure that the Hospital Board and Management are accountable to	• Increased stakeholder satisfaction with hospital performance		• Baseline and subsequent surveys	Boards ED/MO i/c

— 153 —

SPECIFIC OBJECTIVES	ACTIVITIES	OUTPUTS	INDICATORS	MEANS OF VERIFICATION	RESPONSIBLE UNIT/PERSON
	the MOH/regional authorities. the patients and communities they serve				
Improve quality of patient care and clinical support services in level 2 and level 3 hospitals	Strengthen capacity for delivery of clinical, nursing and clinical supportive services	• Hospital standards and guidelines for patient management developed • Specialised training for health professionals conducted		• Guidelines • National standards and guidelines	HMT/EMT
	Review and establish standards, procedures and structures for patient care management	• Guidelines and standards		• Guidelines	HMT/EMT
	Establish and implement a system for quality assurance and monitoring comprehensive patient care	• Quality assurance scheme of approaches for all aspects (clinical diagnostic, and therapeutic implemented		• HMIS report • Periodic quality assessment report	HMT/EMT
	Adapt national guidelines to revise and broaded the composition of therapeutic committees to include responsibility for quality assurance of diagnostics and therapeutic services	• Composition of hospital therapeutical committees revised and broadened.	• Number of hospitals with therapeutic committee functioning according to revised guidelines	• Minutes of diagnostic and therapeutic committees meeting.	HMT/EMT
	Develop protocols and implement quality assurance scheme/ approaches for all aspects of clinical diagnostic and therapeutic services (including an incentive scheme).	• Quality assurance schemes/approaches for all aspects of clinical diagnostics and therapeutics implemented	Number of hospital with quality assurance and incentive schemes/ approaches	• Minutes of diagnostic and therapeutic committees	HMT/EMT CMO

	Assist voluntary agencies and private health care providers improve quality of care according to national standards and norms.	• Voluntary agency and private hospitals assisted to recruit trained staff, acquire affordable equipment of good quality and establish maintenance system	• Improved quality of care in voluntary agency and private hospitals. • Cross-referral of patients • Joint supervision visits conducted.	• Periodic quality assessment reports	DHS DPP
Broaden and improve health financing options and financial management to move forwards financial viability of level 2 and level 2 Hospital services 3 With safeguards to ensure equitable access to essential care for poor people	Implement a plan for the introduction strengthening of appropriate financial procedures	• Financial guidelines and procedures developed		• Financial management manuals and reports	DHS/DPP/CA
	Develop the finance management capacity of the Hospital Management Team and finance department	• Introduction of procedures commenced in all hospitals • Training programs introduced.	•	• Performance appraisal reports	
	Identify/develop sources of revenue, and improve collection	• Number of financing options introduced		• Balance sheet	ED MO i/c
	Introduce a business oriented approach to financial management throughout the hospital, which includes detailed budgetary controls, business plans as well as the wide use of management reports	• Proportions of own income contribution to recurrent budget • Bussiness oriented accounting policy applied		• Financial reports • Financial reports • Financial procedures documents	ED/ MO i/c
	Strengthen external and internal auditing	• External and internal auditing mechanisms established		• Audit report	ED MO i/c
	Introduce cost centre accounting and unit costing	• Cost centre Financial statements		• Cost centre Financial statements	

	Develop criterial for exemption of poor people and introduce mechanisms for subsidisation of services with in come from other source	• Exemption criterial and mechanisms for exception of poor people introduced		• Exemption register • Minutes of exemption meetings	ED MO i/c
Introduce comprehensive, effective and active human resource management	Review and introduce policies, systems and procedures for managing human resources	• Staff employed directly by hospital		• Staff contracts	DHR DAP ED MO i c
	Establish the human resources departments in level 2 and level 3 hospital	• Human resources department and plan established		• Organogram of Human resources department and HRH plan	ED MO i/c
	Identify requirements for specialised personnel to fulfil the referral of level 2 and levels 3 hospital	• Requirements for specialised personnel identified.		• Assessment reports	ED MO i c
	Recruit and retain competent specialist personnel*	• Competent specialists recruited.		• Personnel records	ED MO i/c
Strengthen and Integrate Administrative and clinical support system	Develop and implement policy Procedures and organisation Structure for: Medical records, Information systems, Laundry, Catering, Security, Transport Services, Estates and Housing, Communications	• Plans for administrative systems and staff training plan elaborated			Boards ED MO i/c
	Strengthen capacity for administrative support systems	• Recruitment and staff training plans elaborated		• Plans	ED MO i/c
	Strengthen and integrate clinical support systems (including drugs, diagnostic and dental supplies	Well defined and integrated hospital supplies department and systems established		• Integrated requisition and issues • Stock taking reports	ED MO i/c

	Identify and acquire specialised clinical equipment and other facilities to fulfil the referral functions of level 2 and level 3 hospitals	Specialised clinical equipment and facilities identified and acquaired		Assessment reports Inventory lists	ED MO i/c
	Set up/strengthen clinical equipment, plant and crafts management, maintenance and repair system.	Equipment plant and craft maintenance workshop established/strengthened or contracted out		Maintenance schedules	ED MO i c
	Set up/strengthen estate management and in trastructive maintenance system	System established or contracted on		Maintenance schedules	ED MO i/c
	Provide transport and strengthen transport management system	Transport provided and transport management system strengthened or contracted out		Maintenance schedules Plan Project reports	ED MO i c
Rehabilitate equipment plant and buildings and establish systems and capacity to manage, and maintain them.	Institute hospital policy for maintenance, replacement and disposal	Policies and plans developed		• Plan	ED MO i c
	Assess existing capacity and develop plans for future maintenance development	• ADB Rehabilitation project harmonised with MMC reforms			
	Develop capacity to manage and maintain available facilities.				
	Implement Hospitals' Rehabilitation Plan and harmonise with the hospital reform process	• ORTE Project harmonised with hospital reform			

— 156 —

Strengthen the referral system at level 2 and level 3 hospitals to support level 1 hospital services	Develop and implement guidelines and procedures for effective referral of patients (and services)between level 2 and level 3 hospitals and other levels of the health system (for public private, and VA health providers).	• Referral guidelines and procedures develop. • Standard referral forms developed to include feedback report.			DHS
	Clarify roles of different levels of the referral system.	Roles and functions of each referral level clarified.		Hospital HMIS Report	DHS
	Develop and implement feedback mechanism from level 2 and levels 3 health facilities to lower referring levels	• Feedback provided to referring levels standard feedback forms • Feedback register established anzd maintained in level 2 and level 3 hospital		• Feedback reports • Feedback register	ED/MO i/c
Strengthen specialised in level 2 and level 3 hospital and institution	Conduct situational analysis of specialised services (oral health, mental health. Diagnostic services. Equipment maintenance. mortuary and Blood transfusion services in leve 2, 3 hospital	Situation analysis of oral mentral health. Diagnostic services medical equipment, mortuary and Blood transfusion services conducted		• Assessment report	DHS
	Develop and implement plans for strengthening specialised services.			•	DHS
	Oral Health	Dental equipment in dental clinics rehabilitated Dental laboratories established and equipped		• Implementation plans • Reports	DHS

	Mental Health	▪ Documentation, training and research capacity of the National Mental Health Resource Centre Strengthened.	▪ Appropriate ▪ Equipment ▪ Manpower	▪ Assessment reports	
			Services and training a Mirembe and Isanga Institution upgraded and Established.		▪ Assessment reports
			Psychiatric Units in level 2 hospitals established or straightened.	•	
		Diagnostic Services	Role of central pathology laboratory at MNH as a National reference laboratory detailed.		Implementation plans
			Laboratory services of Mbeya Referral Hospital upgraded to category a standards		
	2.9.2		KCMC Research Laboratory integrated with clinical diagnostic laboratory		

			Histopathology services at Bugando Medical Centre established	•	
		Blood transfusion services at all levels strengthened.		•	
Support provided for national and referral functions of service delivery, teaching and research	Develop a Memorandum of Understanding between the hospital and the MUCHS and proceed to implement	• Memoranda of Understanding developed	•	• Agreement documents	
	Develop working relationship of the hospital with MOI and ORCI	• •	• •	• •	
	Develop and implement good referral procedures between the hospital and other levels of the health system	• Referral guidelines in place	•	• Guidelines	
	Analyse the situation of the Central Pathology Laboratory and Equipment Maintenance Workshop and determine future relationships	• •	• •	• •	
	Analyse the situation of health staff training which will not be the responsibility of MUCHS, and determine future arrangements and accountability for this.	• Situation analyses conducted and plans developed	•	• Reports and plans	

	Provide teaching facilities for attached health worker training schools	• Plans for implementation or guidelines developed	•	• Plans	
	Develop and implement good referral procedures between the hospital and other levels of the health system	• •	• •	• •	
Strengthen services in specialised hospitals and institutions	Support reform pilot project at MOI	• Reviews undertaken	•	• Review reports	
	Introduce contract employment for hospital staff in MOI with the start of Phase II operations	• • Contracts agreed	• •	• • Contracts	

STRATEGY 3: ROLE OF CENTRAL MINISTRY OF HEALTH

A. Concerns and Purpose

With the devolution of power from the central to the local level, the role of the MoH headquarters will be: to formulate technical policies, regulations, legislation; and to develop guidelines to facilitate the implementation of the national health policy. At present the MoH has limited capacity to analyse macro policies and to develop specific technical policies required to meet the ongoing Civil Service Reform. This concern is underscored by the limited training of staff, lack of policy information and dissemination, weak advocacy, and inadequate logistics. Closely related to the requirements of policy formulation and analysis, is the need to further improve the Health Management Information System (HMIS) so that performance in the decentralised system is measured and can be used for policy decisions.

B. Current Status

The MoH clearly understands its new role as facilitator of health services and overall initiator of health reforms.

As such therefore the MoH is embarking on piloting a number of sectoral initiatives, e.g. CHF, establishing district health boards (DHBs) in districts where reforms are being tested. It is also developing guidelines to streamline the process of decentralization. In order to effect the HSR, the MoH with collaboration with Local Government and Civil Service Department a number of workers have been retrenched to reduce the size of workforce and to improve the quality of work. This is a major challenge to the MoH as retrenchment without creating incentive packages might not be achieved accordingly.

However, MoH currently is involved in rethinking of the norms and standards in view of the mushrooming of private practice facilities in urban areas most of which observe abysmal standards and in so doing is compelled to introduce an inspectorate unit and review the existing legislation so as to bring it in line with on going HSR.

MoH have already started the process of improving the quality of services for example Integrated Supervision guidelines and training guidelines on quality assurance are being developed. Similarly the MoH is appreciating the desirability of integrating vertical programmes which were hitherto controlled either from the centre or directly by donors.

This doesn't undermine the integrity of vertical programmes as most e.g. EDP, EPI and Malaria, have had a very significant role, but which now need to be incorporated into PHC management.

The MoH are training DHMT in HIMS in almost all districts and advocacy and communication strategy has been developed. MoH is equally well then on imparting necessary autonomy to the statutory bodies like the Medical Council of Tanganyika, the Nurses Council, Pharmacy Board etc.

In line with the re-defination of its role according to the HSR, there is a need to MoH HQs to have a well representative organisation, functioning and management restructuring to increase central level efficiency.

C. Key Components

Policy development & analysis

Support will be provided to further develop the Central Ministry of Health's capacity to formulate, develop and implement policies. The Ministry of Health will not merely analyse health issues and formulate health
policies, but also translate them into operational plans and programmes that are feasible, implementable and can be monitored and their impact evaluated.

Decentralisation/Devolution of Power

Central Ministry of Health will have the overall responsibility for the on-going decentralisation and health reform process. It will formulate training programmes and ensure that the health reforms are being implemented. The RHMT will supervise and coordinate districts to ensure that HSR activities are implemented.

At the regional level, the RHMT will supervise and coordinate HSR activities to ensure that they are implemented.

Links with Civil Service Reforms

The government is in the process of streamlining the civil service to increase productivity. The objective is to reduce the growth and size of the governments' workforce, yet ensuring an uninterrupted delivery of services and improved quality. Employment will be service-demand driven and reward-based on quality performance and dedication to service.

Organisational structure

The Ministry of Health is being reviewed by the Civil Service Reform Programme for re-adjustment and will take on a smaller structure with its functions and roles defined. The staff is expected to be reduced and the remaining motivated for better performance. The Boards/councils and commissions are going to be autonomous such as Medical Council, Nurses Council, etc. while Government Chemist will become an agency.

Setting norms and standards

The national basic package of essential public health measures and clinical interventions is being defined. The package is expected to be a way of setting national priorities for tackling the major health problems in Tanzania. The interventions in the package will be defined according to the level of the facility. Clear guidelines and protocols for each component of the package will be defined. Health workers will be trained in the effective implementation of the package and interventions activities will be incorporated in the district health plans.

The successful provision of a cost-effective package of essential interventions entails the existence of quality in the delivery of health care. MoH will develop the necessary standards to improve quality of care and ensure that the different health personnel will be trained to perform their tasks according to the standards. MoH will also oversee that the standards are applied in private practice.

Performanceg and evaluation

Work in this ocus on strengthening the development of relevant performance indicators and building up thd operations research. MoH will need training in these areas together with better informalogy, and support for dissemination of information.

Integration Oprogrammes

MoH's presetonal set up has led to the existence of numerous vertical programmes that sometime coad of supplementing each other. Vertical programmes have resulted in duplication ofch as training and supplies as well as a serious lack of co-ordination The final outcome has ben distribution of health services in the country. MoH recognises the urgent need for integ committed to fully support and guide the process in collaboration with all stakeholders a

Necessary legew of HSR

A number of lations that are directly or indirectly given to guide health professional bodies, practice, and lth administration need to be reviewed and new ones to be formulated to accommodate the legal framework of the HSR, as follows:

Legislation to

- The Miers and Dentists ordinance Cap.409
- Nurses (Registration) Act 1997.
- The P (Regulation) Act 1977 as amended.
- Pharmoisons Act, 1978
- The O66
- The Mordinance, 1937
- Publicion and Regulations
- Any oh view of HSR

Legislation to l

- The Hgislation
- Any obn in view of HSR

Advocacy forunication

Reforms in thestill new concepts among politicians, health workers, other stakeholders, and the populair awareness and involvement in all the stages of the reform process, the commitment MoH has therefore already developed a communication and promotion strategy. Actate the reforms include establishing national, regional and district communicationg training workshops, advocacy seminars and sensitisation meetings for health providelps, media personnel, health providers, and health facility staff ; developing infor radio and television programmes, news flashes, cartoons and press releases; prodion of leaflets, posters and fact sheets: and promotion of traditional and cultural media ges.

Research Development

Health systems research should be encouraged to be done by MoH programmes, the private sector, health practitioners and the communities themselves. It will include learning how to work with other sectors in a wide development of activities that may prove as important for health as the tasks undertaken in the health sector. Furthermore, evaluative research should be encouraged to determine the effectiveness, acceptability and efficiency of the health services and programmes and also to appraise planned activities. National guidelines specifying priorities will be developed and revised regularly based on the experiences and results. This will also ensure that systems research results are put into use in the delivery of health care.

The Health Systems Research Unit in MoH will be responsible for health systems research activities, including behavioural research. The unit will formulate, supervise and research activities. Its role is not to carry out research activics itself. The Unit needs to be strengthened and more funds allocated. MoH will
financially support operational research initiatives, facilitate the establishment of a documentation data bank, and the means for dissemination of research results. MoH has already set up a research fund.

Biomedical research will be approved, monitored and evaluated by National Institute for Medical Research (NIMR) which will oversee that the biomedical research is in consonance with the national priorities. NIMR has started to undertake systems research as well. With the strengthening of the Health Systems Research Unit in MoH, negotiations will be undertaken with NIMR to limit its role to biomedical research only.

Strengthening the Statutory Administrative and Regulatory Bodies/Institutions

There are categories of statutory administrative and regulatory bodies with specific functions to regulate, license and perform certain field of administrative activities. Statutory bodies which include the Tanzania Food and Nutrition Centre, National Institute for Medical Research, National Food Control Commission and Medical Stores Department will be strengthened and given the necessary autonomy to perform their functions. The Government Chemical Laboratory will be transformed into Executive Agency. The autonomy will aim at improving income generating activities and better financial management.

On other statutory regulatory bodies like the professional regulatory bodies which include the Medical Council of Tanganyika, Nurses and Midwives Council, the Pharmacy Board, the Opticians Council, Pharmacy Board and the Laboratory Technologists (Registration) Council will be given the necessary autonomy to strengthen the different professions in the the health sector. Their primary function relates to training and maintenance of standards of professional practices whether private or public. Autonomy has to go hand in hand with a mechanism for adequate funding of their activities. Similary, other regulatory bodies such as the National Food Control Commission, the Private Hospitals Advisory Board and the Private Health Laboratory Board will be strengthened in order to ensure that quality of service is properly maintained.

STRATEGY 3 ROLE OF CENTRAL MINISTRY OF HEALTH

OBJECTIVE: To improve capacity for sector wide management; policy development, analysis and national planning; development of guidelines for national policy implementation; performance monitoring, evaluation, legislation and regulation of service delivery and practice.

Specific Objective	Activity	Outputs	Indicators	Means of Vertication	Responsible
Consolidate the new central MoH structure for implementation of new functions and roles					
	...quired qualifications. Skills and experience to fill positions in the new MoH structure and retain them by appropriate remuneration and working conditions	... service staffed by skilled health personnel	Recruitment of skilled personnel	Staff list with credentials/qualifications	DAP
	Orient/re—orient key MoH staff on their new roles functions and responsibilities	Staff oriented	Number of staff oriented	Orientation reports	DAP
	Develop and establish machanism for inter-sectoral collaboration in sector wide management of health care delivery services	Mechanism for intersectoral collaboration established	Types of mechanisms established and functioning	Periodic reports	DPP

オリジナル入手資料のとおり

Build capacity for policy development, analysis and national planning for health					
	Provide required skills to members of the budget technical committee in health planning., budgeting and financial management in line with Health sector reforms	Skills in health planning budgeting and financial management provided	Number of technical committee trained	Training reports	DPP
	Introduce modern communication and data processing facilities	Communication and data processing facilities installed	Number of facilities and equipments provided	Inventory	DPP
	Provide technical support to MoH sections, regions and districts for development, interpretation and planning for implementation of national policy guidelines	Technical support for planning provided	Number of sections districts and regions supported in planning and budgeting	Reports and plans	DPP
	Strengthen co-ordination of health systems research identification of research problems, dissemination and utilisation of research results	- Health system Research strenghened - Inventory of research in place	Number of health system research conducted on identified problems	Research reports	DPP
	Orient/re-orient MoH staff in modern concepts of health economics and planning	Skills in health economics and planning in place	Number of staff oriented	Orientation reports	DPP

Develop/revise and implement joint plans for advocacy and communication of HSR with MRALG. Other sectors and partners.					
	Prepare plans for advocacy and IEC on HSR with MRALG and MoE	Plans for advocacy prepared	Advocacy plans for each level in place	Plans of actions	DPP. MoE MRA&LG
	Facilitate/conduct advocacy and IEC for HSR in target districts	Advocacy conducted	Number of district with advocacy conducted	Advocacy report	DPP. MoE MRA&LG
	Surpervise, monitor and evaluate implementation of advocacy and IEC plans	Supervision. monitoring and evaluation conducted	Number of districts supervised monitored and evaluated	Reports	DPP. MoE. MRA&LG
Decentralise and develove power to districts.					
	Develop/revise criteria and guidelines for establishment, composition and functioning of DHBs	Criteria and guidelines established	Availability of criteria and guideline	Guidelines	DPP. CSD. MRA&LG
	Provide Local Authorities with information and technical assistance for establishment of DHBs	Technical assistance provided	Number of districts supported	Technical reports	DPP

	Orient DHBs members on roles, functions and responsibilities	Members of DHBs Oriented	Number of districts with oriented DHBs	Orientation reports	DPP
Develop/revise policy and operational Guidelines for implementation of national health policy					
	Develop/refine essential health packages and guidelines for priority setting and costing for different levels of care	National essential health interventions package established and costed.	Essential health interventions package for each levels of health care delivery available.	Health package document	CMO
	Support preparation of Comprehensive district Health Plans and setting priorities according to available resource envelope	District supported to prepare comprehensive health plans	Number of districts with comprehensive health plan	Comprehensive district health plans	DPP DHS DPS DHR
	Develop/revise guidelines for health promotion prevention, management control and surveillance of communicable and non-communicale diseases	Guidelines developed/revised	Types of guidelines available	Guidelines document	DPS
	Establish norms and standards for health practice and health care facilities	Norms and standards established	Types of norms and standards available	Norms and standards documents	CMO
	Develop/revise policy and operational guidelijnes clinica, diagnostic, therapeutic and referral services in delivery of curative health services	Guidelines developed/revised	Types of guidelines available	Guidelines documents	DHS

	Develop guidelines processes. machanisms and plans for gradual integration of service delivery part of vertical programmes.	Guidelines processes mechanisms and plans developed	Integration Plans available	Plan documents	DPP DPS
Develop mechanisms for performance monitoring and evaluation of health services					
	Develop performance indicators. models and regulations for contracting and reporting of health care delvery.	Performance indicator. models and Regulations developed	Indicators. models and regulations Available	Protocals, MOU and agreements	DHS DPP
	Develop MoH staff capacity in contracting, performance monitoring, allocation system and capital planning	Capacity of MoH technical staff developed	Number of staff trained	Training reports	CMO
	Design and implement performance monitoring, allocation system and incentive mechanisms.	Performance monitoring and incentive mechansism designed and implemented	Performance monitoring and incentive mechanism in plance	Reports and protocals	CMO
Strenghthen National Systems and capacity to oversee hospital services	Develop appropriate national plans and policy guidelines for Hospital services and reform	• Plans and policy guidelines developed	• Availability of policy guidelines and plans	• Policy guideline and plan documents	DHS
	Establish systems and capacity for contracting, financing and monitoring hospital services	• Contracting, financing and monitoring systems established	• Availability of systems • Capacity building plans	• Framework documents	DHS

	Assist hospital to introduce reforms	• Referral and Regional hospital reforms assisted	• Availability of plans and criteria for financing	• Financial plans	DHS MoE
Develop and revise the legal framework needed for the Health Sector reform.					
	Formulate new and revise existing health legislation to provide legal basis for implementation of various policy guidelines and to accommodate old and new management structures in line with HSR.	Legislation formulated and revised	Number of legislation formulated and revised	Gazetted Acts	DPP
	Conduct advocacy for revised legal framework	Advocacy conducted	Number of target groups oriented	Reports	DPP
	Harmonise and consolidate existing public health legislation into a single Act.	Public Health legislation consolidated	Availability of the single Act for public Health	Gazetted Act	DPP
	Involve various stakeholders in the process of formulating and revising health legislation.	Stakeholders involved in the process of formulating and revising health legislation	Number and categories of stakeholders involved	Reports	DPP
	Strengthen MoH legal unit to meet increasing demands of legal support for various MoH sections in line with HSR and sector wide management of health care delivery	MoH legal Unit strengthened	Number of additional staff recruited and trained	• Personnel data and job description • Staff with relevant Post graduate training	DPP DAP

- 171 -

Regulate Service delivery and health practice to ensure provision good quality health care services in public. voluntary agency and private health care facilities					
	Strengthen the Health Inspectorate Unit of MoH and establish technical Inspectorate teams in all MoH departments	Technical and Management Audit for all hospitals strengthened	Checkiklist for supervisors/Inspector	Supervision Reports of the Inspectorate Unit of MoH and departmental Inspectorate or supervisory teams	CMO
	Facilitate and support professional bodies to establish systems and mechanisms for self regulation of health practice and protection of patients against malpractice	Mechanism for self – regulations of professional bodies established	Effective self – regulation mechanisms available	Reports and proceedings of professional bodies	CMO
	Facilitate and support Association of Private Hospitals in tanzania (APHTA). Christian Social Service Commission and other apex organisations of health service providers to self-regulate and monitor quality of service provided.	Mechanisms for self-regulations of health service providers established	Effective self regulation of health service providers available	Reports and proceedings of apex organizations of service providers	CMO

Promotion of traditional practitioners in health service delivery.	• Formulate policy guideline for alternative healing practice	Policy guideline formulated, prited and disseminated	Availability of policy guidelines	Policy guidelines documents	DHS
	• Formulate legislation to monitor and register the activities of traditional practioners	Legislation formulated and traditional practitioners registered.	Availability of legislation and registration of traditional practioners	Gazetted Act and register book	DHS
Design and implement appropriate management systems and linkage to central government bodies such as CSD, MRALG, MoF, Planning Commission.	Participate in inter ministerial coordination meetings.	Inter-ministerial coordination meetings conducted	Number of meetings	Minutes of the meetings	DHS
Develop and strengthen roles, functions and relationship of statutory autonomous and semi-autonomous institutions, agencies, Boards, Councils and Commissions.					
	Initiate and complete the process for the transformation of selected bodies into Executive Agencies.	Process for the formation of agencies undertaken.	Availability of documents	Framework document, Strategic Plan document and business support document	CMO
	Introduce performance management reforms and motivation systems to personnel	Performance management reforms and motivation system to personnel introduced	Improved job satisfaction and efficiency for personnel	Personnel records	CMO

	Introduce realistic income generating measures to increase self sufficiency.	• Realistic income generating measures in place • Improvement of financial management in place	Accomplishment of market assessment to clients	Price List in place	CMO
	Development and improvement of systems and capacity to manage and maintain equipment. buildings and provide materials and supplies	• Chemicals and reagents procured • Equipment repaired and new ones purchased • Renovation and completion of constructing of buildings (Government Chemical Laboratory)	Availability of good buildings, equipment, materials, chemicals and supplies.	Records	CMO CGC
B. REGIONS					
Consolidate the new structure of the Regional health Management team in the Regional Secretariat for implementation of new roles and functions.					
	• Provide technical support to the MRA&LG on roles and functions of RHMT within the regional Secretariat	• Roles and functions of RHMT incorporated	RHMT with appropriate skills mix available	• Staff list with credentials/qualification	DPP

Provide technical support to district health services and regional health services	• Building capacity to RHMT on interpretation of national policy quidelines, district health plans, quality assurance and advocacy of HSR	• Capacity of RHMT strengthened to support DHMTs and DHBs.	• Number of RHMTs strengthened	• Training reports	DHR
	Conduct supervision, monitoring and evaluation of district health services	District health services supervise	Number of DHMTs and DHBs supervise	Supervision reports	RHMT

STRATEGY 4: HUMAN RESOURCE DEVELOPMENT

A. Concerns and Purpose

The health sector reform as part of the Civil Service Reform programme is the Government's response to the pressing need to improve performance of the health sector, resulting in the delivery of better quality health services at all levels. The vision is to evolve an efficient, responsive, accountable, adequately compensated and effective health service. Human resource development involves the processes of policy formulation and planning, education and training, and deployment and management of the health workforce within a health system. The main aim is to develop human resources for health to implement the health reforms effectively by improving skills and building management capacity at all levels of the health system.

The Government's objective since independence has been to create self-sufficiency in human resources. Health Sector plans for the early seventies were geared towards the production of large numbers of health workers for the rapidly expanding health services. Currently the need is for quality improvement and keeping up the ongoing HSR. To date more than 30 cadres of health personnel are being trained by the MoH, each with their own set of duties. The policy for the development of human resources for health (HRH) which provides general guidelines to improve the scope and quality of health services is in place. This was followed by the development of a five year plan which among other things, addresses the discrepancies which do exist between the policy intentions and reality such as:

(a) Poor performance/low quality of health services offered;

(b) Imbalance and maldistribution of workforce (i.e. geographical distribution and skill mix) who are concentrated in urban areas and large referral hospitals, becoming less accessible to rural in favour of urban areas;

(c) Lack of management skills among the health workers who are in the managerial positions;

(d) Inadequate management and deployment of human resources for health (e.g. inadequate salaries but overstaffing in some units);

(e) Low level of education among health workers (pre-service and continuing: the level of education among health workers is low, the largest cadres such as Nurse B, RMA, MCHA, Medical Attendants having been recruited at standard seven level; plus few health workers get opportunities for new skill development).

(f) Shortage of qualified applicants to be trained as health workers;

(g) Low morale of health workers, partly as a result of delays in promotion and inefficient handling of staff administrative issues leading to low job satisfaction and motivation among health staff. The fact that the salaries of health workers are unsatisfactory, is an important factor contributing to the demoralisation among the health force.

(h) Lack of accurate data regarding present HRH requirements and future needs.

Therefore there is a need and scope for rationalisation of the training and deployment systems in line with various policy intentions.

B. Current Status

Various steps have been taken to improve the performance of health workers. An analysis was done in 1994/95 on recruitment, training and deployment needs, which contribute to a more rational process of downsizing the number of personnel and maintaining quality. Curricula are being developed for those cadres who do not have them while existing ones undergo regular revision to bring them into conformity with requirements.

Selection of pre-service and in-service candidates for training in the health sector is done centrally by the Ministry of Health Headquarters. This has proved to be unsatisfactory because of the lack of a system of career advice in schools, forgery of certificates among other problems.

Supervision of health training institutions is conducted by teams comprising of MOH officials, staff from schools and hospitals. The information collected is shared among staff of the training department, principals and other staff of schools. Financial constraints make it difficult to cover all schools.

In all health training institutions trainees contribute part of training fee (cost sharing) in a move to mobilise and improve finances in the institutions.

C. Key Components

Effective human resource development builds upon several key components: capacity
building (both pre-service or basic and in-service training): employment including recruitment procedures and bonding; deployment in which levels are manned according to budget availability and staff transferred from over-staffed to under-staffed facilities; and retrenchment of weak performing workers or those who are less skilled or have volunteered to take early retirement as well as those lost by attrition etc.

Retrenchment and employment

One of the serious challenges of HRH in line with HSR has been the retrenchment exercise. In view of the low level qualified staff and overstaffing at many lower levels, and the large share of the budget being allocated to salaries. MOH has been engaged in a retrenchment exercise. In the past people were recruited without consideration of the requirements of the job and also not taking into consideration approved staffing norms. This now results in the need for retrenchment.

Although the retrenchment policy aims at bringing about efficiency, in some quarters it has brought inefficiency because the lower skilled staff are not replaced with staff with higher qualifications. In other words, it is accepted that staff with lower level qualifications should disappear but not the post. A number of posts left vacant have created an added workload to the staff left behind.

One result of retrenchment has been reduction of female workers, who tend to be concentrated on the less educated and "lower" end of the health care system. This has gander considerations for the workers as well as access by female clients to female health workers.

The decision by the Government to suspend recruitment of new employees especially medical doctors, nurses and other allied health personnel have brought a negative impact in the delivery of health services.

Staff of health facilities

To get rid of the above described shortcomings, MOH will ensure that every health facility has the required number of personnel with the required knowledge and skills and that the personnel are adequately remunerated. Staffing in health facilities will be based on the following key components:

- Staffing norms, guides or standards for specific work locations or facilities will be developed.
- Modalities will be established to attain a fair geographical distribution of human resources and their skill mix.
- MOH in consultation with the Civil Service Commission will develop competitive remuneration packages.
- Entry requirements to health schools will be raised to attain a higher aggregate level of education among the health workforce and the qualification of teachers will be raised
- Heads count to determine the current staffing and subsequently to build an HRH database as part of the new HMIS will be undertaken.

D. PLANS

STRATEGY 4: HUMAN RESOURCE DEVELOPMENT: Plan for Work July 1999 – 2002

OBJECTIVE: Implement a Human Resources Program to Train Adequate number of Health Staff to Manage the Services

SPECIFIC OBJECTIVES	ACTIVITY	OUTPUT	INDICATORS	MEANS OF VERIFICATION	RESPONSIBLE PERSON/UNIT
1. Improve Performance of Health Workers.	• Establish and enhance access of a computerised personnel data base for the whole health sector.	Expanded and accessible computerised personnel data base for the whole sector available.	Number of staff data computerised.	Computerised data sheet	DHR
	• Update the 5 year HRH Plan to match with the 3 year Pow for HSR.	Updated 5 year HRH plan to match with 3 year POW	Updated HRH 5 year plan	Updated 5 year HRH Plan	DHR
	• Review curricula of all cadres in line with HSR requirements.	Reviewed curricula	Number of reviewed curriculum	Curriculum review reports	DHR
	• Match training opportunities with health sector worker needs	Selection according to needs	Number of individuals selected	Report of selection proceedings	DHR
	• Provide in-service training to MOH-HQ Regions and Districts Management staff on new policy issues and their new roles	In-service training on policy provided	Number of staff trained	Training report	DHR
	• Provide technical training to fill gaps in knowledge and skills for health care providers at all levels.	Training technical skills provided.	Numberof staff trained.	Training Report	DHR
	• Provide health learning Materials (HLM) to the health training institutions.	Health learning materials provided	No.of materials purchased.	Presence of learning materials	DHR
	• Conduct annual a one year MPH course at MUCHS.	MPH certificate to graduands mainly DMOs and other workers.	No.of MPH graduates trained annually.	MPH Training records	DHR/MUCHS

	Establish Medical laboratory technology training schools at Bugando Medical Centre (BMC), Kilimanjaro Christian Medical Centre (KCMC) and Mbeya Referral Hospital (MRH)	▪ Bugando Laboratory Assistants Training centre upgraded to Diploma level ▪ Diploma in Medical Laboratory Technology courses established at KCMC and MRH	DMLT courses established at BMC. KCMC and MRH The School of Medical Laboratory Technology at MMC remains with Advanced Diploma in Medical Laboratory Technology (ADMLT) course only.	Training curricula	▪ DHR ▪ DHS
	• Orientate students of Higher learning Institutions (Universiet) with policies and strategies of HSR and involve them in areas of HRD	Orientation done to the students of Higher Learnig Institutions (HLI) on policy and strategies of HSR. Involvement of HLI in area of HSR	No. of students trained.	Training records	DHR
	• Review and improve renumerations and incentive packages of Health workers at all levels.	Renumeration of incentive packages reviewed and improved.	No. of professional staff by category retained.	Personal records	DAP DHR
	• Provide necessary working tools and improve working environment.	Necessary working tools provided.	Number of health institutions with essential working tools	Inventory records	DHR HBs

2. Strengthen capacities of zones, regions and districts in sustaining Human Resource Development	• Enhance decentralization of training.	Decentralized training improved.	No. of training undertaken.	Training report	DHR
	• Develop system /guidelines for selection of students	Selection system/ guidelines established	Number selected students according to selection criteria	Selection Report	DHR
	• Strengthen and provide budget support to the Zonal continuing education centres to perform training functions for health employees based on training needs assessment.	Improved performance of zonal continuing education centres	Number of strengthened zones	• Number of staff trained • Availability of working tools	DHR
	• Update distance education guidelines, modules and accreditation for upgrading in community health, district management and technical training.	Continuing Education guidelines and modules revised	Number of updated guidelines and modules	Presence of the updated guidelines and modules	DHR
	• Conduct DHMT training in phases to cover all district (115 districts).	DHMT training provided to the staff of 115 districts.	Number f distrits provided with DHMT training	Training reports from zones	DHR
	• Provide capacity building in district, region and zones in line with HSR Programme of Work.	Improve performance of DHMTs, RHMTs and HBs	Number of districts of staff provided with training	Training	DHR
	• Improve function of DHMTs, RHMTs and hospital management team with training in management	Improved performance of managers	Number of management staff trained	Training report	DHR

	• Empower basic training institutions to be able to select candidates for different professions with locally relevant selection criteria	• Authority to select candidates • Relevant selection guidelines in the zones	Number f students selected using the local relevant selection criteria	Selection report	DHR
	• Provide Support to conduct Education Audit to assess curricula, teachers competence and assessment methods at all training institutions.	Improved teachers/trainers competence	Number of teachers performing up to standards	Supervision report	DHR
3. Improve financing of human resource development.	• Review the cost sharing guidelines for the Health Training Institutions	Reviewed cost sharing guidelines	Revised guideline	Financial report	DHR
	• Review training costs in order to derive at rational training fee.	Rational training fee charge derived	Training fee charge	Financial report	DHR
	• Steamline and rationalize the health training institutions.	Health training institutions rationalized.	Reduced number of training institutions.	School data report.	DHR
	Involved private and NGO in provision training services.	Private and NGO.s involved in training.	Number of private and NGO. institution providing training services.	Training report	DHR
	Develop guidelines for contracting out some service in training institution.	Guidelines developed for contracting out some services	Developed guidelines	Institution report	DHR
4. Strengthen the National Support System for Human Resource for Health	• Establish guidelines for management of human resource for health at all levels in line with public service, management and employment guidelines.	Human Resource for Health management guidelines established.	Availability and use of Human Resource for Health guidelines at all levels of the health care system.	Human Resource for Health management guidelines.	DHR/DAP
	•Develop staff norms guides and standards for specific work locations of health facilities.	Staffing norms and standards guidelines established.	Number of districts facilities using staffing norms and standards as per guidelines.	Staffing norms and standards guidelines.	DHR/DAP

	• Establish and implement a fair geographical manpower distribution of health human resources according to manning levels and their skill mix in collaboration with the Local Government	Manpower distribution guidelines established.	Number of facilities staffed according to manpower distribution guidelines.	Manpower distribution guidelines.	DHR

STRATEGY 5: CENTRAL SUPPORT SYSTEMS

A. Concern and Purpose

In order for MoH to deliver its services efficiently, it must have support systems in place to ensure that personnel, finances, drugs and medical supplies, equipment, physical infrastructure, transport and Health Management Information System (HMIS) are dealt with in a uniform way.

The problems facing health care are clearly reflected throughout the country in the delivery of health services; they are mainly related to under funding and inadequate management capacity at various levels of health care delivery system. Limited services are being offered without supporting systems i.e. monitoring and supervision, communication and consultation, skills updating and logistic support.

When it comes to drugs and medical supplies management, MSD has continued to be the main body responsible for procurement of drugs and medical supplies for the public health facilities. However, there is still a shortage of some drugs and medical supplies at MSD and in the public health facilities. Another concern especially in the health facilities is the irrational use of drugs and misuse of medical supplies.

Medical equipment in most of the public health facilities is below acceptable standards and in most cases inadequate and poorly maintained.

Estates and infrastructures in majority of the health facilities are poorly maintained and require renovation.

In the area of transport management at the district level, utilisation of the available vehicles in some districts are not related to the set objectives.

It is also imperative to focus on the HMIS collection of data, its analysis and their utilisation in planning and decision making.

The purpose of the strategy is, therefore, to develop support systems that will strengthen and facilitate provision of better health services to the people.

B: Current Status

As clearly pointed out in the development objective of the health policy, to encourage the health system to be responsive to the needs of the people, intermediate and long term solutions are required to iron out problems that currently affect the delivery of health care services. The MoH therefore has the objective of developing support systems at the National level so that are implemented throughout the country.

To prevent the shortage of drugs and other medical supplies in public health facilities, the MoH is piloting the indent and capitalisation programmes to sustain the availability of drugs and medical supplies in all health facilities.

Hospital Therapeutic Committees have been established in various district and regional hospitals to function as a control body within the respective health facilities to ensure rational use of drugs and other medical supplies.

MSD has been strengthened in terms of personnel and rehabilitation of warehouses to help improve its procurement and storage capacity to cater for the increased volume due to the integration of vertical programmes.

The MoH has developed Standard Guidelines for staff compliments at each level of health care provision. However, this guide needs to be revised from time to time to incorporate inputs from the experiences of health workers manning the facilities.

The MoH has developed laboratory policy guidelines and standards to facilitate the standardisation of equipment, techniques and implementation of quality assurance schemes.

A project to rehabilitate radiology, laboratory and dental equipment has been initiated in which the Tanzanian Government contributes 40% and the Royal Netherlands Government the remaining 60%.

The MoH has established the Central Transport Unit (CTU) whose main functions are to establish and supervise transport management systems in the districts. Each district now has two vehicles, one for supervision activities and another for distribution of drugs, vaccines and other medical supplies using the district transport matrix system.

Tertiary and secondary health facilities have been utilising part of the collection from the cost-sharing fund to carry out minor rehabilitation and renovation of the existing infrastructures. In other areas, the primary health care committees have been sensitising the community to contribute funds for minor renovation in dispensaries and health centres.

Currently all districts have health personnel who have been trained in HMIS and provided with computers to enable them to collect, store and analyse various data from health facilities.

Key Components

Technical Personnel

Optimal utilisation of the workforce requires a modern personnel management system. Guidelines will be established for management of human resources at all levels on the basis of the following key elements:

Employment: Explicit job description, establishment control, recruitment procedures, personnel records and database, induction, proper and rational distribution of personnel and utilisation of support staff.

Retaining: Career structures, promotion procedures, living and working conditions and pays incentives.

Supporting: Supervision, communication and consultation, continuing education (skill updating) and logistic support.

Developing: Performance appraisal, continuing education (new skills)

Staffing norms, guides or standards for specific work levels of facilities will be revised. Modalities will be established to attain a fair geographical distribution of health human resources and their skill mix. DHBs in consultation with MoH and Civil Service Commission will develop remuneration packages.

Drugs and Medical Supplies Management

Adequate amounts of essential drugs and medical supplies should be maintained to offer reliable, effective and quality health services. Effective drugs and medical supplies management, can only be achieved through careful selection. procurement, distribution, quality assurance and rational use including justifiable prescribing.

The Pharmaceutical Sector Master Plan (PSMP) describes comprehensively the procurement, storage, distribution and use of drugs in the country. However, this is out of date and needs to be reviewed to cope with the reforms that are currently going on.

Support will be given to health facility staff to build their capacities to enable them perform realistic quantification of drugs and medical supplies requirements using the available morbidity pattern and consumption data in their respective areas.

Information on actual drug and medical supplies utilisation patterns and accessibility are missing. The responsible sections in the MoH will revise HMIS forms by adding essential indicators and adjusting the existing ones to enable the MoH and districts to monitor the utilisation patterns of drugs and medical supplies.

Facility requisition based system (pull) will be introduced in phases to replace the current kit system (pushy) for primary health facilities countrywide. At the same time, a Drug Revolving Fund will be initiated in all secondary and tertiary health facilities through the Hospital Capitalisation Programme. The MoH has prepared training programme for health workers in administrative, logistic and budgeting procedures and quantification skills necessary to operate, support and maintain such systems. Special emphasis will be made on the training of prescribers on rational prescribing and rational use of drugs.

Medical Equipment Management

Effective procurement, management and efficient maintenance of medical equipment are very important in the provision of effective, safe and affordable health care at all levels in the country.

The MoH will develop and implement a policy on medical equipment management. Such a policy will include development of standard lists for each level and a firm replacement policy. Selection of medical equipment will be governed purely by MoH specifications based on need assessment/replacement and standard lists. A system for planned preventive maintenance will be developed and include provision of workshops, tools and training of equipment managers and technicians. Budget lines for preventive maintenance will be established at various levels.

Estate and Infrastructure Management

The MoH will develop and implement a policy on estate and infrastructure management. When planning new health facilities, the estate and infrastructure policy will include

i) criteria for siting of new health facility and
ii) standards for construction of new facilities, including standard module designs that will facilitate conversions and add-on constructions if upgrading is needed; standards for construction materials; standards for estate equipment and furniture and criteria for determine levels and prioritisation of rehabilitation.

Management of estate and infrastructure will cover:

i) the development of in-house capacity to manage or advice on contracts to ensure conformity with standards and quality,
ii) rehabilitation of existing facilities to a level that will facilitate preventive maintenance and
iii) establishment of preventive maintenance systems and training modules for technicians and health staff. Budget lines for preventive maintenance will be established at the various levels.

Transport Management

The transport policy is to provide adequate vehicles for the distribution of drugs and medical supplies, supervision visits and movement of patients. Such a policy will include guidelines on vehicle (including motorbike) replacement, running and monitoring.

Transport planning, budgeting, management and administrative systems will be strengthened. This will involve training of DHMTs and RHMTs on route scheduling as well as vehicle planned preventive maintenance (PPM) schedules. Suitable public mechanical workshops for repair of vehicles will be selected for each district. Transport budget will be based on the route schedules and PPM schedules developed for each district. The use of Transport Management Information System (TMIS) forms for the transport data bank will be enforced. Each DHMT and RHMT will be provided with vehicles to cater for the above mentioned activities.

The Central Transport Unit (CTU) will provide support to regions and districts in transport management and ensure that procedure is correctly followed. CTU will be responsible for the operation of TMIS and for the establishment and maintenance of the various databases.

Health Management Information System

The MoH is planning to develop and strengthen an integrated functional routine data collection system in all health facilities. The Health Information and Research section at the MoH will provide support to RHMTs and DHMTs in ensuring that collection of data is correctly done and used in planning and decision making. The section will be responsible in supporting regions and districts in proper maintenance of installed computer systems.

D. Plans for 1998/99 - 2000/01

STRATEGY 5: CENTRAL SUPPORT SYSTEM

OBJECTIVE: **To strengthen the national support systems for drugs and medical supplies, medical equipment, physical I infrastructure, health management information system and transport management.**

OBJECTIVE	ACTIVITIES	OUTPUT	INDICATORS	MEANS OF VERIFICATION	RESPONSIBLE UNIT/PERSON
Strengthen drugs and supplies management system	Strengthen procurement, storage, distribution system at MSD	▪ MSD establishment revised to enable recruitment of staff for specialised disciplines ▪ Logistics and Supplies management information system strengthened	▪ No. of specialised staff recruited ▪ Availability of updated logistics and supplies management system	Personnel records HMIS reports	MSD DHS
	Review of the Pharmaceutical Sector Master Plan to match with the current reforms	▪ Pharmaceutical Sector Master Plan reviewed	▪ Availability of the reviewed master plan	Reports	DHS/PSU/MSD/ DPS
	Develop and implement plans to integrate vertical programme supply systems into MSD	▪ Plans to integrate vertical supply systems developed ▪ Vertical supply systems integrated into MSD (Family Planning supplies, TB/Leprosy drugs, NACP/STD supplies, diagnostic supplies and dental supplies)	▪ Availability of integration plans ▪ Availability of contraceptives, TB/Leprosy drugs, AIDS/STD drugs, diagnostic supplies and dental supplies at MSD	Integration plan document CRINs and store ledgers	DPP MSD

	Expand gradually use of indent system for procurement of drugs and medical supplies from MSD to all districts	Use of indent system for procurement of drugs and supplies from MSD gradually expanded to all districts	No. of districts procuring through indenting system	CRINs and store ledgers	MSD DHS
	Capitalisation of district,, regional and referral hospitals	A Drug Revolving Fund established and operational in all hospitals	Constant availability of essential drugs and medical supplies in hospitals	Reports and Store ledgers	DHS DPP
	Expand gradually use of diagnostic supplies kit to all district hospitals, health centres and dispensaries	Use of diagnostic kit system gradually expanded to all districts	No of districts receiving diagnostic kits	CRINs and store ledgers	DHS
	Update essential lists for drugs, laboratory, diagnostic and dental supplies according to health packages delivered by different levels of health facilities	Updated essential drugs and medical supplies lists based on health packages in place	All essential drugs and medical supplies available at MSD	CRINs and store ledgers Stock taking reports	DHS MSD
	Develop guidelines and conduct orientation on planning for diagnostic and dental supplies at district level (quantification methods, budgeting procedures and rational use of resources)	Guidelines on planning for diagnostic and dental supplies at district level developed District personnel oriented on use of diagnostic and dental supplies planning guidelines	Availability of supplies planning guidelines in all health facilities Number of district with personnel oriented on use of guidelines	Records	DHS
	Revise HMIS monitoring forms to reflect use of indent system and utilisation patterns of essential drugs and medical supplies	HMIS monitoring forms revised to reflect indenting and essential drugs and medical supplies utilisation.	HMIS reflects information on indenting of drugs and medical supplies	Records and reports	DHS HIR Section

Strengthen Medical Equipment Management system	Update and enforce medical equipment policy guidelines.	▪ Equipment policy guidelines updated ▪ Inventory of medical equipment in all hospitals conducted ▪ Standard equipment lists for each level revised ▪ A firm replacement policy developed	Availability of updated equipment policy guidelines, standard equipment list and replacement policy.	Policy guidelines	DHS
	Establish and strengthen health care equipment preventive maintenance network through central and zonal workshops based in secondary tertiary referral hospitals	▪ Health care equipment maintenance and repair workshops provided with tools, spare parts, trained managers and technician. ▪ Budget lines for preventive maintenance established at levels	▪ Availability of an equipment maintenance and repair network Availability of budgets for preventive maintenance and repair of equipment at all levels	Preventive maintenance and equipment repair records Budgets and Financial reports	DPP DHS HMT/EMT
	Develop and implement a training programme for technicians and users on equipment procurement, management, preventive maintenance and budgeting.	Training programme on equipment procurement, management, preventive maintenance and budgeting developed and implemented	Number of technicians and users trained	Supervision, monitoring and evaluation reports	DHS
	Develop and implement a scheme to supervise, monitor and evaluate quality of maintenance and repair of medical equipment	Scheme to supervise, monitor and evaluate quality of maintenance and repair of medical equipment developed and implemented	Number of workshops attaining high quality standards of preventive maintenance and equipment repair	Supervision, monitoring and evaluation reports	DHS
Strengthen plants and crafts management	Update and implement policy guidelines on plants and craft management	Policy guidelines on management of plants and crafts updated and implemented	▪ Availability of updated policy guidelines and implementation plan	Policy guideline document	DPP

Strengthen estate management	Update guidelines for establishment of public, voluntary agency and private health facilities	▪ Criteria for siting of new health facilities updated ▪ Standards and modules for construction of new facilities updated ▪ Standards for estate equipment and furniture updated	Availability of updated guidelines	Guideline documents	DPP
	Develop in-house capacity for management of estate at all levels	▪ In house capacity to advise on contracts and ensure conformity with standards developed ▪ Preventive maintenance and rehabilitation systems established ▪ Training modules for technicians and health staff developed	Number of health facilities with in-house capacity for management of estate	Training reports	DPP
	Develop guidelines and orient health staff on community involvement in estate management, rehabilitation and preventive maintenance	Guidelines for community involvement in estate management, rehabilitation and preventive maintenance developed and health staff oriented	▪ Availability of guidelines ▪ Number of health staff oriented	▪ Guidelines document ▪ Orientation reports	DPP
Strengthen transport management	Update policy guidelines on transport management taking into account experiences from test regions	Policy guidelines on transport management updated based on experiences from test regions	Availability of updated guidelines	Guidelines	DPP
	Implement plans to strengthen Central Transport Unit to co-ordinate transport management and	CTU strengthened to co-ordinate transport management and maintenance system	Availability implementation plans	Implementation plans	DPP

	maintenance system				
	Study experience on use and availability of reliable maintenance facilities for different types of vehicles and recommend on standardisation of vehicles to a few models	Vehicles used by health sector standardised to a few models based on experience on use and availability of reliable maintenance facilities at all levels	Number and type of vehicle models selected	Guideline document	DPP
Develop and Strengthen an integrated functional routine data collection system	Finalisation of hospital HMIS development and installation in 20 regions	Hospital HMIS installed in all 20 hospitals in Tanzania mainland	Number of hospitals operating HMIS	HMIS hospital reports	HIR Section
	Orientation of RHMTs and DHMTs on HMIS data analysis, presentation and use in planning and decision making	Orientation course conducted for RHMTs and DHMTs	Number of orientation courses conducted foro RHMTs and DHMTs	Training reports	HIR Section
	Establish and integrated disease sentinel surveillance system	An integrated sentinel surveillance system established	Number of sentinel sites established	Sentinel reports	HIR Section
	Review of the HMIS	HMIS reviewed	Number of HMIS workshops conducted	Workshop report	HIR Section
	Maintenance of installed computer systems in regions and districts	Installed computer systems maintained	Number of computers sufficiently maintained	Maintenance reports	HIR Section

STRATEGY 6: HEALTH CARE FINANCING

A. Concerns and Purpose

Underfunding at all levels of health services in Tanzania has led to shortages of drugs and medical supplies, deterioration of physical structures, and low staff morale. Health expenditure has for many years been substantially supported by external finance, with resource allocation favouring expensive curative care. There are inadequate resource management skills, and hence heavy dependence on a single source of financing (i.e. government: both domestically-raised resources and donor funds) for provision of health services.

According to data compiled by the Ministry of Health in May 1996, between 1977 and 1992 funds allocated to the health sector declined from 7.5% to 4% of government expenditure. Due to this, the Government took steps to reverse the trend by allocating a higher percentage of its budget to the health sector. From 1992/93 to 1996/97 the Government reversed the trend and the estimated percentage increased from 4.4% in 1992/93 to 11.4% in 1993/94, 11.6% in 1994/95, 12.1% in 1995/96 and 12.3% in 1996/97.

Although these figures indicate increased Government allocation, a recent review conducted by the Tanzanian Government in collaboration with the World Bank estimated that the Government is able to finance only 29% of the total financial requirements of the health sector. This figure is based on the current per capita spending figure of US$3.46 (government and donor expenditure on health) and a total requirement of US$12, the minimum required to provide acceptable health services (including provision of water and sanitation, amounting to a third of the total) as recommended by the World Bank elsewhere - for example Cambodia - an estimate for basic minimum health care costs is US$5 per capita. Therefore, although the current level of health financing is grossly inadequate with the expenditure at US $3.46 per capita (this figure includes donor and government funding), it is nevertheless apparent that with a major effort Tanzania should be able to mobilise sufficient resources over the period of the plan to significantly improve the health status of her population, even if the World Bank's (WB) estimate of US$8/capita (without sanitation and water) is still some way off.

The introduction of the Health Sector Reform (HSR), by the Government of Tanzania has additional resource mobilisation as a major priority with the aim of ensuring sustainable financing of the health sector, by expanding and diversifying the resource base. In order to narrow the existing financial gap, alternative ways of financing health care are being explored and some have already been introduced. These alternative financing methods include:

- Cost Sharing which was started in 1993/94, by introducing user fees to public hospitals in phases.
- Government has also launched a pilot test in Igunga district (Tabora region) of a Community-based prepayment scheme (Community Health Fund), and roll on to Nzega, Iramba, Singida Rural, Songea Urban, Songea Rural and Hanang Districts.
- In addition, Government has finalized the designing of health insurance scheme, a preliminary plan for such a scheme has been developed.

Developing these sources of additional finance will be a priority for the Ministry of Health during the plan period 1999/2000-2001/2: as such, they are given some prominence in this section. All these approaches are intended to lead to an improved and sustainable health sector service. These measures will also lead to improving the viability of the public system and increasing the volume of resources available for health services, thus allowing the Government to target scarce central tax-funded expenditures for the poor and to preventive and community health interventions.

B. Current Status

A National Health Insurance scheme as part of broad financing reforms is in its pre-implementation stages. Assessment of potential for establishing a national health insurance in Tanzania has been completed. The National Health Insurance team that oversee the establishment of scheme has been formed. Study tours to Kenya, South Africa, Thailand and Philippines have been made as a learning process that has facilitated the designing process.

The Community Health Funds (CHF) has been pre-tested in Igunga District as a prepayment scheme that will ensure greater security of access to health care, and empower households and communities in health care decisions and participation. The progress in Igunga district has been rolled over to other six districts.

User charges have now been introduced in all referral, regional and district hospitals. Performance and impact evaluation of user charges at hospital levels is now undertaken. The evaluation lesson will be used during the introduction of cost sharing to lower level health facilities.

C. Key Components

Central Government Funding via Ministry of Health, Prime Ministers Office; and Local Government

Central Government Funds

The central Government finances the health services in two ways:

(i) The Ministry of Health provide funds to the referral and specialized/national hospitals and the various medical schools. It also provides funds to parastatals such as the Muhimbili Medical Centre (MMC), the Tanzania Food and Nutrition Centre (TFNC), and the National Institute for Medical Research (NIMR). The Ministry gives subventions to KCMC and Bugando referral hospitals, voluntary agency owned hospitals and the District.

(ii) The Prime Minister's Office provides funds for the running of regional and district hospitals including salaries for the employees.

Local Government Funds

The Local Governments are responsible for the running of dispensaries and health centres in rural areas. They have to provide funds for: procurement of drugs and medical supplies; salaries and staff training and development; and maintenance of the dispensaries and health centres. Local Governments get their funds from central Government subventions and local taxes. Tables showing the budgetary allocations to the Health sector during 1996/97 – 1998/99 under the Ministry of Health, Regions and the Councils are as shown below:

Table I. Recurrent Budget (Tshs '000')

	1996/97			1997/98			1998/99		
	P.E	O.C	Total	PE	OC	Total	PE	OC	Total
Ministry of Health	12,197,084.0	5,542,706.2	17,739,790.2	11,373,060.0	10,661,860.4*	2,034,920.4	11,750,176,300/=	17,126,611,700/=	28,876,788,000/
Regions	6,029,755.9	2,609,474.5	8,639,230.4	6,678,435.2	570,732.8*	7,249,168.0	7,676,960,600/=	756,553,400/=	8,433,514,000/=
Councils	11,696.046.4	6,483,735.3	18,179,781.7	12,134,753.0	833,229.9*	12,967,982.9	13,512,000/=	850,230,600/=	14,718,742,600/=
Totals	29,922,886.3	14,635,916	44,558,802.3	30,186,248.2	12,065,823.1	42,252,071.3	33,295,648,900	18,733,395,700/=	52.029,044,600/=

Source: Ministry of Finance September, 1998

Note * implies that, funds earmarked for the purchase of kerosine and drugs during 1997/98 in the regions and the Councils have been transferred to the Ministry of Health budget allocations.

P.E: implies Personal Emoluments which consist of the Government's wage bill

O.C: implies the 'Residual' left to fund the general operating costs of departments, and includes components such as travelling, office supplies, maintenance and running expenses, as well as some remaining monetary allowances.

<u>Development Budget</u>

The development budget has always borne the brunt whenever there is a budget crisis. As a result, there is a shortfall between approved estimates and disbursements. For example, in 1996/97, only a mere Tshs. 156.2 million out of the approved budget of Tshs. 27.4 billion had been disbursed (RPFB 1997/98 -1999/2000). In addition to the problems of budget crisis, most of the development projects are underfunded. It also suffers from serious underfunding and poor reporting of donors. Under these circumstances, a clean up operation which focused on the need for setting priorities in order to reduce the number of projects - so that they can be fully financed - is already undertaken. However under funding for the selected priority projects continues due to deterioration of economic growth and shortageof funds from the government. At the same time, all projects with foreign funding will be included in the government budget only after there has been a firm commitment for disbursements, before end of March of each year.

In table II below, development budget allocations suggest that there has been an increasing trend between 1995/96 to 1997/98 of between 3.7% to 10.9% - thus suggesting that the Health sector is among the top priority sector's of the economy.

Table II. Development Budget (Tshs '000')

Budgetary Allocations	1995/96	1996/97	1997/98
Total Govt. Development budget (regions and ministries)	21,159,221.0	27,428,950.0	28,457,431.0
Regions and Ministries health dev. Budget	585,640.0	1,796,551.0	2,653,355.0
% of total dev. Budget allocated to health (Ministry and Regions)	2.7%	6.5%	9.3%
Total dev budget for all District Councils	1,736,40.0	2,382,870.0	2,381,006.0
Health development. Budget (Councils)	280.475.0	451,72.0	712,989.0
% of total development. Budget allocated to heath (Councils)	16.1%	18.9%	19.9%
Grand Total (ministries, regions, and councils) Development budget	22,895,626.0	29,811,820.0	30,838,437.0
Grand total development budget allocated to health (ministries, regions and councils)	866,115.0	2,248,274.0	3,366,344.0
% of grand total development budget allocated to health sector (ministry, regions and councils)	3.7%	7.5%	10.9%

Source: Ministry of Finance July, 1997

Reliability and transparency

The Government funding system is transparent to all sectors and if economic growth is stable, ministries, regional authorities and district councils will get the allocated budget ceiling i.e. its reliability lies on stability of the economy. The budget guidelines normally issued by the Government before preliminary budget preparations, stipulates quite clearly the budgetary allocations for each sector, and this has to be adhered to. After budget estimates have been passed by the parliament, the figures are clearly shown in the Public Expenditure supply votes (Recurrent and Development) for Ministries, regions and district councils. The procedures for getting funds is clear and its accountability and auditing work follows financial regulations given by the Ministry of Finance.

Donor funding

Major donors provide funds to the Ministry of Health for the running of national, regional and district health projects, while others assist by bringing their experts and offering medical equipment and medicines. Such assistance is usually directly extended to the Government or routed through international organizations such as Danida, WHO, UNICEF, SIDA etc.

Despite the fact that, there has been an extremely positive response from donors in support of health sector reforms currently going on in many countries, associated with this support has been a serious problem of external dependency and selective project support. Many countries have been trying to move the health system in the direction of national sustainability. The change of approach from project to programme has led to more oriented assistance. Experience gained over the years suggests that donors have their own priorities that influence to a certain extent their preferred areas of assistance. However, some donors are seen as patronising; they impose unhelpful conditions; they finance far too many of their own nationals as Consultants; the Government/Donor relationship lacks transparency; and that the two do not demonstrate accountability towards one another.

It is thus very important that the Government needs to be able to highlight the advantages and disadvantages of any donor support, with a view to pointing out possible ways of managing the support extended and creating transparency to foster accountability. This will be particularly important to develope a sector-wide approach eventually leading to 'basket' or joint-account funding, which will require agreement between Government and participating donors as a whole on common funding, procurement, disbursement, accounting, auditing, reporting, monitoring and evaluation procedures.

Funding by Missions (NGOs)

NGOs make significant contributions towards rendering health services to the communities in Tanzania. A good number of the existing hospitals, health centres and dispensaries belong to Voluntary Agencies (VAs) and parastatals. These facilities are widely spread in rural areas where the majority of the people live. Some NGOs run several health and medical schools for health workers. These organizations also contribute their own funds to run their hospitals, health centres and the medical schools. The government provides grants to VAs in order to subsidize costs for services rendered in rural areas by the NGOs.

It is thus important for the Government to create a conducive environment in order to encourage more NGOs to participate in health service provision at a recommended standard and quality that will also be accessible by all.

The existing system and legislation, do not favour transparency in relation to NGOs' financial contributions to the health sector. Under the health sector reform strategy, it is of fundamental importance that existing legislation should be reviewed and updated in order to ensure transparency, standards and good quality care.

In developing the resource envelope for an eventual move towrds a sector-wide approach and the associated financing opportunities and requirements, effort will be put towards assessing the resource contributions of the NGOs and missions to the resources available to the health sector as a whole.

Funding by Private Providers of Health Care Services

Private practice in the health sector began with the introduction of trade liberalization and various developments in the economy as a whole. By enacting the Private Hospital Regulation Amendment Act 1991, the Government was committed to allowing private practice (even for profit) in the country. The health sector recorded an increase of pharmaceutical stores and private clinics. The contribution of private health care providers in rendering health services, has been noted specifically in improving peoples' health. However, most of the private health care providers are concentrated in urban areas. The quality of health care provided needs to be monitored quite regularly so as to ensure a standardardized good quality of care. Moreover, legislation needs to be amended to allow room for more transparency. Again, a mechanism has to be developed to ensure that efforts by the private sector complements those by the government. It is conceived that, the government will still remain the main provider of public services while the private sector provides services after charging fees (Health Sector Reforms, 1995). This will reinforce the intention to shift resources towards preventive health measures, and particularly enhance access to them by the poor.

National Health Insurance

The potential resource contribution to the health sector of a National Health Insurance (NHI) Scheme is massive. The need to design and implement a national formal sector health insurance scheme in Tanzania is a result of a number of concerns that have been raised regarding the financial crisis in the health sector. The concerns are based on the observed decline in the amount of resources flowing into the sector, which has resulted in a decrease in the availability and quality of health services provided.

Introduction of the user fee in public health facilities accelerate the need of national health insurance, since the universal health insurance coverage provided through taxation was removed.

A National Health Insurance. scheme as part of the broad financing reforms is in its pre - implementation stages. One of the studies found that up to 80% of employees were operating medical schemes in various ways, with medical costs amounting to 12% of the total personal emoluments (PE). The study suggested that an organised health insurance scheme for Tanzania could reasonably mobilise enough resources to pay for 25% for MOH's recurrent budget. Studies to assess NHI scheme feasibility and potential to generate additional revenue has been completed and recommended favourably towards establishment of the scheme. The proposed Bill is expected to tabled in the January 1999 Parliamentary session.

The objective of an NHI Scheme would be:-

a) To increase financial resources and reduce the financing gap in the health sector.

b) To facilitate private financing of curative health services allowing reallocation of resources to public health care services which are preventive in nature

c) Through institutional arrangements, promote development of the private sector in order to participate in the financing of health care services.

At the central level the scheme would be administered by an autonomous government agency who will contract same of its services in the regions and districts e.g. claim processing, and reimbursement to competent insurance agents through a competitive tendering process. The government recruited a health insurance Pre-implementation Team which was responsible in completing the design. Its responsibility will also extend towards assisting the Board of the National Health Insurance fund to set up NHFI I offices and recruitment of its management.

Community Health Fund

As part of government policy on health sector reform, much effort has been extended in encouraging the community involvement and participation in supporting their own health. Community Health Funds have, of recent times, been advocated as a way of extending health coverage to a majority of the rural populations in developing countries.

By involving the communities directly, they develop a sense of ownership of the health facilities that might even attract their direct participation of offering labour. At the same time, those communities contributing to such schemes, normally are motivated to participate in planning for their own health services and acquire experiences to recognize priority health problems in their own community, and thus contribute to the bottom-up planning that is essential in health planning.

The introduction of a community health fund scheme in Igunga district, Tabora region, as a pilot for pre-testing the establishment of the scheme in Tanzania, was intended to enable the Government to observe the problems that are likely to be experienced especially in communities that have not had such experience. By so doing, the experiences gained from Igunga will form the basis and criteria for extending the scheme into other six districts as rolling on and finally to all districts in the country. However, implementation and evaluation of the Community Health Fund will involve a far more vigorous understanding of the costs of providing different combinations of basic health services, and assessment of what people are willing and able to pay for a basic package of quality services. The greater the value-for-money that can be achieved, the more the country will gain.

A CHF scheme would provide residents of a typical rural district with the opportunity of acquiring a health card. The health card would be issued at a flat rate determined with Community consultation and would contain entitlement to a basic package of curative and preventive health services. It would be offered at a time when the family is most able and willing to pay, thus providing security of access to a health facility throughout the year. Contributions would likely take place at harvest time, with the option of contributing in instalments. Households unable to pay the membership fee would be classified as such by the Ward Committee and awarded a Community Health Fund card on a sliding fee basis or be given free of charge. Households unwilling to join the Community Health Fund would be required to pay user fees for health services at health facilities when a member of the Household falls sick or is injured.

From the Community Health Fund management perspective, funds would eventually be pooled from many households in a district, so as to incorporate the fundamental insurance principles of risk pooling. This would thus enable the Community Health Fund member to enjoy a basic package of curative and preventive health services at a dispensary or RHC of their choice. The Community Health Fund will be autonomously managed with guidance from the District Health Board. It would be in a position to negotiate with health care providers to honour entitlement of its health card holders. This is because Community Health Fund management can attract large numbers of members, and will be in a good position to act on their behalf to "get a good deal" because of its market power.

From a health provider perspective, the Community Health Fund represents a potentially reliable source of income and clientele. From a government or regulatory perspective, a provider, operating in conjunction with Community Health Fund financing would contribute greatly to its goals of decentralization particularly fiscal decentralization and district based care. This would, of course, require close monitoring and evaluation to ensure that health care standards are maintained.

The CHF Guidelines on operations and development have already been developed, based on the Igunga pilot test that aims to contribute to the Government's objectives of health reform by shedding light on how one particular financial mechanism can contribute to efficiency, equity, sustainability, decentralization and private sector development. Further work will be undertaken, again based on the Igunga experience, to ensure sustainability of CHF schemes and to determine their full potential for resource mobilisation during the plan period. The progress and success of CHF in seven districts will pave the way for rolling on to all other districts in Tanzania.

Cost sharing

The implementation of cost-sharing (user-charges) in hospitals in Tanzania started in July 1993. The policy decision was motivated by the financial difficulties and shortfalls experienced in the health sector for a number of years which led to unavailability of essential drugs, medical supplies and a decrease in quality of health services provided by public facilities. The implementation was conducted in phases according to the level of facilities and type of services. Phase I involved increasing rates of user-charge for Grade I & II patients in referral, regional and district hospitals that had Grade I & II facilities in July, 1993. Phase II started on 1st January 1994, and involved the introduction of user-charges in Grade III patients in referral and regional hospitals. Phase III which started on 1st July 1994, involved the introduction of user charges for Grade III patients in district hospitals. However, Phase IV (final) which was intended to introduce user charges in Health Centres and Dispensaries has not been implemented, as it needs more preparation in terms of awareness/public sensitization, financial management and reporting systems.

The main objective of the cost-sharing scheme is to generate additional revenue that will assist in running and improving the quality of health services that are provided in publicly owned health facilities in the country. In principle, revenues collected from user charges are retained and used locally by the collecting facility on items directly related to improving availability and quality of care. These revenues are potentially important resource additions to Government budget allocations for health.

An evaluation exercise carried out by MoH in 1996 covered thirteen hospitals (two referral, five regional and six district), 368 health care providers, 52 advisory committee members and 356 outpatients and patient escort (consumers) of whom 41% and 59% were males and females respectively. Findings from the evaluation revealed that, on revenue performance, a total of Tshs. 1.47 billion had been collected up to May,1996. 38% of the collection came from referral hospitals, 17% from district hospitals, while 25% was from District designated hospitals. In 1993/1994, a total of Tshs 264.7 million was collected, while Tshs 775.4 million was collected in 1994/95. The collections made in 1994/95 accounted for only 50% of the projected revenue collections throughout the country. Further analysis revealed that the main areas of revenue generation were the consultation fee (which accounted for 53.8% but at the moment consultation fee has been stopped) of the total collections, followed by admission fee (28.1%), drug fee (11.3%), and medical examination fee (6.8%).

The Cost sharing Policy for the next three years will be evolved in view of experience learned and will require the following tasks to be performed:

a) Consolidate and improve the implementation of cost sharing in hospitals - i.e. to support the hospitals in management, supervision, audit, monitoring and evaluation of the implementation of the cost sharing policy.

b) Promote and provide advocacy on the concept of cost sharing by developing appropriate mass media communication programmes.

c) Introduce "revolving Funds" to the public health facilities so that the problem of unvailability of drugs in Public health facilities is gradually reduced

d) Capitalise 20 districts hospital with drugs and set up a drug revolving fund with 100% cost recovery.

e) Extend cost sharing user charge to the lower health facilities i.e. Health centres and dispensaries. This will be implemented jointly with CHF prepayment scheme paid voluntarily by household for comprehensive health care for the whole family for the year. Experience gained from Igunga District show that for those who have not joined CHF have to access for the service by a user fee. The introduction of user fees at Health centres and dispensaries in Igunga without complaints or political concerns is number one success of CHF scheme as a financing source and underling the correctiveness and effectiveness of Ministry of Health Policies in cost sharing.

   This success has paved the way for introduction of cost sharing to lower level health facilities jointly with CHF for cost effectiveness reasons

STRATEGY 6: **HEALTH CARE FINANCING: Plan for Programme of Work July 1999 - June 2002**

OBJECTIVE: **To Broaden Financing Options and Improve Financial Management**

SPECIFIC OBJECTIVES	ACTIVITY	OUTPUT	INDICATORS	MEANS OF VERIFICATION	RESPONSIBLE PERSON/UNIT
1. To Establish cost Sharing Mechanisms to lower level Health Facilities and Community Fund to all Districts	• Review CHF implementation in seven districts	Consolidated report on CHF Lessons	Useful lesson learned from 7 pilot districts	Evaluation Report	DPP
	• Modify the CHF Guidelines based on the review of seven districts	Modified/revised Guidelines in place	Lessons included in Revised Guidelines	Modified Guidelines	DPP
	• Promote and Advocacy of CHF and cost sharing National wide	Increased awareness on CHF and cost sharing	CHF and Cost sharing revenue collection	CHF and cost sharing Accounts	DPP
	• Extension of CHF to all districts and cost sharing to Health Centres and dispensaries	CHF functional in all districts and Cost sharing in all Health Centres and dispensaries	Number of districts implementing CHF and cost sharing	CHF and Cost sharing reports in all districts	DPP
	• Monitoring and Evaluation of CHF and Cost sharing implementation activities	CHF and cost Sharing strengthened	Action taken on results	Monitoring and Evaluation Report	DPP
	•Improve implementation of Cost Sharing in Hospitals	Cost sharing Mechanisms in hospitals improved	Increase in revenue collection	Hospital accounts	Hospital Boards
	• Compile and Revise Hospital Unit cost studies	Different Unit cost Reviewed	Compiled report in place	Hospital Unit cost	DPP

	• Introduce Revolving funds in Public health facilities to reduce the unavailability of drugs	Revolving funds introduced	Number of Public health facilities with Revolving funds	Revolving funds in public facilities	DPP
	• Introduce Revolving funds in 29 religious hospital (CSSC)	Revolving funds introduced in religious hospital.	Number of regious hospital with Revolving funds	Revolving funds in 29 religious hospital.	DPP
	• Test full cost recovery of drugs in 10 district after capitalisation	Full cost recovery of drugs in 10 districts	Number of district with cost recovery	full cost recovery in 10 district Hospitals	DPP
2. To Implement National Insurance Scheme	• Rent offices and Procure office equipments & supplies for National Health Insurance Fund (NHIF)	- NHIF Office provided -Office equipment and supplies purchased	-NHIF operating on rented offices - Number of Equipments and supplies purchased	Lease contract -Inventory of office equipments & supplies	DPP
	• Appointment of Members of NHIF Board	NHIF Board operational	Gazetted notice for appointment	Appointment letters	DPP
	• Briefing of accredited health providers and administrative contractors	Accredited health providers and administrative contractors briefed	No of accredited health providers and administrative contractors briefed	Briefing notes	DPP
	• Advocacy for NHIF	More revenue collected	Eligible contractors contribute to the scheme	NHIF accounts	DPP
	• Computerization of the Scheme.	NHIF operations computerized	Computerised scheme in place	Printed database	DPP

	• Purchase of vehicles for operational use	3 - 4 vehicles purchased	Number of vehicles in place	Purchasing invoice and receipts	DPP
	• Monitoring and Auditing NHIF	Strengthened NHIF scheme according to results	Action taken on results	Monitoring Report and NHIF Accounts	DPP
3. To Strengthen Planning and Budgeting process	• Participate in Public Expenditure Review.	Data collected, analysed and submitted to the Review team and PER report	PER results included in the Rolling Plan and Forward Budget Guidelines	Review Report	DPP
	• Preparation of Annual Plans and Medium Term Plans according to Rolling Plan and Forward Budget Guidelines	Annual Plans and Medium Term Plans prepared	Approval of annual & Medium Term Plans and use	Plan Documents	DPP
	• Purchase of office Equipments for Budget preparation (computers Binding Machine & photocopier)	Office equipments purchased	2 computers 1 binding machine 1 heavy duty photocopier	Inventory of office equipments	DPP
	• Training in Health Planning, budgeting, expenditure management for government funds as well as Project Funds (refer also to Strategy 3).	Training conducted for staff.	Four (4) staff trained per year	Training Report	DPP

STRATEGY 7: PUBLIC/PRIVATE MIX

A Concern and Purpose

Public/private mix involves simultaneous health services provision by the Government and the private sector in which the government takes the role of providing guidelines and regulating the services. In 1977, with the introduction of the Private Hospitals (Regulation) Act the practice of health care services for profit was restricted. Given the series of major economic and social changes in the 1980s, the government has adopted a different approach to private sector health care services. The amendment of the above mentioned Act in 1991 gave recognition to the individual qualified medical practitioners and dentists to manage and own hospitals and clinics for profit.

The private sector, including NGOs provide 40% of all health care services. They play a very important role in providing health care. However, the private sector has not been involved in national health policy formulation, and their contribution to health has not been fully recognised. There is little government support and linkages to the private sector. The Public/Private Mix Strategy aims at addressing these issues by fostering linkages to the private sector, promoting partnerships between the public and private provision of health services and providing support to the private sector.

B. Current Status

Mistrust continues to exist between the public and the private and voluntary agencies. There is very little co-operation and co-ordination of planning and delivery of health services among public, private and voluntary agency providers. Currently no mechanism is in place that promotes carrying out of joint inspection of health facilities (Public and Voluntary) to promote quality. Since re-introduction of private practice in 1991, very little inspection of private health facilities has been taking place although private health facilities have mushroomed.

There is currently no regulation of Traditional Medical Practice in place. Concerning drug regulation, the Pharmacy Board does not ensure quality control in private pharmacies.

Legislation has been passed to regulate private laboratories and a board that will regulate private laboratories has been established.

Contracting out of some health support service such as catering, vehicle maintenance and laundry to the private sector has been intitiated in some public health facilities. There is need to pub in place a system that will failitate cdontracting out of some preventive and clinical services to private health providers.

Although the government recognises the role of traditional medicine in our societies. But, todate there is no regulation of traditional medicine in place. Currently there is no mechanism developed (in place) that promotes carrying out of joint collaboration between the traditional health and orthodox medical practitioners. There is a need to put in place a system that will facilitate the promotion of traditional medicine at the district, region and central level.

C. Key Components

Developing new ways of promoting private sector participation

There is mistrust in the existing relationship/collaboration between the public and private sectors. MoH need to re-examine the relationship and create an environment that will assure the private sector that the proposed reforms are geared towards restructuring the health care delivery services on a competitive basis. The Government's role vis a vis the private sector should be that of a policy-maker, regulator and monitor of the health care services.

Since the introduction of the 1991 Act, there has been mushrooming of health care facilities concentrated in urban areas. This has led to increased spending on health care due to higher unit costs and utilisation of services. Several factors have driven these increases, including fees for service, providers have stakes in the financial performance of hospitals or clinics through share ownership, and the fact that many providers benefit financially from selling drugs.

The private sector has a major role to play with the burden on the health services increases over time due to the rapidly expanding HIV/AIDS epidemic, the ageing of the population and other epidemiological shifts. However, the sector need to be regulated so that the patients are ensured of quality service at an affordable price.

Hospitals and clinics

Licensing of new private facilities will be based on the assessment of need against a set of objective criteria. More detailed work on the development of these criteria is required. Statutory control will be the responsibility of the MoH.

Government should collaborate with the Association of Private Hospitals in drafting guidelines for supervision and monitoring of private health services to ensure quality of health care delivery. Emphasis should e put in the guidelines on continuous in-service training.

Pharmacies

The Pharmacy Board has been empowerd by the Act of Parliament to control importation; distribution; sale anduse of pharmaceuticals in the country. The Pharmaceutical and Poisons Act, 1978 is outdated and needs to be reviewed in order to cater for reforms and liberalisation of trade that are currently taking place.

The Pharmacy Board does not have the autonomy to execute its duties effectively. The Pharmacy Board Secretariat is under staffed. The Regional Pharmacists and Regional Medical Officer who are Drug Inspectors by law can not cover inspectorate activities throughout the country in a manner that is required.

Distribution of Pharmaceutical outlets in the country does not provide equitable services to the Tanzanian communities. Source regions have many Pharmaceutical outlets while others have less.

The quality of products moving on the Tanzania market is questionable. Drugs come in through various parts of entries which are not well controlled.

The current output of Pharmaceutical personnel from the training institutions. The available training Institutions are underutilised.

Private health laboratories

Many new health laboratories has shut up since liberalisation. In order to ensure quality laboratory services an Act has been approved and guidelines for implementation are being drafted.

Traditional medicines practices and alternative methods of healing

Traditional medicine practices are recognised in the National Health Policy (1990) and the HSR (1996) and through the Medical Practitioners and Dentists Ordinance Chapter 409 and the 1978 Act of the Pharmacy and Poison Act. However, these services sometimes cause risks to the patient's health (through quacks, charlatans, opportunists etc.). Therefore the undesirable practices need to be addressed under defined regulatory mechanism. There is no legislation at the moment to govern, control and co-ordinate traditional medicine practices and alternative methods of treatment. This has led many traditional medicine practitioners and their clients to operate in secrecy and fear due to the ambiguous legal and medical status. This has hampered the advancement of traditional medicine practices.

Contracting out of services

MoH will explore arrangements for contracting out services that can more efficiently be managed by the private sector or where the private sector has comparative advantages over he delivery of services.

— 206 —

D. Plans for 1999/2000-2002

STRATEGY 7: PUBLIC PRIVATE MIX

OBJECTIVE: **Promote private sector involvement in the delivery of health services**

SPECIFIC OBJECTIVE	ACTIVITY	OUTPUT	INDICATOR	MEANS OF VERIFICATION	RESPONSIBLE
Promote private sector involvement in the delivery of health services at all levels	• **Develop policy guidelines which strengthen/promote involvement of private sector**	• Private sector more involved in provision of quality of health care.	• Number of DHBs having integrated health services delivery (takes into account roles played by Private Providers and voluntary agencies) • Number of Private hospitals and voluntary agencies hospitals included and designated as secondary/tertiary levels.	• District health services delivery plans. • MOH hospital classification records	DHS DPP DHS
	• **Develop joint strategy MOH, private and voluntary agencies in order to strengthen capacity of referral hospitals and reduce need for treatment abroad.**	• Some tertiary referral private and voluntary agencies hospitals strengthened.	• Number private/voluntary agencies referral hospitals strengthened • Number of patients with disease conditions previously referred treated locally	• Records in MOH • Health returns	DHS
	• **Revive and strengthen the grand in- aid committee to ensure the smooth**	• Grant- in aid remitted on time to voluntary agency hospitals	• Number of voluntary agency health facilities receiving grant	• Accounts records	DPP

	flow of funds voluntary agencies health services.		regularly and on time		
	• **Review and update Grant in -aid allocation system to take into account other factors such as health packages delivered, into consideration other than number of beds alone**	• Funding of grant aided institutions reviewed to include other factors	• Number of voluntary agencies receiving grants based on new guidelines	Accounts records	DPP
	• **Introduce an accreditation system, that will accredit all hospitals in the country public, private both and voluntary on annual basis in order to uplift standards** • **Include the private and voluntary agencies in orientation process for health reforms .**	• All hospitals private, public and voluntary accredited according to health package they provide. • Private health providers and voluntary agencies included in MOH health reforms orientation	• Number of public and private health institutions accredited. • Number of private and voluntary agency staff oriented	• Accreditation register • Training reports	DHS DHR
	• **Promote privte NGOs and community groups in health education and behaviour change**	• Better understanding of health probles by all • Improvement of quality of health servives and quality of life values in life	• Level of awareness and quality of participation	• Supervision reports	DHBs DPP
	• **In collaboration with private health providers and**	• New health facilities established in need areas, by private sector	• Number of health facilities setup or expanded by private	• Health facilities records	DPP MOF Revenue

	Ministry of Finance provide ways or incentives that will encourage the private sector set up and improve the quality of their health services allover the country	and voluntary agencies, or existing ones expanded, to fit in with health packages expected of themes.	sector		Authority APHTA
	Promote private and NGOs and community groups to be involved in health education and community behaviour change	Better understanding of health problems by all Improvement of quality of service			
	Involve private sector in development of supervision guidelines, development of QA, norms and standards to ensure provision of quality assurance	• Private sector and voluntary agencies represented and participate in development process	Number of private health provider associations and religious health provider associations represented or consulted during development process	✓ Minutes reports	PHC secretariat

— 208 —

	Develop progressive policies to assist district health boards and hospital health boards to contract out some services to the private sector	Some services identified and contracted out	Number types of services contracted out.	• Returns and signed contracts	DPP
	Allow DHBs or HBs to negotiate with some private health providers or voluntary agencies to contract to them some of the health delivery services	Some health delivery services contracted out of private sector by DHBs or HBs	Number of contract signed between DHB/DHBs to contract out some services	• Signed contracts	DHBs HBs

	Encourage coordination and dialogue between private/ public providers e.g. inventory of services available and exchange of information	Prublic / private health services including referrals coordinated, specialised equipment used cost effectively	Number of cross referrals and services provided	Patient returns	DHS APHTA
Promote establishment of community pharmacies especially in rural areas	Conduct advocacy to encourage communities to establish pharmacies in designed areas	Advocacy undertaken throughout the country.	Communities increased awareness of need to establish community pharmacies	Reports on advocacy coverage	Chief pharmacist
	Establish guidelines for setting up of community pharmacies	Guidelines established	Availability of guidelines to communities	Guidelines	Chief pharmacist
	Increse out put of appropriate pharmacaceutical personnel	Increaese production of pharmaceutical personnel from trainining institutions	Percentage increase in out put of pharmaceutical personnel	Training Records	Chief pharmacist
Improve collaboration with traditional medicine	**Update existing guidelines to fit in with HSR priorities**	Guidelines updated	Number of DHBs using up dated guidelines	Updated guidelines	PHC Secretariat
	Promote research in traditional herbs/medicinal plants	Research undertaken on traditional herbs	Number of researches conducted and feed back provided to owners of herbs	Research results	Chief Pharmacist

STRATEGY 8: MINISTRY OF HEALTH AND DONOR RELATIONSHIP

A. Concern and Purpose

MoH has had a long relationship with donors in support of projects and programmes. This relationship has enabled MoH to fund, receive technical assistance and carry out operational researches for individual Health projects and programmes.

Despite the above achievements, there have been some shortcomings in the form of assistance through this relationship. One of the problems has been that donors often do not follow Government financial procedures in disbursing and accounting of funds but prefer to disburse funds directly to the beneficiary institutions, using their own procedures and not the Treasury system. This practice has made it difficult for the Government to account for and co-ordinate donor funds.

Management of various health projects and programmes have remained vertical leaving little room for sharing information and actions. Furthermore, individuals projects and programmes have continued to mount independent missions for project reviews and appraisals resulting into overburdening MoH staff in servicing separate missions.

Efforts will be made to reverse the state of affairs. This will be instigated by improving the transparency and accountability of funds disbursed by donors and the Government; instituting mechanisms to ensure that support to the health sector is addressed in its totality with sharing of information and actions.

B. Current Status

Currently most programmes and projects in the health sector are still running vertically, meaning each donor finances his/her programme or project as before with very little if any knowledge of it in the MOH. This as earlier, stated has created problems on where and the use of these funds to the extent that Government s unable to know exactly how much assistance it receives and its effect on the economy.

However of late negotiations, discussions have been going on between MoH and donors a statement of intent was signed by a number of donors at the beginning of this year, to move towards addressing health sector priorities in its totality.

More importantly most of the donors are at a point of reviewing their support to the health sector. This is an opportunity to restructure the present support and relationship.

C. Key Components

Sector-Wide Approach

The Sector-Wide Approach entails that all participating parties develop and fund one POW which covers all national, regional and district health requirements. Under this approach the MOH and donors are required to meet the following conditions:

- Development and fund one Programme of Work and one yearly Action Plan;
- One set of common administrative arrangements such as financial management and procurement;
- MOH managing funds and implementation of programme activities;
- Strict adherence to signed agreement and conditions;
- MOH and donors be more transparent and show openness regarding their governing policies and views on implementation;
- MOH and donors show flexible when implementing the plans.

Donor Co-ordination

Donor co-ordination falls under the Planning Department. Its role is to attract funding and see that the agreements between the concerned parties are fulfilled. The Planning Department will be strengthened in terms of human resources, skills and physical resources to set up a strong External Donor Co-ordination Unit. The framework paper for MoH/Aid coordination will be revised and improved to meet current requirement.

Joint funding

As one measure in enhancing integration of health services and improving resource utilisation, common mechanisms for financial disbursement and accounting will be introduced. As a transtional stage before Ministry of Finance completes the requirement for donors to use Government Exchequer systems, intermidiate arrangement will be developed to facilitate common administrative and financial management of the POW, which comforms to the block grants recommended by Local Government Reforms.

Gradually this intermediate arrangement will be transformed into the government/donor financial management arrangement as required by Treasury. All major co-operating partners will be asked to follow one system of planning, disbursement, procurement, implementation, monitoring, accounting and auditing. Support will focus on the whole sector rather than on vertical programmes or discrete projects. Donors will reschedule appraisal missions to coincide with joint annual review and evaluation missions.

Updating of the plan of work will have the following annual circle;

- Before the end of February each year the Ministry of Health and Ministry of Regional Administration and Local Government, collects information from headquarters, regions and districts on realistic plans for the coming year. Treasury provides budget ceilings.

- Plans, ceilings and expected user fees are shared with donors in March. Donors indicate their expected funding level.

- MOH and MRALG compiles these commitments and work out a formula for sharing of financial resources.

- Government and donor funds will be disbursed by MRALG to the respective regions and districts through recommended block grants arrangement and those for Ministry of Health negotiation will take place on mechanisms of disbursement.

- Annual accounts, audit reports, and annual progress and performance reports will be collected by MRALG and communicated to MoH to form the input to the joint MoH/donor review in November.

Funds will only be used on agreed plans at all levels. Management of funds will meet acceptable standards on accounting and reporting. A strong monitoring and internal audit unit will be set up in headquarters, regions and districts. The accounting unit will be strengthened. Reliable external audit will be conducted according to international standards. MOH will quarterly prepare and circulate financial reports to interested parties. Rigorous training and retraining will be done to adapt and maintain the Financial Systems. Procurement systems will meet international standards. General planning, budgeting, management and administrative systems will be strengthened.

MOH/Donor's Meeting:

MOH/Donor's Meeting:

Progress meetings with the local representatives of the donors will be held in between the joint meetings in May and November. Individual meetings with donor to clarify certain aspects and modalities will be organised, if requested but it is expected that most discussions will take place at the joint meetings.

Review and Evaluation

Reviews and evaluations will be the responsibility of MOH and its collaborating partners. The Planning Department will be responsible for organising the reviews and evaluations. Prior to the joint reviews and evaluations, draft terms of reference will be prepared by MOH and circulated and agreed with the donors. Since the POW covers all programmes in the MOH, separate review and evaluation missions requested by donors will not be organised.

D. PLANS

STRATEGY 8: MINISTRY OF HEALTH AND DONOR RELATIONSHIP: **Plan for Program of Work July 1999 – June 2002**

OBJECTIVES: **To develop and implement a comprehensive system for donor, Government of Tanzania involvement, coordination monitoring and evaluation of the health sector.**

SPECIFIC OBJECTIVES	ACTIVITY	OUTPUTS	INDICATORS	MEAN OF VERIFICATION	RESPONSIBLE PERSON/UNIT
1. Establish mechanism to support three year Programme of Work	•Identify sources of funds for financing Plan of Action and Programme of Work and agree on the mode of financing i.e. Joint or parallel	Sources of Funds for finance Plan and mode of financing identified	Finance Plan for POW & POA	Papers of Agreement	DPP/MRALG
	•Develop key monitoring & evaluation performance <u>indicators</u> for joint monitoring and evaluation of the Health Sector	Key Indicators to monitor & evaluate performance developed	Monitoring and evaluation protocols	Monitoring & evaluation performance report	DPP
	•Identify and compile consultancy needs and TOR elaborated in implementation of Plan of Work, address mechanisms for joint funding the consultancies.	A list of consultancy needs and terms of reference elaborated.	consultants recruited	Consultants reports a	DPP
	• Intergrate information on budget, research and health information	Intergrated sectoral health statistics	Availability of sectoral health statistics	Reports.	DPP
2.Operationalisation of POW including preparation of transitional	•Convene quarterly donor coordination meetings	Four donor coordinating meetings held in one	Number of quarterly meetings held	Minutes of the donor G.O.T. meeting	DPP

financing arrangement through MRALG		year			
	•Technical policy and guidelines to ensure maximum benefit from Technical Assistance.	Technical policy and guidelines on Technical Assistance Developed	The extent of adherence to technical guidelines on recruitment and use of Technical Assistance	The Technical policy and guidelines report	DPP/DHR
	•Introduce joint funancing systems in districts in phases.	Joint financing system introduced in all districts.	Number of districts covered by joint financing systems	Accounts based on Joint financing systems	DPP/CA/MRALG and MOF
	•Organise and conduct scheduled joint missions including joint annual reviews.	Schedule of Joint missions available and quarterly up-dated.	Missions conducted Jointly.	Joint mission reports	DPP
	•Adhere to the Agreed financial System.	POW financed.	Activities implemented, accounted and audited.	Activities and audited report	DPP/CA
	•Agree on a common external audit system	External Audited Account	Approval of audited health accounts by all Parties	External audit report	CA (MOH)
	•Prepare quarterly financial and performance report to share with partners	Quarterly financial Performance and reports available	Quarterly performance and financial report produced.	Quarterly performance and financial report available	CA/DPP
	•Planning Department organise and conducts Joint annual review	Joint annual review conducted	Dates for Joint Review appear in Annual Plans	Report of Joint annual review	

5. FINANCING THE HEALTH SECTOR PROGRAMME OF WORK JULY, 1999 – JUNE, 2002

5.1 The Resource Envelope

The Health Sector Reform 3 year Programme of Work (1999 - 2002) will attempt to co-ordinate resources from the Government of Tanzania, multilateral and bilateral donor funds and other sources e.g. Community Health fund, National Health Insurance and Cost Sharing funds. It is expected that US$198,444,072 will be available to support the POA in the first year. US$199,255,774 is expected to be made available for the second year of the programme and US$187,030,471 in third year. It is expected that the government contribution will increase from year to year in line with budgetary allocation to fit in with POW needs.

The indicative figures showing Government and donor contributions are shown in the Table below:

Summary resource envelope by source July 99- June 2002

SOURCES	July 99 – June 2000		July 2000 – June 2001		July 2001 – June 20002		Total July 99- June 2002	
	In US$	%	In US$	%	In US$	%	In US$	%
Government of Tanzania	93,639,254	47 %	98,363,217	49%	103,281,378	55%	295,283,849	50%
External Donors and Multi-rateral Agents	101,161,818	51 %	97,249,557	49%	80,106,093	43%	270,400,430	46%
Cost sharing Initiatives	3,643,000	2 %	3,643,000	2%	3,643,000	2%	10,929,000	2%
TOTAL BUDGET US DOLLARS	**198,444,072**	**100%**	**199,255,774**	**100%**	**187,030,471**		**584,730,317**	**100%**