

**THE UNITED REPUBLIC OF TANZANIA
MINISTRY OF HEALTH**



**Second Health Sector Strategic Plan (HSSP)
(July 2003-June 2008)**

“Reforms towards delivering quality health services and clients satisfaction”

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- Terms of Reference
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Abbreviations:

AIDS	: Acquired Immune Deficiency Syndrome
AMMP	: Adult Morbidity and Mortality Project
ANC	: Ante Natal Care
ARV	: Anti Retroviral (Drugs)
BCC	: Behavioural Change Communication
BFC	: Basket Financing Committee
BOT	: Bank of Tanzania
CA	: Chief Accountant
CAG	: Controller and Accountant General
CCHP	: Comprehensive Council Health Plans
CHF	: Community Health Fund
CHF	: Community Health Fund
CHMT	: Council Health Management Teams
CHSB	: Council Health Service Board
CIA	: Chief Internal Auditor
CMO	: Chief Medical Officer
CNO	: Chief Nursing Officer
CSD	: Civil Service Department
CTU	: Central Transport Unit
DANIDA	: Danish International Development Agency
DAP	: Directorate of Administration and Personnel
DFID	: Department For International Development
DHS	: District Health Services/Directorate of Hospital Services
DPP	: Directorate of Policy and Planning
DPS	: Directorate of Preventive Service
DPT-HB	: Diphtheria Pertusis Tetanus – Hepatitis B (Vaccine)
DRF	: Drug Revolving Fund
EC	: Ethics Commission
EPI	: Expanded Programme on Immunisation
FP	: Family Planning
FY	: Financial Year
GoT	: Government of Tanzania
GTZ	:Deutsche Gesellschaft fuer Technische Zusammenarbeit
HAART	: Highly Active Anti Retroviral Therapy
HBS	: Household Baseline Survey
HIV	: Human Immune Deficiency Virus
HMIS	: Health Management Information System
HMT	: Hospital Management Team

HR	: Human Resources
HRD	: Human Resources Development
HSD	: Medical Stores Department
HSPS	: Health Sector Programme Support
HSR	: Health Sector Reform
HSRS	: Health Sector Reform Secretariat
HSSP	: Health Sector Strategic Plan
IMCI	: Integrated Management of Childhood Illnesses
IMR	: Infant Mortality Rate
KCMC	: Kilimanjaro Christian Medical Centre
Kfw	: Kreditanstalt fuer Wiederaufbau
LGA	: Local Government Authorities
LGR	: Local Government Reform
LHRC	: Legal Human Rights Commission
MCDGC	: Ministry of Community Development, Gender and Children
MCH	: Maternal Child Health
MLDW	: Ministry of Livestock Development and Water
MLYD	: Ministry of Labour and Youth Development
MMR	: Maternal Mortality Rate
MOF	: Ministry of Finance
MoH	: Ministry of Health
MOI	: Muhimbili Orthopaedic Institute
MOJCA	: Ministry of Justice and Constitutional Affairs
MTEF	: Medium Term Expenditure Framework
MTEF	: Medium Term Expenditure Framework
MTP	: Medium Term Plan
MTUHA	: Mfumo wa Taarifa za Uendeshaji Huduma za Afya
NACP	: National Aids Control Programme
NGO	: Non-Governmental Organization
NHIF	: National Health Insurance Fund
NIMR	: National Institute of Medical Research
NORAD	: Norwegian Agency for Development
NSS	: National Site Surveillance
NLTP	: National Tuberculosis and Leprosy Programme
ORCI	: Ocean Road Cancer Institute
PCB	: Prevention of Corruption Bureau
PER	: Public Expenditure Review
PLWHA	: People Living With HIV/AIDS
PMO	: Prime Ministers Office
PMTCT	: Prevention of Mother to Child Transmission
POA	: Plan of Action
PORALG	: Presidents Office, Regional Administration and Local Government
POW	: Programme of Work
PRSP	: Poverty Reduction Strategy Paper

RAS	: Regional Administrative Secretary
RHMT	: Regional Health Management Teams
RS	: Regional Secretariat
SD	: Standard Deviation
STI	: Sexual Transmitted Infections
SWAp	: Sector Wide Approaches
SWOT	: Strength, Weaknesses, Opportunities, Threats
TACAIDS	: Tanzania Aids Commission
TB	: Tuberculosis
TEHIP	: Tanzania Essential Health Intervention Project
TFNC	: Tanzania Food and Nutrition Centre
TOR	: Terms of Reference
UHP	: Urban Health Project
USD	: United States Dollar

1. Background Information

1.1 Health in Tanzania

1.1.1 Health and Nutritional Status

Tanzania has achieved high rates of coverage of antenatal care (90%), immunization (DPT3 87%-in 2001) and vitamin A supplementation (over 90%-in 2002). 68% of the households use iodised salt. The contraceptive prevalence rate has doubled since 1991-92, from 10 to 22% of all women. Measles, which used to be a common cause of child death, has been effectively contained. Despite these impressive gains, the general health and nutritional status of the population of Tanzania remains poor. Trends in the decline of infant (99/1000) and under-five (158/1000) mortality, which had been steady between the mid-1950s and mid-1980s stagnated and are being reversed. About one quarter of all under-five deaths occur within the first month and two-thirds within the first year after birth. Tanzania is not on track to meet the 2015 targets of reducing under-five mortality by two thirds unless urgent actions are taken. Approximately 90% of all child deaths are attributable to common and preventable illnesses such as malaria, pneumonia, diarrhoea, malnutrition, HIV/AIDS and complications of low-birth-weight. Eight out of ten children die at home and six of them without any contact with formal health services. There are large disparities between rural-urban, and various income quartiles with the rural poor being the most disadvantaged.

Malnutrition rates are unacceptably high among children and women. About 16 percent of Tanzanian children are born with low birth weight (below 2500 grams). Low birth weight has a greater risk of continued under-nutrition and mortality in the first year of life, and pre-disposes children to chronic diseases (such as heart disease, and diabetes) during adulthood (Barker et al., 1989). Low birth weight is also a proxy indicator of maternal deprivation, thus perpetuating the inter-generational cycle of deprivation and malnutrition. The onset of malnutrition starts soon after birth, and peaks by 12-18 months of age. 44% under-five children are stunted (implying significant chronic malnutrition) and 30% under weight. Rural- urban differentials are pronounced, the rural poor being the most disadvantaged. Malnutrition rates that were on the decline in 1980s have remained largely stagnant in the 1990s. Food insecurity, inadequacies in the frequency of feeding and micronutrient deficiencies (iron, iodine, and vitamin A), and frequent illness predispose children to high risk of malnutrition. Micronutrient malnutrition is rampant among women, about 14% in the high land and nearly 80% in coastal areas are anaemic during pregnancy, and nearly 70% are vitamin A deficient. About 25% of maternal deaths are associated with anaemia.

1.1.2 Maternal Health

Nearly 9000 women in Tanzania die annually due to pregnancy related causes, (MMR=529 per 100,000 live births) and another about 250,000 women become disabled due to the same causes, seriously compromising their reproductive health. About 26% adolescent girls have their first birth by the age 19 years. (source) HIV/AIDS. Too early and too frequent pregnancies have additional risk to maternal illness and deaths. The proportion of women receiving antenatal care and delivering with skilled personnel varies considerably across income levels and urban/rural residence. The declining number of deliveries in the health facilities (60%-1984, 44%-1991/92, 38%-1996, 36%-1999) may be a reflection of the government policy on this area to train TBAs at the community level to conduct safe delivery at home. This is an indicator success of the TBA programme.

1.1.3 HIV/AIDS

Superimposed on this bleak scenario is the looming threat of the HIV/AIDS pandemic that threatens to overwhelm meagre capacities at family, community and health facility levels. It is also posing a serious problem on the country's economy and development. Over 2.0 million Tanzanians are HIV infected, and an estimated cumulative total of 722,490 suffer from AIDS. Only 1 in 5 AIDS cases is reported. Young people aged 15-24 accounts for 60% of new HIV infections and girls aged 15-19 has a six-fold risk of infection compared with boys of the same age. As adults die of AIDS, many young children are left orphaned and their survival opportunities are seriously at risk. Orphans are estimated to be 2,000,000. About 72,000 babies become infected annually through mother-to-child transmission of HIV (MTCT). This will have the effect of raising the under-five mortality rate by a factor of 43 percent, thus wiping out all cumulative gains in child health and nutrition to-date.

1.1.4 Demographic characteristics

The population of Tanzania Mainland has grown from 12,313,469 in the first Post Independence census in 1967 to 33,584,607 according to the census held in August 2002. Male population for 2002 is 16,427,702 and female is 17,156,905 with a sex ratio 96 (number of males per 100 female). The infants and under-five children constitutes about 5% and 20% of the total population respectively. The average household size has decreased from 5.2 in 1988 to 4.9 in 2002. In Tanzania due to insurgence of HIV/AIDS, the dependency ratio and the demographic profiles will be changed in the near future. The Annual Average Inter-censal Growth Rate is 2.9.

1.1.5 Health Services System

Tanzania has a fairly well distributed health care system. About 80% of the population has access to health services and over 90% of the population live within 10 km. The average per capita out patient department (OPD) attendance is 0.71. An increasing trend (from 0.95 to 1.3 per capita) was observed in one district. There are about 4,844 health facilities of which 2,877, 848, 283 and 836 are government owned, voluntary, parastatal, and private respectively. Although efforts have been made regarding the supply of drugs and training of staff, the quality of health services delivery does not yet meet the minimal standard of quality services.

The current referral system is of a pyramidal pattern: patients are referred from dispensary and health centres to district and regional hospitals. The referral system of patients from one unit to another should follow the skills that are required to address the problems of the patients. Moreover, since the Government has established an open door policy

1.2 Introduction

This document is a broad strategic plan for the health sector. The Health Sector Strategic Plan 2003-2008 (HSSP) provides an overview of the strategic objectives across the sector.

This document provides a summary of the achievements and constraints in the health sector, the present priorities and the way forward to achieve quality health care.

The main focus for the new HSSP is “*provision of quality health service*”.

1.2.1 New Issues in this Plan

The previous POW (1999–2002) focused mainly on reforming the health sector and putting the systems in place. It was implemented according to eight distinctive strategies (strategies annex: 2). As we move towards the health service delivery and the quality assurance of health care to the population, the Health Sector Strategic Plan (HSSP 2003-2008) integrates the 9 strategies (original eight plus one new strategy on HIV/AIDS) into three components:

- (i) the District Component, including the district hospital, health centres, dispensaries and community health services.
- (ii) the Secondary and Tertiary hospitals and other tertiary level institutions related to health care such as teaching institutions; and
- (iii) the central level component include the role of the region as well as the Ministries.

Components \ Strategies	1	2	3	4	5	6	7	8	9
	Dis-trict	Hos-pital	Role MoH	HRD	Sup-port ser-vices	Finan-cing	PPP	MoH/ dono-r/ M&E	HIV/ AIDS
1. District Health Service	X			X	X	X	X		X
2. Hospital (2 ^o and 3 ^o) services		X		X	X	X	X		X
3. Central Level (Support services)			X	X	X	X	X	X	X

1.2.2 The plan is designed to highlight the:

- (i) Greater integration of health services;
- (ii) Importance of human resources;
- (iii) Importance of the Public Sector Reform process and the role of Civil Service Department focusing on issues of pay reform and staffing levels;
- (iv) The role of PORALG in overseeing the proper functioning of the regional and district hospitals, health centres, dispensaries and community level health services.

Inherent in the plan is the MOH commitment to continuing to integrate vertical programmes into the health service delivery system.

The outputs, targets and indicators are formulated in a matrix framework. The indicators are consistent with the Millennium Development Goals. More specifically with the indicators selected for measuring performance in the sector (i.e. the Health Sector Performance Profile), as well as those health indicators included in other key strategy documents such as the National Multi-sectoral HIV/AIDS Strategy and the Poverty Reduction Strategy monitoring master plan. The matrix framework will allow periodic and annual review of progress at different levels.

1.2.3 Structure of the document

The report is structured in the following sections:

- Section 1 Describes underlying principles and areas of focus
- Section 2 highlights new developments in the sector particularly since the adoption of the previous Health Sector Strategic Plan (1999-2002)
- Section 3 gives a brief overview of progress and a situation analysis by strategy
- Section 4 presents the Strategic Framework (2003-2006)
- Section 5 presents the implementation arrangements
- Section 6 explains the health sector strategic plan and the implementation (Matrix); Section 7 the Financing of this plan
- Section 8 presents Monitoring and Evaluation
- In Volume II the matrix and situational analysis have been elaborated

1.3 Future Priorities

1.3.1 Essential Health Package

In view of the prevailing level of burden of disease as well as to maximize the impact of limited resources, the Government will emphasize the “Essential Health Package” (EHP). It will ensure the delivery of EHP at all level to meet the needs of the poor. The government budget will be targeted more to the basic health care service and the essential health package in order to finance priority initiatives to tackle major causes of burden of disease (BoD). Accordingly, the sectoral MTEFs will be developed following the same principles. The delivery of basic health services at the district level and below including communities will be strengthened. District Health Service Boards will be rolled over to take responsibility for management decisions for districts health services, and will be made accountable to the LGAS for their outputs and outcomes, ensuring that communities are fully involved through their health committees.

1.3.2 Role of Central level (MOH)

It is envisaged that the role of the central ministry will be further enhanced to address issues of policy, governance, regulations, legislation, financing, monitoring and quality assurance. The implementation responsibility has been devolved from PORALG to district and regional levels. The tertiary hospitals and other related institutions at this level will be managed by executive boards.

Well functioning central support systems will be crucial for the effective management of services at the hospitals and district-level and below. MOH will facilitate the strengthening of procurement and management of pharmaceuticals and medical supplies. Furthermore, MOH will play its role regarding standardisation of equipment, devising quality assurance schemes and strengthening of the Health Management Information System, including its extension to hospitals. The assessment of existing infrastructure and development of realistic plans and strategies for prioritisation of rehabilitation of health infrastructure will be initiated as well.

1.3.3 Human Resource Development

The issue of human resources for the health sector is to be addressed as a priority in order to respond adequately to the need for improved health services. Primary concerns in the area of human resource development include: the right sizing and skill mix of the workforce in order to meet current and future needs, quality of training, balanced allocation of human resources across service levels and geographical areas, and incentives and remuneration packages.

1.4 Section 1: Principles / areas of focus

In the preparation of this second Health Sector Strategic Plan covering the period 2003-2008, a number of guiding principles were agreed upon. These principles will focus on:

- The poor and vulnerable
- Equitable service delivery
- Gender mainstreaming
- Output based performance monitoring
- Fostering Partnership
- Integration of vertical programmes into the comprehensive district plans (including HIV/AIDS)
- Decentralisation
- Community participation
- Intersectoral collaboration

Section 2: New developments / Context

2. Government Policy Statement:

2.1 Poverty Reduction Strategy

By nature, the health sector is poverty reduction responsive. It takes care of the sick and it advises and assists the healthy to stay healthy. The majority of those who come to seek for health care come from the poor segment of the population. Poverty begets ill health and ill health begets poverty. The majority of the poor 60% live in the rural areas and 40% of the poor live in septic fringes of the urban areas (squatters).

According to Vision 2025, the Poverty Eradication Strategy 2010 and subsequent Poverty Reduction Strategy (1999), the health sector is among the 14 sectors, which are central to poverty reduction. The investments in the sector have subsequently increased from 10.1% of the Government budget to 14% in the last three years. When the reforms implementation started, the budget was 3.46 USD per capita; progressively, it has increased to 6 USD per capita by 2002.

In this regard the POW 1999 – 2002 established the systems and structures including mechanisms and logistics in partnership with PORALG to improve the health services for the poor and vulnerable. The next step and the challenge for the HSSP is to improve the quality of service delivery with emphasis among other critical interventions on immunisation, HIV/AIDS control, IMCI and nutrition, TB, and Malaria and mental health

2.2 The National Health Policy (2002)

The National Health Policy of 1990 was reviewed and finalized in 2002. New developments such as Proposal for Health Sector Reform of 1994, Tanzania Development Vision 2025, Poverty Reduction Strategy 2000, Gender mainstreaming, the focus on vulnerable groups, and HIV/AIDS, have been integrated in the new policy document.

The vision of the health policy in Tanzania is to improve the health and well being of all Tanzanians, with a focus on those at risk, and to encourage the health system to be more responsive to the needs of the people. In order to achieve this vision the health sector will facilitate the provision of equitable, quality and affordable basic health services, which are gender sensitive and sustainable, delivered for the achievement of improved health status. (objectives annex 3.)

2.3 Linkage with Local Government Reforms

The Ministry of Health through the Health Sector Reform Secretariat (HSRS) will continue to collaborate with Local Government (PORALG) regarding the implementation of the Local Government Reform at different levels. In the regions, the Regional Secretariat plays a crucial role for (i) supporting the health delivery services through the Regional management Teams (ii) assessing Council Health Plans; (iii) ensuring community participation in the management of the facility through the Health Service Boards; (iv) undertaking major rehabilitation of the district hospitals and primary health care facilities.

The government has made changes in the legislation which enables it to: (a) proceed with the

implementation of the local government reform according to the government's visions and objectives for a strengthened local government system; (b) co-ordinate and give direction to the work on sector reforms so that they are consistent with the objectives for the public service and local government reforms; and (c) fulfil government commitments.

PORALG through the Local Government Reform Programme prepares the communities to fully participate in the planning and implementation, in order to build a sense of ownership. MOH and PORALG jointly coordinate maintenance/improvement of structures, supply of hospital equipment and other logistics. This Plan will further uplift these efforts, which will lead to improvement of quality, quantity, accessibility and sustainability of the health services.

In order to ensure an effective coordination of both Health Sector and the Local Government Reforms, the Permanent Secretaries of the MOH and PORALG co-chair the SWAp and Basket Financing Committee meetings while the technical staff of both ministries collaborate on a day-to-day basis. A team from PORALG and MoH Policy and Planning Department works towards the improvement of the district health services and infrastructure. This activity will be progressively transferred under the district health services component. Furthermore the annual health reviews are jointly planned, prepared and conducted by the two ministries with the participation of development partners and other stakeholders including private sector and civil society.

2.4 Public Service Reform

The Government launched a comprehensive Civil Service Reform programme in 1993 in order to define a policy direction towards reducing its direct involvement in the national economy, through liberalisation of the economy and privatisation of non-strategic public enterprises; and to create an enabling environment for enhanced private sector participation in the provision of social services.

A corresponding reduction in the role and functions of the Government in the direct delivery of these services is proposed. In this context also, the role, size and composition of the civil service would be reassessed.

In synchronisation with public service reform, the MOH rationalized its work force through provision of five-year human resource development plan and the establishment of staffing levels at all health service delivery units including health management structures. Furthermore, the Ministry has put significant effort into the capacity building of its staff, the improvement of the working environment but the crucial aspects of appropriate remuneration, motivation, incentives and retention of the staff have to be dealt with directly by the Civil Service Department.

2.5 Health Sector HIV/AIDS Strategy

Some important developments have influenced the approach of the current strategic plan. First, HIV/AIDS has become a major cause of adult morbidity and mortality with serious impact on the health services in terms of quality of care as a result of increased service demand coupled with attrition of the workforce and stigma attached to HIV/AIDS. Second, TACAIDS has assumed responsibility for coordinating the multi-sectoral response leaving the Ministry of Health to focus on the health sector response. Finally there are technical developments in methods of care and prevention. However, there are still major challenges in the area of collaboration and integration within the sector and between sectors, and in implementing community involvement.

Under the new Health Sector HIV/AIDS Strategy (2003-2005) HIV/AIDS will be integrated in activities of line departments within the structures of MoH and institutions in the health sector. As an integral function of MOH, HIV/AIDS will be planned and implemented in the framework of the Annual Budget of MOH and work plans of directorates/departments, and will be financed through the MTEF and other sources including TACAIDS.

The NACP will be relocated into the office of the Chief Medical Officer (CMO). This is a strategic position, which makes it possible for NACP to act proactively and to relate directly with directorates and departments and to assist them to integrate HIV/AIDS in their functions. This position also gives NACP access to all the health institutions in and outside the public health sector for the purpose of providing technical assistance, guidance and supervision of compliance to set standards in implementing HIV/AIDS interventions. Appropriate authorities and levels in the health sector will fulfil roles and functions of the HIV/AIDS strategy.

The MOH need to perform its statutory authority as a line Ministry with responsibility for the technical performance of the health personnel in the district compared to those of PORALG and LGAs who have administrative responsibilities. There is a need to continue with the influential role of the MOH on LGAs to incorporate interventions of this strategy into the comprehensive council health plans.

In the situation analysis key elements of the HIV/AIDS strategy are identified as the “way forward”

Section 3: Overview of progress and situation analysis (1999-2002) Strategy (POW)

3.1 Situation analysis

The situation analysis examines key gains, constraints and way forward for the nine strategies of health sector reform (eight plus HIV/AIDS). Common themes emerge throughout that need to be reflected as priorities in the HSSP 2003-2008. They include:

- Quality assurance
- Human resource (recruitment, incentives, deployment, training)
- Systems capacity (with emphasis across strategies on drug and commodity procurement, storage and distribution)
- Integration of services
- HMIS

Finally, HIV/AIDS is critically affecting performance of the health sector in many ways including demands for care of PLWA and impact on the health sector staff.¹

3.2 Strategy one: district health services

3.2.1 Key gains: The Ministry of Health achieved important gains over the past three years in Strategy One. First, decentralization has been extended to all 113 districts in the country. Particular improvements have been noted in quality of council health plans, dissemination and training on council planning guidelines; in drug and commodity supply; in transport management, plant and craft management, estate management, though these are still in need of support. Most importantly however, quality health services in general are increasingly available at district level.

A series of donor-financed district pilot interventions (TEHIP, AMMP, GTZ/Mbeya, GTZ/Tanga, and DANIDA in Kagera and in Dar es Salaam) are offering best practices for scaling up in areas including decentralization, essential health package, integrated service delivery and quality assurance. These pilots have also contributed to improved district health planning, management, and data collection and analysis for planning and decision-making.

3.2.2 Key constraints: The situation analysis identifies a number of constraints to further enhancing council health services. A pervasive issue results from the differing calendars for phased implementation of government reforms (LGR, HSR, CSR) with particular impact on successful decentralization of responsibility for service delivery to the councils.

Progress at district level is affected by the lack of progress in some of district HSR strategies. For example, the referral system remains weak, in part due to poor progress in the hospital reform strategy. This has direct implications, therefore, on the quality of health services available to district populations.

Human resources are a constraint to enhanced district health services: there is a documented shortage of both numbers and skills in district health staff. Recruitment of district staff lags and authorizations to fill vacant posts are not addressed in a uniform manner nationwide.

¹ The full text of the situation analysis is provided in Annex 4.

The resource envelope for district health services has increased; however, it is difficult for districts to capture all available health resources during their annual planning process. This is mainly attributed to continued existence of vertical programs, and to voluntary agencies and NGOs not fully reporting their funding sources.

The districts still have a number of challenges, which include implementing the essential health package according to the local Burden of Disease in line with available resources. The district minimum package of information needs to be operationalised and be used for planning and decision-making.

Limited progress was made in area of major rehabilitation of Primary Health Facilities.

3.2.3 Way Forward: To continue achieving positive change, district health service activities need to be prioritised in the HSSP, building on success achieved since 1999 and focusing more on quality service delivery including strengthening of district health services referral system. The situation analysis suggests the following priorities.

First, the Ministry/PORALG need to view provision of quality district health services as their priority. This includes accelerating the process of decentralization of health services focusing on quality service delivery. It includes helping local authorities to better define priorities in the essential health package based on burden of disease; ensuring that the EHP is implemented nationwide; integrating service delivery; and focusing strongly on quality assurance of services. For these elements, the government can build on the positive track record since 1999 as well on lessons learned in pilot districts.

Second, human resource issues need to be addressed rationally. While this is a priority across the board for the HSSP, it is worth focusing on the specific HR needs at district level. Activities targeting HR must focus specifically on changes needed to improve quality health service delivery. These include rational deployment of staff; addressing shortage of staff in a timely manner; and reviewing staff incentives especially for health staff serving in remote rural areas and provide on job training on integrated health service delivery. Strengthening those organizations that support district level health providers should also be considered, though not at the expense of direct support for district health services. This would include cascade system of district supportive supervision and improving skills of regional health management teams to provide technical assistance to CHMT demands and needs. Support the scaling up of good practices done by different organisations in supporting CHMT skills management.

Quality is a priority across the HSSP. At district level, it needs to be reflected in service delivery through use of appropriate tools to assess performance; in HR development to create a culture of quality in service delivery; and in proactive involvement of the community as consumer of these services.

HMIS remains a priority at all levels in the new HSSP. At district level there is need for priority information collection (minimum package of information) to be used for planning and decision-making,

Another equally important issue is establishment of mechanisms that will ensure rehabilitation and periodic maintenance of infrastructure

3.3 Strategy two: Secondary and Tertiary Hospital Services

3.3.1 Achievements over last period: There were few successes achieved under strategy two,

secondary and tertiary hospital services.

3.3.2 Constraints: Major constraints centre on funding, deterioration of infrastructure; existing management practices; and more importantly, slow progress in changing the legal environment for hospital reform. More fundamental perhaps, the objectives set out in the previous program of work were numerous, not prioritised and extremely ambitious.

3.3.3 Way forward: Key priorities for the next period identified in the situation analysis include introducing modern hospital management approaches, improving the referral system; building capacities among district, regional and other staff to contract, finance and monitor outsourced hospital services. In this strategy, quality of services is also an important priority for the coming HSSP.

3.4 Strategy Three: Role of Central Ministry of Health

3.4.1 Key achievements: The Ministry of Health has achieved a certain level of success in its transformation into a facilitative policy making organization. There have been few significant changes in structure within the Ministry to meet the challenges under HSR; despite this, it has been able to assume a solid policy making role. Guidelines for district planning were formulated and actively disseminated which produced, in turn, greatly improved district health plans. The Ministry produced a range of guidelines over the past three years; it needs to disseminate these as proactively as it did the district planning guidelines in order for these policies to be clearly understood and implemented at district level.

3.4.2 Constraints: The different progress in implementation of the various government reforms, which affected changes in district health services, also had impact for Strategy Three. In addition, there was insufficient advocacy of health sector reform, resulting in poor understanding of the reform process outside of the central ministry. The failure to fully integrate vertical programs, limited capacity of regional level to provide support to districts according to their new roles and functions also inhibited achievement of Strategy Three.

3.4.3 Way forward: In the next three years, the priorities at central level need to reflect support for areas identified as priorities at the district and to a lesser extent secondary levels. The situation analysis identifies several priority items. Development of a National Quality Assurance Framework for health services will contribute significantly to improved quality district health service delivery. The Ministry should build on its success in formulating and disseminating district planning guidelines in other areas – in particular focusing on ensuring that the policies are well understood and implemented. There is urgent need to strengthen capacity of regions in order for them to effectively perform according to expectations.

The Ministry needs to continue the process of integrating its vertical programs, and through this process, increasing its efficiency by reducing duplication and conflicting messages and guidelines. The MOH needs to perform its supportive role to effectively facilitate districts and hospitals to provide quality health services

3.5 Strategy Four: Human Resources Development

3.5.1 Achievements: *Management and technical capacities* at district level improved over the past three years as a result of intense capacity development at that level. Training activities have been decentralized to the Zonal Training Centres, bringing services closer to the users.

3.5.2 Constraints: There is inadequate human resources coordination at central level. Affecting the health sector across the board are issues related to civil service: they include de-motivation of staff due to unclear personnel management systems and absence of systematic incentive structures; understaffing; absence of rational deployment of existing staff; low capacity of training institutions; and poor working environment. Equally difficult is the transition in management the employment of staff from CSD to LGA. During the transition period, there is a sense of too many organizations managing the human resources of health sector. The MOH and PORALG have not succeeded to establish workable system that would ensure filling vacant health posts at health facilities.

3.5.3 Way Forward: Human resources continue to be a critical issue in the health sector In the next three years, investments in human capacity development needs to clearly reflect government priorities for the sector and in particular, needs to focus on further strengthening district health service delivery.

As mentioned above, suggestions for improved human capacity are not elaborated in this section: instead, they are prioritised under relevant strategies where the focus is more easily linked to how improved human capacities will improve results.

3.6 Strategy five: Central Support System

3.6.1 Achievements: Objectives for this HSR strategy focused on six discrete areas. Positive results were achieved in each. Drug and commodity availability improved at district levels. In addition, a unified commodity management system was introduced that is linked to the MSD system. The MSD system itself is undergoing improvements. The indent system is being expanded Plant and craft management; estate management and transport management have also improved since 1999, though all need further effort.

3.6.2 Constraints: The HMIS remains a critical challenge: despite significant investments, the Information System does not produce reliable data. The situation analysis identifies a number of HMIS related issues: low capacities of staff who use it; under-utilization; late reporting; excessive reporting requirements for data entry staff; and inadequate use of data for planning and decision making. Other central systems require continued improvement: in particular, there is poor capacity at council level to manage vehicle fleets, as well as poor council control of vehicle use. Although management of estate has improved, absence of resources has prevented MOH from rehabilitating facilities as planned.

3.6.3 Way forward: Suggested priorities in the situation analysis include complementary funding mechanisms for drugs as a means of ensuring better availability; expansion of the indent system as part of decentralization to all districts; and formulation and dissemination of guidelines on estate management.

Priorities to address the issue of HMIS have been elaborated adequately under relevant chapters in the document.

3.7 Strategy Six: Health Care Financing

3.7.1 Achievements: Strategy six, with clearly articulated, realistic and prioritised objectives, achieved good results. Government has modestly increased resources to the health sector and the proportion of allocations for district health services has increased as compared to central ministry allocations. User fees, the community health fund and the National Health Insurance have all been either initiated or reinforced.

3.7.2 Constraints: The sector does not yet use a resource allocation formula to ensure equitable access to financial resources. It also needs to increase interventions focusing on rural and poor populations and based on the burden of disease. The current exemption policy particularly for the poor is weak. Like other strategies, the health care financing strategy identifies human resources as an issue: in particular, insufficient staff is trained in the use of epicor; and generally skills are weak. Delays in disbursements represent an on-going challenge to the sector. Finally, there is insufficient information on health expenditures in the private and voluntary sectors.

3.7.3 Way forward: The situation analysis identifies a number of key priorities. Cross cutting for all aspects of health care financing is to improve financial management. The Public Expenditure Review should continue on an annual basis. The resource allocation formula should be finalized, as well as the costing after prioritisation within the essential health package. For areas including user fees, the Community Health Fund and National Health Insurance, the recommendations are to expand coverage and at the same time to establish mechanisms to cushion the poor.

There is need to support integration of vertical programme finances into the CCHP.

3.8 Strategy Seven: Public Private Partnerships

3.8.1 Achievements: Strategy seven focuses on promoting private sector involvement in delivery of health services; and improving the collaboration with traditional medicine. With regard to promoting a better public private mix in service delivery, the only significant achievement reported is the registration of new facilities. There was success with regard to collaboration with traditional medicine, through passage of a Bill on Practice of Traditional Medicine.

3.8.2 Constraints: There is generally poor collaboration between the private sector and government: examples include inadequate dissemination by government of its policies and guidelines. Private sector networks, which would facilitate communication and collaboration, are rare. The private sector is still weak and it needs revamping. There is still mistrust between the public and the private sector.

3.8.3 Way forward: The situation analysis identifies several priorities for Strategy Seven. A first priority is to support the formation of networks for interaction between private and public sectors. The second priority is to separate the Public Private Partnership desk from the hospital registration desk.

3.9 Strategy Eight: Ministry of Health and Donor Relationship

3.9.1 Achievements: The situation identifies a number of positive achievements in Ministry of Health/Donor relations since 1999. They include the adoption of a Sector Wide Approach; the agreement of a number of partners to provide support through basket funding; institutionalisation of the Public Expenditure Review Process; and significant efforts at donor coordination through various mechanisms.

3.9.2 Constraints: Key constraints, which need to be addressed, include improvement in donor coordination; financing modalities and management of off budget resources; and continued support of vertical programs.

3.9.3 Way forward: The priority for continued success in improving Ministry of Health and

donor relations is continued strengthening of application of SWAPS to improve health service delivery.

3.10 Strategy Nine: HIV/AIDS

As part of its strategy development process, the Ministry of Health has developed a health sector HIV/AIDS strategy. Key achievements, constraints and future priorities identified in the strategy are summarized in the HIV/AIDS situational analysis under ten broad themes: epidemiological surveillance and social research; behaviour change communications (Adolescents and other vulnerable populations); stigma and discrimination; STI prevention and control; blood safety; voluntary counselling and testing; PMTCT and other prevention programs; care and support for PLWA; home-based care and psychosocial support; and formulation of a Health Sector Strategy for HIV/AIDS/STI research coordination.

3.10.1 Achievements: Tanzania has made some progress in the ten thematic areas discussed above. In summary: a solid surveillance system is now in place in NACP, including guidelines for second-generation surveillance and protocols for ANC surveillance. ANC and behavioural surveillance (including youth) are underway in 6 regions.

Overall awareness of HIV/AIDS in Tanzania is over 96%. Activities successfully focused on target populations including special programs for Adolescent Reproductive and Sexual Health (ARSH) through traditional, mass and innovative media in its BCC campaigns and in partnership with the private sector.

NACP has achieved good regional STI control coverage through a complex program that has included training service providers, procuring and distributing drugs, and IEC/BCC interventions for different target groups. For blood safety, achievements include an HIV/AIDS/STD laboratory at NACP, training of staff in all blood transfusing sites, provision of testing materials to hospitals, development of guidelines on appropriate use of blood and screening of blood in all hospitals.

VCT centres were established in 170 facilities; over 200 counsellors were trained; and NACP established strong partnerships with voluntary agencies involved in quality VCT service provision.

PMTCT is in a pilot phase in five public facilities in Tanzania, and benefiting from intense research, resources and planning. Required guidelines, IEC materials, and training materials are being developed and pre-tested in preparation for dissemination nationwide. Two activities built a foundation for a future drug access initiative for PLWA: a situation analysis to examine capacity of the health system to take this on; and development of guidelines for clinical management of HIV/AIDS. NACP established an organized home-based care model in the public sector and developed a training approach for district, health facility and community levels. Twenty-eight districts have HBC services; over 100 providers and trainers were trained as TOTs; and close to 200 voluntary agencies, NGOs and CBOs are providing HBC services.

3.10.2 Constraints: Constraints in the ten thematic areas relate to human and financial resources, development of relevant policies; prioritising HIV/AIDS activities in the area of accessible ARVs; and extending services deep into communities where they are needed through improved integration of HIV/AIDS/STI services. The absence of a robust drug and commodity procurement, storage and distribution system is an additional issue that cuts across thematic areas. Finally, government's activities to distribute widely and promote condoms, through public

and private sector channels, periodically meet with some opposition.

Specific constraints affecting individual thematic areas include the following. Cultural and societal pressures severely impact on the success of communication activities (i.e. gender, religion etc.). The legal environment makes it difficult to reach high-risk target populations with appropriate BCC messages (in particular sex workers). For STI control, problems include coverage; quality of STD care and management, reporting, issues with syphilis screening and availability of drugs. Human resources (increasing numbers of trained personnel including supervisors); supplies; strengthening of the national quality assurance system; and accelerating the establishment of a National Blood Transfusion Service are key issues in blood safety. For VCT, additional issues related to poor quality of services, which results in poor client uptake.

Stigma and poor male participation represent significant constraints to successful PMTCT programs, as does poor compliance by pregnant women. An overarching issue for PMTCT in Tanzania is the relatively low rate of hospital births. The constraints to establishment of a drug access program are significant: financial resources; human capacity; institutional capacity in facilities at national, regional and district levels; poor procurement, storage and distribution capacity for ARVs. For home-based care, there is insufficient support to HBC providers from hospitals and district health teams and inadequate community participation in HBC services.

3.10.3 Way forward: Across the board, priorities for improved HIV/AIDS/STI services focus on human capacity development; improving drug and commodity logistics; integration into existing services; and formulation of required policies to allow Tanzania to unroll its PMTCT and treatment initiatives. The situation analysis strongly suggests the need to address stigma and discrimination as an integral element of any HIV/AIDS intervention.

Specific priorities for different thematic areas follow. For surveillance, priorities are to expand ANC and behavioural surveillance to 12 regions in three years; integrate HIV/AIDS/STI surveillance in to existing system; and strengthen STD and AIDS surveillance through a sentinel surveillance system. For BCC, partnership between relevant government and private agencies will be needed to develop and implement a comprehensive ARSH activity. Advocacy activities to reduce stigma and encourage providers to work with high-risk populations are also BCC priorities.

For VCT, NACP's strategy is to gradually increase the number of sites providing quality VCT services while concurrently creating demand for VCT through communication programs. The priorities for the PMTCT program are to put in place all required systems for scale up (personnel; network of institutional and community counsellors; systems for psychosocial support; client follow up; procurement, storage and distribution system; and PMTCT guidelines). Priorities for a drug access program are complex. They range from improving human capacity, improving diagnostic and monitoring capacity in medical facilities; improvement of the system for procuring, storing and distributing ARVs; to formulating a policy on ARVs.

It is essential for the NACP to develop comprehensive worksite interventions for health sector staff. There is a need to address the Health sector infrastructure and the support services to cushion the big burden of HIV/AIDS on the hospital services. It is clear that the issues of employment of more human resources, their deployment, retention and incentives need to be urgently addressed if the services are to continue.

Section 4 - Health Sector Strategic Framework

4.1 Introduction

Under this section a **focused** **prioritised** overview to guide planning operations over the years 2003-2008 is described. The list of actions and focal areas presented below will be the main focus for action and change over the next five years. The required actions have been fully integrated in the broader Health Sector Strategic Plan July 2003 to June 2008, matrices presented in section 6.

The core thrust of the strategic framework has considered

- Guiding principles outlined in section 1
- Building on progress achieved
- Current critical issues and constraints, including the recommendations made by the 2003 technical review of district health services
- The most practical solution options within the resource limits.

Given the overall vision of “**assuring quality health services accessible to all Tanzanians and responsive to their needs**” the strategic framework focuses on **health services delivery**, mainly at district level but also at secondary and tertiary hospitals. All the other inputs provided through the regional level and the central ministries in order to implement the national health policy are perceived as the necessary **support to health service delivery**.

The presentation below follows that logic, starting from health service delivery at the district level.

The district agenda shall focus on quality service delivery within the context of comprehensive district health planning.

The secondary and tertiary hospitals will assure efficient quality referral services and technical support to district hospitals.

The region shall assure ready availability of supervisory and technical support to councils; and ensure adherence to policy and guidelines.

The central ministry agenda comprises of developing the necessary policies and regulatory framework, tracking policy implementation, reform management, monitoring and quality control.

The burden on capacity building for districts and the regions is vested in Zonal Training Centres in collaboration with the region within the Zone.

To give impetus and credence to the reforms community and household level production of health shall be promoted. In addition to advocacy increased emphasis shall be given to: politically visible elements such as rehabilitation measures, community ownership of dispensaries, health centres and community control of local health funds, drugs and supplies through facility governing committees accountable to the Council Health Service Boards (CHSB).

4.2 Content of the strategic framework:

4.2.1 District Level

(a) Quality of health services

- Attainment of Improved quality of management of district health services focusing on quality of care realised.
- Improved service delivery using the essential health interventions package attained.
- HIV/AIDS activities at district hospital, health centre, dispensary, Ward and Village/Mtaa level integrated into CCHP.
- Attainment of enhanced Health promotion through multisectoral networking at district and ward level realised.
- Increased health action advocacy through dispensary and health centres down to the household level undertaken
- Innovative ways to manage service agreements established.
- Innovative incentives and staff benefits to increase staff motivation introduced.
- Measures to address epidemic preparedness and response in planning and management of district health care introduced.
- Adequate facilitation provided during the establishment of Health Facility Committees and the Council Health Service Board.
- Increased accountability attained by publishing annual district health budgets and provision of information to facilities about their annual budgets carried out.
- Annual district health performance data published and discuss with health staff
- Client satisfaction tools used to assess quality of service delivery
- Based on skills assessment done by regional level district human resources in-service training plans developed by districts.
- Advocacy on Health Sector Reform aspects to the villages and household level undertaken.
- Environmental and occupational health management including health care waste management established
- Appropriate use of HMIS data for planning and quality control institutionalised at district
- Programme for infrastructure rehabilitation and periodic maintenance with strong local participation element introduced

(b) Reducing the financing gap in the health sector

- Management of user fees, CHF, DRF and Health insurance schemes strengthened
- Community ownership of Health Centres and dispensaries introduced

(c) Equity of access to health services

- Exemption system for the poor and vulnerable working according to guidelines and monitor of impact of fees on the poor regularly done and corrective action taken when indicated

(d) Equity of resource allocation

- System to ensure fairness in resource allocation in terms of equity introduced.

4.2.2 Secondary and Tertiary Hospitals

- A discipline and a cadre of hospital managers introduced (long term). For the (Medium term) the process, including agreement on an institutional framework completed.
- All hospitals have Hospital Strategic Plans and operational plans.
- Establishment of Hospital Boards accelerated and the legal framework operationalised
- Efficient and systematic costs management system developed
- A programme for infrastructure rehabilitation and preventive maintenance with a strong local participation element introduced.
- Staff motivation and staff retention realised by creating innovative ways of providing incentives and opportunities for enhanced benefits.
- A package of quality services in line with national norms and standards delivered.
- Specific quality services for HIV/AIDS patients provided
- Measures to mitigate the impact of HIV/AIDS epidemic on hospital staff taken.
- Prevention, counselling and support to HIV/AIDS patients provided.
- Improved emergency and epidemics preparedness and responses introduced.
- Performance audit including monitoring of service delivery outputs enhanced.
- Accountability and transparency checks with timely reporting ensured.

4.2.3 Central Support

4.2.3.1 Regional Level

- Managerial and technical support to districts on quality service provision including emergency and epidemics preparedness and response provided.
- More effective discharge of inspectorate function assured.
- Performance audit including monitoring of service delivery outputs on a quarterly basis enhanced, quality assurance of district health services including client satisfaction assessment, accountability and transparency checks introduced
- Timely reporting including benchmarking and peer review modalities provided for and undertaken
- Advocacy/promotion of inter district exchange experiences intensified
- Comprehensive analysis of skills and human resource needs at district level including training needs assessment of district undertaken in collaboration with Zones/Centre completed.
- Districts supported to strengthen data collection, data management and use of data for decision-making.
- Policy guidelines on integration translated into action

4.2.3.2 Central Ministries

(a) Improving health financing, budgeting and equitable allocation of resources

- Advocating for an increased level of government allocation for health from own sources done

- Pooling of finances to support the health sector further strengthened
- Support for strengthening management of cost sharing/CHF/Health insurance schemes through enhancing community voice and ownership of dispensaries, health centres and hospitals provided
- Councils supported in making effective exemption system for the poor and vulnerable
- Advocacy to MOF for implementation of the allocation instrument based on explicit criteria undertaken
- Allocation aspect of existing comprehensive council planning guidelines improved
- Financing arrangement for staff incentive scheme especially for staff posted to rural locations established

(b) Human Resources

- Long term manpower planning and production system established
- Distribution, motivation and retention of staff attained
- Full network of ZTCs throughout the country set up and short-term capacity building and skills-based learning modules produced
- Zonal Training Centres teamwork on continuing education including exploring how to increasingly apply distance learning completed

(c) Quality of Health Services

- The concept of Medical and Clinical Audits introduced
- Quality standards and protocols tailored to suite local abilities and constraints rolled out Nationally
- Rehabilitation and maintenance of health infrastructure and equipment undertaken according to plan
- Service agreement and contracting out modalities for use by councils and secondary and tertiary level hospitals prepared and introduced
- Effective options for enforcement of accreditation of health institutions (public and private) explored and the most practical option initiated
- Regular consultations/collaboration with professional bodies, professional associations, private providers and civil society to enhance discipline, ethics, code of conduct, standards, morality and caring attitudes by health workers undertaken
- Comprehensive integrated sustainable quality assurance schemes at health delivery points developed
- Supportive supervision on regular basis undertaken applying effective supervision tools.

(d) HIV/AIDS/STI Health Services

- Human capacity development to cope with the consequences of the epidemic on availability of skilled human resources introduced
- HIV/AIDS integrated into existing services according to HIV/AIDS health sector strategy
- PMTCT and HAART initiatives introduced and strengthened at the relevant service levels
- Implementation of care, support, preventive and crosscutting issues undertaken according to HIV/AIDS health sector strategic plan
- HIV/AIDS incorporated into council planning and budget guidelines

(e) Integration of health services

- Pre and in service capacity development of health staff undertaken according to plan

- Integration process agenda set and monitored closely at all levels
- Integration of health services in the councils monitored and evaluated
- Development of legal instruments to enhance integration of health services completed and integration process initiated
- Promote operational research promoted and the operational research results applied results to improve integration of services in councils

(f) Monitoring and evaluation

- Performance audit including monitoring of service delivery outputs at district and referral hospitals introduced
- Health sector performance based on PRS and Health Sector profile as elaborated under section 8 assessed periodically

(g) Specific actions to support the Sector Reforms

- MOH and partners invest on minimum information package at district and facility levels.
- Contract management for key reform tasks improved.
- Planning guidelines harmonised/streamlined by MOH and PORALG
- Technical management guidelines harmonised by MOH.
- Ongoing work on enacting/review/ development of Legislative instruments on track.
- The ongoing work on IEC on health reforms including operationalisation of the Clients Charter enhanced.
- Working modalities between MOH and PORALG through intensified networking and exchange of information and plans harmonised and streamlined. Adequate technical and support capacity ensured and availed to councils.
- Research and health information as evidence for policy reviews and development ensured.
- Composition of the RHMT agreed by the MoH, PORALG and CSD and the necessary staff changes based on skills assessment implemented; and an efficient regional health support function within the RS supported by PORALG
- MOH capacity for policy analysis with a gender focus. strengthened

(h) Provision of logistical Support

- Drugs/medical supplies, HMIS, transport and estate management operational changes to enhance health services delivery undertaken

Section 5 - Implementation Arrangements

5.1. The Role of the Main Actors in Implementing this Strategic Plan

The implementation of the HSSP will be through MTEFS of MoH, PORALG, RAS, the Comprehensive Council Health Plans and others. Strategic Objectives and outputs that fall under the Ministry of Health headquarters will be implemented annually through MTEF of the MOH. The MOH/HQ is also responsible for Zonal training centres and appointment of third referral hospital boards. The members of the third referral hospital boards are appointed by the Minister for Health but the boards are semi-autonomous in their operations as stipulated by the Act of the parliament

On the other hand the regional hospitals are administered by PORALG through the RAS. The Minister responsible for PORALG in consultation with the Minister of Health will appoint the regional hospital boards as stipulated in the health service act and policy guidelines. Implementation of district health services will also be done through Annual Comprehensive Council Health Plans.

Implementation of the strategic plan will be a responsibility of each of the four directorates in the MOH. Because of the importance the MOH attaches to implementation of the HSSP, the plan under the matrices has clearly spelt out the responsibilities for implementation of outputs by sector and councils.

On the private sector the Government will continue to provide a conducive environment for the private sector to play a role in the health Sector. Moreover, the intention is to continue to support those institutions, such as DDHs and VAs, in the provision of basic services where there is no Government facility, there should not be a competition rather complementation between the public services, private for profit and non profit services.

5.2 Co-ordination/management

5.2.1 Implementation of the plan will be monitored on a semi-annual basis through the Sector Wide Approach Steering committee that will be chaired by the Permanent Secretary, Ministry of Health. This is in line with the terms of reference of the Health SWAP Committee.

5.2.2 Performance Monitoring for the health sector will be done annually during the main review in March of each year.

5.2.3 On a monthly basis, coordination, management and monitoring will be ensured through monthly management meetings that will specifically address implementation progress by responsible directorates in the MOH, PORALG, the RAS and Councils.

5.2.4 Some of the Local Government Reform coordination mechanisms will assist to strengthen coordination and synchronization of planning and implementation of the HSSP. Among these include the following:

- Coordination meetings organized by the PORALG with planning directorates of Ministry of Health and other ministries that will devolve their sector functions to the 122 LGR Councils.

- Quarterly meetings of the Steering Committee for Local Government Reforms Implementation on which the MOH is represented.
- 5.2.5 For partners who will pool their funds to support the HSSP, support will be coordinated through the Basket Financing Committee (BFC) that meets once after every three months. The mechanisms to be followed for channelling funds are described under financing mechanisms section 7 of this plan.
- 5.2.6 At the district and sub-district levels, the services are devolved with a clear intention of putting greater mandate of management of the services, their administration, and implementation at the hands of the community through their Boards and Committees. This will assist in policing the services for quality assurance, continuity and sustainability, creation of renovations including complimentary financing and above all community ownership.
- 5.2.7 To achieve these, the MoH/PORALG and Development Partners will continue to dialogue through the established SWAp Committees, BFC Committees as these committees receive feedback from the Technical Committee and sub-committees from time to time and also from other stakeholders and clients who use the health services.
- 5.2.8 In this plan there is a monitoring and evaluation Section 8 that has explained how to monitor implementation. This is in line with the NHP.
- 5.2.9 To have more time for implementation we have to reduce the time of transactions Costs, reporting systems and conditional milestones. The government formats are expected to be used as much as possible and internal and external evaluators have to use the progress reports to measure performance of the sector.

Section 6 - Health Sector Strategic Plan – Implementation Matrix (2003-2008)

6.1 Introduction

This Health Sector Strategic Plan 2003/2008 is a bridge between POW 1999 to 2002 from the reforming the systems and structures of the health sector, establishment of boards and operating tools to that of consolidating the gains achieved in the last 3 years of operation. This strategic plan has placed more focus on service delivery. In line with the MoH Client Service Charter and the Local government mandate for quality health care and services, it is imperative therefore that the HSSP meets the challenges and expectations of the communities. Our development partners who are assisting the health sector have expectations also that need to be met. The partners need to justify that their tax payer's money is wisely spent to reflect its value, so is the government. This strategic plan, with objectives and targets castled under 3 components of district health services, secondary and tertiary hospitals, and central support will answer to those expectations. Using the logical framework approach and applying the horizontal and vertical logic has developed the matrices.

The overall vision of the strategic plan 2003-2008 is to “improve the health and well-being of all Tanzanians with a focus on those at risk”. This overall objective will be reached by two main strategies: (a) assuring quality health services accessible to all Tanzanians and responsive to their needs; and providing an enabling environment for implementing the national health policy through an effective regional level and central ministries. Strategy (b) is in full support of strategy (a), or in other words quality health service delivery cannot be assured without the necessary support function provided by this strategy

The emphasis of the 2003-2008 strategic plan is therefore on “**district health services**” component 1, where most of the essential health services are provided close to the communities. The trust of the next 3 years will be to improve significantly the quality of those essential health services, make CHMTs and district health providers more accountable to the local communities, and strengthen community ownership.

Good quality of health services delivered at the district level requires an efficient hospital referral system and an effective medical support function. This will be built and strengthened under component 2, “**the secondary and tertiary hospitals**”.

Both district health services and referral hospitals require the necessary policy, managerial, technical and logistical support to be provided by the central level. Component 3 “**Central support**” will assure this through an effective regional level and a well focused central ministry. The main focus of both levels will be to assure that the national health policy is understood and implemented, supporting effective, equitable, accessible health services of good quality.

6.2 In summary, the matrixes consist of three components as follows:

1. District health services
2. Secondary and Tertiary hospital services
3. Central support
 - 3.1 Regional level
 - 3.2 Central Ministries

It should be noted that the matrices of the Health Sector Strategic Plan present a wider scope of

activities than those presented in section 4. While the main priorities presented in section 4 are all integrated in the matrices, the latter give a more comprehensive view, taking into account the role of the different levels and including specific outputs voiced by MOH departments, PORALG, RHMTs and CHMTs during the preparation of the plan.

Section 7 – Financing the HSSP (2003-2008)

7.1 Introduction

The financing of the HSSP will be expected to demonstrate that resources are being effectively programmed in an appropriate and cost-effective manner in order to deliver on the identified priorities and critical key targets, with the overall goal of delivering better health services to the population, with particular attention to the most vulnerable groups of society. This is further underpinned by the Poverty Reduction Strategy (PRS) with the focus on health as one of the priority sectors and the commitment to enhance increased allocations to the Sector over the medium term.

The Health Sector will continue to be financed by domestic and foreign sources of funds. A Sector Wide Approach (SWAp) has been adopted with the objective that all available funding (domestic and foreign) to the sector supports a single sector policy and expenditure programme.

New domestic sources of funding have been developed over the period of the last POW to strengthen the resource base and to enhance the sustainability of the Sector. It is expected that these new sources of funds (CHF, NHIF, Health Service Fund) will strengthen their revenue base as functioning and coverage is further enhanced. However, in the implementation of such schemes, special attention will be given to protecting the needs of the poorer and vulnerable groups in accessing health services.

During the course of the implementation of the HSSP, greater attention and focus will be given to further engaging the private sector and creating an enabling environment for them to support the health sector. Thus, in certain circumstances, where it is more efficient and effective from an economic point of view, consideration will be given to out sourcing and entering into service agreements with NGO providers.

7.2 Resources for the HSSP

There are many stakeholders involved in financing the HSSP over the three-year period (Table 3, Projected Resource Envelope). They include the following:

(a) Domestic Resources

Health as one of the priority sectors within the PRS is expected to receive an increase in Government resources both in nominal terms and as a share of the budget over the life of the HSSP. Resources will be channelled through the Central Ministry of Health, Regional Administration and Local Government, and the Rural and Urban Councils in support of the sector.

(b) Foreign Resources

Development Partners have developed a number of different ways of supporting the Health Sector over the years. Funds are provided directly to support earmarked activities and/or projects through the Ministry of Health or PORALG development budgets. In addition, a joint funding arrangement (basket funding) has been created that uses the Government Exchequer system and follows one system of planning, disbursement, procurement, implementation, monitoring, accounting and auditing. The support under this approach focuses on the whole sector rather than on a vertical programme or discrete projects. However, beginning FY04, the magnitude of resources available under the basket fund will drop dramatically following the shift of one

Basket Partner to direct budget support under the Poverty Reduction Budget Support (PRBS). Thus there is uncertainty of funding the sector through this mechanism, particularly at the central level, and the extent to which shortfalls will be offset by general budget support beyond FY04

(c) Other Sources of Funding

➤ **Cost-Sharing Schemes**

The functioning and coverage of the various cost-sharing initiatives will be greatly strengthened and enhanced to contribute to the resource envelope of the Sector whilst at the same time protecting the poorer members of society. This will include further harmonisation of operations; strengthening financial management systems; greater supervision, auditing, monitoring and evaluation of the implementation including revenue targets; reviewing and strengthening the exemption mechanisms for the poorer and vulnerable members of society; and addressing issues with respect to pre-payment schemes. Specifically:

Community Health Fund: Measures will be taken to improve the CHF scheme and to roll out to the rest of the councils;

National Health Insurance Fund (NHIF): To widen the membership coverage, expand to the Zones, greater advocacy and at the same time provide meaningful benefits to the members.

Drug Revolving Fund (DRF): To strengthen the general management of the DRF in the Hospital Pharmacy.

➤ **Private Sector**

The Government will continue to provide a conducive environment for the private sector to play a role in the health Sector. Moreover, the intention is to continue to support those institutions, such as DDHs and VAs, in the provision of basic services where there is no Government facility, there should not be a competition rather complementation between the public services, private for profit and non profit services.

➤ **Locally generated resources at the Council level**

The desire is to see a greater commitment of the contribution of locally generated resources programmed to public health services at the local level.

Table 3 Projected resource envelope (TSh bn)

	FY04	FY05	FY06
Ministry of Health			
Recurrent	72.20	83.70	96.90
Development	3.60	5.20	5.70
Central Basket	4.80	4.80	4.80
Central Government	80.60	93.70	107.40
PORALG			
Recurrent	62.20	71.50	82.20
Development	1.70	1.90	2.10
Council Basket	17.30	17.30	17.30
Local Government	54.70	31.90	36.20
Total Region/LGA	135.90	122.60	137.80
Total on Budget	216.50	216.30	245.20
Off Budget			
Other foreign assistance	62.00	28.50	20.10
Cost-sharing – hospitals	1.70	1.90	2.10
Community Health Fund	1.00	1.50	2.25
National Health Insurance Fund			
Off-budget revenues	64.70	31.90	24.45
Total	361.80	341.90	377.05

Table 3 above on the projected resource envelope has been taken from the Final Draft Health

Sector PER Update FY03. However, the indicative figures for FY05 and FY06 should be treated with extreme caution, as more accurate information is required particularly for basket funding, off-budget foreign assistance and other sources of funds.

Table 3 was further updated to take into consideration changes in health basket funding, as the majority of basket resources will be channelled to support the council basket with the residual supporting specific identified priorities at the central level. No data for basket funding beyond FY04 is currently available and therefore the same figures have been programmed for FY05 and FY06.

On foreign assistance, particularly off budget, further analysis will be undertaken during the course of the HSSP, to unpack the existing projects both from the Ministry of Health and local government development budgets, and others contained in the Ministry of Finance external database.

In terms of other sources of funds, the only data available is that reported on the Community Health Fund operating in primary health centres and the cost-sharing Health Service Fund operating in hospitals. It is expected that the revenue gained from these sources will increase over the medium term based on past patterns and the desire of the Ministry to enhance their revenue base. There is no information currently available on the National Health Insurance Fund

7.3 Allocation of Funds

The overall objective of the HSSP is to deliver better health services to the population, with particular attention to poorer and more vulnerable groups of society. Strategies to achieve this objective and in-line with the PRS, include strengthening immunisation services, improvement in the availability of drugs and medical supplies, provision of quality health services through delivery of the essential health package, and strengthening and reorienting the delivery of secondary and tertiary services, to ensure more effective support of basic health care. Thus the Sector will be expected to increasingly allocate funds to priority areas and programmes, including increasing resource allocations to finance the local government comprehensive council health plans annually.

Table 4 below is an indication of the estimated future costs of **sectoral priority activities and programmes** for the period FY04 to FY06.

Table 4 MoH Financing Requirements of Priority Activities (TSh bn)

	FY04	FY05	FY06
Central MOH, admin and reforms	16.4	16.8	18.0
Running costs	6.5	6.5	7.6
Priority activities, of which:			
Undertake health sector reforms	2.6	2.0	1.5
Payment of utilities and arrears	1.3	1.3	0.9
Strengthening of M&E through HMIS and research	1.5	2.0	2.5
Capacity building (training institutions)	4.5	5.0	5.5
National, referral, regional hospitals	45.5	51.1	58.9
Running costs	13.8	15.9	18.3
Priority activities of which:			
Drug procurement	9.7	11.2	12.9
Purchase of medical supplies and equipment	5.2	7.8	11.7
Strengthening of diagnostic services	2.9	3.7	4.7
Payment of utilities and arrears	1.3	1.3	1.3
Undertake hospital reforms	0.6	0.4	0.3
Rehabilitation of health facilities	12.0	10.8	9.7
District, primary & preventive services	93.8	100.2	108.6
Running costs, including arrears	48.3	48.3	48.9
Priority activities, of which:			
Purchase of drugs (district hospital, HC and dispensaries)	23.0	26.5	30.5
Purchase of medical supplies and equipment	5.5	5.8	6.1
Grants and subventions to Vas and DDHs	6.0	6.0	6.0
Undertake District health sector reforms	1.5	1.3	1.2
Rehabilitation of health facilities	9.5	12.3	15.9
Implement public health programmes including:	57.2	59.6	63.6
Immunisations	12.6	13.9	15.3
Reproductive and child health including IMCI	12.6	11.7	10.9
TB and leprosy control	6.3	7.3	8.5
Malaria prevention and control	5.2	5.4	5.6
Sector response to HIV/AIDS and awareness campaign	9.1	9.1	10.0
Nutrition	3.0	3.3	3.3
Support community initiatives	3.0	3.5	4.2
Other preventive	5.4	5.4	5.8
Total resources to priority activities (Tsh bn)	212.9	227.7	249.1

Table 5 below is based upon the information contained in the budget guidelines issued by the Ministry of Finance and The President's Office, Planning and Privatisation in January 2003, information collected from Development Partners directly or through the PER process. Basket resources for the central level are included within the development foreign development resources of the table and basket resources supporting the Councils has been excluded from the table because of the uncertainty of the magnitude of funding available at the time of development. It is also worth noting that resources specifically for HIV/AIDS activities in the Health Sector have been included in the TACAIDS ceiling and the Ministry of Health is currently awaiting guidance from the Ministry of Finance as to how to programme these resources into the MTEF. The Table has been extracted from the draft MTEF FY04 – FY06, which is currently being developed and focuses on the proposed allocation to priority areas and programmes for FY04 only.

Table 5 Proposed allocation of MoH Budget Ceiling to MoH Priority Areas MTEF FY04

	GOT	OTHER		
	GOT	HSPS	WB	Other
Administration, Finance, Planning and Agencies	2.75	1.01	-	-
Running costs including utilities, Administration, Personnel, Gender and finance services	1.35	0.13		
Accounting and finance services	0.17	0.07		
MTEF, PER, NHA, SWAP, Joint Review, Advocacy, CTU, budget preparation, HMIS and Research	0.36	0.13		
Management of HSPS		0.61		
Support to Executive Agencies (TFDA and CGC)	0.72			
Health services Regulation, Inspection, Emergency/Disaster Preparedness and Response	0.15	0.07		
Regional, Districts, Primary & Preventive Services of which:	38.73	-	-	-
PORALG	19.35			
Local Government and Regions OC	16.27			
Local Government and Regions Development	3.11			
Preventive Services including: Implementation of Public Health Programmes	10.83	0.27	-	-
Support District Health Sector Reforms (including vehicles for supervision)	0.50			
Immunizations (including BCG)	2.97			
Reproductive and Child Health including IMCI and Contraceptive (Depo provera)	0.90			
TB and Leprosy Control	0.65			
Malaria Prevention and Control	2.00			
Sector Response to HIV/AIDS and Awareness Campaign*	-			
Environmental Health and sanitation	0.12			
Health education services	0.13			
Support community initiatives	0.06			
Studies and consultancies (NIMR)		0.27		
Other Preventive	3.50			
Curative Services including National Referral Hospitals	49.77	3.22	-	-
Running costs (including utilities and arrears)	0.81			
Priority Activities of which:	48.96	3.22	-	-
Drugs and Medical Supplies for District, Region and Referral Hospital	14.00			
Purchase of Drugs kits for H/Center and Dispensaries**	9.00	2.93		
Drug distribution system		0.29		
Purchase of Medical Equipment	1.20			
Strengthen of Diagnostic Services	0.60			
Subventions to Referral and Specialized Hospitals	15.11			
Subventions to DDH and VA Hospitals	6.80			
Support Private Public Partnership	0.25			

Strengthen Blood Safety*	-			
Undertake Hospital Reforms	1.00			
Other activities (including PMTCT, VVP, Mental Health, Oral Health and Traditional Medicine)	1.00			
Human Resource Development	4.26	0.36	-	-
Running costs	0.30			
Priority Activities of which:	3.96	0.36	-	-
Running costs of training institutions (including Zonal Education Centers)	1.00			
Support Postgraduate training	0.60			
Fellowships -national/regional				
Teaching Materials, Equipment and Supplies	0.70			
Training Grants to Parastatals Institutions	0.40			
Curriculum Review and Development	0.05			
Improving quality of teaching and learning process	0.50			
Training in Rational drug use		0.07		
Training in planning and management		0.29		
IMCI training				
Post-internship training				
Teaching methodology training				
Research methodology				
Rationalize Health training institutions	0.05			
Other training activities	0.66			
TOTAL Resources to Priority Activities (bn Tshs)	106.34	4.86	-	-
Add funds allocated for HIV/AIDS outside Health Sector ceiling				
Treatment of STI	14.38			
Blood Safety	0.99			
*Total funds allocated for MOH-HIV/AIDS activities outside Sector ceiling	15.37	-	-	-
Total Health Sector Allocation	121.71	4.86	-	-
Add:				
PE	42.11			
Total Health Sector Recurrent	163.82			
Add:				
Development Local	3.55			
Construction	1.30			
Counterpart funds	1.00			
Undertake Health Sector Reforms	0.25			
Rehabilitation of Health Facilities	1.00			
Development Foreign	45.04			
	212.41			

7.4 Financial Management Systems

A number of financial management systems have been introduced into the sector and these will be further improved over the life of the HSSP and in-line with the ongoing strengthening of public sector financial accountability and management under the PSRP. This will include further institutionalisation of the PER process and further improvement of the linkage between the MTEF and the annual budget process. This will also entail re-looking at the budget coding and structure (recurrent and development), to allow better identification by level of the system, by

priority programmes and key objectives of the sector.

Particular attention will be paid to a general strengthening of budget execution and management of resources at all levels of the sector, including the proper utilisation of funds, based on identified prioritised plans/budgets and government procedures and regulations.

There is a strong desire to acquire more robust costing data for priority areas and identified cost centres within the Sector to better assess the realism of future estimates, and to be able to prioritise available resources between activities and levels of the system. Discussions on the objectives and usefulness of such an exercise will be further elaborated on and discussed with stakeholders in the sector.

Finally, further steps will be taken to strengthen the SWAp process in Tanzania which embraces both project support and basket funding to enhance co-ordinated planning and implementation of activities based on a limited number of jointly identified priorities and milestones that are strategically programmed within the identified resource envelope available to the sector. This will include further work around the sector development budget.

Box 2: Recent trends in health sector expenditure (Source: Health Sector PER Update 2003)

- Allocations to the health sector had grown consistently and substantially between FY00 and FY02, with increases coming from both Government and basket funds. This trend was evident in both budgets and expenditures.
- Off-budget expenditures still accounted for over 40% of the total, although the trend was downwards due to the sector-wide approach. Foreign funding more generally was up from 53% in FY00 to 56% in FY02.
- Recurrent spending dominated, at over 80% of the total, both in terms of budgets and actual expenditure. This was due in part to the fact that development expenditures are generally substantially below budget estimates.
- There was evidence of trend in expenditure away from secondary and tertiary hospitals, and towards district-based health services, from 50% to 60% over the review period. Similarly, spending on preventive activities also rose from just over a third in FY00 to an estimated 43% in FY02.
- Basket funding was under spent by 22% in FY01, largely due to delays in agreeing the actual budget. Almost 30% of the central basket was spent on employment allowances in FY01, more than on medical supplies and services (27%) this was because the government funds are released early and hence used for the core activities including drugs. The pool funds catch up with the discretionary activities as they are released late. Estimates for FY02 showed a substantial change with drugs and supplies accounting for 57%.

(Health Sector PER 2003)

Section 8 – Monitoring and Evaluation

8.1 Introduction

In the previous three-years under the POW, the Joint Health Sector Review has mainly resulted into the generation of a number of milestones, which were regarded as conditions to be implemented before the next Joint Review. As we move out of the process of health sector reform into the implementation of services provision with the focus at the district level services, appropriate indicators at key levels have been developed geared towards monitoring performance based on service outputs and outcomes performance.

At the sectoral level, annual and periodic performance indicators have been developed to assess progress of the Sector towards meeting the objectives of the reform and improved service delivery within the sector. In addition, they also include the enhanced health sector poverty monitoring indicators, which were updated in February 2003. It is worth highlighting that these indicators have been selected to provide a spread across the main areas of health and health care. However, it is acknowledged that these are core indicators and they do not presume to capture every aspect of health. The health sector and the health services are very complex and hence the indicators are proxy for indicating the direction of change.

In terms of Council Health Performance, 19 indicators have been established to monitor progress in the implementation of the Comprehensive Council Health Plan. These indicators will continue to be used to measure the progress of implementation of CCHP, and the services delivered. The results will be complemented by periodic clients surveys for Quality assurance.

8.2 Monitoring HSSP implementation progress

This will be monitored by measuring progress made towards achievement of key process outputs of three components of HSSP.

8.3 Health Sector Performance

Sectoral Performance monitoring will be undertaken on an annual basis as part of the annual review of the sectoral MTEFs and HSSP – focus will mainly be on process. In addition, the annual and periodic performance indicators to assess progress of the Sector towards meeting the objectives of the reform and improved service delivery within the sector will also be used to support this assessment

8.4 Council Performance

Monitoring of council health services will in addition be through the 19 council performance indicators (inputs, process, output and outcomes) see annex 6.

8.5 Monitoring Process

The monitoring process will be done through:

- Quarterly progress report
- Annual progress reports
- Health Sector Performance Profile
- Annual Health Sector reviews, SWAPS and BFC committee
- Review of comprehensive plans/ annual report to be submitted by 113 councils

8.5 Data Sources

The sources of data will include the following:

- Health Management Information System
- National Sentinel Surveillance System
- National Population Census
- Demographic Health Surveys
- Household Budget Survey
- Periodic health service delivery survey and other surveys
- National Program reports
- Study reports as they may be commissioned from time to time

Table of Sectoral Performance Indicators – Annual and Periodic including Health PRS Indicators

Sectoral Performance Indicators – Annual & Periodic, including Health PRS Indicators

No.	Category	Indicator	Source	Level of reporting	PRS Indicator	Frequency
1	Input	Total GoT Public allocation to health per capita	Annual PER Health Update for numerator; National Population Census 2002 for denominator	Central Regional District	No	Annual
2	Input	Total GoT and donor (budget and off-budget) allocation to health per capita	Annual PER Health Update for numerator; National Population Census 2002 for denominator	National	No	Annual
3	Input	Recurrent expenditure broken down by level Central, Hospital Services; Preventive Services	Annual PER Health Update for numerator; National Population Census 2002 for denominator	National	No	Annual
4	Input	Distribution of Medical Officers as a proportion of the staffing norms by health facilities	Integrated Human Resources System (PSRP) for numerator; Staffing levels for Health Facilities/Institutions for denominator.	Region	No	Annual
5	Input	Distribution of Assistant Medical Officer as a proportion of the staffing norms by health facilities	Integrated Human Resources System (PSRP) for numerator; Staffing levels for Health Facilities/Institutions for denominator.	Region	No	Annual
6	Input	Distribution of Public Health Nurse as a proportion of the staffing norms by health facilities	Integrated Human Resources System (PSRP) for numerator; Staffing levels for Health Facilities/Institutions for denominator.	Region	No	Annual
7	Input	Percentage of GoT funds available for budgeted and actual district health activities against the total overall funds available for districts	Public Expenditure Supply Vote; Quarterly Technical and Financial Reports of Phase I, II and III LGAs	District	No	Annual
8	Process	Number of districts reporting and showing use of the HMIS, NSS, Performance Monitoring data in the preparation and use of health plans.	Quarterly Technical and Financial Reports of Phase I, II, III LGAs	District	No	Annual

9	Process	Proportion of public health facilities in a good state of repair	Health Management Information System	Region	No	Annual
10	Process	Percentage of public health facilities without any stock outs of 4 tracer drugs and 1 vaccine	Health Management Information System	Region	No	Annual
11	Process	Average number of days with no drug kits in public health facilities.	Health Management Information System	Region	No	Annual
12	Output	Cost-sharing fees collected by the public health facilities as a proportion of targets.	MoH Appropriation Accounts and Hospitals Annual Financial Reports.	Facility	No	Annual
13	Output	Number of outpatient attendance per capita.	Health Management Information System for numerator; National Census for denominator	National, Regional and District	Yes	Annual
14	Output	TB treatment completion rate (cure rate)	National TB and Leprosy Programme	National, Regional District	Yes	Annual
15	Output	Total number of family planning acceptors (new and old)	Reproductive and Child Health Services	National, Regional and District	Yes	Annual
16	Outcome	The proportion of children who receive three doses of vaccine against diphtheria, pertussis (whooping cough), tetanus and Hepatitis B by their first birthday.	Expanded Programme on Immunisation (EPI)	National, District	Yes	Annual
17	Outcome	Percentage of children born to HIV-infected mothers who are HIV+	PMTCT Programme	National, Regional and District	Yes	Annual
18	Outcome	HIV prevalence 15-24 age group	Sentinel HIV Surveillance	Sentinel Sites	Yes	Annual
19	Outcome	Proportion of births taking place in Government Health Facilities	Health Management Information System	National, Regional, District	Yes	Annual
20	Outcome	Top 6 causes of morbidity among OPDs attendees and top 6 causes of mortality	Health Management Information System, National Sentinel Surveillance System	Regional, District and Sentinel Sites	No	Annual
21	Impact	Percentage change in mortality attributable to malaria among children under-five	National Sentinel Surveillance System	Sentinel Sites	Yes	Annual
22	Impact	Proportion of deaths to women of child-bearing age due to maternal causes	National Sentinel Surveillance System	Sentinel Sites	No	Annual

Periodic Indicators

1	Output	Proportion of population reporting to be satisfied with health services	Household Budget Survey	National and Regional	Yes	Periodic
2	Outcome	Proportion of births attended by a skilled health worker	Demographic Health Survey	National, Urban/rural, Regional	Yes	Periodic
3	Outcome	The proportion of children who receive three doses of vaccine against diphtheria, pertussis (whooping cough), tetanus and Hepatitis B by their first birthday.	Demographic Health Survey	National, Urban/Rural, Regional	Yes	Periodic
4	Impact	Infant Mortality Rate (IMR)	Demographic Health Survey, National Population Census	National, Regional	Yes	Periodic

5	<i>Impact</i>	<i>Ratio of the IMR of the poorest quintile to the IMR of the least poor quintile</i>	<i>Demographic Health Survey, National Population Census</i>	<i>National, Regional</i>	<i>Yes</i>	<i>Periodic</i>
6	<i>Impact</i>	<i>Under-five mortality rate</i>	<i>Demographic Health Survey, National Population Census</i>	<i>National, Regional</i>	<i>Yes</i>	<i>Periodic</i>
7	<i>Impact</i>	<i>Life expectancy at birth</i>	<i>National Population Census</i>	<i>National, Regional and District</i>	<i>Yes</i>	<i>Periodic</i>
8	<i>Impact</i>	<i>Proportion of under-fives moderately or severely stunted (height for age)</i>	<i>Demographic Health Survey</i>	<i>National, Urban/Rural, Regional</i>	<i>Yes</i>	<i>Periodic</i>
9	<i>Impact</i>	<i>Proportion of under-fives moderately or severely wasted (weight for height)</i>	<i>Demographic Health Survey</i>	<i>National, Urban/Rural, Regional</i>	<i>Yes</i>	<i>Periodic</i>
10	<i>Impact</i>	<i>Proportion of under-fives moderately or severely underweight (weight for age)</i>	<i>Demographic Health Survey</i>	<i>National, Urban/Rural, Regional</i>	<i>Yes</i>	<i>Periodic</i>
11	<i>Impact</i>	<i>Total fertility rate 15-49</i>	<i>Demographic Health Survey, National Population Census</i>	<i>National, Urban/Rural, Regional</i>	<i>Yes</i>	<i>Periodic</i>