BRN Healthcare NKRA Lab

Lab Report – Part I
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# Executive Summary

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The objective of this Health Sector Lab is to develop concrete plans in specific health care areas and align it with the trajectory towards the Tanzania Development Vision 2025 targets.

The Lab will focus on aspects that will make Tanzania’s health and social welfare sector provide quality healthcare for all of the country’s citizens.

The Lab will assist in identifying critical factors that are considered essential to increase substantially the successful implementation of the Tanzania’s health care strategies...¹

Hon. Dr. Seif Rashid
Minister of Health and Social Wellfare

¹Statement for the Opening Ceremony of Big Results Now Lab for Health Sector held at the Kunduchi Beach Hotel, Dar Es Salaam, 22nd September 2014
Healthcare NKRA in the next 3 years

- 80% of primary health facilities to be rated 3 Stars and above
- 100% balanced distribution of skilled health workers at primary level
- 100% stock availability of essential medicines
- 20% reduction in maternal mortality ratio and neonatal mortality rate in 5 regions

**June 2018**
- 2,623 dispensaries with minimum one skilled HRH
- 22.5 million Total OPD Visits to benefits in improved Health services
- 8.2 million under-5 OPD Visits
- 3,849 additional Health facilities with 100% Stock Availability
- 80% of health facilities at identified regions are elevated from level 1 & 2 to level 3 and above

**December 2017**
- 100% stock availability
- 90% average inventory accuracy rate
- 8 regions to implement HRH redistribution between their own districts

**June 2016**
- 13 million follow up SMSes sent through mHealth system
- 4 Blood units collected
- Average order lead time of 14 days
- Average order turnaround time (MSD) of 3 days
- 90% on-time delivery of ordered items

**June 2015**
- 6,760 Health Facilities to be rated from Star 1 – 5
- Signing of contract between MSD and Private sector distribution at 5 regions

**December 2015**
- 15% reduction in the number of facilities without Skilled HRH nationwide
- 45 unmanned Health facilities operational with skilled private HRH
- 70% of graduated bonded students who serves in healthcare facilities

**June 2017**
- 60% of health facilities at identified regions are elevated from level 1 & 2 to level 3 and above
- 80% of health facilities open and use own bank account
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Healthcare in Tanzania in a glance

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<tr>
<th>Total Population:</th>
<th>44.93 mil</th>
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<tr>
<td>Under 15 years old:</td>
<td>44.1%</td>
</tr>
<tr>
<td>15-64 years old:</td>
<td>52.2%</td>
</tr>
<tr>
<td>65 years &amp; above:</td>
<td>3.8%</td>
</tr>
<tr>
<td>Annual Population Growth rate:</td>
<td>2.7%</td>
</tr>
<tr>
<td>Life expectancy at birth (years):</td>
<td>61(M)/58(F)</td>
</tr>
<tr>
<td>Under 5 Mortality Rate/1,000 live births</td>
<td>81</td>
</tr>
<tr>
<td>Infant Mortality Rate / 1,000 live births:</td>
<td>51</td>
</tr>
<tr>
<td>Maternal Mortality Rate/per 100,000 live birth</td>
<td>454</td>
</tr>
<tr>
<td>Births in health facilities</td>
<td>58%</td>
</tr>
<tr>
<td>Skilled Birth Attendance</td>
<td>62%</td>
</tr>
<tr>
<td>Leading Cause of Admission and Death in Hospitals</td>
<td>Malaria</td>
</tr>
<tr>
<td>Prevalence of Malaria Parasitemia (&lt;5)</td>
<td>9.2%</td>
</tr>
<tr>
<td>HIV Prevalence, 14-49</td>
<td>5.3%</td>
</tr>
<tr>
<td>ART Coverage among persons with advanced HIV</td>
<td>65.3%</td>
</tr>
<tr>
<td>Hospital admission per 100 persons per year</td>
<td>3.6</td>
</tr>
<tr>
<td>OPD visits per person per year</td>
<td>0.7</td>
</tr>
</tbody>
</table>

<table>
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<tr>
<th>Total Health Expenditure per capita</th>
<th>USD 37.3</th>
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<tr>
<td>Govt. Expenditure on Health per capita</td>
<td>USD 14.7</td>
</tr>
<tr>
<td>Govt. Expenditure of Health as % of Total Govt. Expenditure</td>
<td>11.1%</td>
</tr>
<tr>
<td>Out of pocket expenditure</td>
<td>31%</td>
</tr>
<tr>
<td>Total No. of Doctors</td>
<td>2,269</td>
</tr>
<tr>
<td>Total No. of Paramedical practitioners</td>
<td>7,874</td>
</tr>
<tr>
<td>Total number nurses/midwives</td>
<td>21,736</td>
</tr>
<tr>
<td>Total health professionals per 10,000 pop</td>
<td>7.3</td>
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In 1999, Tanzanian Government launched Tanzanian Development Vision 2025 and healthcare has been one of the primary focus...

**Higher quality of livelihood**

1. Access to quality primary health care for all

2. Access to quality reproductive health service for all individuals of appropriate ages

3. Reduction in infant and maternal mortality rates by three quarters of current levels
...and various healthcare strategic plans have been developed to enhance the healthcare services

<table>
<thead>
<tr>
<th>Healthcare Strategic Plans</th>
<th>Maternal &amp; child health/ mortality</th>
<th>Disease prevention and control</th>
<th>Health facilities, Infra &amp; service delivery</th>
<th>Healthcare human resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. National Strategy for Growth and Reduction of Poverty (NSGRP)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>2. Tanzania’s Health Sector Strategic Plan III (HSSP III)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>3. Primary Health Services Development Programme (PHSDP) 2007 – 2017</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>5. The National Road Map Strategic Plan To Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>
In addition, Healthcare related Programmes introduced by Development partners have been generally focussed on combating infectious diseases, followed by Mother and Child Health.

Women, newborn and children are the most vulnerable group, despite an overall decrease in infant mortality rate and an increase in life expectancy.

A generalised HIV/AIDS epidemic on the mainland and other widespread communicable diseases – tuberculosis (TB), malaria, respiratory infections, and diarrheal diseases.

Malaria is the leading cause of death for Tanzanian children and is a major cause of maternal mortality, though there has been more than 75% reduction of malarial cases in 2009 compared to the 2000-2004 average.

Underlying food insecurity leads to nutritional deficiencies especially in rural mainland – Vitamin A, iodine, iron etc.

**Sources:** Tanzania Global Health Initiative Strategy (2010 – 2015); WHO; UNICEF
The health status of the Tanzania population has continued to improve in recent years. This is evidenced by the improvement of the life expectancy at birth.

Source: World Bank; CIA World Factbook (2014 est.)
However, the life expectancy and mortality is still low compared to global average …

### Life expectancy at birth – WHO Region (2012)

- **Global average**
- **Africa**
- **Tanzania**
- **South-East Asia**
- **Eastern Mediterranean**
- **Western Pacific**
- **Americas**
- **Europe**

### Adult mortality – WHO Region (2012)

- **Global average - 156**
- **Africa**
- **Tanzania**
- **South-East Asia**
- **Eastern Mediterranean**
- **Western Pacific**
- **Americas**
- **Europe**

Various reports show that Tanzania has mixed performance across the health care sector between 2009 – 2013

**What went well**

- **50% of HSSP III indicators improved significantly between 2009 – 2012** and are on-track to achieve target by 2015.
- Most of these activities involved preventive measures and treatments

**50% of HSSP III’s plans are NOT on-track**

**What can be improved**

- **27.5% of HSSP III indicators have NOT improved** partly due to wide gaps between issues pertaining to gender, geographical locality, lack of required skillsets among local medical staffs and community capabilities to afford healthcare services
- Most of these indicators require capacity building and manpower in serving the general populace

**What needs to be addressed**

- **22.5% of HSSP III indicators’ performance worsened** due to lack of awareness, lack of facilities, drugs and poor nutritional conditions
- These initiatives often require sufficient funding to improve the condition

Source: MoH, team analysis
There are significant regional differences in HMDG Coverage in Tanzania

Legend
- <55% HMDG Coverage
- 55-59% HMDG Coverage
- >60% HMDG Coverage

Poor performing regions
- Regions that have weaker health systems than expected on the basis of their level of socioeconomic development
- Poorest 40% made up 49% of these regions’ total population
- Between 98 -109 under 5 mortality rate per 1,000 births
- Skilled birth attendance below 62% (national average)
- High fertility rate ~7.1 children per mother
- FP Satisfied rate ranges between 6%-40% & below national average

Average performers
- Regions where the strength of the health system is what one would expect on the basis of their level of development
- Poorest 40% made up 44% of these regions’ total population
- Between 58 -109 under 5 mortality rate per 1,000 births
- Skilled birth attendance around national average
- Average fertility rate ~5.3 children per mother
- FP Satisfied rate averages at 40-60% (~national average)

Good performers
- Regions that have stronger health system than expected on the basis of their level of socioeconomic development
- Poorest 40% made up 37% of these regions’ total population
- Averages 85 under 5 mortality rate per 1,000 births
- Skilled birth attendance above national average
- Low fertility rate ~3.1 children per mother
- FP Satisfied rate averages above national average (i.e. 60% & above)

SOURCE : Tanzania HSSP III Midterm analytical review (2012)
This is partly contributed by significant regional differences in Health system strength in Tanzania

*based on 2011-2012 data from HMIS

(1) (Health facility density + Hospital beds density) /2
(2) Clinicians and nurse-midwife density
(3) (Admission rates, case fatality rates, OPD utilization rates) /3
There are multiple issues and challenges currently faced by Tanzania’s Healthcare Sector

<table>
<thead>
<tr>
<th>Area</th>
<th>Key Challenges</th>
</tr>
</thead>
</table>
| Health Facilities         | • Most Hospitals and clinics have inadequate and with limited facilities (SARA, SIKIKA)  
                              • The barriers of healthcare goals: healthcare infrastructure, health worker coverage, decentralisation of health system, and procurement bottlenecks |
| Service Delivery          | • Unsatisfactory quality of health care provision at all levels and the drop in the performance of healthcare services due to the limited human resources  
                              • The performance and efficiency of the forecasting, procurement, supply and quality control for essential medicines and vaccines are inadequate  
                              • Major barriers to access delivery services including long distance to health facility, lack of transportation and unfriendly services  
                              • Referral system has serious challenges including limited number of ambulances; unreliable logistics and communication system; and low community based facilitated referral system |
| Human Resource for Health | • Widespread shortages (~ 50% - 70%) of qualified health workers exist at all levels (i.e. specialised/regional/district hospitals, health centres, dispensaries, etc) and more severe in rural districts.  
                              • There are disparities in the distribution of human resources between urban and rural areas  
                              • The shortages of staff is exacerbated by the increasing burden of disease |
There are multiple issues and challenges currently faced by Tanzania’s Healthcare Sector (Cont.)

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<th>Area</th>
<th>Key Challenges</th>
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<tr>
<td>Health Information System</td>
<td>• There current Health Management Information System (HMIS) is expected to collect data from all health facilities but reporting is often incomplete</td>
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<td>• Information from the system is often irretrievable due to insufficient capacity for data analysis.</td>
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<td>• As a result, the health sector remains over-reliant on surveys for planning and monitoring</td>
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<tr>
<td>Health Financing</td>
<td>• Under funding of the healthcare sector has undermined the health infrastructure across the country</td>
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<td>• The inputs to the sector in terms of equipment, supplies, transport and communication remain insufficient</td>
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<td>• Tanzania’s healthcare system functions in an environment of limited financial and human resources, and the overall budget relies heavily on foreign aid – the mainland’s 2009/10 health sector budget was approximately $684.3 million, of which 36% came from donor sources</td>
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<tr>
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<td>• Medical services require payment upfront/a prepaid plan (National Insurance). Only 8.6% of the population can afford the insurance – those who cannot afford are unable to enroll in the insurance scheme and are less likely to get treatment</td>
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Many programmes and plans are in place but have yet to yield favorable results, it’s a long journey to achieve Tanzania’s Aspiration.

1999
Tanzanian Government launched Tanzanian Development Vision 2025 and healthcare has been one of the primary focuses.

2000 - 2013
Various Healthcare-centric programmes were developed over the years aiming to achieve TDV 2025’s goal.

2000 – 2013
The Healthcare sector is not doing well among the peers...

2013
Current results 50% of HSSP III’s plans are NOT on-track.

2014 onwards
Without Healthy population, Tanzania will NOT achieve its aspiration.

2014 onwards
Long way to catch up to catalyse the effort in achieving the aspired productive & healthy Tanzanian population by 2025.
Tanzania’s healthcare performed better than its peer but lower than global average

**Tanzania’s Healthcare performance in East Africa**

**Life Expectancy at Birth (2012) - East African Community**
- Tanzania: 61 years
- Global: ~64 years
- EAC: ~59 years

**Under 5 Mortality Rates (2012) - East African Community**
- Tanzania: 54 deaths per 1,000 live births
- Global: 48 deaths per 1,000 live births
- EAC: 57 deaths per 1,000 live births

**Maternal Mortality Rates (2012) - East African Community**
- Tanzania: 410 deaths per 100,000 live births
- Global: 500 deaths per 100,000 live births
- EAC: 446 deaths per 100,000 live births

**Overview of Tanzania’s Healthcare statistics**

- In 2012, Tanzania performed at ~5% above the average life expectancy rate in Africa but slightly below Global average life expectancy age of 64 years for an average individual. In Tanzania, the life expectancy at birth is recorded at 61 years of age on average.

- Globally, Tanzania is still considered having high Under 5 mortality rate at ~11% above global average of 48 deaths for every 1,000 live births. Tanzania currently registers ~54 deaths per 1,000 live births.

- Maternal mortality rate (MMR) in Tanzania is second highest regionally, after Burundi. In 2012, the country registered 410 deaths for every 100,000 live births, which is about ~49% higher than global average although considered relatively low compared to other African countries (i.e. WHO indicated Africa’s MMR at 500 in 2012).

- Regionally, Tanzania performed better than its peers in achieving a higher life expectancy at birth and its under 5 mortality rates. However, Tanzania’s Maternal mortality rate is among the lowest in EAC, performing at ~8% higher than the EAC average MMR of 446 deaths per 100,000 live births. The high EAC MMR rates are partly contributed by poor performance in Burundi and Tanzania.

SOURCE: WHO (2012)
As Tanzania is heading towards middle income country status, its healthcare status performance should be heading towards that of other middle income countries.

**Characteristics of middle income countries:**
- Improved productivity
- Improved learning
- Reduced family size & poverty
- Improved disease environments
- Higher accumulation of wealth
- Higher investment attractiveness

**SOURCE:** WHO, Worldbank, Gapminder, Team analysis
Poor health reduces GDP per capita by reducing both labor productivity and the relative size of the labor force.

- **Child illness**
  - Higher fertility and child mortality
  - Reduced access to natural resources & global economy
  - Reduced investment in physical capital
  - Lower GDP per capita
  - Higher dependency ratio
  - Labor force reduced by mortality and early retirement

- **Adult illness & malnutrition**
  - Reduced access to natural resources & global economy
  - Reduced investment in physical capital
  - Lower GDP per capita
  - Higher dependency ratio
  - Labor force reduced by mortality and early retirement

**Legend**
- Yellow: Implications
- Blue: Economic impact
- Red: Social impact

Without a healthy population, Tanzania risks NOT achieving TDV2025’s Aspirations…

USD 272.6 million\(^1\)

Losses to GDP

420,000 total mortality

A portion of USD 431 million\(^2\)
Spent on Treatment could be used for development purposes…

Note:

(1) Based on WSP’s studies on average annual lost due to premature deaths, productivity losses due whilst sick or assessing healthcare and loss in national income due to burden of chronic diseases. The 5 key diseases encompassed Diarrhea, LRI, infectious diseases, NTD, Malaria, Diabetes, Cardio & circulatory diseases, etc.

(2) MoF’s 2013/14 Budget allocation based on annual average exchange rate at TSH 1618 per dollar

Source: WSP, WHO, IHME, GBD 2010, MoHSW Midterm review, MoF, team analysis
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Healthcare NKRA is the 8th Lab under the Big Results Now program, which is an integral part of Tanzania’s Development Vision 2025

Tanzania Development Vision 2025

• Overarching development goals
• Launched 2000

MKUKUTA

Long Term Perspective Plan (LTPP)

*FYDP I
- HSSP III
- One Plan

*FYDP II
- HSSP IV
- Plan Two

*FYDP III
- HSSP V

Healthcare NKRA

Catalytic projects with Big Fast Results

2015/16 Annual Dev. Plan
2016/17 Annual Dev. Plan
2017/18 Annual Dev. Plan

BRN is a methodology with an aim to instill accountability and discipline of implementation

*Five-Year Development Plan
Lab is the 2nd step in BRN Transformation Methodology

1. **Strategic Direction**
   - Leadership retreats/workshops to ascertain the direction needed

2. **Labs**
   - Establish in detail what needs to be done

3. **Open Day**
   - Share lab output with people and seek their feedback

4. **BRN Roadmap**
   - Tell the people what we are going to do

5. **KPI targets**
   - Setting KPIs for the whole Cabinet

6. **Implementation**
   - Problem solving, on the ground implementation

7. **IPR / Verification**
   - External validation on results achieved

8. **Annual report**
   - Tell the people what we have delivered
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GoTz Decided to conduct Healthcare NKRA Lab

Pre-Lab consultative meeting

Aug’ 2014

Sep’ 2014

Sep – Oct’ 2014

Jan’ 2015

4-days rigorous discussions among 80 key decision makers and leaders in industry including the Minister, PS, CMO and DPS PMO-RALG to set direction for NKRA Healthcare Lab

Pre-Lab Analysis
Numerous follow up discussions and stakeholders engagement to deep dive on sectorial issues to set a baseline study for identified focused areas

Healthcare NKRA Lab
From over 100 initiatives proposed, over 100 lab members have subsequently deep-dived and prioritized 22 key initiatives & enablers to be implemented in the next 3 years
In Pre-lab consultative meeting, 80 leaders in Tanzania’s healthcare sector came up with a long list of issues

The team discussed, debated and shortlisted from 41 to 19 key challenges

1. Limited resources
2. Address Not Communicable Disease (Diability)
3. Coverage of services
4. Communicating results and awareness of services, awareness of health problems/citizens feedback
5. Governance issues between federal and local/regional
6. Financing healthcare, how do we treat the dollar
7. Improve pecuniary health financing
8. Interdependency among support agencies
9. Infrastructure availability (hospitals without basic utilities, equipment and medications)
10. Incentives for those investing
11. Availability of drugs at health facilities/stockage
12. Health research - neglected (financing, environment)
13. Wides coverage of NHIF
14. Insurance use (not encouraged)
15. Ability to pay and willingness to pay - insurance premiums
16. Integration of services at public institutions
17. Healthcare for vulnerable group
18. Welfare of social welfare officers
19. Investing in technology/capitalized in technology to solve health problems
20. Local production of medical goods
21. Budget for MoH
22. Quality issues/professional practice
23. Collaboration between professional associations and councils
24. Encourage health Tourism
25. How do we invest in healthcare - financial and human capital development
26. Shared funding - integrated funding (NGO/Donor agencies)
27. Skills gap (encourage training of community volunteers)
28. Market based solutions
29. Unlocking the value of the government research
30. Venture Capitalist – financing

Source: BRN Pre-Lab Consultative Meeting
During Pre-lab Consultative meeting, 4 key areas were identified

Prioritization Matrices

4 Focus Areas identified

- Uncoordinated community health worker initiatives
- Failure to capitalize in (ICT) technology to solve health problems
- Inadequate availability & irrational use of commodity
- Lack of Private Sector participations

~80 Leaders in Healthcare sector in Tanzania agreed to leverage on communications technology, community participation, healthcare commodity and private sector participation to move our health agenda forward
Through subsequent syndications and stress test, we have narrowed the areas into 2 main work streams

Key parameters

- BRN Terms? (3 years)
- Additional cost?
- Need to change policies?
- Need more people to implement?
- Impact to population?
- Impact to health?
- A ready-made solution?
- Enforcement of regulation?
- Political impact?
- Results in 1 year?
- Under MoHSW jurisdiction?
- Is it sustainable?
- Nationwide initiative?
- Geographical focus?
- Is it transformational?

Key Work-streams Identified

- Redeployment & distribution policies
- Human Resources for Health
- Performance Management of Health Facilities, HRH & Quality of Services
- Commodities distribution
- Inventory Management
- Performance Management
- Health Commodities Management
Due to relatively poor performance in Reproductive, Maternal and Child care services (RMNCH) in 5 regions, the healthcare lab included a special focus under RMNCH work stream.

The aggregated score for percentage of usage of modern contraceptives and low delivery rates at institutions and combining both HMIS 2012 and DHS 2010.

The Lake Zones and Western Zone have the lowest performance in the areas of maternal and neonatal health care.

Low Performing Regions in Family Planning & Institutional Delivery

SOURCE : DHS 2010, HMIS 2012, Team Analysis
### Healthcare NKRA Lab participants

<table>
<thead>
<tr>
<th>Ministry of Health Social Welfare</th>
<th>Ministry of Finance</th>
<th>PMO-RALG</th>
<th>President's Office Remuneration Board</th>
<th>POPC</th>
<th>POPSM</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image" alt="Ministry of Health logo" /></td>
<td><img src="image" alt="Ministry of Finance logo" /></td>
<td><img src="image" alt="PMO-RALG logo" /></td>
<td><img src="image" alt="President's Office Remuneration Board logo" /></td>
<td><img src="image" alt="POPC logo" /></td>
<td><img src="image" alt="POPSM logo" /></td>
</tr>
</tbody>
</table>

**Key Metrics:**
- **138 members**
- **65 agencies**
- **22 initiatives**
- **4 Work streams**
- **32,000 man hours of work**
Healthcare NKRA focuses on 2 sub-sector of Health system under HSSP III & a special focus on RMNCH...
BRN Healthcare Lab (22 Sep – 31 Oct 2014)

**WEEK 1**
(Sep 22 – 26)
Key challenge identification

**WEEK 2**
(Sep 29 – Oct 3)
Problem definition and prioritisation

**WEEK 3**
(Oct 6 – 10)
Big ideas brainstorming and solution identification

**WEEK 4**
(Oct 13 – 17)
10,000 ft & 1,000 ft implementation programme writing

**WEEK 5**
(Oct 20 – 24)
3 ft Detailed implementation programme writing & Budget calculation

**WEEK 6**
(Oct 27 – 31)
Finalisation & documentation Detail budget

The lab output increased delivery capabilities for participants and momentum for initiatives
Based on the aspirations, lab has prioritised the most crucial challenges

Prioritisation of key challenges in Tanzania’s Healthcare sector

Key challenges identified:
- Human Resources for Health – 12 challenges
- Health facilities – 12 challenges
- Health commodities – 7 challenges
- RMNCH – 30 challenges

1. Insufficient retention packages (i.e. housing for staff)
2. Undue influences in posting of staff
3. Lack of amenities in rural areas
4. No mid career recruitment for public sector
5. Mismatch between advertisement and existing labour market
6. Unclear lines of collaboration in PPP
7. Delayed posting of graduates from health institutions
8. Lack of tracking mechanism of posted staff at MoHSW
9. Mismatch between required cadre and budgeted allocation
10. Lack of feedback mechanism to LGA on recruitment process
11. Negative attitude and professionalism of HRH at health facilities
12. Experience of corruption and favoritism in health facilities
13. Inadequate use of info for planning and service improvement
14. Unfavorable conditions for handling emergency cases
15. Distraction from planned service delivery activities
16. Poor implementation & enforcement of guidelines and circulars
18. Lack of accountability, rewards & consequences
19. Limited autonomy at lower level health facilities
20. Procurement process for tracer medicines takes too long
21. Inaccurate quantity procurement due to inadequate quantification
22. Erosion of MSD working capital
23. Weak inventory management and storage management
Healthcare NKRA Lab focuses on 4 key areas

Current Situation in Tanzania

- **13 regions** are below National Averages for Density of Clinicians and Nurses
- **Inequalities in the distribution of skill mix**
- **554 Dispensaries** across the countries without Skilled Health Workers

Areas of Focus

- Develop universal distribution mechanism
- Streamlining Recruitment and Supply Processes
- Develop Implementation plan for national roll-out and incentives to sustain health workers distribution

Health Commodities

- **Funding gap** of around TZS120bn for procurement of essential medicines
- **Low order fulfillment rate** (35%)
- **Pilferages** of commodities are **rampant**
- **Actors** along supply chain **are not monitored**

Performance Management

- **81%** of health facilities suffer poor sanitation system
- Incidence of **corruption** is as high as 69%
- **>50% of health workers are absent** or late during work hours

Areas of Focus

- Improving supply chain management
- Improving financing of Health commodities
- Ensure governance accountability throughout all levels of supply chain

RMNCH

- **Low annual reduction rate** for MMR & NMR compared to countries with similar economic demographic (i.e. Bangladesh, Vietnam, etc)
- **Only 25% health facilities** are able to provide all 7 signal functions required for BEmONC

Areas of Focus

- Roll out Community awareness programs & upgrade existing health facilities to BEmONC & CEmONC standards
- Enablers for CEmONC and BEmONC facilities

SOURCE : BRN Healthcare Lab
... and identified 22 initiatives and enablers for Big Results Now!

1. Prioritize employment permits allocation
2. Skilled HRH through PPP/Private Engagement
3. Redistribution of healthcare workers within region
4. Optimising the pool of new recruits
5. Synchronize recruitment process @ Central level
6. Empowering LGAs in Human Resource Management
7. Implement Star Rating System
8. Fiscal decentralisation by devolution
9. Social Accountability
10. Performance targets & contracts
11. Improve Governance & accountability
12. Strengthen management of MSD’s Finance
13. Private sector to complement MSD
14. ICT platform through Mobile Apps for tracking
15. Introduce SMS for community reporting
16. Scale up 5S-Kaizen TQM initiatives
17. Community Health workers for RMNCH
18. mHealth (SMS) and MCHW App through PPP
19. CEmONC services expansion
20. BEmONC services expansion
21. Regional Satellite blood bank facilities
22. 360 Degree Mass media campaign through PPP

Special focus: RMNCH
## Executive Summary

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>1</td>
<td>Healthcare NKRA in a glance</td>
</tr>
<tr>
<td>2</td>
<td>Overview of Healthcare in Tanzania</td>
</tr>
<tr>
<td>3</td>
<td>Cases for change</td>
</tr>
<tr>
<td>4</td>
<td>BRN and Healthcare as NKRA</td>
</tr>
<tr>
<td>5</td>
<td>BRN Healthcare Lab</td>
</tr>
<tr>
<td>6</td>
<td>Healthcare NKRA Implementation plan</td>
</tr>
</tbody>
</table>
22 Initiatives and enablers to be rolled out in 3 Years (2015 – 2018)

3 years roll-out plans

Implementing 22 Initiatives

- Prioritize employment permits allocation
- Skilled HRH through PPP/Private Engagement
- Implement Star Rating System
- Fiscal decentralisation by devolution
- Performance targets & contracts
- Optimising the pool of new recruits
- Synchronize recruitment process at Central level
- ICT platform through Mobile Apps for tracking
- Scale up SS-Katzen TIM initiatives
- Social Accountability
- Private sector to complement MSD
- Empowering LGAs in Human Resource Management
- Improve Governance & accountability
- Introduce SMS for community reporting
- Redistribute of healthcare workers within region
- CEmONC services expansion
- BEmONC services expansion
- Community Health workers for RMNCH
- 360 Degree Mass media campaign through PPP
- Strengthen management of MSD’s Finance
- Regional Satellite blood bank facilities
- mHealth (SMS) and MOXAP App through PPP
Human Resources for Health

**HRHD**

### Implementation will be done in 3 phases… (1/4)

<table>
<thead>
<tr>
<th>Phase 1</th>
<th>Phase 2</th>
<th>Phase 3</th>
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</thead>
</table>

- Prioritise allocation of employment permits to 9 targeted regions with critical skilled HRH shortage and ensure prioritization of the underserved regions for the period between 2015 - 2018 to ensure balanced HRH distribution is achieved
- Provide skilled HRH through PPP/Private sector engagement
- Synchronising the recruitment process at the Central level
- Empower LGAs recruitment & retention
- Reinforce orientations and induction for newly hired staff
- Enforcing retention & incentive policy at LGA
- Ring fencing New HRH recruits entitlements (subsistence allowance)

- Redistribution of health care workers within the regions reinforcement of HRH redistribution within and between LGA in a region to ensure balanced distribution of staff.
- Reinforce bonding policy
- Introduce compulsory attachments for clinicians and nurses
- Develop coaching and mentoring model to strengthen skills of human resource management
- Redistribution of HRH within regions

**SOURCE : BRN Healthcare Lab (2014)**
Implementation will be done in 3 phases… (2/4)

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>▪ Assessment, rating and identification of specific strengthening programme for primary level health facilities                                                                                                                                                                                                                                                                                                                                                             ▪ Specific strengthening of health facilities based on assessment at selected regions                                                                                                                                                                                                                                                                                                                                                          ▪ 80% of health facilities to be at 3-Star at selected regions</td>
<td></td>
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<tr>
<td>▪ Use of performance targets and contracts at the primary facilities                                                                                                                                                                                                                                                                                                                                                                                                  ▪ Implement fiscal decentralization by devolution from council level to health facility level</td>
<td></td>
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<tr>
<td>▪ Increase social accountability at facility level to address local health priorities/concerns</td>
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</tr>
</tbody>
</table>

SOURCE : BRN Healthcare Lab (2014)
Implementation will be done in 3 phases… (3/4)

**Phase 1**
(Jan 2015 – June 2015)
- Introduction of Donation Checklist to coordinate vertical Programmes
- Appointment of Prime vendors to complement MSD in distribution
- Issuance of updated cost sharing guidelines to LGAs
- Fast tracking MSD roll out of Prime vendors countrywide to 8 zones
- Fast tracking MSD Direct Delivery by outsourcing distribution services to private sector from zone stores to health facilities

**Phase 2**
(July 2015 – June 2018)
- Restore MSD working capital for self sustainability through, repayment of debt, frontloading of funds and coordination of vertical program commodities.
- Incorporate MSD to allow for commercial operation including strategic investors engagement and development partners engagement
- Implement operating cost reduction initiative
- Create internal and external controls to address pilferages
- Improved management of supply chain actors
- Introducing performance based reward framework
- Introduction of ICT mobile apps platform (eLMIS, ILSGateway, DHIS2) lower level facilities
- Roll out SMS initiative to report commodities stock-outs by community
- Implementation of quality improvements interventions (5S-KAIZEN-TQM)

**Phase 3**
(July 2018 onwards)
- Off take agreement with domestic manufacturers for production of 6 identified tracer medicines

**HC**
Health Commodities

**Source:** BRN Healthcare Lab (2014)
Implementation will be done in 3 phases… (4/4)

<table>
<thead>
<tr>
<th>Phase 1</th>
<th>Phase 2</th>
<th>Phase 3</th>
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</table>
| ▪ Task shifting of provision of CEmONC signal functions to the well skilled, and mentored, motivated lower cadre staff
  ▪ Improve the supply of appropriate equipments, instruments, medicines and supplies to facilitate CEmONC at strategically selected health centres
  ▪ Improve the Referral Health System to support CEmONC at strategically selected health facilities to address Second Phase Delay
  ▪ Conduct needs assessment for each facility to be upgraded to BEMoNC
  ▪ Re-emphasise training and induction programs for health workers to increase skills and work performance
  ▪ Community Health workers to improve RMNCH Services
  ▪ Use of Mobile phones SMS to facilitate utilization of RMNCH service launched
  ▪ Develop integrated 360 Degree mass media campaign that can be multi sponsored through PPP | ▪ Improved sanitation and health care waste management at health facility.
  ▪ Institutionalise the use of mentorship teams who will inspire other health care workers to build up skills and positive attitude
  ▪ Enhancing RMNCH services uptake through Outreach services to hard to reach communities
  ▪ Establish 5 Regional satellites blood transfusion centres in the 5 targeted regions | ▪ To be determined by MoHSW & Implementers |

SOURCE: BRN Healthcare Lab (2014)
Phase 1 Roll-out Plan: Jan 2015 – June 2015

SOURCE: BRN Healthcare Lab (2014)
Phase 2 Roll-out Plan: July 2015 – June 2018

SOURCE: BRN Healthcare Lab (2014)
## Regional implementation timeline (1/2)

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Simiyu</td>
<td>HRHD</td>
<td>HC</td>
</tr>
<tr>
<td>Geita</td>
<td>HRHD</td>
<td>HC</td>
</tr>
<tr>
<td>Kigoma</td>
<td>HRHD</td>
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<tr>
<td>Mwanza</td>
<td>HC</td>
<td>SR</td>
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<tr>
<td>Mara</td>
<td>HC</td>
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<tr>
<td>Kagera</td>
<td>HRHD</td>
<td>HC</td>
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<tr>
<td>Shinyanga</td>
<td>HRHD</td>
<td>HC</td>
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<tr>
<td>Rukwa</td>
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<td>Katavi</td>
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<td>HC</td>
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<tr>
<td>Tabora</td>
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<tr>
<td>Singida</td>
<td>HRHD</td>
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<tr>
<td>Morogoro</td>
<td>HC</td>
<td></td>
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<tr>
<td>Dar Es Salaam</td>
<td>HC</td>
<td></td>
</tr>
<tr>
<td>Pwani</td>
<td>HC</td>
<td></td>
</tr>
</tbody>
</table>

*Subject to changes based on assessments (i.e. HRH Distribution, RMNCH Programmes & Star Rating assessments)

SOURCE: Healthcare NKRA lab
# Regional implementation timeline (2/2)

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Dodoma</td>
<td>SR</td>
<td>HC</td>
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<tr>
<td>Arusha</td>
<td>SR</td>
<td>HC</td>
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<tr>
<td>Manyara</td>
<td>SR</td>
<td>HC</td>
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<tr>
<td>Mbeya</td>
<td>SR</td>
<td>HC</td>
</tr>
<tr>
<td>Tanga</td>
<td>SR</td>
<td>HC</td>
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<tr>
<td>Mtwara</td>
<td>SR</td>
<td>HC</td>
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<tr>
<td>Lindi</td>
<td>SR</td>
<td>HC</td>
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<tr>
<td>Kilimanjaro</td>
<td>SR</td>
<td>HC</td>
</tr>
<tr>
<td>Iringa</td>
<td>SR</td>
<td>HC</td>
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<tr>
<td>Ruvuma</td>
<td>SR</td>
<td>HC</td>
</tr>
<tr>
<td>Njombe</td>
<td>SR</td>
<td>HC</td>
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</tbody>
</table>

*Subject to changes based on assessments (i.e. HRH Distribution, RMNCH Programmes & Star Rating assessments)
## Post Lab Syndications

<table>
<thead>
<tr>
<th><strong>Obtain Approval from key implementers</strong></th>
<th><strong>Develop Business Models</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Continue with the compulsory services</td>
<td>▪ N/A</td>
</tr>
<tr>
<td>▪ Rework on 3-feet plan to include the development and submission of Cabinet papers</td>
<td></td>
</tr>
<tr>
<td>▪ Decision to fast track the initiatives</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th><strong>Human Resources for Health</strong></th>
<th><strong>Health Facilities</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Director of Health Quality Assurance, MoHSW has agreed with the action items to pre-test the assessment tool at Mkuranga district</td>
<td>▪ Post pre-testing, MoHSW to develop action plans for the nationwide assessment in Jan 2015</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Health Commodities</strong></th>
<th>****</th>
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<tbody>
<tr>
<td>▪ TELCOs’ confirmed that the use of ICT to improve healthcare services is implementable.</td>
<td>▪ Private Sectors have agreed to run the diagnostic services as a Prime Vendor. Moving forward, private sectors to develop a concept note describing the ideal business model for outsourcing a sustainable diagnostics services</td>
</tr>
<tr>
<td>▪ MDU to discuss the ICT implementation model and cost sharing during the implementation stage</td>
<td></td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>CONTENTS</th>
</tr>
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<tbody>
<tr>
<td>Executive Summary</td>
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<tr>
<td>Summary of Issues</td>
</tr>
<tr>
<td>1   Human Resources for Health</td>
</tr>
<tr>
<td>2   Performance Management for Health Facilities</td>
</tr>
<tr>
<td>3   Health Commodities</td>
</tr>
<tr>
<td>4   Reproductive, Maternal, Neonatal &amp; Child Health</td>
</tr>
<tr>
<td>Summary of Initiatives</td>
</tr>
<tr>
<td>High level targets and funding requirement</td>
</tr>
<tr>
<td>Overview of Initiatives by area of focus</td>
</tr>
<tr>
<td>Funding Requirement</td>
</tr>
<tr>
<td>Key Performance Indicators</td>
</tr>
<tr>
<td>Governance</td>
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</tr>
</tbody>
</table>
15 regions in Tanzania Mainland are below National Averages for Density of Clinicians and Nurses

**Density of Clinicians and nurses per 100,000 population**

<table>
<thead>
<tr>
<th>Region</th>
<th>Clinicians</th>
<th>Nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Above Nat Ave</td>
<td></td>
<td></td>
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<tr>
<td>Below Nat Ave</td>
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</tbody>
</table>

**Criticality of issues**

- **13 Regions**
  - Below National Average for Density of Skilled HRH per 10,000 population

- **15 Regions**
  - Below National Average for Density of Clinicians per 10,000 population

- **14 Regions**
  - Below National Average for Density of Nurses per 10,000 population

- **0 Region**
  - Achieve WHO Skilled attendance at birth 22.8 per 10,000 population

**Implications**

- About half of Tanzania mainland are below national averages for density of clinicians and nurses, this affect the quality of healthcare services in regions currently underserved

Source(s): MOHSW, BRN Lab Analysis
### Summary of Issues

<table>
<thead>
<tr>
<th></th>
<th>Issue</th>
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<tbody>
<tr>
<td>1</td>
<td>Human Resources for Health</td>
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<td>Performance Management for Health Facilities</td>
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<td>3</td>
<td>Health Commodities</td>
</tr>
<tr>
<td>4</td>
<td>Reproductive, Maternal, Neonatal &amp; Child Health</td>
</tr>
</tbody>
</table>
There are 13 key performance issues in Tanzania’s Healthcare at primary level

5 HRH issues

1. Lack of knowledge and skills among health workers
2. Negative attitude and professionalism
3. Lack of or incorrectly set personal performance indicators
4. Lack of accountability (with corruption and favouritism)
5. Lack of rewards and consequences

8 health facilities issues

1. Inadequate use of information collected at facility for planning and service improvement
2. Unfavourable conditions for handling emergency cases
3. Ineffective social accountability at the health facility level
4. Limited autonomy at lower level health facilities
5. Poor state of health infrastructure
6. Poor organisation of health services delivery
7. Poor facilities for handling biohazard wastes
8. Dysfunctional referral system
<table>
<thead>
<tr>
<th></th>
<th>Summary of Issues</th>
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<tr>
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</tr>
<tr>
<td>4</td>
<td>Reproductive, Maternal, Neonatal &amp; Child Health</td>
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</table>
There are 5 key bottlenecks contributed by several internal and external factors which affect proper governance of the health commodities supply chain.
## Summary of Issues

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<tbody>
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<tr>
<td>4</td>
<td>Reproductive, Maternal, Neonatal &amp; Child Health</td>
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</tbody>
</table>
Tanzania’s performance on MDG 5 target is still below target

- Neonatal mortality rate has declined from 32 deaths to 26 deaths per 1,000 live births by 2010.
- Under five mortality rate has declined from 112 to 81 per 1,000 births by 2010 (TDHS 2010), and have shown further decline in 2013 to 54 (UN Interagency Report). Achieving MDG 4 Target.
- Maternal mortality ratio from 578 per 100,000 (2004/05) to 453 per 1000,000 (TDHS 2010), recent estimates shows that the ratio is 410 per 100,000 (UN estimates).

7,900 mothers die each year due to complications during delivery and labour.

62.2% were due to obstetric complications.

## CONTENTS

### Executive Summary

### Summary of Issues

### Summary of Initiatives

1. Overview of Key initiatives
2. Initiatives for Human Resources for Health
3. Initiatives for Health Facilities
4. Initiatives for Health Commodities
5. Initiatives for Reproductive, maternal & child health

### High level targets and funding requirement

### Overview of Initiatives by area of focus

### Funding Requirement

### Key Performance Indicators

### Governance
## Summary of Initiatives

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
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<tbody>
<tr>
<td>1</td>
<td><strong>Overview of Key initiatives</strong></td>
</tr>
<tr>
<td>2</td>
<td>Initiatives for Human Resources for Health</td>
</tr>
<tr>
<td>3</td>
<td>Initiatives for Health Facilities</td>
</tr>
<tr>
<td>4</td>
<td>Initiatives for Health Commodities</td>
</tr>
<tr>
<td>5</td>
<td>Initiatives for Reproductive, maternal &amp; child health</td>
</tr>
</tbody>
</table>
## 22 Key initiatives under Healthcare NKRA

| 1 | Prioritize employment permits allocation |
| 2 | Skilled HRH through PPP/Private Engagement |
| 3 | Redistribution of healthcare workers within region |
| 4 | Optimising the pool of new recruits |
| 5 | Synchronize recruitment process @ Central level |
| 6 | Empowering LGAs in Human Resource Management |
| 7 | Implement Star Rating System |
| 8 | Fiscal decentralisation by devolution |
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| 22 | 360 Degree Mass media campaign through PPP |

**Special focus : RMNCH**
Our transformation vision for Tanzanian Healthcare system

### Healthy Tanzanians

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Reproductive &amp; Child Health</td>
<td>Prioritize allocation of Employment permits to regions with critical shortage of skilled HRH</td>
</tr>
<tr>
<td></td>
<td>Provide skilled HRH through PPP/Private sector engagement</td>
</tr>
<tr>
<td></td>
<td>Redistribution of healthcare workers within regions</td>
</tr>
<tr>
<td>Malaria, HIV/AIDS, TBs &amp; infectious diseases</td>
<td>Star Rating System</td>
</tr>
<tr>
<td></td>
<td>Fiscal decentralisation by devolution from council level to health facility level</td>
</tr>
<tr>
<td>Noncommunicable diseases &amp; injuries</td>
<td>Improving governance, Accountability, and sense of ownership of Health commodities supply chain</td>
</tr>
<tr>
<td></td>
<td>Strengthen management of MSD working capital for sustainable availability of medicines &amp; medical supplies</td>
</tr>
<tr>
<td>Others</td>
<td>To complement MSD in the procurement &amp; Distribution of medicines by engaging private sector</td>
</tr>
</tbody>
</table>

### Human Resources for Health

- Prioritize allocation of Employment permits to regions with critical shortage of skilled HRH
- Provide skilled HRH through PPP/Private sector engagement
- Redistribution of healthcare workers within regions

### Healthcare Facilities

- Star Rating System
- Fiscal decentralisation by devolution from council level to health facility level

### Health Commodities

- Improving governance, Accountability, and sense of ownership of Health commodities supply chain
- Strengthen management of MSD working capital for sustainable availability of medicines & medical supplies
- To complement MSD in the procurement & Distribution of medicines by engaging private sector

### Additional Activities

- Optimising the pool of new recruits
- Synchronize recruitment process @ Central level
- Empowering LGAs in Human Resource Management
- Social accountability
- Performance targets & contracts
- Introduction of ICT mobile apps platform for lower level facilities
- SMS to report on stock outs and quality of health services
- Scale up 5S-Kaizen TQM initiatives
### Summary of Initiatives

<table>
<thead>
<tr>
<th></th>
<th>Initiative</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Overview of Key initiatives</td>
</tr>
<tr>
<td>2</td>
<td><strong>Initiatives for Human Resources for Health</strong></td>
</tr>
<tr>
<td>3</td>
<td>Initiatives for Health Facilities</td>
</tr>
<tr>
<td>4</td>
<td>Initiatives for Health Commodities</td>
</tr>
<tr>
<td>5</td>
<td>Initiatives for Reproductive, maternal &amp; child health</td>
</tr>
</tbody>
</table>
# Prioritize utilisation of employment permits for regions with critical shortage of skilled HRH

<table>
<thead>
<tr>
<th>Title</th>
<th>Prioritize allocation of employment permits to regions with critical shortage of skilled HRH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief description</td>
<td>Negotiate for reallocation of approved funded posts for 2014/2015 to 9 targeted regions with critical skilled HRH shortage and ensure prioritization of the underserved regions for the period between 2015 - 2018 to ensure balanced HRH distribution is achieved.</td>
</tr>
<tr>
<td>Key Stakeholders</td>
<td>POPSM-HCM, PMO-RALG, LGAs</td>
</tr>
<tr>
<td>Project owner</td>
<td>MOHSW</td>
</tr>
<tr>
<td>Ease of implementation</td>
<td>Very High</td>
</tr>
</tbody>
</table>

## Case for change (as is)

Tanzania is facing a severe HRH crisis. The deficit across all cadres is 52% severely compromising provision of quality health services (MOHSW 2014). There are 33,768 nurses and clinicians, 72% provide services at the primary health level. (Health BRN, 2014). The HRH available to provide skilled attendance at birth is 7.74/10,000 population - a third of the WHO recommended level of 22.8/10,000.

HRH is unevenly distributed across regions, districts and health facilities. 74% of MDs are found in urban settings with a doctor population ratio being 17 times more favourable for urban. Kilimanjaro, Dar es Salaam and Mwanza have 3/4th of all skilled HRH (HRH Profile 2014). Katavi has the lowest density of nurses and clinicians of 2.75 per 10,000 population while Kilimanjaro has the highest at 15.5 per 10,000 (BRN 2014). 554 facilities are not functional because they don’t have a single health worker, 135 (25%) are in the 9 regions with critical HRH shortage (HMIS 2014).

The current HRH planning process is complex and relies on LGAs to identify their HRH needs and then submit them to POPSM for approval. The criteria used in honouring HRH requests does not take into account the existing distribution of skilled HRH workforce in the country.

## KPIs

- Prioritized regions at / above National Average (Density of Skilled HRH/10k population) 100%
- HRH situation analysis conducted and remedial plan developed Annually
- % of employment permits for skilled HRH allocated to primary health care services in identified regions with critical skilled HRH shortage 40%

## Aspiration (to be)

Prioritisation in allocation of employment permits for balanced distribution of skilled HRH at the primary health level in place and functioning.

## Key activity (task)

<table>
<thead>
<tr>
<th>Action party</th>
<th>State date</th>
<th>End date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health lab BRN</td>
<td>13 October 2014</td>
<td>31 October 2014</td>
</tr>
<tr>
<td>HCM-POPSM</td>
<td>3 November 2014</td>
<td>30 June 2017</td>
</tr>
<tr>
<td>PS-MOHSW</td>
<td>03 November 2014</td>
<td>30 June 2017</td>
</tr>
</tbody>
</table>

- Withhold process of posting skilled HRH to LGAs based on granted employment permits for 2014/15 to allow reassessment of HRH needs and re-allocation to the 9 regions with critical HRH shortage.
- POPSM supports prioritization of regions with critical HRH shortage in allocation of employment permits for the next 3 financial years (2015/2016, 2016/17 & 2017/18)
- Form a Special inter-ministerial HRH Distribution Task Force Group.
### Provide skilled HRH through PPP/Private sector engagement

<table>
<thead>
<tr>
<th><strong>Title</strong></th>
<th>Provide skilled HRH through PPP/Private sector engagement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Brief description</strong></td>
<td>The Public Healthcare facilities in the rural areas that are not functioning due to lack of skilled health workers. Initiative to focus to bring in private healthcare providers via Public Private Partnership (PPP) agreements to operate from government facilities to ensure that the public has access to healthcare.</td>
</tr>
<tr>
<td><strong>Key Stakeholders</strong></td>
<td>PPP implementers (APHTA, PRINMAT, FBOs etc), PMO-RALG, LGAs</td>
</tr>
<tr>
<td><strong>Project owner</strong></td>
<td>Ministry of Health and Social Welfare –PPP Department</td>
</tr>
<tr>
<td><strong>Ease of implementation</strong></td>
<td>Medium</td>
</tr>
</tbody>
</table>

### Case for change (as is)

There are currently 544 Dispensaries nationwide without any skilled HRH. In order to provide quick access to skilled HRH to the public, private sectors are to be invited to take control of the facilities with primary focus on the critical regions.

### Aspiration (to be)

Increase Private sector participation in rural areas via PPP agreements to ensure that 25% (135) of the 544 dispensaries are manned with private skilled health workers by 2017/2018

### Key activity (task) | Action party | State date | End date
---|---|---|---
Review and modify existing Service Level Agreement to be used for PPP arrangement. | MOHSW-PPP (lead), MOHSW - Legal | 3-Feb-15 | 27-Feb-15 |
Conduct individual engagement meetings with potential PPP implementers NGOs (PRINMAT and others) FBO and APHTA and LGA | MOHSW-PPP (lead), MOHSW - DHRD | 23-Mar-15 | 29-May-15 |
Roll out of PPP arrangements in 3 phases for 2015/2016, 2016/2017. 2017/2018. Expected 45 facilities to utilized by private implementers annually | LGAs,NGOs, FBOs, APHTA | 7-Sep-15 | 30-Jun-18 |

### Other Impact

- Estimated 1.4mn people with access to healthcare
- Rationalize building cost worth TZS 24.9 BN

### DP’s Funding

- N/A

### Total Private Investment

- TZS 10,327.5 mil

### Total Public Investment

- TZS 57,3 mil

### KPIs

| Number of Health facilities manned by skilled private HRH through PPP arrangements | 135 |
### Redistribution of health workers within the regions

<table>
<thead>
<tr>
<th>Title</th>
<th>Redistribution of health care workers within the regions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief description</td>
<td>Reinforcement of HRH redistribution within and between LGA in a region to ensure balanced distribution of staff.</td>
</tr>
<tr>
<td>Key Stakeholders</td>
<td>PMORALG, MOHSW</td>
</tr>
<tr>
<td>Project owner</td>
<td>RAS/DED</td>
</tr>
<tr>
<td>Ease of implementation</td>
<td>Medium</td>
</tr>
<tr>
<td>Other Impact</td>
<td>• May lead to redistribution of other cadres</td>
</tr>
<tr>
<td>Total Private Investment</td>
<td>N/A</td>
</tr>
<tr>
<td>DP’s Funding</td>
<td>N/A</td>
</tr>
<tr>
<td>Total Public Investment</td>
<td>TZS 3,426.9 mil</td>
</tr>
</tbody>
</table>

### Case for change (as is)

Currently there is inequalities in distribution of available health care workers within the LGA and between LGAs in the same region. Example; in one Health Centers in Namtumbo DC there were more than 20 nurses while in a dispensary 8km away there was no single nurse. These inequalities can be reduced by redistribution from one facility to another and from one LGA to another within a region.

### Aspiration (to be)

To ensure that skilled HRH are distributed equitability so as to ensure access to healthcare for all of the public.

### KPIs

- **Regions to implement HRH redistribution between their own districts**: 16 regions
- **Reduction in the number of facilities without Skilled HRH within the 16 regions**: 100%

### Key activity (task)

<table>
<thead>
<tr>
<th>Activity</th>
<th>Action party</th>
<th>Start date</th>
<th>End date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Formation and appointment of Taskforce to oversee HRH Distribution in 16 Regions</td>
<td>DLG – PMO-RALG</td>
<td>7-Apr-15</td>
<td>30-Apr-15</td>
</tr>
<tr>
<td>Phase I: Balanced Distribution of Health Care Workers Achieved in 8 Regions (Mwanza, Mtwara, Mara, Dodoma, Manyara, Ruvuma, Lindi and Tanga) in FY 2015/16</td>
<td>DLG – PMO-RALG</td>
<td>5-May-15</td>
<td>31-May-16</td>
</tr>
</tbody>
</table>
## Optimising the pool of new recruits: Reinforce bonding policy

<table>
<thead>
<tr>
<th>Title</th>
<th>Optimising the pool of new recruits: Reinforce bonding policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief description</td>
<td>Students and health workers of all cadres funded by the government are required to be engaged on contractual obligation to serve in the public health sector as per contractual obligation after graduation</td>
</tr>
<tr>
<td>Key stakeholders</td>
<td>Ministry of Health and Social Welfare, Ministry of Education and Vocational training – Loan board</td>
</tr>
<tr>
<td>Project owner</td>
<td>Ministry of Health and Social Welfare – Human resource for Health Department</td>
</tr>
<tr>
<td>Ease of implementation</td>
<td>High</td>
</tr>
</tbody>
</table>
| Other Impact | • More districts get better trained HRH  
• A more efficient use of government supported HRH  
• Better use of public resources |
| Total Private Investment | N/A |
| DP’s Funding | N/A |
| Total Public Investment | TZS 7.3 mil |
| KPIs |  |
| Number of graduates bonded by cadres | TBD |
| Number of graduated government scholars students who serves in government healthcare facilities | TBD |
| Casf for change (as is) | The Tanzania government spends enormous amounts of money in order to train skilled HRH. In 2013/2014 alone, Total amount of funds committed as grants to MD and Nursing students was TSH 5.56 bil by the Loans Board. Although bonding agreements are signed (ie students are required to serve the health sector whether in private or public facilities for 5 years), this is rarely enforce and there is no tracking of the whereabouts of the government scholars upon graduation. |
| Aspiration (to be) | To ensure that all skilled HRH which receives government assistance for their studies joins the healthcare sector |
| Key activity (task) | Action party | State date | End date |
| Policies, guidelines and standing orders related to bonding of all health care workers training reviewed and circular to guide the implementation of the bonding policy developed & disseminated | POPSM (Lead), PMORALG, MOHSW,LGAs, Professional councils, Higher learning Loan board | 7-Jan-15 | 30-Oct-15 |
| Bonding agreement revised to cover all government funded students at all levels | PoPSM, MoHSW- Legal section | 2-Nov-15 | 11-Dec-15 |
# Optimising the pool of new recruits: Compulsory attachments for Clinicians and Nurses

<table>
<thead>
<tr>
<th>Title</th>
<th>Optimising the pool of new recruits: Introduce Compulsory attachments for Clinicians and Nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief description</td>
<td>Newly recruited HRH (Nurses and clinicians) should be designated to work at primary health care level (mostly in rural areas) for two years as a pre-condition for professional registration. The cadres to be attached include Nurse, Clinical Assistants &amp; Officers and MD’s.</td>
</tr>
<tr>
<td>Key Stakeholders</td>
<td>Tanganyika Medical Council, The Nursing and Midwifery Council, PMORALG, Training Institutions, LGAs</td>
</tr>
<tr>
<td>Project owner</td>
<td>MoHSW</td>
</tr>
<tr>
<td>Ease of implementation</td>
<td>Low</td>
</tr>
</tbody>
</table>

### Case for change (as is)

Tanzania is facing a severe HRH crisis. The deficit across all cadres is 52% severely compromising provision of quality health services (MOHSW 2014). HRH is unevenly distributed across regions, districts and health facilities. 74% of MDs are found in urban settings with a doctor population ratio being 17 times more favourable for urban. Kilimanjaro, Dar es Salaam and Mwanza have 3/4th of all skilled HRH (HRH Profile 2014). Compulsory Service will act as a means to ensure that the supply for skilled HRH is increase to overcome the above mentioned challenges.

### Aspiration (to be)

To attach all newly recruited nurses and clinicians and to the Primary Health Care Facilities (priority being to the nine mostly marginalised regions).

<table>
<thead>
<tr>
<th>Key activity (task)</th>
<th>Action party</th>
<th>State date</th>
<th>End date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing and Midwifery Regulations amended &amp; Regulations developed for Medical and Dental Practitioners Act of 2014 to accommodate the two years compulsory Service</td>
<td>TNMC registrar, Registrar Tanganyika Medical council (lead) MoHSW (Head-Legal section),</td>
<td>1-Jan-15</td>
<td>15-Jun-15</td>
</tr>
<tr>
<td>Internal Circular on Compulsory Service Attachment at primary health care level for new recruits (Nurses and Clinicians) developed</td>
<td>MoHSW(DAHRM (lead) &amp; Legal Department), POPSM</td>
<td>1-Jun-15</td>
<td>30-Jun-15</td>
</tr>
<tr>
<td>Implementation, Monitoring and Evaluation of Compulsory Service attachment at primary health care level for new recruits</td>
<td>MoHSW (DAHRM) (Lead), PMORALG, LGAs</td>
<td>1-Sep-15</td>
<td>1-Apr-18</td>
</tr>
</tbody>
</table>

### Other Impact

- Newly graduated HRH better oriented
- Districts better served due to compulsory attachment

### Total Private Investment

N/A

### DP’s Funding

N/A

### Total Public Investment

N/A

### KPIs

- Compulsory Attachment status confirmed: 6 cadres
- Number students undergoing compulsory service: 100%
## Synchronising the recruitment process at the Central level

<table>
<thead>
<tr>
<th>Title</th>
<th>Synchronising the recruitment process at the Central level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief description</td>
<td>Direct posting of skilled healthcare workers immediately after graduation for middle level cadres and completion of internship training for graduate doctors and nurses</td>
</tr>
<tr>
<td>Project sponsor</td>
<td>Government – Ministry of Finance</td>
</tr>
<tr>
<td>Project owner</td>
<td>Presidents Office Public Service Management – Human Capital Department, Ministry of Health and Social Welfare</td>
</tr>
<tr>
<td>Ease of implementation</td>
<td>Medium</td>
</tr>
</tbody>
</table>

### Case for change (as is)

The current situation is that new healthcare workers complete their training between July and August, however the employment permit is released between second and third quarter of the respective financial year thus creating a gap between timing of completion of training and employment. In the cause of waiting the new graduates opt for alternative employment in other Institutions (NGOs), causing depletion to clinical work and creating imbalance between rural and urban HWs distribution.

### Aspiration (to be)

All new graduates are absorbed in the health care system immediately after graduation and completion of internship training for Doctors and graduate nurses to ensure balanced distribution.

### KPIs

- **Number of graduates of the seven cadres allocated employment permit by September 30**
  - 100%
- **% of posted graduates reporting to their duty stations in the LGAs**
  - 100%

### Other Impact

- Enhanced use of trained resources.
- Better, timely and fairer distribution of HRH in the districts.

### Total Private Investment

- N/A

### DP's Funding

- N/A

### Total Public Investment

- N/A

### Key activity (task) |
| Action party |
| Start date |
| End date |
| Identify needs of skilled healthcare workers in all health facilities (Public & Private) in LGAs | LGA/DMO | Nov, 2014 | June, 2018 |
| Established database of graduating skilled Health Workers from various Health Training Institutes | MOHSW, PMO-RALG, MOF & POPSM | Jul, 2015 | June, 2018 |
| Posting of skilled healthcare workers for 2015/2016 | DAHRM - MOHSW | October, 2015 | December, 2018 |
| Track posted healthcare workers in LGA health facilities | DAHRM - MOHSW | October 2015 | December 2018 |
### Empowering the LGAs in Human Resource Management (Reinforce orientations and induction for newly hired staff)

**Title**
Empowering the LGAs in Human Resource Management (Reinforce orientations and induction for newly hired staff)

**Brief description**
Institutionalization of systematic orientation and induction of all newly recruited staff at the LGA level to ensure better retention and awareness of working conditions.

**Key Stakeholders**
PMO-RALG, MOHSW

**Project owner**
LGAs/DED

**Ease of implementation**
High

**Case for change (as is)**
Newly hired staff are not being oriented and inducted at the LGA level leading to insufficient information with regards to their working environment, their roles as public servants and unrealistic expectations. Staff circular No. 4 of 2005, which directs all employers to conduct orientation and induction within 6 months of recruitment has been largely ignored by the LGAs due to financial constraints.

**Aspiration (to be)**
All newly recruited staff are systematically orientated and induced to enable them to adapt to the work environment and enhance retention.

**KPIs**

<table>
<thead>
<tr>
<th>KPIs</th>
<th>Case for change (as is)</th>
<th>Aspiration (to be)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No of newly recruited staff who have been oriented</td>
<td>100%</td>
<td>All LGAs</td>
</tr>
<tr>
<td>Execution of the Orientation and induction plans of LGAs annually</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Total Public Investment**
TZS 7,610,000

**Total Private Investment**
N/A

**DP’s Funding**
N/A

**Other Impact**
- LGAs able to manage better.
- Improved performance of hired HRH.

### Key activity (task)

<table>
<thead>
<tr>
<th>Action party</th>
<th>Start date</th>
<th>End date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developed a draft directive letter to instruct Council Directors conduct orientation and induction to all newly recruited staffs to be signed by Director of Local Government</td>
<td>HC/LAB</td>
<td>20-Oct-14</td>
</tr>
<tr>
<td>Distributed the printed orientation guidelines with the signed letter signed by Director of Local Government</td>
<td>DLG/PMO-RALG (lead), DHRD&amp;DAHRM</td>
<td>3-Aug-15</td>
</tr>
<tr>
<td>DLG instructs RAS to instruct LGAs to create orientation and Induction plan for all newly recruited staff. The plans are to be submitted to RAS for consolidation and monitoring via RHMT.</td>
<td>DLG/PMO-RALG</td>
<td>17-Aug-15</td>
</tr>
</tbody>
</table>
## Enforcing retention & incentive policy at LGA

<table>
<thead>
<tr>
<th>Title</th>
<th>Empowering the LGAs in Human Resource Management (Enforcing retention &amp; incentive policy at LGA)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief description</td>
<td>Incentive guideline should be developed and disseminate to LGAs to enable development of local incentives to attract and retain staff. The Incentives will then be mainstreamed to their CCHP for funding.</td>
</tr>
<tr>
<td>Key Stakeholders</td>
<td>PMO-RALG, MOHSW</td>
</tr>
<tr>
<td>Project owner</td>
<td>LGAs/DED</td>
</tr>
<tr>
<td>Ease of implementation</td>
<td>High</td>
</tr>
</tbody>
</table>

### Case for change (as is)

Most of the rural areas are facing shortage of HRH due to inadequate incentives to attract and retain staff in their locality. The Pay and Incentive Policy (2010) which was developed by the Central Government was not utilized due to high cost considerations. More proactive LGAs have offered localized incentive and retention schemes which has help boost their retention of HRH.

### Aspiration (to be)

All LGAs to developed own localized retention and incentive schemes for HRH workers

### KPIs

<table>
<thead>
<tr>
<th>KPIs</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>HRH incentive guideline</td>
<td>1 created</td>
</tr>
<tr>
<td>Execution of the submitted retention &amp; incentive improvement plans of LGAs</td>
<td>All LGAs</td>
</tr>
</tbody>
</table>

### Key activity (task) | Action party | State date | End date
--- | --- | --- | ---
To conduct assessment of HRH incentive & retention scheme provided by each individual LGA | MOHSW, PMORALG | 26-Jan-15 | 6-Mar-15 |
To develop and endorse HRH incentive & retention package guideline for LGAs | MOHSW,PMORALG,P MOPSM | 9-Mar-15 | 4-Sep-15 |
Disseminate the incentive & retention package guideline to LGAs | MOHSW,PMORALG | 9-Sep-15 | 2-Oct-15 |
Implement and monitor the use of incentive package guideline by LGAs | MOHSW,PMORALG,L GAs | 5-Oct-15 | 22-Jul-18 |
Creating awareness & engaging final year students in 153 HTI's (Priority to 7 Cadres of BRN) on retention & incentive policies of the LGAs | DMOs | 1-Mar-16 | 30-Jul-16 |

### Other Impact

- Improved capacity of LGAs to manage HRH
- Better retention of hired staff.
- Incentives institutionalized by LGAs
### Empowering the LGAs in Human Resource Management (Develop coaching and mentoring model to strengthen skills of Human Resource Management)

<table>
<thead>
<tr>
<th>Title</th>
<th>Brief description</th>
<th>Key Stakeholders</th>
<th>Project owner</th>
<th>Ease of implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop coaching and mentoring programs to be lead primarily by RHMTS to address the human resources management gaps within the Councils</td>
<td>PMO-RALG, RHMTs, CHMTs</td>
<td>MOHSW</td>
<td>High</td>
<td></td>
</tr>
</tbody>
</table>

**Case for change (as is)**

The facilities at primary care level are under the authority of the LGAs who are the employers of HRH. LGAs (CHMTs) plays a crucial role in the overall management of HRH including work force planning, recruitment, retention, local incentives, performance management and etc. Performance and pro-activeness of the CHMT is very much depended on the district leadership.

**Aspiration (to be)**

All LGAs to be coached and mentored in human resource management best practices by 2015/2016

<table>
<thead>
<tr>
<th>Key activity (task)</th>
<th>Action party</th>
<th>State date</th>
<th>End date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mentoring and Coaching Programme for HRM Skills to 168 LGAs Developed</td>
<td>Identified Implementing Partner (lead) MoHSW - DHRD, PMORALG - ADLG HR</td>
<td>10-Aug-15</td>
<td>10-Oct-15</td>
</tr>
<tr>
<td>Developing -60 Trainers/Coachers (50 Coachers (2 from @RHMT), 5 from ZHRC, 2 MOHSW, 2 PMORALG</td>
<td>MOHSW-HR, Private Implementer</td>
<td>2-Nov-15</td>
<td>7-Nov-15</td>
</tr>
<tr>
<td>Mentoring and Coaching Programme for HRH Planning Skills to 168 LGAs implemented in three phases</td>
<td>MOHSW-HR, Coaches</td>
<td>15-Nov-15</td>
<td>18-Mar-16</td>
</tr>
<tr>
<td>HRM practice in 168 LGAs monitored through the 25 RHMT</td>
<td>RHMTs</td>
<td>17-Aug-15</td>
<td>14-Aug-17</td>
</tr>
</tbody>
</table>

**Other Impact**

- Enhanced capacity of LGAs to manage HRH.
- Coaching and mentoring model developed.

**Total Private Investment** N/A

**DP’s Funding** N/A

**Total Public Investment** 14,609,462

KPIs

- Coaching and mentoring training conducted to all LGAs
- All LGAs

- LGA submitting quarterly reports to RHMT on performance
- All LGAs
## Ringfencing New HRH Recruits entitlements (Subsistence allowance)

<table>
<thead>
<tr>
<th>Title</th>
<th>Ringfencing New HRH Recruits entitlements (Subsistence Allowance)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief description</td>
<td>LGA to ringfencing subsistence allowance for new HRH recruits at district level and the newly recruited health care workers receive their subsistence allowances immediately upon reporting to their working stations</td>
</tr>
<tr>
<td>Key stakeholders</td>
<td>PMO-RALG, MOF</td>
</tr>
<tr>
<td>Project owner</td>
<td>LGAs (DED)</td>
</tr>
<tr>
<td>Ease of implementation</td>
<td>Medium</td>
</tr>
</tbody>
</table>

### Case for change (as is)

All newly hired HRH staff are entitled to subsistence allowances upon being posted. The purpose of the allowance is to allow for the staff to pay for essentials and to assist in acclimatizing to the new environment prior to disbursement of their salary. In practice however, LGAs tend to divert the allocated funds for these allowances to other expenses causing long delays before the staff receives the said allowance.

### Aspiration (to be)

All LGAs to ensure that subsistence allowance of HRH is a protected item in the budget and will ensure disbursement within a week after reporting of the staff.

### Key activity (task) | Action party | State date | End date |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Subsistence allowance for new HRH recruits budgeted and ring fenced</td>
<td>MOF (Budget Dept.), PMORALG (DLG Dept.),</td>
<td>1-Dec-14</td>
<td>28-Feb-15</td>
</tr>
<tr>
<td>Funds allocated for subsistence allowance for new HRH recruits utilized as budgeted</td>
<td>MOF (Budget Dept.), PMORALG (DLG Dept.),</td>
<td>20-Sep-15</td>
<td>16-Oct-15</td>
</tr>
<tr>
<td>PMORALG to instruct internal auditors to monitor the implementation and utilization of fund allocated (ring fencing new recruits entitlements)</td>
<td>PMORALG (DLG Dept.), LGAs/Internal Auditors/DED</td>
<td>21-Dec-15</td>
<td>30-Jan-16</td>
</tr>
</tbody>
</table>

### Other impact

- Better retention of recruited HRH.
- Increased zeal, morale and better performance of recruited HRH.

### Top 3 KPIs

- Substance allowance is given the protected status: One off
- Subsistence allowance will be provided within a week after reporting of the staff: All LGAs

### Total Private Investment

N/A

### DP’s Funding

N/A

### Total Public Investment

N/A
### Summary of Initiatives

<table>
<thead>
<tr>
<th></th>
<th>Initiative</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Overview of Key initiatives</td>
</tr>
<tr>
<td>2</td>
<td>Initiatives for Human Resources for Health</td>
</tr>
<tr>
<td>3</td>
<td><strong>Initiatives for Health Facilities</strong></td>
</tr>
<tr>
<td>4</td>
<td>Initiatives for Health Commodities</td>
</tr>
<tr>
<td>5</td>
<td>Initiatives for Reproductive, maternal &amp; child health</td>
</tr>
</tbody>
</table>
### Specific strengthening of health facilities (assessment)

#### Title
Assess, rate and develop specific facility improvement plans for 1- and 2-Star primary level health facilities

#### Brief description
All facilities at primary level will be assessed to get the baseline data. The assessment will be done in phases starting with district facilities and then to the health centers and the dispensaries. After getting the baseline data, the facility improvement plan will be developed and incorporated into the annual health facility plan and budget. The facility plan and budget will then be consolidated by CHMT to be incorporated in the Comprehensive Council Health Plan (CCHP).

#### Project sponsor
LGAs/ Local Government Authority – Through HF plans & CCHP

#### Project owner
CHMT/DMO and HF in charges

#### Ease of implementation
High

#### Case for change (as is)
There is a need to establish a mechanism for star rating of health facilities that is linked to the performance of the health facility and staff.

#### Aspiration (to be)
80% of primary health facilities rated at 1- & 2-Star to be at 3-Star and above by 2017/2018

#### Other Impact
Stepwise improvement of facilities at primary level from baseline to three stars and above leading to overall quality health services delivered to clients by 2018

| Total Private Investment | TZS 1.4 bn |
| DP’s Funding            | TZS 1.4 bn |
| Total Public Investment | TZS 2.2 bn |

#### KPIs by Years

<table>
<thead>
<tr>
<th>Year</th>
<th>KPI</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014/15</td>
<td>100% assessment and rating of all primary health facilities</td>
</tr>
<tr>
<td>2015/16</td>
<td>20% of health facilities at identified regions are elevated to level 3 /above</td>
</tr>
<tr>
<td>2016/17</td>
<td>60% of health facilities at identified regions are elevated to level 3 /above</td>
</tr>
<tr>
<td>2017/18</td>
<td>80% of health facilities at identified regions are elevated to level 3 /above</td>
</tr>
</tbody>
</table>

#### Key activity (task) | Action party | Start date | End date
--- | --- | --- | ---
Develop database to capture assessment report | MoHSW/HSIQAS/ICT | 1 Nov 2014 | 12 Dec 2014 |
Orientation of the 27 national team. The orientation will be on the check list, data base and data entry | MoHSW/HSIQAS/ICT | 15 Dec 2014 | 31 Dec 2014 |
National team to orient the regional assessment team (6 per council). The orientation will be on the check list, data base and data entry | National team | 2 Jan 2015 | 19 Jan 2015 |
Assessment of all primary health facilities at district level (hospital at district level, Health Centre and dispensaries) | National and Regional team | 19 Jan 2015 | 27 Feb 2015 |
Conduct post assessment review to discuss the challenges and mitigation plan | Assessors’ team leads | 2 Mar 2015 | 14 Mar 2015 |
All facility plans and budgets to be consolidated by CHMT and incorporated in the Comprehensive Council Health Plan (CCHP) | CHMT/DMO | 16 Mar 2015 | 31 Mar 2015 |
Develop a detailed implementation plan to roll out the intervention program in the 12 regions | HSIQAS | 1 Apr 2015 | 17 Apr 2015 |
Establishment a national health services accreditation body and leverage with other regional and international bodies | HSIQAS/DPP/Legal Services Unit | 1 Apr 2015 | 31 Dec 2017 |
## General strengthening of health facilities (fiscal decentralisation)

<table>
<thead>
<tr>
<th>Title</th>
<th>Implement fiscal decentralisation by devolution from council level to health facility level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief description</td>
<td>Health facilities, with the oversight from the HFGC, should be accountable in collecting revenues ((NHIF claims, CHF/蒂卡 membership, user fees), undertake financial planning and budgeting based on information and data required for effective implementation of facility plans. The allocation of Block grants, Council Own Source, Basket Funds will be disbursed to HF bank accounts to be used for delivery of health services to community.</td>
</tr>
<tr>
<td>Project sponsor</td>
<td>DED/ RAS</td>
</tr>
<tr>
<td>Project owner</td>
<td>CHMT/DMO and HF in charges</td>
</tr>
<tr>
<td>Ease of implementation</td>
<td>Medium</td>
</tr>
</tbody>
</table>

**Case for change (as is)**
Revenue collected at health facilities and their allocation from the central government are administered at the Council level. HFs expenditures managed at the council level and are not easily accessible by the HFs, causing lack of innovation and inability to solve local health problems timely at health facility level. Furthermore, there is no culture of using data for decision making and planning in most HFs.

**Aspiration (to be)**
Health facilities will be empowered to plan and manage funds for infrastructure maintenance (building and equipment), improvement of waste management, emergency care and referral system, while reduce stock-outs of medicines and other health commodities.

<table>
<thead>
<tr>
<th>KPIs (% HFs open and use own bank account)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014/15</td>
</tr>
<tr>
<td>2015/16</td>
</tr>
<tr>
<td>2016/17</td>
</tr>
<tr>
<td>2017/18</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Key activity (task)</th>
<th>Action party</th>
<th>Start date</th>
<th>End date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improvement of revenue collection at health facility level with effective billing on NHIF, CHF/蒂卡 and collection of user-fees, handling petty cash (with the absence of the accountant)</td>
<td>CHMT-DHS, CHF coordinator, HF in charge and others</td>
<td>12 Jan 2015</td>
<td>13 Mar 2015</td>
</tr>
<tr>
<td>Empower HFGC on providing oversight to the HFs (plans, procurement, financial management, progress) and monitor the implementation of the HF plan, budget and expenditure</td>
<td>CHMT-DMO &amp;DHS, HF in charge, HFGC</td>
<td>12 Jan 2015</td>
<td>17 Jan 2016</td>
</tr>
<tr>
<td>Improvement of financial management at the health facility level (in the absence of the accountant)</td>
<td>CHMT-DHS, MoHSHW-DHS</td>
<td>5 Jan 2015</td>
<td>13 Mar 2016</td>
</tr>
<tr>
<td>All health facilities open, operate and manage bank accounts for all funds generated by or allocated to the health facility for service delivery</td>
<td>DMO, HF in-charge, PMO-RALG, MoF-AG, DED</td>
<td>17 Nov 2014</td>
<td>28 Nov 2014</td>
</tr>
<tr>
<td>Develop a template for annual health facility profile report (HMIS report)</td>
<td>MOHSW-DPP</td>
<td>3 Nov 2014</td>
<td>23 Dec 2014</td>
</tr>
<tr>
<td>Revise and translate the health facility planning and the annual facility profile report templates into Kiswahili and disseminate them to health facilities.</td>
<td>MOHSW-DPP</td>
<td>13 Jan 2015</td>
<td>20 May 2015</td>
</tr>
<tr>
<td>Development of annual health facility plans that incorporate the facility improvement plans to elevate it to a higher star rating, as determined by the assessment report.</td>
<td>Health Facilities, CHMT</td>
<td>20 Apr 2015</td>
<td>Onwards</td>
</tr>
<tr>
<td>Prepare quarterly and annual health facility progress reports and submit to CHMT for consolidation</td>
<td>Health Facilities, CHMT</td>
<td>1 Oct 2015</td>
<td>Onwards</td>
</tr>
</tbody>
</table>

**Other Impact**
Improved revenue collection and management of collected revenues and operate bank account

**Total Private Investment**
- TZS 22.1bn

**DP’s Funding**
- TZS 22.1bn

**Total Public Investment**
- TZS 22.1bn
### General strengthening of health facilities (social accountability)

<table>
<thead>
<tr>
<th>Title</th>
<th>Increase social accountability at the facility and community level to address local health priorities/concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief description</td>
<td>In the course of delivery of health services, public participation is required for ensuring good governance and overall oversight of health service delivery. This can be achieved through community participation in planning and monitoring the implementation of the health facility plans by using various mechanisms including the Community Score Card (CSC), HFGCs, Patient Charter, Social Accountability Mechanism (SAM), Open Government Partnership (OGP) at all levels.</td>
</tr>
<tr>
<td>Project sponsor</td>
<td>DED, MoHSW &amp; PMO-RALG</td>
</tr>
<tr>
<td>Project owner</td>
<td>CHMT/DMO and HFIs in-charge and HFGCs, DPP/MoHSW</td>
</tr>
<tr>
<td>Ease of implementation</td>
<td>Medium</td>
</tr>
</tbody>
</table>

**Case for change (as is)**

There is lack of community awareness and knowledge on their rights, roles and mechanisms for holding health facilities accountable in delivery of quality health services. Furthermore, the facilities rarely involves the community in planning and monitoring implementation of health services.

**Aspiration (to be)**

Community influences the delivery of health care, strengthening the quality of care and allocation of health resources.

**KPIs (% LGAs roll-out community scorecard as a tool for social accountability monitoring of health facility and community)**

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014/15</td>
<td>12</td>
</tr>
<tr>
<td>2015/16</td>
<td>42</td>
</tr>
<tr>
<td>2016/17</td>
<td>26</td>
</tr>
<tr>
<td>2017/18</td>
<td>20</td>
</tr>
</tbody>
</table>

**Key activity (task)**

- **Use Community Score Card and client service charter as tools for monitoring accountability of health facilities and communities to improve service delivery**
  - **Action party**: MOHSW/ PMORALG/CHMT
  - **Start date**: 15 Nov 2014
  - **End date**: Onwards

- **Health Facilities should share with the community information on facilities plans, revenue, expenditure, medicines and progress implementation report as per Open Government partnership (OGP) commitment**
  - **Action party**: Health Facility In charge
  - **Start date**: 1 Jan 2015
  - **End date**: Onwards

- **Mobilise the community to monitor facilities processes in handling health emergencies**
  - **Action party**: HFGCs, Health Facility In charge
  - **Start date**: Jan 2015
  - **End date**: Onwards

**Other Impact**

- Improved quality of health services by responding to community needs as the HFGC will be involved in the process of setting priorities, development, implementation and monitoring of facility health plans. This will be determined by star rating of the facility.
- Good governance of the health facility will be effected through Social Accountability Mechanism (SAM), Open Government Partnership (OGP) at all levels.
### General strengthening of health facilities (performance targets and contracts)

<table>
<thead>
<tr>
<th>Title</th>
<th>Introduce the use of performance targets and contracts at the primary facilities to address and enforce staff accountability in delivery of quality health services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief description</td>
<td>This initiative will address challenges of inadequate accountability by enforcing compliance to regulations, procedures and adherence to the client service charter. This will be achieved by linking /tie accountability with staff recognition, rewarding and performance measured through OPRAS. The initiative will therefore focus on: • Staff accountability to reduce instances of absenteeism, negative attitude, corruption and favouritism so as to increase productivity • Recognition and reward to link with performance of individual/facility. • OPRAS to link performance contract with performance targets of health facilities and individuals</td>
</tr>
<tr>
<td>Project sponsor</td>
<td>Local Government Authority (LGA)</td>
</tr>
<tr>
<td>Project owner</td>
<td>CHMT/DMO and HF in-charge</td>
</tr>
<tr>
<td>Ease of implementation</td>
<td>High</td>
</tr>
<tr>
<td>Case for change (as is)</td>
<td>Absenteeism, patient abuse, corruption and favouritism are among the issues faced in health facilities (Sikika 2011). The client charter is available only at the councils level, thus majority of staff are not aware of its existence while the communities are not aware of their rights (Kirenga et al, 2009). Although staff and facility recognition and rewards are ongoing, they are not implemented to scale. The performance assessments tools such as IPC (2013) are not integrated, hence do not address facility performance indicators/targets holistically – no integrated tool to address the individual performance and link to facility target.</td>
</tr>
<tr>
<td>Other Impact</td>
<td>Gradual increase in level of client satisfaction from the baseline to 75% leading to an increased utilisation of health cares services by 50%, by the year 2017/2018</td>
</tr>
<tr>
<td>Total Private Investment</td>
<td>-</td>
</tr>
<tr>
<td>DP’s Funding</td>
<td>-</td>
</tr>
<tr>
<td>Total Public Investment</td>
<td>TZS 6.2 bn</td>
</tr>
<tr>
<td>KPIs by Years</td>
<td></td>
</tr>
<tr>
<td>2014/15</td>
<td>Conduct survey to establish baseline</td>
</tr>
<tr>
<td>2015/16</td>
<td>65% Increase service users satisfaction</td>
</tr>
<tr>
<td>2016/17</td>
<td>70% Increase service users satisfaction</td>
</tr>
<tr>
<td>2017/18</td>
<td>75% Increase service users satisfaction</td>
</tr>
<tr>
<td>Aspiration (to be)</td>
<td>Increase clients’ satisfaction through provision of quality health services by making health care provider more accountable.</td>
</tr>
<tr>
<td>Key activity (task)</td>
<td>Action party</td>
</tr>
<tr>
<td>Installation of functional complaint’s collection tools eg SMS, complaints room/desk, suggestion box and social media) with all the necessary tools needed like pens, paper, mobile phones.</td>
<td>HF in-charge</td>
</tr>
<tr>
<td>Customise and display client’s services charter, price lists, free Services, working hours, staff identities and Organisation chart.</td>
<td>HF in-charge</td>
</tr>
<tr>
<td>Introduce performance contracts timesheet , enhance OPRAS and link it with recognition and reward</td>
<td>HF in-charge</td>
</tr>
<tr>
<td>Monitoring and evaluation.</td>
<td>CHMT</td>
</tr>
</tbody>
</table>
## Summary of Initiatives

1. Overview of Key initiatives
2. Initiatives for Human Resources for Health
3. Initiatives for Health Facilities
4. **Initiatives for Health Commodities**
5. Initiatives for Reproductive, maternal & child health
# Stop the pilferages

## Title
**Improving governance, accountability, and sense of ownership of Health Commodities supply chain to eliminate frequent occurrence of stock-out**

## Brief description

<table>
<thead>
<tr>
<th>A) Creating internal and external controls to address pilferages:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Scale up health commodities tracking</td>
</tr>
<tr>
<td>• Prevent and take action on unethical practices</td>
</tr>
<tr>
<td>• Involvement of community and civil society organisations</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B) Improved management of supply chain actors</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Review draft MoHSW organisational structure</td>
</tr>
<tr>
<td>• Secure approval of MoHSW structural changes</td>
</tr>
<tr>
<td>• Orient commodity-related stakeholders</td>
</tr>
<tr>
<td>• Provision of commodity management guidelines and tools</td>
</tr>
<tr>
<td>• Enhance functionality of CHSBs, FGCs and MTCs</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>C) Introducing performance based reward framework</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Put in place performance management framework at all levels</td>
</tr>
<tr>
<td>• Monitoring and Evaluation of Performance Framework</td>
</tr>
</tbody>
</table>

## Other Impact
- Zero pilferages by 2017
- Full leadership in supply chain system

## Total Private Investment
N/A

## DP’s Funding
TZS 0.333 Bn

## Total Public Investment
TZS 1.15 Bn

## Top 3 KPIs

| % of facilities audited | 100% |
| % of facilities supervised by CHMT | 100% |
| % proportion of facilities found with commodity pilferage | 0% |

## Case for change (as is)
There are frequent stock outs preventing ordinary citizens accessing better health services, mainly due to poor governance and accountability across levels of the commodity supply chain.

## Aspiration (to be)
Reduction of commodity pilferage from the baseline survey to 0% by 2017

## Key Milestones

<table>
<thead>
<tr>
<th>Action party</th>
<th>State date</th>
<th>End date</th>
</tr>
</thead>
<tbody>
<tr>
<td>To address pilferages of health commodities across all levels of supply chain</td>
<td>PS – MOH&amp;SW</td>
<td>July 2015</td>
</tr>
<tr>
<td>Put in place a performance management framework to supply chain actors</td>
<td>PS – MOH&amp;SW</td>
<td>July 2015</td>
</tr>
<tr>
<td></td>
<td>PS – PMO-RALG</td>
<td></td>
</tr>
<tr>
<td>Improved management of supply chain actors</td>
<td>PS – MOH&amp;SW</td>
<td>January 2015</td>
</tr>
<tr>
<td></td>
<td>PS – PMO-RALG</td>
<td></td>
</tr>
</tbody>
</table>
## Support funding for medicines

<table>
<thead>
<tr>
<th>Title</th>
<th>Strengthen management of MSD working capital for sustainable availability of medicines and medical supplies</th>
</tr>
</thead>
</table>
| Brief description | 1. Restore MSD working capital for self sustainability through, repayment of debt, , frontloading of funds and coordination of vertical program commodities.  
2. Incorporate MSD to allow for commercial operation including strategic investors engagement and development partners engagement  
3. To implement operating cost reduction initiative by;  
• Route optimization, outsourcing; improve management efficiency; Share Key Performance Indicators with MOH, DPs, and RHMTs on a quarterly basis  
4. Government should timely pay for services rendered (supply chain costs) to avoid accumulation of debt at MSD through options such as Delivery Duty Paid Contracts.  
5. Implement bulk procurement strategy for economies of scale, sustainable and cost effective operation |

| Other Impact | N/A |
| Total Private Investment | N/A |
| DP’s Funding | TZS 0.47 Bn |
| Total Public Investment | TZS 4.83 Bn |

| Project sponsor | MSD |
| Project owner | MoHSW |
| Ease of implementation | High |

### Case for change (as is)

Working capital of MSD has been depleted due to growth of debt. The health commodities procurement has been erratic and unsustainable due to inadequate funds for operation. Providing a room for MSD to operate as commercial entity and provides more autonomy for decision making and powers to borrow for supplementing its working capital deficiencies to ensure sustainable availability of medicines and medical supplies as they are needed.

### Aspiration (to be)

All MSD procurement are bulk procurement which are more cost effective and sustainable

### Key activity (task)

<table>
<thead>
<tr>
<th>Key activity (task)</th>
<th>Action party</th>
<th>State date</th>
<th>End date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obtain guarantee to borrow funds from Ministry of Finance (MOF)</td>
<td>MSD, MOF</td>
<td>1 Mar 2014</td>
<td>31 Mar 2015</td>
</tr>
<tr>
<td>To prepare business proposals to various financial institutions for financing consideration</td>
<td>MSD, MOF</td>
<td>1 Mar 2014</td>
<td>31 Mar 2015</td>
</tr>
<tr>
<td>To increase implementation of bulky procurement</td>
<td>MSD</td>
<td>1 Nov 2014</td>
<td>30 June 2017</td>
</tr>
</tbody>
</table>

### Top 3 KPIs

- **Current Ratio**: Current Assets/Current liabilities
- **Acid test ratio**: Current Assets – stock/current liabilities
- **Margin recovery**: % of Margin for cost recovery
### Improve procurement & delivery

<table>
<thead>
<tr>
<th>Title</th>
<th>To complement MSD in the procurement &amp; distribution of medicines by engaging private sector</th>
</tr>
</thead>
</table>
| Brief description | 1a. Fast tracking MSD roll out of Prime vendors countrywide to 8 zones  
The assessment of MSD capacity to deliver medicines to health facilities is around 65% in average. Thus the remaining 35% needs to be complemented by the private sector in order to improve medicines availability at the health facilities (Refer; GIZ Medicines Management Assessment 2011)  
1b. Fast tracking MSD Direct Delivery by outsourcing distribution services to private sector from zone stores to health facilities  
Direct delivery of medicines undertaken by MSD has significantly improved availability of medicines to the facilities. It is identified that the low capacity of resources at MSD and the running costs increase with increase in the population. |
| Project sponsor | MOHSW |
| Project owner | MSD |
| Ease of implementation | Easy; To fast-track the already started projects which have greater impact in terms of availability of medicines to the facilities but faces some challenges which can be resolved by these initiatives |
| Case for change (as is) | Currently MSD has engaged 16 prime vendors from all 9 zones. However only Dar es salaam zone is practicing the use of prime vendor services thus there is a need of roll out the use of prime vendor to all MSD zones country wide.  
Currently MSD is outsourcing about 40% of its distribution of commodities from centre to zones. The success of operational cost reduction and complexity of fleet management transferred to the private logistics company. The same experience can be rolled out to outsource similar services from zones to health facilities. |
| Aspiration (to be) | Increasing order refill rate of medicines and timely delivery of medicines to the health facilities by 2016. |
| Key activity (task) | Action party | State date | End date |
| Mentoring of Zonal PMU staff. to execute prime vendor operation | MSD | Jan 2015 | Dec 2017 |
| Qualifying and engaging logistics companies to complement MSD direct delivery distribution services. | MSD & Private Sector | Dec 2014 | Dec 2015 |
| Monitoring service level agreement for prime vendors and logistics companies | MSD | March 2015 | Dec 2017 |

### Other Impact
- Reduced costs; and
- Timely delivery of commodities

| Total Private Investment | N/A |
| DP’s Funding | TZS 0.27 Bn |
| Total Public Investment | TZS 5.89 Bn |

### Top 3 KPIs
- Number of call off orders to prime vendors by 2015: 15
- Number of signed contracts and deliveries by 2015: 15
- % of medicines supplied against call off orders by 2015: 90%
## Initiative overview – Track end-to-end

<table>
<thead>
<tr>
<th>Title</th>
<th>Introduction of ICT mobile apps platform (eLMIS, ILSGateway, DHIS2) lower level facilities</th>
</tr>
</thead>
</table>
| Brief description | 1. Changing from paper based communication and data management to ICT mobile apps platforms such as eLMIS at all levels (facility level to the national level) will result into accurate and timely planning and demand forecasting, accurate order generation and timely delivery of commodities at health facility level hence reduced stock out.  
2. This will be achieved through – training of health care providers, RHMTs and CHMTs on health ICT mobile apps platforms  
3. Logistics Management Units at Central and Zonal levels to collaborate with RHMT/ CHMT in supporting facilities in planning and ordering process.  
Carrying out last mile connection of all district hospitals and near by facilities to national ICT backbone. |
| Project sponsor | PMORALG / DPs |
| Project owner | LGAs/MOHSW,LMU |
| Ease of implementation | Medium |
| Case for change (as is) | Inaccurate capturing of consumption data at facilities resulted in inaccurate available data at PSS / MOHSW level, directly impacting PSS’ capability do accurate forecasting. This is caused by inadequate record keeping tools at the facilities. In a study conducted by MoHSW and USAID shows that less than 50% of health facilities have updated stock cards which affects quantification and ordering capability at health facilities level. |
| Aspiration (to be) | 100 % improved communication and data management in supply chain in health facilities by 2017/2018 |
| Key activity (task) | Action party | State date | End date |
| Assessment of mobile network connectivity availability as per geographic locations of the health facilities | MOHSW/LMU | 1 Nov 2014 | 31 Dec 2014 |
| Create a Project Management Team that will implement the project | Councils | 8 Dec 2014 | 7 Jan 2015 |
| Prepare a technical and financial proposal for funding | Councils | 8 Dec 2014 | 7 Feb 2015 |
| Other Impact | • Improvement in consumption data and inventory management |
| Total Private Investment | N/A |
| DP’s Funding | N/A |
| Total Public Investment | TZS 7.15 bn |
| Top 3 KPIs | | | |
| Use of ICT platforms(eLMIS) at lower facility levels (HCs and dispensaries) | 50% |
| Use of ICT platforms(eLMIS) by CHMTs | 100% |
| Availability of ICT infrastructures at facility level | 50% |
## Initiative overview – Sustain with tools & best practices (SMS)

<table>
<thead>
<tr>
<th>Title</th>
<th>Introduce use of SMS to report on stock outs and quality of health services by service users and civil society.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief description</td>
<td>This approach will be used by the community/clients/beneficiaries so as to report their feedback on the health services they have received including whether they have received medicines. This is meant to address the issue of stock outs through beneficiaries involvement.</td>
</tr>
<tr>
<td>Project sponsor</td>
<td>Full Council</td>
</tr>
<tr>
<td>Project owner</td>
<td>MOHSW-PSS, PMORALG</td>
</tr>
<tr>
<td>Ease of implementation</td>
<td>Medium</td>
</tr>
<tr>
<td>Case for change (as is)</td>
<td>There are frequent stock outs preventing ordinary citizens accessing better health services and at the same time there is no mechanism for ordinary citizen to give feedback back to the responsible authorities on frequent stock outs.</td>
</tr>
<tr>
<td>Aspiration (to be)</td>
<td>Stock out SMS reporting to be implemented by mid 2016</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Impact</th>
<th>Responsiveness of the health sector</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Private Investment</td>
<td>N/A</td>
</tr>
<tr>
<td>DP’s Funding</td>
<td>N/A</td>
</tr>
<tr>
<td>Total Public Investment</td>
<td>TZS 0.18 bn</td>
</tr>
</tbody>
</table>

### Top 3 KPIs

| % of stock-out complaints solved by 2015/16 | 50% |
| % of stock-out complaints solved by 2016/17 | 100% |

### Key activity (task)

<table>
<thead>
<tr>
<th>Action party</th>
<th>Start date</th>
<th>End date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Identification of the SMS platform to report stock outs and quality of health services</td>
<td>e-Government Agency MOH&amp;SW –ICT Unit</td>
<td>July 2015</td>
</tr>
<tr>
<td>3. Advocacy/ sensitisation of the initiative</td>
<td>MoHSW Health Education, LGA</td>
<td>Dec 15</td>
</tr>
<tr>
<td>4. Roll out of the initiative</td>
<td>e-Government Agency, MoHSW-ICT Unit, MoHSW agencies (TFDA, MSD, PSS, LGAs)</td>
<td>Feb 16</td>
</tr>
</tbody>
</table>
## Initiative overview – Sustain with tools & best practices (5S-KAIZEN-TQM)

<table>
<thead>
<tr>
<th>Title</th>
<th>Scale up 5S-KAIZEN-Total quality Management(TQM) initiatives to lower health facilities level in order to improve inventory management and storage of health commodities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief description</td>
<td>Introduce 5S-KAIZEN-TQM quality improvement approach at district and the facility level to change the attitude of staff and improve inventory management skills including on how to improve record keeping, reporting, ordering and storage conditions at health center and dispensary levels. Train/coaching and mentoring to healthcare workers at lower facility level on 5S-KAIZEN-TQM Conduct quarterly audit/stock taking on medical commodities and promote rational use of medicine in primary health facilities Fast-tracking disposal of expired medical commodities from MSD stores and health Facilities Construct / rehabilitating storage facilities in primary health facilities according to standards</td>
</tr>
<tr>
<td>Project sponsor</td>
<td>JICA/POMRALG/MOHSW</td>
</tr>
<tr>
<td>Project owner</td>
<td>MOHSW</td>
</tr>
<tr>
<td>Ease of implementation</td>
<td>Medium</td>
</tr>
<tr>
<td>Case for change (as is)</td>
<td>There is poor record keeping at lower health facilities with inaccurate reports and ordering submitted to MSD leading to wrong procurement planning, forecasting and quantification. This contributes to stock outs as it leads to understocking or overstocking of health commodities. Record keeping tools are also not consistently available at the lower level health facilities. Introduction of 5S-KAIZEN-TQM at lower facility levels will change the attitude of staff and improve inventory management skills including record keeping, reporting, ordering and storage.</td>
</tr>
<tr>
<td>Aspiration (to be)</td>
<td>70% quality improvement in commodities storage and inventory management at lower level facilities in phase I regions by 2016 80% of expired medical commodities disposed annually at lower health facilities by 2016</td>
</tr>
<tr>
<td>Key activity (task)</td>
<td>Action party</td>
</tr>
<tr>
<td>Revise 5S-KAIZEN-TQM implementation guidelines and training modules (Swahili Version) to align with primary health facility level training needs</td>
<td>MOHSW/Councils</td>
</tr>
<tr>
<td>Conduct bi-annual audit/stock taking on medical commodities and promotes rational use of medicine in primary health facilities</td>
<td>MOHSW/Councils</td>
</tr>
<tr>
<td>Print 5S-KAIZEN-TQM training materials</td>
<td>MOHSW/Councils</td>
</tr>
</tbody>
</table>

### Other Impact
- Better inventory management techniques by healthworkers

#### Total Private Investment
N/A

#### DP’s Funding
TZS 0.16 bn

#### Total Public Investment
TZS 12.80 bn

### Top 3 KPIs
- KPI: % of dispensaries and health centers adhering to good storage standards 85%
- KPI: Proportion of lower level health facilities submitting accurate consumption reports to MSD quarterly 80%
- KPI: % of expired drugs disposed annually at national and local level 80%
## Summary of Initiatives

<table>
<thead>
<tr>
<th></th>
<th>Initatives</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Overview of Key initiatives</td>
</tr>
<tr>
<td>2</td>
<td>Initiatives for Human Resources for Health</td>
</tr>
<tr>
<td>3</td>
<td>Initiatives for Health Facilities</td>
</tr>
<tr>
<td>4</td>
<td>Initiatives for Health Commodities</td>
</tr>
<tr>
<td>5</td>
<td><strong>Initiatives for Reproductive, Maternal &amp; Child Health</strong></td>
</tr>
</tbody>
</table>
### Community Health workers to improve RMNCH Services

<table>
<thead>
<tr>
<th>Title</th>
<th>Use community Health workers to improve RMNCH services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief description</td>
<td>Some RMNCH services are best provided at home example Family Planning and Postnatal services. Furthermore, demand creation of RMNCH services is better achieved at door step approach</td>
</tr>
<tr>
<td>Project sponsor</td>
<td>Local government and development partners</td>
</tr>
<tr>
<td>Project owner</td>
<td>Local government</td>
</tr>
<tr>
<td>Ease of implementation</td>
<td>medium</td>
</tr>
</tbody>
</table>

### Case for change (as is)

- CHWs not built within existing health care structure
- No standardized training curriculum, selection criteria, package of service, scope of work and remuneration
- Multiple vertical donor funded CHW interventions scattered all over the country—more than 3,000 trained in Lake Zone by Plan International and AMREF
- Ongoing MOHSW initiative to officiate CHW as Medical Attendants with one year training and government scheme remuneration

### Aspiration (to be)

- Improve uptake of RMNCH services (family planning, ANC, institutional delivery, PNC
- Improve access to safe blood

### Key activity (task)

<table>
<thead>
<tr>
<th>Action party</th>
<th>State date</th>
<th>End date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Map all existing CHWs in 5 Regions</td>
<td>RHMT/CHMT</td>
<td></td>
</tr>
<tr>
<td>Train CHWs based on needs (3-weeks training package)</td>
<td>RHMT/CHMT</td>
<td></td>
</tr>
<tr>
<td>Introduce performance based incentives for CHWs. Use community pregnant women registers</td>
<td>RHMT/CHMT</td>
<td></td>
</tr>
<tr>
<td>Health facility in charge to supervise performance of CHWs.</td>
<td>RHMT/CHMT</td>
<td></td>
</tr>
</tbody>
</table>

| Total Private Investment | TBD |
| DP’s Funding | TBD |
| Total Public Investment | TZS 13.5 bn |
| Top 3 KPIs | TBD |
| TBD | TBD |
| TBD | TBD |
Enhancing RMNCH services uptake through outreach services to hard to reach communities

**Title**: Enhancing RMNCH services uptake through Outreach services to hard to reach communities

**Brief description**: The country has pockets which are hard to reach and population which is nomadic

**Project sponsor**: Local government and development partners

**Project owner**: Local government

**Ease of implementation**: medium

**Total Private Investment**: TBD

**DP’s Funding**: TBD

**Total Public Investment**: TZS 848 million

**Top 3 KPIs**

- Outreach visits conducted in a quarter in the council: 80%
- Outreach visits conducted in a quarter in the community: 80%
- TBD

**Case for change (as is)**

- Low utilization of RMNCH services is associated with long distance to health facility, women reporting problems associated with getting permission to seek antenatal care, not being supported by the husband or partner, lack of money, and accompanying attendants
- Because more than 44% of women deliver outside the official health facilities, they don’t have access to postpartum family planning. In addition, post-abortion family planning services utilization is low
- Outreach services enable women and their families to receive selected RMNCH services at their localities. Such services will be provide at selected points within the community or skilled providers from high level of health facilities visit dispensaries to offer quality services.
- Mobile outreach is vital service delivery approach to expand access to various RMNCH services among women, men and their families in underserved areas.
- There are some areas which are hard to reach and not served by health facilities. Example nomadic populations, islands

**Aspiration (to be)**

To provide equitable RMNCH services to the community
### Title
Use of Mobile phones SMS to facilitate utilization of RMNCH service

### Brief description
There is about 30 mil SIM cards line registered in Tanzania. mHealth/SMS initiative will be utilized to deliver (i) awareness building messages and (ii) track MNCH clients by CHWs and Health care providers

### Project sponsor
Local government and development partners

### Project owner
Local government

### Ease of implementation
medium

### Case for change (as is)
- Routine patients-health facility interface may not be enough to communicate key issues, including on RMNCH thus the need for innovative, feasible and ubiquitous strategies to improve the interface
- Mobile phones are ubiquitous in the country with almost 30mill phones and accessibility in most parts of the country
- Evidence that even women from families without ownership of mobile phones, contact through entrusted people’s phones is feasible

### Aspiration (to be)
Timely attendance for 4+ prenatal, delivery, postnatal health services and during pregnancy related complications

### Top 3 KPIs
<table>
<thead>
<tr>
<th>TBD</th>
<th>TBD</th>
</tr>
</thead>
</table>

### Key activity (task)
<table>
<thead>
<tr>
<th>Action party</th>
<th>State date</th>
<th>End date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contextualize and introduce SMS messaging at health facilities</td>
<td>RHMT/CHMT</td>
<td></td>
</tr>
<tr>
<td>CHWs/HCWs to register and communicate with the registered women and their families to receive RMNCH messages</td>
<td>RHMT/CHMT</td>
<td></td>
</tr>
<tr>
<td>Engage mobile companies to offer incentives/ award to women participating in SMS initiative (those who have accessed RMNCH services)</td>
<td>RHMT/CHMT</td>
<td></td>
</tr>
<tr>
<td>Introduce facility emergency toll free number to facilitate referral of RMNCH cases</td>
<td>RHMT/CHMT</td>
<td></td>
</tr>
<tr>
<td>Key activity (task)</td>
<td>Action party</td>
<td>State date</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------------</td>
<td>--------------</td>
<td>------------</td>
</tr>
<tr>
<td>Map health facilities that will feasibly conduct outreach activities on their own without affecting other facility based services and provided with transport and additional commodities and supplies for the outreach.</td>
<td>RHMT/CHMT</td>
<td></td>
</tr>
<tr>
<td>Two modalities of outreach services will be conducted  (i) from health facility to community to offer short term family planning, immunization, FANC etc (ii) from district hospital and health centres to dispensaries to provide essential RMNCH package</td>
<td>RHMT/CHMT</td>
<td></td>
</tr>
<tr>
<td>Leverage efforts and resources of regions/districts, key partners and communities to strengthen outreach services through shared planning and responsibilities</td>
<td>RHMT/CHMT</td>
<td></td>
</tr>
<tr>
<td>Orient health care providers on essential skills required to conduct outreach services</td>
<td>RHMT/CHMT</td>
<td></td>
</tr>
<tr>
<td>Align mass media communication, SMS and community health workers in order to ensure communities are aware when the visits will be happening in their localities</td>
<td>RHMT/CHMT</td>
<td></td>
</tr>
<tr>
<td>Implement Innovative approaches using motorcycles (Bodaboda), motor boats and bicycles wherever feasible, to reach young population in communities where infrastructures are feasible for this means of transportation</td>
<td>RHMT/CHMT</td>
<td></td>
</tr>
</tbody>
</table>
### Infrastructure and Utilities

<table>
<thead>
<tr>
<th>Title</th>
<th>Improve the infrastructure including utilities to facilitate CEmONC service delivery at strategically selected health centres</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief description</td>
<td>Well constructed buildings for service delivery together with availability of water and electricity supply contributes significantly to facilitate quality of care in CEmONC facilities. Delivery of the nine life saving signal functions requires presence of the right infrastructure and utilities for 24/7 and throughout the year.</td>
</tr>
<tr>
<td>Project sponsor</td>
<td>DED</td>
</tr>
<tr>
<td>Project owner</td>
<td>DMO and Facility In Charges</td>
</tr>
<tr>
<td>Ease of implementation</td>
<td>Medium</td>
</tr>
<tr>
<td>Other Impact</td>
<td>• Reduce Maternal and Neonatal Deaths • Reduce Delay to reaching facilities for CEmONC services</td>
</tr>
<tr>
<td>Total Private Investment</td>
<td>N/A</td>
</tr>
<tr>
<td>DP's Funding</td>
<td>TZS 8.6 bn</td>
</tr>
<tr>
<td>Total Public Investment</td>
<td>TZS 36.1 bn</td>
</tr>
<tr>
<td>KPI: No of CEmONC HF</td>
<td></td>
</tr>
<tr>
<td>2014/15</td>
<td>79</td>
</tr>
<tr>
<td>2015/16</td>
<td>91</td>
</tr>
<tr>
<td>2016/17</td>
<td>104</td>
</tr>
<tr>
<td>2017/18</td>
<td>104</td>
</tr>
</tbody>
</table>

### Case for change (as is)

Some facilities have no reliable supply of water nor electricity for provision of EmONC services 24/7. Also some facilities have no standard buildings for service delivery in terms of maternity and neonatal wards, theatres and accommodation for staff. Only twenty one percent (21%) of all facilities had reliable electrical power supply, 45% improved water source, .... Functional buildings and ....staff accommodation (SARA 2012)

### Aspiration (to be)

Constant reliable water and electrical supply using available sources and its alternatives. Functional buildings for service delivery in selected facilities; built according to specified standards (MOHSW/PMORALG) by 100% by 2017/18 in selected EmONC facilities

### Key activity (task)

<table>
<thead>
<tr>
<th>Task 1: Construct/Upgrade maternity and labour rooms</th>
<th>Action party</th>
<th>State date</th>
<th>End date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Task 2: Construct/Upgrade theatres</td>
<td>DED, DMOs, HF in-charge</td>
<td>Jan 2015</td>
<td>Onwards</td>
</tr>
<tr>
<td>Task 3: Construct/Upgrade RCHS OPD</td>
<td>DED, DMOs, HF in-charge</td>
<td>April 2015</td>
<td>Onwards</td>
</tr>
<tr>
<td>Task 4: Procure and install generator/Solar Power System and distribute</td>
<td>CDED, DMOs, HF in-charge</td>
<td>April 2015</td>
<td>Onwards</td>
</tr>
<tr>
<td>Task 5: Establish water source from drilled wells/ rain harvesting/public water supply</td>
<td>Council Pharmacists and HF in-charge</td>
<td>Dec 2014</td>
<td>Onwards</td>
</tr>
<tr>
<td>Task 6: Install running water system from source to facilities and staff accommodation quarters.</td>
<td>Council and Regional Pharmcists</td>
<td>Jan 2015</td>
<td>Onwards</td>
</tr>
<tr>
<td>Task 7: Procure storage tanks, water pumps etc</td>
<td>CHMT/RHMT</td>
<td>Jan 2015</td>
<td>Onwards</td>
</tr>
</tbody>
</table>
**Task shifting of provision of CEmONC signal functions to the well skilled, and mentored, motivated lower cadre staff**

<table>
<thead>
<tr>
<th>Title</th>
<th>Tailor-made three month skill-based training and one month guided clinical practice followed by monthly supportive supervision to the Assistant Medical Officers, Nurse-midwives and clinical officers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief description</td>
<td>Reliable provision of all the nine signal functions through-out the year requires well-skilled and mentored enough to be responsive to the needs of the patients with various obstetric complications. With the current shortage in the human resource for health especially in rural settings, the shortage for quality staffs to attend life-threatening emergency obstetric complications. A team of two AMOs, two nurse-midwives to be trained for surgery and provision of safe anaesthesia. After the three months training, they will require one month of supervised clinical practice in a high volume facility(high case load). Monthly supportive supervision and mentoring is crucial to ensure retention of good practices and skills</td>
</tr>
<tr>
<td>Project sponsor</td>
<td>DED</td>
</tr>
<tr>
<td>Project owner</td>
<td>DMO and Facility In Charges</td>
</tr>
<tr>
<td>Ease of implementation</td>
<td>Medium</td>
</tr>
</tbody>
</table>

**Other Impact**
- Reduce Maternal and Neonatal Deaths
- Reduce Delay to reaching facilities for CEmONC services

| Total Private Investment | TBD |
| DP's Funding | TBD |
| Total Public Investment | TBD |

**Top 3 KPIs**
- TBD
- TBD
- TBD

**Case for change (as is)**
There is a critical shortage of Human resource for health in Tanzania and only 20% of the BEmONC facilities in Tanzania had at least one skilled BEmONC staff(2012). Training and mentoring of staffs in Kigoma (among other interventions) ensured smooth task-shifting that was marked by decreased case fatality rate to 1.3(June 2013) and facility-based maternal mortality by 18% in two years(CDC 2014)

**Aspiration (to be)**
Available of at least four skilled and motivated staff per selected facility(Two AMO and two nurse/midwives to provide anaesthesia) and monthly supportive supervisions and mentoring visits by experienced practitioners at least in the first six months

**Key activity (task)**

<table>
<thead>
<tr>
<th>Task</th>
<th>Action party</th>
<th>State date</th>
<th>End date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Task 1: Identify two AMOs and two nurse-midwives/clinical officers to train for signal functions(include anaesthesia)</td>
<td>DED, DMOs, PBD</td>
<td>January 2015</td>
<td>February 2015</td>
</tr>
<tr>
<td>Task 2: Train them in a recognized centres for these trainings</td>
<td>PDB, MOHSW, Principals AMO training centres,DED, DMOs,</td>
<td>February 2015</td>
<td>May 2015</td>
</tr>
<tr>
<td>Task 3: Attach them in a high volume referral centre for supervised/guided clinical practice</td>
<td>RMO, DED, DMOs, Health Facility in-charge</td>
<td>June 2015</td>
<td>July 2015</td>
</tr>
<tr>
<td>Task 4: Deploy them to the constructed CEmONC sites</td>
<td>DED, DMOs, Health Facility in-charge</td>
<td>July 2015</td>
<td>Onwards</td>
</tr>
<tr>
<td>Task 5: Do monthly supportive supervision and mentoring by senior practitioners/specialists for two months</td>
<td>MOHSW, PDB, DED, DMOs</td>
<td>August 2015</td>
<td>Jan 2016</td>
</tr>
<tr>
<td>Title</td>
<td>Improve the supply of appropriate equipments, instruments, medicines and supplies to facilitate CEmONC at strategically selected health centres</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brief description</td>
<td>Constant availability of appropriate equipments, instruments, medicines and supplies is essential to facilitate CEmONC at the selected facilities to ensure smooth functioning of the nine life-serving signal functions. Lack of specific equipment and/or stock-out of some of the supplies and medicine renders the facility unable to manage one or more of the leading causes of maternal death and morbidity.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Project sponsor</td>
<td>DED</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Project owner</td>
<td>DMO and Facility In Charges</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ease of implementation</td>
<td>Medium</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Case for change (as is)**

There is interrupted and frequent stock outs of medicines and medical supplies at facilities. Some facilities lack essential equipment to provide EmONC services, therefore compromise the quality of care. Availability of essential commodities for EmONC was found to be between 35% to 67% of the facilities. Readiness score for EmONC was found to be 53% (SARA 2012)

**Aspiration (to be)**

Sustained availability of Essential equipment, medicines, instruments and supplies for provision of EmONC services 24/7 throughout the year. Readiness Scores for EmONC should be 95% in the implementing facilities by 2016/17

**Key activity (task)**

<table>
<thead>
<tr>
<th>Task</th>
<th>Action party</th>
<th>State date</th>
<th>End date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Task 1: Procure equipment for CEmONC at strategically selected facilities</td>
<td>DED, DMOs, HF in-charge</td>
<td>Jan 2015</td>
<td>Onwards</td>
</tr>
<tr>
<td>Task 2: Conduct Planned Preventive Maintenance and repair for equipment</td>
<td>DED, DMOs, HF in-charge</td>
<td>April 2015</td>
<td>Onwards</td>
</tr>
<tr>
<td>Task 3: Procure instruments for CEmONC at implementing facilities</td>
<td>CDED, DMOs, HF in-charge</td>
<td>April 2015</td>
<td>Onwards</td>
</tr>
<tr>
<td>Task 4: Conduct Planned Preventive Maintenance and repair for instruments</td>
<td>DED, DMOs, HF in-charge</td>
<td>April 2015</td>
<td>Onwards</td>
</tr>
<tr>
<td>Task 5: Project needs for medicines and supplies for a year for each facility yearly</td>
<td>DED, DMOs, HF in-charge</td>
<td>Dec 2015</td>
<td>Onwards</td>
</tr>
<tr>
<td>Task 6: Order medicines and supplies quarterly three months before stock outs</td>
<td>Council Pharmacists and HF in-charge</td>
<td>Dec 2014</td>
<td>Onwards</td>
</tr>
<tr>
<td>Task 7: Review report and requisition forms by Council Pharmacists before submission to MSD for ordering medicines and supplies</td>
<td>Council and Regional Pharmacists</td>
<td>Jan 2015</td>
<td>Onwards</td>
</tr>
<tr>
<td>Task 8: Redistribute medicines and supplies from facilities with excess to facilities with deficiencies</td>
<td>CHMT/RHMT</td>
<td>Jan 2015</td>
<td>Onwards</td>
</tr>
</tbody>
</table>
**Title**

Improve the Referral Health System to support CEmONC at strategically selected health facilities to address Second Phase Delay

**Brief description**

A working referral system is essential to support Health Care Service delivery from community to dispensaries, health centres, district hospitals and beyond; sometimes by-passing this arrangement for severe emergency cases to facilities with desired services; using communication channels and transport to facilitate referrals according to the MOHSW Referral Guideline. Funding for fuel included in the CCHP budget plans

**Project sponsor**

DED

**Project owner**

DMO and Facility In Charges

**Ease of implementation**

Medium

**Case for change (as is)**

There are no vehicles and communication channels for referrals. There are no data at referring and referral facility on referred patients, feedback to referring facilities from higher level which would encourage lower level facilities to improve the referral of patients is absent, absence of funds to facilitate referrals. Majority of patients conduct self referral with consequent overcrowding at higher level facility and poor quality of services

**Aspiration (to be)**

Reliable transport using vehicles/boats and communication channels be in place, data kept in both facilities, with minimal self referral, by passing the referral channels if necessary. Information in the counter referral of patients is used to improve knowledge and care at lower levels. Functional referral system reducing overcrowding at higher levels and improve quality of service and reduces delays in reaching appropriate care.

**Other Impact**

- Reduce Maternal and Neonatal Deaths
- Reduce Delay to reaching facilities for CEmONC services

**Total Private Investment**

TBD

**DP’s Funding**

TBD

**Total Public Investment**

TBD

**Top 3 KPIs**

- **Ambulances procured by DEDs**
  - 23 ambulances
- **Outsourced ambulances from individuals**
  - 23 ambulances
- **Number of patients referred from facilities to facilities**
  - 15 % of deliveries

**Key activity (task)**

<table>
<thead>
<tr>
<th>Task</th>
<th>Action party</th>
<th>State date</th>
<th>End date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Task 1: Update and customize the referral guidelines to local needs</td>
<td>MOHSW-DCS</td>
<td>Nov 2014</td>
<td>Dec 2014</td>
</tr>
<tr>
<td>Task 2: Document in registers referred patients at referring facility and higher level and keep copies of referral letters at both facilities in a folder and case notes</td>
<td>Facility in Charge</td>
<td>Dec. 2014</td>
<td>Onwards</td>
</tr>
<tr>
<td>Task 3: Conduct counter referral to the referring facility at discharge and a copy kept in case notes</td>
<td>Facility in Charge</td>
<td>Dec 2014</td>
<td>Jan 2015</td>
</tr>
<tr>
<td>Task 4: Establish reliable communication between facilities within the council and the region (Procure two mobile phone per facility, airtime and establish closed user group)</td>
<td>DMO, Facility in Charge</td>
<td>Nov 2014</td>
<td>Onwards</td>
</tr>
<tr>
<td>Task 5: Facilitate referrals from communities made by community health workers to health facilities by identifying local car owners and mobilize community to set funds for fuel</td>
<td>Facility in Charge, CHWs, Village/Ward Executive Officers</td>
<td>Dec 2014</td>
<td>Onwards</td>
</tr>
<tr>
<td>Task 6: Procure one ambulances/vehicles/Boats per CEmONC health centre to facilitate referral of patients between facilities and that can provide services on route (mobile emergency care units)</td>
<td>DED</td>
<td>Dec 2014</td>
<td>30 June 2015/16</td>
</tr>
<tr>
<td>Task 7: Outsource ambulance services from individuals in places with no public ambulances for transport from homes to facilities and from facilities to higher level facilities</td>
<td>DED, WEO/VEO</td>
<td>2016/2017</td>
<td>Onwards</td>
</tr>
</tbody>
</table>
### Title
Improved sanitation and health care waste management at health facility.

### Brief description
Improve sanitation and health care waste management at health facility level guided by Health/Environmental Officers.
The construction of sanitation systems and health care waste management facilities at CEmONC facilities including placentae pits and incinerators.

### Project sponsor
DED

### Project owner
Facility In-charges

### Ease of implementation
Medium

### Case for change (as is)
Sanitation facilities were in less than 25% and Health waste management systems were in less than 15% of the health facilities (SARA Report, 2012). Those found are not constructed according to standard guidelines and SOPS, consequently wastes are disposed improperly leading to high risk of acquiring infections. Equipment for waste collection, handling, storage up to final disposal is not available. Facilities are non complaint to SOPs on sanitation and health care waste management.

### Aspiration (to be)
Proper sanitation and Health waste management systems available at least to 80% of health facilities with EmONC. Sanitation and waste management systems constructed according to standards and guidelines, and equipment for proper waste collection, handling, storage and final disposal procured for safety.

### Key activity (task)
<table>
<thead>
<tr>
<th>Task 1: Procure coloured bins, coloured bags, safety boxes, wheelbarrow etc. for on-site transport and personal protective gears</th>
<th>Action party</th>
<th>State date</th>
<th>End date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Facility in Charge, HFGCs</td>
<td>Jan 2015</td>
<td>Dec 2015</td>
<td></td>
</tr>
<tr>
<td>Task 2: Construction of standard incinerators and placenta pits in facilities involving Environmental Officers</td>
<td>Health Facility Mngt Team, DED</td>
<td>April 2015</td>
<td>June 2015</td>
</tr>
<tr>
<td>Task 3: Orient staff on IPC Guidelines and distribute</td>
<td>CHMT/RHMT</td>
<td>April 2015</td>
<td>June 2015</td>
</tr>
<tr>
<td>Task 4: Implementation of construction and Monitoring of Health Care Waste Management activities</td>
<td>Health Facility Mngt Team/CHMT</td>
<td>July 2015/16</td>
<td>July 2017/18</td>
</tr>
<tr>
<td>Task 5: Supportive Supervision conducted annually</td>
<td>MOHSW- DPS/DHQA</td>
<td>Dec 2015</td>
<td>Dec 2015</td>
</tr>
<tr>
<td>Task 6: Training of staff on the handling of health care wastes</td>
<td>CHMT/RHMT</td>
<td>Dec 2014</td>
<td>March 2014</td>
</tr>
</tbody>
</table>

### Other Impact
- Reduce Maternal and Neonatal Deaths
- Reduce Delay to reaching facilities for CEmONC services

### Total Private Investment
TBD

### DP’s Funding
TBD

### Total Public Investment
TBD

### Top 3 KPIs
- TBD
- TBD
- TBD
Conduct Mapping to identify needs for each for potential facility to be upgraded to BEmoNC

<table>
<thead>
<tr>
<th>Title</th>
<th>Conduct needs assessment for each facility to be upgraded to BEmoNC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief description</td>
<td>In order to come up with the actual budget for each facility to be upgraded for BEmoNC which is fully functioning the first task will be to conduct mapping in all five regions identified from BRN lab.</td>
</tr>
<tr>
<td>Project sponsor</td>
<td>Local Government Authority</td>
</tr>
<tr>
<td>Project owner</td>
<td>DED</td>
</tr>
<tr>
<td>Ease of implementation</td>
<td>High</td>
</tr>
<tr>
<td>Case for change (as is)</td>
<td>Needs assessment conducted by CDC (........) reported that............In addition to that, lab members were unable to access information which confirms number and type of short courses attended by staff at each facility and available equipments from each facility.</td>
</tr>
</tbody>
</table>

Aspiration (to be)

Equip x% (True north) of the BEmoNC centres

Other Impact

- Reduce Maternal and Neonatal Deaths
- Reduce Delay to reaching facilities for CEmoNC services

| Total Private Investment | TBD |
| DP’s Funding | TBD |
| Total Public Investment | TBD |

Top 3 KPIs

| # of HF assessed | TBD |
| Actual Budget | TBD |
| Gaps to be identified (skills, equipments and renovations) | TBD |

Key activity (task) | Action party | State date | End date |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Prepare assessment tools (Ass guide, time table..................)</td>
<td>BRN lab</td>
<td>28 Oct 2014</td>
<td>8 Nov 2014</td>
</tr>
<tr>
<td>Communicate with CHMT about the need for assessment of HF to be upgraded to BEmoNC</td>
<td>MoHSW, RHMT, CHMT and HF</td>
<td>10 Nov 2014</td>
<td>30 Nov 2014</td>
</tr>
<tr>
<td>Conduct mapping of HFs to identify gas</td>
<td>MoHSW and CHMT</td>
<td>3 Dec 2014</td>
<td>20 Dec 2014</td>
</tr>
<tr>
<td>Report writing on the identified gaps</td>
<td>MoHSW &amp; CHMT</td>
<td>5 Jan 2015</td>
<td>15 Jan 2015</td>
</tr>
<tr>
<td>Procure equipment, supplies, construction/renovations and staff posting</td>
<td>MoHSW (HRH), DED &amp; HF</td>
<td>25 Jan 2015</td>
<td>25 June 2015</td>
</tr>
<tr>
<td>Monitoring and evaluation of all activities under this initiative</td>
<td>MoHSW, RHMT &amp;CHMT</td>
<td>10 July 1015</td>
<td>30 July 2015</td>
</tr>
</tbody>
</table>
Institutionalise the use of mentorship teams who will inspire other health care workers to build up skills and positive attitude

Title
Identification of Mentorship teams who will conduct mentorship and inspire other health care workers to build up skills and positive attitude

Brief description
The identification of team will be in different levels in the region and district, and identified according to needs. The mentorship teams will have specific areas to mentor at different levels of service delivery. At district hospital level, mentorship will be done at emergency operations, labour ward, ANC, Post natal and Family planning. At health center level, mentorship will conducted within the hospital in the areas of caesarian sections, theatre management, anesthesia, labour ward, ANC, Post natal and FP. At all levels of health facilities, mentorship will be done to all clinicians and nurses on life serving skills and customer care. The district will also identify persons with best practices who will be the role model so as to inspire other health care workers.

Project sponsor
DED

Project owner
DMO

Ease of implementation
High

Case for change (as is)
According to in-depth assessment in midwifery competences in MNCH services in Tanzania conducted by MoHSW, MUHAS and WHO, there is poor management of patients and unnecessary referrals due to lack of skills for most of health care provider at primary health facility level

Aspiration (to be)
>% of all primary health facilities to have competent skilled personnel, thus improved management of patients

Other Impact
• Reduce Maternal and Neonatal Deaths
• Reduce Delay to reaching facilities for CEmONC services

Total Private Investment
TBD

DP’s Funding
TBD

Total Public Investment
TBD

Top 3 KPIs

Mentorship teams
One in each service delivery

Reports of mentorship conducted
TBD

Reduced referral cases
TBD

Safe operations conducted at district and health centre
TBD

Key activity (task)
Action party
State date
End date
regional advocacy about training and mentorship programs
MoHSW, RHMT and CHMT
15 Nov 2014
30 Nov 2014
Procurement of equipment for training lab.
MoHSW, DPs & CHMT
15 Nov 2014
30 Nov 2014
Circular on Mentorship Team to be sent to the CHMTs
MoHSW
1 Dec 2014
24 Jan 2015
Develop terms of reference for the mentorship teams. This ToR to include developing the selection criteria for the members of the mentorship teams (focussing on technical and soft skills), mentorship methodology, selection of mentorship sites etc
MoHSW, RHMT and CHMT
1 Dec 2014
31 Dec 2015
Selection of mentorship teams by the CHMT guided by the TOR. Members of the CHMT mentorship team will be based on expertise required, not necessarily within the CHMT.
CHMT
1 Dec 2014
31 Dec 2015
CHMT mentorship team to develop a plan for mentorship, identify and select mentorship sites based on identified gaps from the research and feedback from the supportive supervision team. This plan is to be communicated to the facilities.
CHMT mentorship team
1 Dec 2014
31 Dec 2015
Implement mentorship plan. (Conduct mentorship in emergency, life saving skills, theatre management and anesthesia, use of pantograph, manual remove of placenta, and others)
Mentorship team
Jan 2015
Dec 2015
Monitor and evaluation of mentorship activities
HMT
Mar 2015
June 2017
## Re- emphasise training and induction programs for health workers to increase performance

<table>
<thead>
<tr>
<th>Title</th>
<th>Re-emphasise training and induction programs for health workers to increase skills and work performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief description</td>
<td>This training will involve TOT, induction training and practical (5+1) days. Induction training will be for 5 days, whereby 32 people will be trained by 8 trainers. This will be repeated every after 3 Months until all staff to be trained are covered</td>
</tr>
<tr>
<td>Project sponsor</td>
<td>DED</td>
</tr>
<tr>
<td>Project owner</td>
<td>DMO</td>
</tr>
<tr>
<td>Methods</td>
<td>Lecture, practical, exchange program</td>
</tr>
</tbody>
</table>

### Other Impact
- Reduce Maternal and Neonatal Deaths
- Reduce Delay to reaching facilities for CEmONC services

### Total Private Investment
TBD

### DP’s Funding
TBD

### Total Public Investment
TBD

### Top 3 KPIs
- Mentorship teams: TBD
- Reports on training and induction: TBD
- Reduced referral cases: TBD
- Number of cases filled on the log book: TBD

### Case for change (as is)
According to in-depth assessment in midwifery competences in MNCH services in Tanzania conducted by MoHSW, MUHAS and WHO, there is poor management of patients and unnecessary referrals due to lack of skills for most of health care provider at primary health facility level.

### Aspiration (to be)
- % reduced referral cases per facility.
- % reduced maternal and newborn mortality

### Key activity (task)

<table>
<thead>
<tr>
<th>Key activity (task)</th>
<th>Action party</th>
<th>State date</th>
<th>End date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Selection of mentorship teams by the CHMT guided by the TOR. Members of the CHMT mentorship team will be based on expertise required, not necessarily within the CHMT.</td>
<td>CHMT</td>
<td>1 Dec 2014</td>
<td>31 Dec 2015</td>
</tr>
<tr>
<td>CHMT mentorship team to develop a plan for mentorship, identify and select mentorship sites based on identified gaps from the research and feedback from the supportive supervision team. This plan is to be communicated to the facilities.</td>
<td>CHMT mentorship team</td>
<td>1 Dec 2014</td>
<td>31 Dec 2015</td>
</tr>
<tr>
<td>Implement mentorship plan. (Conduct mentorship in emergency, life saving skills, theatre management and anaesthesia, use of pantograph, manual remove of placenta, and others)</td>
<td>Mentorship team</td>
<td>Jan 2015</td>
<td>Dec 2015</td>
</tr>
<tr>
<td>Monitor and evaluation of mentorship activities</td>
<td>HMT</td>
<td>Mar 2015</td>
<td>June 2017</td>
</tr>
</tbody>
</table>
**Regional Satellite Blood Transfusion Centres**

<table>
<thead>
<tr>
<th>Title</th>
<th>Establish 5 Regional satellites blood transfusion centres in the 5 targeted regions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief description</td>
<td>Well functioning and accessible blood transfusion services are essential to saving lives in maternal newborn and child health services. Many pregnant women with obstetric hemorrhages die if they do not receive blood transfusion within two hours from start of bleeding. So access to blood transfusion services are critical to save pregnant women 24/7 and throughout the year.</td>
</tr>
<tr>
<td>Project sponsor</td>
<td>Regional Administrative Secretary and MOHSW (National Blood Transfusion Services)</td>
</tr>
<tr>
<td>Project owner</td>
<td>RMO/NBTS</td>
</tr>
<tr>
<td>Ease of implementation</td>
<td>Medium</td>
</tr>
<tr>
<td>Total Private Investment</td>
<td>TBD</td>
</tr>
<tr>
<td>DP’s Funding</td>
<td>TBD</td>
</tr>
<tr>
<td>Total Public Investment</td>
<td>TZS 1.4 Bil.</td>
</tr>
</tbody>
</table>

### Case for change (as is)

- Currently, Blood Transfusion Services are located at zonal centres far away from health facilities that conduct CEmONC services, and access is a concern. Blood collection has been difficult with populations far away from the zonal Blood Banks.
- Many women in pregnancy and child birth as well as newborn and children die due to lack of blood transfusion services. Data from Kigoma region (2013) shows that 41% of women in child birth died of haemorrhages and Mara region recorded 33% of such women who died of same conditions who needed blood transfusion.

### Aspiration (to be)

- To establish centres and mobilize blood donors and distribute safe blood to those in need especially pregnant women and newborn as close as to where they receive CEmONC services by 100%.
- Accessible blood transfusion services to pregnant women and children in CEmONC centres will address and reduce deaths due to haemorrhages by

<table>
<thead>
<tr>
<th>Topline KPIs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
</tr>
<tr>
<td>Blood units collected in 5 regions 2015/2016</td>
</tr>
<tr>
<td>Blood units collected in 5 regions 2016/2017</td>
</tr>
<tr>
<td>Blood units collected in 5 regions 2017/2018</td>
</tr>
</tbody>
</table>
### 360 Degree Mass media campaign through PPP

<table>
<thead>
<tr>
<th>Title</th>
<th>Develop integrated 360 Degree mass media campaign that can be multi sponsored through PPP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief description</td>
<td>There is lack of information in the community on availability and access to RMNCH services</td>
</tr>
<tr>
<td>Project sponsor</td>
<td>MOHSW / DPs</td>
</tr>
<tr>
<td>Project owner</td>
<td>MoHSW / DEU / PR Agency / DPs</td>
</tr>
<tr>
<td>Ease of implementation</td>
<td>Easy</td>
</tr>
<tr>
<td>Total Private Investment</td>
<td>Potential PPP</td>
</tr>
<tr>
<td>DP’s Funding</td>
<td>TBD</td>
</tr>
<tr>
<td>Total Public Investment</td>
<td>TZS 1553.75 million</td>
</tr>
</tbody>
</table>

#### Case for change (as is)

- Community members have low knowledge on pregnant danger signs and other RMNCH
- Myth, socio-cultural issues and misconceptions affect variously uptake of RMNCH services
- Inadequate community engagement in RMNCH, including voluntary blood donation
- Mass media campaigns are the most cost effective and scalable way of encouraging health behaviours and health-seeking behaviours

#### Aspiration (to be)

Improve uptake of RMNCH services (family planning, ANC, institutional delivery, PNC)
Improve access to safe blood

#### Top 3 KPIs

- Establish KAP surveys throughout the 18 months
  - Baseline scores to be established
- Secure 5 sponsors and above
  - Sponsorship of up to 1.5 billion
- Successful RMNCH Mass Media Campaign launched
  - Launch by Feb 2015

#### Key activity (task)

<table>
<thead>
<tr>
<th>Activity</th>
<th>Action party</th>
<th>State date</th>
<th>End date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generate evidence to inform communication interventions and customization of RMNCH media to suit local context of each region and district</td>
<td>RHMT/CHMT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Create and air creative TV and/or radio talk shows and programmes with specific public dialogue (consider utilizing testimonials, and real life experience, soap opera)</td>
<td>RHMT/CHMT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Engage influential leaders including Ministers, RC, DC, RMO, DMO, MPs and religious leaders to deliver key RMNCH message through media</td>
<td>RHMT/CHMT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Utilize appropriate folk media and recorded drama</td>
<td>RHMT/CHMT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monitor and Evaluate the communication intervention</td>
<td>RHMT/CHMT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CONTENTS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Executive Summary</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Summary of Issues</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Summary of Initiatives</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High level targets and funding requirement</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>1</strong> High Level KPIs &amp; Targets</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>2</strong> High Level funding requirement</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overview of Initiatives by area of focus</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Funding Requirement</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Key Performance Indicators</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Governance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>High level targets and funding requirement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>High Level KPIs &amp; Targets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>High Level funding requirement</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Overall aspirational Targets & KPIs for BRN Healthcare

**FY 2015/2016**
- All Regions at / above National Average for skilled HRH
- 75% utilisation of employment permits for HRH
- 15% reduction in the number of facilities without Skilled HRH nationwide
- 80% stock availability
- 80% order fill rate
- 20% of health facilities at identified regions are elevated from level 1 & 2 to level 3 and above

**FY 2016/2017**
- All Regions at / above National Average for skilled HRH
- 80% utilisation of employment permits for HRH
- 42% reduction in the number of facilities without Skilled HRH nationwide
- 100% stock availability
- 100% order fill rate
- 60% of health facilities at identified regions are elevated from level 1 & 2 to level 3 and above

**FY 2017/2018 & Beyond**
- All Regions at / above National Average for skilled HRH
- 90% utilisation of employment permits for HRH
- 70% reduction in the number of facilities without Skilled HRH nationwide
- 100% stock availability
- 100% order fill rate
- 80% of health facilities at identified regions are elevated from level 1 & 2 to level 3 and above
## High level targets and funding requirement

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>High Level KPIs &amp; Targets</td>
</tr>
<tr>
<td>2</td>
<td>High Level funding requirement</td>
</tr>
</tbody>
</table>
TZS 185 Billion are required to implement BRN healthcare

<table>
<thead>
<tr>
<th>Budget allocation by work streams, TZS (Billion)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Human Resources for Health</td>
</tr>
<tr>
<td>Health Facilities</td>
</tr>
<tr>
<td>Health Commodities</td>
</tr>
<tr>
<td>Reproductive, Maternal, Neonatal &amp; Child Health</td>
</tr>
<tr>
<td>TOTAL</td>
</tr>
</tbody>
</table>

SOURCE: BRN Healthcare Lab (2014)
<table>
<thead>
<tr>
<th>CONTENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive Summary</td>
</tr>
<tr>
<td>Detailed Description of Healthcare NKRA Issues</td>
</tr>
<tr>
<td>Summary of Initiatives</td>
</tr>
<tr>
<td>High level targets and funding requirement</td>
</tr>
<tr>
<td>Overview of Initiatives by area of focus</td>
</tr>
<tr>
<td>1 Initiatives for Human Resources for Health</td>
</tr>
<tr>
<td>2 Initiatives for Healthcare Facilities</td>
</tr>
<tr>
<td>3 Initiatives for Health commodities</td>
</tr>
<tr>
<td>Special focus</td>
</tr>
<tr>
<td>Funding Requirement</td>
</tr>
<tr>
<td>Key Performance Indicators</td>
</tr>
<tr>
<td>Governance</td>
</tr>
</tbody>
</table>
# Overview of Initiatives by area of focus

<table>
<thead>
<tr>
<th></th>
<th>Initiatives for Human Resources for Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Initiatives for Healthcare Facilities</td>
</tr>
<tr>
<td>3</td>
<td>Initiatives for Health commodities</td>
</tr>
</tbody>
</table>
6 Initiatives to improve Human Resource for Health

- Prioritize employment permits allocation
- Skilled HRH through PPP/Private Engagement
- Empowering LGAs in Human Resource Management
- Optimising the pool of new recruits
- Synchronize recruitment process @ Central level
- Redistribute healthcare workers within region
- Prioritize employment permits allocation
**Our transformation vision for Tanzanian Healthcare system**

### Healthy Tanzanians

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reproductive &amp; Child Health</td>
<td>Malaria, HIV/AIDS, TBs &amp; infectious diseases</td>
</tr>
</tbody>
</table>

### Human Resources for Health

- Prioritize allocation of Employment permits to regions with critical shortage of skilled HRH
- Provide skilled HRH through PPP/Private sector engagement
- Redistribution of healthcare workers within regions

### Healthcare Facilities

- Star Rating System
- Fiscal decentralisation by devolution from council level to health facility level
- Social accountability
- Performance targets & contracts

### Health Commodities

- Improving governance, Accountability, and sense of ownership of Health commodities supply chain
- Strengthen management of MSD working capital for sustainable availability of medicines & medical supplies
- To complement MSD in the procurement & Distribution of medicines by engaging private sector
  - Introduction of ICT mobile apps platform for lower level facilities
  - SMS to report on stock outs and quality of health services
  - Scale up 5S-Kaizen TQM initiatives

### Additional Initiatives

- Optimising the pool of new recruits
- Synchronise recruitment process @ Central level
- Empowering LGAs in Human Resource Management
- Social accountability
- Performance targets & contracts
- Fiscal decentralisation by devolution from council level to health facility level
- Star Rating System
- SMS to report on stock outs and quality of health services
There are 6 Initiatives to improve Human Resources for Health (1/3)

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Expected outcome(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prioritize application of employment permits to regions with critical</td>
<td><strong>100%</strong> Prioritized regions at / above National Average &amp; <strong>40%</strong> of employment permits for skilled HRH allocated to primary health care services in identified regions with <strong>critical skilled HRH shortage</strong></td>
</tr>
<tr>
<td>shortage of skilled HRH</td>
<td></td>
</tr>
<tr>
<td>Provide skilled HRH through PPP/Private sector engagement</td>
<td><strong>135</strong> Number of Health facilities manned by skilled private HRH through PPP arrangements</td>
</tr>
<tr>
<td>Redistribution of health care workers within the regions</td>
<td><strong>16</strong> Regions to implement HRH redistribution between their own districts &amp; attain <strong>100%</strong> reduction in no. facilities without Skilled HRH</td>
</tr>
</tbody>
</table>
There are 6 Initiatives to improve Human Resources for Health (2/3)

Optimising the pool of new recruits:
(a) Reinforce bonding policy

(b) Introduce Compulsory attachments for Clinicians and Nurses

Synchronising the recruitment process at the Central level

Expected outcome(s)

Number of graduates bonded by cadres & number of graduated government scholars students who serves in government healthcare facilities

6 compulsory attachment status for 6 cadres confirmed & 100% students undergoing compulsory services

100% Number of graduates of seven cadres allocated employment permit by Sep 30th annually & 100% report for duty at allocated LGAs
Empowering the LGAs in Human Resource Management:

(a) Reinforce orientations and induction for newly hired staff

(b) Enforcing retention & incentive policy at LGA

(c) Develop coaching and mentoring model to strengthen skills of Human Resource Management

(d) Ring-fencing New HRH Recruits entitlements (Subsistence allowance)

**Expected outcome(s):**

100% of newly recruited staff who have been oriented

All Execution of the Orientation and induction plans of LGAs annually

Establishment of 1 HRH Incentive guideline
All LGAs to execute the submitted retention & incentive improvement plans of LGAs

Coaching and mentoring training conducted to 156 LGAs
156 LGAs to submit quarterly reports to RHMT on performance

Substance allowance given protected status, Subsistence allowance to be provided within a week after reporting of the staff for all LGAs
The HRH Distribution true north is set as 100% equitable distribution of skilled health workers at primary level by 2017/18

Different interpretations of “equitable”

- “Refer to outpatient and inpatient numbers”
- “Correlate to Population”
- “It depends…”
- “Equitable”
- “based on workload”
- “Needs”
- “MNCH indicators to be used as basis”

WHO* adapted the model by Campbell et al+ to illustrates HRH Availability in the published report “A Universal Truth: No health without a workforce, 2013”

Theoretical coverage by ‘availability’ of health workforce

* WHO, A Universal Truth: No health without a workforce, 2013
Based on two levels of interpretations of “Equitable HRHs”

Taking into consideration the various definitions and interpretations of “equitable”, and in line with the focus of the lab, equitable are defined via two levels of indicators

(Level 1) Density of population
(Level 2) Health needs

**Level 1 Density of population**

The Density of Population is calculated as:

\[
\frac{\text{Number of Clinicians / Nurses}}{\text{Number of population / region / country}}
\]

Upon completion of Level 1, whereby all the regions have reached the Tanzanian National Average for Density of Skilled HRH, Level 2 indicator will be utilised to determine equitable distribution for the regions

**Level 2: Needs based on Health Indicators**

Key health indicators are to be used to identify geographical areas of concern whereby a higher density of Clinicians or and Nurses maybe required. Some of the indicators identified are:

1. Mortality (Infant Mortality, Leading Causes of Death, etc)
2. Morbidity (Low Birth-weight, Cancer rate, STDs, AIDS, Tuberculosis)
3. Immunisation and screenings

Every Tanzanian has the right to healthcare services
By taking into consideration two cadres – Clinicians and Nurses

1. Clinician

The Clinician refer to two sub-categories of (1) Medical Doctors and (2) Allied Medical Practitioners.

The 2 sub-categories are represented by 4 cadres in Scheme of Services

1) Medical Officers
2) Assistant Medical Officers
3) Clinical Officers
4) Assistant Clinical Officers / Clinical Assistant

WHO defines “Human resources for health” ("HRH") or “health workforce” as “all people engaged in actions whose primary intent is to enhance health”


2. Nurse

The Nurse category is represented by 3 cadres which includes enrolled nurses, registered midwives as recognised by the Tanzanian Nursing and Midwifing Council as well as trained nurses (3 year course)

1) Nursing Officer
2) Assistant Nursing Officer
3) Nurse

Source: BRN Lab Analysis and Conclusion, MOHSW – Scheme of Service, Manning Level
Primary healthcare provides the first point of contact in the health care system*. In Tanzania, the Primary Healthcare level is comprised of three main categories of healthcare facilities:

1. Dispensaries
2. Health Centre
3. District Hospitals

Tanzanian HR policy requires that for every 50,000 population there should be five dispensaries and one health centre*.

- Each Dispensary should be provided with two qualified HRH
- Each Health Centre should be provided with four qualified HRH


*WHO Website, Primary Healthcare topic
By targeting 13 underserved regions, the lab aims to achieve 100% equitable distribution of skilled health workers at primary level by 2017/18.

**13** Regions

- **Below National Average for Density of Skilled HRH per 10,000 population**

**15** Regions

- **Below National Average for Density of Clinicians per 10,000 population**

**14** Regions

- **Below National Average for Density of Nurses per 10,000 population**

**0** Regions

- **Achieve WHO Skilled attendance at birth 22.8 per 10,000 population**

### 2014 vs 2018

- **13** underserved regions
  - Regions with density rate below 2014’s national average for clinicians and nurses

- **Regions currently above national average**
  - Regions with density rate above 2014’s national average for clinicians and nurses
Prioritize allocation of employment permits to regions with critical shortage of skilled HRH

Provide skilled HRH through PPP/Private sector engagement

Redistribution of health care workers within the regions

Optimising the pool of new recruits

Empowering the LGAs in Human Resource Management

Synchronising the recruitment process at the Central level

In summary, the lab has identified 6 key initiatives to achieve 100% equitable distribution of skilled health workers at primary level by 2017/18
## Overview of Initiatives by area of focus

<table>
<thead>
<tr>
<th></th>
<th>Initiatives</th>
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<tbody>
<tr>
<td>1</td>
<td>Initiatives for Human Resources for Health</td>
</tr>
<tr>
<td>2</td>
<td>Initiatives for Healthcare Facilities</td>
</tr>
<tr>
<td>3</td>
<td>Initiatives for Health commodities</td>
</tr>
</tbody>
</table>
4 Initiatives to improve Healthcare facilities

- Implement Star Rating System
- Fiscal decentralisation by devolution
- Performance targets & contracts
- Social Accountability
Our transformation vision for Tanzanian Healthcare system

<table>
<thead>
<tr>
<th>Human Resources for Health</th>
<th>Healthcare Facilities</th>
<th>Health Commodities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prioritize allocation of Employment permits to regions with critical shortage of skilled HRH</td>
<td>Star Rating System</td>
<td>Improving governance, Accountability, and sense of ownership of Health commodities supply chain</td>
</tr>
<tr>
<td>Provide skilled HRH through PPP/Private sector engagement</td>
<td>Fiscal decentralisation by devolution from council level to health facility level</td>
<td>Strengthen management of MSD working capital for sustainable availability of medicines &amp; medical supplies</td>
</tr>
<tr>
<td>Redistribution of healthcare workers within regions</td>
<td></td>
<td>To complement MSD in the procurement &amp; Distribution of medicines by engaging private sector</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Initiatives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Optimising the pool of new recruits</td>
</tr>
<tr>
<td>Synchronise recruitment process at Central level</td>
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<td>Empower LGAs in Human Resource Management</td>
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<tr>
<td>Social accountability</td>
</tr>
<tr>
<td>Performance targets &amp; contracts</td>
</tr>
<tr>
<td>Introduction of ICT mobile apps platform for lower level facilities</td>
</tr>
<tr>
<td>SMS to report on stock outs and quality of health services</td>
</tr>
<tr>
<td>Scale up 5S- Kaizen TQM initiatives</td>
</tr>
</tbody>
</table>
There are 4 Initiatives in improving Healthcare Facilities conditions & quality of services (1/2)

Assess, rate and develop specific facility improvement plans for 1- and 2-Star primary level health facilities

Expected outcome(s)

80% of health facilities at identified regions are elevated to level 3 & above by 2017/18

Implement fiscal decentralization by devolution from council level to health facility level

100% of Health Facilities open and use own bank account by 2017/18
There are 4 Initiatives in improving Healthcare Facilities conditions & quality of services (2/2)

Increase social accountability at the facility and community level to address local health priorities/concerns

Introduce the use of performance targets and contracts at the primary facilities to address and enforce staff accountability in delivery of quality health services

**Expected outcome(s)**

100% of LGAs roll-out community scorecard as a tool for social accountability monitoring of health facility and community by 2017/18

Health facilities to achieve 75% and above customer satisfaction by 2017/18
Our approach in achieving the True North

80% of primary health facilities rated at 1- & 2-star to be at 3-Star and above by 2017/2018

- Development of criteria and assessment tool to rate primary level health facilities (public, private and FBOs). During assessment, we identify the specific gaps in health facilities that needs to be improved.

- Specific facilities strengthening solution (A)

- General strengthening solutions on health facilities and HRH (B)

- Implementation plan for specific facilities strengthening (A)

- Implementation plan for general strengthening (B)

Identify solutions/enablers that has high impact and can be quickly implemented. These solutions are independent on the assessment of health facilities.
Rating systems are currently being utilised within the healthcare sector around the world

Health facility rating system in other countries

**Stepwise Laboratory Improvement Process Towards Accreditation [Tanzania]**

Laboratory accreditation represents an effective strategy to ensure the improvement of the quality of laboratory services in order to fulfil the patients’ needs and improve the patient care. 19 laboratories in Tanzania from (14) regions, (1) district, and (3) private hospitals have achieved a star ranking level for recognition of Implementation of Laboratory Quality Management as per WHO AFRO Stepwise Laboratory Quality Improvement Process toward Accreditation (SLIPTA) Framework

**CDC - Laboratory Accreditation Programme [Sub-Saharan Africa]**

Through a 5-step accreditation process (star rating), labs will be able to gradually receive credit for improvement and eventually attain accreditation. This extra help is seen as critical to reach a consistent high standard of work.

**COHSASA [Rwanda]**

This is an approach where Pre-Accreditation certificates at Progress, Entry and Intermediate levels. Progress certificates are also issued to individual departments within a facility, and to the facility as a whole, and these provide an incentive to continue the process of meeting increasing levels of compliance with standards, away from an initial baseline.

**SafeCare [Nigeria, Ghana, Kenya & Tanzania]**

Stepwise certification towards accreditation - The methodology dissects the improvement process of healthcare providers in survey-able, measurable steps. Thus, an improvement trajectory is created that provides positive incentives for healthcare providers to move upwards in quality, ultimately to the level that qualifies them for full accreditation.

Benefits of a rating system

**Graded quality improvement**

- Encourage and assist hospitals that do not initially achieve accreditation, but which make significant strides, to continue the path to excellence.

- Gradual certification process provides an incentive to continue the process of meeting increasing levels of compliance with standards, away from an initial baseline.

- Some rating systems allow facilities to receive credits for improvement – and eventually attain accreditation

**Financial Incentives**

- Facilities with higher ratings or certification receive a sizable discount from its insurance carrier or are paid more according to its level

**Increased transparency and quality for clients**

- Star rating can help to move services towards high quality patient – centered care

- Help the consumer to choose among competition plans

- Increase transparency and awareness with regards to quality

Source(s): [www.jointcommission.org](http://www.jointcommission.org), [www.cdc.gov/globalaids](http://www.cdc.gov/globalaids), [www.safe-care.org](http://www.safe-care.org)
The lab studied a success story of Health facilities rating system currently in use in King Faisal Hospital, Rwanda (COHSASA)

King Faisal Hospital, Rwanda

Quality Improvement program started in 2005 after the signing of a memorandum of understanding between the Ministry of Health and the Council for Heath Services Accreditation of Southern Africa. The process involved three of teaching and referral hospitals, KFH, Kigali; University Central Hospital of Kigali; University Teaching Hospital of Butare. The plan was to incrementally introduce the other hospitals into the program and share skills, knowledge and information gained from King Faisal Hospital, Kigali for the benefit of the health system countrywide.

In the baseline survey done in February 2006, KFH scored 41%. From there it underwent several surveys coupled with gradual improvements. In February 2010, the hospital scored 86% and received the pre-accreditation certificate. In February 2011, KFH scored 99% in another survey and achieved the goal of acquiring full accreditation status.

Score of KFH has increased over the years:

- **2006**: 41%
- **2010**: 86%
- **2011**: 99%

"Even though we haven't achieved accreditation level, KFH,K has benefited from the process in the sense that is definitely helping the hospital improve the standards of care and accountability to our patients in our quest for excellence"

Juliet Mbabazi, acting CEO for KFH (2010)

Source(s): www.jointcommission.org.; www.cdc.gov/globalaids; www.safe-care.org
There are Four Steps and best practices to ensure success of a rating mechanism

1. A Department of Continuing Quality Improvement was set up within the KFH in early 2007. Its main activities are:
   - Overseeing the development of a comprehensive safety and quality improvement program that includes data collection and analysis
   - Providing overall necessary direction to ensure that all services are in accordance with standards established from national regulations and international accreditation standards
   - Providing suggestions to customer care and ensuring that clients’ feedback improves hospital initiatives
   - Advising the management regarding patient safety, performance improvement, accreditation efforts and strategies that ensure compliance
   - Collaborating with all staff in the monitoring, reporting and improvement activities related to clinical guidelines, healthcare quality, safety initiatives, accreditation and regulatory requirement.

2. Certification process
   - Helped to establish clearer guidelines and procedures and more specific ways to measure the progress in achieving quality standards.
   - Offers clear and tangible methods to track and measure the performance improvement process which is extremely valuable.
   - It unifies staff and make them work as a team toward the goal of meeting the certification requirements
   - Gold Seal / Star Rating is tangible proof of dedication that facility is doing what it should be doing.

3. Insurance benefits
   - Access to sizable discounts of Insurance, the facilities linked with insurance companies which were providing discounts of insurance.
   - Payment to be done differently depending on different Rate/level the facility attained

4. Affordable Loans
   - Access to affordable loans which helps to boost the improvement process

Source(s): [www.jointcommission.org](http://www.jointcommission.org), [www.cdc.gov/globalaids](http://www.cdc.gov/globalaids), [www.safe-care.org](http://www.safe-care.org)
With an aspiration set based on the logical framework to justify the characteristic of a 5-Star health facility

<table>
<thead>
<tr>
<th>Assessment Area</th>
<th>Characteristics of Facility at 5 Star level</th>
</tr>
</thead>
</table>
| Facility Management & Governance            | ✓ strong governance structure  
  ✓ implements best practices for managing resources  
  ✓ appropriate skilled staffing complement as per staffing establishment  
  ✓ excellent working conditions/environment for staff including housing and appropriate incentives                                                                                                                                 |
| Use of Facility Data                        | ✓ accurate and comprehensive data  
  ✓ staff who can perform data analysis  
  ✓ staff who uses the data for service improvement                                                                                                                                                                                                                  |
| Performance Assessment                      | ✓ functioning performance system for staff  
  ✓ staff who have met over 80% of their performance targets                                                                                                                                                                                                        |
| Social Accountability                       | ✓ strong functioning HFGC/Council Health Service Board that is responsive to the needs of the community  
  ✓ facilitates an inclusive planning process for HF plans and by *fully* executing these plans.                                                                                                                                                                    |
| Organisation of Services                    | ✓ well-organized setup for service delivery.  
  ✓ well-organized and efficient process for maintaining and accessing records.                                                                                                                                                                                   |
| Emergency Cases                             | ✓ fully trained staff and a strong functioning system to triage, refer if needed  
  ✓ *successfully* handle emergency cases as per the norms for the facility type                                                                                                                                                                                  |
| Health Infrastructure & Infection Prevention Control (IPC) | ✓ consistently available power, running water, and functional equipment  
  ✓ Has infection, prevention and control and waste management systems that are implemented according to national guidelines.                                                                                                                                                   |
| Clinical Services                           | ✓ RMNCH, FP, outpatient and inpatient, and specialist services are fully provided according to standard protocols  
  ✓ minimal patient waiting times                                                                                                                                                                                                                               |
| Clinical Support Services                   | ✓ continuous availability of medicines that are appropriately stored and rationally used  
  ✓ availability of quality diagnostic services according to the standards of the facility type  
  ✓ For HC and Hospitals, they must have fully functioning operating theater with measures in place to prevent sepsis   |
And ensuring sustainability of Star Rating System by rewards and consequences

### Monetary rewards – more stars, more money

1. **Through Results-Based Financing (RBF)**
   Current reward formula (per type of reimbursement):
   
   \[
   \text{Current total (Tzs)} = \text{Unit cost} \times \text{no. of outputs} \times \% \text{score on quality determined by RBF}
   \]

   Modified reward formula to include Star Rating:
   
   \[
   \text{New total (Tzs)} = \text{Star Rating Factor} \times \text{Current total (Tzs)}
   \]

   **With 5 Stars, facility has potential to increase RBF amount by 50%**

<table>
<thead>
<tr>
<th># of Stars</th>
<th>Rewards Rating Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>★</td>
<td>1.00</td>
</tr>
<tr>
<td>★★</td>
<td>1.00</td>
</tr>
<tr>
<td>★★★</td>
<td>1.10</td>
</tr>
<tr>
<td>★★★★</td>
<td>1.25</td>
</tr>
<tr>
<td>★★★★★</td>
<td>1.50</td>
</tr>
</tbody>
</table>

2. **NHIF**

   Reimbursement increases by facility rating - same rating factor as RBF applied to specific NHIF reimbursement

### Non-monetary rewards – more stars, more recognition

1. Visible placement on facility for staff, patients, and community to see:
   - Number of stars
   - Monetary reward posted.
   - Trend of ratings over time

2. Greater decentralised devolution to facility to:
   - manage increasing amounts and complex transactions
   - hire staff

### Consequences

If decline in rating score:

- Facility will **receive targeted technical support** for facilities which are performing worse than before
- Facility will **receive smaller financial reward** from RBF and NHIF, based on the reward formula
- Facility will be publicly known through posting at facility (star rating, trend, and monetary decrease)

Source(s): BRN Healthcare (2014)
**Assessment Background**

1. **Health Facilities**
   - 1 district hospital
   - 3 health facilities
   - 15 dispensaries

2. **Assessment Duration**
   - 4 days (18-21 Oct)

3. **Team Composition**
   - Total 8 assessors
   - 4 team (2 people each team)
   - Each team accompanied by a CHMT member

**Assessment Results**

| Health Facilities Star Ranking – Kisarawe Council |
|---------------------------------|------------------|
| 1 Star                          | 5                |
| 2 Star                          | 11               |
| 3 star                          | 3                |

**General Observation:**

- There is a lack of water in the health facilities
- Electricity is not available from the national grid.
- The health facilities are not clean.
- Separation of healthcare waste is not done
- There is no laboratory space in the dispensaries

**Opportunities for Improvements**

1. Selection of team should follow the criteria as well or positive attitude to deliver the assessment
2. Ideal assessment to be done during working hours especially morning hours to ensure that clients evaluation are captured e.g. exit interview
3. Further refinement to be done on the criteria especially criteria for dispensaries
4. Assessors should include non-health personnel to assess the governance, client satisfaction and social accountability criteria
5. All indicators are mandatory to be scored
6. Prepare detailed logistics plan for nationwide assessment

**Next Steps**

- To ensure the success of nationwide assessment, a trial-run assessment in collaboration with CHMT and RHMT will be done at Mkuranga District from 25-28 November.
- The following are the action plans for the trial-run:

<table>
<thead>
<tr>
<th>No</th>
<th>Activity</th>
<th>Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Develop logistic plan and budget</td>
<td>7 Nov</td>
</tr>
<tr>
<td>2</td>
<td>Identify assessors for Mkuranga</td>
<td>11 Nov</td>
</tr>
<tr>
<td>3</td>
<td>Revise criteria and rating weightages</td>
<td>12 Nov</td>
</tr>
<tr>
<td>4</td>
<td>Communicate with the RHMT and CHMT on requirements of assessment (letter signed by PS)</td>
<td>15 Nov</td>
</tr>
<tr>
<td>5</td>
<td>Orient the assessors (20 assessors, 5 CHMT Mkuranga, 2 RHMT Pwani)</td>
<td>21 Nov</td>
</tr>
</tbody>
</table>

Source(s): BRN Healthcare (2014)
There are 4 processes involved in rolling out specific health facilities strengthening programme nationwide

1. **Assess and rate health facilities**
   - Develop criteria for the assessment tool
   - Rate the health facilities using the developed assessment tool

2. **Develop specific intervention program (only Star 1 & 2 in)**
   - Identify the conditions of the health facilities/service delivery, then develop specific intervention programmes

3. **Implement intervention program**
   - Roll-out of specific strengthening programme

4. **Re-assess and rate health facilities**
   - Re-assess health facilities to identify health facilities that have achieved 3 Stars and above
   - Repeat the process of developing specific intervention programmes for health facilities rated below level 3

**Iteration process**

**Description**

- To address the on-the-ground issues, the lab will develop a criteria specific to the issues and then devise a rating mechanism to assess the health facilities
- The assessment will be done to all Public, FBOs and Private primary level health facilities by FY2014/2015

**Lab / BRN focus**

- Devise specific intervention plan for *12 mainland regions
- Specific strengthening of health facilities will be focused on *12 mainland regions only, based on the developed intervention plan
- 80% of primary health facilities in the 12 regions will achieve 3 Stars and above
- Provide rewards for health facilities that elevates into 3 Stars and above, while impose consequences for health facilities that do worse

* Regions may change after results of the nationwide assessment

Note: (1) All facilities will get health facilities improvement plan after the assessment, but only 1 & 2 Star facilities in focus regions will be monitored under BRN programme

Source(s): BRN Healthcare (2014)
6,760 health facilities will be rated in batches by leveraging on the national and regional team by March 2015

National Team

(HSIQAS)

27 people
(to cover 24 regions and 3 municipals of Dar es Salaam Region)

Regional Team

~36 assessors (6 per council)

Council Team

6 assessors/LGA
(assessors to jointly assess district hospitals)

Team A
2 assessors/disp & HCs

Team B
2 assessors/disp & HCs

Team C
2 assessors/disp & HCs

1. MoHSW (DCS, DPS, DHR)
2. Muhimbili National Hospital
3. National Institute for Medical Research
4. Medial Store Department
5. Tanzania Food and Drug Authority

Total number of Hospitals at district level, Health Centers & Dispensaries

6760

Total number of assessors

972

Estimated assessment duration

~ 4 weeks
1 HF / 3Days / team (6)

Estimated assessment duration

~ 4 weeks
1 HF / Day / team (2)

6,760 health facilities will be rated in batches by leveraging on the national and regional team by March 2015.
While health funds are confined at the LGA, leaving limited autonomy, accountability and responsibility for health facilities

- Under the current D & D structure, almost all health funds end up at the LGAs
- Besides Pwani Region, all primary health facilities (~80%) do not have a bank account to store funds
- Health funds are not effectively disbursed to the health facilities because the needs of CHMT are placed as a higher priority than the respective health facilities
- The funds are either disbursed in kind (when the LGAs feel like it), or with relevant claim receipts/requests by the health facilities – usually takes a long time for funds to be disbursed

Source(s): MoHSW (2014)
Limited fiscal decentralisation often leads to serious health facilities issues.

### Focus Areas

#### Commodities & Equipment
- There is a frequent stock out of tracer medicines in health facilities
- Medical equipment are not well maintained and are not upgraded

#### Governance
- User fees collected at health facilities are not submitted to the LGAs
- Patients data destroyed or not recorded in order to retain user fees for personal use or otherwise – corruption practices
- Most health facilities do not have a functioning Health Facilities Governing Committee (HFGC), taking into considerations that members of the HFGC perform their roles on voluntary and part-time basis with no regular income.

#### Infrastructure
- Poorly maintained health facilities, eg. lack of waste disposal management, appalling sanitary system, dirty operation theatres, leaking roof
- Dysfunctional referral system and poor emergency care
- No innovative way to access or harvest clean water.
- No alternative electricity supply (unable to invest in solar panels etc)

#### Services Delivery
- Demoralised health workers providing unsatisfactory health services (with negative attitude, high corruption rate etc)
- Poor data collection and data usage for service improvement
- Limited social accountability

Source(s): MoHSW (2014)
The aspired situation for an effective fiscal decentralisation, where health facilities can spend their own funds for service improvement

- Funds are mandatorily disbursed to the health facilities; CHMT can only keep a small portion of the money
- LGA will play an advisory role in for health facilities - capacity building on financial management and planning processes
- All health facilities should have a **bank account** to collect all sources of funds and generate income over time

Source(s): BRN Healthcare (2014)
By introducing performance targets and contracts at primary health facilities, Healthcare NKRA will address and enforce staff accountability in ensuring quality of services meets minimum requirements.

**Proposed Structure**

- **DMO KPI**
  - DMO to translate HSSP and ensure that facility’s goals are aligned with the CCHP.
  - Facilities in charge to ensure that individual OPRAS/contracts KPIs are aligned to facility targets.

- **Performance contracts to be introduced to key management positions**

**Individual KPIs should link to District KPIs**

- **HD i/c Dispensaries**
  - Individual KPIs

- **HF i/c Health Centres**
  - Individual KPIs

- **MO i/c District Hospitals**
  - Individual KPIs

- **Private / FBO Health Facilities**
  - Individual KPIs

*Private & FBO HF with service agreement*

Source(s): BRN Healthcare (2014)
While addressing and enforcing accountability will increase customer satisfaction through linking performance targets to customer satisfaction.

**Improved quality service & increased customer satisfaction**

- Introducing Performance Contracts and enforcing OPRAS
- Increasing transparency and client awareness

**Performance Contract**
- Performance Contract

**OPRAS**
- OPRAS

**DMO**
- DMO

**RAS/ RMO**
- RAS/ RMO

**HF in charge (Health Centres)**
- HF in charge (Health Centres)

**Individual KPIs**
- Individual KPIs

**Name tag**
- health workers can easily be identified and named for their performance

**Organisational chart**
- guide health workers to know their rights and responsibilities; health workers can be identified

**Price list**
- transparent and fair medical fees; prevent possible gaps for corruption

**Client charter**
- highlight health workers’ commitment to provide the expected services; enable clients to know their rights

**Complaints mechanism**
- ensuring client feedback is taken in seriously and being used for service improvement. Methods include SMS and call.

**Rewarding high performers**
- incentivising the good performing health workers in maintaining their service quality

Source(s): BRN Healthcare (2014)
Various social accountability mechanism at the health facility level will ensure sustainability of the quality of services in the long run

Use Community Score Card & Client Service Charter to monitor accountability of health facility and communities

Health Facilities should share with the community information on:
- Facilities plans
- Revenue
- Expenditure
- Medicines
- Progress Implementation Report

As per Open Government partnership (OGP) commitment

Client Charter

Community Score Card

- Mobilise the community to monitor facility processes and handling health emergencies
- The continuous monitoring of health facilities will ensure services are delivered in the satisfactory manner

List of emergency services
- Blood transfusion services
- Emergency services
- Referral services by call

Source(s): BRN Healthcare (2014)
In summary, the lab has identified 4 key initiatives to achieve 80% of primary health facilities to be rated 3 Stars and above by 2017/2018:

- Assess, rate and develop specific facility improvement plans for 1- and 2-Star primary level health facilities.
- Implement fiscal decentralization by devolution from council level to health facility level.
- Increase social accountability at the facility and community level to address local health priorities/concerns.
- Introduce the use of performance targets and contracts at the primary facilities to address and enforce staff accountability in delivery of quality health services.
<table>
<thead>
<tr>
<th></th>
<th>Overview of Initiatives by area of focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Initiatives for Human Resources for Health</td>
</tr>
<tr>
<td>2</td>
<td>Initiatives for Healthcare Facilities</td>
</tr>
<tr>
<td>3</td>
<td>Initiatives for Health commodities</td>
</tr>
</tbody>
</table>
6 Initiatives to improve Health Commodities

- Private sector to complement MSD
- Strengthen management of MSD’s Finance
- Improve Governance & accountability
- ICT platform through Mobile Apps for tracking
- Introduce SMS for community reporting
- Scale up 5S-Kaizen TQM initiatives
Our transformation vision for Tanzanian Healthcare system

<table>
<thead>
<tr>
<th>Healthy Tanzanians</th>
<th>Reproductive &amp; Child Health</th>
<th>Malaria, HIV/AIDS, TBs &amp; infectious diseases</th>
<th>Noncommunicable diseases &amp; injuries</th>
<th>Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>Human Resources for Health</td>
<td>Prioritize allocation of Employment permits to regions with critical shortage of skilled HRH</td>
<td>Provide skilled HRH through PPP/Private sector engagement</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Redistribution of healthcare workers within regions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Healthcare Facilities</td>
<td></td>
<td>Star Rating System</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Fiscal decentralisation by devolution from council level to health facility level</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Commodities</td>
<td>Improving governance, Accountability, and sense of ownership of Health commodities supply chain</td>
<td>Strengthen management of MSD working capital for sustainable availability of medicines &amp; medical supplies</td>
<td>To complement MSD in the procurement &amp; Distribution of medicines by engaging private sector</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Introduction of ICT mobile apps platform for lower level facilities</td>
<td>SMS to report on stock outs and quality of health services</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>Scale up 5S-Kaizen TQM initiatives</td>
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</tr>
</tbody>
</table>

- Prioritize allocation of Employment permits to regions with critical shortage of skilled HRH
- Provide skilled HRH through PPP/Private sector engagement
- Redistribution of healthcare workers within regions
- Star Rating System
- Fiscal decentralisation by devolution from council level to health facility level
- Introduction of ICT mobile apps platform for lower level facilities
- SMS to report on stock outs and quality of health services
- Scale up 5S-Kaizen TQM initiatives
There are 6 Initiatives for improving availability of health commodities (1/2)

**Improving governance, accountability, and sense of ownership of Health Commodities supply chain to eliminate frequent occurrence of stock-out**

**Strengthen management of MSD working capital for sustainable availability of medicines and medical supplies**

**To complement MSD in the procurement & distribution of medicines by engaging private sector**

**Expected outcome(s)**

- 100% Health Facilities audited and supervised by CHMT, 0% proportion of facilities found with commodities pilferages
- To establish baseline for Current ratio, acid test ratio & % Margin recovery
- 15 number of call off orders to prime vendors & 15 signed contracts by 2015, 90% of medicines supplied against call off orders by 2015
There are 6 Initiatives for improving availability of health commodities (2/2)

**Introduction of ICT mobile applications platform at lower level facilities for improved communication and data management in supply chain**

- 100% CHMTs & 50% lower facility level use of ICT Platform (eLMIS) by 2017/18

**Introduce use of SMS to report stock outs and quality of health services by service users and civil society**

- 70% of stock-out complaints resolved within 21 days by 2015/16, 100% of stock-out complaints resolved within 21 days by 2017/18

**Inventory Management: Scale up 5S-KAIZEN-Total quality Management (TQM) initiatives from district level to lower health facilities level**

- 85% of dispensaries and health centres adhering to good storage standards, 80% of lower level health facilities submitting accurate consumption reports to MSD

**Expected outcome(s)**
There is a pressing need to stop health commodities pilferages by naming & shaming, report to the police, PCCB and prosecuting wrongdoers

<table>
<thead>
<tr>
<th>Premises Encountered with Government Medicines Illegally</th>
<th>Police Cases &amp; Prosecution</th>
<th>Warning &amp; Confiscation</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>37</td>
<td>25</td>
<td>12</td>
<td></td>
</tr>
</tbody>
</table>

Prosecution of medicines theft cases needs to be enforced and published to STOP pilferages

- **Create fear among perpetrators**
- **Message of no mercy**
- **Deters further wrongdoing**

- To create fear to those with intention of engaging in theft and community at large
- To send a message to the entire community that there is no mercy to corrupt persons.
- Change the public outlook to view theft offenders as something shameful
- Prevent a convicted person from repeating an offence
- Institutionalize a deterrent measure besides having strict punishments in place

Source: TFDA (Sep 2011-May 2014)
A rigorous quarterly facility audits to monitor and inspect commodities will be rolled out to districts to ensure accountabilities are in place.

Quarterly health facilities audit by RHMTs and CHMTs will be introduced for impartial auditing of stock availability of health commodities.

By June 2015

50% proportion of facilities found with commodity pilferage.

By July 2017

0% proportion of facilities found with commodity pilferage.

Enforcing collection of consumption data will provide the needed transparency while fully owned and monitored by the facilities.

<table>
<thead>
<tr>
<th>Name of Facility: Ubongo</th>
<th>Facility No.:__________</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>No. of medicines delivered to health facility this quarter (A)</th>
<th>No. of medicines prescribed (B)</th>
<th>No. of medicines available at time of audit (C)</th>
<th>Amount lost or missing (A-B) - C</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>65</td>
<td>20</td>
<td>15</td>
</tr>
</tbody>
</table>

Known by tracing deliveries from MSD

Facility collection of consumption data will be enforced

Known at quarterly audit

Indicate medicine lost or missing due to pilferages

Used during facility audit.
The cost of storage, clearance and distribution for some vertical programs, although committed to be paid by the Government are currently being funded by essential medicine budget.

Erosion of MSD capital has reduced the ability of MSD to procure essential medicines, leading to frequent stock outs at MSD level.

*Government funds, basket funds and cost sharing funds, *VP = Vertical Programs
( Based on historical 4 years analysis trend (Government debt CAGR (27%), Working capital -40%)
The lab is proposing 3 pronged interventions, anchoring on better management of vertical programs, specific MSD KPI monitoring by a public board, and staggered recapitalization of MSD

**MSD Government Debt & Working Capital, 2008-2014**

**3 pronged strategy**

Better management of vertical programs

- a) 3 way MOUs signatories between MOF, MOHSW and DPs to avoid miscommunication on supply chain cost
- b) Introduction of checklist for clarity of steps and cost

Recapitalisation of MSD working capital in phases

- c) Government to commit and repay the outstanding debt in phases (proposed 3 year)
- d) Government to restructure & recapitalise MSD in phases
- e) MSD to review pricing structure of 11.6% over product value for appropriate charging

Monthly public KPI monitoring to ensure key operational efficiencies

- f) 3 key operational KPIs to be published publicly on a monthly basis

**CRITICAL ENABLERS**

- Improve coordination, management & mobilization of funding

**SOURCE:** Health Commodities workstream analysis
Procurement & distribution of medicines can be improved by engaging private sector to complement MSD

**Engage private distributors as prime vendors**
- 16 local private distributors pre-qualified as prime vendors for Dar es Salaam
- The initiative aims to fast track roll out of Prime vendors countrywide to implement Prime Vendor model in 8 Zones

**Improve procurement process by using framework agreements**

**Engagement of private sector for transportation & distribution**

Outsourcing of distribution to 3rd party logistics can save MSD potentially **TZS 153.6 mil** per year, equivalent to 90,319 Albendazol (100 tablets)

**Cost per km per ton, TZS**

<table>
<thead>
<tr>
<th></th>
<th>MSD in-house</th>
<th>Outsourced</th>
</tr>
</thead>
<tbody>
<tr>
<td>289</td>
<td>190</td>
<td></td>
</tr>
</tbody>
</table>

**KPIs**
- Average order lead time of 14 days
- Average order turnaround time (MSD) of 3 days
- 100% on-time delivery of ordered items

SOURCE: Health Commodities workstream analysis
Tracking of the end-to-end process of ordering, delivery and consumption is key to maintain optimum stock.

**How to implement**

- Order done quarterly flows directly from health facility to MSD Zonal store via a mobile app that will be integrated with eLMIS.
- District pharmacist and any other authorized person/employee will have real time access to inventory & consumption data.
- Monthly consumption data to be submitted to MSD for monitoring and evaluation for quarterly deliveries.

**KPIs**

- 100% average inventory accuracy rate
- 70% of orders made through ICT platform by 2016/2017

**SOURCE**: Health Commodities workstream analysis
The inventory management practices at health facilities need to be improved through best practices such as 5S-KAIZEN-TQM

5S concept

5S concept will improve healthcare and administrative service contents with regard to preparedness, standardization and timeliness

- Sort
- Standardize
- Set
- Shine
- Sustain

• In 2007, pilot project started at Mbeya regional hospital under JICA sponsorship
• Up to 2014, scaling up, 67 hospitals currently practicing 5S and 13 hospitals at KAIZEN stage

How to implement

- Introduce 5S-KAIZEN-TQM quality improvement model at MSD and the facility level
- Train/coaching and mentoring to healthcare workers at facility level and MSD staff at central and zonal level
- Construct / rehabilitate storage at facilities

Phase I: Geita, Simiyu, Mara, Mwanza, Pwani, Dar es Salaam, Kagera, Shinyanga, Kigoma, Tabora, Singida, Katavi (71 Councils)

Phase II: Rukwa, Kilimanjaro Dodoma, Arusha, Manyara, Tanga, Morogoro, Iringa, Mbeya, Njombe, Ruvuma, Lindi and Mtwara (88 Councils)

KPI

• 100% inventory accuracy rate

SOURCE: MoHSW, HMIS, Toolkit for Commodity Management
At the same time, community involvement can contribute towards better governance and management of health commodities.

Work flow for SMS reporting of commodities stock out

- **SMS on stock-out sent by civil society / visitors to health facilities**
- **SMS received by web portal. Accessed by DMO, RMO, PMO-RALG Health Dept & MoHSW-PSS**
- **DMO accesses portal for information on stock-outs. They will verify the information with the Health Facility they manage**
- **DMO either redistributes stocks from other facilities or directs health facilities to order medicines.**
- **Health facility orders from MSD / Supplier**
- **Information on stock-out is made publicly available**
- **DMO will update the Central Portal and close the case (ticket)**

**KPIs**

<table>
<thead>
<tr>
<th>Year</th>
<th>Complaint Resolved</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015/16</td>
<td>70% within 21 days, 50% within 7 days</td>
</tr>
<tr>
<td>2016/17</td>
<td>85% within 21 days, 70% within 7 days</td>
</tr>
<tr>
<td>2017/18</td>
<td>100% within 21 days, 90% within 7 days</td>
</tr>
</tbody>
</table>

**How to implement**

- Development of a **SMS gateway on top of the ILS Gateway** platform which could collect data for a wide range of health commodities.
- Selection of service provider to provide SMS gateway and application services.
- **Mass advocacy and communication** of the initiative in the media.

SOURCE: Health Commodities workstream analysis
Leveraging private involvement to free up MSD financing

**1. Outsourcing diagnostic services**

- Outsourcing diagnostic and other specialised services can be another source of revenue for health facilities, especially tertiary (i.e. Muhimbili National Hospital) and secondary (Regional) hospitals.
- Apart from increasing the quality of diagnostic services at the facility, this will also free up MSD from the workload to procure and distribute.
- Advantages of outsourcing:
  - Minimise management costs and risks associated with depreciation and maintenance of the equipment.
  - Minimise irrational use of medicines through accurate diagnosis.
  - Minimise expiries and stock-outs due to practicing weekly stock taking.
  - Improve equipment uptime and optimal utilisation.

**Regency Hospital:**

- Previously, 70-80 samples per day were processed.
- After outsourcing the lab services, the lab is now processing 400 samples per day and the laboratory has moved from 5 days to 24/7 center.

**Benefits**

- Addressing challenges faced by the Hospital Administration, in decision making on investment of necessary equipment, maintenance implications, ensuring stock availability, staffing.
- Minimizing hospital’s management complexity as private company will be 100% responsible for all activities related to diagnostics.
- Can be transformed to a source of income by receiving rent from the sub-contractor by using the facility and/or of the profit sharing generated by the laboratory services provided (i.e. 80%/20% model).

SOURCE: Health Commodities workstream analysis
Quick win: opportunities for private sector involvement with some facilitation by the Government to free up MSD

There are current challenges that will need to be looked at in order to create an enabling environment for domestic manufacturing to take off in the country, as per below:

### Challenges

<table>
<thead>
<tr>
<th>Challenges</th>
<th>High Level Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>VAT payments for imported raw and packaging materials (no VAT charged to imported medicines and medical supplies)</td>
<td>Removal of VAT by TRA for imported raw and packaging materials</td>
</tr>
<tr>
<td>Delays in payment from MSD resulting in lost of credibility to bankers and raw material suppliers</td>
<td>Timely payments to be done by MSD through re introduction of letter of credit</td>
</tr>
<tr>
<td>Preferential scheme at MSD not functioning very well as there is no assurances on orders and marketing</td>
<td>MSD needs to assure domestic manufacturers on orders</td>
</tr>
<tr>
<td>Preferential Pricing for domestic manufacturers for selective tracer medicines</td>
<td>Comparison should be delivery to MSD warehouse with 15% preferential pricing*</td>
</tr>
<tr>
<td>Delays in registration of products at TFDA</td>
<td>Expedited review of dossiers from domestic manufacturers at TFDA to ~60 days</td>
</tr>
<tr>
<td>Lack of skilled industrial pharmacists in manufacturing industries</td>
<td>Introducing industrial pharmacy course in University curricula</td>
</tr>
<tr>
<td>Absence of negative list (to be produce locally only)</td>
<td>Introduction of negative list for selective tracer medicines</td>
</tr>
</tbody>
</table>

- Imported products contributed around 80% of the overall market while only 20% is locally produced.
- Major local manufacturers are Shelys, Keko, TPI, Mansoor Daya and Zenufa.

**Source:** Syndication with various industry players (Please refer syndication notes and concept notes in appendix), Team Analysis – Commodities, Work stream BRN Healthcare Lab
1. MOHSW and PDB Implementation Team to lead further discussions with relevant industry players and subject matter experts to establish detailed cost benefit analysis for (6a) and (6b) for the period of Jan 2015 – June 2015

2. The Government to decide whether to proceed with the proposed recommendation after taking evaluating detailed cost benefit analysis, key challenges and high level recommendation made relevant stakeholders and industry players (please refer slide (143 – 149))

3. MOHSW and PDB to develop implementation plan to execute the recommendations based on 3 – 5 years timeline after decision made

Source: Team Analysis – Commodities Work stream BRN Healthcare Lab
The initiative will allow Tanzanians access to health commodities on not less than 5.4 million OPD visits to public health facilities each year.

### 2015-2016

- **80% stock availability**
  - 13.4 million total OPD visits
  - 5.7 million under-5 OPD visits
  - 2,689 additional health facilities with 100% stock availability

### 2016-2017

- **100% stock availability**
  - 19.3 million total OPD visits
  - 8.2 million under-5 OPD visits
  - 3,849 additional health facilities with 100% stock availability

Source: MOHSW, Team Analysis – Commodities Work stream BRN Healthcare Lab

These numbers refer to a previous year, unless we extrapolate to project 2016/17 numbers.
In summary, the lab has identified 6 key initiatives to achieve 100% stock availability of essential medicines by 2016 / 2017

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improving governance, accountability, and sense of ownership of Health Commodity supply chain to eliminate frequent occurrence of stock-out</td>
<td><strong>Introduction of ICT mobile apps platform (eLMIS, ILSGateway, DHIS2) lower level facilities</strong></td>
</tr>
<tr>
<td>Strengthen management of MSD working capital for sustainable availability of medicines and medical supplies</td>
<td><strong>Introduce use of SMS to report on stock outs and quality of health services by service users and civil society</strong></td>
</tr>
<tr>
<td>To complement MSD in the procurement &amp; distribution of medicines by engaging private sector</td>
<td><strong>Inventory Management: Scale up 5S-KAIZEN-Total quality Management (TQM) initiatives from district level to lower health facilities level</strong></td>
</tr>
</tbody>
</table>
Healthcare NKRA’s Special Focus:
Reproductive, Maternal, Neonatal & Child Health

Key Initiatives

- CEmONC services expansion
- BEmONC services expansion
- Community Health workers for RMNCH
- Reproductive, Mother, Neonatal & Child Health

Key Enablers

- mHealth (SMS) and MCHW App through PPP
- 360 Degree Mass media campaign through PPP
- Regional Satellite blood bank facilities
6 Initiatives to be implemented under RMNCH (1/2)

Expanding CEmONC services at strategically selected **health centers** and **hospitals** to serve as satellite sites.

Strategically selected **dispensaries and health centers** to provide full fledge BEmONC (7 signal functions).

**Expected outcome(s)**

- **Reduction of maternal mortality ratio** from 453 to 291 (per 100,000 live births) and **neonatal** mortality rate from 20 to 10 (per 1000 live births), **by 2017/2018**

- 100% quality (measured be agreed Standards Base Management Tool) of services in facilities selected for provision of a **continuum of care package** which includes **FP, ANC, BEmONC, PNC**
Mobilise **Community Health workers** to improve RMNCH services

Enhanced awareness and outreach through **mHealth (SMS) and Maternal CHW App through PPP**

Regional Satellite **Blood bank facilities** supporting CEmONC

Develop integrated **360 Degree mass media campaign** that can be multi sponsored through PPP

**Expected outcome(s)**

Utilize community based initiatives to improve RMNCH awareness to 100% and uptake by 50% at community level by 2017/18

Increase childbirth by skilled birth attendant to 80%, four antenatal care attendance to yy% & postnatal care attendance to zz%

Establish centres and mobilize blood donors and distribute safe blood to those in need especially pregnant women and new-born as close as to where they receive CEmONC services by 100%.

Improve uptake of RMNCH services (family planning, ANC, institutional delivery, PNC Improve access to safe blood)
Providing CEmONC at hospitals and expanding to strategically selected health centers to serve as satellite sites.

Improving primary health care facilities to provide RMNCH and BEmONC services.

Regional Satellite Blood bank facilities supporting CEmONC

Develop integrated 360 Degree mass media campaign that can be multi sponsored through PPP.

N.B: interventions are focused along the continuum of care, and to compliment Sharpened One Plan’s family planning efforts.
Tanzania’s performance on MDG 5 target is still below target

- Neonatal mortality rate has declined from 32 deaths to 26 deaths per 1,000 live births by 2010.
- Under five mortality rate has declined from 112 to 81 per 1,000 births by 2010 (TDHS 2010), and have shown further decline in 2013 to 54 (UN Interagency Report). Achieving MDG 4 Target.
- Maternal mortality ratio from 578 per 100,000 (2004/05) to 453 per 1000,000 (TDHS 2010), recent estimates shows that the ratio is 410 per 100,000 (UN estimates).

<table>
<thead>
<tr>
<th></th>
<th>2004</th>
<th>2010</th>
<th>Target 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neonatal</td>
<td>32</td>
<td>26</td>
<td>19</td>
</tr>
<tr>
<td>Children under 5</td>
<td>112</td>
<td>81</td>
<td>54</td>
</tr>
<tr>
<td>Maternal</td>
<td>578</td>
<td>453</td>
<td>193</td>
</tr>
</tbody>
</table>

7,900 mothers die each year due to complications during delivery and labour.

62.2% were due to obstetric complications.

Rwanda, Botswana and Bangladesh have made significant progress in achieving MMR MDG 5 targets, but not Tanzania

• Evidence shows that emphasis on the continuum of care will drive the Maternal & Neonatal Mortality Ratio down.

Density of Clinicians per 10,000 population

<table>
<thead>
<tr>
<th>Country</th>
<th>Density of Clinicians per 10,000 population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tanzania</td>
<td>7900</td>
</tr>
<tr>
<td>Uganda</td>
<td>5900</td>
</tr>
<tr>
<td>Burundi</td>
<td>3400</td>
</tr>
<tr>
<td>Rwanda</td>
<td>1300</td>
</tr>
</tbody>
</table>

Maternal mortality ratio

<table>
<thead>
<tr>
<th>Country</th>
<th>Maternal Mortality Ratio (per 100,000)</th>
<th>MDG Target 2015</th>
<th>Best improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burundi</td>
<td>330</td>
<td>320</td>
<td>170</td>
</tr>
<tr>
<td>Uganda</td>
<td>200</td>
<td>170</td>
<td>170</td>
</tr>
<tr>
<td>Kenya</td>
<td>400</td>
<td>193</td>
<td></td>
</tr>
<tr>
<td>Tanzania</td>
<td>432</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rwanda</td>
<td>740</td>
<td>350</td>
<td></td>
</tr>
</tbody>
</table>

Source: Fulfilling the health agenda for woman and children The 2014 Report, TDHS2010
The lack of skilled attendant during antenatal care (ANC) and at birth leads to unnecessary deaths

96% of pregnant women attend at least 1 ANC – Only 43% attend 4 or more ANCs

Source: DHS2010

Births at institution & with skilled birth attendance

Delivery at health facilities

- 2005: 47%
- 2012: 56%

Skilled Birth Attendance

- 2005: 43%
- 2010: 51%
- Target 2015: 80%

TDHS 2010, HMIS 2012, SARA (2013), MTR One Plan
Women and children continue to die from three key delays:

Leading causes of maternal death in health facilities

**Phase 1: Delay in decision to seek appropriate care**
- Low status of women
- Poor understanding of complications and risk factors in pregnancy and of when medical interventions are needed
- Previous poor experience of health care
- Acceptance of maternal death
- Financial implications

**Phase 2: Delay in reaching care**
- Distance to health centres and hospitals
- Availability of and cost of transportation
- Poor roads
- Geography e.g. mountainous terrain, rivers

**Phase 3: Delay in receiving adequate health care**
- Poor facilities and lack of medical supplies
- Inadequately trained and poorly motivated medical staff (unresponsive staff, etc)
- Inavailability of 24/7
- Inadequate referral systems

15 out of 100 pregnant women might have complication during pregnancy, labour and delivery.

www.maternityworldwide.org, team analysis, CCBRT
Most maternal death are caused by complications during delivery, and it can be averted by providing BEmONC and CEmONC.

The majority of maternal deaths in Tanzania are due to direct obstetric complications, which occur at the time of birth and during postnatal period. Obstetric hemorrhage and hypertensive disorders account for more than 50% of all maternal deaths.

- Delay 1, 2, 3 contributing to maternal and neonatal deaths

Leading causes of maternal death in health facilities

- Obstetric 62.60%
- Indirect 24.80%
- Others 12.60%

Only 9% Health Facilities Meet CEmONC criteria

Total 1,297 HFs

- Met all criteria for CEmONC 9%
- Met all criteria for BEmONC 25%
- 66%

Source: HMIS 2012

Source: SARA Report 2012

Context of RMNCH Special Focus

• The majority of maternal deaths in Tanzania are due to direct obstetric complications, which occur at the time of birth and during postnatal period. Obstetric hemorrhage and hypertensive disorders account for more than 50% of all maternal deaths.
• Delay 1, 2, 3 contributing to maternal and neonatal deaths

Countdown 2015, UN Interagency Report 2014, TDHS2010, MMRF
**Key interventions in addressing the 3 delays**

**Initiative 2a & 2b** – Engaging community through Community Health Worker, supported by mHealth/SMS tools, aims to address Delay 1 and Delay 2

**Initiative 1a & 1b** - (BEmONC & CEmONC) aims to address the Delay 3 at Health Facilities

**Delay 1:** Recognition and decision to seek care

**Delay 2:** Transport to care

**Delay 3:** Receiving quality care

**Enablers** – Strengthens the engagements both ways through Safe blood transfusion & mass media campaign through PPP

Source: www.maternityworldwide.org, team analysis, CCBRT
Putting in to account all interventions

- Emergency obstetric care
- Skilled birth attendance (SBA)
- Clean birth practices
- Immediate assessment and stimulation
- Neonatal resuscitation
- Antenatal corticosteroids for pre-term labor
- Antibiotics for pROm
- MgSO4 management of eclampsia
- AMTSL -- Active Management of the Third Stage of Labor
- Induction of labor for pregnancies lasting 41+ weeks
- Percent of women within a level of care receiving a skilled attendance and the care that is standard (100% quality) for the given level

Tanzania MMR Past experience [2000-2012]

- Clean birth practices: 71%
- Labor and delivery management: 10%
- Antibiotics for pROm: 8%
- MgSO4 management of eclampsia: 7%
- AMTSL--active management of the third stage of labor: 3%
- IPTp/ ITN: 1%

Source: LIST Analysis-Lives Saved Tool Analysis
Emergency obstetric care distribution before and after intervention

Following rehabilitation of health facilities we project 80% of facility deliveries to be distributed as presented in the above table (30% and 50% of deliveries in BEmOC and CEmOC respectively. Only 20% of deliveries occurred at home will not be assisted by skilled attendant)

The estimated impact reported in this analysis is only based on changes in coverage of interventions listed in this report. If you account for other interventions such as community mobilization, improvement and redistribution of human resources and other intervention we are likely to have lower estimates of maternal and newborn mortality. Scaling up package considered in LIST will bring maternal to 265 and neonatal to 9.
Based on the improved coverage and key interventions at the 5 regions, the trend in maternal mortality and neonatal mortality.

Labor delivery management
Percent of women within a level of care receiving a skilled attendance and the care that is standard (100% quality) for the given level:

- **BEmoC** - Management of delivery at a health center and covers case management of direct obstetric complications.
- **CEmoC** facility - Management of delivery at a hospital and covers case management of direct obstetric complications. This is in addition to all interventions included in Basic Emergency Obstetric Care.
- **Escential care** - Management of delivery at a dispensary of facility that do not qualify for BEmoC and CEmoC

Combining the efforts from the health facility improvement (**BEmONC & CEmONC** supported by **Blood Transfusion**) with efforts from **community health workers** supported by **mHealth** combined with a combined **mass media campaign**, the work stream aims to reduce MMR and NMR by 5% every year.

Source: LiST Analysis, Team Analysis
In summary, the lab has identified 6 key initiatives to achieve 20% reduction in Maternal Mortality Ratio (MMR) and Neonatal Mortality Rate (NMR) in 5 regions:

1. Mobilise **Community Health workers** to improve RMNCH services
2. Enhanced awareness and outreach through **mHealth (SMS)** and Maternal CHW App through PPP
3. Strategically selected **dispensaries and health centers** to provide full fledged **BEmONC** (7 signal functions).
4. **Regional Satellite Blood bank facilities** supporting **CEmONC**
5. Expanding **CEmONC** services at strategically selected **health centers and hospitals** to serve as satellite sites
6. Develop integrated **360 Degree mass media campaign** that can be **multi sponsored** through PPP
<table>
<thead>
<tr>
<th>CONTENTS</th>
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<tbody>
<tr>
<td>Executive Summary</td>
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<tr>
<td>Summary of Issues</td>
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<tr>
<td>Summary of Initiatives</td>
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<tr>
<td>High level targets and funding requirement</td>
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<tr>
<td>Overview of Initiatives by area of focus</td>
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<tr>
<td>Funding Requirement</td>
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<tr>
<td>1 Overview of Healthcare NKRA Funding Requirement</td>
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<tr>
<td>2 Funding requirement for FY 2015/16-2017/18</td>
</tr>
<tr>
<td>3 Funding requirement by Initiatives</td>
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<tr>
<td>Key Performance Indicators</td>
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Healthcare NKRA require TZS 185 Billion spread across 3 years

Budget requirement to implement BRN Healthcare 2014/15 – 2017/18

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<tr>
<th>Year</th>
<th>Development Expenditure</th>
<th>Recurrent Expenditure</th>
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<td>TOTAL</td>
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SOURCE: BRN Healthcare Lab (2014)
## Funding Requirement

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<td>2</td>
<td>Funding requirement for FY 2015/16-2017/18</td>
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<tr>
<td>3</td>
<td>Funding requirement by Initiatives</td>
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</table>
Where ~80% of Total budget requests of TZS 185 Bn are primarily anchored on PMO-RALG…

Bulk of the budget request aims to upgrade existing Health facilities to BEmONC, CEmONC standards
### Funding Requirement

<table>
<thead>
<tr>
<th></th>
<th>Overview of Healthcare NKRA Funding Requirement</th>
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</thead>
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<td>Funding requirement for FY 2015/16-2017/18</td>
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<td>3</td>
<td>Funding requirement by Initiatives</td>
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Budget Proposal Breakdown for Human Resources for Health

Total Budget requirement for Human Resources for Health activities:

**TZS 14 Bn**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Budget Proposal Breakdown</th>
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<tr>
<td>Prioritize employment permits allocation</td>
<td>TZS 0.00 Bn</td>
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<td>2014/15</td>
<td>0.00 Bn</td>
</tr>
<tr>
<td>2015/16</td>
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<td>2016/17</td>
<td>0.00 Bn</td>
</tr>
<tr>
<td>2017/18</td>
<td>0.00 Bn</td>
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<tr>
<td>Optimising the pool of new recruits</td>
<td>TZS 0.07 Bn</td>
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<tr>
<td>2014/15</td>
<td>0.000 Bn</td>
</tr>
<tr>
<td>2015/16</td>
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<tr>
<td>2016/17</td>
<td>0.000 Bn</td>
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<tr>
<td>2017/18</td>
<td>0.000 Bn</td>
</tr>
<tr>
<td>Skilled HRH through PPP/Private Engagement</td>
<td>TZS 10.38 Bn</td>
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<td>2014/15</td>
<td>0.00 Bn</td>
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<tr>
<td>2015/16</td>
<td>1.78 Bn</td>
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<td>2016/17</td>
<td>3.44 Bn</td>
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<tr>
<td>2017/18</td>
<td>5.16 Bn</td>
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<tr>
<td>Synchronize recruitment process @ Central level</td>
<td>TZS 0.00 Bn</td>
</tr>
<tr>
<td>2014/15</td>
<td>0.00 Bn</td>
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<td>0.00 Bn</td>
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<td>2017/18</td>
<td>0.00 Bn</td>
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<td>Redistribution of healthcare workers within region</td>
<td>TZS 3.43 Bn</td>
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<td>2014/15</td>
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<tr>
<td>2015/16</td>
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<td>2016/17</td>
<td>1.71 Bn</td>
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<tr>
<td>2017/18</td>
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<tr>
<td>Empowering LGAs in Human Resource Management</td>
<td>TZS 0.40 Bn</td>
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<tr>
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<td>0.00 Bn</td>
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<td>2015/16</td>
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<td>2016/17</td>
<td>0.00 Bn</td>
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<tr>
<td>2017/18</td>
<td>0.00 Bn</td>
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</tbody>
</table>
Total Budget requirement for Performance Management for Health Facilities:

**TZS 32 Bn**

<table>
<thead>
<tr>
<th>Component</th>
<th>TZS 22.06 Bn</th>
<th>TZS 3.64 Bn</th>
<th>TZS 6.24 Bn</th>
<th>TZS 0.355 Bn</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fiscal decentralisation</td>
<td>2014/15: 5.32 Bn</td>
<td>2014/15: 1.92 Bn</td>
<td>2014/15: 0.00 Bn</td>
<td>2014/15: 0.052 Bn</td>
</tr>
<tr>
<td></td>
<td>2015/16: 5.89 Bn</td>
<td>2015/16: 0.00 Bn</td>
<td>2015/16: 3.53 Bn</td>
<td>2015/16: 0.103 Bn</td>
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<td></td>
<td>2016/17: 5.64 Bn</td>
<td>2016/17: 0.00 Bn</td>
<td>2016/17: 1.31 Bn</td>
<td>2016/17: 0.103 Bn</td>
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<tr>
<td></td>
<td>2017/18: 5.22 Bn</td>
<td>2017/18: 1.72 Bn</td>
<td>2017/18: 1.39 Bn</td>
<td>2017/18: 0.097 Bn</td>
</tr>
</tbody>
</table>

Performance targets & contracts:

| Year | 2014/15: 0.00 Bn | 2015/16: 3.53 Bn | 2016/17: 1.31 Bn | 2017/18: 1.39 Bn |

Social Accountability:

| Year | 2014/15: 0.052 Bn | 2015/16: 0.103 Bn | 2016/17: 0.103 Bn | 2017/18: 0.097 Bn |

Implement Star Rating System:

| Year | 2014/15: 1.92 Bn | 2015/16: 0.00 Bn | 2016/17: 0.00 Bn | 2017/18: 1.72 Bn |
Total Budget requirement for Health Commodities activities:

**TZS 31 Bn**

<table>
<thead>
<tr>
<th>Activity Description</th>
<th>Budget Breakdown</th>
<th>Year 2014/15</th>
<th>Year 2015/16</th>
<th>Year 2016/17</th>
<th>Year 2017/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve Governance &amp; accountability</td>
<td>TZS 1.15 Bn</td>
<td>0.00 Bn</td>
<td>0.96 Bn</td>
<td>0.19 Bn</td>
<td>0.00 Bn</td>
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<tr>
<td>Strengthen management of MSD's Finance</td>
<td>TZS 4.85 Bn</td>
<td>0.37 Bn</td>
<td>1.52 Bn</td>
<td>1.12 Bn</td>
<td>1.84 Bn</td>
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<tr>
<td>Private sector to complement MSD</td>
<td>TZS 5.89 Bn</td>
<td>1.69 Bn</td>
<td>3.03 Bn</td>
<td>0.19 Bn</td>
<td>0.99 Bn</td>
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<tr>
<td>ICT platform through Mobile Apps for tracking</td>
<td>TZS 7.15 Bn</td>
<td>0.00 Bn</td>
<td>7.15 Bn</td>
<td>0.00 Bn</td>
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<tr>
<td>Introduce SMS for community reporting</td>
<td>TZS 0.18 Bn</td>
<td>0.00 Bn</td>
<td>0.18 Bn</td>
<td>0.00 Bn</td>
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<td>Scale up 5S-Kaizen TQM initiatives</td>
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## Budget Proposal Breakdown for RMNCH

**Total Budget requirement for RMNCH activities:**

### TZS 107 Bn

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<tr>
<th>Activity Description</th>
<th>TZS 36.12 Bn</th>
<th>TZS 44.96 Bn</th>
<th>TZS 14.39 Bn</th>
<th>TZS 7.32 Bn</th>
<th>TZS 2.79 Bn</th>
<th>TZS 1.76 Bn</th>
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<tr>
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<td>2016/17: 0.51 Bn</td>
<td>2017/18: 0.51 Bn</td>
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<tr>
<td>BEmONC services expansion</td>
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<td>2014/15: 0.00 Bn</td>
<td>2015/16: 22.35 Bn</td>
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<td>Community Health workers for RMNCH</td>
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<tr>
<td>mHealth (SMS) and MCHW App through PPP</td>
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<td>Overview of Initiatives by area of focus</td>
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## Human Resources for Health Topline KPIs

<table>
<thead>
<tr>
<th>No.</th>
<th>Topline KPIs</th>
<th>Baseline</th>
<th>2015-16</th>
<th>2016-17</th>
<th>2017-18</th>
<th>Owner</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Proportion of Regions attaining the 2014 baseline national average of Density of Skilled HRH per 10k population annually.</td>
<td>National Average: 7.74 skill HRH per 10000 population in 2014</td>
<td>60%</td>
<td>80% (+20%)</td>
<td>100% (+20%)</td>
<td>MoHSW, PMO-RALG, POPS, MoF</td>
</tr>
<tr>
<td>2</td>
<td>% utilisation of employment permits for HRH</td>
<td>2013/2014 utilisation rate of work permits: 68% of 11,221</td>
<td>75% (+7%)</td>
<td>80% (+5%)</td>
<td>90% (10%)</td>
<td>Special HRH Distribution Task Force Group, MoHSW, PMO-RALG, POPS, MoF</td>
</tr>
<tr>
<td>3</td>
<td>Number of facilities without skilled HRH.</td>
<td>498 dispensaries without skilled HRH</td>
<td>348 (-150)</td>
<td>198 (-150)</td>
<td>148 (-50)</td>
<td>Special HRH Distribution Task Force Group, MoHSW, PMO-RALG, POPS, MoF</td>
</tr>
</tbody>
</table>

**Key:**

- **xx** → Cumulative figure
- **(+xx)** → year-on-year increase/decrease
## Health Facilities Topline KPIs

<table>
<thead>
<tr>
<th>No.</th>
<th>Topline KPIs</th>
<th>Baseline</th>
<th>2015-16</th>
<th>2016-17</th>
<th>2017-18</th>
<th>Owner</th>
</tr>
</thead>
</table>
| 4   | % of primary health facilities rated at 1- & 2- Star to be at 3-Star and above by 2017/2018 | Baseline to be obtained, after nationwide assessment of the primary health facilities from Jan – Mar 2015 | *20%    | *60 (+40%) | *80% (+20%) | • MoHSW – DHQA  
• PMO-RALG - Head, Health TWG                                                                 |

* percentage of primary level health facilities to be 3-Star and above may change after results of the nationwide assessment

**Key:**
- **xx** → Cumulative figure
- **(+xx)** → year-on-year increase/decrease
# Health Commodities Topline KPIs

<table>
<thead>
<tr>
<th>No.</th>
<th>Topline KPIs</th>
<th>Baseline</th>
<th>2015-16</th>
<th>2016-17</th>
<th>2017-18</th>
<th>Owner</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Stock availability (HMIS):</td>
<td>33%</td>
<td>80%</td>
<td>100%</td>
<td>100% (maintain)</td>
<td>• Chief Pharmacist</td>
</tr>
<tr>
<td></td>
<td>1. % facilities with availability of each medicine</td>
<td></td>
<td>(+47%)</td>
<td>(+20%)</td>
<td></td>
<td>• MoHSW - Pharmaceutical Services Unit</td>
</tr>
<tr>
<td></td>
<td>2. % facilities with availability of all 10 medicines</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Order fill rate:</td>
<td>65%</td>
<td>80%</td>
<td>100%</td>
<td>100% (maintain)</td>
<td>• Director of Zonal Operations, MSD</td>
</tr>
<tr>
<td></td>
<td>% of items ordered are received by HF to determine whether an order is filled</td>
<td></td>
<td>(+15%)</td>
<td>(+20%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>in the correct quantities with the correct products.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Key:**

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</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>Pre-pregnancy*</td>
<td>45% / 15%</td>
<td>50% (+5% / 35%)</td>
<td>60% (+10%)</td>
<td>70% (+10%)</td>
<td>• MoHSW</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• PMO-RALG</td>
</tr>
<tr>
<td>8</td>
<td>Pregnancy*</td>
<td>18% / 43%</td>
<td>50% (+32% / 7%)</td>
<td>70% (+20%)</td>
<td>80% (+10%)</td>
<td>• MoHSW</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• PMO-RALG</td>
</tr>
<tr>
<td>9</td>
<td>Labour &amp; Delivery*</td>
<td>70% / 78%</td>
<td>70% (maintain)</td>
<td>75% (+5%)</td>
<td>80% (+5%)</td>
<td>• MoHSW</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• PMO-RALG</td>
</tr>
<tr>
<td>10</td>
<td>Newborn Health*</td>
<td>68% / 65%</td>
<td>70% (+2% / 5%)</td>
<td>75% (+5%)</td>
<td>80% (+5%)</td>
<td>• MoHSW</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• PMO-RALG</td>
</tr>
</tbody>
</table>

*Extracted from HMIS Scorecard

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<table>
<thead>
<tr>
<th></th>
<th>Key Performance Indicators</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>Topline KPIs</td>
</tr>
<tr>
<td>2</td>
<td>Initiatives KPIs</td>
</tr>
</tbody>
</table>
### Human Resources for Health Initiatives KPIs (1/4)

<table>
<thead>
<tr>
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<th>2017-18</th>
<th>Owner</th>
</tr>
</thead>
</table>
| 1.0 | Prioritized regions at / above National Average (Density of Skilled HRH/10k population) | National Average: 7.74 skill HRH per 10000 population | 80%      | 90% (+10%) | 100% (+10%) | • Special HRH Distribution Task Force Group  
• MoHSW  
• PMO-RALG  
• POPSM  
• M0F |
| 1.1 | HRH situation analysis conducted and remedial plan developed | Not applicable | Annually | Annually | Annually | • Directors of Administration and HR, MoHSW  
• PMORALG  
• Deputy Director of Finances, POPSM |
| 2.0 | % of employment permits for skilled HRH allocated to primary health care services in identified regions with critical skilled HRH shortage | Allocated employment permits of skilled health workers for 2014/2015 is 38% assuming reprioritisation analysis developed at the Lab is accepted by POPSM. If not it is 32% | 40% (+2% / +8%) | 40% (maintain) | 40% (maintain) | • Director of Human Capital Management, POPSM |
| 3.0 | Number of Health facilities manned by skilled private HRH through PPP arrangements | N/A      | 45       | 45       | 45       | • PPP  
• DED  
• MoHSW  
• LGA |
| 3.1 | 16 regions to implement HRH redistribution between their own districts | N/A      | N/A      | 8 regions | 8 regions | • RAS, RS |

**Key:**
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### Human Resources for Health Initiatives KPIs (2/4)

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<th>2017-18</th>
<th>Owner</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.0</td>
<td>Number of new students bonded by cadres</td>
<td>N/A</td>
<td>100%</td>
<td></td>
<td>100%</td>
<td>(maintain)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• HLSLB, MoEVT</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• DHRD, MoHSW</td>
</tr>
<tr>
<td>4.1</td>
<td>Number of existing students bonded by cadres</td>
<td>Baseline to be developed by DAHRM, MOHSW. Lab was not able to collate the data as the data was located with multiple agencies/government ministries</td>
<td>50%</td>
<td>75%</td>
<td>90%</td>
<td>(25%) (15%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• HLSLB, MoEVT</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• DHRD, MoHSW</td>
</tr>
<tr>
<td>4.2</td>
<td>% of graduated bonded students who serves in healthcare facilities</td>
<td>Baseline to be formulated annually by DAHRM, MOHSW. This done by adding the number of bonded students who are graduating (or finishing internship) for the year</td>
<td>70%</td>
<td>80%</td>
<td>90%</td>
<td>(+10%) (10%)</td>
</tr>
<tr>
<td>4.3</td>
<td>Compulsory Attachment status confirmed for 6 cadres</td>
<td>N/A</td>
<td>N/A</td>
<td>100%</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Registrar, MTC</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Registrar, TNMC</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Attorney General, AGC</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• DHRD, MoHSW</td>
</tr>
<tr>
<td>4.4</td>
<td>% of graduates undergoing compulsory service at a health facility</td>
<td>N/A</td>
<td>N/A</td>
<td>70%</td>
<td>90%</td>
<td>(+20%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Registrar, MTC</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Registrar, TNMC</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• DHRD, MoHSW</td>
</tr>
</tbody>
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**Key:**
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</tr>
</thead>
<tbody>
<tr>
<td>5.0</td>
<td>Release of employment permits for the 7 cadres by 30 September each year</td>
<td>N/A</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>• DHRD, MoHSW, • POPSMB</td>
</tr>
<tr>
<td>5.1</td>
<td>% of graduates that are allocated employment permits</td>
<td>To be developed by MoHSW</td>
<td>50%</td>
<td>75% (+25%)</td>
<td>90% (+15%)</td>
<td>• HLSLB, MoEVT, • DHRD, MoHSW</td>
</tr>
<tr>
<td>5.2</td>
<td>% of posted graduates reporting to their duty stations in the LGAs</td>
<td>N/A</td>
<td>80%</td>
<td>90% (+10%)</td>
<td>100% (+10%)</td>
<td>• DHRD, MoHSW, • POPSMB</td>
</tr>
<tr>
<td>6.0</td>
<td>Letter of instruction from Director for LGA to Council Directors</td>
<td>N/A</td>
<td>100%</td>
<td>N/A</td>
<td>N/A</td>
<td>• Luanda, DLG, • PMO-RALG</td>
</tr>
<tr>
<td>6.1</td>
<td>% of newly recruited staff who have been oriented</td>
<td>0</td>
<td>80% (+80%)</td>
<td>90% (+10%)</td>
<td>100% (+10%)</td>
<td>• DMOs, • LGAs</td>
</tr>
<tr>
<td>6.2</td>
<td>Completion of HRH incentive guideline</td>
<td>N/A</td>
<td>100%</td>
<td>N/A</td>
<td>N/A</td>
<td>• DAHRM, MoHSW</td>
</tr>
<tr>
<td>6.3</td>
<td>Execution of the submitted retention &amp; incentive improvement plans of LGAs</td>
<td>N/A</td>
<td>N/A</td>
<td>163</td>
<td>163 (maintain)</td>
<td>• DMOs, • LGAs</td>
</tr>
</tbody>
</table>

Key:
- **xx** → Cumulative figure
- (+xx) → year-on-year increase/decrease
# Human Resources for Health Initiatives KPIs (4/4)

<table>
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<tr>
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<th>Objective</th>
<th>Baseline</th>
<th>2015-16</th>
<th>2016-17</th>
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</tr>
</thead>
<tbody>
<tr>
<td>6.4</td>
<td>Develop HR Management training model</td>
<td>N/A</td>
<td>N/A</td>
<td>100%</td>
<td>N/A</td>
<td>• DAHRM, MoHSW</td>
</tr>
<tr>
<td>6.5</td>
<td>Coaching and mentoring training conducted to all LGAs</td>
<td>168 LGAs</td>
<td>N/A</td>
<td>168</td>
<td>N/A</td>
<td>• DASHRM, MoHSW</td>
</tr>
<tr>
<td>6.6</td>
<td>LGAs submitting quarterly reports to RHMT on HRM performance</td>
<td>168 LGAs</td>
<td>N/A</td>
<td>N/A</td>
<td>168</td>
<td>• CHMTs</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• LGAs</td>
</tr>
<tr>
<td>6.7</td>
<td>% LGAs to ensure that subsistence allowance for new recruits are applied</td>
<td>N/A</td>
<td>100% of</td>
<td>100% of</td>
<td>100% of</td>
<td>• Budget Section, MoHSW</td>
</tr>
<tr>
<td></td>
<td>under protect status for budgeting purposes</td>
<td></td>
<td>LGAs</td>
<td>LGAs</td>
<td>LGAs</td>
<td>• MoF</td>
</tr>
<tr>
<td>6.8</td>
<td>% LGAs provide subsistence allowance within a week after reporting of the</td>
<td>N/A</td>
<td>100% of</td>
<td>100% of</td>
<td>100% of</td>
<td>• Council Directors</td>
</tr>
<tr>
<td></td>
<td>staff</td>
<td></td>
<td>LGAs</td>
<td>LGAs</td>
<td>LGAs</td>
<td>• LGAs</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
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- **(+xx)** year-on-year increase/decrease
# Health Facilities Initiatives KPIs

|-----|-----------|---------|---------|---------|---------|-------|
| 7.0 | % assessment and rating of all primary health facilities | 100% | - | - | 100% | • DHQA-AD HSIQAS, MoHSW  
| | | | | | • Head, Health TWG – PMO-RALG |
| 7.1 | % of health facilities rated at level 1 and 2 in *12 regions identified and elevated to level 3 and above by June 2018. | - | 20% | 60% (+40%) | 80% (+20%) | • DHQA-AD HSIQAS, MoHSW  
| | | | | | • Head, Health TWG – PMO-RALG |
| 8.0 | 80% of health facilities use facility funds (self-generated and allocated) for improving service delivery by June 2017:  
| | % health facilities open and use own bank account | 10% | 50% (+40%) | 80% (+30%) | 100% (+20%) | • DPP-District Health Services, MoHSW  
| | | | | | • DLG-AD LGA financing, PMORALG |
| 9.0 | 80% LGAs have functioning social accountability mechanisms by June 2017:  
| | % LGAs roll-out community scorecard | 12% | 54% (+42%) | 80% (+26%) | 100% (+20%) | • DPP-AD Policy, MoHSW  
| | | | | | • Head, Health TWG – PMORALG |
| 10.0 | 80% of health facilities to achieve 75% and above customer satisfaction by June 2018 | Conduct survey to establish baseline | 65% users satisfaction | 70% users satisfaction (+5%) | 75% users satisfaction (+5%) | • DPP-District Health Services, MoHSW  
| | | | | | • DLG-AD LGA financing, PMORALG |

*Regions may change after results of the nationwide assessment

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</thead>
<tbody>
<tr>
<td>11.0</td>
<td>% of facilities audited for status of stock availability</td>
<td>0%</td>
<td>65% (+65%)</td>
<td>100% (+35%)</td>
<td>100% (maintain)</td>
<td>• DMO</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• LGAs</td>
</tr>
<tr>
<td>11.1</td>
<td>% of facilities provided supportive supervision by CHMT based on commodity</td>
<td>0%</td>
<td>70% (+70%)</td>
<td>100% (+30%)</td>
<td>100% (maintain)</td>
<td>• DMO</td>
</tr>
<tr>
<td></td>
<td>toolkit (Mentoring, provision of tools and guidelines and constant</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• LGAs</td>
</tr>
<tr>
<td></td>
<td>feedback to health facilities)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.2</td>
<td>% proportion of facilities found with commodity pilferage</td>
<td>To be</td>
<td>Baseline to 50%</td>
<td>Baseline to 25%</td>
<td>Baseline to 0%</td>
<td>• DMO</td>
</tr>
<tr>
<td></td>
<td>established in Feb-April 2015</td>
<td>50%</td>
<td>(-25%)</td>
<td>(-25%)</td>
<td>0%</td>
<td>• LGAs</td>
</tr>
<tr>
<td>11.3</td>
<td>Order fill rate (%)</td>
<td>65%</td>
<td>80% (+15%)</td>
<td>90% (+10%)</td>
<td>100% (+10%)</td>
<td>• Director of Zonal</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Operations, MSD</td>
</tr>
<tr>
<td>11.4</td>
<td>% Optimal Storage Space Utilisation</td>
<td>To be</td>
<td>TBD</td>
<td>TBD</td>
<td>100% (TBD)</td>
<td>• Director of Logistics,</td>
</tr>
<tr>
<td></td>
<td>set with roll out of software March 2015</td>
<td>established</td>
<td>(+10%)</td>
<td>(+10%)</td>
<td></td>
<td>MSD</td>
</tr>
<tr>
<td>12.0</td>
<td>Debt decrease rate (TZS)</td>
<td>92 billion</td>
<td>62 billion</td>
<td>32 billion</td>
<td>0</td>
<td>• Director of Finance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(-30 billion)</td>
<td>(-30 billion)</td>
<td>(-30 billion)</td>
<td>(-32 billion)</td>
<td>and Planning MSD</td>
</tr>
<tr>
<td>12.1</td>
<td>Acid test ratio (%)</td>
<td>100%</td>
<td>125% (+25%)</td>
<td>150% (+25%)</td>
<td>200% (+50%)</td>
<td>• Director of Finance</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>and Planning MSD</td>
</tr>
</tbody>
</table>

Key:
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- **(+xx)** Year-on-year increase/decrease
### Health Commodities initiatives KPIs (2/4)

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<th>2017-18</th>
<th>Owner</th>
</tr>
</thead>
<tbody>
<tr>
<td>13.0</td>
<td>Number of call-off orders to prime vendors</td>
<td>Currently, one (1) call off order was issued to Salama Pharmaceuticals Ltd and delivered</td>
<td>15</td>
<td>35 (+20)</td>
<td>60 (+25)</td>
<td>• Director General, MSD</td>
</tr>
<tr>
<td>13.1</td>
<td>Number of signed contracts and deliveries</td>
<td>Currently there are 15 contracts which have been signed between MSD and Prime vendors while no contracts exist for private distributors</td>
<td>15</td>
<td>35 (+20)</td>
<td>60 (+25)</td>
<td>• Director General of MSD and Executive Directors of Prime Vendors</td>
</tr>
<tr>
<td>13.2</td>
<td>% of medicines supplied against call off orders</td>
<td>One (1) call off order from Dar zone was sent to Salama Pharmaceuticals Ltd and ordered health commodities was supplied 100%</td>
<td>90%</td>
<td>95% (+5%)</td>
<td>100% (+5%)</td>
<td>• Zonal Managers, MSD</td>
</tr>
<tr>
<td>13.3</td>
<td>% adherence to delivery schedule</td>
<td>No baseline data exists for private distributors (currently no any private distributors to deliver to health facilities)</td>
<td>90%</td>
<td>100% (+10%)</td>
<td>100% (maintain)</td>
<td>• Zonal Managers, MSD</td>
</tr>
<tr>
<td>13.4</td>
<td>% of quality complaints from the facilities (for both prime vendors and private distributors)</td>
<td>No baseline data exists for private distributors (currently no private distributors to deliver to health facilities)</td>
<td>10%</td>
<td>5% (-5%)</td>
<td>0% (-5%)</td>
<td>• Zonal Customer Service Officer, MSD</td>
</tr>
</tbody>
</table>

**Key:**
- **xx** → Cumulative figure
- **(+xx)** → year-on-year increase/decrease
# Health Commodities initiatives KPIs (3/4)

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<tbody>
<tr>
<td>14.0</td>
<td>Reduce % of paper-based health commodity order requisitions from health facilities to 5% by 2016/2017</td>
<td>100% (6000 facilities)</td>
<td>50% (3000 facilities)</td>
<td>5% (30 facilities)</td>
<td>0% (All facilities orders converted to ICT platform usage)</td>
<td>HHS • PMO-RALG</td>
</tr>
<tr>
<td>14.1</td>
<td>% of health workers who have received training on mobile application usage in inventory management</td>
<td>0%</td>
<td>44% (first 2663)</td>
<td>56% (remaining 3337)</td>
<td>N/A</td>
<td>HHS • PMO-RALG</td>
</tr>
<tr>
<td>14.2</td>
<td>Inventory accuracy rate</td>
<td>0%</td>
<td>70% (+70%)</td>
<td>90% (+20%)</td>
<td>100% (+10%)</td>
<td>DMO • PMO-RALG</td>
</tr>
<tr>
<td>15.0</td>
<td>% of stock out complaints solved</td>
<td>0%</td>
<td>50% (+50%)</td>
<td>100% (+50%)</td>
<td>100% (maintain)</td>
<td>PSS • DED/CHMTs • MoHSW</td>
</tr>
</tbody>
</table>

Key:
- **xx** Cumulative figure
- **(+xx)** Year-on-year increase/decrease
## Health Commodities initiatives KPIs (4/4)

<table>
<thead>
<tr>
<th>No.</th>
<th>Objective</th>
<th>Baseline</th>
<th>2015-16</th>
<th>2016-17</th>
<th>2017-18</th>
<th>Owner</th>
</tr>
</thead>
<tbody>
<tr>
<td>16.0</td>
<td>% of dispensaries implementing 5S approach by phase</td>
<td>0%</td>
<td>40% (+40%)</td>
<td>80% (+40%)</td>
<td>100% (+20%)</td>
<td>DHQA, MoHSW</td>
</tr>
<tr>
<td>16.1</td>
<td>% of health centers implementing 5S approach by phase</td>
<td>0%</td>
<td>40% (+40%)</td>
<td>80% (+40%)</td>
<td>100% (+20%)</td>
<td>DHQA, MoHSW</td>
</tr>
<tr>
<td>16.2</td>
<td>% of dispensaries and health centers adhering to good storage standards for health commodities</td>
<td>0%</td>
<td>50% (+50%)</td>
<td>80% (+30%)</td>
<td>100% (+20%)</td>
<td>RHMT/CHMT Report, PSS, MoHSW</td>
</tr>
<tr>
<td>16.3</td>
<td>Proportion of lower level health facilities submitting accurate consumption reports to MSD</td>
<td>0%</td>
<td>70% (+70%)</td>
<td>90% (+20%)</td>
<td>100% (+10%)</td>
<td>MSD, PSS, MoHSW</td>
</tr>
<tr>
<td>16.4</td>
<td>% of health facilities with all required record keeping tools in a quarter</td>
<td>0%</td>
<td>70% (+70%)</td>
<td>90% (+20%)</td>
<td>100% (+10%)</td>
<td>RHMT/CHMT Report, PSS, MoHSW</td>
</tr>
<tr>
<td>16.5</td>
<td># of low level health facilities staff trained on 5S</td>
<td>0%</td>
<td>40% (+40%)</td>
<td>80% (+40%)</td>
<td>100% (+20%)</td>
<td>DHQA, MoHSW</td>
</tr>
<tr>
<td>16.6</td>
<td># CHMTs trained on 5S-KAIZEN-TQM</td>
<td>0%</td>
<td>60% (+60%)</td>
<td>80% (+40%)</td>
<td>100% (+20%)</td>
<td>DHQA, MoHSW</td>
</tr>
</tbody>
</table>

**Key:**
- **xx** → Cumulative figure
- **(+xx)** → Year-on-year increase/decrease
## RMNCH initiatives KPIs

<table>
<thead>
<tr>
<th>No.</th>
<th>Objective</th>
<th>Baseline</th>
<th>2015-16</th>
<th>2016-17</th>
<th>2017-18</th>
<th>Owner</th>
</tr>
</thead>
<tbody>
<tr>
<td>17.0</td>
<td>No. Community Health Workers mobilised</td>
<td>6,654</td>
<td>16,969 (+10,315)</td>
<td>16,969 (maintain)</td>
<td>16,969 (maintain)</td>
<td></td>
</tr>
<tr>
<td>18.0</td>
<td>mHealth (50 SMS/women)</td>
<td>Baseline</td>
<td>13 million SMS</td>
<td>26 million SMS (+13 million)</td>
<td>39 million SMS (+13 million)</td>
<td></td>
</tr>
<tr>
<td>19.0</td>
<td>No. of CEmONC facilities</td>
<td>79</td>
<td>91 (+12)</td>
<td>104 (+13)</td>
<td>104 (maintain)</td>
<td></td>
</tr>
<tr>
<td>20.0</td>
<td>No. of BEmONC facilities</td>
<td>Baseline</td>
<td>207</td>
<td>357 (+150)</td>
<td>453 (+96)</td>
<td></td>
</tr>
<tr>
<td>21.0</td>
<td>Total Blood Units Collected (facilities / blood units collected per year)</td>
<td>2 (35,000 / year)</td>
<td>4 (90,000 / year)</td>
<td>4 (100,000 / year)</td>
<td>5 (120,000 / year)</td>
<td></td>
</tr>
<tr>
<td>22.0</td>
<td>Mass media awareness</td>
<td>79</td>
<td>91 (+12)</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
</tbody>
</table>
CONTENTS

Executive Summary

Summary of Issues

Summary of Initiatives

High level targets and funding requirement

Overview of Initiatives by area of focus

Funding Requirement

Key Performance Indicators

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1 Healthcare NKRA Governance Structure

2 Key implementers by Initiatives

3 NKRA Delivery System
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</table>
Healthcare NKRA Governance Structure

**President**

**Transformation & Delivery Council**

**Interministerial Technical Committee Meeting**

**President’s Delivery Bureau (PDB)**

---

**NKRA Steering Committee**

**Chair:** Hon. Dr. Seif Suleiman Rashid (Minister of Health and Social Welfare)

**Members:**
- Dr. Donnan Mbando (PS MoHSW)
- TBD (CMO, MoHSW)
- Dr. Servacius Likwelile (PS MoF)
- Mr. Omari Issa (PDB CEO)
- HMDU
- Mr. Jumanne A. Sagini (PS PMO-RALG)
- Dr. Deo Mtasiwa (DPS PMO-RALG)
- Mr. Mwaifani (MD MSD)

---

**Project Owner – MOHSW**

**Implementers**

- **Human Resources for Health**
  - DAHRM, MoHSW
  - POPSM
  - PMORALG

- **Health Commodities**
  - PSU, MoHSW
  - MSD
  - PMO-RALG

- **Health Facilities**
  - DAHRM, MoHSW
  - PMO-RALG

- **RMNCH**
  - RCHS, MoHSW
  - PMO-RALG
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</table>
### Key Implementers for NKRA Healthcare Initiatives (1/3)

#### Prioritize employment permits allocation
- **Owner:** PS POPSM
- **Other key implementors:** MOHSW, PMO-RALG

#### Skilled HRH through PPP/Private Engagement
- **Owner:** Permanent Secretary of MoHSW
- **Other key implementors:** PMO-RALG, Private Implementers

#### Redistribution of healthcare workers within region
- **Owner:** Permanent Secretary of PMO-RALG
- **Other key implementors:** MOHSW, POPSM

#### Optimising the pool of new recruits
- **Owner:** Permanent Secretary MoHSW
- **Other key implementors:** MoEVT, Professional Councils, POPSM

#### Synchronize recruitment process at Central level
- **Owner:** Permanent Secretary POPSM
- **Other key implementors:** PMO-RALG, Private Implementers

#### Empowering LGAs in Human Resource Management
- **Owner:** Permanent Secretary of PMO-RALG
- **Other key implementors:** MoHSW

#### a) Reinforce orientations and induction for newly hired staff
- **Owner:** Permanent Secretary of PMO-RALG
- **Other key implementors:** MoHSW

#### b) Retention & Incentive policy at LGAs
- **Owner:** Permanent Secretary MoHSW
- **Other key implementors:** PMO-RALG, Professional Councils

#### c) coaching and mentoring model to strengthen skills of HRM
- **Owner:** Permanent Secretary MoHSW
- **Other key implementors:** PMO-RALG, Professional Councils

#### d) Enforcing Subsistence Allowance
- **Owner:** Permanent Secretary MoHSW
- **Other key implementors:** PMO-RALG, Private Implementer

#### Implement Star Rating System
- **Owner:** HSIQAS (MoHSW)
- **Other key implementors:** RHMT, CHMT/DMOs

#### Fiscal decentralisation by devolution
- **Owner:** DMO
- **Other key implementors:** Health facilities, CHMT-DHS, PMO-RALG, CHF coordinator, MoF-AG, MoHSW-DPP

#### Social Accountability
- **Owner:** DMO
- **Other key implementors:** Health Facilities, HFGCs, CHMT, PMO-RALG
## Key Implementers for NKRA Healthcare Initiatives (2/3)

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Owner:</th>
<th>Other key implementers:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Performance targets &amp; contracts</strong></td>
<td>DMO</td>
<td>- Health Facilities</td>
</tr>
<tr>
<td><strong>Private sector to complement MSD</strong></td>
<td>MSD</td>
<td>- Private Sector</td>
</tr>
<tr>
<td><strong>Scale up 5S-Kaizen TQM initiatives</strong></td>
<td>MOHSW</td>
<td>- PMO-RALG</td>
</tr>
<tr>
<td><strong>Community Health workers for RMNCH</strong></td>
<td>LGAs, DPs</td>
<td>- Health facilities</td>
</tr>
<tr>
<td><strong>Improve Governance &amp; accountability</strong></td>
<td>PS MOHSW, PS PMO-RALG</td>
<td>- LGAs, Health Facilities</td>
</tr>
<tr>
<td><strong>ICT platform &amp; Mobile Apps for tracking</strong></td>
<td>MOHSW</td>
<td>- EGA, PMO-RALG, LGAs</td>
</tr>
<tr>
<td><strong>CEmONC services expansion</strong></td>
<td>DEDs</td>
<td>- DMO and facility in charges</td>
</tr>
<tr>
<td><strong>mHealth (SMS) and MCHW App through PPP</strong></td>
<td>LGAs, DPs</td>
<td>- LGAs</td>
</tr>
<tr>
<td><strong>Strengthen management of MSD’s Finance</strong></td>
<td>PS MoHSW, PS PMO-RALG</td>
<td>- LGAs, Health Facilities</td>
</tr>
<tr>
<td><strong>Introduce SMS for community reporting</strong></td>
<td>MOHSW</td>
<td>- EGA</td>
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<td><strong>BEmONC services expansion</strong></td>
<td>LGAs, DEDs</td>
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<td><strong>Regional Satellite blood bank facilities</strong></td>
<td>Regional Administrative Secretary, MOHSW (National Blood Transfusion Services)</td>
<td>- RMO /NBTS</td>
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<tr>
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<td>- LGAs, Health Facilities</td>
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<tr>
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<td>Regional Administrative Secretary, MOHSW (National Blood Transfusion Services)</td>
<td>- RMO /NBTS</td>
</tr>
</tbody>
</table>
Key Implementers for NKRA Healthcare Initiatives (3/3)

Owner:
- MoHSW
- DPs

Other key implementers:
- MoHSW
- DEU
- PR Agency
- DPs
### Governance

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
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<td>NKRA Delivery System</td>
</tr>
</tbody>
</table>
Delivery System is expected to be established by March 2015

Level 1: Leadership, governance and prioritisation

Level 2: Performance management and problem-solving

Level 3: Implementation and delivery

President

TDC

Interministerial Technical Committee Meeting

President’s Delivery Bureau (PDB)

Performance dialogue

PDB CEO reports to President

PDB supports NKRA Steering Committee

MDU sends updates on lab implementation

PDB runs labs

MDU reports to PS / Minister

MDU

MoHSW

NKRA Steering Committee

TDC

Lead Ministries

 Ministers

MDU

Lead Ministries

MDU

Ministers

Ministers

Ministers

President

President

PDB CEO

TDC

MDU

MoHSW

NKRA Steering Committee

Interministerial Technical Committee Meeting

MDU

Lead Ministries

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Stakeholder sign-off

I hereby affirm my support for the findings of the BRN Healthcare NKRA Lab (conducted between 22nd September 2014 to 31st October 2014) and endorse the lab’s recommended initiatives and implementation Programme. I also hereby pledge the efforts of my ministry/department/agency/organization to achieving the initiatives and outcomes detailed in this report.

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<tr>
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<th>Performance Management of Health Facilities</th>
<th>Improving accessibility to Health Commodities</th>
<th>Special focus on Reproductive, Maternal, Neonatal &amp; Child health in 5 regions</th>
</tr>
</thead>
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<td>H.E. Dr. Jakaya Mrisho Kikwete, President, United Republic of Tanzania</td>
<td></td>
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</tr>
<tr>
<td>Hon. Saada Mkuya Salum (MP) Minister for Finance, United Republic of Tanzania</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
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<td>Hon. Dr. Seif Seleman Rashidi (MP) Minister for Health &amp; Social Welfare, United Republic of Tanzania</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hon. Hawa Abdulrahman Ghasia (MP) Minister of State - PMO-RALG United Republic of Tanzania</td>
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</thead>
</table>
| **Ambassador Ombeni Y Sefue**  
Chief Secretary, United Republic of Tanzania | ![Signature](signature.png) | ![Signature](signature.png) | ![Signature](signature.png) | ![Signature](signature.png) |
| **Jumanne Abdallah Sagini**  
Permanent Secretary, Prime Minister’s Office – Regional Administration & Local Government  
United Republic of Tanzania | ![Signature](signature.png) | ![Signature](signature.png) | ![Signature](signature.png) | ![Signature](signature.png) |
| **Dr. Donan Mmbando**  
Permanent Secretary, Ministry of Health & Social Welfare, United Republic of Tanzania | ![Signature](signature.png) | ![Signature](signature.png) | ![Signature](signature.png) | ![Signature](signature.png) |
| **<TBA>**  
Chief Medical Officer  
Ministry of Health & Social Worker, United Republic of Tanzania | ![Signature](signature.png) | ![Signature](signature.png) | ![Signature](signature.png) | ![Signature](signature.png) |
Overview of Key Roles & Responsibilities of Agencies and Departments

**MOHSW**
- Overall coordination and implementation of the Healthcare NKRA

**Department Health Quality Assurance-MOHSW**
- Responsible for overall coordination and supervision for quality improvement and audit activities related to health commodities

**Department Policy and Planning (Budget Section)-MOHSW**
- Responsible for overall coordination for budget request, consolidation and disbursement related to health commodities

**Pharmaceutical Services Section-MOHSW**
- Responsible for overall coordination and supervision for quantification, procurement and distribution activities within the supply chain, inclusive of vertical program (together with Program Managers Department of Preventive)

**ICT Section - MOHSW**
- Responsible for overall coordination (together with other departments and units within MOHSW) for initiatives/enablers related to the usage of ICT (SMS reporting and mobile apps at health facilities)

**POPSM**
- Ensure that the employment permits of skilled Human Resource for Health is prioritized, issued timely and in accordance to the needs of the of each individual region.

- Ensure that the employment permits of assistant accountant (for fiscal decentralisation) are approved
### Overview of Key Roles & Responsibilities

<table>
<thead>
<tr>
<th>Role</th>
<th>Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>PMO-RALG</td>
<td>Coordination directives to the regions &amp; districts to ensure on the ground implementation of the initiatives at the LGA level</td>
</tr>
<tr>
<td>Health Department - PMORALG</td>
<td>Responsible for overall coordination and administrative oversight to RHMTs/CHMTs in regards to health commodities activities</td>
</tr>
<tr>
<td>MOF</td>
<td>To ensure adequate allocation and funding to prioritise Healthcare NKRA initiatives, Responsible for overall coordination for budget allocation and disbursement to MOHSW, including repayment of government receivables to MSD</td>
</tr>
<tr>
<td>MOEVT</td>
<td>To ensure participation and implementation of bonding and compulsory attachment initiatives via the Higher Learning Institutions and Higher Education Students' Loans Board</td>
</tr>
<tr>
<td>RAS/RHMT</td>
<td>Monitoring and implementation coordination of initiatives at the LGA level</td>
</tr>
<tr>
<td>LGAs</td>
<td>On the ground implementation of initiatives for primary healthcare facilities (Dispensaries, Health Centres, District Hospitals)</td>
</tr>
<tr>
<td>CHMTs</td>
<td>On the ground implementation of initiatives for primary healthcare facilities at the district level (Dispensaries, Health Centres, District Hospitals)</td>
</tr>
</tbody>
</table>
Overall coordination and processing of Nursing Officers, Assistant Nursing Officers, Nurses for synchronized direct posting and compulsory service attachments

Responsible to maintain an efficient and optimised operation for procurement, storage and distribution of medicine to all public health facilities, though various initiatives, ie;
1. Implementation of the engagement of the private sector in the procurement and distribution of medicines from Zones to health facilities
2. Engagement of prime vendor to compliment the supply chain during stock out

Bonding policy execution for students sponsored (partial or fully) through funds provided by HESLB as well as monitoring whilst bonded students are still in their educational

Provide necessary information of the production of skilled HRH via Training Institution Information System

Provide necessary information of the production of skilled HRH via Training Institution Information System

Disseminate and coordinate use of PPP for non functioning government primary care health facilities amongst its members
### Overview of Key Roles & Responsibilities for RMNCH

<table>
<thead>
<tr>
<th>The Nursing &amp; Midwifery Council</th>
<th>Overall coordination and processing of Nursing Officers, Assistant Nursing Officers, Nurses for synchronized direct posting and compulsory service attachments</th>
</tr>
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<tbody>
<tr>
<td>Tanganyika Medical Council</td>
<td>Overall coordination and processing of Medical Officers, Assistant Medical Officers, Clinical Officers, Clinical Assistants for synchronized direct posting and compulsory service attachments</td>
</tr>
<tr>
<td>Telco operators</td>
<td>Provide the mHealth services</td>
</tr>
<tr>
<td>APTHA</td>
<td>Disseminate and coordinate use of PPP for non functioning government primary care health facilities amongst its members</td>
</tr>
<tr>
<td>FBO</td>
<td>Participate in the use of PPP for non functioning government primary care health facilities</td>
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</table>
### Key initiatives under Healthcare NKRA...

<table>
<thead>
<tr>
<th>#</th>
<th>Initiative</th>
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<tbody>
<tr>
<td>1</td>
<td>Prioritize employment permits allocation</td>
</tr>
<tr>
<td>2</td>
<td>Skilled HRH through PPP/Private Engagement</td>
</tr>
<tr>
<td>3</td>
<td>Redistribution of healthcare workers within region</td>
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<tr>
<td>4</td>
<td>Optimising the pool of new recruits</td>
</tr>
<tr>
<td>5</td>
<td>Synchronize recruitment process @ Central level</td>
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<tr>
<td>6</td>
<td>Empowering LGAs in Human Resource Management</td>
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<tr>
<td>7</td>
<td>Implement Star Rating System</td>
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<tr>
<td>8</td>
<td>Fiscal decentralisation by devolution</td>
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<tr>
<td>9</td>
<td>Social Accountability</td>
</tr>
<tr>
<td>10</td>
<td>Performance targets &amp; contracts</td>
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<tr>
<td>11</td>
<td>Improve Governance &amp; accountability</td>
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<tr>
<td>12</td>
<td>Strengthen management of MSD’s Finance</td>
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<tr>
<td>13</td>
<td>Private sector to complement MSD</td>
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<tr>
<td>14</td>
<td>ICT platform through Mobile Apps for tracking</td>
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<tr>
<td>15</td>
<td>Introduce SMS for community reporting</td>
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<tr>
<td>16</td>
<td>Scale up 5S-Kaizen TQM initiatives</td>
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<tr>
<td>17</td>
<td>Community Health workers for RMNCH</td>
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<tr>
<td>18</td>
<td>mHealth (SMS) and MCHW App through PPP</td>
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<td>19</td>
<td>CEmONC services expansion</td>
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<tr>
<td>20</td>
<td>BEmONC services expansion</td>
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<tr>
<td>21</td>
<td>Regional Satellite blood bank facilities</td>
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<tr>
<td>22</td>
<td>360 Degree Mass media campaign through PPP</td>
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</tbody>
</table>

Special focus: RMNCH
Stakeholder sign-off

I hereby affirm my support for the findings of the BRN Healthcare NKRA Lab (conducted between 22nd September 2014 to 31st October 2014) and endorse the lab’s recommended initiatives and implementation Programme. I also hereby pledge the efforts of my ministry/department-agency/organization to achieving the initiatives and outcomes detailed in this report.

<table>
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<tr>
<th>Initiatives</th>
<th>Minister MoHSW</th>
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<th>Minister MoF</th>
<th>Chief Secretary, GoTz</th>
<th>Permanent Secretary, MoHSW</th>
<th>Chief Medical Officer, MoHSW</th>
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<tbody>
<tr>
<td>Human Resources for Health Distribution</td>
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