

# PRIMARY CARE SYSTEMS PROFILES & PERFORMANCE (PRIMASYS)

## Tanzania Case Study

### Overview

The United Republic of Tanzania is a low-income country with a population of 43 million.<sup>1</sup> The annual population growth stands at 2.7%. Average household size is about 4.8, with variations between urban (5.3) and rural (1.8). About 30% of the population lives in urban areas and the remainder in rural localities.<sup>1</sup> During the past 10 years, Tanzania has successfully reduced death rates in younger age groups and surpassed the Millennium Development Goal-related to child mortality. Between 1999 and 2010, infant mortality fell from 99 to 51 per 1000 live births, while under-five mortality declined from 147 to 81 per 1000 live births.<sup>2</sup> Despite such progress, health outcomes in Tanzania are still lower than expected for its level of economic development (Table 1).

The health sector infrastructure is expanding, with continuous efforts to increase the number of dispensaries in rural areas. The Primary Health Care Development Programme (2007–2017) is the major health sector strategy to improve access and expand health services in underserved areas, with the aim of establishing one dispensary per village and one health centre per ward. Geographic accessibility is thus improving through establishment of new health facilities, yet not all facilities provide the necessary basic health services. The 2012 Service Availability and Readiness Assessment (SARA) for Tanzania indicated that primary health care service availability varied considerably. Services

that were available in less than 30% of facilities included antiretroviral therapy for HIV, basic surgery, cardiovascular and chronic respiratory infection services, diabetes services, blood transfusion and advanced delivery services.<sup>3</sup> Remote rural areas are still disadvantaged compared to urban areas. Health issues of women are not adequately addressed to cover their needs. Furthermore, health system referral is weak. Although regional referral hospitals are in place in all regions, they are challenged by insufficient availability of key clinical staff.

Coverage of child immunization is high in Tanzania, with three quarters of health facilities offering child immunization services.<sup>4</sup> In terms of chronic malnutrition, Tanzania is one of the 10 worst affected countries in the world with 42% of children age less than five years being stunted.<sup>2</sup>

Tanzania spends significantly less public money on health than comparable countries. For several years, public expenditure on health has remained flat in real terms, meaning that the proportion of the Government's overall budget that is allocated to health has declined from 11.9% in 2010/11 to 8.7% in 2013/14. In addition, the 2011/12 National Health Account (NHA) data demonstrates an increase in donor dependence to fund health care in Tanzania, which accounted for about 48% of total health sector resources in 2011/12, an increase from 40% in 2009/10.

1 Basic Demographic and Socio-Economic Profile. Key Findings. 2012 Population and Housing Census. Dar es Salaam: National Bureau of Statistics; 2014.

2 Tanzania Demographic and Health Survey (TDHS), 2010. Dar es Salaam: National Bureau of Statistics and ICF Macro; 2011.

3 Tanzania Service Availability and Readiness Assessment (SARA) 2012 – final report submitted for review. Dar es Salaam: Ministry of Health and Social Welfare; 2013.

4 Mid-Term Review of the Health Sector Strategic Plan III 2009–2015. Dar es Salaam: Ministry of Health and Social Welfare; 2013.

**Table 1** Primary health care statistics in Tanzania

<b>Demographic indicators (TDHS 2010)<sup>2</sup></b>	
Total population	44 928 923
Growth rate	2.7%
Fertility rates	5.4
<b>Outcome indicators</b>	
Maternal mortality	454/100 000
Infant mortality	51/1000
Under-five mortality	81/1000
<b>Service coverage indicators</b>	
Skilled birth attendance (% of pregnant women)	50%
Contraceptive prevalence (% of women ages 15–49 years)	27%
Full immunization coverage (% of children aged 12–23 months)	75
Four recommended antenatal care (ANC) visits	36%
First ANC visit before the fourth month of pregnancy	15%
Children who slept under an insecticide-treated bednet (ITN) last night (% of under-5 children)	64%
Pregnant women who slept under an ITN last night (% of pregnant women)	57%
<b>Health financing indicators</b>	
Total expenditure on health per capita	US\$ 37.3
Total public expenditure on health per capita	US\$ 14.7
Share of health in the government budget	8%
Out-of-pocket payments as proportion of total expenditure on health	31.8%

## Governance

Tanzania operates a decentralized health system, organized around three functional levels: district (primary level), regional (secondary level), and referral hospitals (tertiary level). Within the framework of ongoing local government reforms, regional and district councils have full responsibility for delivering health services within their areas of jurisdiction (Figure 1). They report administratively to the Prime Minister's Office Regional Administration and Local Government (PMO-RALG).

The district councils are mandated for planning, implementation, monitoring and evaluation of health services. Each council has a District Medical Officer (DMO) who heads the Council Health Management Team (CHMT) and is answerable to the District Executive Director, the head of the council. CHMTs are responsible for provision of services in dispensaries, health centres and district or 'district-designated' hospitals. The Regional Health Management Teams (RHMTs) are responsible for interpreting health policies at the regional level. The Ministry of Health and Social Welfare (MoHSW) is responsible for policy formulation, supervision and regulation of all health services throughout the country, as well as playing a direct role in the management of tertiary health services.

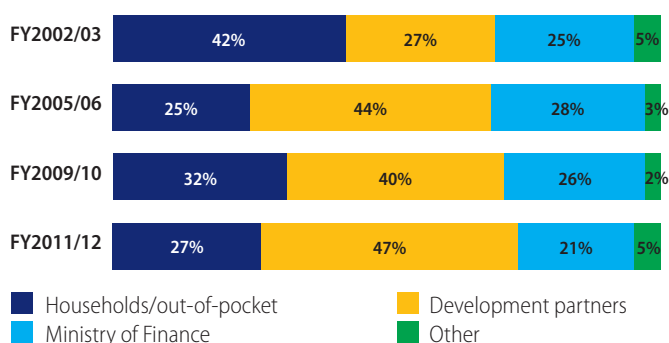
The Ministry of Finance and Economic Affairs (MoFEA) manages the overall revenue, expenditure, and financing. Its duties include preparing the central government budget and determining expenditure allocations to different government institutions. The President's Office, Public Service Management (PO-PSM) assists in matters of personnel and administration pertaining to the entire government system. This includes responsibilities for personnel policies, administration and coordination of training and recruitment. PO-PSM oversees staff establishment, schemes of service and promotions and the issuing of vacancies against which posting are based. Local Government Authorities (LGAs) and Ministries, Department and Agencies (MDAs) are responsible for lodging requests with PO-PSM for staff to fill their local needs. The MoHSW has the role of posting staff in accordance with PO-PSM approved vacancies. The MoFEA allocate funds for salaries as per approved vacancies.

Use of a Sector Wide Approach (SWAp) has been an important element in the governance structure of the health sector in Tanzania since the mid-late 1990s. The SWAp provides the framework of collaboration among stakeholders including MoHSW, PMO-RALG, MoFEA, civil society, private sector and bilateral/multilateral development partners (DPs) including United Nations (UN) agencies active in health. It aims to coordinate financing, planning, and monitoring mechanisms.



facilities and matched 100 percent by the government. With the current fragmented district CHF pools, the richer councils receive higher matching funds (as subsidies) compared to the poor councils. Additionally, at the moment, CHF risk pools are relatively small and cover mostly the middle-income groups. The National Health Insurance Fund (NHIF) has one nation-wide pool into which all premium revenue collected together with returns from investments are deposited. The relatively large pool gives it financial viability.

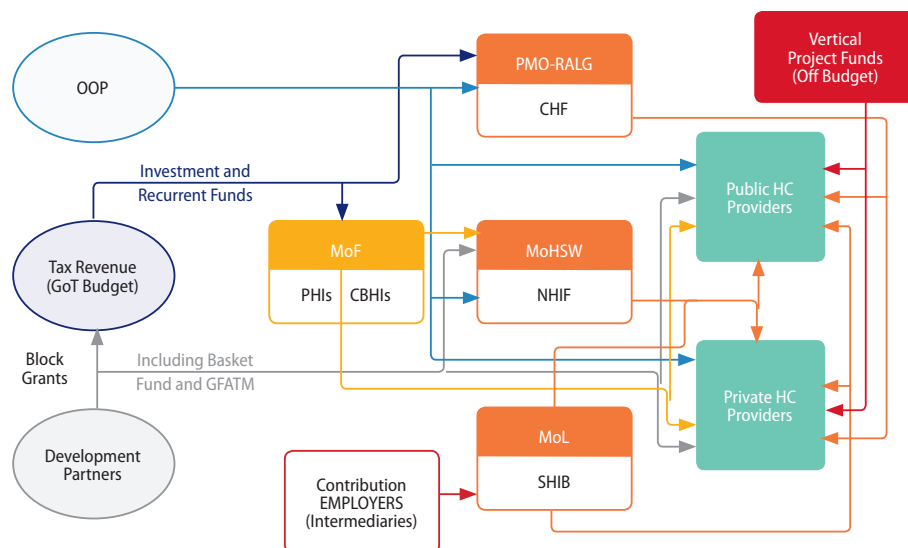
**Table 2 Total health expenditures by source**



Source: (National Health Accounts, 2012<sup>8</sup>; 2014).<sup>9</sup>

On the contrary, Social Health Insurance Benefit (SHIB) and the isolated community-based or mutual health insurance schemes (CBHI/MHIS) have small risk pools. In the case of CBHI/MHIS, the small size of the pools makes pooling relatively inefficient due to the low financial stability and sustainability, as well as limits equity effects through redistribution. In the case of private insurance, the risk pool is only balancing risks partially as insurance contracts are written individually and negotiated between the company or individual seeking insurance coverage.

**Figure 2 Current health financing structure**



Source: Tanzania Health Financing Strategy (2016–2020).

## Results Based Financing

Traditionally, government and development partners funds for the improvement of service delivery have concentrated on increasing inputs, such as infrastructure, equipment, supplies, drugs and vaccines. Despite the increase in investments, the health sector has been facing the challenge of unequal access and coverage to health services, low quality and inefficient delivery of services, and inadequate management capacity.

In order to address these challenges, the government of Tanzania through the MoHSW is planning to implement the Results Based Financing (RBF) to improve accessibility, utilization (quantity) and quality of health services to communities, including vulnerable groups, through increased accountability and responsiveness. In 2015, the MoHSW designed the RBF scheme and developed an operational manual to facilitate the implementation process. The RBF is expected to be rolled out in all districts in Tanzania.

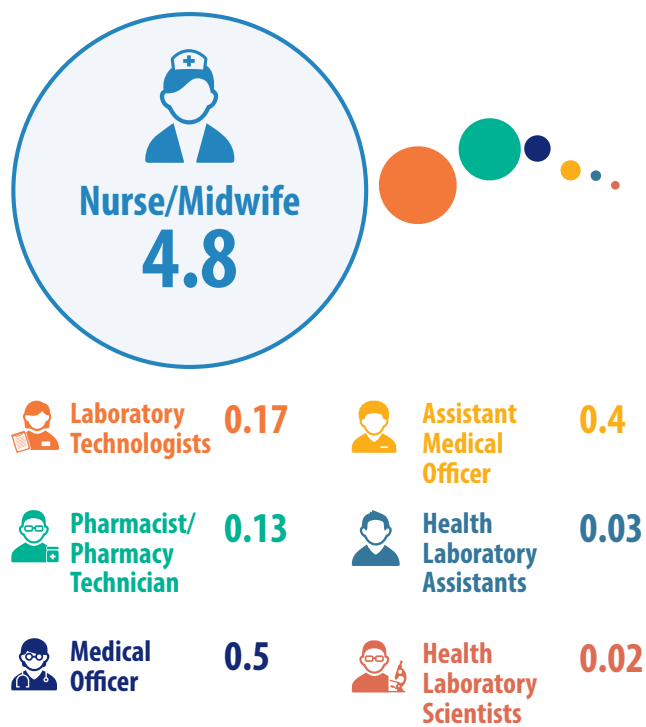
RBF is a new strategy which has the potential to reform the health sector with system-wide effects on service delivery, leadership and governance, human resources, health management information systems, medicines and health technology. RBF seeks to increase coverage of the population by incentivizing health facilities to increase delivery of core services in the Basic Health Services package. The focus is at the council level (Local Government Authority) and health facilities, where the interaction with the population takes place.

9 National Health Accounts FY 2011/12. Dar es Salaam: Ministry of Health and Social Welfare; 2014.

## Human resources for health

In Tanzania, primary health care service delivery is constrained by both a shortage and inequitable distribution of skilled human resources for health (HRH). The number of health personnel (professionals) available to provide quality health services in dispensaries, health centres, district level hospitals, regional referral hospitals, and national zonal and specialized hospitals is 63 447 and the current estimated shortage is estimated to be 82 007, or about 56.38%.<sup>4</sup> Figure 3 indicates HRH per population as of 2012.

**Figure 3 Human resources for health per population (10 000) in Tanzania (2012)**



Source: MOHSW, 2013.<sup>4</sup>

The existing workforce is unevenly distributed, with the situation being worst in dispensaries and in rural areas.<sup>10</sup> Many staff prefer to work in urban rather than rural areas due to poor working and living environments in the latter. There is a clear regional disparity with regard to HRH availability. Kilimanjaro, Dar-es Salaam, Iringa, Lindi and Pwani are more fully staffed, for example, in comparison with rural regions such as Kagera, Rukwa, Tabora, Kigoma and Shinyanga.<sup>11</sup>

Retaining health-related staff is a recurrent problem due to challenges such as compensation and working conditions. The internal (to private sector) and external (to other countries) 'brain drain' is one of the prominent exacerbating factors. The Government has been increasing salaries annually since 2006 in an attempt to improve HRH retention. A retention scheme for health care workers is also currently being developed. At present, specific upper-level health professionals are given incentives, such as housing, which can be considered to be motivation to achieve work performance excellence. In addition, although there is no national mechanism or guidance on retention of staff, some council-specific initiatives to motivate staff have been tried. Likewise, the Benjamin Mpaka AIDS Foundation (BMAF) is building staff houses in many rural areas; district councils provide settling-in or duty allowances and non-financial incentives (e.g. transport).

## Timeline of relevant PHC policies

In the 1980s, Tanzania went through a severe economic crisis that adversely affected the management and financing of basic social services, including health care services.<sup>12</sup> As part of addressing these problems, the health sector was appraised in 1993, and in 1994 health sector reforms were proposed. The key components of the reforms included: decentralization of decision-making power and authority; the introduction of user fees in public health care provision; and public-private partnerships in health services delivery. The reform process resulted in the first *Health Sector Strategic Plan (HSSP1)* and the *Health Sector Programme of Work (POW) 1999–2004* funded through the SWAP arrangement. The reforms have continued to be implemented through subsequent *Health Sector Strategic Plans*: HSSP I 1999–2004; HSSP II 2005–2009; HSSP III 2009–2015; and HSSP IV 2016–2020.

### **Introduction of the Primary Health Services Development Programme (PHSDP):**

In order to address weaknesses in the provision of health care in the primary level facilities, the Government designed and initiated a reform programme called the 'Primary Health Services Development Programme (PHSDP) 2007–2017' or *Mpango wa Maendeleo wa Afya ya Msingi (MMAM)* in Kiswahili.<sup>13</sup> The Government of Tanzania recognises that despite the good network of primary health facilities, access to health care is still a challenge for parts

10 Mshana, E. Petit et al. Synthesis of human resources for health studies conducted 2000–2011. Pemba Consultants; 2011.

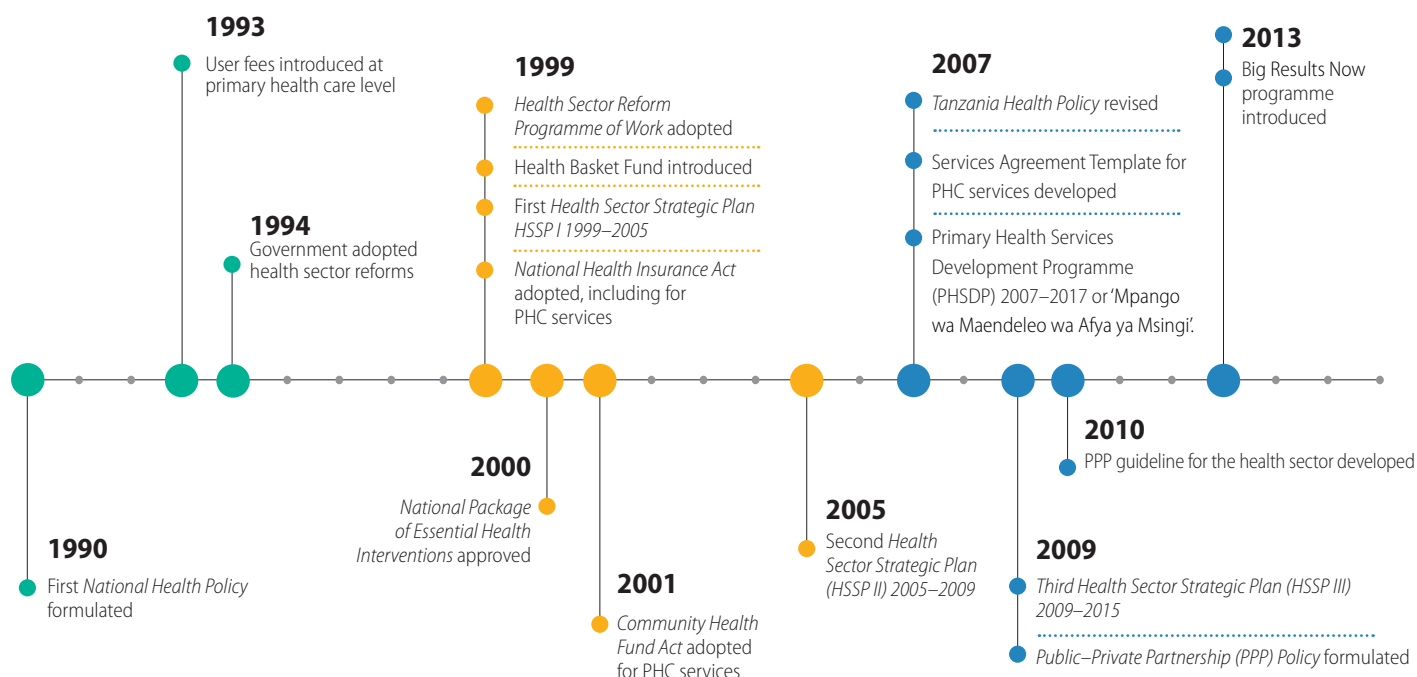
11 Human resource for health and social welfare strategic plan 2014 – 2019. Dar es Salaam: Ministry of Health and Social Welfare; 2014.

12 Wangwe S., H. Semboja and T. Tibandabage (eds) (1998). *Transitional Economic and Policy Options in Tanzania*. Tanzania Political Economic Series, 1, Dar es Salaam: Mkuki na Nyota Publishers.

13 Primary Health Services Development Programme (PHSDP) 2007–2017. Dar es Salaam: Ministry of Health and Social Welfare; 2007.



**Figure 4** Chronology of events on the development of primary health care reforms in Tanzania



of the population, with some people living more than 10 kilometres from the nearest health facility. The MMAM programme seeks to improve access to health services by ensuring that every village will have a dispensary and every ward has a health centre. The main areas of focus of the MMAM programme are strengthening the health system, rehabilitation, human resource development, the referral system, increasing health sector financing and improving the provision of medicines, health care waste management, sanitation, equipment and supplies.

**National key result area in health care (Big Results Now programme):** In 2013, the Government adopted the 'Big Results Now' (BRN) programme in order to enhance the implementation of the *National Strategy for Growth and Reduction of Poverty* (NSGRP) or Mpango wa Kukuza Uchumi na Kupunguza Umasikini Tanzania (MKUKUTA) in Kiswahili through improved prioritization, focused planning, and efficient resource management. BRN is a methodology that aims to instil implementation accountability and discipline. Leadership by Government officials is essential. A Presidential Delivery Bureau (PDB) is facilitating planning and monitoring of the sectoral plans. In the Fiscal Year (FY) 2014–15, the approach was initiated in six sectors, expanding to other sectors in FY 2015–16.

The four key results areas that were formulated in the Health and Social Welfare sector are: **(i) Human resources for health** interventions, which aim to attain 100% balanced

distribution of skilled health workers at the primary level in thirteen underserved regions by 2017–18; **(ii) Health commodity** targets focus on ensuring 100% stock availability of essential medicines in all primary health facilities in the country; **(iii) Health facility performance management improvement** goals include achieving 80% of primary health facilities at a 3-star or above rating by 2017–18 in twelve identified priority regions; and **(iv) Reproductive maternal neonatal adolescent and child health** (RMNCAH) services target the achievement of 20% reduction in maternal and neonatal mortality rates in five identified priority regions by 2017–18. Figure 4 provides timeline of the key primary health care reforms in Tanzania.

## Planning and implementation

In Tanzania, the process of planning has been devolved to the district health authorities. At the district level, the Council Health Management Teams (CHMT)<sup>14</sup> have been formed with the remit to assess the health needs of the population and prepare a *Council Comprehensive Health Plan* (CCHP), which has to make the best use of limited resources in meeting local needs. Identification of health priorities has to begin at the grassroots level, with district-level monitoring of adherence to budget ceilings, as well as

<sup>14</sup> The CHMT consists of eight core members namely: the District Medical Officer (DMO) who is also the head of the committee, District Nursing Officer, District Laboratory Technician, District Health Officer, District Pharmacist, District Dental Officer, District Social Welfare Officer and District Health Secretary (secretary to the team).

national policy requirements on core issues. In principle, the CHMT determines priorities based on input from hospitals, health centres, dispensaries, the community and other stakeholders before the planning period.

The final plan is approved by a Full Council Meeting, which is comprised of elected councillors representing communities, and the District Executive Director (DED). The Full Council is the highest political body at the district level and, at least theoretically, has the overall authority over health services in the district. Having been approved by the Full Council, the CCHP is forwarded to the MoHSW and the Prime Minister's Office Regional Administration and Local Government (PMO-RALG), through the regional health secretariat, for final approval. PMO-RALG and MoHSW assess the CCHP and give the final approval before funds can be disbursed to local government authorities.

However, decentralization in the health sector has not been fully achieved, hindering the operations of facilities. Health facilities have limited financial autonomy to utilize their own funds. Until recently,<sup>15</sup> most PHC facilities did not even have a bank account. Funding for PHC was historically channelled to local government authorities, which often serve as a major bottleneck preventing resources reaching lower levels. In addition, there has been limited progress in engaging the private health sector through public–private partnerships (PPPs).<sup>4</sup> A mid-term review (MTR) for the *Health Sector Strategic Plan (HSSP) III FY09–FY15* concluded that the health sector is making progress in all strategic areas, but the overall pace is slower than anticipated; there is greater progress in systems development (policies, strategies, guidelines, work plans, etc.) than in service delivery.<sup>4</sup> Innovations are only slowly trickling down to front-line health facilities. Vertical disease control programmes are performing better than either general or reproductive health services.

## Regulatory processes

There are many actors in the PHC system in Tanzania. These actors include the MoHSW (on behalf of public providers), private for-profit organizations, private non-profit, nongovernmental organizations, faith-based organizations, community-based organizations, sole providers, and traditional practitioners. Furthermore, there is also internal regulation of codes of conduct and standards completed by

established professional associations (e.g. Medical Association of Tanzania, Pharmaceutical Board) in the health sector.

In the process of implementing reform of the health system, the government has laid a good foundation in formulation of regulatory frameworks, and the main challenge remains their enforcement.<sup>16</sup> The Tanzania Food and Drug Authority (TFDA) was established in 2001 by an act of parliament. The TFDA is mandated to ensure quality, safety and efficacy of medical products marketed in Tanzania. Furthermore, the MoHSW has established a regulatory and quality assurance department. The Tanzania Bureau of Standards also participates in regulating health-related commodities. The Medical Stores Department (MSD) indirectly regulates the quality of pharmaceuticals and medical supplies by bulk ordering and inspection assisted by TFDA.

The non-degree level programmes for health professional education fall under the MoHSW and are accredited by the National Council for Technical Education (NACTE), which is responsible for setting entry qualification and educational standards. The degree programmes are under the Ministry of Education and Vocational Training and are regulated by the Tanzania Commission for Universities (TCU).

## Monitoring and information systems

The national health management information system (HMIS) is under development, and uses the internet-based DHIS-2 software. This is a reporting system requiring health facilities to report on a monthly basis to their respective districts on the situation of various health services and systems including vaccinations, treatments provided, attendances in MNCH, human resources and drug use. The HMIS is implemented in all health facilities. However, the HMIS has limited effectiveness in delivery of quality health information in the country. The quality of analysis of available information requires further coordination and capacity development and to be institutionalized.

As part of PHC monitoring and evaluation, the districts are required to submit quarterly and annual reports on health services provision and performance in their respective districts. The districts and regions use an operational software to support data aggregation and report submission. According to the district and regional level respondents, health facilities need to be equipped with sufficient registers,

<sup>15</sup> PMO-RALG has recently directed councils to open bank accounts for all health facilities.

<sup>16</sup> Mujinja PGM, Kida TM. (2014). Implications of Health Sector Reforms in Tanzania: Policies, Indicators and accessibility to health services. Economic and Social Research Foundation (ESRF) Discussion Paper No.62.

trained HMIS staff, and regular supportive supervision from higher management levels. This will help to improve the data collection system leading to better quality and more reliable health information.

According to regional and district level stakeholders, use of information at the grassroots level for planning and decision-making is still limited. The organizational culture surrounding the HMIS is still mainly focused on producing figures for use at management levels, rather than local prioritization or decision making. However, stakeholders report that some work has started on improving capacity for data collection, analysis and use across the sector but more work is required.

Tanzania has a well-established system of sentinel surveillance to assess performance and regular surveys to compile and extract information on trends in development, demography, poverty, health and social well-being. Research is increasing, national reports are more available and optimization of the research outputs requires a systemic approach. The development of information and communication technologies has the potential to change the face of health service delivery in the country.

## Way forward

- There is need for the central Government to further devolve decision making to the local government level. Similarly, local government authorities need to strengthen the Council Health Management Board and assign more controlling responsibilities and formal relations to Council Social Services Committees.
- In order to address health financing challenges, the government needs to increase the budget for the health sector. In addition, the government needs to address fragmentation issues in health financing through fast-tracking the *Health sector financing strategy*, and the associated expansion and consolidation of health insurance around a new mandatory single national health insurance programme.
- In order to address challenges related to regional disparities in HRH availability, the Government needs to increase the number of health personnel by increasing production and retention strategies. Currently, many staff prefer to work in urban rather than rural areas due to poor working and living environments in the latter.
- The Government needs to increase funding for medicines and medical supplies in order to improve their availability in health facilities. Similarly, the Government needs to improve disbursement practices (irregular disbursements, late in the financial year; long lead times for disbursed funds to be credited to health facility accounts at Medical Stores Department).
- In order to improve the quality of the HMIS in Tanzania, health facilities need to be equipped with sufficient registers, trained HMIS staff, and regular supportive supervision from higher management levels. This will help improve data collection and lead to improved quality and reliability of health information. Currently, the culture around the HMIS is still focused on producing data for the higher levels.

This case study was developed by the Alliance for Health Policy and Systems Research (AHPSR) in collaboration with the Bill & Melinda Gates Foundation, as part of the Primary Care Systems Profiles and Performance (PRIMASYS) initiative. PRIMASYS supports the development of case studies of primary health care (PHC) systems in low- and middle-income countries (LMICs) in order to bridge the knowledge gap on PHC systems at national and sub-national levels. Using findings from a combination of key informant interviews and focus group discussions with key stakeholders, as well as quantitative data available nationally, PRIMASYS provides insights to support PHC system strengthening and improve implementation, effectiveness and efficiency of health programmes in LMICs.

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