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MID TERM REVIEW (MTR) OF THE HEALTH SECTOR STRATEGIC PLAN V (HSSP V)

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FOREWORD

The Mid-Term Review (MTR) of the Health Sector Strategic Plan V (2020-2025) is an important interim guide for the implementation of long-term strategic interventions in the health sector. The report provides a snapshot of the current status of the health sector, highlighting areas where progress has been made and identifying where further efforts are needed to achieve the set targets for 2025. Significant achievements have been observed in the health sector, while the equity analysis will help guide us in identifying the populations or regions of the country that require a larger infusion of resources, effort, quality improvements, and investment to achieve parity with the national average. The timeframe of HSSP V (2020-2025) has also highlighted many unexpected setbacks during this period, including the COVID-19 pandemic, re-emerging epidemics, climate changes leading to droughts and floods, demographic shifts accelerating urbanization, and the rapid growth of an elderly population. Additionally, there has been a setback in external financial and technical support from various donor countries. The gaps identified and the strategies to address these inequities will inform the development of HSSP VI (2026-2030).

The publication of this MTR report will be valuable to senior management and technical experts from the Ministry of Health (MOH), the President's Office-Regional Administration and Local Government (PO-RALG), and other Government Ministries, Departments, and Agencies (MDAs) that impact the health sector. These include, but are not limited to, the President's Office-Public Service Management (POPSM), the Ministry of Finance (MOF), and the National Bureau of Statistics. The report will also be useful for policymakers, parliamentarians, civil society, and the broader community. Some stakeholders may need assistance in interpreting certain sections of the report, and the MOH is prepared to provide this support, as we, as the custodians of the national health policy, are accountable for some or most of these results.

It is noteworthy that the MTR was prepared using a combination of quantitative and qualitative research methods, all embedded within an implementation research framework. Additionally, information from existing reports—surveys, the digital health information system, in-depth observations, interviews, and operational research—was also used as reference material. The MOH and stakeholders prepared this report with experts from national institutions and international partners based in Tanzania. This highlights the increasing local capacity developed through close collaboration with seasoned experts from the World Health Organization (WHO). We anticipate that future reports from the MOH program will demonstrate similar levels of analytical thinking, with comparative and equity considerations.

On a personal note, the report provides me with a thorough audit of where we currently stand and what I need to focus on within my area of responsibility. I hope that all stakeholders in the health sector will use this report to intensify efforts in service provision and enhance standards for recording, documenting, and reporting.

On behalf of the Ministry of Health, I would like to express appreciation to the World Health Organization and the Swiss and Irish Embassies for providing the financial and technical support required for this activity. I wish all stakeholders success in the implementation of the remaining period of HSSP V.


Dr Seif Abdallah Shekalaghe
Permanent Secretary
Ministry of Health

ACKNOWLEDGEMENTS

The midterm review of the implementation of the Health Sector Strategic Plan V (July 2020 – June 2025) is a vital undertaking by the Ministry of Health. The Ministry’s leadership and staff could not have completed this assignment alone. Therefore, I would like to extend our sincere gratitude to all individuals, institutions, and organizations—public or private, national or international—that contributed their hard work and investment, enabling us to achieve this milestone. Experts from most health programmes within the Ministry, along with non-state actors who participated in the development of the inception report during the meeting in Dodoma in September 2024, as well as all consultants and members of the thematic teams representing communities, civil society, and faith-based organizations responsible for the fieldwork in November 2024, provided invaluable support. Their contributions shaped this review and enhanced the quality, accuracy, and completeness of the data and information used in this report.

It is difficult, if not impossible, to mention everyone individually. Therefore, to all those who contributed in any way to this endeavour, please accept the Ministry’s deep appreciation for a job well done.

On behalf of all contributors, I would like to highlight the collective effort that made this report possible. At the Ministry of Health, I extend particular recognition to the Policy and Planning section. The team, led by Dr Vivian Wonanji, Head of the Health Sector Resource Secretariat, and Mr. Raynold John, conceived the initial idea and sought crucial support.

I also appreciate the contributions of Anna Nswila, former Director of Health Services at the President’s Office – Regional Administration and Local Government (PO-RALG), for her valuable support.

We are deeply grateful to the Ifakara Health Institute (IHI), under the leadership of Dr Sally Mtenga (former Head, Health System Impact Evaluation and Policy Department and Dr Honorati Masanja (Chief Executive Director), for their invaluable contributions. The World Health Organization (WHO), through the WHO Representative, Dr Charles Sagoe-Moses, also played a pivotal role. Dr Fedjo Tefoyet (WHO Team Lead, Universal Health Coverage) and Leticia Rweyemamu (WHO staff) provided essential technical advice and backstopping support. Their combined vision, leadership, and management were instrumental to the success of this endeavour.

We extend our sincere appreciation to the WHO Country Office, the AFRO Regional Office, and the Headquarters in Geneva for embracing this initiative and providing technical, financial, and moral support. The IHI consulting team, comprising Dr Sally Mtenga (Lead Consultant), Dr Francis Levira, Dr Getrude Molllel, Hipolite Tarimo, and Samuel Lwambura demonstrated exceptional research, analytical, and implementation capabilities in support of this national cause.

Special thanks go to WHO for supporting the consultancy firm Global Public Health Solutions (GPHS) through Dr Peter Nsubuga, Aziz Maija, and Professor Erick Tchouake. We also acknowledge the contributions of other consultants from the National Institute for Medical Research (NIMR), specifically Dr Paul Kazyola and Dr Sophia Kagoye Adam, as well as Dr Angel Dilip from Apotheker and Serafina Mkuwa from AMREF.

Dr. Eric van Praag, Technical Editor at IHI, deserves recognition for his support in compiling the final report, with special thanks to Ifakara’s Communications Office, particularly Bilal Aziz and Jane Moshi—for supporting the editing and formatting of the report.

We also acknowledge the technical support provided by various units and departments within the Ministry of Health, the twenty-one research assistants assisting the field interviews and the WHO Country Office, which all were crucial to the review team's success.

Finally, we express our gratitude to the Swiss and Irish Embassies for their generous funding to WHO, which enabled this work to be undertaken. Their continued support is deeply appreciated.

Once again, on behalf of the Ministry of Health and on my own behalf, I thank you all.



Dr. Grace Magembe
Chief Medical Officer
Dodoma
March 2025

ACRONYMS/GLOSSARY

CCHP	Comprehensive Council Health Plans
CHSB	Council Health Service Board
CPD	Continuous Professional Development
DC	District Council
DCF	Development Cooperation Framework
DHIS2	District Health Information System 2
DPs	Development Partners
eLMIS	Electronic Logistics Management Information System
EMR	Electronic Medical Record
FGDs	Focus Group Discussion
FYDP	Five-Year Development Plan
GOT	Government of Tanzania
GoT-HoMIS	Government of Tanzania-Health Operation Management Information System
HBF	Health Basket Fund
HFGC	Health Facility Governing Committee
HiAP	Health in All Policies
HIS	Health Information System
HSSP	Health Sector Strategic Plan
ICT	Information, Communication and Technology
IDI	In-depth Interview
IP	Implementing Partner
JAHSR	Joint Annual Health Sector Review
JAHSTRM	Joint Annual Health Sector Technical Review Meeting
LGA	Local Government Authority
MC	Municipality Council
MMAM	Mpango wa Maendeleo wa Afya ya Msingi (Primary Health Care Development Programme)
MDG	Millennium Development Goals
MoF	Ministry of Finance
MOH	Ministry of Health
MSD	Medical Stores Department
MTR	Mid-Term Review

NCDs	Non-Communicable Diseases
NTDs	Neglected Tropical Diseases
OPD	Out-patient Department
PEPMIS	Public Employee Performance Management Information System
PHC	Primary Health Care
PO-PSMGG	President's Office Public Service Management and Good Governance
PO-RALG	President's Office-Regional Administration and Local Government
PPP	Public Private Partnership
RMNCAH-N	Reproductive, Maternal, Neonatal, Child, Adolescent Health and Nutrition
SDGs	Sustainable Development Goals
SWAp	Sector Wide Action plan
TWG	Technical Working Groups
UN	United Nations
WHO	World Health Organization
WISN	Workload Indicators of Staffing Needs

EXECUTIVE SUMMARY

The approach for this Mid-Term Review (MTR) of the Health Sector Strategic Plan V (2021-2026) was developed during a broad stakeholder meeting held in Dodoma, Tanzania, in September 2024. The meeting brought together the Ministry of Health, PO-RALG, the donor and UN community, and various non-state actors.

The Ministry of Health (MOH) and WHO contracted IHI, an independent national research institution, as the lead implementing agency, with consultancy support from AMREF, NIMR, Apotheker, and the Global Public Health Solutions in Atlanta, USA. Financial support was provided by the Swiss Embassy.

The MTR aims to provide an in-depth review of the implementation status of HSSP V. A conceptual framework was developed using the WHO building blocks as a foundation, incorporating additional multisectoral and equity components. This framework follows a Theory of Change approach, mapping inputs to impact, with progress measured through both quantitative and qualitative indicators.

Teams were selected to implement and document their results across ten thematic areas: Public Health Policy; RMNCAH-N; Community Engagement; Communicable and Non-Communicable Diseases; Service Delivery; Health Financing; Human Resources for Health; Health Commodity Management; ICT; and Results-Based Management/M&E.

The comprehensive thematic reports are available online at this link:

<https://www.ihl.or.tz/publications/list-and-reports/>

The methodology for each thematic area followed a parallel mixed-methods cross-sectional design with a carefully planned sequence of workflow steps.

To ensure representation of national priorities outlined in HSSP V, one region was purposefully selected from each of the eight national zones. Within each region, two councils were chosen based on socio-economic and disease burden criteria. To maintain objectivity, healthcare facilities within each council were randomly selected.

The main data collection tools included document reviews at all levels, in-depth interviews, focus group discussions, and field observations—all carefully prepared and standardized.

Findings from this review are presented in detail across ten thematic documents, each corresponding to a thematic area. This compiled MTR document provides a summary of these findings along with an overarching analysis.

HSSP V is well aligned with national health policies and international guidance through the UN. Major achievements have been observed in governance strengthening at the council and hospital levels, expanded infrastructure across the public and private sectors, improved flows of supplies and equipment, and a gradual but clear shift towards digitalization at all levels. Public-private partnerships have been instrumental in these advancements. These achievements have contributed to improved impact indicators, such as a reduction in institutional maternal mortality, more effective surveillance of emerging threats, and a slow but steady improvement in access to universal healthcare.

However, many challenges persist at all levels, preventing the full realization of HSSP V targets. Significant disparities remain between policies agreed upon at the governance level and their tangible implementation at the community level. HSSP V often lacks specific indicators to capture these disparities, particularly in areas such as equity, social determinants of health, financial disbursements, and quality of care.

With the rapid expansion of digitalization, interoperability of reporting systems is crucial and should incorporate operational feedback mechanisms to enhance health benefits. At the primary healthcare level, particularly in hard-to-reach rural areas and high-density urban areas, many of the aforementioned achievements have been more difficult to detect. Despite the Government of Tanzania's Parliament approving the Universal Health Insurance Act, enrolment increases remain limited, as operationalization is not yet optimal.

While external funding is declining, local resource mobilization and more cost-effective planning and implementation have not been consistently observed at national and sub-national levels.

Certain health issues resulting from demographic and climate changes, which were not initially addressed in HSSP V but have emerged between 2021 and 2025, need urgent attention. Holistic geriatric care should be prioritized through diploma- and degree-level training for nurses, clinical officers, medical doctors, social welfare officers, and community health workers (CHWs). Mental health remains a growing concern for both adolescents and the elderly and has not yet been sufficiently addressed. Additionally, recognition and rewards for CHW volunteers, who have played a key role in surveillance of emerging infections, should be explicitly incorporated alongside the CHWs now trained under the new CHW programme.

Key recommendations:

- Develop alternative financing and cost-effectiveness measures including domestic resources including taxes to support the Sector Wide Approach and ensuring sustainable public-private partnerships.
- Leadership training at regular intervals to reduce frequent staff changes.
- Policy alignment to ensure that all the strategic plans and guidelines contribute towards achieving the strategic objectives of the HSSPs.
- Gender mainstreaming across all levels and all sectors.
- Rapid expansion of PPP initiatives including a process of mutual trust building, transparency and joint accountability.
- A clear dissemination and orientation plan at all levels for major policy and strategic documents, disease specific guidelines including these MTR findings in clear concise format in Kiswahili will ensure better engagement and joint decision making. Revival of dormant community level health committees is crucial.
- Capacity building to integrate social determinants of health through Health in All Policies at all levels.
- Better coordination for monitoring, planning and lessons learned between all stakeholders (public, private, institutions and IPs) in particular at sub-national level.
- Actively promoting equity understanding and interventions throughout our health system reflecting those opportunities for access to health are equal for both genders, are equal for all socio-economic levels, are equal for rural and urban areas, are equal for all age groups children, adolescents, adults, the elderly and the disabled.
- Establishment of a specific zone Dar es Salaam combining the three municipalities (like TRA and Department of Police) to allow additional resources and an integrated approach to reflect health care needs of the urban poor.

- Expansion of HSSP Indicators and targets in all domains to reflect gender and geographic equity, funding and disbursements, quality of service delivery and social determinants of health.
- Single Unified Community digital systems to be used by relevant Ministries and all implementing partners. Harmonization of different medical digital reporting systems to continue to continue and health care workers to be trained and supervised accordingly for optimal use.
- Revive mandatory audits for data quality and performances of staff in public and private sector.
- Effectuating of standards keeping in quality assurance and strengthening for key areas such as staff recruitment, deployment and appraisal; bi directional referrals, supply and commodity management as well as data handling.
- Attention to underserved rural areas through infrastructure, equipment, adherence to deployment criteria, incentives, succession plans and supervised service delivery.
- Addressing (re)-emerging infections and health issues due to climate change and demographic changes in an integrated manner focusing on the existing health system in particular and strengthening surveillance by grass root volunteers by incentivizing them.
- Attention to care for the elderly through investing in medical and nursing geriatrics as a specialization both at degree and diploma level.

I INTRODUCTION

I.1 Background

Strategic guidance for the health sector has been very prominent in Tanzania since Independence. The Arusha Declaration in 1967 and the global Alma-Ata Declaration in 1978 set the tone for a people's-oriented health for all policy. Various more specific national health policies, Acts of Parliament and strategic health plans have formulated and guided the implementation at national and subnational levels.

The second National Health Plan (1972-1980) called for free and comprehensive basic health services to all Tanzanians. The Local Government Authority (LGA) Act of 1982 stipulated the modalities for decentralized health care and was revised and strengthened in 1998.

The Vision 2025 calls among others for a high quality of livelihood for its citizens, good governance, a well-educated society, sustainable growth and shared benefits.

The National Health policy 2007 currently under final revision will have innovation as a leading theme.

Since then, the Ministry of Health (MOH) and the office of Regional Administration and Local Government (PO-RALG) have developed five-year Health Sector Strategic Plans (HSSP) in close coordination with implementing partners and donors. A Mid Term Review by all stakeholders has occurred for most HSSPs.

In 1999, the Government of Tanzania initiated the formulation of five years' strategic plans to guide the development of the health sector in accordance with the latest National Health Policy.

The HSSP I (1999-2002) emphasized cost/effective district health services while HSSP II (2003-2008) initiated reforms towards quality services and client satisfaction. During this period the MMAM (PHC) policy for 2007 to 2017 was launched emphasizing equity, affordability and multisectoral involvement.

HSSP III (2009-2015) focused on Partnerships for delivery of the MDGs improving accessibility to district and referral facilities and addressing MCH services and specific disease control programmes.

HSSP IV (2015-2020) shifted again to 'reaching all households with quality care' and put PHC in the forefront.

HSSP V (2021-2026) had to be built on the unfinished agenda of HSSP IV due to a variety of economic and structural reasons implementation had not been achieved.

As we just passed the mid-point of the HSSP V, this report of the Mid Term Review (MTR) is meant to guide all implementing partners to assess progress made, identify challenges and offer practical solutions to address these with the aim to ensure that the goals of HSSP V are met by mid-2026. In addition, this MTR serves as a preparational tool for the design of HSSP VI.

1.2 Objectives

1.2.1 Main Objective of the MTR of HSSP V

To provide an in-depth review on the progress of the implementation of the Tanzania HSSP V with its time frame of July 2021 to June 2024.

1.2.2 Specific Objectives

1. To explore the relevance, awareness, and utility of the HSSP-V among all key stakeholders including health-service users in the community.
2. To assess policy alignment, service delivery, and stakeholder engagement in the development and execution of HSSP V.
3. To assess the health sector's pace and extent of mobilization of resources as outlined in the HSSP V, and recommend required modifications and refinement.
4. To assess the progress and factors that hinder or accelerate the achievement of HSSP V objectives and targets.
5. To evaluate the effectiveness, efficiency, relevance, and sustainability of the strategies and interventions implemented.

1.2.3 Scope, concept and thematic areas

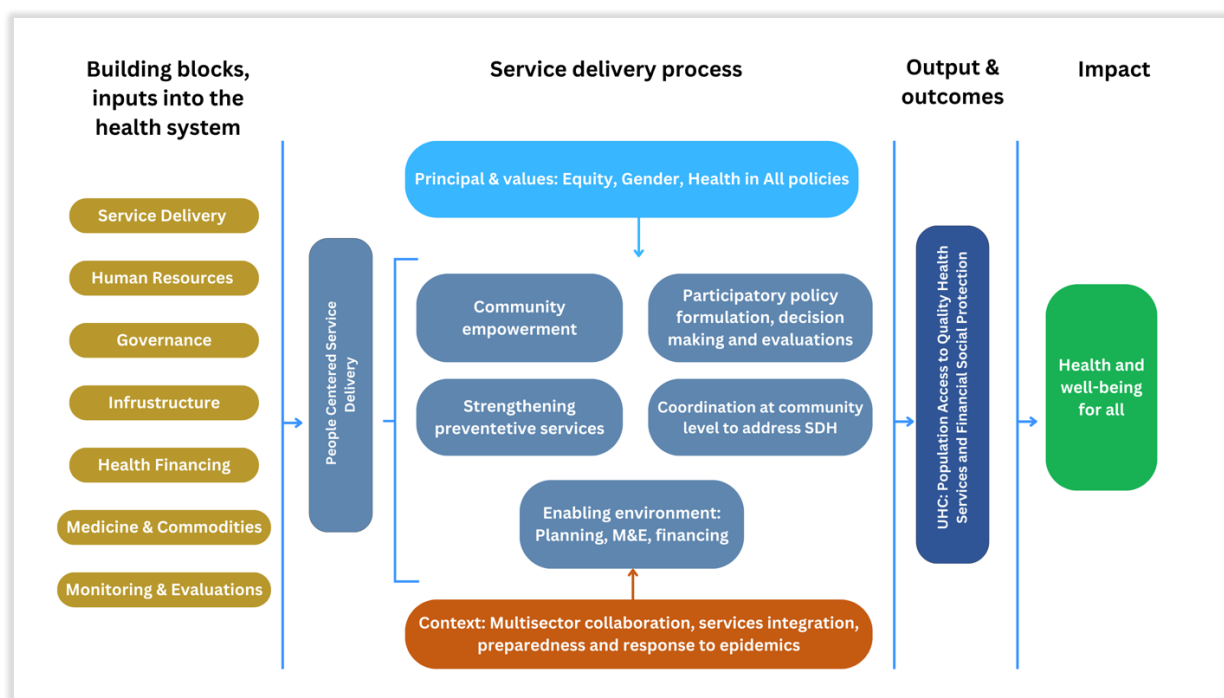
This report on the MTR HSSP V will cover a review of the four strategic priorities outlined in the HSSP V namely the Organization of health Services; the Delivery of Health Services; the Performance of the Health System; and the Functioning of the Health Systems (ref HSSP V).

This MTR follows a conceptual framework adapted from the WHO building blocks outlined in the HSSP V. This adaptation was made during the MTR inception meeting in Dodoma on September 20th, 2024, to visualize the WHO building blocks. It also incorporates contextual factors, principles, and values to illustrate a proposed Theory of Change (See Fig. 1, available in the Public Health Policy and Planning Thematic Report in this link: <https://www.ihl.or.tz/publications/list-and-reports/>)

The Theory of Change pathway identifies the steps in a health system, from inputs to results and outcomes, for healthier communities interacting with their health and welfare providers through their involvement in health promotion, disease prevention, and service delivery. These activities are fundamental principles for achieving sustainable and affordable health improvements. Further guidance for this conceptual framework was obtained from the National Tanzania Health Policy 2007 (currently being revised), the GOT Development Vision 2025, and the Sustainable Development Goals (SDGs), which were internationally adopted by all UN member states in 2015 for the period up to 2030 (UN, 2025).

Indicators and targets as mentioned in HSSP V conceptual framework were the basis for this mid-term review and reflect the strategic priorities for monitoring through our existing monitoring and evaluation services (annex 2 HSSP V). The MTR inception-meeting identified ten thematic areas (see Table I) from these strategic priorities to be reviewed by ten teams of experts and research assistants guided by a consultant for each thematic area team.

Figure 1: Schematic representation of HSSP V conceptual framework based on the Theory of Change



Adapted from WHO by Sally Mtenga, Gertrude Joseph and Peter Nsubuga

Table 1: The 10 Thematic Areas

Thematic Areas
1. Public Health Policy and Planning
2. Reproductive, Maternal, Neonatal, Child and Adolescents Health
3. Communicable and Non-Communicable Disease
4. Community Engagement
5. Service Delivery
6. Health Financing
7. Human Resources for Health (HRH)
8. Health Commodities Management
9. Information Communication Technology (ICT) and Data management
10. Results based Management through M&E

2 METHODOLOGY

2.1 Reporting design

The ten thematic area teams conducted their fieldwork from September to December 2024 and produced ten detailed reports, each containing their findings, discussions, and recommendations based on the overall study design. These reports are available at this link: <https://www.ihi.or.tz/publications/list-and-reports/>

This compiled MTR report provides an overview of the overall concept, background, and methodology, along with summary descriptions of each thematic area. It also outlines the way forward for the remaining period of HSSP V and the preparation for HSSP VI.

2.2 Study design

A parallel mixed-methods cross-sectional design was employed involving qualitative and quantitative surveys. Qualitative surveys evaluated stakeholders' perceptions, utility of the strategy, satisfaction levels, and the perceived impact of the strategic interventions. Quantitative methodologies assessed the progress made towards achieving HSSP V targets by analysing key performance indicators (KPI) mainly found from the available reports and information systems such as HIMS and DHIS2.

2.3 Evaluation Framework

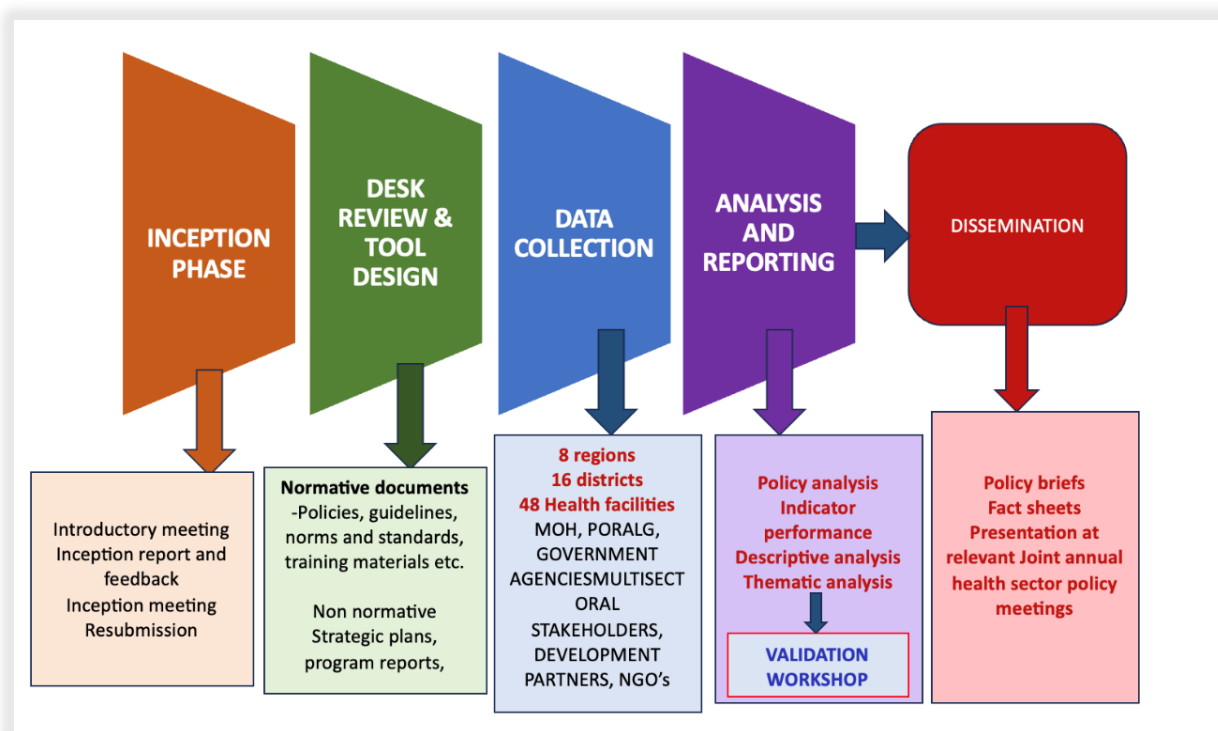
A methodological framework for this MTR was developed during an inception workshop held in Dodoma on September 26, 2024, where the objectives, scope, methodology, and site selection were outlined by a team representing the MOH, IHI, WHO, consultants, and representatives from the non-government and private sectors:

See the Inception Report at this link:

https://www.ihi.or.tz/media/List_and_report/MTR_Inception_-_REPORT_eversion.pdf

The sequence of workflow steps for this review is outlined in Figure 2. The evaluation questions for each of the ten thematic areas were discussed and agreed upon, as detailed in Appendix I.

Figure 2: The process of the MTR of HSSP V in sequential steps



2.4 Study Sites

Geographical scope - national level

The geographic scope of this MTR of HSSP V is Tanzania Mainland. At the national level, policy and strategic technical developments were reviewed through the Ministry of Health, while aspects of health service delivery were assessed in collaboration with PORALG, the responsible ministry. Health performance indicators were obtained from the relevant ministries and evaluated across all 26 regions and 184 districts.

Furthermore, the MTR directly engaged stakeholders through in-depth interviews with selected NGOs, research institutions, development partners, health funding agencies, and experts working at the national or subnational level.

Geographical scope - Subnational level (Regional and Council level)

To gain a comprehensive understanding of the implementation of HSSP-V service delivery at the primary health care level (both government and non-government), and to assess progress toward HSSP-V targets, this review conducted rapid physical assessments in eight regions, each representing one of Tanzania's eight zones. Key responsible staff were interviewed as part of these assessments. The questions used in the rapid assessment were primarily qualitative in nature, with a focus on semi-structured interviews.

The regions include **Kigoma** (West), Arusha (Northern), **Rukwa** (Southwestern), **Dar es Salaam** (Eastern), **Geita** (Lake Zone), **Mtwara** (Southern), **Dodoma** (Central), **Njombe** (Southern Highland). Within each region, a purposeful selection was made of two Councils based on rural-urban and best performers and poor performers according to the burden of neonatal deaths in the district.

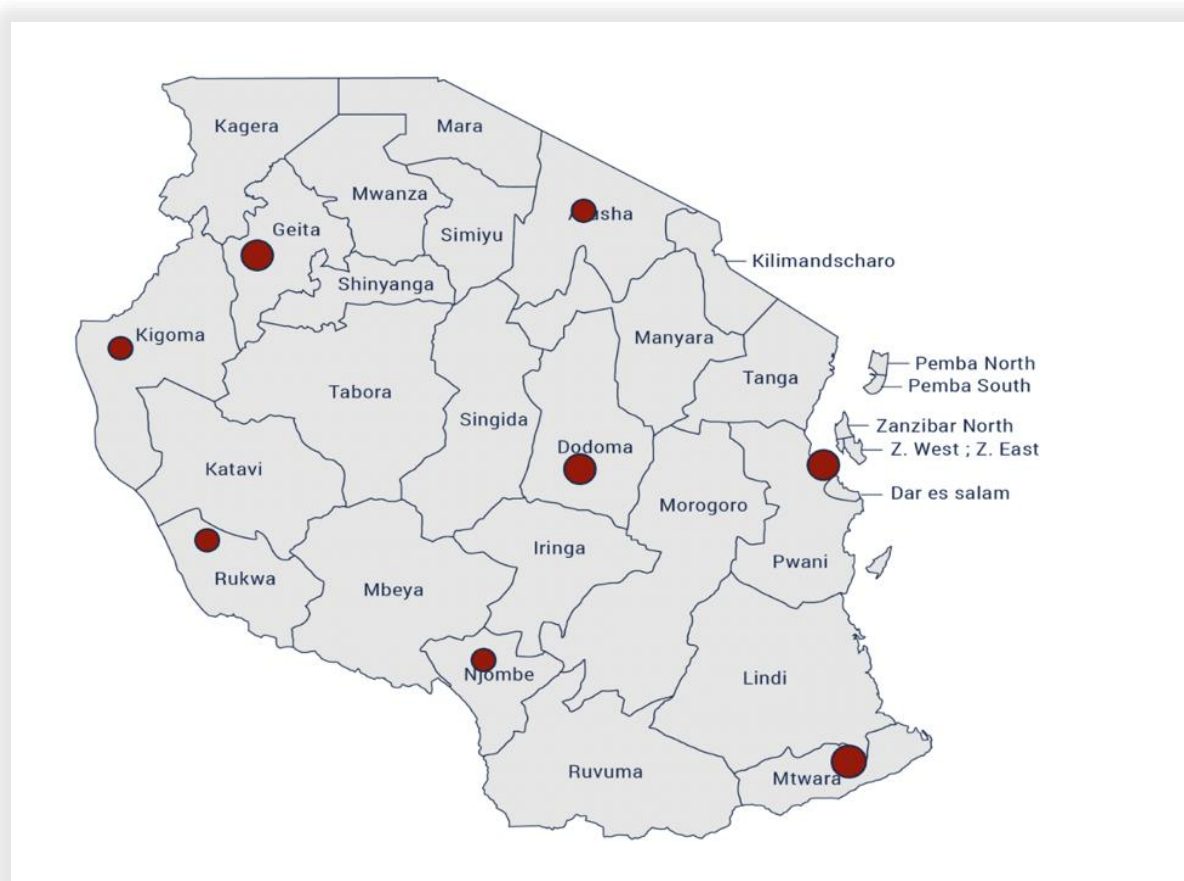
Besides ensuring representation of all eight administrative zones of Tanzania and the burden of RMNCAH indicators (number of neonatal or maternal deaths reported on HMIS/DHIS2), the following additional criteria were considered:

- Socioeconomic status and burden of urban poverty.¹
- Burden of communicable and non-communicable diseases such as Malaria, HIV, TB, and Hypertension (see table 2).

Within each district, a total of three public and private healthcare facilities—a district hospital, a dispensary, and a health center—were randomly selected to assess service availability, conduct quality evaluations, and gather client and community perspectives.

The map below shows the regions where the MTR was conducted.

Figure 3: Geographical scope



¹ https://www.nbs.go.tz/nbs/takwimu/hbs/Tanzania_Mainland_Poverty_Assessment_Report.pdf

Table 2: Regions and district councils selected for quantitative survey

Region	Poverty index	Councils	Low burden		High burden	
			Urban	Rural	Urban	Rural
Kigoma	High	Kigoma MC	✓			
		Kibondo DC				✓
Arusha	Low	Arusha CC			✓	
		Longido DC		✓		
Rukwa	Very high	Sumbawanga MC			✓	
		Kalambo DC		✓		
Dar es Salaam	Very low	Temeke MC			✓	
		Ubungo MC	✓			
Geita	Very high	Bukombe DC				✓
		Geita TC	✓			
Mtwara	Moderate	Mtwara MC	✓			
		Masasi DC				✓
Dodoma	Low	Dodoma CC			✓	
		Kondoa DC		✓		
Njombe	Very low	Njombe TC			✓	
		Makete DC		✓		
Total			4	4	5	3

2.5 Qualitative approach

Participants:

Stakeholders identified for the qualitative study were selected purposefully based on their functions and responsibilities to the areas covered in this MTR and categorized into four groups:

Stakeholders Group 1: (HSSP V developers and those responsible for the implementation of HSSP-V) - those who developed the HSSP V (independent consultants from different institutions who participated in providing technical support for HSSP V development), and those who have an institutional memory of health sector and its vision and mentioned as team members in the HSSP V document.

Stakeholders Group 2: (decision makers) - those participating in decision-making and policy-making processes but also responsible for the implementation of HSSP V. This includes the Permanent Secretary, the Chief Medical Officer from the Ministry of Health, the Director of Health, Nutrition and Social Welfare Services at PO-RALG; Directors from the Ministry of Health i.e., Directorate of Policy and Planning, Preventive Services, Curative Services and Programmes, Chief Pharmacist, Heads of Technical Working Groups; Heads of health institutions such as MUHAS, NIMR, NHIF and MSD; and representatives of various religious organizations.

Stakeholders Group 3: (HSSP-V implementers and users) - those that are expected to implement and utilize the HSSP V. This includes the Regional Medical Officers, District Medical Officers, health care providers, community health workers, researchers, Non-Government Organizations (NGOs) and Implementing Partners (IP). Selected hospitals, health centers, and dispensaries, covering both rural and urban service delivery settings. Health professionals from different levels of healthcare delivery, representatives from community-based organizations, LGAs, district-level officials, researchers, and healthcare providers. Health care providers who are targeted in this study will be those working at the primary health care facilities at the respective study districts.

Stakeholders Group 4: (Beneficiaries of the strategy) - the local community members at the study sites. A theoretical and preliminary list of the participants is included in Table 2 below. A snowball technique was applied to ensure the inclusiveness and gender and professional diversity of participants to enrich the understanding of the HSSP V development, implementation process, relevance and value of the objectives and strategies within the health sector.

Approaches qualitative research:

I. Desk review

A desk review was made of normative and non-normative documents guiding the performance of the health sector in the country. Reports of various departments, annual health sector performance reports, reports of the technical working committees, and reports of the sector-wide approaches was reviewed to inform the implementation of various governance aspects of the health sector and the progress achieved so far. Central to the desk review is the review of the HSSP-V on how it was developed, who participated in the development process, the strategic objectives, the theory of change and the expected targets. This information provided a contextual background of the MTR report.

Any observed gaps were highlighted to inform the critical issues that need to be considered when developing the next HSSP.

The desk review also included a comprehensive policy mapping of all existing policies and strategic plans within the health sector to identify areas aligned with the HSSP-V and duplication of the strategies. The main outputs of the policy mapping were the online repository of policies and strategies in the health sector and a summary of their objectives, year of publication, and alignment with the HSSP-V.

2. In-depth Interviews (IDIs)

Seventy-seven IDIs with key informants were conducted to follow up on issues that emerged during desk work review. IDIs also elicited stakeholders' perceptions, views, and perspectives regarding the status of all thematic areas.

3. Consultative meetings

Several consultative stakeholders' meetings were held to ascertain stakeholders' variation of views, consensus building, and clarifications of the observations found from IDI interviews and desk reviews.

4. Focus Group Discussions (FGD)

A Focused Group Discussion guide was developed and used to rapidly explore variations of participants' views on quality of care, the role of health promotion, the link between community structures and health care systems, and the unmet service needs. It was administered to forty-six discussions, eighteen with groups of beneficiaries, eight FGDs with CHWs and twenty LGA members.

5. Exit Interview guide

A semi-structured exit interview guide was developed and applied to 228 clients after attending the health facility at PHC level. The health facility in charge was informed about the study's objective ensuring smooth interaction between research assistants and the patients at the respective health facilities.

Key aspects to be explored during IDIs, FGDs, and consultative meetings were:

Service Delivery Gaps; Resource Gaps; and Effectiveness and Efficiency issues of service delivery. Strategic and policy recommendations were solicited at the end the consultative meetings.

Qualitative Tools:

I. Policy mapping framework: As part of the MTR, a comprehensive mapping of existing health sector policies was developed of all normative and non-normative policies and assessed on the level of alignment to the HSSP-V strategy.

The following documents were assessed:

National Health Policy (2007); National Health Policy Evaluation Report (2020); Medium-Term Strategic Plan (2021/2022 – 2025/2026); Mandatory health service standards and guidelines; Policy options (endorsed by the Parliament or any other relevant institution); Regional and global resolutions (ratified by the Parliament); Strategic plans endorsed by the Permanent Secretary.

Also, living documents were assessed: National Health Policy, Strategic and operational plans not yet endorsed by the Permanent Secretary; Reports recommendations; non-mandatory learning materials and implementation guides.

2. An in-depth interview guide was developed to capture the opinions and views of stakeholders regarding the development of the HSSP-V strategy, the functionality of the various technical working committees, and the functionality of several aspects mentioned in HSSP-V such as sector-wide approach, community engagement, data availability and accessibility, utility of the HSSP-V strategy and others.

2.6 Quantitative methods

Quantitative data were collected based on indicators stipulated during the design of the HSSP V Monitoring and Evaluation framework. In addition, the health information system provided routine data used to evaluate the current data against HSSP V target indicators. As well surveys to health facilities, LGAs, and other stakeholders were held to collect data on implementing HSSP V. Data sources included the 2022 National Census, TDHS-2022, DHIS2, annual program reports, Tanzania National Nutrition survey, etc.

The indicators included in the results framework of the HSSP-V, or their proxies, were used for the quantitative part of the evaluation of the HSSP V. Exit interview guide questionnaires were used to assess the community's service satisfaction, availability, affordability and accessibility, acceptability and accommodation.

2.6.1 Sampling and Recruitment of the study participants

Participants were recruited with the support of the Ministry of Health officials, Regional Medical Officers and District Medical Officers. Healthcare workers at the specific health facilities within the study districts were identified through a convenient sampling process based on their availability and purposive sampling based on their professional background. Similarly, the method was applied to other health professionals in the NGOs, Government and research institutions.

In addition, the Community Team interviewed community members at the study site to understand health service satisfaction, availability accessibility, adequacy, affordability and acceptability. During the exit interviews at the health facilities, the clients were selected purposively by considering their gender (men and women), age (young and adults), and geographical (rural and urban). Purposive and convenience sampling were applied when determining the key informants' participants who possess special knowledge about certain topics within the health sector.

The selection of the health facilities followed a probabilistic sampling technique, particularly systematic sampling followed by simple random sampling considering urban and rural districts, health facility level (Dispensary/Health centre/Hospital) and the health facility ownership (private/FBO and public facilities) from the health facility registry portal ². Out of the selected 16 districts for MTR, up to 48 health facilities were selected (Table 3).

² <https://hfrs.moh.go.tz/web/index.php?r=portal%2Findex>

Table 3: Expected Health Facilities per the study regions

Regions		Dispensaries		Health Centres		Hospitals	
		Public	Private/FBO	Public	Private/FBO	Public	Private/FBO
Kigoma	Kigoma MC	Machinjioni		Buhanda HC			Baptist
	Kibondo DC	Nyakasanda	-		Dona HC	Kibondo DH	
Arusha	Arusha CC		Anointing Medical Centre		Total care		Arusha Lutheran Medical Centre
	Longido DC	Kamwanga		Olmoti		Longido	
Rukwa	Sumbawang a MC	Malagano		Katumba Azimio			Dr. Atman
	Kalambo DC	Madibila		Matai		Kalambo DH	
DSM	Temeke MC		Arafa Kilakala	Mbagala Roundtable			TOHS
	Ubungo MC		Istiqaaama		Hekima	Sinza	
Geita	Bukombe DC	Kagwe		Msonga		Bukombe DH	
	Geita TC		Kasamwa		Geita Gold Mine		Sakamu
Mtwara	Mtwara MC	Magereza		Likombe		Ligula	
	Masasi DC		Lupaso		St. Theresia		St. Benedicts
Dodoma	Dodoma CC	Kikuyu		Kikombo			St. Camillus
	Kondoa DC		Haubi Va		Passionist Itololo	Kondoa DH	
Njombe	Njombe TC	Nole		Muongano		Njombe Town DH	
	Makete DC		Ihanga		Magoye		Consolatha

2.7 Sample size

The saturation principle was applied to determine the sample size for the target audience (Saunders et al., 2018). Similarly, at the community level, the final sample size was determined by achieving saturation of views. All interviews targeted men and women, both young and adult, aged 18 to 60 years (the active population). A detailed description of the participants and the method used is provided below:

- **Health facility Site Checklists:** Conducted at 48 health facilities, central medical store and 3 zonal stores).
- **Exit Interviews:** Conducted with 228 clients (72 at dispensaries, 82 at health centers, 74 at hospitals).
- **Focus Group Discussions:** 46 discussions conducted (18 community beneficiaries, 8 Community Health Workers, 20 Local Government Authorities).
- **In-depth interview:** 77 interviews various stakeholders including (HSSP V developers (from MOH, non-government organizations and private consultants), HSSP V implementers (district and regional medical officers, health care providers, research institutes, implementation partners, development partners, religious representatives (Christians and Muslims).

A team of experienced research assistants was recruited from the IHI human resource database and deployed to conduct interviews at the specific study regions. Before the commencement of the data collection, the research assistants (N=22) were trained and oriented about the study objectives and methods and reminded about ethical considerations. All interviews were audio-recorded after consent. Each interview took about 1 hour. The interviews were conducted in places convenient to participants, where privacy and freedom of expression were guaranteed.

The interviews were mostly conducted in Kiswahili, then transcribed and translated into English. All tools were digitised for easy management and analysis. All qualitative interviews were audio-recorded based on the participant's consent. The research team shared the expanded notes with the thematic leads while in the field for consistency. At each site, daily debriefing sessions were held to share experiences and progress on data capturing and to see if any challenge requires mutual intervention. Transcription of qualitative data and coding was started at field site. To ensure robustness, representatives of the steering committee, MOH, PORALG, and the Joint review team also joined the field team during data collection.

2.8 Data analysis

Qualitative data analysis

All data were anonymized. Some were transcribed, while others were included in the expanded notes (reference) to facilitate rapid analysis. Thematic content analysis, aided by NVivo 14, MS Excel, or MS Word, was used to identify both inductive and deductive themes emerging from participants' narratives.

Core themes related to HSSP V policy implementation, achievements, and challenges were identified and categorized based on the topics outlined in the interview guides/tools.

The interpretation of findings involved multiple stakeholders to ensure accuracy and resolve any potential misinterpretations.

Quantitative data analysis

Descriptive data analysis was employed for quantitative data. Data triangulation from data sources stipulated for HSSP V indicator matrix was carried out to provide a broader reflection of key domains that relate to HSSP V implementation progress. A chi-squared test was used to explore association between key performance indicators and determinants of health such as residency, sex, and geographic location. Primary data sources for HSSP indicators are from Demographic Health Surveys (DHS), routine health information system (DHIS2), reports from the specific departments at MOH, and global or regional estimates from World Bank, WHO, UNICEF, UNFPA, UNAIDS and other international organization.

A data validation meeting convened in Morogoro. The meeting involved various stakeholders from the MOH, regional and district health professionals, non-governmental organizations and local private consultants. The meeting provided more insights into data interpretation, and any additional information which was required to complement the findings.

2.9 Review Limitations

Although a broad diversity of stakeholders was involved and a wealth of information gathered, the methodology was based on a snapshot review of observations and discussions and thus some limitations need to be recognized.

Some key informants were unavailable due to conflicting circumstances. While indicator data were available at the national level, such data were rarely accessible at the regional or primary health care (PHC) level, and therefore could not be analyzed. Data are often of poor quality in particular routine facility data making conclusions about outputs and outcomes questionable. The National Health Policy of 2007 was referred to for policy directions and the HSSP V for indicators and targets but updates on policy and new indicator reports could not be used as these were not yet formally published such as the new national health policy and the STEPS 2022 survey report of chronic disease risk factors at household level. Finally, there were logistical constraints hampering the completeness of this MTR such as funding delays, reduced time for training and field work and competing high priority events.

2.10 Ethical considerations

The MTR protocol was approved by the Ifakara's Ethics Review Committee (approval IHI/IRB/No: 04-2025). Written informed consent forms were secured before interviewing the respondents. Privacy of information collected, protection of respondents, and consent were ascertained before any interview.

3 RESULTS FROM THE TEN SUMMARIES OF THE THEMATIC AREA REPORTS (ACHIEVEMENTS, CHALLENGES AND RECOMMENDATIONS)

3.1 Public Health Policy and Planning

Achievements and Challenges

The priorities indicated in the HSSP-V were guided by multiple and relevant normative and non-normative policies. Building on these policies is one of the strengths of the HSSP-V strategy reflecting policy alignment and continuity of the wider national and international agenda.

Strengthening accountability and leadership in Tanzania's health sector has yielded notable progress in decentralization, community engagement, and governance. In Collaboration with Development Partners, MOH has developed the training materials for leadership performance management tools and continuous trainings are conducted at CEDHA, Arusha and PHC Training Centre, Iringa. However, delays in endorsing policies, limited leadership skills at numerous places, particularly at grass root level, poor disaggregation of data used for decision making, fragmented implementation of programmes and supply chain management constraints, require urgent attention. Competency development among health staff at all levels need to be a regular and ongoing integrated service.

The Public-Private Partnership (PPP) in Tanzania's health sector has progressed through strengthened policies, active dialogue, and service agreements with private and faith-based organizations (FBOs). Key achievements include enhanced diagnostic services via placement contracts, improved access through local pharmaceutical partnerships, and expanded healthcare coverage in underserved areas together with Service level Agreements with Zonal and Designated District Hospitals. A conducive PPP environment was enabled by setting PPP laws and Regulations, Guidelines and Standard Operating Procedures. Harmonization between the public and the private sector through quality management systems (QMS) Framework from MOH (Department Quality Assurance) was achieved. Registration, accreditation and certification have improved through the Registrar for Public Health Facilities.

Challenges persist in harmonizing and ensuring public-private quality standards, addressing dual employments, and ensuring regular medicine availability in rural areas. The PPP forum structure is in place in various regions but often not functioning optimally.

The implementation of Sector Wide Approach (SWAp) has made commendable progress at national level in fostering dialogue, strengthening accountability, and enhancing resource management.

Improving the functionality of the TWG

"... there are too many technical working groups that could be merged to improve efficiency and add value. There is a need to review the organization of the TWGs to see which ones can be merged and how the terms of reference can be reorganized so that all the members can be oriented to understand how they can contribute. The use of evidence to guide agenda and priority setting also needs to be improved" [DP]

Task force meetings, joint field visits and Joint Annual Health Sector Review (JAHSR) provide robust mechanisms for monitoring and decision-making, while basket funding and technical working groups enhance resource utilization. It has allowed dialogue between Development Partners (DPs), Government of Tanzania (GOT), Implementing Partners (IP), Private Sector and other key stakeholders for the implementation of the Health Sector Strategic Plan. The Development Cooperation Framework and the Common Management Arrangement remain active to stimulate implementation.

However, critical gaps remain in funding transparency, functionality, transparency and effective decentralization of SWAp mechanisms at regional and council level. Not all Development Partners contribute to the Health Basket Fund (HBF). Some contribute directly to implementing partners and through Multilateral Agencies such as Global Fund and GAVI making it very difficult for regional authorities and Councils to account directly for their contributions. Tracking resources off budget remain a challenge, it increases the chances for duplication of efforts and fragmentation thus reducing efficiency and effective utilization of resources.

Functionality of the ten TWGs at national level remains underutilized for many of them as meetings are infrequent, SWAp coordinators not formally participating, and leadership changes hampering coordination and consistency. Where TWGs are fully functional it is able to provide relevant strategic advice and technical expertise to facilitate effective strategic directions as per MOH policies and programs.

Governance of health facilities has been functioning more effectively. The Councils Health Service Boards (CHSB), Hospital Management Boards, and Health Facility Governing Committees each at their own level oversee managerial functions. Clear decision making within these structures is hereby made possible as was observed at some councils. However, the guidelines need to be reviewed and updated to align with the current health sector reforms. Functioning of the primary health committees at village and ward level remains however infrequent or non-functional. Their link with LGA's is ineffective despite a commitment in the HSSP V to strengthen it.

Community participation is well enacted and there is a clear representation through the health facility governing committee and at the councils. However, community representatives need to be empowered to actively participate, question planning decisions, provide recommendations, follow up and feedback on quality provision and accessibility of the health care services.

Social determinants of health (SDHs): The SDHs concept is currently integrated into non-health sector strategies through Health in All Policies (HiAP). Capacity strengthening is ongoing at the ministry level. Enactment of Universal Health Insurance Act in 2023 and Tanzania Social Action Fund (TASAF) programmatic support to poor households are vivid evidence that SDHs are being addressed. SDHs as an essential component of health development is taught at master's level at many universities.

However, awareness of the SDHs concept remains low at implementation levels such as Primary Health Care making it difficult to address the social determinants of health across all sectors and field of lives beyond diseases. No practical evidence could be found of long-term interventions to address economic and social determinants of health to improve health care access and well-being for the poorest at the grassroots.

This challenge can be addressed by streamlining the HiAP in strategic and implementation approaches with a focus on multisectoral actions relevant to the principles of PHC.

The HSSP V proposed to MOH to recognize the three municipalities in Dar es Salaam as a specific health zone like TRA and the Police Forces to allow additional HR resources and an integrated approach to address specific challenges in health care for the urban poor. Disease outcomes for this subpopulation is worse than in comparable other poor urban or rural areas (Levira et al.,2017; Mberu et al 2016), Despite the importance of this commitment from HSSP V, it is still not yet established.

Most critical, the health sector focus from HSSP V needs to be more inclusive of inclusion of access to safe water, to education, to electricity and to economic opportunities. This universal access to a multisectoral approach will allow the achievement of the goal of health and wellbeing for all.

Social protection: Substantial progress has been made with social and financial protection programs including the endorsement of universal health insurance for all. Improved Community health Fund (ICHF) remains active although at low level. With government subsidy and the support of other institutions such as TASAF the vulnerable and poor households have been supported to enrol into the schemes to enable them access health care. However, challenges remain: the Equity Trust Fund still needs to ensure long-term commitment of disbursing loans to enhance equity by paying the poor and vulnerable people. Multisectoral arrangement in the implementation of UHI is important to ensure that all sectors contribute to its implementation. No evidence was found that MOH and TASAF are sufficiently collaborating to ensure that the ongoing TASAF-social protection programs address key emerging social determinants for example in the area of mental health and as well in access to health care services of special groups such as adolescents (boys and girls) and persons with disabilities. Alignment between TASAF programs and MOH social protection initiatives at the health facilities still needs to be focused on.

Gender: The health sector has made significant investment in mainstreaming gender responsive measures. Gender based violence indicators are now included in routine health facility reporting (DHIS2) which shows progress towards measuring gender-based violence against women and children. Gender is included in the National Five-Year Development Plan (2021-2026). However, physical and emotional violence against women and children remains very prevalent. Although HSSP V commits to enhance gender awareness in the pre-graduate training and gender equality in decision making bodies, these aspects have not been adequately achieved. No evidence at the PHC level of using these indicators and thus promoting gender awareness could be seen. Mainstreaming of gender equality programmes into other sections and other sectors than reproductive health is not sufficiently concrete. The quality indicators for health of women and of men need to be focused on and measured and not the number of men and women in gender-responsive programs.

Despite women's economic contribution to Tanzania's sustained economic growth, their ability to access, inherit, control land and financial resources remains limited. Furthermore, their capacity to engage in the labor market, and generate revenue is limited.

As these are partly entrenched into inherent social norms and cultural values, these need nevertheless been challenged through education. Gender inequality at various levels of the health care system remains striking as staff ratios in our health system are still wide.

For example, there are 21 male and only 5 female RMOs. At MOH there are 538 male and 413 female staff. These indicators need to be reflected in the next HSSP at all levels. The National Gender Policy and Strategic Plan still need to be transformed in concrete action plans ready for implementation. More quality gender equity and equality indicators are needed in the routine data systems beyond just 'gender-based violence'.

Health Equity: Physical access to health care has increased substantially in diverse geographical areas including specialized care. Currently there is a district hospital at every district. Provision of specialized care is provided in remote parts of the country and at the primary health care facilities. However, stakeholders recommended that the physical expansion of health facilities need to be accompanied with the provision of quality health care specifically the availability of human resource and medical equipment at the primary health care in both rural and high-density urban areas. Comprehensive equity indicators need to be included in the HSSPs and in routine data system. Most importantly, the health needs of adolescents both girls and boys, the elderly as a rapid growing subpopulation, adult men to access early health facilities and people with disabilities need strategic attention and action.

Awareness of the HSSP-V strategy: There is limited awareness or involvement among stakeholders of the HSSP V in particular those at the primary health facility and community levels because a summary document was never distributed nor did they get any orientation training. In fact, several lower-level health care providers confuse HSSP V with other council or disease specific plans.

Utilization of the HSSP-V strategy: Utilization of the strategy is limited at all levels. There were very few organizations in the health sector that referenced the HSSP-V in their documentations. We found only a limited number of academic papers and policies that cited HSSP V relevant to governance, financing, or policies.

Three policy documents were found to be based on the HSSP V milestones: WHO document addressing Social Determinants of Health; MOH One Plan III for RMNCAH-N and the policy on National Climate Change.

Only ten programs/projects were initiated based on the HSSP V strategic guidance among these the costing document of HSSP V and the direct financing document. This review could not find any other published programs or projects which were initiated based on HSSP V.

Recommendations

- I. The Directorate of Policy and Planning of MOH to develop a robust, evidence-based methodology for problem analysis of health outcomes and prioritization of interventions to inform the formulation of HSSP VI. The problem analysis and prioritization process for the HSSP VI would benefit from a stronger integration of locally generated evidence, greater disaggregation of data, and more actionable strategies to tackle systemic inequities. As the design of HSSP V did not have a clear and articulated Theory of Change (TOC) it is proposed that TOC for HSSP VI looks at the health system in a holistic and participatory way from inputs to impact, identifying each step in its process that needs strengthening to achieve a functional, sustained and user-provider owned health care system. (See Thematic Area Public Health Policy and Planning report on line).

The selection of indicators for each step will allow measurements of the utilization and effective coverage. In this way the Theory of Change will serve as a feasible and actionable roadmap for achieving its strategic goals and will allow addressing all persistent and emerging health challenges. The Monitoring and Evaluation Division to update on quarterly basis indicators selected per technical working group on the Tanzania Health Portal to inform the discussions on the progress in implementing policy commitments.

2. The M&E division to establish a robust monitoring framework with gender- and equity-disaggregated indicators to track progress in addressing health inequities. and establish digital feedback channels for underserved populations.
3. PORALG to institutionalize quarterly joint stakeholders' coordination and monitoring meetings at District and Regional level with the participation of SWAp members from those levels, with clear mandates and resource allocation. Decentralization of SWAP need to be at the primary health level because all the stakeholders should be there
4. MOH together with the Chair of the Development Partners Group Health to convene biannual high-level comprehensive donor meetings to align off-budget funding with national health priorities. It is strongly recommended that the alignment of all financial resources follows the Government System according to the Discounted Cash Flow principles. In collaboration with the Ministry of Finance (MOF), to expand resource tracking studies to capture off-budget funding comprehensively and publish updates on funding sources and allocations on the Tanzania Health Portal before yearly Join Annual Health Sector Reviews.
5. The Office of the Permanent Secretary to instruct adoption of online platforms for hybrid TWG meetings to reduce costs and improve participation. Coordination of the TWGs by MOH need improvement to ensure timely execution of the agreed agenda, use of evidence to guide deliberations and priorities, active follow up of the agreed agenda and feedback. Frequent change of leadership slows down the implementation of commitments. Fulltime SWAP coordinators are required to enhance efficiency. The development partners need to be actively engaged in the TWGs to receive specific feedback on the utilization of basket funds and progress of various programs. More collaboration is needed with the donors to ensure effective partnership. MOH representatives in SWAP need to provide regular feedback on how service delivery and access to quality health services can be improved at the grass root level. By addressing these challenges, the health sector can further reduce duplication of efforts, optimize resources, and achieve the goals of HSSP V in a sustainable and inclusive non-fragmented manner.
6. The Office of Chief Medical Officer to finalize and disseminate the Primary Health Services Implementation Development Strategy (PHSIDS) and revised Primary Health Care Committee (PHCC) guidelines to implementers and communities.
7. MOH to promote training and implementation on equal opportunities for each gender and for each age group reflecting the specific needs of adolescents and the elderly as well specific needs of the disabled persons to planning and implementing staff at all but particularly at PHC level across all sectors.
8. MOH to commission with technical support of WHO and UNICEF, a study on urban health inequities and tailored interventions addressing key vulnerabilities.
9. The ICT Unit to develop and operationalize an electronic platform for accessing policy plans, strategic documents, and guidelines to improve coordination and accountability. With support from development partners, to design a comprehensive digital transformation program for primary health care facilities to enhance data collection and use.
10. PORALG and local councils to expand community representation in Health Facility Governing Committees (HFGCs).

11. Ministry of Health and PORALG, with technical assistance of WHO and MUHAS, to design a curriculum for targeted training for Health services managers and clinical leaders in leadership, financial oversight, evidence-based decision-making, designing and implementing quality of care initiatives.
12. Ministry of Health and the Prime Minister’s Office to expedite the endorsement and implementation of the National Health in All Policies (HiAP) Framework by June 2025 to institutionalize multisectoral collaboration on social determinants of health.

3.2 Sexual, Reproductive, Maternal, Neonatal, Child and Adolescents Health

Achievements and Challenges

Findings are presented from a statistical analysis of progress and performance in Reproductive, Maternal, Newborn, Child, and Adolescent Health and Nutrition (RMNCAH-N) indicators during the 2019-2023 period as part of the review the performance of the current Health Sector Strategic Plan V (HSSP V) (2021-2026) and as well the One Plan III (2021/2022-2025/2026) which are currently halfway of their implementation. The findings at a national and subnational level are based on an extensive analysis of health facility data from the DHIS2 database (from January 2019 to December 2023), Vaccine Information Management System (VIMS) (from January 2019 to December 2023), national surveys and administrative data. National survey data on levels and trends on several health indicators were obtained from the Tanzania Demographic and Health Survey (MOH, 2022). Additionally, we include quotes obtained from qualitative interviews among key RMNCAH+N implementing partners and stakeholders.

Overall, Tanzania has made progress towards achieving RMNCAH-N impact indicators during its first implementation of the HSSP V and One Plan III.

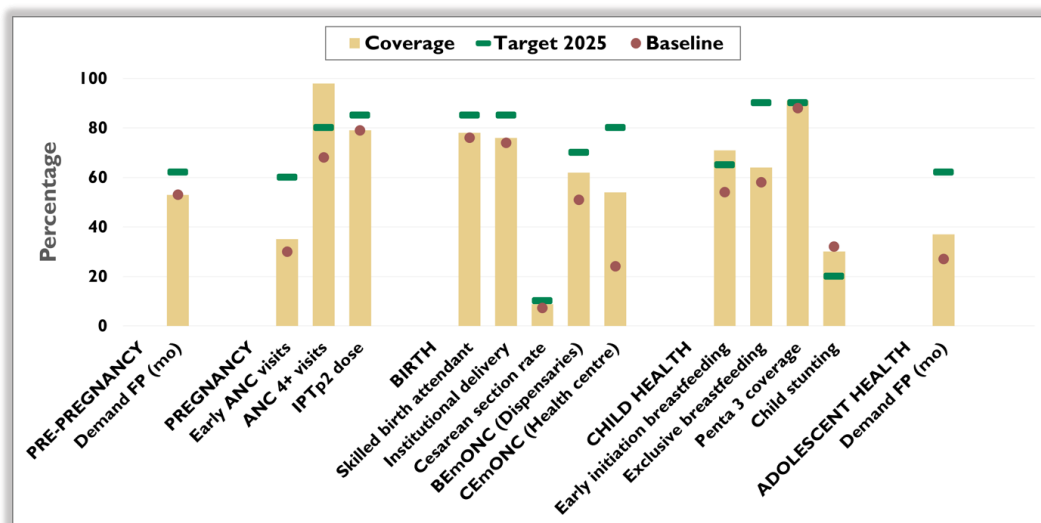
Institutional Maternal mortality that occurs in health facilities declined from 94 in 2018 to 65 per 100,000 live births in 2023, averaging 78 over six years, from MPDSR data. Regional referral hospitals accounted for one-third of deaths, followed by district hospitals (29%) and health centers (20%). However, the integration of maternal deaths reporting systems between DHIS2 and MPDSR could be an important step further to better track the progress of institutional maternal mortality. Over nearly two decades, neonatal mortality only declined by 25% (from 32 to 24 deaths per 1,000 live births) between the 2004/05 and 2022 TDHS surveys, compared to larger declines in under-five (62%) and infant (51%) mortality.

As one official said:

“Quality of care. You know that many newborns die within 7 days of birth, meaning the care of the baby while it is in its mother's womb before birth (...) that is, we were concentrating too much on the mother but not the baby (...) but also the care of newborns after birth is not good. So, if they would look at the quality of care, it would be very good.” – MOH representative

Majority of indicators along the RMNCAH continuum are on the right track in reaching the HSSP V targets, however attention is needed in some indicators such as early ANC visits, unmet needs for FP, demand for family planning satisfied by modern methods among currently married women of reproductive age and adolescents and child stunting.

Figure 4: Progress towards RMNCAH-N coverage indicators in the continuum of care.



Data sources: DHIS2 (2019-2023), TDHS (2015/16, 2022), SARA (2020, 2023)

Despite the high coverage of interventions, geographical and wealth inequalities remain as one of the challenges. High institutional maternal mortality ratio and child mortality rates are still observed in Dar es salaam and other urban areas. Coverage of majority of interventions are still lagging behind for the poorest and while regional coverage has improved, coverage at a council level is still important.

Also, despite the availability of RMNCAH-N services, readiness to provide services is still an issue, particularly staff readiness is still below 50% across all RMNCAH-N services.

Further progress in RMNCAH-N indicators is possible when inequalities are addressed, integration of services is considered and the Ministry of Health's efforts extends beyond infrastructures including staff training and motivation.

Recommendations

1. Prioritize Adolescent Health in High-Need Regions: The Ministry of Health should prioritize resource allocation and targeted interventions for adolescent health in regions with higher rates of teenage pregnancy such as Songwe Region, by implementing targeted training programs for family planning and adolescent health services at dispensaries and health centers.
2. Regional Health Management Teams (RHMTs) to develop and implement coverage extension plans focusing on integrating family planning and adolescent health services.
3. Ministry of health and Developing partners to allocate additional equipment and infrastructures based on coverage extension plans Strengthen health system inputs in lagging regions by prioritizing infrastructure development and resource allocation.
4. Directorate of Human Resources for Health Ministry of Health to design and implement a comprehensive program for training and motivating healthcare workers, prioritizing lower-level healthcare facilities.
5. Strengthen Multi-Sectoral Collaboration for Adolescent Health: The Ministry of Health should establish formal partnerships with the Ministry of Education, Ministry of community development, and relevant stake holders, i.e., Joint TWGs meetings to address multisectoral factors affecting adolescent health.
6. RMNCAH unit to develop and implement an integrated maternal death reporting system to ensure comprehensive tracking in health facilities and beyond labor wards.

7. DPP to commission a mapping of health interventions for disadvantaged populations in urban and rural areas and a study on equity in access to health services in urban settings situational analysis of maternal and newborn health in Dar es Salaam to identify targeted interventions.
8. The Ministry of Health (MOH) should intensify efforts to strengthen domestic resource mobilization to ensure sustainable funding for Reproductive, Maternal, New born, Child, and Adolescent Health (RMNCAH) programs, with a particular focus on lifesaving reproductive health (RH) commodities reducing dependency on external funding.

3.3 Communicable and Non-Communicable Diseases control

3.3.1 Infectious Diseases (Communicable Diseases)

Achievements and Challenges

The review of progress on infectious disease focused on HIV/AIDS, Tuberculosis, Malaria and Neglected Tropical Diseases (NTD). The health sector has made an appreciable progress in achieving the targets set for HIV/AIDS indicators. The HIV incidence rate has decreased to 0.17 (THIS 2022/2023) from 0.29 (THIS 2016/2017). This is a reduction of 41.3% of incidence rate (the target is 50% reduction by 2026). The Newborns with HIV infection remains high at 6.9% (AHSP 2023), while the National AIDS, STIs and Hepatitis Control Programme (NASHCoP) strategy mid-term review of 2022 reported 8.1%. This is way far behind the target of 3%. The progress towards achieving the 95-95-95 targets has been achieved on the 2nd and 3rd 95s, challenges remain with the first 95. The percentage of adults and children with HIV known to be on treatment 12 (24; 60) months after initiation of ART is high, currently at 96%.

Malaria parasite prevalence among children 6-59 months has increased from 7.5% (TMIS 2017) to 8.1% (MOH-TDHS-MIS, 2022). A 0.6% increase in the prevalence of malaria parasite among children aged 6-59 months is a wakeup call to review the preventive strategies for malaria. Regions such as Tabora (23%), Mtwara (20%), Kagera (18%), Mara (13%), Kigoma (13%), Geita (13%), Lindi (11%) and Simiyu (11%) where higher prevalence were recorded requires special attention to reverse the trend. There is an increase in the utilization of ITN, however more efforts are needed to further increase the utilization of ITN. Reports show 64% in 5-year-old children and 65% among pregnant women (MOH-TDHS-MIS, 2022) use ITN, this has improved from 56% (TMIS2017) and 51% (TMIS 2017) respectively.

Two measure indicators for tuberculosis were evaluated, these are; TB incidence per 100,000 population and TB treatment coverage (with success). Overall, there is a big progress towards achieving the targets set for these indicators.

The health sector has made remarkable progress is addressing lymphatic filariasis (LF) and trachoma. In 2021, there were 110 Councils which had eliminated LF, but as of June 2024 a total of 114 Councils reached elimination of LF. This is a great progress towards achieving elimination of LF in 119 Councils by 2026. On trachoma, the target is to have 84 Councils eliminated worm infections with Trachomatous Trichiasis. A review has revealed that as of June 2024 54 Councils has eliminated Trachomatous Trichiasis, which is an increase from 38 Councils.

Challenges remain with the control and elimination of schistosomiasis, as no progress has been made as number of endemic councils remains 184. The biggest challenges observed during the review is that Neglected Tropical Diseases (NTD) have no indicators in the HSSP V to guide proper monitoring and evaluation of performance.

Recommendations

1. Prioritize improvement of the uptake of HIV Testing Services to improve the performance on the 1st 95 target set by UNAIDS.
2. Add an indicator on the detection of latent TB as it remains to be one of the threats to the progress made in the detection and treatment of TB.
3. Additionally, an indicator on TB and other chronic diseases co-morbidity is needed to be able assess how integrated service delivery can help to leverage resources at the same time yielding better outcomes.
4. An indicator on the vector control (Entomological interventions) strategies should be added in strategy to expand the focus areas for appraisal on the prevention of malaria.
5. NTD indicators for (Impact and Coverage need to be included in the control strategy for these diseases to get a deserved attention.
6. NTDs should be integrated in the routine healthcare reporting so that routine data on the burden and service delivery for NDT can be accessed through HMIS.

3.3.2 Non-Communicable Diseases (NCD)

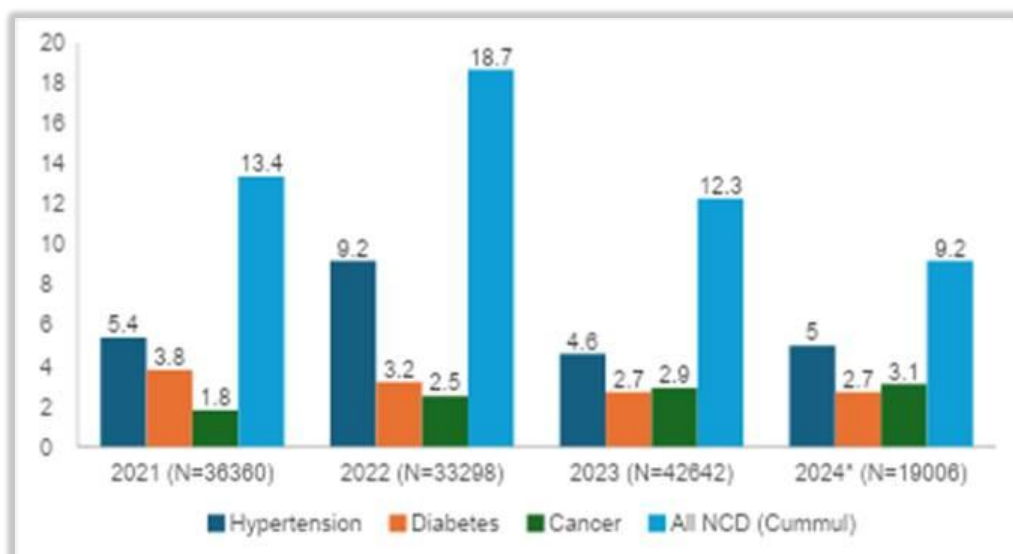
Achievements and Challenges

Non-Communicable Diseases are a group of diseases most of which are chronic and need massive resources to treat or manage. Most NCD are preventable through different strategies such as behavioural change, nutritional interventions, active or change of lifestyle and health education etc.

A review of HSSP V priorities on NCD has revealed a long list of priorities most of which will not achieve notable progress by 2026. Most priorities lack indicators, thus making it difficult to assess progress. Going forward, it is recommended that priorities for NCD should be unpacked to focus on a specific NCD e.g., Hypertension, Diabetes Mellitus etc. as the burden, dynamics and some determinants of NCD are diverse. The drivers of NCD are multisectoral, thus requiring a multisectoral approach in addressing these diseases. This review revealed the several gaps on policies for NCD. Some of these include; Most policies were developed at the time NCD was not viewed as a public health concern, hence not considered as a multisectoral problem; there is a low awareness on the burden of NCD and their implications on social economic development agenda, the implementation of the SWAp strategy seems to be biased on HIV and Nutrition, and there is a limited horizontal operation of the multisectoral coordination desks at the PMO, which affects the implementation of SWAp particularly on NCD.

Mortality due to NCD remain above 10% which is higher above the HSSP V target. The leading cause of mortality among NCD is hypertension. This requires a special attention from prevention, curative and research perspectives.

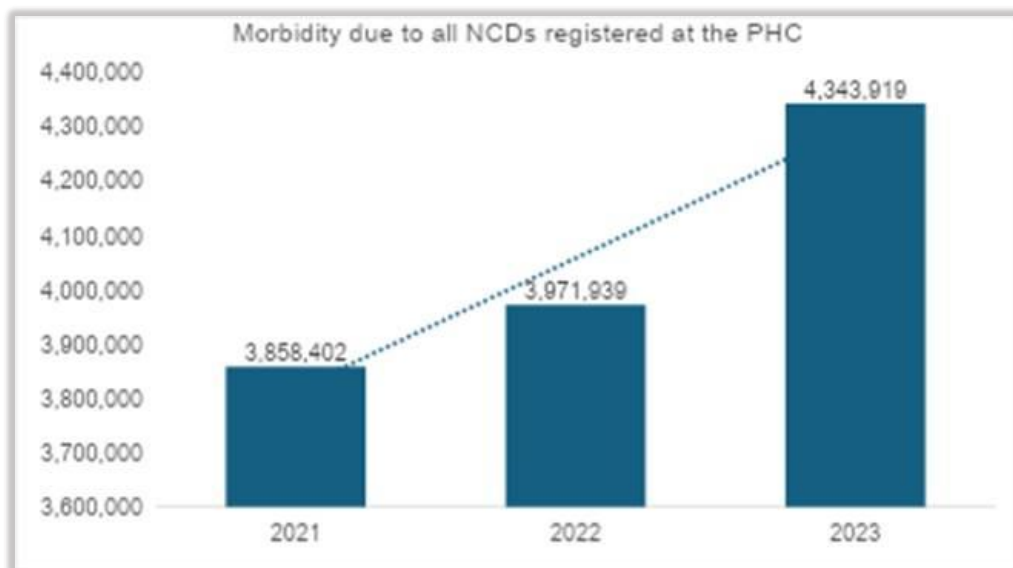
Figure 5: Annual mortality due to NCD as recorded from the PHC



Source: DHIS2

The morbidity due to NCD has revealed an annual incremental trend. The OPD data from PHC show that from 2021 the number of patients seeking care and treatment services increased from 3,858,402 to 4,343,919 in 2023.

Figure 6: Trend according to the type of NCD



Source: DHIS2

Hypertension continues to be the leading cause of morbidity among all NCD. The provision of healthcare services for mental health has improved over the past three years. The PHC facilities have begun to provide services for mental health.

Recommendations

1. A key area of focus is health financing where research should be prioritized for feasible financing mechanisms for NCD in Tanzania.
2. Research focusing on capacity strengthening for delivery of quality services for NCD is highly needed especially as the decentralization of services continues. Furthermore, implementation research on preventive strategies for NCD should be promoted to generate evidence on how best the interventions should be implemented to slow down a growing burden of NCD.
3. Sustenance of the introduction of Mental Health at PHC level and further improvements are recommended to ensure patients have an increased access to the mental health services. Furthermore, regular capacity strengthening for PHC should be deliberately supported to ensure quality of service delivery for mental health.

3.4 Community Engagement

Achievements and Challenges

HSSP V emphasizes the critical role of communities in improving health outcomes by prioritizing community engagement in health promotion, disease prevention, and service delivery through Community Health Workers (CHW) and local health committees.

A significant gap in the implementation of community engagement strategies is the shortfall in CHW training, with first-year enrollments falling to less than half of the projected target.

This raises concerns about meeting the long-term goal of training 109,971 CHWs by 2026/2027, which may affect the program's scalability and overall effectiveness.

Integrating CHWs will mean strong local community involvement, inclusive governance, evidence-based approaches, and the use of digital information and connectivity platforms like Unified Community System (UCS). However, while progress has been made with the launch and guidelines of the Integrated and Coordinated CHW Programme in January 2024, there are significant challenges in achieving the set targets. It was observed that existing CHWs are mainly supported by implementing partners emphasizing single disease or health issue community activities such as HIV/AIDS, nutrition, WASH or MCH.

Health literacy and awareness efforts have led to improvements in sanitation and hygiene practices, and various initiatives are contributing to behavior change at the community level.

However, this review highlights a significant gap in behavioral risk factors knowledge exacerbated by low awareness of critical health issues. Many communities lack a comprehensive understanding of the connection between behavior and health outcomes, resulting in persistent misconceptions as narrated below:

“Some seasons are not good and not necessarily that people are not practicing healthy behaviors, it is just a passing wind “upepo umepita” coming with diseases like cholera and diarrhea.” - FGD women, Mtwara

This gap highlights the need for health promotion that tackles social determinants like education, living conditions, and access to water and sanitation.

Greater collaboration between the health and education sectors through further integration of health topics into educational curricula, is needed to build on these successes and ensure long-term improvements in community health outcomes.

The roll out of the new Community Health Program as well as the Universal Health Insurance implementation is a great opportunity for promoting self-employment for community staff as well as newly trained health professionals such as midwives, clinical officers, and doctors who have recently join the health labor market.

Progress on community engagement

Several strategies to enhance community engagement and empowerment have been developed and are being implemented to strengthen health systems at the grassroots level. However, community members still perceive health as primarily the government's responsibility, which diminishes their active participation in behavior change initiatives.

As narrated by a CHW from Njombe:

"Limited interaction between community leaders and the people makes things worse. Health issues are often just touched on briefly during street or village meetings or in the occasional outreach programs. On the other hand, people believe that the government should do everything for them, hindering their active participation in health-related initiatives."

Key initiatives to overcome these include the active involvement of CHWs, the enhancement of local government committee roles, and the promotion of multi-sectorial collaboration to address social determinants of health. The implementation of the 2021 National Operational Guideline for Community-Based Health Services has begun, providing a framework for community-focused interventions. The introduction of the Revised Primary Health Care Committee Guideline in 2022 further supports these efforts by strengthening local governance structures to enhance community participation.

In January 2024, Tanzania launched the Implementation Guideline for the Integrated and Coordinated Community Health Workers Program, marking a significant milestone in formalizing and integrating CHW roles. To support CHW implementation, MOH developed a revised National Operational Guideline for Community Based Health Program in 2024.

In addition, the National Community Engagement Guideline for Primary Health, initiated in 2024 and nearing completion, aims to standardize community engagement in Tanzania by establishing context-specific methods, utilizing government structures, improving coordination among stakeholders, and enhancing capacity for effective health intervention.

In line with HSSP V's focus on enhancing community awareness and health literacy, Tanzania launched two "Mtu ni Afya" awareness campaigns in 2023 and 2024, emphasizing prevention, community engagement, and environmental hygiene with the theme "My Health, My Responsibility." In response to the Marburg outbreak and monkey pox (Mpox) threat, Tanzania developed and implemented a Contingency Plan for Monkeypox Disease in 2024. This plan prioritized Risk Communication and Community Engagement (RCCE), involving CHWs and local leaders to raise awareness, educate the public, and strengthen community preparedness against the disease. These RCCE efforts while improving public understanding of the virus and ensuring a coordinated response at the community level, also contributed to the improving water, sanitation and hygiene indicators.

While progress has been made in community engagement strategies, resource constraints and community misconceptions continue to limit the effectiveness of these efforts. Additionally, HSSP V lacks specific indicators to monitor community engagement's impact on health outcomes. This may be partially attributed to the limited involvement of local government representatives in the strategic decision-making process during HSSP V development.

Integration and impact

The Implementation Guideline for the Integrated Community Health Workers Program, introduced in January 2024, initially set a target to train 28,000 CHWs across 10 priority regions during the 2023/2024 period. In September 2024, the training began with the inclusion of an additional region, but only 11,515 CHWs were enrolled, resulting in a shortfall of 16,485 trainees. In each of the 11 regions, two districts have been selected to train two CHWs (one male and one female) from each hamlet/Mtaa.

In addition, at the village/Mtaa level, there is a CHW Peer Leader who is the welfare focal person for the fellow CHWs. Aligned with HSSP V priorities, the training program emphasizes a comprehensive package of community-based health care, social welfare, and nutrition services delivered through ten structured modules.

MTR Community Engagement

- Key Findings**
 - Steady progress in **implementation of various guidelines**
 - 4,048 CHWs trained** across 11 regions, enhancing community health services. However, this falls short of the target by **16,485** for 2023/2024
 - Major **gaps in funding** and resources hinder achievement of CHW training targets
 - Improvements** in specific targets for **education and environmental health** in 2023 contributed by several awareness campaigns to promote health literacy, environmental hygiene, and disease prevention i.e.
 - Mtu ni **Afya** awareness campaign in 2023 and 2024 focus on improving sanitation and environmental hygiene
 - Implementation of the **Risk Communication and Community Engagement (RCCE)** activities during the **Marburg outbreak (2023)** and **Mpox threat Response (2024)**
- Key Challenges**
 - Financial constraints** hinder the achievement of the target to **train 28,000 CHWs** for the 2023/2024 period.
 - Inadequate Capacity Building for Health Facility Governing Committees (HFGCs)** weakens community engagement theme
 - Lack of specific and measurable indicators for community engagement** in the Health Sector Strategic Plan V (HSSP V) i.e. functionality of HFGCs, CHW services, partly contributed by minimal involvement of LGAs in HSSPV development workshops
 - Limited budget for health promotion activities** to enhance community awareness of Social Determinants of Health
 - Misalignment** between the Integrated and coordinated **CHW program** and the National Unified Community System (**UCS**)
- Strategic Recommendations**
 - Strengthen financial support for the sustainability of CHW programs
 - Strengthen the capacity of HFGCs
 - Streamline alignment between IPs and district health teams on CHW payment through DHFF
 - Increase Community Engagement Indicators in HSSP V M&E framework
 - Increase funding for community health promotion on social determinants of health
 - Aligning CHW program with UCS

To strengthen community monitoring systems and enhance continuity of care as outlined in HSSP V, Tanzania introduced the Unified Community System (UCS) in 2023. UCS is a digital information platform designed to integrate community-based health services, supporting health promotion, early screening, and efficient referral processes to health facilities. It facilitates real-time monitoring of health interventions and indicators, enhancing efficiency, accountability, and the overall effectiveness of community health systems. UCS is currently utilized in all 26 regions in Tanzania and provides a platform of various community level indicator visibility.

To date, the Unified Community System (UCS) has facilitated over 10,000 referrals from community health actors including Community Pharmaceutical Premises (CPP) to health facilities. As envisioned in HSSP V, UCS exemplifies a successful public-private partnership (PPP) at the primary health care level, by integrating private sector support to enhance service provision.

Strengthening Local Government Structures to Ensure Community Accountability in Health Programs

HSSP V commits to strengthening community governance and enhancing the capacity of committees to promote community participation in health decision-making. Building on the 2022 Revised Primary Health Care Committee Guideline, which highlights the roles of Ward and Village PHC Committees in inclusive health governance, development of materials for training of trainers is underway necessary to capacitate PHC on their roles. Furthermore, the 2023 AHSP report and HSSP V data collection findings underscores that decentralizing management responsibilities to health facilities and communities has significantly improved community engagement in health sector planning, budgeting, and service delivery. Key challenges include the limited recognition of CHWs within local government committees, which restricts their involvement in critical decision-making processes.

"Sometimes, we need a platform to raise our concerns about health services, but there is no clear guidance on where to direct them. While we may discuss issues with village officers, little action is taken. Village meetings are rare, and when they do occur, health matters are often discussed only briefly and with minimal focus" - FGD, adult men, Dodoma

Furthermore, the capacity of local government structures, such as Health Facility Governing Committees (HFGCs) and village councils, remains insufficient for effectively executing their mandated responsibilities, undermining the overall governance and accountability in health service delivery as exemplified in the following:

"That's exactly the situation I find myself in; how can I prioritize issues when I am unaware of the government's strategies for this year or even for the next five years? If I, as a local government authority, am not informed about HSSP V, how can I effectively communicate this to my community? As someone responsible for implementation, I should be fully informed, even about whether the chairperson has received a letter and shared it with the public" - FGD village council

The new integrated and coordinated CHW and PHC Committee guidelines, currently being implemented, have elevated the role of CHWs by formally recognizing them as key members of PHC committees, reporting to village Government and working closely with social welfare office.

Recommendations

1. National Community Health Task Force to jointly develop and implement a National CHW Recruitment and Training Acceleration Plan with involvement of the Ministry of Education, to meet training and deployment targets to address the shortfall in CHW training. Additionally, the prioritization and mobilization of resources to support for CHW training plans, ensuring comprehensive coverage and alignment with the objectives set forth in HSSP V.
2. Directorate of Policy and Planning and PO-RALG to update the Direct Health Facility Financing (DHFF) Implementation Framework to ensure alignment with CHW payment processes. Additionally, orientation of HFGCs on their roles in finance, leadership and overall governance is recommended.
3. Directorate of Policy and Planning to revise the HSSP Monitoring Framework to include community engagement indicators and CHW performance metrics.
4. Ensure adequate capacity building for Health Facility Governing Committees (HFGCs) regarding their roles and responsibilities.

5. Directorate of Preventive Services should prioritize increasing funding for health promotion initiatives and addressing social determinants of health. These measures are essential to combating misconceptions within communities and fostering improved health outcomes.
6. During the implementation of the Integrated and Coordinated CHW Program, alignment with the Unified Community System (UCS) should be prioritized. The Directorate of Preventive Services and the Directorate of ICT must collaborate to enhance the efficiency and effectiveness of integrated reporting and two-directional referral systems through training, support and supervision. This alignment will optimize resource utilization, improve coordination, and strengthen the delivery of health interventions at the community level in order to improve access for all.
7. Include process indicators in the next HSSP, such as monitoring the functionality of HFGCs, service provided by CHWs, gender inclusion, and the use of community scorecards, which are necessary to effectively track and evaluate community engagement efforts.
8. Directorate of Preventive services to develop in collaboration with the PO-RALG, the Ministry of Education and the Ministry of Community Development, a School Health Collaboration Plan to integrate health education topics into school curricula. Include topics on sanitation, nutrition, child safety, health screening, and vaccinations in school curricula, and organize visits to conduct health screenings and awareness sessions in schools.

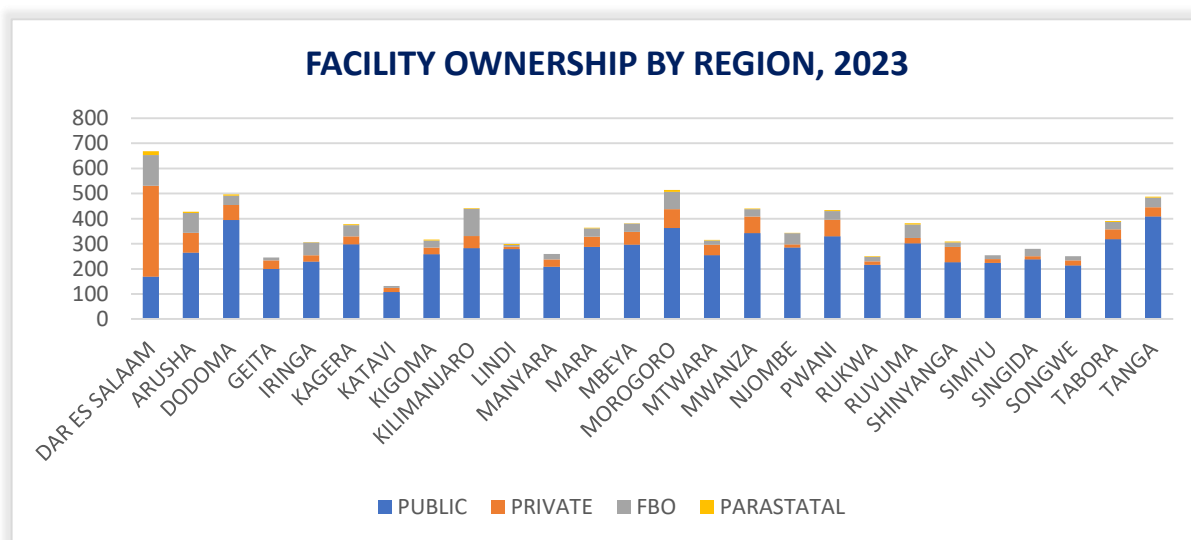
3.5 Service Delivery

Achievements and Challenges

Over the HSSP V implementation period, the number of health facilities in Tanzania has increased from 8,458 to 9,366. The majority of the health facilities (75%) are owned by the government. Disaggregating by service levels, nationwide, the government owns 90% of dispensaries and health centers, whereas the private sector owns almost half of the hospitals in the country. In Dar es Salaam, the region that was highlighted in the HSSP V to require specific considerations to improve the health status of the citizens, 25% of the facilities are of public ownership.

Katavi region has the lowest crude number of health facilities despite having the highest annual population growth rate, whereas Geita Region has the lowest health facility density of 0.8 facilities per 1,000 population, falling furthest behind in the national target of 2.5. Health facility ownership is shown in the figure below. Dar es Salaam has the highest population density of above 3,000 people per square kilometer.

Table 4: Facility ownership by region



Adapted from MOH, 2024 Tanzania Health Facility Atlas 2023, Dodoma, Tanzania

Out Patient Department (OPD) utilization reflects how services are accessible and acceptable by the intended surrounding communities, especially for primary health care, which serves as an entry point to medical care for majority of the population. Tanzania has set a target of 1.2 OPD utilization per person per year by 2025. However, the trend is rather staggering, and the country is at risk of not achieving the set target. OPD utilization per person per year was 0.85 in 2020, the figure that has stagnated at 0.67, 0.7, and 0.78 for 2021, 2020, and 2023 respectively. On the other hand, Tanzania has set an optimal target of 4.2 hospital admission rate per 100 population to be achieved by 2025. Similar to OPD utilization, the hospital admission rate nationwide is staggering at the rate of 2.68, 2.74 and 2.78 for 2021, 2022 and 2023 respectively.

The government also aimed at improving super-specialised services and medical tourism in the country so as to reduce referral of patients to abroad and to attract foreigners seeking medical care in Tanzania. The number of foreigners coming to Tanzania to seek for medical treatment has increased from 6472 in the financial year 2022/2023 to 9462 in 2023/24. Leading health facilities in providing services to clients from foreign countries are MNH, JKCI, MOI, Aga Khan, Saifee and Ocean Road Cancer Institute.

Majority of the clients come from neighbouring countries including Malawi, Comoro, Zambia, Burundi and Congo- DRC. The government continues to strengthen infrastructure, resources and capacity for transplant services in the country, including renal and bone marrow transplant.

Over the HSSP V implementation period, the government aimed at strengthening service integration so as to improve efficiency and effectiveness of the health system in the country.

However, the MTR data collection found out that the understanding of healthcare workers at facility levels on the meaning and essence of integration is still limited, necessitating awareness and knowledge building initiatives. Referral of patients across the care cascade in the country continues to improve, however, there is a challenge of uni-directional flow of information with limited feedback modalities, lack of a functional and integrated electronic referral system and limited interaction between facilities.

Lower facilities reported not receiving feedback from higher facilities, so opportunities to learn and improve care were hampered.

Quality of services

Quality of health services is a cornerstone of an effective and efficient healthcare system. It enables maximization of the benefits of the investments made to improve availability and access to health services, ultimately contributing to healthier population.

The country's target is at 85% of primary health care facilities to have at least three stars on star rating assessment by 2025. Annual targets set aimed to achieve at least, 40% and 50% of the primary healthcare facilities to have achieved 3 stars by the end of 2022 and 2023 respectively. Contrary to the set targets, the current trend is still far behind, where only 14% of the facilities assessed in 2022 had attained at least three stars, a slight decline from 18% in 2017/18. The latest Star rating assessment was done in only ten regions, which were Kilimanjaro, Mtwara, Shinyanga, Singida, Songwe, Kigoma, Katavi, Mara, Njombe and Rukwa. Of 2587 facilities visited, 111 (4.3%) scored zero star, 920 (35.6%) scored 1 star, 1197 (46.3%) scored 2 stars and only 359 (14%) scored 3 stars. None of the visited facilities scored 5 stars, and only 21 (0.8%) scored four stars.

Laboratory diagnosis

The government committed to supply effective and modern diagnostics supplies to the health facilities based on their levels and standard of operation.

There is significant progress on the availability and distribution of the diagnostics machines and services over the HSSP V implementation period. The number of ISO accredited laboratories has improved from 40 in 2021 to 65 laboratories in 2023. 13 laboratories were accredited in 2023 alone. Until 2023, a total of 740 hematology-, 773 chemistry- and 754 urine analyzers have been installed at different facility levels in the country.

Furthermore, the country has a total of 1419 stand-alone diagnostic facilities, which include 16 diagnostic centers, 1360 level IA2 (Dispensary Laboratory), 14 operating Level IA1 (Health Centre Laboratory), 15 Level IIA2 (District Laboratory), 3 Level III Multipurpose Health Laboratory, 8 Level III Single Purpose Health Laboratory and 3 optical laboratories. The three level III multipurpose health laboratories are located in Dar es Salaam, Mwanza and Tabora, whereas the eight level III single purpose health laboratories are located in Dar es Salaam (1), Dodoma (1), Katavi (1), Mbeya (1) and Mwanza (4). Overall, 1412 (99.5%) of the stand-alone diagnostic facilities are of private ownership.

Challenges

Health service delivery

- Consistently low health facility density in the Geita region.
- High population density coupled with low proportion of public health facilities in Dar es Salaam pose accessibility and affordability challenge.
- Inadequate understanding of health care providers on health service integration.
- Unidirectional flow of information in patient referrals.
- Inadequate utilization of digital platforms for patient referral and cross-facility communication.
- Lack of routine assessment of quality of health services in all the regions.
- Out of pocket expenditure for health delays patients from seeking care, especially when offered cold-referral to higher facilities.
- Lack of documented legal guidance pertaining to blood donation, organ donation and organ transplant.

Recommendations

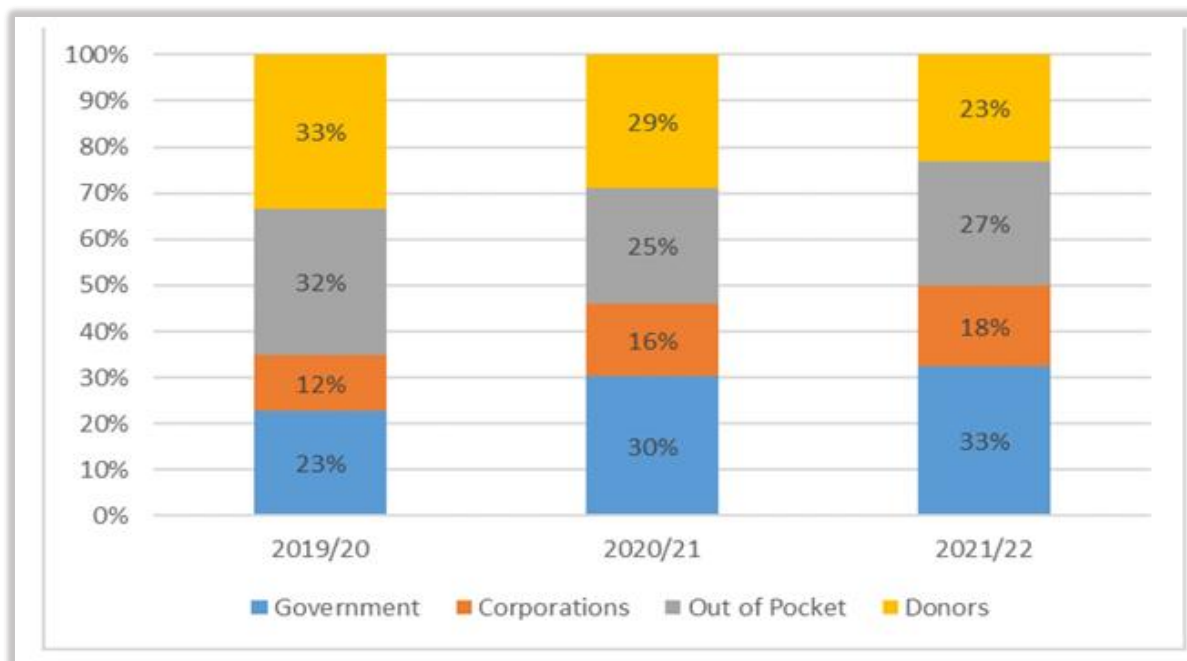
1. Formalization and characterization of slum areas in the country.
2. Stratification of health facility density targets per facility levels.
3. For urban, congested areas like Dar es Salaam, redesign and plan health delivery in major facilities into centers of excellence with specific specialties.
4. Institute gatekeeping mechanism, to reduce open entry of patients into any level of health care delivery but strengthen operational bi-directional referral mechanisms to enable strengthening of referral facilities, provide feedback for follow up to lower levels and provision of mutually informed specialized and super-specialized care.
5. Conduct initiatives to improve health care providers awareness on the importance of service integration by considering electronic integrated patient management system at all PHC levels.
6. Centralized resource pooling from implementing partners and donors, for the government to cascade care in an integrated fashion.
7. Institute regular facility level regular self-assessment for quality of care, and periodic nation-wide assessment.

3.6 Health Financing

Achievements and Challenges

The composition of the domestic and foreign health sector budget shows an increase in the domestic contribution (government, corporations and citizens' out of pocket) from 71% of the total expenditure in 2021 to 77% in 2022.

Figure 7: Health expenditure by source of funding



Source: Ministry of Health (2023)

The increase in domestic financing is partly because health insurance schemes are incorporated in the calculation, and the government's contribution to healthcare financing increased from 30% in 2021 to 33% in 2022. While donor financing remains an important source of funding, it shows a clear declining trend, dropping from 29% in 2020 to 23% in 2022. During this same period, out-of-pocket contributions averaged 26%.

Furthermore, the government share of the total health budget from all sources has increased from 9% of the GDP in 2021 to 10.3% in 2023. If the upward trend and growth rate continue to rise, the 12% HSSP V target 2025/2026 could be achieved.

A challenge is how to increase health insurance coverage. In 2023, the percentage of the total population with health insurance coverage, across all schemes, remained stable and low, at 15.3%. Not everyone contributes to health insurance, and the absence of government funding to address coverage gaps increases challenges, particularly in Njombe. A significant gap (42 percent) must be bridged to achieve the HSSP V target of 58% population coverage by 2025/2026.

For the function of collecting funds, the Domestic General Government Health Expenditure (GGHE-D) as a percentage of Gross Domestic Product (GDP) remained at 2% from 2021 to 2023, well below the HSSP V target of 5% for 2025/2026.

The 2022 national health insurance coverage remained well below the targeted threshold of 58% in 2022 and significant regional disparities exist. Thus, a higher proportion of health expenditures funded by the government, combined with decreased dependence on households and external donors, would be required to enhance financial stability and greater equity in healthcare access.

As one Government official mentioned:

"The current health financing plan is not sustainable. It is not clear how funds will be made available to address local priorities. We have a basket fund but this is not a suitable funding mechanism since most of the funds are contributed by donors. A sustainable funding mechanism is important to sustain the health sector's strategic areas and support the coordination structure" – MOH representative

Contrary to the HSSP V plan, pooling of funds in the health financing landscape in Tanzania is highly fragmented with multiple funding pools. A comprehensive analysis of pooling data reveals that since 2021, pooling has been dominated by partner funds through the Basket Fund and direct user payments via User Fees. Comparing the current situation to the period before the HSSP V (2019-2020), funds available through insurance schemes (CHF and NHIF) have significantly declined. However, no monitoring indicators and no 2025/2026 HSSP V targets for the implementation of this single pool were defined.

For the function of purchasing services and paying providers, since the beginning of HSSP V, the essential health commodities in primary health facilities have been increasingly available but remain insufficient. We have also noted a decline in resource utilization and fund execution rates, likely attributed to delayed fund disbursements and the lack of widespread digitalization across health facilities. This absence hampers the ability to streamline fund collection, enable strategic purchasing, and facilitate timely provider payments. Finally, the estimation of the costs of the National essential healthcare package for UHC has not been achieved.

The governance of health financing is overseen by the Health Care Financing Technical Working Group (TWG), which has consistently played a pivotal role in setting quarterly milestones to guide annual dialogue meetings within the financing sector.

The costing methodology of the HSSP V is not aligned with the Human Resources for Health (HRH) strategic plan or the costing for medicines and medical products, failing to adequately address the financial resources required to achieve the objectives. A key issue is the insufficiency of internally generated funds at health facilities to address HRH shortages, as seen in the Dar es Salaam Region.

Recommendations

1. Increase resource allocation to the healthcare sector by introducing a fiscal space analysis and consider measures such as sin taxes and other relevant taxes
2. Develop alternative financing mechanisms using domestic resources by conducting a fiscal space analysis of health
2. Analyze and estimate the costs of the national essential healthcare package for Universal Health Coverage (UHC). Impact on the overall budget to be assessed in order to inform decision-making.
3. Regional TWGs should be developed at the regional level where they do not yet exist. Indeed, the recommendation is to establish TWGs at both the regional and district level to collaborate with, and report to, the PO RALG within one year.

4. Implement the Health Insurance Act by making health insurance enrollment mandatory and develop earmarked funds for direct and indirect mandatory contributions to health from various sectors (concrete public-private partnerships)
5. Engage political leaders at all levels to promote health insurance and raise awareness of its importance for population wellbeing.
6. As part of the Universal Health Insurance Act, the government will fund health coverage for the poor by continuing levying taxes on specific activities such as gambling and on other products. The collected funds will be allocated to provide health insurance to economically disadvantaged populations, while those who can afford it will be required to purchase insurance to cover their medical expenses.
7. For pooling of funds, central, regional, and local coordination structures should be created to manage a new single fund pool, with health insurance coverage extended to the informal sector. An organizational and financial audit should be conducted to ensure effective fund management. For purchasing services and paying providers, efforts should focus on improving the execution rate of collected funds, accelerating disbursements to healthcare services and facilities, and introducing an electronic system to track direct donor funding for regional and local governments.
8. Use public private partnership mechanisms to increase the government healthcare expenditure
9. Recognizing the limited performance indicators in HSSP V, several new indicators are proposed for inclusion in HSSP VI (July 2026–June 2031) to ensure more robust monitoring of health financing progress.

3.7 Human Resources for Health (HRH) Strategic Plan and evaluation of Human Resources Production Plan 2014

Achievements and Challenges

1. Increased Workforce Production:

Over 24,000 health workers were produced annually across 219 mid-cadre Health Training Institutions and 12 Higher Learning Institutions with targeted efforts to expand rare cadre training. Over 500 postgraduate students are trained annually in and outside the country, specialization and super-specialization programs to expand specialized and super-specialized care in the regional, zonal, specialized and national hospitals.

Competency-based curricula updates were initiated for priority cadres like anesthetists and radiographers.

2. Improved HRH Information Systems:

Progress has been made with the integration of HRHIS with other national regulatory systems such as Human Capital Information Systems (HCIMS), Health Facility Registry (HFR), TCU, the National Council for Technical and Vocational Education and Training (NACTVET), Professional Council and Boards (PHAB). Enhanced workforce planning capabilities at national and regional levels.

3. Infrastructure Upgrades:

Significant investments in health facility modernization, including housing for health workers and new diagnostic technologies; 70% of health facilities reported improved living and working conditions for HRH.

4. Retention Initiatives:

Rural-focused strategies, including housing and allowances, were implemented in select regions. Digital Continuing Professional Development (CPD) platforms reached over 128,000 health workers by January 2025, improving access to continuous training.

5. Introduction of Performance Management Systems:

The Public Employee Performance Management Information System (PEPMIS) system was introduced in FY 2023/24 to link staff performance to measurable productivity indicators and health outcomes.

Persistent Challenges

1. Urban-Rural Workforce Imbalances:

Urban areas host 63,973 (53.4%) of the available workforce, while rural regions have 55,705 (46.6%). Limited use of tools like Workload Indicators for Staffing Needs (WISN) for equitable deployment.

The following Regions have a >75% shortage of health workers: Songwe, Simiyu, Geita, and Katavi and should be targeted immediately.

As a MOH representative said:

“First of all, there are few employees, so when there are few employees, the services are not good, not only are there few, but their competence is not good and the competence is not good because, we are going backwards because this is a cross-cutting issue of employees, we are here but also those who bring them to our colleges, that is, measuring the quality of colleges has become a problem right now, there are people who need to look at the quality of colleges, the curriculum they use, they need to look at whether they are teaching the people they are supposed to work with...” - MOH representative

2. Limited HRH Financing:

There is some reliance on international donors, with inadequate local contributions and budget prioritization. Wage budget constraints are affecting recruitment and retention efforts.

3. Gaps in Training Infrastructure:

Only 21.9% of training institutions are government-owned, leading to inequities in access and quality and there is delayed rehabilitation of health training facilities in rural areas.

4. Retention and Motivation:

Poor working conditions and insufficient career progression opportunities hinder workforce stability in rural areas.

Recommendations

1. The MOH HRH Directorate and Regional Health Management Teams to build capacity of district and facility-level staff on HRH data tools. Expand the integration and utilization of HRH Information Systems (HRHIS) and WHO's WISN method to ensure evidence-based staffing decisions.
2. The HRHIS Unit of MOH to regularly audit HRH data quality to improve workforce tracking and planning.
3. Align training programs with current and future health sector needs while addressing quality gaps.
4. Diversify and increase funding sources to meet workforce needs by advocating for increased government budget allocations for HRH programs; to establish a fund for HRH development supported by international donors and local businesses; and to mobilize community-based resources through local government authorities and private sector partnerships.
5. Strengthen Multisectoral Engagement and Governance through improved collaboration among government, private sector, and development partners. Establish regular forums for stakeholder engagement to align priorities and resources. Create a centralized coordination mechanism to streamline HRH investments and foster partnerships for shared training programs and infrastructure development.

6. Enhance Performance Management of human resources by linking workforce performance to measurable outcomes to drive accountability and productivity and as well implementing and expanding PEPMIS to monitor performance against service delivery targets; integrating performance feedback loops into routine HRH management processes and and rewarding high-performing staff with career growth opportunities and incentives.
7. Promote HRH Research and Evidence-Based Policy by investing in HRH research to inform planning and policy decisions and establish annual research dissemination forums for HRH stakeholders as well as prioritizing studies on workforce distribution, retention, and emerging health sector needs and Incorporate research findings into strategic HRH decisions at national and regional levels.
8. Integrate Equity and Inclusion in all HRH Policies by addressing gender and geographic disparities in HRH planning and implementation. Design leadership training programs targeting women to increase their representation in senior roles and establish incentives for women to pursue high-demand cadres like specialists and managers. Lastly embed equity principles in HRH recruitment and deployment policies.
10. Prioritize equitable workforce distribution through targeted recruitment and deployment while as well develop rural-focused incentives such as housing, allowances, as well as non-financial incentives like professional career growth plans and mentorship programs to stabilize workforce in hard-to-reach areas.
11. Allocate resources for recruitment in underserved regions and newly constructed facilities, starting with regions with >75% staffing shortage (Songwe, Simiyu, Geita, and Katavi).
12. Finalize construction and rehabilitation of training institutions, prioritizing rural areas.
13. Update and implement competency-based curricula, focusing on rare cadres like anesthetists and radiographers.
14. Professional Councils together with HRH of MOH to establish standardized CPD requirements linked to career progression and re-registration. Expand CPD access in rural areas through digital platforms and mobile training units.
15. The Regional and District Health Management Teams to strengthen local HRH planning processes to address regional and council needs.
16. Develop a resilient HRH framework to address public health emergencies by regular trainings on emergency response and pandemic preparedness. Develop policies for rapid workforce deployment during crises. Establish a reserve health workforce to address sudden surges in demand.

3.8 Health Commodities Management

Achievements and challenges

Progress in Improving Access to Diagnosis and Technologies

According to the Service Availability and Readiness Assessment (SARA) survey diagnostic readiness dipped slightly from 72% in 2020 to 68% in 2023. However, tracer diagnostic item availability at MSD improved from 31% to 41% (MOH, 2023).

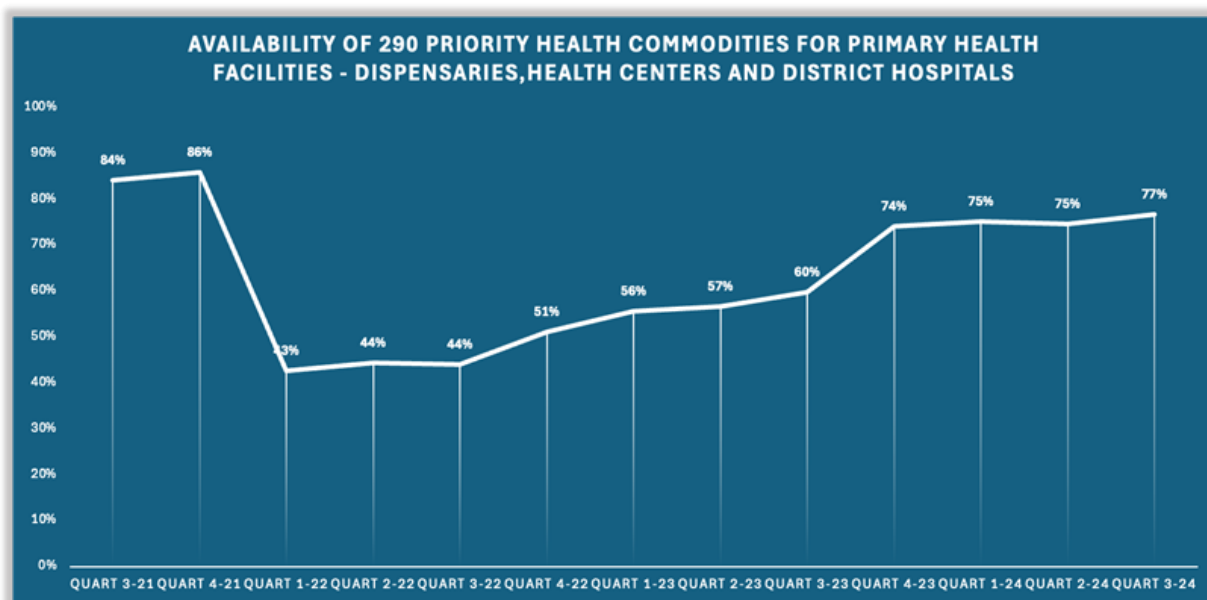
Investments in medical device maintenance and trained biomedical personnel are promising. AI-based forecasting tools are being explored to enhance supply planning.

Despite these efforts, rural areas face significant challenges, highlighting the need for targeted interventions.

Progress in Availability of Medicines, Equipment, and Health Technologies

The Medicine and health technology availability (based on the 290-priority list) is strong in regional and tertiary hospitals (95% and 93% respectively). However, primary health facilities lag behind with 72% availability, falling short of the 95% target (figure 9). While wastage at the Medical Stores Department (MSD) is low (below 1%), 12% of surveyed health facilities reported expired medicines. The electronic logistics management information system (eLMIS), currently implemented in 50% of facilities, improves supply chain management, but wider adoption is crucial.

Figure 8: The availability of 290 Priority Health Commodities for Primary Health Facilities—Dispensaries, Health Centers, and District Hospitals



Source: Analyses from data of Milulu et al. (2024)

Progress in Strengthening Pharmaceutical Manufacturing, Quality Control, and Regulation:

Pharmaceutical manufacturing has grown, with local manufacturers increasing from four to thirteen since 2021, supported by public-private partnerships:

Expansion of the MSD mandate to local production of health commodities has resulted into the expansion of the Idofi manufacturing plant and the establishment of MSD mask production facilities, which produce surgical and N95 masks.

Regulatory reforms have reduced medicine registration timelines from 24 months to 10-12 months. The expiration of the National Pharmaceutical Action Plan (NPAP) in 2022 has created a gap that needs to be addressed to sustain this progress. The National Pharmaceutical policy that was formulated in 1991 is outdated and does not reflect advancements in pharmaceuticals, emerging health challenges, or new global health frameworks.

Progress in Integration of Evidence-Based Traditional and Alternative Medicine in Health Services:

Efforts to integrate traditional and alternative medicine into health services include pilot projects in seven regional hospitals, yet high production costs, regulatory barriers, and low public awareness limit expansion.

Recommendations

1. Improve demand forecasting, fully integrating eLMIS into all health facilities, expanding local pharmaceutical production and increasing funding for procurement as well as robust scientific research to validate the efficacy of traditional medicines.
2. Update the National Pharmaceutical Policy, the National Pharmaceutical Action Plan and strengthening regulatory frameworks for traditional medicine which all are critical to sustain progress and ensure equitable access to all registered health products.

3.9 Information Communication Technology (ICT) and Data Management

Achievements and Challenges

- System Harmonization: Reducing 33 different electronic systems into 21.
- Interoperability Progress: Alignment of Electronic Medical Record (EMR) systems with DHIS2 is underway and expected to be completed by December 2024.
- EMR Expansion: Over one third of all PHC facilities now utilize EMR systems.
- Capacity Building: Continuous ICT training and the introduction of ICT champions have improved knowledge dissemination.
- Visualization Tools: Enhanced Health Management Information Systems (HMIS) with dashboards for data-driven decision-making.

Challenges

- Human Resource Gaps: A shortage of ICT personnel at grassroots levels limits system implementation and maintenance.
- Infrastructure Deficiencies: Many facilities rely on outdated or non-existent ICT infrastructure, with only 34% computer availability as per Service Availability and Readiness Assessment (SARA) tool (MOH, IHI and GFATM, 2023).
- Interoperability constraints: Challenges in unique identifiers (e.g., NIDA IDs limited to adults), inconsistent coding standards of medicines and diseases across systems, and inadequate computing power hinder effective data exchange.
- Independent Systems: Proliferation of fragmented systems complicate integration efforts.

Recommendations

1. Prioritize ICT infrastructure upgrades and equitable supply to all facilities.
2. Stronger coordination in particular at PHC level through RMHTs and CHMTs for ICT activities.
3. Scale up GoTHoMIS and telemedicine solutions to lower-level facilities for wider access.
4. Strengthen and support RHMTs and CHMTs to perform quality checks and periodic M&E assessments to ensure robust data collection, reliability and data management.
5. Strategically deploy ICT personnel for real-time support and troubleshooting at district and lower-level facilities.
6. Harmonize program-specific and surveillance systems within the HMIS.
7. Continue fostering interoperability with a focus on universal identifiers and high-computing infrastructure.
8. Incorporate research findings into strategic HRH decisions at national and regional levels.

3.10 Results based management through M&E

Achievements and Challenges

Monitoring and evaluation (M&E) are an integral part of HSSP V, which was established to monitor the implementation of priority interventions and evaluate their relevance, effectiveness, efficiency, impact, and sustainability. M&E activities are guided by the national M&E plan of HSSP V; the integrated M&E framework for One Plan III for Reproductive Maternal Newborn Child Adolescent Health (RMNCAH), the Human Resources for Health (HRH) strategic plan and the Non-communicable Diseases (NCD) strategic plan.

This national M&E plan takes into account existing M&E plans and strategies for HIV, malaria, TB, and other major health sector programs in Tanzania to maximize harmonization and alignment and does consider monitoring practices in other sectors where relevant.

M&E and ICT units, in collaboration with the PORALG, supported the implementation of comprehensive monitoring of HSSP V during the period 2021-2024.

Furthermore, the national M&E plan presents the status of implementation of M&E and ICT strategies, the functionality of M&E and ICT technical working group, the relevance of integrated M&E plan and framework, and a comprehensive analysis of HSSP V indicators. Comprehensive lessons learned during the implementation are presented in the full report.

The health system has made significant progress in establishing guidelines and policy frameworks for strengthening M&E implementation in the country.

M&E tools have been developed or updated to respond to the demand for high-quality data. The development of Unified Community Systems (UCS), Afya electronic Hospital Management System (Afya e-HMS), and Afya supportive supervision (AfyaSS) are evidence of significant development designed to ensure facility- and community-based data are comprehensively captured. The ICT unit has continued to support the development of ICT infrastructure (hardware and software) to support data collection, analysis, and reporting. Work is ongoing to ensure systems developed in the past and the new ones are integrated. The government has made substantial developments to achieve the interoperability of systems. Interoperability remains a challenge, with some private facilities utilizing EMR unable to submit data to DHIS2.

M&E and ICT technical working group have been brought together with the aim to coordinate all stakeholders who are significantly contributing to the strategic goals of the Ministry of Health.

Recommendations

- I. MOH to Review and Revise the performance of indicators used for monitoring HSSP. The next HSSP should be developed based on each step in the renewed theory of change approach that is aligned with the new M&E framework and strategic outcomes. Consider additional indicators to monitor facility based neonatal outcomes; adolescents health and pregnancy outcomes as well as indicators to monitor equity outcomes by age, gender and socioeconomic and geographical disparities. Incorporate service delivery process indicators (governance, accountability, etc.) to monitor key underlying assumptions of HSSP's success. The M&E Plan for each HSSP should incorporate intermediate outcome indicators to enable health systems to track annual progress between Demographic Health Surveys. The revised HSSP indicator list should ensure balance of indicators of key strategic outcomes and as well process indicators.

2. Strengthen monitoring of service delivery and disease burden for poor-performing indicators through conducting robust surveys or epidemiological studies to estimate disease burden and impact of interventions for indicators that rely on modeled estimates such as PMTCT.
3. Finance HMIS data collection tools Funds must be allocated for printing and supplying Health Management Information Tools (HMIS) such as the paper-based health management record system books (MTUHA) to health facilities to guarantee the generation of high-quality data at the facility level.
4. Strengthen patient-level electronic medical records systems. The use of patient-level EMR systems has the potential to improve data quality and enhance the interoperability of health information systems. HIV programs that use EMR through Care and Treatment Clinics (CTC) are experiencing substantial challenges in managing patients' records as patients are living longer with the use of ARV and often migrate and/or drop out of treatment without a transfer of data to the original CTC.
5. The health sector should develop long-term strategies to deal with the complexities of HMIS, including anticipating high data volume and using unique identifiers such as national identification numbers or fingerprints without compromising patient confidentiality while maintaining medical records linkage between different health facilities.
6. Address fragmented funding health Information Systems such as District Health Information System version 2 (DHIS2) is designed to support reporting of all services and disease statistics for all programs. However, some development partners tend to focus on improving a few aspects of DHIS2 depending on their interest rather than supporting the entire HMIS.

"The problem is partners because they come with their money specific for certain diseases or programs like they want their money only to support malaria and not any other areas of HMIS. Fragmentation of funding is the main challenge the government faces." - Government official

7. Promote a holistic support for HMIS as it is the backbone of all programs that report service delivery and monitor the burden of any disease and health issue.
8. Improve interoperability and harmonization of systems. With over 180+ existing standalone apps and systems by various stakeholders, more efforts are needed to develop interoperability frameworks; optimizing electronic health records; and using open-source tools. Furthermore, there is a need to intensively evaluate different systems to identify commonalities, differences, and apps or systems that should be integrated.

4 DISCUSSION ACROSS ALL THEMATIC AREAS

Consistent across all thematic areas are the improvements made during the first half of the HSSP V period in infrastructure covering new hard to reach areas, regular provision of equipment and supplies, increasing the number of trained health workers through expansion of private universities and colleges, decentralized financing of peripheral health facilities and as well the strengthening of national oversight through multiple strategic plans and guidance materials.

Equally consistent across all thematic papers are major challenges of which the lack of quality stands out. In service delivery, info and data management, supply management, financial rigour all reflect observed inefficiencies due to lack of quality, poor supervision and lack of feeling of accountability.

Without doubt the poor quality is also being fed by lack of resources but examples were observed and also published where motivated and trusted leaders were in charge, improvements in the quality of operationalizing the health services were evident. (Ntuli et al., 2023).

Evolution of the context:

4.1 Major demographic and epidemiological changes

During the HSSP V implementation period also other major changes took place influencing the type of needed responses to ensure equal and quality health access.

Demographic changes resulted in a higher proportion of elderly people and a high these elderly people get more older requiring another approach in health service delivering being able to address mobility, hearing, visual impairments in an integrated way. These types of geriatric services are realized by many stakeholders but not as yet developed in Tanzania.

Demographic changes also resulted in further rapid growth in urbanization with very different health service needs and its organization as the urban population is to a large extent consists of young people often poorly educated, and often day by day employed and lacking the social cohesion and family structures of rural communities.

HSSP V implementation was interrupted by the COVID-19 pandemic whereby Tanzania had to reorganize its health delivery system at all levels to face the demands and needs in order to develop an effective epidemic outbreak response which influenced the priority settings as outlined in the HSSP V. Surveillance and emergency preparedness as well as rapid mobilization of laboratory services, community education and disease management changed the HSSP V priorities and resource mobilization and allocation. Threats and actual outbreaks remain a reality with cholera in 2024 now in 18 Regions, possible Ebola and actual Marburg outbreaks in isolated areas in the country.

Neglected Tropical Diseases and emerging and re-emerging infectious diseases of epidemic nature and health impairments like those affecting the elderly (geriatrics) were not mentioned in HSSP V and thus not part of the MTR but noted as being already a part of the burden of disease and health issues due to demographic and environmental changes in Tanzania and thus need to be highlighted as future priorities for the rest of the HSSP V phase HSSP VI.

4.2 Evolving aspects of evaluating health services and/or health systems

HSSP V stipulates an evaluation framework based on the WHO health service building blocks as defined two decades ago (WHO,2007). Already during the inception meeting it was noted that any evaluation of a health system needs to reflect a more comprehensive pathway measuring each step from inputs, activities to outputs and outcomes which has to involve multisectoral influences as well as a stronger reflection of the capacity of communities and their direct care providers to participate fully to obtain an impact on a healthier society. Also, other contextual aspects such as traditions and climate change need to be reflected. Several peer reviewed papers reflect this broader approach to the building blocks of a health system (Sacks et al. 2019; Rutasha Dadi et al 2023)

The evaluation pathway presented at the Inception Meeting of the MTR was considered a theory of change modality and used for this MTR.

IHI and UNICEF developed a more detailed outline, which is described and visualized in the thematic area report *Public Health Policy and Planning*, accessible online in the folder at this link: https://www.ihl.or.tz/media/List_and_report/MTR_Inception_-_REPORT_eversion.pdf. They suggested to the MOH that this outline be considered in preparing for HSSP VI.

By adopting a more comprehensive health service evaluation framework, as seen in HSSP V—building on WHO’s 2007 building blocks—it follows that additional targets and indicators are necessary to reflect multisectoral and other determinants of health.

Suggested indicators to enhance the monitoring of HSSP V and the upcoming HSSP VI will need to be developed by the team preparing for HSSP VI.

5 WAY FORWARD

5.1 Sustainability and maintaining quality

Throughout all thematic areas the call for attention to quality stands out while acknowledging the substantial progress is made over the last three years in improvements in tangible outputs such as more infrastructure, more training, more supplies and equipment. Quality improvement will ultimately lead to better outcomes and impact.

Standing out are the calls for quality at the PHC level in service delivery reflecting patients and community's needs, quality in data entry and management and quality in workers performance.

Information is key to sustainable solutions as it will create ownership and understanding and therefore boost commitment for long-term solutions. It is therefore crucial that strategic planning documents such as future HSSPs are available in language and style to be understood to all planners at the local level including community leaders, members of PHC committees and facility government board members.

Meanwhile existing strategic documents from programs which are currently not visible at PHC level need to be simplified, translated in Swahili and distributed and discussed in order to create a better sense for the need of quality. Resources will be required and need to be prioritized.

With the current external donor financial support being challenged and often reduced and even worse unlikely to be increased, innovative ways to improve efficiencies within decision making and with organization and implementation of services need to be identified. An independent think-tank as an advisory body could give this a first go, for example TPHA or the Parliamentary Committee on Health and Social Welfare.

Also, the principle of social enterprises for health needs to be considered building on the work the PPP community has started.

5.2 Harmonization

Throughout all thematic areas, the issue of fragmentation was highlighted as a major stumbling block towards doing more with less.

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ANNEX 1: FIELD TEAM FOR MIDTERM REVIEW OF HEALTH SECTOR STRATEGIC PLAN V

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