

Mid-Term Review (MTR) of the Health Sector  
Strategic Plan V (HSSP V)

# Public Health Policy and Planning Thematic Report


Submitted to The Ministry of Health,  
Dodoma – Tanzania

By The Ifakara Health Institute

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In March 2025

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## Abbreviations

CCHP	Comprehensive Council Health Plans
CCBRT	Comprehensive Community Based Rehabilitation Tanzania
CHSB	Council Health Service Board
DPs	Development Partners
DCF	Development Cooperation Framework
DHIS	District Health Information System
FGDs	Focus Group Discussion
FYDP	Five-Year Development Plan
FBO	Faith Based Organization
GII	Gender Inequality Index
GGI	Global Gender Gap Index
HFGC	Health Facility Governing Committee
HBF	Health Basket Fund
HSSP	Health Sector Strategic Plan
HiAP	Health in All Policies
IDI	In-depth Interview
IHI	Ifakara Health Institute
JAHSR	Joint Annual Health Sector Review
JAHSTRM	Joint Annual Health Sector Technical Review Meeting
KCMC	Kilimanjaro Christian Medical Center
LGA	Local Government Authority
MTR	Mid-Term Review
MoF	Ministry of Finance
NCDs	Non-Communicable Diseases
NTDs	Neglected Tropical Diseases
PO-RALG	President's Office Regional Administration and Local Government
PO-PSMGG	President's Office Public Service Management and Good Governance
PHC	Primary Health Care
PPP	Private Public Partnership
QMS	Quality Management Systems
SDG	Sustainable Development Goals
SDH	Social Determinants of Health
TWG	Technical Working Groups
WHO	World Health Organization

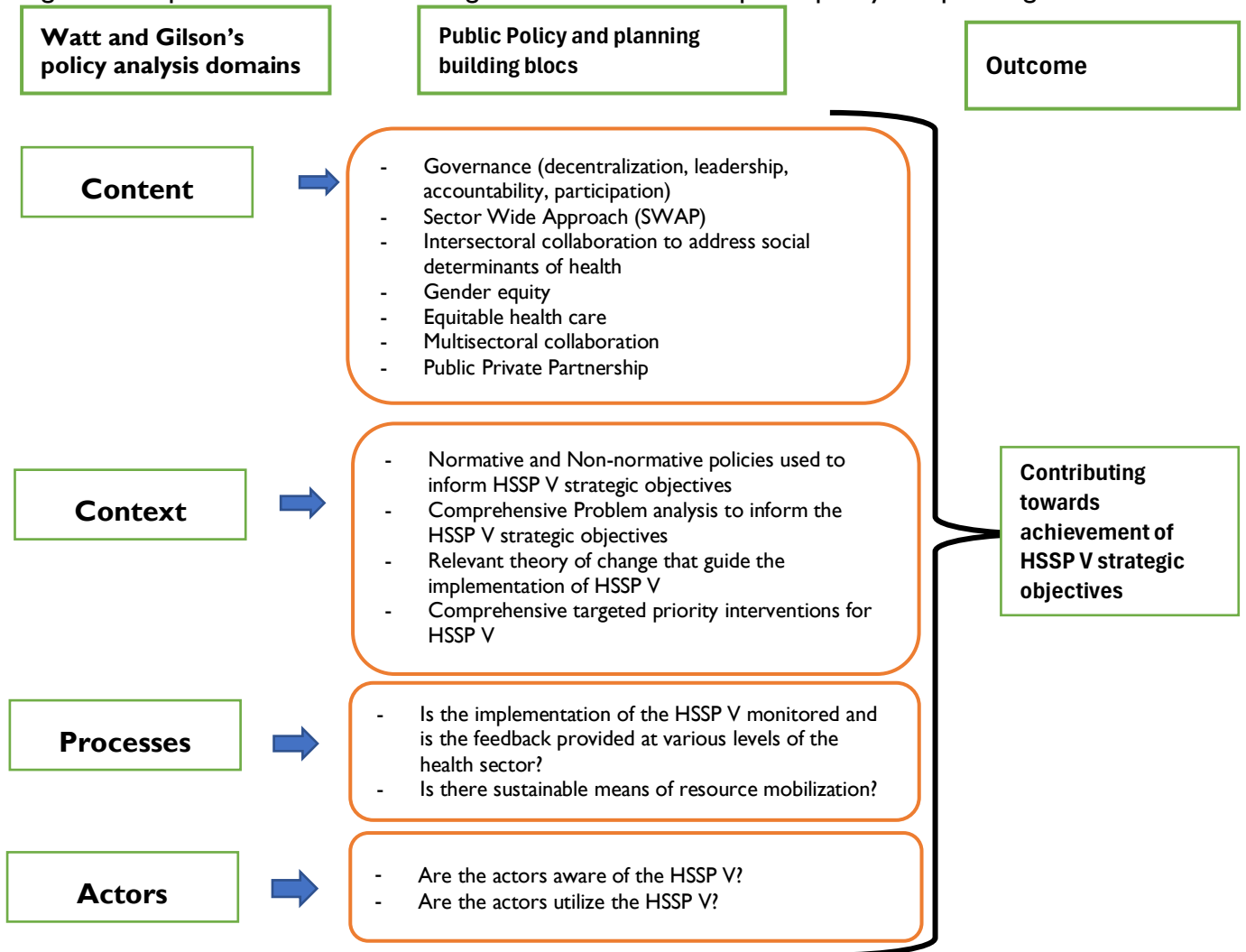
## Acknowledgements

We would like to extend our sincere appreciation to the Directorate of Policy and Planning at the Ministry of Health, particularly Dr. Vivian Wonanji, Raynold John and others. We also acknowledge all the MOH directors, heads of units, the regional medical officers, district medical officers, health facility in charges and health care providers from the eight regions of Tanzania where the study was conducted, including Kigoma (West), **Arusha** (Northern), **Rukwa** (Southwestern), **Dar es Salaam** (Eastern), **Geita** (Lake Zone), **Mtwara** (Southern), **Dodoma** (Central), **Njombe** (Southern Highland). Furthermore, WHO, Development Partners Group for Health (DPGH), research and academic institutions, Religious representatives, non-government organizations (implementers). Their support, commitment and tireless efforts to make this study successfully is highly appreciated.

# I. Conceptual framework

This report presents the findings which emerged from the Public Policy thematic area. The overall conceptual framework that guided the Mid-Term Review is included in the compiled report merging summaries of all thematic areas. This thematic report however, provides specific policy analysis guided by the framework developed by Walt and Gilson's (1994). This policy analysis framework examines strategic directions through four key elements (**content, context, actors, processes**). The assumption is that efficient public policy and planning will provide a critical **environment** to support current and future HSSP implementation. The HSSP V included five public policy and planning building blocks. The building blocks have been tailored within the Walt and Gilson's framework to respond to the HSSP V- MTR as illustrated in the diagram below.

Fig I: Conceptual framework used to guide the evaluation of public policy and planning



## 2. Summary of the Methodology

The findings presented in this report resulted from the desk review of various normative and non-normative health policies and reports; analysis of routine data (DHSI2); in-depth interviews (IDIs) and consultative meetings with all stakeholders mentioned in the acknowledgment section. Thematic content analysis was used to categorize the participant's narratives as per the key research questions included in the expanded design matrix (EDM). We included some few excerpts to support data interpretation.

(Comprehensive information about the methodological approaches is provided in chapter 2 of the compiled report).

### **Note:**

This report provides a comprehensive account of implementation status of governance, policy and planning within health sector, in alignment with the commitments outlined in the Health Sector Strategic Plan V (HSSP-V). The first sections of the report address key items specified in the Terms of Reference (TOR).

## 3. Summary of the findings

## 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.

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 as meetings are infrequent, SWAp coordinators not formally participating and leadership changes hampering coordination and consistency.

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.

### 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]*

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 Tanzanian'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 males and only 5 females RMOs. At MOH there are 538 males and 413 females 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.

One respondent said that:

*“If you go to this village’s dispensary [name withheld] and ask the clinician in charge do you know HSSP V the answer will be no. If I ask the DMO of this district, can you tell me some basic principles on the HSSP V the answer will be not clear” – Community representative*

**Utilization of the HSSP-V strategy:** Utilization of the strategy is limited at all levels. However, most stakeholders admitted that HSSP V is relevant and is a valuable document and if well utilized, it can guide planning, budgeting, and implementation of various health policies and services in the country. 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.

Some stakeholders were of the opinion that the HSSP V is in the English language making it difficult to follow, understand the targets and monitor performance.

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

1. The Directorate of Policy and Planning (DPP) of MOH to mobilize adequate resources for a dissemination plan to be executed of upcoming HSSPs as well as this MTR.. The HSSP and MTR reports and/or summaries need to be in both Kiswahili and English to allow accessibility by stakeholders and implementers at **all levels**.

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*“...the document is too academically written; first, it needs to be summarized in a straight and actionable language; what should be done and why? A maximum of five to ten pages’ document is enough. It should be shared with all the CHMTs (Council Health Management Teams), as well as district or council level implementation partners” District representative.*

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2. DPP need also 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.

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.

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.

6. 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.
7. 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.
8. 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.
9. MOH to commission with technical support of WHO and UNICEF, a study on urban health inequities and tailored interventions addressing key vulnerabilities.
10. 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.
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. PORALG and local councils to expand community representation in Health Facility Governing Committees (HFGCs)
13. 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.

## 4. Analysis of the context of HSSP V

## 4.1. Use of normative and non-normative policies to guide the HSSP V priorities

### **Findings**

The priorities included in the HSSP V were guided by multiple and relevant normative and non-normative policies. They include Tanzanian National Health Policy (2007), Tanzania's Development Vision 2025, and the Third Five-Year Development Plan (FYDP III), one Plan III 2020/21-2025/26, HRH Strategy 2020-2025, National Strategic plan for prevention and control of NCDs 2020/21-2025/26.

In addition, international policy documents were also used including the African Union Agenda 2063 document, East African Community (EAC), Southern African Development Community (SADC) (specifically on protocol that relates to strengthening the provision of essential medicines, disease control and disaster management, World Health Organization (WHO) documents and the United Nations' (UN) Sustainable Developments Goals documents especially SDG 3: health and well-being and other SDGs which were related to health were crucial for HSSP-V. The use of these policies is one of the strength of the HSSPV-strategy reflecting policy alignment and the continuity of the wider national and international agenda.

### **Challenges**

The HSSP V indicated that the Health Policy Implementation Strategy 2020 – 2030 was in an advanced stage. However, during the MTR, there was no any new health policy in place. The national policy that is still being used is the one from 2007.

### **Recommendations**

1. The new health policy needs urgent finalization, submission to Parliament, endorsement and dissemination and orientation at all levels. Any updates related to the new health policy need to be clearly communicated to various stakeholders in order to harmonize understanding and clear any confusion.

## 4.2. A relevant and comprehensive problem analysis

### **Findings**

The **Health Sector Strategic Plan V (HSSP V)** was developed based on a comprehensive assessment of the public health situation, addressing unfinished priorities from HSSP IV and emerging challenges. Results of interviews conducted for the Mid-Term Review (MTR) evaluation are showing that the gaps identified in HSSP V remain valid and still relevant to be addressed.

Development of the strategy used relevant experts, and data from credible sources such as the Health Information Management System (HIMS) to ensure that the strategy reflected current realities.

Continuing the agenda from HSSP IV was meant to focus on addressing long-term persistent challenges (such as non-communicable diseases (NCDs), maternal and child health, and infectious diseases) without introducing entirely new priorities that could disrupt ongoing progress.

## **Challenges**

In this mid-term review we found some gaps resulting from the problem analysis:

1. Stakeholders felt that there is poor integration of locally generated evidence from peer-reviewed publications, routine information systems, and disease surveillance reports to inform prioritization based on the burden of disease, and the social determinants of health such as lifestyle aspects. Mental health and NCDs burden were not as yet integrated into the health planning while infectious diseases remained a priority in planning and implementation resulting in fragmented disease oriented approaches.

*“some areas of health are not given priority such as mental health, NCDs despite increasing burden. See, in the basket fund, the main interest is to support reproductive and maternal health, and immunization services and the like, so how can other areas be financed? Addressing local priority needs becomes more important in the context of the universal health insurance since the government needs to do something for the NCD patients to enable their access to appropriate health services. I think it is high time for the health sector to have a strong bargaining power and say to donors that “these are our priorities with strong evidence. You can tell donors that if you want to support HIV or Malaria, remember that the same patients suffer from NCDs as well. In Rwanda if the donor comes with funds which does not support the priorities of the sector, they will not accept those funds unless the funder agree to adjust the funds and address their priorities and the priority of the sector” – Representative from the Development Partners*

2. Issues such as inequities in urban versus rural healthcare delivery, though acknowledged, lack detailed analysis in absence of disaggregated data. Therefore, the problem analysis falls short in pinpointing systemic drivers of major deprivations and root causes despite identifying key barriers.
3. Multiple stakeholders felt that although community participation at the primary health care through various health structures is improving, the local ownership in prioritization and decision making remain low. They were strongly concerned that the health sector’s priorities are donor driven while there is no concrete channel that would enhance communities’ recommendations on what should be the priorities in the health sector.

## **Recommendations**

1. The health sector strategic objectives and priorities need to be developed based on detailed problem analysis that reflect the underlying drivers of health inequities and major deprivation across population groups rather than a focus on mainly infectious diseases.
2. A comprehensive understanding of the social determinants of health as well as the use of locally generated evidence from multiple sources is crucial.
3. The strategy has been developed at a time when Tanzania, was confronted by the COVID-19 pandemic. Although most priorities remain relevant, a new direction in health is now imperative, that takes into consideration the pre-pandemic health gains,

address the lessons learned from the pandemic including surveillance planning and strengthening emergency responses.

### 4.3. Relevance and Comprehensiveness of HSSP-V targeted Priority Interventions

#### Progress and challenges

Most stakeholders mentioned that the HSSP V Strategic Domains (SDs) and Strategic Outcomes (SOs) are comprehensive and relevant building on HSSP IV mentioned persistent health problems despite the new emergencies like COVID-19 in 2020/21.

The strategy is organized into 30 Strategic Domains (SDs) under five Strategic Outcomes (SOs). However, to address all strategic domains remains overly ambitious and limits effective uptake in a decentralized manner by local authorities.

Resource constraints remain an issue but how to address these health system challenges in a practical and efficient manner which is relevant at the local level remains unclear. For example, alignment of HR distribution driven by available funding and infrastructure remain unclear. Also actionable strategies to address gender, income and educational disparities to access health care, as per HSSP V recommendations were not found to be integrated in the planning process.

### 4.4. Critical analysis of the HSSP-V Road Map and Theory of Change (TOC)

#### Findings, gaps and challenges

Although the conceptual framework including a roadmap built on the WHO building blocks is well presented in HSSP V, it lacks clarity on how comprehensive these building blocks are given the broader concept of health and how various blocks relate to each other. Realistic short-medium- and long-term targets and indicators need to be set and at national level collaboration and linkages with regulatory bodies such Tanzania Food and Nutrition Centre (TFNC), Tanzania Bureau of Standards (TBS), and Tanzania Medicines and Medical Devices Authority (TMDA) need to be clear and specific. At the district and facility PHC level limited involvement of communities and the absence of practical collaboration mechanism between Ministries, faith based organizations and private sector was not visible in the HSSP V roadmap. Research institutions and implementation partners need to be taken into account as well. Final point in the Roadmap according to stakeholders is that Societal barriers need to be detailed and addressed for involvement of grass root organizations for equitable uptake of service utilization.

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*“the HSSP-V does not have a clear roadmap for achieving the set targets: “it is not implementable with the resources we have. If the text is clear but not realistic and thus not feasible, then you can’t implement it. So, a clear roadmap to me is a feasible roadmap. And the feasibility of V is an issue for me.” - Regional stakeholder*

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Below we present a proposed theory of change pathway, from **inputs** to **impact** look at the health system in a holistic and participatory way, identifying each step in its process that needs strengthening to achieve a functional, sustained and user-provider owned health care system. 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.

### Fig 1: The Theory of Change (TOC) pathway

Proposed Theory of Change of the Tanzanian Health Sector Strategic Plan VI 2027-2032

**Principles:** People centered - Equity and Inclusivity – Gender Equality – Emergency preparedness - Resilience – Environmental sustainability - Scale

**Approaches:** Multisectoral collaboration - Health in all policies – Partnership/SWAp – Evidence based

Enabling factors	Change Strategies	Outputs	Intermediary outcomes	Outcomes	Impact
<ul style="list-style-type: none"> <li>Political will</li> <li>Middle income country status</li> <li>Universal Health Insurance act</li> <li>Foundation for a strong digital health information system</li> <li>Domestic expertise</li> <li>People centered service delivery</li> </ul>	<p>Strengthen accountability mechanisms and leadership capacity</p> <p>Leverage domestic and external resources and partnerships</p> <p>Promote quality and use of evidence for decision making at all levels</p> <p>Innovate for scale</p> <p>Operationalise integration of strategy, structure, processes and tools</p> <p>Strengthen linkage between community, health facility, district, region and national level</p> <p>Decentralization and community, engagement and empowerment</p> <p>Participatory policy formulation, decision making and evaluations</p> <p>Coordination at community level to address SDHs</p>	<p>Champion effective change management Strong governance, leadership and management</p> <p>Increased domestic resource mobilization, allocation, efficiencies and functional UHI</p> <p>Available, appropriately distributed, motivated and competent work force</p> <p>Reliable supply chains, including planned preventive maintenance</p> <p>Integrated, high quality HMIS with electronic medical records at the core</p> <p>Optimized organization of care to respond to population needs</p>	<p>Increased confidence and trust in health system</p> <p>Healthy and beneficial individual and community practices</p> <p>Timely and appropriate service utilisation</p> <p>Absence of catastrophic health expenditure</p> <p>Health services are accessible, including through referral mechanisms</p> <p>Health services are efficiently equipped, staffed and ready to provide care</p> <p>Health service provision is (1) effective – adhere to standards and guidelines, (2) safe – causes no harm, and (3) respectful – positive user experience</p>	<p>High effective coverage of promotive, preventive, curative, rehabilitative and palliative health interventions as outlined in the National Essential Health Care Intervention Package</p>	<p>Improved Population health and wellbeing across the life course</p>

**Supportive environment: Learning and continuous improvement: Embedded Implementation Research and Evidence-based Implementation Practice at all levels of the system**

<p><b>Implementation outcomes of change strategies:</b> Appropriateness; Acceptability; Feasibility; Adoption; Fidelity; Coverage; Cost; Sustainability</p>	<p><b>Other outcome measures:</b> Government share of the total health budget from all sources (%); Health insurance coverage as % of total population (all schemes); Health workforce density per 10,000 population and distribution by major cadre; Essential medicines (tracers) availability; Data accuracy for tracer indicators; Number and distribution of health facilities per 10,000 population</p>	<p><b>Other outcome measures</b> Use of ITN among children under 5 / among pregnant women; Tobacco use among persons aged 18 years and over; Institutional delivery; /Early/ ANC attendance: Satisfied demand for family planning; Emergency preparedness average of 13 core capacities defined by IHR)</p>	<p><b>Disease of interest</b> RMNCAH, Immunization, Nutrition, Cancers, Infectious diseases (incl. HIV, TB, malaria), NTDs, NCDs, Zoonotic diseases, EECC, mental health, ECD</p>	<p><b>Other outcome measures</b> Life expectancy at birth, Quality of Life, Teenage pregnancy rate Mortality, including MMR, NMR, U5MR Morbidity, including stunting, anemia, obesity</p>
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## 2. Creating an enabling environment for its services governance

Contributors: (IHI and UNICEF)

The HSSP-V requires the government to strengthen leadership, good governance and accountability in the health sector to safeguard the achievements. The Strategy aims at

empowering all levels of government and communities; involving them in health services provision. Since the commencement of the health sector reforms in Tanzania, in the early 1990s, the health planning and its implementation have been decentralized to the council health management teams (CHMTs) headed by district medical officers (DMOs). The ministry of health and other partners has sustained the various governance, leadership and the capacity building initiatives at various levels.

## 2.1. Progress toward the targets

Targets 2025/ Commitment	Baseline	Current achievement	Progress status
90 % of councils with functional Council Health Service Boards (CHBS)s	65%	78%	On track
70 % of health facilities implementing QI plans	30%	50%	Needs Attention
Adoption of performance-based budgeting	0	Partially implemented	Needs Attention
Alignment of Subsector Health and Disease Specific Strategies	0%	0	Needs Attention
Addressing the issues in HSSP V that are beyond the mandate of the MoH by implementing HiAP	No tracking mechanism		

### 2.1. Interventions that contributed to governance progress

Decentralization approach is actively executed at all levels: Decentralization has improved resource allocation efficiency. The local authorities are empowered by delegating planning, budgeting, and resource allocation responsibilities to councils, hospital boards, and health facility governing committees (HFGCs), strengthening community involvement and fostering accountability.

The autonomy of HFGCs in planning, budgeting, and fund management has facilitated resource allocation that aligns some community priorities such as shortages and needed repairs while empowering citizen's participation in decision-making towards the aim of reaching ownership, thereby enhancing transparency and accountability. This is particularly evident in the implementation of the Direct Health Facility Financing (DHFF) mechanism.

*"The governance of the health sector and the functionality of various structures could be improved if we strengthen the issues of accountability, responsibility, and transparency. These elements are needed at various levels of the system. Ownership of the technical working groups and having a clear vision are very critical. The locals need to take the lead and not leave the agenda to the development partners" [TWG-Member]*

For the past years, there has been increased capacity strengthening activities of the health care providers in various areas. The members of the council, hospital boards and HFGC are trained to function or operate within their scope of work. Their main task is to make sure that people are receiving improved health services. Capacity strengthening has been implemented through different modalities including training, outreach services (see the joint annual field visit section), and identifying competent people as council members. However, there is no continuation of the capacity building initiatives which deter efficiency at various levels.

Community participation is mandated through health facility governing committees. However, community members rarely actively participate since there is limited capacity to contribute to the discussions and provide critical arguments in favor of quality health care.

Some communities have maintained their participation through contributions in the construction of the health facilities while councils and hospital board members play their part in planning and budgeting. In addition, decentralized planning and DHFF have empowered some community members to participate in setting priorities and monitoring healthcare delivery. But it requires more effort to ensure a wider representation of the community's voices in health planning, ensuring accountability, responsibility and transparency.

Primary Health Service Implementation Development Strategy (PHSIDS) 2022- 2032 commit to guide the improvement of quality health care services at the primary health care. This is an important commitment and if well implemented can spearhead attainment of the HSSP V targets. Importantly, there is an alignment between PHSIDS and HSSP V, various components of the HSSP V are considered as key priority areas of PHSIDS including access to quality health services, Human Resources for Health (HRH), availability of Medical products, technologies and related supplies, and Healthcare Financing.

## 2.2. Interventions which were not planned but executed

The Primary Health Care (PHC) Committee Guidelines (2022) were revised by PORALG to update committee structures, meeting schedules, roles and responsibilities in strengthening

multisectoral approach in primary healthcare. There is alignment between PHC guideline and HSSP V principles. Inter-Sectoral coordination, addressing social determinants of health through health in all policies, community engagement, promotion of health insurance for all, are all considered as the roles and responsibilities of the PHC committee members (PHC, 2022).

### 2.3. Challenges and unfinished agenda

1. The PHSIDS objective of guiding the improvement of quality health care services at the primary health care still remains behind despite physical access to health facilities.
2. The Health financing strategy was planned in the HSSP IV; however as of today, the strategy has not yet been reviewed thus jeopardizing many of HSSP V priorities.
3. Limited capacity to question, analyze data and use data for decision making among the health facility governing committee members and among the district and regional level staff.
4. Most strategic plans do not provide the estimated costs of implementation. There is a tendency to give a brief overview of possible donors, but sources of income per strategy are left out, or not aligned with the sectoral budget.
5. The PHSIDS (2022–2032) and PHCC guidelines have not been widely disseminated to implementers, limiting their adoption at the community level.
6. Primary healthcare committee members lack awareness of HSSP V priorities, affecting their ability to align plans and decisions with strategic goals. This is aggravated by frequent staff turnover limiting the impact of capacity building efforts.
7. Insufficient policy alignment and coordination within the health sector: there is a notable variation in how well different departmental strategic plans align with HSSP V. Some plans only partially align, others moderately, and some fully align with HSSP V objectives, goals, and implementation plans.
8. Coordination of multiple health efforts at the primary health care is happening but at higher levels the coordination becomes irregular or fragmented due to multiple initiatives which are not aligned and not jointly planned.
9. Although decentralization also improves resource allocation efficiency, and empowerment, but overlapping activities by government and non-governmental actors reduce efficiency in resource utilization, complicating coordination.
10. Fragmentation of health interventions reduces efficiency and effectiveness.

One DP expressed her concerns regarding the fragmentation of health interventions:

*"The challenge that I see with the governance is that the interventions are not aligned across various actors. Everyone struggles for visibility but not for efficiency and effectiveness. We could achieve better health outcomes if there was good coordination of partner's intervention to prevent overlap and duplication of effort. For example, based on the evidence we could decide*

*that let's (funders and implementers) focus on improving adolescent health outcomes instead of having scattered interventions (Representative from the Development Partners)"*

## 2.4. Recommendations

1. Although each health department is required to have a strategic plan that acts as a roadmap for implementation, there is a pressing need to harmonize these plans and assess the feasibility of their objectives to ensure that goals are met effectively, rather than simply checking off items on a list.
2. The Health Financing Strategy needs to be reviewed, and more importantly, updated to be in line with the current priorities.
3. Local funding mechanism need to be identified to support timely implementation of HSSP-V targets and meet equitable health care. Strengthening synergy between political administrative structures such as Regional Administrative Secretary and regional health structure and empower them to mobilized funds for quality improvement at various health facilities.
4. Empower stakeholders at the primary health care to analyze data and use for decision making.
5. Since health is a cross cutting priority, a joint budget and resource mobilization to address HSSP-V targets need to be supported by non-health sectors as well. However, this initiative need to be vigilantly promoted.
6. PO-RALG and MOH need to develop a strategic plan for improving the quality of health care for service provision and motivation of staff. For example, staff motivation such as availability of working tools, training and promotion, housing facilities, provision of salaries on time, need to be comprehensively provided in all locations.
7. Concrete channels are needed to understand communities' recommendations on what should be the priorities of the health sector.

## 3. Strengthening intersectoral Collaboration to address the social determinants of Health:

### 3.1. Progress toward the targets

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Targets/ Commitment	Baseline	Current achievement	Progress status
Decentralized priority-setting in weaker regions and councils to address equity and gender issues	Limited	Moderate progress: additional resources allocated to targeted regions	Needs Attention
Creation of crosscutting taskforces for key areas to address interlinked issues	Limited	Taskforces established but limited in scope and impact	Needs Attention
Enforcement of laws and regulations governing occupational health services	Weak	Strengthened enforcement in specific regions	On Track
Social determinants of health will be addressed across all diseases...Action will be through policies and strategies, financial support for insurance schemes, as well as grassroots interventions to increase access to care	Limited	Moderate progress: Social determinant of health concept is currently mainstreamed through health in all policies framework. Awareness is ongoing but need improvement particularly among the primary health care committee members to enhance multisectorial action in addressing the social determinants of health at grassroots	Needs Attention

### 3.2. Progress in addressing social determinants of health

1. Previously confined to the health domain and linked to specific diseases, SDHs are now seen as a cross-cutting issue integrated into broader public policy. Since the inception of HSSP-V, stakeholder awareness of SDHs has increased significantly, transitioning from infancy in 2016 (Mtenga et al., 2016) to growing acceptance and integration by 2024.
2. Fostering intersectoral coordination and Commitment for Health in All Policies (HiAP): Two resource persons, the Director of Policy and Planning and a Policy Analyst, were appointed to strengthen intersectoral collaboration. They are supported by a functioning HiAP Secretariat, comprising representatives from MOH, PORALG, and sectoral ministries, that's coordinates implementation and progress tracking under the stewardship of the prime Minister's office.

The Joint Annual Health Sector Review (JAHSR) Policy meeting of January 2018 agreed to form an inter-sectoral collaboration thematic discussion group to address social determinants of health (SDH) as per Annual Policy Commitments of 2018/2019. The group comprised the Ministry of Health, Ministry of Water, Ministry of Education, Science and Technology, Ministry of Works, Transport and Communication, Ministry of Agriculture, President's Office-Regional Administration and Local Government and President's Office Public Service Management and Good Governance. Consultation and advocacy meetings on the HiAP concept to address SDH were then conducted at Prime Minister's Office (PMO) as the coordinator of government business for their buy-in. The HiAP concept was well received which led to interministerial collaboration meetings with 13 sectoral ministries that were initially identified. The meetings were convened by PMO in collaboration with the Ministry of Health (MoH) where Directors of Policy and Planning (DPPs) were engaged. They analyzed health-related areas from their sectoral policies and identified areas for inter-sectoral collaboration. High level advocacy meeting with Permanent Secretaries was held in October 2018 where they agreed in HiAP ownership, appointment of sectoral Ministries Liaison person, capacity building of HiAP technical team (i.e. DPPs, Liaison person on minimum), finalization and operationalization of Joint Plan of Action, linkages with existing health Sector Wide Approach (SWAp) reviews and submission of HiAP Framework at high level Ministerial Policy Forums.

The following were achieved as a result of this initiative:

- a) Capacity building sessions, refresher trainings and orientation were conducted to Directors of Policy and Planning, Policy Analysts, Monitoring and Evaluation officers from the sectoral ministries, Academia and Non-State Actors. The forums were used to share knowledge, experience and agree on the way forward in strengthening multisectoral collaboration in addressing SDH through HiAP.
  - b) Draft National HiAP Framework for addressing SDH: development of the framework was expanded to all sectoral ministries to ensure whole-of-government approach. The endorsement of the framework has been delayed since 2022 following covid19, frequent changes of government leadership and staff turnover.
  - c) Integrating health-related focus areas into the policies of thirteen sectors, including non-health ministries. Each sector, including health, education, agriculture, finance, culture, agreed to allocate budgets for SDH priorities relevant to their mandates.
3. Involvement of Tanzania in high level HiAP meetings to share country experience and best practices on multisectoral collaboration in addressing SDH including Tampele University, Finland and Mombasa-Kenya.
  4. Mainstreaming SDHs in Academic Curricula: The Nelson Mandela African Institute and Ifakara Health Institute have incorporated SDHs, gender, and equity into postgraduate programs, creating a pipeline of professionals equipped to implement SDH strategies effectively.

5. Partnerships with academic and non-governmental organizations have produced tangible outputs, such as the Physical Activity Guidelines for Tanzania Mainland and Zanzibar (2021) and the Food-Based Dietary Guidelines (2023).
6. Gender-based violence (GBV) and violence against children (VAC) are addressed through One-Stop Centers in several regions. These centres provide integrated services for victims of violence, supported by regional and district committees tasked with ending violence against women and children.
7. The ECD (Early Childhood Development) Program promotes holistic well-being beyond the “diseases”, addressing nutrition, security, and early learning opportunities.
8. Global Recap group coordinated by the MOH have been engaged to develop and improve regulatory guidelines to address the common social determinants of unhealthy lifestyle related to non-communicable diseases. Multiple partners such as MUHAS, IHI, MZUMBE university, TAWLA, NBS, TFNC and Tanzania Bureau of Standards, were involved. Some related outputs include Physical activity guideline for Tanzanian Mainland and Zanzibar (2021) and Tanzania Mainland Food-Based Dietary Guideline (2023).
9. Population with access to electricity in Tanzania has generally improved. By 2022, about 46% of Tanzanians have access to electricity (Statista, 2024). In 2022, more than 4.5 million people have been provided access to electricity, and adding new connections for more than 1,600 healthcare facilities and nearly 6,000 education facilities. Access to electricity has also supported the creation of employment and business opportunities for many citizens and particularly women, and improved outcomes for students in remote parts of the country (World Bank, 2022).

### 3.3. Challenges

1. Economic empowerment particularly among women is still limited. Although the women participation in economic activities has increased, women are paid less than their male counterparts in the labor force. In addition, the World Health Reports in the year 2022 indicates that although women contribute significantly to Tanzania’s sustained economic growth, persistent gaps such as women’s land tenure security, and poor financial inclusivity for women deter an optimal country’s economic development and contribution. A World Bank study 2018 indicates that increasing women's participation in the workforce could raise Tanzania's GDP by 3.6%. This demonstrates the importance of women’s economic empowerment for the broader development goals of the country.
2. Unreliable electrical supply in most areas of the country remain a challenge and deter optimal health, social and economic development. Although percentage of households connected to electricity in mainland Tanzania has improved, rural areas remains under privileged. Almost nine out of ten households in Dar es Salaam (87 percent) and seven out of ten in other urban areas (70 percent) are connected to electricity. In contrast,

about four in ten households (36 percent) are connected to electricity in rural areas (NBS, 2022).

3. Access to clean water is still lagging behind which pose a critical challenge particularly in rural areas deterring optimal health and social economic development in diverse ways.
4. Misalignment between Tanzania Social Action Fund (TASAF) and MOH social protection initiatives reduces efficiency and effectiveness actions under health in All Policies on vulnerable groups.
5. Delayed Endorsement of Policies: The National HiAP Framework though developed, has yet to be endorsed, slowing progress in strengthening multisectoral collaboration for addressing SDH.
6. Limited Awareness of SDH: Stakeholders at various levels, particularly in primary healthcare and non-health sectors, lack a clear understanding of SDH and HiAP. This hinders their integration into ongoing initiatives.
7. Urban health vulnerabilities related to unhealthy lifestyle are yet to be adequately addressed at optimal. The social determinants of urban health inequities have not been critically examined to provide useful evidence for interventions. This is another source of health inequities.
8. Inadequate Data for Monitoring: Insufficient gender and equity-related data at all levels hinders effective monitoring and evidence-based decision-making.
9. Dependence on External Funding: Many SDH-related programs, such as gender and healthy lifestyle empowerment initiatives rely on short-term external funding, limiting their scalability and sustainability.

### 3.4. Recommendations

1. Social-determinants perspective in the health sector is narrow, it needs to be inclusive to allow broader evaluation of economic opportunities, electricity, water, education, political participation. This may enhance sustainability of multisectoral actions in addressing social determinants of health through health in all policies at all levels/all diseases clusters and at the primary health care level.
2. Comprehensive awareness creation at various levels on the concept of social determinants of health and health in all policies.
3. Strengthen Awareness and Capacity-Building by developing targeted training programs on SDHs, HiAP, and equity concepts for stakeholders across sectors and levels.
4. Universal access to clean water and electricity in urban and rural areas could address multiple social determinants of health.

5. Endorsement of the National HiAP Framework for addressing SDH to strengthen intersectoral collaboration, policies and plans for addressing the underlying determinants of health and improve population health and health equity.

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*“There is still a poor coordination and alignment of the Ministry of health and the TAMISEMI. There is still a miscommunication, or not being as one meaning, not aligning with the common vision when it comes to implementation “ MOH Representative.*

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## 4. Gender equality and equity

**Concept:** Gender is part of the broader socio-cultural context. In this review we define gender within the “socially constructed” aspects of male-female differences (gender) from “biologically determined” (sex) aspects. The emphasis is beyond just “how many” males and females, but on the quality of their relations in all aspects of social-economic, political and health. We have examined gender equity and equality, gender development and health. All these are important components of gender.

Gender **equality** in health and development denotes provision of the equal rights, opportunities and equal access to resources regardless of gender and their social-economic status aiming for equal health and development outcomes (Belingheri, 2021).

Gender **equity** in health and development denotes fairness in the provision of individual resources based on their disadvantages and social-economic vulnerability that aims to improve **fair** health and development outcomes (McDonald, 2000a).

### 4.1. Progress towards the targets

Targets/Commitment	Baseline	Current Achievement	Progress status
Stimulate awareness in gender issues in pre-graduate training	Not very clear	<p>No vivid evidence the support achievement of this target. No vivid evidence that the MOH and ministry of Education have specific interventions to address this commitment.</p> <p>Nevertheless, through the RMNCH unit, MOH has been encouraging girls and boys to pursue education advancement and fight against gender based violence and inequities.</p> <p>There is an inclusion of gender based violence indicators in the routine health facility (DHIS2) which provide progress towards measuring gender-based violence against women and children</p>	Needs attention
The health sector will enhance gender equality in decision making bodies	Limited	<p>Guidelines for CHSB and HFGCs require women &amp; men representation.</p> <p>RMNCH engage with other actors to address social cultural issues that deter gender inequity. They also promote women empowerment in various communities.</p>	Needs attention

## 4.2. Interventions to improve gender equity and equality

1. Gender is integrated in national plans, including the National Women and Gender Development Policy of 2000, the National Strategy for Gender and Development of 2002, the 2016 National Plan of Action to End Violence Against Women and Children, and the National Development Vision 2025
2. Inclusion of gender based violence indicators in the routine health facility (DHIS2) data and national surveillance which provide periodic progress towards measuring gender equity and an entry point in addressing GBV in various regions.
3. Tanzania’s national health policy encourage equitable, quality and affordable basic health services, which are gender sensitive and sustainable
4. Development partners have hugely supported the profile of gender in sexual and reproductive health, to promote for specific milestones in this area, and for the gathering of sex-disaggregated data in the health sector.
5. Gender-Based Violence (GBV) Prevention and Response Plans that works on established protocols within health facilities for GBV survivors, offering medical, psychological, and legal support. This policy addresses the health impacts of GBV, providing safe spaces and treatment for women who experience.
6. One stop centers provide support to adolescents and other people who have experienced gender based violence.

## 4.3. Challenges

### Data related:

1. Limited Gender-Disaggregated Data and Analysis: The HSSP V lack of robust disability and gender-disaggregated data collection and analysis. which limit the comprehensive analysis of how the sector is addressing gender equity. The absence of comprehensive

data, becomes challenging to effectively monitor and evaluate the improvement made in addressing gender inequality and health outcomes, leading to ineffective interventions and resource allocation.

#### **Capacity related:**

2. Capacity for gender analysis and mainstreaming is limited, and largely focused on the **number** of men and women and not the quality of health outcomes attained for men and women to clearly explore the aspects of health which are determined by gender.

#### **Knowledge related:**

3. Weak Promotion of Gender in Primary Healthcare: In the past few years, gender in health concept has not been comprehensively promoted to gain support of all sectors and stakeholders at the primary health care.
4. Limited efforts to enhancing gender awareness in pre-graduate training and improve gender equality in decision making bodies, despite these commitments being in HSSP V.

#### **Gender related:**

5. Gender-Based Violence and Teenage Pregnancy increased. Rising Gender-Based Violence (GBV) Cases: GBV among adults increased by 67% from 159,508 cases in 2019 to 266,417 cases in 2023, with 81% (215,466 cases) affecting women (DHIS1, 2024). Teenage Pregnancy: 22% of women aged 15-19 gave birth in 2022, showing a slight decline from 27% in 2015/16 (TDHS, 2022).
6. Gender based violence against children remains prevalent. Physical violence cases rose from 19,090 to 20,147 in 2024. Emotional violence is the most prevalent type (508,599 cases), followed by physical violence (316,549 cases) and sexual violence (108,846 cases) (DHIS2, 2024).
7. Women and girls who are victims of GBV face stigma when seeking healthcare services, often resulting in underreporting of violence and lack of adequate care. The HSSP V does not sufficiently address how to dismantle these societal barriers to improve service uptake by GBV survivors.
8. Gendered workplace violence at the primary health care is not given attention. This may hinder optimal performance of female health workers in health care delivery.
9. Unmet Commitments on Gender and Disability Inclusion: Despite HSSP-V commitment to enhance disability inclusion and gender awareness in the pre-graduate training, and gender equality in decision making bodies, these aspects have not been adequately achieved.
10. Persistent socio-economic inequalities against women: Gender development index for 2022 shows that women were 28 percent less likely to have the same social-economic opportunities as males in Tanzania. This shows that women in Tanzania are more disadvantaged than men in the all aspects of human development including education, health and income.
11. Under representation of female staff at various leadership positions within the health care system remains significant. The ratio of women versus men staff at the Ministry

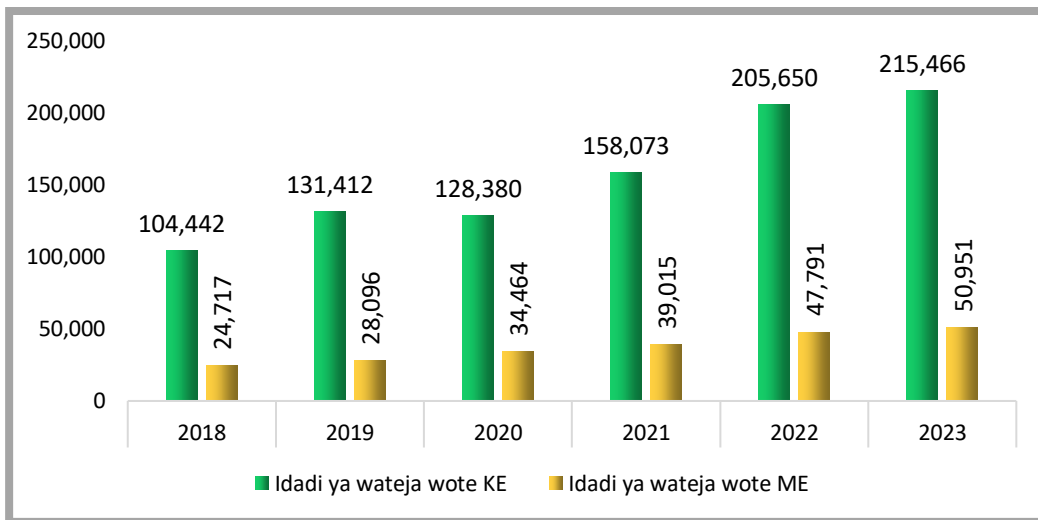
and across various levels of the health care system is wider. For example, Male RMOs are **21**, while females are only **5**. At MoH there are 538 male staff, and 413 female staff.

**Disease burden related:**

- 12. Women still bear the burden of non-communicable diseases. Prevalence of hypertension at older ages among females (8.2%) compared to males (7.7%).
- 13. Gestational diabetes mellitus among pregnant women is 160 out of 582
- 14. HIV prevalence is markedly higher among women than among men in the age groups from 30-49 years (TDHS, 2022).
- 15. Men’s health care seeking is still low, for example, 35% of men age 15–49 have never been tested for HIV (TDHS, 2022).
- 16. Prostate cancer for men is not given the attention it deserves.

**Policy related:**

- 17. Inadequate Gender Mainstreaming in Health Financing Policies: Although HSSP V advocates for a responsive health sector to all demographics, current financing mechanisms fail to incorporate gender-sensitive approaches effectively. The review highlights that female-specific vulnerabilities remain underrepresented in budget allocations, policy adjustments, and program design, which exacerbates disparities rather than minimizing them.
- 18. Narrow Focus of Gender Mainstreaming Efforts: While gender is recognized as a cross cutting issue its operationalization is mainly concentrated in the RCH unit limiting its impact across the broader health sector.



Source: DHSI2

**4.4. Recommendations**

- I. Specific gender equity and equality indicators are needed to monitor progress of health sector performance and identify critical gaps.

2. The national essential health care intervention package, the primary health care structures need to prioritize gender equity and equality measures. This will ensure that a gender sensitive approach takes root in implementation strategies and at the service-delivery level of the health care system.
3. Research on gendered workplace violence at the primary health care is needed to understand how this aspect affect health care worker's performance and motivation.
4. The Ministry of Health need to identify a gender coordinator to improve coordination and integration across several sectors, ministries and structures.
5. Strengthening the capacity of health facilities and management systems to routinely collect, analyze, and use gender-disaggregated data. Gender-disaggregated data is crucial for identifying disparities and developing targeted interventions, enables gender impact assessments, improving decision-making and fostering equity in health resource allocation.
6. Routine data need to guide appropriate awareness creation messages on gender equity and interventions against gender-based violence.

## 5. Equity: Improve health of vulnerable groups

### 5.1. Progress towards the targets

Targets/ Commitment	Baseline	Current achievement	Progress status
<b>Improve health of vulnerable groups</b> by ensuring that the poor and vulnerable groups including <b>adolescents</b> at the grass roots are empowered with health education, covered by health insurance and are able to access health care services	Limited	Moderate progress: Health education has been ongoing but mainly targeting children under five and women.  No sustained health interventions targeting adolescents, people with disability and aged to ensure their access to evidence based services.	Needs Attention

		<p>There is a good progress on universal health insurance. The policy has been signed.</p> <p>The trust/equity fund has been legalized to finance the poor. No evidence on how the chronically ill people will be covered.</p>	
Addressing geographic and social economic disparities	Limited	Every district is served with district hospital both in rural and urban. The challenge of long-distance to the health facilities in rural and urban has been significantly addressed.	On track
Closing the gap between long-distance to health facilities in rural and urban	Limited	Well achieved. Every district is served with the district hospital both in rural and urban areas.	On Track
Ensure that the health system monitor how the vulnerable groups are being reached with health insurance and health care services	Not clear	<p>No concrete monitoring and evaluation report that provide the status of how the vulnerable and poor population are being reached with health insurance and health care services</p> <p>No specific equity indicators in the routine data and in other data systems</p>	Needs attention

## 5.2. Interventions that contributed to Health Equity progress

Endorsement of universal health insurance by the parliament in 2023, is an evidence of government fulfillment of its commitment to ensure that everyone is covered by health insurance and able to access health care.

The trust/equity fund has been legalized to finance the vulnerable groups who have limited capacity to enroll into the health insurance.

Finalization and endorsement of the Primary Health Comprehensive Council Health Plan (CCHP) which will ensure that multiple actors from all sectors are engaged to address the social determinants of health which are the sources of health inequities.

Physical extension of health facilities: Each district in Tanzania has a district hospital with essential surgical services infrastructure. Some health care facilities have been upgraded to enhance universal health coverage. In the period of 2021 to 2024, many more hospitals, health centers and dispensaries in rural and urban areas have been constructed to address the challenge of long-distance to the health facilities and address inequities in access to health

care. However, the quality of care provision remains a challenge especially with regards to adequate qualified, motivated and supervised human resources and functional equipments.

**Madaktari wa Mama Samia (Samia Suluhu Super Specialist Programme):** In the year 2021 to mid-2024, the health sector has implemented important initiatives to ensure equitable access to specialized services through ‘Madaktari wa Mama Samia’ program. One of the critical challenge included in the HSSP-V was an issue of a shortage of specialist doctors and nurses in regional referral hospitals, leading to inadequate healthcare services and long waiting times for patients. This challenge has been posing a critical challenge towards achieving equitable quality health care especially in periphery and marginalized regions.

Samia Suluhu Super Specialist Programme has already shown some success in providing services to patients who needed complicated surgeries in rural and urban areas, address shortage of specialists in Tanzania’s healthcare system particularly in remote rural areas by training doctors and nurses to a higher level of expertise, and ensure that patients regardless of their social-economic background receive the best possible care.

### 5.3. Pending challenges and unfinished business:

1. Despite important progress in addressing equitable health care, most stakeholders felt that the health sector is not fully achieving it’s target of ‘not leaving anyone behind’, since most vulnerable groups especially the majority of the poor people both in rural and urban can’t afford the health care services as they are not covered with health insurance.
2. Limited attention is given to people with disability, NCD and chronically ill people, as well as adolescents, men, and aged. Their health care needs are not clearly explored and there are no comprehensive interventions that responds to their needs.
3. Stakeholders felt that the rising burden of NCD and the associated high costs of NCD management implies that many chronically ill people are left behind because they cannot afford the services:

*“NCD is rising and cost of treatment is high. The burden of NCDs now account for about two-fifths of all disability-adjusted life years (DALYs) as well as 34% and 31% of all deaths and premature deaths, respectively, has doubled in the past two decades. The majority of primary healthcare facilities are not adequately prepared to manage NCDs. Rural and hard to reach population including nomads have accessibility challenges” – NGO Representative*

4. Increasing disparities between rural and urban still require major investment. Recent evidence suggests that there is increasing disparities in health outcomes between rural

**The challenge of physical distance to health facilities has been greatly addressed.....  
BUT**

*“But remember that ‘availability is not accessibility’, still there are people who are sick but cannot go to the health facilities because they cannot afford the services. Moreover, the current health facility structures have not been prepared to respond to the needs of elderly people, people with disability, and adolescents. We need to “change a narrative, moving from availability of health facilities to accessibility of quality health services [NGO, Representative]*

and urban. Rural residents remain to be the most vulnerable groups (Kitole et al ,2023).

5. Lack of specific equity indicators to monitor and evaluate progress towards reaching equitable health care access in Tanzania. HSSP-V consider equity as a cross cutting pillar, however it is not addressed in all health systems clusters.
6. Adolescents in Tanzania represent more than 13% of the entire population however, there is limited investment on adolescents' health despite a clear evidence of increasing complexity of their health and well-being. This is a missed opportunity towards long-term investment in healthy adulthood. The next HSSP need to strategically emphasize about investment in adolescent health and well-being with clear strategies.
7. Urban health vulnerabilities related to unhealthy lifestyle are yet to be adequately addressed at optimal. The social determinants of urban health inequities have not been critically examined to provide useful evidence for interventions.

Multiple stakeholders had varied views emphasizing that the health sector is yet to adequately address the issue of equitable health care:

*“No, we are not (we are not reaching the target of ‘not leaving anyone behind’). If you are a poor in this country, and you are sick, you cannot afford the care, you are left Behind’ (we are) not yet fully (achieving the target) in health service delivery, and it affects both genders”*

*“The health care providers have not been trained on sign+languages, how do you expect them to provide appropriate services to the disabled people? and there is also insufficient walk ways and ram, and other supporting infrastructure for disabled people. That means we may be leaving this group of population behind because their health care needs are not addressed”*

*“In certain aspects males are not reached properly, for example, males on HIV medication are disadvantaged because they are often working, so the working hours of clinics are not convenient, and then they feel easier stigmatized at a health facility. Women feel much more comfortable accessing the health services than males. So, that is one side. TDHS (2022) report shows that 35% of men age 15–49 have never been tested for HIV”.*

*“We need a holistic approach for older people, although they are exempted but experience difficulties in accessing the exemption at the health care. They usually have multiple health issues in the same body at the same time. So, you need nurses and doctors who are experts in many fields for example like eye care but also in mental health, also in orthopaedic surgery and also in diabetes. In Tanzania there is no geriatrics at the primary health care as a specialization at degree or diploma level, there are plans but hardly any action yet as it requires resources. So, the emphasis on geriatrics is new, it is a priority”.*

#### 5.4. Recommendations

1. Develop specific equity indicators to monitor how vulnerable groups, disabled, aged and poor in rural and urban residence are accessing health care.
2. Health information systems, and national surveys need to include specific equity indicators that are of priorities to the local context such as gender and health, aged and health in rural/urban disparities and inclusivity. The progress to be presented during sector review and technical working committees.

3. Analysis of achievements on health care access need to be assessed at ward and village level, beyond the district level.
4. Create localized mechanism/funds and implementation plan to support sustained effort to delivering specialized health care in rural and urban areas by recruiting the unemployed professionals rather than removing experts from their point of care.
5. Strengthen the geriatrics services and other multiple services that respond to the needs of older people.
6. Capacity strengthening (trainings, guidelines, policies) that are being delivered for public health care providers should also be provided to the private health care providers to create standardized care in public and private health facilities.
7. Ensure that the expert that has been invested by Mama Samia program is available within regions, and fully shared and scaled up in all district hospitals.
8. Functional and equitable health insurance for all is imperative to achieve equitable health care in line with the HSSP-V target of not leaving anyone behind. This require, identifying individuals in the informal sector to determine the most effective approach for including them in health insurance scheme. The current health insurance initiative need to recognize that the poor and vulnerable populations continue to be disproportionately excluded from various social health protection schemes as such strategic actions are needed to increase equitable access to health insurance.

One stakeholder had the following opinion:

*“The number one priority is that health is a human right, so, a functional and affordable health insurance system is to me essential, for an amount that can be afforded. Currently we do not have that functional nor appreciated. Recent statistics show that poor families pay per year up to 20 or 30% of their income to healthcare while employed people only pay 6% of their monthly income for insurance. So, we need an honest, functional and effective insurance system.”- Health system advisor.*

9. Strengthen the urban health initiatives to address vulnerabilities related to environmental hazards, unhealthy lifestyles such as sedentary life, unhealthy food consumption, limited physical exercise, and pollution. Best practices emanated from projects such as “Equity Promotion Project for the Marginalized living in Urban settings in Dar es salaam, Tanzania” implemented by Ifakara Health Institute (<https://ihi.or.tz/our-projects/project/112/details/>) need to be critically analyzed and scaled up.
10. Improve quality of health care at the primary health care in rural and urban to ensure that the poor people have good access to such services. This can be achieved through medical audit, good quantification strategies, improve supply chain system management, strengthening relationship/collaborating with private sector, improve budgeting and ordering, good storage system and other hiccups which may be identified through continuous monitoring (for medical and supply thematic area).

11. A systematic monitoring and evaluation of the impact of ‘Mama Samia program’ and its cost effectiveness is important to support scaling up and sustainability of such programs throughout the country.

## 6. Strengthening Public Private Partnership for Health (PPPH) to improve availability of quality health services

### 6.1. Progress toward the targets

Targets/ Commitment	Baseline	Current achievement	Progress status
Placement contracts or service level agreements.	Limited	Placement contracts implemented in several health facilities, enhancing diagnostics access. 86 Faith Based Organizations (FBOs) have entered a service agreement with the local government for the provision of services.	<b>On Track</b>
Monitoring of Private health care facilities to ensure compliance with existing contracts and guidelines.	Inconsistent	Monitoring improved but coverage remains limited	<b>Needs Attention</b>
Establishing a single registration, accreditation and certification system for healthcare services	Non existent	Legal structure under development Several laboratories are accredited at a high cost.	<b>Needs Attention</b>
Strengthening the monitoring of private sector performance	Weak		<b>Needs Attention</b>

### 6.2. Interventions that contributed to PPP

1. Revitalization of Technical Working Group 4 on PPPs is creating a favorable environment for private health sector participation, including faith-based hospitals and pharmaceutical companies. In addition to TWG, regular PPP dialogues involving MoH, POLARG, the Christian Service Commission (CSC), and the Association of Private Health Facilities of Tanzania (APHFTA) have strengthened communication and collaboration.
2. National PPP Policy Strategy (2021/22–2025/26) and the PPP Act (2023) were developed to provide a legal framework for private sector engagement. The implementation is

showing transitioning from viewing private entities as competitors to recognizing their integral role in healthcare delivery.

3. About 86 FBOs have entered the service agreements with local governments, aligning their services with national health sector policies. Under these agreements, the government covers salaries for some healthcare workers, provide supervision, and offer subsidies for selected medical commodities.
4. Enhanced partnerships have created a conducive environment for medical tourism and foreign specialist camps, increasing service offerings and attracting international patients.
5. Expanded prime vendor systems have increased efficiency in delivering medicines and medical supplies to public health facilities, improving availability.
6. Partnerships with local pharmaceutical companies, such as Kairuki Pharmaceuticals Ltd and Shelly's, are improving the supply of intravenous fluids and medicines. MSD plans to establish a manufacturing plant in the southeastern zone to strengthen supply chains.
7. Placement contracts have equipped hospitals with diagnostic machines, suppliers covering installation and maintenance costs. This arrangement ensures technological updates at no additional cost to the government.
8. The establishment of a dedicated PPP desk at MoH, with an appointed coordinator, has improved oversight and operational support for PPP initiatives.
9. Service agreements with FBOs and private facilities have contributed in expanding healthcare access, especially in urban centers where over 70% of health services are delivered by private entities and in underserved areas, narrowing gaps in service delivery.
10. Subsidies and salary support for private facility staff contribute to social protection but lack a structured monitoring framework.

### 6.3. Challenges

1. Many stakeholders have limited understanding of PPP frameworks, hindering effective collaboration and implementation.
2. Despite the prime vendor system, rural areas continue to experience shortages of essential medicines and supplies
3. Many doctors working in private facilities are also employed in government hospitals. Nonregulated dual employment arrangement undermines public sector health facilities performance.
4. While efforts to establish a single registration and accreditation system are underway, delays in developing the legal framework is leading to insufficient alignment between quality management systems in the public and private sectors, affecting service delivery consistency.

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*MOH (Ministry of Health) has very little info what is happening in the private sector, what is the quality, what is being monitored and how is it reported. We have no way to link it with our national monitoring plan. So that is a big area, where we still need to work on.*

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## 6.4. Recommendations

1. Finalize Accreditation Systems. Expedite the establishment of a single accreditation and certification system to streamline quality assurance processes across sectors.
2. Provide awareness about PPP modality of working to stimulate the buying among various stakeholders.
3. PPP in health sector need to develop and implement a staff benefit motivational package and retention plan that would favor both public and private.
4. Promote optimization of quality care in public and private health facilities in big cities and in rural areas. In cities, private health facilities provide many health services to many people including government officials.
5. More research is needed to inform about the best modality that would improve the performance of PPP widely to contribute to the optimal quality of care.

## 7. Strengthening accountability and leadership in the health sector for better results

### 7.1. Progress toward the targets

Targets/ Commitment	Baseline	Current achievement	Progress status
MOHCDGEC and PO-RALG will continue developing leadership performance management tools and assessment	Achieved	Initial steps taken. In Collaboration with Development Partners;-MOH has developed the training materials for leadership performance management tools and the training is conducted in the Training Centers (CEDHA -Arusha) PHC -Iringa	On track
The MOHCDGEC will stimulate awareness-raising and competency	Moderately achieved.	Need to strengthen Advocacy Communication Strategy to	Needs Attention

Targets/ Commitment	Baseline	Current achievement	Progress status
development among health staff at all levels		ensure all the strategic documents are timely disseminated and not only distributed	
Develop a resource mobilization plan, monitoring and evaluation.	Weak	Resource mobilization plan drafted	Needs Attention
Strengthen planning, budgeting, execution, monitoring and evaluation	Fragmented	Increased integration but gaps remain in execution	On Track
Capacitate RMOs, DMOs, and health managers with managerial skills	Ad hoc	<ul style="list-style-type: none"> <li>• Training programs conducted;</li> <li>• Broader reach needed</li> </ul>	On Track but additional resources needed

## 7.2. Interventions that contributed to progress accountability and leadership

- I. Decentralization of health planning and implementation to Council Health Management Teams (CHMTs) initiated since the introduction of health sector reforms in the 1990s, has empowered local health systems but requires continuous investment in leadership and accountability mechanisms.
  - District councils prepare annual CCHPs reflecting local priorities and allocate funds to address critical needs at district hospitals, health centers, and dispensaries.
  - Community representatives are tasked to identifying health priorities and participating in budgeting, planning and monitoring. They also mobilize communities for the construction of health facilities.
  - Ward meetings are held quarterly to gather community input, integrating citizen perspectives into health system decisions.

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*“Our task is to provide guidance, we let the council members plan and decide what they want to implement we just provide minimal guidance, and they are allowed to budget and relocate their source collections” [District representative]*

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2. Over the years, capacity-building activities have targeted CHMTs, council members, hospital boards, and Health Facility Governing Committees (HFGCs). These stakeholders have been trained on their roles, financial management, planning, and decision-making to enhance health service delivery.

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*“We trust these health facility committees and hospital boards since they are trained on the roles so we let them decide and plan for the sake of improving health services in their communities”*  
*[Regional representative]*

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3. Funds generated through user fees, health insurance schemes, and other sources are managed by HFGCs. Community members collaborate with facility in-charges to prepare budgets and monitor expenditures, ensuring transparency and alignment with community needs.
  4. Through multiple meetings, various stakeholders have been receiving and providing feedback on sector’s performance progress at all levels. The feedback is stronger as you move up to the higher level and becomes weaker to the primary and community level.
  5. The governing boards, council and the HFGCs usually voice against the common challenges related to medicine stock out, human resource, and diagnosis equipment. This has contributed to the improved availability of those items in the health facilities.
  6. The CHMT conduct supportive supervision in the health facilities. During the supervision they review the facility expenditure and provide advice to the facility management.
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7. Reducing practice of lobbying, claiming, giving, and receiving bribes. The interviews with various participants have suggested that the practices of lobbying, claiming, giving and bribes have reduced for the past few years. Possible measures include staff motivation; regular training to the health care providers on moral issues related to employment values and policies; friendly language; electronic payment system to minimize the cash in hand; improving working environment to ensure availability of equipment to support several functions; holding accountable staff who mistreat patients; allocation of social welfare officers to support patient’s social welfare. Some health facility billboards contain the telephone numbers of DMOs, RMOs to assist in providing opinions or report any practices related to bribe. Some health facilities have posted information on the types of services which are being provided and the prices.

### 7.3. Challenges and unfinished agenda

1. The Council Health Service Board and HFGC guidelines, revised in 2022, remain unsigned, hindering optimal community participation and implementation.
2. Poor data quality due to errors, incomplete records, and inadequate staff training, weak IT infrastructure, inconsistent electricity, and internet connectivity hinder effective use of DHIS2 data for decision making.
3. While efforts to reduce bribery and lobbying have shown progress, some community members are hesitant to report unethical practices.

### 7.4. Recommendation

1. Improve feedback on health sector performance to the community and at the primary health care level. PORALG and MOH together with the primary health care officials need to strategize this aspect.

## 8. Strengthening Multisectoral collaboration

### 8.1. Progress towards strengthening multisectoral action

Promotion of multisectoral collaboration and concept has improved since the launching of the HSSP-V involving several sectors such as the ministry of education, ministry of finance, ministry of agriculture, ministry of culture, arts and sports, media, prime minister's office, regulatory authorities such as Tanzania bureau of standards.

### 8.2. Interventions that contributed to progress

The Prime Minister's Office remain active player in coordinating and facilitating multisectoral actions to address various issues and challenges that span across different government sectors.

Coordination of the multisectoral actions has been institutionalized for HIV/AIDS, Malaria, NCDs, and Nutrition within their specific clusters.

Advancement in multisectoral action has been evidence with NCD multisectoral Steering committee which is being chaired by the Permanent Secretary in the Prime Minister's Office.

The Ministry of Health play a key role in the multisectoral action as the secretariat of the NCD Steering Committee which includes representation from health and non-health sectors (i.e.; Health in All Policies) such as Ministry of Education, Science and Technology; Ministry of Information, Communication and Information Technology; Ministry of Culture Arts and Sports, and the Regional Administration and Local Government.

The Regional, District and Ward/Village Multisectoral Committees meet at least four times a year, oversee day-to-day multisectoral activities. Participating partners and ministries fund their own representatives to attend the meetings, and additional support is provided by development partners such as WHO and the Tanzania Diabetes Association, if needed.

### 8.3. Challenges and unfinished agenda

1. Awareness of the importance of multisectoral approach remains limited among the primary health care level committee members and non-health sectors.
2. The coordination of multisectoral actions are fragmented across various disease clusters which limit sharing of resources, lessons and systemic achievements
3. There is no clarity on how the PMO can effectively coordinate all multisectoral actions in the country.
4. Activeness of and effectiveness of Multisector actions are mainly confined to some specific diseases such as NCDs, HIV/AIDS, leaving out the focus on the social determinants of health which contribute to the general well-being of the people.
5. Some confusion exists among stakeholders on these two concepts, multisectoral and health in all policies. It is important that there is a clarity on how the two concepts are implemented within the same sector.

### 8.4. Recommendations

1. The multisectoral approach needs to be defined comprehensively with clear roles and responsibilities in the HSSPs. Health in All Policies (HiAP) approach may help in that also the SWAp governance structure.
2. Activeness of and effectiveness of Multisector action should not only be on specific clusters such as NCDs, Nutrition and HIV/AIDS, but the focus should be in addressing the broader social determinants of health that can be addressed by all sectors across disease clusters.
3. Integration of multisectorial collaboration is important to prevent fragmentation and improve efficiency. For example, the Nutrition multisectoral action can be merged with NCD multisectorial action as well as with HIV/AIDS. Besides with co-morbidities, the health system is now moving towards integration of services and initiatives to improve efficiency.
4. Improve collaboration between POLARG, MOH and Ministry of Community development, other non-health sectors and private sectors to drive the implementation of various HSSP V strategic outcomes at the primary health level including at the community level.
5. There should be proper formulated platforms where progress on inter-sectors outcomes will be shared to maintain performance.
6. The ongoing multisectoral forums are good but need to have more discussion on how the PMO can effectively coordinate all. Here is where the contribution of HiAP is crucial as an umbrella approach.

## 9. Strengthening SWAp to reduce duplication of efforts in the health sector

### 9.1. Progress toward the targets

Targets/ Commitment	Baseline	Current achievement	Progress status
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Foster SWAp dialogue structure to reaffirm principles of development cooperation	Weak	Established active forums; Progress in alignment to national health structures and accountability.	On Track
Align SWAp TWG formation with six health system building blocks	Fragmented	TWGs not fully aligned; Disease-oriented sub-groups are more functional.	Partially achieved but needs Attention
Decentralize SWAp structures to regional and district levels	Non existent	Structures created at some levels but even without these structures, Coordination is stronger at decentralized levels.	
Increase transparency in off-budget funding with partners	Limited	Resource tracking studies and reporting on off-budget funding have improved but not all the resources are captured.	Needs Attention
Foster SWAp dialogue structure to reaffirm principles of development cooperation	Limited	Active forums established; progress in alignment to Government agenda.	Needs attention
Create of single platform for policy	Limited	Platform for clinical and public health guidelines created Mapping of policies and strategies ongoing	On Track

## 9.2. Interventions that contributed to progress

The SWAp framework in Tanzania integrates multiple stakeholders, including government entities (MOH, PORALG, MOF), development partners (DPGs), private service providers, CSOs, and NGOs. Key interventions have strengthened dialogue, coordination, and resource management within the health sector. Within MOH, various TWGs address technical issues with stakeholders

### I. Annual Dialogue Platforms

- Joint Annual Health Sector Review (JAHSR)-Technical Review and Policy Meetings have been held annually, with broad participation to assess implementation progress, prioritize policy commitments and coordinate resource mobilization efforts.

- Annual Regional and District Medical Officers (RMOs and DMOs) meetings have been reviewing implementation of health policies and plans at the primary healthcare level.
  - Joint Annual Field Visits preceding the JAHSR have strengthened the understanding of sector realities and promoted actionable feedback among national and subnational stakeholders.
2. **The Basket Fund Mechanism**, supported by multiple development partners, continues to function effectively to provide a flexible funding mechanism aligned with HSSP-V priorities directly to primary health care facilities. The recent participation of a new development partner underscores the mechanism's credibility.
  3. **SWAp Technical Committee (TC)** quarterly meetings bring together Government representatives and SWAp members to review progress in implementing HSSP-V under the leadership of the Ministry of Health Permanent Secretary.
  4. **Some RMOs and DMOs are leading SWAp activities at regional and district levels.** A platform is under development to facilitate their access to policy documents and subsector plans.
  5. Government leadership in SWAp processes has increased, with regular forums and dialogue platforms established.
  6. **Technical Working Groups (TWGs)** aligned with 10 HSSP V thematic areas provide technical guidance and support evidence-based decision-making. Disease oriented technical working groups were transformed in sub-groups. Members participate in supervision visits and contribute to the elaboration of JAHSR progress reports.  
  
However, the functionality and regularity of TWGs need to be improved to ensure evidence utilization in decision making, clear terms of references, documentation sustainable funding to support implementation of action plans.
  7. Decentralized structures and basket funding are promoting local accountability, though integration at subnational levels needs improvement to avoid fragmentation.
  8. JAHSR provides a robust mechanism for monitoring sector performance aligning priorities, and addressing resource allocation gaps.
  9. In-person-only TWG meetings limit attendance and increase costs, hindering consensus building for decision-making.

### 9.3. Challenges and unfinished agenda

1. **Inactive or Inconsistent TWG Participation:** Competing priorities of TWG members often result in inconsistent attendance. Low attendance for some TWGs may be explained by inability to access reliable and synthesized evidence for decision-making.
2. **Funding Constraints:** Poor coordination of on-budget and off-budget funding streams limits predictability. Dependence on external funding, and resistance to adopting technology for organize online meetings delays activities planning and

implementation for some of the TWGs and increases missed opportunities for resource-saving.

3. **Transparency Issues:** Efforts to improve off-budget funding transparency remain insufficient, limiting accountability and alignment of external funding with HSSP-V.
4. **Frequent ad hoc meetings** disrupt the agreed SWAp calendar, causing delays in decision-making and coordination.
5. Subnational SWAp structures are not yet fully operational, **limiting the effectiveness of RMOs and DMOs in leading localized coordination efforts.**
6. **Leadership skills:** although SWAp structures are managed by professionals but some of them have not received leadership training.
7. Lack of orientation for the new members: in the past few years there has been re-allocation of the members and some of the old member retiring. But there is limited orientation sessions given to the new members which affect activeness of the committees.

#### 9.4. Recommendations

All the above challenges require concrete plan of action to improve the functionality of the TWG, governance and leadership.

*“I think that the TWG need fully employed staff who will coordinate two or three TWGs. The current leaders are employed and they cannot commit adequate time to coordinate the functionality of the groups and follow up the progress and commitments. Sometimes it takes time for the meeting to happen and the meetings actually depend on the availability of funds from donors. The DPG is working very effectively because we decided to employ a person who will provide adequate time in the coordination of the group. They need to employ a secretariat which will support the functions of the TWGs” – TWG Representative.*

## 10. Recommendations for different Directorates and offices of Ministries

**Directorate of Policy and Planning** to develop a robust, evidence-based methodology for problem analysis and prioritization of health outcomes and interventions by July 2025 to inform the HSSP IV.

**The Office of Chief Medical Officer** to disseminate the Primary Health Services Implementation Development Strategy (PHSIDS) and revised Primary Health Care Committee (PHCC) guidelines to implementers and communities before June 2025.

**Ministry of Health 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 by June 2025.

**Directorate of policy and planning in collaboration with the Ministry of Finance and Planning (MOFP)**, 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 Joint Annual Health Sector Reviews.

**PORALG** to institutionalize quarterly joint monitoring meeting at District and Regional level with the participation of SWAp members at regional and district levels, with clear mandates and resource allocation before December 2025.

**Ministry of Health ICT Unit** to develop and operationalize an electronic platform for accessing policy plans, strategic documents, and guidelines by December 2025 to improve coordination and accountability.

**Ministry of Health Permanent Secretary to instruct** adoption of online platforms for hybrid TWG meetings by March 2024 to reduce costs and improve participation.

**Ministry of Health Permanent Secretary and DPG-Health Chair** to convene biannual high-level meetings with Gavi, Global Fund, and Global Financing Facility starting from January 2025 to align off-budget funding with national health priorities.

**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 before September 2025.

**PORALG and local councils** to expand community representation in Health Facility Governing Committees (HFGCs) and establish digital feedback channels for underserved populations by June 2025.

**Ministry of Health Policy and planning** to missioned with technical support of WHO and UNICEF, a study on urban health inequities and tailored interventions addressing key vulnerabilities, by December 2025.

**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.

**Ministry of Health Monitoring and Evaluation Unit** to establish a robust monitoring framework with gender- and equity-disaggregated indicators to track progress in addressing health inequities before July 2025.

**Ministry of Health ICT Unit**, with support from development partners, to design a comprehensive digital transformation program for primary health care facilities by December 2025 to enhance data collection and use.

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## 12. Updated result frameworks

Results	Baseline 2023	Target 2026	Milestone 2025	Source of Data	Preconditions	Responsible for Implementation
<b>Outcome 1.:</b> Governance and Leadership for Health Sector Performance is strengthened	Weak accountability and limited leadership capacity at regional and district levels	Full operational accountability framework implemented and leadership strengthened at all levels	80% of targeted leadership positions trained and functioning effectively	JAHSR Reports, TWG Progress Reports	adequate funding allocated for leadership programs mobilized	MOH, PORALG, and RHMTs/CHMTs
<b>Output 1.1:</b> Develop leadership performance management tools and assessments	No standardized leadership performance tools exist	Tools developed, piloted, and rolled out to all regions and districts	Tools piloted in 50% of regions	Annual Leadership Assessment Report	TWGs operational; funding for tools and assessments secured	MOH Monitoring and Evaluation Unit
<b>Output 1.2:</b> Build capacity of health leaders (RMOs, DMOs) in leadership and evidence-based decision-making	Limited training programs available	100% of targeted leaders trained	70% of targeted leaders trained	Training Reports, JAHSR Updates	Training modules finalized; Capacity-building partners engaged and aligned	MOH Training Department, PORALG

Results	Baseline 2023	Target 2026	Milestone 2025	Source of Data	Preconditions	Responsible for Implementation
<b>Outcome 2:</b> Transparency in Health Sector Funding is enhanced and resources allocated based on outputs	Resource tracking is fragmented and limited to on-budget funds	Comprehensive resource tracking system operational, capturing off-budget funds	75% of resource tracking system components operational	Annual Resource Tracking Reports	Collaboration with partners to align funding; IT infrastructure secured	MOH, MOFP, Development Partners
<b>Output 2.1:</b> Expand resource tracking studies to include off-budget funding	Only on-budget resources tracked	Off-budget funds included in all tracking studies	Off-budget funding captured for 50% of districts	Annual Financial Reports	Engagement with off-budget funders	MOH, MOFP, and DPG-H
<b>Output 2.2:</b> Develop and operationalize an electronic platform for accessing health sector financial data	No centralized platform exists	Platform operational and accessible to stakeholders	Platform piloted and feedback integrated	Platform Progress Reports, Stakeholder Feedback	IT resources available; stakeholder buy-in secured	MOH IT Unit, MOFP

Results	Baseline 2023	Target 2026	Milestone 2025	Source of Data	Preconditions	Responsible for Implementation
<b>Outcome 3: Multisectoral Collaboration strengthened to Address Social Determinants of Health (SDH)</b>	HiAP framework draft exists but is not endorsed or implemented	HiAP framework endorsed, operationalized, and integrated into sectoral plans	Framework endorsed and initial implementation underway	HiAP Progress Reports	Political will and multisectoral collaboration sustained	MOH, Prime Minister's Office, PORALG

Results	Baseline 2023	Target 2026	Milestone 2025	Source of Data	Preconditions	Responsible for Implementation
<b>Output 3.1:</b> Conduct capacity-building on SDH and HiAP for key sectoral stakeholders	Limited understanding of SDH and HiAP concepts	100% of targeted stakeholders trained	70% of stakeholders trained	Training Reports, Workshop Evaluations	Development of training modules completed	MOH, WHO, Development Partners
<b>Output 3.2:</b> Pilot multisectoral actions for addressing urban health inequities	Urban health inequities poorly understood and unaddressed	Pilots completed in 3 major urban areas	Baseline studies and initial pilots completed	Baseline Study Reports, Pilot Evaluations	Partnership with urban planning authorities established	MOH, PORALG, Urban Councils
Results	Baseline 2023	Target 2026	Milestone 2025	Source of Data	Preconditions	Responsible for Implementation
<b>Outcome 4.1:</b> Access to Quality Health Services through Strengthened Public-Private Partnerships (PPP) is improved	Limited PPP implementation; weak monitoring of private sector compliance	PPP agreements expanded to 90% of regions with monitoring frameworks operational	PPP agreements expanded to 60% of regions	PPP Progress Reports	PPP policy finalized; monitoring tools developed	MOH, APHFTA, FBOs
<b>Output 4.1:</b> Develop a single accreditation and certification system for private healthcare facilities	Fragmented accreditation and certification processes	Accreditation system established and operational	System piloted in select regions	Accreditation Reports	Policy endorsement and implementation roadmap in place	MOH Regulatory Division
<b>Output 4.2:</b> Expand prime vendor systems to rural areas to improve access to essential medicines	Limited rural implementation	Prime vendor system operational in 80% of rural districts	Vendor systems piloted in	Vendor Progress Reports	Partnerships with vendors established	MOH, MSD, Private Vendors

Results	Baseline 2023	Target 2026	Milestone 2025	Source of Data	Preconditions	Responsible for Implementation
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50% of rural districts