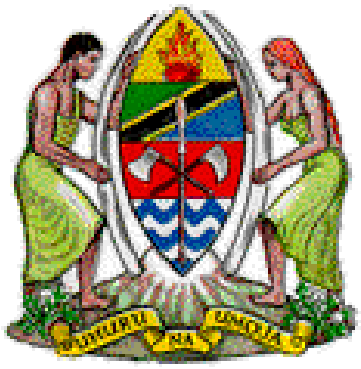

Health Sector Performance Profile Report 2008 Update

Mainland Tanzania July 2007 – June 2008

Ministry of Health and Social Welfare

October 6, 2008

HEALTH SECTOR PERFORMANCE PROFILE REPORT 2008 UPDATE

Mainland Tanzania July 2007 – June 2008

Acronyms

ADDO	Accredited Drug Dispensing Outlet
CCHP	Comprehensive Council Health Plan
CFS	Consolidated Fund Services
CHMT	Council Health Management Team
CM	Child Mortality
CSO	Civil Society Organisation
DSM	Dar es Salaam
FBO	Faith-Based Organisation
FP	Family Planning
FY	Financial Year
GFATM	Global fund for AIDS TB and Malaria
GOT	Government of Tanzania
HC	Health Centre
HMIS	Health Management Information System
HR	Human Resources
IMCI	Integrated Management of Childhood Illness
IMR	Infant Mortality Rate
ITN	Insecticide-Treated Net
JAHSR	Joint Annual Health Sector REview
KCMC	Kilimanjaro Christian Medical Centre
LGA	Local Government Authority
MOFEA	Ministry of Finance and Economic Affairs
MOHSW	Ministry of Health and Social Welfare
MSD	Medical Stores Department
MTEF	Medium Term Expenditure Framework
NHIF	National Health Insurance Fund
NIMR	National Institute of Medical Research
NN	Neonatal
OC	Other Charges
ORCI	Ocean Road Cancer Institute
PE	Personal Emoluments
PER	Public Expenditure Review
PNN	Post-Neonatal
POPSM	President's Office, Public Service Management
RCHS	Reproductive and Child Health Section
RHMT	Regional Health Management Team
STI	Sexually Transmitted Infection
TB	Tuberculosis
TDHS	Tanzania Demographic and Health Survey
THMIS	Tanzania HIV/AIDS and Malaria Indicator Survey
TSPA	Tanzania Service Provision Assessment

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Foreword

This ***Health Sector Performance Profile Report*** presents the assessment of health system performance in Mainland Tanzania for financial year 2007/8. The Ministry of Health and Social Welfare (MoHSW) considers the role of Monitoring and Evaluation as an important instrument for measuring inputs; process; outcomes and impact. In this way we can measure progress towards national Policy objectives and international commitments. The assessment also identifies areas were performance has been lower than expected so that remedial measures can be taken.

This year's report follows a new format developed for Annual Performance Assessment of MDAs, developed by the Ministry of Finance and Economic Affairs. This covers all of the areas included in last year's Performance Assessment report plus some new ones. The major components of the assessment are:

- Performance against the 33 health sector performance indicators (including MKUKUTA and PAF indicators)
- Assessment of progress towards milestones agreed at last year's Joint Annual Health Sector Review
- Implementation status of activities, targets and strategic objectives set out in the MTEF
- Assessment of health service performance at the Council level
- Highlight of key findings of the Public Expenditure Review for the Health Sector
- Assessment of the current status of Human Resources for the sector
- Conclusions (including outstanding issues and challenges)

Every effort has been made in this report to assemble available information, check it, and report accurately on the various indicators. Multiple sources of information have been used. The milestone assessment is a narrative report on actions taken and achievements registered. The MTEF report draws upon the implementation status of all of the activities in the current year MOHSW plan and budget (grouped according to strategic objectives). The PER section draws from latest health sector Public Expenditure Review, supplemented by additional analysis. The section on council health sector performance draws upon the analysis conducted of 132 Comprehensive Council Health Plans as well as the progress reports for the third quarter of FY 2007/8. The chapter on Human Resources is based upon a new analysis using the HR data contained in government's payroll database.

Reporting on the 33 health sector performance indicators has drawn upon data from a number of sources. The Tanzania HIV/AIDS and Malaria Indicator survey is the source for most of the new data on HIV, malaria and childhood mortality. Human Resource comes from the payroll database. Financial indicators come from the PER, supplemented by further analysis that was undertaken on data for health in Ministry of Finance spreadsheet reports of local government expenditures and budgets. Reports on performance on TB control, EPI , Reproductive Health and ART for HIV patients come from records maintained by the respective sections.

While the report undoubtedly makes a major contribution to Monitoring and Evaluation, its scope has been limited by some constraints, notably problems with the availability of robust and credible routine data. This highlights the importance of strengthening the Health Management Information System.

The work was done under the coordination of the Directorate of Policy and Planning through Health Information and Research Section in collaboration with Joint Annual Health Sector Review Organizing Committee. Thanks are cordially extended to all who participated in one way or another in this endeavor. My sincere appreciation is expressed to Ifakara Health Institute who assisted with checking and assembling data, compiling the text and editing the final version.

Now the challenge is how this report will be effective in improving health delivery systems in the country.

Mr. Wilson C. Mukama
Permanent Secretary,
Ministry of Health and Social Welfare, Mainland Tanzania.

Executive Summary

This report provides a comprehensive and objective assessment of the performance of the health sector for financial year 2007/8.

Wherever possible, data have been updated for the 33 health sector performance indicators – which also include a sub-set of MKUKUTA and PAF indicators. As in previous years, a minority of indicators could not be updated owing to limitations with the routine data systems. The picture that emerges is quite encouraging. Financial resources for health have continued to increase, with a larger share being allocated to the regional and district levels in line with government's "decentralization by devolution" policy. New data from the THMIS on childhood mortality confirms a major improvement in the early years of the new millennium. The same survey found a reduction in HIV prevalence, including both males and females between 15 and 24 years of age. Similarly, a range of indicators demonstrate major progress in malaria control – that has already translated into lower rates of severe anaemia and lower incidence of fever in under-fives. Tuberculosis control also exhibits strong performance – with a year-on-year increase in the cure rate over the past five years. The proportion of deliveries that take place in health facilities also appears to have increased – a pre-requisite for making progress on the Roadmap for Maternal, Neonatal and Child Health. One indicator (DPT-HB3 immunisation) has a declining trend over the past three years, albeit from quite a high level.

A detailed description is provided of progress towards milestones agreed at last year's Joint Annual Health Sector Review. Out of 15 milestones, 3 were fully-achieved; 10 were partially-achieved and 2 were not achieved. But this crude assessment obscures the fact that significant advances in all of the areas specified by the milestones.

The assessment of MTEF implementation illustrates that two thirds of activities specified were fully implemented and a further quarter were largely implemented. This leaves only around 11% of all activities in the MTEF for which implementation was partial (40-%-60% implemented) or poor (less than 40% implemented).

Key findings are presented from the assessment of Comprehensive Council Health Plans and the third quarter technical and financial reports from 132 councils. The standard of technical reports was high, with 88% of councils meeting the required threshold score. Performance on financial reports was poorer, with 40% of councils failing to make the grade without extra assistance. This is partly because of some confusion over content, partly due to high turnover of health sector accounts staff, and partly due to inadequate supportive supervision from the regions.

The public expenditure review highlights document a continued increase in total expenditure on health, almost doubling in dollar terms per capita from $7.4 in FY2004/5 to reach $14 in FY 2007/8. This partly reflects an overall expansion of government expenditure. As a share of the total, health declined by about one percentage point to slightly less than 10% of the government budget in 2007/8. Over the last two years a greater share of health resources are controlled at Regional and Council level – although the latter is largely attributable to increases in salaries. Recurrent budget execution improved between 2005/6 and 2006/7 at MOHSW. Release of block grants and basket funds to the councils has been reasonably complete and timely.

The new analysis of human resources presented here shows a total public sector health workforce of over 54,000, of whom 75% are stationed at the district level. Around 7,000 of the total workforce are stationed at non-governmental health facilities. The payroll shows rather slow growth in new personnel since 2002. Once attrition is taken into account the net growth in the workforces is far too slow to make serious progress in solving the human resource crisis in the sector.

Reference information for many of the tables and charts can be found at the Annexes.

Chapter 1: Introduction

This report provides an overview of health sector progress and performance during financial year 2007-2008. It follows the new MoFEA format for annual performance reports. The main departure from this is that the report attempts to capture information about government health services as a whole (Councils, Regions, Ministry of Health the new format is summarised below.

Ministry of Finance and Economic Affairs Format	Health Sector Performance Profile Update
Part 1: Foreword, Introduction	Chapter 1: Introduction & overview
Part 2: Overall Performance	
Section 2.1 Progress towards outcomes	Chapter 2: Progress against 33 health sector indicators
Section 2.2 Progress in improving service delivery	
Section 2.3 Information from Evaluations	Not applicable, no new evaluation
Section 2.4 Milestones / Priority Interventions	Chapter 3: Milestones report
Section 2.5 Issues, challenges	See concluding chapter
Part 3: Achievement of Annual Targets	Chapter 4: MTEF implementation status
n/a	Chapter 5: Review of Council Health Performance
Part 4: Expenditure	Chapter 6: Highlights from the PER Update
Part 5: Human Resources Review	Chapter 7: HR Status in the Health Sector
…Section 2.5 above	Chapter 8: Conclusion, Issues & Challenges

The report is intended to provide an objective, evidence-based, assessment of performance with reference to official indicators and targets. The data reported here come from a variety of official sources, including:

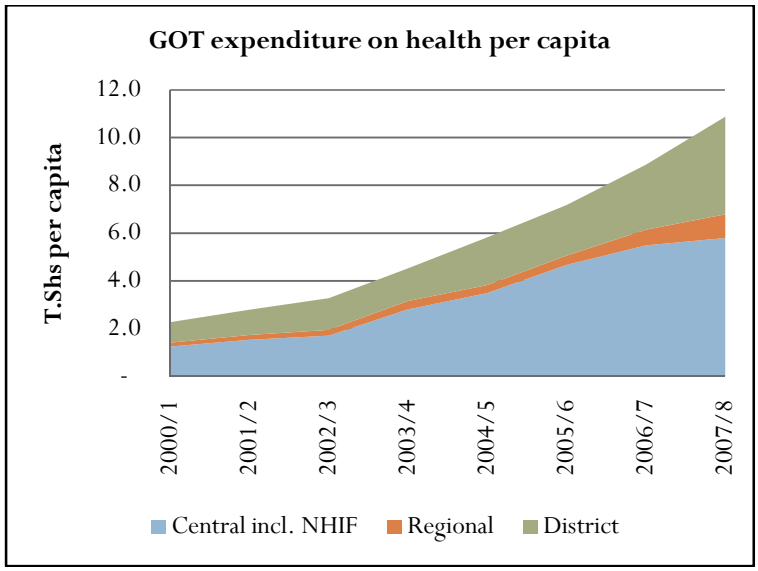
- Service delivery statistics from MOHSW
- Expenditure data from the Public Expenditure Review
- MTEF implementation status from MOHSW
- Milestone implementation status from MOHSW
- Human resource data from POPSM and MOHSW
- Tanzania HIV/AIDS and Malaria Indicator Survey (THMIS)

Chapter 2 presents the latest performance information on thirty-three health sector indicators. These comprise a mix of input, process, output, outcome and impact indicators. The indicator set will be revised slightly next year, in line with the monitoring and evaluation framework for the new Health Sector Strategic Plan.
Chapter 3 provides a summary of progress against the Milestones that were agreed at last year's Joint Annual Health Sector Review (September 2007).
Chapter 4 examines implementation performance against the strategies, objectives and targets set out in the MTEF of the Ministry of Health and Social Welfare for financial year 2007/8.
Chapter 5 reviews council health performance, drawing upon the Regional / Central review of council comprehensive plans and their implementation
Chapter 6 provides highlights on health sector expenditure, based on the latest Public Expenditure Review update.
Chapter 7 summarises pertinent information on Human Resources in the Health Sector.
Chapter 8 provides conclusions and highlights outstanding issues and challenges

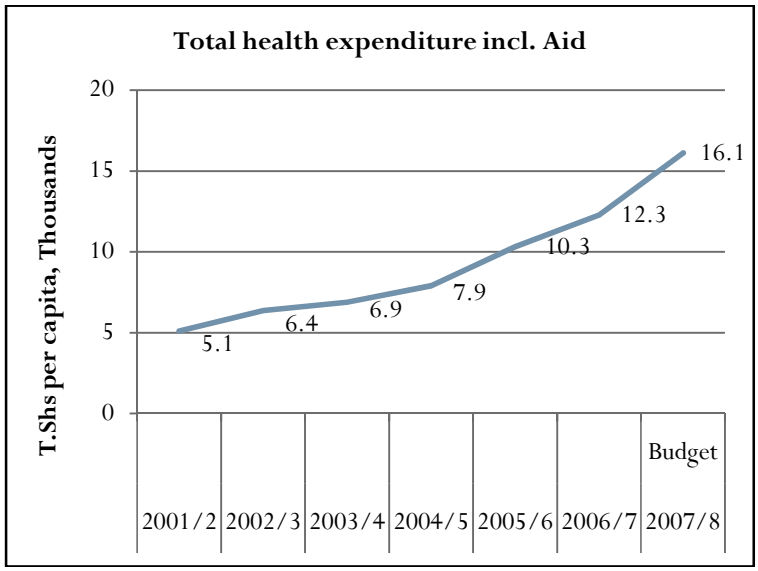
Chapter 2: Performance against Indicators

In this section we present the latest available information against the 33 health sector performance indicators. From 2008/9 a new set of indicators will be adopted, in line with the Monitoring and Evaluation Framework for the new Health Sector Strategic Plan. Tables with precise figures for the indicators can be found at Annex 1.

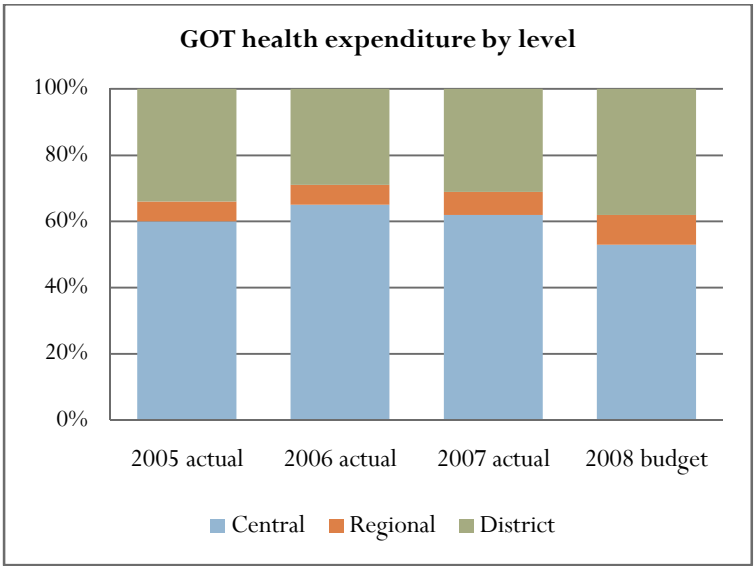
Indicator No. 1. Government expenditure on health (excluding aid) has more increased more than four-fold since 2000/01. The most rapid increase in the past two years has been at the regional and district levels.



Indicator No. 2. Including aid, total health expenditure has more than tripled, with a 31% increase between 2006/7 and 2007/8. The 2007/8 budget allocation is equivalent to T.Shs 16,000 (US$14) per capita. This excludes "off-budget" aid.



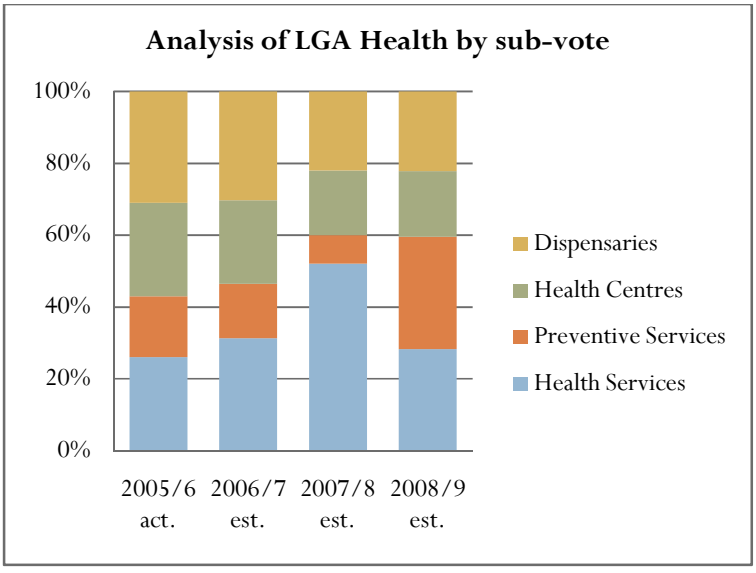
Indicator No. 3: Allocation by level shows a shift towards a larger share for the regional and district levels, particularly in FY2007/8.



Indicators No. 4,5,6. These indicators are supposed to measure current staffing of medical officers, assistance medical officers and nurses against the respective "staffing norms" for the respective cadres. The indicator has not been reported on since 2002 owning to the absence of accurate and timely information on either the nominator or the denominator. However, Chapter 6 provides analysis of the current human resource situation in the health sector, drawing from the payroll database operated by President's Office Public Service Management.

Indicator No. 7. At the district level, the share of all LGA resources allocated to the health sector has remained fairly steady at 16%-17% over the past four years.

The allocation of health funds between sub-votes has shown some volatility – probably due to the inclusion of basket funds into the development budget. The pattern observed shows a decline in the allocation to dispensaries and health centres, and a larger allocation to "Health Services" (the district hospital and CHMT) and preventive services.



From 2007/8 LGA data includes basket funds (hence the major jump from 2.3 billion to 65 billion. Personal Emoluments have absorbed a growing proportion of LGA recurrent health spending. Other Charges stagnated, then declined. However, this has been off-set to some extent by basket funds (under Development)

	2005/6 act	2006/7 est.	2007/8 est.	2008/9 est.
PE	47,988,240,000	89,937,828,800	108,671,239,700	125,121,938,561
OC	27,328,076,300	27,317,232,000	28,943,258,002	19,892,830,698
Recurrent (sum PE+OC)	75,316,316,300	117,255,060,800	137,614,497,702	145,014,769,259
Development	2,084,835,400	2,344,593,000	65,058,970,600	65,598,118,769
Total	**77,401,151,700**	**119,599,653,800**	**202,673,468,302**	**210,612,888,028**
PE as % Recurrent	*64%*	*77%*	*79%*	*86%*
PE as % Total	*62%*	*75%*	*54%*	*59%*

Indicators Number 8 – 13. Performance on these indicators is not reported here because the underlying HMIS data is not sufficiently robust or complete to make credible estimates. This highlights the urgency and importance of re-establishing the functionality of the HMIS at all levels.

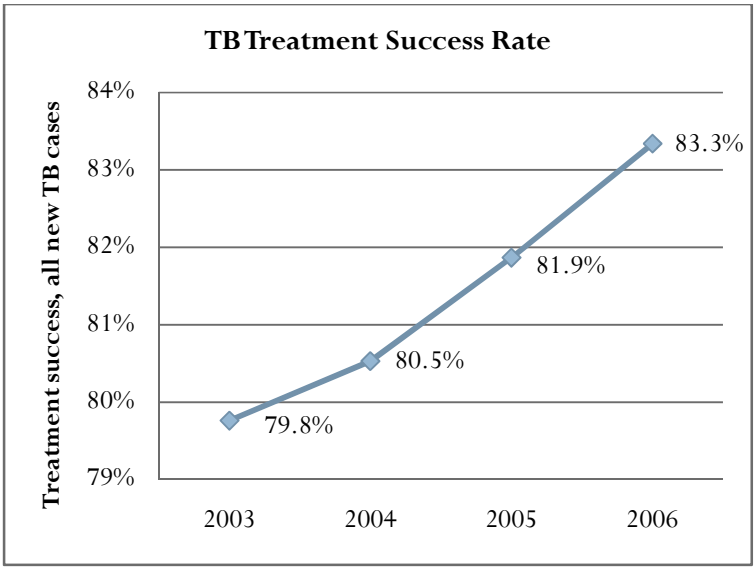
The indicators were:

Indicator s/n and description	Last reported figure
8. Proportion of district demonstrating use of HMIS and NSS information in plans	2003
9. Proportion of public health facilities in good state of repair	2003
10. Proportion of public health facilities without any stockout of 4 tracer drugs & 1 vaccine	never
11. Average number of days with no drug kits in public health facilities	2002
12. Cost sharing fees collected by public health facilities as % of target	2001
13. Outpatient attendance per capita per year	2004

It should be noted that a new, survey-based, estimate of outpatient attendance will become available shortly when the new Household Budget Survey (2007) is released.

Indicator No. 14. Tuberculosis control continues to show strong performance. The treatment success rate (cure /completion) has improved for all TB types. Deaths, treatment failures and patients lost to follow-up have all declined. New cases notified have declined year-on-year since 2004 (after more than a decade of increase).

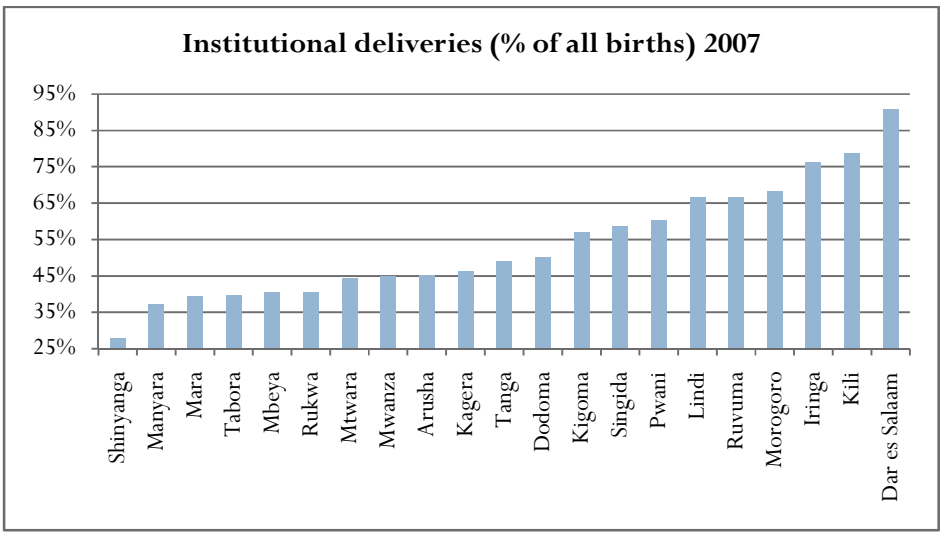
	2003	2004	2005	2006	2007
New AFBP cure rate	77.1%	78.3%	78.6%	80.3%	n/a
New AFBN cure rate	81.4%	82.2%	84.1%	85.1%	n/a
New Extra-Pulmonary cure rate	82.1%	82.1%	84.7%	86.5%	n/a
All (new) cases cure rate	79.8%	80.5%	81.9%	83.3%	n/a
Treatment failure %	2.0%	1.7%	1.3%	1.2%	n/a
Died %	6.5%	6.6%	6.1%	5.3%	n/a
AFBP out of control	4.0%	3.6%	3.5%	3.2%	n/a
Total new cases	59,723	60,749	59,296	57,415	
Total cases notified		65,666	64,200	62,102	61,950



Indicators No 15, 18, 19.

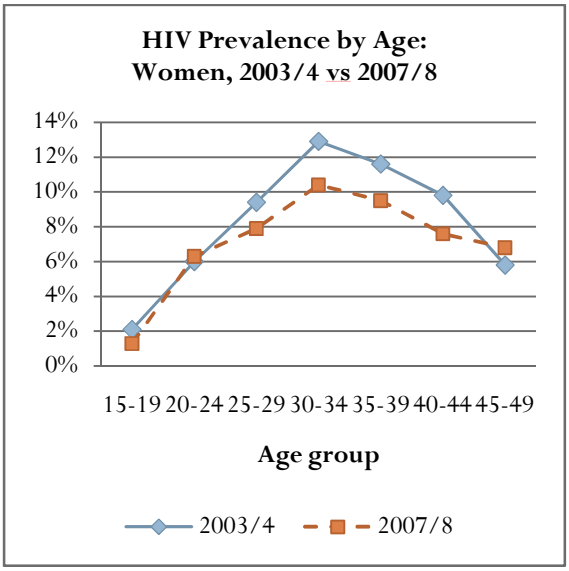
Indicator	Last Reported
15. Number of FP acceptors (new+continuing)	2004/5
18. % births taking place in government health facilities	2004/5
19.% pregnant women who attended antenatal clinic	2004/5

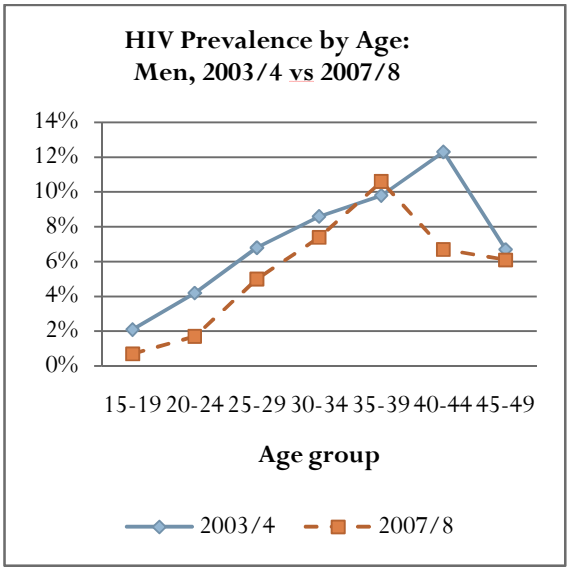
These indicators rely upon HMIS data. In previous years the figures have either not been available, their reliability has been questionable, or there has been confusion over the proper denominator. New data on births in health facilities have been sourced from RCH zonal annual reports for 2007 and compared to the official NBS projection of births (by region) for 2007. With the exception of two or three districts, the data look plausible. They indicate that **51% of all expected births in 2007 took place in health facilities**. The TDHS 2004/5 data (based on births 2000-2004) showed that 37.5% of expected births took place in government facilities; a further 3.1% in non-profit facilities and 6.4% in private-for-profit facilities (making 47% overall). Assuming that the RCH data captures only government and non-profit facilities, it indicates that the proportion of births in health facilities has risen from 41% (2000-2004) to 51% in 2007 - a ten percentage point increase. Institutional delivery rates by region are portrayed below.

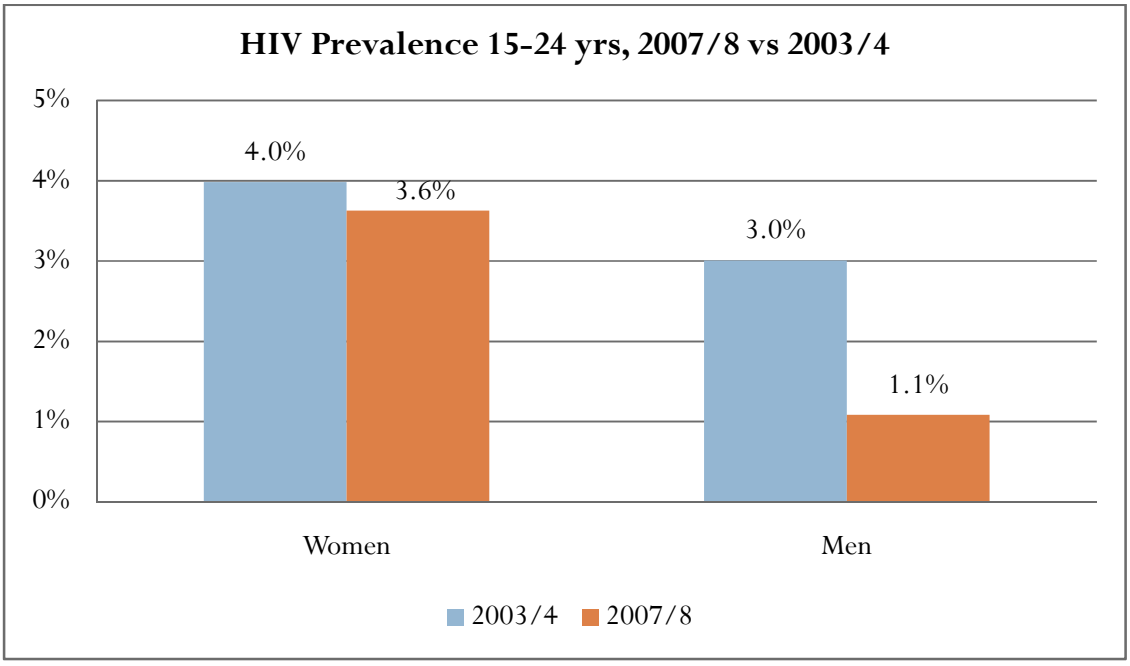


Data for the other two RCH indicators (family planning and ANC attendance) are still being compiled.

Indicator No. 16. New HIV prevalence data from the THMIS indicates a decline in prevalence for both males and females across most age groups.

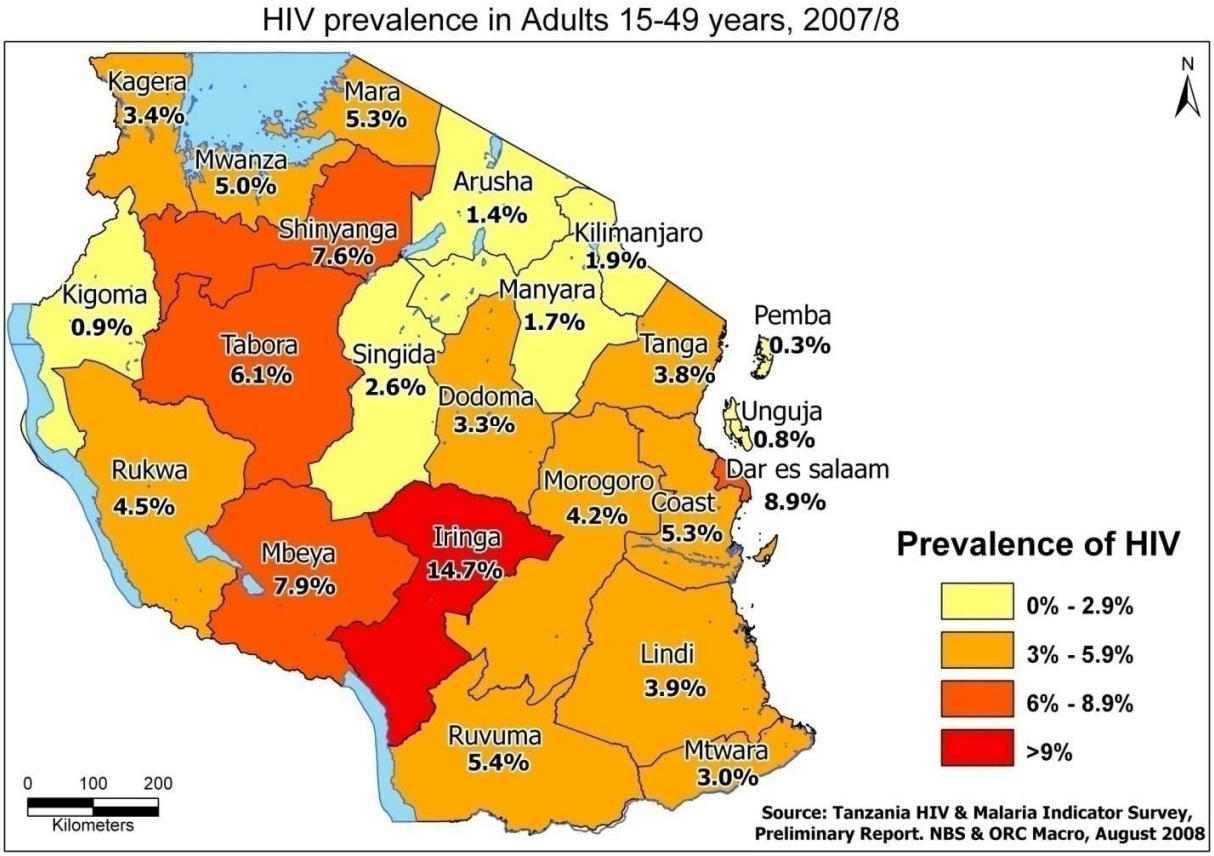






In the 15-24 year age group, prevalence is a lower than in 2003/4 for both females and males – although the decline appears to be larger for the latter.

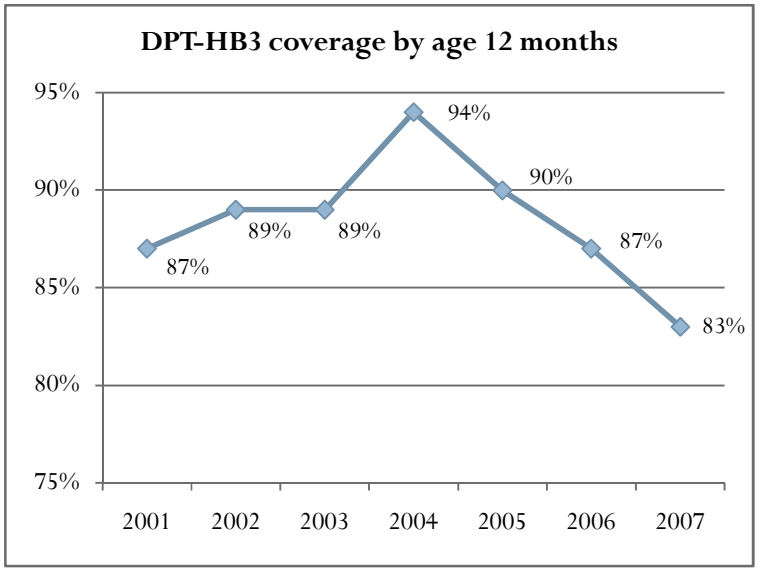
Across the country, major variations are evident between regions.



Four regions (DSM, Iringa, Mbeya and Shinyanga) had prevalence above 7%. Another four mainland regions (Arusha, Kilimanjaro, Kigoma and Manyara) had prevalence rates of less than 2%. Seventeen out of 21 mainland regions showed a decline in prevalence (males + females combined) between 2003/4 and 2007/8.

Indicator No. 17. The latest available data for vaccination coverage (by age 12 months) are shown below. Each antigen shows coverage of over 80%. However, as the graph depicts, there has been some slippage in DPT-HB3 coverage since its peak in 2004.

Immunisation Coverage 2007	
BCG	88.2%
Polio	87.7%
DPT-HB3	83.1%
Measles	89.6%

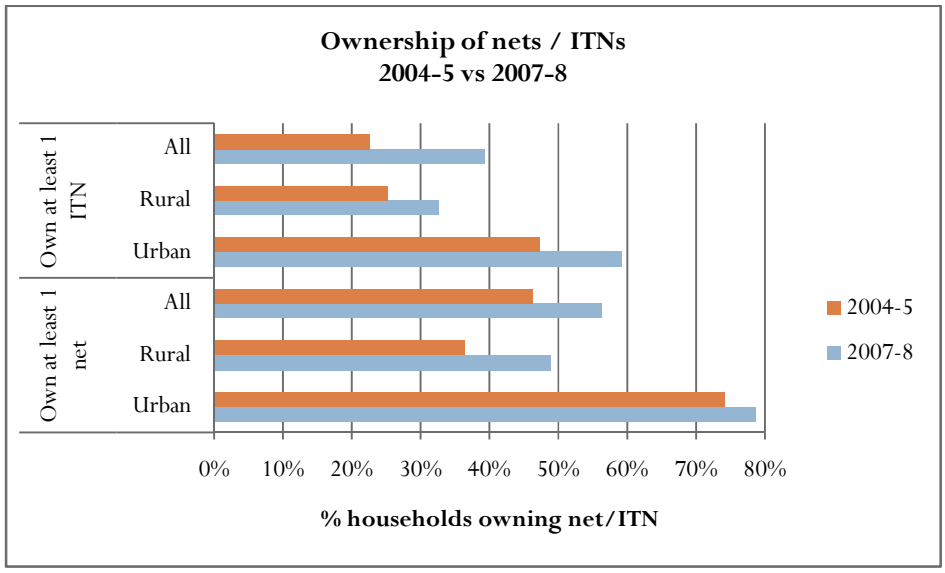


Indicator No. 20: Top six causes of morbidity and mortality (under-fives and over-fives).

Updated information for this indicator was not available at the time of writing.

Indicator No. 21. This indicator was originally conceived to measure changes in mortality attributable to malaria. This indicator cannot be reliably measured and would be difficult to interpret even if it could be. Instead we report new malaria data from the just-completed THMIS.

Ownership of nets/ITNs has increased since 2004/5 in both urban and rural households.



ITN use by vulnerable groups has shown a similar improvement, with a roughly 10 percentage point increase both for under-fives and for pregnant women.

		Urban	Rural	All
under 5 slept under ITN	2004/5	40%	10%	16%
	2007/8	49%	21%	26%
PW slept under ITN	2004/5	39%	10%	16%
	2007/8	48%	21%	27%

There has been an even steeper improvement in the proportion of pregnant women who received Intermittent Preventive Treatment (IPTp) – and there is surprisingly little gap between urban and rural women.

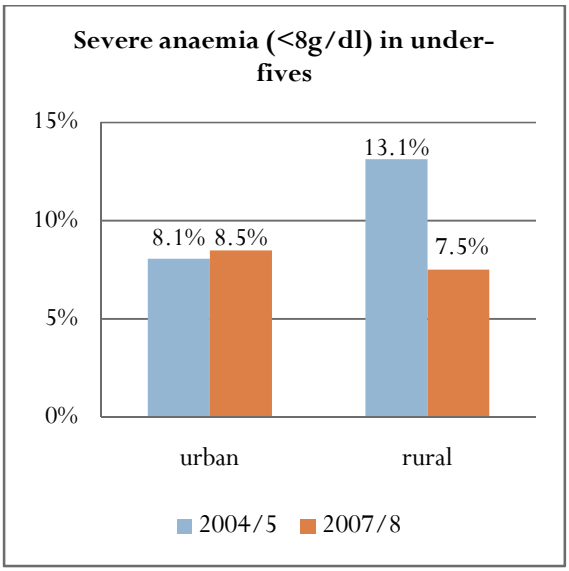
	urban	rural	all
2004-5	29%	20%	22%
2007-8	69%	55%	57%

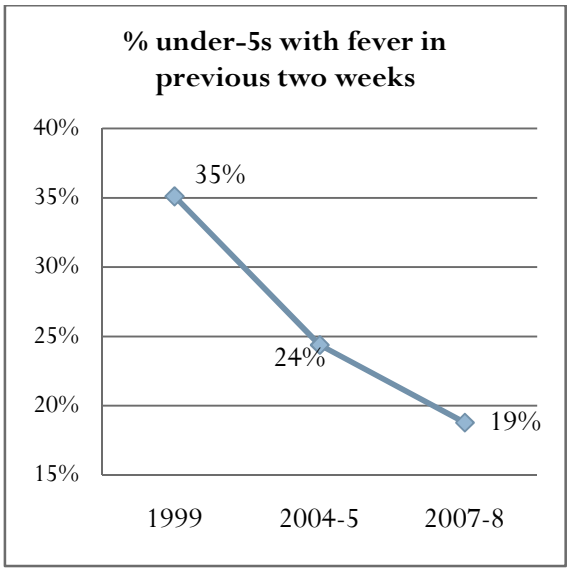
Nearly 20% of children under-five were found to be positive for malaria parasites – with prevalence in rural areas being more than double that of urban areas. Parasitaemia increases rapidly with age, from less than 10% under the age of one to around 20% in children aged two or more.

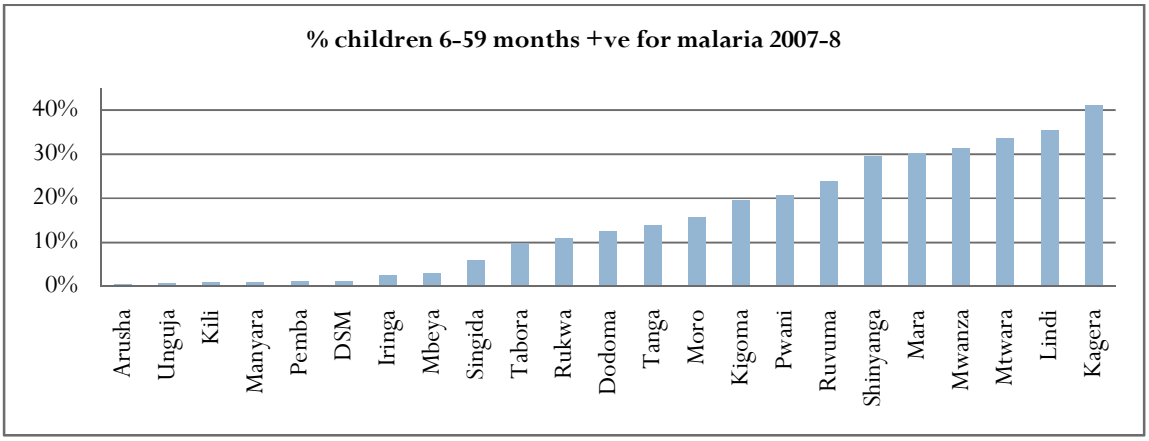
Proportion of children positive for malaria

Age group (months)	% of children 6-59 months
6-11	9.1%
12-23	14.4%
24-35	19.6%
36-47	19.5%
48-59	21.9%
urban	8.1%
rural	19.7%
All 6-59	17.7%

No previous nationally-representative data are available to which the new data can be compared. However, sentinel site data (Rufiji and Ifakara DSS) indicates a reduction in all-age parasitaemia of 60%-70% over the past 8 to 10 years. The decline in severe anaemia and fever also indicate that a major reduction in childhood malaria has occurred.







Also notable is the major variation in malaria prevalence across regions – from less than 5% to over 30%.

Indicator No. 22 (% of deaths in women of child-bearing age attributable to maternal causes). The latest available data (TDHS 2004/5) was reported in last year's report. No new national estimate of maternal mortality will be available until it is next measured in the 10-years adult mortality module of the DHS, expected around 2015.

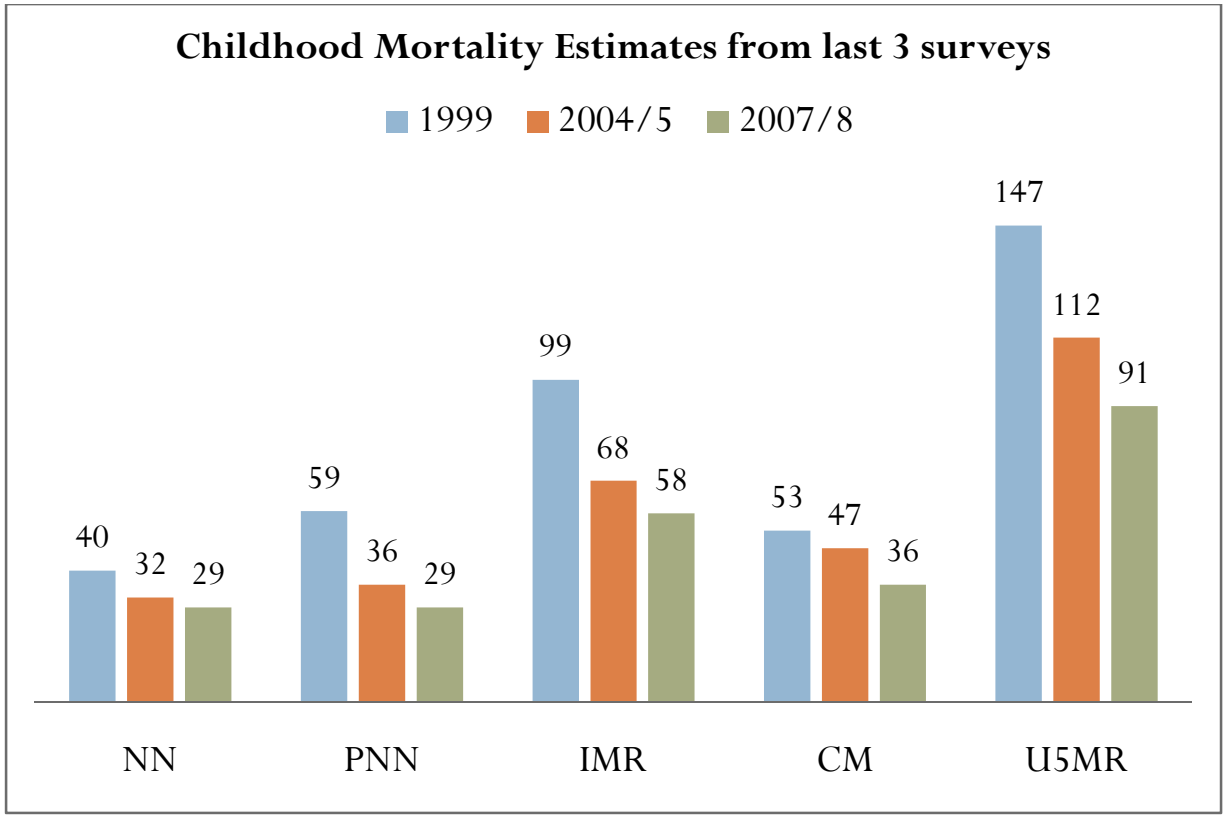
Indicator No. 23 (proportion of the population reported to be satisfied with health services)

This indicator has no consistent source data. Different surveys ask slightly different questions and are not directly comparable. Most recent data (TSPA 2007) shows what proportion of people mentioned various problems (waiting time, medical supplies etc) encountered with specified services (e.g. STI clinic, family planning) – but not an overall satisfaction rating for health services. Voices of the Poor 2007 (shown below) reports the proportion of adults (who had used a health facility) reporting specific problems with health services. Over a quarter of respondents had no response (*meaning no problems?*). This data is more informative regarding the ranking of problems encountered, rather than as a measure of overall satisfaction with health services.

	Dar es Salaam	Other urban	Rural
Cost of treatment & drugs	62	69	61
Availability of drugs	50	56	45
Time waiting to be served	55	52	42
Accessing health facility	34	35	42
Politeness of health staff	25	23	16
Availability of maternity services	13	14	13
Cleanliness of facility	10	10	10
Immunisation availability	3	3	2

Indicators No. 24 (skilled attendance) and 25 (DPT3 coverage) are both periodic indicators. No new survey-based information has become available since the 2004/5 data, reported last year.

Indicators No. 26-28. Data was collected in the recent Tanzania HIV and Malaria Survey on birth history and survival to generate new direct estimates of infant and under-five mortality. The figures reported here are preliminary, pending the release of the final report later this year. These figures confirm those reported in *The Lancet*, documenting a steep decline in mortality in the early years of the millennium. The new under-five mortality estimate is more than 20 points lower than the 2004/5 survey. If the recent rate of progress can be sustained, the Mkukuta 2010 target of 79 per 1,000 live births should be attained, and the MDG 2015 target of 48 is within reach.



NN= neonatal, PNN = post-neonatal, IMR = Infant Mortality Rate (1q0), CM = Child Mortality Rate (4q1), U5MR = under-five mortality rate (5q0)

Indicator 29. No new data on life expectancy will be available until the next Census (around 2012). The latest projections of the NBS (Volume 12, December 2006) anticipate a steady increase in life expectancy, from around 51-52 in 2002 to 57 (male) and 59 (female) in 2010. However, given the recent improvements in under-five mortality, HIV prevalence and ART treatment, these projections now appear pessimistic. We expect that life expectancy will show a bigger improvement than the official projection when it is next measured.

Indicators 30-33. No new data is available on child malnutrition (stunting, wasting, underweight) nor on total fertility rate. These indicators will next be measured around 2010 in the next demographic and health survey.

Chapter 3: Progress towards Milestones

This chapter presents progress against the milestones adopted at last year's Joint Annual Health Sector Review. Out of the 15 milestones:

- 3 milestones were fully achieved
- 10 milestones were partially achieved
- 2 milestones were not achieved

As the more detailed assessment in the table below makes clear, considerable progress has been registered in all areas – even in cases where the milestone itself was not achieved (eg deployment of Nutrition focal persons to councils).

Summary Progress towards milestones FY2007/8

1	**Financing**		
	Develop a Health Care Financing Strategy that will input for 3rd HSSP by June 2008.	A broad strategy for health financing is part of the Health Sector Strategy Plan III. The detailed strategy will be developed as part of the implementation of HSSP III by Dec 2008.	Partially Achieved
2	**Financing**		
	A Medium–Term Strategy for the health basket funds is developed by the end of December 2007	The generic document outlining the Medium Term Strategy for health basket fund has been completed and a memorandum of understanding to that effect has been signed by GOT and DP representatives in August 2008	Achieved
3	**Human Resource**		
	Increase enrolment in pre-service training from the current 1,013 to 6,458 in 2008	• Enrolment for Pre-service for all levels of certificates, diploma and degree in Public and Private sector has increased from 1,013 in 2006 to to 3,831in 2008, equivalent to 60 % of the milestone target. • Govt has increased grants from Tshs. 30,000 to Tshs. 40,000 per student. • Detailed assessment of the situation in all health training institutions and support needed is being done.	Partially Achieved
4	**Human Resource**		
	Develop/ establish innovative mechanisms to foster and monitor HRH retention, productivity and motivation by August 2008	• Establishment for pay for performance (P4P) will be operational by June 2009 • The scheme of service for all health cadres has been finalized and is awaiting approval by the Master Workers' Council in November 2008. • New Salary structure for health cadres has been introduced i.e. TGHS. Starting salaries have been raised. • Health workers have access to bank Loans • Improvement of working environment i.e. supply of drugs, working tools, renovations of buildings etc is ongoing. • Promotions due have been effected and allowances (uniform, travel, per diems) have been revised • Under the emergency hiring programme and the Mkapa foundation, fellows have been hired and posted to hard-to-reach areas. At the end of their contract, some have been absorbed into the public sector. • The process of establishing a Comprehensive Information system for HR is ongoing. A meeting	Achieved

		with POPSM and other stakeholders was conducted in July 2008 to identify needs and gaps.	
5	**Pharmaceuticals**		
	National Medicines Policy and master plan disseminated, and the new drug allocation formula used to allocate drugs and medical supplies to districts and hospitals starting FY08/09	• The National Medicine Policy has been reviewed and formatted in line with the Cabinet Secretariat Guidelines in August 2008. • The Master Plan for the Pharmaceutical Sector will be developed in October 2008. • A consultancy report on development of an Equitable Resource Allocation Formula for Medicines and Medical Supplies was submitted to MoHSW in November 2007. The Pharmaceutical sub-committee approved the drug resource allocation based on Population (70%), Disease Burden (15%) and Poverty Index (15%). Appropriate forms/tables for the formula have been developed.	Achieved
6	**Mapping of Health Care Providers**		
	Mapping of public and private services providers is completed by March 2008.	The mapping exercise has completed the listing and verification of health facilities. The next stage is to collect geo-code information (position of health facility) as well as availability of health services.	Partially Achieved
7	**CCHPs**		
	Assessment of CCHPs for FY08/09 concludes that there is greater inclusion of FBOs, CSOs and private sector activities.	• The MOHSW advised PMO-RALG to instruct the LGAs to include activities in the CCHPs to address FBOs, CSOs, NGOs and Payment for Performance (P4P) • The FBO activities are financed according to the guidelines. However, there is no provision in the guidelines to use Government block grant and health basket funds to fund private-for-profit activities.	Partially Achieved
8	**RHMTs**		
	TORs (roles & functions) for RHMTs have been produced and there is an explicit budget line for the RHMTs in the vote of the Regional Administrative Secretary FY08/09 MTEF	• TORs (roles and functions) for RHMTs, Regional Referral Hospital Management Teams, and Regional Referral Hospital Boards have been developed, approved and signed by MOHSW and PMORALG. • In the 2008/9 budget each region was allocated 100 million TShs to enable RHMTs to carry out their supervisory role for LGAs.	Achieved
9	**Regional & Referral Hospitals**		
	All referral hospitals and regional hospital have annual plans (*per the planning & reporting guidelines*) as basis for their budgets for FY08/09	• All referral hospitals have Annual Plans prepared from their Strategic Plans. • Eight Regional Hospitals have annual plans and the remaining 13 will be covered through the ongoing hospital reforms.	Partially Achieved
10	**Public Private Partnership**		
	National PPP Steering committee has produced a plan and budget for the implementation of the Service Agreements for approval by SWAp Technical Committee by December 2007	• A plan was prepared and presented in the last bi-annual SWAp meeting held in April 2008. • MoHSW prepared a budget for implementing Service Agreement (by all Local Governments) and requested PMO-RALG to instruct all Local Governments to start using the document to make agreements as a strategy to implement MMAM. • Advocacy was conducted at Zonal centres and Regions. Some councils have signed the agreement and the process is ongoing.	Achieved
11	**Operational Plan**		
	Operational Plan based on new	MTEF and POA for MoHSW for 2007-08 have been	Not achieved

	Monitoring and Evaluation Strategy be developed by December 2007	operational up to June 30th 2008 and preceded the development of the new HSSPIII and its M&E framework. The operational plan for 2008/9 is based on the new Health Sector Strategic Plan III which includes an M&E strategy.	
12	**Health Sector Performance**		
	Health Sector Performance Annual Report disseminated by August 2008	The draft Health Sector Performance Report for 2008 has been completed and will be disseminated after getting more input/feedback from this JAHSR meeting.	Achieved
13	**MNCH Roadmap**		
	Capacity Development Plan to support ZTCs, regional & district health management teams to be developed.	• The Strategic and Business plans for Zonal Health Resource Centres have been developed • National roadmap for acceleration the reduction of maternal, newborn and child health 2008-2015 is in place indicating effective interventions to be implemented at all levels.	Achieved
14	**Nutrition**		
	Nutrition's focal point designated in all Local Government Authorities by March 2008	The MOHSW has reviewed its scheme of service to include the Nutrition cadre. After approval of the same by POPSM, and the post established in the LGAs, the MOHSW will work closely with PMORALG to post staff to LGAs. In the interim, due to shortage of this cadre, some existing staff will be reassigned to LGAs to perform nutrition related tasks.	Partially Achieved
15	**HIV/AIDS Workplace Programme**		
	Workplace HIV/AIDS programmes are instituted throughout the health sector by August 2008	• Workplace HIV & AIDS programme is being implemented according to the Strategic Plan for HIV and AIDS for Health Workers (2006-2011). • Developed and launched an HIV & AIDS Strategic Plan for Health Workers • Developed HIV & AIDS Workplace Intervention Guidelines and Training Manuals. • Trained 25 HIV & AIDS Departmental Co-ordinators and 20 Peer Educators • Trained top management for MoHSW including Directors, Assistant Directors and RMOs on HIV & AIDS Workplace Interventions • Supervised the Manyara, Kagera, Mbeya, Mara, Mwanza, Tanga, Kigoma, Kilimanjaro, Arusha and Iringa Regions for the implementation of HIV & AIDS workplace interventions. • Conducted Knowledge, Attitude and Practice Survey	Achieved

The progress report on milestone demonstrated that most of the milestones were either completed or were partially implemented with exception of milestone no seven which was not done. With regards to the Human Resource milestone number three the performance was affected by limited enrolment capacity in the training institutions. It is suggested that in order to reach the pre-service enrolment target, implementation is to support private especially FBOs health training colleges to increase pre-service enrolment. More explanatory remarks will be provided in the full "milestones" report.

Chapter 4 Assessment of Annual (MTEF) targets

The resources allocated to different departments and institutions in the Ministry have been used to accomplish the Ministerial objectives and targets with the aim of contributing to the achievement of the National Strategy for Growth and Reduction of Poverty, the Millennium Development Goals and health sector strategies in general. During MTEF preparation, priorities were developed from following Objectives:

1. HIV/AIDS and its impact reduced;
2. Equitable and gender sensitive health and social welfare services ensured
3. Quality essential health and social welfare services provided
4. Burden of disease reduced;
5. Research, training and continuous professional development for improved performance, enhanced.
6. Institutional; capacity and organization of the ministry to implement its core functions enhanced;
7. Policies, legislation, regulation for efficient and effective service delivery improved;
8. An efficient and effective governance system for the delivery of services in place;
9. Financing gap reduced;

Performance analysis

The performances of activities are categorized in four levels as follows:-

- Level 1. Activities that its utilization rate above 80 percent that activity is considered to be fully implemented (excellent performance)
- Level 2. Activities that its utilization rate is between 61 – 80 percent that activity is considered as partially Implemented (very good performance)
- Level 3. Activities that its utilization rate is between 41 – 60 percent that activity is considered as partially implemented (Average performance)
- Level 4. Activities that its utilization rate is between 0 - 40 percent are considered as poor performance

The table below shows that, on average, 65 percent out of 469 of all planned activities were fully implemented and few of them were about to be fully implemented. A further 24 percent of activities were largely implemented. The remaining 11% of activities had poor implementation status. In some cases this was due to delayed or incomplete funding release, in others because of delays inherent in the Procurement process.

A full description of objectives, targets and implementation status can be found at Annex 2.

Summary Implementation Status for MOHSW MTEF Activities by Sub-Vote

Department (sub-vote)		Total number of activities	Implemented 81% -100%	Partially implemented 61% - 80%	Partially implemented 41% - 60%	Not Implemented < 40%
Administration and Personnel	No. of activities	68	46	13	6	3
	% implementation	100 %	68 %	19 %	9 %	4 %
Finance and Accounts	No. of activities	29	21	6	1	1
	% implementation	100%	72 %	22 %	3 %	3 %
Policy and Planning	No. of activities	27	17	3	2	5
	% implementation	100 %	63 %	11 %	7 %	19 %
Hospital services	No. of activities	39	24	9	4	2
	% implementation	100%	62 %	23 %	10 %	5 %

Chief Medical Officer	No. of activities	57	31	22	2	2
	% implementation	100%	55 %	39 %	3 %	3 %
Preventive Services	No. of activities	132	89	35	6	2
	% implementation	100%	67 %	27 %	5 %	1 %
Food and Drug Authority	No. of activities	45	32	12	1	0
	% implementation	100%	71 %	27 %	2 %	0 %
Social Welfare	No. of activities	38	26	6	4	2
	% implementation	100%	68 %	16 %	11 %	5 %
Human Resources development	No. of activities	34	21	5	5	3
	% implementation	100%	62 %	15 %	15 %	8 %
Total Vote 52 MOHSW	**No. of activities** **% implementation**	**469** **100 %**	**307** **65 %**	**111** **24 %**	**31** **7 %**	**20** **4 %**

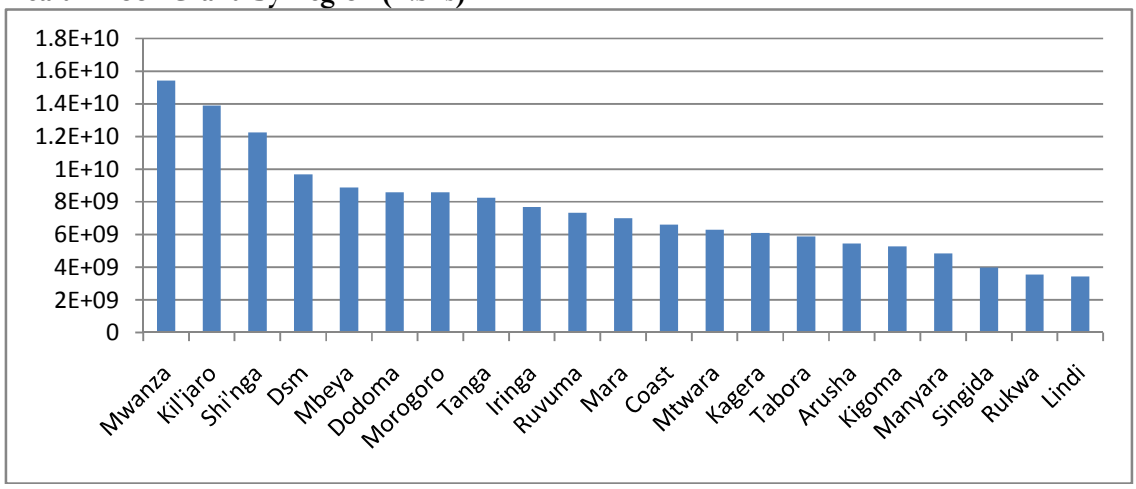
Chapter 5: Council Health Sector Performance

The Comprehensive Council Health Plans and third quarter progress reports (Jan-March 2008) were systematically reviewed to assess their qualification for basket funding. Also reviewed were the Management, Monitoring and Capacity-Building Plans of the 21 Regions. The key findings are summarised in bullet form below.

Comprehensive Council Health Plans

- Three quarters of councils have less-qualified staff in key positions (District Medical Officer, District Health Officer, District Health Secretary).
- A certain amount of duplication in the planning process takes place because of incompatibility between PlanRep and the CCHP guidelines.
- Most councils included Payment for Performance (P4P) in their plans and budgets, as instructed. Those that had not included it were requested to amend accordingly.
- Regions and Councils benefiting from Global Fund support have reflected this in their plans and budgets.
- Many councils report continuing problems with medical supplies. Many basic items were said to be out of stock at MSD and other items were reported to be sub-standard. These reports were confirmed in a sample of 22 Councils surveyed for status of drugs, medical supplies and equipment.
- There are wide variations across regions and councils in the size of the block grant for health. This is attributable to the low staffing in some regions, resulting in smaller allocation of funds for Personal Emoluments
- Funds arising from cost-sharing, community health fund and national insurance were expected to be equivalent to 15% of the Other Charges component of the block grant.

Health Block Grant by Region (T.Shs)



Third Quarter Progress Reports

Technical and Financial Reports were assessed against objective criteria[1] and scored accordingly. Councils in Manyara, Morogoro and Tanga performed best, while scores of councils in Iringa, Mwanza and Mara performed least well.

[1] Presentation of the report; adherence to format; implementation status of activities; reasons for partial implementation

The assessment of the **technical reports** found:

- 70% (92 out of 132) councils technical reports were well-presented
- 80% of councils adhered to the approved report format

Implementation status of plans revealed that:

- 18% of councils had fully implemented their activities (80%-100% implementation)
- 28% of councils had mostly implemented their activities (60%-79%)
- 32% of councils had partially implemented their activities (40%-59%)
- 20% of councils had activity implementation rate of less than 40%

It should be noted that this represents implementation status by the third quarter of the year – not the full financial year.

Overall 88% of councils scored above the minimum threshold. Three reports were missing. 28% of councils are judged to require further technical support to improve their CCHP reporting.

The assessment of the **financial reports** found:

- 76% adhered to the approved format
- 51% included all sources of funds

Overall 40% (53 out of 132) councils failed to attain the minimum score in the assessment of financial reports, and three reports were missing. 43% of councils are judged to require further technical support on financial reporting.

Failure to link Planrep printouts with accounting return form of the progress report is a major reason for inadequate performance in technical and financial reports. Shortage of qualified key personnel in CHMTs and frequent turnover of health sector accountants in Councils were also identified as major constraints. This is coupled with inadequate support from the RHMTs.

Regional Plans

The regional management, monitoring and capacity-building plans were also assessed according to objective criteria. While there was good performance in setting out the "work plan matrix" and inclusion of P4P, Gantt charts were missing in all 19 plans[2]. In some plans the Strategic Objectives were judged to be "weak" while others provided insufficient information on targets and indicators.

Conclusion

The assessment concludes that:

- Continuous improvement is needed to raise the quality of plans and reports
- More support is needed from the Regions to quality-assure district plans and reports
- Systematic training is needed for Council Health staff – particularly newly-appointed ones. This could be provided by Zonal health resource centres, with back-up from the Region. Alternatively it could be set up as a short course at one or more of the higher learning institutions
- Inconsistencies between CCHP guidelines and PlanRep need to be resolved. The councils need clearer guidance on which extracts from PlanRep should be attached to the CCHP.
- Persistent problems with the performance of MSD need to be addressed
- Future assessment exercises should place greater emphasis on assessing whether councils are addressing priority health problems and the burden of disease.

[2] Two regions Ruvuma and Tabora submitted their plans late and so are not covered in this summary.

Chapter 6: Public Expenditure Review

The Health Sector Public Expenditure Review (2007 Update) provides a detailed analysis of the level, composition and trends in health sector spending at the central, regional and council levels. For the most part, the report focuses on analysis of FY 2006/7 data, although aggregate budget information for FY 2007/8 is also presented.

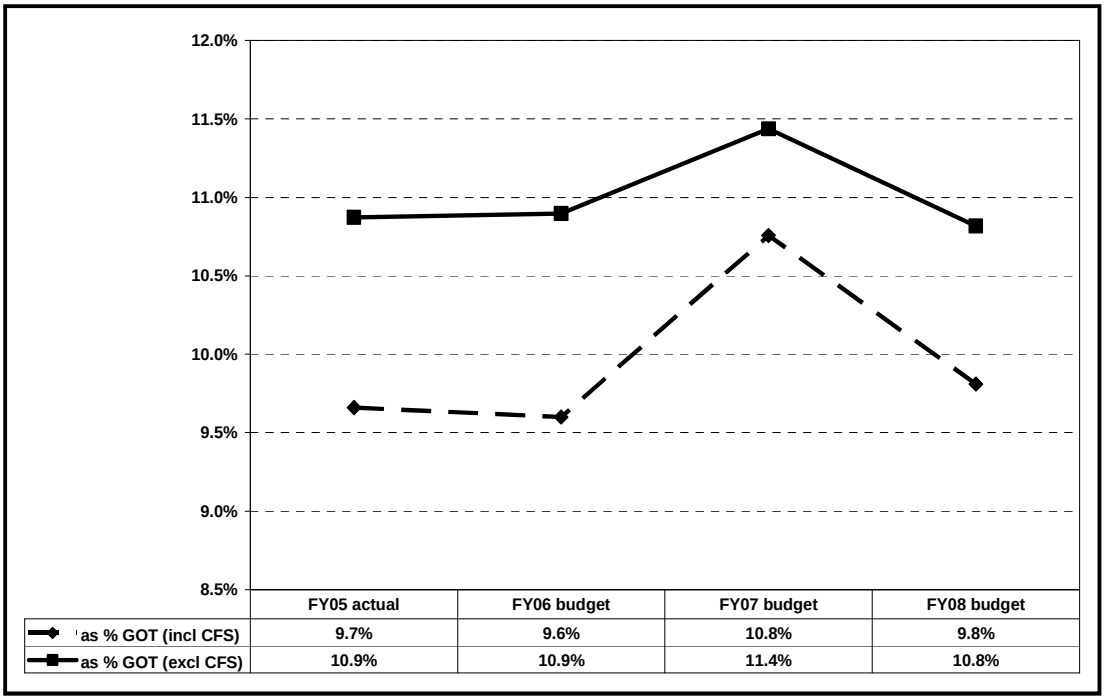
Data on expenditures financed by external aid remain problematic. Those included in the budget are subject to error and misclassification. It is difficult to tell from year to year whether fluctuations in aid are real, or simply an effect of variation in the completeness of figures reflected in the budget. No reliable (government) figures exist for "off-budget" aid, which includes some very large areas of assistance such as PEPFAR. The analysis presented here excludes all "off-budget" aid.

As already discussed in Chapter 2, total on-budget health expenditure has risen from US$7.4 per capita to US$14 per capita in FY2007/8. This represents an increase of more than 60% in real terms since 2004/5. In relation to the overall government budget (including Consolidated Fund Services), health's share has fluctuated around the 10% mark, although the latest year represents a fall of roughly one percentage point compared to FY 2006/7.

Total On-budget health spending

	FY2004/05		FY2005/06		FY2006/07		FY2007/08
	App Est	Actual	App Est	Actual	App Est	Actual	Estimates
Recurrent	232.41	230.59	307.44	268.91	398.85	368.89	432.22
Development	75.86	58.40	118.33	115.73	122.23	103.26	215.95
Total	**308.28**	**288.99**	**425.77**	**384.64**	**521.07**	**472.15**	**648.17**
Annual growth - budget			*38%*		*22%*		*24%*
Annual growth - actual				*33%*		*23%*	

Health as % of Total Government expenditure

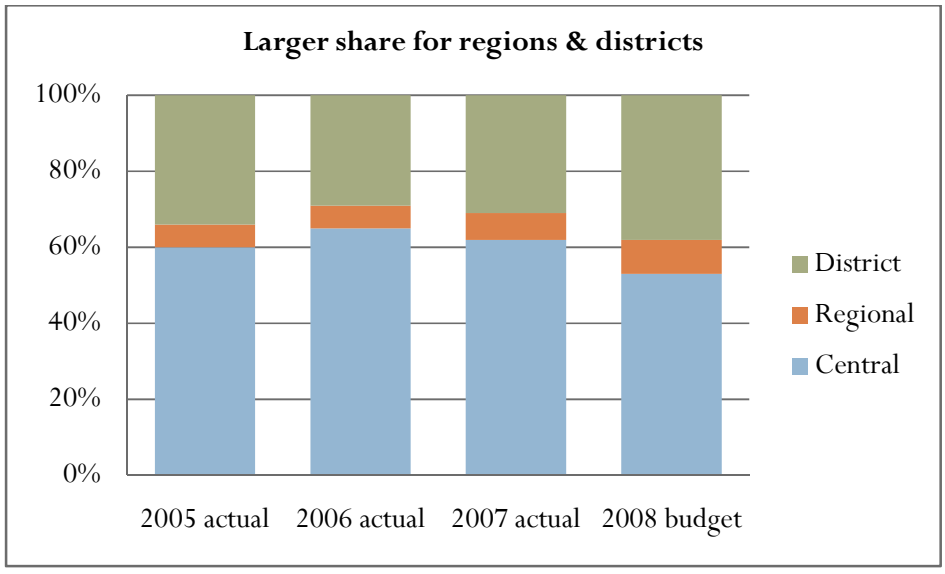


Budget execution in the health sector has been fair. On the recurrent budget, the proportion actually spent rose from 89% in 2005/6 to 94% in 2006/7. However, budget execution on the development budget declined – possibly as a result of aid-funded expenditures not being fully captured.

Summary of Areas of Strength
• Completeness and timeliness of releases from Treasury or Development Partners is generally NOT the major obstacle for health care funding. • No problem with PE releases - Completeness of PE disbursements systematically exceeds 100 % • Disbursement patterns of donor funds into the Health Sector Basket Fund holding account tend to be frontloaded in the first two quarters
Summary of Areas of Weakness
• Main sources of delay in budget execution is due to the overly bureaucratic nature of the allotment of health resources, procurement processes and administrative processes that have to be followed in order to trigger payment, including an approval for spending >TSH1,000,000 requires approval by the Permanent Secretary • OC disbursements regularly fall around 80% - shortfall of OC releases causes substantial problems in the reprioritization and downward adjustment of budget plans during budget implementation at the ministerial level • Despite perception that resources for medicines are prioritized, the completeness and timeliness of the essential drug budget is lagging behind the overall budget performance

Across levels of government, regional level and council level control a greater share of the health budget than before. The share controlled by MOHSW has declined accordingly. Nonetheless, MOHSW Recurrent Budget still contains a number of large items that are finally expended by hospitals and councils, notably:

- Drugs, medical supplies and medical equipment
- Subventions to national, specialist and referral hospitals
- Subventions to non-governmental hospitals



A separate analysis of health budgets and expenditures at the Local Government level confirms a steep increase in the total budget at that level. However, almost all of the increase in the recurrent budget is due to an increase in PE,

while the OC component actually declined in 2007/8 (budget). As we shall see in the next chapter, the increase in PE is largely because of pay increases rather than a substantial increase in the number of health personnel. Note also that the sudden increase in the development budget in 2007/8 is due to the inclusion of Basket Funds in the LGA development budgets.

By budget category	2005/6 act	2006/7 est	2007/8 est.	2008/9 est.
PE	47,988,240,000	89,937,828,800	108,671,239,700	125,121,938,561
OC	27,328,076,300	27,317,232,000	28,943,258,002	19,892,830,698
Recurrent	75,316,316,300	117,255,060,800	137,614,497,702	145,014,769,259
Development	2,084,835,400	2,344,593,000	65,058,970,600	65,598,118,769
Total	**77,401,151,700**	**119,599,653,800**	**202,673,468,302**	**210,612,888,028**
PE as % Recurrent	*64%*	*77%*	*79%*	*86%*
PE as % Total	*62%*	*75%*	*54%*	*59%*

As a share of total LGA expenditure, health has maintained a fairly constant share of 16%-17%.

Health as % total LGA	2005/6 act	2006/7 est	2007/8 est.	2008/9 est.
Recurrent	16%	16%	17%	16%
Development	40%	20%	23%	18%
Total	16%	16%	19%	17%

Chapter 7: Human Resources

According the Hon. Minister's budget speech for presentation of the 2008/9 budget, the central MOHSW gained about 200 new employees in FY 2007/8, being 34% of the 594 positions for which employment permits had been issued.

The same source documents that a total of 4,812 new health staff were hired by regions and districts, being equivalent to 75% of the 6,437 employment permits issued. Of these, 3,645 were assigned to work at health centres and dispensaries, while 1,167 were assigned to regional secretariats and other ministries.

As part of the preparation for this report, a special analysis was conducted of the public service payroll for health employees of MOHSW, its subvented institutions, and health departments of regions and districts as of August 2008. This reveals a total number of **54,176** employees, of whom 75% were stationed in the districts. The full breakdown of the health workforce by level is presented below.

ANALYSIS OF HEALTH WORK FORCE BY LEVEL, AUGUST 2008

MOHSW PROPER (VOTE 52)		
Sub-Vote Code	**Sub-Vote Description**	**No.**
1001	Admin & General	145
1002	Finance & Accounts	90
1003	Policy & Planning	24
2001	Curative Services	1,706
2002	Chemical Laboratory	17
3001	Preventive Services	236
4001	Tukuta	45
4002	Social Welfare	578
5001	Human Resource Dept	871
	SUB-TOTAL MOHSW PROPER	**3,712**
SUBVENTED INSITUTIONS		
	Vote Description	**No.**
	Muhimbili Medical Centre	2,748
	Bugando Hospital	420
	Govt Chemical Laboratory	106
	KCMC	221
	NIMR	491
	ORCI	227
	SUB-TOTAL SUBVENTED INST.	**4,213**
REGIONAL HEALTH DEPARTMENTS		**No.**
	Curative	5,685
	Preventive	102
	SUB-TOTAL REGIONS	**5,787**
DISTRICT HEALTH DEPARTMENTS PLUS GRANT-AIDED HOSPITALS		
	District Designated Hospitals	4,295
	Voluntary Agency Hospitals	2,089
	All Councils Health Departments	34,080
	SUB-TOTAL DISTRICT LEVEL	**40,464**
TOTAL HEALTH WORKFORCE		**54,176**

We also undertook an analysis of new staff hired at district health departments, year by year, from 2002 to date (August 2008)[3].

This reveals that a total of nearly 10,000 staff were added to council health department payroll between *calendar year* 2002 and 2008. There is no clear trend in the numbers over this period. Note that these new additions to the payroll will have been offset by staff leaving the payroll (resignation, retirement, death), so these figures do NOT represent the annual growth in the health workforce at council level. In fact, we would expect attrition of at least 1,000 health staff per year – implying very little, if any, net growth in the health workforce at council level over this period.

New Hire, council level only

Year	No.
2008	1,682
2007	2,258
2006	1,247
2005	979
2004	507
2003	1,674
2002	1,295
Total 2002-2008 calculated	*9,642*
Staff with misclassified hire date	*3*
TOTAL NEW HIRE, 2002-2008	9,645

The payroll database provides a wealth of information, including the potential to analyse staff numbers by Region and District as well as by cadre – although cadre information is incomplete[4]. A payroll cleaning and data verification exercise is due to be conducted next financial year. This database will then provide an even more powerful tool for analysis and monitoring of the health workforce.

[3] Using the "hire date" field for every record
[4] For example, cadre data is only available for 26,270 out of the 34,080 staff at council level

Chapter 8: Conclusion

The report has presented the assessment of health system performance in Mainland Tanzania for financial year 2007 – 08. Drawing from available survey and routine information, the overall picture is fairly encouraging, particularly with regard to childhood mortality trends, malaria control, HIV prevalence and TB control. In contrast, there has been slippage in the coverage of DPT-HB3 in children under 1 year of age.

Reporting on the 33 health indicators is hampered by the lack of robust HMIS data, on which many of the indicators depend. This highlights the importance of re-invigorating the HMIS system.

From next financial year, the indicator set is due to be revised. It will be replaced by a new set of indicators, as per the Monitoring and Evaluation Framework of the new Health Sector Strategic Plan. The (draft) of the new indicators is shown at Annex 3.

Resources for the health sector have increased, particularly at the Regional and Council levels. However, the sector did not increase quite as rapidly as the total government resource envelope, resulting in a one percentage point fall in health's share of the GOT budget.

The human resource situation is still a cause for grave concern. While there has been a major increase in payroll expenditure, this is almost entirely due to wage inflation rather than an increase in the number of health workers. Available data from the payroll database shows no clear trend towards accelerated hiring of new staff. Moreover, the number of new health workers over the past seven years has been running at around 1,500 per year – resulting in little, if any, net increase in the health workforce.

Execution of plans and budget by the Ministry of Health and Social Welfare has been good. Absorption of the recurrent budget has improved, and the vast majority of planned activities have been fully or largely implemented. At the council level, implementation of activities was lower – but it should be recalled that this assessment was undertaken in the third quarter rather than the year-end.

It is hoped that this report meets is objective of informing stakeholders of progress and challenges in the health sector. By providing objective measures of performance across a wide range of areas, the report shows clearly those areas where performance has been particularly good – as well as areas requiring remedial action.

ANNEXES

Annex 1: Table of Performance against 33 Health Sector Indicators

Annex 2: MTEF Implementation by MOHSW Department

Annex 3: New Health Sector Performance Indicators (Draft Monitoring and Evaluation Framework for HSSP III).