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

Service Delivery Report

Submitted to The Ministry of Health,

Dodoma – Tanzania

By The Ifakara Health Institute,

Dar es Salaam – Tanzania

In March 2025

World Health Organization

ISO 9001: 2015 certified
IFAKARA HEALTH INSTITUTE
research | training | services

INVESTIGATORS

Principal Investigator:

Dr. Sally Mtenga

Co-Investigators:

Dr. Getrud Mollel

Dr. Francis Levira

Table of Contents

List of figures

Executive summary

Health service delivery in Tanzania operates in a complex landscape of mixed healthcare financing modalities amidst the country's commitment of achieving Universal Health Coverage (UHC) alongside other Sustainable Development Goals (SDGs). HSSP V implementation began months after Tanzania's Gross National Income (GNI) per capita increased above the lower-income threshold, qualifying the country for a lower-middle income status in July 2020. Among other effects, this is expected to translate to better economic investment into the health system and holistic improvement of health service delivery.

Three years have elapsed since the implementation of HSSP V commenced. The country's investment in the health sector has improved, which is expected to influence the entire landscape of health service delivery. This MTR offers an opportunity to study the strengths and weaknesses of the plan itself, to understand the progress in attaining the set goals, and factors that positively or negatively influence the progress. A mixed-method cross-sectional approach was employed to ensure a comprehensive assessment of the implementation progress of HSSP V

Over the HSSP V implementation period, the number of health facilities in Tanzania has increased from 8458 to 9366. Majority of the health facilities are owned by the government, except for Dar es Salaam region where almost three quarters of the facilities are not public facilities. Katavi region has the lowest crude number of health facilities despite having the highest annual intercensal population growth rate whereas Geita Region has the lowest health facility density in the country. Dar es Salaam has the highest population density of above 3,000 people per square kilometres.

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

Regarding quality of care, the country targets 85% of primary health care facilities to have at least three stars on star rating assessment by 2025. Contrary to the set targets, the current trend is still far behind, where only 14% of the facilities assessed in 2022 had attained at least three stars, a slight decline from 18% in 2017/18. The latest Star rating assessment was done

in only ten regions, which were Kilimanjaro, Mtwara, Shinyanga, Singida, Songwe, Kigoma, Katavi, Mara, Njombe and Rukwa. Of 2587 facilities visited only 359 (14%) scored 3 stars.

The government also aimed at improving super-specialised services and medical tourism in the country so as to reduce referral of patients to abroad and to attract foreigners seeking medical care in Tanzania. The number of foreigners coming to Tanzania to seek medical treatment has increased from 6472 in the financial year 2022/2023 to 9462 in 2023/24. Leading health facilities in providing services to clients from foreign countries are MNH, JKCI, MOI, Aga Khan, Saifee and Ocean Road Cancer Institute. Majority of the clients come from neighbouring countries including Malawi, Comoro, Zambia, Burundi and Congo- DRC. The government continues to strengthen infrastructure, resources and capacity for transplant services in the country, including renal and bone marrow transplant.

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

Overall, the country has made commendable progress in improving service delivery over the HSSP V implementation period. Recommendations from the MTR will serve to enhance achievement of the set targets in the remaining implementation period and formulation of HSSP VI.

1 Context of service delivery in the HSSP V implementation period

Tanzania continues to improve investments in the health sector with an overarching goal of achieving quality livelihood for all citizens without leaving anyone behind. The HSSP V builds on the country's continuous strategic vision and objective planning, outlining the needed investments, activities to be implemented, and targeted outcomes in successive five-year phases, in line with the directions illustrated in the National Health Policy. HSSP V implementation began months after Tanzania's Gross National Income (GNI) per capita increased above the lower-income threshold, qualifying the country for a lower-middle income status in July 2020. Among other effects, this is expected to translate to better economic investment into the health system and holistic improvement of health service delivery.

The HSSP V plan outlines the country's vision for achieving equitable, quality, accessible, and sustainable health services for all people. It stipulates the strategic objectives, implementation plan and indicators for improving health services delivery, alongside investments required in the health system inputs such as human resources, health financing, infrastructure, commodities, and information systems. Currently, the health service delivery in Tanzania operates in a complex landscape of mixed healthcare financing modalities amidst the country's commitment of achieving Universal Health Coverage (UHC) alongside other Sustainable Development Goals (SDGs).

The policy commitments operationalized through HSSP V prioritize health system strengthening with consequent improvement of service availability, access, quality, and utilization at the primary, secondary, and tertiary levels comprehensively. Furthermore, the plan insists on the provision of people-centered and resilient health services amidst growing population size, continuing urbanization, climate changes, outbreaks and disasters and emerging/re-merging diseases. HSSP V was developed amidst the COVID-19 global pandemic which has undeniably influenced resource allocation, health service delivery, and care modalities worldwide, including in Tanzania. Carrying on the HSSP IV unfinished business pertaining to health service delivery, the HSSP V aimed to ensure the implementation of essential health services at primary health care level, strengthen provision of specialized care at regional levels and super-specialized services at zonal facilities and above while strengthening the referral systems.

2 Commitments of the Health Sector Strategic plan

1.1 Improved organisation of the health facilities, with adequate referral

1.1.1 Package of service

1. The NEHCIP-TZ will be revisited in the context of the creation of mandatory health insurance will serve as the basis for providing care at various levels. guide for entitlements of patients in the context of health insurance.

1.1.2 Essential Health Services at Primary, Secondary and Tertiary Levels

1. Build the capacity of communities to deliver community-based and homebased care
2. Improving the infrastructure, equipment and staffing by specialist health care professionals in these hospitals
3. RRHs are envisaged as future hubs for innovation of health care in the regions Referral system
4. Strengthen specialized and super-specialized care to international standards.

1.1.3 Referral system

1. Improve gatekeeping and referral so that hospitals at regional, zonal, specialized and national level facilities can focus on provision of specialist and super-specialist services that are not available in PHC levels

1.2 Geographical, social-cultural and financial barriers in accessing quality and people-centred basic health services for all people are being addressed.

1.2.1 Coverage expansion

1. A long-term investment plan for construction of new health facilities at all levels will be developed, based on realistic health requirements
2. Expanding provision of specialized and super specialized services like organ transplant and device implants

1.2.2 Infrastructures: A network of health facilities is in place that guarantees equitable access to essential health services for the whole population

3. Avail infrastructure (including staff housing) and equipment for health facilities, including for people with special needs
4. Existing structures and equipment will be maintained or renovated to be functional and efficient
5. All new health facilities will be equipped to meet minimum standards
6. Use of new mobile technology, ICT and artificial intelligence will be promoted to increase access to quality diagnostic services

1.3 Quality of care: Ensure availability of quality of essential health care services and interventions

1. Provide people-centred care
2. Enhance clinical audit and supervision mechanisms in line with established guidelines
3. Facilitate an agreement on the joint quality improvement approach to be used in the sector, and the harmonisation of all quality tools developed by programmes, departments, NGOs and others
4. Small scale quality improvement (QI) approaches that target the behaviour of providers or patients will be incorporated in facilities
5. Where needed, further capacity building in quality of care and compassionate care will be provided
6. Establishment of an accreditation system managed by a single independent sectoral accreditation board for public and private health care facilities
7. The Star-rating will be strengthened, with self-assessment and web-based tools.
8. Health facilities (public and private) that have reached five stars will receive official certification.
9. Government will harmonise registers, licenses, and accreditation systems, for public and private health care.
10. Patient Charter will be promoted countrywide
11. Adherence to the guidelines will be part of the support to health facilities

1.4 Epidemic and disaster preparedness and response

1. Strengthen and expand the national PHL system by establishing a new facility in Dodoma.
2. Expand isolation centres
3. Ensure all zonal and national level laboratories have international accreditation while
4. Ensure regional and district level laboratories have at least 3-star rating according to the World Health Organisation (WHO) system towards accreditation

3 Relevance of the theory of change

Although the HSSP V stipulates various commitments, objectives and strategies to achieve the desired goal of improving health services in Tanzania, it lacks a clear articulation of the theory of change. The theory of change would outline the position of the HSSP V in the realization of the National Health Policy, and the specific pathways through which the strategic objectives would translate into the desired outcomes and impact, without leaving anyone behind. However, it can be extrapolated from the text by bringing several sections together that the government will strengthen all aspects of health system inputs, to achieve the desired relevant outputs of improving service availability, accessibility and quality of health services. However, lack of an explicit theory of change offers limited clarity of the agreed assumptions and processes including the respective process indicators that are expected to yield to fruitions of the desired goals.

4 Rationale for the MTR

Three years have elapsed since the implementation of HSSP V commenced. The country's investment in the health sector has improved, which is expected to influence the entire landscape of health service delivery. Moreover, the HSSP V has been implemented in a rather different context as compared to previous ones due to the COVID-19 pandemic which has undeniably influenced health service delivery and sectoral planning. This MTR offers an opportunity to study the strengths and weaknesses of the plan itself, to understand the progress in attaining the set goals, and factors that positively or negatively influence the progress. Furthermore, the MTR will outline the targets that the country has already attained,

on track to attain, and those that may not be achieved even at the end of the plan's implementation period if the implementation processes remain the same. Overall, the MTR will offer recommendations to equitably improve healthcare delivery in the remaining period of HSSP V and provide evidence-based propositions for the design directions to be considered in the HSSP VI.

5 Main Objective:

The main objective of the MTR is to assess the progress of implementation of the HSSP V, and to recommend measures to enhance its implementation over the remaining span of the plan.

1.5 Specific objectives:

Specific to the health service delivery status in the country, the objectives are;

a. To assess the progress made in improving availability, utilization, and quality of health services over the HSSP V implementation period.

b. To assess the contribution of health system structures,in health service delivery in the country over the HSSP V implementation period

c. To explore the contribution of services delivered in PHC level, to the achievement of HSSP V targets

d. To explore the factors enhancing or hindering the achievement of HSSP V strategic objectives with regard to health service delivery in the country.

6 Summary of the methods

A mixed-method cross-sectional approach was employed to ensure a comprehensive assessment of the implementation progress of HSSP V. The MTR combined qualitative and quantitative approach, preceded, informed and complemented by a desk review of relevant reports, policy documents and implementation data. Quantitative data was collected and analysed descriptively to obtain trends and other aspects of performant metrics, triangulated with qualitative data which was collected through in-depth interviews, key informant interviews and stakeholder's consultation. Such methodological triangulation enabled capturing of diverse perspectives and contextual factors that hinders or influence HSSP V implementation and consequential achievement of its outcomes.

7 Results

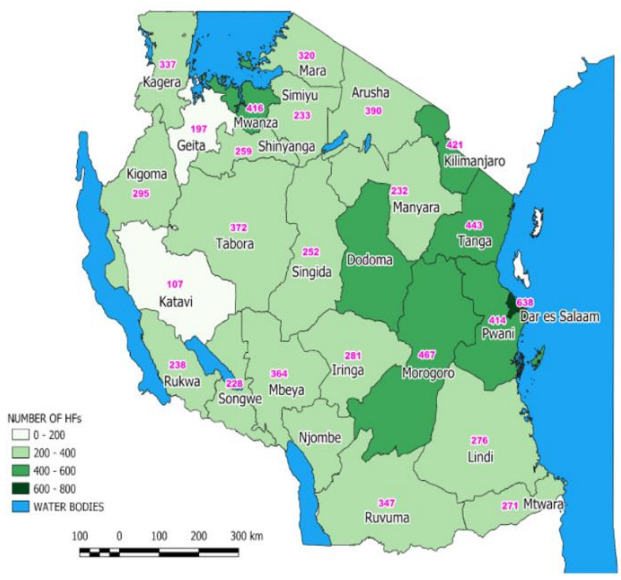
8 Service availability and accessibility: Improved Health Infrastructure for Equitable Access

1.6 Progress towards the target

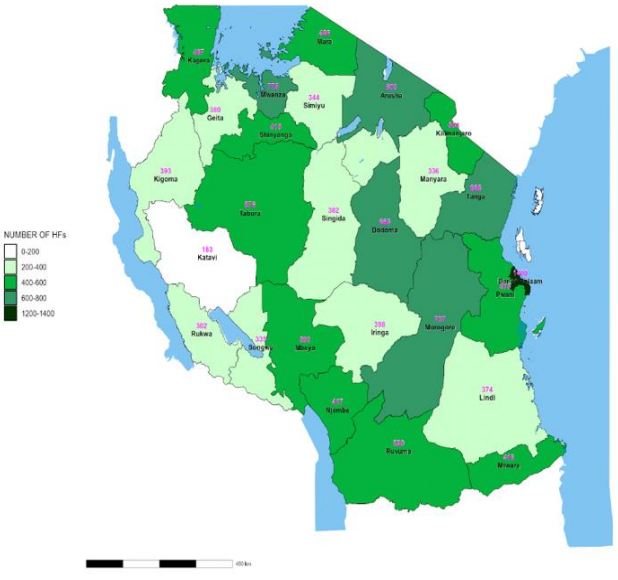
1.6.1 Number and distribution of health facilities

Tanzania's mainland is currently home to 59.8 million people, a population that has grown at an annual intercensal rate of 3.2%, with the Katavi regional population growing at the highest rate of 7.1%. Such a population growth rate plausibly requires a proportional increase in health service availability, similar to other social services. Service availability hereby refers to a physical presence of health facility units, including the necessary infrastructure, health personnel and all other aspects of health system inputs.

The number of health facilities in Tanzania has increased from 8458 to 9366 between 2020 and 2023. Government health facilities have consistently contributed almost three-quarters of the total number of health facilities in the country. Despite having the highest population growth rate, Katavi region has the lowest crude number of health facilities as compared to other regions, the situation remains the same throughout the HSSP V implementation period so far, as shown in the illustrative maps in the figure 1 below.



Health facility distribution by region, 2020 *(source: 2021 AHSP)*



Health facilities distribution by region, 2023 *(source: 2023 health facility atlas)*

Figure 1: Health facility distribution by region in 2020 and 2023

Disaggregating, the number of dispensaries has increased from 7163 to 7804, health centers from 926 to 1126 whereas the number of hospitals has increased from 369 to 436 over the first half of the HSSP V implementation period. Figure 2 below shows the annual number of health facilities by level. The majority of health facilities in the country are of primary health care level, with dispensaries and health centers combined accounting for over 90% of the total number of health facilities, and serving as a primary entry into medical care for 95% of the total population

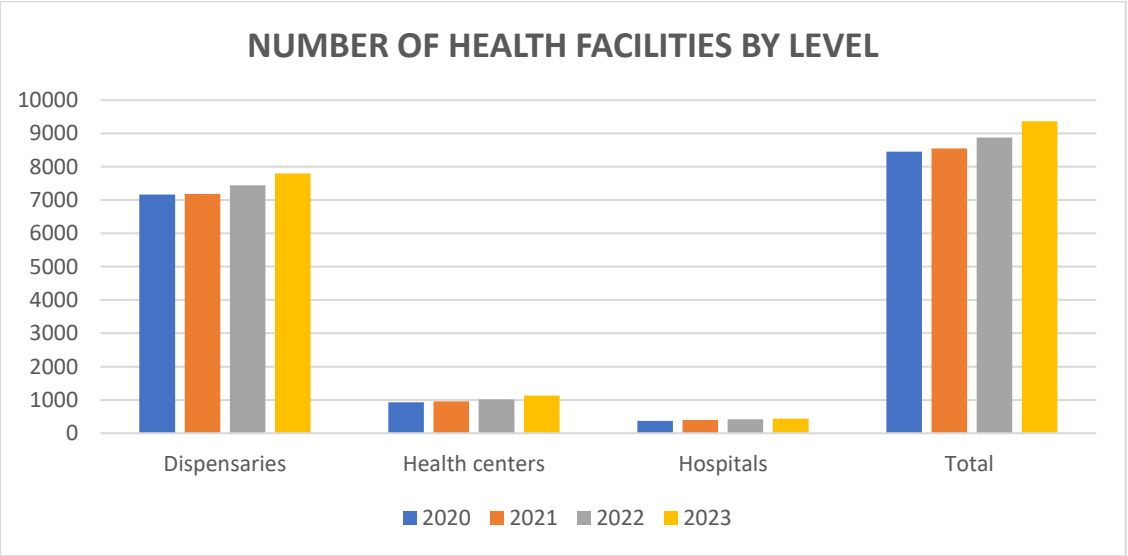


Figure 2: Number of health facilities by level

1.6.2 Facility ownership

The majority of health facilities in Tanzania are owned by the government, accounting for 75% of all the total number of facilities in the country. However, public-private partnerships with Faith Based Organisations (FBOs) and private facilities contribute immensely to the progress made in service delivery. Non-government-owned health facilities play a vital role in the healthcare system, in resource mobilization and contributing towards providing care, including specialized and super-specialized services, particularly in urban and peri-urban regions. The private sector owns 50% of the hospitals in the country, as compared to approximately only a quarter of dispensaries as shown in figure 3 below.

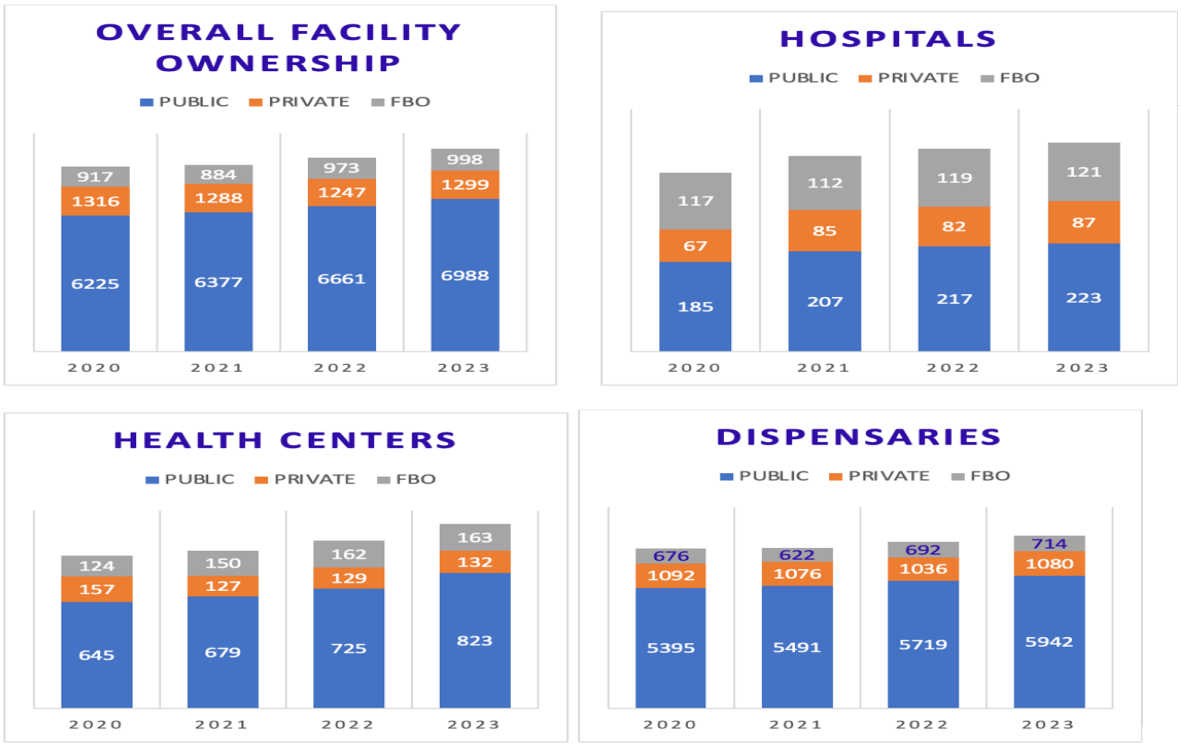


Figure 3: Health facility ownership by level

Region-wise, the majority of the health facilities are owned by the government except for Dar es Salaam where only 25% are public facilities. Considering the rapid urbanization of Dar es Salaam, the presence of slums and areas with poor social determinants of health such as overcrowding, inadequate housing, and limited access to water and sanitation facilities, the fact that only a quarter of health facilities in the city are government-owned may have negative implication on access to affordable health care by the majority of the people. The government should continue to put efforts on the expansion of coverage of public health facilities in the city alongside strengthening of PPP initiatives. Furthermore, increasing insurance coverage with effective gate-keeping mechanisms may also ensure population's access to health services in both public and private facilities.

Figure 4 below shows the facility ownership in each region in Tanzania mainland.

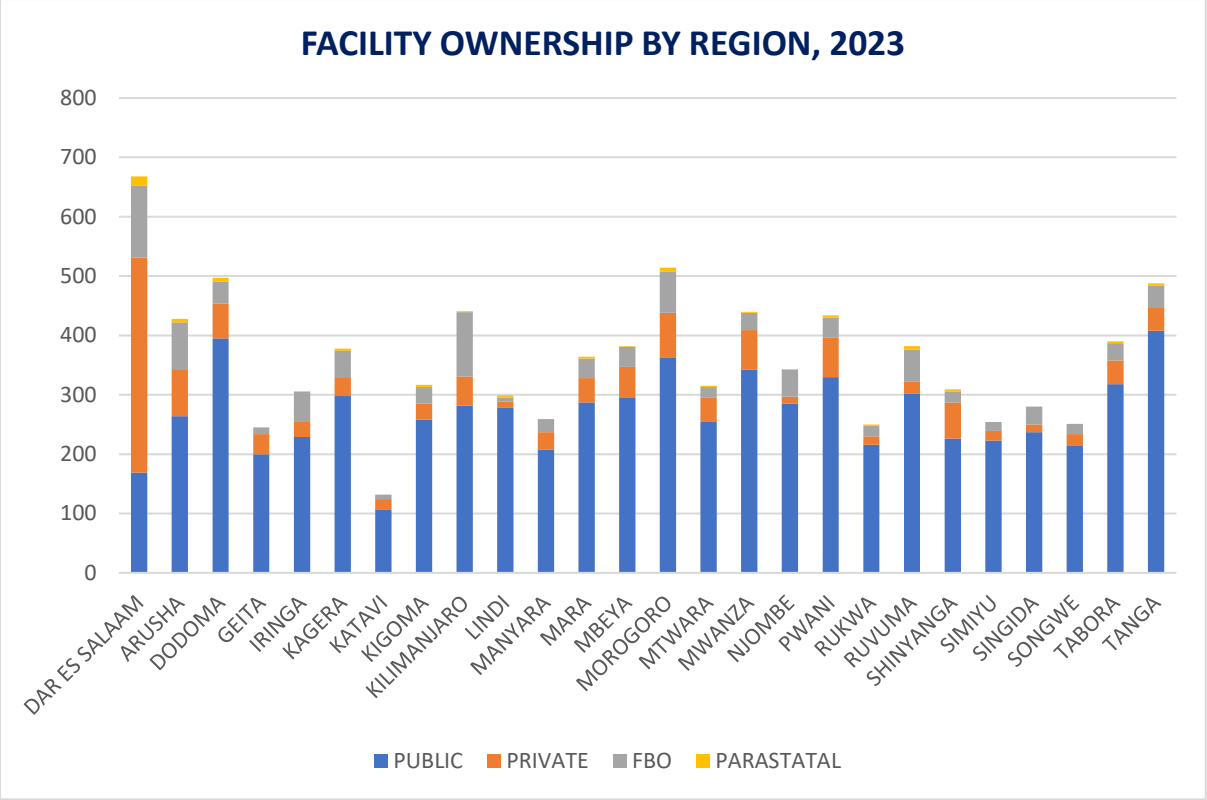


Figure 4: Health facility ownership by region

1.6.3 Health facility density

1.6.3.1 Overall health facility density

Health facility density, which is the number of health facilities per 10,000 population is regarded by WHO as the "*primary indicator of outpatient service access*", although the Tanzania SARA reports use it as an indicator for general service availability. Nevertheless, besides the crude number of health facilities, health facility density offers a more meaningful comparison of the number of facilities serving the population size of a particular region.

Overall, Tanzania's health facility density was reported to be 1.87 in 2017, which dropped to 1.4 in 2020, and increased to 1.97 in 2023 as reported in respective SARA reports. The seeming decrease trend between 2017 and 2020 should be interpreted with caution because health facility density data in SARA surveys is calculated from a sampled number of facilities, and the population status of the sampled regions and districts may sway the results. In spite of that, the country has set a target of achieving a population density of 2.5 facilities per 10,000 population by 2025 (shown in figure 5 below), making it worth evaluating the available trends while taking into account the data limitations.

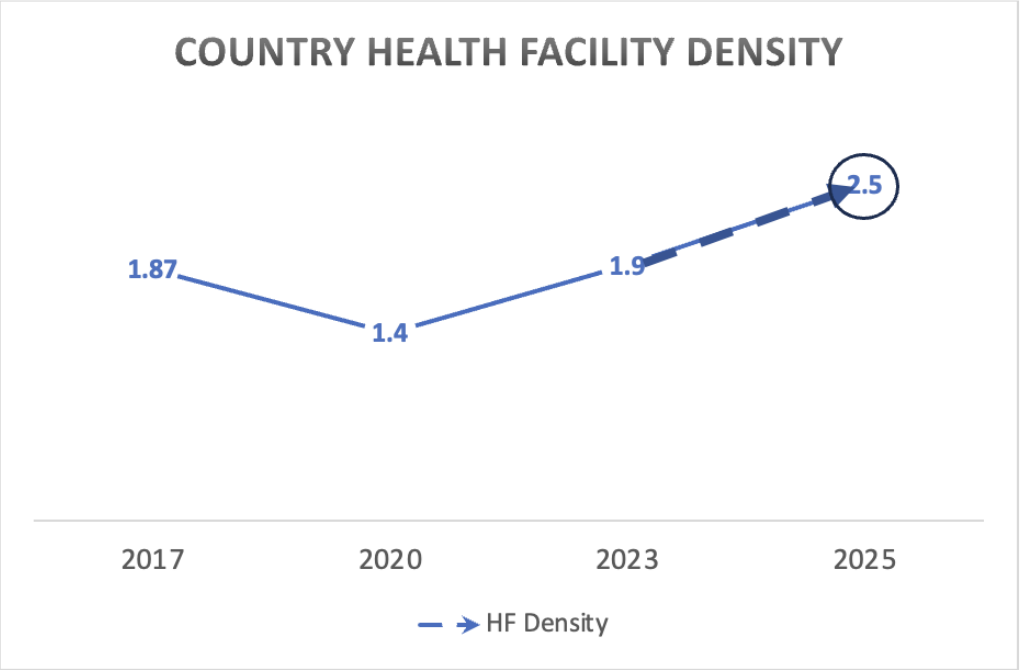


Figure 5: Progress of health facility density

Delving into district-level health facility density, Bukombe district and Geita district councils had the lowest health facility density of 0.7 facilities per 10,000 in 2020 and 2023 respectively. Both districts are found in Geita region. According to the 2022 census, Geita is the third region in Tanzania mainland with the highest annual intercensal population growth rate which has risen from 2.6% to 5.4% in just one decade. Rapid increase in the population size may account for persistent low facility density in Geita region. In order for the country to be on track to achieving the target health facility density, there is a need for an active investment in building and equipping health facilities while taking into account the regional population growth rate. Other regions with high population growth rates are Katavi, Pwani, Lindi and Tabora.

1.6.3.2 Regional health facility density

Considering the region population size reported in the latest census of 2022, and number of health facilities in each region as reported in the 2023 national health facility census, Lindi region has attained the target health facility density, whereas Geita region has the lowest health facility density similar to the findings of SARA surveys.

The map (figure 6) below shows regional facility density calculated from the population and number of facilities per region, as extrapolated from the data shown in table 1 that follows.

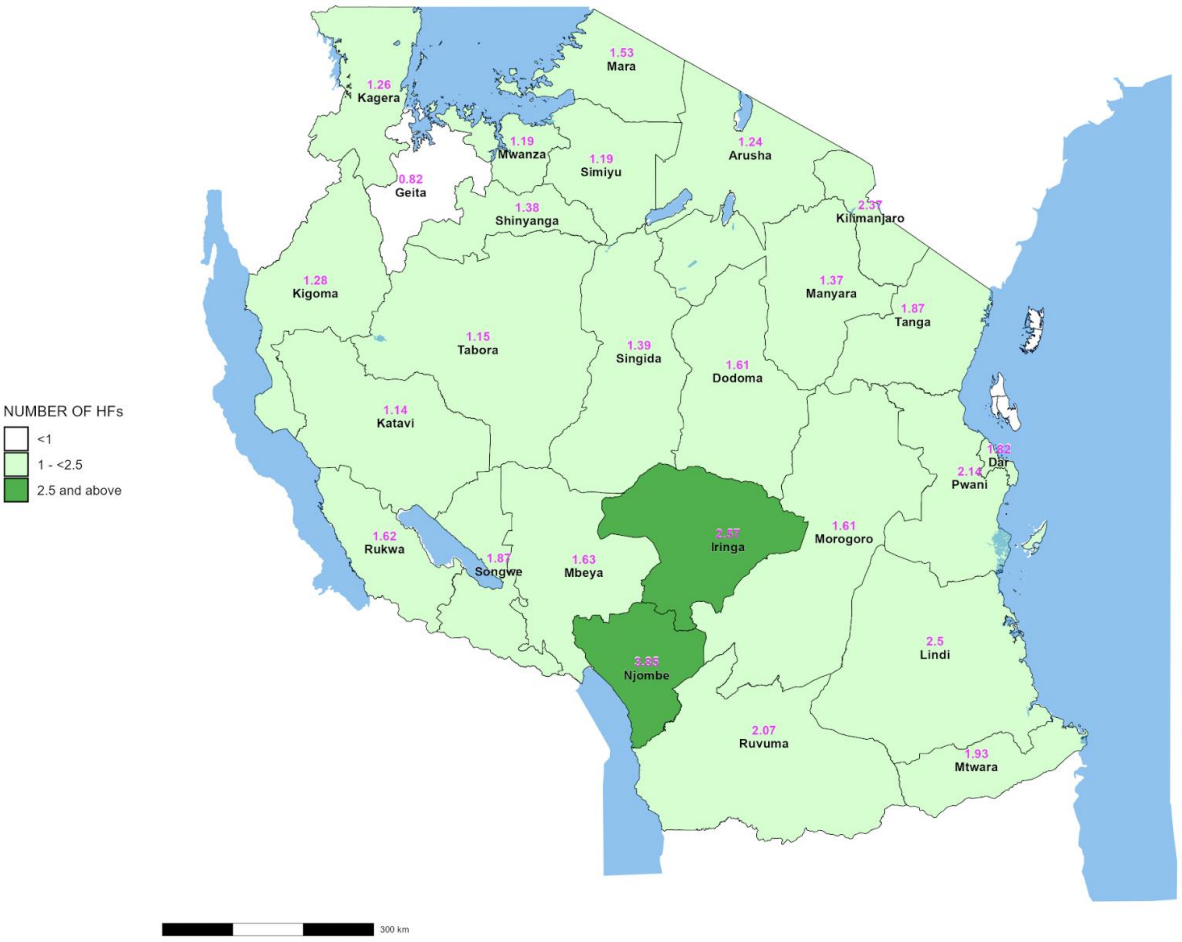


Figure 6: Health facility density by region

Table 1: Calculated Health facility density by region

REGION	FACILITIES	POPULATION	FACILITY DENSITY
DAR ES SALAAM	668	5,383,728	1.24
ARUSHA	428	2,356,255	1.82
DODOMA	497	3,085,625	1.61
GEITA	245	2,977,608	0.82
IRINGA	306	1,192,728	2.57
KAGERA	378	2,989,299	1.26
KATAVI	132	1,152,958	1.14
KIGOMA	317	2,470,967	1.28
KILIMANJARO	441	1,861,934	2.37
LINDI	299	1,194,028	2.50
MANYARA	259	1,892,502	1.37
MARA	364	2,372,015	1.53
MBEYA	382	2,343,754	1.63
MOROGORO	514	3,197,104	1.61
MTWARA	315	1,634,947	1.93
MWANZA	440	3,699,872	1.19
NJOMBE	343	889,946	3.85
PWANI	434	2,024,947	2.14
RUKWA	250	1,540,519	1.62
RUVUMA	382	1,848,794	2.07
SHINYANGA	309	2,241,299	1.38
SIMIYU	254	2,140,497	1.19
SINGIDA	280	2,008,058	1.39
SONGWE	251	1,344,687	1.87
TABORA	390	3,391,679	1.15
TANGA	488	2,615,597	1.87

1.6.3.3 Health facility distribution in metropolitan cities.

Plausibly, a higher number of health facilities is required in regions with higher population size, a fact that may be overlooked when considering only the crude numbers. Table 2 below shows the population size of six main cities of Tanzania, with respective population density (number

Table 2: Population size in the major cities with respective number of health

of people per kilometer square) and the total number of health facilities by 2023. It can be extrapolated from the table that, even though Dar es Salaam appears to have the highest number of health facilities, it is serving a much larger population size, which is congested in a relatively smaller geographical area as shown by a population density of over three thousand people per square kilometer.

Region	Population 2022	Population density population/km^2	Total number of health facilities by 2023
DSM	**5,383,728**	**3865**	**668**
Mwanza	3,699,872	391	440
Tanga	2,615,597	98	488
Dodoma	3,085,625	75	497
Arusha	2,356,255	63	428
Mbeya	2,343,754	62	382

There are many implications of such discrepancy in health service delivery, exacerbating inequities in health facility distribution. This indicates that health facilities in Dar es Salaam have to serve a larger population congested in a relatively smaller geographical area, in addition to those traveling to the country's most developed city for referral or individually seeking better diagnostics and care. Furthermore, Dar es Salaam is grappling with urban poverty, a multifaceted challenge that translates to poor social determinants of health including relatively higher rates of informal settlements, over-crowdedness, poor sanitation, unemployment, and limited access to basic services.

Although HSSP V indicated the government's commitment to establish new zones and integrated approaches to address challenges and implications of urban poverty in health service delivery, the situation largely remains the same. Through the Health Equity Project for the Marginalized living in Urban Settings in Dar es Salaam "HEPP" project, the government, (through PORALG) in collaboration with IHI and financial support from the Korea Foundation for International Healthcare have conducted a situational analysis for objective assessment of health inequities in the urban settings. Phase two of HEPP project will implement participatory

approaches to improve community-based health facilities, strengthening urban health and equity stewardship.

1.6.4 General service readiness

Health service general service readiness is improving overtime. General Service readiness is a composite indicator that assesses five key health service provision areas. These include the availability of basic amenities, basic equipment, standard precautions, laboratory diagnostic services and availability of essential medicines. The general Service Readiness Index for Tanzania has improved modestly from 57% in 2017 to 69% in 2020 and 71% in 2021, indicating the government's continuous commitment to strengthen health service delivery in the country. However, the availability of basic amenities has declined from 85% to 58% between 2020 and 2023. Tracer items in basic amenities assessment specifically include the availability of power source, improved water source, consultation rooms with adequate privacy, sanitation facilities, communication equipment, computers with email access, and emergency transportation. Figure 7 below shows the progress in service delivery performance.

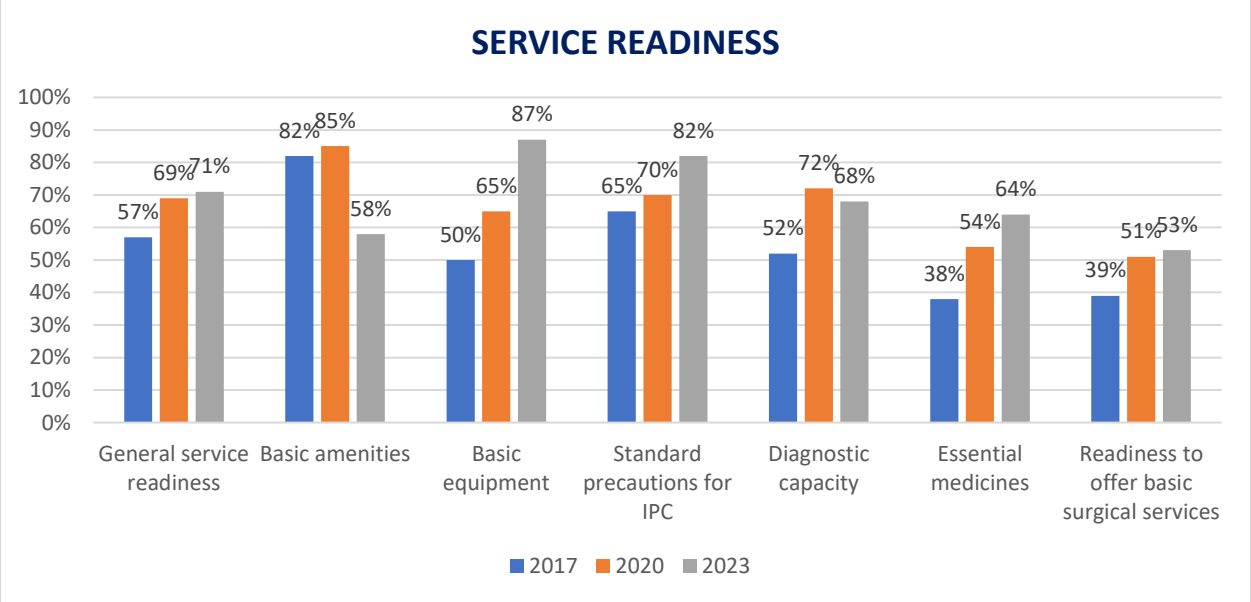


Figure 7: Overall service readiness progress

1.6.5 Service utilization

1.6.5.1 OPD service utilization

OPD utilization per person per year is among the key indicators for health service utilization in a particular population. It reflects that services are accessible and acceptable by the intended surrounding communities, especially for primary health care, which serves as an entry point

to medical care for the majority of the population. Tanzania has set a target of 1.2 OPD utilization per person per year by 2025. However, the trend is rather staggering, and the country is at risk of not achieving the set target. OPD utilization per person per year was 0.85 in 2020, the figure that has stagnated at 0.67, 0.7, and 0.78 for 2021, 2020, and 2023 respectively. The OPD utilization overtime does not correspond with the increase in the number of health facilities

Table 3 below shows the number of OPD attendances from 2020 to 2023, figures remain largely stable over time .

Table 3: Annual OPD attendances

OPD ATTENDANCE	2020	2021	2022	2023
< 1 month	409015	391859	434913	546096
1 month to <1 year	4984537	4253991	4348906	5212070
1 year to < 5 years	10356183	9446618	9480138	10735843
5 to 59 years	22238086	22041294	22060430	24484350
60+ years	5343016	5344523	5279872	5545268
Total OPD attendances	10356183	9446618	9480138	10735843

As shown in table 4 below, the most common diagnoses from OPD attendance in primary health care also remain the same over time . Top three diagnoses are upper respiratory tract infections followed by urinary tract infection and Malaria.

The top fifteen causes of OPD utilization have persistently been as shown in table 4 below.

Table 4: Leading OPD diagnoses

S/N	Diagnoses	2021	2022	2023
1	Upper Respiratory Infections	9,671,095	9,622,293	11,304,704
2	Urinary Tract Infections	5,224,293	5,277,421	5,738,960
3	Malaria mRDT +ve	4,146,676	3,286,065	3,366,031
4	Pneumonia, Non-Severe	1,462,626	1,462,399	1,750,895
5	Hypertension	1,405,637	1,456,881	1,668,048
6	Diarrhea With No Dehydration	1,391,814	1,337,023	1,491,075
7	Other Non-Infectious GIT Diseases	1,118,194	1,216,264	1,441,224
8	Intestinal Worms	1,053,767	1,035,398	1,108,827
9	Peptic Ulcers	851,930	894,585	1,106,840
10	Skin Infection - Fungal	773,478	784,654	909,257
11	Other Surgical Condition	685,959	713,057	770,466
12	Diabetes Mellitus	680,445	672,430	756,264
13	Pneumonia, Severe	660,197	579,260	628,394
14	Rheumatoid And Joint Diseases	475,890	512,504	619,092
15	Mild/Moderate Anaemia	456,582	509,329	590,643

Regional distribution for OPD attendance and the most common diagnoses are shown in the maps on figure 8 below.

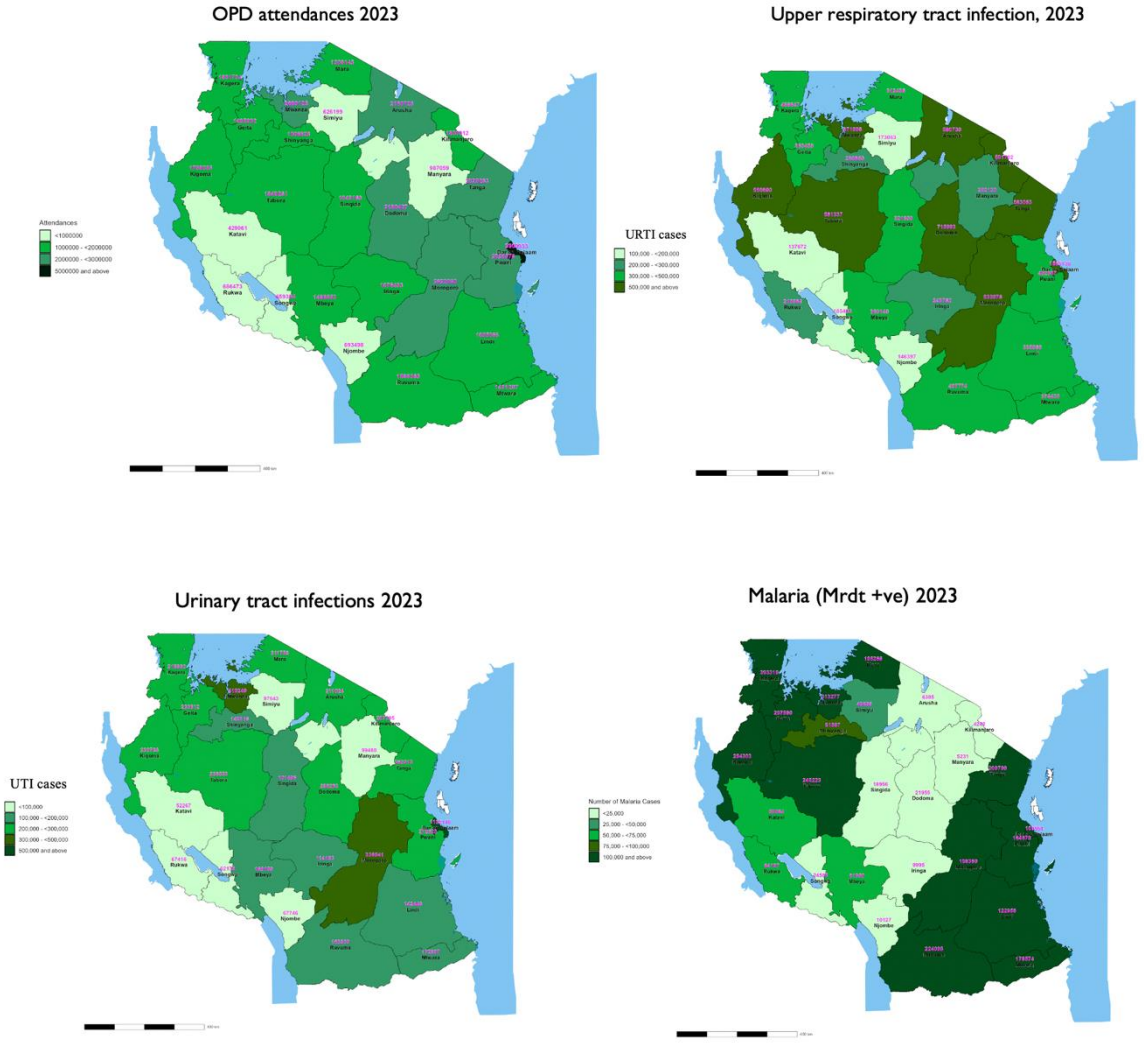


Figure 8: Regional variations in OPD attendances and top three OPD diagnoses

1.6.5.2 Hospital admissions

Hospital admission per 100 persons per year is a metric that indicates populations' utilization and accessibility of the health facilities. Very high hospital admission rates may indicate a higher burden of disease in a particular area whereas very low rates may indicate unavailability or inaccessibility and unacceptability of the services. Tanzania has set an optimal target of 4.2 hospital admission rate per 100 population to be achieved by 2025. Similar to OPD utilization, the country is staggering at the rates of 2.68, 2.74 and 2.78 for 2021, 2022 and 2023 respectively, a decline from the baseline of 3.2 in 2020.

Looking at crude numbers, hospital admissions have remained the number of annual admissions have remained stable over time as shown in table 5 below, with regional variations as shown in the map on figure 9

Table 5: Annual IPD attendances

INPATIENT ADMISSIONS	2020	2021	2022	2023
*IPD admissions, 5+ years	1,249,778	1,218,136	1,183,473	1,253,641
*IPD admissions, < 5	551,207	444,192	447,298	529,001
*Total IPD admissions	1,800,985	1,662,328	1,630,771	1,782,642

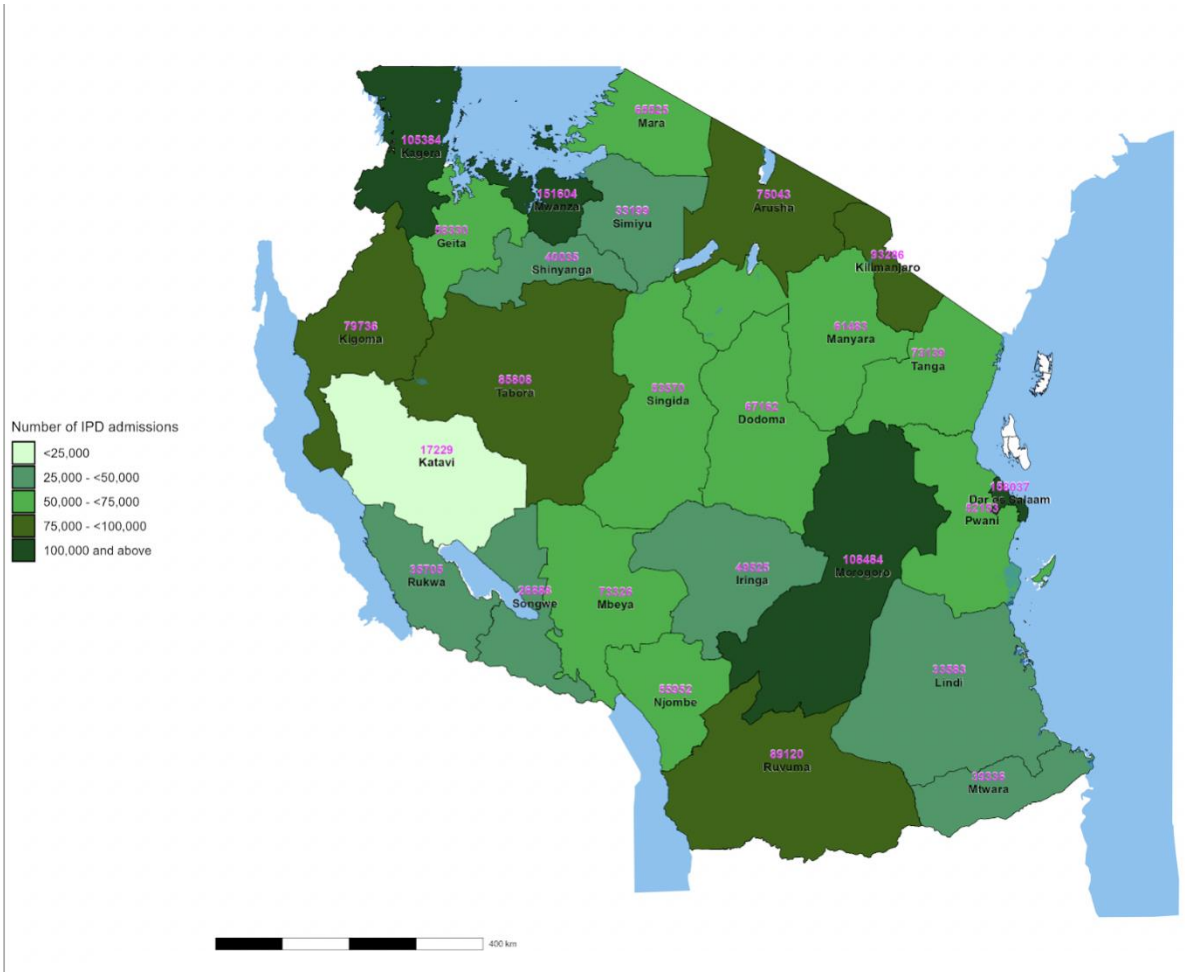


Figure 9: Regional variations in IPD admissions

Figure 10 below shows the progress of OPD utilization and Inpatient admissions towards the 2025 targets

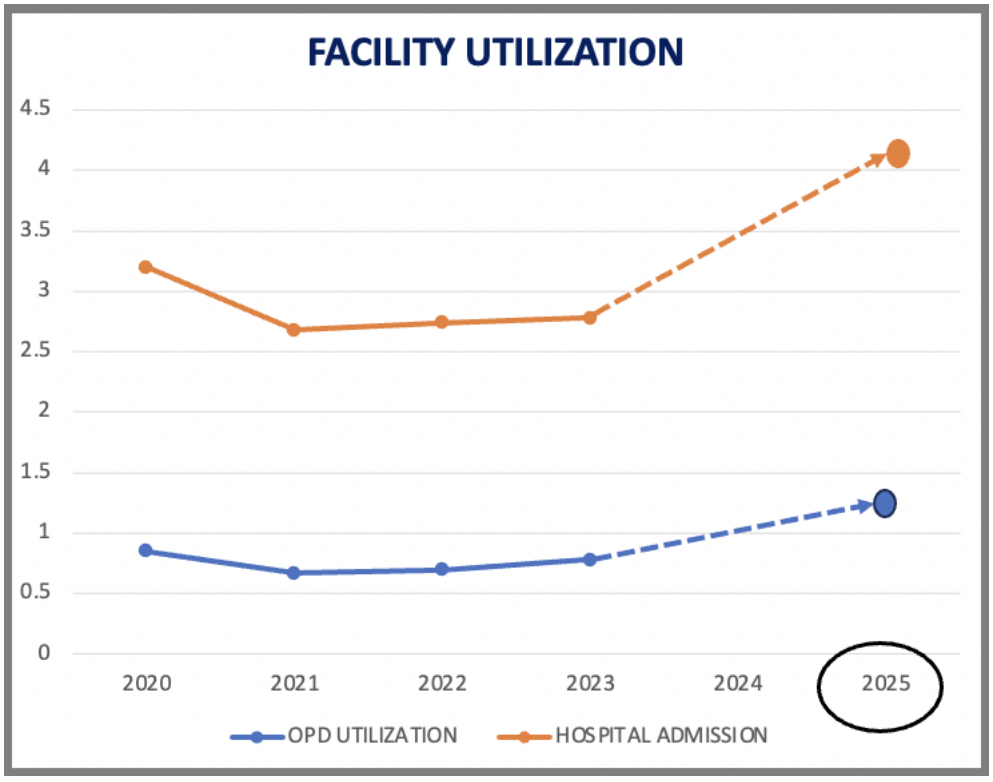


Figure 10: Progress on facility utilization

1.6.6 Quality of services

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

The country targets 85% of primary health care facilities to have at least three stars on star rating assessment by 2025. Annual targets set aimed to achieve at least 40% and 50% of the primary healthcare facilities to have achieved 3 stars by the end of 2022 and 2023 respectively. Contrary to the set targets, the current trend is still far behind, where only 14% of the facilities assessed in 2022 had attained at least three stars, a slight decline from 18% in 2017/18. The latest Star rating assessment was done in only ten regions, which were Kilimanjaro, Mtwara,

Shinyanga, Singida, Songwe, Kigoma, Katavi, Mara, Njombe and Rukwa. Of 2587 facilities visited, 111 (4.3%) scored zero star, 920 (35.6%) scored 1 star, 1197 (46.3%) scored 2 stars and only 359 (14%) scored 3 stars. None of the visited facilities scored 5 stars, and only 21 (0.8%) scored four stars. Regional performance of the baseline versus the subsequent star rating assessment was as shown in the maps in figure 11-13 below.

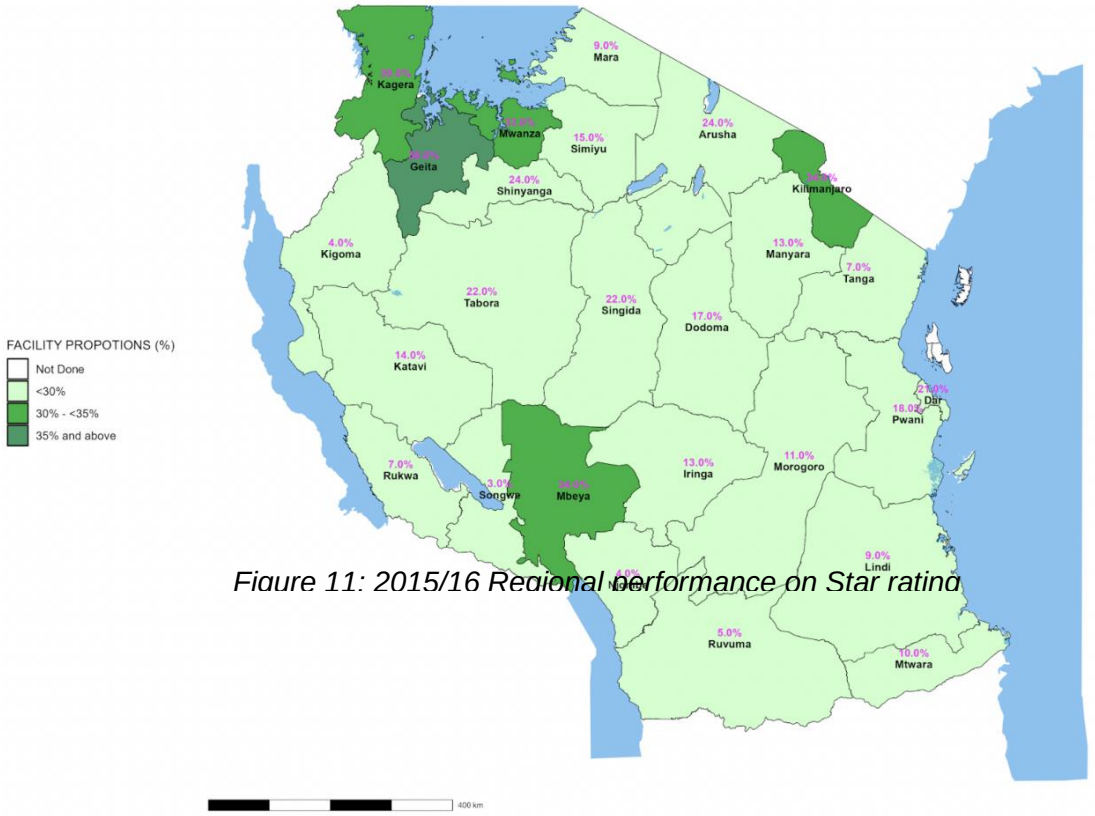


Figure 11: 2015/16 Regional performance on Star rating

Figure 12: 2017/18 Regional performance on Star rating assessment

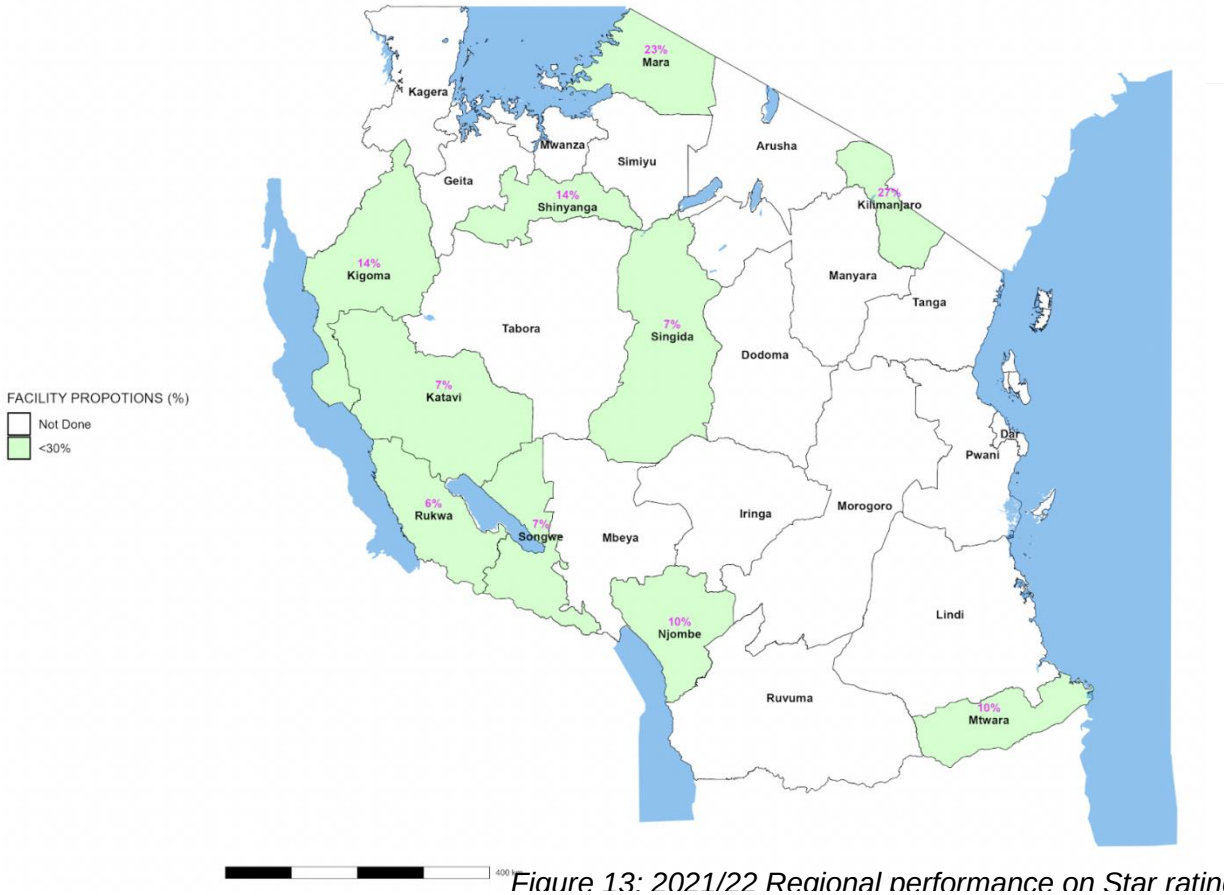


Figure 13: 2021/22 Regional performance on Star rating

REGION	Proportion* of facilities with 3 stars performance in 2015/16	Proportion* of facilities with 3 stars performance in 2017/18	Proportion* of facilities with 3 stars performance in 2021/22
TOTAL No. OF FACILITIES	6993	7289	2587
OVERALL	2%	18%	14%
DAR ES SALAAM	6%	24%	ND
ARUSHA	7%	21%	ND
DODOMA	1%	17%	ND
GEITA	0%	36%	ND
IRINGA	1%	13%	ND
KAGERA	2%	30%	ND
KATAVI	1%	14%	7%
KIGOMA	0%	4%	14%
KILIMANJARO	8%	34%	27%

LINDI	0%	9%	ND
MANYARA	0%	13%	ND
MARA	2%	9%	23%
MBEYA	1%	34%	ND
MOROGORO	1%	11%	ND
MTWARA	0%	10%	10%
MWANZA	0%	33%	ND
NJOMBE	1%	4%	10%
PWANI	0%	18%	ND
RUKWA	0%	7%	6%
RUVUMA	1%	5%	ND
SHINYANGA	1%	24%	ND
SIMIYU	0%	15%	ND
SINGIDA	1%	22%	7%
SONGWE	1%	3%	7%
TABORA	2%	22%	ND
TANGA	2%	7%	ND

**proportions are calculated from total number of facilities per region*

The government of Tanzania continues to implement various initiatives aimed at improving the quality of health services countrywide. The Ministry of Health has prepared a standardized QI training package and has conducted cascading training of trainers (TOTs) in ten regions of Tanzania mainland. Furthermore, the ministry has promoted a nation-wide promotion of patients' charter. However, only 36 (75%) of the facilities visited during MTR primary data collection had the clients' charter displayed. All district hospitals visited had QI teams in place, but only 62% and 73% of the dispensaries and health centers had functioning QI teams respectively. Patients perceived quality of care was acceptable where 97% of patients interviewed on the exit questionnaire reported that they received respectablecare, 98% reported that care was provided in acceptable privacy and 86% reported that the waiting time was acceptable.

..."The government has established the national QI steering committee which is led by the ministry of health, overseeing quality improvement initiatives up to facility level, as shown in the national QI management system shown below. However, there is a need to ensure that star rating

assessment is done in every region, and if possible, facilities should be able to do periodic self-assessment due to resource constraints … (MOH official)

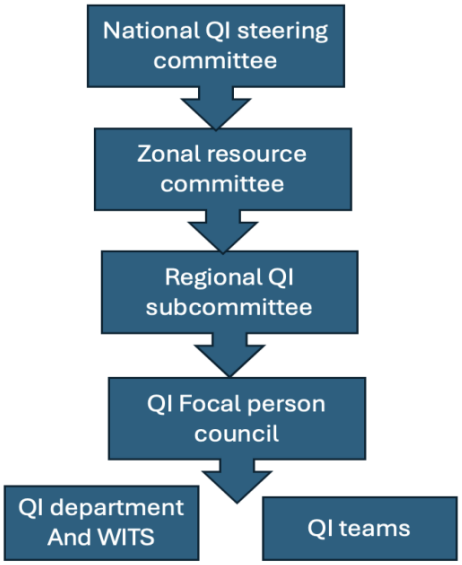


Figure 14: National QI management system

Health facilities visited during the MTR adhere to the placement of signage and public display of telephone numbers of key officers of the facility, as well as having suggestion boxes at key points. These constitute concrete examples evidencing implementation of the Clients' Charter beyond simply displaying it. Complaints handling mechanisms are supported by capture of complaints in earmarked registers.

1.7 National package of essential health services

The Tanzania national essential health care intervention package complements the investments made in improving the health system structures by stipulating key health interventions to be delivered at each level of health care delivery. It stipulates health interventions according to all public health functions including prevention, health promotion, curative, rehabilitation, and palliative care. The current version of the essential intervention package is more than a decade old, plausibly not in keeping with the changes in disease burden, disease outbreaks, and the current capacity of health facilities to deliver the services. It was one of the goals that the essential intervention package will be revised in the HSSP V implementation period to align with the current advancements, demands and overall health system structure. The process of updating the package has begun, currently in the final stages of intervention prioritization and design of its implementation strategy.

1.8 Specialized and super-specialized services

The national hospital has continued to strengthen its excellence in provision of specialized services at regional level and both specialized and super-specialised services at zonal and national levels. Organ transplant and medical tourism are key areas that the government planned to invest in, and improve over the HSSP V implementation period.

1.8.1 Medical tourism

Medical tourism is coordinated under the directorate of curative services, under the assistant director of public and private health facilities under the section of medical treatment abroad. The committee was appointed in 2021, which was initially reporting directly to the Minister of health until 2023 when a specific coordinator for the medical tourism was appointed. To date, there are no specific guidelines, protocols or legal documents guiding the operations under the medical tourism section.

The number of foreigners coming to Tanzania to seek medical treatment has increased from 6472 in the financial year 2022/2023 to 9462 in 2023/24. Leading health facilities in providing services to clients from foreign countries are MNH, JKCI, MOI, Aga Khan, Saifee and Ocean Road Cancer Institute. Majority of the clients come from neighbouring countries including Malawi, Comoro, Zambia, Burundi and Congo- DRC.

1.8.2 Organ transplant services

The government continues to improve human resources, infrastructure and capacity to conduct organ transplant services at Zonal and National hospitals in the country. Leading hospitals for provision of organ transplant services include MNH, Benjamin Mkapa, Bugando, and KCMC hospitals. Organ transplant services available in the country include renal transplant, bone marrow transplant, and cornea transplant. Capacity strengthening is ongoing for liver, stomach and cardiac transplants

1.9 Health service integration

Traditionally, health care services in Tanzania is provided in a mixed fashion, with vertical programs dominating in the provision of care for HIV, TB, Malaria and reproductive health.

Recognizing limitations of vertical programs in efficient and effective functioning of the health system, the government of Tanzania aims to improve integration of services.

However, understanding of healthcare workers at facility levels on the meaning and essence of integration is still limited, as evidenced by the following quotes that were obtained during MTR primary data collection.

…..Service integration means providing appropriate care for the patient, to make it easy for other departments/doctors to care for the patient… (Dispensary hcw)

….. Service integration means ensuring that health facilities have all the departments i.e OPD, inpatient etc.., and ensuring communication between the departments (Health center HCW)

….Vertical programs for example for HIV, ensure that the clients get these services for free, hence integrating other services becomes a disadvantage… (District hospital HCW)

However, health care workers commented that efforts to ensure integration of health services should be largely centralized at the ministry and planning levels rather than at health care provision/implementation levels at the facility. This is to ensure that Service integration effectively considers key aspects of care such as procurement, human resource management, training and capacity building, and monitoring tools.

1.10 Referral system

The government continues to improve the functionality of the referral system, steadily working from the community referrals, PHC facilities to secondary and tertiary facilities. However, the gatekeeping at the tertiary hospital is not fully implemented as patients can decide to skip the referral flow, to any facility level in the country due to open door referral practices. Inadequate implementation of gate-keeping mechanisms may dampen efficiency at secondary and tertiary facilities when spending resources to manage conditions that could be effectively managed at primary healthcare levels.

Furthermore, the referral system is challenged by uni-directional flow of information with limited feedback modalities. Other limitations include lack of a functional electronic referral system and limited interaction between facilities' electronic systems. Although the government works to improve availability of emergency transport systems and ambulances for immediate transfer of patients, readily available transport once needed is still among common challenges especially at dispensary level as seen in the quotes hereunder. However, M-MAMA works effectively for maternal referrals.

...The main challenge is the delay in referral processes, few ambulances, and challenges in obtaining the money for fuel on time, "sometimes patients have to wait… (District hospital HCW)

… for us here, we do not have any form of transport. Not even a motorcycle. So patients who require referral have to wait for the car from the higher facilities to come and pick them.. (Dispensary HCW)

Furthermore, it was found that although out-of-pocket patients do not have to pay for ambulances or transports upon emergency referral to higher facilities, such patients tend to be reluctant to go to higher facilities in fear of inability to afford care. Similarly, cash patients who are given cold referral to attend higher facilities for more specialized care and treatment tend to delay seeking for such care.

…..the difference for cash patients is that, when you don't have insurance, even if you give them a referral letter, they go home and stay there until it's too late. They are afraid of the costs when they go to higher facilities …… (Health center HCW)

1.11 Diagnostic Services

1.11.1 Laboratory diagnosis

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

Furthermore, the country has a total of 1419 stand-alone diagnostic facilities, which include 16 diagnostic centers, 1360 level IA2 (Dispensary Laboratory), 14 operating Level IA1 (Health Centre Laboratory), 15 Level IIA2 (District Laboratory), 3 Level III Multipurpose Health Laboratory, 8 Level III Single purpose Health Laboratory and 3 optical laboratories.

The three level III multipurpose health laboratories are located in Dar es Salaam, Mwanza and Tabora, whereas the eight level III single purpose health laboratories are located in Dar es Salaam (1), Dodoma (1), Katavi (1), Mbeya (1) and Mwanza (4). Overall, 1412 (99.5%) of the stand-alone diagnostic facilities are of private ownership. The regional distribution of stand-alone diagnostic laboratories is shown in the map in figure 15 below.

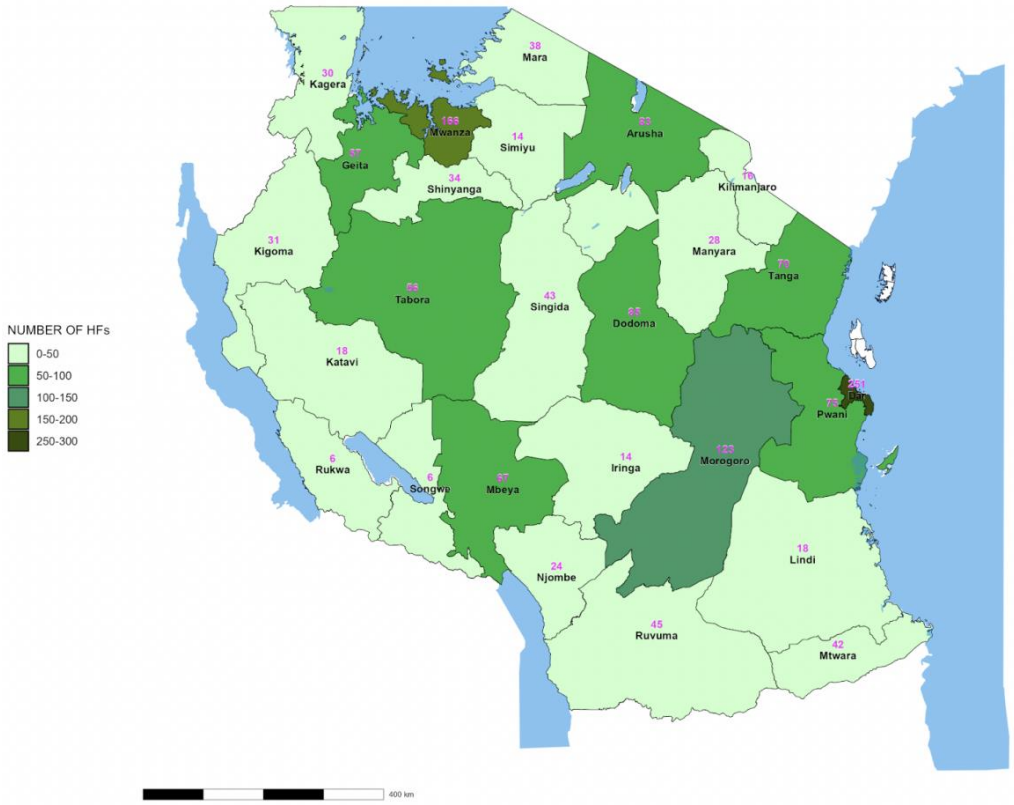


Figure 15: 2023 Regional distribution of stand-alone diagnostic facilities

1.11.2 Radiological services

Similar to laboratory diagnostics the government also continues to invest into improving radiological diagnostic facilities in the country. The table below shows the status in 2023 against the targets that are to be achieved by the end of HSSP V implementation period in 2025. The target of equipping National, Zonal and Specialized hospitals with MRI has been achieved, and the government is on track for equipping them with CT scans by 2025

Table 6: Status of radiological devices

Indicator	Status 2023	Target 2025

CT scan services at National, Zonal, Specialised and Regional referral hospitals	38	41
MRI services at National, Zonal and Specialized	11	11
X-ray services at National, Zonal, Specialized, RRH, Council hospitals and health centres	346	1408
Radiotherapy services at specialized and zonal hospitals	2	8
Tele-radiology coverage at National, Zonal, Specialized, regional referral hospitals and council hospitals	23	41
Radiology and imaging facility met radiation safety requirements	1400	1408
Ultrasound services at National, Zonal, Specialized, RRH, Council hospitals, health centres and dispensaries	677	9489

.

1.11.3 Safe Blood Transfusion

The ministry of health is working to ensure improvement in the number and safety of blood donation and transfusion. According to the 2023 National Health facility atlas, the country has 8 zonal level blood transfusion centers which are located in Dar es salaam, Dodoma, Kilimanjaro, Mbeya, Mtwara, Mwanza and Simiyu.

The HSSP V emphasised the need to have the Country Blood Safety act that to protect the donors, health care providers and the recipients, this is yet to be accomplished as there is no legal basis for the NBTS operations. However, lack of the law has not impacted the increase in the voluntary blood donation/collection where the number of units of blood collected have increased from 221,279 in 2020 to 578,827 in 2024. Figure 16 below shows the trend of the units of blood collected over the HSSP V implementation period.

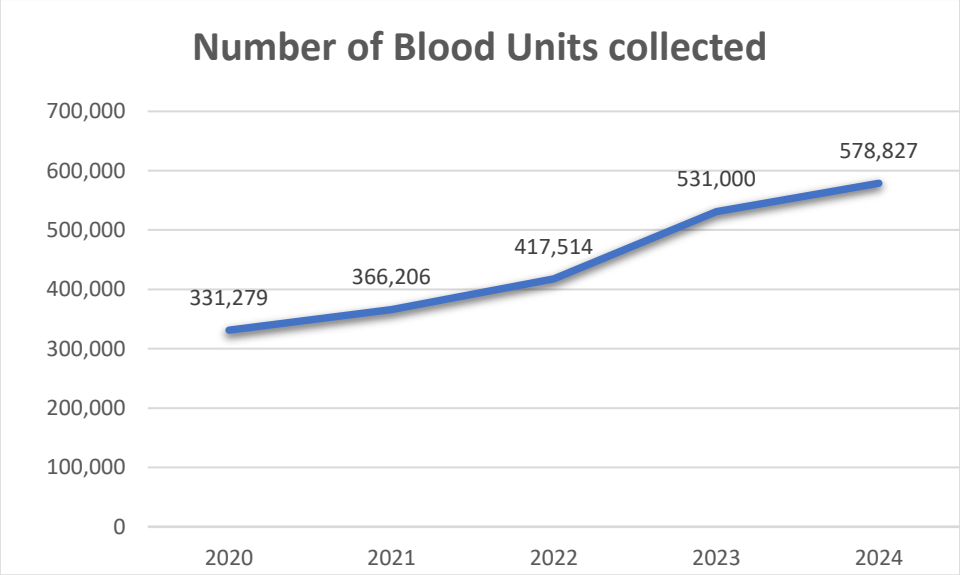


Figure 16: Annual blood unit collection

Further the NBTS have introduced a number of interventions to ensure sustainable collection, processing and distribution of safe blood. This includes celebration of World Blood Donation Day and conducting campaigns to reach the blood collection targets. Using automated machines for processing and analysing blood collected as well as capacitating facilities to collect blood for easy distribution, samples are taken to NBTS centres for testing only. However, this is challenged by inadequate number of staff at the facilities to work on blood collection, as there is no designated personnel for blood collection workups.

> *"For the higher-level hospitals like regional referral hospitals and zonal hospitals, they do collect blood and we encourage that. But we are facing a challenge because same laboratory staff are the ones working on blood collected and it is like additional work to them"* (NBTS personnel)

1.11.4 Public Health Laboratories

The National Public Health Laboratory (NPHL) is the sole operating laboratory as a public health (PHL) laboratory providing a range of services including training and surveillance. Kibong'oto Infectious Diseases Hospital is also in preparations to serve as the PHL. According to JEE on the IHR core capacities the NPHL has made progress in its indicators where overall surveillance, specimen referrals, quality systems, testing capacity modalities, and national diagnostic network continue to improve as compared to 2012, refer to Table 1 above. The

NPHL continues to retain its ISO accreditation (ISO:15189 by SADCAS) since 2007 and has been maintaining its accreditation since then. the current accreditation started in 2019 - 2024

9 Climate change and health delivery

Like any other country in the world, Tanzania is vulnerable to the negative effects of climate change on health and other aspects of life and wellbeing. Calamities observed from the inception of the HSSP V that could be attributed to climate change including tropical storm Jobo, Hidaya, floods and disease outbreaks such as COVID, Cholera and Marburg. Additionally, climate change can potentially alter behaviour of the infectious disease's pathogens and vectors, consequently increasing the observed burden of disease. Tanzania's climate is predicted to experience more extended droughts, more unpredictable rainfall patterns that could cause severe flooding, and sea level rise, all of which could make the country's already water-stressed water resources even more vulnerable. It is necessary for the government to continue enhancing climate resilience so as to protect lives on land in the waters.

10 One Health Approach for Zoonotic Diseases

The HSSP V pointed out that the control for zoonotic disease is of high importance to be tackled by multisectoral collaboration using one health approach. The human, environment and animal interfaces complexities have resulted in approximately 60% of pathogens affecting humans are of zoonotic origin and 75% of the emerging and re-emerging diseases are originally from animals. Further the land use and the change in animal population and climate creates an intricate change in the disease burden amidst the rise in the non-communicable diseases. The top six priority zoonotic diseases in Tanzania include Rabies, Viral haemorrhagic fevers, zoonotic influenza, anthrax, trypanosomiasis and brucellosis, in addition to the 2019 global pandemic of COVID 19. One health initiative is coordinated by the Prime Minister's office, under the Disaster management Division. The role of the health sector through WHO Integrated Disease Surveillance and Response (IDSR) is vast. Availability of IDSR guidelines, Technical Working Groups, legal frameworks and political will to combat zoonotic diseases has enabled the country to enhance its preparedness , detection and response to emerging and re merging zoonotic diseases. The HSSP V highlighted

that the joint strategy for zoonoses prevention and control will be updated in conjunction with government ministries and agencies. The update has been done successfully by updating the National One Health Strategic Plan (NOHSP) 2015-2020 to NOHSP 2022-2027. The strategy has underscored the HSSP V emphasis on addressing food security and all other threats shared by the human, anima and environment interface.

11 Epidemics and Disaster Preparedness and Response

The HSSP V aimed at building a resilient and robust health and community system with sufficient capacity to prepare for, detect, prevent, respond and recover from the health epidemics, emergencies and disasters. During the MTR, the country has made a significant improvement in most of the core capacity defined by the International Health Regulation (IHR 2005), Table 7 below, summarises the progress before and after implementation of the HSSP V. These changes have been released due to strong political and one health platform in place. Also, the National Disaster management Strategy 2022-2027, has provided the frameworks necessary for the health emergencies management. Further the country has several guidelines, policies, contingency and response plans for different emergencies to execute the IHR requirements. The country's status of the 19/13 modified IHR core competences of the emergence preparedness are summarised in the table below.

The HSSP V emphasised the importance of planning for integrating the psychosocial and mental health care responses in emergencies, unfortunately mental health hasn't been featured in the disaster management strategy. Community engagement, awareness creation and risk communication are pivotal in preparing for, responding and preventing epidemics and other disasters; Tanzania has demonstrated progress by having the Risk communication and Community Engagement systems in place during the Joint External Evaluation of Core Capacities of the IHR (2005) in 2023 as compared to 2020. However biosafety and biosecurity efforts need to be continuously enhanced to prevent unintentional exposure to diseases/pathogens.

The HSSP V highlighted the need for the national register to recover emergencies, incidents, victims, and ranges of trauma, this is yet to come to existence as Tanzania doesn't have the

disasters and emergencies database/records. There is a plan to put a database in place that would help in management of the emergency cases and the recovery progress.

> *"…We don't have the database with all records of the epidemics, disasters and the range of conditions, however that is in the plan to be created by the ministry"….* (MOH official)

Table 7: The Performance Indicators for the IHR Core Capacities for Emergency Preparedness and Response

IHR Core capacity	Indicators	2020 (16/17)	2022/23	Indicator	IHR Technical Area
national legislation, policy and financing	P.1.1 Legislation, laws, regulations, administrative requirements, policies or other government instruments in place are sufficient for implementation of IHR (2005)	2	2	P1.1. Legal instruments	P1. Legal Instruments
	P.1.2 The State can demonstrate that it has adjusted and aligned its domestic legislation, policies and administrative arrangements to enable compliance with IHR (2005)	3	1	P1.2. Gender equity and equality in health emergencies	
IHR coordination, communication and advocacy	P.2.1 A functional mechanism is established for the coordination and integration of relevant sectors in the implementation of IHR	3	2	P2.1. Financing for IHR implementation	P2. Financing
			2	P2.2. Financing for public health emergency response	
			3	P3.1. National IHR Focal Point functions	P3. IHR coordination, National IHR Focal Point functions and advocacy
			4	P3.2. Multisectoral coordination mechanisms	
			4	P3.3. Strategic planning for IHR, preparedness or health security	
Antimicrobial resistance	P.3.1 Antimicrobial resistance detection	1	4	P4.1. Multisectoral coordination on AMR	P4. Antimicrobial resistance (AMR)
	P.3.2 Surveillance of infections caused by antimicrobial-resistant pathogens	1	4	P4.2. Surveillance of AMR	

IHR Core capacity	Indicators	2020 (16/17)	2022/23	Indicator	IHR Technical Area
	P.3.3 Health care-associated infection (HCAI) prevention and control programmes	3	1	P4.3. Prevention of multidrug-resistant organisms	
	P.3.4 Antimicrobial stewardship activities	1	3	P4.4. Optimal use of antimicrobial medicines in human health	
			3	P4.5. Optimal use of antimicrobial medicines in animal health and agriculture	
Zoonotic diseases	P.4.1 Surveillance systems are in place for priority zoonotic diseases/pathogens	2	2	P5.1. Surveillance of zoonotic diseases	P5. Zoonotic disease
	P.4.2 Veterinary or animal health workforce	2	3	P5.2. Response to zoonotic diseases	
	P.4.3 Mechanisms for responding to infectious and potential zoonotic diseases are established and functional	3	2	P.5.3. Sanitary animal production practices	
Food safety	P.5.1 Mechanisms for multisectoral collaboration are established to ensure rapid response to food safety emergencies and outbreaks of food-borne diseases	2	4	P6.1. Surveillance of foodborne diseases and contamination	P6. Food safety
			1	P6.2. Response and management of food safety emergencies	
Biosafety and biosecurity	P.6.1 Whole-of-government biosafety and biosecurity system is in place for human, animal and agriculture facilities	2	2	P7.1. Whole-of government biosafety and biosecurity system is in place for human, animal and agriculture facilities	P7. Biosafety and biosecurity
	P.6.2 Biosafety and biosecurity training and practices	3	3	P7.2. Biosafety and biosecurity training and practices in all relevant sectors (including human, animal and agriculture)	

IHR Core capacity	Indicators	2020 (16/17)	2022/23	Indicator	IHR Technical Area
Immunization	P.7.1 Vaccine coverage (measles) as part of national programme	4	5	P8.1. Vaccine coverage (measles) as part of national programme	P8. Immunization
	P.7.2 National vaccine access and delivery	4	4	P8.2. National vaccine access and delivery	
			5	P8.3. Mass vaccination for epidemics of vaccine preventable diseases	
National Laboratory system	D.1.1 Laboratory testing for detection of priority diseases	3	4	D1.1. Specimen referral and transport system	D1. National laboratory systems
	D.1.2 Specimen referral and transport system	2	3	D1.2. Laboratory quality system	
	D.1.3 Effective modern point-of-care and laboratory-based diagnostics	3	4	D1.3. Laboratory testing capacity modalities	
	D.1.4 Laboratory quality system	3	4	D1.4. Effective national diagnostic network	
Real time survaillance	D.2.1 Indicator- and event-based surveillance systems	3	4	D2.1. Early warning surveillance function	D2. Surveillance
	D.2.2 Interoperable, interconnected, electronic real-time reporting system	3	3	D2.2. Event verification and investigation	
	D.2.3 Integration and analysis of surveillance data	4	3	D2.3. Analysis and information sharing	
	D.2.4 Syndromic surveillance systems	3			
Reporting	D.3.1 System for efficient reporting to FAO, OIE and WHO	2			

IHR Core capacity	Indicators	2020 (16/17)	2022/23	Indicator	IHR Technical Area
Workforce development	D.3.2 Reporting network and protocols in country	2		D3.1. Multisectoral workforce strategy	D3. Human resources
	D.4.1 Human resources available to implement IHR core capacity requirements	3	2		
	D.4.2 FETP1 or other applied epidemiology training programme is in place	4/2	3	D3.2. Human resources for implementation of IHR	
	D.4.3 Workforce strategy	2/3	4	D3.3. Workforce training	
			1	D3.4. Workforce surge during a public health event	
Preparedness	R.1.1 National multi-hazard public health emergency preparedness and response plan is developed and implemented	2	3	R1.1. Emergency risk assessment and readiness	R1. Health emergency management
	R.1.2 Priority public health risks and resources are mapped and utilized	2	3	R1.2. Public health emergency operations centre (PHEOC)	
Emergency response operations	R.2.1 Capacity to activate emergency operations	2	4	R1.3. Management of health emergency response	
	R.2.2 EOC operating procedures and plans	3	1	R1.4. Activation and coordination of health personnel in a public health emergency	
	R.2.3 Emergency operations programme	1	4	R1.5. Emergency logistic and supply chain management	

IHR Core capacity	Indicators	2020 (16/17)	2022/23	Indicator	IHR Technical Area
	R.2.4 Case management procedures are implemented for IHR relevant hazards	2	3	R1.6. Research, development, and innovation	
Linking public Health and security authorities	R.3.1 Public health and security authorities (e.g. law enforcement, border control, customs) are linked during a suspect or confirmed biological event	2	3	R2.1. Public health and security authorities (e.g. law enforcement, border control, customs) are linked during a suspected or confirmed biological, chemical or radiological event	R2. Linking public health and security authorities
Medical countermeasures ad personnel deployment	R.4.1 System is in place for sending and receiving medical countermeasures during a public health emergency	2	4	R3.1. Case management	R3. Health services provision
	R.4.2 System is in place for sending and receiving health personnel during a public health emergency	2	1	R3.2. Utilization of health service	
Risk communication	R.5.1 Risk communication systems (plans, mechanisms, etc.)	2	2	R3.3. Continuity of essential health services	
	R.5.2 Internal and partner communication and coordination	2	3	R4.1. IPC programmes	R4. Infection prevention and control (IPC)
	R.5.3 Public communication	2	3	R4.2. HCAI surveillance	
	R.5.4 Communication engagement with affected communities	2	3	R4.3. Safe environment in health facilities	
	R.5.5 Dynamic listening and rumour management	2	3	R5.1. RCCE systems for emergencies	R5. Risk communication

IHR Core capacity	Indicators	2020 (16/17)	2022/23	Indicator	IHR Technical Area
			4	R5.2. Risk communication	and community engagement (RCCE)
			3	R5.3. Community engagement	
Points of Entry	PoE.1 Routine capacities are established at points of entry	2	3	POE1. Core capacity requirements at all times for POE (airports, ports and ground crossings)	POE. Points of entry and border health
	PoE.2 Effective public health response at points of entry	2	4	POE2. Public health response at POE	
			4	POE3. Risk-based approach to international travel related measures	
Chemical events	CE.1 Mechanisms are established and functioning for detecting and responding to chemical events or emergencies	3	3	CE1. Mechanisms established and functioning for detecting and responding to chemical events or emergencies	CE. Chemical events
	CE.2 Enabling environment is in place for management of chemical events 3 Radiation emergencies	2	2	CE2. Enabling environment in place for management of chemical event	
Radiation emergencies	RE.1 Mechanisms are established and functioning for detecting and responding to radiological and nuclear emergencies	2	3	RE1. Mechanisms established and functioning for detecting and responding to radiological and nuclear emergencies	RE. Radiation emergencies
	RE.2 Enabling environment is in place for management of radiation emergencies	3	3	RE2. Enabling environment in place for management of radiological and nuclear emergencies	

IHR Core capacity	Indicators	2020 (16/17)	2022/23	Indicator	IHR Technical Area
	Average	**Level 3**	**Level 3-4**	**Slight improvement in almost all areas of emergency and disaster preparedness especially**	

12 Challenges that limit achievement of HSSP V targets

AREA	CHALLENGE
Context and design of the document	- Lack of a clear articulated theory of change - Some commitments stipulated to be implemented in the HSSP V implementation period lack respective indicators for effective monitoring
Health service delivery	- Consistently low health facility density in Geita region - High population density coupled with low proportion of public health facilities in Dar es Salaam pause accessibility and affordability challenge - Inadequate understanding of health care providers on health service integration - Establish context-relevant indicators for systematic assessment of the progress made in service integration - Unidirectional flow of information in patient referrals - Inadequate utilization of digital platforms for patient referral and cross-facility communication - Lack of routine assessment of quality of health services in all the regions - Out of pocket expenditure for health delays patients from seeking care, especially when offered cold-referral to higher facilities - Lack of documented legal guidance pertaining to blood donation, organ donation and organ transplant,and medical tourism

13 Recommendations

The following recommendations may improve health service planning and delivery over the remaining HSSP V implementation period, and in the formulation of HSSP V

- Ensure adequate translation of implementation commitment in the HSSP into measurable indicators
- Design of a well elaborated theory of change for HSSP V
- Formalization and characterization of slum areas in the country

- Stratification of health facility density targets per facility levels.
- For urban, congested areas like Dar es Salaam, redesign and plan health delivery in major facilities into centers of excellence with specific specialties.
- Institute gatekeeping mechanism, to reduce open entry of patients into any level of health care delivery, to enable strengthening of referral facilities in provision of specialized and super-specialized care
- Conduct initiatives to improve health care providers' awareness on the importance of service integration

- Centralized resource pooling from implementing partners and donors, for the government to cascade care in an integrated fashion.
- Institute regular facility level regular self-assessment for quality of care, and periodic nation-wide assessment.
- Quantify the financial gains of medical tourism practices into the health sector, and other sectors
- Design and institute guidelines on the medical tourism practices
- Design and institute guidelines on organ transplant

14 References

1. Annual Health Sector Performance Profile 2021.
2. Annual Health Sector Performance Profile 2022-Draft
3. Annual Health Sector Performance Profile 2023 Draft.
4. National Census Report, United Republic of Tanzania, 2022
5. Basic Standards for Dispensaries, Health Centres, Stand-alone Dental Clinics and Stand-alone Rehabilitation Medicine Facilities, 2017. (n.d.).
6. Basic Standards for Hospital at Level III & IV and Super Specialized Clinics at Level III,2017.
7. Basic Standards for Hospitals at Level I and II & Stand-Alone Facilities at Level I and II, 2017. (n.d.).
8. Dar, E., & Salaam, T. (n.d.). One Health Zoonotic Disease Prioritization for Multisectoral Engagement in Tanzania,2017.
9. Data Use and Quality Improvement in Tanzania. (n.d.).
10. FINAL HEALTH FACILITY ATLAS 2023 MTR_2023.
11. Health Organization, W. (2024). Joint external evaluation of the International Health Regulations (2005) core capacities of the United Republic of Tanzania: mission report, 14-18 August 2023. https://iris.who.int/.
12. Joint External Evaluation of IHR Core Capacities of the Unite Republic of Tanzania,2016. (2016).