Public Expenditure Review of Health Sector (2015 - 2018)

Primary Health Care

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ART	antiretroviral therapy
BEMONC	basic emergency obstetric and newborn care
CHF	community health fund
CHMTs	council health management teams
DHFF	Direct Health Facility Financing
DHIS	District Health Information System
FY	financial year
HBF	Health Basket Fund
HFS	health financing strategy
HRH	human resources for health
HSSP	Health Sector Strategic Plan
iCHF	improved community health fund
IMCI	integrated management of childhood illnesses
LGAs	local government authorities
MBP	minimum benefit package
MKUKUTA	Mkakati wa Kukuza Uchumi na Kupunguza Umaskini Tanzania
MMR	maternal mortality rate
MMAM	Mpango wa Maendeleo wa Afya ya Msingi
MoH	Ministry of Health
MoHCDGEC	Ministry of Health, Community Development, Gender, Elderly and Children
MoHSW	Ministry of Health and Social Welfare
MTR	midterm review
NACP	National AIDS Control Programme
NBS	National Bureau of Statistics
NCDs	noncommunicable diseases
NHIF	National Health Insurance Fund
NMR	neonatal mortality rate
NSSF	National Social Security Fund
OCGS	Office of the Chief Government Statistician
PHC	primary health care
PHCDP	Primary Health Care Development Programme
PMO-RALG	Prime Minister's Office, Regional Administration and Local Government
PMTCT	prevention of mother-to-child transmission
PORALG	President's Office, Regional Administration and Local Government
RBF	results-based financing
RMNCAH	reproductive, maternal, neonatal, child and adolescent health
SARA	Service Availability and Readiness Assessment
SDGs	Sustainable Development Goals
SHIB	Social Health Insurance Benefit
SNHI	Single National Health Insurance
SSA	sub-Saharan Africa
TB	tuberculosis
TDHS	Tanzania demographic and heath survey
THMIS	Tanzania HIV/AIDS and malaria indicator survey
TMIS	Tanzania malaria indicator survey
TZS	Tanzania shillings
UHC	universal health coverage
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
WHO	World Health Organization

The broad vision of Tanzania's development goals in its pursuit to be a middle income country by 2025 is set out in the Tanzania Development Vision 2025. This vision highlights as its goals ensuring universal access to quality health services by improving primary health care (PHC) and reproductive health services, reducing infant and maternal mortality rates and increasing life expectancy to the level attained by middle income countries.

Health sector's policy and regulatory framework

Tanzania's PHC priorities are elaborated in the health policy, while the Health Sector Strategic Plan IV (July 2015–June 2020) (HSSP IV) provides the Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDGEC) with the guiding framework for the detailed planning and implementation of the health sector's activities. A primary focus of HSSP IV is to make a standard minimum benefit package of services fully accessible to all Tanzanians and ensure that the services are funded fully by the resources pooled for a Single National Health Insurance (SNHI). Several medium term plans guide the specific vertical disease programmes.

Structure and governance of the PHC System

The PHC structure is organised as a pyramid. At the first level community-based health workers provide health promotion and prevention services to families in villages and other neighbourhoods under the umbrella of the vertical disease control programmes. Above this are three functional levels, that is the district or primary, regional or secondary, and referral or tertiary level clinics or hospitals.

Tanzania invested in PHC early and included in the benefit packages key cost-effective interventions to reduce maternal and child mortality. However, there are considerable inequities in accessibility and quality of the services. To address these and other weaknesses in the provision of health care in the primary level facilities, the government designed and initiated the Primary Health Care Development Programme 2007–2017 or Mpango wa Maendeleo wa Afya ya Msingi (MMAM) in Kiswahili.

Health sector financing and recent reforms

Mainland Tanzania's health system is funded through a mix of mechanisms including general government revenue, and funding from external development partners, multiple health insurance schemes governed by different government authorities, and out-of-pocket funds from users. The government has several initiatives to enhance financial autonomy at health facilities to improve the performance of the PHC system and the technical and allocative efficiency of resources.

Population and health context

Tanzania has made significant progress in a number of key health indicators. The continued gains in health and the improving socioeconomic conditions, including the improved health services, have ensured declines in infant and child mortality and increased life expectancy. The declines in mortality, coupled with the high fertility rates, early marriage with 36% of women getting married before their 18th birthday, and low contraceptive use of only 32% have fuelled population growth in recent times. Approximately 56% of the population is under 19 years of age, and the adolescent population is projected to grow to 33 million by 2050 from 12 million in 2015. Tanzania can be best described as a pre-demographic dividend country characterized by rapid population growth and a growing youthful population. Its neonatal, infant and under-five mortality rates are better than the regional averages, but it clearly lags behind its neighbours in the maternal mortality rate (MMR) and HIV/AIDS prevalence level.

Objectives of this review

The purpose of this review is to examine the performance of the health sector in implementing its priorities, and its budget allocation and expenditure. The review examines the intra-sectoral annual public expenditure allocation for the sector for the implementation period of HSSP IV (2015–2018) in comparison with HSSP III (2009–2015). It goes beyond the conventional health sector public expenditure reviews by:

- Analysing the trends in the sources of funding for the health sector over 2009–2018 with a focus on PHC services;
- Analysing the effectiveness and efficiency of expenditures at the PHC level;
- Analysing the trends in policy formulation, health outcomes and financing of the sector, including the implications of fiscal decentralization on investment in human resources for health (HRH) and administration of health facilities;
- Performing a comparative analysis of the performance of the health budget relative to those of neighbouring peer countries and the sub-Saharan Africa region based on agreed international benchmarks.

Overview of health spending

Global health budgeting and expenditure

Tanzania increased its health budget between 2014 and 2018, more than doubling it in nominal terms. However, health expenditure as a proportion of the overall government spending decreased from 9.6% to 7% over that period. Per capita spending on health doubled to US$ 36.80, though it is still less than the estimated US$ 54 the country needs to attain universal health care. Tanzania has yet to fulfil its Abuja Declaration commitment of spending 15% of its budget on health.

Government tax revenue forms the largest portion of the public health budget. It increased from 38% to 41% between 2014 and 2018. Donors provide a significant part of the budget. Their on-budget support between 2014 and 2018 decreased from 19% to just 10% while their off-budget support increased from 43% to 50%. Reimbursements to public providers from complementary health insurance schemes including the National Health Insurance Fund (NHIF) and community health funds (CHFs), plus out-of-pocket user fees directed to public facilities provided a small but growing share of the total public health expenditure. Out-of-pocket spending for services, pharmaceuticals and other health care costs continued to be a large share of health spending, estimated at 24%.

The Government of Tanzania recognises that the current fragmented nature of health financing and the significant reliance on external financing are not sustainable, pose challenges to the efficient and effective delivery of health services and are major causes of inequities in access to health care. To address this, the government developed the health financing strategy (HFS) to harmonise the health financing architecture anchored on a new mandatory SNHI. HFS is aligned with HSSP IV and outlines a path to universal health coverage (UHC) through SNHI.

Recurrent health expenditure grew progressively, going from 62% in 2014 to over 90% in 2017 owing to a steady increase in the wage bill and allowances. The 2018 approved budget estimate showed a substantial increase in the allocation for development expenditure and subsequent actual expenditure. This increase was in part due to the government's priority to invest in infrastructure, including constructing and renovating health facilities.

While the government's allocated budget is used to finance the wage bill and a small proportion of recurrent costs, disease programmes largely rely on external financing from development partners. Vertical disease programmes are by and large financed by development partners. For example, approximately 76% of the spending for HIV/AIDS and 52% of the malaria spending coming from donors. From FY 2013/14 to FY 2017/18 the bulk of the expenditure went to malaria with 30%, HIV/AIDS with 20%, and reproductive, maternal, neonatal, child and adolescent health (RMNCAH) with 21%. Analyses show that even with the substantial external financing, vertical disease programmes face a resource gap in their envisaged needs detailed in national strategic plans.

The HIV/AIDS programme now consumes the biggest share of the expenditure, and it has made considerable progress in achieving its targets. Mortality due to AIDS was more than halved in the past decade. The consensus is that Tanzania faces programmatic and financing challenges that hinder the attaining of its objective of reaching the 90-90-90 targets, i.e. 90% of the people living with HIV know their HIV status, 90% of people who know their HIV status have access to HIV treatment and 90% of the people on HIV treatment achieve undetectable levels of HIV in their body by 2020. The targets for 2030 are 95-95-95.

As the leading cause of morbidity and mortality in children under the age of five, malaria has received considerable investments in Tanzania. Though the programme is not expected to achieve its target of lowering the prevalence of the disease to less than 1%, there was a 55% decline in all-cause mortality in children under the age of five between 2000 and 2015, half of which can be attributed to malaria control interventions. The malaria programme will continue to face shortfalls in financing its strategic plan that will imperil its goal of eliminating malaria by 2030.

The progress toward achieving maternal and neonatal health goals and the related Sustainable Development Goals (SDGs) has been uneven, in large part owing to funding and implementation challenges. Tanzania also faces a rising burden of noncommunicable diseases (NCDs), which are a major source of illness and account for approximately 31% of all deaths in the country. Projections by the Ministry of Health indicate that the costs for NCD and mental health services will grow faster than for any other disease between 2021 and 2026.

The implementation of the decentralisation by devolution policy has progressed well as the share of the health budget allocated and disbursed to the regions and local government authorities (LGAs) has increased progressively. Since 2013 the government has consistently directed almost half of all health resources to the LGA level. The proportion of the recurrent health budget spent at the LGA level has increased from 36% to 47%, and the development expenditure by over 70%.

In general, the overall performance of the health sector budget was relatively high between FY 2007/08 and FY 2014/15, averaging over 85%, after which it declined to less than 75% in FY 2014/15, 61% in FY 2015/16 and FY 77% in FY 2016/17. The low budget performance was related to the late disbursement of funds and non-release of funds, in particular non-basket funds.

Trends in budgeting and expenditure at the decentralised level

LGAs rely primarily on the central government's funds for day-to-day operations including for salaries. Development activities are funded largely by donors through the Health Basket Fund (HBF) and off-budget support. Councils' revenue input for their costs is minimal.

The central government allocates resources to councils based on a formula introduced in 2004 and also disburses funds for the procurement of drugs and medical supplies destined for LGAs through MoHCDGEC. Human resources account for about 80% of the spending by LGAs, mostly as personal emoluments or salary and wage payments.

Block grants from the Ministry of Finance constitute the largest portion of LGA funding. Their volume increased from TZS 408.5 billion, or 65.5%, in FY 2012/13 to TZS 778.8 billion, or 61.6%, in FY 2016/17. The next largest contributor to LGA funding is HBF. These funds have been disbursed directly to health facilities through the Direct Health Facility Financing (DHFF) mechanism since FY 2017/18. The third source of LGA funds is off-budget support coming directly from donors.

The allocative efficiency of LGA level disbursements needs improvement. There are deep inequalities in the per capita allocation and spending on health among regions and councils and LGAs.

In FY 2016/17 some districts had five times more health spending per capita than others. These variations persist despite all the districts benefitting from a real increase in per capita financing. Budget execution at the subnational level improved progressively over time, growing from 51% in FY 2012/13 to 84% in FY 2016/17.The under-execution of the budget resulted from the late disbursement of funds or unplanned expenditure by the central government rather than from issues related to the absorptive capacity of the councils. The implementation of the results-based financing (RBF) and DHFF mechanisms has contributed in improving the quality of services in health facilities in the LGAs. The financial autonomy brought to PHC facilities and their governance structures through DHFF, in particular, has impacted the decision space and thereby influenced the quality of service.

Impact of expenditure on health outcomes

The current level of expenditure on health in Tanzania falls below major international benchmarks and is insufficient to achieve national and UHC targets. The Ministry responsible for health estimated the cost of implementing HSSP IV and achieve the set targets to be TZS 21,945 billion. The actual total annual health expenditure during the first three years of HSSP IV implementation was TZS 1.71 billion in FY 2015/16, which was 43% of the estimated budget, TZS 1.84 billion in FY 2016/17, which was 44.4% of the estimated budget, and TZS 2.58 billion in FY 2017/18, which was 60% of the estimated budget.

The shortfalls in health expenditure indicate that there is significant reliance on external funds and out-of-pocket spending to finance the health sector, pose serious challenges to Tanzania's goal of achieving UHC and imperil the sustainability of the recent health and socioeconomic gains.

Tanzania has made progress in increasing access to and quality of services and in improving health outcomes. This progress is the result of the increased spending on health. However, the progress toward achieving HSSP IV and UHC targets for child, maternal and neonatal health has been uneven, in large part due to funding and implementation challenges.

HIV transmission has declined steadily over the past 15 years, but since 2010 the prevalence of the disease has remained stable at about 5%, partly owing to more people with HIV surviving longer on treatment, lower levels of infections and population growth. The burden of HIV/AIDS in adults 15 years or over is not uniform but varies by place of residence, with the levels at 4.2% for rural versus 5.5% for urban areas; by sex, with the levels for females at 6.3% versus 3.4% for males; and by region, where difference is significant, for example the level is 0.3% in Lindi versus 11.6% in Njombe. The epidemic, though generalised, is driven by a high occurrence of new infections in segments of the population such as mobile groups, sex workers, men who have sex with men, and adolescent and young women aged between 15 and 24 years.

Significant progress has been observed in reducing under-five mortality, which declined from 147 per 1,000 live births in 1999 to 52 in 2018. Child health outcomes have improved overall from the sustained efforts in a few high impact programme areas including the high coverage of routine under-five immunisation, vitamin A supplementation, integrated management of childhood illness, use of insecticide-treated bed nets and improved treatment of malaria.

The rapid scaling up of malaria control interventions accounted for 58% of the reduction in child mortality. While health outcomes have improved amongst the poorest children, such children are twice as likely to die before the age of five than children from the highest wealth quintile, and wide disparities exist in coverage of child health interventions.

The level of MMR decline is well below the HSSP IV and One Plan II target of 292 deaths per 100,000 live births, plus the most recent data suggest that institutional maternal mortality rates are not declining. The neonatal mortality rate also stagnated between 2005 and 2018, and neonatal deaths now account for 37% of child deaths.

Tanzania continues to make gradual progress towards its family planning and fertility targets, including in teenage fertility rates. Contraceptive use levels rose from 20% to 32% between 2005 and 2018. Progress in decreasing teenage fertility, on the other hand, has stagnated over the past decade, and the proportion of teenagers who had a child or who were pregnant was 23% in 2010 and 21% in 2018.

Several factors have contributed to the slow progress in improving maternal and newborn health. Unlike child health initiatives, maternal health and family planning programmes tend to not include all the essential interventions, are of a more limited geographical coverage and tend to be implemented and funded inconsistently.

NCDs account for nearly half of all hospital deaths, and all health facilities are reporting an increased disease burden. Awareness on NCDs at the community level and knowledge on them among health care workers are low. There is little evidence of NCD prevention activities in facilities or of investment in human and financial resources to implement the national strategy.

The Government of Tanzania prioritised expanding the number of dispensaries in rural areas to increase coverage of services in underserved locations. However, many of the newly constructed facilities remain without staff or equipment and infrastructure. Furthermore, the availability of basic health services in the functional health facilities is uneven. There are persistent inequalities between urban and rural populations and poor and rich households and among regions. While coverage of some services such as malaria diagnosis and treatment and curative care for sick children is at over 80%, that of laboratory diagnostic services, basic surgery procedures, cardiovascular and chronic respiratory infection services, and blood transfusion services is at below 50%.

There are significant variations in some access indicators. For example, delivering in a facility is positively associated with a woman's wealth status and education and varies across regions. Similarly, while about 70% of urban children with a fever are seen at a health facility or by a provider, only 43% of rural children get such treatment. Coverage and access to services are in part undermined by the low quality of services in the facilities. The implementation of star rating for health care facilities tracks has improved the quality of care in some facilities, and the share of facilities with the minimum three star ranking rose from 2% in 2016 to 19% in 2017.

The shortage and misdistribution of qualified HRH is a major challenge in expanding and improving health service delivery in Tanzania with rural dispensaries being the most affected. There are 7.7 doctors and nurses per 10,000 people, which is below the regional average of 13 and much lower than the World Health Organization's (WHO) recommendation of 23. Analysis of the available data shows that the HRH gap continues to widen and to have grown from 13% in FY 2015/16 to 40% in 2019. Increasing the number and ensuring the geographical balance of qualified HRH are key priorities for Tanzania.

Key Findings

- The current level of government investment in health is inadequate to achieve HSSP IV targets and ultimately UHC. The spending level has risen but the allocation as a proportion of the total government budget has stagnated over time. The current level is below the recommended per capita and proportional spending thresholds. Tanzania spends a higher proportion of its total government expenditure on health than its neighbours, but its per capita spending is lower than theirs.

- The financing of the health budget is fragmented and heavily reliant on taxation and external sources with a modest contribution from complimentary financing including health insurance schemes. Out-of-pocket spending for health is high, it contributes to the inequities in access to health care and it exposes households to impoverishment through catastrophic health expenditures.

- Health insurance coverage levels in Tanzania are stagnant and the benefits are limited, plus the sector faces significant challenges in efficiency owing to the fragmented nature of the health insurance landscape.

- The government has progressively raised the allocation of funds for the local government level, particularly during HSSP IV. Spending at the central level remains significant, though it is getting less so as procurement and payment of wages continue to be done at the local government level.

- There is significant variation in the government's health allocations among the regions and districts, with some councils not receiving sufficient funds to implement their plans.

- The bulk of the budgeted LGA expenditure goes to the payment of wages, as councils rely on the central government funds for their day-to-day activities and to pay salaries. Development activities such as equipping new health facilities and purchasing health commodities are funded largely by donors through HBF and off-budget donor support.

- Progress has been made in devolving financing to LGAs, but this level needs better allocative efficiency. The current approach appears to disproportionately affect the already marginalized councils.

- The implementation of RBF and DHHF mechanisms has contributed in improving the quality of services in health facilities in LGAs.

- There are positive developments in expanding programme coverage for health service delivery and quality during the implementation of HSSP IV. Yet, many of the HSSP IV targets will not be met, including those for MMR and neonatal mortality rate (NMR). There are persistent inequalities in almost all indicators between urban and rural populations and the poorest and richest households and amongst regions. The various disease programmes rely heavily on external funding, but even with the substantial levels of this financing, they experience shortfalls in meeting the implementation needs indicated in the national strategic plans.

- While the number of health workers, especially clinical personnel, is increasing, the workforce is maldistributed with considerable shortages in dispensaries and in rural area.

Recommendations

Increase government spending on health through innovative funding methods

- Government spending on health is insufficient to accomplish the current health sector strategic plan targets. To achieve the goal of UHC by 2025 through expanding coverage of quality health services and by increasing financial protection, Tanzania needs to increase spending on health to US$ 54 per capita. The government can define the measures to expand the fiscal space for health by exploring the potential domestic revenue sources such as levies and earmarked taxes, and by leveraging existing public–private partnerships to expand the private sector's role in financing health care.

Implement the SNHI scheme

- Implementation of SNHI will improve access to and equity of health care and the financial position of individual health facilities and allow for elimination of inequitable exemption systems. It is, therefore, a priority to move SNHI forward and follow the necessary legal procedures for its adoption. Prior to the implementation of SNHI, the improved CHF (iCHF) should be strengthened by its expansion to more regions and ensuring its acceptability by the community.

Advocate for coordination of donor funding to align with the country's priorities and strategies

- The government should encourage donors to bring their aid on its budget to reduce inequities and duplication in support and the heavy administrative burden that results from the co-existence of many small projects. Donors should be encouraged to proactively take into account the country's strategy during the creation of their country assistance plans and to align them with the government's funding cycles. HBF represents a good opportunity for donors to use government systems to support primary care directly.

Address the inequities in budget allocation across and within regions

- While the government has made good progress in prioritising financing of LGAS, it needs to reassess its approach for budget allocation to them to reduce inequities across and within regions. There is need to ensure that allocations are based on the transitioning epidemiological, operational and socioeconomic realities of the LGAs. Furthermore, there should be a balance in the allocations for wages, development and goods and services. Investments in infrastructure should be accompanied with increased allocations for personnel, goods and services to ensure that the infrastructure will be operational.

Continue investing in key health programmes and address inequities in accessing services

- Encouraging progress has been made in achieving key health outcomes notably in the reduction of under-five mortality. However, challenges remain particularly in neonatal and maternal mortality and in the increasing burden of NCDs. There are significant geographical, household wealth and education-related inequities in accessing health care. In this light, investment should be considered in the priority areas to enhance health outcomes. The focus should include increasing access to emergency obstetric and newborn care services particularly in underserved areas and groups; increasing investments in child health services for underserved areas and groups; scaling up HIV/AIDS response to end AIDS by 2030, emphasising incidence reduction in key groups; and investing in the implementation of the NCD strategy to significantly reduce the burden of NCDs and alleviate their weight on under-resourced health facilities.
- Concrete steps should be taken to address the persistent inequities in health care delivery. The HSSP IV midterm review and other evaluations show that resource allocation alone is not enough to solve inequity and there is need for progressive and proactive study of poorly performing health facilities and vulnerable populations to help the councils to quickly address needs where they are identified.

Scale up and redistribute health workers to achieve equity and efficiency

- The human resources available and their distribution are insufficient to meet the HSSP IV service delivery targets. The scaling up of HRH needs to match the scaling up of the health services for their supply to meet their demand while at the same time addressing the critical gap of health workers in PHC facilities.
- There is a need for human resources planning that is smart and need and evidence based. Initiatives to improve HRH allocation and motivation should prioritise increasing the number and geographical balance of qualified human resources. They should also consider adopting innovative incentive mechanisms to motivate staff to relocate to remote and poor regions for prolonged periods of time.

1. INTRODUCTION 1

1.1 Overview of the health sector

The broad vision of Tanzania's development goals in its pursuit to be a middle income country by 2025 is set out in the Tanzania Development Vision 2025. Vision 2025, which provides the long-term direction for national development, emphasises that to attain a high quality of life the improvement of the health sector is crucial. In particular, the vision highlights as its goals ensuring universal access to quality health services by improving primary health care (PHC) and reproductive health services for all, reducing infant and maternal mortality rates and raising life expectancy to the level attained by middle income countries. These aspirations also underpin the second Five Year Development Plan, 2016/17–2020/21, and the National Strategy for Growth and Reduction of Poverty, known in Kiswahili as the MKUKUTA.

Tanzania's macroeconomic performance during the past decade has been solid. Real GDP growth estimates for 2015 to 2018 all were above 6%, and 5.8% for 2019. The poverty rate declined, though modestly, from 28.2% in 2021 to 26.1% in 2019 (World Bank in Tanzania, 2020), but the absolute number of poor citizens has not declined owing to the high population growth rate. The country's overall population is estimated to be about 58 million (NBS, 2019).This analysis of investments in the health sector is conducted with reference to Tanzania's macroeconomic context, as allocations to different sectors are in part influenced by the growth rate (World Bank, 2019).

1.1.1 Health sector policy and regulatory framework

Tanzania's health sector's priorities are highlighted in several overarching national policy frameworks that emphasize investment in achieving universal access to quality health services as key to advancing human development.

The Government of Tanzania's vision for the health sector as elaborated in the Tanzania Health Policy[1] (2007) is "… to improve the health and well-being of all Tanzanians with a focus on those most at risk, and to encourage the health system to be more responsive to the needs of the people". Various sector-specific medium-term plans interpret the national health policy with clear strategies, objectives and plans to achieve its vision. The Health Sector Strategic Plan IV (July 2015–June 2020) (HSSP IV) is the key Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDGEC) document that provides the guiding framework for the detailed planning and implementation of the health sector's activities. A primary focus of HSSP IV is to make a standard minimum benefit package of primary and secondary health care services fully accessible to all Tanzanians with a focus on the poor and vulnerable groups and to ensure that these services are fully funded within the available resources pooled for the Single National Health Insurance (SNHI) scheme.

1 One major key policy issue is the review of the 2007 health policy, which started in 2015 but has not been completed to date.

The full list of services can be found in Appendix 1. In addition, several medium-term plans guide service delivery at the PHC level of specific vertical programmes. These include the National Road Map Strategic Plan to Improve Reproductive, Maternal, New-born, Child and Adolescent Health 2016¬–2020 (the One Plan II), the National Malaria Strategic Plan 2014–2020, the Tanzania

Health Sector HIV and AIDS Strategic Plan IV 2017–2022 and the Primary Health Care Development Programme 2007–2017 or Mpango wa Maendeleo wa Afya ya Msingi (MMAM) in Kiswahili (PHCDP, 2007).

PHC is acknowledged globally as an essential tool for advancing universal health coverage (UHC) and the 2030 Agenda for Sustainable Development adopted by the United Nations in 2015. Investing in PHC has been shown to yield high returns and promote sustainability of service delivery (Dugani et al., 2018). Indeed, Tanzania embraced PHC ahead of many countries to accelerate progress on child survival and included in its benefit packages key cost-effective interventions to reduce maternal and child mortality.

Despite Tanzania's early investment in PHC, considerable variations have been noted in geographical accessibility and quality of service (PHCDP, 2007). To address these variations and other weaknesses in the provision of health care in the primary level facilities, the government designed and initiated PHCDP. This programme had the objective to accelerate the provision of quality PHC services for all by 2017 by establishing one dispensary per village and one health centre per ward. The main areas of focus were strengthening health systems, rehabilitation of health facilities, human resource development, referral system improvement, health sector financing and provision of medicines, equipment and supplies. This programme was implemented by MoHCDGEC in collaboration with other government administration sections including the Prime Minister's office, Regional Administration and Local Government (PMO-RALG), regional secretariats, local government authorities (LGAs) and village committees.

1.1.2 Structure and governance of PHC

IHealth services in Tanzania are delivered through a decentralized cascading system in which PHC services constitute the base. The President's Office, Regional Administration and Local Government (PORALG) is responsible for service delivery through communities, dispensaries, health centres and district hospitals. At the base of the pyramid are community-based health workers providing health promotion and prevention services to families in villages and other neighbourhoods under the umbrella of the vertical disease control programmes. Above this are the three functional levels of district facilities at the primary level, regional hospitals at the secondary level and referral hospitals at the tertiary level. . At the district level PHC services are provided through dispensaries that deliver preventive and curative outpatient services at the ward level with each catering for three to five villages for a total population of 10,000 on average.

The health centre serves as the referral level for the dispensary and provides a broader range of services including surgical services and inpatient care. It covers a population of 50,000 on average. District hospitals provide services to 250,000 people on average each. All councils have hospitals that provide medical and basic surgical services to referred patients. Regional and zonal referral hospitals, special hospitals and national hospitals offer specialist and more advanced medical care.

Delivery of PHC services is facilitated by various oversight and decision-making structures. Regional health management teams have the responsibility to supervise council health management teams (CHMTs), which have oversight of all hospitals, health centres and dispensaries within their council (see Appendix 2 for the PHC organisational and decision-making structure).

1.2.3 Health sector financing and recent reforms

Mainland Tanzania's health system is funded through a mix of mechanisms, including general government revenue, funding from development partners and multiple health insurance schemes governed by different government authorities, and out-of-pocket payments by users. The government is the primary source of financing for the sector with revenue from income and value-added taxes and donor contributions, and it provides core funding for the health care workforce.

External resources play a prominent part with contributions coming from development partners through basket funding, programme funding and off-budget funding. The Health Basket Fund (HBF) was created in FY 1999/2000 to promote a sectorwide approach among development partners to strengthen the decentralized health systems in Mainland Tanzania through providing relatively flexible funding to central ministries and regional secretariats (and LGAs) as a contribution to the government's efforts of ensuring PHC provision to all (Kapologwe et al., 2019). Pre-payment schemes, including social health insurance schemes and out-of-pocket contributions, comprise a small but growing portion of the funds. The main pre-payment schemes are the NHIF, the National Social Security Fund (NSSF) and CHF (Kapologwe et al., 2019). HSSP IV calls for a single national health insurance scheme that will consolidate health insurance schemes and will be mandatory for all Tanzanians. The ministry of health is in the process of implementing this.

The government launched several initiatives to enhance financial autonomy at health facilities with the aim of improving the performance of its PHC system and technical and allocative efficiency of resources. In 2015, the RBF financing mechanism, a disbursement method based on the measured performance of health facilities against a set of key indicators, was launched. By April 2018, RBF had been scaled up to eight regions and was distributing funds to 1,713 facilities.

The DHFF mechanism was adopted to strengthen the autonomy of health care workers at the PHC level and ultimately strengthen PHC service delivery. DHFF intended to address the concerns of delays in disbursement of funds from the councils that resulted in insufficient funding reaching frontline facilities, which is where the vast majority of health services are provided, and the issue of CHMTs dominating the prioritization and planning process and limiting the engagement of the communities. By 2019, 547 health centres and 4,816 dispensaries were receiving and managing funds through DHFF.

The prerequisites for health facilities to qualify for DHFF include:

- At least one qualified health staff
- Availability of an annual health facility plan
- Availability of HMIS data
- An active health facility bank account as per treasury guidelines
- Availability of a health revenue accounting person
- Availability of a functional communication channel

Source: DHFF Financing Guide

1.2.4 Population and health contexts

Tanzania has made significant progress in several key health indicators. The continued gains in health and the improving socioeconomic conditions, including in health services, have ensured declining infant and child mortality and rising life expectancy. Tanzania has met and surpassed the 2015 targets for life expectancy of 62 years for women and 59 years for men, with the country's life expectancy now at 65 years, which is higher than the regional average of 61 years (Table 1). This dramatic change is due to the significant progress in key indicators, including child survival and adult mortality decline, which most likely are the result of the reductions in mortality due to malaria and other childhood illnesses and HIV/AIDS.

The declines in mortality, coupled with the high fertility rates, early marriage where 36% of the women get married before their 18th birthday, and the low contraceptive use of 32% have fuelled the high population growth rates in recent times. Between 2002 and 2019 the population grew from 34.4 million to about 58 million. Should the population growth rate remain constant at nearly 3% annually, Tanzania is projected to have 100 million people by 2042. Approximately 56% of the population is under 19 years of age, and the adolescent population is projected to grow from 12 million in 2015 to 33 million by 2050. Tanzania can be best described as a pre-demographic dividend country characterized by rapid population growth and a growing youthful population.

Table 1: Trend of Demographic Indicators

	2005	2010	2015	2019
Population (growth rate)	38,379,769	44,928,923	51,482,633	58,005,461
	(2.9%)	(2.7%)	(3%)	(3%)
Fertility (Mainland)	5.7	5.4	5.2	4.8
Urban	3.5	3.7	3.8	-
Rural	6.4	6.1	6	-
Life expectancy	54.3	58.6	63.1	65.5
Male	52.8	56.8	65.1	67.2
Female	55.9	60.4	65.1	63.6

Source: World Development Indicators

Table 2 provides a snapshot of Tanzania's performance on key health indicators in comparison with neighbouring countries and sub-Saharan Africa (SSA). Neonatal, infant and under-five mortality rates are better than the regional average, are similar to Kenya and Uganda's and are higher than Rwanda's. Stunting levels are higher than in neighbouring countries with the exception of Rwanda, but are comparable to the SSA average. One area Tanzania clearly lags behind its neighbours is in MMR, though its level is comparable to the SSA average. Tanzania's HIV prevalence is also higher than the SSA average.

Table 2: Comparison of Tanzania's key health indicators with those of its neighbours

	Tanzania[a]	Kenya[b]	Uganda[c]	Rwanda[d]	SSA (2015)
Neonatal mortality	25	22	27	19	29.5
Infant mortality (per 1,000 live births)	43	39	43	31	57.2
Under five mortality/1000 live births	67	52	64	42	87.5
Stunting < 5 years (%)	34	26	29	37.9	35
Wasting < 5 years (%)	5	4	4	2.2	NA
Maternal mortality ratio (per 100,000 live births)	556	362	438	210	557
Prevalence of malaria among 6–59 months old (%)	7.3~~₳~~	8**	3.0	2.2**	NA
Prevalence of HIV (%) 15-49 years	5.3¥	5.6	6.0	3.1**	4.0

Sources:
a Tanzania: 2015 TDHS; Malaria Indicator Survey 2017; AIDS Indicator Survey 2015
b Kenya: 2014 DHS; Malaria Indicator Survey 2015; Kenya AIDS Indicator Survey 2012
c Uganda: 2015/16 DHS; Uganda Population Based HIV Impact Assessment 2016/17
d Rwanda DHS 2015

As Tanzania strives to transform its economy to reach the middle income country status, the health sector will need to become more responsive to the transitioning health landscape by ensuring investments are made in quality PHC services, the health system is resilient and financing is sustainable in order to achieve UHC as a precursor to producing a thriving labour force.

Tanzania largely met its 2015 health indicator targets under the Third Health Sector Strategic Plan (HSSP III) (2009–2015) except the targets for reproductive, newborn and maternal health. Social and geographical inequities still exist despite the growth in the health sector infrastructure and HRH. HSSP IV seeks to build on the gains made during HSSP III by improving the performance of the health and social welfare areas in both the coverage and quality of services to match those of middle income countries. The overarching aim of HSSP IV is to reach all households with essential health and social welfare services.

This purpose of this review is to examine the performance of the health sector in the implementation of its priorities and its budget allocation and expenditures. The review examines intra-sectoral public expenditure allocation for the health sector on an annual basis for the period of HSSP IV (2015–201820 drawing comparisons with HSSP III. Specifically, the review moves beyond conventional health sector public expenditure reviews by:

- Analysing the trends in the sources of funding for the health sector from 2009 to 2018 with a focus on PHC services;
- Analysing the effectiveness and efficiency of expenditure at the PHC level;
- Analysing the trends in policy formulation, health outcomes and financing of the sector, including the implications of fiscal decentralization on investment in HRH and administration of health facilities;
- Performing a comparative analysis of the performance of the health budget relative to those of neighbouring peer countries and the SSA region based on agreed international benchmarks.

It is envisaged that the analysis and insights from this report will inform future policy formulation, planning and budgeting in the health sector.

1.3 Limitations of the review

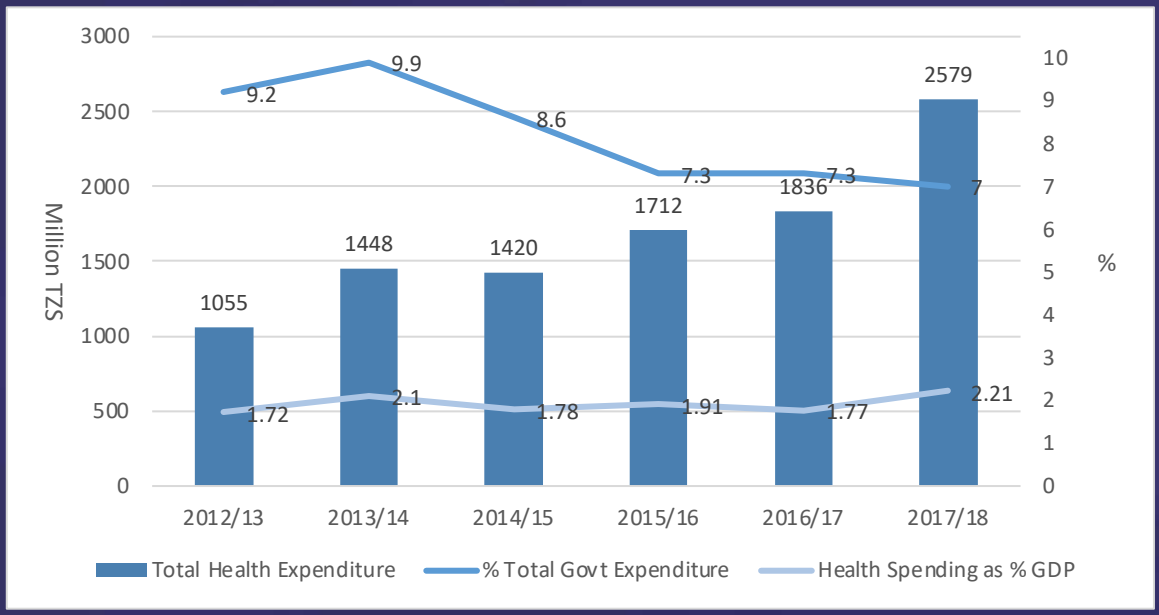
The findings of this report are based on an analysis of findings from budgeting and expenditure data provided by MoHCDGEC, a review of previously undertaken public health expenditure reviews and other research and reviews of PHC and PHE, evaluation of HSSP IV, and a desk review of other literature on health financing, PHC and national health surveys. It should be noted that only a limited number of public health expenditure reviews were available, the most recent one covering FY 2016/17.

2. OVERVIEW OF HEALTH SPENDING

2.1 Tanzania's global health budgeting and expenditure

The total health expenditure expanded steadily in nominal terms between FY 2012/13 and FY 2017/18. The approved budget for FY 2017/2018 allocated TZS 2.58 trillion to the health sector, a 34% nominal increase on the previous fiscal year or a 28% increase if accounting for inflation. Health expenditure as a percentage of GDP remained largely constant and hovering around 2% over FY 2012/13 to FY 2017/18 (Figure 1). There was a modest increase in per capita spending on health between FY 2012/13 and FY 2017/18, from US$ 15.20 to US$ 36.80. The effects of the growth in health spending were offset by the effects of high population growth and inflation. Tanzania has yet to fulfil its Abuja Declaration commitment of spending 15% of its budget on health.

Figure 1: Total health expenditure as a proportion of total government expenditure and GDP

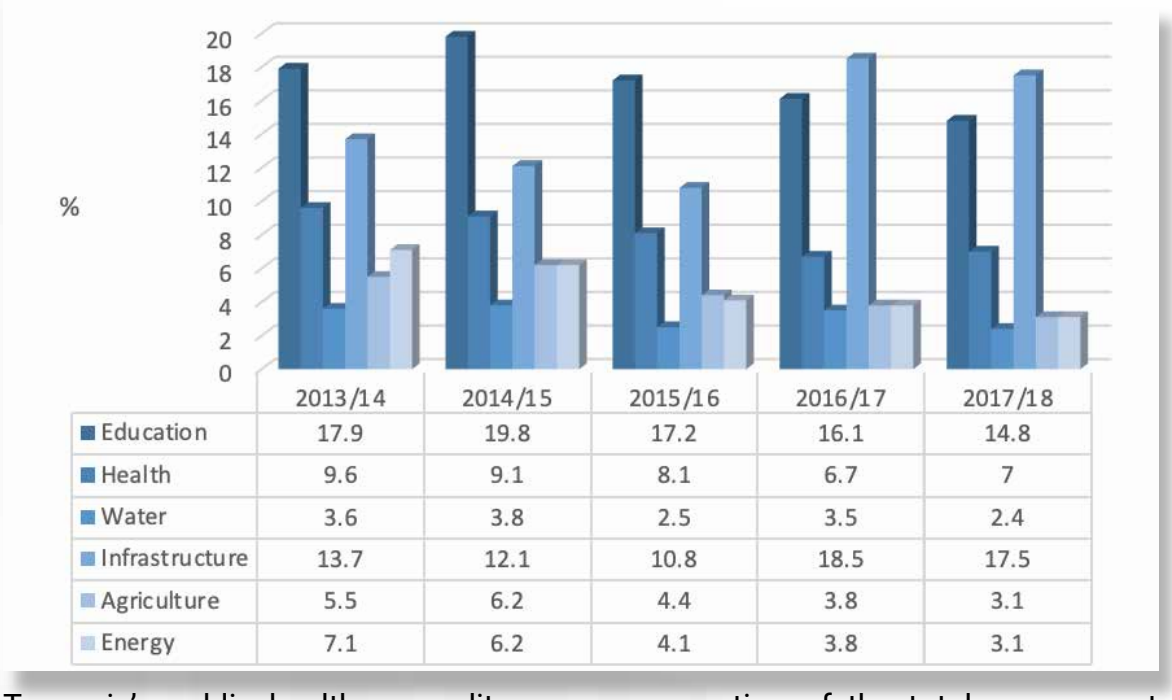


The current level of spending is lower than the needed and recommended spending thresholds. The total investments fall short of the estimated minimum financial requirements to provide basic health services to the population. HSSP IV estimates that the total health financing needs to be US$ 42 per person per year or 4.6% of GDP (UNICEF budget brief), while WHO estimates that to reach the SDGs target for UHC, the health financing requirements for essential services should be between US$ 54 and US$ 86 per capita. Furthermore, WHO recommends that low income countries should invest an average of 5% of their GDP in health financing to achieve UHC.

2.1.1 Comparing government expenditure on health sector with investment in other sectors

The proportion of the budget allocated to and expenditure on health by the government have decreased steadily, going from 9.6% in FY 2013/14 to 7% in FY 2017/18. This is despite the fact that the nominal allocations increased. This can be explained in part by the fact that health expenditure did not grow at the same pace as the overall government expenditure unlike other in sectors such as infrastructure (Figure 2).

Figure 2: Sector expenditures as proportion of total government expenditure



	2013/14	2014/15	2015/16	2016/17	2017/18
Education	17.9	19.8	17.2	16.1	14.8
Health	9.6	9.1	8.1	6.7	7
Water	3.6	3.8	2.5	3.5	2.4
Infrastructure	13.7	12.1	10.8	18.5	17.5
Agriculture	5.5	6.2	4.4	3.8	3.1
Energy	7.1	6.2	4.1	3.8	3.1

Tanzania's public health expenditure as a proportion of the total government expenditure and as a percentage of GDP was higher than that of its neighbours Kenya and Uganda between 2016 and 2018 (Table 3). However, health spending per capita was lower than Uganda's and Kenya's, and considerably so in the case of Kenya.

Table 3: Comparative Health Expenditure Statistics

	Tanzanian			Kenya			Uganda		
	2016	**2017**	**2018**	**2016**	**2017**	**2018**	**2016**	**2017**	**2018**
Health expenditure per capita	37.2	35.5	36.8	75.5	75.9	88.4	42.2	42	43.1
Public health expenditure as percentage of total government expenditure	9.5	9.5	9.4	7.96	7.9	8.55	5.1	5.1	5.1
Total health expenditure as percentage of GDP	3.96	3.63	3.63	2.2	2.06	2.2	1	0.97	1
Out-of-pocket expenditure as a percentage of current health expenditure	21.9	24	24.0	25	24	23.6	38.6	38.9	38.4

Source: World Health Organisation, Global Health Expenditure Database

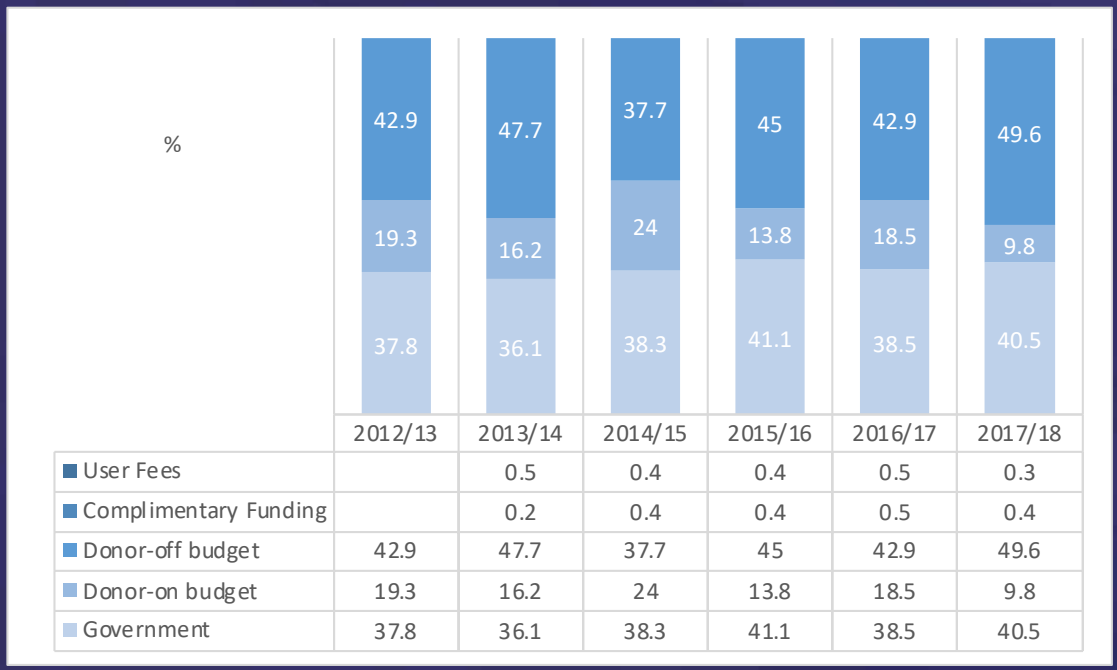
2.1.2 Sources of public health financing

The public health system is financed by the government tax revenue spent on health, donor on- budget and off-budget spending, reimbursements to public providers from complementary health insurance schemes including NHIF and CHFs and spending by public facilities from resources received as out-of-pocket user fees.

The government's contribution to health spending increased modestly from 37.8% in 2013 to 40.5% in 2018 (Figure 3). Donor support continues to be important in financing health care in Tanzania, but on-budget support has been declining. Development partners accounted for about 19% of on-budget health expenditures in FY 2012/13 but their support declined to just less than 10% in FY 2017/18. The Global Fund is the largest on-budget contributor, followed by HBF. The proportion of off-budget donor support increased over 2013 to 2018 from 43% to 50%.

The United States government support for HIV/AIDS and malaria constitutes the largest source of off-budget donor support. The recent trend of donor support shifting to off-budget financing for projects and programmes has made it far more difficult for the government to coordinate donor contributions and increased the likelihood of effort duplication and inefficiency. Also, and according to the 2007 health policy, it jeopardizes the effort to ensure equity in health care access, as weak coordination has led to some regions benefitting significantly more from support than have others. Furthermore, donor support can be unpredictable, and expected contributions sometimes do not materialise.

Figure 3: Financing of health expenditure, FY 2012/13–FY 2017/18c



	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
User Fees		0.5	0.4	0.4	0.5	0.3
Complimentary Funding		0.2	0.4	0.4	0.5	0.4
Donor-off budget	42.9	47.7	37.7	45	42.9	49.6
Donor-on budget	19.3	16.2	24	13.8	18.5	9.8
Government	37.8	36.1	38.3	41.1	38.5	40.5

Health insurance schemes, i.e. NHIF and CHFs, plus user fees paid directly to health facilities make up a small but expanding share of the total public health expenditure, and stood at just under 0.5% of the total health expenditure between 2014 and 2018. Out-of-pocket spending on services, pharmaceuticals and other health products continued to take up a large share of the health spending, estimated at 24% (WHO, 2016).

The current household contribution to the total health expenditure of 24% is more than the 15–20% benchmark suggested in the World Health Report (2010), is comparable to the low and medium income countries average of 30% but is lower than the SSA average of 50%. Women spend more on health care than do men, and women in the lowest wealth quintile have significantly higher costs than women in the next two wealth brackets (TDHS, 2015). Reducing out-of-pocket payments is important in improving health seeking behaviour, increasing access to health care and reducing health care disparities related to income and gender.

The government recognises that the current fragmented nature of the health financing structure is not sustainable and poses challenges to the efficient and effective delivery of health services. Financing the health system through tax revenue faces challenges including in delivery, monitoring and governance of the funds owing to the division of roles and responsibilities for channelling and managing the funds among PORALG, MOHCDGEC, regional health teams in zonal and regional hospitals, and LGAs. Furthermore, with its multiple national insurance schemes such as NHIF, CHF, iCHF, NSSF-SHIB (Social Health Insurance Benefit) and private health insurance schemes, the current health insurance architecture is replete with coordination difficulties, duplication of activities and processes, and fragmentation of the population of contributors and beneficiaries. This minimises the economies of scale and reduces the opportunities for cross-subsidisation from the wealthy to the poor and from healthy people to sick people.

Furthermore, the high degree of dependence on out-of-pocket payments is widely recognised as a major cause of inequities in access to health care and the cause of the higher prevalence of impoverishing and catastrophic health expenditures for households. For these reasons the government is implementing reforms through a health financing strategy (HFS) that will promote greater reliance on domestic and sustainable resources to accomplish its health goals.

HFS aims to harmonise the fragmented health financing architecture and is anchored on the new and mandatory SNHI. It is aligned with HSSP IV and outlines a path to UHC through SNHI. As a mandatory contributory scheme, SNHI would expand coverage to 70% of the population with a minimum benefits package by FY 2020/21, assuming that NHIF could begin operations in FY 2017/18 (MoHCDGEC 2016b). The benefits package is focused on outpatient primary care provided at PHC facilities.

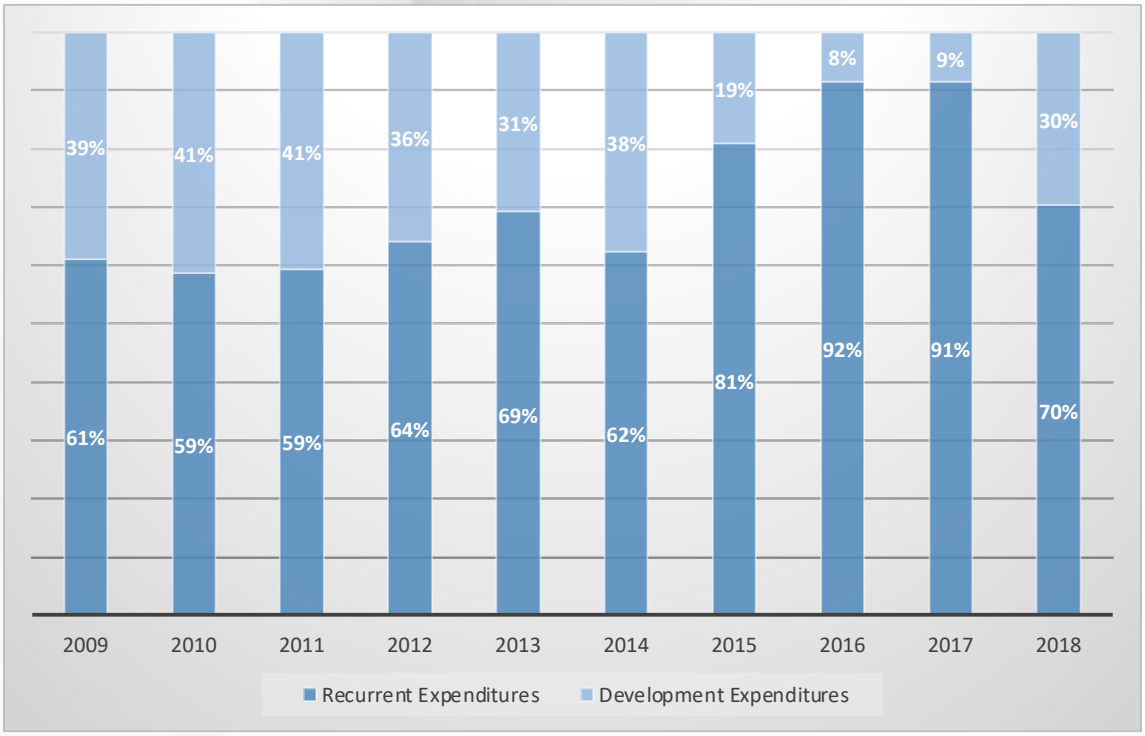
2.1.3 Composition of total health budget allocation and expenditures

The MoHCDGEC budget is split into recurrent and development budgets. The development budget is meant for the extension of the services in either quality or quantity. It also covers capital investments. The recurrent budget covers personnel emoluments in the form of wages and salaries and other costs such as those for goods and services, including health commodities. The services include the outputs of all units, not just the medical services. Development programmes often coincide with disease-specific programmes and may at times finance non-wage expenditure of such programmes, since most of the spending in such programmes is by development partners.

Figure 4 shows the trend of recurrent and development expenditure from HSSP III (2009–2014) to the current health strategy (2015–2018). Recurrent expenditure grew progressively over the last decade and increased from 62% in 2014 to over 90% in 2017. The was due to a steady increase in the wage bill and allowances. The 2018 approved budget estimate showed a substantial increase in the allocation for development expenditure, which was reflected in the subsequent actual expenditure. This increase was in part associated with the government's priority to invest in infrastructure, including in the construction and renovation of health facilities (WB PHER, 2020) and also with the significant donor support for the development budget. For 2016, 2017 and 2018 donor support constituted 85% (TZS 375 billion), 62% (TZS 198 billion) and 57% (TZS 450 billion) of the development budget, respectively (MTR HSSP IV Finance).

The HSSP IV financial midterm review notes that a large portion of the development budget was allocated to curative and pharmaceutical services, i.e. the purchase of drugs and commodities, which should be part of recurrent expenditures, while less than 10% was allocated to preventive services. This is an indication of the limited fiscal space for actual development initiatives such as service expansion and quality improvement.

Figure 4: Trend of recurrent versus development expenditures



2.1.4 Budgeting and expenditure by disease programme

While the government allocated budget is used to finance the wage bill and a small proportion of the recurrent costs, vertical disease programmes rely largely on external financing from development partners. Approximately 76% of HIV/AIDS spending and 52% of malaria spending is from donors. For instance, the Global Fund has invested over US$ 1.8 billion (TZS 3.8 trillion) in Tanzania's health sector since 2006 to support a wide range of prevention, care and treatment interventions for HIV/AIDS, tuberculosis (TB) and malaria (Results for Development, 2017). The Global Fund provides the largest share of the external financing for TB and malaria, while the United States Government has the largest investment in HIV/AIDS, which is roughly twice that of the Global Fund.

The Global Fund and the United States were expected to finance 98% of the costs of adult HIV/AIDS treatment between 2018 and 2020.

Table 4 shows the trend of on-budget expenditure by year for each disease programme for FY 2013/14 to FY 2017/18, but the data for 2016/17 were not available. The bulk of the expenditure was for malaria with 30%, HIV/AIDS with 20% and reproductive, maternal, neonatal, child and adolescent health (RMNCAH) with 21%. The expenditure shown in Table 4 reflects neither the total costs for these programmes, as commodities are usually purchased at their source by donors using pooled procurement methods, nor the substantial off-budget support from donors for some programmes.

The estimates on the financial resources required to implement each programme and on the impact of the programme in HSSP IV were generated by MOHSW using the OneHealth tool. [6]Even with substantial external financing, vertical disease programmes face resource gaps for their needs detailed in national strategic plans. For example, the HIV/AIDS programme's strategic plan estimated the programme's need for 2018 to 2020 to be TZS 3,887 billion, but the programme ended up with a gap of TZS 437 billion even after the government provided TZS 358 billion of budget, the Global Fund TZS 776 billion, and other external funding TZS 2,316 billion (refer to Appendix 3 for cost estimates for all programmes).

Table 4: Total health expenditure by disease programme by financial year (TZS millions)

Programmes	FY 2013/14	FY 2014/15	FY 2015/16	FY 2017/18
HIV/AIDS	980,678.61	684,998.55	1,221,887.72	1,092,662.57
Malaria	553,440.53	611,114.96	1,096,342.94	1,656,539.00
Tuberculosis	57,504.75	71,086.22	41,080.05	8,709.55
RMNCAH	506,563.59	484,381.76	378,813.09	1,155,926.26
Neglected tropical diseases	37,129.92	24,860.62	14,365.48	396.67
Diagnostics/Laboratory	199,719.96	205,922.78	317,907.47	155,123.23

Source: MoHCDGEC (2020)

An evaluation of Tanzania's health outcomes suggests that the key child health programmes prioritized globally, that is vaccines, malaria and HIV/AIDS, have been implemented with high coverage in Tanzania, but maternal health and family planning programmes have seen less comprehensive implementation and coverage (Afnan-Holmes et al., 2015).

The HIV/AIDS programme continues to have the biggest expenditure, with the bulk of the funds going to the life-prolonging treatment for an ageing HIV/AIDS cohort. The incidence of HIV/AIDS has almost been halved in the last decade, though this has not been adequate to control the epidemic. Despite its documented progress, Tanzania faces programmatic and financing challenges in attaining its objective of reaching the 90-90-90 targets for HIV/AIDs, i.e. 90% of the people living with HIV know their HIV status, 90% of the people who know their HIV status are on HIV treatment and 90% of people on HIV treatment achieve undetectable levels of HIV in their body, also known as viral suppression, by 2020. The targets for 2030 are 95-95-95. The Tanzania HIV investment case (2019) shows the total expenditure on HIV/AIDS to have been US$ 355 million in 2015 with US$ 37 million as government expenditure, US$ 475 million in 2016 with US$ 50 million as government expenditure, US$ 607 million in 2017 with US$ 52 million coming from the government and US$ 599 million in 2018 with $55 million as government expenditure.

6 The OneHealth tool is a model for medium to long term (3 to 10 years) strategic planning in the health sector. Created by an international consortium comprising WHO and other United Nations agencies, and Avenir Health, this tool combines disease programme and system-wide perspectives to estimate the cost of health service delivery and health system components.

As the leading cause of morbidity and mortality in children under the age of five, malaria has received considerable investments towards its control. The goal of the malaria strategic plan 2012–2020 is to reduce malaria prevalence to less than 1% by 2020. One of the two main funders of the malaria control interventions, the Global Fund, has provided US$ 69.5 million since 2014, US$ 35.7 million as on-budget support and US$ 26.8 million for the purchase of health products, while the President's Malaria Initiative, the second main funder, has invested at least US$ 40 million annually over that period as off-budget support (R4D, 2017). However, like with the HIV/AIDS programme, the malaria programme has faced shortfalls in financing its strategic plan. Though the programme is not expected to achieve its target, its investments in malaria control have been associated with half of Tanzania's 55% decline in all-cause mortality in children under the age of five between 2000 and 2017. The country, through the National Malaria Control Programme, has now elaborated an ambitious plan to achieve zero deaths from malaria and to eliminate malaria nationwide by 2030. Investments in RMNCAH look to further reduce maternal and newborn deaths by covering the pre-pregnancy period through family planning, the pregnancy period, labour and delivery, and the postnatal period, plus newborn health with interventions such as essential newborn care, early initiation of breastfeeding, prevention and management of newborn infections and timely postnatal visits. The progress toward achieving the targets of the Millennium Development Goals for child, maternal and neonatal health and the related SDGs has been uneven, in large part owing to funding and implementation challenges. To achieve the national and international goals, the government set new RMNCAH goals in HSSP IV and One Plan II that outlined the priority interventions and services to rapidly scale up the coverage of RMNCAH services to meet the targets for maternal and newborn health. One Plan II calls for the rapid scaling up of institutional delivery, provision of comprehensive and basic emergency obstetric and newborn care services through hospitals and health centres, and provision of antenatal and postnatal care. The plan also emphasizes the delivery of HIV/AIDS services for pregnant women and children, reproductive health services and adolescent friendly services.

Data for the overall expenditure on RMNCAH were not available for analysis, but the projections made using the OneHealth tool estimated that the financial resources needed for RMNCAH programming under One Plan II and HSSP IV would increase by nearly one-third from US$ 108 million in FY 2015/16 to US$ 143 million by FY 2019/20.

The evidence available, though limited, indicates that NCDs are a growing cause of morbidity and mortality in Tanzania. WHO (2017) indicates that NCDs are a major cause of illness and account for approximately 31% of all deaths. A national survey of NCDs (Mayige et al., 2012) found a high prevalence of chronic disease risk factors in Tanzania including tobacco use, unhealthy

diet habits, physical inactivity and harmful use of alcohol. . In addressing this, MoHCDGEC developed the Strategic and Action Plan for the Prevention and Control of Noncommunicable Diseases (2016–2020) that targets four categories of NCDs: cardiovascular diseases, cancer, chronic respiratory diseases and diabetes. These contribute substantially to the morbidity and mortality attributed to NCDs but can be largely prevented or controlled through early detection and treatment.

An analysis of the allocations and expenditures for NCDs was not possible as data were not available. Projections by MoHSW using the OneHealth tool indicated that with the rising burden of NCDs and mental health the costs of their services would grow faster than those of any other programme. They were expected to rise from 17% (US$ 164 million) of the total health service costs in FY 2015/16 to 27% (US$ 326 million) by FY 2019/20, making these the disease categories with the highest cost.

2.1.5 Decentralisation of the health budget and subnational resource allocation

An accurate measure of the progress towards the decentralisation by devolution goals is the percentage of health sector resources controlled by LGAs and the regional administration. The implementation of the decentralisation by devolution policy has made progress, as the share of the health budget allocated and disbursed to the regions and LGAs has increased over the years and health facilities and communities have been progressively empowered to manage their own affairs. Health spending at the local government level has seen a steady increase over the past 10 years. The spending on recurrent costs tripled from TZS 154 billion in 2009 to TZS 695.7 billion in 2017, while development expenditure increased six-fold from TZS 70.2 billion in 2009 to TZS 419.3 billion in 2017).[7]

Since 2013, the government has consistently directed almost half of all health resources (allocated and spent) to the LGA level. In FY 2008/09 LGAs accounted for 30.3% of the budgeted and 32% of the actual expenditures, and by FY 2016/17 these had increased to 51% and 45%, respectively. Over that period the regional level accounted for less than 1% of the annual health expenditure.

When broken down by type of expenditure, between 2009 and 2017 the recurrent health budget spent at the LGA level increased from 36% to 47% and the development expenditure by over 70% (Table 5). Concurrent with the increase in spending at the LGA level, the spending at the central level (MOHCDGED) as a proportion of overall expenditure decreased by 10%, recurrent spending by 11% from 56% to 45% and development spending by 13% from 67% to 54% (Table 5).

7 The total nominal health budget was TZS 805 billion for FY 2015/16 , TZS 796 billion for FY 2016/17 and TZS 1,078 billion for FY 2017/18 (HSSP IV MTR-Finance).

Table 5: Breakdown of recurrent and development expenditures by level of government

	2009	2010	2011	2012	2013	2014	2015	2016	2017
Recurrent expenditure (%)									
MOHCDGED/MOHSW	56.4	49.1	53.4	49.1	52	54.2	54.4	49.9	45.1
Regional administration and hospitals	7.5	6.8	6.7	7.9	8.5	7.7	7.7	8.2	7.7
LGAs	36	44.1	39.9	42.9	39.5	38.1	37.9	41.9	47.3
Development expenditure (%)									
MOHCDGED/MOHSW	67.3	74.3	66.9	69.7	61.3	74	58.6	42.4	54.3
Regional administration and hospitals	6.8	5.3	1	2.8	6	1.9	6.4	9.4	1.6
LGAs	25.9	20.2	31.9	27.4	32.1	23.8	34.5	47.6	43.9
PMO-RALG /PORALG	0.1	0.2	0.2	0.1	0.6	0.4	0.5	0.6	0.1

2.1.6 Execution of the global health sector budget

In general, the overall performance of the health sector budget has been relatively high, and averaged over 85% between FY 2007/08 and FY 2014/15. It declined to 75% in FY 2014/15 and 61% in FY 2015/16 before improving to 77% in FY 2016/17. The low budget performance was due primarily to late disbursement and non-release of funds, in particular non-basket funds. Budget execution rates varied across different spending categories and geographical regions.

The execution level of the recurrent budget consistently exceeded 80% between FY 2007/08 and FY 2015/16, and in some years it was reported to have been over 100%, an indication that carryover funds from previous years had been utilised after budget reallocations.

The execution of the development budget was generally much lower than that of the recurrent budget, partly because of the lengthy and difficult procurement procedures that delayed the implementation of the budget. The implications of low budget execution are that the planned activities are not implemented on time or completely (HSSP IV-MTR, 2018).

2.2 Budgeting and expenditure at the decentralised level

LGA health budgets are financed by budgetary allocations from the government also known as block grants, donor basket and non-basket funds, funds from council sources and fees and subscriptions from various schemes (Table 6). LGAs and councils are also directly funded by nongovernment sources and such funds are not reflected at the central government level.

The central government distributes resources to local governments based on a formula introduced in 2004. This formula takes into account the regional characteristics and variations in the poverty level, population size, disease burden and child mortality, and the difficulty of access of the location from the district medical vehicle route.

The central government also disburses funds for the procurement of drugs and medical supplies destined for LGAs through MoHCDGEC.

Block grants from the Ministry of Finance constitute the largest share of LGA funding, and their volume grew considerably from TZS 408.5 billion (65.5%) in FY 2012/13 to TZS 778.8 billion (61.6%) in FY 2016/17 (Table 6). There is a significant variation in government health allocations among the regions and districts, in part owing to the fact that the distribution of funds is based on a recurrent formula rather than on the identified service delivery or epidemiological realities on the ground. This has led to considerable variations in funds allocated, with some councils not getting sufficient finances to implement their plans (Dutta, 2015; Sikika, 2012).

Table 6: Sources of LGA funding

	FY 2012/13		FY 2013/14		FY 2014/15		FY 2015/16		FY 2016/17
	Budget-ed	Ex-pended	Budget-ed	Ex-pended	Budget-ed	Ex-pend-ed	Budget-ed	Ex-pend-ed	Budgeted
Block grants	408.5	223.6	513.5	265.5	481.9	390.8	523.5	436.4	778.8
HBF	106	64.2	103.6	75.8	89.1	80.3	64.1	80.2	106.6
Own sources	26.1	12.5	25.8	9.8	34.8	15.8	50.5	15.4	27
User fees	0.49	0.13	0.24	0.12	0.06		0.2		0.33
CHF	21.5	3.3	9	2	10.6	1.8	17.3	1.9	23.5
Other	60.9	15.1	40.3	15.5	35.4	52.6	39.8	52.5	274.1

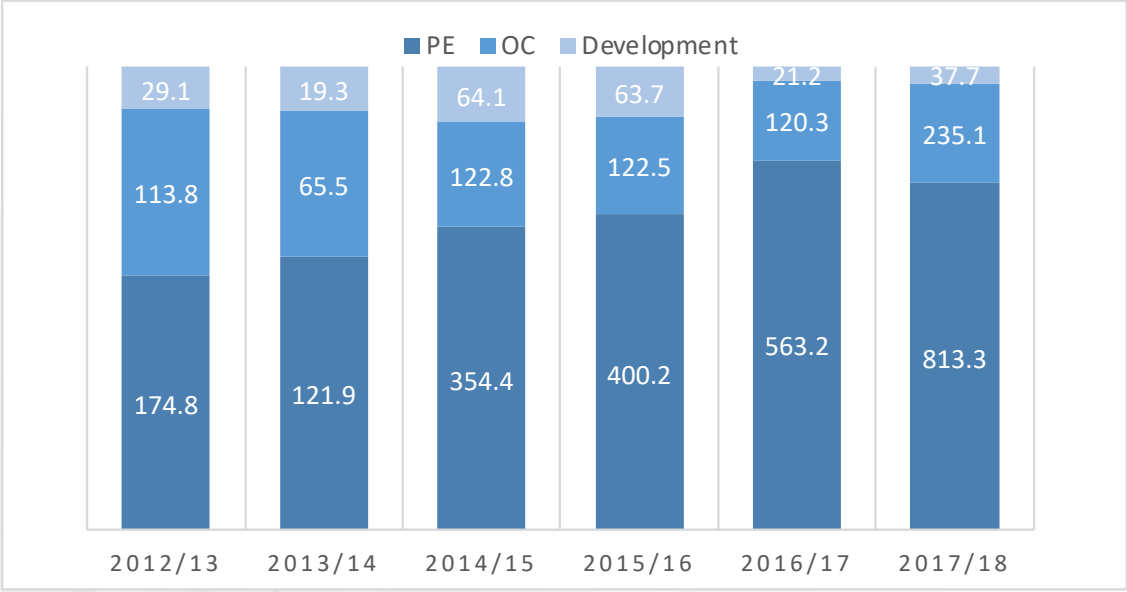
HBF is the second largest contributor of LGA funding. It funds non-wage recurrent expenditure and a significant portion of the LGA development budget. HBF support declined progressively from 17% in FY 2012/13 to 8% in FY 2015/16, a reflection of donors' progressive shifting to off-budget support. Since FY 2017/18, HBF funds have been disbursed directly to the health facilities through the DHFF mechanism. HBF is considered as the main source of the available funds at the facility level, followed by cost sharing funds (Njau & Enemark HBF MTR 2019).

Councils also receive off-budget support directly from donors, which is the third highest source of funds for LGAs.

Donor off-budget support increased from 9% to over 21.6% between FY 2012/13 and 2016/17 (PHER 2010/11, 2015/16, 2016/17). Resources from the councils accounted for less than 5% of their actual expenditure but had increased from 1% in FY 2010/11 to 4% in FY 2015/16.

Human resources account for about 80% of the spending by LGAs, mostly as personal emoluments or salary and wage payments (Figure 5). The share of other costs, i.e. those related to goods and services, remained largely constant between 2013 and 2018 while development expenditure, i.e. capital investments, did not exceed 10% of the budget (PHER 2010/11, 2015/16, 2016/17.

Figure 5: : Breakdown of LGA recurrent and development spending (TZS billion)



In summary, councils rely on central government funds for day-to-day running of activities and to pay salaries. Development activities such as equipping new health facilities and purchasing health commodities are funded largely by donors through HBF and other off-budget support. The councils' revenue input for their running costs is minimal, a situation that poses a threat to the sustainability of health interventions should an interruption of the flow of funds from the government or development partners occur.

At the sub-LGA level, frontline health facilities, that is dispensaries, health centres and community health services, accounted for about 50% of the LGA expenditure between 2013 and 2018, while CHMTs' expenditure was between 26% and 34% (Table 7).

Table 7: Trend of budget allocation and spending at the LGA level special votes in TZS billion (as % of allocation)

	FY 2012/13	FY 2013/14	FY 2014/15	FY 2015/16	FY 2016/17	FY 2017/18
CHMTs	82.3 (78)	98 (26.6)	179.1 (32.5)	184.7 (31.5)	214.3 (30.4)	362,468.83 (33.6)
Council hospitals	65.6 (6.2)	61.8 (16.8)	112 (20.3)	113.3 (19.3)	96.7 (13.7)	126,560.52 (11.7)
Health centres	65.2 (6.2)	87.1 (23.7)	109.8 (19.9)	119.8 (20.4)	144.6 (20.5)	314,461.80 (29.2)
Dispensaries	87.5 (8.3)	116.7 (31.7)	140.4 (25.5)	157.6 (26.9)	244.8 (34.8)	264,702.30 (24.6)
Community health	15.6 (1.5)	4.5 (1.2)	9.7 (1.8)	10.7 (1.8)	3.8 (0.5)	9,842.06 (0.9)

Much progress has been made in devolving LGA financing, but better allocative efficiency is needed at that level, as per capita allocation and spending on health are unequal among regions and councils or LGAs. In FY 2016/17 per capita health expenditure among the districts with the highest spending was five times that of the lowest spenders (WB 2019; Ministry of Finance Epicor reporting platform). These variations persist despite all districts benefitting from a real increase in per capita financing. The inequities can be attributed in part to the differences in prioritization of health in the budget in the regions and councils and to the inadequacies in the budget allocation criteria.

2.2.1 Efficiency of budget execution at the LGA level

Budget execution at the subnational level improved progressively over time, going from 51% in FY 2012/13 to 84% in FY 2016/17 for the total LGA budget, 55% to 83% for the government block grants and 61% to 123% for HBF. The budgeted amounts were consistently higher than the allocated amounts, a factor that affected budget execution. The under-execution of the budget resulted also from the late disbursement of funds or unplanned spending at central government level rather than from low absorptive capacity of councils. Funds disbursed to the LGAs were spent in full (WB, 2019). Delays in disbursements have led to delays in funding implementation, affecting performance negatively and leaving LGAs overly dependent on the off-budget support from donors (HSSP IV MTR-Finance).

2.2.2 Decentralisation of financial management to the facility level

The implementation of RBF and DHFF has contributed in improving the quality of service in LGA health facilities. The financial autonomy brought to PHC facilities and their governance structures by DHFF has impacted the decision space and influenced service quality (Kapologwe et al., 2019). Government increases in budget allocation for the health sector, especially for the pharmaceutical and equipment expenditure, have improved the quality of services in the health facilities.

The DHFF mechanism is seen as one of the major successes of HSSP IV. It allows health facilities to allocate HBF funds based on local priorities, though within certain limitations. Not only has the money been very well spent, for example to address issues revealed in the star rating process, but it also has been accounted for very well. The challenge remains with ensuring that adequate funds are available from the central government.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3. IMPACT OF EXPENDITURE ON HEALTH OUTCOMES

3.1 Government commitment to spending on health

As Tanzania strives to reach the middle income country status, its health sector has focused attention on the quality of health services in tandem with the pursuit of universal health access. PHC is central to Tanzania's strategy to advance towards UHC through SNHI.

In the past decade the country has made considerable progress in lowering the burden of communicable diseases, particularly through improving child health outcomes and controlling epidemics. The government has invested in the development of sound evidence-based policies and strategies, including adopting PHC early as a driving force in advancing towards UHC[8]. However, the current level of national spending on health is below major international benchmarks and is insufficient to achieve national and UHC targets. Although steady progress has been made in increasing the total nominal health expenditure over time, expenditure on health as a proportion of the total government expenditure has stagnated during this past decade. MoHSW calculated the cost of implementing HSSP IV and achieving the set targets to be TZS 21,945 billion, that is if the coverage of the key interventions remained constant from FY 2015/16 to FY 2019/20 and if the numbers of facilities and HRH were constant over the HSSP IV implementation years.

The costs were considered to increase each year, going from TZS 4,013 billion in FY 2015/16 to TZS 4,859 billion in 2019/20, which would translate into the equivalent of a stable per capita expenditure of around US$ 42. But the actual total annual health expenditure between FY 2015/16 and FY 2017/18, the first three years of HSSP IV implementation, was TZS 1.71 billion for FY 2015/16, which was 43% of the estimated budget; TZS 1.84 billion TZS for FY 2016/17, which was 44.4% of the estimated budget; and TZS 2.58 billion for FY 2017/18, which was 60% of the estimated budget.

The below target health expenditure and the resulting stagnation of per capita expenditure, coupled with the rapid population growth, imperil Tanzania's goal to achieve UHC. The current level of investment in health points to significant reliance on external funds and out-of-pocket spending in the sector to finance its operations. This has led to persisting inequities in access to quality health services and poses serious challenges for the sustainability of the recent health and socioeconomic gains. Evidence shows that investing US$ 5 per person per year in 74 countries with high disease burdens, Tanzania included, would yield high rates of return, producing nine times the economic and social benefit by 2035 (Steinberg et al, 2019).

8 PHC-oriented health systems have been shown to bring enormous benefits but require substantial financial investments (Steinberg et al., 2019).

3.2 Progress in improving priority health outcomes

Tanzania has made progress in increasing access to and quality of services and improving health outcomes as a result of increasing spending on health. However, the progress toward achieving HSSP IV and UHC targets for child, maternal and neonatal health has been uneven, in large part due to funding and implementation challenges (see Appendix 4 for a list of outcomes). The following section reviews the progress made in achieving the targeted health outcomes and reducing inequalities specifically in diseases and conditions that contribute significantly to the morbidity and mortality burden and affect life expectancy.

3.2.1 HIV/AIDS

HIV transmission has declined steadily over the past 15 years (Table 8). But since 2010 its prevalence has remained stable at about 5% as more people living with HIV are surviving longer on treatment, new infections continue to occur and the population is growing. The burden of HIV/AIDS among adults 15 years old or older varies by place of residence, with levels at 4.2% for rural and 5.5% for urban areas; by sex, with 6.3% of females and 3.4% of males affected; and across regions, with Lindi having the lowest level of 0.3% and Njombe the highest level of 11.6%. The gains in HIV/AIDS have been made through scaling up antiretroviral therapy (ART) and effective prevention interventions such as voluntary medical male circumcision and prevention of mother to child transmission (PMTCT).

Table 8: HIV prevalence

HIV prevalence	2008	2015	2017
15–64 year olds (%)	5.7	5.1	5.3
15–24 year olds (%)	2.4	1.96	1.4

Source: 2010 and 2015 demographic and health surveys; 2007/08 HIV/AIDS and malaria indicator survey

The expansion of HIV treatment services has saved thousands of lives, with 50% fewer annual deaths occurring in 2017 than in 2010 (UNAIDS, 2019). Moreover, new infections have decreased by nearly half, going from 120,000 annually in 2000 to 65,000 in 2017 (UNAIDS, 2018), though this decline has been as fast as for the deaths, meaning that more people will continue to be initiated on long term life-prolonging treatment.

The HIV/AIDS epidemic, though generalised, is driven by the high occurrence of new infections in certain segments of the population including mobile populations, sex workers and men who have sex with men. Women, in particular adolescent and young women aged 15–24 years, are disproportionately affected. The incidence of HIV is currently highest among adolescents aged 15–19 years, especially females.

3.2.2 Child health and nutrition

Table 9: Key child health indicators

	2005	2010	2015
Infant mortality per 1,000 live births	68	51	43
Under-five mortality per 1,000 live births	112	81	67
Stunting < 5 years (%)	44	42	34
Prevalence of malaria 6–59 months (%)	18	9	7.3~~A~~

Source 2005, 2010 and 2015 TDHS; ~~A~~2017 TMIS

Significant progress has been observed in reducing under-five mortality in the last 20 years, which declined from 147 per 1,000 live births in 1999 to 67 in FY 2015/16. Child health outcomes have improved overall owing to the sustained investment in a few high impact programme areas, including routine under-five immunisation, vitamin A supplementation, integrated management of childhood illness (IMCI), use of insecticide-treated bed nets and improved treatment for malaria. Modelling outcomes of health investments indicated that antimalarial medicines, considered as saving 20% of all under-five's lives, oral antibiotics said to have saved 10% of the lives and oral rehydration solution, regarded to have saved 9% of the lives, underpinned by sustained high coverage vaccination rates, had the largest impact. However, wide disparities remain in the coverage of these interventions and thus also in their outcomes. While health outcomes amongst the poorest children continue to improve, these children are still twice as likely to die before the age of five than those from the highest wealth quintile.

Child immunization coverage in Tanzania remains high. Some 88% of children have received the pentavalent vaccine and 90% the measles vaccine (TDHS, 2016). Tanzania's immunization coverage rates are among the highest in the African region. Coverage is high in all socioeconomic groups, though further improvements can still be made by focusing on children with mothers from the lowest wealth quintiles, or with no education or from rural areas and in regions where vaccine coverage is significantly lower than average.

Stunting rates in children, a sign of chronic malnutrition, which is the underlying cause of nearly 50% of the deaths of children under five, has continued to gradually decrease over the past decade, going from 44% (TDHS, 2005) to 35% (TDHS, 2015). Stunting is related to a child's geographical location and it is higher in rural areas, to mothers' education and to household wealth, where it is higher the lower these factors are. Disparities in stunting levels also exist between regions, and range from 14.6% in Dar es Salaam to 56.3% in Rukwa.

The proportion of children fed according to the recommended infant and young child feeding (IYCF) practices, which was already low before the introduction of HSSP IV, decreased from 24% to 10% between 2010 and 2015 (TDHS, 2015). IYCF is positively related to urban residency and high household wealth. Overall, the likelihood of a child receiving key child health interventions increased with the mother's level of education and household wealth.

3.2.3 Malaria

The rapid scaling up of malaria control interventions accounted for 57.7% of the reduction in child mortality in Tanzania (Gansey, 2020). The prevalence of malaria, the leading cause of morbidity and mortality in children under five years of age, more than halved between 2005 and 2015 from 18% to 7%. However, malaria prevalence varies according tothe place of residence and was at 2.1% in urban areas and 9.2% in rural areas; with household income with the levels at 0.6% for the highest quintile and 14.2% for lowest quintile; and with the mother's education level, and stood at 2.9% where mothers had secondary school or higher education levels against 11.1% where mothers had no education.

The decrease in the burden of malaria resulted from the scaled up and sustained use of insecticide-treated nets, which were distributed to all households, and the prompt treatment of fevers with the more effective artemisinin combination therapy that was made available in all public health facilities (TMIS, 2017).

3.2.4 Maternal, neonatal and infant health

The decline in MMR is way off the HSSP IV and One Plan II target of 292 deaths per 100,000 live births. The neonatal mortality rate stagnated between 2005 and 2015, and neonatal deaths now account for 37% of all child deaths (see Table 10).

Table 10: Key maternal and neonatal health indicators

	2005	2010	2015
Neonatal mortality per 1000 live births	32	26	25
Infant mortality per 1,000 live births	68	51	43
Maternal mortality ratio per 100,000 live births	578	454	556

Source "2005, 2010 and 2015 Demographic and health survey"

Several factors have contributed to the slow progress in improving maternal and newborn health. Unlike child health initiatives, maternal health and family planning programmes tend to not include all the essential interventions and are of a more limited geographical coverage (Afnan-Holmes et al., 2015). Furthermore, the inconsistently implemented and financed efforts to ensure equitable access to maternal and newborn services for poor households, for example waivers and user fees, have yielded less than optimal outcomes. Some progress has been made in increasing reproductive, maternal and neonatal services but less so in improving quality-related indicators. The progress in service delivery and its outcomes are discussed in more detail in the following paragraphs.

Timely antenatal care is key in reducing the risk of low birth weight and maternal morbidity from conditions such as maternal anaemia, pre-eclampsia and malaria infection. Most pregnant women attended antenatal care clinics but only 27% of them started antenatal visits in their first trimester and only 62% made the recommended four visits. Urban women were more likely than rural women to make four or more ANC visits and to seek care early in their pregnancy.

Delivering a baby in a health facility with the assistance of a skilled health worker is important in ensuring the birth environment is clean and the delivery is safe and in preventing adverse outcomes. Health facility deliveries and deliveries assisted by a skilled birth attendant have increased significantly in the last decade, growing from 50% in 2010 to 77% in 2018, and are on track to meet the HSSP IV target of 80% for 2020. There are differences in the coverage of the services between urban and rural areas, with the levels for facility delivery standing at 86% and 56%, respectively. Facility delivery numbers also vary widely by region and range from 40% in Simiyu region to 94% in Dar es Salaam. Wealth is another factor, and only 41% of the pregnant women in the lowest quintile deliver in a facility compared with 94.4% for the highest quintile.

Obstetric emergencies account for the deaths of nearly 6,500 women and 39,000 newborns yearly, while an estimated 5.9% of maternal deaths are due to HIV/AIDS-related causes. Facility surveys (IHI SARA, 2017) show some progress in increasing the availability of basic emergency obstetric and newborn care services at the PHC level but the rate of increase is insufficient to achieve the coverage rates needed to significantly reduce MMR and NMR[9]. In contrast, progress has been made in increasing coverage of postnatal care

9 Basic emergency obstetric and newborn care is an integrated strategy that aims to equip health facilities to deal with the major causes of direct obstetric emergencies that account for the vast majority of maternal and newborn deaths. The strategy comprises a package of seven key obstetric services or signal functions expected of a facility (1) administer parenteral antibiotics, (2) administer uterotonic drugs (parenteral oxytocin), (3) administer parenteral anticonvulsants (e.g., magnesium sulfate), (4) perform manual removal of the placenta, (5) perform removal of retained products of conception, (6) perform assisted vaginal delivery, and (7) perform basic neonatal resuscitation.

for women and newborns in the first 48 hours after birth, a critical period in the prevention, early detection and treatment of complications and for provision of advice and services on child health. Significant variations exist in the coverage of this service between urban and rural women with the levels at 48% and 29%, respectively; between wealthy and poorer women, with coverage levels at 53.3% and 22% for women the highest quintile and lowest quintiles, respectively, and among regions, ranging from 9% in Simiyu to 72% Iringa. Tanzania continues to make gradual progress towards its family planning and fertility targets. Contraceptive use reduces the number of high risk and high parity births, and hence maternal mortality.

Contraceptive use in married women aged 15–49 years increased by 60% between 2005 and 2015, from 20 to 32%. Urban women were more likely to use modern contraceptives than were rural women, with the usage levels at 35% and 31%, respectively. Modern contraceptive use increased also with household wealth and education and varied significantly across the regions. Some 61% of the women expressed the need for modern family planning, which means that not all married women who needed contraceptives were receiving them. Progress in decreasing teenage fertility has stagnated over the past decade. The percentage of teenagers who had a child or who were pregnant was 23% in 2010, and 21% in FY 2015/16 and 21% in 2018.

3.2.5 Noncommunicable diseases

A national strategy exists to address NCDs, but the HSSP IV midterm evaluation found little indication that the health system was working to address or control this emerging threat. The scaling up of the coverage of NCD and mental health interventions was limited under HSSP IV owing to the prioritization of other health services, particularly the lifesaving services related to maternal and child health. Though NCDs accounted for nearly half of hospital deaths and all health facilities were reporting an increased disease burden, there was low awareness on NCDs at the community level, low level of knowledge on them among health care workers and little evidence of their prevention activities in facilities or investment in human and financial resources to implement their strategy. Even for limited scaling up of preventive and curative NCD services, the NCD and mental health programme requires significant levels of human resources and funding.

3.2.6 Coverage, access and quality of health services

The emphasis of the MMAM programme was on expanding the number of dispensaries in rural areas to increase service coverage in underserved areas. To this end, over TZS 130 billion was allocated in the FY 2018/19 health budget for the construction and renovation of health facilities.

However, many of the newly constructed facilities remain without staff, equipment or adequate infrastructure (WB PER, 2020). In addition, the availability of basic health services in the functioning health facilities is uneven.

Despite the improvements in the coverage of some services, there are persistent inequalities between urban and rural populations and the poorest and richest households and among regions. For example, over 80% of the facilities provide malaria diagnosis and treatment, curative care for sick children, antenatal care, STI diagnosis and treatment, child immunization, child vaccination and family planning (TSPA, 2014-15). Conversely, while delivery and newborn care services are provided by 75% of the facilities, basic emergency obstetric and newborn care (BEMONC) services are available in only 20% of the dispensaries and 39% of the health centres. Services such as caesarean delivery and blood transfusion are available in hospitals only, which make up less than 5% of the facilities nationally.

Access to services has improved in some areas, though significant variation remains for some access indicators. For example, despite the risein the proportion of women delivering in health facilities from 50% in 2010 (TDHS, 2010) to 63% in 2016 (TDHS, 2015-16), only50% of the women in rural areas deliver in a facility, compared with 86% in urban areas. Delivering in a facility was positively associated with a woman's wealth status and education and varied across the regions. Similarly, 69% of urban children were taken to a health facility or provider when they had fever but only 43% of rural children benefited from such treatment. Coverage and access to services are in part undermined by the low quality of the services at the facilities. It is documented that accessing and using poor quality services undermines the achievement of the desired health outcomes (Rengli et al., 2019). In response to the many challenges faced by the facilities in delivering quality health services, the Ministry of Health initiated a five-star facility rating system in 2015 as part of the Big Results Now initiative. The rating system tracks antenatal care visits, the proportion of babies delivered in health facilities, the provision of folic acid, contraceptive prevalence, and the availability of tracer drugs.

The quality of care appears to have improved considerably in all regions according to the star rating system (MTR HSSP IV). The share of the facilities with the minimum three star ranking increased from 2% in 2016 to 19% in 2017. The improvements were in part due to the implementation of the RBF programme that incentivises quality improvement in health facilities by adjusting disbursements according to the performance of a facility. The increase in facilities with three or more stars, though significant, is substantially below the HSSP IV target of 50 for primary health facilities rated with at least three stars by 2020.

3.2.7 Human resources for health

Assessments prior to the HSSP IV period revealed that shortages and misdistribution of qualified HRH were major challenges in expanding and improving health service delivery in Tanzania, with rural dispensaries being the most affected (MoHSW, 2014b). For example, in 2012, as many as 500 facilities were found to be non-operational owing to staff shortages (MoHSW, 2014a).

The government planned to increase the number of human resources available in the country from 121,829 in FY 2015/16 to 150,635 by FY 2019/20 (HSSP IV, 2015). Analysis using the OneHealth tool comparing the number of HRH needed to the number available under HSSP IV revealed a growing HRH gap. The overall HRH gap was 13% in FY 2015/16 and was expect to increase to 40% by FY 2019/20 (Barker & Dutta, 2015). Human resources for health were projected to cost US$ 2,134 million under HSSP IV and to increase from US$ 358 million to US$ 500 million between FY 2015/16 and FY 2019/20.

The allocations for recurrent expenditure for health, a proxy measure for the resources allocated for human resources, were found to be US$ 173.5 million for FY 2015/16, US$ 124.6 million for FY 2016/17 and US$ 129.2 million for FY 2017/18, which were far below the estimated levels needed to implement HSSP IV.

Although the number of health workers, especially clinical personnel, was rising, the workforce was maldistributed with considerable shortages in dispensaries and rural areas. The HSSP IV midterm review found serious inequities in staff distribution among regions but also within regions and councils. Many staff preferred to work in urban rather than rural areas, which had poor working and living environments (Primary Health Care Systems Case Study – Tanzania; WHO, 2016). There were 7.7 doctors and nurses per 10,000 people, which was below the average for SSA and far lower than WHO's recommendation of 23.

4. KEY FINDINGS AND RECOMMENDATIONS 34

4.1 Key Findings

- The current level of government investment in health is inadequate to achieve HSSP IV targets and ultimately UHC. The spending level has risen but the allocation as a proportion of the total government budget has stagnated over time. The current level is below the recommended per capita and proportional spending thresholds. Tanzania spends a higher proportion of its total government expenditure on health than its neighbours, but its per capita spending is lower than theirs.

- The financing of the health budget is fragmented and heavily reliant on taxation and external sources with a modest contribution from complimentary financing including health insurance schemes. Out-of-pocket spending for health is high, it contributes to the inequities in access to health care and it exposes households to impoverishment through catastrophic health expenditure.

- Health insurance coverage levels in Tanzania are stagnant and the benefits are limited, plus the sector faces significant challenges in efficiency owing to the fragmented nature of the health insurance landscape. This poses difficulties in the country's efforts to sustainably fund its health strategies and ultimately attain UHC.

- Most of the government's spending on health is on recurrent items, indicating that capital improvements and additions such as quality improvement and scaling -up of services receive lower attention.

- The government has progressively raised the allocation of funds for the local government level, particularly during HSSP IV. Spending at the central level remains significant, though it is getting less so as procurement and payment of wages continue to be done at the local government level.

- The execution of the global health budget has been generally high. Periodic delays in disbursement of funds across certain channels have led to problems in budget execution and planning.

- Budget execution at the subnational level has improved over time; and its under-execution has been related to the late disbursement of funds and or unplanned expenditure at the central government level rather than an adequate absorptive capacity of councils.

- There is significant variation in the government's health allocations among the regions and districts, with some councils not receiving sufficient funds to implement their plans.

- The bulk of the budgeted LGA expenditure goes to the payment of wages, as councils rely on the central government funds for their day-to-day activities and to pay salaries. Development activities such as equipping new health facilities and purchasing health commodities are funded largely by donors through HBF and off-budget donor support.

- Progress has been made in devolving financing to LGAs, but this level needs better allocative efficiency. The current approach appears to disproportionately affect the already marginalized councils.

- The implementation of RBF and DHHF mechanisms has contributed in improving the quality of services in health facilities in LGAs.

- There are positive developments in expanding programme coverage for health service delivery and quality during the of implementation of HSSP IV. Yet, many of the HSSP IV targets will not be met, including those for MMR and neonatal mortality rate (NMR). There are persistent inequalities in almost all the indicators between urban and rural populations and the poorest and richest households and amongst regions. The various disease programmes rely heavily on external funding, but even with the substantial levels of this financing, they experience shortfalls in meeting the implementation needs indicated in the national strategic plans.

- While the number of health workers, especially clinical personnel, is increasing, the workforce is maldistributed, with considerable shortages in dispensaries and in rural area.

4.2 Recommendations

- **Increase government spending on health through innovative funding methods**

  Government spending on health is insufficient to accomplish the current health sector strategic plan targets. To achieve the goal of UHC by 2025 through expanding coverage of quality health services and by increasing financial protection, Tanzania needs to increase spending on health to US$ 42 per capita. The government can define the measures to expand the fiscal space for health by exploring the potential domestic revenue sources such as levies and earmarked taxes, and by leveraging existing public–private partnerships to expand the private sector's role in financing health care

- **Implement the SNHI scheme**

  Implementation of SNHI will improve access to and equity of health care and the financial position of individual health facilities and allow for elimination of inequitable exemption systems. It is, therefore, a priority to move SNHI forward and follow the necessary legal procedures for its adoption. Prior to the implementation of SNHI, the improved CHF (iCHF) should be strengthened by its expansion to more regions and ensuring its acceptability by the community.

- **Advocate for coordination of donor funding to align with the country's priorities and strategies**

  The government should encourage donors to bring their aid on its budget to reduce inequities and duplication in support and the heavy administrative burden that results from the co-existence of many small projects. Donors should be encouraged to proactively take into account the country's strategy during the creation of their country assistance plans and to align them with the government's funding cycles. HBF represents a good opportunity for donors to use government systems to support primary care directly.

- **Address the inequities in budget allocation across and within regions**

  While the government has made good progress in prioritising financing of LGAS, it needs to reassess its approach for budget allocation to them to reduce inequities across and within regions. There is need to ensure that allocations are based on the transitioning epidemiological, operational and socioeconomic realities of the LGAs. Furthermore, there should be a balance in the allocations for wages, development and goods and services. Investments in infrastructure should be accompanied with increased allocations for personnel, goods and services to ensure that the

- **Continue investing in key health programmes and address the inequities in accessing services**

  Encouraging progress has been made in achieving key health outcomes notably in the reduction of under-five mortality. However, challenges remain particularly in neonatal and maternal mortality and in the increasing burden of NCDs. There are significant geographical, household wealth and education-related inequities in accessing health care. In this light, investment should be considered in the priority areas to enhance health outcomes. The focus should include increasing access to emergency obstetric and newborn care services particularly in underserved areas and groups; increasing investments in child health services for underserved areas and groups; scaling up HIV/AIDS response to end AIDS by 2030, emphasising incidence reduction in key groups; and investing in the implementation of the NCD strategy to significantly reduce the burden of NCDs and alleviate their weight on under-resourced health facilities.

  Concrete steps should be taken to address the persistent inequities in health care delivery. The HSSP IV midterm review and other evaluations show that resource allocation alone is not enough to solve inequity and there is need for progressive and proactive study of poorly performing health facilities and vulnerable populations to help the councils to quickly address

- **Scale up and redistribute health workers to achieve equity and efficiency**

  The human resources available and their distribution are insufficient to meet the HSSP IV service delivery targets. The scaling up of HRH needs to match the scaling up of the health services for their supply to meet their demand while at the same time addressing the critical gap of health workers in PHC facilities.

  There is a need for human resources planning that is smart and need and evidence based. Initiatives to improve HRH allocation and motivation should prioritise increasing the number and geographical balance of qualified human resources. They should also consider adopting innovative incentive mechanisms to motivate staff to relocate to remote and poor regions for prolonged periods of time.

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Appendix 1: Tanzania's national package of essential health interventions

A primary focus of HSSP IV was to make a standard minimum benefit package of primary and secondary health care services fully accessible to all Tanzanians particularly the poor and vulnerable groups and to ensure that these services were fully funded within the available resources pooled for SNHI. HSSP IV envisioned the formulation of the MBP drawing from the existing National Essential Health Care Intervention Package[10]. However, owing to delays in approving HFS, the formulation of the standard MBP has been stalled, and so the National Essential Health Care Intervention Package has continued to serve as the basis for the financing of service delivery at various levels in health care delivery.

Reproductive and child health

- Safe motherhood: maternal conditions – Intermittent presumptive treatment of malaria (pregnancy), antenatal care, obstetric care, postnatal care, gynaecology, STD, HIV/AIDS care, micronutrient supplementation for mothers
- Safe motherhood: perinatal conditions – STD screening; support for traditional birth attendants; safe delivery practices; newborn care; micronutrient supplementation for low birth weight babies; village birth registers
- Immunization – BCG (tuberculosis); diphtheria; pertussis; neonatal tetanus; measles; poliomyelitis; hepatitis B
- Integrated management of childhood illnesses (IMCI)
- Malaria; pneumonia; diarrhoea; measles; malnutrition; anaemia
- Family planning
- Nutritional deficiencies – Nutrition information, education, and communication; breast-feeding support groups; growth monitoring and pupil health screening; micronutrient supplementation (iron, vitamin A); monitoring salt iodization; deworming; school feeding

Communicable disease control

- Malaria – IMCI (early care seeking and case management); insecticide-treated bed nets; intermittent presumptive treatment in pregnancy; home-based care; school health education about malaria prevention; epidemic preparedness; sustainable source reduction; information, education, and communication
- Tuberculosis and leprosy – tuberculosis directly observed treatment, short course (DOTS); leprosy multidrug therapy; home-based care

10 Ministry of Health and Social Welfare, United Republic of Tanzania. 2013. National Essential Health Care Interventions Package-Tanzania (NEHCIP-Tz).

Noncommunicable disease control

- Cardiovascular diseases – IEC on smoking, alcohol, diet, and exercise
- Diabetes – Preventive and promotive IEC; routine checking of blood pressure
- Neoplasms – Breast and cervical cancer screening
- Injuries and trauma care
- Mental disorders
- Anaemia and nutritional deficiencies

Treatment for common diseases

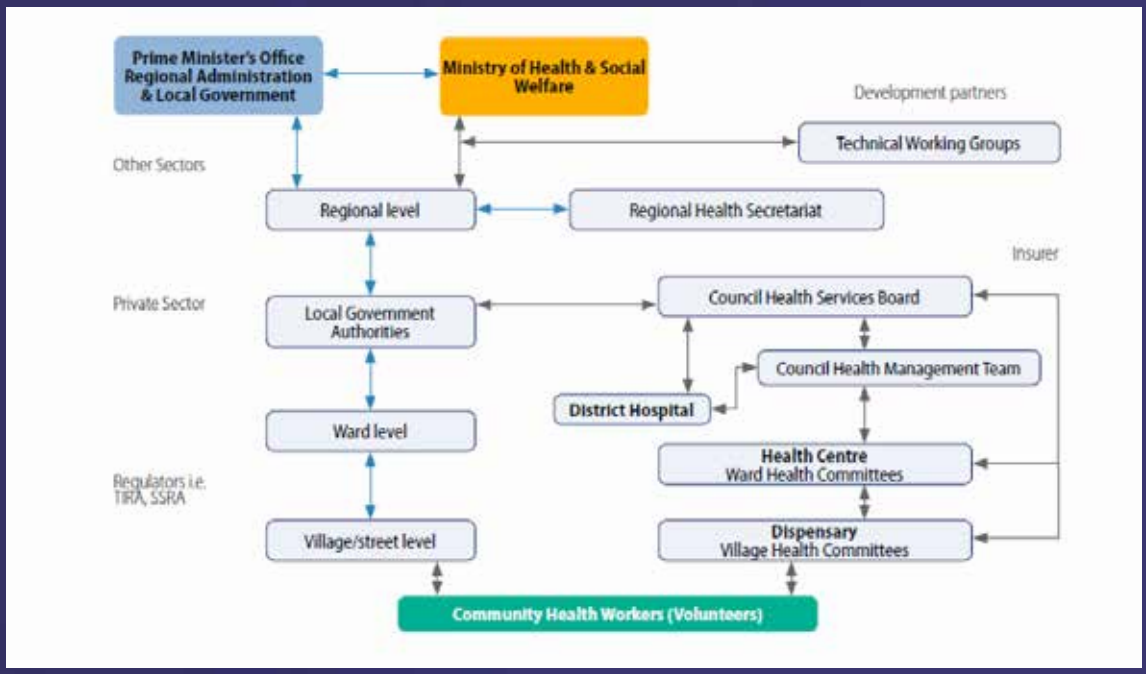
- Helminths, skin, ocular, and oral conditions

Community health promotion and disease prevention

- School health
- Water hygiene and sanitation
- Information, education and communication

Source: Ministry of Health, Tanzania. 2013. National package of essential health interventions in Tanzania. Government of Tanzania, Dar es Salaam, Tanzania.
Note: In the essential package, there are more than 50 technical interventions but not all have equal priority in different settings.
NB: Package has been updated

Appendix 2: Key PHC organizational structures and decision-making bodies



Source: WHO (2017). Primary healthcare systems: A case study from the United Republic of Tanzania. Geneva: World Health Organization

Appendix 3: HSSP IV costs (TZS billions) by programme and health system component

	FY 2015/16	FY 2016/17	FY 2017/18	FY 2018/19	FY 2019/20
Programmes, interventions and services					
HIV/AIDS	602	598	594	630	644
NCDs and mental health	340	415	499	585	674
Malaria	260	188	186	185	185
Maternal, newborn, and reproductive health	139	153	158	171	169
Immunizations and vaccines	126	120	116	105	97
Oral care	134	146	158	172	188
General health services	130	132	135	137	139
Child and adolescent health	82	103	115	131	127
Tuberculosis and leprosy	92	121	112	113	119
Environmental health	50	43	49	43	43
Orthopaedic and trauma services	40	41	42	43	43
Neglected tropical diseases	27	24	20	19	20
Department of Social Welfare	14	15	17	21	23
Ophthalmology	5	5	4	3	3
Nutrition*	4	5	5	5	6
Health promotion	4	4	4	2	2
Alternative and traditional medicine	1	0.4	0.4	0.3	0.3
Subtotal (TZS billion)	2,054	2,112	2,214	2,366	2,481

Health systems					
Human resources	740	807	879	948	1,034
Infrastructure	590	610	574	548	565
Logistics	388	414	440	469	509
Governance	117	119	124	120	134
Health financing	92	34	51	78	74
Health information systems	33	35	76	54	63
Subtotal (TZS billion)	1,959	2,020	2,145	2,217	2,377
Grand total (TZS billion)	4,013	4,133	4,359	4,582	4,859
Grand total (US$ million)	1,942	2,000	2,110	2,218	2,352
US$ per capita	36	36	37	38	40

Appendix 4: HSSP IV and UHC progress indicators

Indicator	2010	2015	2018	HSSP IV 2010 target
Reproductive, maternal, newborn and child health				
Contraceptive prevalence rate for currently married women 15¬–49 years (%)	27%	32%	N/A	CPR = 45
Percentage of women 15–19 years who have begun childbearing	22.8	21	20.8 (TMIS, 2017)	-
Women with at least 4 ANC visits	42.7	51	61 (DHIS, 2018)	80
Percentage of women delivering in a health facility	50.2	63	77 (DHIS, 2018)	80
Percentage of women attended by a skilled provider during delivery	50.6	64	77 (DHIS,2018)	80
Emergency obstetric services: facilities that can provide BEMONC (%)	5% (HSSP III)	25% (EMOC Survey, 2015)	BEMONC – 20% of dispensaries and 39% of HC; 81% of hospitals (SARA, 2017)	70% (HC and Dispensaries); 100% (Hospitals)
Postnatal care within 48 hours: Women Newborns	30.8% N/A	34% 42%	66% 65%	60% 80%
Percentage of children 12–23 months received pentavalent vaccine	88%	89%	91% (DHIS, 2018)	90%
Children fed in accordance with IYFC practices	21%	9%		-
Infectious diseases				
Children <5 years with recent fever treated with ACT	36.8% (TMIS, 2012)	85% (TDHS, 2015)	89% (TMIS 2017)	80%
Percentage of household population sleeping under a treated net Children < 5 years Pregnant women	75% 72%	54% 54%	55% 51%	80%

PMTCT				
HIV prevalence (15 years +)	5.1 (THMIS, 2011/12)	4.9 (THIS, 2016)	5.0 (TA-CAIDS, 2018)	
HIV prevalence in adolescents and young adults 15–19 years 20–24 years	1.0 3.2	0.7% 2.2% (THIS, 2016)	N/A	0.8% and 2.4% by (2017, NACP)
ART coverage Adults Children	37.5 (adults and children, NACP)	65% (NACP) 25% (NACP)	75% (All NACP, 2018) 47% (NACP, 2018)	95% 80%
PMTCT (pregnant women tested for HIV during ANC and received results)	85%	91%	N/A	90%
TB case detection rates	N/A	36% (NTLP, 2014)	50% (NTLP 2018);	72%
Noncommunicable diseases				
Obesity (adults) Females Males	15% 2.5% (WHO STEPS, 2012; 25–64 years)	11% 3% (WHO; 2016, 18+ years)	N/A	No increase
Smoking (adults)	14% (WHO STEPS, 2012; 25–64 years)			-
Raised blood pressure (adults)	26%	21%	N/A	25% reduction
Service capacity and access				
MO/AMO/10,000	0.7 (HMIS, 2004-5)	0.9 (HRHIS, 2012)	Total 0.88 (DHIS,2018)	-
Nurse midwives/10,000	4 (2011)	5 (2014)	6.2 (2018)	7
Annual outpatient visits per capita	0.69 (HMIS,2012)	0.92 (DHIS 2015)	1.06 (DHIS 2017)	-
Health facilities without stock-out of 10 tracer medicines (including 1 vaccine)	(Indicator was 4 tracer drugs and 1 vaccine)	86.6% (DHIS 2014)	95.9% (DHIS2, 2018)	-
Facilities with 3 star or higher rating	N/A (baseline star rating assessment in 2015)	2% (Star rating assessment 2015/16)	19% (star rating assessment 2017/18)	50%

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