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James White, Barbara O'Hanlon, Grace Chee, Emmanuel Malangalila, Adeline Kimambo, Jorge Coarasa, Sean Callahan, Ilana Ron Levey, and Kim McKeon

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1 2 3 4 16 15 14 13

World Bank Studies are published to communicate the results of the Bank's work to the development community with the least possible delay. The manuscript of this paper therefore has not been prepared in accordance with the procedures appropriate to formally edited texts.

ISBN (paper): 978-1-4648-0040-5
ISBN (electronic): 978-1-4648-0042-9
DOI: 10.1596/978-1-4648-0040-5

Cover photo: Dr. Frank Lyaruu and an assistant review lab work at his private facility in Arusha, Tanzania. © Sean Callahan

Library of Congress Cataloging-in-Publication Data

White, James, 1980- author.
Private health sector assessment in Tanzania / James White, Barbara O'Hanlon, Grace Chee, Emmanuel Malangalila, Adeline Kimambo, Jorge Coarasa, Sean Callahan, Ilana Ron Levey, and Kim McKeon.
p.; cm. — (World Bank studies)
Includes bibliographical references.
ISBN 978-1-4648-0040-5 (alk. paper) — ISBN 978-1-4648-0042-9
I. World Bank, issuing body. II. Title. III. Series: World Bank studies.
[DNLM: 1. Delivery of Health Care—Tanzania. 2. Private Sector—Tanzania. 3. Quality Assurance, Health Care—Tanzania. W 84 HT3]
RA399.T34
362.109678—dc23 2013022868

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Acknowledgments

The assessment team is very grateful for the continued support from the Tanzania Ministry of Health and Social Welfare and the Tanzanian Public-Private Partnership Technical Working Group (PPP-TWG). In particular, the team would like to thank Permanent Secretary Regina Kikuli, Dr. Edwin Mung'ong'o, Dr. Kiangi, Mariam Ally, and Dr. Mariam Ongara for their assistance and support throughout the assessment process. The team would also like to thank Dr. Adeline Kimambo and Dr. Emmanuel G. Malangalila for their contributions in the preparation and stakeholder interview stages of the assessment, as well as Erick Msoffe for his coordination of logistics during the assessment. Numerous individuals gave of their time to provide information through key informant interviews. We are extremely grateful for the input and insight we received from individuals at various ministries, health facilities, and organizations, including the following:

- National Government: Ministry of Health and Social Welfare, PPP-TWG, Quality Assurance Unit, Health Financing TWG, Tanzania Commission on AIDS (TACAIDS), Pharmaceuticals, Commodities, Infrastructure and Food Safety TWG, Reproductive and Child Health Vertical Program, National Malaria Control Program, National AIDS Control Program
- Regional Government: Coast Region Regional Health Management Team (RHMT), Kibaha Rural Council Health Management Team (CHMT), Kibaha Township CHMT, Mkuranga CHMT, Arusha RHMT, Arusha CHMT, Kilimanjaro RHMT, Moshi CHMT
- Director General Dr. Marina Njelekela of Muhimbili National Hospital
- Medical Council of Tanzania
- Nurses Council of Tanzania
- Private Nurses and Midwives Association of Tanzania
- Medical and Laboratory Scientists Association of Tanzania
- Pharmacy Council of Tanzania
- Tanzania Food and Drugs Authority
- Tanzania Medical Stores Department
- Association of Private Health Facilities in Tanzania (APHFTA) and APHFTA Northern Zone

- Mission for Essential Medical Supplies and Services
- Tanzania Christian Social Services Commission
- Health center staff from numerous private sector facilities
- Nongovernmental and civil society organizations
- Doctors in private practice
- Private pharmacies
- Private insurance companies
- Private health care businesses
- Medical training institutions

Abbreviations

ACT	Artemisinin-based Combined Therapies
ADDO	Accredited Drug Dispensing Outlet
AIDS	Acquired Immune Deficiency Syndrome
AIS	AIDS Indicator Survey
AMFm	Affordable Medicines Facility—malaria
AMIH	Action Medeor International Healthcare
ANC	Antenatal Care
APHFTA	Association of Private Health Facilities in Tanzania
ART	Antiretroviral Therapy
ARV	Antiretroviral
BAKWATA	National Muslim Council of Tanzania
CBO	Community-Based Organization
CCHP	Comprehensive Council Health Plan
CHAI	Clinton Health Access Initiative
CHF	Community Health Fund
CHIF	Community Health Insurance Fund
CHMT	Council Health Management Teams
CIDA	Canadian International Development Agency
CIDR	Center for Development and Research
CPD	Continuing Professional Development
CSO	Civil Society Organization
CSR	Corporate Social Responsibility
CSSC	Christian Social Services Commission
CTC	Counseling and Testing Center
DCA	Development Credit Authority
DDH	Designated-District Hospitals
DHS	Demographic and Health Survey
DLDB	Duka La Dawa Baridi (Private Drug Shops)
DMO	District Medical Officer

DOTS	Directly Observed Therapy, Short course
ELCT	Evangelical Lutheran Church in Tanzania
FBO	Faith-Based Organization
GDP	Gross Domestic Product
GOT	Government of Tanzania
H/PPP	Public-Private Partnerships for Health
HC	Health Center
HERA	Health Research for Action
HESLB	Higher Education Student Loan Board
HIV	Human Immunodeficiency Virus
HKMU	Herbert Kairuki Memorial University
HRH	Human Resources for Health
HSA	Health System Assessment
HSSP III	Health Sector Strategic Plan III
IFC-HIA	International Finance Corporation—Health in Africa
ILO	International Labor Organization
IMAI	Integrated Management of Adolescent and Adult Illness
ITN	Insecticide-Treated Net
LGA	Local Government Authority
LLITN	Long-Lasting Insecticide-Treated Net
M&M	Morbidity and Mortality
MAT	Medical Association of Tanzania
MCH	Maternal and Child Health
MEMS	Mission for Essential Medical Supply
MLSA	Tanzanian Medical Laboratory Scientists Association
MMAM	Mpango wa Maendeleo ya Afyaya Msingo (Primary Health Care Service Development Program)
MMTSP	Second Malaria Medium-Term Strategic Plan
MOEVT	Ministry of Education and Vocational Training
MOF	Ministry of Finance and Economic Affairs
MOH	Ministry of Health
MOHSW	Ministry of Health and Social Welfare
MOSTHE	Ministry of Science, Technology, and Higher Education
MOU	Memorandum of Understanding
MSD	Medical Stores Department
MSH	Management Sciences for Health
MUHAS	Muhimbili University of Health and Allied Sciences
NACP	National AIDS Control Program

NACTE	National Council for Technical Education
NGO	Nongovernmental Organization
NEML	National Essential Medicines List
NHA	National Health Accounts
NHIF	National Health Insurance Fund
NIMR	National Institute of Medical Research
NMCP	National Malaria Control Programme
NMSF	National Multi-Sectoral Strategic Framework on HIV/AIDS
NPPPSC	National PPP Steering Committee
NSGRP	National Strategy for Growth and Reduction of Poverty
NSSF	National Social Security Fund
OOP	Out-of-Pocket
OI	Opportunistic Infection
PCR	Polymerase Chain Reaction
PEPFAR	President's Emergency Plan for AIDS Relief
PFP	Private For-Profit
PMO-RALG	Prime Minister's Office—Regional Administration and Local Government
PMTCT	Prevention of Mother-to-Child Transmission
PMTI	Private Medical Training Institute
PNFP	Private Not-For-Profit
PO-PSM	President's Office—Public Service Management
PPD	Public-Private Dialogue
PPP	Public-Private Partnership
PPP-TWG	Public-Private Partnership Technical Working Group
PRINMAT	Private Nurses and Midwives Association of Tanzania
PSA	Private Health Sector Assessment
PSU	Pharmaceuticals and Supplies Unit
RCH	Reproductive and Child Health
RHMT	Regional Health Management Team
RMO	Regional Medical Officer
SCMS	Supply Chain Management System
SHIB	Social Health Insurance Benefit
SHMH	Shree Hindu Mandal Hospital
SHOPS	Strengthening Health Outcomes through the Private Sector
SLA	Service-Level Agreement
SME	Small and Medium Enterprises
SSRA	Social Security Regulatory Authority

TACAIDS	Tanzania Commission on AIDS
TB	Tuberculosis
TC-SWAp	Technical Committee of the Sector Wide Approach
TCU	Tanzania Commission for Universities
TFDA	Tanzania Food and Drug Authority
THE	Total Health Expenditures
THE_{CH}	Total Health Expenditures Child Health
THE_{HIV}	Total Health Expenditures HIV/AIDS
$THE_{MALARIA}$	Total Health Expenditures Malaria
THE_{RCH}	Total Health Expenditures Reproductive and Child Health
THE_{RH}	Total Health Expenditures Reproductive Health
TIC	Tanzanian Investment Corporation
TIKA	Tiba Kwa Kadi (urban form of Community Health Fund)
TNBC	Tanzania National Business Council
TNCHF	Tanzania Network of Community Health Funds
TPI	Tanzania Pharmaceutical Industries
TPSF	Tanzania Private Sector Foundation
T Sh	Tanzanian Shilling
TWG	Technical Working Group
VAT	Value Added Tax
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

Executive Summary

Country Context

Tanzania exemplifies the developing world's struggle to achieve "middle-income" country status while confronting widespread poverty and substantial health challenges—such as persistently high child and maternal mortality, human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS), tuberculosis (TB), and malaria. Over 74 percent of mainland Tanzania's 41.9 million people live in rural areas where, despite strong national economic growth over the past decade, income levels remain among the lowest in Africa and an estimated one-third of Tanzanians live in abject poverty. Stable leadership, strong political will, significant international donor support, and Tanzania's standing as one of the fastest growing economies in East and sub-Saharan Africa (with a five-year average real gross domestic product (GDP) growth rate of 6.9 percent 2006–11)—have not translated into improved health or social outcomes for the average Tanzanian. Malaria remains a leading cause of morbidity and mortality, costing an estimated US$240 million every year in lost GDP. An HIV/AIDS prevalence rate of approximately 5.6 percent among adults aged 15–49 years translates into an estimated 1.4 million people living with AIDS—with an additional 105,000 new infections and 85,900 AIDS-related deaths annually. High infant and under-five mortality (50/1,000 and 108/1,000, respectively), only three in 10 mothers receiving postnatal care, and a consistently high maternal mortality rate of 454 out of every 100,000 live births suggest substantial barriers to health access and effective service delivery. However, despite these challenges, the Government of Tanzania (GOT)—now implementing its Health Sector Strategic Plan (HSSP) III (2009–15)—has made strides in improving the delivery of essential health services. HIV prevention efforts have reduced prevalence from 7.3 percent in 2000 to 5.6 percent in 2009; prevention of mother-to-child transmission coverage was estimated at close to 59 percent in 2011; and a strong multipronged malaria prevention and treatment strategy has significantly improved access to first-line malaria therapy throughout the country.

In seeking to sustain and intensify these gains, the GOT has become a regional leader in acknowledging the benefits of leveraging private health sector capacity

and resources to address national health challenges and realize the objective of country-owned health responses. However, despite a relatively well-developed policy environment for public-private collaboration in health, the process and methods for operationalization of private sector engagement and public-private partnership (PPP) are not well known. This has significantly limited actual implementation of public-private collaboration within the health system, with continuing missed opportunities to strengthen Tanzania's health system through enhanced engagement and mobilization of private sector resources in health.

Purpose of the Assessment

In this context, Tanzania's National PPP Policy and HSSP II included a call for a private health sector assessment. Accordingly, following a regional technical exchange in Mombasa, Kenya, Tanzania's Public-Private Partnership Technical Working Group (PPP-TWG) requested that the Health in Africa (HIA) initiative of the International Finance Corporation (IFC) conduct an assessment of the private health sector in mainland Tanzania. Given a history of collaboration between HIA and the USAID-funded project Strengthening Health Outcomes through the Private Sector (SHOPS), which has included holding regional technical workshops on private sector engagement that have drawn representatives from over 14 African countries, HIA engaged SHOPS to lead the effort. With funding support from HIA and the USAID Office of HIV/AIDS, SHOPS assembled a nine-person assessment team composed of health system experts from IFC, SHOPS, USAID, and local stakeholder organizations.

Adopting Tanzania's relatively well-developed PPP policy framework as the basis for a preparatory dialogue, USAID/Tanzania and the PPP-TWG underscored the importance of highlighting the challenges that limit private sector involvement in health and inhibit PPP reforms, with the ultimate purpose of assisting the PPP-TWG and other stakeholders in developing a prioritized agenda for more effective private health sector engagement and PPP-focused health sector reforms within the context of the Tanzanian health system. The broad focus of the assessment was the status of existing PPPs within the Tanzanian health system, with specific attention also to the opportunities for operationalizing improved private health sector engagement in the key health areas of HIV/AIDS, malaria, TB, and reproductive and child health (RCH)—specifically related to the policy-making process, health financing, and service delivery.

Methodology

The private health sector assessment (PSA) team comprised four health systems and private sector experts representing the SHOPS project and HIA initiative. Additionally, two Tanzanian health system experts were involved during the preparatory, data collection, and analysis phases of the assessment. A comprehensive desk review of existing literature, combined with secondary analysis of Demographic and Health Survey, AIDS Indicator Survey, and National Health Accounts data,

were conducted in order to promote efficiency and inform the assessment focus and strategy prior to the initiation of field work in country. From May 21 to June 1, 2012, the PSA team conducted key stakeholder interviews in mainland Tanzania with over 160 individuals from nearly 90 different organizations representing the public, private for-profit (PFP), and private not-for-profit (PNFP) sectors. The team conducted interviews at facilities at all levels of the health system, as well as with private sector umbrella organizations, government bodies and officials, faith-based and nongovernmental organization (FBO/NGO) leadership, private insurance companies, and a wide range of additional stakeholders. Interviews were conducted in four regions—Dar es Salaam, Pwani, Arusha, and Kilimanjaro—in order to gather a wide range of perspectives, validate existing information, and provide a comprehensive assessment of public-private engagement opportunities. Focal areas included the policy and enabling environment in relation to the following key functions: enhancing a private sector role in health, private health sector service delivery, private sector human resources for health (HRH), access to essential pharmaceutical and medical commodities, and the role of the private sector in health financing. Findings from each of these health system components were taken into account in developing recommendations for enhancing operationalization of PPPs in Tanzania's health system. While each private health sector area provides specific recommendations for increased private health sector engagement, the PSA ultimately proposes strategic, prioritized recommendations to assist the PPP-TWG, GOT, and other key stakeholders in moving toward operationalization of PPPs within the health system. The strategic recommendations are prioritized according to three levels of private sector engagement: (P1) Public-Private Interaction, (P2) Public-Private Dialogue, and (P3) Public-Private Partnership.

The Tanzanian Private Sector Landscape

Composed of a diverse range of both for-profit and not-for-profit organizations, the private health sector in Tanzania is making significant contributions across all health sector levels and health focal areas within the national health system. Despite this, the full scope of private health sector activity and contributions to health are typically excluded, or minimally represented, in assessments and evaluations of the health system. When one looks at the full scope of private sector activities beyond service delivery—including medical training, commodity supply, and health financing—a more realistic image emerges of a Tanzanian private health sector that is diverse, widespread, and complex. Over one-third of the general health services available in the country could be accessed through private sector health facilities, FBOs, and other not-for-profit facilities; these have become a critical extension of health services into rural and hard-to-reach areas. Moreover, a wide range of private facilities provide key supportive diagnostic and pharmaceutical dispensing services. Despite these contributions, a large portion of the private health sector has not been effectively engaged or included in national health planning processes. In particular, it is not effectively considered or involved in the creation of Comprehensive Council Health Plans (CCHP) at the district level or in vertical program planning efforts. The PSA seeks to provide a more accurate landscape of private sector

presence and activity in Tanzania's health system, revealing the significant opportunities that exist to further leverage private health sector capacity in strengthening accessibility and delivery of essential health services.

Key Findings and Recommendations

The assessment has revealed significant opportunities—in both the short and long term—to more effectively leverage private health sector capacity and resources to address Tanzania's urgent health challenges. Findings and recommendations from each of the assessment areas are presented below. The final section of the report presents strategic priorities that aim to assist the GOT and PPP-TWG in strategically engaging the private health sector for rapid health gains and more long-term sustainable health system reform.

Policy and Enabling Environment to Mobilize the Private Sector in Health

Effective mobilization of the private health sector for improved health outcomes requires a policy and operating environment that enables strong public-private dialogue, interaction, and cooperation, and ultimately health system partnership. The policy and enabling environment section of this assessment looked at the historical context for PPPs in health—including relevant legislation and policy reforms in Tanzania's economic liberalization—as well as the existing policy environment guiding private sector involvement in the health sector. As one of the first governments in the region to create a comprehensive policy framework encouraging a greater role for the private sector in health, Tanzania is a pioneer in working with the private health sector. The creation of the Ministry of Health and Social Welfare's (MOHSW's) PPP-TWG is also a demonstration of the GOT's commitment to promoting dialogue and development of public-private collaboration in health. However, strong political will, the creation of a conducive national policy environment for PPPs, and a comprehensive legal and regulatory environment supporting the private health sector have not translated so far into effective operationalization of PPPs for health at lower levels of the health system. Sensitization of local government authorities (LGAs) on the utility and process of PPP implementation at district and facility level is a known and expressed priority for the next phase of PPP operationalization in Tanzania's health system.

Key findings and recommendations in the policy and enabling environment for the private sector in health are as follows:

Findings	*Recommendations*
• There is political commitment at all levels of the Tanzanian government supporting PPPs	• Strengthen national capacity to effectively regulate, supervise, and assure quality of public and private health sector services
• There is a comprehensive legal and regulatory environment supporting the private health sector	• Address barriers to private health sector access to affordable finance
• The PPP Unit is underresourced for its mandate and scope to engage the private sector	• Target and harmonize incentives for private providers delivering essential health services

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Findings	*Recommendations*
• There are significant market barriers limiting private health services, including limited access to finance • The absence of a sectorwide public-private dialogue (PPD) forum in health inhibits effective multisectoral dialogue on health system issues	• Establish and strengthen key public and private sector institutions and processes that will elevate and promote effective sectorwide PPD. These include strengthening linkages between MOHSW and PMO-RALG, building the PPP Unit's capacity, and creating an umbrella organization for the private health sector • Strengthen information sharing and networking at all levels

Service Delivery in the Private Health Sector

Strong service delivery systems must aim to ensure that high-quality, reliable, and accessible health services are consistently provided at all levels and in all regions of the health system. In Tanzania, a wide range of facilities managed by the private sector (both for-profit and not-for-profit) are making significant contributions in enhancing the coverage and quality of both basic and specialist health services. In particular, FBOs and NGOs have been critical in extending the reach of government health service provision into rural or hard-to-reach areas. Across mainland Tanzania, PFP and PNFP facilities account for 11.2 and 19.9 percent of total health expenditures made at health facilities respectively. In addition, private sector facilities and community-based organizations are becoming an increasingly important source of HIV/AIDS, TB, malaria, and RCH services in both urban and rural settings. PFP facilities are especially active in the provision of family planning commodities, providing 27 percent of national services. PFP facilities are also important sources of diarrhea and malaria treatment, accounting for 20 and 24 percent of services respectively. PNFP facilities are more active in antenatal care and HIV counseling and testing, providing 9 percent and 13 percent of national services, respectively. However, while larger facilities and private sector apex organizations are represented in national-level TWGs and forums, at the district and facility level private sector entities are less frequently included in planning and coordination, often dependent upon the motivations and perspectives of local health leadership. Opportunities exist to strengthen the private health sector's involvement in collaborative planning, service delivery coordination, information exchange, and effective continuity of referral between the sectors in the interest of improved service delivery throughout the health system.

Key findings and recommendations for service delivery in the private health sector are as follows:

Findings	*Recommendations*
• Available private health sector infrastructure and service delivery capacity not fully utilized • Limited and inconsistent communication between the public and private health sectors is limiting effective service delivery coordination	• Make dialogue with the private sector routine LGA/Council Health Management Teams business • Increase private sector training opportunities on key health services • Increase public-private attachment and shared CPD opportunities

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Findings	*Recommendations*
• Weak service delivery reporting from the private sector/lack of report-back from the public sector contributes to weak dialogue and distrust between public and private service providers • nadequate access to continuing professional development (CPD) and other training opportunities is limiting the expansion of private health sector service delivery • There are significant missed opportunities to harmonize diagnostic equipment across public and private sectors • Overhead costs and price of nonessential commodity inputs limits the incentive to expand private health service baskets • Increased involvement and investment of corporate actors is needed in Tanzania's health system	• Support the Tanzanian Medical Laboratory Scientists Association to facilitate the coordination and harmonization of multisectoral diagnostic/equipment use • Pursue opportunities for increased PPP in the provision of nonclinical health facility services. This could include, for example, facility waste disposal, security, catering, and cleaning services

Private Sector Human Resources for Health (HRH)

A strong health workforce is critical to ensure the consistent availability of high-quality and reliable health services. The assessment revealed that despite widespread recognition of this health system priority, mainland Tanzania faces a severe HRH crisis with significant deficits—both in terms of quantity and quality—in almost all health sectors and professional cadres. This is particularly true in rural areas and in the private health sector. Private health facilities—largely responsible for their own HRH plans and management—are disconnected from the MOHSW's HRH strategic plans and coordination efforts. In addition, acute financial challenges, saturated enrollment capacity, infrastructure challenges, and teaching resource limitations have all weakened the ability of private medical training institutes (PMTIs) to enroll and graduate additional health professionals. The HRH and PMTI situation in Tanzania is an important element constraining the expansion of private health sector involvement and contribution to the Tanzanian health system.

Key findings and recommendations in the area of private sector HRH are as follows:

Findings	*Recommendations*
• The national HRH shortage is compounded in the private sector by "brain drain" to the public sector • PNFP and PFP employees are often unable to participate in CPD opportunities • Private health sector personnel are not included and/or leveraged as part of LGA HRH planning • PMTIs experience significant constraints that weaken their ability to train new health workers • There are significant barriers to entry for the growth of new PMTIs	• Develop a mechanism for joint public-private HRH planning as part of each LGA's Comprehensive Council Health Planning (CCHP) process • Expand opportunities to second public sector staff to PFP facilities • Incorporate PMTIs in broad private health sector strengthening efforts

Access to Essential Pharmaceutical and Medical Commodities

Ensuring that health service providers have consistent access to high-quality medical products and pharmaceutical commodities is an imperative component of a functional and effective health system. Tanzania's central medical stores department (MSD) is meant to operate as an independent parastatal organization, ensuring consistent access to high-quality, safe, and affordable pharmaceutical commodities. However, reported challenges such as overly bureaucratic tendering and procurement systems, weak postmarket surveillance, frequent MSD stock-outs, and facility-level disruptions to the supply chain are all limiting dependable provision of safe and affordable medicines. Both PFP and PNFP facilities face significant challenges in ensuring consistent and efficient access to pharmaceuticals and other medical products, notably including reports of "excessive" retail mark-ups via private wholesalers. Supply chain efficiencies throughout the health system can be improved by strengthening MSD's capacity to provide reliable procurement options to government-affiliated FBO/NGO facilities, and by providing safe and more affordable procurement channels to PFP facilities.

Key findings and recommendations in the area of access to essential pharmaceutical and medical commodities are as follows:

Findings	*Recommendations*
• Drug prices high relative to other markets • Frequent MSD stock-outs lead to rationing and disruption of supply chain in both public and private sectors • Public sector often relies on private supply during stock-outs • There are too many wholesalers and distributions and too few areas served • There is a weak relationship between private wholesalers and Tanzania Food and Drug Authority (TFDA) • Poor postmarket surveillance has led to private sector drug supply of questionable quality	• Conduct a market survey of the entire pharmaceutical sector • Catalyze industry consolidation through licensing requirements for wholesalers and distributors • Explore private sector pooled procurement and/or bulk purchasing through newly incorporated MEMS • Assist public facilities to procure drugs through private sector during stock-outs • Support the creation of management body supporting ADDOs • Strengthen TFDA's postmarket surveillance capacity • Pursue opportunities to increase Pharma representation on PPP policy forums

The Role of the Private Sector in Health Financing

Adequate financing, as well as appropriate utilization, pooling, and allocation of funding, are critical components to ensuring accessibility to high-quality health care. The assessment examined current trends in Tanzania's health expenditures and health financing, exploring whether there is a potentially larger role for private providers within the current financing structure in the pursuit of public health goals. Donors remain the largest source of financing for health in Tanzania, with contributions provided through general budget support, a health sector

basket fund, and direct program financing (including off-budget financing). Increasing the utilization of health financing mechanisms such as insurance, as well as of contracting and purchasing arrangements such as service-level agreements, may help to reduce donor dependency and promote the sustainability of Tanzania's health system. Using appropriate purchasing and payment policies within insurance schemes such as Tanzania's National Health Insurance Fund, Social Insurance Benefit, Community Health Funds (CHF), and private insurers could also significantly expand opportunities for private health sector contributions to public health goals, while reducing inequity in health spending.

Key findings and recommendations on the role of the private sector in health financing are as follows:

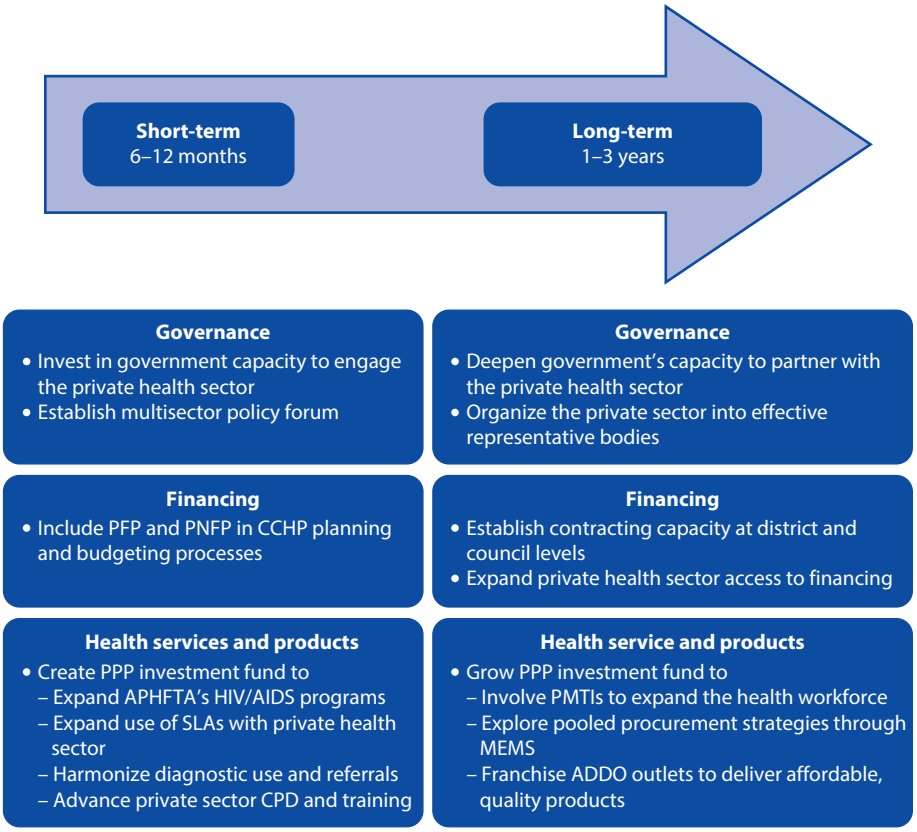
Findings	*Recommendations*
• A notable percentage of Tanzanians seek health care in the private sector • Councils have not fully considered private providers in their budget allocations • Service agreements are underutilized • Exemption policies are not uniformly applied and do not meet their objectives • Insurance coverage can decrease inequities in health spending • Insurance schemes support public and private providers • Overall, health insurance sector is not well coordinated • CHF is not achieving intended results	• Develop a coherent financing policy that minimizes financial barriers to care, with defined roles for NHIF, SHIB, and CHF • Increase the GOT's use of service-level agreements • Revise the exemption policies to ensure they meet objectives • Ensure transparent dissemination of costing findings • Partner with private insurers to educate the public on benefits of health insurance

Strategic Priorities

The vision of a Tanzania in which all citizens enjoy positive health outcomes, maintained by a resilient and well-functioning health system, can be actualized through strategic public-private cooperation. This report proposed specific recommendations for increasing private sector engagement in different components of the Tanzanian health system. The GOT, development partners, and other local stakeholders are free to consider and implement any of these recommendations to strengthen the private sector role in delivering essential health products and services. The PSA Team prioritized the recommendations from the comprehensive list for each health system building blocks to develop a set of strategic priorities that will foster better public-private collaboration and expand access to quality, affordable health care through the private sector. The strategic priorities are organized by critical health system building blocks: governance, health financing, and health services/products. The team also identified actions that can produce results in the short term (6–12 months) while considering more long-term system changes that will require more time to deliver impact. Figure ES.1 provides an overview of short- and long-term strategic priorities. (For

a prioritized list of recommendations as voted by local stakeholders, please refer to appendix B.)

Figure ES.1 Short- and Long-Term Strategic Priorities



Source: World Bank data.

Governance: Short-Term Actions

Recommendation #1: Invest in MOHSW's Capacity to Engage the Private Health Sector

Invest in the MOHSW to strengthen the PPP unit's capacity, to enable the initial mobilization of PPPs for health while laying the groundwork for necessary, long-term investments in building operating systems and new expertise. Specific activities involve formalizing the PPP Unit mandate, building the capacity of the PPP Unit and Department of Policy and Planning, and implementing a new communication strategy to engage the private health sector.

Recommendation #2: Establish a Multisectoral Forum that Promotes Effective Sectorwide PPD

Formally establish the National PPP Steering Committee as a sector-wide forum, to create a space for all private health sector groups to discuss health system

issues that directly impact their constituencies. This can motivate key subsectors to organize themselves and enable the private health sector to participate in national forums.

Governance: Long-Term Actions

Recommendation #3: Deepen Government's Capacity to Partner with the Private Health Sector

Build on the short-term investments in the PPP Unit to create formal operating systems and greater capacity within the MOHSW to broker and manage PPPs. Specific activities include developing a formal *Operations Manual* that outlines the PPP Unit's policies and procedures and building knowledge on PPPs in health.

Recommendation #4: Organize the Private Health Sector into Effective Representative Bodies

Success of the health PPD forum is contingent upon an organized private sector with strong representative member organizations to participate. Consolidating the private sector will include both (1) assisting private health sector segments to form umbrella organizations and (2) strengthening existing but still developing associations in the private health sector (for example, Private Nurses and Midwives Association of Tanzania (PRINMAT), National Muslim Council of Tanzania (BAKWATA)).

Health Financing: Short-Term Actions

Recommendation #5: Increase PFP and PNFP Involvement in CCHP Processes

The MOHSW should further invest in the PPP Unit's efforts to orient regional-, district-, and council-level management teams toward the private sector. Equipping regional, district, and council management to involve all stakeholders in planning and budgeting through the CCHP process and in quarterly monitoring meetings creates an annual strategy that leverages all available health resources and highlights opportunities for increased PPP and multisectoral collaboration to meet key district health challenges.

Health Financing: Long-Term Actions

Recommendation #6: Establish Capacity at the Decentralized Level to Purchase and/or Partner with the Private Health Sector

The MOHSW PPP Unit can strengthen LGA purchasing of services through PFP and PNFP facilities as a way to both strengthen the national service delivery network and provide enhanced health consumer choice. Wide dissemination of trainings is needed to enhance councils' and private sector stakeholders' knowledge of purchasing agreements.

Recommendation #7: Expand Private Sector Access to Finance (Particularly to Upgrade Facilities)

Private sector facilities seeking to expand their service baskets often fail initial facility and infrastructure inspections—requiring financial investments in facility

upgrades that most are not able to provide. By assisting the Association of Private Health Facilities in Tanzania (APHFTA) to develop private health sector financial management capacity, and by working with financial lenders to better understand private health sector lending, there are opportunities to provide private health providers with enhanced access to finance opportunities for improvement/expansion of service delivery.

Health Services and Products: Short-Term Actions

Recommendation #8: Manage and Scale Up PPPs in the Health Sector (Short-Term)

The ultimate success of the PPP Unit and PPP-TWG will be successful public-private collaboration to implement PPPs to improve health service delivery and strengthen the health system. The PSA team recommends pursuing several short-term PPP proposals that will support concurrent PPP dialogue and coordination strengthening efforts. These short-term efforts include expanding APHFTA's HIV/AIDS programs; expanding the use of service-level agreements with the private health sector; harmonizing multisectoral diagnostic use and referral; and advancing private sector CPD and training opportunities.

Health Services and Products: Long-Term Actions

Recommendation #9: Involve and Coordinate with PMTIs to Expand the Health Workforce

Provide PMTIs with technical assistance on business management, support financial institutions in conducting market research for potential medical loan expansion, and partner PMTIs with public facilities to expand private student practicum opportunities, in order to utilize PPPs to strengthen PMTI expansion of the health workforce.

Recommendation #10: Manage and Scale Up PPPs in the Health Sector (Long-Term)

Beyond the short-term recommendations stated above, there are several other PPPs that the PPP Unit and PPP-TWG should pursue to strengthen the delivery of health services and products. These include pursuing private sector pooled procurement strategies through MEMS or other secondary supply channels, and improving the viability and sustainability of ADDO outlets.

Conclusion

The intent of this private health sector assessment is to support the GOT, the PPP-TWG, and other key stakeholders in enhancing public-private engagement at all levels of the Tanzanian health system. Through providing a more accurate description of current private health sector contributions to health, and proposing actionable recommendations to address health needs in Tanzania through increased public-private collaboration, this assessment seeks to provide a "roadmap" for optimizing private sector inputs within the context of the overall health

system. The information contained in this report is intended to create opportunities for multisectoral dialogue, to enhance collaborative planning efforts, and ultimately to facilitate partnerships that lead to increased health systems efficiencies and sustained health services. Tanzania has already accomplished much in this area, with expressed commitment to partnership from stakeholders in both the public and private sectors, and a strong policy foundation to enable public-private collaboration. While considerable, the health challenges Tanzania faces are not insurmountable. By seizing existing partnership opportunities and fostering a health system that leverages the skills, resources, and talents of all health actors, the goal of delivering accessible and high-quality health care to all Tanzanians is achievable.

CHAPTER 1

Introduction and Methodology

Background

Many Tanzanians envision a country in which all its citizens can enjoy a right to positive well-being, protected against threats to their health throughout their lifetime. Given the substantial health challenges facing the country, making this vision a reality will require a collaborative health system that capitalizes on the resources and abilities of all health system actors, in order to effectively deliver and maintain high-quality, accessible, and reliable health care for every Tanzanian. The United Republic of Tanzania (comprising mainland Tanzania and the semi-autonomous Zanzibar Archipelago) exemplifies the struggle of many less developed countries to achieve "middle-income country" status while confronting widespread poverty as well as substantial health challenges—such as high child and maternal mortality, human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS), and malaria. As table 1.1 shows, Tanzania has one of the fastest growing economies in East and Sub-Saharan Africa—with a five-year average real gross domestic product (GDP) growth rate of 6.9 percent in 2006–11 (IMF 2010)—coupled with relatively low inequality, demonstrated by a World Bank GINI coefficient of 37.6. Nevertheless, it remains one of the poorest countries in the world, with a 2011 GDP per capita of US$456 (World Bank 2011a).[1] Strong political will, consistent economic growth, and substantial

Table 1.1 Economic and Health Development Indicators

Indicator	*Source of data*	*Tanzania*	*Year of data*	*Average value in Sub-Saharan Africa*	*Year of data*
GDP per capita (constant 2000 US$)	WDI-2011	456.14	2010	1,220.77	2010
GDP growth (annual percentage)	WDI-2011	6.98	2010	5.03	2010
Gini Index	WDI-2011	37.58	2007	42.30	2007
Per capita total expenditure on health at international dollar rate	WHO	68.00	2009	211.78	2009
Life expectancy at birth (years)	WDI-2011	56.59	2009	55.74	2009

Source: Health Systems 20/20 Database. Accessed July 16, 2012, from http://healthsystems2020.healthsystemsdatabase.org/datasets/CountryReports.aspx.
Note: GDP = gross domestic product; WDI = World Bank Development Indicators; WHO = World Health Organization.

international donor support have not translated into significant improvements for the average Tanzanian, and poor health outcomes continue to limit gains in economic and social development.

At the request of the Tanzanian Public-Private Partnership Technical Working Group (PPP-TWG), this assessment focuses on mainland Tanzania and does not reflect the situation in Zanzibar. In mainland Tanzania, the Government of Tanzania (GOT) currently faces considerable health challenges that significantly restrict social and economic progress. Malaria is a leading cause of morbidity and mortality, accounting for over 40 percent of outpatient visits (UNDP 2010) and costing an estimated $240 million every year in lost gross domestic product (Makundi et al. 2007). Infant and under-five mortality remain high (at 50/1000 and 108/1000 respectively), while chronic malnutrition stunts growth in 42 percent of children under five (WHO 2012). There remain substantial barriers to health access and effective service delivery, as indicated by the low percentage of births attended by skilled professionals (51 percent), low incidence of postnatal care (only three in 10 mothers) (DHS 2010), and a consistently high maternal mortality rate of 790 out of every 100,000 live births (WHO 2011a). In addition, Tanzania faces a considerable HIV/AIDS epidemic. With a population of approximately 41.9 million and an adult (15–49 years) prevalence of approximately 5.6 percent, there are an estimated 1.4 million people in mainland Tanzania living with HIV/AIDS—with 105,000 new infections and 85,900 AIDS-related deaths occurring annually (UNAIDS/WHO 2008). With approximately 74 percent of its population living in rural areas (NBS 2011), the GOT faces substantial barriers in the adequate provision of national health services, especially in the key health areas of malaria, HIV/AIDS, and reproductive and child health (RCH).

Context

National efforts to reduce these health burdens have been significant. The GOT is currently implementing the Health Sector Strategic Plan (HSSP) III (2009–15) (MOHSW 2009a), which was developed in line with the goals of the National Strategy for Growth and Poverty Reduction (MKUKUTA), the National Health Policy (MOHSW 2007b), and the Millennium Development Goals. HIV prevention efforts have led to a 23 percent reduction in HIV prevalence—from 7.3 percent in 2000 to 5.6 percent in 2009 (UNAIDS/WHO 2008). In addition, antiretroviral treatment (ART) coverage expanded by 82 percent between 2007 and 2009, and tuberculosis (TB) treatment completion rates improved to 87.1 percent by 2007. However, despite this progress, major challenges exist in sustaining and propelling health system improvements. Eighty-five percent of HIV/AIDS funding comes from external donors, reflecting a high level of donor dependency throughout the health system. Severe shortages in trained health personnel as well as inadequate capacity to train and retain health professionals limit the quality of both public and private services. In addition, the ongoing process of Decentralization by Devolution, while promoting extension of primary care services, stretches the ability of health managers to

coordinate between health system levels and has led to imbalances between well-resourced vertical programs (such as HIV/AIDS) and the rest of the health system (UNAIDS 2009).

Similar financial and technical health system challenges throughout the developing world have led to growing international recognition of the potential for the private health sector to contribute to increased access and improved quality of health services, through public-private cooperation. The Tanzanian government—a regional leader in this regard—developed a National Public-Private Partnership (PPP) Policy in 2009 and is working on a Strategic Plan to determine the overall direction of PPPs for improved health outcomes. In meeting the health goals outlined in the Tanzania Development Vision 2025—ensuring access to primary health care for all, reducing infant and child mortality, and increasing life expectancy to typical "middle-income" standards—the National Health Policy (2003) has emphasized "promoting and sustaining public-private partnerships in the delivery of health services" (MOH 2003). In a landscape of constrained public resources and declining donor funding for health, there is significant potential for the private health sector (both commercial for-profit and not-for-profit entities) to contribute to increased accessibility and improved quality of health services. The GOT has acknowledged this by encouraging the adoption of "diversified complementary health care financing options, which are sustained involving Public-Private Partnerships and other resources" (MOH 2003). Given that an estimated 40 percent of health facilities in Tanzania are owned by the private sector (commercial, faith-based, or not-for-profit) (MOHSW 2009b), more efficient utilization and inclusion of the private health sector presents a significant opportunity to strengthen the Tanzanian health system as a whole.

Assessment Purpose and Scope

Gathering information about the scope and quality of private sector actors and their contributions to health is a critical first step in establishing PPPs to improve the Tanzanian health system. An assessment of the private health sector was called for in Tanzania's National PPP Policy and HSSP III, and was proposed in the 2010 PPP Milestone under HSSP III and in the Technical Consultation on the Sector Wide Approach (TC-SWAp) process. In response to this priority, the GOT requested that the International Finance Corporation's (IFC's) Health in Africa (HIA) initiative conduct an assessment of the private health sector in mainland Tanzania; HIA subsequently engaged the USAID-funded Strengthening Health Outcomes through the Private Sector project (SHOPS) in this effort. But while the Tanzanian Ministry of Health and Social Welfare (MOHSW) as well as diverse private health sector actors have committed to strengthening PPPs for health, the actual process and status of operationalizing PPPs in Tanzania is not well understood. For this reason, the Private Health Sector Assessment (PSA) team's preparatory dialogue process with the PPP-TWG underscored the importance of conducting a private health sector assessment that would go beyond a

narrow "valuation" of the private health sector. Accordingly, the Tanzania PSA not only reports on the existing private health sector activities but also highlights the challenges involved in operationalizing PPP reforms. The ultimate purpose of the assessment exercise is to assist the PPP-TWG and other GOT stakeholders in developing a prioritized agenda for more efficacious private health sector engagement and PPP-focused health sector reforms in the Tanzanian health system.

In preparation for this assessment, the PSA team had frequent discussions with the Tanzanian PPP-TWG and USAID mission about the specific technical and health system areas to focus on. Based on the key health challenges in Tanzania, it was agreed that the assessment team would examine opportunities for improved private health sector engagement in the key health areas of HIV/AIDS, malaria, TB, and RCH, with particular attention to the policy making process, health financing, and service delivery.

To achieve the goal of promoting private health sector engagement and improved public-private collaboration, the scope of the PSA included the following:

1. Assessing the policy environment and existing dialogue processes for greater private sector engagement
2. Clarifying existing PPP interactions at different levels of the health system
3. Identifying, assessing, and evaluating opportunities for PPP arrangements to strengthen health service provision
4. Assessing private health sector capacity to conduct self-regulation
5. Recommendations for the operationalization and tracking of PPP implementation.

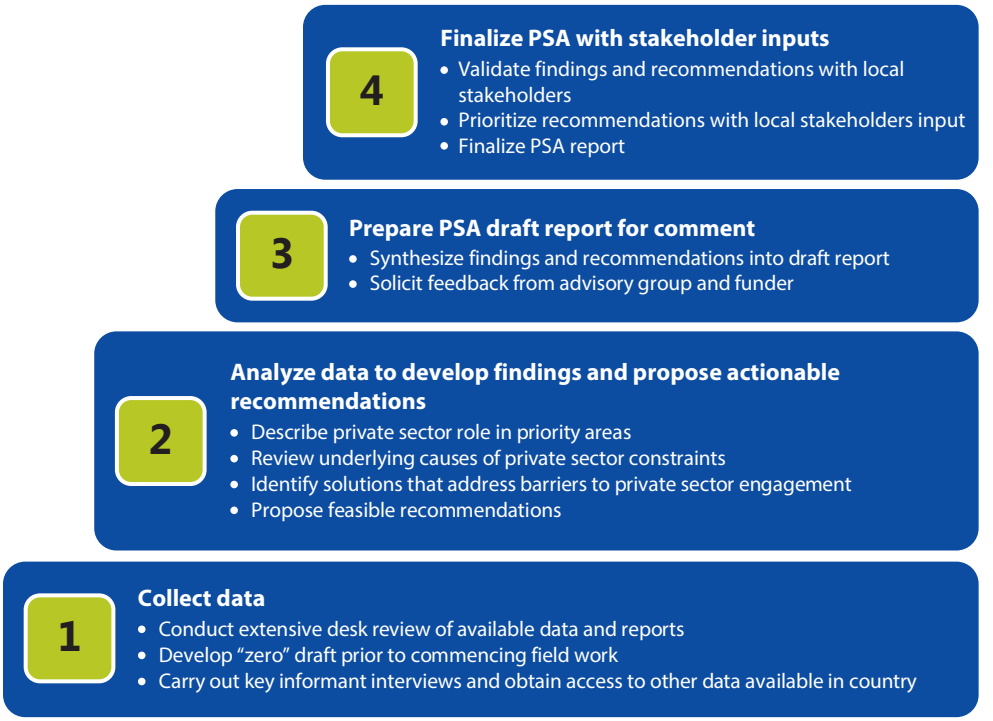
The PSA and subsequent dialogue process is an initiative of the PPP-TWG, as a collaborative venture including the MOHSW, other GOT representatives, members of the private health sector, and various donor partners. HIA and SHOPS have previously entered into successful partnerships to conduct regional technical exchanges with more than 14 African countries on how to engage the private sector, as well as conducting similar assessments in Kenya, Malawi, and Namibia.

Methodology

As figure 1.1 shows, a private health sector assessment consists of four steps: data collection, data synthesis and analysis, report preparation, and report finalization. All four steps emphasize collaboration and engagement with local stakeholders in order to ensure accuracy and buy-in for the key findings and recommendations.

In the case of Tanzania, the PSA team comprised four international private sector experts—staff from the USAID-funded SHOPs project and the IFC's HIA Initiative—and two Tanzanian experts, one with expertise on the Tanzanian public health sector and the other on the Tanzanian private health sector.

Figure 1.1 Steps in a Private Health Sector Assessment (PSA)



Source: World Bank data.

Step One: Collect Data

To better understand the current political, economic, and social landscape in Tanzania, the PSA team began with a background review of gray literature (that is, unpublished reports and government materials), published key policy documents, and previous studies on the private health sector and PPP arrangements in Tanzania. In addition, the PSA team conducted a secondary analysis of past surveys—including the past three Demographic and Health Surveys (DHS), AIDS Indicator Surveys (AIS), and National Health Accounts (NHA) report. This preliminary analysis and literature review provided an overview of the mainland Tanzanian health system as well as the key policies related to private health sector provision of care, current government plans to work with the private health sector, and existing health PPPs. Secondary analysis of the DHS, AIS, and NHA data provided a quantitative description of the general public's utilization of private health care providers. Together, these two streams of analysis provided a comprehensive picture of emerging issues within the private health sector, pointing to the key areas to focus on during the in-country stakeholder interviews.

Following the literature review, the PSA team travelled to Tanzania from May 21 to June 1, 2012, to conduct key stakeholder interviews in mainland Tanzania and to fill in information gaps and gauge stakeholders' willingness to engage in public-private dialogue. Using a key informant interview guide

fine-tuned by SHOPS through its previous private health sector assessments (PSAs) and including modules focused on each of the WHO Health System Building Blocks, the assessment team met with a broad range of representatives from the public, PNFP, and PFP health sectors. The PSA team interviewed over 160 individuals from approximately 90 different organizations, including government officials, donors present in Tanzania, USAID implementing partners, private umbrella organizations, private insurance companies, faith-based organization (FBO) and nongovernmental organization (NGO) representatives, industry representatives, and private health care providers. In addition, the PSA team traveled to four regions: Dar es Salaam, Pwani, Arusha, and Kilimanjaro. A list of all stakeholders interviewed by sector is included as appendix A. The assessment team selected key stakeholders based on a number of criteria, including their role in the Tanzanian health sector, the degree to which they represented their respective fields, and the size and scope of their work.

The PSA team worked closely with Tanzanian counterparts during this first step. Prior to travelling to Tanzania, the international members of the PSA team met with the PPP-TWG (see chapter 3 for description) to finalize the terms of reference for the PSA and to identify key stakeholders for interviews. The PPP-TWG also helped organize the stakeholder interviews, and in some cases, participated in the meetings. During the trip, the PSA team consulted the PPP-TWG to solicit initial feedback on the preliminary findings and recommendations.

Step Two: Analyze Data to Develop Findings and Propose Actionable Recommendations

The analysis began while in country. Through nightly debriefings, the PSA team shared information, vetted initial findings, and began to form actionable recommendations. The PSA team held two consultative meetings: the first was with the PPP-TWG to share preliminary findings mid-way through the trip, and the second was with a larger stakeholder group at the end of the trip, to present a first-cut outline of findings, priorities, and recommendations. While drafting the report, the PSA also sent questions back to the Tanzanian PSA team members and/or to the PPP-TWG members for additional information and clarification.

Step Three: Prepare the Report

Based on the initial data analysis and stakeholder interviews, individual team members prepared their respective modules. The assessment team leader compiled these sections into one consolidated draft, which was then shared with the entire PSA team and SHOPS senior management for comments on the content and structure of the report. The team then shared a second draft for verification and feedback with a wider technical audience, including members of the PPP TWG and USAID.

Step Four: Finalize the PSA Report

The assessment team leaders shared the third draft of the report and recommendations with local stakeholders in a dissemination workshop in Dar es Salaam on

November 14th and 15th, 2012. During this workshop, stakeholders verified the assessment team's findings and prioritize the report's recommendations for future technical assistance. Their feedback is discussed in appendix B. Following this discussion, the assessment team produced a final draft that reflects the comments and concerns that local stakeholders raised.

PMTI Assessment and Private Provider Mapping

This assessment coincides with two other separate reports. The first, conducted by SHOPS staff prior to the PSA team's arrival in April 2012, focused on the role of private medical training institutes (PMTIs) in training health workers in Tanzania. The SHOPS team reviewed both published and grey literature regarding these institutions and then interviewed a wide swath of stakeholders, including: PMTI staff; PMTI students; officials at the MOHSW, Ministry of Education, and the Higher Education Student Loan Board (HESLB); education accreditation agencies; financial institution staff; and donors and implementing partners working to improve Tanzania's human resources for health (HRH). These interviews focused on identifying key opportunities and constraints in expanding the role of PMTIs to produce a greater number of health workers in Tanzania. The PSA team used the results of the PMTI assessment to inform and supplement the HRH and access to finance sections of this report.

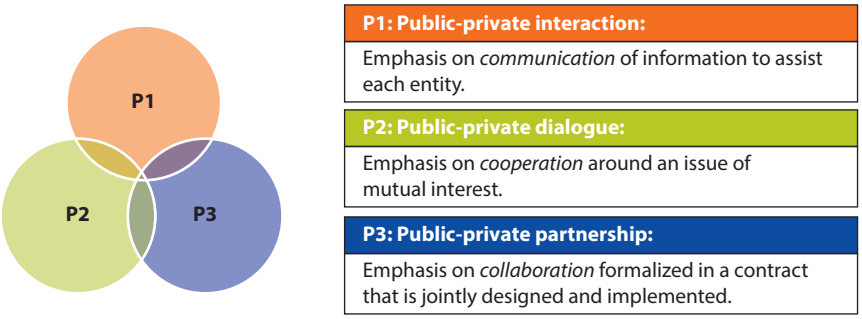
The second additional assessment, conducted by consultants with Tanzania's National Institute of Medical Research (NIMR), is a mapping of the private health sector in mainland Tanzania using information from the registries of the various health councils in the MOHSW as well as membership lists from umbrella organizations like the Christian Social Services Commission (CSSC), National Muslim Council of Tanzania (BAKWATA), and the Association of Private Health Facilities in Tanzania (APHFTA). Although the NIMR mapping exercise is separate from this private health sector assessment, that work will facilitate the implementation of many of the PSA's recommendations by developing a master list of the ownership, HRH skill and capacity, and infrastructure and material resources for all private health care providers, manufacturers, and other health industries in mainland Tanzania. The master list is intended to enhance the understanding of the private health sector's capacity to (1) deliver health services and products; (2) self-regulate and comply with MOHSW licensing procedures and standards of care; and (3) contribute to the management of health information systems. The NIMR team will work with individual district councils and district medical officers (DMOs), through the Prime Minister's Office of Regional and Local Governance (PMO-RALG), to validate this information prior to finalizing it.

Key Concepts

This section offers definitions of some key concepts used throughout the report.

Private Sector in Health: The private health sector in Tanzania, as chapter 2 illustrates, is diverse, comprising both PFP organizations (commercial, self-sustaining) and PNFP organizations (faith-based, nongovernmental, or community-based).

Figure 1.2 Levels of Private Sector Engagement



Source: Barnes 2011; USAID SHOPS Project led by Abt Associated (2011).

Private Sector Engagement: The PSA analysis focuses on the scope and degree of government engagement of the private sector. As figure 1.2 shows, there are three levels of private sector engagement: (P1) public-private interaction; (P2) public-private dialogue; and (P3) public-private partnership (Barnes 2011). The three types of public-private engagement are often related and not necessarily a stepwise process—indeed, a single "engagement" may involve dialogue as a first phase and interactions as a second phase, leading to a full operational partnership as the summative phase. It is difficult to enter into a health PPP in the absence of communication or interaction between the sectors, building the basis for trust. Likewise, it is unlikely that partners will enter into formal agreements if there has not previously been some level of cooperation.

Public-Private Partnerships: Public-Private Partnerships (P3) are the most complex and difficult form of engagement. PPPs involve a formal agreement between the public and private sector partners, with clearly defined roles and responsibilities for each around their joint implementation of an activity designed to address a weakness in the health system. Typically, the agreement specifies the investment from each partner and the conditions under which each will assume risks and reap benefits. Often there is confusion on the definition of a PPP, with some experts focusing on the particular mechanism used (for example, infrastructure transaction, contracting, leasing). The lesson learned is to encourage those working on health PPPs in a particular setting to agree on a working definition and to use it consistently. (See box 3.2 for the definition used by Tanzanians in the PPP Health Policy.)

Overview

The report is divided into eight chapters, covering a wide range of technical areas. Chapter 2 presents Tanzania's Private Health Sector Landscape, providing a more detailed description of the national health system and of the private health sector specifically, including its size and distribution in mainland Tanzania.

The landscape also presents a brief overview of the health subsectors and the way in which the private health sector is situated within the larger health system. Chapter 3 discusses government stewardship of the private health sector and the enabling environment for leveraging private health sector resources and capabilities. Chapter 4 focuses on private health sector service delivery and the involvement of private health sector actors in the provision of essential services such as HIV/AIDS, RCH, TB, and malaria. It identifies the services the private health sector is currently providing and points to opportunities for improving private sector engagement in expanding access to essential services. It also identifies trends in key health markets, relating developments in key health areas to MOHSW strategic plans and to opportunities for private sector engagement. Chapter 5 provides an overview of HRH in the private sector, including staffing shortages at private facilities and opportunities for increasing the quantity and quality of trained medical professionals through PMTIs. Chapter 6 focuses on private sector access to essential pharmaceutical and medical commodities, as well as opportunities for improved commodity access as part of strengthening private sector contributions to the health system. Chapter 7 analyzes trends in public and private health financing, including the use of service-level agreements (SLAs), the National Health Insurance Fund (NHIF), and health expenditures. Chapter 8 concludes the report with strategic, actionable recommendations for improving public-private engagement and PPPs for improved health outcomes in Tanzania.

Note

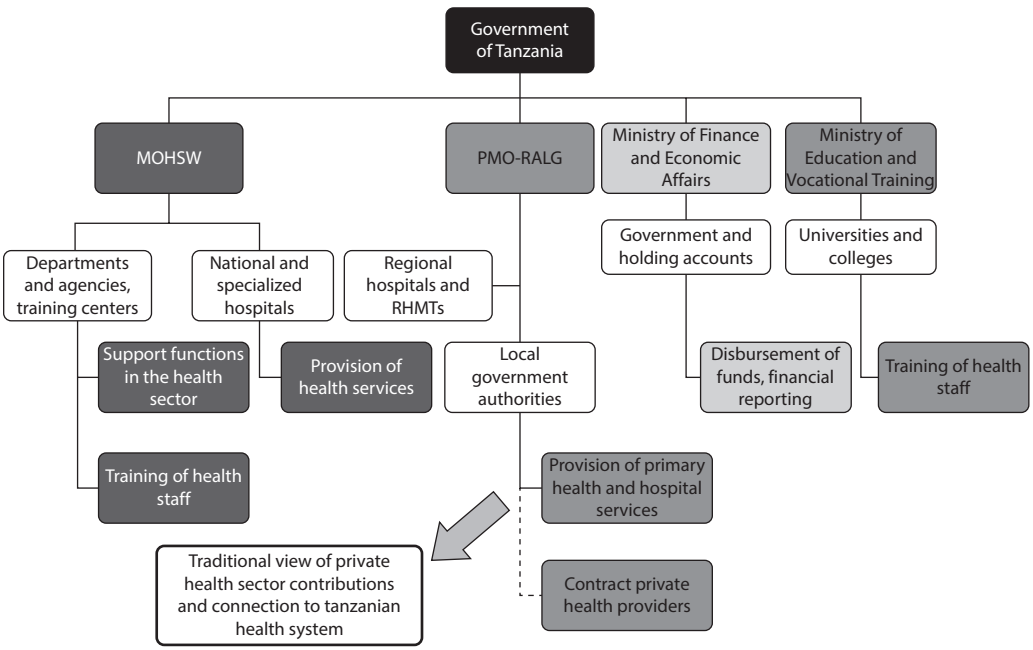
1. All dollar figures are U.S. dollars.

CHAPTER 2

The Private Health Sector within the Tanzanian Health System

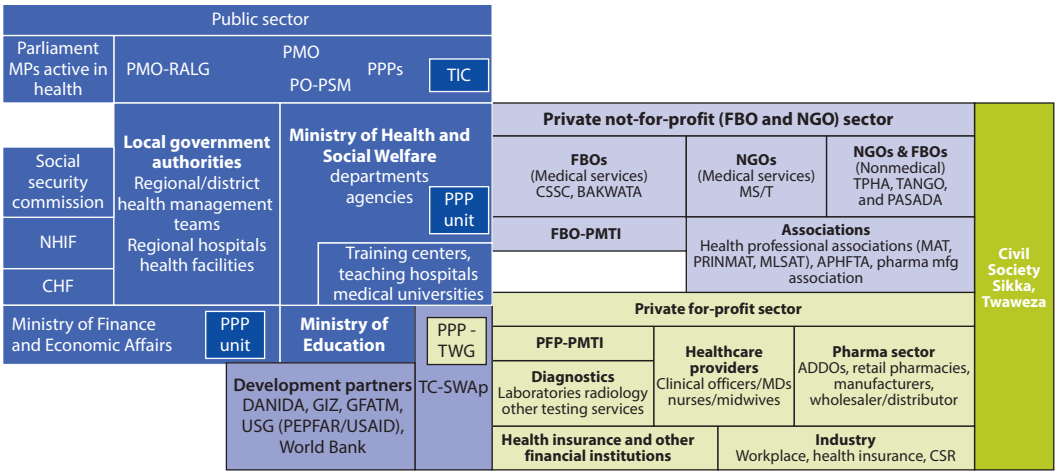
One of the objectives of this report is to present a comprehensive picture of the various actors contributing to the Tanzanian health system. This chapter provides an overview of the different stakeholders working in health, in particular highlighting how the private health sector fits within the national health system. Figure 2.1 provides a "snapshot" of how the various actors in the Tanzanian health system are traditionally depicted. Figure 2.2 presents an alternative (and necessarily more complex) view of the Tanzanian health system,

Figure 2.1 Traditional Tanzanian Health Sector Landscape



Source: HSSP III.

Figure 2.2 Multisectoral Health Landscape in Tanzania



Source: World Bank data.

including the full range of public, private not-for-profit (PNFP), and private for-profit (PFP) health actors. A companion table (see appendix C) offers a brief description of the roles and responsibilities of various health sector stakeholders. The landscape underscores that the private sector is engaged in a wide range of health-related activities beyond health services and contributes significantly the health system.

A New View of the Tanzanian Health System

Traditionally, most assessments and evaluations of Tanzania's health system focus primarily on the organization of government leadership, related government ministries, and public delivery of health services. The scope and contribution of the private health sector as part of the Tanzanian health landscape is often excluded or minimally represented, as in figure 2.1.

Figure 2.2 presents an alternative view of the Tanzanian health landscape that includes a broad range of health sector actors and portrays the complexity of the Tanzanian health system. This figure is organized by key sectors in health: development partners; public sector; PFP; PNFP; and civil society. Although not an exhaustive listing of the entities in each sector, this figure illustrates the diverse range of groups—even within each sector—that contribute to the health system. Based on a previous private health sector assessment, there is a common perception that the public sector delivers 60 percent of health services in Tanzania, and the private sector provides 40 percent (Munishi et al. 1995). This rough estimate, however, is not up-to-date and does not capture the contributions of the private sector beyond service delivery, such as medical training, commodity supply, and health financing. Table 2.1 below further defines the acronyms of keys actors in each sector.

Table 2.1 Legend of Acronyms for Key Actors, by Sector

Government sector		*Private not-for-profit sector*	
CHF	Community Health Fund	APHFTA	Association of Private Health Facilities Tanzania
LGAs	Local Government Authorities	BAKWATA	National Muslim Council of Tanzania
MOSTHE	Ministry of Science, Technology, and Higher Education	CSSC	Christian Social Services Commission
MOF	Ministry of Finance and Economic Affairs	MAT	Medical Association of Tanganyika
MOHSW	Ministry of Health and Social Welfare	MS/T	Marie Stopes/Tanzania
PMO	Prime Minister's Office	PMTI	Private Medical Training Institute
PMO-RALG	Prime Minister's Office–Regional Administration and Local Government	PRINMAT	Private Nurses and Midwives Association of Tanzania
RHMT	Regional Health Management Team	TPHA	Tanzania Public Health Association
TIC	Tanzania Investment Centre	TANGO	Tanzania Association of NGOs
International donors		*Private for-profit sector*	
DANIDA	Danish Technical Cooperation	ADDOs	Accredited Drug Dispensing Outlet
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria	CSR	corporate social responsibility
GIZ	German Technical Cooperation	*Civil society*	
PEPFAR	President's Emergency Plan for AIDS Relief	Sikika	Tanzanian NGO for youth and Youth Action Volunteers
USG	United States Government	Twaweza	"We can make it happen" citizens' initiative
USAID	United States Agency for International Development	PASADA	Pastoral Activities and Services for People with AIDS Dar es Salaam Archdiocese

Source: World Bank data.

Tanzanian Health System Sectors

The Public Health Sector

The leading sector in the Tanzanian health system is the public sector, with stakeholders in the executive and legislative branches of government—Prime Minister's Office—Regional Administration and Local Government (PMO-RALG) and Parliament—as well as various line agencies and ministries. The primary actor in the public sector is the Ministry of Health and Social Welfare (MOHSW), with support from other government agencies such as the Ministry of Finance and Economic Affairs (MOF) and the Ministry of Science, Technology, and Higher Education (MOSTHE).

The current division of roles and responsibilities within the public health sector is largely dictated by the 1998 Policy Paper on Local Government Reform, which emphasizes the devolution and decentralization of finances and policy implementation to Local Government Authorities (LGAs) (COWI 2007). At the national level, the MOHSW focuses on policy, governance, and financing of health services. Generally, the MOHSW develops key health policies, monitors and regulates the different health actors, oversees medical research, and manages level-three hospitals (national, referral, and specialized). It is also responsible for coordinating with other relevant ministries, including the MOF for funding support and the MOSTHE for training and education of the various health cadres.

At the district level, PMO-RALG focuses on oversight of and coordination with the LGAs, which have considerable independent authority in planning, financing, overseeing, and delivering health services. LGAs consist mainly of government bodies at the district and subdistrict level. At the district, town, and municipal levels, Council Health Management Teams (CHMT) implement health policies, allocate funding and resources, and work through PMO-RALG to gather health and service data to report to the MOHSW. Council Health Management Teams (CHMTs) also provide health services through public facilities at the district level. Additionally, at the regional level, 21 Regional Health Management Teams (RHMTs) supervise regional hospitals and advise the Regional Secretariat on health-related policy issues.

In 2007, the MOHSW initiated the Mpango wa Maendeleo ya Afyaya Msingo (MMAM) program to expand delivery of primary health care services for all by 2010. Subsequently, the MOHSW invested to expand, rehabilitate, staff, and equip many facilities (upward of 8,100 in 62 districts). Moreover, the MOHSW has increased Ministry staff salaries to be more competitive in the labor market. Although demand for health services in public facilities has increased as planned, an unintended result has been the migration of medical staff from the private sector to the public sector. This has created healthy competition between the public and private sectors (particularly PFP facilities), but has also exacerbated human resource shortages in the private health sector. Despite the public sector's dominant position within the health sector, there is room for strategic and systematic engagement with the private sector—both PFP and PNFP.

The Private Health Sector

The private health sector is diverse and complex, comprising a wide range of actors and stakeholder groups, and engaged in a wide range of health activities. Historically, the Tanzanian private health sector (particularly faith-based organization [FBOs]) have played a significant role in expanding service delivery and providing supportive functions such as pharmaceutical dispensing and laboratory diagnostics. Private health sector involvement in the Tanzanian health system has grown relatively quickly over the past 20 years, in part responding to government policy changes (such as removing the ban on private practice in 1991). Until recently, however, the government has not actively involved the PFP sector in policy and planning or engaged them directly in expanding service delivery.

The Private Not-for-Profit Sector

Outside of public facilities, the PNFP sector is the second largest group offering health and support services in Tanzania. The PFNP sector includes FBOs, charitable not-for-profit organizations, NGOs, and community-based organizations (CBOs). FBOs, in particular the CSSC, are most prominent in terms of total infrastructure, number of staff, and geographic reach. Although PNFP facilities are found in both urban and rural settings, their role is more pronounced in rural areas, where they typically function in areas not served by the MOHSW.

Box 2.1 The Christian Social Services Commission (CSSC)

The CSSC's five zonal offices have national reach, linking individual owners of faith-based health facilities with local government. CSSC currently administers 897 facilities run by member churches:

- 697 dispensaries at the village/ward level
- 101 health centers at the divisional level
- 99 hospitals (37 council district hospitals, 10 referral hospitals at regional level, and 2 zonal specialist consultancy hospitals in Mwanzi and Kilimanjaro).

Where there is no MOHSW facility, FBO hospitals in 34 districts serve as Designated-District Hospitals (DDHs).

Faith-Based Organizations. The CSSC is the largest FBO coordinating body in Tanzania, with interdenominational membership representing the Episcopal Conference, the Catholic Church, and the Christian Council of Tanzania, which in turn comprises 15 national churches and 14 para-church organizations and ministries. The CSSC plays a leadership and service delivery role (see box 2.1). CSSC members participate with the MOHSW in policy and planning initiatives at the central and regional levels. CSSC member facilities are a principal source of preventive and curative health services in Tanzania—particularly at the health system district level and above, and in rural areas lacking public facilities. As government partners, CSSC facilities are able to procure commodities via the Tanzania Medical Stores Department (MSD), receive financial grants from MOHSW basket funding (excluding salaries or capital development), and share staff through ministry staff secondment. The vast majority of FBO facilities are financed by user fees (set by the individual facilities and LGAs), as well as through international and local donors, income generation projects (such as hostels, gardening or maize processing), and/or NHIF (on average, less than 10 percent of facility financing). In keeping with CSSC's mission to ensure the poorest and most vulnerable citizens receive care, user fees are set to ensure equity of access. FBOs also play an important role in training health professionals for both FBO and public service. Because of the long and close working relationship with the MOHSW, many view the FBOs as an extension of the government.

There are also many FBOs, such as BAKWATA and others that operate dispensaries, health facilities, and/or larger hospitals outside the CSSC network. A strong example is the Shree Hindu Mandal Hospital (SHMH) in Dar es Salaam (box 2.2). As with many health facilities outside the CSSC network, SHMH operates in "very loose agreements with the government" that are largely relationship based. Many smaller not-for-profit health facilities, lacking similar relationships, would benefit from a stronger and more formalized relationship with the MOHSW and/or LGAs.

Box 2.2 Shree Hindu Mandal Hospital

SHMH provides a comprehensive package of general and specialist services, in addition to basic health services in its outpatient clinics. SHMH has pioneered key health services in the private sector. In 2000, SHMH launched free TB treatment and was the first CTC site to provide HIV care and treatment. The hospital now has over 2,800 patients on ART, and 10 percent on second-line therapy, and is the main referral hospital for late stage ART initiation and salvage therapy.

Community-Based Organizations. Several nongovernmental/not-for-profit organizations currently fill specific service delivery gaps at the village/ward level of the Tanzanian health system. Embedded within communities lacking public services, these organizations typically provide a specific package of services related to a focal health area. For example, the Private Nurses and Midwives Association of Tanzania (PRINMAT) operates a network of maternity homes delivering key family planning, antenatal care (ANC), and delivery/postnatal RCH services (box 2.3). Other examples of CBOs active in Tanzania include the following: Pathfinder International's network of community-based family planning and reproductive health services; PATH's integrated TB/HIV work at the community level; Population Services International's Familia program, focused on extending community-based access to affordable contraceptive commodities; and Marie Stopes/Tanzania, also delivering family planning and other essential RCH services.

In addition to delivering health services in both urban and rural areas, CBOs play an important role in the provision of nonclinical health and social services, such as health education, policy research, and advocacy. For example, CBOs such as the HIV support group PASADA are an important source of supportive care and welfare services for persons living with AIDS. NGOs such as the Tanzania Public Health Association conduct public health research on issues such as smoking and noncommunicable diseases, and advocate for policies to help change health consumer behavior.

Box 2.3 PRINMAT Network of Maternity Homes

PRINMAT operates as an association for private nurses and midwives as well as a not-for-profit network providing maternal and child health services. Founded in 2000, the PRINMAT network comprises 70 member-operated maternity homes in 17 regions of Tanzania, with plans to expand to 100 facilities by 2015. PRINMAT focuses on increasing access to high-quality RCH services in remote areas not currently covered by the government. PRINMAT maternity homes offer ANC, delivery, postnatal, family planning, health education, and prevention of mother-to-child transmission (PMTCT) and home-based HIV care services.

To date, the FBO/NGO sector has been an important partner to the MOHSW in delivering services, training health workers, and increasing health care access to hard-to-reach populations. However, there are substantial opportunities to further harness FBO/NGO capacity through strengthened SLAs in areas of underserved population groups. Additionally, there is untapped capacity in FBO PMTIs to increase the number of medical and nursing HRH.

Private For-Profit Sector

The PFP sector in Tanzania is diverse, engaged in a number of health activities beyond the delivery of health services:

- *Service delivery*: APHFTA is the principal organization coordinating a significant percentage of facilities in the PFP sector. There are approximately 878 PFP facilities in Tanzania offering limited or wide-ranging health services, including 36 hospitals, 55 health centers, and 787 dispensaries. Overall, the PFP sector is providing approximately 15 percent of hospital services (see boxes 2.4 and 2.5 for more details) (MOHSW 2012). Key informant interviews demonstrated that the PFP sector is an important source of clinical support

Box 2.4 Mikumi Hospital

Mikumi Private Hospital in Dar es Salaam is an 18-bed inpatient and outpatient facility offering voluntary counseling and testing (VCT)/HIV care, RCH, malaria treatment, operating room facilities, X-ray and ultrasound, and basic laboratory diagnostics. Like most PFP facilities, Mikumi Hospital does not provide TB care—a therapeutic realm that has been largely centered in government and PNFP hospitals and health centers.

Box 2.5 Muhimbili National Hospital—Public/Private Mix

Muhimbili hospital—the country's level-three national superspecialist hospital in Dar es Salaam—is a public-private hybrid model. Approximately 40 percent of the hospital's 1,259 beds (housing approximately 1,100 inpatients per day) are for private "fee-bearing" services. Described as an "intramural private practice," beginning at 1 pm each day, several of the hospital's publicly employed physicians and support personnel provide private outpatient consultation, in a specified private wing of the hospital. Rates charged for consultation, though higher than public rates, are slightly lower than an average private consultation. Patients admitted to the hospital via private consultation are admitted to a private ward; there is a special hospital-based pharmacy to serve private clients, with mainly name-brand pharmaceuticals. Funds from private care subsidize public services and allow the hospital to procure pharmaceuticals and other commodities from private wholesalers, when the central MSD is out-of-stock—a frequent occurrence.

services, such as blood testing and diagnostics. PFP providers are concentrated in urban centers, especially Dar es Salaam, where higher population concentration means patient volumes that can sustain operations. However, as map 2.1 demonstrates, there are PFP facilities of various sizes and service levels even in rural areas.

- *Medical products and technology*: The PFP sector is also heavily active in the field of medical technologies, equipment, and products, including a large number of wholesalers and distributors that supply retail pharmacies as well as accredited drug dispensing outlets (ADDOs) and FBO/NGO facilities even in remote areas of mainland Tanzania.
- *Human resources*: As chapter 5 demonstrates, the private sector employs a significant number of doctors, nurses, and pharmacists, indicating possibilities for the MOSHW to leverage PFP sector staff and expertise to address some of the coverage gaps in the public system. The PFP sector also contributes to the production of HRH, albeit with only three PMTIs.
- *Private health financing*: Private financing is a major contributor to financing health services, mostly through individual out-of-pocket (OOP) payments. Most agree, however, that OOP expenditures (that is, user or consultation fees) are not the most equitable or effective way to finance health or achieve better health outcomes. To address these system gaps, the government is promoting several public health insurance schemes that allow for private commercial providers to deliver publicly financed health services. Moreover, there exists an array of private health insurance options, although still limited, used primarily by large public and private employers as an employee benefit. (See chapter 7.)
- *PFP and governance*: Although the PNFP sector has been actively collaborating with the MOHSW for many years, the PFP sector has not been as involved in health policy and planning until recently. The national donor mechanism (TC-SWAp) has created an opportunity for the PFP sector to more fully participate in donor program planning and coordination, resulting in stronger relationships among the public, PFP, and PNFP sectors—and increasing opportunities for the PFP sector to interact in government policy and planning (chapter 3).

With a broad network of health facilities, robust health distribution systems, and key expertise not fully available in all areas of the public sector, the PFP sector is well positioned and willing to work more collaboratively with the public sector to address national health goals. There are, however, barriers to private sector growth in key health areas. Collaboration between PFP providers and the public sector remains weak, with limited engagement by national or local government authorities except through APHFTA. Most commercial facilities offer free immunizations for infants and children, as well as subsidized malaria treatment (through the Affordable Medicine Facility of the Global Fund to Fight AIDS, Tuberculosis and Malaria). Nevertheless, numerous stakeholders cited the lack of government subsidization for the delivery of other essential consumable commodities as the primary constraint in expansion of essential health services in the private sector.

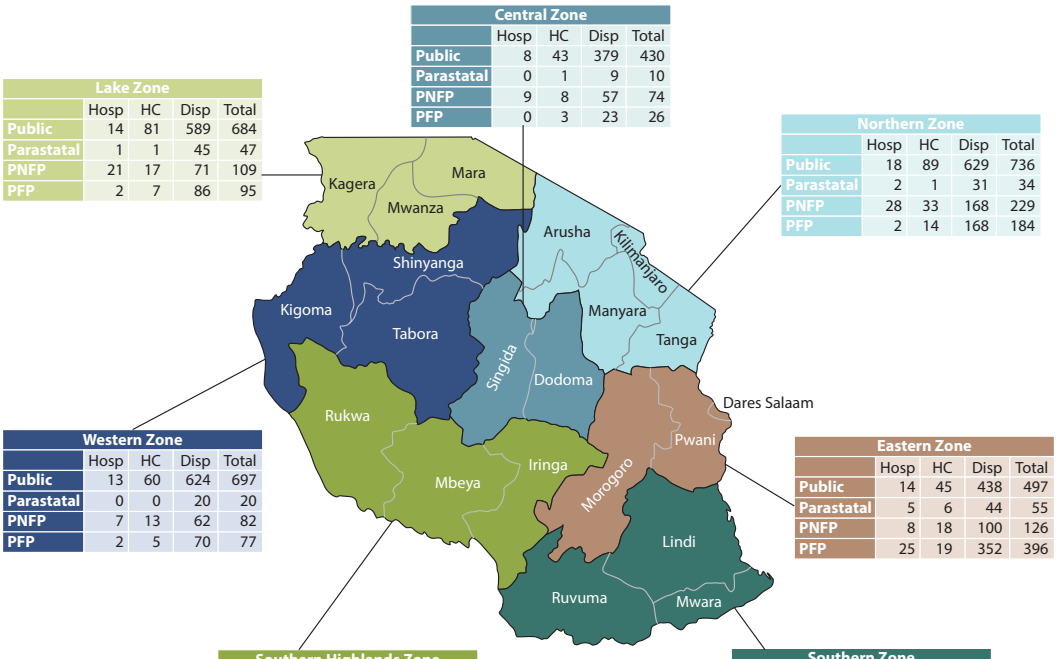
Public/Private Mix

The mix of public and private facilities varies from region to region. As map 2.1 demonstrates, public facilities outnumber PNFP and PFP facilities across all seven DHS zones. It is important to note that the number of facilities alone is not a robust measurement of each sector's contribution to service delivery but can serve as a first cut to a more nuanced analysis, discussed in chapter 4. Subsequent chapters will provide further analysis and interpretation of the public/private mix in Tanzania's health system.

Table 2.2 ranks each zone in terms of total number of facilities, with the largest number of health facilities concentrated in the Northern Zone (containing Arusha) and Eastern Zone (containing Dar es Salaam). The Southern and Central Zones contain the least number of facilities. It is interesting to note that the two most populous zones—Lake and Western—have fewer health facilities, public or private, than other zones with fewer inhabitants.

The map in map 2.1 shows that the private health sector is present in all seven zones of mainland Tanzania, including remote and rural areas. The PNFP sector—mainly FBOs—operates in both rural and urban areas; it has an equally strong presence in rural areas as the public facilities. In several cases, in fact, the

Map 2.1 Health Facilities, by DHS Zone



Central Zone	Hosp	HC	Disp	Total
Public	8	43	379	430
Parastatal	0	1	9	10
PNFP	9	8	57	74
PFP	0	3	23	26

Lake Zone	Hosp	HC	Disp	Total
Public	14	81	589	684
Parastatal	1	1	45	47
PNFP	21	17	71	109
PFP	2	7	86	95

Northern Zone	Hosp	HC	Disp	Total
Public	18	89	629	736
Parastatal	2	1	31	34
PNFP	28	33	168	229
PFP	2	14	168	184

Western Zone	Hosp	HC	Disp	Total
Public	13	60	624	697
Parastatal	0	0	20	20
PNFP	7	13	62	82
PFP	2	5	70	77

Eastern Zone	Hosp	HC	Disp	Total
Public	14	45	438	497
Parastatal	5	6	44	55
PNFP	8	18	100	126
PFP	25	19	352	396

Southern Highlands Zone	Hosp	HC	Disp	Total
Public	15	67	726	808
Parastatal	0	1	11	12
PNFP	17	35	118	170
PFP	5	5	72	82

Southern Zone	Hosp	HC	Disp	Total
Public	13	49	504	566
Parastatal	0	0	8	8
PNFP	11	10	49	70
PFP	0	2	16	18

Source: MOHSW 2012.

Table 2.2 Ranking of Zones, by Total Number of Health Facilities

Zone	*Total # of facilities*	*% of total population*
1. Northern	1,183	15.8
2. Eastern	1,074	15.0
3. Southern Highlands	1,072	14.1
4. Lake	935	19.0
5. Western	876	19.1
6. Southern	662	8.6
7. Central	540	8.3

Source: MOHSW 2012 and Ministry of Finance 2011.

PNFP sector has more hospitals in rural areas than does the public sector. For instance, in the Central Zone there are nine PNFP hospitals compared to eight public hospitals. In the Lake Zone there are 21 PNFP hospitals and 15 public, and in the Southern Highland Zone there are 17 PNFP hospitals and 15 public. However, the public sector clearly has more health clinics and dispensaries overall than do the PNFP and PFP sectors, individually or combined.

One can characterize the PFP sector as predominately solo practitioners working in health clinics and dispensaries, mostly in major urban areas such as Dar es Salaam, Arusha, and Mwanza and their outlying areas. In the Eastern Zone, the PNFP and PFP show numbers of health facilities (of all types) comparable to the public sector, underscoring the overconcentration of health services in Dar es Salaam and its suburbs: hospitals (19 public and 33 private), health clinics (51 public and 37 private), and dispensaries (552 public and 522 private). However, there are a number of PFP hospitals in Tanzania as well: in the Eastern Zone, there are more PFP hospitals than public and PNFP hospitals combined. Although the PFP sector is mainly concentrated in urban areas, there are PFP hospitals in predominantly rural areas as well, such as the Western and Lake Zones, although none in the Southern or Central Zones.

Civil Society Organizations

There are a few civil society organizations (CSO) engaged in Tanzania's health sector, largely focused on policy dialogue and advocacy, and serving as a focal point for their members in negotiations with the public sector. Their primary goal is to represent a health consumer and patient perspective in the policy-making process. Most prominent are the organizations Sikika and Twaweza, which both aim to improve grassroots advocacy and broader participation in the health sector, as well as the Tanzania Public Health Association which coordinates the efforts of public health officials including government policy makers, community health workers, and other civil society representatives.

Development Partners

Many development partners work with the PFP and PNFP sectors in Tanzania. The most prominent donors working with the PFP sector are USAID, GIZ,

DANIDA, and the Global Fund to Fight AIDS, TB, and Malaria. These development partners primarily play a funding and technical support role, providing 39.6 percent of Tanzanian total health expenditure (THE) in 2009/10. Most of these donors channel their support through the SWAp; through the Technical Committee of the Sector-Wide Approach (TC-SWAp) mechanisms, donors in partnership with the MOSHW program channel these resources through multiple technical working groups (TWGs) that coordinate all activities within specific technical areas. (See chapter 3 for more details on TC-SWAp and the PPP-TWG.)

Danish Development Assistance (DANIDA)

DANIDA has over 10 years of experience in working with the Tanzanian business sector. DANIDA primarily offers direct funds to its counterparts, and contracts long-term resident advisers to sit with their Tanzanian counterparts and/or short-term technical assistance.

In the health sector, DANIDA has focused on building the MOHSW's institutional capacity in the pharmaceutical sector. DANIDA has supported capacity building through training and other mechanisms to Tanzania Food and Drug Authority (TFDA) and MSD. DANIDA has also helped build the MOHSW's policy framework and institutional capacity to engage the private sector. In addition, DANIDA has provided resources and training to help establish and staff the PPP Unit.

Through its long-term adviser, DANIDA has successfully assisted the PPP Unit to draft and approve a comprehensive PPP framework including a PPP/Health Policy, PPP/Health National Strategic Plan, and PPP/Health guidelines (currently in draft). DANIDA will also assist the regional PPP Focal Persons, once they are identified.

Finally, DANIDA also supports nonstate health actors like the CSSC and APHFTA to build their institutional capacity. DANIDA uses the basket fund mechanism to support the CSSC. (They provide direct funding to APHFTA, because basket funds do not support funding PFP entities through this vehicle; see chapter 7.) Nonetheless, APHFTA receives direct funding from multiple donors such as USAID and the Global Fund.

Gesellschaft für Internationale (GIZ)

GIZ is a leader in supporting various functions and activities in the private sector, with a long history in working with both PFP and PNFP groups. In 1998, GIZ helped create a space to involve the PFP in donor programming, by establishing the PPP-TWG. Subsequently, in early 2002, GIZ supported the creation of the CSSC so that FBOs could better partner with the public sector.

During the last 10 years, GIZ has created many opportunities for the public and private sectors to interact, helping move private sector policy forward. In 2007, GTZ helped conceptualize and promote the concept of the National PPP Steering Committee, an inclusive forum involving a wide range of PFP and PNFP stakeholders to discuss sector-wide issues. GIZ has also been instrumental in

helping the MOHSW acknowledge the private sector role in health and has encouraged the MOHSW to establish a PPP Desk to interact with the private sector. Also, GIZ invested considerable effort to help the MOHSW design the SLA template and systems for negotiating and tendering the SLAs. The first generation of SLAs used this mechanism to allow FBOs to become designated referral hospitals.

GIZ has also directly supported private sector initiatives. GIZ funds have supported large-scale work-based health programs with major companies in Tanzania. GIZ has also supported the pharmaceutical and equipment sector, working with private drug and equipment wholesalers and equipment distributors like Action Medeor and TAMIQ.

United States Agency for International Development (USAID)

USAID is a third donor partner actively working with the private sector in Tanzania. To date, most of USAID's private sector work has focused on leveraging the commercial sector to work in health through corporate social responsibility programs, work-based health programs, easier access to credit, and international PPPs. USAID's private sector engagement has been focused primarily in the area of HIV/AIDS, working on service delivery, capacity building, and infrastructure and technology. Table 2.3 illustrates the breadth and scope of USAID's activities with the for-profit sector. USAID conveyed that it is committed to expanding the number, type, and ranges of PPPs, not only expanding access to services but also helping to build government capacity to broker and implement PPPs.

Table 2.3 USAID-Supported PPPs

Active PPP[a]	*Dates (FY)*	*USAID funding*	*Partner funding*	*Total funding*	*Partners*
BridgeIT	2007–11	$2,903,359	$758,615	$3,661,974	MOEVT, Forum for African Women Educationalists, Nokia, Nokia Institute for Technology, Pearson Foundation, Vodacom
DCA Credit Guarantee	2008–18	$2,000,000	$18,000,000	$20,000,000	AfDB, CRDB Bank (10% of risk USAID; 90% of risk partners)
Baylor Int'l Pediatric AIDS Initiative	2008–13	$22,500,000	$22,500,000	$45,000,000	Abbott, BMSquibb, Baylor College of Medicine, Texas Children's Hospital
DCA Credit Guarantee	2010–15	$7,500,000	$2,500,000	$10,000,000	PRIDE Tanzania & Standard Charter Bank (75% of risk USAID; 25% risk partner)
Coca-Cola/USAID Water and Development Alliance	2010–12	$1,600,000	$1,200,000	$2,600,000	Coca Cola, USAID, Local Bottling Companies
APHFTA	2010–13	$584,563	$637,550	$1,222,113	PharmAccess, Bienmoyo, Wharton
21st Century Basic Education Program	2009–14	$49,000,000	$45,000,000	$94,000,000	MoEVT, Cisco, Intel, Microsoft, UhuruOne, Zantel
Global Development Connection (GDC)	2011–15	$624,100	$1,012,000	$1,654,100	MOEVT Mainland, MOEVT Zanzibar, Gallaudet University—USA, Tanzania Deaf Society (Mainland and Zanzibar), Starkey and other foundations—USA
Kisa Project	2010–12	$150,000	$290,000	$440,000	AfricAid
Kilombero Plantation Limited	2011–15	$150,000	$500,000	$650,000	Yara, Syngenta, Norad Fund, Capricorn Investment Group, AGRICA
Community Health Insurance Fund in Kyela	2010–13	$497,467	$1,006,162	$1,503,629	CIDR, Biolands Ltd, Elton John AIDS Foundation, GIZ, Kyela District
Artisanal & Small-Scale Miners HIV/AIDS & Health	2011–14	$333,000	$402,000	$735,000	Tanzania Chamber Minerals & Energy, Africa Barrick Gold, Africare
Rural Health Clinics	2011–13	$702,966	$702,966	$1,405,932	SolarAid, Arizona State University, Man Group, Daey Ouwens
Health Workers Training & Systems Strengthening	2010–13	$8,500,000	$8,500,000	$17,000,000	Touch Foundation, McKinsey, Weill Cornell Medical College, Abbott Fund
Google		$13,000	$13,647	$26,647	Google, JGI, USAID
Grand Total		**$97,058,455**	**$103,022,940**	**$199,898,745**	

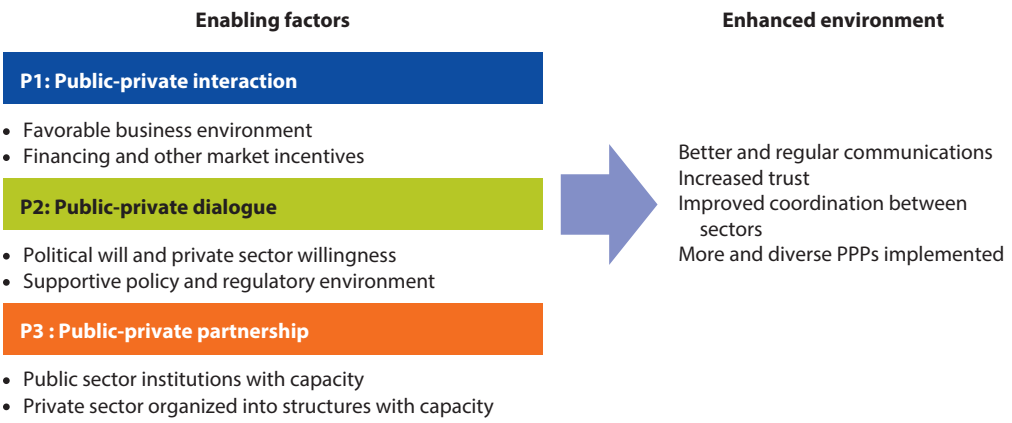
Source: World Bank data.
a. Activities in italics indicate health-focused PPPs.

CHAPTER 3

Policy and Enabling Environment to Mobilize the Private Sector in Health

This chapter analyzes the operating environment that influences the private health sector role in the Tanzanian health system. Figure 3.1 highlights six critical enabling factors, by level of engagement. Factors include the following: political will and commitment to work with the private sector; willingness of the private health sector to partner with the public sector; conditions for communication and dialogue between the sectors; policy and regulatory framework facilitating or blocking a private sector role; institutional arrangements; and government capacity to identify, negotiate, and manage PPPs. Combined, they influence the public sector's ability to coordinate and partner with the private sector and to leverage the private sector's contributions to the health system.

Figure 3.1 Enabling Factors for Private Sector Engagement in Health



Source: World Bank data.

Historical Context for Public-Private Partnerships in Health

A private sector role in health care is a relatively new phenomenon in Tanzania. In 1967, the Tanzanian government issued the Arusha Declaration, committing the government to providing universal access to free health care and banning private sector delivery of health services. In keeping with the Declaration, the government rapidly expanded its facilities to reach rural populations and by 1978 succeeded in establishing a health facility within 10 kilometers of 90 percent of Tanzania's rural villages. The postindependence period featured a dual-system health environment in Tanzania, in which the public sector delivered health care alongside FBOs. The PFP sector was hard hit with the enactment in 1977 of the Private Hospital Regulations Act that officially banned all PFP activities in health.

Several barriers challenged the government in meeting its commitment to universal health service access. Underfunding of health services led to drug supply shortages, deteriorating health facilities, and low staff morale. By the late 1980s the health system was in a serious decline, prompting the Tanzanian government to rethink its policy toward the private health sector. With the introduction of a market-based economy, the Tanzanian government liberalized the health sector in 1991. The Private Hospital Regulations Amendment Act reestablished private medical and dental services.

The demand for improved services, particularly among the rural poor, led to the Health Sector Reform policies of 1994 and 1996. Once approved, the then Ministry of Health (MOH) developed a Health Sector Reform Program and Action Plan for 1992–2002 to implement the health reforms outlined in the Health Sector Reform policies. Partnership with the private sector was identified as one of six strategies to reform and modernize the health sector.

Health sector reforms, including PPPs, are closely linked with the decentralization and other local government reforms pursued by the GOT. In 1998, the Tanzanian government approved the Local Government Reform Program, devolving decision making and accountability to municipalities and district councils on public health-related matters (among others). This policy specified the government's intention at the district and municipal levels to work closely with both for-profit and not-for-profit organizations to achieve improved health outcomes.

The Public Procurement Act of 2001 provided the regulatory basis for the Tanzanian government to outsource public services to private operators. The Tanzanian government updated the Public Procurement Act in 2005 and outlined procedures to respond to solicited and unsolicited proposals for PPPs. However, the approach in the revised Procurement Act was based on a privatization model and not a PPP model.[1]

In 2000, the MOH (later renamed MOHSW) developed key performance indicators and outputs to assess PPPs in health. The indicators to measure PPPs included the following:

- Number of partnerships
- Contribution of each partner (public and private)
- Client satisfaction.

The MOH set an ambitious timeframe to put into place the policies and guidelines needed to implement PPPs: (1) policy and legal review by 2001; (2) institutional mechanisms promoting PPPs by 2002; and (3) guidelines to enable private providers to qualify for government financing and mechanisms for joint facility inspection in place by 2002 (ESRF 2011). As the following section summarizes, while the Tanzanian government did not meet it original deadlines, it has successfully put into place a comprehensive PPP health policy and institutional framework.

Policy Environment

Tanzania is a pioneer in working with the private health sector (see boxes 3.1 and 3.2 for the MOHSW's definition of the private health sector and public-private partnerships). The government is one of the first in the region to create a comprehensive policy framework encouraging a greater role for the private sector in health. The following section reviews three categories of policies and laws that provide the foundation for private sector engagement and PPPs in health.

Policies Supporting a Private Sector Role in the Tanzanian Economy

Vision 2025

Like many African countries, the government of Tanzania has announced a vision statement setting out the principles guiding Tanzanian growth and development. The private sector plays an important role in Vision 2025 as "an engine of growth for building a strong, productive and renewing economy." Vision 2025 also

Box 3.1 Private Sector Definition

In the HSSP III, the MOHSW defines the private sector as follows:
"The private sector consists of non-state actors, e.g. nongovernmental organizations, faith-based organizations, community-based organizations and the private for-profit."

Source: HSSP III, p. 33.

Box 3.2 PPP Definition

In the HSSP III, the MOHSW defines the PPPs as:

> PPPs in health can take a variety of forms with differing degrees of public and private responsibility and risk. They are characterized by the sharing of common objectives, as well as risks and rewards, as might be defined in a contract or manifested through a different arrangement, so as to effectively deliver a service or facility to the public.

Source: HSSP III, p. 33.

proposes "unleashing the power of the private sector" for economic growth and other social purposes. Vision 2025 defines the government's role as the regulator that establishes the rules of engagement between the public and private sectors and encourages "competency and a spirit of competitiveness." Although these principles are for the economy and development overall, they set the tone for private sector involvement in the health sector.

National Strategy for Growth and Reduction of Poverty (NSGRP 2005)

The NSGRP acknowledges the responsibility of both the public and private sector to work together to achieve national objectives through social services. The NSGRP recommends strategies that include growing the private sector, building private sector capacity, scaling-up PPPs, and creating a consultative mechanism between the public and private sectors to facilitate dialogue, build trust, and create accountability. However, as the Health Research for Action (HERA) report (2005) states, "translating the NSGRP into financial commitment to PPPs is found difficult." Stakeholder interviews confirm that this remains true today.

For more information on the Tanzanian general PPP Act and the 2011 PPP Guidelines, please refer to appendix D. In addition, appendix D contains an in-depth description of the institutional framework to implement PPPs across all economic and social sectors.

Health Policies and Legislation Supporting a Private Sector Role in the Health Sector

Several health policies, laws, and plans convey the MOSHW's intent to partner with the private sector in a wide range of health activities. Below is a summary of the key documents that provide the policy foundation for engaging and collaborating with private stakeholders in health sector, both PFP and NFPF.

Health Policy (2007)

In 2003, the Tanzanian government updated the 1990 National Health Policy. The 2003 draft of the Health Policy acknowledges the private sector contribution to health—including the for-profit sector—and sets the tone for partnerships. The draft states PPPs are "complementary not confrontational." The 2003 Policy explicitly states:

> The MOHSW anticipates that a mutually beneficial cooperation of public-private partnerships shall exist among, public, faith-based organizations, NGO, private and informal and civil society sectors in the identification and prioritization of health needs of the population through a joint for a (sic). The partnership will jointly and transparently mobilize and share resources for development and efficient delivery of well-regulated health services while ensuring accountability to the public they serve.

Moreover, the Health Policy defines several principles guiding the collaboration and relationship between the public and private sectors, including the following: (1) mutually beneficial cooperation; (2) jointly and transparently mobilizing and sharing resources; (3) continuing communication, cooperation,

coordination, and collaboration; (4) jointly regulating health facilities in both sectors; and (5) promoting health services by private sector organizations. The Health Policy acknowledges that the private health sector has a role in policy and planning as well as in monitoring quality. The draft 2003 Health Policy does not state how it will achieve these guiding principles.

In 2007, the Tanzanian government updated and approved a National Health Policy, retaining most of the principles and language of the 2003 draft. The final health policy acknowledges the private sector contribution to the health sector and sets as one of its principal goals to "improve partnerships between public sector, private sector, religious institutions, civil society and community to provide health services." The National Health Policy defines a few specific areas of collaboration with the private sector, including the commercial sector; in general, however, the private sector is captured in the catch-all phrase "other stakeholders." Unfortunately, the final National Health Policy did not retain the guiding principles on working with the private health sector, announced in the 2003 draft.

Primary Health Care Service Development Program 2007–17 (MMAM)

The purpose of MMAM is to extend primary health care services to all by 2012 and consolidating those gains in the following five years. On the public side, MMAM is a joint effort among several government agencies: MOHSW; PMO-RALG; Regional Secretariat; LGAs; and Village Committees. On the private sector side, MMAM recognizes that the private sector has important resources that can be harnessed to extend primary health care services to rural populations; however, these PPPs work almost exclusively with MOHSW's long-standing partner, the FBOs. The PFP participation has been limited to health infrastructure and delivery of nonclinical services (for example, laundry, waste management, food services). And there is little mention of involving the private sector stakeholders in policy and planning at the decentralized levels where all the service and programmatic decisions are made, effectively preventing PPPs opportunities with the PFP.

Health Sector Strategic Plan July 2009–June 2015 (HSSP III)

The HSSP III further reinforces the private sector role in the health sector, mentioning the private sector in several key strategies. PPPs continue to figure as one the MOHSW's strategic areas. Strategy #6 states:

> PPPS will be important for achieving the goals of the health sector. PPP forums will be installed at national, regional and district levels. The Service Agreements [SLAs] will be used by all LGAs to contract private providers for service delivery. The private training institutions will be increasingly involved in production of HRH, based on their specific competencies.

PPPs are also identified as a cross-cutting issue, emphasizing the Ministry's perspective that involving the private sector complements government efforts:

> The health sector will benefit from complementarity: more delegation and more partnerships, cutting back duplication and unhealthy competition.

Box 3.3 Summary of PPPs in HSSP III

Governance: The MOHSW acknowledges a role for the private sector role in governance and management (pages 51, 59); it proposes a national-level dialogue forum of all stakeholders, while involving the private sector RHMT discussion, to deliver the essential health package. Also, the MOHSW refers to involving the private sector in various policy and planning proposals supporting its strategic directions as outlined in the HSSP III.

Health Services and Products: PPPs are the main strategy to leverage private HRH and infrastructure for the essential health package and the drugs needed (page 33). The MOHSW states it will invest in stimulating private sector investment in services (page 51).

Human Resources for Health: Greater planning coordination with other stakeholders like the private sector to produce the health professionals urgently needed. In particular, the MOHSW is looking to the private sector to assist in preparatory, in-service, and continuing professional development (page 30). Also, MOHSW proposes collaborating the private sector to make optimal use of all HRH, public and private alike (page 51).

Health Care Financing: The MOHSW also encourages private participation in health insurance. The MOHSW proposes rational allocation of public funds between public and private sector, based on competencies and performance through SLAs (page 59).

The HSSP III gives broad scope to the private sector in many of the health system building blocks (box 3.3). At the same, the document reports a general lack of understanding of PPPs at all levels of the MOHSW as well as among district and local councils. Moreover, HSPP III admits how difficult it is to partner because the private sector is disorganized and fragmented.

Most of the stakeholders interviewed for this assessment agreed that the MOHSW will maintain its approach on PPPs with all private stakeholders. In fact, many interviewed stated that the private sector will have a greater role in the upcoming HSSP IV, possibly including specific steps to operationalize PPPs.

Health Legislation

The Private Hospital Act and Private Health Laboratory Acts are the only items of health legislation that specify the role of the private sector as partners in delivering and financing health services. A 2005 legal and regulatory review concluded that, although most other health laws and acts are silent on the private sector role, they leave room for the public sector to contract out health services to the private sector (Mapunda 2005). The same review recommended two actions that have since been implemented by the Tanzanian government: (1) reexamine all the health laws to acknowledge and specify the private sector role in health; and (2) enact a new law governing PPPs.

Subsequent to the 2005 review, the government has taken major steps toward defining the private sector role, both in general and in health. A further MOHSW review of all the health laws concluded that two pieces of legislation empowered

the MOHSW to establish and sustain PPPs: (1) The National Health Service Act authorizes the MOHSW to establish a coordinated mechanism between public and private heath actors and to implement SLAs between councils and private health providers. (2) The Public-Private Partnership Act of 2010 specifies the purpose, role, and terms and conditions for PPPs in general that also apply to the health sector (discussed below).

Public Financing of Private Sector

There are two sources of public financing of private providers: (1) government of Tanzania block grants (which are not health specific); and (2) development partners' basket funds for health. Interpretations vary regarding the Comprehensive Council Health Plan (CCHP) guidelines, creating doubt on whether block grants can be used to fund PFP facilities. Moreover, there is disagreement about whether a CHMT can use basket funds to finance PFP providers, particularly through the SLA mechanisms. But as chapter 7 highlights, there is limited awareness among CHMTs regarding how to use SLAs and their ability to increase access and efficiency between the sectors.

Private Sector Policy in the Health System: Strategic H/PPP Plan 2010–15

In addition to the health policies and legislation summarized above, the MOHSW has taken a further step to formulate strategies and guidelines that specifically address how the Ministry will engage and partner with the private health sector, by developing the Strategic Public-Private Partnerships for Health (H/PPP) Plan 2010–15 (see box 3.4). This first-ever Strategic H/PPP Plan details how the MOHSW will operationalize the current HSSP III Strategy #6: establishing PPP forums at all levels, using SLAs to partner with the private sector, and leveraging private training institutions to produce HRH.

The MOHSW has identified three strategy areas to achieve these goals:

1. **Ensure conducive environment to operationalize PPPs in health.**
   - Review and identify legal and regulatory barriers to PPPs at all levels.
   - Advocate for needed policy reforms.
   - Conduct operational research on PPP.
   - Assist all health providers to obtain necessary legal status in order to participate in PPPs.

Box 3.4 Policy Reform Areas

The Strategic H/PPP Plan identified three immediate policy actions:

1. Include private universities in HRH policy and planning.
2. Review and update Nursing Council guidelines on private practice.
3. Support Registrar's efforts to change legislation to permit enrolled nurse-midwives and nursing officers to practice in the private sector.

Source: Strategic H/PPP Plan, p. 10.

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2. **Ensure effective implementation of health PPPs.**
   - Establish and maintain the PPP-TWG and PPP Steering Committee secretariats.
   - Strengthen MOHSW capacity to implement PPPs.
   - Strengthen Regional Medical Officer (RMO) capacity and create institutional mechanisms in all regions.
   - Strengthen capacity needs of key private sector organizations representing major private sector stakeholder groups.
3. **Enhance PPPs health and nutrition services.**
   - Promote inclusion of PPPs in CCHPs.
   - Strengthen costing and negotiation skills among partners.
   - Facilitate peer review mechanisms on PPPs.
   - Document and share lessons learned.

The Strategic H/PPP has identified some "quick wins" to jump start implementation of health PPPs, including some that are already underway: (1) move PPP office to Policy and Planning at MOHSW (in progress); (2) conduct annual stakeholder PPP meeting for all councils; (3) draft PPP policy guidelines (in draft); (4) establish a PPP Steering Committee Secretariat (in progress); (5) disseminate SLA to all councils and identify implementation challenges; (6) align SLA with MMAM to only construct/rehabilitate health facility where there is no other provider present; (7) modify CCHP guidelines for basket funds; (8) conduct costing analysis of specific services by different sectors (underway); (9) develop and disseminate Regional/District PPP committee guidelines; and (10) initiate PPP peer review for CHMTs.

H/PPP Guidelines

As noted above, the PPP Unit has a draft in circulation for internal review and will consult with external stakeholders as a next step. The PPP Office hopes to finalize and approve these guidelines by the end of this year.

Regulatory Framework Overseeing the Private Health Sector

The government can use regulations to achieve several policy objectives, such as improving quality and safety and promoting equitable distribution of facilities and HRH. Below is an overview of the key regulations that directly impact private provision of health services.[2]

Facility Licensing

There is a centralized system for registration of all facilities, requiring annual renewal to maintain a facility's license. Private providers interviewed stated that the process is time consuming and costly and that they are unclear what the fees are used for. Most would agree that the fees should be used to improve the facility licensing system and to strengthen inspectorate capacity, particularly at the district and council levels. Issuing a license for new facility and/or expansion for an existing one is based solely on whether these facilities meet standards for size,

staffing, and equipment. However, these standards are not linked to scope of practice or need. Given the urgent HRH constraints, a possible strategy would be to "relax" HRH requirements for licensing facilities—particularly in remote and rural areas—and to set facility standards in keeping with the range of health services offered. Additionally, little consideration is given to the strategic needs for health facilities: for example, does a CHMT need to create a new or expanded health facility, given existing public and private capacity, or can it perhaps incentivize the public and/or private sector to open a new facility in an underserved area?

Professional Licensing

There is currently a centralized system for licensing health professionals. However, the government has missed an important opportunity to help strengthen quality by requiring periodic renewal of the professional license, based on maintaining knowledge and skills through continued professional development.

Quality Standards

In 2004, the MOHSW approved a quality framework, "Tanzania Quality Improvement Framework." There is still, however, no comprehensive national quality assurance system in place. In 2012, the MOHSW is in the process of rolling out the Quality Improvement Framework, as outlined in the recent HSA. The central level will focus on strengthening its regulatory role, while the regional and district levels will implement service standards and facility accreditation. The same report revealed that MOHSW is struggling to meet its implementation plans (Health Systems 20/20 2011, 17–20).

It is important to note that the Quality Improvement Framework does not distinguish between the public and private sector, promoting a single set of standards and procedures to be applied consistently across the sectors. However, the MOHSW has recently been using facility standards as a means to de-register several private health facilities. Many of the private providers interviewed bitterly complained that the MOHSW was holding PNFP facilities to a higher standard, while a comparable public facility in the same community would not meet MOHSW's minimum standard. These actions put in danger the already fragile relationship between the public and private sector.

Inspection

A centralized inspectorate is in place, but needs to be decentralized. At the district level, CHMTs conduct regular supervision of public and private health facilities. In some cases, an APHFTA staff person is included in the CHMT supervision teams visiting both public and private facilities. According to the guidelines, each health facility should be visited four times a year. Each visit requires planning and preparation, the actual site visit, immediate verbal feedback, and final written feedback including a follow-up action plan. Both the HERA and the HSA studies found that the regularity of the supervision visits in fact depends on CHMT and available resources (Health Systems 20/20 2011, 17–20); some CHMTs give it priority while others do not.

Regulation and Supportive Supervision

Private facilities (both for-profit and not-for-profit) are regulated by the municipal health authorities. MOHSW representatives are expected to visit hospitals once per month and health centers and dispensaries once every one to two months. Regulatory visits include: gathering stock and dispensing information; vetting HIV and other essential health services; and ensuring adequate human resource coverage. CSSC facilities (in particular, designated district hospitals visited for this assessment) reported a positive relationship with municipal health authorities but acknowledged that this was because "the government takes responsibility for DDHs as they would for a public facility." Other private facilities reported variable interaction with regulatory health authorities, citing problems such as unpredictable visits, spot checks without adequate supportive follow-up, and limited opportunities to discuss problem areas. While the majority of private facilities visited acknowledged the imperative of effective regulation, several stated that regulatory requirements and findings were often too strict. For instance, facilities at the health center level and above are required to employ a full-time pharmaceutical assistant—but, due to shortages of qualified human resources in the country, many are unable to secure one even though they have funding to do so. While several private facilities stated that government regulatory visits could present an opportunity to improve their facility and services by revealing and addressing challenges, their experience was more punitive than supportive. There was widespread feeling expressed in the private facilities that regulatory supervision was carried out "to punish the private sector," flagging areas in need of improvement but without addressing the facility's limited capacity or knowledge to correct them.

Relationships between the Sectors

PMO-RALG

In Tanzania, public health services are provided through two government agencies—the MOHSW and PMO-RALG. The MOHSW is responsible for stewardship of the health sector as well as policy, planning, and other key governance functions. In addition, the MOHSW manages the referral hospitals. PMO-RALG, however, manages and administers the majority of health services under MOHSW's guidance and stewardship. For a variety of reasons, PMO-RALG has not been actively involved with MOHSW leadership, including the following: (1) PMO-RALG is responsible for implementing all social services at the district levels and below, of which health is just one of many and (2) PMO-RALG has not had the full-time staff—until recently—necessary to work closely with national- and district-level MOHSW leadership. Recently, PMO-RALG has assigned six full-time staff to work with MOHSW leadership, including one who will work on PPP issues.

Collaborative Planning

Although CSSC facilities (in particular, DDHs and voluntary agency hospitals) typically enjoy a high level of technical and administrative collaboration with

public health authorities, at the local level the annual process of creating the CCHP highlights the absence of private actors (both for-profit and nonprofit) in on-the-ground planning activities. While a limited number of private actors are typically engaged in the preparatory phase of CCHP creation, key informants state that private sector perspectives, input, and activities are often excluded from the formalization of CCHPs. Representation of commercial, FBO, and not-for-profit entities is described as "less than ideal," and those involved in the process are not "fully informed about the needs and capacity of lower-level private facilities." Private sector representatives state that they are asked to participate in "pre-planning" and/or provide financial information to inform preliminary budgetary discussions, but they are left out of formal planning dialogue. Conversely, several LGA representatives stated that the private sector needed to "understand how their work will support the work of the government" and "must understand how to align their activities with council priorities." Inclusion of private sector actors in council planning activities is often contingent on the motivation of LGA leadership; information exchange and multisectoral collaborative planning need to be prioritized. For example, in Arusha and Kilimanjaro regions few RCH-focused private sector actors have historically been invited to participate in regular quarterly maternal mortality audits. In order to strengthen council-level strategic planning activities, sensitization of LGAs on PPP mechanisms and collaborative operational planning are needed.

Coordination

Key informants frequently cited limited government capacity to effectively manage or engage all the relevant private sector actors as a reason for current limited engagement of private sector actors in health planning activities. Private/public platforms at the council level are either nonexistent or poorly coordinated, with rare exceptions where district health leadership has prioritized multisectoral involvement. FBOs (in particular CSSC facilities) are much more likely to participate in treatment and/or managerial coordination meetings; for-profit involvement, however, is an obvious gap in several of the regions visited. Barriers to more effective multisectoral coordination include lack of understanding of specific PPP mechanisms, roles, and responsibilities, and confusion over who should initiate and lead multisectoral coordination efforts. Several private actors stated they "were ready to be engaged," while LGAs stated that they were "without guidance or support from national level" to initiate PPP coordination activities. As in the case of planning efforts, larger facilities and those connected to apex organizations were much more likely to report participation in council or district planning activities. Prioritization of multisectoral stakeholder forums and private sector participation in mortality audits and other technical forums could significantly improve harmonized service delivery.

Information Exchange

Underpinning limited collaborative planning and service delivery coordination is a demonstrable lack of communication between public and private actors at all

levels of the health system. Although forums and TWGs have been established to encourage collaborative dialogue, fundamental differences of approach and opinion limit the efficacy of multisectoral communication. Public sector informants perceive private actors (particularly those in the for-profit sector) as uncooperative and solely focused on profit motives, and several private actors expressed a desire for public actors to acknowledge their contributions to the public good. These differences of perspective have limited effective dialogue. Private facilities are expected to provide various surveillance reports weekly, monthly, and quarterly, but they rarely receive any follow-up or report back on regional trends or data use. Some LGAs (RHMT/CHMT) are not providing adequate supportive supervision, leading many private actors to view these reporting requirements as punitive measures. Several RHMTs also lack sufficient quantities of data tools (that is, registers, monitoring and evaluation tools), and private actors are asked to report without the necessary materials. Lack of communication and communication failures are severely limiting opportunities for effective public-private collaboration.

Referral

Efficacy of referral between public and private providers was reported as highly variable. Informants from both public and private Level 2 and 3 facilities stated that lower-level PFP and PNFP facilities often referred patients to them for surgical, pediatric, obstetric, and other specialist consultation. In addition, public facilities sometimes refer patients to private specialist hospitals for complex lab investigations (for example, viral load). In almost all cases, the referring facility reported a lack of communication or follow-up from the receiving facility, with care providers often having to await the patient's return to learn the results. As one private provider stated, "a referral letter out is a 'closed case,' I won't hear back unless I know one of the consultant physicians working at the receiving hospital." Lack of referral communication is severely limiting effective care coordination. In addition, private providers stated that patients referred to public facilities reported abusive treatment when arriving at public facilities with a referral letter from a private facility. Strengthening the referral process between public and private facilities, as well as between PFP and PNFP facilities, is a key area to be strengthened in the interests of improved patient care.

Business Environment

Although the financial sector in Tanzania has expanded rapidly, with substantial growth in private credit, the banking system remains small, with limited access to financing opportunities for the private health sector. Among the banks interviewed by the PSA team, current banking investments in health businesses generally amounted to less than 1 percent of bank loan portfolios. Interviews conducted with the financial banking sector and private health facility managers confirmed the findings of the 2009 Dalberg Report (Dalberg Global Investment Advisors,

2009), which noted that the following investment needs in the health sector required greater access to capital:

- Expansion of clinical infrastructure for additional medical procedures
- Extension of health training facilities to some hospitals
- Equipment such as x-ray and ultrasound machines
- Hiring additional staff.

Access to Finance

Pharmacies and smaller clinics interviewed indicated a greater need for working capital to purchase medicines and reagents more regularly, and to improve facility infrastructure. The majority of private health practices in Tanzania are established with personal savings and/or loans from friends and families. In a few cases, private providers were able to secure a loan to initiate private practice because they had the requisite collateral. Many private providers stated that they were unable to expand to meet community needs with key services such as ART, TB, and expanded RCH services, because they had limited revenue to invest in facility and/or equipment upgrades.

Credit needs in the private health sector, and success rate in obtaining loans, varied by size of health facility and type of operation. Hospital managers interviewed indicated financing needs between T Sh 50 million and T Sh 150 million ($27,027 to $81,081) for equipment upgrades and infrastructure investments. Smaller facilities (for example, dispensaries) indicated financing needs of approximately T Sh 15 million ($8,108), both in working capital (to purchase pharmaceuticals and other commodities) and for larger investments in equipment and infrastructure. Larger dispensaries, health centers, and hospitals (with access to collateral) were more likely than smaller hospitals to succeed in obtaining loans for start-up or extension of the practice (Dalberg Global Investment Advisors, 2009). However—as indicated in the Dalberg Report—only 50 percent of health businesses that apply for loans are successful, and the majority of unsuccessful applicants are unlikely to try for a loan again (Dalberg Global Investment Advisors, 2009). The most prohibitive factor limiting commercial bank lending to smaller health businesses was identified as the collateral constraint—the central bank requirement of 125 percent collateral for term lending. In short, private practitioners seeking to initiate a new clinical practice and/or extend services at an existing practice face major constraints.

In general, while Tanzania's commercial banks and financial institutions are interested in expanding health sector access to finance, there is currently limited financial institution knowledge about health sector lending. All the commercial banks in Tanzania interviewed by the PSA team indicated an interest in pursuing opportunities to lend to the health sector, but also stated they do not fully understand the risks and challenges associated with lending in the health sector. Banks such as Akiba and NMB (with an emphasis on lending to small and medium enterprises [SME]) stated an interest in expanding their health sector lending, but said they would require additional market research to better understand the different

needs of clinical businesses, pharmacies, drug distributors, and other segments of the health sector. Opportunities exist to explore financing strategies to minimize commercial banks' risks. All the private financial institutions interviewed were interested in learning more about a proposed health sector development credit authority (DCA) as a mechanism to reduce risk and overcome collateral constraints. Many expressed an interest in learning more about potential health care loan products, with a focus on basic SME lending. Box 3.5 includes additional recommendations for increasing access to finance for private health facilities.

Box 3.5 Increasing Access to Finance

Why is it important? The private health sector's ability to access finance and capital is essential to its long-term sustainability and growth, as availability of financing has a strong impact on the quality of health services. Private providers usually work with financial institutions (for example, banks, investment firms, pension funds) to access short-term loans and long-term capital investments in order to upgrade and increase the size of their facilities, extend health training opportunities, lease and purchase equipment (for example, x-ray, ultrasound), and hire additional staff.

What are the challenges? Although the Tanzanian financial sector has rapidly expanded the availability of private credit in recent years, it is still relatively small and a limited number of banks have actual experience lending to the private health sector. This lack of experience has created a number of challenges:

1. Banks and investors may misjudge the risks and opportunities associated with lending to private facilities due to a lack of accurate understanding of the size and scope of the private health sector.
2. Many private providers are unaware of the steps in the loan application process.
3. Many owners and managers of private health facilities (often medical professionals) lack essential business and financial management skills. Without important documents like audited financial statements and strategic business plans, these facilities are limited in their ability to prove their financial worth and ability to repay loans.

Financial institutions have therefore instituted a number of risk mitigation strategies including high interest rates and strict collateral requirements—requirements that private health facilities are often unable to meet.

What should be done? Improving access to finance requires concurrently working with financial institutions and the private health sector to reduce the risk of investing in and making loans to private health facilities. There are two key approaches that key stakeholders should take:

1. Promote the use of financial management and administration best practices at private health facilities to help document their financial status and demonstrate their long-term feasibility. LGAs and private associations (for example, APHFTA, CSSC, and PRINMAT) could jointly finance, develop, and implement courses on contracts management, project

box continues next page

Box 3.5 Increasing Access to Finance *(continued)*

financing, and human resource management for their collective members. APHFTA currently offers a three-day course on basic financial management for members interested in participating in its Medical Credit Fund loan program that could serve as the basis for an expanded, more comprehensive effort.

2. Work with banks and donors to create new products and financing mechanisms including a health sector Development Credit Authority (DCA), loans targeted toward smaller facilities and pharmacies, and equipment leasing agreements.

These approaches would help in a number of ways. First, they would help private providers document their financial sustainability to potential lenders and investors. Second, they would prepare private facilities to engage in PPPs, especially those involving SLAs and other contracting mechanisms. By partnering with the public sector, private health facilities could demonstrate their long-term sustainability and make themselves more attractive options for investment financing. Lastly, they could create more favorable lending terms for the private health sector. A DCA through USAID/Tanzania, in particular, would help mitigate some of the risk to banks by partially guaranteeing loans to private facilities. Such a guarantee could result in loans that are more favorable to private health facilities (for example, lower interest rates, lower collateral requirements).

Terms of Finance

Even when a private provider is able to access financing through a commercial lending institution, the terms of the loan create additional constraints, such as burdensome collateral requirements, high interest rates, and limited capacity to apply for loans. Current loan size and tenor (term) are generally sufficient and not considered barriers.

The collateral requirement greatly restricts access to finance, especially for sole proprietorships (the majority of private health practices). The Central Bank of Tanzania has several measures in place on commercial lending which include the following: (1) limitations on foreign lending, (2) low single obligor limits, and (3) a 125 percent collateral requirement for commercial loans (with the exception of loans that are 100 percent cash secured). The vast majority of commercial banks interviewed require collateral in the form of property or land. Some banks—notably Akiba Bank—indicated flexibility in terms of accepting movable collateral for term loans. Akiba will accept movable collateral up to T Sh 20 million ($10,810) and even 75 percent collateral for short-term loans with a tenor of less than one year. For credit requests with term loans over a year and/or over T Sh 50 million (around $27,000), Akiba Bank requires fixed collateral in the form of land or title to real estate. In terms of microfinance institution lending, the micro-finance institution Tujijenge requires that individual loans be collateralized by 10 percent cash and 90 percent movable collateral.

Many of the private health providers interviewed indicated a willingness to pledge fixed collateral such as land or homes—but, given the high cost of medical

equipment and facility renovations, they questioned whether the collateral would be sufficient to obtain the loan amounts needed. Further, several of the commercial banks interviewed indicated that the lack of a credit reporting system makes it difficult to ascertain the credit worthiness of loan applicants, therefore necessitating adhering to the Central Bank collateral requirement.

High interest rates are another key constraint. Nominal interest rates in Tanzania are high, but with approximately 18 percent inflation as of April 2012, real interest rates for SME lending range from 18 to 22 percent. Private providers interviewed stated that interest rates at or above 20 percent were a major constraint to borrowing.

Health practice managers reported low knowledge and capacity for applying for bank loans as well as a perception that banks require too much information on loan applications. Most health practices interviewed by the PSA team were unable to provide adequate revenue and expense information; they therefore could not satisfactorily complete a "bankable" loan application because they could not demonstrate capacity to repay the loan. Many small facilities lack accurate monthly revenue and expense calculations or financial statements, as most maintain only a basic cash flow record. Commercial banks interviewed cited the lack of regularly audited financial statements and business plans as key problems in extending credit to the private health sector. Larger facilities employing full-time accountants and financial support staff are more able to provide regularly audited financial statements—a contributing factor for higher rates of lending to larger private health facilities. Limited business and financial management skills are another constraint in securing loans, as doctors are often not trained in business skills or their management role, and most medical support staff lack financial management skills.

Current loan size and tenor are generally sufficient and not considered barriers. All of the Tanzanian commercial banks interviewed offer medium-term loans of three to five years—with three-year terms preferred by most banks. The vast majority of private health businesses interviewed did not cite tenor of loans as a major problem, though they indicated the need for tenors as long as 10 years, given their interest in costly infrastructure improvements and/or purchase of expensive diagnostic equipment. While the availability of term financing is not a serious problem in Tanzania, tenors of 10 years, though feasible, may be more difficult to obtain, dependent on market conditions. Loan sizes offered by most commercial banks are appropriate for the physical capital needs of most private health facilities interviewed (between $540 and $4,000 minimums, and $250,000 to $540,000 maximums). However, as stated above, the collateral required to access larger loans is beyond the reach of most private health practices.

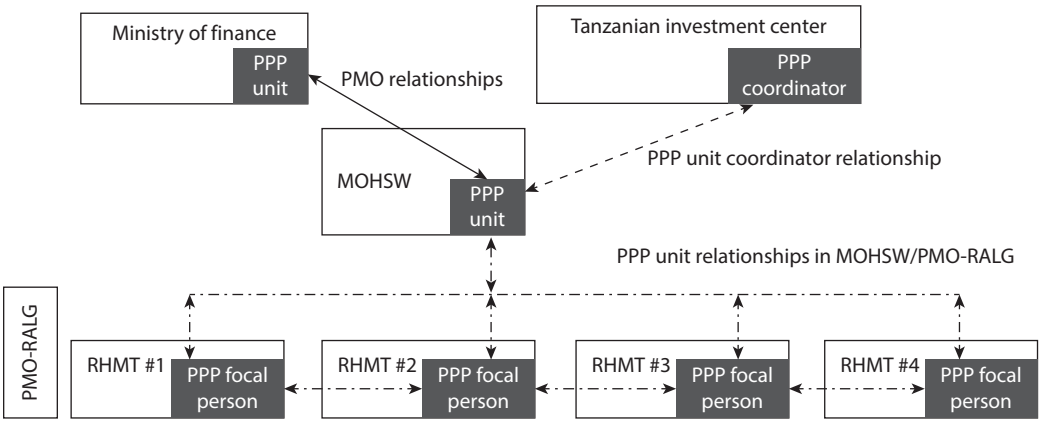
As the MOHSW and vertical disease programs seek to expand private health sector involvement in key health challenges such as HIV/AIDS, malaria, TB, and RCH, improving the terms for financing will help private facilities to upgrade infrastructure and purchase commodities as required to expand their services. (For more information on each of the financial institutions, please refer to Annex E.)

Institutional Structure

The PPP Act and other legislation have established institutional structures to operationalize the PPP Act and to implement PPPs in all facets of the Tanzanian economy including health, and to dialogue and promote PPPs. For an in-depth description of the institutional structure to implement general PPPs, refer to appendix D. The following is an overview of the institutional structure to implement PPPs in health. Figure 3.2 illustrates the external relationships between the MOHSW and other government agencies as well as the internal relationships.

The PMO, through the Tanzania Investment Center (TIC) and MOF, oversees all PPPs in Tanzania. TIC recently established a PPP Coordinating Unit to perform an advisory role for all ministries including health; this unit is available to assist the MOHSW PPP Unit to identify, structure, vet, and monitor PPPs. In addition to advice, the PPP Coordinating Unit performs technical review and oversight. Once the MOHSW PPP Unit has structured a PPP deal and it has been approved by the ministry leadership, then the MOHSW PPP Unit must submit *all* its PPP proposals to the PPP Coordinating Unit. The PPP Coordinating Unit analyzes the PPP proposal to ensure that it is technically sound and compliant with the law and guidelines (for example, the PPP is well designed). The MOHSW PPP Unit has presumably ensured that the PPP aligns with ministry priorities. It is important to note that the PPP Coordinating Unit does not have the authority to reject a PPP proposal. Its role is strictly advisory, and it can only make recommendations on strengthening the proposal and/or on whether to proceed with the PPP. The MOHSW PPP Unit must also submit *all* PPP proposals to the MOF. The MOF performs fiduciary oversight and focuses on risk, finances, and due diligence. Even though some of the PPPs may not require government financing, each and every one still must be submitted to the MOF for review. As noted, the PPP Guidelines are in review, and many of these details are under discussion.

Figure 3.2 Health PPP Implementation Structure



Source: World Bank data.

The PPP Act defines "contracting authority" as any Ministry, government department or agency, LGA, or statutory corporation. At the national level, this would most often be the Permanent Secretary for the MOHSW; however, at the LGA level, the contracting authority would most often be the District Executive Director, bringing the function under the scope of PMO-RALG (figure 3.2). The MOHSW PPP Unit is responsible for identifying, structuring, vetting, financing, and monitoring PPPs. It is important to note that the MOHSW is one of the first ministries to establish a PPP Unit (others include Finance, Agriculture, and Transportation). Based on history, the MOHSW PPP Unit resides within the Department of Curative Services, because the first types of health PPPs involved hospitals the PPP functions accordingly emerged from this department. MOHSW leadership is discussing moving the PPP Unit to the Department of Policy and Planning, a more common location of health PPP Units (PSP-O*ne* 2009).

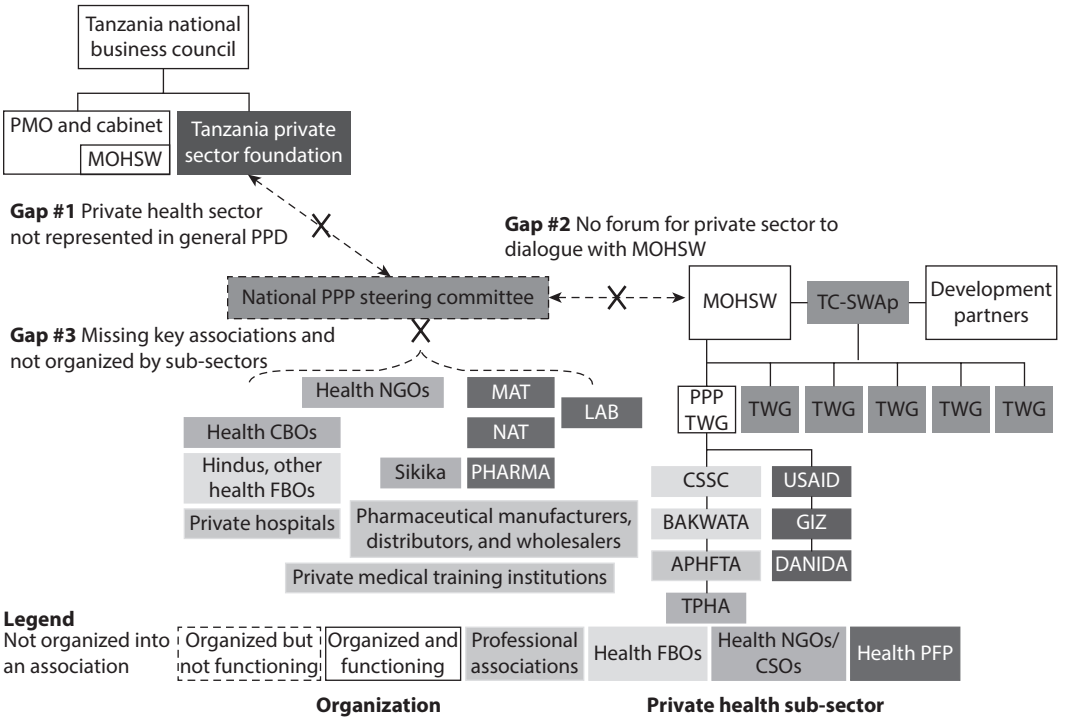
The MOHSW PPP Unit is a small unit with major responsibilities. Currently the PPP Unit has only one staff person, supplemented by DANIDA's long-term resident adviser, and has minimal resources to hire short-term consultants to help with its scope. The Unit's primary roles and responsibilities include the following: (1) provide advice on strategic use of PPPs; (2) raise awareness on and advocate for PPPs in health; and (3) assist MOHSW departments to implement PPPs. The Health PPP Strategy plans to create regional capacity in PPPs by assigning a PPP focal person, first at the regional level and eventually at the council level. When this strategy is in place, the PPP focal person will be responsible for identifying, negotiating, designing, vetting, and implementing (including monitoring and evaluating) the health PPPs, with help from the PPP Unit. In addition to providing these advisory services to MOHSW staff, the PPP Desk Officer is also responsible for managing the health PPPs through the approval processes with the MOF and for coordinating with the PPP Coordinator at the TIC.

Forums to Dialogue on Public-Private Partnerships

Network for Africa, a SHOPS-managed online community, brought together public and private sector stakeholders from across Africa at two recent technical exchanges in Mombasa and Dar es Salaam to share PPP best practices and lessons learned. Participants at both workshops underscored the importance of public-private dialogue (PPD). All participants agreed that such discourse is a necessary condition before ministries of health can begin to implement PPPs, as the dialogue helps build trust, facilitates an enabling policy environment, identifies opportunities, and promotes PPPs in health. (For an in-depth description of the general PPD forum, please refer to Annex D.) The following section describes the evolving PPD forum in the health sector.

Figure 3.3 presents the various stakeholder groups within the health sector, as well as the different health PPD forums. The first PPD forum is the National PPP Steering Committee (NPPPSC) that has been somewhat active since 2004. It evolved from an informal group of "interested partners" to a group recognized by both the MOHSW and the donor community. The NPPPSC played an

Figure 3.3 Public-Private Dialogue Structure in Health



Source: World Bank data.

integral role in several initiatives, such as incorporating private perspective into HSSP III, developing and pioneering the SLA, and drafting the first-ever Strategic Health PPP Plan in 2009. Since then, the NPPPSC has taken a back seat to the PPP-TWG. Even after the PPP-TWG drafted and agreed on the terms of reference and identified the 20 participating stakeholder groups, the NPPPSC was never formally established. Confusion between the different mandates of the NPPPSC and PPP-TWG was cited in interviews as one of the main reasons.

The second and possibly most important PPD health forum is the TC-SWAp, a comprehensive government/development partner coordination mechanism. The Permanent Secretary for Health and the leader of the Donor Group colead the TC-SWAp. The TC-SWAp sets the agenda and direction for the annual work plan. There are 11 technical working groups (TWGs) formed around the priority areas identified by the Permanent Secretary. The TWGs draft annual work plans with specific targeted results and are obligated to report twice a year on progress toward achieving the milestones.

The third forum, which is the only PPD, is the PPP-TWG. The 2009 Health Sector Review discussed the possibility of establishing more health PPPs to address service delivery gaps and recommended forming a coordinating body between the public and private sectors. In response, the TC-SWAp created the

PPP-TWG in 2010. There are 12 members. The MOHSW PPP designated officer, with assistance from the private sector, chairs the PPP-TWG. PNFP and PFP organizations actively participate, including APHFTA, BAKWATA, CSSC, and TPHA. Development partners who support the private sector, such as DANIDA, GIZ, and USAID (representing the Development Partners Group for Health) are also very active.

Many stakeholders interviewed for this assessment indicated that the PPP-TWG has been particularly productive. The main functions of the PPP-TWG are to (1) exchange information between the sectors; (2) coordinate programs and activities across the health sector; and (3) report on progress toward achieving its results to the TC-SWAp. The PPP-TWG meets every month, and there are many informal interactions among PPP-TWG members as well. As a group, they also attend and participate in other policy and planning venues, such as the joint annual health sector review meeting, yearly annual work plan, and drafting the five-year strategic planning. Attendance has been consistent among a small core group of PPP-TWG members. A few of the original PPP-TWG members, such as Sikika, have stopped attending, citing various reasons: (1) there are so many TWGs that they had to prioritize and therefore dropped out; and (2) they believe that the donors heavily influence the TWG's agenda. Their absence represents a significant gap in CSOs representing consumer and academic perspectives on health sector issues.

As figure 3.3 illustrates, key segments of the PFP and PNFP sectors in health are still underrepresented in health policy and planning. There are varying reasons why these subsectors are excluded:

- The health NGOs constitute a broad range, from international- and national-level NGOs delivering health services to policy and advocacy NGOs advocating on behalf of various constituency groups. The existing umbrella NGO organizations do not "fit" the entire health sector. The Tanzanian Association of NGOs—a network representing and building NGO capacity —includes all development NGOs, including health. Similarly, the NGO Policy Forum brings together policy and advocacy NGOs, but health NGO participation in this forum has been very limited. Finally, the MOHSW is at times reluctant to involve health NGOs. The diversity of the NGO sector, along with the sense that NGOs operate outside the MOHSW's jurisdiction, fuel suspicion and mistrust exist between the public and NGO health sectors.
- Diversity, geographic remoteness, and large numbers prevent the health CBOs from organizing and participating in health planning and policy. There is a significant number of CBOs—by some estimates, well over a thousand (HERA 2005, 39). This group of health actors comprises small, locally based groups providing support/welfare services in health, most often located in remote areas. Many CBOs have been mobilized to support family planning/reproductive health and HIV/AID services. In fact, United States' President's Emergency Plan for AIDS Relief (PEPFAR) has fueled an expansion of CBOs to provide VCT, home-based care, and PMTCT.

- There have been efforts among the professional health associations to organize into an HRH umbrella organization. There are over 26 associations representing a wide range of health cadres. Key among them are the Medical Association of Tanzania (MAT), the aforementioned PRINMAT, and the Medical Laboratory Scientists Associations of Tanzania. The professional health associations have established the Tanzania Health Professional Association as an apex body with its own constitution. Interviewees from these associations expressed a keen desire to be more formally involved in policy and planning, but observed that there is no forum or mechanism to dialogue with the MOHSW. The same informants reported that there is no formal relationship between the MAT and private sector providers. The relationship with APHFTA is collegial, they said, but there is room to strengthen it.
- Unlike other East Africa countries, important segments of the PFP sector (such as private hospitals, pharmaceutical manufacturing, distributors and wholesalers, and PMTIs) have not organized into collective groups. APHFTA concurs that there is a need for an umbrella organization that represents *all* PFP activities, to capture those PFP actors that are not facility based.

Figure 3.3 also reveals that the private health sector is not present in any governmentwide PPD. Although the MOHSW participates in the Tanzania National Business Council (TNBC) biannual meetings, there is no equivalent private sector partner in the Tanzania Private Sector Foundation (TPSF). As in some other countries, such as Kenya and Uganda, the Tanzanian health sector is not only an important social sector but is also an engine for economic growth.

Key Findings

Figure 3.4 reviews the operating and policy environment in Tanzania, gauging the extent to which they support, or inhibit, private sector engagement in health, and provides an overview of the key findings in the form of a score card measuring the enabling environment.

Political commitment exists at all levels of the GOT supporting PPPs. Since 1994, there has been a sea change in the Tanzanian government's mindset toward the private sector. The government no longer discusses "whether we should" work with the private sector but is now focused on "how can we partner" with the private sector. In Tanzania, the current policy discussions focus on how to make PPPs work for the maximum benefit of all stakeholders. The political commitment to engage and partner with the private sector comes from the top, starting with the PMO and the MOF and reinforced by MOHSW leadership. This commitment is strongly supported by development partners in the health sector.

The Tanzanian health system has gradually developed into a more diverse and pluralistic sector, taking into account all types of services providers, and progressively embraces a vision of the health sector as one health system. With this new vision, the MOHSW is evolving toward a more regulatory role with policy responsibilities: leading health sector reform, policy making, and strategic

Figure 3.4 Enabling Factors Score Card

Enabling factors	Low	Med	High	Notes	
Political will and willingness to work together		✓		+ Top-level gov't commitment (OPM) + Strong support from MOHSW leadership + Donor commitment and investments in private sector	– Unclear understanding of PPPs
Policy forum with shared leadership and balanced representation		✓		+ Increasing trust with both PNFP and PFP + Excellent coordination and information sharing through PPP-TWG	– No sector-wide forum to dialogue
Supportive policy and regulatory framework			✓	+ Private sector involved in policy/planning at national level + Comprehensive policies in general and in health + All health policies and planning documents acknowledge private sector contribution + Few regulatory barriers for private sector	– Private sector not involved in policy and planning at LGA level
Government institutional structures (med) and capacity	✓	✓		+ PPP unit established + Guidelines to implement PPPs in place	– PPP unit under resourced – Little capacity and insufficient systems to expand contracting function – Few LGAs understand PPPs and service agreements
Favorable business environment Financing and other incentives to work together	✓ ✓			+ Gv't procures services through service agreements + Increasing private sector interest to coordinate and partner with gov't + Gv't financing policy permits public and private health insurance + All health insurance schemes include private providers	– Access to capital difficult and expensive – Poor and limited business skills – LGAs unclear if can use service agreements to contract PFP – Basket guidelines unclear if can fund PFP – Health insurance market too small to incentivize PFP
Organized private sector and structures with capacity	✓			+ PFP and PNFP have significant infrastructure and national reach + PNFP well organized + PPP-TWG facilitates coordination and partnerships + /– Potential for low-risk, high-impact PPPs + /– Emerging experience in PPPs	– Many important PFP actors not integrated into dialogue – Many important PFP representational organizations are weak – Limited private sector capacity to broker and manage PPPs
Community demand for quality health services			✓	+ Community demand is high for quality health services through the private sector + Private sector wants uniform standards in place + Positive experience in joint supervision of public and private sector facilities	– Limited government capacity to monitor quality – Uneven enforcement of quality standards between public and private sectors

Source: World Bank data.

planning for the whole health sector; ensuring quality and safety of all health services and products; and monitoring and evaluation. At the same time, a growing number of districts and councils are involving other stakeholder groups in planning, financing, and delivery of services.

Still, some MOHSW leadership and staff are reluctant to collaborate with for-profit providers, while many do not fully understand the term "PPPs." The resistance to the commercial sector reflects a lack of trust between the sectors, a persistent "us" versus "them" attitude, and myths about the private sector not based on evidence and information. A key issue is the matter of profit: the public sector struggles with the private sector's need to earn a profit on health activities; and the private sector resists transparency regarding its costs of service delivery. The 2005 HERA report identified the problem of MOHSW's misunderstanding

of the PPPs, and seven years later this confusion still persists, particularly at subnational levels. For example, some district and regional staff narrowly define PPPs as collaboration only with FBOs to deliver health services. Others use PPP narrowly to mean SLAs and contracting of health services. Very few, in fact, from national to regional management, understand a fundamental principle of PPPs: partners enter into the partnership as equals.

There are comprehensive legal and regulatory policies supporting the private health sector. Since the groundbreaking 2005 HERA Technical Review, there has been much progress toward creating an enabling legal and regulatory environment for health PPPs. Several laws and policies acknowledge and appreciate the role of private sector in health. The PPP Law and the just-released PPP standards provide the overarching framework for PPPs across all sectors in the Tanzanian economy. Moreover, there is strong support from the PMO and PPP Commissioner for the health sector to take a lead role in translating the PPP Law to the health sector. The MOHSW has involved key stakeholders to establish the various instruments needed to successfully partner with the private sector: PPP Health Policy; PPP Strategic Plan; and PPP Guidelines (in draft). In fact, Tanzania has one of the most comprehensive policy frameworks on health PPPs in the region and should be commended for its leadership in this area. With this framework in place, it is time to foster a conversation between the sectors to raise awareness of the new policies and regulations and to ensure their impact on planning and programming services and other key activities in the health sector.

There remain, however, some gaps in regulations that directly impact the private sector:

- *Lack of national standards for accreditation and quality assurance.* Quality in the private sector is variable; there is a wide range of providers ranging from formal to less formal actors, who often work in poorly regulated environments. Quality is variable, however, in the public sector as well. Creating national standards that treat public and private facilities as equals will incentivize both types of facility to maintain or improve quality. Moreover, standardized accreditation systems could be linked to public health goals, helping align private providers to national health objectives.
- *Inefficient and costly facility licensing process.* The HERA report underscored the time and costs expended by private providers to obtain and renew a facility license. Interviews revealed that the MOHSW applied these regulations differently between public and private sectors, for example, closing a private facility while allowing a public facility in the same area to operate without meeting government standards. Updating registration criteria in light of new accreditations standards and streamlining the facility licensing process will encourage private providers to comply with standards—but only if the regulations are applied uniformly across sectors.
- *No requirement for continuing professional development (CPD) when professionals renew their licenses.* Existing legislations allows for permanent licensing and

does not require CPD. MAT, in collaboration with the Medical Council, is currently reviewing the Medical Act with the goal of changing the Act to require renewal of a professional license every two to three years, based on achieving CPD hours. MAT has developed a framework and is currently piloting it. While the Pharmacy Council requires CPD hours for pharmacists and pharmacist technicians to renew their licenses every three years, to date it has only developed the training curriculum and has not yet started training or established a system to confirm CPD hours.

The PPP Unit is underresourced for its mandate and scope to engage the private sector. The MOHSW has created a comprehensive and realistic policy framework on paper to enable health PPPs, but it has yet to make it a reality in practice. To move the health PPP agenda, the MOHSW will need to invest in and build its own PPP Unit, operating at the central and regional levels. Challenges facing the PPP Unit in health include the following:

- *Insufficient resources and staff assigned to the PPP Unit*. The PPP Unit receives a modest budget from the MOHSW, supplemented by donor funds. The budget covers the salary for one full-time person, and a full-time resident adviser is sponsored by DANIDA. But the budget does not exist for the PPP Desk Officer to hire the short-term technical staff needed to become fully operational (for example, to conduct the policy/legal reviews, build the operating systems, and carry out training).
- *The PPP Unit is missing basic tools and systems.* Other African PPP Units have simple instruments to guide the PPP Unit's operations, such as terms of reference, a working definition of health PPPs to fit the national context, job descriptions for PPP Unit staff at the central and regional level, and an organization chart explicitly linking the PPP Unit to other government agencies and establishing lines of authority and communication between the Central PPP Unit and the PPP Focal Persons. Brokering PPPs requires guidelines and systems. The MOHSW should be recognized for its role in drafting guidelines for health PPPs in Tanzania, which are close to finalization. What is missing are standardized processes, such as: a PPP tracking system; a uniform and open tender process; a consistent approach to due diligence, risk analysis, costing, and evaluation; and PPP monitoring and tracking.
- *The PPP Unit requires new skills and competencies* such as health economics, financing, contract law, dialogue and facilitation, and program management. The MOHSW capacity in these areas resides in the Department of Policy and Planning, and the PPP Unit has difficulty tapping these resources given its current location in Curative and Hospital Services. The PPP Unit needs to reside in a department with like-minded professionals working on health system issues. Moreover, it is critical to build current staff's capacity in some of these areas, as well as to allocate sufficient funds to allow the PPP Unit to hire short-term TA in missing skills areas.

- *Lack of understanding and practice in health PPPs.* The PPP Unit relies on the regional and country units to propose PPP opportunities. However, PPPs are not included in CHMT's scope of work and routine activities. As a result, these units do not actively involve the private sector stakeholders, particularly for-profit ones, to participate in policy and planning. If private actors are invited to a meeting, it is done in a way that makes it difficult for them to participate. Moreover, there is still considerable confusion on whether basket funds can be used for PPP with PFP partners.

There are significant market barriers limiting private health services, including access to affordable financing. Despite the very favorable policy environment, there are certain conditions in the business environment that present barriers to entry into the health market. The current tax structure creates disincentives for PFP providers to expand services; as volume and size of facility increase, so do taxes. Moreover, private providers do not quality for tax exemptions or receive donated inputs, as do FBO/NGOs, even when they deliver an essential health package. The absence of financial incentives (for example, greater opportunities for contracting and other partnership arrangements, participation in coordinated public health insurance schemes) will limit private sector growth into the essential health services where they are needed most. Limited access to finance and terms of loans (for example, interest rates) also create strong barriers to private sector expansion. Finally, many private providers, particularly those in solo practice, do not have business and financial skills needed to manage their private practice or to qualify for a bank loan.

The absence of a sectorwide PPD forum in health inhibits effective multisectoral dialogue. By all accounts, both the TC-SWAp and PPP-TWG have been effective coordination mechanisms between the public and private health sectors. In Tanzania, donors have a positive working relationship with the MOHSW and collaborate well between themselves. Similarly, the PPP-TWG has been an effective mechanism for collaboration between the public and private sectors. The PPP National Steering Committee (when active) and the PPP-TWG successfully created a "space" that did not exist before, to work on policy and planning with the MOHSW and for bringing this sector into the donor sphere of influence. And the PPP-TWG has helped build trust between the sectors, demonstrating they can successfully work together to accomplish important results such as establishing a PPP Unit (2009), developing terms of reference for the NPPPSC (2010), drafting the PPP Health Strategic Plan (2011) and PPP policy guidelines, and developing a PPP tracking framework (2012).

As effective as the PPP-TWG may be, it has its limitations as a national forum for public-private dialogue. First, the PPP-TWG primarily focuses on donor-sponsored activities and is not designed to be a public-private forum that addresses health sectorwide issues. Its main purpose is to coordinate all donor activities with the MOHSW that involve working with the private sector. There

is an opportunity for the PPP-TWG to mainstream private sector collaboration into the other TC-SWAp working groups (organized by the WHO health system building blocks) and to assist them in identifying concrete partnership opportunities. Potential examples include the following: (1) conducting studies to document private finances to inform the health finance working group, (2) promoting sectorwide labor planning in the HRH working group, and (3) assisting the LGA working group to involve PFP and PNFP stakeholders in decentralized budgeting and planning. Second, the PPP-TWG does not include key segments of the PNFP sector (see figure 3.3): since many of these groups are not part of donor programming, they do not have a role to play on the PPP-TWG. And because some of the subsectors, such as private medical training institutions or pharmaceutical manufacturers, are not organized into umbrella associations, it is difficult to invite them to participate in a forum like the PPP-TWG. In short, without the NPPPSC, there is no forum for all private stakeholders to discuss health sector policy and planning issues that affect the entire sector.

Recommendations to Strengthen the Enabling Environment

This section offers concrete recommendations and next steps to foster a more positive environment to harness and grow the private health sector in Tanzania.

Strengthen national capacity to effectively regulate, supervise, support, and assure quality of health services and goods in both the public and private sectors. The PSA revealed three key regulatory areas that can improve the quality of private health services: (1) strengthening national standards for accreditation and quality assurance; (2) streamlining facility licensing process; and (3) requiring CPD for professionals to renew their licenses. Given the importance of these reforms, the PSA team recommends consistently involving private sector leaders and representatives from the start in a consultative process. The MOHSW can work through the National PPP Steering Committee to spearhead this process.

Address barriers to private health sector access to affordable finance. The PSA team recommends a multipronged approach to increase access to credit and strengthening private providers' business skills. (1) Work with APHFTA on improving the business management training materials for private health providers. (2) Develop a DCA guarantee for the health sector and work with financial institutions to expand health sector lending, through training bank staff as well as developing new products such as leasing. (3) Analyze the level of profitability for various types of health businesses in Tanzania to gauge whether loans are affordable (and whether interest rates are too high).

Target and harmonize incentives for private health sector actors delivering identified essential health services. Private providers interviewed stated that high taxes and levies can deter them from expanding their preventive and curative essential health services. For example, PFP providers are penalized through taxes when they expand services, and they pay higher costs to access needed equipment and drugs even when used for government priority health services.

This is also an issue for many FBO/NGOs; although they are tax exempt, they still pay levies which contribute to increasing service delivery costs. The investment branch at TIC described a simple process to apply for tax relief: the facility or organization submits a proposal that (1) analyzes tax/tariff/value added tax impact; (2) makes the case that tax/tariff/VAT limits private sector development, economic growth, and job creation in the health sector; and (3) explains how growing the private health sector also provides a public good for example, health impact). TIC responds to proposals within six months.

Establish and strengthen institutions and processes for effective public-private dialogue. There are different strategies needed to put into place the institutional arrangements needed to facilitate greater public-private sector interactions. In the case of the public sector, the government needs to invest in building the systems and capacity of the key entity charged with engaging the private sector—the PPP Unit. The private sector, on the other hand, needs to get organized by creating new structures that represent key subgroups. Finally, the National PPP Steering Committee should transform into a sectorwide level.

MOHSW and PMO-RALG. Although PMO-RALG has recently made efforts to strengthen its relationships by assigning six new full-time staff to work directly with MOHSW, more needs to be done. Involving the PMO-RALG actively and systematically in key MOHSW functions and processes will help strengthen the relationship and improve coordination between policy and implementation of health services. Moreover, bringing PMO-RALG closer will also help the integrate private providers into the overall health system The nexus between the public and private health sectors is the CCHP process in which budgeting and planning decisions, including coordination between the sectors, are made. PMO-RALG has established guidelines on how to carry out the CCHP process. The PPP Unit can work more closely with PMO-RALG to ensure that the guidelines include other key stakeholders in health like the private sector.

MOHSW PPP Unit's capacity. The MOHSW has put into place a comprehensive policy framework supporting PPPs in the health sector, but it has been slow to develop a substantial number and broad range of health PPPs. The primary constraint is the PPP Unit's limited capacity. The PSA recommends that MOHSW and donors fully invest in the health PPP Unit in the following areas: (1) increasing the number of PPP Unit staff; (2) training a core group in new skills areas; (3) standardizing operating systems to build, track, and assess PPPs; (4) training central- and regional-level staff in new operating systems; and (5) assisting PPP Unit staff to broker the first round of health PPPs.

Umbrella organization for the private health sector. The health PPD forum's success rests on two crucial assumptions: (1) an organized private health sector and (2) strong member organizations. There is still considerable room to further organize the private health sector. The PSA team determined that many of the recommendations proposed in HERA 2005 to structure the private sector have

not been implemented, due in large part to lack of trust and suspicion between the sectors. Lack of organization of the private health sector will jeopardize the NPPPSC's ability to foster dialogue and create meaningful exchange between the sectors. The PSA team believes there has been a substantial change in attitudes and perceptions between the two sectors, and that the timing is right to "push" the Tanzanian private health sector to get organized.

Elevate public-private dialogue to a sectorwide level. Even though the PPP-TWG has been an effective and productive PPD forum in health, all the PPP-TWG members interviewed noted a need to formally establish the National PPP Steering Committee as a sectorwide forum. Formalizing the NPPPSC will address many of the PPP institutional and organizational gaps identified in the analysis.

- It will create a space for all private health sector groups to discuss health system issues that directly impact their constituencies. Moreover, the forum will allow the various private actors to participate more consistently with the MOHSW in policy and planning at the national level.
- It will incentivize the different sectors, such as the professional associations and larger health NGOs, to organize themselves, by providing a purpose and a forum for them to advocate. Moreover, as the sectors organize and effectively dialogue with the MOSHW, groups like the CSSC may be supported to revive the Tanzania Interfaith Forum initiative to form a powerful intergroup.
- It can join the TPSF and fully represent all the private health sector interests in national forums like the TNBC. Participation in such a national forum will give the health sector the focus and attention it merits, given its economic size and development importance.

To avoid becoming a "talk shop" in which few decisions are made and no actions are taken, it is important that the sector-wide forum be defined as "problem driven and action oriented" by narrowing its activities to focus on concrete actions in which the public and private sector can work together. Examples include addressing market barriers (for example, tax structure), public-private collaboration to accelerate TB control, and expanding health services to underserved areas through existing infrastructure (including private health sources).

Strengthen information sharing and networking at all levels. A short-term win is to bring together the public and private sector to agree on key health indicators that they will regularly report on to the MOHSW. In exchange, the MOHSW will agree to share more widely ministry plans and reports to help inform the private sector on government priorities. Another "quick win" is to review the annual meeting and planning processes at the national and district level to identify opportunities to involve the private sector. Two examples include inviting a wider range of private sector groups to participate in the Annual Health Sector Review and to clarify the norms guiding the CCHP

process to identify and involve key private sector groups in each council and district.

Notes

1. In a privatization model, a public enterprise is shifted completely to the private sector. PPP models include a number of different partnership arrangements ranging from informal, ad hoc PPPs to more formal, structured partnerships, such as contracts and leases.
2. Based on stakeholder interviews and synthesis of HERA Technical Review (HERA 2005, 28–32).

CHAPTER 4

Service Delivery in the Private Health Sector

A wide range of facilities managed by the private health sector are making significant contributions to health service provision in Tanzania. As indicated in table 4.1, of the estimated 6,342 health facilities operating in Tanzania, 1,924 are run by parastatal, PFP, or PNFP organizations—meaning that over one-third of general health services in the country can be accessed through private sector health facilities. In some geographic areas, the private sector (for-profit and not-for-profit) is the principal supplier of health services. For example, only 11 of the 63 health facilities in Moshi municipal council are operated by the government, with more than 82 percent of council health services provided by faith-based and for-profit health facilities. The private health sector—through the provision of human resources, specialized diagnostics, and consultative services—has been critical in extending the reach of government health services into rural and hard-to-reach areas.

As shown in figure 4.1, private health facilities currently contribute to service delivery at all levels of the Tanzanian health system—from village- and ward-level dispensaries and maternity homes to high-level specialist and designated referral hospitals at the regional and zonal levels.

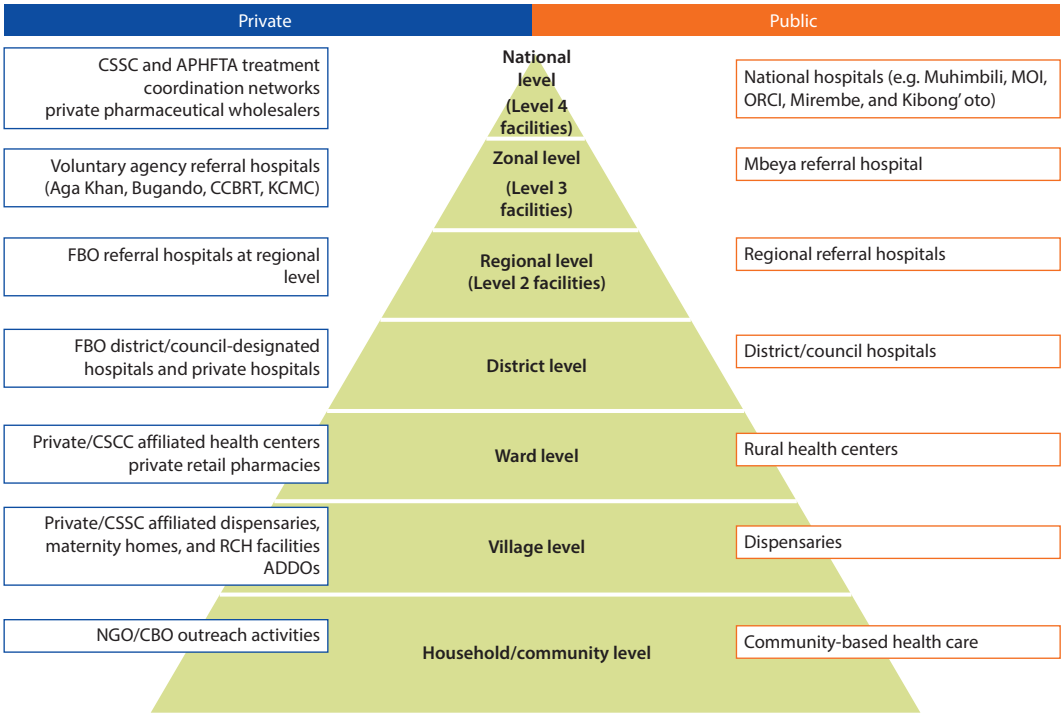
The Tanzanian private health sector is an important source of both general and specialist health services in the country. Particularly in the key health areas

Table 4.1 Total Number of Health Facilities in Tanzania

Facility type	*Government*	*Parastatal*	*PNFP*	*PFP*	*Total*
Hospitals	95	8	101	36	240
Health centers	434	10	134	55	633
Dispensaries	3,889	168	625	787	5,469
Total	**4,418**	**186**	**860**	**878**	**6,342**
Percent of total	**69.6**	**3.0**	**13.6**	**13.8**	**100.0**

Source: MOHSW 2012.
Note: PFP = private for-profit; PNFP = private not-for-profit.

Figure 4.1 The Tanzanian Health System Referral Pyramid



Source: World Bank data.

of HIV/AIDS, RCH, TB, and malaria, the private health sector serves as an important extension of and complement to public provision. (For a comparison of such key health metrics in Tanzania and Sub-Saharan Africa, see appendix F.) Although a large proportion of private provision occurs in the absence of formal agreements (SLAs or memoranda of understanding [MOUs]), the leadership of Tanzania's vertical disease programs have acknowledged the important contributions of private sector actors in these health areas. Using THE as a proxy for facility use, table 4.2 demonstrates that, although the public health sector remains the main source for key health services, private health facilities (in particular PNFP facilities) are making significant contributions in the delivery of HIV/AIDS, malaria, and RCH services. Each of these areas is discussed in detail below.

Table 4.2 Provider Distribution as a Percentage of Total Health Expenditures

Facilities	*% of THE*	*% of THE_{HIV}*	*% of $THE_{MALARIA}$*	*% of THE_{RCH}*
Public facilities	46.6	35.9	52.5	67.9
PFP facilities	7.6	2.7	5.9	6.9
PNFP facilities	13.5	14.6	13.4	18.0
All health facilities	67.7	53.2	71.8	92.8

Source: Department of Policy and Planning, MOHSW, 2012.

HIV/AIDS

With an adult (15–49 years) prevalence of around 5.6 percent, mainland Tanzania has a high HIV burden: approximately 1.4 million people are living with HIV; 105,000 new infections are diagnosed each year; and 85,900 annual AIDS-related deaths are recorded. Prevalence is higher among women than men (6.6 percent vs. 4.6 percent) and in urban rather than rural areas (8.7 percent vs. 4.7 percent). Although still high, the adult prevalence rate has declined since 2003/04, when it was 7.0 percent. Adult HIV/AIDS mortality has also contributed to an orphan crisis in Tanzania, with an estimated 970,000 orphans and vulnerable children as a result of the epidemic. Updated surveillance and prevalence data are expected soon as a result of the MOHSW's ongoing AIDS/Malaria Indicator Survey.

Provision of Private Sector HIV/AIDS Services

Tanzania's HIV/AIDS response is coordinated by two separate programs: the National AIDS Control Program (NACP), and the Tanzanian Commission on AIDS (TACAIDS). The NACP was created in 1988 to serve as the main implementing arm of the MOHSW's response to the HIV/AIDS epidemic. This role has included the provision of testing, education programs, HIV research and surveillance, monitoring and evaluation of HIV programs, and shaping MOHSW policy. As the Secretariat to the National AIDS Committee, it also coordinates with other MOHSW departments, international donors, and NGOs. TACAIDS, operating within the PMO, was created in December 2000 to coordinate a multisectoral response to the HIV/AIDS epidemic. This task consists of (1) working with donors, other GOT ministries, LGAs, CSOs, FBOs, and other partners to develop the *National Multi-Sectoral Strategic Framework*; (2) coordinating efforts to leverage the resources of all health sector actors; and (3) monitoring the HIV/AIDS crisis in the country. The multisectoral response is jointly coordinated by the NACP and TACAIDS, who have involved private sector actors (mainly FBOs) in drafting the National HIV/AIDS Strategic Plan (currently under review). A similar multisectoral approach was demonstrated in drafting the HIV/AIDS law (2008) and HIV components of the National PPP Policy (2009).

The National Multi-Sectoral Strategic Framework on HIV/AIDS (NMSF III, 2008–12) outlines the priorities and responsibilities of multisectoral actors in implementing the national HIV/AIDS response. NMSF III identifies eight goals, which revolve around the following four themes:

- Improving the enabling environment for a strong, multisectoral response, including advocacy and political commitment; fighting stigma, denial, and discrimination; building a regional, district, and community response; and mainstreaming HIV/AIDS
- Preventing the transmission of HIV/AIDS by promoting abstinence and the use of contraceptives; focusing on vulnerable populations; expanding workplace health programs; expanding VCT; and improving PMTCT efforts

- Providing a strong continuum of care, treatment, and support, especially to HIV-TB patients
- Mitigating the impact of the disease on orphans and vulnerable children, people living with HIV, and affected communities.

The private health sector has played an important role in pursuing the goals of the NMSF III through the provision of HIV/AIDS prevention and treatment services, as part of Tanzania's national AIDS response (see box 4.1). However, challenges persist that inhibit full realization of private sector potential in addressing the epidemic. The Tanzanian HSSP (2003–06) first outlined the

Box 4.1 APHFTA's Contribution to HIV/AIDS Services

Established in 1994, the Association of Private Health Facilities in Tanzania (APHFTA) is one of the key private health sector representatives engaged in health policy and planning. Headquartered in Dar es Salaam, APHFTA also has four zonal offices across mainland Tanzania that it uses to better engage with private health facilities and government at the local level. In addition to its advocacy role, APHFTA offers continuing professional development opportunities, small business management training, small loans, and quality assurance to its 500+ members in both the PFP and PNFP sectors.

APHFTA is currently working with the public sector in Tanzania to address the HIV/AIDS epidemic in three main ways. First, it has helped increase private sector capacity by working with NACP to streamline training programs for private providers. Together, APHFTA and NACP have reduced the required time to complete training in ART provision from two weeks to eight days; in clinical counseling from eight weeks to four weeks; in provider-initiated counseling to five days; and in TB and HIV/AIDS services to five days. Second, APHFTA is working with NACP to establish private ART provider sites across the country through a multistep process that includes a facility self-assessment, APHFTA review and site visits, APHFTA training to help meet MOHSW/NACP standards, joint APHFTA-NACP supportive supervision, and reporting on a quarterly basis from private facilities to APHFTA and NACP. APHFTA members deliver a variety of services throughout the HIV/AIDS continuum of care (VCT, treatment for opportunistic infection [OI], and ART), PMTCT, and TB screening. Finally, APHFTA is working with NACP to promote male circumcision as a prevention method through a costing survey and pilot training program at private health facilities in two districts.

With minimal donor investment ($1 million over the last five years), APHFTA has yielded many beneficial results, including the following:

- More than 1,000 private health care providers—including counselors, clinicians, laboratory technicians, and home-based care providers—trained in HIV/AIDS, PMTCT, and care and treatment for sexually transmitted infections
- 91 VCT centers and 91 fully qualified, MOHSW-approved private ART provider sites that have tested and counseled over 132,000 patients, initiated over 10,000 patients on ARVs, treated over 1,120 HIV-infected pregnant women with ARV prophylaxis, and provided nutritional support to over 7,000 patients

box continues next page

Box 4.1 APHFTA's Contribution to HIV/AIDS Services *(continued)*

- Eight private health facilities that are trained and equipped to deliver safe male circumcisions. In the first two months after training, these facilities performed 1,600 circumcisions for less than US$22 each.

Moving forward, APHFTA is looking for even more opportunities to build on these initial successes and continue scaling up private sector provision of HIV/AIDS services to eventually reach 25–30 percent of people living with HIV/AIDS. To achieve this goal, APHFTA would increase its training of private providers; expand the network of private ART providers to all 400 private health facilities that potentially have the requisite technical capacity; and increase efficiencies at the existing 91 sites by addressing stock-outs in commodities (such as HIV test kits and ARVs) and by increasing access to affordable OI drugs. Other possible avenues include increasing the number of VCT sites, scaling up its male circumcision pilots beyond the initial two districts, and organizing and networking all ADDOs to deliver key HIV/AIDS drugs and supplies.

Photo B4.1.1 APHFTA Services

(L) A private mobile clinic site for HIV services; (R) Private providers at an APHFTA training.
Source: Presentation by Dr. Samwel Ogillo, APHFTA CEO, July 2012.

imperative of mobilizing a multisectoral HIV/AIDS response in order to effectively scale up the provision of comprehensive prevention and treatment services. Accordingly, private sector entities (both for-profit and not-for-profit) have played an integral role in scaling up the national HIV/AIDS response over the past decade. Both the NACP and TACAIDS have highlighted the imperative of involving *all* clinical settings (regardless of ownership) in the national care and treatment plan. With approximately 42 percent national ART coverage as of 2010, and estimates of health sector financing of HIV at less than 50 percent of the level necessary to address the pandemic, both the NACP and TACAIDS are emphasizing the need to further leverage private sector resources and capacity in strengthening the national response. Most providers (in all private sector areas) are engaged in prevention efforts, with treatment activities occurring in a number of private facilities, ranging from private dispensaries to larger health centers and hospitals. In addition, faith-based treatment networks (specifically the CSSC and Muslim Organization for HIV/AIDS) have collaborated to form an Interfaith

Apex for HIV/AIDS in order to strengthen FBO collaboration with TACAIDS and the NACP.

However, several challenges continue to prevent many small-scale private providers from expanding their provision of HIV treatment and chronic care services. Like many small public facilities, lower-level private facilities initially fail HIV/AIDS service quality inspections carried out by district leadership and the NACP. Costs for required improvements to infrastructure, pharmaceutical storage, waiting spaces, and human resource coverage must be borne by the provider—effectively barring smaller clinics with limited resources from engaging in the national AIDS response. In addition, health clinics wanting to provide HIV treatment services are expected to have three HIV-trained personnel—a clinician, an ART nurse, and a VCT counselor. As most private dispensaries and small health facilities do not have adequate staff to cover training-related absences, it is difficult for clinics to access and attend trainings for the required number of personnel. For example, the standard Integrated Management of Adolescent and Adult Illness (IMAI) trainings required for new providers of HIV services are two weeks in length—an impractical endeavor for staff at small facilities who cannot leave their posts unattended.

In addition, some informants stated that private clinics are often owned and staffed by specialists or experienced physicians. Because the NACP initially rolled out HIV/AIDS service trainings to clinical officers—a mid-level medical cadre—there is a sense that HIV service delivery has been stigmatized as a "lower cadre/limited medical scope" activity. In addition, the public centers and agencies providing HIV trainings do not often invite private sector participants, reflecting not only poor coordination at the council level but also a perception of lower quality of care in the private sector. Ironically, as one informant from the NACP noted, the perception that HIV service quality is much lower in the private sector is "likely related to knowledge issues which they can only address through access to HIV/AIDS training"—from which they are often excluded.

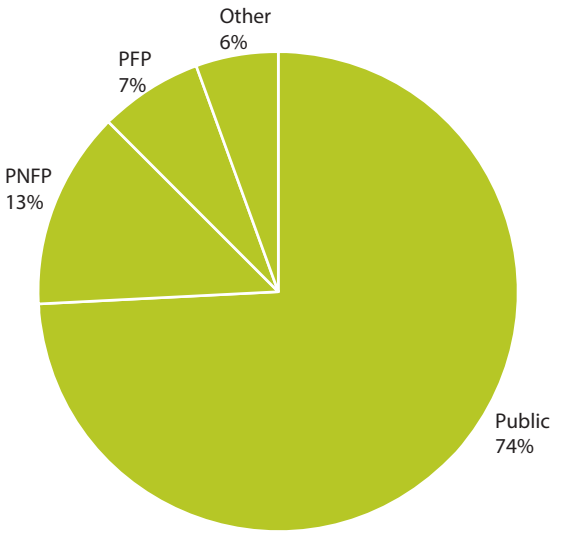
A final issue limiting scale-up of HIV/AIDS services in the private sector relates to the financing of HIV/AIDS services. The only items that are provided for free to private providers are antiretroviral drugs (ARVs), some drugs for treatment of opportunistic infections, and other commodity inputs such as condoms. However, HIV/AIDS treatment is classified as a free or exempted service. Private sector providers (particularly small-scale for-profit clinics) are reluctant to engage in HIV service provision because they are expected to deliver services for free, covering all staff costs, overhead, and additional commodity inputs. As TACAIDS, the NACP, and LGAs all acknowledged, MOUs or other agreements with private providers would be necessary to establish mutually agreement on service provision, fees for HIV service (to cover overhead costs), and perhaps subsidies of key drugs and other inputs not currently provided under current procurement arrangements. All key actors share a desire to more heavily leverage private sector resources and capacity in strengthening the national HIV/AIDS response. However, constraining factors cited by key informants included "limited financial resources," "inadequate access to trainings," "stretched human resource capacity at TACAIDS," "slow

movement from partners," and "weak incentives for private providers to scale up HIV services"—preventing the realization of a sustained, comprehensive multisectoral AIDS response as envisioned in HSSPs and other guiding documents.

As outlined in figure 4.2, the public sector remains the primary source for HIV testing in mainland Tanzania, providing 74 percent of all tests. The private sector, including both PNFP and PFP facilities, accounts for approximately 20 percent of tests. When disaggregated by urban and rural settings, the results do not change significantly: When compared with rural settings, PFP facilities in urban areas provide a slightly larger percentage of tests and public facilities provide a correspondingly smaller percentage. PNFP facilities account show similar levels of testing in both urban and rural areas. There are some differences in the patients tested, as between PNFP and PFP facilities. A typical PNFP patient is more likely to be from a rural area (68 percent) while a typical PFP patient is likely to be from an urban area (64 percent), probably due to the geographic concentration of the different facility types. As indicated in figure 4.3, patients from the wealthiest quintiles account for the greatest percentage of HIV tests at both PNFP and PFP facilities.

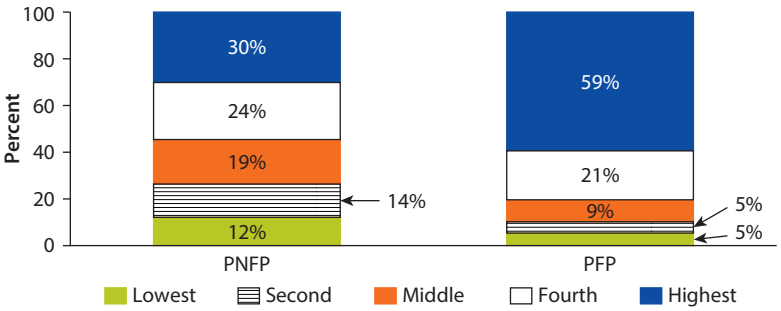
Similar to HIV testing, the public sector is also the dominant source for PMTCT—providing 86 percent of PMTCT services in mainland Tanzania (see figure 4.4). The private sector as a whole accounts for 14 percent. This smaller market share relative to general HIV testing is a reflection of the public sector's dominance in both HIV testing and ANC (see "Utilization of Private Sector RCH Services"). Again, there are only slight differences between urban and rural settings, with PFP facilities providing a slightly larger share of PMTCT services in urban areas than in rural areas.

Figure 4.2 Source of Last HIV Test for Adult Women, Ages 15–49, 2010



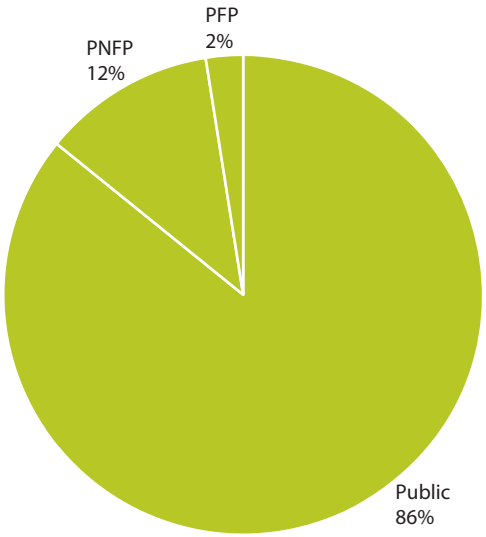
Source: DHS 2010.
Note: Source of HIV testing relatively stable over past 10 years.

Figure 4.3 Client Profile for HIV Testing at Private Facilities, 2010



Source: DHS 2010.
Note: PNFP = private not-for-profit; PFP = private for-profit.

Figure 4.4 Source of PMTCT (Received HIV Test as Part of ANC), 2010



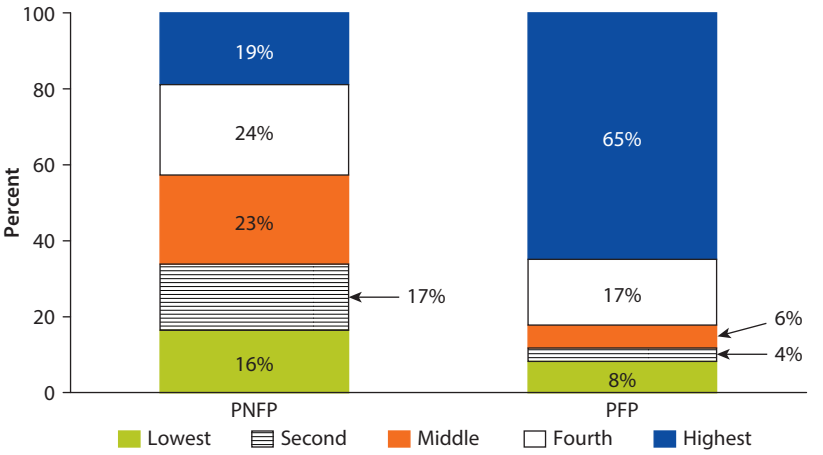
Source: DHS 2010.
Note: Source of PMTCT relatively stable over past 10 years. PNFP = private not-for-profit; PFP = private for-profit.

The profile of patients seeking PMTCT services in the private sector is similar to that of patients seeking HIV tests. Patients at PNFP facilities are much more likely to come from rural areas (73.5 percent) while patients at PFP facilities are much more likely to come from urban areas (72.1 percent). As shown in figure 4.5, patients at PNFP facilities are more likely to come from middle-upper income quintiles, although the income distribution of patients is relatively even. Patients at PFP facilities are much more likely to come from the top two wealth quintiles.

Utilization of Private Sector HIV/AIDS Services

The decline in HIV prevalence mentioned above can be attributed to the successful expansion and uptake of VCT, PMTCT care, and ART roll-out—all emphasized in the GOT's strategic plan for HIV/AIDS. Between 2004 and 2010,

Figure 4.5 Client Profile for PMTCT at Private Facilities, 2010



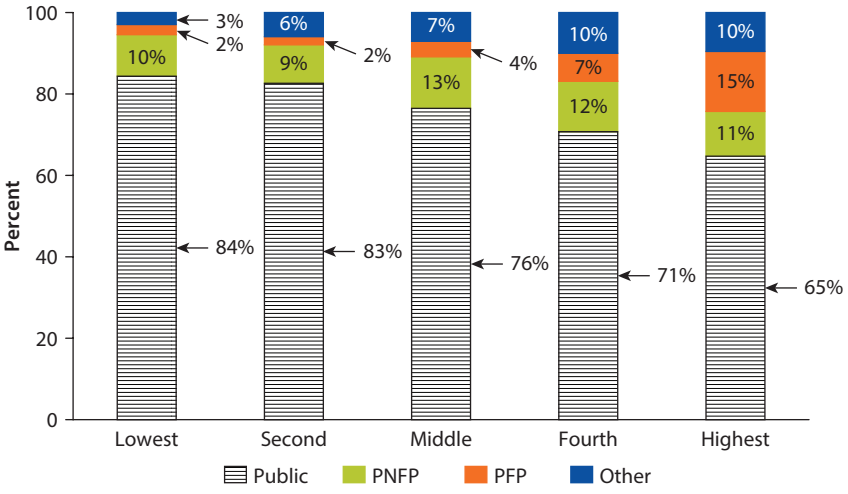
Source: DHS 2010.
Note: Client profiles for PFP based on small sample size (51). PNFP = private not-for-profit; PFP = private for-profit.

the number of adult (15–49 years) men and women who took an HIV test and received their results within the preceding 12 months increased from 6.5 and 6.2 percent to 25.1 and 29.7 percent, respectively. PMTCT rates also improved, as the number of pregnant women who received HIV counseling and testing as part of ANC likewise increased from 8.5 percent in 2004 to 55.0 percent in 2010. During this same time period, the number of people on ART rose even more dramatically, from 3,000 to 258,100. By 2010, an estimated 42 percent of people with advanced HIV infections were on ART. Per GOT policy, ARVs are provided free of charge to patients at all facility types; however, most PFP and some PNFP facilities charge a consultation and/or registration fee for provision of the service.

Across mainland Tanzania, the public sector remains the predominant source of HIV testing across all income quintiles—although utilization of the public sector for HIV testing services declines as income increases, from 84 percent in the lowest quintile to 65 percent in the highest (figure 4.6). Likewise, as income rises, patients are more likely to go to private facilities for HIV tests. Even for the highest-income quintile, private facilities only account for 26 percent of HIV testing. This overall trend in public versus private sources remains the same in both rural and urban areas; the only real difference is the split between PNFP and PFP facilities. Across all wealth quintiles, urban populations are more likely than rural populations to get tested for HIV at a PFP facility than at a PNFP facility.

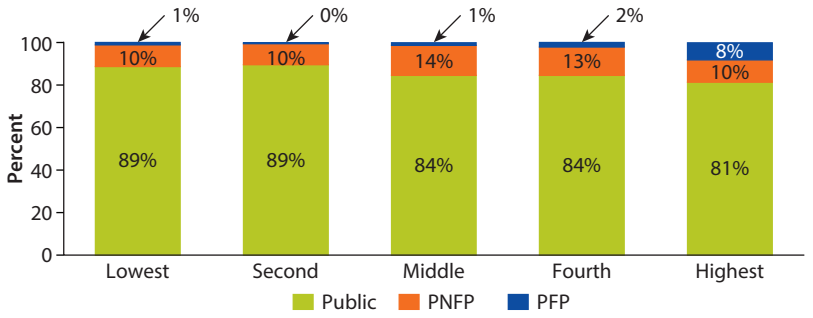
As indicated by figure 4.7, the public sector is also the predominant source for PMTCT services across all income quintiles (greater than 80 percent utilization). As income increases, the number of people using the private sector for PMTCT services also increases, although the change is smaller than for HIV testing. The PNFP sector plays a supporting role in the provision of PMTCT services, with 10 percent of women in the lowest income quintile and 10 percent in the highest seeking services via PNFP sources. The share of patients going to PFP facilities for PMTCT services is negligible for all but the wealthiest quintile. These trends all

Figure 4.6 Source of HIV Tests Sought, by Wealth Quintiles, 2010



Source: DHS 2010.
Note: Source of HIV tests by wealth quintile relatively stable over past 10 years. PNFP = private not-for-profit; PFP = private for-profit.

Figure 4.7 Source of PMTCT Sought, by Wealth Quintiles, 2010



Source: DHS 2010.
Note: Source of PMTCT by wealth quintile relatively stable over past 10 years. PNFP = private not-for-profit; PFP = private for-profit.

hold true in both rural and urban settings. Again, the only difference is that the share of people across all quintiles going to PFP facilities is slightly larger in urban than in rural areas.

Reproductive and Child Health (RCH)

RCH issues—including family planning, maternal health, and child health—remain a significant barrier for Tanzania, especially in rural and poorer environments. In 2010, the total fertility rate was 5.4 children per woman aged 15–49. Only 54.1 percent of births took place at a health facility, and approximately 51.1 percent were not attended by a trained medical professional. However, 97.7 percent of women received some ANC. Child health indicators remain

troubling: in 2010, 42.3 percent of children under five were stunted; 15.7 percent were wasted; and 14.6 percent had experienced diarrhea in the previous two weeks. About 56.1 percent of those children received treatment from a health facility; 16.0 percent received no treatment at all.

Provision of Private Sector RCH Services

Mainland Tanzania's RCH services are coordinated by the MOHSW RCH Unit, which has developed several strategy documents to improve maternal and child health outcomes such as the *National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn, and Child Deaths in Tanzania, 2008–15* and the *Integrated Community Maternal, Newborn, and Child Health Guidelines*. These plans emphasize the close links between family planning, maternal health, and infant and child survival. They call for improved quality of care and stronger ties between health care providers and women, children, and their communities. Additionally, the National Health Policy and HSSP III provide goals to be achieved in terms of maternal mortality ratios, infant and under-five mortality rates, contraceptive prevalence rates, and proportions of children stunted and/or wasted. Strong policy development and a multisectoral response (particularly emphasizing the involvement of the faith-based sector) have resulted in improvements in almost every RCH metric over the past 10 years. Most importantly, there have been large drops in all of the mortality measures. Between 2004 and 2010, the maternal mortality ratio declined from 578 deaths per 100,000 live births to 454.[1] Mortality rates decreased from 107.8 to 60.0 deaths per 1,000 live births for infants and 161.1 to 93.0 deaths per 1,000 live births for children under five. However, even as the percentage of married women using any form of contraceptives increased from 25.4 in 1999 to 34.8 in 2010, the percentage of women with unmet need increased from 21.8 to 25.1.

All RCH services in Tanzania are considered an essential public service, with expected mandatory provision at all health facilities at the dispensary level and above, in all sectors. As such, the private health sector is an important provider of immunizations, family planning, ANC and delivery, and postnatal care. Immunization services are an exempted service: it is expected to be provided for free in all sectors, and the office of the DMO is responsible for distribution of vaccines and refrigeration facilities to providers. FBOs in particular were identified by the MOHSW RCH Unit as significant providers of RCH services in rural areas, where the provision of a wide range of RCH services and community outreach initiatives have been critical in reaching rural areas outside the reach of government services. Faith-based facilities connected to the Catholic Church do not provide oral or injectable contraceptives; however, other faith-based dispensaries and DDHs are in many ways functioning as government RCH facilities, providing family planning commodities, community outreach, training programs, vaccines, and other essential RCH services. In addition to FBOs, not-for-profit CBOs (such as PRINMAT maternity homes) have been integral in extending RCH service coverage to rural areas. According to key informants, the PFP subsector reaches a smaller percentage of the population, centered largely in urban areas. Importantly,

there is widespread suspicion that some CBOs and most PFP facilities are charging "consultation fees" for these exempted RCH services, a suspicion that has hampered efforts to increase their involvement in RCH service delivery. Key informants suggest that a significant proportion of private sector actors "provide [RCH services] for clientele that can afford it," and that although this "reduces the public sector burden," there is concern that private providers (with the exception of the CSSC and other faith-based facilities) are driven by profit motives rather than commitment to the provision of an essential public service.

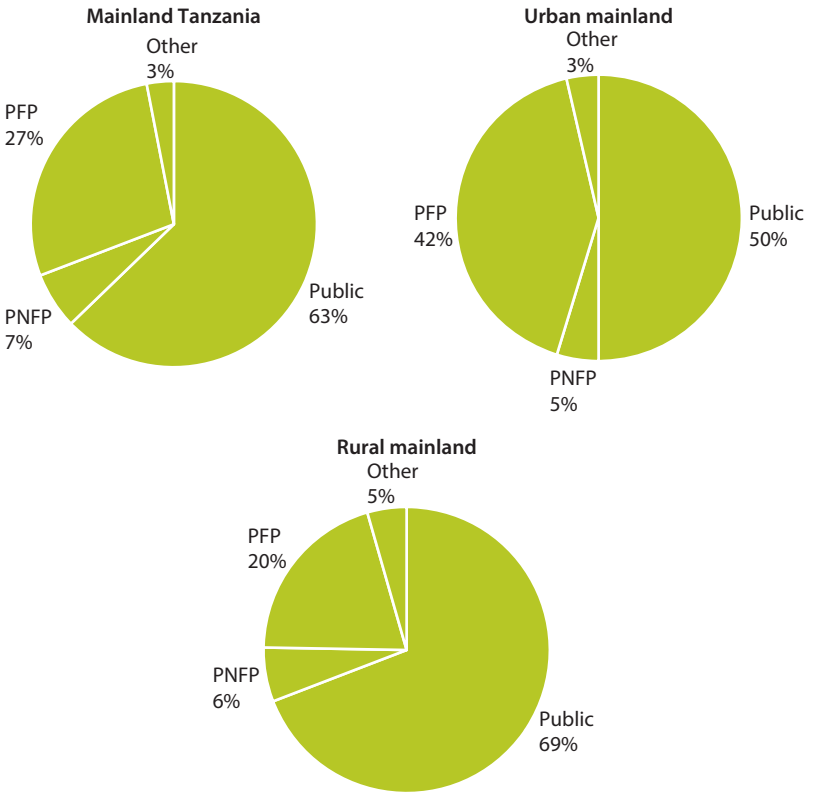
As in the case of HIV/AIDS, there are significant challenges in scaling up and more adequately coordinating multisectoral provision of RCH services. Perceptions of poor private sector infrastructure, inability to adhere to "baby friendly" facility infrastructure standards, concerns over weak RCH knowledge at private facilities, and suspicion of accepting payment for exempted services have all limited MOH efforts to scale up private provision of RCH services outside the faith-based/not-for-profit category. PFP and many PNFP providers argue that they are excluded from RCH training opportunities, limiting their ability to adhere to treatment and facility standards; public sector informants maintain that it is private providers' failure to adhere to standards has triggered their exclusion from training opportunities. The strength of relationships with LGAs appears to be the most influential driver of RCH service quality at private health facilities. Strong relationships between FBOs and local RCH leadership are associated with a wide range of RCH service delivery via FBO facilities; conversely, weak relationships along with poor quality or lack of RCH services characterize many other private sector facilities. Closer involvement of the two sectors would undoubtedly strengthen multisectoral RCH service provision, through joint planning, participation of PRINMAT and other key private sector RCH service providers in quarterly maternal mortality audits and regional RCH meetings, and private sector representation on RCH-related technical working groups.

The private sector provides nearly one-third of contraceptive commodities across mainland Tanzania (figure 4.8). The PFP sector provides the bulk of the private sector share, accounting for 27 percent of all contraceptives. PNFP facilities play a smaller role, as the source of only 7 percent of contraceptive commodities—likely a reflection of restrictions on contraceptive distribution among FBOs. This trend is even more pronounced in the urban settings, where the PFP facilities provide 42 percent of contraceptives.

The profile of customers accessing contraceptive commodities in the private sector is similar to that of patients accessing HIV services. The typical customer sourcing contraceptives from a PNFP facility is more likely to be from a rural area (72.6 percent). PFP facilities show little difference between urban customers (51.4 percent) and rural customers (48.6 percent). As shown in figure 4.9, over 50 percent of the consumers come from the top two wealth quintiles at both PNFP and PFP facilities. The client profile for PFP facilities is more skewed towards the higher income quintiles, with almost half (48 percent) of customers coming from the top group.

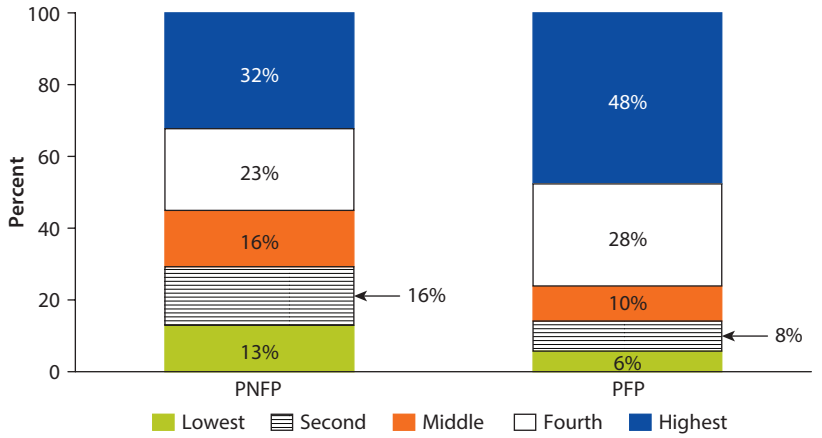
Although close to 98 percent of women reported receiving some sort of ANC during their last pregnancy, 57 percent of them did not complete at least four

Figure 4.8 Source of Contraceptives, 2010



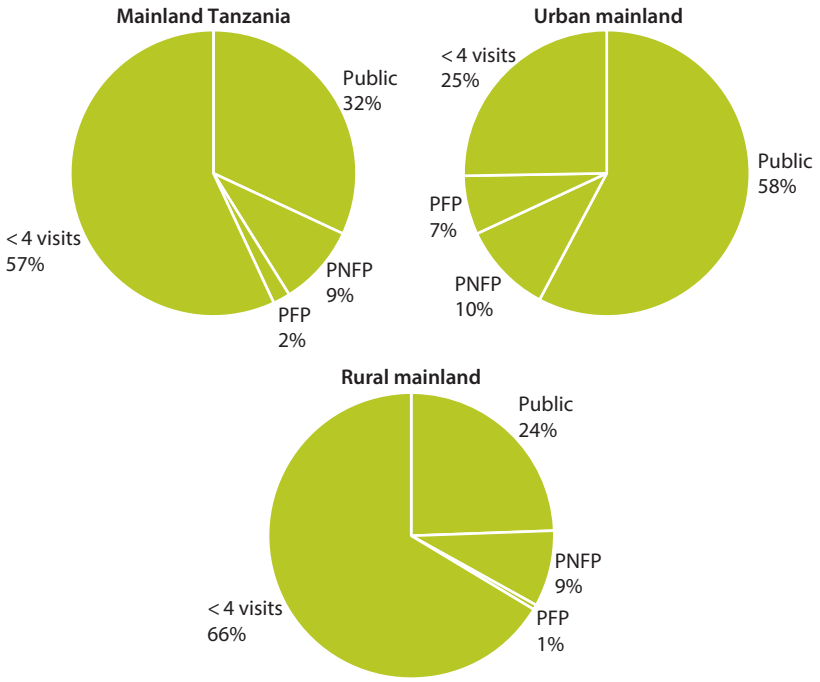
Source: DHS 2010.
Note: Source of contraceptives relatively stable over past 10 years. PNFP = private not-for-profit; PFP = private for-profit.

Figure 4.9 Client Profile for Contraceptives at Private Facilities, 2010



Source: DHS 2010.
Note: Client profile for PNFP based on small sample size (112). PNFP = private not-for-profit; PFP = private for-profit.

Figure 4.10 Source of Antenatal Care (ANC) for Women with 4+ ANC Visits, 2010



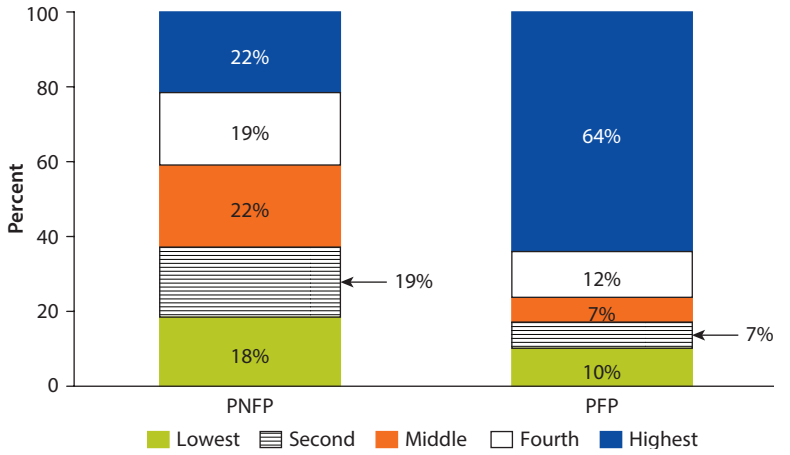
Source: DHS 2010.
Note: Source of ANC relatively stable over past 10 years. PNFP = private not-for-profit; PFP = private for-profit.

ANC visits during their last pregnancy. As outlined in figure 4.10, available data demonstrate that the public sector is the largest provider of ANC, at 32 percent. The private health sector provides a total of 11 percent of ANC services, with PNFP facilities accounting for the vast majority. Women in rural settings are much less likely to report receiving ANC at a health facility of any kind, but the overall trends in reported data remain the same: public sector dominance, followed by PNFP and then PFP facilities.

Although it is difficult to develop an accurate profile of women seeking ANC at private facilities with such limited data, the picture that emerges based on what is available is consistent with that of PMTCT patients. PNFP facilities are more likely to provide ANC services to a woman in a rural area (74.1 percent) than an urban area. PFP facilities are much more likely to serve women in urban areas (73.4 percent) than in rural settings. The income distribution of women seeking ANC in the PNFP sector is relatively even (figure 4.11). With 22 percent each, the share of women coming from the highest- and middle-income quintiles is only slightly larger than the 18 percent coming from the lowest quintile. The PFP sector again most often serves women in the highest two income quintiles (76 percent), but it is significant that 10 percent of women accessing ANC in PFP facilities are from the lowest-income quintile.

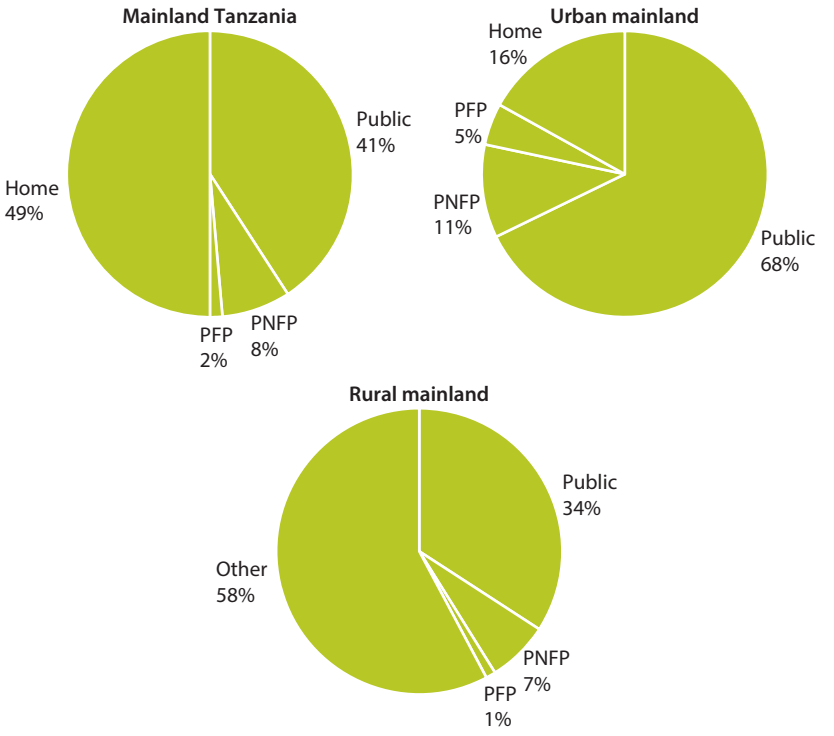
As figure 4.12 demonstrates, nearly half of all births in Tanzania take place at home (49 percent), and almost as many in public sector facilities (41 percent).

Figure 4.11 Client Profile for ANC in the Private Sector, 2010



Source: DHS 2010.
Note: Client profile for PFP based on small sample size (66). PNFP = private not-for-profit; PFP = private for-profit.

Figure 4.12 Source of Delivery, 2010



Source: DHS 2010.
Note: Source of delivery relatively stable over past 10 years. PNFP = private not-for-profit; PFP = private for-profit.

The private sector accounts for 10 percent of deliveries and the vast majority of those births occur at PNFP facilities. There are significant differences between urban and rural areas. 84 percent of births take place in a health facility in urban

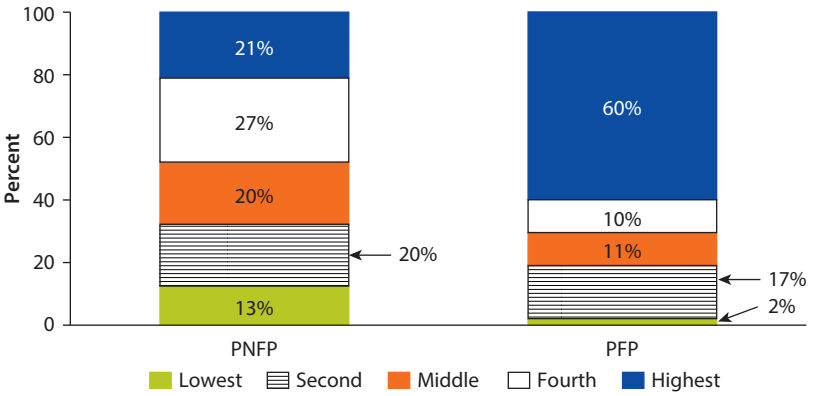
areas compared with 42 percent of births in rural—likely a reflection of disparities in health facility access. The percentage of births at public facilities in urban areas is double that in rural areas (68 percent vs. 34 percent). Second, similar to ANC, the PFP sector provides a larger share of delivery services vis-à-vis the PNFP sector in urban than in rural settings. In both settings births in the PNFP sector outnumber births in the PFP sector, though.

The client profile of women delivering in the private sector is consistent with that of women seeking ANC there. PNFP facilities are much more likely to care for a woman from a rural area (71.2 percent) than from an urban area, while PFP facilities are more likely to care for a woman from an urban setting (64.0 percent). As seen in figure 4.13, women who deliver in the PFP sector are most likely to be from the highest-income quintile (60 percent) with an additional 21 percent coming from the middle or fourth quintiles. Only 2 percent of women giving birth in the PFP sector are from the lowest-income quintile. The income distribution of women giving birth in the PNFP sector is much more even, with one-third coming from the lowest two income quintiles.

The private sector is an important resource in promoting child health. Although nearly one-third of children under five requiring diarrhea treatment do not receive it, private facilities treat approximately 25 percent of diarrhea cases (see figure 4.14). PFP facilities were found to treat almost four times as many children as PNFP facilities. Nevertheless, the public sector remains the primary source of diarrhea treatment, with 44 percent of cases. These trends are similar for both rural and urban settings, although PFP facilities account for a higher percentage in urban areas and PNFP facilities account for slightly more in rural areas.

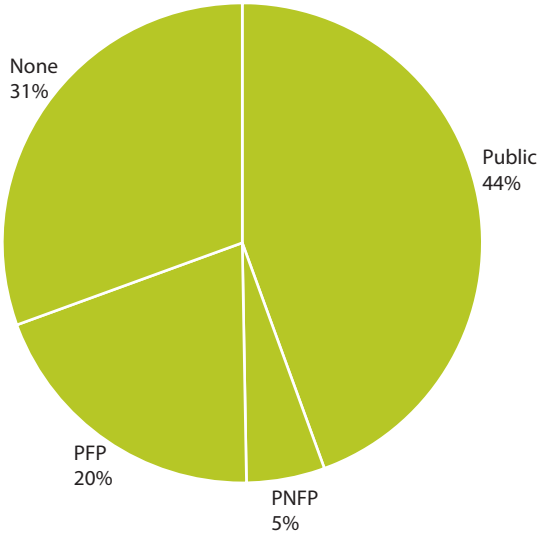
The profile of patients accessing diarrhea treatment in the private sector is slightly different than for other kinds of treatment. A typical patient at a PNFP or PFP facility is more likely to come from a rural setting than an urban one, at 61.6 percent and 67.0 respectively. The income distribution of patients at both

Figure 4.13 Client Profile for Deliveries in the Private Sector, 2010



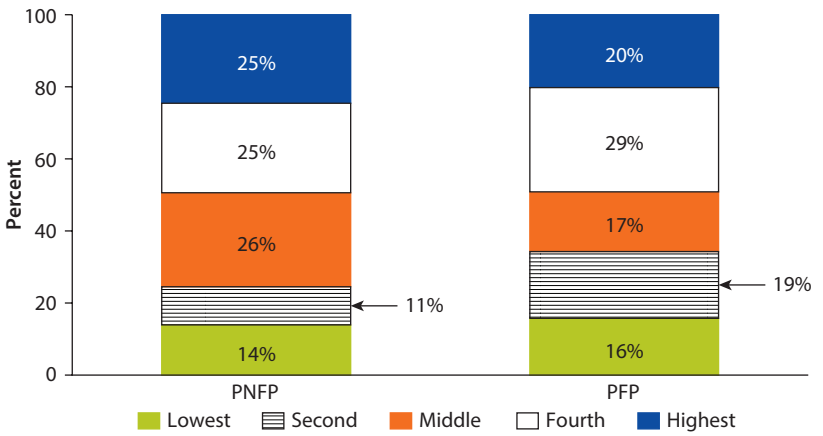
Source: DHS 2010.
Note: Client profile for PFP based on small sample size (62). PNFP = private not-for-profit; PFP = private for-profit.

Figure 4.14 Source of Diarrhea Treatment, 2010



Source: DHS 2010.
Note: Source of diarrhea treatment relatively stable over past 10 years. PNFP = private not-for-profit; PFP = private for-profit.

Figure 4.15 Client Profile for Diarrhea Treatment in the Private Sector, 2010



Source: DHS 2010.
Note: Client profile for PNFP (35) and PFP (120) based on small sample sizes. PNFP = private not-for-profit; PFP = private for-profit.

types of facilities is similar, with approximately half of all diarrhea patients coming from the upper quintiles (figure 4.15). In this case, the income distribution of patients at PFP facilities is slightly less skewed than that at PNFP facilities. 35 percent of patients in the PFP sector come from the bottom two wealth quintiles, while only 25 percent of patients in the PNFP sector come from those two quintiles.

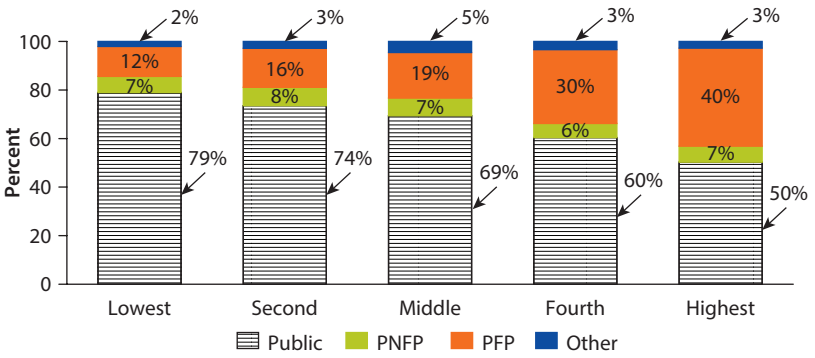
Utilization of Private Sector RCH Services

The private sector (both PFP and PNFP facilities, dispensaries, and retail outlets) are important sources of family planning commodities in Tanzania. As indicated by the figures below, a significant number of patients in all income quintiles across mainland Tanzania are accessing family planning commodities via the PFP sector (and to a lesser extent via the PNFP sector).

Although patients at private facilities are generally more likely to come from the upper wealth quintiles, a significant percentage of these higher-income groups do obtain contraceptives from the public sector. Across mainland Tanzania, 79 percent of patients from the poorest quintile get their contraceptives from a public source (figure 4.16). This number declines as income rises, but even the wealthiest quintile still gets 50 percent of their family planning commodities from the public sector. Conversely, as wealth increases, the number of patients accessing contraceptives through the PFP sector increases—from 12 percent in the poorest quintile to 40 percent in the richest. The PNFP sector consistently provides contraceptives to 6–8 percent of people across all income quintiles. The trend is similar in the rural population, although the total private sector share is slightly smaller. In the urban areas, although the PFP market share still increases as wealth increases, the changes are much smaller and the public-private split is much more stable.

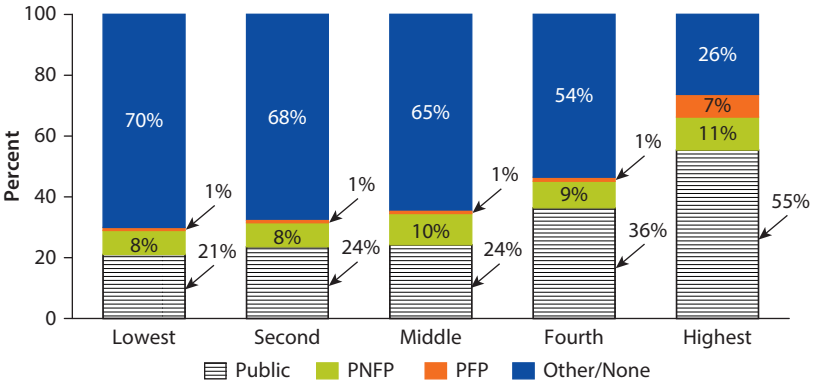
Less than half the women in mainland Tanzania reported receiving ANC at a health facility during their last pregnancy, with that number increasing as wealth increases (figure 4.17). The public sector remains the preferred source of ANC, serving the largest share of women in all income quintiles. Except for the highest quintile (18 percent), the private sector's total share of ANC services stays at approximately 10 percent for each income group. In all five quintiles, the PNFP sector is the second most preferred source. Only 1 percent of women in the majority of income quintiles and 7 percent in the highest quintile utilize the PFP sector for ANC. The same general trends occur in both rural and urban settings. However, fewer people in the rural areas receive ANC at health facilities, and the contribution from the PFP sector is negligible for all income levels. Urban

Figure 4.16 Source of Contraceptives, by Wealth Quintiles, 2010



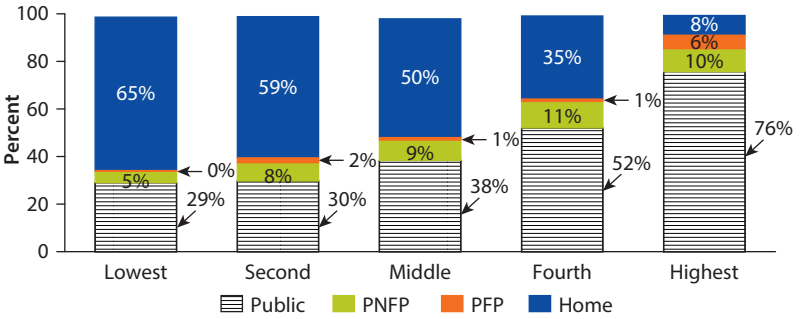
Source: DHS 2010.
Note: Source of contraceptives by wealth quintile relatively stable over past 10 years. PNFP = private not-for-profit; PFP = private for-profit.

Figure 4.17 Source of ANC, by Wealth Quintiles, 2010



Source: DHS 2010.
Note: Source of ANC by wealth quintile relatively stable over past 10 years. PNFP = private not-for-profit; PFP = private for-profit.

Figure 4.18 Source of Delivery, by Wealth Quintiles, 2010

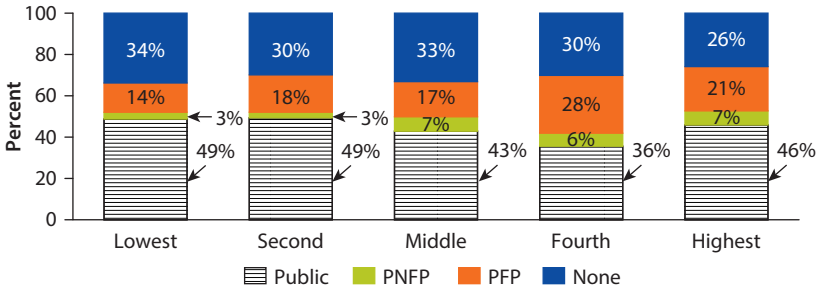


Source: DHS 2010.
Note: Source of delivery by wealth quintile relatively stable over past 10 years. PNFP = private not-for-profit; PFP = private for-profit.

populations report higher rates of uptake across all income levels, and the PFP-PNFP split is almost even for the top two urban income groups.

Figure 4.18 demonstrates that facility births increase as income increases. Nationally, women in the middle and poorest quintiles are more likely to give birth at home, with delivery in the public sector facilities increasing and home births declining in higher quintiles. Women who do not deliver at home or in public facilities are more likely to go to PNFP facilities (between 8 and 11 percent). Except for the highest income quintile, the number of women giving birth at a PFP facility is negligible. The same differences occur when the numbers are disaggregated by urban and rural populations: women in rural areas are more likely to give birth at home for all quintiles than women in urban areas. In urban areas, the number of women giving birth at a health facility increases as wealth increases. The only deviation from the total mainland pattern is that the PFP sector plays a much larger role for the richest quintile, accounting for 20 percent of births.

Figure 4.19 Source of Diarrhea Treatment, by Wealth Quintiles, 2010



Source: DHS 2010.
Note: Source of diarrhea treatment by wealth quintile relatively stable over past 10 years. PNFP = private not-for-profit; PFP = private for-profit.

The percentage of children under five who are treated for diarrhea is relatively stable across all five wealth quintiles, ranging from 66 percent in the lowest to 74 percent in the highest (figure 4.19), with public sector facilities utilized most heavily across the board. Except for the fourth quintile, the percentage of children treated for diarrhea at a public facility ranges from 43 to 49 percent; PFP facilities are the second most popular source of treatment. In rural areas, roughly equal percentages of children receive treatment at public, PFP, and PNFP facilities. However, urban areas show no common pattern of facility use. Except for the wealthiest quintile, the poorest quintile has the highest percentage of diarrhea cases treated at a health facility. Surprisingly, the poorest income group's utilization of public facilities for diarrhea treatment (41 percent) is comparable with their utilization of PFP facilities (36 percent)—and similar to utilization among the highest-income quintile (43 percent public utilization compared to 44 percent PFP).

Tuberculosis

Mainland Tanzania has a high TB burden. In 2010, the incidence and prevalence rates stood at 177 per 100,000 people and 183 per 100,000, respectively. There is a relatively well-developed treatment network: 77 percent of TB cases were detected, and 88 percent of detected cases were successfully treated. 56,400 TB patients were also tested for HIV, with a little more than one-third (21,000) testing positive for coinfection. As a result of this testing, 6,684 TB patients testing positive for HIV were initiated on ART. These figures show an improvement over the past 10 years. In 2000, TB incidence and prevalence rates were as high as 236 per 100,000 people and 233 per 100,000 people. Approximately 68 percent of TB cases were detected, but only 78 percent of detected cases were successfully treated. As recently as 2005, only 1,613 TB patients were tested for HIV (841 tested positive), and none of them were receiving ARVs.[2]

The National Tuberculosis and Leprosy Program, under the MOHSW, is responsible for implementing the GOT's TB-focused initiatives. The main program is run in coordination with the international Stop TB Partnership. Tanzania's

Stop TB program has focused on expanding the implementation of directly observed therapy (DOTS), better managing multidrug resistant TB, increasing the number of labs capable of TB testing, and improving collaboration between HIV and TB programs. The NACP and TACAIDS are involved in this last goal by helping to scale up integrated TB and HIV services. As exemplified by the increases in coinfection testing and treatment, these initiatives have had some initial success.

Private sector facilities in Tanzania have limited involvement in the direct treatment of TB, which is still perceived largely as a role of public service provision. Prior to 2007, the Stop TB strategy included the provision of free anti-TB drugs to all facilities (public, PFP, and FBO/NGO). However, under HSSP III, the Stop TB Strategy has focused on expanding DOTS into the FBO and NGO facilities. Although some larger commercial for-profit facilities do provide DOTS, HSSP III does not include them in its strategic plan for expanding TB treatment access. FBO hospitals also serving as DDHs or Council hospitals do provide both diagnosis and treatment of TB; however, lower-level private facilities restrict their TB activities to suspect identification and referral to district-level facilities. In the case of small-scale private facilities, the financial and human resource investments required to provide TB services are too great to incentivize expansion of their service basket to include TB diagnosis and treatment. Ensuring adequate and consistent procurement of drugs, developing infection control infrastructure, and adequately training staff to provide TB services are significant investments that are beyond the interest or ability of many small-scale private providers. In particular, the for-profit sector is reluctant to introduce TB services, which (like HIV/AIDS and RCH) are exempted services requiring free provision without recoup of overhead or staff expenses. In addition, due to high turnover of private sector health personnel—with many leaving the private sector for higher public sector wages and pensions—investments in TB training for private sector staff are often wasted due to low private sector human resource retention. Private sector facilities remain important focal points of TB suspect identification, but, without significant investment, they remain limited in formal diagnosis and treatment.

PATH International (one of the more active TB-focused NGOs in Tanzania) is working closely with APHFTA and other partners to increase private sector involvement in TB and TB/HIV coinfection work—even if treatment remains the purview of the public sector. An innovative strategy being pursued is the utilization of private retail pharmacies for TB screening activities. Initiated in 2009 via USAID TB2015 funding, the program is currently being piloted in the Kisarawe district of Pwani Region using ADDOs. Pharmacists and pharmacy technicians are trained in basic symptoms of TB and HIV, empowered to refer suspects to TB intervention points, and provided with tools to record and track referrals made. While reports on outcomes of the pilot are currently being drafted, early indications suggest that the program has increased the number of TB suspects presenting at intervention points, and loss-to-follow-up has decreased as the program developed. There are currently plans to scale up the program nationally. PATH is also training "sputum fixers" who can rapidly

interpret slides for diagnosis—a new health cadre that PATH is working to absorb into MOHSW structures via council health committees. In addition, PATH is working with regional and district health committees to create protocols guiding "TB/HIV in private practice," which will outline roles and responsibilities of private providers and clarify processes for the MOHSW supply of reagents, microscopy and slides, and necessary TB medications. Scaling up the involvement of private sector providers in the identification, diagnosis, and treatment of TB remains a challenge, but innovative efforts to leverage private sector capacity are in development.

Malaria

Tanzania has a high malaria burden. The disease accounts for 40 percent of all outpatient visits, and with 17–20 million annual cases and 80,000 annual deaths, it is one of the leading causes of morbidity and mortality in mainland Tanzania. It also is responsible for 36 percent of deaths in children under five—more than any other disease. During the 2007/08 AIDS and Malaria Indicator Survey, 17.7 percent of children under five tested positive for malaria. These children were disproportionately from rural, poorer households.

Provision of Private Sector Malaria Services

The GOT's malaria programs are coordinated by the National Malaria Control Programme (NMCP) within the MOHSW. The NMCP is currently guided by the *Second Malaria Medium Term Strategic Plan (2008–13)* (MMTSP), which aims to reduce the malaria disease burden by 80 percent from 2007 levels.

To achieve this goal, the NMCP makes no strategic or technical distinction between private and public engagement. The mobilization of private health sector capacity and resources is a significant component of the MMTSP, with the NMCP's objective of diffusion of malaria prevention and treatment activities across the entirety of the Tanzanian health system. The private health sector (both for-profit and not-for-profit) is making significant contributions to the NMCP's core interventions: integrated prevention efforts and effective management of acute malarial disease. Private dispensaries, health centers, pharmacies, CBOs, and advocacy organizations provide significant support to the NMCP's integrated approach to vector control.

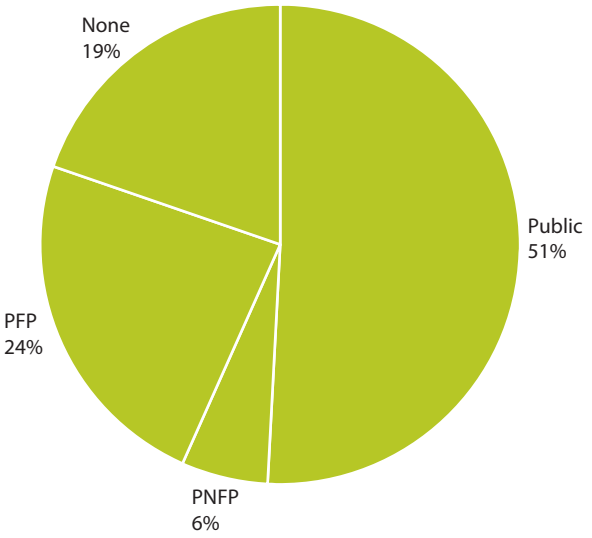
The NMCP employs a two-pronged approach to combating malaria: (1) vector control, including indoor residual spraying, and (2) improved diagnosis and treatment. Behavior change communication surrounding the use of bed nets and increased awareness of the signs and symptoms of malaria are both central to success of the MMTSP. The MMTSP also calls for increased partnerships with the private sector through the expansion of the ADDO network and the provision of subsidized artemisinin-based combined therapies (ACT) to private facilities for patients under the age of five. The first MMTSP (2002–07) sought to increase early detection of the disease and access to treatment. It also included the National Voucher Scheme to increase access to insecticide-treated nets

(ITNs) for pregnant women and children under the age of five. As a result of these programs (especially the National Voucher Scheme), 74.7 percent of households had access to any sort of bed net, 63.4 percent had an ITN, and 53.4 percent had a long-lasting insecticide-treated net (LLITN) in 2010. The private Tanzanian company A-Z Textiles is Africa's largest producer of LLITNs and—through distribution partners such as the NMCP, World Vision, and UNICEF—has provided crucial commodity inputs in advancing the prevention of malaria in Tanzania. In part due to the reliable supply of LLITNs, in 2009 the NMCP provided over 8.7 million nets to children under five, and an estimated 17.6 million free bed nets provided to the general population.

The NMCP credits the collaboration between private and public actors as integral in having reduced under-five malaria incidence from 148/1,000 (1999) to an estimated 81/1,000 (2010). Furthermore, key informants at the NMCP highlighted the imperative of strengthening multisectoral prevention efforts in meeting their goal of a 50 percent reduction in acute malaria incidence by 2013. According to the NMCP, the private health sector is also a principal provider of malarial management—ensuring prompt diagnosis and treatment of acute disease, providing intermittent preventive treatment in pregnancy (IPTP), and—at larger health facilities—inpatient management of complicated malaria. Private sector providers and CBOs are also active in promoting the NMCP's supportive interventions, such as community trainings on completing treatment dose, participating in Tanzania's Malaria Day, conducting community trainings on signs and symptoms, and providing surveillance data to support the NMCP's monitoring and evaluation and disease trend monitoring. In the words of the NMCP, "the government cannot reach our malaria goals alone—public, private and community collaboration is the key to success." This has included private sector participation in carrying out indoor residual spraying in Dar es Salaam, broad private sector distribution of bed nets, and involvement of the CSSC and other private sector representatives in NMCP prevention coordination efforts.

In terms of funding, providing resources, and implementing Tanzania's malaria response, the private sector "has been a critical partner in advancing (the NMCP) strategy." Challenges exist, however, that, as with other vertical disease programs, continue to limit full realization of private sector potential. Limited understanding of PPP mechanisms in both sectors (particularly in regard to structure and operationalization of formal partnership mechanisms) has limited malaria partner coordination at the council level. Private sector partners complain that they are often left out of malaria trainings and CPD opportunities, which would enhance their ability to provide more comprehensive malaria interventions. Progress has been made by the Affordable Medicines Facility—malaria (AMFm) pilot program (led by the Global Fund, as discussed in chapter 6), which provides affordable multisectoral access to ACTs. However, the NMCP points to missed opportunities to leverage private sector CSR, and other financing mechanisms, to ensure sustainable locally financed ACT access. The NMCP has several program priorities that will continue to "require engagement, collaboration and cooperation" with the private health sector. Several key PPP opportunities are currently being prioritized

Figure 4.20 Source of Treatment for Fever or Cough, 2010



Source: DHS 2010.
Note: Source of treatment for fever or cough relatively stable over past 10 years. PNFP = private not-for-profit; PFP = private for-profit.

by the NMCP, in pursuit of an effective national malaria response: increasing access to ACTs through a greater number of public and private sector facilities; increasing availability to drugs in remote areas via ADDOs; increasing affordability and reliability of ACTs via locally sustainable financing; and increasing use of ACTs by ensuring private sector access to a reliable supply of commodities.

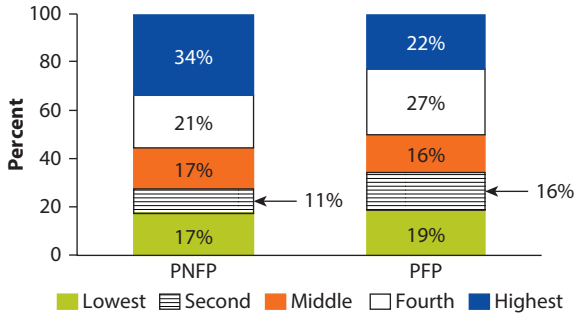
Figure 4.20 shows the source of treatment for fever or cough—a proxy for malaria treatment. The public sector remains the primary source (51 percent) of fever/cough treatment. Overall, the private health sector is also an important treatment source of fever and cough, providing 30 percent of treatment. As in the case of diarrhea treatment, the PFP sector plays a much larger role than the PNFP sector. This pattern of treatment is the same when the numbers are split into rural and urban settings.

The profile of patients seeking treatment for a fever or cough at PFP and PNFP facilities is roughly similar. In both cases, patients are more likely to come from rural areas than from urban (67.1 vs. 32.9 percent for PFP, and 56.7 vs. 43.3 percent for PNFP). Patients seeking treatment for fever and cough in the PFP and PNFP sectors come from all wealth quintiles (figure 4.21). In the PNFP sector, the largest share (34 percent) comes from the highest-income quintile, with nearly half (45 percent) coming from the bottom three quintiles. In the PFP sector, the largest share of patients comes from the fourth quintile (27 percent), with 51 percent of patients coming from the bottom three wealth quintiles.

Utilization of Private Sector Malaria Services

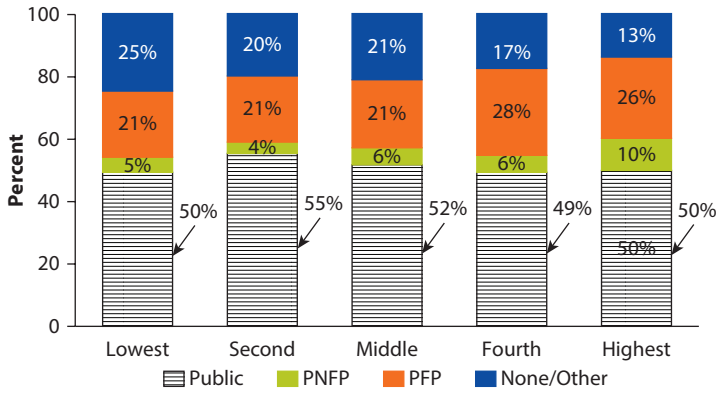
Approximately 50 percent of Tanzanians in all-income quintiles seek out malaria treatment in the public sector (figure 4.22). Due to the NMCP's multisectoral

Figure 4.21 Client Profile for Fever or Cough Treatment in the Private Sector, 2010



Source: DHS 2010.
Note: PNFP client profile based on small sample size (82). PNFP = private not-for-profit; PFP = private for-profit.

Figure 4.22 Source of Treatment for Fever or Cough by Wealth Quintiles, 2010



Source: DHS 2010.
Note: Source of treatment for fever/cough by wealth quintile relatively stable for past 10 years. PNFP = private not-for-profit; PFP = private for-profit.

approach, the private sector plays a significant role in treating malaria, treating 25 to 36 percent of cases, depending on income quintile. Utilization of PFP facilities is higher than PNFP facilities among all income quintiles in across mainland Tanzania. This pattern holds also, for the most part, when the population is split into urban and rural areas. The one exception is the highest wealth quintile in urban areas, where utilization of PFP facilities for malaria treatment (42 percent) is slightly higher than utilization of public facilities (40 percent).

Key Findings

Private health sector infrastructure and service delivery capacity is not being fully utilized. Private facilities, for-profit and not-for-profit, currently comprise a significant proportion of service delivery infrastructure available in Tanzania—but this capacity is not being fully leveraged or utilized as part of a comprehensive multisectoral health system approach. Limited communication, coordination,

and collaboration between the public and private health sectors wastes opportunities to more systematically take advantage of private health sector service delivery capacities.

Limited and inconsistent communication between the public and private health sectors is limiting effective service delivery coordination. Lack of communication between public and private health sector actors is both a cause and consequence of ineffective health system coordination efforts. Of note, missing communication links between the MOHSW, the PMO-RALG and the office of the president have limited opportunities for effective operationalization and coordination of PPP efforts. As such, there is a need to clearly define the respective roles and responsibilities of these bodies, and to strengthen the links. Limited opportunities for dialogue, inadequate joint determination of standards and strategies in addressing key health challenges, and unclear policies on LGA private sector engagement have restricted effective multisectoral communication and collaboration. Minimal or inconsistent inclusion of the private health sector in key planning processes—such as quarterly strategic planning at the district/council level, CCHP development, and vertical program work planning—has led to duplication of effort, distrust between the sectors, and lost opportunities to maximize resource utilization. With the exception of apex bodies such as the CSSC and APHFTA, there have been limited opportunities for parties from both sectors to address issues of distrust that hamper more unified service delivery efforts. While public actors perceive the PFP sector as "solely profit driven businesses," the private sector argues that their "contributions to public good are not adequately recognized." Lack of opportunities for fruitful dialogue and communication drive this distrust and prevent effective collaboration.

Weak service delivery reporting from the private sector, coupled with lack of report-back from the public sector, is contributing to weak dialogue and distrust between public and private service providers. While private health sector personnel do provide various weekly, monthly, and quarterly reports to LGAs, this was reported as a key area requiring strengthening. Lack of supportive supervision on data reporting from LGAs, inadequate supply of data collection tools and registers, and minimal training of private sector personnel on data collection standards and requirements are negatively impacting the quality of surveillance and routine reporting from the private health sector to public health authorities. In addition, lack of "report back," or dissemination of disease surveillance and data trends, contributes to the frustration felt by private health sector personnel and limits their incentives for adequate data reporting and utilization.

Inadequate access to CPD and other training opportunities is limiting the expansion of private health sector service delivery. Lack of training opportunities for private sector health personnel (in both the not-for-profit and for-profit sectors) has limited the ability of private sector health staff to advance their skills in the areas of HIV/AIDS, RCH, TB, and other key health areas, effectively limiting the provision of essential health services in many private sector facilities. Compounding

this problem, and contributing to poor coordination of service delivery across a number of health areas, is minimal inclusion of private health sector personnel in technical forums such as morbidity and mortality (M&M) meetings in hospital settings, district-level RCH maternal mortality audits, and other technical skills development opportunities. Limiting training opportunities for private sector health personnel effectively limits the scope and reach of vertical disease programs, missing important opportunities to involve private sector human resources.

There are significant missed opportunities to harmonize diagnostic equipment across the public and private sectors. Opportunities to maximize the harmonized utilization of diagnostic equipment across both sectors are being missed. For instance, senior informants at Muhimbili Referral Hospital (the nation's largest specialist facility) were unaware that a PCR genotyping machine was available at SHMH to confirm ART drug resistance. Similarly, while public-to-public and private-to-private referrals for diagnostics are common (for viral load assessment, complex lab work, ultrasound, and so on), there is very limited diagnostic referral between public and private facilities. Leveraging the specialist equipment of both sectors for use throughout the entirety of the health system is not occurring, wasting both resources and opportunities for improved patient care.

Overhead costs of service provision and the high price of "nonessential" commodity inputs is limiting the incentive for expansion of private health service baskets. Essential commodity inputs for HIV/AIDS (ART, condoms), RCH (immunizations, contraceptives), and malaria (ACT) are either wholly or partially subsidized for private sector service delivery. However, associated costs, such as staff and facility overhead, are not subsidized. Thus, for fee-exempted cost-share services such as HIV/AIDS and RCH, the private facility is expected to provide free services without adequate coverage of total costs of treatment provision. Without a formal contracting and treatment reimbursement mechanism, there is little incentive for private health facilities to expand their basket of services to include these services, in view of the necessary investments in both infrastructure (for RCH and HIV services) and human resources. In addition, because private providers often procure pharmaceuticals and/or other commodities via wholesalers at high mark-ups, the commodity input costs of service extension are prohibitive. These factors limit the incentive and the capacity for private providers to scale up their involvement in addressing national health priorities such as HIV/AIDS, RCH, TB, and malaria.

Increased involvement and investment of corporate actors is needed in Tanzania's health system. Opportunities to involve corporate entities in the development of corporate social responsibility and workplace wellness programs have not been fully exploited. Reinvigorating CEO workshops, creating opportunities for corporate interaction with TACAIDS and the government's vertical disease programs, and promoting the creation of workplace wellness programs and policies will provide opportunities to extend the coverage of priority health programs. Encouraging the creation of workplace wellness programs is a key

opportunity for the promotion of PPP, and will allow vertical disease programs to access a large number of young people employed at corporate locations throughout the country (such as Airtel and various manufacturing facilities).

Recommendations to Strengthen Private Sector Service Delivery

Establish dialogue with the private sector as a routine part of LGA/District Health Management Team functions. Limited communication and weak dialogue are hindering opportunities for stronger private sector contributions to the Tanzanian health system. The exclusion of private health actors from key forums and planning activities effectively excludes valuable skills, capacity, and resources from essential health services. Encouraging DMOs and other local government health leadership to make PPD and program coordination a routine part of council meetings will increase opportunities for face-to-face multisectoral collaboration. In addition, opportunities exist to expand the composition of CHMTs to accommodate increased representation from the private sector. Making private sector engagement in CCHP processes mandatory and inclusive will also promote more effective council health plans based on collaborative and comprehensive planning. CHMTs would also benefit from supportive guidance on facilitating multisectoral dialogue, while scaling up the inclusion of PFP and additional PNFP health facilities in the CCHP dialogue and preparation process. Further, LGAs and public health facilities should encourage private sector participation in existing public sector technical dialogue. Fostering opportunities for knowledge exchange via hospital-based M&M meetings, quarterly maternal mortality audits, and other technical forums discussing disease and surveillance trends will provide opportunities for multisectoral collaboration, cross-sector capacity development, and CPD. By including (for example) PRINMAT nurses and midwives in maternal mortality audits, and by expanding the involvement of lower-level CSSC facilities in CCHP processes, LGAs can increase valuable community-level knowledge while maximizing the opportunities for community-based health personnel to strengthen their skills.

Increase private sector training opportunities in key health services. Open all training opportunities to all types of private providers, whether they are donor funded or government funded. The private health sector is ready to engage in the delivery of essential services such as HIV/AIDs, but is limited by their ability to access training or CPD opportunities. Starting with the vertical programs (for example, intensive IMAI or RCH training for private health sector actors), private sector personnel should be mobilized to address key health challenges facing the Tanzanian health system. At present, private sector actors (particularly in rural areas, where service expansion is needed most) have limited opportunities to access CPD or skills expansion trainings that would allow their inclusion in vertical program responses, due to the cost of trainings, requirement of extended absence from private health facility, and other training access barriers—effectively limiting the expansion of private sector service packages. In mobilizing private sector resources to respond to key health challenges (HIV/AIDS, malaria, RCH) there is

a need to emphasize "private sector only" training programs to increase service delivery coverage. In some councils, public staff have provided short-term coverage to private health facilities in times of extended staff absence due to illness or HRH shortage. Formalizing this practice should be explored to allow private sector staff to attend trainings. In addition to formal trainings, both sectors should seek to organize private-public sector exchange attachments in order to increase multisectoral capacity in key specialties (for example, cardiology, nephrology).

Increase public-private attachment and shared CPD opportunities. Increasing clinical/technical attachment and CPD opportunities at public facilities, and exploring mentorship opportunities via the vertical disease programs, could significantly scale up the number of health personnel involved in priority health areas. Public and private actors should also explore opportunities for public-private sector clinical dialogue and exchange attachments in key specialties (cardiology, nephrology, and so on) to foster information exchange and clinical skill development in both sectors. This could be done through increased private provider involvement in existing morbidity and mortality meetings, maternal mortality audits, and other clinical forums.

Support the Tanzanian Medical Laboratory Scientists Association (MLSA) to facilitate the coordination and harmonization of diagnostic/equipment use across the public and private sectors. The MLSA is eager to identify and support opportunities to coordinate diagnostic/equipment use between the sectors and improve the efficacy of diagnostic referral between public and private diagnostic providers. In the event of reagent stock-outs, equipment failures, or limited utilization of existing equipment, improving knowledge of (and access to) existing equipment resources between the sectors can improve patient care and eliminate the need for facilities in both sectors to heavily invest in equipment already available elsewhere. The private health sector currently possesses equipment and expertise that could be made available to the public sector through purchasing agreements; conversely, public sector referral or equipment loan for small-scale private clinics could spare them having to rent ultrasound and other key service equipment at exorbitant prices. The MLSA should be supported to convene a one-time membership forum in order to create a compendium of available diagnostic resources across the sectors and identify coordination prospects. The MLSA as a membership body can encourage informal or formal "contracts" or "purchasing agreements" in order to better share diagnostic resources across the sector. Linking these agreements to financing mechanism (for example, NHIF) may also minimize OOP expenditures to patients while providing much needed diagnostic capacity to both sectors.

Pursue existing PPP opportunities for nonclinical supportive service provision in health facilities. The public sector currently employs personnel to provide supportive health facility services, such as cleaning, waste disposal, catering, and security. LGAs describe this responsibility as time consuming—absorbing

administrative capacity from hospital and council leadership that could be spent on health service delivery. PPP opportunities exist to outsource these services to private companies, allowing management at facility and council level to focus on service delivery priorities.

Notes

1. The 2004/05 DHS reports that large sampling errors in that year's survey data may have distorted this measurement.
2. DHS does not provide data on source of TB treatment, therefore case detection and treatment statistics are not disaggregated by source.

CHAPTER 5

Private Sector Human Resources for Health

The Private Sector Human Resource Crisis

Effective management and development of human resources for health (HRH) is the backbone of a well-functioning health system—both in terms of ensuring the effective delivery of health services and improving patient outcomes. This priority is reflected in Tanzania's HSSP III, which emphasizes HRH as "essential for improving accessibility and quality of health services" (HSSP III 2009, 6). However, mainland Tanzania faces a severe HRH crisis with significant deficits—in terms of both quantity and quality—in almost all health subsectors and professional cadres. Table 5.1 gives a summary of total HRH deficits by cadres. Shortages of adequately trained health personnel and specialists, particularly in the private sector and in rural areas, constrain the ability of the Tanzanian health

Table 5.1 Status of Health Workers, by Cadre

Cadre	*Manning*	*Available*	*Deficit*	*Percent deficit*
Medical doctors	910	489	421	46.3
Specialist doctors	268	94	174	64.9
Trained nurses	9,761	6,382	3,379	34.6
Enrolled nurses	17,053	7,796	9,257	54.3
Pharmacist/technician	645	330	315	48.8
Chemist	274	126	148	54.0
Assistant medical officer	2,238	1,417	821	36.7
Laboratory technician	1,036	568	468	45.2
Health officer	2,660	1,177	1,483	55.8
Radiographer	222	120	102	45.9
MCH aide	702	1,038	–336	47.9
Clinical officer	492	347	145	29.5
Assistant clinical officer	1,787	826	961	53.8
Total	**38,048**	**20,710**	**17,338**	**45.6**

Source: HMIS 2012.

system to adequately respond to key health challenges such as human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS), reproductive and child health (RCH), and malaria. Systemwide, the most severe shortages are found in rural areas and among specialist doctors, pharmacists and pharmacy technicians, assistant clinical officers, and enrolled nurses. Although the Government of Tanzania (GOT), private health associations, and private (both faith-based and for-profit) medical training institutes have acknowledged the importance of improving strategic workforce planning and management practices, significant challenges remain that limit adequate staffing levels at private facilities.

The President's Office of Public Service Management (PO-PSM) is ultimately responsible for the GOT's HR policy, with the MOHSW responsible for HRH policy guidelines within the health sector. The current MOHSW HRH Strategic Plan (2008–13), developed in partnership with a variety of public and private stakeholders, seeks to address key obstacles inhibiting effective human resource planning, adequacy of training opportunities, and partnership across the sectors. The MOHSW also partners with several other government agencies, including the following:

- MOSTE, to oversee both public and private medical training institutions
- MOF, for funding of public facilities
- PO-PSM for HR policy, including HRH and approval of manning levels for public health facilities
- PMO-RALG and LGAs, for administration of public facilities at the regional and local level.

Under the current strategic plan and HSSP III, LGAs have gained increasing management authority over HRH planning through their annual development of CCHPs. As discussed in "Relationships between the Sectors," private health sector participation in this process varies by district and is highly dependent on the good will of individual DMOs and CHMTs. LGAs (in partnership with the MOHSW) are responsible for adequate staff recruitment, retention, and CPD/training. However, private sector access to the eight MOHSW Zonal Training Centers established to facilitate CPD was reported by key informants as "limited." As a result of this limited access, private health facilities are largely responsible for their own HRH plans and management—with private health associations (such as APHFTA and the CSSC) providing support in strengthening private sector HRH planning processes and providing CPD/training opportunities in addition to those offered by the LGA/DMO. Thus, although private health personnel are required to license with the respective medical or nursing council, they are significantly disconnected from national- and district-level HRH planning processes.

For a number of reasons, Tanzania's nationwide HRH shortage is compounded in the private health sector (see table 5.2). In 2006, the MOHSW raised the salaries of all public health sector employees, leading to significant numbers of health

Table 5.2 HRH Shortages in Private Facilities, 2006

Facility level	*No. of facilities*	*Required staff per facility (2005)*	*Required staff for all facilities (2005)*	*Available staff (2006)*	*Staff shortage (2006)*	*Percent staff shortage (2006)*
Hospitals	132	197	26,004	3,251	22,753	87.5
Health centers	150	36	5,400	758	4,642	86.0
Dispensaries	1,641	7	11,487	1,842	9,645	84.0
Total	**1,923**	**n.a.**	**42,891**	**5,851**	**37,040**	**86.4**

Source: Chee et al. 2011.
Note: n.a. = not applicable.

personnel leaving the private health sector for higher salaries and pensions available in the public sector. High turnover of private health sector staff, "brain drain" of highly qualified personnel to the public sector, and lower private sector salaries have all contributed to persisting perceptions of "low-quality personnel" retained in the private health sector. Managers of private health facilities argue that without raising user fees they cannot pay adequate salaries to attract and retain highly qualified personnel; too, they worry that their investments in training for private staff will be lost if personnel continue to leave for work in the public health sector. Private sector HRH shortages are even more acute in rural areas. Medical professionals trained in urban areas (especially Dar es Salaam) prefer to remain in urban settings—and most private facilities do not have the resources to develop incentive packages to draw medical professionals to rural areas. For all these reasons, the private health sector in Tanzania remains understaffed, with limited resources to attract highly qualified personnel, to train existing personnel, or to improve HRH capacity at the facility level—thus perpetuating perceptions of poor quality in the private sector.

Private For-Profit Medical Training Institutes

Tanzania's HRH shortages impair the quality of care, through reduced staffing levels at health facilities and greater service delivery burdens on existing health workers. Expanding the availability of preservice education, both in the public and private sectors, is an essential step to increasing the size of Tanzania's health labor force. Given Tanzania's pressing HRH shortages and its strong private health sector, strengthening the capacity of for-profit PMTIs is an important contribution for producing more health workers.

Currently there are 11 accredited PMTI in Tanzania, with approximately 6 percent of total medical students enrolled. Of the 27 universities and university colleges under the jurisdiction of the Tanzanian Commission for Universities (TCU), six offer medical programs, and four of these are private universities. Of the 57 medical training schools given at least provisional accreditation by the National Council for Technical Education (NACTE), there are nine private commercial medical training schools. The PSA examined four PMTIs in depth, focusing on the opportunities and constraints facing PMTIs at the both the university and diploma level: Herbert Kairuki Memorial University; International Medical

Table 5.3 Key Descriptive Characteristics of Assessed PMTIs

PMTI	*Year medical training began*	*Type of program*	*Tuition cost (T Sh, millions)*	*2011 Enrollment*
Herbert Kairuki Memorial University	2009	Degrees in medicine and nursing	5.3 tuition 5.7 with total fees	120
International Medical and Technical University	1995–96	11 degree academic programs in medicine and nursing	6.25 tuition	1,000 approx.
Massana	2006	Nursing diploma	1.6 (includes housing) 300,000 field expenses	48
Mount Ukombozi	2009	Laboratory assistant diploma	1.2 not including housing	102

Source: World Bank data.

and Technical University; Massana School of Nursing; and Mount Ukombozi Health Sciences Training Centre. The selected PMTIs vary in size, length of programs, degree type, and tuition costs. Table 5.3 gives the key descriptive characteristics of the institutions assessed.

Policy Landscape for Private Medical Education

Overall, Tanzania has an enabling policy landscape to support the growth of private medical education. The TCU accredits private universities according to the same set of criteria and quality standards as public universities. Likewise, the diploma-level accreditation system through NACTE utilizes identical accreditation measures for both public and private institutions. Overall, the accreditation system is rigorous, with strong standards in place regarding: adherence to national curricula; teacher-to-student ratios; quality of instruction; corporate governance; and financial systems. However, PMTIs find it particularly difficult to comply with these accreditation standards, particularly at the diploma level, given the complex requirements for corporate governance procedures as well as difficult to fill teacher-to-student ratios, given pressing tutor shortages in Tanzania. Thus, while Tanzania's accreditation system is rigorous and ensures the quality of medical education in Tanzania, the demanding requirements for full accreditation status constitute a barrier to the growth of new PMTIs. Furthermore, most PMTI proprietors are private health care practitioners, with little training in the financial, governance, and institutional mechanisms required for the provision of higher education.

Notably, though, Tanzania has a public student loan program that extends to both public and private universities. Established in 1994, the HESLB provides financial support to students pursuing priority area advanced/higher diplomas and degrees in medicine, dentistry, pharmacy, nursing, and veterinary sciences. Annual loans of up to T Sh 2.6 million are available to support tuition, accommodation, room and board, books, field training, research, and any special required expenses. The loans bear an interest rate of 6 percent per annum and are allocated using a new means testing system, initiated in 2011, that examines

how much the parents paid in school fees at the secondary school level. Loans covering tuition are paid directly to the university by the HESLB, and the rest is paid directly to the student quarterly.

Although it is laudable that the HESLB supports Tanzanian university students to attend both public and private universities, several key challenges impair the ability of the HESLB to support growth in PMTIs. First, HESLB loans can only be used at private universities and cannot be used at mid-level diploma or certificate PMTIs. (Nor is there any other government source of student loans.) Second, private university tuition fees far outpace the available HESLB loans. For instance, HKMU charges T Sh 5.7 million annually for a medical degree, while the HESLB loan ceiling of T Sh 2.6 million has remained in place for four years—and interviews with HESLB administrators indicate that the current ceiling is likely to remain in place for the foreseeable future. Low repayment rates to the HESLB (approximately 42 percent as of February 2012) impede the ability of the HESLB to consider raising the ceiling level. Assessment findings indicate that students do not understand the HESLB loan terms, including interest rate and repayment time period details. Finally, delays by the MOF in transferring funds to the HESLB for ultimate disbursement to students and universities caused significant student protests over the last year.

Students attending PMTIs face a significant financing challenge, in view of (1) the lack of government student loans or financial aid for diploma or certificate students, and (2) serious gaps between the HESLB ceiling and private medical degree tuition costs.

Challenges in Increasing the Number of Graduates

PMTIs face a myriad of complex and interconnected challenges that impede their ability to graduate a higher number of health workers in Tanzania. Financial challenges are the most acute, but there other constraints weakening the ability of PMTIs to enroll more students. While public or not-for-profit private training institutions may experience similar challenges in recruiting new tutors, receiving accreditation, or administering student loan program, this assessment documents the unique challenges experienced by private for-profit medical training institutions.

The assessed PMTIs are at full or close to full enrollment capacity, and suffer from infrastructure and teaching resource limitations. While some PMTIs employ radio, television, and Internet outlets to advertise their degree and medical training programs, structural limitations impede their ability to fully meet demand. In addition, the academic quality of applicants reduces the number of students that can enroll in or successfully complete PMTI. Weak secondary school requirements for science yield a large number of applicants with insufficient passing grades in prerequisite pre-medical sciences courses. For instance, a notable example is Massana School of Nursing in Dar es Salaam, which can admit 50 nursing students per year but will only graduate 21 in 2012—because 14 of the 35 nursing students who began the three-year diploma program had forged passing results for the prerequisite science courses from their secondary schools.

Insufficient Numbers of Medical Instructors

The Tanzanian higher medical education landscape suffers from a dearth of qualified medical instructors and tutors. Many PMTIs have particular difficulties in recruiting and retaining medical instructors, compared to public institutions. The Ministry of Education indicates that public institutions, on average, have a student-instructor ratio of 11, while PMTIs have a higher ratio of 16. For some PMTIs, the shortage of training instructors has almost resulted in the loss of their accreditation. For instance, IMTU almost lost its TCU accreditation in 2008 due to lack of qualified instructors and only survived by making major investments in 2009 in faculty, facilities, and curriculum programs. A positive aspect to this major investment was a significant increase in enrollment by 2010.

At the university level, private medical universities may experience higher turnover of staff because of fewer long-term contracts with instructors. These universities may also rely on foreign instructors; for instance, up to 50 percent of the medical instructors at HKMU are non-Tanzanian. Public universities and institutions are able to provide more stable pensions and job security than their private counterparts. While there are some exceptions at the diploma level, most PMTIs experience acute challenges in attracting and retaining a sufficient number of medical instructors.

Limited Infrastructure

All interviewed PMTIs experience limited and poor-quality infrastructure. There is a widespread lack of laboratory space, demonstration equipment, and student housing. These limitations reduce the number of new students PMTIs can accept and can impede accreditation, as well as posing a significant barrier to entry for new PMTIs. For instance, NACTE indicated that the Mount Ukombozi Health Sciences Training Centre must finish refurbishing its laboratory facilities for students before it can accept new students in September 2012. These infrastructure needs likely affect the affordability of tuition, as PMTIs typically pass on some infrastructure development costs to students.

There are some important government and donor-funded initiatives to subsidize infrastructure development in private universities; for instance, HKMU was the recipient of a T Sh 1.2 billion loan from the Tanzania Education Authority to fund new student housing and a laboratory. Nevertheless, PFP mid-level institutions are particularly at risk. A new Canadian International Development Agency (CIDA)-funded initiative will help support infrastructure upgrades for mid-level training institutions in remote areas. While it primarily targets faith-based training institutions, this program could also be used to support PFP mid-level institutions.

Financial Challenges

All PMTIs are highly dependent on student tuition fees or HESLB payments for revenue. Most PMTIs require fully paid tuition prior to the start of each semester. All the assessed PMTIs reported some students dropping out in the second semester of an academic year, due to lack of ability to pay tuition. Many of the

drop-out students eventually do graduate but are forced to take time off to work or to raise funds from family members.

Meanwhile, PMTIs maintain a number of fixed expenses, including instructor salaries and infrastructure costs. As a result, most PMTIs are experiencing significant financial difficulties. Even the well-established Herbert Kairuki Memorial University relies on an overdraft facility at 21 percent interest to pay for monthly expenses.

Revenue diversification is essential to help PMTIs stabilize financially, make necessary infrastructure improvements, and emerge in a position to enroll more students. Revenue diversification is particularly important, since public universities receive higher government financial support per student than private universities, and PFP mid-level training institutions receive no government support at all. Examples of revenue diversification options include: increased linkages with international universities for research support; offering and selling CPD courses; and increased intake of foreign medical students paying higher tuition fees.

Private medical universities have strong basic financial management practices, including audited financial statements, active boards of directors, and business plans. However, the newer mid-level PMTIs experience capacity and staffing constraints in financial management. Both accreditation agencies indicate a need for improvement in resource management, corporate governance, and strategic planning by PMTIs.

Finally, commercial financial institutions have limited experience lending to PMTIs or students. For the assessment, five financial institutions were interviewed to gauge market prospects for commercial lending to PMTIs and students. All five loan portfolios indicate a fair amount of consumer lending, and three banks have lent to primary and secondary schools at low levels. With the exception of HKMU, none of the assessed PMTIs have accessed credit. However, financial institutions are open to lending to PMTIs and do not see any additional credit considerations that would make lending to a PMTI more problematic than other types of schools. With the growth of a Tanzanian middle class, demand for private education at the secondary level is expanding and the market for private education overall is likely expanding.

To date, only one bank, Banc ABC, has developed a private student loan product. Student loan products are inherently risky without government guarantees, due to the lack of salary while enrolled in school. Banc ABC's student loan product for working students was discontinued shortly after its debut in 2011 due to the high market interest rate and loan fees, in competition with zero interest rate education loans/advances available from employers on ad hoc basis. Giving parents to access salary-based "parent loans" to fund their children's medical education may be a less risky and more appealing prospect to financial institutions.

Key Findings

The nationwide human resource shortage is compounded in the private sector by "brain drain" to the public sector. Higher salaries and pensions available in the public sector are drawing health personnel out of the private health sector, exacerbating

HRH shortages at both PFP and PNFP facilities, particularly in rural areas. Although this trend has helped fill staffing gaps at public facilities, it has prevented private facilities from attracting high-quality health personnel and specialists. Frequent departure of private health sector personnel to the public health sector limits incentives for private sector health managers to invest in training opportunities, and perpetuates the perception of low-quality health workers in the private sector.

PNFP and PFP employees are often unable to participate in CPD opportunities. Multiple stakeholders from private facilities confirmed that their staff are unable to participate in public sector CPD and in-service trainings. Although these trainings are technically open to all medical professionals, public sector employees are often given preferential access. The severe shortage of human resources in the private sector also means that private facilities—especially PFP facilities without access to seconded public sector staff—often cannot afford to give their staff leave to attend CPD or other trainings. Without opportunities to advance their skills or learn about government health priorities, private sector personnel remain disconnected from the public health sector HRH strategy and are not leveraged in addressing key health challenges.

Private health sector personnel are not included or leveraged as part of LGA HRH planning. Tanzania's current HRH challenges are caused not only by limited supply of new health personnel but also by missed opportunities to adequately utilize available health personnel across all sectors. CSSC facilities have benefitted from the use of public health personnel seconded to CSSC facilities; in some councils, similar arrangements have allowed smaller PFP and PNFP facilities to fill short-term human resource gaps with public personnel. Formalizing such arrangements for staff sharing at the council level would allow small private facilities to send personnel for CPD and training opportunities. In addition, in rural areas public staff secondments to existing FBO or NGO facilities would make use of existing private sector health infrastructure without requiring significant investment in rural health expansion from the public sector. Incorporating private sector human resources into the larger LGA HRH strategy and planning process can promote more effective utilization of existing human resources.

PMTIs experience significant constraints that weaken their ability to train new health workers. Although PMTIs could serve as an important source of preservice education in Tanzania, important constraints weaken their ability to enroll new students. These constraints include overreliance on tuition fees for revenue and cash flow; insufficient sources of public and private financing for student tuition, particularly at the mid-level diploma and certificate level; weak corporate governance; insufficient numbers of qualified students and available instructors; and limited space and infrastructure to place more students. While those challenges are daunting, the PSA offers several relatively inexpensive options to remediate these constraints, including: options for policy reform at the HESLB level; prospects for private financing for tuition by parents of PMTI students; and specific ideas for revenue diversification at the PMTI level.

There are significant barriers to entry for the growth of new PMTIs. Currently, there are only 11 PMTIs in Tanzania, representing 6 percent of total medical students. While PMTIs could contribute more fully to the expansion of preservice education in Tanzania, there are significant barriers to entry for the growth of new PMTIs. Tanzania's strong accreditation system, while commendable in its efforts to protect the quality of Tanzanian higher education quality, requires strong cash reserves, infrastructure development, staffing levels, and equipment needs in order to qualify for provisional or final accreditation. These stringent entry requirements prevent potential proprietors from completing plans to introduce new PMTIs to the market. Options to remedy these high barriers to entry include (1) phased accreditation plans, which relax requirements in the first two years of operation, or (2) options for a new PMTI to be paired initially with a strong existing institution, for shared infrastructure and equipment. New developments in the franchising of international medical education could be investigated by the GOT, and prospective franchisees could be incentivized to open new schools in Tanzania. International franchisees are more likely to be able to conform to initial requirements for accreditation.

Recommendations

Develop a mechanism for joint public-private HRH planning as part of the LGA CCHP process. The flow of private health sector medical professionals to the public sector as a result of higher salaries and pensions negatively impacts the ability of private and FBO facilities—especially those in the rural areas—to deliver key health services. Developing a mechanism for joint public-private HRH planning could help identify and address factors that contribute to competition between the sectors. At the LGA level, the CCHP process could serve as this mechanism, if it includes a more substantive role for the private sector. Potential options include increasing transparency, adding a private sector representative to discuss health sector compensation, and ensuring that regular salary benchmarking analysis occurs in both the public and private sectors to inform retention discussions.

Expand opportunities to second public sector staff to PFP facilities. The MOHSW and LGAs should investigate expanding their program of seconding staff to include PFP facilities. This expansion will help mitigate the severe HRH shortages at PFP facilities and will formalize the existing exchange that is already occurring at some locations. As part of this reform, the MOHSW should develop clearer guidelines for what is expected of the private facility and the seconded personnel. It should also better clarify in the contracts how the exchange will affect the seconded personnel's benefits and tenure at their home facility.

Incorporate PMTIs in broad private health sector strengthening efforts. PMTIs have unique needs and challenges that differ from private health facilities and practitioners. However, there are many opportunities to strengthen the ability of PMTIs to more successfully expand the health workforce in the context

of broad private health sector strengthening. First, efforts to increase access to finance for private providers can be implemented in tandem with efforts to improve commercial lending to PMTIs, as well as to work with financial institutions to develop and market "parent loans" as a private sector solution to escalating tuition costs. Second, opportunities to expand PPPs should incorporate PMTIs for innovative solutions to health sector problems. For instance, HKMU partners with public district hospitals to give students the hands-on, practical learning experience they need, while exposing them to health care working conditions across the country. This partnership offers some much-needed, though limited, revenue diversification for HKMU, while helping to expand practicum offerings for Tanzania's medical students. Finally, strengthening private sector representation should incorporate efforts to better integrate PMTI policy needs—particularly around government-funded student loans and accreditation issues—within the agenda of APHFTA's interactions with the GOT. AFPHTA's business and management training efforts for private providers can be augmented to include modules for PMTI proprietors around important areas such as revenue diversification, corporate governance, and tuition-dependent cash flow management.

CHAPTER 6

Access to Essential Pharmaceutical and Medical Commodities

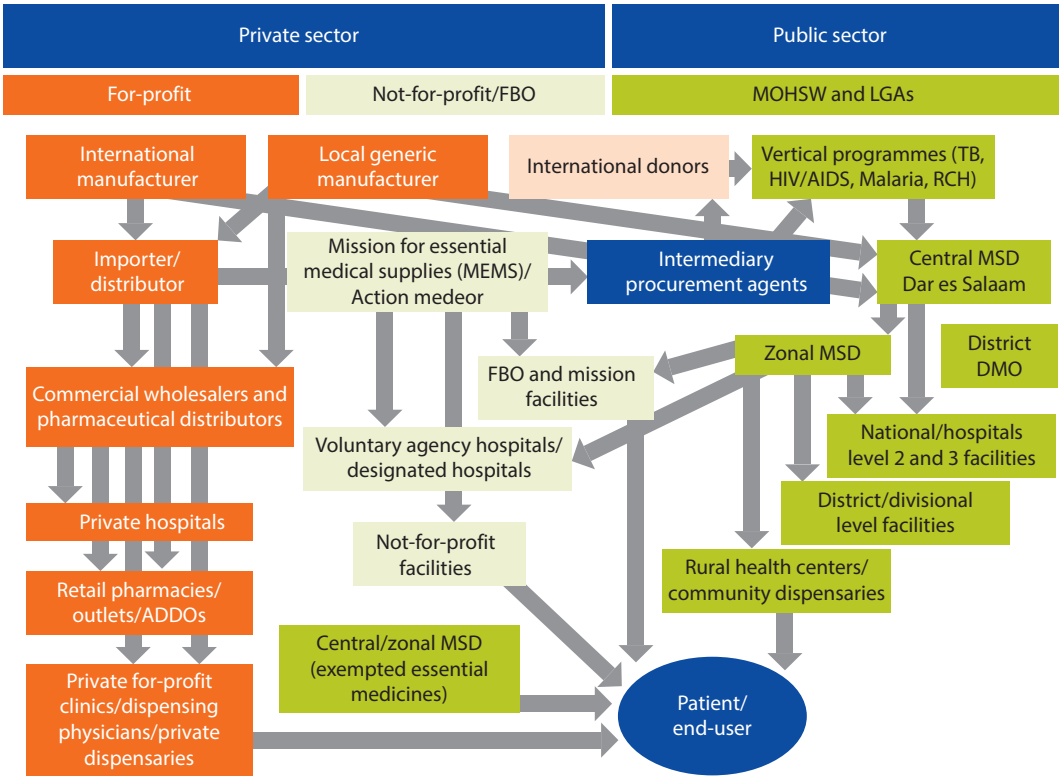
Ensuring that health service providers have consistent access to high-quality medical products and pharmaceutical commodities is imperative for a functional and effective health system. Both the MOHSW HSSP III and the USAID/Tanzania Country Strategic Plan (2005–14) emphasize Tanzania's medical supply chain and drug access as critical health system components in need of strengthening in order to effectively address malaria, human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS), tuberculosis (TB), and other key national health challenges. Given this imperative, the Ministry of Health and Social Welfare (MOHSW) has committed to ensuring "constant and adequate availability of pharmaceutical, medical supplies and equipment of acceptable quality in the supply chain system for public health facilities and accredited private facilities" (MOHSW 2009a, 43).

Although the public sector is the largest actor in the pharmaceutical sector, there is a growing private sector presence in all aspects of this sector, including the manufacturing of key drugs and medical products. There are 291 TFDA-approved private pharmaceutical import/wholesale distributors in Tanzania, concentrated mainly in or around Dar es Salaam—although it is unknown how many are currently active. The distributors supply not only private health facilities but also an estimated 661 private pharmacies and 6,000+ private medicine retailers (for example, ADDOs).

Overview and Structure of the Tanzanian Supply Chain

Importation, procurement, and supply of pharmaceuticals and medical products in Tanzania are regulated by several key documents. Government procurement and financing of medical commodities is guided by the National Medicines Policy (revised 2008) and the Public Finance Act (2001), while the Medical Stores Department Act of 1993 created Tanzania's MSD under an act of Parliament. The Tanzania Food, Drugs and Cosmetics Act (No.1 of 2003) created the TFDA

Figure 6.1 Organization of Tanzanian Supply Chain



Source: World Bank data.

and, under section 5(c), outlines the National Guidelines for Monitoring Medicines Safety (revised 2010). MSD's selection and procurement of medicines are further guided by the National Essential Medicines List (NEML), last updated in 2006, and the Standard Treatment Guidelines, last updated in 2007. Figure 6.1 outlines the flow of pharmaceuticals through the Tanzanian supply chain in the public, PFP, and PNFP sectors.

The Pharmaceutical and Supplies Unit (PSU)

The PSU (part of the MOHSW) is responsible for the overall management and coordination of Tanzania's medical supply chain. Main functions of the unit include the formulation and implementation of the country's pharmaceutical policies, budgeting for purchase of medicines and medical supplies, and the provision of technical support to other government supply chain bodies. The MOHSW-PSU holds ultimate responsibility for the effective enactment of the country's drug policy, including the preparation of the annual medicines and medical supplies budget for Tanzania's public health (and affiliated FBO/NGO) facilities. The MOF allocates funds annually to the MOHSW, which in turn apportion funds to MSD, indicating funds for individual referral hospitals, regional hospitals, and

district facilities. District-level budgeting and planning for health services (as well as utilization of MSD subaccounts for pharmaceutical and supply procurement) are carried out by individual CHMTs, which respond to procurement requests and coordinate with health leadership at the facility level.

The Medical Stores Department

Created in 1993 by an Act of Parliament, MSD is a nonprofit business entity with an independent board of governors appointed by the MOHSW and the PMO; it is responsible for the procurement, storage, and distribution of medicines and medical supplies to all public and approved NGO/FBO facilities, including CSSC-designated hospitals and health centers. MSD functions include almost all activities in the supply chain management cycle with the exception of dispensing: PSU/MSD collaborative creation of the NEML; assembling a national MSD product catalogue selected from the NEML; ordering and procurement; quality management; and distribution/logistics management. MSD is also responsible for the management and oversight of district procurement subaccounts allocated by government to individual districts/facilities via the District Executive Director account. MSD's ability to successfully perform such a wide range of functions in the Tanzanian medical supply chain is directly related to its autonomy. However, key informants reported that "recent government control has tightened," with MSD now performing as a "near public entity instead of an autonomous body." Laborious public procurement and tender processes, reliance on limited government financing, and restrictions on procurement of key vertical program commodities (for example, ART, condoms, and malaria medications) have all limited MSD efficiencies and restricted the department's ability to adequately service the health system.

Forecasting

Facility-level directors (in both public and government affiliated FBO/NGO facilities) are responsible for forecasting, determining their product needs, and ordering from MSD via the DMO. For most facilities, the ordering and administration of district-level medical supply "starts and ends with the DMO's office" (MOHSW 2008b).

Procurement

Public facilities procure pharmaceuticals primarily via their MOHSW/MOF designated accounts and subaccounts which are held and managed with MSD. Approved NGOs and FBOs are allowed to procure via MSD on a cash-and-carry basis—ensuring MSD procurement cost recovery from these facilities. MSD offers limited procurement opportunities for PFP and unapproved PNFP organizations; distribution to these facilities is restricted to vertical program commodities (such as ARVs, TB medications, and immunizations) and controlled substances such as opioids and analgesics (for example, pethedine and morphine). Overall, the general advantage of MSD is their ability to pool procurement for the entirety of the public health system and a significant portion of the NGO/FBO sector. MSD also has the capacity to perform some post-importation quality assurance via its independent labs.

Distribution

MSD packages ordered and in-stock supplies and delivers them to the DMO (that is, district or zonal stores department), who then distributes to individual health facilities. The exception is the larger district, regional, and referral hospitals, which (due to volume) order directly from MSD. Fears regarding uncontrolled leakage of medical products outside Tanzania and regarding competition in the wholesale pharmaceutical market have limited efforts to expand private sector access to MSD distribution. Key informants stated that overall MSD is "relatively well funded" via the MOHSW budget and has a "fairly extensive storage and distribution system" that is able to deliver product to zonal and district stores departments within "reasonable lead-times." With a reasonably well-developed procurement and distribution infrastructure, MSD is also responsible for the distribution of vertical program public goods (to both public and private health facilities) via the zonal stores, according to the vertical program plan. MSD charges donor distributing agents or the individual vertical programs a 14–18 percent storage and distribution handling fee. Reports from key informants suggest that the government is largely in arrears on this MSD "handling fee," limiting MSD's cost-recovery on vertical program procurement and contributing to MSD's "intermittent cash flow crises." Currently, MSD is rolling out a system of direct delivery to facilities. With support from external partners, phased expansion of the MSD transport fleet is planned over the next three years; previous efforts to outsource distribution more fully have been restricted by Tanzania's limited transport and project logistics sector.

The USAID/Deliver and PEPFAR supported Supply Chain Management System (SCMS) Projects provide technical assistance to MSD in operational and supply chain management. The Deliver Project is a global USAID-funded initiative that aims to increase the availability of essential health commodities worldwide. In Tanzania, Deliver has developed an Integrated Logistics System, which remains largely paper based. The project has supported the development of an Electronic Resource Planning system, currently being rolled out in several regions. USAID/Deliver has also supported reproductive health commodity security initiatives (in particular for contraceptives), as well as efforts to improve quantification and procurement of antimalarial commodities via funding from the President's Malaria Initiative.

SCMS/Tanzania is a Management Sciences for Health (MSH)/John Snow International joint partnership focused on improving procurement mechanisms through strengthened supply chain management. The project, which runs in parallel to USAID/Deliver, focuses largely on the provision of technical assistance to support the NACP in strengthening the procurement and supply of medicines and products required by PEPFAR-funded activities. SCMS activities include: improving product availability by working to reduce stock-outs of ARVs and other key HIV commodities; supporting the development of MOHSW capacity in commodity forecasting and need quantification; developing MSD infrastructure in order to improve the distribution of HIV/AIDS commodities; and strengthening information management throughout the supply chain. Recently SCMS has

supported a proposal for the creation of a Logistics Management Unit that would absorb current SCMS functions of monitoring commodity availability, routine quality assurance, and strengthening the TFDA's role in conducting postmarket commodity surveillance. The proposal is currently under review, with the ultimate goal of transferring responsibility of these activities (and supporting Logistics Management Unit capacity development) at the central and zonal levels.

TFDA, Pharmacy Council, and Bureau of Standards

The TFDA, the Tanzanian Pharmacy Council, and the Tanzanian Bureau of Standards (under the Ministry of Trade and Industry) are collectively responsible for oversight of medicine and medical product quality, regulation of wholesale importation, and registration of wholesale premises. Recent changes to laws and regulations (as of November 2011) have mandated the Pharmacy Council with registration of wholesale pharmaceutical premises, while the TFDA maintains responsibility for regulating wholesale importation and providing import permits. However, there are clear challenges in dividing up these two roles. The TFDA is primarily responsible for ensuring quality of medicines and performing postmarket surveillance, while the Bureau of Standards is responsible for oversight of medical products such as gloves, condoms, and equipment.

In terms of TFDA regulation, pharmaceutical dispensing in Tanzania is divided into two approved categories: Part 1 includes pharmacies offering the full range of prescription and nonprescription medicines; and Part 2 includes small private retail pharmacies and *duka la dawa baridi (DLDB)* drug outlets, which offer a limited range of over-the-counter and nonprescription drugs. A joint assessment in 2001 by MSH and MOHSW on rural availability of medicines found issues of persistent stock-outs at rural facilities as well as noncompliance with Part 2 regulations. The assessment revealed a number of unqualified DLDBs overcharging patients for medications, stocking and dispensing unapproved drugs, and doing inadequate assurance of drug quality (Center for Pharmaceutical Management 2003). In an effort to improve the quality of Part 2 facilities, Part 2 DLDBs have been replaced by ADDOs in 15 regions, with an additional six regions planned for transition by July/August 2012. The TFDA has maintained responsibility for finalizing the ADDO program and, once completed, will transition registration and oversight responsibility to the pharmacy council. In areas without a Part 1 facility, the TFDA and the Pharmacy Council are also expanding the dispensing package of some Part 2 facilities to include some items on the NEML, in order to limit deprivation of key medicines in rural areas.

Private Sector Supply Chains

There are three notable alternative supply chains to MSD in Tanzania focused on the provision of pharmaceuticals and medical supplies to commercial, not-for-profit, and faith-based facilities. In procuring products not carried by MSD or during periods of MSD stock-out (discussed in detail below), both public and private NGO/FBO facilities may choose to purchase from the following distributors.

Action Medeor International Health Care

Initiated over 40 years ago by Action Medeor (Germany), the Tanzania-based Action Medeor International Healthcare (AMIH) provides pharmaceuticals, medical commodities, and advisory services to mission hospitals. Targeting the PNFP health sector (that is, church-affiliated health centers, national and international NGOs, and charitable institutions), AMIH serves as a procurement and distribution agent for over 300 essential medicines and medical supplies. Approved facilities are able to procure from Action Medeor on a cash-and-carry basis; medicines registered in Tanzania are value added tax (VAT) exempted by the Tanzanian Revenue Authority, and other products carry a 20 percent VAT. Medicines are distributed direct to the facility via dispatch services or by bus. Action Medeor states that the system "operates as an alternative supply system to already existing systems in the country in a complementary spirit of cooperation for the benefit of the customers" (Action Medeor 2012).

Mission for Essential Medical Supply (MEMS)

Established in 2001 and launched in 2004, MEMS is an initiative of the Evangelical Lutheran Church in Tanzania (ELCT). MEMS was established in response to three issues; poor availability of essential medications to FBO hospitals via MSD; the prohibitively elevated price of drugs from private wholesalers; and questionable quality of drugs procured via private commercial sources. MEMS is meant to complement MSD. Organized as a Prime Vendor Model, MEMS pools FBO hospital/health facility procurement and purchases medical commodities at negotiated lower rates from a prime commercial for-profit wholesaler (currently Pyramid Pharma Limited Tanzania). MEMS stocks a wide variety of essential medicines and medical products, with the exception of TB medications, vaccines, ARVs, and reproductive health commodities, which are delivered via the various MOHSW vertical programs. In addition, MEMS provides what they call "value added" services, such as quality assurance, stock management, and technical assistance on rational use. In exchange for these capacity development services, MEMS charges a 10 percent service fee—which, importantly, may bring the cost of their products to just slightly less than, or even equal to, that of an independent commercial wholesaler. Therefore FBO/NGO facilities tend to use MEMS as they would any other supplier, purchasing some commodities via MEMS if the total cost (inclusive of the 10 percent fee) is lower than the procurement cost via an alternate source. This has restricted MEMS' customer base. In order to strengthen MEMS' customer base and expand the network of FBO partner facilities, the ELCT is in the process of incorporating MEMS as a PNFP company under the oversight of the CSSC. A draft memorandum was signed by CSSC leadership in May 2012, and the formal registration process is now underway. Importantly, distribution to commercial private sector facilities (including ADDOs) is included in MEMS' business incorporation articles—making pooled and/or independent commercial private sector procurement via MEMS a potential mechanism to be explored.

Commercial Wholesalers, Importers, and Pharmaceutical Retailers

There are over 185 TFDA-approved private pharmaceutical import/wholesale distributors in Tanzania, concentrated mainly in or around Dar es Salaam—although it is unknown how many are currently active. Private distributors are the main source of pharmaceutical and medical products for commercial for-profit health facilities in the country, as well as an estimated 661 private pharmacies and 6,000+ private medicine retailers (for example, ADDOs; see box 6.1 for a discussion of ADDOs). Faith-based and other not-for-profit organizations also utilize private wholesalers as an alternative to MSD or MEMS during periods of stock-outs or for items not available via the public/FBO procurement channels.

Box 6.1 Can ADDOs Expand Access to Essential Medicines?

What is an ADDO? Tanzanians in rural and poor urban areas often rely on duka la dawa baridi (DLDB), or private drug shops, to get their medicines when public dispensaries and health centers have insufficient stock. DLDBs are licensed to sell only nonprescription medicines, but typically they provide a much broader range of products and services. Tanzania is in the process of converting all DLDBs to ADDOs, which are licensed to sell both over-the-counter and a short list of prescription drug products for which they have market authorization from the TFDA. ADDO owners and employees complete courses covering both management and clinical skills to allow them to operate an ADDO.

Located in peri-urban and rural areas, there are currently over 2,000 ADDOs nationwide. These retail outlets offer quality medicines for illnesses commonly found in the communities they serve: skin diseases, upper respiratory illnesses, malaria, helminths, fungal diseases, viruses, hypertension, maternal health and family planning. Open long hours (10–18 hours daily) and six days a week, ADDOs are convenient for many communities. Often, the ADDOs are better stocked than their public dispensaries.

The ADDO story. Originally piloted through a USAID program, the Tanzanian government committed to creating ADDOs nationwide. The ADDO program's goal is to professionalize medicine sellers with facility requirements, standardized training for dispensing staff, and quality drugs. The government plans to complete the conversion of all DLDBs into ADDOs by the end of 2012. After the initial pilot in 2003, the ADDO program was implemented in eight regions namely Ruvuma, Morogoro, Mtwara, Rukwa, Singida, Lindi, Coast, and Mbeya. As of 2011, training has been completed in six additional regions—Dodoma, Kigoma, Tanga, Mara, Manyara, and Iringa—and these prospective ADDOs are waiting for final inspection.

The government put into place several measures to ensure the ADDOs maintain quality services. Under decentralization, CHMTs are now responsible for the quality of ADDOs. An innovative regulatory system, using local government officials deputized as inspectors by TFDA, helps ensure that accredited shops maintain approved standards and that nonaccredited shops are closed down. All ADDO dispensing staff are required to be accredited through a TFDA-approved dispenser thirty-day course as well as periodic refreshing training. Along with the dispenser training, ADDO owners participate in a six-day management training course.

box continues next page

Box 6.1 Can ADDOs Expand Access to Essential Medicines? *(continued)*

Can ADDOs achieve their potential? There have been several reviews of the ADDO program, including a recent one to assess ADDO's ability to appropriately treat childhood illnesses. The report concluded that ADDOs are a frontline source of care for childhood and other illness. In many cases, ADDO provides an essential "back-up" source of drugs to treat the most common ailments when medicines are not available in public dispensaries. Many of the consumers interviewed for this survey expressed satisfaction with ADDOs, stating the ADDOs staff are friendly and available. Despite the advances in professionalizing the ADDOs, many challenges remain. Although ADDOs are better stocked, their prices are often out-of-reach for the poorest. The same assessment recommended the ADDO program, with sufficient resources and assistance, can offer a short-term solution to reach the underserved/marginalized populations that are not being reached by dispensaries (SHOPS 2012). National experience in applying the AMFm subsidy for anti-malarials throughout the country could be instructive in developing an approach to maximize the potential of an ADDO network. This has included organizing fragmented wholesalers and retailers to streamline ACT distribution, and developing low-capacity facilities and ADDOs themselves to provide malaria medications at an affordable price.

Key informants also confirmed that public health facilities are also frequently forced to source from private distributors, due to frequent MSD stock-outs; however, since the majority of public facility financing is held in MSD accounts, they must rely on income generated via user fees or alternate sources in order to procure medicines privately. This was highlighted as one of the benefits of the Muhimbili Hospital public-private mix model—where user fees generated via Muhimbili private practice are directed to non-MSD procurement for provision of public services. While private wholesale distributors provide a more reliable procurement source, key informants described the cost of private pharmaceutical procurement as "prohibitive," with high mark-ups on commodities and intermediary "agents" charging commission in excess of 15 percent. In addition, the PSA team was told repeatedly that despite their high cost, the privately procured pharmaceuticals carry no assurances of quality or TFDA approval.

Availability of Medical Commodities

As shown in table 6.1, private facilities and pharmaceutical retail outlets play a key role in national pharmaceutical dispensing. Private Part 1 retail pharmacies, ADDOs, and DLDBs provide over 50 percent of dispensing services in Tanzania, underscoring the important role private pharmaceutical outlets play in ensuring Tanzanians have reliable access to key prescription and over-the-counter pharmaceuticals.

MSD stock-outs are reported as "very common," with both public and affiliated FBO/NGO facilities often turning to private wholesalers or alternate procurement sources to fill supply gaps and to supplement medicines obtained

Table 6.1 Estimated Number of Pharmaceutical Dispensaries

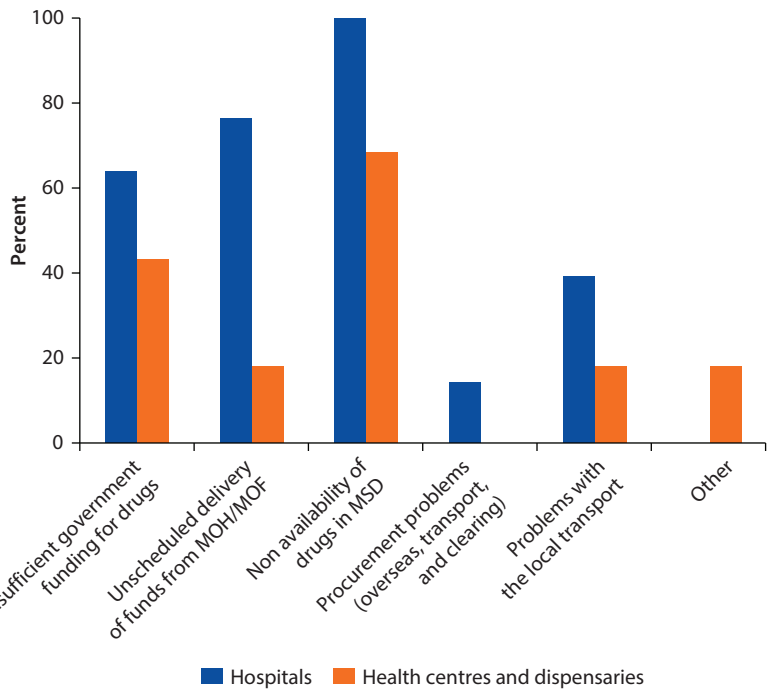
Type of premise	*Estimated number*	*Percent of total*
Pharmacies (all)	12988	100
Public pharmacies	4185	32.2
Private facilities	659	5.1
Not-for-profit facilities	155	1.2
Faith-based/mission hospitals	853	6.6
Retail wholesalers	375	2.9
Private retail	661	5.1
Accredited ADDOs	2215	17.5
Transitional DLDBs	3885	29.9

Source: MOHSW 2010.

through MSD. The possible reasons for lack of essential drug supply are outlined in figure 6.2, highlighting MSD stock-outs and delayed or insufficient government funding for pharmaceutical commodity procurement.

A 2011 *Medicines and Medical Supplies Availability Report* carried out by local Tanzanian NGO Sikika reports that "it is generally accepted that the budget allocated for the health sector, and within that, for medicines and medical supplies, is not sufficient to cater for all of the citizens' needs" (Sikika 2011). As shown in

Figure 6.2 Possible Reasons for the Drug Shortages in Tanzania



Source: Euro Health Group 2007, 48.
Note: MOH = Ministry of Health; MOF = Ministry of Finance and Economic Affairs; MSD = medical stores department.

figure 6.2 (and confirmed by interviews carried out during the PSA), deficiencies in essential medical supply are largely attributed to insufficient allocation and/or inconsistent disbursement of funds to MSD from the central government. MSD reports that lack of consistent funding for procurement and long procurement lead times, as well as "overly bureaucratic" tendering systems requiring multiple forms, approvals, and signatures, are the predominant factors leading to unavailability of drugs in MSD stores. In addition, drugs procured for the vertical programs (that is, ARVs and TB medications) are subject to restricted procurement and tendering criteria, which MSD reports "limits our ability to fill supply gaps quickly." Given that public facility procurement budgets are held on account at MSD, public facilities report serious difficulties in accessing alternative sources of funds to supplement their MSD supply—meaning that central MSD stock-outs often result in facility-level stock-outs of essential medications. FBO/NGO facilities (and public facilities with user fee or other income sources) supplement their supplies via private wholesalers; while they report greater consistency of supply and reliable delivery via these sources, they also state that "inflated prices on the open market" and "drugs of unknown quality" remain prohibitive factors in ensuring consistent supply of high-quality drugs to their patients.

Demand, Accessibility, and Pricing of Drugs

Efforts to limit or reduce the retail cost of essential medicines are critical in ensuring the sick (and particularly the poor) can access medications at accessible price points. Health consumer access to essential medications is in large part determined by the relationship between commodity supply, geographic availability, and both the wholesale cost and retail prices of medicines. Surveys assessing the price and accessibility of pharmaceuticals in Tanzania have found that for the majority of Tanzanians, the retail cost of medicines (more so than geographic distribution or consumer knowledge) poses the most significant barrier to essential medication access (WHO 2011b). The Tanzanian National Drug Policy 1991 and other guiding documents have emphasized the GOT's commitment to ensuring the availability and affordability of safe high-quality medications to all Tanzanians. However, as a result of frequent MSD drug stock outs and suspected leakage of medicines to the black market, many Tanzanians end up paying out-of-pocket for basic and essential medications at retail pharmacies where the price of key medicines can be up to six times more than in the public sector (WHO 2011b).

In addition, although many key medications are more regularly available in the nongovernmental organization (NGO) sector than in the public sector, markups on key medicines are often comparable to private retail with similar out-of-pocket expenses passed on to patients. A 2004 survey conducted by the GOT, European Union and WHO further argued that several medicines were "more expensive than necessary" across all sectors, making the out-of-pocket price for both acute and chronic care medications unaffordable to the majority of Tanzanians (Mhamba 2010).

Box 6.2 Variance in the Price of Medicines

A 2007 GOT survey found that prices for a basket of key medications were as follows:

- 10 percent higher in **urban public** facilities than in **rural public** facilities
- 30 percent higher in **urban private** facilities than in **urban public** facilities
- 32 percent higher in **rural private** facilities than in **rural public** facilities
- Similar in **urban private** facilities and **rural private** facilities
- Similar in **rural private** facilities and **rural mission** facilities
- 32 percent higher in **urban mission** facilities than in **rural mission** facilities

Source: Mhamba 2010.

Priority population groups are heavily affected by this trend. Forty percent of female respondents to Tanzania's 2004/05 DHS stated that money and cost of medications were barriers to accessing care, while a 2010 GOT assessment found that pediatric medicines in Tanzania were on average four times higher than international reference prices, with generics priced nearly 154.9 percent higher in the Tanzanian PFP and PNFP health sectors than in the public sector (MOHSW 2011). As discussed in box 6.2, as a result of weak and/or lacking price controls there is significant variance in the price of medicines both across the country (urban/rural) and across the health sectors as well. An earlier joint assessment carried out by the GOT, European Union and WHO found that 17.1 percent of assessed medicines in Tanzania had prices greater than five times international reference prices, with 70 percent priced between one and five times more expensive and less than 10 percent available below their respective international reference price (MOHSW 2004). The authors attributed the higher ratio costs over reference price to either higher acquisition costs or high mark-ups between wholesale purchase and final price to patient. In the public sector these mark-ups average 16.72 percent, compared to the significantly higher retail mark-ups of 56 percent and 60 percent in the PFP and PNFP health sectors respectively. In short, when key medications are unavailable from public facilities, the out-of-pocket costs of medicines are unaffordable for the majority of Tanzanians.

Improving the Price and Affordability of Medicines

The prices of key medicines in Tanzania vary greatly between location and sector, with many Tanzanians unable to afford medications from private retail pharmacies that are on average retailed at prices significantly higher than international reference prices. Reducing the out-of-pocket retail cost of medicines and improving affordability (drug price relative to average income) remains a challenge for the GOT and national health leadership. The following considerations affect both the wholesale procurement cost and out-of-pocket retail prices incurred by

patients, and represent potential areas of to improve availability, accessibility, and affordability of key medicines in Tanzania;

Price Controls

Legislative controls on the price of medicines in Tanzania are significantly underdeveloped, which has resulted in the wide price variation observed between the health sectors and across the country. Price control of essential medicines only takes place as part of the MSD tender process, and as such does not guarantee the lower price will be passed on to consumers in retail settings.

Taxes, Customs Duty and VAT

Government-imposed fees and taxes, such as duties on imported medicines and value added tax (VAT), are significant drivers of increased final retail price of medicines in the PFP and PNFP sectors. As of July 2007—with the exception of drugs imported by the public sector and essential medicines such as antiretrovirals, anti-TB drugs and antimalarials—all imported medicines are subject to a 10 percent tax. While governments worldwide often impose such import duties as a means to generate revenue and incentivize local manufacturing, some studies have argued that import tariffs typically do neither (WHO 2009). In fact, one study argued that in over 90 percent of countries assessed, the revenue generated by pharmaceutical import tariffs amounted to less than 0.1 percent of national gross domestic product (GDP) and typically increased the final retail cost of medicines, passing the cost on to sick patients who are least able to afford medicines purchased in retail settings. Several international partners have expressed concern that the decision to continue imposing importation tariffs on drugs imported to Tanzania may make medicines even more unaffordable.

Health Service Waivers

Although the government of Tanzania has developed a comprehensive exemption policy waiving fees for essential services provided to children under five and adults over 60, there are no such exemptions uniformly afforded to the chronically poor, vulnerable, or destitute. In addition, the exemption policy is not uniformly applied and does not guarantee that targeted populations will receive all necessary pharmaceuticals if out-of-stock in a public facility and/or available at high-cost via a private source.

Health Insurance (NHIF and CHF)

Health insurance schemes available in Tanzania do not guarantee access to medicines and do not cover medicines purchased in retail pharmacies (Mhamba 2010). Given the frequent stock-outs of key medicines in the public sector, current insurance options do not guarantee patients' will be able to access and/or purchase necessary medications. As CHF/NHIF coverage remains relatively low throughout much of Tanzania, expansion of the funds to include additional pharmaceutical coverage could incentivize increased community participation in CHF/NHIF and protect patients in the event of unavailability of drugs in the public sector.

Supply and Access to Vertical Program Medical Commodities

As part of ongoing health system strengthening reforms, and reflecting MSD's relatively well-developed procurement and distribution network, the procurement and supply of vertical program commodities are largely integrated into the MSD supply chain management cycle. Forecasting and quantification of HIV/AIDS and TB medicines, antimalarials, and RCH commodities are carried out by the respective vertical programs. As a component of forecasting, each program supplements its MSD procurement with commodities provided by international and local donors. Vertical program commodities are then procured and distributed to facilities via the MSD distribution network—with some distribution carried out by the vertical programs directly. PFP and PNFP facilities access vertical program commodities via the DMO and zonal or district stores department.

HIV/AIDS Commodities

All NACP commodities are provided free to both public and private facilities via the MSD. This includes condoms, ARVs, test kits and reagents, drugs for the treatment of opportunistic infections, and other essential HIV/AIDS commodities. While many of these supplies are imported, Tanzania also has an important domestic source of generic pharmaceuticals (see box 6.3). The supplies are shipped directly from MSD to larger facilities or to the district or zonal medical stores department for collection, at no charge to the facility. Private facilities desiring access to these commodities liaise with the DMO and district HIV/AIDS officer to gain access to MSD supply. In order to qualify for HIV/AIDS commodity supply, a private facility must have been approved by the NACP to provide HIV/AIDS treatment services. Representatives of private facilities report that "more than 80 percent of VCT and HIV trainings offered are restricted for the public sector." Therefore, although the private sector has approval to access HIV/AIDS commodities via MSD, they lack the opportunity to acquire the necessary training to do so. In addition, both public and private sector informants reported frequent stock-outs of key OI drugs (and periodic interruptions to ARV supply), which limited their ability to provide consistent and safe HIV/AIDS treatment. Responding to complaints of inconsistent supply from facilities and HIV service providers, SCMS has launched an HIV/AIDS-focused Prime Vendor Model (currently via Pyramid Pharma Tanzania) for the purchase of 37 essential OI treatment drugs. Although this has set up "somewhat a parallel HIV/AIDS supply chain," it was deemed a necessary complement to MSD to ensure that facilities had access to quality assured, registered, and appropriately imported HIV/AIDS commodities, in line with U.S. government regulations. Quality assurance of the drugs is provided by the lab at the Muhimbili University of Health and Allied Sciences (MUHAS). SCMS reports that "since we are failing some of the drugs during this process…we know that there are potentially many 'bad drugs' on the market coming in via private sources." SCMS is now looking to work more closely with the TFDA on

Box 6.3 Tanzania Pharmaceutical Industries

The relationship between Tanzania Pharmaceutical Industries (TPI) and the GOT represents a strong PPP arrangement enhancing the availability of key pharmaceutical products in Tanzania. Previously a 100 percent state-owned enterprise, the company was partially divested during Tanzania's period of economic liberalization in the early 1990s. Currently 60 percent privately owned (with GOT plans to divest further), TPI is a key producer and distributor of generic medications—including generic antiretrovirals produced under the TRIPS flexibility. For commodity inclusion as part of the NACP/TACAIDS vertical program, 100 percent of ART production at TPI is provided to MSD, with 80 percent of other generic medications also directed to MSD. Under Tanzania's PPP policy, TPI is afforded VAT exemptions as well as import and excise duty exemptions, and pays reduced sales tax; and because this lowers their costs on machinery and other commodity inputs, TPI can often provide preferential pricing to MSD compared to foreign supply (typically in the range of 15 percent lower). Although the public sector currently holds an 80–100 percent share of TPI production, TPI is currently in the process of expanding their production capacity, which will allow it to increase generic pharmaceutical provisions to the private health sector. The PPP between TPI and the GOT (both in terms of multisectoral ownership and financial exemptions) demonstrates how effective multisectoral partnership can effectively enhance the availability of key health system inputs.

Photo B6.3.1 TPI Facility and Product Packaging

(L) Production facility for generic antiretroviral medications at Tanzania Pharmaceutical Industries (TPI); (R) Packaging for TPI products.
Source: SHOPS Project 2012.

strengthening postmarket surveillance of HIV/AIDS commodities (and other essential medications), based on the lessons learned from the launch of the HIV/AIDS prime vendor model.

TB Commodities

As outlined in "Tuberculosis," private sector dispensing of TB commodities is extremely limited as the TB DOTS program is currently dominated by the public

sector and affiliated FBO facilities. The Tanzanian TB Control Program performs all forecasting and quantification functions for the procurement of key TB commodities, such as AFB smear testing materials and essential medications (Rifampicin, Isoniazid, Ethambutol, and Pyrazinamide) as well as second- and third-line medications. Supply via MSD is channeled to approved public, PNFP and limited PFP facilities, as with HIV/AIDS commodities. As per guidelines related to the TB DOTS program, the importation and sale of TB commodities via private wholesalers and/or other MSD alternatives is heavily restricted.

Antimalarial Commodities

The affordable, consistent, and reliable provision of ACTs and other key antimalarial commodities (such as bednets) to service providers—in all sectors of the health system—is a central component of the NMCP's strategy. Strongly contributing to this effort is the Global Fund-led AMFm, a Phase 1 pilot project currently being implementing in eight countries, including Tanzania and Zanzibar. The AMFm aims to enable countries to increase the provision of affordable ACTs via the public and private sectors by negotiating reduced prices for ACTs with drug manufacturers and requiring consistent sale prices to first-line buyers in both the public and private sector. In Tanzania, the AMFm has successfully reduced the price of ACTs and, in partnership with the NMCP, seeks to ensure that patient access costs are the same in public and private facilities, ADDOs, and retail pharmacies. The NMCP has credited the AMFm with successfully expanding the availability of ACTs throughout the country; however, there is concern over sustainability, should the pilot project not continue. As outlined in chapter 4, LLITNs have been made widely available via NMCP and external donor distribution efforts. The production of LLITNs at A-Z Textiles Tanzania (the largest producer of bednets in Africa) has ensured consistent access to quality-assured bednets for millions of Tanzanians. Antimalarial commodities are distributed to facilities via MSD zonal and district medical stores, and can be procured via approved AMFm first-line buyers (for example, JD Pharma, Astro Pharm).

RCH Commodities

RCH public goods—such as vaccines for required childhood immunizations, family planning commodities (that is, condoms and contraceptives) and some PMTCT-related HIV commodities (that is, NVP/EFV, in collaboration with the NACP)—are procured and distributed by MSD via district stores departments, at no charge to the facility. Additional supply of noncontrolled commodities (such as condoms or contraceptives) may also be provided direct to facilities via external donor partners (such as USAID, Marie Stopes International, and Population Services International) or from the RCH vertical program directly. RCH commodities are often susceptible to stock-out or delayed supply via MSD and thus are among the products public and FBO/NGO facilities are required to source either at high cost from private wholesalers or via donation from external donors.

Key Findings

Drug prices high relative to other markets. Several international studies conclude that the retail cost of drugs in Tanzania is higher than in most countries in the region—in some cases as much as five times greater than international reference prices. High acquisition costs or high mark-ups between wholesale purchase and final price to patient are the main drivers of the high drug prices. High drug prices are found across all sectors, including the NGO sector in which mark-ups on key medicines are often comparable to private retail. The high drug cost poses the most significant barrier to essential medication. With frequent stock-outs in public facilities, the poor often rely on the private sector to purchase medicines and they are least able to afford the high drug prices.

Frequent MSD stock-outs lead to rationing and disruption of supply chain in both sectors. Key informants from all sectors report that essential drugs at MSD are frequently out of stock, which leads to disruption of drug availability in both sectors. Stakeholders cited several reasons to explain irregular MSD drug supply, such as insufficient or inconsistent budget allocations for MSD procurement, poor contract management, overly cumbersome procurement procedures, and weak forecasting by MSD. This has encouraged many public and PNFP facilities to ration pharmaceuticals and other commodities through the supply chain or to "over-order" when stock is available at MSD. The result is fluctuations in demand that make efforts at forecasting and quantification extremely difficult for MSD to manage. Furthermore, shortages of key commodities at the facility level are significantly and negatively impacting the efficacy of vertical program national strategies. Since government budget allocations for pharmaceutical procurement are held on account at MSD, public health facilities have only a limited degree of control over the use of their procurement budgets. MSD stock-outs force public and PNFP facilities to source drugs from the private sector, complicating private sector forecasting efforts

The public sector often relies on private supply during stock outs. During MSD stock-outs, public facilities have little or no discretionary funding to procure drugs outside of MSD. Instead, they rely on funding from other budget sources, such as user fees, to procure these medicines, usually from a private source at high cost. Moreover, the public sector has a limited ability to procure outside of the MSD supply chain, restricting competition—further exacerbating high market prices of pharmaceuticals. Increasing the amount of discretionary procurement funding available to public facilities would enable them to utilize alternate procurement sources during periods of MSD stock-out, without requiring the use of resources earmarked for other service provision inputs.

There are too many private wholesalers and distributors and too few areas served. The private supply chain is highly fragmented with an excessive number of private wholesalers and distributers for the size of the market. With so many wholesalers and distributors competing for the same market in and around Dar

es Salaam, few can achieve the economies of scale necessary to warrant investment in a national distribution system. In countries where the number of distributors and wholesalers is restricted and minimal margins are assured, suppliers compete on the quality of their products, the speed and convenience of resupply, and their credit terms. Even a country like Senegal, with a smaller economy and private sector, wholesalers are able to ensure resupply anywhere in the country in less than 24 hours.

There is a weak relationship between private wholesalers and TFDA. With an estimate 291 separate private pharmaceutical wholesalers in Tanzania, It is has been suggested that management and effective regulation of the numerous commercial sources of pharmaceuticals is realistically beyond the capacity of the TFDA and other key government bodies. In addition, private wholesalers report little incentive to work closely with government: delayed and cumbersome TFDA processes and overly bureaucratic government requirements limit their desire to work with the public sector. In addition, key informants from private importer/wholesalers state that public tender payments often go unpaid or are significantly delayed. There are currently few opportunities for private wholesalers or importers to become involved in PPP dialogue—limiting opportunities to openly pursue relationship-building between the public sector and private pharmaceutical sources.

Poor postmarket surveillance and regulation allow for drug supply of questionable quality. The SCMS Prime Vendor Model for HIV/AIDS medications (including increased quality assurance via MUHAS laboratories) has revealed a potentially extensive problem of "poor drug quality" throughout the health system. Unfortunately, drug quality is rarely monitored at the point of importation, much less at the retail level. The main problem is the lack of monitoring and enforcement. To improve efforts at ensuring a quality supply of drugs in the private sector, the MOHSW will have to invest in TFDA's capacity to perform postmarket surveillance. Moreover, TFDA can partner with local institutions such as MUHAS to help assure the private drug supply's quality.

Recommendations

Conduct a full pharmaceutical market survey. Many in Tanzania state that approximately 70 percent of Tanzania's national drug requirement is met through importation, with 30 percent of national need met by local production. Although Tanzania does possess a relatively well developed pharmaceutical manufacturing sector in comparison to its regional neighbors, a large proportion of active pharmaceutical ingredients are imported from India and China. In addition, complex medicines (both brand name and generic) are almost exclusively imported, with local production focusing on less sophisticated medicines such as antibiotics, cough and cold drugs, antipyretics and analgesics (Mhamba 2010). A full market survey of the Tanzanian pharmaceutical sector is needed in order to

test the 70/30 percent assumption, and to better understand the total volume, sales, number of suppliers and other key metrics affecting the availability, price and affordability, and accessibility of medicines in Tanzania.

Catalyze industry consolidation through licensing requirements. The GOT may consider regulation to compel consolidation of the number of wholesalers and distributors in the market. The government could auction a limited number of licenses. Applicants would have to demonstrate sufficient capacity to distribute drugs nationally, as well as a minimum storage and IT capacity for recording importation, lot tracking and recall management. To encourage the applicants to make the needed investments, the GOT would have to assure minimum margins as well as ceiling margins through legislation. With assured minimum margins and fewer players in the marketplace, wholesalers would want to invest in distribution capacity and strengthen their ability to cover the entire country, thereby securing greater market share. Moreover, competition would focus more on quality as well as price.

Explore private sector pooled procurement and/or bulk purchasing through newly incorporated MEMS. The MEMS supply chain has recently incorporated into a business, providing an opportunity for both PFP and PNFP facilities and providers to pool drug procurements and/or purchase in bulk thereby helping drive down the cost of drugs offered in private settings. A similar opportunity emerged over a decade ago through the now defunct National Pharmaceutical Company which distributed drugs to public and private facilities as a complement to MSD. There are several options. MEMS could start with established networks, such as APHFTA, PRINMAT, and other small-scale private sector facility networks to set up mechanisms for pooled procurement and/or bulk purchasing. This approach would strengthen PFP facility access to affordable and reliable commodity inputs, while also strengthening MEMS' position as a complementary supply chain to MSD for PNFP facilities currently facing frequent MSD stock-outs.

Assist public facilities to procure drugs through the private sector during stock-outs. The MOHSW could make it easier for public facilities to purchase drugs stock-outs by increasing more discretionary funding and streamlining the drug procurement process. Although increasing public facility budgets may be difficult, making more discretionary funding available could reduce market disruptions resulting from over-ordering and supply rationing. Prequalifying a limited number of wholesalers and distributors at the regional level would be an easy mechanism to simplify purchasing drugs during stock-outs. The RHMT would administer a competitive process based on key criteria and enter into purchasing agreements with a few who meet the criteria. Then, all district and council level facilities could order needed supplies from these suppliers at a negotiated and hopefully more affordable price. The opportunity to prequalify may also attract wholesalers and distributors to finally invest in establishing a regional presence instead of always shipping supplies from Dar es Salaam.

Support the creation of a management structure supporting ADDOs. Although the TFDA's efforts to formalize Part 2 private retail pharmacies (previously known as DLDB drug outlets) into the ADDO program are an important first step, there remain untapped opportunities to maximize ADDO contributions to the health system. Accounting for 17.5 percent of pharmaceutical dispensaries in Tanzania, ADDO dispensaries are an important facet of the health system and remain an important source of medicines for malaria, TB, and other priority diseases. However, ADDOs require additional technical assistance to improve quality and promote sustainability. Priority areas for technical assistance include (1) establishing a management body to manage, administer, and monitor quality; and (2) assisting ADDOs to pursue financial sustainability. Efforts to strengthen the quality, sustainability, and management of ADDOs through networking can further improve their ability to provide essential pharmaceutical dispensing services and expand their activities in providing health interventions (for example, PATH's ADDO TB screening model). The management entity could grow its capacity to offer support and technical assistance in a full range of clinical, business, and finance areas. The PSA team also proposes helping ADDOs to address two cost barriers. First, remove financial barriers to drugs purchased at ADDO outlets by expanding the current NHIF/National Social Security Fund (NSSF) program to contract with a greater number of ADDOs and by reimbursing ADDOs that fill prescriptions from contracted private providers under a government SLA. Second, reduce drugs' wholesale prices by creating linkages with product/drug wholesalers, allowing franchised ADDOs to pool their procurement with MEMS, and continuing to supply them subsidized and/or donated donor products through vertical programs. While this report does not outline a specific approach to ADDO management reform, opportunities to strengthen the ADDO network should be explored by donors in partnership with the Pharmacy Council (ADDO leadership), the TFDA, MOHSW and regional health leadership, and private sector stakeholders such as TAPI.

Strengthen the TFDA's postmarket surveillance capacity through the proposed Logistics Management Unit. Ongoing USAID/Deliver and PEPFAR/SCMS TFDA capacity development efforts are essential in ensuring improved quality, surveillance, and safety of Tanzania's private sector pharmaceutical supply. SCMS efforts to develop a Logistics Management Unit—enhancing TFDA's post market surveillance system through strengthened ties to independent quality control (for example, the laboratory at MUHAS)—will strengthen the quality of Tanzania's pharmaceutical supply and could provide an avenue for improved PPP between private wholesalers and TFDA.

Pursue opportunities to increase Pharma representation on PPP policy forums. The relative strength of existing PPP policy forums and TWGs provides a strong venue for increased pharmaceutical sector representation in national planning and dialogue. Increasing representation from private wholesalers, MSD, and other key pharmaceutical sector agents provides the opportunity to discuss tender processes, exemptions, prime vendor, and pooled procurement opportunities.

CHAPTER 7

The Role of Health Financing in Enabling a Sustainable Private Health Sector

This chapter focuses on two areas of financing of health. First, it examines the current role and impact of private expenditures in financing health. More importantly, however this chapter focuses on how health financing in Tanzania can enable sustainable private participation in health, exploring financing mechanisms such as public and private health insurance and service level agreements to incentivize the private sector to deliver public health services.

Health Financing Trends

From independence through 1993, the health sector was mainly financed through general government budget and development assistance. Since the 1990s, there have been many changes in the health system and health financing, including the introduction of user fees in public facilities, decentralization of financing and service provision to local governments, and growth of private health insurance and private for-profit (PFP) providers. Donors are the largest source of financing for health, with contributions through general budget support, a health sector basket fund, and direct program financing, including off-budget financing.

The introduction of user fees in the 1990s was supported also by a policy of exemptions and waivers. Exemptions apply to a large portion of the population, including children under five, pregnant women, people over 60, as well as patients with diabetes, human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS), leprosy, tuberculosis (TB), polio, and cancer. In addition, fees are waived for people who are unable to pay.

As part of its strategy of ensuring universal access, the Government of Tanzania (GOT) has introduced several insurance schemes aimed at reducing the financial risk of health care costs for households. Nonetheless, the most

recent demographic and health survey (DHS) shows that 93 percent of the population is not covered by any health insurance plan. Except for the insurance scheme for civil servants operated by National Health Insurance Fund (NHIF), no single scheme covers more than 5 percent of the population.

Subnational-level government health facilities are financed primarily through two funding streams—government block grants and basket funding. Other sources of nondirected funding include user fees, contributions to the Community Health Fund (CHF), and reimbursements from the NHIF; these sources represent a much smaller portion of total funding. There are ongoing efforts by the Ministry of Health and Social Welfare (MOHSW), with assistance from its partners, to develop a new financing strategy for the sector.

Total Health Expenditures

As shown in table 7.1, THE has been increasing over time, and per capita THE today is nearly twice as high as in 2002/03. Nonetheless, the annual per capita health expenditure of US$41 remains lower than the Sub-Saharan Africa regional average of $110 (WHO 2012). Health expenditures continue to increase as a percent of gross domestic product (GDP), representing 8.2 percent of GDP in 2009/10.

Health Expenditures by Source

As shown in table 7.2, donor funding for health continues to increase and, at 40 percent of THE, represents the largest source of health spending. Households (a source of private financing) were the second largest source of health spending,

Table 7.1 Trends in Total Health Expenditures

	2002/03	*2005/06*	*2009/10*
THE (in million US$)	734	1,442	1,751
THE per capita (US$)	21	38	41
THE as a % of nominal GDP	5.0	7.6	8.2

Source: Department of Policy and Planning, MOHSW, 2012.
Note: THE = total health expenditures; GDP = gross domestic product.

Table 7.2 Total Health Expenditures, by Source
million T Sh

	2002/03		*2005/06*		*2009/10*	
Financing source	*Value*	*% of total*	*Value*	*% of total*	*Value*	*% of total*
Households	325,353	42	445,003	25	750,298	32
Donors	212,412	27	783,205	44	919,362	40
MOF	196,853	25	498,403	28	603,922	26
Other private	39,479	5	53,400	3	49,345	2
Total	**774,097**	**100**	**1,780,011**	**100**	**2,322,927**	**100**

Source: NHA 2009/10, MOHSW.
Note: MOF = Ministry of Finance and Economic Affairs.

representing 32 percent of THE, while government spending represented 26 percent of THE. Between 2005/06 and 2009/10, household expenditures for health grew at a much higher rate than other sources of funding: household expenditures for health increased 69 percent, to a total value of T Sh 750 billion in 2009/10. Over this same period, donor spending increased 17 percent, while government spending increased 21 percent.

Financing Agents

The role of the MOHSW in managing health expenditures has declined over time. Increasingly households, subnational governments, and nongovernmental organizations (NGOs) are playing a larger role in managing or controlling health funding, partly driven by how donors have directed support. In 2009/10, the MOHSW, together with other government ministries, managed 18 percent of health expenditures, compared with 46 percent in 2005/06, as shown in table 7.3. Over that same period, the role of subnational governments increased from managing 11 percent of health expenditures in 2005/06 to 19 percent in 2009/10. Also notable is the increase in the role of NGOs over that period, increasing from managing 9 percent of health expenditures to 25 percent. Households also control a larger share of health expenditures, increasing from 26 percent to 32 percent. Insurers continue to represent a small share as financing agents, directing just 3 percent of health expenditures, but they are active strategic purchasers of services.

Health Expenditures by Provider

The 2009/10 data show some unexpected changes in how funding was spent. As shown in table 7.4, the share of health expenditures at public facilities nearly doubled, from 24 percent of THE in 2005/06 to 47 percent in 2009/10. During

Table 7.3 Total Health Expenditures, by Financing Agent
million T Sh

	2002/03		*2005/06*		*2009/10*	
Financing agent	*Value*	*% of total*	*Value*	*% of total*	*Value*	*% of total*
MOHSW/other GOT	74,030	35	18,805	46	28,843	18
Subnational authorities	67,347	9	02,921	11	440,050	19
NHIF/other insurers	22,449	3	64,080	4	62,454	3
Household OOP	314,284	41	62,803	26	740,875	32
Private firms/ parastatals	27,093	3	53,400	3	69,789	3
NGOs	23,997	3	151,301	9	580,915	25
Donors	44,898	6	26,700	1	—	0
Total	**774,098**	**100**	**1,780,010**	**100**	**2,322,926**	**100**

Source: NHA 2009/10, MOHSW.
Note: MOHSW = Ministry of Health and Social Welfare; GOT = Government of Tanzania; NHIF = National Health Insurance Fund; OOP = out-of-pocket; NGOs = nongovernmental organization; — = not available.

Table 7.4 Total Health Expenditures by Provider
million T Sh

	2002/03		2005/06		2009/10	
Provider	*Value*	*% of total*	*Value*	*% of total*	*Value*	*% of total*
Public facilities	133,841	17	423,642	24	1,083,374	47
FBO facilities	94,915	12	142,109	8	312,593	13
Private for-profit facilities	90,399	12	147,978	8	126,473	5
Pharmacies	141,350	18	220,721	12	50,094	2
Public health programs	127,339	16	402,282	23	553,320	24
Other (incl. admin.)	186,248	24	443,223	25	197,072	8
Total	**774,092**	**100**	**1,779,955**	**100**	**2,322,926**	**100**

Source: NHA 2009/10, MOHSW.
Notes: FBO = faith-based organization.

this period, expenditures at for-profit facilities decreased in absolute value from T Sh 148 billion to T Sh 126 billion, down to 5 percent of THE. Expenditures at pharmacies decreased 77 percent, from T Sh 221 billion to T Sh 50 billion, representing 2 percent of THE. However, the 2009/10 NHA was subject to data constraints related to household expenditures at pharmacies, which limit the reliability of this estimate.

The observed changes in spending at public facilities may be attributable to several factors. First, additional funding from households may be directed toward public facilities, given their recent quality improvements. Secondly, increases in funding for HIV/AIDS, malaria, and reproductive health tend to be directed to public facilities, as shown in the next chapter.

Expenditures on HIV/AIDS, Reproductive and Child Health, and Malaria

Table 7.5 shows sources of health expenditures across three priority health areas in 2009/2010. The differences in household financing among these three health areas, as a percentage of THE, indicates the concentration of donor funding. In HIV/AIDS, where there has been significant donor funding, household expenditures are

Table 7.5 Total Health Expenditures, by Source
million T Sh

Financing source	*THE*		*THE_{HIV}*		*THE_{RCH}*		*$THE_{MALARIA}$*	
	Value	*% of total*	*Value*	*% of total*	*Value*	*% of total*	*Value*	*% of total*
Households	750,298	32	107,410	17	320,078	51	177,370	40
Donors	919,362	40	437,151	70	97,154	16	180,349	40
MOF	603,922	26	71,258	12	257,081	41	87,653	19
Other private	49,345	2	6,425	0	9,846	2	5,963	1
Total	**2,322,927**	**100**	**622,243**	**100**	**634,615**	**100**	**451,334**	**100**

Source: NHA 2009/10, MOHSW.
Note: MOF = Ministry of Finance and Economic Affairs.

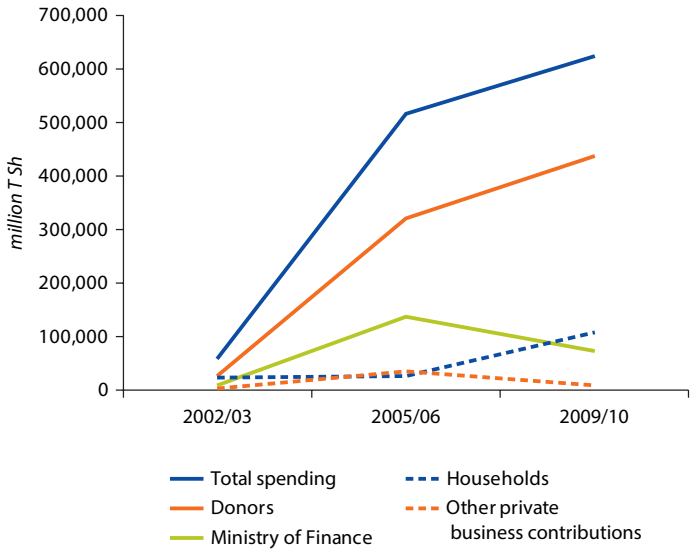
only 17 percent of total, compared to 32 percent of THE overall. Of total expenditures in HIV/AIDS, 70 percent comes from donors. At the same time, household expenditures for RCH and malaria represent a much larger share of total expenditures, at 51 percent and 40 percent, respectively. Donors also provide a large share of malaria funding (40 percent) but a much smaller share of RCH funding (16 percent).

HIV/AIDS

Figure 7.1 shows changes in total health expenditures for HIV/AIDS (THE_{HIV}) over time, by source. THE_{HIV} in 2009/10 reached T Sh 622.2 billion (amounting to 26.8 percent of THE). THE_{HIV}, has increased over 1,000 percent since 2002/03, from a starting point of T Sh 56.1 billion, driven largely by donor funding. Of note, the absolute value of government (MOF) spending on HIV is declining. As this is not true across all health expenditures, it reflects possible displacement of government financing by sources such as donor funding.

Regarding the deployment of these funds, in 2009/10, 22.5 percent of total spending on HIV/AIDS was channeled through PFP and PNFP facilities, for VCT and treatment services. Financing flowing through private financing agents increased from 51.1 percent of THE_{HIV} in 2002/03 to 74.1 percent in 2009/10. PEPFAR, the Clinton Health Access Initiative (CHAI), and the Global Fund are three of the most prominent programs supporting the provision of HIV services. Almost 80 percent of donor funds in 2009/10 were channeled through private sector NGOs/FBOs.

Figure 7.1 Trends in Source of $THE_{HIV/AIDS}$



Source: NHA 2009/10, MOHSW.

Reproductive and Child Health

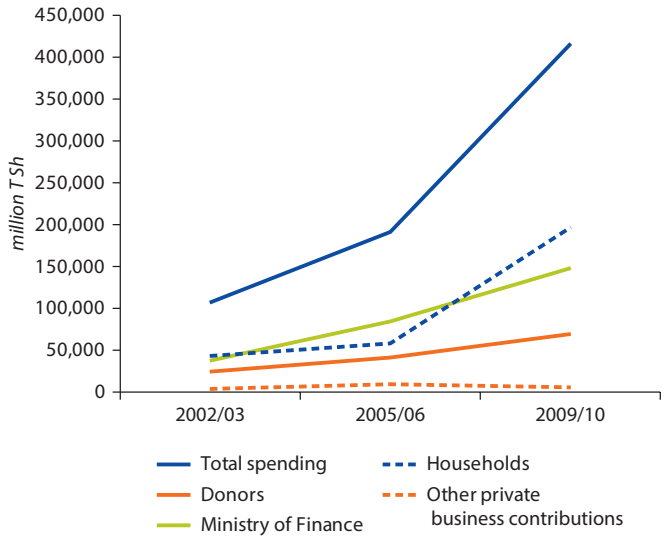
In 2009/10, total health expenditures for reproductive and child health (THE_{RCH}) reached T Sh 634.6 billion. Figure 7.2 shows trends in sources of THE for reproductive health (THE_{RH}) over time—with recent growth in THE_{RH} funding driven largely by households and government spending. Unlike THE_{HIV}, donor funding has increased only minimally.

In 2009/10, public financing agents—mainly LGAs and the MOHSW—managed just 37.5 percent of total health expenditures for child health (THE_{CH}) and 35.4 percent of THE for reproductive health (THE_{RH}). However, 75.3 percent of THE_{RH} was spent at public facilities, largely on inpatient/outpatient care, ANC, and deliveries. Similarly, 69.7 percent of THE_{CH} was spent at public facilities, largely on inpatient/outpatient care and school health services.

The private sector plays a large role in financing health expenditures on reproductive health and child health. Unlike the other key health areas, private financing—namely household expenditures—was the largest source of THE for both reproductive and child health. Private financing agents controlled 64.5 percent of THE_{RH} and 62.3 percent of THE_{CH}. Spending at FBO/NGO facilities for both reproductive health and child health issues (at 18.5 percent of THE_{RH} and 19.35 percent of THE_{CH}) exceeded spending at PFP facilities (at 6.0 percent and 8.7 percent respectively). This money was spent almost exclusively on inpatient/outpatient curative care, with a small amount going to private clinics for deliveries.

Development partners contributed only 15 percent of THE_{RCH}. THE_{RCH} also differed from the other key health areas in that development partners channeled

Figure 7.2 Trends in Source of THE_{RH}



Source: NHA 2009/10, MOHSW.

their funds evenly between public and private financing agents. 50.4 percent of development partner funding went to MOHSW, LGAs, and other public agents, with the remaining 49.6 percent going through NGO/FBOs.

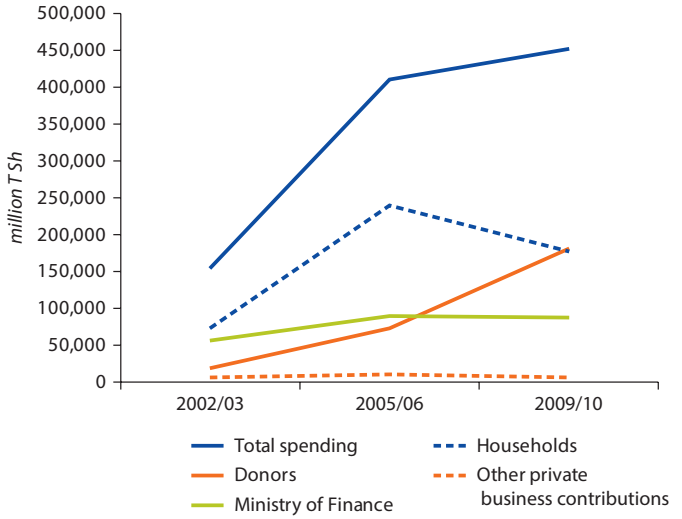
Malaria

In 2009/10, total health expenditures on malaria ($THE_{MALARIA}$) equaled T Sh 451.3 billion, representing a 194 percent increase over 2002/03. This increase was driven in large part by a 900 percent increase in donor funding from its initial minimal level, which replaced private households as the largest source of $THE_{MALARIA}$. Figure 7.3 shows changes in $THE_{MALARIA}$ over time, with growth in $THE_{MALARIA}$ driven largely by increasing donor funding with a corresponding decrease in household expenditures.

Public financing agents—especially the MOHSW and LGAs—were responsible for 33.8 percent of $THE_{MALARIA}$ in 2010. 78.2 percent of $THE_{MALARIA}$ was spent at public facilities. Of those funds, approximately two-thirds of expenditures went toward treatment, and the remaining one-third went largely toward prevention and vector management programs.

In 2009/10, 66.2 percent of $THE_{MALARIA}$ was financed by private agents, mainly households and NGOs. Similar to spending on HIV/AIDS, funding channeled through NGOs increased significantly, from 3.9 percent in 2002/03 to 27.0 percent of $THE_{MALARIA}$ in 2009/10. $THE_{MALARIA}$ at private facilities equaled 17.6 percent of $THE_{MALARIA}$: 14.5 percent at FBO/NGO facilities, and 3.1 percent at PFP facilities. 95 percent of these funds went towards inpatient and

Figure 7.3 Trends in Source of $THE_{MALARIA}$



Source: NHA 2009/10, MOHSW

outpatient treatment, with the remainder spent on prevention and vector management programs.

Donors accounted for 40 percent of funding for malaria programs, with the most prominent being the Global Fund and the United States' President's Malaria Initiative. In 2009/10, two-thirds of donor funds were channeled through NGO financing agents. The remaining one-third was channeled through the Tanzanian government—mainly the MOHSW.

Providers of HIV/AIDS, Reproductive and Child Health and Malaria

HIV/AIDS, RCH, and malaria program funding has driven the changes in providers used, as shown in table 7.6. Increased funding in these areas has been primarily directed toward government and FBO facilities through public health programs. For example, between 2005/06 and 2009/10, funding to public facilities for HIV/AIDS and RCH increased approximately tenfold. FBO facilities have also received large increases in funding for these three health areas, while expenditures in private facilities have been reduced. With significant increases in funding to public and PNFP facilities, it is possible that private providers have been "crowded out" and that local, private resources that could possibly contribute to health improvements in these three areas have been displaced.

Table 7.6 Spending for HIV/AIDS, RCH, and Malaria, by Provider

million T Sh

Providers	*2005/06*	*2009/10*	*Percent change*
HIV/AIDS			
Public facilities	23,768	223,070	839
FBO facilities	5,684	90,771	1497
Private for-profit facilities	19,635	16,610	–15
Pharmacies	6,717	65	–99
Public health programs	274,365	248,675	–9
Other (incl. admin.)	186,527	43,053	–77
Reproductive Child Health			
Public facilities	26,199	286,643	994
FBO facilities	14,725	71,934	389
Private for-profit facilities	56,223	24,987	–56
Pharmacies	25,243	38	–100
Public health programs	48,574	26,191	–46
Other (incl. admin.)	20,271	6,081	–70
Malaria			
Public facilities	36,814	237,003	544
FBO facilities	43,093	60,288	40
Private for-profit facilities	104,079	26,438	–75
Pharmacies	84,134	94	–100
Public health programs	52,819	116,197	120
Other (incl. admin.)	89,469	11,314	–87

Source: NHA 2009/10, MOHSW.
Note: FBO = faith-based organization.

Characteristics of Private Health Expenditures

Out-of-Pocket Spending

The large majority of household expenditures on health are in the form of OOP payments at the time of care. High OOP payments place a heavy financial burden on households, pushing some into poverty, and also cause people to delay seeking care, possibly leading to even higher cost of treatment or to mortality.

In 2009/10, OOP expenditures represented 32 percent of THE and 93 percent of total private expenditures on health. The rate of OOP expenditures is high for the region, and is increasing despite evidence of higher rates of insurance coverage (table 7.7).

Uses of Out-of-Pocket Spending

Households, through OOP spending, direct a larger share of their expenditures to private facilities (PFP and PNFP) than is reflected in THE. As shown in figure 7.4, 56 percent of OOP spending is at public facilities, while 31 percent is at FBO facilities, and 10 percent at PFP facilities. This spending pattern is driven both by accessibility (relative availability of public/private facilities) and patient preferences, and is influenced by factors such as drug availability, wait times, and staff attitude.

Public Funding of Private Health Providers through Council Governments

The government budget for health is allocated directly to LGAs through two main mechanisms—the block grant funded by the GOT and basket funding funded by development partners. The block grant to LGAs is not targeted to the health sector, and LGAs have authority to make allocations between sectors. The block grant provides more than 50 percent of health sector funding at the council level. It is generally used to finance human resources, allowance, transport, and maintenance.

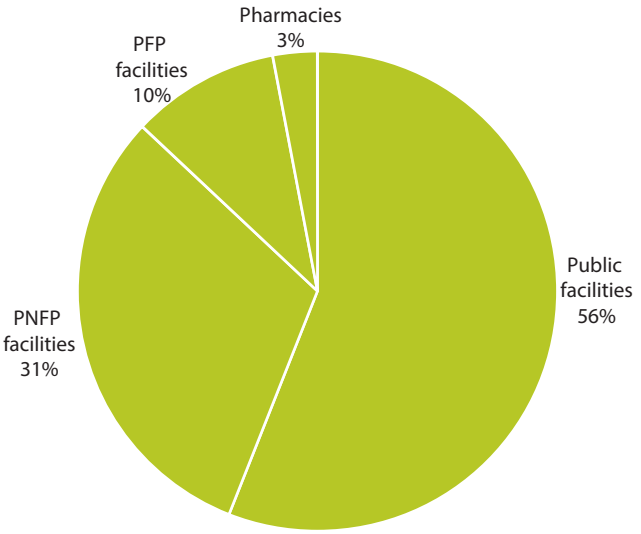
The basket funding is a pooled health sector support mechanism funded by development partners. Funds are used for operational costs, other than personnel.

Table 7.7 Out-of-Pocket Spending
million T Sh

	2002/03		*2005/06*		*2009/10*	
Financing source	*Value*	*OOP as % of expenditure*	*Value*	*OOP as % of expenditure*	*Value*	*OOP as % of expenditure*
Household OOP payments	314,284	n.a.	462,803	n.a.	740,875	n.a.
Total private expenditures	364,832	86	498,403	93	799,643	93
Total health expenditures	774,097	41	1,780,011	26	2,322,927	32

Source: NHA 2009/10, MOHSW.
Note: OOP = out-of-pocket, n.a. = not applicable.

Figure 7.4 Uses of Household Out-of-Pocket Payments



Source: NHA 2009/10, MOHSW.
Note: PNFP = private not-for-profit; PFP = private for-profit.

It has been in operation since 2000, and is overseen by MOHSW, PMO-RALG, and development partners who contribute to the basket. Total basket funding in 2009/10 was T Sh 128,796 million (Haazen 2012), which is equivalent to 21 percent of total government funding for health (T Sh 603,922 million). Analysis of 2010/11 expenditures at subnational governments show that basket funding accounts for 18 percent of subnational health expenditures. Table 7.8 provides the sources of funding across local government authorities; basket funding is the largest source of flexible funding for council governments.

Planning and budgeting at the council level is conducted every year through the CCHP. The CCHP Guidelines provide guidance to councils on budget allocations among CHMT operations, various types of facilities, and community initiatives. The CCHP Guidelines also support PPPs and direct councils to consider both public and private providers and to make rational resource allocations among them. Specifically, councils are directed to allocate between 10 and 15 percent of basket funding to "voluntary agency hospitals." Interpretation varies, and clarification of the type of facilities that qualify would be useful: whether to include for-profit; whether to include only hospitals; and whether only one facility per council (or more) can be contracted. In any case, there does not appear to be data compiled on how council funding is allocated by type of provider.

As directed by a PMO Circular in 2008, and in the CCHP Guidelines, LGAs should enter SLAs with private providers that will receive council funding. As there was only limited sensitization of councils, as a rule SLAs do not appear to be used widely. In field visits, the team found some CHMTs that were not familiar with SLAs at all, and none of the councils visited by SHOPS team had executed

Table 7.8 Sources of Funds and Total Amount for 125 LGAs

T Sh

	2010/11		*2011/12*
Sources	*Approved budget*	*Actual expenditure*	*Estimates*
Block grants	216,454,617,771	170,980,370,156	275,144,699,103
Basket Fund	57,378,810,288	53,762,902,631	65,992,031,177
Global Fund	4,788,370,409	844,741,984	4,792,297,004
UNICEF	1,951,577,906	910,947,561	10,721,692
CHF	3,519,419,856	2,627,257,173	4,411,925,252
NHIF	1,657,255,399	1,036,486,116	2,453,000,212
Cost sharing	9,497,199,609	7,156,968,446	12,465,167,399
Own source	6,439,655,159	2,703,534,631	9,202,929,745
DRF	346,419,322	439,892,812	459,369,100
In-kind	199,884,711,219	24,020,575,605	40,310,387,269
JRF	495,966,083	428,269,210	388,804,735
LGDG	2,297,364,394	1,128,398,612	5,913,877,254
MMAM	32,898,294,754	14,397,617,202	37,039,790,240
Others	43,494,961,697	17,692,256,874	44,571,021,795
Total	**581,104,623,869**	**298,130,219,016**	**503,156,021,977**

Source: Health Sector Public Expenditure Review 2010/2011, MOHSW.
Note: DRF = Drug Revolving Fund; JRF = Joint Rehabilitation Fund; LGDG = Local Government Development Grant.

SLAs with private providers. There are approximately 40 reported agreements nationally, with only one known agreement with a for-profit provider.

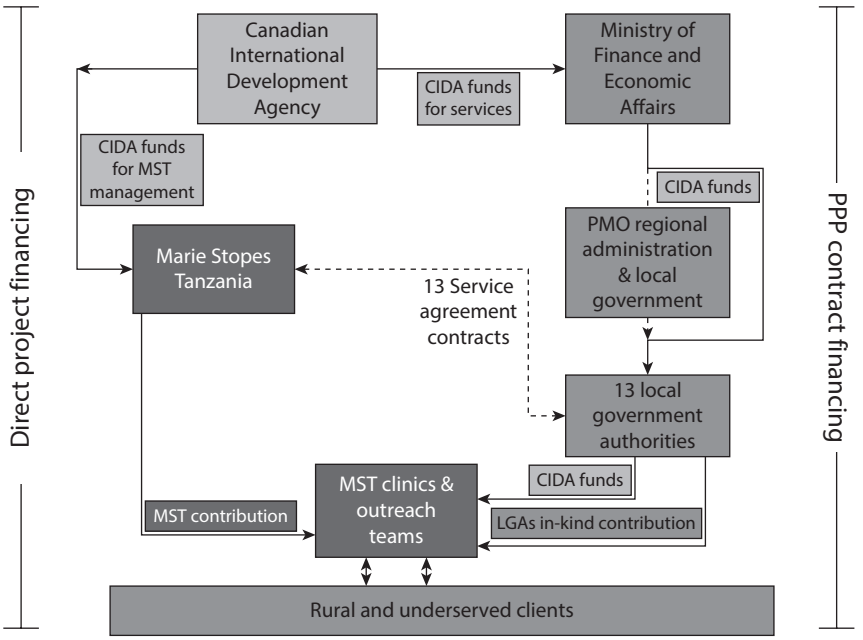
While there was a history of agreements with FBO hospitals, through DDH agreements, the innovation of the SLA was to tie funding to outputs. DDH agreements, on the other hand, may or may not have specified funding levels; where there were funding agreements, they were based on budget inputs, not service outputs. The template for SLAs included the NHIF reimbursement price list for reimbursing services provided, which seems unnecessarily complicated. It is not clear how many of the agreements entered into are actually using this reimbursement mechanism. Many agreements currently only refer to budget support. There are also some reports that FBO facilities are not receiving the funding agreed upon in these agreements, putting them at financial risk. There are no data on the extent of this problem, however, or the effect on the operation of these facilities. The innovation of output-based funding may have been lost in implementation.

SLAs are potentially a very useful mechanism for directing LGA funding to facilities that extend high quality priority services, aiming to provide more service options for consumers while providing incentives to providers to increase service volume (see boxes 7.1 and 7.2). However, lack of appropriate sensitization has limited their use. Further, councils will require support to estimate their potential financial obligations when they enter such agreements, and to ensure that the estimated funding is included as they prepare the CHMT budget. More guidance to councils to develop simple reimbursement mechanisms would be useful to minimize the administrative burdens.

Box 7.1 Contracting Marie Stopes Tanzania to Deliver RCH Services

From 2005 to 2011, thirteen Local Government Authorities entered into Service Level Agreements (contracts) with Marie Stopes Tanzania (MST). The SLAs were predominantly financed by the Canadian International Agency for Development (CIDA) with the dual purpose of increasing Tanzania's rural population's access to comprehensive services and offering LGAs experience in contracting another type of nonstate health provider beyond FBOs.

Initially, CIDA directly funded MST to offer a comprehensive package of services through MST's centers and outreach programs. MST successfully delivered high volumes of quality services to rural and underserved population groups. But CIDA also wanted to support the government's capacity to steward the health sector and during a second program phase, created a new funding approach (see figure below). CIDA allocated funds to the Ministry of Finance to cover MST's service delivery related costs and relied on standard public financial flows to reach the targeted districts. At the district level, MST entered into SLAs with 13 LGAs to receive payment. The SLAs were cost-based, single-tiered contracts that allowed for both contracting-in (MST outreach in public facilities) and contracting-out (MST center-based) services. CIDA also financed directly MST's costs to manage the partnerships. Both MST and LGAs also made in-kind contributions toward the partnership.



The government experience in contracting MST illustrates both the challenges and benefits of contracting.

- The lack of both LGAs' and MST's experience created many delays in the contracting process. Contracting for the first time may require a steep learning curve and additional time to educate both partners on contracting procedures, costing of services and PPPs.

box continues next page

Box 7.1 Contracting Marie Stopes Tanzania to Deliver RCH Services *(continued)*

- Invest the time upfront to create a common understanding of the contract's terms, including expected financial procedures, conditions for payment, roles and responsibilities and mechanisms to resolve conflict.
- Build and sustain partner by developing a communication strategy that ensuring regular communications with all the key stakeholders throughout contract management.
- Decentralization of government authority adds to the number of stakeholder involved and hence the complexity of contracting. Map out all the institutional structures involved, the lines of authority and roles and responsibilities.
- Many governments, including Tanzania, are slow to pay. Mitigate risks by securing advance payment and/or a fund to help work through the delays.

Despite the many issues, management problems did resolve themselves overtime and the partnership was able to deliver results. Through this PPP, MST reached more than 600,000 people with integrated services in 13 rural districts. Services included comprehensive family planning, voluntary HIV testing, STI services, antenatal and postnatal care, and newborn and under-5 services for a target population of underserved men, women and children. The contracting experience offers an interesting example of how donors can help grow the private sector while at the same time benefit the population.

Source: Adapted from MSI Health Financing Case Series 2012.

Box 7.2 Mobilizing Private Sector Capacity through Contracting

What is contracting? Governments throughout the developing world are increasingly exploring methods of engaging the private health sector to maximize health system efficiencies, improve quality, and extend coverage of essential health services. Many policy makers view contracting arrangements such as service level agreements (SLAs) as a promising option. In this partnership mechanism, governments and nonstate health service providers create a binding agreement that clearly outlines duties and responsibilities of both parties, specifies the basket of services the service provider will provide to a specific target population, and commits the government to financially reimburse the provider for services rendered. Contracting, when mutually beneficial, allows the government to retain a strong regulatory role in managing service provision while leveraging private health sector capacity to compensate for HRH shortages, lack of health system capacity, or overburdened public facilities.

What are the challenges? In Tanzania, although the policy and institutional structures for contracting and building PPPs are already in place, a number of challenges have limited the use of SLAs:

1. Key stakeholders at the local level vary in their understanding and acceptance of the utility of contracting mechanisms and SLAs.
2. Although the MOHSW created an SLA template in 2007, there is no dedicated mechanism or tool to monitor and evaluate SLA implementation.

box continues next page

Box 7.2 Mobilizing Private Sector Capacity through Contracting *(continued)*

3. Local health councils have no independent budget to implement SLAs, leaving them dependent on donor funding to do so.
4. Weak collaboration between LGAs and the private health sector (particular PFP providers) during the annual CCHP process limits the potential of SLAs to extend service coverage.

What should be done? Scaling-up the use of SLAs to formally include additional PNFP and PFP providers could significantly extend the availability of essential health services in Tanzania. These partnerships would help especially in rural and underserved areas where a small number of private providers (primarily FBOs) are already partnering with the government. Pursuing the following priorities could strengthen the use and utility of SLAs:

1. Sensitize both public sector leadership and private providers on the benefits of SLAs.
2. Utilize existing LGAs, CHMTs, and other community health planning forums as a local PPD forum to discuss SLA opportunities.
3. Establish umbrella organizations representing the full range of private sector actors—such as APHFTA, BAKWATA, CSSC, and Marie Stopes Tanzania—to advocate for and technically advise their members on SLA implementation.
4. Link national and community health insurance schemes to SLAs, diversifying the financing mechanisms for SLAs and promoting sustainable reimbursement of private providers under the terms of the SLA.
5. Provide government- or development partner-led trainings for LGAs, private providers, and CHMT staff on contracting utility, roles and responsibilities, and the creation and vision of SLAs.
6. When appropriate, assess opportunities to formalize existing informal and semi-formal agreements between LGAs and private health providers in their region.

Health Insurance and Private Providers

The GOT is committed to universal coverage, and social health insurance is a core element of its policy. There is no explicit policy favoring public or private insurers, or strategic policies on the appropriate mix of insurers for insuring universal coverage. Several different types of government-sponsored insurance schemes are promoted—the NHIF covering civil servants, the Social Health Insurance Benefit (SHIB) for private sector employees, the CHF for rural residents, and its complement Tiba Kwa Kadi (TIKA) for urban residents. Private health insurance is also available, primarily targeting the high income population. Additionally, there are various micro-insurance schemes available that cover very small populations. The generous exemptions policy, together with the quality of health services in rural areas, affects the attractiveness of health insurance, particularly when benefits are limited to primary care.

There also appear to be differences in interpretation of the exemptions policy and especially its application in FBO and private facilities at all levels. Officially,

private and FBO facilities were to be included in the exemptions policy for targeted groups, with a provision that they could claim payment from the government. In practice, these exemptions have not been uniformly applied outside of the public sector, largely because there was no mechanism or budget established for such payments, and partially because individual facility managers did not believe that the policies applied (Haazen 2012). Additionally, systematic reviews of the exemptions policies found that they only moderately reduce out-of-pocket expenditures, with wealthier households accruing more benefits than poorer households. Although exemption-eligible patients were about half as likely to pay a user fee for outpatient care as exemption-ineligible patients (44 percent vs. 89 percent), the difference for inpatient care was much smaller (70 percent vs. 86 percent) (Haazen 2012). With the introduction of district budgets for DDHs and SLAs, there are now mechanisms for FBO and for-profit facilities to receive government payment, and in these situations it is generally agreed that exemptions policies should apply. Nonetheless, it would be useful to clarify and ensure that private providers are fully trained on this policy, which seems to be a source of resentment for both public officials and private providers.

National Health Insurance Fund

The NHIF is a mandatory health insurance scheme for civil servants, under the MOHSW and Social Security Regulatory Authority (SSRA). It covers civil servants, their spouses, and a maximum of four dependents. Civil servants are subject to a required premium of 6 percent of the employee salary, equally shared between the employer and employee. In 2001, the initial membership size was 164,708 principal members, growing to 488,925 members and 2,583,195 total beneficiaries as of March 2012.

The NHIF offers both inpatient and outpatient care as part of its benefits package. All government facilities are automatically accredited as NHIF providers, while individual contracts are signed with private providers. The large majority of the 5,381 accredited facilities are public facilities, as shown in table 7.9, which disaggregates public and PFP and PNFP facilities. Although the network

Table 7.9 NHIF Accredited Facilities

Type of facility	*Government*	*PNFP*	*PFP*	*Total*
Referral hospital	10	9	4	23
Regional hospital	22	22	4	48
District hospital	86	71	5	162
Health center	407	127	10	544
Dispensary	3,794	396	12	4,202
Pharmacy	0	0	134	134
ADDO	0	0	268	268
Total	**4,319**	**625**	**437**	**5,381**
Percent of total	**80%**	**12%**	**8%**	**100%**

Source: Data provided by NHIF during key informant interview.
Note: PNFP = private not-for-profit; PFP = private for-profit.

in urban areas is quite extensive, the NHIF believes there is still room to expand its network of PFP and PNFP providers in rural areas in order to promote member choice.

The NHIF reimburses its service providers on a fee-for-service basis. There is a standard list of services and reimbursement rates that is applied nationally and varies by type of facility, irrespective of the sector. In a few larger hospitals, reimbursement had been based on a daily capped rate, but that has reverted back to fee-for-service as of March 2012.

As a rule, facilities consider the claim reimbursement rates to be low, and in some cases insufficient to fully cover costs. Although there are documented improvements in claims reimbursements, the claims process is considered to be cumbersome and slow. In fact, while reimbursement is contractually required within 60 days, the average claim was paid in 42 days in 2010, and 34 days in 2011, and the NHIF has set an ambitious target of 15 days for claims processing. One reason for the facilities' dissatisfaction is that, for government facilities, reimbursement is made through the CHMT, which may not notify each facility of the funds received. To resolve this problem, in some facilities, the NHIF notifies each facility of the reimbursement amounts, even though the funding is sent through the CHMT. Too, some of the perceptions of cumbersome claims processing linger from earlier years, when both the NHIF and its providers were still working to operationalize the system. Most providers do report that claims reimbursement has improved.

A larger portion of NHIF funding is directed to private facilities than government facilities. Claims payment data by service provider for the nine months ending March 2012, shown in table 7.10, reveal several issues. First, although government facilities account for 80 percent of all accredited facilities, only 43.6 percent of total claims come from government facilities. Either members prefer to use private (PFP and PNFP) facilities, or government facilities do not file claims and are thus not reimbursed for services to NHIF members. NHIF members also are more likely to reside in urban areas, which tend to have many PFP provider options.

Also notable is that the average amount paid per claim for private facilities is higher than for government facilities, even though there is standard pricing. One plausible explanation is that government facilities are unable to provide the

Table 7.10 NHIF Payments, by Type of Provider, July 2011–March 2012

Type of provider	*Number of paid claims*	*% of total claims*	*Amount paid (billion T Sh)*	*% of total payment*	*Average claim amount*
Government facilities	1,013,516	43.6	12.25	30.1	12,083
PNFP facilities	957,433	41.2	19.20	47.3	20,050
PFP facilities	144,479	6.2	5.39	13.3	37,321
Private pharmacies and ADDOs	209,165	9.0	3.79	9.3	18,113
Total	**2,324,593**	**100.0**	**40.63**	**100.0**	**17,476**

Source: NHIF 2012.
Note: PNFP = private not-for-profit; PFP = private for-profit; ADDOs = Accredited Drug Dispensing Outlets.

appropriate diagnostics and treatment, so their claims represent only whatever services were available and not what was necessary for the patient's condition. Private facilities are more likely to have equipment and medicines available and are thus able to provide complete treatment and bill NHIF accordingly. There is also the possibility of overprovision from private providers, although that does not seem to be a serious concern.

The NHIF has been under scrutiny due to its low payout rate and high level of reserves. In 2010, payments to providers (T Sh 20.1 billion) represented 23 percent of total premiums collected (T Sh 85.8 billion). Total accumulated reserves were T Sh 242.6 billion, based on a 2009 audit report. There are multiple interpretations of the high reserves: possibly the NHIF premium is too high, or reimbursement rates could be increased; members may continue to underutilize health services; or the reserves represent a source of funds to cross-subsidize other insurance schemes.

Social Health Insurance Benefit

The SHIB was established in 2006 as part of the NSSF under the Ministry of Labour and Employment and overseen by the SSRA. Health insurance is one of seven benefits provided under the NSSF. Contribution to the NSSF is compulsory for all formal employees in the private sector and parastatal organizations. The SHIB scheme is financed through NSSF contributions, currently 20 percent of employee salary shared equally by the employee and the employer. While contribution to the NSSF automatically qualifies an employee for SHIB membership, employees must individually register with the SHIB to access benefits.

Currently, there are approximately 50,000 registered SHIB members, out of a total of 500,000 NSSF members. Reasons for low enrollment include insufficient public information; employer-provided health care for some private employees; and limited access to accredited facilities in some areas. The NSSF estimates that approximately 300,000 of its members have health insurance benefits provided through their employers, through private insurers or other mechanisms. The NSSF's goal is to enroll 200,000 over the next year, representing those NSSF members that do not currently have health insurance.

The network of providers is limited, with approximately 350 public and private service providers nationally that are individually contracted. Generally, the SHIB seeks to include providers based on member preferences. All providers are accredited by the SHIB, based on MOHSW guidelines. The SHIB pays providers based on standard capitated fees, although a few specialized facilities have alternative reimbursement arrangements. The capitated fee is T Sh 36,000 per capita for urban hospital or specialized rural hospital, and T Sh 22,000 per capita for a rural hospital (equivalent to a government district hospital) or health center. The SHIB is in the process of reconsidering its capitation fees and will likely differentiate not only between urban and rural facilities, but also between government/faith-based and for-profit facilities. This change is in recognition of preferential tax treatment, as well as medicine access, that is provided to government and faith-based facilities.

The SHIB reports that with the increase in members, they expect to expand their provider network as well. Likely the increase in private providers will be higher because their members prefer them to government facilities; moreover, the SHIB believes it has more leverage to ensure good quality with private providers. One of their biggest challenges is ensuring member satisfaction with services, and there have been complaints of drug stock-out problems at accredited facilities. The SHIB is considering enrolling private pharmacies in order to address this issue, but that is likely a few years from fruition.

Community Health Fund and TIKA

The CHF started in 1996 as a pilot scheme in Igunga district and was later adopted as the strategy for providing coverage to the entire rural population of the country (MOH 1999). TIKA was introduced more recently and targets people in urban areas. Initially, the CHF was under the direct supervision of the MOHSW, but in 2009 the NHIF was directed to take over management and supervision of CHF and TIKA. Nearly all districts have introduced the CHF, but few municipalities have introduced TIKA.

Membership in the CHF is voluntary, and premiums are set per household. Once a member, individuals can access health services without paying user fees at the point of service. Contributions to the CHF are matched one-for-one through a government matching grant. Annual premiums in most districts are T Sh 5,000 or T Sh 10,000, although they may be as high as T Sh 30,000 per household of up to six members. In most districts, the CHF covers fees at dispensary and health centers only, but in some districts hospital coverage is also provided. As a rule, CHF members may only use government facilities, although there are selected examples of districts where members may use FBO facilities that are contracted through an SLA (Singida, Igunga.)

CHF membership has not yet reached the target of 85 percent of the population in rural areas. The 2010 DHS found between 2 percent and 3 percent of the population covered by community-based health insurance. Data from the NHIF show current CHF membership at 3,685,968, or over 8 percent of the population (estimated population 43 million). However, estimates of membership may be subject to error, as some reports include only current members while others include accumulated or ever-members (Chee, Smith, and Kapinga 2002). There is low uptake in membership and high drop-out of CHF members, notwithstanding a few isolated successes.

There have been many reasons suggested for low membership. The most important may be that the design of the product is unattractive—the benefit package is insufficient to justify the premiums. User fees are generally low in any case (T Sh 300–1,000 depending on the type of facility), and when coupled with the generous waiver and exemption policies, households do not see a benefit from CHF membership. Poor quality of services is often cited as discouraging renewals. At the same time, those members who do fall sick also derive no value from their membership. There were also reports that some councils and facilities were not aware of how to use CHF funds, which merely accumulated. There has

been support to strengthen CHF in various regions, focused on increased education and sensitization, improved management, and investment in quality improvements. The NHIF expects to provide a proposal for a redesigned CHF that could address some of these issues.

Some variants to the CHF have also been piloted with NGO support. One such scheme, supported by the International Center for Development and Research (CIDR,) is the Community Health Insurance Fund (CHIF), operating in Kyela district since 2010. Some important design features introduced under the CHIF include (1) expansion of the benefit package, to include FBO providers, private pharmacies, and emergency transport; (2) professional management with CIDR staff, including an operations staff of four and field officers to conduct education and promotion; (3) active management of the funds collected to ensure that they are used to improve services. The premium charged is T Sh 2,000 per individual, although an additional T Sh 3,000 subsidy per individual is provided by a local cocoa company. Additionally, like the CHF, the CHIF receives the GOT matching fund of T Sh 5,000. To date, there are 16,203 beneficiaries, representing 16 percent coverage in the district.

Private Sector Health Insurance

The market for private health insurance in Tanzania has been active since the 1990s. To date, Tanzania has about 15 registered insurance companies, of which five have a health insurance component, covering approximately 120,000 people—less than 1 percent of the total population. Private health insurance companies do not report to the MOHSW or the SSRA but are—like other forms of private insurance—supervised by the Tanzania Insurance Regulatory Authority. Premiums can range from T Sh 120,000 per year for inpatient coverage only with benefit limits, to over T Sh 1,000,000 for comprehensive coverage including evacuation and international hospitalization. This market primarily serves the high-income population and is generally purchased by employers, although individual plans account for a small fraction of the market.

Currently, the largest private insurer is AAR Medical Services Company, which comprises AAR Insurance and AAR Health Services. Originally established in 1998, AAR Health Services delivered outpatient care for members while reinsuring inpatient risk. AAR Insurance was created in 2007. AAR Health Services operates four clinics in Dar and one in Arusha, three of which are open to the public in addition to AAR members. Its membership has doubled in the last year and there are currently 80,000 policy holders. AAR contracts with approximately 250 public and private providers throughout the country, including approximately 10 government hospitals. It reports that the process of contracting with a government facility is very cumbersome, at times taking several years. Reimbursement rates are individually negotiated with providers.

Some other established insurance providers include Strategis, Jubilee, and Momentum. Strategis Insurance has been active in Tanzania for seven years, with more than 10,000 insured nationally. It contracts with more than 100 government and private providers. It believes that the biggest barrier to acceptance of

insurance in rural areas is the lack of quality providers, thereby diminishing the value of insurance coverage.

Both AAR and Strategis believe that the health insurance market is growing, and many of their clients are first-time purchasers of health insurance. They also highlight the importance of educating people about the benefits of health insurance, as it is still a new product. There is interest in providing lower-price products, but little investment in this market to date.

Medical Benefits Schemes

Medical benefits schemes refer to employer-managed medical benefits for their employees and beneficiaries. While employers have provided both on-site health services and reimbursement of health costs in the past, there is a trend toward more professional *medical budget management*. Health Focus is one company that provides this service, managing company health budgets, including negotiating contracts with providers and processing claims. It can also provide assistance in the operation of on-site health facilities. Health Focus has contracts with 125 public and private providers throughout the country. Costs per employee are generally lower than costs of private insurance premiums. However, as employers are assuming all risk of high employee health care costs, the lower cost in effect represents the savings from not purchasing insurance.

Micro-Insurance Schemes

The number of health micro-insurance schemes has increased over time. Currently, about 36 schemes have registered under the Tanzania Network of Community Health Funds (TNCHF). It is difficult to track these schemes, as many do not register with the TNCHF, and those who do register may operate for a few years then dissolve or become dormant. Most of the schemes are sponsored by religious groups, cooperatives, and other associations. Many were initiated with support from international organizations such as the International Labor Organization (ILO), PharmAccess, GIZ, and the CIDR. The number of members covered by these schemes is limited, with some schemes covering as few as 100 members. The range of services covered also varies. There is no systematic documentation of the contribution of such schemes to the overall health financing envelope, although it is surely limited.

VIBINDO, an umbrella organization for informal sector groups, operated a micro-insurance scheme, supported by ILO, several years ago in Dar es Salaam. VIBINDO represents approximately 62,000 individuals from 480 member groups. These groups may comprise between five and 100+ members, and include groups of small manufacturers, traders, and service providers. There were 10 schemes operated through its member groups, but only one (with approximately 100 members) remains active. Coverage was for outpatient services, at a cost of T Sh 18,000 per individual. Each group contracted with one selected provider, and contracts stipulated reimbursement rates by service.

Micro Ensure is currently implementing a micro-insurance scheme in Moshi district. This scheme is subsidized by PharmAccess and provides for full outpatient

services at a dispensary or health center, with inpatient coverage for maternity services. It is operated through a coffee cooperative (KNCU) that is composed of 64 coffee societies, with a total population reach of 300,000 people. To date, five societies have implemented the scheme. One key problem in the start-up was that the societies were not collecting the premium as agreed, so now Micro Ensure has a full sales team that goes house to house to collect premiums.

The total premium was set at T Sh 30,000, 60 percent subsidized by PharmAccess, so that actual cost per individual was T Sh 12,000 per year. It has been able to reduce the premium in half, so that the individual cost would be T Sh 6,000, with an additional T Sh 9,000 subsidy from PharmAccess. Micro Ensure contracts with approximately 30 facilities, of which about 10 are government facilities. Benefits are limited to outpatient care with the exception of maternity care, which is included in the benefits package. Providers are paid on a capitated basis, and that rate has been reduced to T Sh 12,000 per year per capita. Along with the insurance product, PharmAccess makes significant investments in the facilities, so that all contracted facilities can meet the Safe Care accreditation standards.

PharmAccess introduced a subsidized insurance product in Dar es Salaam a few years ago with little uptake. It is in discussions with the NSSF to develop another product there, in conjunction with Tujijenge, a microfinance institution. The goal is to develop a scheme that can be entirely self-sustaining, with a full-benefit package including access to public and private facilities. One potential feature to manage costs would be the use of gatekeepers at primary care level as well as enforcement of a mandatory referral policy, so that members could not go directly to more expensive facilities. Although this project is not yet near fruition, it is worth monitoring, as there do not appear to be affordable health insurance options for the middle-income market.

Key Findings

A notable percentage of Tanzanians seek health care in the private sector. The financing data show that consumers use FBO and PFP providers, driven by access as well as preference. For example, 31percent of household OOP expenditures are at PNFP (mostly FBO) facilities, while 10 percent are at PFP facilities. Forty-one percent of NHIF claims are from FBO facilities and 6 percent of claims are from for-private facilities. Providing more funding for FBO and for-profit providers would certainly support consumer choice, and possibly increase coverage of priority services.

Councils have not fully considered private providers in their budget allocations. Several key trends emerged from the NHA analysis related to the financing and control of health expenditures. The MOHSW controls an increasingly small portion of health expenditures, partly driven by how donors have directed funding. Conversely, an increasing share of total government funding for health is directed by local governments, with 19 percent of THE flowing through local

governments, compared with 9 percent in 2002/03. As a result, councils have more decision-making power on how these funds are spent and with what type of provider—public, PFP, and PNFP.

Service agreements are underutilized. CCHP Guidelines support the concept of health PPPs, directing councils to make rational allocations of budget among public and private providers. But in practice, councils do not fully consider private providers, particularly PFP providers, in their budget allocations. Councils have a mechanism for output-based financing of PNFP and PFP providers, through the new SLAs, but they are misunderstood and underutilized. Issuing further guidance on CCHP Guidelines and training councils on how to use SLA to achieve regional health objectives will help maximize the opportunities in working with private providers, particularly PNFP, in underserved areas and in health priorities.

Exemption policy is not uniformly applied and is not meeting its objectives. A lack of adherence to the exemptions policy seems to cause resentment for both public officials and private providers. Although the official policy stipulates that exemptions apply in all health facilities, it does not seem reasonable to expect for-profit providers to recognize exemptions if there is no mechanism for reimbursement from the government. Furthermore, exemptions are not achieving their objectives, as they have only moderately reduced OOP payments and have benefitted wealthier households more than poorer households.

Insurance coverage can decrease inequities in health spending. Households account for 32 percent of THE, with 93 percent of their expenditures through OOP payments. There is room to improve the use of these funds for better health outcomes. While insurers only direct 3 percent of health spending, they are well-positioned to influence quality through active purchasing decisions.

Insurance schemes support public and private providers. Except for the CHF, all of the major insurance schemes provide their members a choice of public and private facilities. Nonetheless, there is opportunity for the NHIF and SHIB to expand their provider networks to include more private providers. Insurers can play an important role in enforcing quality standards through their purchasing decisions, both in their selection of providers and in their reimbursement policies.

Health insurance sector is not well coordinated. Despite a high-level commitment to universal coverage, there is little coordination of various health insurance mechanisms to ensure progress toward this goal. The two largest insurers are government sponsored and regulated by different ministries—the MOHSW for the NHIF, and the Ministry of Labour and Employment for the SHIB. Both schemes are regulated, along with other public pension benefits, by the SSRA. With the NHIF taking responsibility for the CHF, there is potential for applying more professional insurance features to the CHF. Private health insurers are

regulated under the Tanzania Insurance Regulatory Act, which is not specific to health insurance.

CHF is not achieving intended results. Some element of redesign is necessary for the CHF to achieve its intended goals. The NHIF, as the CHF custodian, seems well-positioned to support redesign and implementation. Even small-scale pilot projects—including variants of the CHF like the CHIF in Kyela, and the KNCU scheme in Moshi—recognize the importance of offering a choice of providers. While such demonstrations have not been brought to scale, expanding provider options should be a consideration for changes to the CHF. Even with a more attractive product, however, more education for consumers on fundamental insurance and risk pooling concepts is needed. Since the assessment team completed its field work, the Tanzanian government has begun further discussions among local stakeholders about how best to reform the CHF.

Recommendations

In light of these findings, the PSA team recommends the following priorities for the MOHSW PPP Unit, and highlights a few emerging PPP opportunities.

Develop a coherent financing policy that minimizes financial barriers to care, with defined roles for NHIF, SHIB, and CHF. These multiple government-sponsored insurance schemes create both fragmentation and duplication, while only providing benefits for a small portion of the population. Operating both the NHIF and the SHIB creates unnecessary administrative duplication. In order for the CHF to positively impact health access, it must develop an attractive benefit package and increase enrollment.

Increase use of Service-Level Agreements. The MOHSW PPP Unit can take a leadership role in promoting greater understanding and use of SLAs with LGAs to purchase services through FBO and commercial providers. Sensitization efforts directed at LGAs should cover the following:

- Obligations and benefits of SLAs
- Clarification of whether SLAs can be executed with for-profit providers
- Guidance in appropriate payment and invoicing mechanisms that maintain the output-based funding element of SLAs while minimizing administrative costs
- Training to estimate budget obligations arising from SLAs to ensure that adequate budget is set aside for these service-based payments.

Revise the Exemption Policy to ensure it meets its objective. Agree on how the Exemption Policy should be applied in PNFP and PFP settings and disseminate the clearer guidance to all. Such guidance should distinguish between facilities that receive public support (funding, staff, access to MSD, and so on), through DDH agreements or SLAs, and those that receive no public support.

Ensure transparent dissemination of costing findings. Better data on costs are needed in order to support universal health insurance coverage, and to ensure a level playing field for private providers. Cost data could better inform budgeting for SLAs at the LGA level as well as appropriate insurance reimbursement for public and private providers.

Partner with private insurers to educate the public on benefits of health insurance. Establish a partnership between the NHIF and private insurers to educate the general public about health insurance and possibly market the CHF. Mass education around health insurance and its benefits is needed both for the private insurance industry and for public health. Also, explore how private insurers can offer skills and resources in marketing and management that would be useful to implementation of the CHF both at national and subnational levels.

CHAPTER 8

Strategic Priorities for Increased Private Sector Engagement in Health

The vision of a Tanzania in which all citizens enjoy positive health outcomes, maintained by a resilient and well-functioning health system, can be actualized through strategic public-private cooperation. In previous chapters, this report proposed specific recommendations for increasing private sector engagement in different aspects of the health system. The Government of Tanzania (GOT), development partners, and other local stakeholders are free to consider and implement any of these recommendations to strengthen the private sector role in delivering essential health products and services. In this chapter, however, we prioritize among the recommendations, outlining a strategic approach that identifies short- and long-term actions that may yield the most significant impacts with respect to effectively increasing private sector contributions to address critical public health needs in Tanzania.

Making the Case for Partnering with the Private Health Sector

The purpose of this assessment was to document the size, scope, and capacity of the private health sector in Tanzania. Although not as large as the private health sector in neighboring Kenya, the assessment revealed that there is a sizeable, diverse, and growing private health sector in Tanzania. As the chapter on service delivery (chapter 4) demonstrates, over one-third of general health services in Tanzania can be accessed through private sector sources (MOHSW 2012). Moreover, the private health sector contributes to services in some form at all levels of the Tanzanian health system. In some geographic areas, the private sector is the primary supplier of health services. Contrary to common beliefs, the private health sector does contribute to many of Tanzanian's key public health priorities, such as human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS), malaria, and reproductive, maternal, and child health. In addition, a notable percentage of poorer Tanzanians seek care in private health facilities for some or all of their health service needs.

Interviews with a variety of private health care providers—doctors, pharmacists, lab technicians, nurses, and midwives—revealed a collective desire to play a greater role in meeting national health needs. Yet there are many barriers preventing the private health sector from assuming a larger role in tackling Tanzania's priority health challenges. Perceived barriers included government mistrust of the private health sector, competition between the sectors, and unclear guidelines and lack of government capacity to partner with the private health sector. There are also structural and market barriers such as a fragmented private health sector, that make it difficult for the government to know who to partner with, present challenges to private health businesses that struggle to access finance to upgrade and expand their services, and tax structures that discourage private health sector growth.

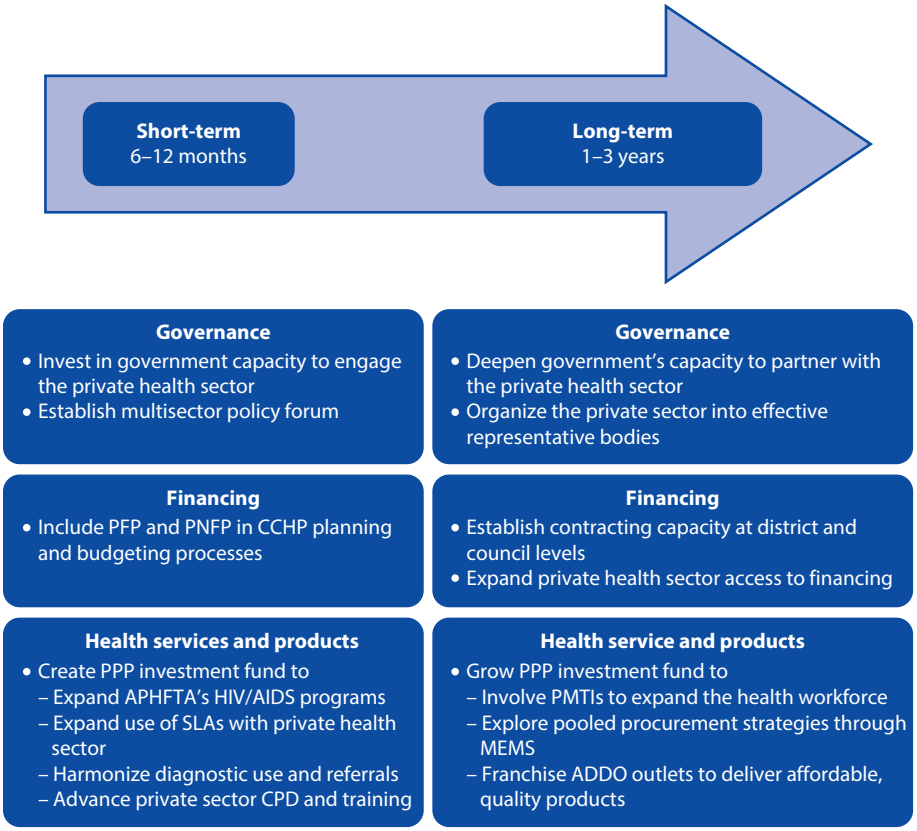
The strategic recommendations in this section strive to create a culture of "shared responsibility," fostering openness between the public and private sectors to better coordinate and work together. This culture of shared responsibility points to a holistic approach in almost all aspects of the health sector, involving all the relevant stakeholders in policy and planning, health financing, health workforce and service delivery. Moreover, leveraging private sector resources—infrastructure, equipment, health personnel, and expertise to name a few—will help the government harness local resources in health, thereby laying the foundation for greater autonomy and lessening reliance on donor funding.

The moment is opportune to foster greater collaboration with the private health sector and to instill this spirit of "we are in this together." Tanzania is a leader in the region with a comprehensive policy and regulatory framework in place to engage the private health sector. Moreover, there is political commitment to do so at multiple levels of government (although variable within Local Government Authorities [LGAs]). The enacted public-private partnership (PPP) Law has given further impetus to working with the private sector, including in health. There is growing partnership experience, initially between the Ministry of Health and Social Welfare (MOHSW) and faith-based organizations (FBOs) through informal agreements and more recently, between MOHSW and FBOs, nongovernmental organizations (NGOs), and a few private for-profit (PFP) providers through formal or semi-formal service level agreements. Finally, there are several development partners already invested in strengthening private health sector engagement and more development partners interested in supporting the MOHSW to partner with the private health sector.

Short- and Long-Term Strategic Priorities

The PSA team prioritized the recommendations from the comprehensive list for each health system building blocks to develop a set of strategic priorities to foster better public-private collaboration and expand access to quality, affordable health care through the private sector. The strategic priorities are organized by critical health system building blocks: governance, health financing, and health

Figure 8.1 Short- and Long-Term Strategic Priorities



Source: World Bank data.

services/products. The team also identified actions that can produce results in the short term (6–12 months) while considering more long-term system changes that will require more time to deliver impact. Figure 8.1 provides an overview of short- and long-term strategic priorities.

Strategic Investments

Governance

Objectives

To strengthen the enabling environment for greater private sector participation in addressing health needs and system gaps, the Private Health Sector Assessment (PSA) team proposes working in three core areas: (1) invest in the Tanzanian government's capacity, through the MOHSW PPP Unit, to engage and partner with the private sector; (2) establish a multi-sectoral forum and facilitate a dialogue process; and, (3) help organize the private sector into effective representative bodies to dialogue and partner with the public sector.

Short-Term Actions

Invest in the MOHSW's Capacity to Engage the Private Health Sector. Creating capacity to effectively engage and partner with the private health sector will require time as well as significant government and donor investment. There are several activities that the PPP Unit can initiate in the short term (6–12 months), while creating the foundation for longer-term activities (up to two years) that will establish operating systems and build new expertise and capacity.

1. *Formalize the PPP Unit mandate:* The PPP Unit lacks fundamental tools and instruments to guide its structure and implementation. Essential steps include (1) developing terms of reference for the PPP Unit; (2) drafting scopes of work for staff persons, based on terms of reference; (3) securing funding, both in the short term and long term, to support the additional staff identified; and (4) communicating the PPP Unit's scope and activities with internal and external stakeholders.

2. *Build capacity of PPP Unit and Department of Policy and Planning:* The PSA team has identified four critical training and capacity development areas needed immediately: (1) contract design and management; (2) feasibility analysis and due diligence approaches; (3) costing of health services and other activities; and (4) PPP portfolio management. A first step is to assess the PPP Unit and Policy and Planning Department's skills, map out training needs, and draft a training plan. A second step is to identify a list of local consultants with requisite skills that can complement the PPP Unit's skills and expertise in the short term.

3. *Advance and institutionalize MOHSW knowledge on existing PPPs in health:* As one of the key functions of the PPP Unit is to be the resident expert and institutional memory on all health PPPs there are several short-term activities that can be undertaken towards this objective. These include building a PPP/Health pipeline[1]: creating an inventory of current PPPs in health; developing a database to track and manage health PPPs; and establishing a system to identify, track and manage PPPs. In order to disseminate PPP knowledge more widely, the PPP Unit should also create and maintain a webpage on the MOHSW website that includes information such as: terms of reference; PPP database; relevant policies, laws and regulations; fact sheets on PPPs in health; a directory of key MOHSW divisions involved in PPPs; and the PPP Unit work plan.

4. *Implement a communication strategy:* The main objectives of a communication strategy are to build internal MOHSW support for the PPP Unit and to inform the private sector what the PPP Unit will do to promote PPPs in health. Possible activities include designing promotional materials and developing informational presentations. Materials might cover: description of the private health sector; discussion of the risks and rewards of health PPPs; definition of health PPPs and overview of PPP Unit functions; and MOHSW priority areas for health PPPs.

Establish a Multisectoral Forum that Promotes Effective Sectorwide PPD. PPP-TWG members interviewed during the PSA concurred with the need to formally establish a National PPP Steering Committee as a sectorwide forum for PPD. Formalizing the NPPPSC—or creating a new one—will create a "space" for

all private health sector groups to discuss issues that directly impact their constituencies. It will also motivate the private health sector to get better organized. The Kenya example of a PPP-Health Kenya (appendix G) provides insight on how the GOT and private health sector partners can formally establish this sectorwide PPD forum. In the short term, actions to reinvigorate the NPPPSC and/or create a new a policy forum include the following:

1. Conducting a stakeholder analysis to identify PPD forum member organizations: Best practice for effective governance structures indicate that a manageable number of members (under 20) is critical for a board's productivity and effectiveness. Conducting a stakeholder analysis will reveal which groups are essential to the forum's political success, who from each organization should participate, and the number from each sector to ensure balanced representation.

2. Convening meetings to establish TORs and rules of engagement for the PPD forum: Once the composition of the PPD forum is determined members should meet to agree upon the forum's purpose (for example, tasks and activities), and organizational structure and processes (for example, shared leadership, joint decision making, and voting procedures). The end product of this meeting will be a partnership document signed by all founding members.

3. Identifying a short-list of priorities to work on together: To focus the PPD Forum, the founding members need to identify some "quick wins" to build trust and demonstrate that the public and private sectors can work together to achieve change. One approach to help develop a short-list entails reviewing national health priorities, discussing which ones lend themselves to a private sector intervention, and then agreeing on three to four projects.

4. Linking the health PPD forum to national and regional forums: The public-private dialogue (PPD) health forum can later establish relationships and linkages with other important policy forums such as the Tanzania Private Sector Foundation (TPSF) and Tanzania National Business Council (TNBC).

Long-Term Actions

Deepen Government's Capacity to Partner with the Private Health Sector. Longer-term strategies focus on consolidating government's gains while building the operating systems and knowledge on PPPs in health. Long-term actions include the following:

1. Establishing operating systems: This includes designing and building the operating systems and supporting operational manuals that outline the PPP unit's functions, policies, and procedures, as well as linkages with other departments within the MOHSW and other government ministries such as the MOF and TIC. Several examples of operating systems and manuals based on other PPP Unit best practices (such as the *Operations Manual* containing Tanzania's Regulations for PPPs and Code of Good Practice for PPPs) are available to guide this process.

2. Building knowledge on PPPs in health: Using the PPP Unit as the gateway to information and knowledge on PPPs in health, the PPP Unit will (1) gather and post tools and methodologies on the PPP Unit webpage; (2) gather and post reference documents and key links with other website on PPPs in health; (3)

communicate on and market PPPs in health; (4) develop quarterly newsletters on MOHSW health priorities and stories on PPP successes and challenges; and (5) post PPP Health policies and guidelines as they come online.

3. *Assisting the PPP Unit to broker and manage PPP deals:* The proof of the PPP Unit's success will be the design and implementation of PPPs for improved health outcomes. The PPP Unit will identify a few feasible proposals for short-term PPPs for improved health service delivery, working through both the PPP inventory and through consultations with the private health sector, via a newly created National PPP Steering Committee and the PPP-TWG. Donors can support technical assistance for the PPP Unit to broker some of the PPP ideas proposed in Health Services and Products.

Organize the Private Health Sector into Effective Representative Bodies. Success of the health PPD forum rests on the assumptions that there is an organized private health sector and strong representative member organizations to participate. To support this vision, the PSA team recommends both (1) assisting private health sector segments to form umbrella organizations representing various aspects of the private health sector; and (2) strengthening the capacity of existing but still developing associations important to the health sector.

1. *Unite PNFP and PFP actors into representative bodies:* To organize the private health sector into effective "blocks," the PSA recommends taking action to unite three important provider groups in the health sector: (1) faith-based; (2) for-profit; and (3) nongovernmental.

1. Promote Inter-Faith Apex Groups: The CSSC plays an important leadership role in the FBO community. The Christian Council of Tanzania and the Episcopal Conference of Tanzania can work together and entrust the CSSC with the mandate to liaise with a wider range of non-Christian FBOs working in health. Also, donor funding can be used to facilitate exchanges and technical assistance between the newly formed interfaith groups and those in Kenya and Uganda. As part of its mandate, the interfaith group can involve and support all FBO member organizations—Christian and non-Christian alike—to take part in CHMT planning, to partner with the MOHSW under SLAs, to access donor funds through basket funds, and to join in donor sponsored training to strengthen FBO member organizations' staff skills.
2. PFP Health Federation: Numerous private entities with competing priorities, distrust, diverse health system involvement, time constraints limiting organizational efforts, and lack of information are just some of the factors inhibiting the private sector from organizing under one umbrella organization. Despite the challenges—and in line with the priorities of APHFTA and other key private sector entities—the PSA team recommends forming a Tanzanian Health Federation as has been done in other Africa countries such as Kenya, Uganda, and Ghana. With donor support, APHFTA can play a leadership role in both convening the federation and facilitating exchanges and technical assistance between the Tanzania Health Federation and the Kenyan Health

Federation, Uganda Health Federation, and Private Health Sector Association of Ghana.

3. NGO Coordinating Mechanism: NGOS have a limited role in policy and planning and yet they are important service delivery actors. The PSA recommends creating incentives—including donor funding—to encourage NGOs to form some type of coordinating structure/forum. Given the quantity, breadth of scope, and diversity of NGOs active in health, the NGO coordinating body could focus on a manageable number of health service NGOs. The core group of founding NGOs members can determine what will be the entities legal status, if any. Forming an NGO coordinating mechanism will enable the MOHSW to consistently and systematically involve larger sustainable NGOs in policy and planning.

2. Build capacity of key private sector organizations: There are several existing groups not currently represented in PPPs and/or policy and planning—primarily because they are not organized or are small, fledgling organizations. They include the professional associations, BAKWATA, private medical universities, and the pharmaceutical and hospital sectors. Over time, the PSA team recommends exploring how to (1) consolidate the health professional associations and (2) strengthen and grow BAKWATA's health activities.

Health Financing

Objectives

Strengthen capacity at the decentralized level for the government to contract for a wide array of services (for example, nonclinical support, clinical and clinical-support services, as well as management and training services).

Short-Term Actions

Increase PFP and PNFP Involvement in CCHP Processes. Despite the significant potential the private health sector can play to address health needs, these private providers are largely excluded from the district CCHP annual and budgeting process. With minimal investments (that is, transport allowances and/or accessing larger meeting space), district health leadership could promote a CCHP that is truly comprehensive by engaging key health actors from all sectors in the annual planning and budgeting processes. Strategically, equipping regional, district, and council management to involve all stakeholders in planning and budgeting through the CCHP process and in quarterly monitoring meetings will create an annual strategy that leverages all available health resources and highlights opportunities for increased PPP and multisectoral collaboration to meet key district health challenges.

In the short term, the PSA team recommends supporting the MOHSW PPP Unit's efforts to orient regional, district, and council management teams in the MOHSW. Currently, the MOHSW has designed an easy to understand training curriculum targeted to public and private sector stakeholders at the regional and district level. The two-day workshop describes (1) the benefits and challenges of

health partnerships; (2) the Tanzanian the policy framework supporting health partnerships; (3) private sector organizations—not-for-profit and for-profit—in each region; (4) different organizations in their region, their comparative advantage, and how they complement each other; (5) the concept of partnerships and types of mechanisms available for PPPs; and (6) the PPP Unit's and RHMT's role in forming partnerships.

The MOHSW will use the PPP training to clarify the Exemption Policy. First, the MOHSW needs to agree on how the Exemption Policy should be applied in PNFP and PFP settings and disseminate clearer guidance to all. Such guidance should distinguish between facilities that receive public support (funding, staff, access to MSD, and so on), through DDH agreements or SLAs, and those that receive no public support.

The orientation is a first step of a series of targeted trainings that aims to bring together both public and private sector actors involved in the CCHP process. Other training workshops planned include building skills on (1) multisectoral planning; (2) participatory budgeting, and (3) scoping and designing PPP opportunities.

Long-Term Actions

Establish Capacity at the Decentralized Level to Purchase and/or Partner with the Private Health Sector. The MOHSW PPP Unit can strengthen the capacity of LGAs to purchase services from PFP and PNFP providers. Contracting private providers to provide priority services would expand consumer choice. Although guidance for entering SLAs are included in CCHP Guidelines, there is limited understanding of how best to use these agreements to expand service delivery. To support councils in considering such decisions, better explanation of the obligations and benefits of SLAs is needed. Wide dissemination and training directed to councils is needed to ensure that they have the knowledge to enter such agreements. Any lingering questions regarding how to enter such agreements with PFP providers must be clarified.

An important component of ensuring that SLAs maintain their output-based funding design, without overburdening LGAs with administrative procedures, will be the creation of appropriate payment and invoicing mechanisms. Reliable cost data are necessary to inform LGAs on appropriate reimbursement rates for different types of providers. It is important that councils understand their financial obligations to these providers under these agreements, and are adequately prepared with budget set aside to pay providers. Training for council staff to assist them in estimating costs of these agreements (based on services to be covered and catchment population) is critical to ensure that private providers are adequately reimbursed.

Expand Private Sector Access to Finance (Particularly to Upgrade Facilities). Private sector facilities seeking to expand their service baskets often fail initial facility and infrastructure inspections—requiring financial investments in facility upgrades that most are not able to provide. Opportunities for expanded service

delivery are lost when private sector facilities that are ready and willing to engage in expanded HIV/AIDS, TB, and/or RCH services cannot access required capital to do so. The PSA team recommends that opportunities for increased private sector access to finance be explored in two ways: (1) assist APHFTA in developing training materials and curriculum to enhance private health sector knowledge of business planning, financial management and access to finance; and (2) expand financial institutional capacity to lend to the health sector. This would include providing banks and financial lenders with (1) an overview of financing needs in the Tanzanian private health sector; (2) better understanding of the risks and opportunities of private health sector lending; (3) analysis of opportunities for health care loans with a focus on basic SME lending; and (4) considerations in developing new health sector lending products. The PSA team recommends working with multiple banks to offer as much choice as possible to private providers and to help mitigate some of the constraints currently facing the financial sector in Tanzania. A preliminary list of bank partners to consider for a DCA and training could include Akiba Bank, CMRB, NMB, and EXIM Bank.

Health Services and Products

Objectives

Increase the number, broaden the range, and expand the location of private providers delivering affordable, quality health services and drugs. The PSA revealed there are many promising PPPs with Tanzanian private providers that could potentially be scaled-up. The PSA team recommends strengthening funding sources (that is, creating a PPP "investment fund") to seed new PPPs ideas and scale up promising ones. The investment fund will focus primarily on identifying and screening promising PPPs approaches and offering technical assistance support to initiate and/or scale-up. In the short term, promising approaches include building on two ongoing private sector initiatives and starting a new one that can be easily accomplished in the short term. Also, the PSA team has identified two prospects that will require more time to design and implement.

Short-Term Actions

Expand APHFTA's HIV/AIDS Programs. With minimum donor investments, APHFTA has the potential to extend and strengthen private sector provision of HIV/AIDS care and treatment services. Supporting APHFTA's expansion plans has the potential to increase coverage of key HIV/AIDS prevention and treatment efforts to reach 25–30 percent of the population in need—making it an investment worth pursuing. Currently, APHFTA receives approximately US$250,000 per year and has proposed that with additional funding they could do the following: (1) *Improve productivity* of existing 91 APHFTA-supported HIV sites by addressing the main obstacle- drugs. With donor support, APHFTA would address stock-outs of HIV test kits and ARVs and make drugs more affordable for treatment of common OIs. (2) *Scale-up private sector provision* of VCT and HIV treatment services to 400 new sites. APHFTA analyzed the private sector infrastructure and determined that there are 400 private facilities with

sufficient capacity (for example, infrastructure, staffing, skills) to deliver HIV/AIDS. APHFTA could easily expand its existing HIV/AIDS programs, including expanding IMAI and other HIV training to a new generation of private providers, and supplying affordable, quality drugs and kits. (3) *Scale-up APHFTA's existing male circumcision projects* to two or three additional districts. Currently, APHFTA members in two districts have demonstrated the private sector can deliver quality male circumcision for less than US$15 per procedure. APHFTA could easily expand this program to another three districts.

Expand Use of SLAs with the Private Health Sector. The MOHSW PPP Unit can take a leadership role in promoting greater understanding and use of SLAs with LGAs to purchase services through FBO and commercial providers. Sensitization efforts directed at LGAs should cover (1) obligations and benefits of SLAs, (2) clarification of whether SLAs can be executed with for-profit providers, (3) guidance in appropriate payment and invoicing mechanisms that maintain the output-based funding element of SLAs while minimizing administrative costs, and (4) training to estimate budget obligations arising from SLAs to ensure that adequate budget is set aside for these service-based payments.

Harmonize Diagnostic Use and Referrals across Public and Private Sectors. The Tanzanian MLSA—with membership representing the public, private, and diagnostic retail sectors—is primed to facilitate the harmonization of diagnostic use and referrals throughout the health sector. The MLSA should be supported in convening a membership forum (a 1- to 2-day event) in order to (1) create a compendium of all available diagnostic resources available across the sector and (2) facilitate multisectoral dialogue on coordination and improved diagnostic referral prospects. The MLSA, which comprises a broad range of health system actors, provides a strong coordinating body through which informal and/or formal contracts or purchasing agreements can be encouraged between member facilities in order to better share, harmonize, and mobilize diagnostic resources through the health sector.

Advance Private Sector CPD and Training Opportunities. As previously introduced, lack of access to training opportunities is significantly inhibiting the private health sector from increasing provision of key health services such as HIV/AIDS, TB, malaria, and RCH. In order to overcome this, CPD opportunities in key health areas should be specifically targeted to the private health sector. In addition to increasing the availability of trainings, improving opportunities for private sector attendance must also be pursued. This could include public sector staff providing short-term coverage at private facilities during training periods (as has been done in the FBO sector) and/or offering intensive or evening and weekend training options for private sector personnel. As a starting point, APHFTA could assist the NACP/TACAIDS in identifying private sector health facilities that meet facility requirements and oversee the IMAI training of identified health personnel to immediately scale up the provision of HIV/AIDS services in

the PFP sector. In the short term, CPD opportunities could be made immediately available by inviting private health professionals and technical staff to participate in existing morbidity and mortality meetings, and regional maternal mortality audits.

Long-Term Actions

Involve and Coordinate PMTIs to Expand the Health Workforce. PMTIs have unique needs and challenges that differ from private health facilities and practitioners. However, there are many opportunities to strengthen the ability of PMTIs to more successfully expand the health workforce in the context of broad private health sector strengthening. In the short term, donors can leverage existing access to finance efforts in Tanzania and work with financial institutions to expand their already existing lending to secondary schools to higher-education medical schools. In tandem, a select number of PMTIs should receive technical assistance to ensure that they have sound business and management practices allowing for the development of a credible business plan and adequate credit management. Likewise, with limited donor support, financial institutions can conduct targeted market research with parents of prospective medical students to best understand how to design and market a "parent loan" product for salaried workers to help finance their child's medical education. In the long term, reform of the HESLB policies to allow government-backed lending for mid-level private diploma and certificate courses will greatly expand the ability of PMTIs to enroll new students. In conjunction with this reform, stronger systems to hold current students accountable for paying back HESLB loans must exist in order to sustain the future of government-backed student loans.

There are ample opportunities to utilize PPPs to strengthen the ability of PMTIs to expand the health workforce. In the short term, PMTIs can partner with public district hospitals to expand practicum opportunities for students, while helping to alleviate short-term health worker shortages. Others types of effective partnerships include twinning with foreign universities to allow a higher number of higher-paying foreign students to attend Tanzanian PMTIs and engaging in comprehensive revenue diversification practices including offering short-term CPD courses or serving as site locations for international studies for research fees. In the long term, the ability of private sector representatives, including APHFTA, to advocate for the unique needs of their PMTI members will help to define the future ability of PMTI to admit more students, train more Tanzanian health workers, and maintain more viable businesses.

Pursue Pooled Strategies through MEMs or Other Private Sector Supply Channels. Private health facilities (both for-profit and not-for-profit) are often compelled to procure pharmaceutical and medical commodities at elevated prices through independent wholesalers. Several key informants throughout the private sector reported this as a prohibitive factor limiting their incentive to expand the scope of services offered at private sector facilities. As MEMS has recently incorporated as a business —allowing it to procure pharmaceutical commodities on behalf of

a larger range of not-for-profit and for-profit facilities—opportunities to pool private sector procurement should be pursued. This could be initiated in the short term by coordinating procurement dialogue between MEMS and established treatment networks such as APHFTA, PRINMAT, and BAKWATA, with the goal of organizing other procurement networks of independent private sector facilities in the long term. Such an arrangement benefits private sector facilities by developing their consistent access to reliable pharmaceutical commodities, lowering their input costs through increased pooled-procurement volumes, and supporting MEMS development as a complementary supply chain to MSD. As MSD strives to overcome persisting stock-out challenges, MEMS also provides an opportunity for designated FBO/NGO facilities to supplement their commodity procurement.

Franchise and Strengthen ADDO Outlets to Deliver Affordable, Quality Products. Strengthening accredited drug dispensing outlets (ADDOs) in order to improve quality and promote their sustainability can potentially extend access to essential drugs in hard-to-reach areas. In addition, with appropriate management and networking, ADDOs could serve as important sources of health information and community-based health interventions. Priority areas for technical assistance to support this network include the following:

1. *Establishing a management entity to oversee the network and monitor quality:* Increasingly, networking or franchising of private providers is being pursued as a method to expand delivery of health services and products through the private sector. A management entity (such as a franchisor) would perform a variety of functions needed to ensure quality and promote sustainability. Initially the franchisor would provide basic management services such as administration and operations support (including drug procurement), as well as ensure adherence to quality standards. Over time, the franchisor entity could expand its management services to include technical assistance in business planning, financial management, record-keeping, marketing, and training. There are at least two possible options to explore: (1) contract out management/franchisor functions to either an existing NGO/FBO with the required capacity or a for-profit management firm; (2) create a new entity to serve as manager/franchisor. In either scenario, donor support during the early stages would be critical, until the ADDOs become more financially viable and able to bear the costs of franchisor services.

2. *Addressing cost barriers to increase the viability of ADDO outlets:* Removing financial barriers at ADDO outlets would greatly increase access and use—particularly among underserved populations—while improving revenue and ensuring viability of the outlets. Possible strategies to address this include (1) expanding the current NHIF/NSSF program to contract with a greater number of ADDOs to reimburse them for drugs delivered to target population groups, or (2) reimbursing ADDOs that fill prescriptions from contracted private providers under a government SLA. Another strategy is to reduce pharmaceutical wholesale prices, thereby reducing retail costs to consumers, by (1) creating linkages between ADDOs and medical wholesalers in order to establish long-term

purchasing arrangements; (2) enabling franchised ADDOs to pool procurement through MEMs or other supply channels to drive costs down through volume increases; and/or (3) continuing to supply subsidized or donated drugs to ADDOs through vertical programs.

Note

1. The PPP pipeline system would track PPPs in various stage of development: PPPs in process, PPPs in procurement, PPPs in implementation, and PPPs in close-out.

APPENDIX A

Key Stakeholders Interviewed

Table A.1 Key Stakeholder List

No.	*Name*	*Organization*	*Title*
Policy and Governance			
1	Regina Kikuli	MOHSW	Acting Permanent Secretary
2	Dr. Edwin Mung'ong'o	MOHSW	Acting CMO
3	Dr. Kiangi	MOHSW	Acting DPS
4	Dr. Mohammad Ally Mohammed	Quality Assurance Unit, CMO's Office	Acting Director Health Quality Assurance
5	Mariam Ally	Health Financing TWG	Chairperson
6	Dr. Fatma Mrisho	TACAIDS	
7	Dr. Mariam Ongara	PPP TWG	Chairperson
8	Mr. Shango	Pharmaceuticals, Commodities, Infrastructure and Food Safety TWG	Chairperson
9	Dr. Neema	Reproductive and Child Health Vertical Program	Director
10	Ally Mohamed	National Malaria Control Program	Director
11	Dr. Lija	National AIDS Control Program	Director
12	Said Amir	Tanzania Investment Centre	PPP Coordination
13	Mr. Mboya	PMO Investment Office	
14	Irinei Kiria	Sikika	CEO
15	Said Impendu	BAKWATA	
Field Visits			
1	Beatrice Byarugaba	Coast Region RHMT	RMO
2	Denis Kamuzola	Coast Region RHMT	Regional Health Officer
3	Joyce Gordon	Coast Region RHMT	Regional Nursing Officer
4	Grace Chuwa	Coast Region RHMT	RCH Coordinator
5	Anne Mwaga	Coast Region RHMT	Regional Health Secretary
6	Lidia Mafole	Coast Region RHMT	Regional Social Welfare Officer
7	Mhando Muya	Coast Region RHMT	Regional Malaria Focal Person
8	Romilius Kawil	Coast Region RHMT	Regional Dental Officer
9	Jeovaness Moleli	Coast Region RHMT	M&E Officer
10	Jovin Katabalo	Coast Region RHMT	Accountant

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Table A.1 Key Stakeholder List *(continued)*

No.	*Name*	*Organization*	*Title*
11	Victoriana Ludovick	Kibaha Rural CHMT	DMO
12	Witness Mulugi	Kibaha Rural CHMT	District Health Secretary
13	Edmond Magupa	Kibaha Rural CHMT	District Health Officer
14	Rehema Pilimo	Kibaha Rural CHMT	District Cold Chain Control Coordinator
15	Jafari Mwamafup	Kibaha Rural CHMT	HMIS Officer
16	Ralbela	Kibaha Rural CHMT	RCH Coordinator
17	Geofrey Mjema	Kibaha Rural CHMT	District Pharmacist
18	Elizabeth Sekaya	Kibaha Rural CHMT	District Nursing Officer
19	Dr. Kaniki	Kibaha Township CHMT	DMO
20	Alan Sayi	Kibaha Township CHMT	RCH Coordinator
21	Geaoge Hunter	Kibaha Township CHMT	Pharmacist
22	Anastel	Kibaha Township CHMT	Laboratory Technician Coordinator
23	Happiness Haintis	Kibaha Township CHMT	Eye Service Coordinator
24	Amir Lumumba	Kibaha Township CHMT	Town Health Officer
25	Mariam Mgaja	Kibaha Township CHMT	District HIV/AIDS Coordinator
26	Hope Lutatntina	Kibaha Township CHMT	School Health Coordinator
27	Zainabu Kishebe	Kibaha Township CHMT	HMIS Coordinator
28	Langalanga Gengeli Mihayo	Kibaha Township CHMT	Council Consultant (Mentor) under Wajibika Project
29	Shaha	Kibaha Township CHMT	Malarial Focal Person
30	Esther Kaminda	Kibaha Township CHMT	Social Welfare Coordinator
31	Aziz Msuya	Mkuranga CHMT	DMO
32	Lugano Kiswaga	Mkuranga CHMT	Medical Officer in charge of hospital
33	Philimon Kalugula	Mkuranga CHMT	Medical officer
34	Macelino Pesambili	Mkuranga CHMT	Health Secretary
35	Grace Zephania	Mkuranga CHMT	CHF Coordinator
36	Martha Kimoto	Mkuranga CHMT	
37	Frank Lyimo	Mkuranga CHMT	Health Officer
38	Angelus Mtewa	Mkuranga CHMT	District Health Officer
39	Vumilia Nang'ang'o	Mkuranga CHMT	District Nutritionist
40	Ally Mende	Mkuranga CHMT	District Pharmacist
41	Dr. Frida T. Mokiti	Arusha RHMT	RMO
42	Ms. Mwamine Nyanwela	Arusha RHMT	Regional Nursing Officer
43	Ms. Belinda Mumbuli	Arusha RHMT	RRCHCo
44	Ms. Vones Uiso	Arusha RHMT	RHO
45	Ms. Angolwisye Mwamafupa	Arusha RHMT	RHS
46	Ms. Clara Mollay	Arusha RHMT	Regional Nutritionist
47	George Mrema	Arusha RHMT	RLT
48	Mr. Aziz Sheshe	Arusha RHMT	RIVO
49	Dr. Asmaa Thena	Arusha RHMT	PPP Focal Person
50	Dr. C.D. Mtamakaya	Moshi CHMT	DMO
51	Ms. Fidelista Irongo	Moshi CHMT	DHS
52	Ms. Grace Saria	Moshi CHMT	Mtuha Focal Person
53	Ms. Catherine Kilewo	Moshi CHMT	School Health Coordinator

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Table A.1 Key Stakeholder List *(continued)*

No.	*Name*	*Organization*	*Title*
54	Mr. Mohamed Kombo	Moshi CHMT	Cold Chain Coordinator
55	Ms. Deodata Kilumile	APHFTA Northern Zone	
56	Mr. Edgar Mapunda	APHFTA Northern Zone	Finance
57	Sammy J. Mulemba	Kilimanjaro RHMT	Social Welfare Officer
58	Hawa Nyanga	Kilimanjaro RHMT	Regional Nursing Officer
59	Dayness Alexander	Kilimanjaro RHMT	
60	Dr. Manse A. Chelangwa	Kilimanjaro RHMT	RTLC
61	Ellihoita Kaale	Kilimanjaro RHMT	RRCHCo
62	Dr. Oscar D. Mafole	Kilimanjaro RHMT	Regional Malaria Focal Person
63	Judith Elisa	Kilimanjaro RHMT	Medical Officer I/C
64	Dr. K.B. Saganda	Kilimanjaro RHMT	Regional Pharm
65	Dr. Abdallah Nduka	Kilimanjaro RHMT	Regional Dental Officer
66	Adventina K. Mulokozi	Kilimanjaro RHMT	School Health Coordinator
67	Alex Mamboya	Arusha CHMT	Municipal Health Secretary
68	Happy Saiguran	Arusha CHMT	MIFP
69	Fatma Msimbe	Arusha CHMT	Municipal Nursing Officer
70	Regina Darabe	Arusha CHMT	MRCHO
71	Dr. Ibrahim	Arusha CHMT	MMOH
72	Dr. Materu	Kibosho DDH	Medical Officer I/C
73	Dr. Masoza	Kellen Dispensary	Owner
74		Royal Health Center	
75	Organes Lema	MEMS	Project Manager
76	Paul Mchau	MEMS	Finance Officer
77	Zaina Msami	MEMS	Pharmacist
78	Dr. Frank Lyaruu	Gloria Dispensary and Laboratory	Owner
79	Dr. JJ Lyimo	Arusha X-Ray Center	Owner
80	Michaela K. Msellemu	Upendo Dispensary	Owner
81	Neema Mushi	Boma Healthcare Facility	
Health Financing			
1	Mr. Maligo	PharmAccess	
2	Geert Haverkamp	PharmAccess	Program Director, Tanzania
3	Jan van den Hombergh	PharmAccess	Country Director, Tanzania
4	Akil Akberali	PharmAccess	Senior Finance Manager
5	Ryan Lynch	MicroEnsure	General Manager
6	Haroun Maarifa	Health Focus	
7	Eugene Mkongoti	National Health Insurance Fund	
8	Susan Leon	Strategis Insurance	
9	Andrew Park	GSA Consulting/KfW	
10	Gaston Kikuwi	VIBINDO	
11	Sister Ritta	Tanzania Network for Community Health Funds	
12	Kidani Magwila	Tanzania Network for Community Health Funds	
13	Mr. Mtulia	National Social Security Fund	

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Table A.1 Key Stakeholder List *(continued)*

No.	*Name*	*Organization*	*Title*
14	Tabia Massudi	AAR Insurance	
15	Kai Straehler Pohl	GIZ	Health Financing Officer
16	Gradeline Minja	DANIDA	Program Officer Health, HIV and AIDS
17	Josselin Guillebert	CIDR	
18	Sally Lake	MOHSW	Sr. Advisor, Health Policy, Planning and Management
19	Bjarne Jensen	Health Sector Reform Secretariat	Senior Health Advisor
Councils and Associations			
1	Dr. Berezy Makaranga	APHFTA	Non-Communicable Diseases Coordinator
2	Mr. Samson Chemponda	Tanzania National Business Council	
3	Dr. Samwel Ogillo	APHFTA	Director
4	Mr. Richard Kasesela	Pan African Business Council	
5	Elizabeth Shekalage	Association of Pharmacists	
6	Geofrey Mabuba	APHFTA	HIV/AIDS Coordinator
7	Ms. Kapesa	PRINMAT	
8	Advocate Palloty Luena	Medical Council of Tanzania	Registrar
9	Dr. Moyo	Nurses Council	Registrar
10	Mr. David Sabas	Medical and Laboratory Scientists Association of Tanzania	
11	Dr. Vincent Assey	Medical and Laboratory Scientists Association of Tanzania	
12	Ms. Kinyawa	Pharmacy Council	Registrar
13	Dr. Namala Mkopi	Medical Association of Tanzania	
14	Dr. Maegga	Tanzania Public Health Association	Executive Secretary
Service Delivery and Supply Chain			
1	Mr. Jeroen Van't Pad Bosch	Elizabeth Glaser Pediatric AIDS Foundation	Country Director, Tanzania
2	Ms. Shayo	Cardinal Rugwamba Hospital	Head of Administration
3	Mr. Jovin Tesha	PASADA	Director of VCT
4	Mrs. Parul Chhaya	TMJ Hospital	Director and CEO
5	Dr. Tayab Jafferji	TMJ Hospital	Owner
6	Dr. G Upunda	TMJ Hospital	Director, Diagnostic Services
7	Dr. Walter Ngonyani	Walter Hospital	Owner
8	Dr. Frank	Miko Kasorobo Dispensary	Owner
9	Dr. Rukanzibwa	Safina dispensary	Owner
10	Dr. Hery Mwandolela	Heameda Medical Clinic	Administrator
11	Dr. Antony Petros	Kinondoni B Dispensary	Owner
12	Mr. Lufunyo Muungi	Kinondoni Hospital	Administrator
13	Monica Gidfrey	Kinondoni Hospital	
14	Sr. Pendo Mkwandawire	Kinondoni Hospital	
15	Michael Komba	Kinondoni Hospital	
16	Dr. Adam Mambosho	Mandela Dispensary	Owner
17	Dr. Arcard Kalahashanga	Arafa Mhagala Rangi Tafu Dispensary	Owner

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Table A.1 Key Stakeholder List *(continued)*

No.	*Name*	*Organization*	*Title*
18	Dr. Godfrey Kayombo	G.E. Dispensary	Owner
19	Mr. Msoka	Mikumi Hospital	Administrator
20	Dr. Kaushik	Hindul Mandal Hospital	
21	Joseph Mgaya	Medical Stores Department	Director General
22	Dr. Marina Njelekela	Muhumbili National Hospital	Director General
23	Dr. Abdul Ally	St. Magdalena Dispensary	Owner
24	Mr. Peter Maduki	Christian Social Services Commission	Executive Director
25	Mr. David	Pyramid Pharmacies	Chief Pharmacist
26	Dr. Wills Mbawala	PATH	
27	Mr. Kalpesh	A-Z Textiles	CEO
28	Mr. Ramadhani Madabida	Tanzania Pharmaceutical Industry	CEO
29	Chris Wright	SCMS	
30	Benjamin Mukera	Sumeria Mission Pharmacy	Owner
31	Evance Ongara	Coca-Cola	
32	Mr. Romanus	PSI	Executive Director
33	Sonya	CHAI	
34	Ms. Narelle Magee	MSI	Director of Business Operations
35	Dr. Adeline Kimambo	Tanzania Public Health Association	Chairperson
36	Mr. Leonard Richard	PASADA	Director of HR
37	Dr. Chrispine Kimario	Elizabeth Glaser Pediatric AIDS Foundation	Associate Technical Director
Donors			
1	Gene Peuse	USAID	PPP Advisor
2	Duncan Onditi	CIDA	
3	Dr. Oberlin Kisanga	GIZ	
4	Claudia Kowald	GIZ	PPP Advisor
Private for-Profit Medical Training Institutions (April 2012)			
1	Peter Maduki	Christian Social Services Commission	Executive Director
2	Rehema M. Shambwe	CRDB Bank PLC	Sr. Relationship Manager - SME
3	Tory Ervin	Touch Foundation	Head of External Affairs, Tanzania
4	Lefani Yakobe	General Manager- Finance	Akiba Commercial Bank Ltd
5	Dr. Samwel Ogillo	The Association of Private Health Facilities in Tanzania	Chief Executive Officer
6	Mjule Ndege	Banc ABC	Branch Manager
7	Prof. Joseph K. Shija	International Medical and Technological University	Vice Chancellor
8	Prof. Sifuni Ernest Mchome	Tanzania Commission for Universities	Executive Secretary
9	Prof. Keto E. Mshigeni	Hubert Kairuki Memorial University	Vice Chancellor
10	Mwajuma Shaban Mbaga	Banc ABC	Relationship Officer
11	Geert Haverkamp	PharmAccess Foundation	Programme Director Tanzania
12	Asangye N. Bangu	Higher Education Student Loan Board	Director of Planning, Research and ICT
13	Elibariki Masuke	CRDB Bank PLC	Manager, Business Banking
14	Prof. Magishi Nkwabi Mgasa	Tanzania Commission for Universities	Deputy Executive Secretary

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Table A.1 Key Stakeholder List *(continued)*

No.	*Name*	*Organization*	*Title*
15	Lazaro M. Malili	Ministry of Education and Vocational Training	Project Coordinator, Science Technology Higher Education Project
16	Timothy N. P. Manyaga	National Council for Technical Education	Deputy Executive Secretary, Registration and Accreditation
17	Fordson Musingarabwi	Banc ABC	Country Head, Credit Risk
18	Dr. Mariam Ongara	PPP TWG	Chairperson
19	Gene Peuse	USAID	PPP Advisor
20	Dr. Gilles de Margerie	Canadian Cooperation Office	Senior Health & HIV/AIDS Advisor
21	Jennifer Macias	Tanzania Human Resources Capacity Project	Country Director
22	Angela Makota	CDC/Tanzania	
23	Susan Clark	CDC/Tanzania	
24	Mama Mwakalukwa	HRH TWG	Chair
25	Clair Stokes	PSI Tanzania	Director, Reproductive Health
26	Dr. Muta	MOHSW	Acting Director, Human Resources for Health

Source: World Bank data.

APPENDIX B

Validation and Prioritization Workshop Summary

Background and Workshop Objectives

At the request of the Tanzanian PPP-TWG, IFC's HIA initiative and the USAID-funded SHOPS Project jointly financed and conducted an assessment of mainland Tanzania's private health sector in May 2012. Although USAID has supported PSAs in over 25 countries, this effort represented the first time that a government had officially requested, and contributed financially, to such an assessment. As such, from the beginning, the PSA was a truly collaborative effort between the PPP-TWG, USAID, and IFC. Based on several rounds of discussion between these three groups, the assessment team looked at several key health areas and health system building blocks with the goal of developing actionable recommendations for better leveraging the private health sector and building public-private partnerships for health. Key health areas included HIV/AIDS, reproductive and child health, TB, and malaria. Key health system building blocks included the policy and private sector enabling environment, private sector service delivery, human resources for health and private medical training institutions, the private sector pharmaceutical and medical commodity supply chain, and health financing.

After the two-week data collection trip in May, the assessment team spent several months writing and editing their report, incorporating feedback from internal and external reviewers at USAID, the World Bank, and the PPP-TWG. On November 14 and 15, 2012, the PPP-TWG, with support from the assessment team and IFC, convened a stakeholder workshop titled *Towards Increased Public-Private Cooperation in Health: Findings from the Tanzania Private Health Sector Assessment and Mapping of Health Services* at the Hyatt Kilimanjaro in Dar es Salaam, Tanzania. The day-and-a-half event consisted of an evening opening ceremony and welcome reception on the 14th and full-day workshop on the 15th. With representatives from the public sector, the private sector (both PNFP and PFP), development partners, and implementing agencies, the

assessment team sought to receive feedback on its findings, prioritize its recommendations, and reach consensus on the next steps to increase public-private cooperation in health.

Opening Ceremony

On November 14, 32 representatives from the assessment team, the PPP-TWG, the MOHSW, the MOF, private sector associations, development partners, and implementing agencies gathered to open the workshop. Dr. Donan Mmbando, Chief Medical Officer for the MOHSW, presided over the opening ceremony, with support from Dr. Frank Mhilu, PPP Commissioner at the MOF; Dr. Samwel Ogillo, CEO at APHFTA; Dr. Khama Rogo, Lead Health Specialist and Head of IFC's Health in Africa initiative; and Ms. Susna De, Senior Policy and Health Systems Strengthening Advisor at USAID/Tanzania. The various speakers shared their insights on the PSA and the role that this effort might play in advancing public-private cooperation in health in Tanzania now and into the future. Dr. Mhilu emphasized that utilizing the private sector was "key" to moving the Tanzanian health sector forward. Dr. Ogillo remarked on how far Tanzania has already come in terms of public-private engagement, saying that "[t]his kind of cooperation was a dream just five years ago." While other the speakers reiterated that same point, Dr. Rogo emphasized that the assessment and the workshop were only the first step. Drawing on his vast experience on public-private engagement across east Africa, he stated, "[f]or Tanzania's health goals to be achieved, 'business as usual' will not be enough. We hope that the PSA and companion report will be the match stick that ignites innovation in the health sector.

Assessment Findings and Recommendations

On November 15, Dr. Mariam Ongara, head of the PPP-TWG, welcomed 45 participants from the MOHSW, MOF, district and regional health offices, private associations, PNFP and PFP sectors, and development partners as they gathered to review the PSA's findings and recommendations. Following Dr. Ongara's welcome, Barbara O'Hanlon, Senior Policy Advisor with the SHOPS Project and colead for the PSA, and Andrew Kitua, a consultant with NIMR, led the morning sessions. Ms. O'Hanlon first presented a short summary of the PSA's key findings and recommendations for each of the health system building blocks. Mr. Kitua, who is leading NIMR's efforts to comprehensively map the Tanzanian health sector—including both public and private health facilities—presented his methodology, literature review, and the preliminary results from the qualitative portion of his assessment.

Following these presentations, participants split up into groups based on their areas of expertise: service delivery/human resources for health, health financing, supply chain, and policy. Each group took a more in-depth look at their sections

Table B.1 Prioritized Recommendations by Health System Building Block

Building block	*Prioritized recommendations*
Enabling Environment	1. Strengthen country capacity to provide quality health goods and services
	2. Establish and strengthen PPD institutions and processes
	3. Address barriers to access to finance
Health Service Delivery	1. Develop policy to clearly guide public/private harmonization of diagnostic equipment, possibly through a contracting or reimbursement mechanism
	2. Pursue opportunities for increased PPPs in nonclinical facility services (for example, waste disposal, cleaning)
	3. Revise guidance on composition of CHMT to facilitate dialogue with the private sector
Human Resources for Health	1. Expand opportunities to second public sector staff to PFP facilities
	2. Strengthen private facility management to attract and retain staff
	3. Incorporate PMTI into broader private health sector strengthening efforts
Pharmaceuticals and Supply Chain	1. Consolidate number of suppliers to achieve economies of scale (for example, with respect to price, quality, quantity, range of commodities)
	2. Streamline procurement process, enabling procurement entities to purchase private products. This would include identifying and prequalifying suppliers, increasing flexibility of funds, and allowing parties to enter into procurement agreements.
	3. Strengthen pharmacies and ADDOs through networking and/or franchising
Health Financing	1. Clarify roles between NHIF, NSSF, CHF, and user fees
	2. Prioritize contracting to private providers
	3. Increase access to long-term capital and other forms of finance

Source: World Bank data.

of the report, validating and clarifying the key findings and prioritizing the recommendations. As part of this discussion, participants also attempted to reach a consensus on the immediate next steps to address the identified challenges and promote greater collaboration and partnership between the public and private health sectors. When they finished this internal conversation, each group presented their top three recommendations to the larger group (table B.1 summarizes this output).

After each group finished presenting, the entire collection of stakeholders voted on the ones listed above to prioritize the top five action steps going forward. The resulting short list of activities included the following:

1. Clarifying roles and improving linkages between existing health insurance schemes and user fees. Potential steps include the following:
   - Consider merging SHIB into NHIF.
   - Open CHF to private providers.
   - Leverage CHF grass roots presence with NHIF's strengths as an insurance provider.
   - Rationalize membership, reimbursement rates, and benefit packages across insurance schemes.
   - Increase access to capital for private sector service providers, including long-term financing and other innovations such as equipment leasing.
2. Establish an effective platform and processes for public-private dialogue at all levels of the health system (national, regional, district).

3. Strengthen national/country capacity to effectively regulate, supervise, support, and assure quality of private health services and products.
4. Incorporate private medical training institutions into broader human resources for health planning (originally was broader private sector health strengthening, but this seems to make more sense in a HRH context).
5. Prioritize contracting out with private providers at the district level to make use of underutilized/nonoperational public facilities.

Other activities that received a large number of votes but did not make the top five included harmonizing public-private use of diagnostic equipment and improving access to finance for private health facilities.[1]

Conclusion

Dr. Rogo and Dr. Hasim, Chairman of APHFTA, closed the workshop with a call to action. Summarizing the day's discussion, Dr. Rogo noted the palpable commitment on the part of public and private health stakeholders to increase cooperation between the sectors for the benefit of Tanzanian citizens. In order to place the workshop and the PSA in a larger context, he asked, "Why are we here? We are committed to improving the health of the population, and to preventing deaths due to preventable causes. If by working together, the public and private health sectors can save those lives, this is worth doing."

Dr. Hasim offered concluding remarks to end the day. He observed that the participation and commitment of key stakeholders representing both the public and private health sectors would not have been possible, even five years ago, and is a "dream come true" for him personally. "The Private Health Sector Assessment demonstrates the remarkable progress that has been made in Tanzania, and I am thankful to SHOPS and IFC for making this possible." Overall, the event provided an opportunity for constructive dialogue on Tanzania's continued efforts toward greater private health sector engagement and related health sector reforms to strengthen the Tanzanian health system.

Participants

Table B.2 lists all of the stakeholders who attended the opening reception, the full-day workshop, or both.

Table B.2 Session Participants

No.	*Name*	*Organization*	*Title*
Public Sector: Ministries and Government Agencies at the National Level			
1	Andy O'Connoll	MOHSW	PPP Advisor
2	Dr. Budeba S.M.	MOHSW	PMO-DCS
3	Dr. Donan Mmbando	MOHSW	CMO
4	Dr. Edwin Mung'ong'o	MOHSW	Assistant Director
5	Dr. F.M.H. Mhilu	Ministry of Finance	Commissioner
6	Dr. M.E. Mhando	MOHSW	Director, Curative Services
7	Dr. Mariam Ongara	MOHSW	PPP Head
8	Dr. Patrick Mundunda	MOHSW/NACP	Acting PM-NACP
9	Sally Lake	MOHSW	Advisor PPM
10	Savinas Marouge	Tanzania Commission for Universities	DAQ
11	Simon Ernest	MOHSW	HS-DCS
12	Sylvester Matandibeo	Medical Stores Department	
Public Sector: Health Financing			
13	Dr. Masanja	NHIF	Director - Donor Funded Projects
14	Eugene Mkongoti	NHIF	Director General
15	Hamisi Mdee	NHIF	Deputy Director General
Other Public Sector			
16	Andrew Kitua	NIMR	Consultant
Parliament of Tanzania			
17	Anna Mwaga	Pwani RHMT	Acting RMO
18	Dr. Agnes Duchwa	Mbeya RMO	Acting RMO
19	Dr. Mtumwa S. Mwako	Kilimanjaro Region RHMT	RMO
Private Sector: Access to Finance			
20	Lilian Bulengo	MASSA-Banking Consultants	Principal Director
Private Sector Associations			
21	Adam Zuku	TCCIA	Sr. Chamber Development Officer
22	Adeline Kimambo	TPHA	Chairperson
23	Dr. Hashim	APHFTA	Chairman
24	Issuja Kilian	Benjamin William Mkapa HIV/AIDS Foundation	PO HRH Management
25	Novest Matee	PRINMAT	HR
26	Sabas M. Mrina	MELSAT	President, MELSAT
27	Said Mpendu	BAKWATA	Technical Advisor
28	Samwel Ogillo	APHFTA	CEO
29	Upendo Nduyam	Association of Tanzania Employers	HIV/AIDS Coordinator
Private Sector: Services and Products			
30	Mrs. Parul Chhaya	TMJ Hospital	Director, CEO
Private Sector: Private Medical Training Institutions			
31	M.J. Karoma	Herbert Kairuki Memorial University	Advisor

table continues next page

Table B.2 Session Participants *(continued)*

No.	*Name*	*Organization*	*Title*
Development Partners			
32	Abdul Omar	World Bank	Advisor
33	Barbara O'Hanlon	SHOPS	Senior Policy Advisor
34	Bernard Olayo	IFC	PO-Health
35	Claudia Kowald	GIZ	PPP Advisor
36	Dan Kasirye	IFC	IFC Representative
37	Emmanuel Malangalila	World Bank	SHS
38	Gene Peuse	USAID	PPP Advisor
39	Gradeline Minja	DANIDA	PO
40	Inge Baumgarten	GIZ	
41	Jorge Coarasa	IFC	
42	Kai Straehler-Pohl	GIZ	Health Financing Advisor
43	Khama Rogo	IFC	Head, Health in Africa Initiative
44	Meinholf Kuper	GIZ	Advisor
45	Oberlin Kisanga	GIZ	PPP Advisor
46	Sara Sulzbach	SHOPS	HIV/AIDS Advisor
47	Susna De	USAID	Health
48	Zacharia Lema	GIZ	
49	Zohua Balsava	USAID	Health
Implementing Agencies			
50	Andrew Swionkor	World Health Partners	Director
51	Jan van den Hombergh	PharmAccess	Country Director
52	Jared Elling	PATH	
53	Jennifer Macias	Intrahealth/Capacity +	Country Director
54	Josephine Msambichaka	PSI Tanzania	Director of Social Franchising
55	Karen Pak Oppenheimer	World Health Partners	Vice President
56	Laura Kelley	CHAI	Program Manager
57	Mohammed Mazame	PATH	CPL
58	Ulla Muller	MSI/Tanzania	Country Director
59	Walter J. Mlay	Action Medeor	Head, QA

Source: World Bank data.

Note

1. On November 16, the PPP-TWG met to further discuss these prioritized recommendations and the results of the PSA. Their Top Five list was relatively similar. However, instead of incorporating PMTI and harmonizing diagnostics/equipment usage, they voted to strengthen pharmacies and ADDOs through networking or franchising and to address HRH shortages more broadly.

APPENDIX C

Health Sector Roles and Responsibilities

Table C.1 Health Sector Roles and Responsibilities

	Organization	*Primary roles related to health*
Government of Tanzania (Mainland)	***Parliament***	
	Social Services Committee	Oversees the health sector budget and annual audit reports
	PPP Structure Across Government	
	Prime Minister's Office/Private Sector Development and Investment	Develops policies and guidelines to facilitate investment in the private (and private health) sector in Tanzania
	Tanzania Investment Centre/PPP Coordinator	Promotes and advises the government on investments in PPPs
	Ministry of Finance/PPP Unit	Regulates, finances, manages, advises, and promotes PPP programs
	Ministry of Health and Social Welfare	
	Department of Policy and Planning	Guides health policy formulation, implementation, monitoring, and evaluation
	Directorate of Preventive Services	Focus on the provision of health services in key areas. Includes the National AIDS Control Program, the National Malaria Control Program, Reproductive and Child Health Program, TB/Leprosy Program and other national health programs
	Directorate of Human Resources for Health (DHRH)	Oversee human resources policy on training and development focusing on strategic plans, curriculum development/revision, and provision of health learning materials and examinations
	Directorate of Curative Services	Focuses on policies and overseeing of curative services provided at National referral hospitals, regional referral hospitals, FBO hospitals, and private hospitals
	Directorate of Administration and Personnel (DAP)	Deals with recruitment and distribution of health personnel in collaboration with PO-PSM and PMO-RALG; processes staff promotion and salary adjustments.
	Chief Medical Officer's Office	Coordinates health service delivery across the country. Includes the Preventative Services Division, the Curative Services Division, the Human Resources Development Division, and the Health Quality Assurance Unit

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Table C.1 Health Sector Roles and Responsibilities *(continued)*

	Organization	*Primary roles related to health*
Government of Tanzania (Mainland)	Regulatory Bodies	Register, inspect, and supervise public and private health facilities and providers. Includes the Registrar of Private Hospitals, the Medical Council of Tanganyika, the Pharmacy Board, the Private Health Laboratories Board, the Tanzania Nurses and Midwives Council, the Tanzanian Food and Drug Authority, and so on.
	Medical Stores Department	Procures and provides drugs and medical supplies to all public and some private health facilities
	Tanzania Food and Nutrition Centre (TFNC)	
	Tanzania Food and Drug Authority (TDFA)	
Government of Tanzania (Mainland)	Government Chemistry	
	National Health Insurance Fund (NHIF)	
	Public Health Facilities	Includes dispensaries, health centers, district hospitals, regional hospitals, and referral/consultant hospitals
	National Institute for Medical Research	Conducts and regulates medical research in Tanzania
	Prime Minister's Office	
	PMO-RALG	Charged with facilitating decentralization by devolution. Coordinates with local government authorities, including the Council Health Service Board, the Council Health Management Teams, the Regional Health Management Teams, and others that oversee health service delivery at the district and regional level
	Tanzania Commission on AIDS (TACAIDS)	Coordinates the national response to the HIV/AIDS epidemic
	Regional Secretariats	Oversee regional hospitals and coordinate health services through the Regional Health Management Teams
	Councils/Local government authorities (LGAs)	Provide primary health care and oversee district hospitals through the Council Health Management Teams. Contract with private health care providers for service delivery through the Council Health Service Boards and Council Health Planning Teams.
	MoE and Vocational Training	
	National Council for Technical Education	Focus on registration and accreditation, including monitoring education quality for both public and private technical training institutions, including those for health sector
	Tanzania Commission of Universities (TCU)	Focus on registration and accreditation, including monitoring education quality for both public and private universities (including medical schools)
	Health Financing Schemes	
	MOHSW and others	Multiple schemes, including NHIF, CHF, TIKA, and NSSF
Private not-for-profit	Christian Social Services Commission (CSSC)	Umbrella organization for Christian, faith-based health facilities in Tanzania
	BAKWATA	Umbrella organization for Muslim, faith-based health facilities
	Sikika	Advocacy and policy dialogue NGO that focuses on health governance and finance, HRH, and medicines and supplies

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Table C.1 Health Sector Roles and Responsibilities *(continued)*

	Organization	*Primary roles related to health*
Private not-for-profit	Twaweza	
	Association of Private Health Facilities–Tanzania (APHFTA)	Umbrella organization for private commercial health facilities in Tanzania
	Professional Health Associations	Representative bodies that advocate for HRH cadres and advise the government on health policy. Includes the Medical Association of Tanzania, Tanzania Public Health Association, Medical Laboratory Scientists Association of Tanzania, PRINMAT, and the Tanzania Association of Pharmaceutical Industries among others.
	Tanzania Association of NGOs (TANGO)	Umbrella organization for NGOs. Focuses on capacity-building and policy engagement.
	Tanzania Gender Networking Association	
	Mission for Essential Medical Supplies (MEMS)	Drug and laboratory supply procurement system for faith-based facilities in northern Tanzania
	Faith-based and nonprofit health facilities	Includes dispensaries, health centers, and hospitals; also includes international partners like Marie Stopes International and PATH
	Faith-based health training institutes	Includes Bugundo University College of Medical Sciences and Kilimanjaro Christian Medical College, including allied health and nursing training schools
Private for-profit	Private health training institutes	Includes Hubert Kairuki Memorial University and the International Medical & Technological University including for-profit allied health and nursing institutions
	Private commercial health facilities	Includes dispensaries, health centers, hospitals, pharmacies, drug store/ADDO, laboratories and clinics
	Pharmaceutical wholesalers	Procure and provide drugs and medical supplies for private facilities and pharmacies. Include Pyramid, Salama, and General Pharmacy, among others
	Medical insurance	Private companies including Strategies, Jubilee, and AAR
Business	AIDS Business Coalition Tanzania	Supports businesses with the development and implementation of HIV/AIDS workplace programs
	Pan African Business Council	Provides training and support for HIV/AIDS workplace programs
	CSR	Coca-Cola and other companies have workplace wellness programs
	Tanzania National Business Council	Supports the development and implementation of workplace wellness programs
	A-Z Textiles	Textile manufacturer that produces bed nets. Based in Arusha.
	Tanzania Pharmaceutical Industry	Drug (and ARV) manufacturer based in Arusha.
Development partners	***Bilaterals***	
	GIZ	Funds programs and training in key health areas (HIV/AIDS, family planning, malaria) in the public and private sector
	DANIDA	Funds programs in key health areas and provides support on health financing
	USG—USAID/PEPFAR	Funds programs in key health areas and supply chain management
	Norwegian Agency for Development Cooperation	Funds programs in key health areas
	Netherlands Ministry of Development Cooperation	Funds programs in key health areas
	CIDA	Funds programs in key health areas
	SIDA	Funds programs in key health areas
	Irish Aid	Funds programs in key health areas

table continues next page

	Organization	*Primary roles related to health*
Development partners	***Multilaterals***	
	Global Fund	Funds programs and training in key health areas (HIV/AIDS, TB, malaria)
	UNICEF	
	UNFPA	
	World Bank	
	UNAIDS	
	International NGOs	
	CHAI	Funds programs and training in HIV/AIDS
	AMREF	
	FHI	
	CARE	

Source: World Bank data.

APPENDIX D

PPP Policy Framework and Organizational Structure in Tanzania

General PPP Policy Framework

In the last five years, the Tanzanian government has put into place the policy and legislative framework supporting a greater private sector role in the Tanzanian economy. Below is a summary of the general public-private partnership (PPP) framework.

Public-Private Partnership Policy

In 2009, the Tanzanian government passed the National PPP Policy. The government recognizes that a PPP is *a viable mechanism to address financing, management and maintenance of public goods and services* (National PPP Policy, ii). The Tanzania government firmly believes that creation and operation of an enabling environment will guide the public and private sectors, donor community, and other stakeholders in PPPs to achieve the socio-economic goals outlined in Vision 2025. The National PPP Policy acknowledges that past experience in PPPs has been limited and ad hoc in nature and identifies the health sector as leaders in PPPs with its experience in using SLAs.

The policy lays the foundation legislation and maps out actions needed to realize PPPs, many of which have already been accomplished or are in progress. Key elements include (1) creating an enabling environment through legislation and guidelines (see below); (2) establishing the institutional framework (see chapter 3); (3) putting into place instruments (for example, contracts, leases, concessions, design-build-operate) to incentivize private sector investment; (4) operational guidelines to determine a PPPs technical, financial, economic, and social viability; (5) building public sector capacity to identify, assess, procure, manage, and monitor and evaluate PPPs; and (6) raising awareness through a communication strategy among public and private sectors as well as the general public on the benefits of PPPs.

A unique feature of the Tanzanian National PPP Policy is its broad range of PPP mechanisms. Most African PPP Policies and Acts concentrate almost exclusively

Box D.1 PPP Models

Service Contract: Government contracts private entity to perform specific service that the public sector normally performs. In Tanzania health sector, this form of contract is called an SLA.
Management Contract: Government contracts a private entity to operate, maintain, and manage services of a public asset; in this case it could be a MOHSW health facility.
Lease Contract: Government grants a private entity a lease hold interest in a public asset in exchange for the private entity operating and maintaining the asset in accordance with the terms of the lease. A lease can be used for health facilities and/or equipment.
Concession: Government grants a private entity the exclusive right to provide services as well as operate and maintain a public asset over a long period of time. For example, a private laboratory can either lease (for a shorter time frame) or receive a concession to take over all laboratory functions in a public hospital including remodeling, equipping and supplying, staffing, and performing lab analysis in exchange for charging a below market price and keeping the revenue.

Source: National PPP Policy, 1.

on infrastructure PPPs (for example, Design-Build, Design-Build-Operate, Build-Operate-Transfer, Build-Lease-Transfer, Design-Build-Finance-Operate/Maintain, Build-Own-Operate, and Buy-Build-Operate). The Tanzania National PPP Policy includes these types of PPPs *but also allows for other PPP models* critical to achieving access, efficiency, equity, and quality in the health sector, such as service contracts, management contracts, leases, and concessions (See box D.1 for more definitions).

Another unique characteristic of the National PPP Policy is government understanding that the private sector may not be interested all PPPs, particularly when a private entity cannot make the business case (for example, recoup investment and earn a nominal profit). A classic example in health would be contracting out for private providers to build, staff, and maintain a health facility in a remote area, where the target population is unable to pay. In this case, the National PPP Policy allows the contracting authority to offer special compensation in addition to reimbursement for the services to encourage private sector investment in services and areas (remote, rural, poor, preventive services) that they normally would not consider.

Public-Private Partnership Act, 2010

The Act was passed in 2010 empowering government agencies to enter into PPPs with the private sector in a variety of sectors including health. The Act also created the institutional framework, the PPP Coordinating Unit and the PPP Units in each of the sectors to implement PPPs.

Public-Private Partnerships Guidelines

The PSA team interviewed the staff person in the PMO responsible for drafting in PPP guidelines. They contracted an outside firm that produced a first draft

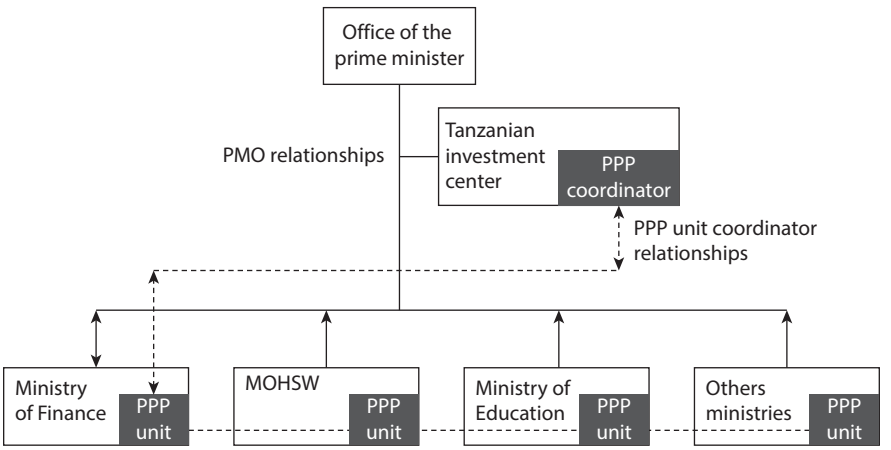
which is currently under internal review. The next step will be outside consultations on the guidelines. The guidelines cover (1) instructions to formulate, appraise, approve, and negotiate PPPs; (2) government capacity to advise and assist different public agencies working on PPPs; (3) sources of financing for PPPs; (4) tendering procedures; (5) risk management; (6) accountability and reporting rules; and (7) investor's guide.

Structure to Implement General Public-Private Partnerships

The 2009 PPP Act created the institutional framework for PPPs in all aspects of the Tanzanian economy. Figure D.1 illustrates the new relationships and organizational structures to implement the PPP Act. The PMO, through the PPP Act, sets the vision and strategic directions for PPPs throughout the economy. Its main functions are as follows: (1) build government capacity to partner with the private sector; (2) foster private sector interest in and create capacity in PPPs; (3) build public support for PPPs; and (4) create a favorable legal and regulatory framework for PPPs.

The PMO has taken several steps to achieve its mandate. First and foremost, it has succeeded in passing the PPP Act and is now in the process of completing PPP guidelines. The PMO has completed a first draft that will be available for comment shortly. In addition, the PMO, in coordination with the MOF, uses the annual budget process to determine the level (in Tanzanian shillings), type, and priorities (for example, sector); the Tanzanian government has allocated an unprecedented amount of government funds to carry out PPPs. Additionally, the PMO has authorized the TIC to build government capacity to implement PPPs and to review all PPP proposals. In addition to working closely with TIC, the PMO also coordinates with the MOF, which has a fiduciary role in reviewing all PPPs. Ultimately the PMO is responsible for managing and coordinating all PPPs between agencies and across ministries.

Figure D.1 General PPP Implementation Structure



Source: World Bank data.

Box D.2 Tanzania Investment Centre at a Glance

The Centre was established in 1997 by the Tanzania Investment Act No. 26 of 1997 to be "the primary agency of Government to coordinate, encourage, promote and facilitate investment in Tanzania and to advise the Government on investment related matters." TIC is a government agency with a high degree of autonomy and receives its funding from multiple sources: government, donor, and other income (generated by fees and advisory services).

TIC is the focal point for investors; it is a "one stop facilitative centre for all investors." TIC produces promotional materials, market analysis and investment guides.

TIC has established Zonal offices in Kilimanjaro, Mwanza and Mbeya. The Zonal offices are responsible for assisting investors to obtain all relevant permits, approvals, and licenses they require in order to set up their business.

Source: www.tic.tz.org.

The TIC will become an increasingly important player in PPPs across all ministries and sectors in the Tanzanian economy (box D.2). In early 2012, TIC expanded its role by creating a PPP Office. The PPP Coordinating Unit's mandate is to bring the public and private sectors together across all ministries and sectors. This Coordinating Unit has a small staff, led by a PPP Senior Officer, and a substantial budget to carry out its mandate. The PPP Coordinating Unit's core tasks are as follows: (1) raise awareness on the benefits of PPPs, particularly among government line agencies and ministries; (2) foster PPD in key development areas; and (3) provide advisory services and strategic advice to ministry PPP Units.

TIC's PPP Coordinating Unit is currently working with all Ministries to encourage them to establish PPP Units. The PPP Coordinating Unit expects each Ministry PPP Unit to (1) build internal capacity on PPPs, (2) translate the PPP Act into regulations supporting PPPs, and (3) build a pipeline of PPPs. The PPP

Coordinating Unit has funds to help Ministries establish their respective PPP Units and is in the process of hiring a firm to provide training to all the newly formed PPP Units. Health is one of the first ministries, along with the Ministry of Finance, to establish a PPP Unit, and as a result is a priority for the PPP Coordinating Unit.

The PPP Coordinating Unit plays an advisory role for ministries and is available to assist a PPP Unit to identify, structure, vet, and monitor PPPs. In addition to advice, the PPP Coordinating Unit performs technical review and oversight. Once the PPP Unit has structured a PPP deal and it has been approved by the ministry leadership, then the PPP Unit submits all its PPP proposals to the PPP Coordinating Unit. The PPP Coordinating Unit analyzes the PPP proposal to ensure it is technically sound and compliant with the law and guidelines (that is, the PPP is well designed) and assumes that the PPP Unit has ensured that the PPP proposal aligns with the ministry priorities and is technically sound. It is important to note that the PPP Coordinating Unit does not have the authority

to reject a PPP proposal. Its role is strictly advisory and can only make recommendations to strengthen the proposal and to proceed (or not) with the PPP.

The PPP Unit must also submit all PPP proposals to the MOF. MOF oversight and review focus on risk, finances, and due diligence. Even though some of the PPPs may not require government financing, each and every one still must be submitted to the MOF for review. As noted before, the PPP Guidelines are in review and many of these details are under discussion.

General Public-Private Dialogue Forum

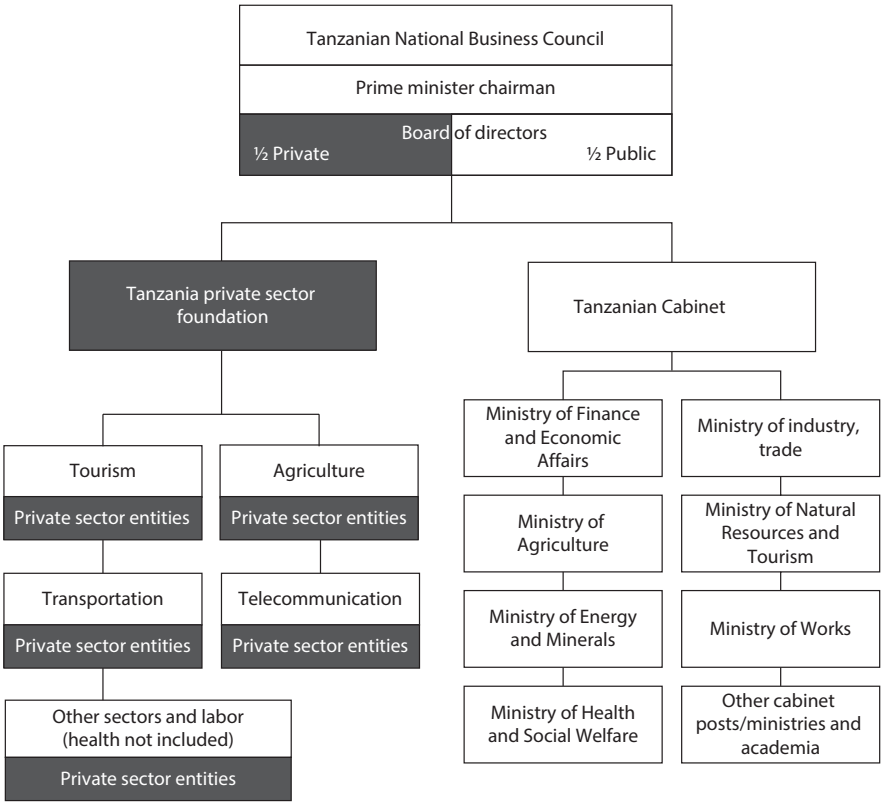
After 12 years of experience in a market economy, several important Tanzanian private sector entities realized the futility of competing with each other when dialoguing and working with the Tanzanian government to create better market conditions and encourage socio-economic development. In 1998, many Tanzanian companies came together to create the TPSF to iron out the differences within the private sector and to speak with one voice in dealing with the Tanzanian government. The TPSF promotes private sector-led social and economic development by (1) providing member services; (2) understanding and representing their common interest; and (3) engaging in effective advocacy with the Tanzanian government. Since its founding, the TPSF has served as the focal point for private sector advocacy and lobbying. The TPSF sponsors CEO Roundtables, forums, magazines, and e-Letters. Energy, infrastructure and business environments are TPSF's focus areas. (See figure D.2.)

The Tanzanian government recognized that its political success depended on how well it could mobilize the private sector. During the 1980s and 1990s, dialogue with the private sector was ad hoc, sometimes with little or no follow-up on decisions made. In 1999, the private sector, with government support, formed the TNBC through a presidential circular, as a mechanism for regular dialogue between the government and the private sector on socio-economic issues. The TNBC is the only forum where the president and entire Cabinet sit together with the private sector to discuss economic and development issues.

The TNBC aims to foster consensus and mutual understanding on strategic issues related to social and economic issues, reviews social and economic legislation, and proposes policy changes to enhance Tanzanian's market competiveness in the world market. The prime minister chairs the TNBC, and the government is represented by full Cabinet participation, including the MOHSW. The TNBC is managed by a Board that comprises 12 members—six from the public and six from the private sectors—that defines technical direction, sets the agenda, and proposes activities for the TBNC. Figure D.2 illustrates the relationship between the public and private sectors through the TNBC.

The TNBC comprises 40 members of equal numbers from the public and private sectors. The government nominates 20 members, including one from academia. The TPSF has an equal number and nominates representatives from different business sectors. One of the private sector representatives comes from the labor movement. The TBNC sponsors many forums. The Council meets twice a year and any member—public or private—can propose agenda topics, which are

Figure D.2 Public-Private Dialogue Structure for Tanzanian Economy



Source: World Bank data.

then approved by the Board. Common topics for Council meetings include investment climate, cost of capital, tax reform, and economic empowerment—all issues relevant to the private health sector. There are also four technical working groups (PPPs, business environment, private sector development, and land reform) that meet frequently to develop policy proposals and recommend strategies. Although the public side of health is represented by the MOHSW, the private health sector does not participate in the TNBC.

APPENDIX E

Summary of Findings on Financial Institutions

Table E.1 summarizes some of the key lending terms of the banks, aas well as the microfinance institutions interviewed and key findings.

Table E.1 Summary of Findings on Financial Institutions

Financial institution	*Branches*	*Currently lending in health sector*	*Interest in lending to health sector*	*Loan terms*	*Interest rates*
Commercial Banks					
Akiba Commercial Bank	15 total 3 branches outside Dar es Salaam	Not significant	Yes	*Tenor:* 3 years *Loan Size:* Business loan up to US$500,000 equivalent maximum. No minimum loan. *Collateral:* Loan value up to approx. $11,000 can use movable collateral and up to 75 percent collateral acceptable. Above $27,000 equivalent need 125 percent fixed collateral.	Up to $27,000 equivalent base rate is 20 percent Up to $11,000 equivalent base rate is 22 percent Solidarity lending base rate is 25 percent Origination fee=1 percent Credit insurance fee=1 percent Salary loans 19 percent base rate
Banc ABC	4 total 1 branch in Arusha	Yes, through Medical Credit Fund facility; 1 or 2 health loans outside of Medical Credit Fund facility	Yes	*Tenor SME:* maximum 4 years *Loan Size:* $250,000 equivalent maximum for SME; $2,000 equivalent minimum *Collateral:* 125 percent collateral but 50 percent can be movable collateral	SME loan 22 percent plus 1 percent origination and 1 percent utilization Consumer loan base rate is up to 26 percent plus fees

table continues next page

Table E.1 Summary of Findings on Financial Institutions *(continued)*

Financial institution	*Branches*	*Currently lending in health sector*	*Interest in lending to health sector*	*Loan terms*	*Interest rates*
CRDB	145 branches all over Tanzania	Not significant	Yes	*Tenor SME*: 5 years *Loan Size:* Maximum $270,000 equivalent with minimum at $540 *Collateral:* for any loan above $27,000 equivalent must have 50 percent of collateral be secured by real estate and collateral coverage is 154 percent may go down to 135 percent	Base rate SME loans is 20 percent Loan applications fees never over 2.5 percent
EXIM Bank	22 branches with 10 in Dar and other branches throughout Tanzania	Not significant	Yes	*Tenor SME:* Retail lending up to $27,000 equivalent 60 months; working capital other term lending 48 months *Loan Size:* Retail maximum is $27,000 equivalent then corporate lending. Minimum retail loan is $1,000 equivalent *Collateral:* Retail loans will be selective in regard to collateral for corporate loans must be fixed collateral at 125 percent of value	Retail: 18–20 percent Corporate 15 percent 2 percent origination. fee retail lending; 1 percent corporate Credit insurance 0.25 percent to 1 percent of loan amount (higher for retail credits)
NMB	145 branches all over Tanzania	Not significant	Yes	*Tenor:* 5 years SME; micro lending up to 24 months *Loan Size:* Maximum SME is $540,000 equivalent and minimum is $$4,000 equivalent. Micro loans up to $4000 equivalent *Collateral:* 125 percent collateral fixed but micro loans up to $270 can use movable collateral	Micro lending: 24 percent SME: 18 percent 1.5 percent origination fee
Microfinance Institutions					
Tujijenge	5 with 3 in Dar es Salaam	Yes, some clinics	Yes	*Tenor:* 2 years for individual loans *Loan Size:* 15 million max. ($8,100 equiv.) *Collateral:* 10 percent cash and 90 percent movable collateral	3 percent flat monthly 2 percent origination fee

Source: World Bank data.

APPENDIX F

Comparison of Key Health Metrics

Table F.1 Comparison of Key Health Metrics in Tanzania and Sub-Saharan Africa

Indicator	*Source of data*	*Tanzania*	*Year of data*	*Average value in Sub-Saharan Africa*	*Year of data*
Infant Mortality Rate (per 1,000 live births)	WDI—2011[a]	50.00	2010	67.52	2010
	DHS 2009/10[b]	60	2010	[b]	[b]
Under 5 Mortality Rate (per 1,000 live births)	WDI—2011	75.80	2010	205.17	2010
	DHS 2009/10	93	2010	[b]	[b]
Maternal Mortality Ratio (per 100,000 births)	WDI—2011	790	2008	568.89	2008
	DHS 2009/10	454	2010	[b]	[b]
Prevalence of HIV, total (percent of population, aged 15–49)	UNAIDS	5.60	2009	5.61	2009
Contraceptive Prevalence (percent of all women, aged 15–49)	WDI—2011	34.40	2010	47.14	2009
	DHS 2009/10	34.80	2010	[b]	[b]
Pregnant women who received 1+ ANC visit (percent)	UNICEF_ Childreninfo.org	76.00	2008	83.17	2008
	DHS 2009/10	97.7	2010	[b]	[b]
Total Fertility Rate (births per woman)	WDI—2011	5.56	2009	4.68	2009
	DHS 2009/10	5.4	2010	[b]	[b]
Unmet Need for Family Planning	DHS 2009/10	25.1	2010	[b]	[b]
Children under five years with diarrhea receiving oral rehydration	WDI—2011	53.00	2005	33.46	2005
	DHS 2009/10	65.4	2010	[b]	[b]
Children under five sleeping under an ITN (percent)	WDI—2011	63.80	2010	37.69	2009
	DHS 2009/10	63.9	2010	[b]	[b]
ART coverage among people with advanced HIV infection	UNAIDS	42.00	2010	34.81	2009
Pregnant women tested for HIV/AIDS during ANC (percent)	TUAPR-WHO	85.92	2010	48.85	2010
	DHS 2009/10	55.0	2010	[b]	[b]

Source: Health Systems 20/20 Database. Accessed July 16, 2012 from http://healthsystems2020.healthsystemsdatabase.org/datasets/CountryReports.aspx.

Note: WDI = World Bank Development Indicators; WHO = World Health Organization.

a. WDI numbers for entire United Republic of Tanzania, including Zanizibar.

b. DHS numbers are for only mainland Tanzania.

APPENDIX G

Kenya PPD Forum

Process: After a consultative meeting to discuss the Kenya PSA findings and recommendations, the Permanent Secretary of one of the two Ministries assumed leadership of the dialogue process. The Permanent Secretary took the first step and extended a formal invitation to approximately 25 high-level government offices, NGO/FBO leaders, and private sector representatives to participate in a meeting to design a PPD. The PSP-*One* project (USAID supported) organized and facilitated the one-day meeting, creating a "safe place" for the meeting participants to talk frankly about the current condition of PPD and how to move forward. By the end of the day, the meeting participants reached agreement on the structure of the PPD mechanism (PPD Outline), roles and responsibilities and the first-year activities (PPD Action Plan). Meeting results were documented in a report that all meeting participants signed off on, resulting in the formation of a PPD group called PPP-Health Kenya.

Each of the PPD partners returned to their respective organizations to build internal support and commitment for participating in the PPD. The PSP-*One* staff converted the PPD Outline into a "letter of intent" that was eventually signed by all organizations (MOH still pending). To continue building support, as a group, all the PPD partners debriefed the Permanent Secretaries of the two MOHs on multiple occasions, first promoting the purpose of the PPD, then moving on to describe the results of their joint activities. In addition, the PPD partners meet one-on-one with leaders and other influential actors within their respective sector—MOH partner meetings with MOH leadership; private sector partners meeting with a wide array of private sector groups through the private sector umbrella organization KEPSA, and NGO and FBO partners working through their respective umbrella organizations, HENNETT and CHAK, respectively. PPP-Health Kenya has also developed marketing materials to help create a positive image of PPPs in health and plan to formally launch the PPD in a signing ceremony at a press conference.

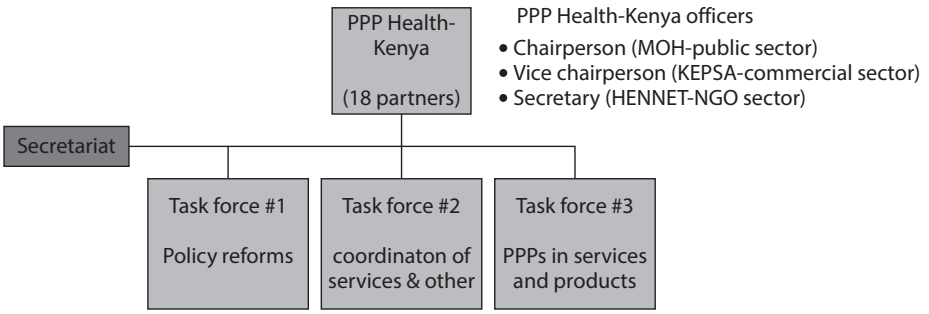
PPP-Health Kenya meets regularly to work on a range of policy as well as analytical activities. Both the SHOPS project (PSP-*One* follow-on) and the IFC *Health in Africa* initiative, continue to support the MOH's efforts to update the

Kenya Health Framework and streamline the Health Acts. In addition, SHOPS is assisting PPP-Health Kenya to take an active role in these two policy streams, ensuring the private sector has a seat at the table and its voice is heard in the policy reforms. PPP-Health Kenya is working with these two donors to create a PPP inventory, map private facilities, and do other analysis needed to identify PPP opportunities.

Building Blocks: The letter of intent codifies elements of PPD:

- **Formal Mandate:** Currently the 18 partner organizations have signed the Letter of Intent. Although a sufficient mandate, the partners are determined to have the MOH gazette the PPD to create legal recognition of this forum.
- **Realigned Institutions:** The letter of intent reflects the partners' shared vision on the PPD and its purpose. Moreover, the partners agreed on "rules of the road" on how they will interact and work with each other.
- **Organizational Structure:** As the diagram illustrates, PPP-Health Kenya created a simple structure—leadership group, secretariat, and working groups organized around the three core activities in the PPP Action plan. The SHOPS project serves as the secretariat for the PPD until it manages to locate its own funding. The structure also defined the PPD's linkages with other ongoing policy forums.
- **Equal/Fair Representation and Participation:** The partners agreed on equal participation with equal numbers of organizations from each sector. Moreover, the rules dictate the PPD leadership be shared and rotated among the three sectors (public, private, NGO/FBO). Decision making is designed to ensure a quorum and equal participation among the sectors. Finally consensus is defined as a 51 percent majority.

Partnership Broker: USAID has continued to support this effort by providing project funds through PSP-O*ne* and SHOPS to hire a local private health sector expert who facilitates the process, offers strategic advice, and conducts policy analysis needed to inform the meetings. The partnership broker has also been critical in smoothing relationships between the partners and helping "translated" between public health approach and private health business perspective.



Source: World Bank data.

Bibliography

Action Medeor. 2012. *Action Medeor International Healthcare Tansania* (accessed July 15, 2012), http://medeor.de/en/medeor-tanzania.html.

Barnes, Jeffrey. 2011. *Designing Public-Private Partnerships in Health*. Bethesda, MD: SHOPS Project, Abt Associates Inc.

Bold, T., J. Svensson, B. Gauthier, O. Maestad, and W. Wane. 2011. *Service Delivery Indicators: Pilot in Education and Health Care in Africa*. Nairobi: African Economic Research Consortium.

Boulenger, D., and B. Criel. 2012. *The Difficult Relationship between Faith-based Health Care Organisations and the Public Sector in Sub-Saharan Africa*. Antwerp: Studies in Health Services Organisation & Policy.

Bultman, J., J. L. Kanywanyi, H. Maarifa, and G. Mtei. 2012. *Tanzania Health Insurance Regulatory Framework Review*. Dar es Salaam: Ministry of Health and Social Welfare.

Center for Pharmaceutical Management. 2003. "Access to Essential Medicines: Tanzania, 2001." Prepared for the Strategies for Enhancing Access to Medicines Program, Management Sciences for Health, Arlington, VA.

Chee, Grace, Kimberly Smith, and Adolph Kapinga. 2002. *Assessment of Community Health Fund in Hanang District, Tanzania*. Bethesda, MD: The Partners for Health Reform*plus* Project, Abt Associates Inc.

COWI. 2007. "Local Government Reform Program—Embedding Decentralisation by Devolution Across Government." Assessment Report for the Ministry of Health and Social Welfare, Tanzania.

Dalberg Global Development Advisors. 2009. *Improving Access to Finance for the Private Health Sector in Tanzania*. Geneva: Dalberg.

Department of Policy and Planning, Ministry of Health and Social Welfare. 2012. *Tanzania National Health Accounts Year 2010 with Sub-Accounts for HIV and AIDS, Malaria, Reproductive, and Child Health*. Dar es Salaam: Ministry of Health and Social Welfare.

DHS. 2010. http://www.measuredhs.com/pubs/pdf/FR243/FR243[24June2011].pdf

Euro Health Group. 2007. *The United Republic of Tanzania Drug Tracking Study*. Denmark: Euro Health Group.

GIZ. 2011. *Partnership Landscape: Country Profile Tanzania*. Bonn: GIZ.

GTZ. 2007. *The Viability of Local Pharmaceutical Production in Tanzania*. Bonn: GTZ.

Government of Tanzania. 2005. "Business Activities Registration Act, 2005." Dodoma, Tanzania.

———. 2007. "HIV and AIDS (Prevention and Control) Bill." Dodoma, Tanzania.

———. 2011. "The Public Private Partnership Act of 2010." Dodoma, Tanzania.

Haazen, Dominic. 2012. *Health Financing Policy Note: Tanzania*. Washington, DC: World Bank, Human Development Department, Africa Region.

Health Management Information System. 2012a. *Number of Health Facilities in Tanzania*. Dar es Salaam: MOHSW.

———. 2012a. *Number of Medical Professionals in Tanzania*. Dar es Salaam: MOHSW.

Health Research for Action (HERA). 2005. *Technical Review 2005: Public Private Partnership for Equitable Provision of Quality Health Services*. Belgium: HERA.

Health Sector Reform Secretariat. 2003. *Resources Allocation Formula for Health Basket Fund*. Dar es Salaam: Ministry of Health and Social Welfare.

Health Systems 20/20. 2011. *Tanzania Health System Assessment Report*. Bethesda, MD: Abt Associates Inc.

———. 2012. Health Systems 20/20 Database (accessed July 16, 2012), http://healthsystems2020.healthsystemsdatabase.org/datasets/CountryReports.aspx.

Hilber, A. M, F. Kessy, and H. Ravelomanantsoa. 2009. *Community Based Health Initiatives Project Dodoma, Tanzania*. Basel: Swiss Centre for International Health.

HSSP III. http://www.unfpa.org/sowmy/resources/docs/library/R226_MOHTanzania_2009_HSSP_III.pdf.

International Monetary Fund (IMF). 2010. World Economic Outlook: Recovery, Risk, and Rebalancing (accessed March 27, 2012), http://www.imf.org/external/pubs/ft/weo/2010/02/index.htm.

Itika, J. S., O. Mashindano, and F. Kessy. 2011. *Success and Constraints for Improving Public Private Partnership in Health Services Delivery in Tanzania*. Dar es Salaam: The Economic and Social Research Foundation (ESRF).

Laterveer, L., M. Munga, and P. Schwerzel. 2004. *Equity Implications of Health Sector User Fees in Tanzania*. Leusden: ETC Crystal.

MEDA Economic Development Associates. 2009. *Tanzania National Voucher Scheme and Under 5 Catch-Up Campaign: Hati Punguzo*. Dar es Salaam: MEDA.

Makundi, E. A., L. E. G. Mboera, H. M. Malebo, and A. Y. Kitua. 2007. "Priority Setting on Malaria Interventions in Tanzania: Strategies and Challenges to Mitigates Against the Intolerable Burden." *The American Journal of Tropical Medicine and Hygiene* 77 (6, suppl.): 106–11.

Mapunda, B. T. 2005. *Review of Health Sector Legislation for the Development of Public-Private Partnerships in Tanzania*. Dar es Salaam: Ministry of Health and Social Welfare.

Mhamba, R. M., and S. Mbirigenda. 2010. "The Pharmaceutical Industry and Access to Essential Medicines in Tanzania." EQUINET Discussion Paper Series 83, Harre.

Ministry of Finance and Economic Affairs. 2011. *The Economic Survey 2010*. Dar es Salaam: MOF.

Ministry of Health. 1999. *Community Health Fund (CHF) Operation Guideline*. Dar es Salaam: MOH.

———. 2002. *Baseline Survey of the Pharmaceutical Sector in Tanzania 2002*. Dar es Salaam: MOH.

———. 2003. *National Health Policy*. Dar es Salaam: MOH.

———. 2004. *Survey of the Medicine Prices in Tanzania*. Dar es Salaam: MOHSW.

Ministry of Health and Social Welfare. 2007a. *Primary Health Services Development Program—MMAM 2007–2017*. Dar es Salaam: MOHSW.

———. 2007b. *National Health Policy*. Dar es Salaam: MOHSW.

———. 2008a. *Human Resource for Health Strategic Plan 2008–2013*. Dar es Salaam: MOHSW.

———. 2008b. *In-Depth Assessment of the Medicines Supply System in Tanzania*. Dar es Salaam: MOHSW.

———. 2008c. *Mapping of partners and financial flows in the medicines supply system in Tanzania*. Dar es Salaam: MOHSW.

———. 2008d. *The National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn, and Child Deaths in Tanzania 2008–2015*. Dar es Salaam: MOHSW.

———. 2009a. *Health Sector Strategic Plan III July 2009-June 2015: "Partnering for Delivering the MDGs*." Dar es Salaam: MOHSW.

———. 2009b. *Health Sector Performance Profile Report 2009 Update: Mainland Tanzania July 2008-June 2009*. Dar es Salaam: MOHSW.

———. 2009c. *National Health Laboratory Strategic Plan 2009–2015*. Dar es Salaam: MOHSW.

———. 2009d. *Public Private Partnership Strategic Plan 2010–2015*. Dar es Salaam: MOHSW.

———. 2010. *Assessment of the pharmaceutical human resources in Tanzania and the Strategic Framework*. Dar es Salaam: MOHSW.

———. 2011. *Assessment of the prices and availability of medicines for children in Tanzania*. Dar es Salaam: MOHSW.

Ministry of Health and Social Welfare HMIS. 2012. *Number of public and private health facilities in Tanzania*. Data requested from MOHSW, Dar es Salaam.

Ministry of Regional Administration and Local Government. 1998. *Policy Paper on Local Government Reform*. Dar es Salaam: MRALG.

Montorzi, G., S. de Haan, C. IJsselmuiden, and L. Mboera. 2009. *An Assessment of the Health Research System*. Geneva: Council on Health Research for Development (COHRED).

Mtei, G., and J. Mulligan. 2007. *Community Health Funds in Tanzania: A Literature Review*. London: Consortium for Research on Equitable Health Systems (CREHS).

Munishi, G. K., A. Yazbeck, D. Deroeck, and D. Lionetti. 1995. *Private Sector Delivery of Health Care in Tanzania*. Bethesda, MD: Health Financing and Sustainability Project, Abt Associates Inc.

Musau, S., G. Chee, R. Patsika, E. Malangalila, D. Chitama, E. Van Praag, and G. Schettler. 2011. *Tanzania Health System Assessment 2010*. Bethesda, MD: Health Systems 20/20 Project, Abt Associates Inc.

National AIDS Control Program (NACP). 2011. *National Guidelines for Quality Improvement of HIV and AIDS Services*. Dar es Salaam: Ministry of Health and Social Welfare.

National Bureau of Statistics and ICF Macro. 2000. *Tanzania Demographic and Health Survey1999*. Dar es Salaam: NBS and ICF Macro.

National Bureau of Statistics and Macro International. 2007. *Tanzania Service Provision Assessment Survey 2006*. Dar es Salaam: NBS.

National Bureau of Statistics (NBS) and ICF Macro. 2011. *Tanzania Demographic and Health Survey 2010*. Dar es Salaam: NBS and ICF Macro.

Private Sector Partnerships-*One*. 2009. *African Public-Private Partnership Units in Health: What Are They and What Do They Do?* Bethesda, MD: PSP-*One* Project, Abt Associates Inc.

Sikika. 2011. "Medicines and Medical Supplies Availability Report." Sikika, Dar es Salaam.

Strengthening Health Outcomes through the Private Sector Project. 2012. "Report of the Tanzania Assessment of Community Services for Childhood Illness." Draft report, SHOPS Project, Abt Associates Inc., Bethesda, MD.

Sulzbach, S., S. De, and W. Wang. 2011. "The Private Sector Role in HIV/AIDS in the Context of an Expanded Global Response: Expenditure Trends in Five Sub-Saharan African Countries." *Health Policy and Planning* 26: i72–i84.

Takang, E., S. Duberstein, T. Rosche, J. Nyonyi, and W. Shango. 2008. *Tanzania: Quantification and Supply Planning for Anti-Malarial Medicines*. Arlington, VA: USAID DELIVER Project.

Tanzania Commission for HIV/AIDS (TACAIDS). 2003. *National Multi-Sectoral Strategic Framework on HIV/AIDS 2003–2007*. Dar es Salaam: TACAIDS.

———. 2008. *Joint Annual Program Review (2008)*. Dar es Salaam: TACAIDS.

Tanzania Commission for AIDS (TACAIDS), Zanzibar AIDS Commission (ZAC), National Bureau of Statistics (NBS), Office of the Chief Government Statistician (OCGS), and Macro International Inc. 2008. *Tanzania HIV/AIDS and Malaria Indicator Survey 2007–08*. Dar es Salaam: TACAIDS, ZAC, NBS, OCGS and Macro International Inc.

Tanzania Health System Assessment 2011. *See* Musau et al. 2011.

Itika, J, O Mashindano, and F Kessy. 2011. "Success and Constraints for Improving Public Private Partnerships in Health Services Delivery in Tanzania." ESRF Discussion Paper No. 36, The Economic and Social Research Foundation, Dar es Salaam, Tanzania.

Todd, S., G. Brubaker, S. Chand, C. Franzen, C. Hafner, A. Kimambo, and P. Pamba. 2009. *Human Resource-Geographical Information Systems Data Development and Systems Implementation for the Christian Social Services Commission of Tanzania*. Chapel Hill, NC: IntraHealth International.

UNAIDS. 2009. Tanzania: Country Situation 2009. http://www.unaids.org/ctrysa/AFRTZA_en.pdf.

UNAIDS/WHO. 2008. Epidemiological Fact Sheet on HIV and AIDS: United Republic of Tanzania. http://apps.who.int/globalatlas/predefinedReports/EFS2008/full/EFS2008_TZ.pdf.

United Nations Development Program (UNDP) Tanzania. 2010. *Millennium Development Goals Goal 6: Combat HIV/AIDS, Malaria, and Other Diseases*. New York: UNDP.

United Republic of Tanzania Planning Commission. 2005. *The Tanzania Development Vision 2025*. Dodoma: Planning Commission.

United Republic of Tanzania President's Office, Planning Commission. 2011. *The Tanzania Five Year Development Plan 2011/2012–2015/2016*. Dodoma: United Republic of Tanzania President's Office.

United Republic of Tanzania Prime Minister's Office. 2001. *National Policy on HIV/AIDS*. Dodoma: PMO.

———. 2007. *The Second National Multi-Sectoral Strategic Framework on HIV and AIDS (2008–2012)*. Dodoma: PMO.

———. 2009a. *National Multisectoral HIV Prevention Strategy 2009–2012*. Dodoma: PMO.

———. 2009b. *National Public Private Partnership (PPP) Policy*. Dodoma: PMO.

United Republic of Tanzania Prime Minister's Office Regional Administration and Local Government. 2007. *Local Government reform Program—Embedding Decentralisation by Devolution Across Government*. Dodoma: PMO-RALG.

———. 2011. *Comprehensive Council Health Planning Guidelines*. Dodoma: PMO-RALG.

United Republic of Tanzania Vice President's Office. 2005. *National Strategy for Growth and Reduction of Poverty (NSGRP)*. Dodoma: Vice President's Office.

USAID/Tanzania. 2004. *USAID/Tanzania Country Strategic Plan FY2005-2014*. Dar es Salaam: USAID/Tanzania.

World Bank. 2011a. *Making Health Financing Work for Poor People in Tanzania: A Health Financing Policy Note*. Washington, DC: World Bank.

World Bank. 2011b. Tanzania World Development Indicators (accessed December 21, 2011), http://data.worldbank.org/country/tanzania#cp_wdi.

World Health Organization. 2009. *Taxing Essential Medicines—A Sick Tax That Hinders Access to Treatment*. Geneva: WHO.

———. 2011a. United Republic of Tanzania: Health Profile. http://www.who.int/gho/countries/tza.pdf.

———. 2011b. *Medicine Prices in Tanzania*. Geneva: WHO.

———. 2012. United Republic of Tanzania (accessed March 27, 2012), http://www.who.int/countries/tza/en/.

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Mainland Tanzania is one of many countries in the developing world struggling to achieve middle-income status while confronting widespread poverty and urgent health issues. Although there are some positive trends in the country's battles with HIV/AIDS, maternal and child mortality, malaria, and tuberculosis, problems persist.

The intent of the study presented in *Private Health Sector Assessment in Tanzania* is to support the government of Tanzania and other key stakeholders in enhancing public-private engagement at all levels of the Tanzanian health system. Composed of a diverse range of both for-profit and not-for-profit organizations, the private health sector in Tanzania is making significant contributions across all health sector levels and health focal areas within the national health system. Despite this progress, the full scope of private health sector activity and contributions to health are typically excluded, or minimally represented, in assessments and evaluations of the health system.

When examining the full scope of private sector activities beyond service delivery—including medical training, commodity supply, and health financing—a more realistic image of a Tanzanian private health sector that is diverse, widespread, and complex emerges. Through providing a more accurate description of current private health sector contributions and proposing actionable recommendations to address health needs in Tanzania through increased public-private collaboration, this assessment provides a road map for optimizing private sector inputs within the context of the overall health system.

The information contained in this report is intended to create opportunities for multisectoral dialogue, to enhance collaborative planning efforts, and ultimately to facilitate partnerships that lead to increased health system efficiencies and sustained health services.

Tanzania has already accomplished much in these areas, with expressed commitment to partnership from stakeholders in both the public and private sectors, and a strong policy foundation to enable public-private collaboration. By seizing existing partnership opportunities and fostering a health system that leverages all health actors, the goal of high-quality health care for all Tanzanians is achievable.

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ISBN 978-1-4648-0040-5

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SKU 210040