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MID-TERM REVIEW PHASE 3 -EXIT PHASE-REPORT OF THE HEALTH PROMOTION AND SYSTEM STRENGTHENING (HPSS) PROJECT- TANZANIA

This publication was produced at the request of the Swiss Development Cooperation (SDC). It was prepared independently by Rutasha Dadi, George Ruhago, Daudi Mboma,Michael Stahl, Pendo Checkingo and Omari Kimbute

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A. Preliminary Pages

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List of Acronyms

CCM	Chama Cha Mapinduzi
CHF	Community Health Fund
CHMT	Council Health Management Team
COVID-19	China Virus Disease-19
CRVS	Civil Registration and Vital Statistics
DAC	Development Assistance Committee
DAS	District Administrative Secretary
DED	District Executive Director
DHIS2.	District Health Information System2
eLIMS	Electronic Logistic Information Management System
EQUITAN	EQUITAN Social Franchise
FGD	Focused Group Discussions
FP	Family Planning
GBV	Gender Based Violence
GePG	Government Electronic Payment Gateway
GoT	Government of Tanzania
GoTHOMIS	Government of Tanzania Health Facility Management Systems
GOZ	Government of Zanzibar
HBF	Health Basket Fund
HMIS	Health Management Information Systems
HPSS	Health Promotion and System Strengthening
HRH	Human Resource for Health
HSSP	Health Sector Strategic Plan
HTM	Health Technology Management
iCHF	improved Community Health Fund
ICT	Information Communication Technology
IHI	Ifakara Health Institute
ILO	International Labour Organization
IT	Information Technology
LGA	Local Government Authority
LMIC	Low- and Medium-Income Countries
MMH	Mnazi Mmoja Hospital
MNH	Muhimbili National Hospital
MoFP	Ministry of Finance and Planning
MOHCDGEC	Ministry of Health Community Development Gender Elderly and Children
MOHSWGEC	Ministry of Health Social Welfare Gender Elderly and Children
MSD	Medical Stores Management
MTR	Medium Term Review
NBS	National Bureau of Statistics
NCD	Non-Communicable Diseases
NECTA	National Education Council Technical Authority
NGOs	Non-Governmental Organization

NHIF	National Health Insurance Fund
ODA	Overseas Development Assistance
OECD	Organisation for Economic Co-operation and Development
OOP	Other Out of Pocket
PHC	Primary Health Care
PORLAG	President's Office Regional Administration Local Government
PPM	Policy Planning and Management
PVS	Prime Vendors System
RAS	Regional Administrative Secretaries
RC	Regional Commissioner
RHMT	Regional Health Management Team
RMNCAH	Reproductive Health Newborn Child and Adolescent Health
RRH	Regional Referral System
SARA	Tanzania Service Availability and Readiness Assessment
SDC	Swiss Agency for Development and Cooperation
SNHI	Single National Health Insurance
SOP	Standard Operating Procedures
STG	Standard Treatment Guidelines
TA	Technical Assistance
TAF	Technical Assistance Framework
TIRA	Tanzania Insurance Regulatory Authority
ToR	Terms of Reference
TZHEA	Tanzania Health Enterprise Architecture
UDOM	University of Dodoma
UHC	Universal Health Coverage
UHI	Universal Health Insurance
UNICEF	United Nations Children Fund
USAID	United States Agency for International Development
WB	World Bank
WHO	World Health Organization
ZRCP	Zanzibar Research Centre for Socio-Economic and Policy Analysis
ZHRI	Zanzibar Health Research Institute
ZSSF	Zanzibar Social Security Fund

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ACKNOWLDGEMENT

This report is presentation of the Midterm Review of Health Promotion and System Strengthening Project. The report presents the findings collected by the MTR team which inquired the relevancy, effectiveness, coherence, efficiency, and sustainability of support the improved Community Health Fund (iCHF), Jazia-Prime Vendor System, Health Technology Management, and Health Promotion interventions as well as appraisal of Information Technology Architecture in Tanzania and an appraisal of SDC niches of engagement after HPSS.

We wish to state at the outset that this report is not the product of the MTR team alone. The MTR team received important technical guidance and needed cooperation from the Switzerland Development Cooperation, the Tanzania government and Regional Secretariat. Foremost; our gratitude to the SDC management for selecting and entrusting us to undertake this exercise and for the support and collaboration we received before and throughout the MTR process which enabled us to benefit from their strong technical and logistical experience in terms of input and advice. We would wish to particularly convey our sincere thanks to Dr. Thomas Teuscher and Hasselmann Viviane for technical guidance, Jacqueline Matoro who coordinated the whole exercise and for a very constructive technical inputs, Ally Kebby for his time and providing key project information and his HPSS national (Elizeus Rwezaura, Phiona Patronila Childunda, Nicolous Kanisa, and Sia Tesha); zonal offices team (Antusa Munishi-Central, Emanuel Dedu-Lake 2, Happiness Makala- Lake 1,and Emanuel Mwanga-Western) for coordination of field visit and valuable inputs, Manfred Stoermer and Basel based team of experts for valuable technical input and Leticia Mashimba for all logistic arrangements and support.

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Although many people contributed to this work, the views and recommendations made are ours, the MTR team, and so are any weaknesses.

B. Executive Summary

1. Assessment of the project's performance in operating a Technical Assistance Facility

EFFECTIVENESS:	**IS THE INTERVENTION ACHIEVING ITS OBJECTIVES?** **Examine: The extent to which the intervention achieved, or is expected to achieve, its objectives, and its results, including any differential results across groups.**

1.1. Improved Community Health Fund

At the time of this MTR all 26 regions were implementing iCHF schemes with structures in place at all levels in line with the government CHF circular (2018). In terms of TA from HPSS, an innovative digital solution CHF-Information Management Information System (CHF-IMIS) regional and council level rollout including as per nationally defined iCHF structure and capacity building were cited and acknowledged as an important HPSS support on strengthening CHF scheme countrywide

iCHF Achievements

Evidently, this MTR shows that irrespective of the iCHF implementation challenges, there are notable significant achievements of the HPSS's project TA within this exit phase

- Findings from this MTR show that enrolment into iCHF is steadily increasing regardless of a few shortcomings. Enrolment has increased more steadily in regions that were supported by the first and second phases of the HPSS project.

- Active membership, referring to families/households whose policies are still active at the time of reporting, being either new enrolees or those that have renewed their policies and remain active, increased from 1.07% in 2019 to 2.84% in April 2021. However, this is still below the target of 5%.

- The amount of funds collected nationally has increased from Tsh. 2.2 billion in FY 2018/19 to Tsh. 11.9 billion in FY 2020/21, representing a more than fivefold increase over this time and reaching half of the four-year target of Tsh. 40 billion

Generally, in the absence of the matching funds from the government, the iCHF scheme is running with half of the projected funds. Lack of adequate matching funds and future capacity of the government to meet her obligation in case of increased enrollment is argued as not healthy for the pooled fund liquidity. In other words, it is presupposed that the government will keep increasing the matching funds as enrollment increases. However, situation has not been the case.

Recommendations

For the remaining interim project exit period:

a) Increase more efforts on unfinished business for remaining period including advocacy and technical support to government for finalization of policy guidelines and interoperability of the digital solution
b) Advocate for the government's commitment to release matching funds

c) Further research: Despite the growing policy and programme interest in iCHF, there is very little research on which to base an assessment of iCHF's impact on providers performance, particularly at tertiary (regional referral hospitals) and zonal levels of the health system.

Long-term recommendations:
While we acknowledge that there is good progress on iCHF performance and a need for evidence generation for advocacy, it is our opinion that support of iCHF is still required to further enhance its management and business operations.

- Given Switzerland's niche and experience in health care financing it is therefore recommended that the SDC stay longer and provide technical support.

It is our understanding that the current policy direction of UHI of which iCHF is a key part will be implemented soon and we anticipate that the government will implement some structural and design changes of the scheme. In this respect, support to iCHF should continue in the following areas:

- Management and coordination of the scheme, especially through establishing a strong "iCHF Unit" at PORALG. Institutional capacity assessment is recommended to this course.
- Advocacy and popularization of iCHF to key decision makers including Members of Parliament, religious and cultural leaders, and empowerment of elected councilors and administrators as part of marketing and promotion of iCHF
- Restructuring of the enrolment personnel into an effective sales agent model and e payments system,

1.2. Jazia-Prime Vendor System
Findings revealed this component is lagging. For example, the approval and endorsement of the Jazia-PVS guidelines has been delayed by almost one year now. Review of the approved micro activity document shows the approval and endorsement were planned to be finalised by December 2020, the Standardized National Auditing Tool was planned to be completed by the end of April 2021 but was still in the development stages. Another tool which was lagging is a training module on eLIMIS for dispenser students, which was scheduled for development this year. In addition, although the process for development of JAZIA digital system started in year 1, with higher user requirement to stakeholder's business mapping activities, the system has not been fully developed pending approval of the guidelines.

Achievements:
Although gaps were noted in this MTR, the PVS-Jazia has significantly contributed to recent improved and increased availability of essential medicines and supplies. Jazia PV system has significantly reduced drug shortage in most public health facilities. However, the value of health commodities procured through Jazia vendor system has been unsteady due to delayed disbursement of basket funds at the primary health care level. It should be noted that PHC facilities especially dispensaries and health centres largely depend on HBF as a source of funding for medicine and supplies.

Recommendations
For the remaining interim project exit period:

- Increase efforts to complete unfinished business for remaining period including advocacy and technical support to government for finalization of policy guidelines and digital solution functionality.

- Given strong HBF and PVS-Jazia complementarity, SDC is recommended to spearhead evidence-based advocacy among HBF partners and government on timely allocation and disbursement of the HBF to health facility levels

Long-term recommendations

- Advocate and provide technical support for institutionalization of Jazia-PVS into national and government policy, legislation, and practice.

1.3. Health Technology Management

Unlike other components, HTM is in its infancy, having been implemented for only eighteen months. What is remarkable from this MTR about the HTM's experience in visited regions, is the high demand for both human and financial resources for implementation and repairing malfunctioning biomedical equipment, especially the new ones. Looking at the high demand of this component we observed in the field it seems its closure will be premature. It should be noted that, of recent the government has invested in and imported highly specialised diagnostic technology as well as surgical related equipment through domestic resources and HBF. However, the investment in equipment was not juxtaposed with investment in human resource training and absorption.

Achievements

- Technical Assistance Facility is on track to reach target from a baseline of 20% of functioning HTM structures at regional level in 2019 to 80% in April 2021. We further noted and commend the increased number of repaired equipment.
- In terms of functioning workshops, only 3(12%) out of 26 regions (presented in Figure 13) had a level 1 workshop (Dodoma, Shinyanga and Mara) at level 3 have a standard functioning workshop; Level 2 regions Kagera,Tabora, Mwanza, Arusha, Mara, Morogoro, Iringa, Dar es Salaam, Mtwara ,Lindi and Tanga have workshops with basic tools. The rest of the regions are at level 1 and with no maintenance rooms.
- Although efforts to create the system of registering all equipment were ongoing, the digital solution was reported to have not started operating. When we inquired if the system is linked to the Health Facility Registry system, it was reported that this was at piloting stage.

Recommendations

- Consider and leverage internal and external SDC capacities for longer technical support to MEIMIS (National Medical Equipment and Infrastructure Management Information System) and link with the national Health Facility Registry System
- Provide TA to ensure the MEIMIS is working on expanding support for inventory of available equipment to a include equipment's procurement tracking system.

1.4. Health Promotion

The project implementation of this component is on track. Very successful rollout of structures and appointment of human resources responsible for health promotion was observed at all levels. However, like outputs two and three (Jazia-PVC and HTM), development of an innovative digital solution for health promotion is lagging. During the time of this MTR, support provided to develop digital observatory of health promotion to enhance M&E, analysis, planning & support was at preparatory stages.

Recommendation

- HPSS is recommended to be engaged with NCD TWG and ensure implementation of health promotion is mainstreamed within the next five years by seizing health promotion leadership opportunity for implementation of the HSSP V.

1.5. Evidence Generation

Deliverables on this output are lagging far behind targeted results. For example, although it was envisaged to have at least one publication per each component by the end of April 2021, during the time of this MTR four publications were made but all on the medicine's component. Lack of evidence generated from this component is denying HPPS project and SDC an opportunity and capacity to provide very important evidence-based advocacy for policy changes. Delay in this section can be partly explained by project capacity to deliver because of staff attrition. During the time of this MTR we observed two (M&E and IT) senior staff had just left HPSS. The new staff were there for almost one quarter.

Recommendations

- Given the importance of this component it is recommended:
- To expedite the process of evidence generation, by hiring highly qualified research private individual or consultancy firms with comparative advantage in the thematic areas to undertake some studies instead of relying on public and academic institutions.
- Specifically, as a mitigation plan to ensure the project capacity is not compromised, we recommend consideration of short to long-term TA Consultancy support to the M&E Research Component at the Dodoma project office, to focus especially on research, while leaving the coordinator to focus on regular project M&E responsibilities.

2. Current and Future of the iCHF

RELEVANCE:	**IS THE INTERVENTION DOING THE RIGHT THINGS?** **Examine: The extent to which the intervention objectives and design respond to beneficiaries', global, country, and partner/institution needs, policies, and priorities, and continue to do so if circumstances change.**

This MTR noted that iCHF is highly prioritised and well-articulated in national policy and strategies. It is evident from this MTR that, the government is in transition and potential future changes with unclear picture and of the future health insurance framework. Expected changes are in terms of administration and management of the health insurance system in Tanzania. A high level of government ownership and leadership will hopefully ensure the iCHF is safeguarded.

Furthermore, HPSS's interventions are very well articulated and mainstreamed into existing government policies, plans, and processes. Specifically, HPSS's initiatives are well articulated in the GoT and CCM ruling party manifesto, draft Health Policy, and Health Sector Strategic Plan IV and V.

Discussion on the future of the Single National Health Insurance with the high-level KI respondents from the MOH (Minister, Director of Policy and Planning and others) revealed that, unlike long term proposed Single National Health Insurance, there are no plans for merging health insurance schemes, instead the government has taken the direction of Universal Health Insurance. One of the senior MOHCDGEC's respondents revealed that within the Universal Health Insurance (UHI) framework the government will establish a scheme, subsuming both iCHF and NHIF without merging the two schemes.

Recommendations

- SDC should continue with environmental scanning on how the UHI discussion evolves and re-adjust accordingly while taking a lead in digital solutions.

- "Wait and see"

> *"If I were SDC, I would wait and see what comes out of the Universal Health Insurance Bill. We don't know what the structure will look like"*
>
> ***KI-Hon. Dr. Dorothy Gwajima- Minister MOHCDGEC***

3. The synergy and complementarity of the HPSS Support

COHERENCE:	HOW WELL DOES THE INTERVENTION FIT? Examine: the compatibility of the intervention with other interventions in a country, sector or institution.

Evidently, assessing in totality, the HPSS TA support to the health system in Tanzania has significantly contributed to the success and achievements made to strengthening implementation of rollout of iCHF countrywide. All regions have structures in place. According to our respondents, at the Regional and District levels, there are CHF coordinators responsible for coordinating the implementation of the scheme at ward and village levels.

IMIS digital solution has improved the data management system. Members are registered using smart phones and their membership information is stored digitally. This allows reliable storage and ease of review, update and retrieval of members' information when needed. iCHF coordinators at regional, district and health facilities levels reported that the new system had made it easier to detect expired CHF cards and thus beneficiaries could be reminded to renew their membership on time.

Complementarity of iCHF and Jazia-PVC interventions was strongly noted co-existing. The HPSS project TA, Development Partners' programmes and support, and government coordination and leadership efforts synergies has proven to be the reason for success of the projects' results.

Recommendation

- A very well designed exist coordination plan should be jointly designed and implemented on who will be doing what for the remaining project period.

4. Appraisal of the present contributions and objectives of HPSS to strengthen the IT health systems architecture in Tanzania

RELEVANCE:	IS THE INTERVENTION DOING THE RIGHT THINGS? Examine: The extent to which the intervention objectives and design respond to beneficiaries', global, country, and partner/institution needs, policies, and priorities, and continue to do so if circumstances change.

Current and Future Direction

The implementation of openIMIS coupled with integration with the mentioned key ICT systems will benefit the future SNHI in whatever design the government will agree to. Health Care costs are growing significantly in the world currently posing a challenge to many health financing schemes. Information systems have proven to be key tools in lowering such costs. Interoperability between clinical, financial, and public health systems such as CRVS and National ID systems allows for the

assessment of effectiveness and the monitoring of cost. Using public health data to forecast health care resources, clinical data to assess outcomes and financial data to track cost provides the critical information infrastructure which can easily drive the UHC.

The Government IT Priorities

The GOT has put more focus on digitization, and there is a significant investment in Information and Communication Technology as a tool to enhance socio-economic development. This is witnessed by the recent establishment of the ICT Ministry which will formulate and monitor policies on information and communication technologies and postal services. The Ministry is expected to drive the digital transformation agenda in Tanzania amid the global fourth phase industrial revolution. The government recognised the importance of leveraging ICTs as a catalyst to develop all economic endeavours to strengthen the industrial and agricultural-based economy. The National ICT Policy focused on ensuring Tanzanians become economically, socially and culturally enriched and become an ICT-enabled knowledge society.

The current eHealth Strategy has an ambitious aim to ensure delivery of a safe, high-quality, equitable, efficient and sustainable health system that is equipped to respond to emerging health sector cost and demand pressures.

The implementation of openIMIS coupled with integration with the mentioned key ICT systems will benefit the future UHI in whatever design the government will agree to. Health Care costs are growing significantly in the world currently. This poses a challenge to many health financing schemes. Information systems have proven to be key tools in lowering such costs. Interoperability between clinical, financial and public health systems such as CRVS and National ID systems allows for the assessment of effectiveness and the monitoring of cost. Using public health data to forecast health care resources, clinical data to assess outcomes and financial data to track cost, provides the critical information infrastructure which can easily drive the UHC

RECOMMENDATIONS

Short term

- Investing in the technical hosting infrastructure of OpenIMIS; in particular, building a data centre with data back-up plans (on-site and in another physical building) is essential. The current risk of losing all data on the central server is very high.

- While it is understandable that integration of IMIS with GoTHOMIS and AfyaCare are already in the HPSS workplan and the GoT policy on iCHF at the moment applies a capitation formula (but is possible in IMIS); it is recommended that consideration should be made on adopting and improving the eClaim module of the system to be able to accommodate a fee for service in the future, if this was to be adopted. This can be achieved by integrating the Health Management Information System (GOTHOMIS and AfyaCare) and the openIMIS system.
- There is also an urgent need to ensure capacity is built for the PORALG team to ensure that they can adapt the system in the future if needed and especially to fix minor technical hick-ups on their own first. To this end, it is necessary to establish a permanent IT team that can devote itself full-time to IT tasks. The motivated Swiss developers can only ensure the sustainability of the knowledge transfer if it is expected that the local IT specialists will not leave their position again after a few months. Establishing an IT service centre to take care of various digital Social Health Protection areas on a national level can make sense.

Long term

- Some of the key investment recommendations in digital health solutions which could play a vital role in future support of UHI include the following: social registries, assessing the quality of care, CRCS and national ID, and telemedicine.

5. Preliminary appraisal of SDC future niches of engagement after HPSS (ideally building on investments made under point 2)

Zanzibar Health Insurance Future Policy Direction

Paradigm shift from the current free health care policy to cost sharing approach for those who can contribute. The Zanzibar Health Insurance Schemes are expected to include both formal and informal sectors and other groups within the society and will cover higher, middle, low income and destitute as a means to improve financial protection and achieve universal health coverage (see below).

Area	Financial commitment Status
Assessment of ZSSF to manage the scheme	Work in Progress by Pharm Access
Actuarial Valuation	Already have commitment
ICT Solution	No commitment
Household categorisation	Already have commitment
Predesign of the Scheme	Completed
Advocacy for Pre design	Already have commitment

Recommendations

- **Holistic approach to health system strengthening**
  - **Spearhead Knowledge and skills transfer from HPSS project** and elsewhere: Involve and leverage technical and management expertise in development of the Zanzibar UHI while keeping in mind that one-size-fits-all will not work; Zanzibar social and demographic characteristics are very unique and different from mainland Tanzania.

  - **Consider joining Health Basket in Zanzibar** for stable health financing, including covering those who need healthcare most- the poor and vulnerable groups; improve constant and adequate supply of commodities; strengthen skilled human resource capacity and support health technology management and health promotion in response to the current shift in demographics and diseases with more urbanisation and high prevalence of non-communicable Diseases

  - **Support should be considered for formulation of policy and guidelines**: Given HPSS strong experience from the Mainland, it is highly recommended that a secular UHI, and other accompanying policies be developed in advance of the reviewed national health policy.

- **Digitization:** Considering the pre-design scheme, the GOZ should invest in the ICT infrastructure (hardware, software and connectivity) that will be ready to facilitate operationalisation of the health insurance scheme by focusing on integrating the payers' and providers' side systems.

- **Coordination of activities:** SDS should take leadership among DPs and be involved in planning and coordination of IT activities. in collaboration with other development partners interested in supporting the Government of Zanzibar in the implementing of the digital interventions.

- **Assessment of available digital tools**: A thorough evaluation of all digital solutions used in the health system must be made before successful implementation of the health insurance system

- **Capacity building:** Capacity building for the Ministry of Health, Social Welfare, Elderly and Children (MoHSWEGC) is necessary particularly in the areas of digitization entailing training and equipment and infrastructure improvement.

- **Electronic payments:** The integration of the health insurance system should be preceded by an analysis of potential contribution collection and provider payment solutions.

- **Health Insurance Operation Software: Support the RoGZ to develop and** Implement a digital health insurance information system to support the planned health insurance in Zanzibar.

- **Registries**: The developed information technology systems should be interoperable with existing systems such as the Civil Registration and Vital Statistic System

SUSTAINABILITY: WILL THE BENEFITS LAST?
Examine: **The extent to which the net benefits of the intervention continue, or are likely to continue:**

Given expressed optimism from the national and subnational level respondents, notable high level of ownership and government leadership from project design, implementation, reviews, and evaluation, HPSS investment in strengthening health system and findings from this MTR the SDC investment will likely last long within the current health sector development agenda. It should be noted that although significant achievements have been realised, the government of Tanzania still needs capacity building in maintaining and sustaining the gains from three phases of the HPSS.

EFFICIENCY: HOW WELL ARE RESOURCES BEING USED?
Examine: The extent to which the intervention delivers, or is likely to deliver, results in an economic and timely way.

The HPSS Project management was good, but project governance left room for improvement, especially on retention of human resource and evidence generation and capitalization which affected evidence-based advocacy and knowledge-sharing. Collaboration and coordination mechanisms left room for improvement. Withstanding the scale of the challenges posed by COVID-19, activities for TA were implemented in a reasonably timely and reliable manner, according to the priorities established by the project document. However, the budget utilization rate of below 37 percent at the middle of the project implementation timeline needs special attention. More attention should be paid to the outcome three with only 15 percent budget burning rate as of April 202. Budget utilization rate attesting activities for this outcome has seriously lagged behind and affecting overall project performance of 37 percent expenditure rate.

Recommendation

- The project should come up with a sharpened acceleration plan for the remaining project lifespan.

SECTION ONE
INTRODUCTION AND BACKGROUND

1.0 Introduction

Globally as well as in Tanzania there is an increasing interest in advocating for advancing Universal Health Coverage (UHC), which calls for all nations to provide quality health care services to all citizens without facing financial difficulties. Tanzania envisioned to ensure her citizens had access to quality services through introducing and implementing the Community Health Fund (CHF) Act of 2001. Although the government of Tanzania has been implementing CHF for more than twenty years, the implementation and uptake of the scheme has been persistently low. In response to these challenges, a new improved community health fund was established in 2018. The new initiative changed the overall structure, management and benefit package of the CHF. These new changes come into effect following the HPSS supported pilot study conducted initially in Dodoma and later in Shinyanga and Morogoro regions from 2011 and 2015 respectively.

The Terms of Reference (ToR) for the mid external mid-term review (MTR)of the Health Promotion and System Strengthening Project (HPSS) provides detailed background. Based on the MTR ToR focus on IT solutions and digitization, which is a strategic objective of both the GoT and the Embassy of Switzerland, phase three of the HPSS project invests significantly in Technical Assistance (TA) for other components and innovation from previous phases that have been rolled out in the country. There is also the component of evidence creation that received important attention in phase three. In this report, key questions are aligned with OECD/DAC criteria.

1.1. Rationale

The MTR focused on covering the 18 months period the of the implementation of phase three. The remaining 30 months of HPSS project implementation will allow significant contribution towards the further development of a specific health insurance system for UHC which may be integrated into a single national health scheme later if the GoT so wishes.

In the current context, digitalization has become a priority area of focus for the government of Tanzania. The Single National Health Insurance (SNHI) discussions are in progress. The Cabinet Paper and the Bill to the Parliament is planned to be tabled in September 2021. SDC's view is that the 30 months project exit phase can still make a substantial contribution towards creating understanding of the future design of the national health insurance and to inform the development of the IT system which will support its operations. In this respect, it will be relevant to investigate the experience of iCHF especially on enrolling the informal sector and rural population. Whatever strategy of insurance will be developed by the government, it should have a mechanism to enrol and renew people in the informal and rural population, and this is a challenge.

New and additional investment to maximize impact on actual investment in HPSS effectiveness and attractiveness to providers and clients of any future governmental health insurance strategy. More broadly, such an investment would strengthen health governance, accountability for health insurance premiums and e-government efficiency in general. Future investment into the E-Health Partnership is expected to make the underlying data systems more functional. Any future social health insurance will require solid, real-time and integrated digital systems to make the SNHI work as intended and produce progress towards UHC. The contribution of developing IMIS and integrating it with the key IT systems therefore is expected to benefit a future SNHI in whatever organizational forms the GoT chooses.

1.2. Objectives of the MTR

This external MTR covered the result framework achieved for the period of November 2019 to March 2021 as well as collected field data from June to September 2021 In addition, it is acknowledged that, this MTR builds on previous HPSS's investment.

1.3. Overall objective

The MTR was to provide a) an external view allowing the priority steering of the US$ 9m investment over the remaining period of the HPSS project phase 3 (around 30 months at the time of the review) and b) to identify options for the Swiss Agency for Development and Cooperation for investments at the interface between digital health and social protection beyond the end of phase three of the HPSS project.

The review namely focused on how HPSS can contribute towards the generic health system management related IT architecture, with a focus on making any future health insurance as efficient and effective as possible. The review also briefly appraised progress to-date of specific activities of HPSS's phase three; medicine management, health promotion and health technology management. This translates into the following three main objectives to be answered by the MTR:

1.3.1. **Assess the project's performance** in operating a Technical Assistance Facility (TAF) during the first half with focus on the 16 months of HPSS phase 3 supporting the nationwide implementation of the reforms generated by HPSS phase 1 and 2 (iCHF, PV-Jazia[1], MEMIS, Health Promotion, for details see attached annual report)

1.3.2. **Appraisal of the present contributions and objectives of HPSS to strengthen the IT health systems architecture in Tanzania** through the countrywide introduction of IMIS for health insurance management, it's linking up with health facility management systems (GotHOMIS and AfyaCare), with the government accounting system (MUSE), and with reporting, analysis, and monitoring tools such as DHIS2. Appraisal of the contributions of HPSS to the IT infrastructure of the government health systems with its support of IT systems in the fields of supplementary medicine supply - Prime Vendor System-Jazia, health technology management, and health promotion supervision. Appraisal of options to strengthen such support activities of the advancement of the health system IT architecture in Tanzania e.g., through the E-Health Partnership for future SDC

[1]The Jazia PVS is a complementary health supply channel that not only supports improving the medicines availability but increases transparency and reduces bureaucracy. It is framed in the context of human resources for health, capacity, and supply chain management including the important aspect of use of available medical products by patients.

investments into digitization and digital systems that make state systems more efficient and corruption free (Outcome 1 of the Cooperation Programme 2021-2024)

1.3.3. Preliminary appraisal on SDC future niches of engagement after HPSS (ideally building on investments made under point 2)

1.4. MTR Specific Questions

This assessment was guided by the OECD DAC's criteria of relevance, effectiveness, coherence, efficiency, sustainability, and impact guiding questions as follows:

Figure 1:OECD/DAC Revised Evaluation Criteria

RELEVANCE:	**IS THE INTERVENTION DOING THE RIGHT THINGS?** **Examine: The extent to which the intervention objectives and design respond to beneficiaries', global, country, and partner/institution needs, policies, and priorities, and continue to do so if circumstances change.**
EFFECTIVENESS:	**IS THE INTERVENTION ACHIEVING ITS OBJECTIVES?** **Examine:** The extent to which the intervention achieved, or is expected to achieve, its objectives, and its results, including any differential results across groups.
COHERENCE:	**HOW WELL DOES THE INTERVENTION FIT?** **Examine: the** compatibility of the intervention with other interventions in a country, sector or institution.
EFFICIENCY:	**HOW WELL ARE RESOURCES BEING USED?** **Examine:** The extent to which the intervention delivers, or is likely to deliver, results in an economic and timely way.
SUSTAINABILITY:	**WILL THE BENEFITS LAST?** **Examine:** The extent to which the net benefits of the intervention continue, or are likely to continue:
IMPACT:	**WHAT DIFFERENCE DOES THE INTERVENTION MAKE?** **Examine:** The extent to which the intervention has generated or is expected to generate significant positive or negative, intended or unintended, higher-level effects.

1.4.1. The specific questions in respect to **the first objective of the MTR** (performance, achievements and gaps of TAF during phase 3) are:

- Is HPSS project phase 3 on track with providing relevant TA to GoT for the nationwide implementation of iCHF, PV, Health Promotion and MEMIS as described in the ProDoc and logical framework?
- How are government institutions taking a lead in rollout of approaches and mechanisms that were piloted and developed by HPSS? (Examine how prepared national partners are to take the lead in their roles eg UDOM in leading the national scale-up in health promotion teaching centres)
- Have the outputs of HPSS project phase 3 resulted so far in increasing coverage with iCHF and reducing stock outs nationwide? An analysis of bottlenecks to achieve impact is expected. (Also examine efforts to improve disbursement rates by

strengthening iCHF teams and giving them tools and capacity to improve facility payments disbursement rates which ultimately improves the iCHF)

- What is the perception of intended beneficiaries at PHC health facilities, LGA, regional and national level with regard to results achieved, through TAF, so far in phase 3?
- What achievements and bottlenecks are being identified namely in respect to community health insurance and the health insurance management system (and to a smaller extent on medicine management, health promotion, health technology management)?
- What are the government's priorities in this field and how does the current set up of the HPSS fit?

1.4.2. The specific questions in respect to the second objective of the MTR

- What are the government's priorities in this field and how does the current set up of the HPSS fit?

- Identify options to invest additional resources into the advancement of the health insurance related IT architecture in Tanzania through the E-Health Partnership[2] are:
- What are investment opportunities in the health insurance related digital system development by the E-Health Partnership in mainland, given the slow progress in iCHF coverage to-date and the stalled health insurance policy dialogue.
- Identify immediate and health insurance relevant gaps in the Tanzania Health Enterprise Architecture[3] or parallel separate investment that HPSS can address through its comparative advantage, and that have a high likelihood to increase iCHF coverage.
- Identify opportunities within the existing financial envelope to engage with Zanzibar on developing a digital basic health insurance scheme.

1.4.3. The specific questions in respect to the third objective of the MTR

- What are the government's priorities in this field and how does the current set up of the HPSS fit?
- To provide a high-level appraisal on niche for future SDC investments into digitization and digital systems that make state systems more efficient and corruption free (Outcome I) are:
- What are potential partnerships between with the Government of Tanzania and Switzerland that will leverage Switzerland's key innovations[4]and bilateral investments to enhance efficient corruption free state institutions government accountability)? (human resource management, distant learning (professional development, accreditation, education, and professional skills development), health insurance, social protection, public finance management,
- What are national and international initiatives (both current and upcoming) in social protection, health insurance or E-Health with focus on UHC where bilateral

[2] Digital health in this report is used interchangeably with eHealth which is an umbrella term that refers to the use of information and communication technologies (ICT) in medicine and other health professions to manage illnesses, mitigate health risks and promote client wellbeing Zanzibar Digital Health Strategy- 2020/21 – 2024/25

[3] Is a blueprint for organisational change defined in models that describe (in both business and technology terms) how the entity operates currently and how it intends to operate in the future. It also includes a plan for transitioning to this future state(See Zanzibar digital health strategy2021-2025)

[4]including IMIS, ICHF, Jazia PVS, MEMIS, school health, and digital innovation capacity embedded in a complex and interraled systems that are part of health system archtectiure)

investments in Tanzania would have high value added and effectively leverages Swiss digital innovation capacity?

SECTION TWO
METHODOLOGICAL APPROACH

2.0. Introduction

This midterm evaluation was conducted from June to September 2021. As part of the preparation for this assignment, an inception virtual meeting was held on May 27, 2021 in attendance of the three consultants as well as the Health Domain Team of SDC. The purpose of this meeting was to ensure common understanding of the consultants to meet the SDC expectations concerning the quality of evaluation deliverables, processes and timelines. The team of consultants had an opportunity to ask for clarifications on the mandate. During the inception meeting, the original thematic areas of the midterm evaluation were modified to align with SDC strategic focus with the HPSS rollout in Tanzania. In addition, this reorganization brought the evaluation issues into better alignment with the OECD evaluation criteria and existing holistic multi-sectoral programming through SDC support.

This evaluation takes note of the situation of the emergence of COVID-19 and its implication in achieving set programme targets. The implication of COVID-19 to HPSS will be presented in the report. All preventive measures were taken including hygiene and sanitizing, social distancing, and face masking.

2.1. Data collection tools

After the approval of the inception report and a comprehensive work plan, which served as a mutual conceptualization of the overall study, the team of consultants met with HPSS project management in Dodoma and embarked on finalising data collection tools. Three tools were developed for national, subnational, and health facilities. This was done with the recognition of the MTR adequately covering the areas of relevance, value for money (efficiency and effectiveness), impact, results, innovations and sustainability and coherence of the project intervention areas of iCHF, Prime Vendor System, and Biomedical Equipment and health promotion supervision.

The team of consultants prepared and reviewed the evaluation tools which were based on OECD; Relevance, Coherence, Effectiveness, Efficiency and Sustainability. Initially, the evaluation tools were questionnaires topic guide developed for Focused Group Discussions (FGDs) and Key Informant (KI) interviews. However, following data collection in Dodoma and Manyara regions FGD was found not to be an ideal approach because of the diverse nature of the respondents and thematic areas. Data collection tools were revised for KI interviews. This approach stretched further the timeline for completion of this assignment.

2.2. Types and Sources of Data

Even if both quantitative and qualitative data and methods were collected and employed for analysis, qualitative formed a major source of data, analysis, and report writing. In order to map SDC support in selected regions, primary data collection tools were designed and aligned with the inception report relevant objectives.

On the other hand, project progress reports and documents generated most of the quantitative and secondary data. This entailed systematic review of documentation on the project as provided by HPSS's project baselines, progress reports, field visit reports and archival documents such as service records, organizational records, survey data and reports. In addition, the evaluation reviewed the government data including regional plans and reports. Another source of data included research, evaluation materials, and materials searched and extracted from the internet. In order to achieve the MTR objectives, SDC's policy and strategic plan documents were very useful in understanding the history, philosophy, and operation of the program and the setting in which it operates. This involved appraising and analysing Switzerland's development and cooperation policy, strategic plans, and country programmes.

This MTR endeavoured to participate and observe discussions and emerging issues in the HPSS project interventions related meetings or events. Specifically, the team visited and engaged with Zanzibar's high-level forum discussion on Universal Health Insurance in the Island. The aim was to identify country and regional priorities, understand general views from decision makers and political leaders, programme managers and collect additional data on felt gaps on potential and future SDC investment in strengthening of the health system in Zanzibar.

2.3. Triangulation

Finally, the methodological approach for data collection included systematic efforts to triangulate different sources of data from document reviews, key informant interviews and direct observation, in order to strengthen the validity of findings and conclusion. Synthesis of the analysis was done, and the field results compared with the literature findings and the quantitative data.

2.4. Field Entry and Sampling Approach

With coordination and facilitation of the HPSS in Dodoma and Zonal Offices, at each regional level, a courtesy visit was made initially to the RHMT and subsequently to each council level. The objective of the courtesy call was to gain familiarity and insights of general health overview, key priorities, and review the sample and plan for field visit.

The evaluation employed a combination of grounded theory, purposive, and theoretical sampling approach for data collection and analysis. The rationale for using this approach rests on its flexibility, reflection, and openness to emerging themes generated from data. On the other hand, theoretical sampling and grounded theory approaches were useful to seek additional data based on concepts developed from initial data analysis.

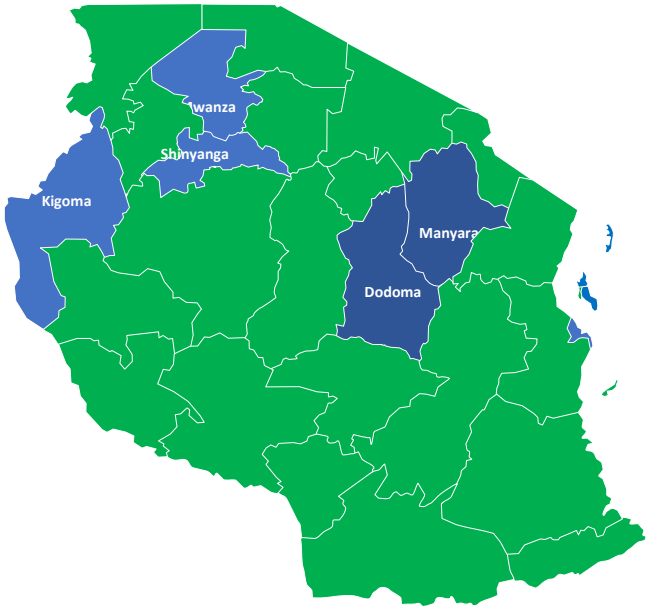
2.4.1. Sample

Data was collected at both national and subnational levels. The following section presents the sample for both Mainland and Zanzibar at national and subnational levels.

2.4.2. Tanzania Mainland

At subnational level data was collected from six regions of Dodoma, Manyara, Shinyanga, Kigoma, Dar es Salaam and Mwanza. While the regional level served as unit of analysis, the subregion level provided data on a sense of government roll-out efforts. In the sub region, the focus was on urban and rural councils. The urban councils were Dodoma, Mwanza, and Dar es Salaam while data generated from Kigoma, Manyara, and Shinyanga represented rural based populations. Within each region, discussions were held with the RHMT, CHMT, Health Centre, Dispensary Management Team, and community level. Involvement of community level respondents was planned with the understanding that community promotion and other project approaches have been mostly through schools and community development officers, as well as community members themselves. Data was collected from school health staff and community development officers for their insight into the health promotion approaches. Evidence generated from urban setting will be useful for Tanzania, which is urbanizing rapidly, and it is evident that poverty and lack of infrastructure are already negatively affecting health and wellbeing in cities.

Figure 2: Map of Tanzania showing sampled regions



Dar es Salaam and Mwanza were proposed to be added because of relatively unique private health facilities concentration, absolute poverty, poor performance of the region and responding to iCHF and poor composite health indicators. The rapidly increasing population is putting pressure on social services including RMNCAH. For example, unlike the national proportion of almost 70 percent public facilities ownership against 30 percent non-public, in Dar es Salaam, of the 572 facilities, 111(19%) were recorded as government leaving more than 80 percent privately owned health facilities. This statistic implies that Dar es Salaam is hugely private centered thus making access to health care difficult among poor households. In addition, although urban dwellers have easy access to health care services, not all health outcomes are better in urban areas and for all urban inhabitants. For example, an in-depth census information analysis by NBS in 2015, and the Ifakara Health Institute (IHI, 2015) showed similar findings (Ifakara Health Institute and the Institute of Health Equity (2016), the work of Calas B. et al (2006) Specifically, several studies including the midterm review of the Health Sector Strategic Plan IV revealed poor health outcomes in urban areas, particularly Dar es Salaam. For these reasons, it was proposed to split the Dar es Salaam community level into three administrative districts of Temeke, Ilala and Ubungo.

Experience from initial data collection in Dodoma, Manyara, showed that, the HPSS project's government counterpart 'Core Team[5]' at regional level were more informed than any other

[5] Core Team in this inquiry means government staff member who is directly involved in the current exit or previous HPSS project design and/or implementation. This includes HPSS Project thematic intervention: Regional Community Health Fund Coordinator

respondents. This MTR took note of recent changes within regional secretariats. For example, initial data collection in Manyara showed that most of the Regional Administrative Secretaries (RASs) in selected regions had just reported two weeks before the field visit. For this reason, RASs except for Kigoma have not been included as sources of data. This is because qualitative researchers often collect data in the field at the site where participants have experience with the issues or problem under study. Efforts were made to gather up-close information by actually talking directly to people and seeing them behave and act within their context and the natural setting. The spill-over effect data collection was conducted mainly at council as well as health facilities and community level. Specifically, a 91% of targeted KI response rate was achieved. The following is a summary of those interviewed.

Table 1: Sample details

LEVEL	RESPONDENTS	NUMBER	Response	Status
NATIONAL	HPSS Project	11	11	
	PORALG	7	5	Remaining: Minister, Deputy PS
	MOH	7	6	Remaining: NHIF-Director
	MoCT	3	3	Minister, Deputy PS, and Director IT
	MOFP	1	1	
	E-Health Partners	4	2	UNICEF, and
	iCHF Partners	2	1	Remaining: GIZ
REGIONAL	RMO	6	5	
	CHF Coordinator	6	6	
	PVS–Coordinator	6	6	
	HTM-Coordinator	6	6	
	Health Promotion-Co	6	6	
COUNCIL	DMO	8	7	
	CHF Coordinator	8	8	
	PVS-Jazia	8	8	
HEALTHFACILITIES	Dispensary In charge (CHF-Focal Point)	8	6	Remaining-Kigoma and Mwanza
	Health Centre In charge (CHF-Focal Point)	8	8	
COMMUNITY	Enrolment Officers and beneficiaries	6	6	
ZANZIBAR	President and Chairman of the Zanzibar Revolutionary Gvt	1	1	
	Principal Secretary	1	1	
	DPP	1	1	
	Head Financing	1	1	
	Head Social Insurance-Zanzibar	1	1	
	Head ICT	1	1	
	Zanzibar Research Centre	3	3	
	Other MOHSWGEC	3	3	
TOTAL		123	114	

2.4.3. Zanzibar

In Zanzibar, both Unguja and Pemba were visited (See Figure 2). KI were drawn from the Ministry of Health Social Welfare Gender Elderly and Children high level decision making officials. These included, initially in Pemba, the Principal Secretary and Health Coordinator(Deputy PS, and in-charge of Curative Services. Later in Unguja, the team of consultants met with Zanzibar MOHSWEGC Director General, Head of Health Financing, Coordinator of Health Insurance, Head of Planning Section and Head of Quality Assurance. It should be noted that the senior management of the MOH was recently revamped and during

and his/her team of accountant and ICT Officer, Regional Health Promotion Coordinator, Regional Biomedical Instrument Coordinator, Regional Pharmacist Jazia-PVS Coordinator.

the time of this review directors were not yet appointed. During the high level meeting on Zanzibar UHI, the team had discussions with the Zanzibar Research Centre for Socio-Economic and Policy Analysis (ZRCP) Executive Director, Deputy Executive Director and Principal Researcher. Other KI included officials from the Jakaya Mrisho Kikwete Foundation (JMKF). The two institutions hosted the meeting in collaboration with the MOHSWGEC. Other invited participants included Muhanna & Company Actuaries and Consultants, and PharmAccess. During the time of submission of the draft report plans were underway to meet with Zanzibar's President Dr. Alli Hassna Mwinyi.

2.5. Data management and analysis

To ensure this assignment met the needs of an international consultant and working in different teams, an ODK software was employed for data collection and storage. The software permits such an administration to take place. Thus, when the final draft instrument had been finalized, it was submitted to our programmers at EQUITAN and rendered into ODK tablets. The EQUITAN app is a simultaneous data capturing and data entry android-based tool. This application enabled field researchers to capture, enter and send data and information to an online server to enable real time data and information sharing and analysis through a dedicated web interface. By combining data capture and entry coupled with application in an automated manner consistency and validation checks were ensured. The human errors in the entire process cycle of capture and entry were reduced by more than 99%. This method involved coding and developing categories following where the data led to expand and refine the evolving thematic areas during the analytical process of data collection and interpretation.

2.6. Finalization of Report

The key preliminary findings were initially shared with SDC, Swiss TPHI team in Basel and the HPSS project team in Dodoma who provided inputs to strengthen the key findings. All these steps were conducted in order to identify and recommend the priority areas and interventions that need to be implemented to achieve the project related objectives and targets in the remaining period towards 2023 and future SDC investment in Tanzania.

2.7. Review Team

A team of four consultants composed the External Review Team. The number was determined by the team's expertise to address the MTR objectives.

Rutasha Dadi, PhD-Health Systems -Policy Planning and Management (PPM)
Development and Health Systems Expert with documented experience of performance evaluations of Technical Assistance Facilities/Technical Assistance provision systems for governments in LMICs to serve national, regional, and district interlocutors. Has a deep understanding of the social and political background of Tanzania and the functioning of the health insurance and digitization landscape and key actors in Tanzania. He has a good understanding and expertise in digital health. A capacity to analyze the outcomes/outputs of the HPSS project with a LNOB/gender lens, good analytical and report writing skills as demonstrated by a successful record of previous work on related topics; and good communication skills and ability to interact with different stakeholders.

Daudi Mboma, Msc IT & Management

Specialist with health system IT architecture experience in LMICs in supporting the development of digitization strategies for governments with superior documented experience in digital government systems for social protection and welfare.

Daudi has worked extensively in formulation of tailormade professional programs to suit different organizational needs, design and implementation of various ICT related projects which aim at solving problems facing rural communities in Tanzania. Daudi is an innovator with eleven (11) years experience in system design, system analysis, project management and ICT4D design and development.

Michael Stahil
A Health Systems Development Expert specialized in social protection and digital interventions for low-income and transitional countries. His focus is on supporting various governments and International Development Partners, such as the United Nations, bilateral and diplomatic missions, EU, and NGOs in strategic decision making for digital interventions.

George Ruhago, PhD-Health Economics
A health economist with vast knowledge and proven expertise in health insurance approaches, management and design for UHC in LMICs, especially with regard to coverage for rural populations and members of the informal sector.

Pendo Chekingo, BA, MSc Development Policy, and Professional PGD M&E
A dynamic Development cum Monitoring and Evaluation specialist with experience in Project Base and developing project documents; managing and supervising multiple projects at once with excellent communication skills. In this assignment she coordinated and provided technical support in tools development, data collection, data management, and report writing.

2.8. Timeframe

The workplan for the MTR included three main phases of preparatory, field entry and data collection, and report writing. After preliminary results from Mainland followed by an exploratory visit to Zanzibar the final consolidated report was thereafter submitted to SDC for review and comments. The detailed timeframe is presented in Table 2.

Table 2: Workplan

Project Preparations	Responsible	Date	Days	Deliverable
PREPARATORY PHASE				
Documentation review and Inception Report submission	EQUITAN	May 27,2021	5	**Inception Report**
Inception Meeting	EQUITAN & SDC	May 27, 2021	1	**Work plan**
Responding to comments from the inception meeting	EQUITAN	May 28, 2021	1	
Approval of responses	SDC	May 28, 2021	1	
Sharing of the draft contract	SDC	May 31, 2021	1	
Review of the draft contract and sharing comments	EQUITAN	May 28, 2021	1	
Contract finalization and Contract signing	EQUITAN & SDC	May 28, 2021	1	
Fieldwork preparations				

Teams travelling From Dar to Dodoma	EQUITAN	June 6, 2021	1	**Data collection tools**
Start-up meeting for Preparation of detailed programme of data collection	EQUITAN/HPSS	June 7, 2021		
Tools designing	EQUITAN	June 7,2021	3	
Tools sharing for review and review	SDC/EQUITAN	Jun-7, 2021	1	
Tools review and approval	SDC	Jun, 2021	1	
FIELD ENTRY AND DATA COLLECTION PHASE		Date	Days	
Data collection in Dodoma, Manyara, and HQ and National Level[6]	EQUITAN/HPSS	Jun-27-July 2	4	
Team A: RD&PC) Data Collection in Shinyanga and Mwanza	EQUITAN/HPSS	July 5-7	3	
Data collection in Kigoma		July 8-11		
Team B: Data collection in Dar es Salaam (GR+DM)	EQUITAN/HPSS	July 8-11	3	
Sharing Synthesis Report/transcribed tools to Michael Stahl: Digital Technology and System Interoperability and Beneficiary Management	EQUITAN	July 11		**Synthesis Report & Transcribed data**
Travel to Kigoma (RD+PC)	EQUITAN	July 11	1	
Travel Back to Dar es Salaam from Kigoma	EQUITAN	July 11	1	
Data collection in Dar es Salaam	EQUITAN	July 8-11	2	
REPORT WRITING PHASE				
Data processing and analysis				
Review field data, translating, transcribing, coding, and sorting for report writing on key results from the field (Coding and cleaning)	EQUITAN	July 13-Aug 6	20	**Preliminary Findings**
Collecting missing data from the MOH, PORLAG -DPS and the Minister), MoCT, E-Health Partners, Kigoma, and Mwanza	EQUITAN	August 4-12	5	
Preparation of draft report and PPT presentation	EQUITAN	August 12	1	
Submission of PPT	EQUITAN	August 12	1	
Review and commenting on the PPT	SDC	August 13	1	
Presentation of the PPT report & Data gaps	EQUITAN	August 13	1	
Sharing of the Digital Synthesis Report with Michael- Stahl International Digital Space Consultant	EQUITAN	August 6	1	**Digital Space Synthesis Report**
Zanzibar Landscape Mapping				
Travel to Zanzibar	EQUITAN/SDC	August 16-18	1	
Courtesy call and initial discussion- policy direction	EQUITAN/SDC	August 16-18	1	
Discussion with key Stakeholders	EQUITAN/SDC	August 16-18	1	
Report on Zanzibar-focus on iCHF's relevance and coherence and collection of missed data in Kigoma, Mwanza, and Dodoma	EQUITAN	August 22	1	**Zanzibar Synthesis Report**
Reporting Finalization				
Preparation of the word report	EQUITAN	August 2-22	20	
Submission of the draft word report	EQUITAN	September 2	3	**Draft Report**
Reviewing and commenting on the word report	SDC	September 3-5	3	
Finalization of the word report	EQUITAN	September 27-30	1	**Final Report**
Final data and report submission	EQUITAN	September 30	5	
Reviewing ad approval of the final deliverables	SDC	September 30	5	**Closure of the Assignment**

[6]Please note that based on availability of KI, there was a possibility of other trips to Dodoma for Interview

SECTION THREE
RESULTS AND FINDINGS
ASSESSMENT OF PHASE 3 TAF PERFORMANCE ACHIEVEMENT AND GAPS

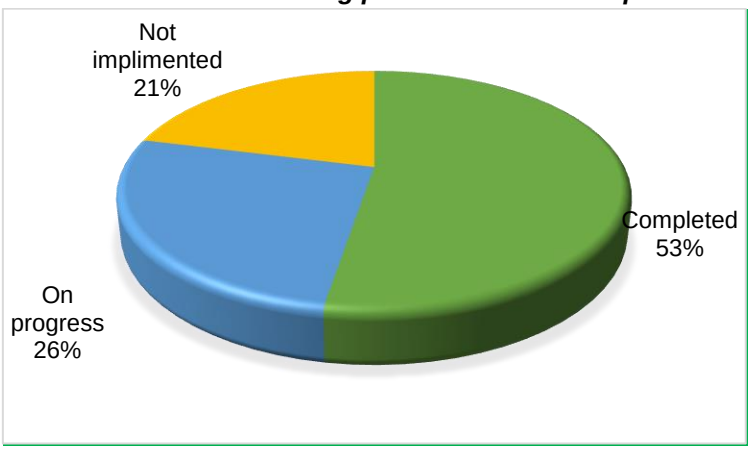
3.0 Introduction

As the title suggests, this MTR was meant to assess whether the HPSS project phase three was on track with providing relevant TA to GoT for the nationwide implementation of Health Financing (iCHF), Medicines Supply and Management, Health Promotion and Health Technology and Management (MEMIS), as described in the program document and logical framework. The focus of this section is reviewing progress made related to HPSS's project Outcome 1: Technical Assistance Facility (TAF) effectively supports national implementation of iCHF, Jazia PVS, openMEDIS and Community Participatory Health Promotion.

It is important from the outset to mention that COVID-19 significantly affected the performance of HPSS exit phase. Following the confirmation of the first case of COVID-19 in Tanzania on 16 March, the government announced various measures, including physical distancing, to limit the spread of the virus. Other measures included the closure of all schools, colleges and higher learning institutions, banning all public gatherings including meetings, training activities and workshops, and restrictions on movements of public servants. Moving to virtual meetings as one mitigation was noted; however, another notable challenge was restriction on international travel especially for Basel based management and technical team.

Generally, COVID-19 negatively affected implementation of the HPSS project activities[7] due to national and international regulation effects. In response to COVID-19, activities and budget were reprogrammed to appropriately operate and respond in the pandemic context. For example, during the first year of the phase three, of the planned 19 activities for implementation of the iCHF thematic area, 10 were completed, five were in progress, and four not implemented as presented in Figure 3.

Figure 3: Year One Health financing planned activities implementation rate



[7] Activity: Actions taken or work performed through which inputs, such as funds, technical assistance and other types of resources are mobilized to produce specific outputs-OECD/DAC 2010

The activities not implemented include conducting and evaluation of progress on ePayment pilot in Shinyanga; support of the preparation of future CHF protocol on matching fund payment and training of regional and council Information Officers on strategies for promoting CHF. Although the ePayment pilot evaluation was not conducted at the time of this MTR, positive changes were recorded in the region. For example, in six months of implementation i.e., October 2020 to March 2021, the region managed to enrol 20,826 households which generated TShs 624,700,000. These early results clearly demonstrate how effective ePayment would be if rolled out country wide.

As noted earlier, the focus of analysis was progress made at output[8] level towards achieving objectives along the results chain. Findings in this section were generated from project performance and progress reports and discussions with project staff at the Technical Assistance Facility (TAF) in Dodoma and self-assessment form, project staff in Basel Switzerland, discussion with project's national level counterparts at the President's Office Regional Administration Local Government (PORLAG) Health Systems Strengthening Resource Centre (HSSRC) and the Ministry of Health Community Development Gender Elderly and Children (MOHCDGEC). Guided by the OECD/DAC Criteria this section is responding to the following question:

EFFECTIVENESS:	**IS THE INTERVENTION ACHIEVING ITS OBJECTIVES?** **Examine: The extent to which the intervention achieved, or is expected to achieve, its objectives, and its results, including any differential results across groups.**

Specifically, this MTR is responding to the following key questions:

a) What is the perception of intended beneficiaries at PHC health facilities, LGA, regional and national level with regard to results achieved, through TAF, so far in phase 3?
b) How are government institutions taking a lead in rollout of approaches and mechanisms that were piloted and developed by HPSS? (examine how prepared national partners are to taking a lead on their roles e.g. University of Dodoma (UDOM) in leading the national scale-up in health promotion teaching centres)
c) Is HPSS project phase 3 on track with providing relevant TA to GoT for the nationwide implementation of iCHF, PV, Health Promotion and openMEDIS as described in the ProDoc and logical framework?

The scoring included assigning three colours of green yellow, and red to the performance output level as shown below:

- On targeted result milestones
- On track , and achievable with modest change and or processes acceleration
- Constrained result and unlikely to be achieved without major change in approach

[8] The products, capital goods and services which result from a development intervention; may also include changes resulting from the intervention which are relevant to the achievement of outcomes/ to which providers contribute directly, or which atributable to provider, OECD/DAC, 2010. https://www.oecd.org/dac/results-development/what-are-results.htm

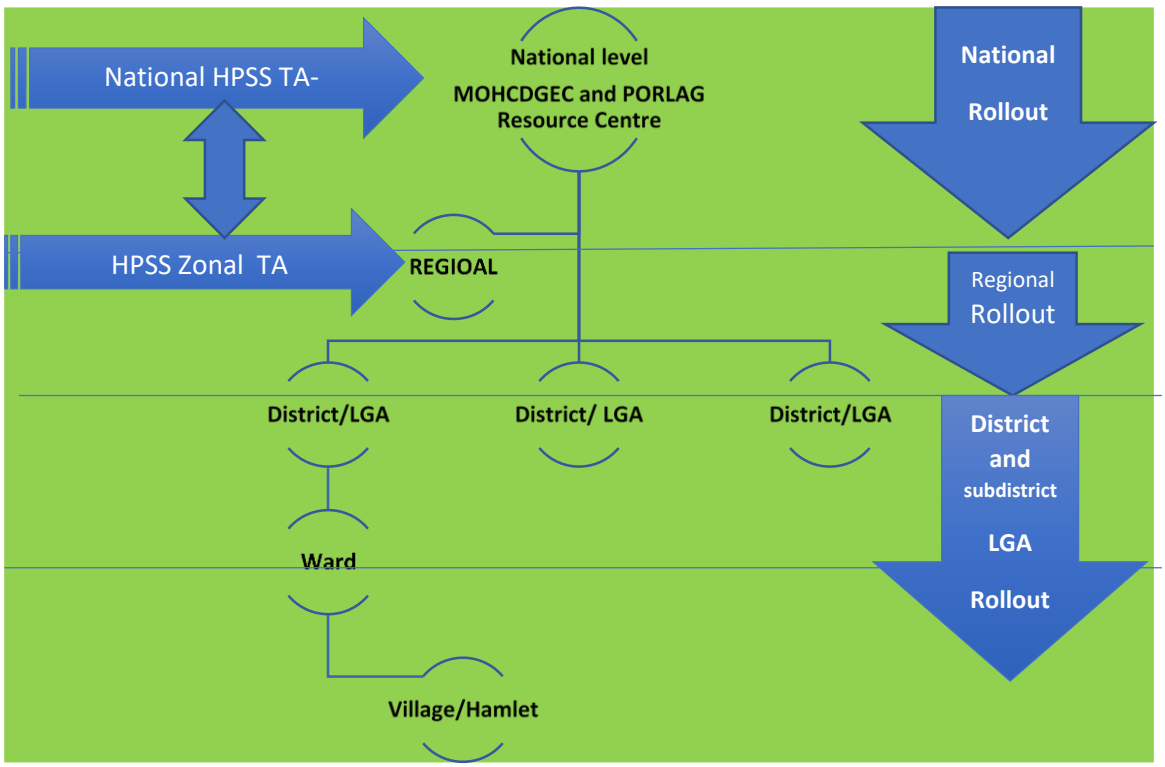
3.1. Assessment of the Implementation of a National System of improved Community Health Fund- iCHF

Output 1.1. The GoT has in place the required structures, staff capacity, tools and procedures for effectively implementing and managing CHF Iliyoboreshwa	

HSSP Support framework

As it is widely recognised, this MTR showed HPSS project support at exist phase concentrates on strategic actions of building capacities for the implementation and management of the innovations to the ministerial teams of experts. At national level support is provided through conducting joint assessments, analysis and development of required documents such as policy guidelines, manuals, Standard Operating Procedures (SOPs) and other important instruments for guiding and steering the institutionalization of the developed digital solution innovations. At lower regional and council level, the Zonal TA aims at enhancing the uptake of and success in improving the iCHF, Jazia PVS, HP and HTM results within the regional and district structures. The layered approach has been documented in project management as most coherent in terms of strengthening complementarity, synergy, and leveraging of expertise for better project results (See Figure 4).

Figure 4: HPSS's layered TA and rollout approach



i. HPSS Technical Assistance and Rollout to Subnational level

Majority of respondents at national level and in sampled regions pointed out iCHF's interventions were on track. At the time of this MTR all 26 regions were implementing iCHF schemes with structures in place at all levels in line with the government CHF circular (2018). In terms of TA from HPSS, an innovative digital solution CHF-Information Management Information System (CHF-IMIS) regional and council level rollout including as per nationally

defined iCHF structure and capacity building were cited and acknowledged as an important HPSS support for strengthening CHF scheme countrywide. In addition, iCHF was commended as the primary catalyst for access to health services and improved financing at health facilities. In addition, insurance awareness regarding health services was reported to be high.

"HPSS has brought improvement in the CHF so there are several issues that we have worked together including developing the IMS system which is used in registering members but also supported in preparing training on how to run the scheme starting from regional level whereby we have 3 experts that control the running of CHF which is the manager, ICTO expert and also an accountant but also at the district level we have the coordinator and IT expert. The trainings have gone as far as all the Enrolment Officers at the villages in the whole country so they have been able to take part in that area, also taking part in creating community awareness to join the scheme, and also providing information through the media channels, they have bought message bundles to create awareness for example also through radio stations, televisions and informing news reporters"

KI-PORALG

Evidently, most regions started implementing iCHF from 2018 following the release of the government circular. This circular was a paradigm shift from the CHF Act, 2001 which mandated local government authority to establish a Community Health Fund in respect of its area of jurisdiction. The team witnessed staff drawn from the pre-existing government workforce. Discussion with iCHF coordinators at national, regional and district levels highlighted their competencies in administration and management of the scheme. Qualification of CHF coordinators we observed varied from nurses, clinical officers, and social welfare officers. This finding is more or less similar to the recent inventory and findings of the CHF Annual Assessment, where the majority of coordinators were drawn from the social welfare, community development, health officer, medical doctor, and dental surgeon cadres.

Similarly, at the regional level, respondents from the six visited regions felt that the iCHF rollout was on track and will likely achieve set targets at the end of the project life span. For example, in Dodoma it was reported that the system is on track:

"since we started the new scheme CHF in 2018 at regional level, the scheme has been operating on its own though HPSS has been supporting on technical support but on issues of financing we utilize 20% of the premium to run the business and 80% to pay for CHF claims on the facilities, we facilitate community sensitization from our own funds and also support other businesses related to CHF for example procurement of materials from CHF funds so you see the technical support we get from HPSS the business can run on its own, what is needed is to continue sensitizing calling more members in the scheme we can renew the business after one year. so, its on track in terms of tools and procedures"

KI-Dodoma-RHMT

At the district level, respondents further reported iCHF interventions to be on the course likely to achieve what was planned. For example, in Mwanza the targeted 4.5% of households had been enrolled on iCHF.

"this district so when you reffers back [a few years] there were very few people but now people are increasing and they are receiving services from various facilities. The system itself is improving day by day, previously there were very many complaints about it but now we proudly say people are settled [content] compared to before whereby a person could not be treated elsewhere apart from the place where they registered but now one can be treated anywhere provided, they have the card. It's on the right track honestly"

KI-Mwanza CHMT

At Magugu health centre, women who were attending services shared positive things to say about the services they received. Through PharmAccess Mom project iCHF premium support, overall enrolment of early pregnancy before twelve weeks significantly increased. Women access costed services including delivery through Cesarean Section thus increasing accountability at facility level. The support has boosted the enrolment coverage working hand in hand with healthcare workers.

"I am very impressed with the services rendered from this facility, ever since I joined iCHF I have never regretted, I came here when I was twelve weeks pregnant and joined immediately through Mom Care project. Myself and my fellow women are served on time, the nurses are good to us, all I can say my pregnancy journey was smooth and I have safely given birth to a healthy bouncing baby boy."

KI- Manyara Health Facility

This MTR made an effort to examine how government institutions were taking the lead in the rollout of approaches and mechanisms that were piloted and developed by HPSS. Evidence from the field indicated that the roll-out has been wholly supervised by the government at national and subnational level. For example, at the regional level, implementation is coordinated under the general leadership of the Regional Commissioner (RC) and directly supervised by the Regional Administrative Secretary (RAS). At technical level, the Regional Health Management Team, the core teams of the iCHF, PVS-Jazia, Health Promotion, and HTM coordinators were found engaging in roll-out as their daily responsibilities. Similarly, the MTR found at the district level, District Commissioner (DC) and District Administrative Secretary (DAS) and District Executive Director and all management team with Council Health Management Team (CHMT) were directly involved in administration, management and promotion of the iCHF. At regional and council level, CHF coordinators were directly responsible for the fund's welfare.

As the CHF Regional Coordinator, my job is coaching, if you don't coach well at district level you will fail at regional level. So, you have to make sure you be a good coach. One of the disadvantages of leading at regional level [is that] I have 3 councils which are running faster [performing better], two councils are medium rate and another 3 are lagging behind so what I do is to balance when you are coaching this business you should pay much time to those that are lagging behind and those that are running fast you coach them well. So, you can have an idea so the way I plan with the poor performing district is different from the way I plan for best performing district.

KI- RHMT Dodoma

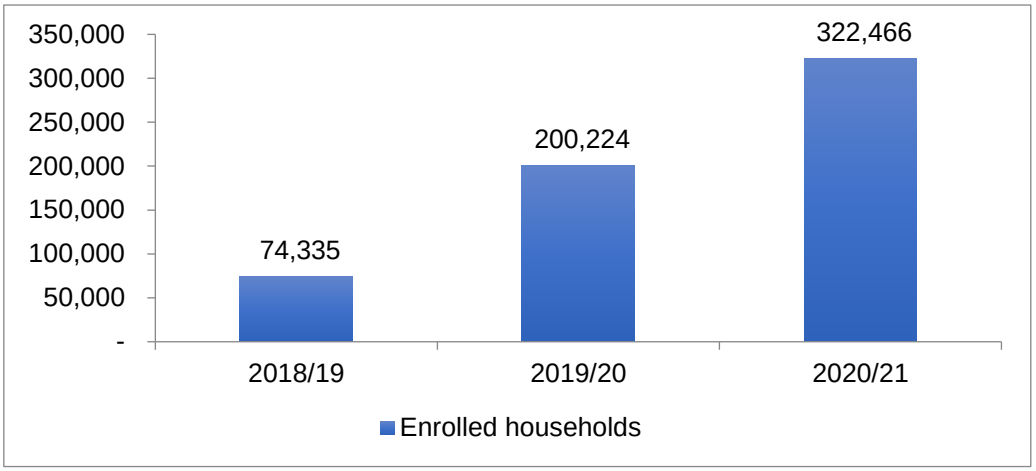
ii. Project Performance

With regards to assessment of performance according to the project's logic framework, output 1.1. measures the following deliverable elements: number of active individuals in IMIS; rate of active clients in iCHF as of the last day of given time/period per population; income from CHF collections plus net income from CHF matching fund; and total amount paid to health facilities.

iCHF Coverage

This MTR sought to respond to the following question: Have the outputs of HPSS project phase 3 resulted so far in increasing coverage with iCHF and reducing stock outs nationwide? Findings from this MTR show that, enrolment of members for iCHF is on a steady increase regardless of some few shortcomings as portrayed in Figure 5.

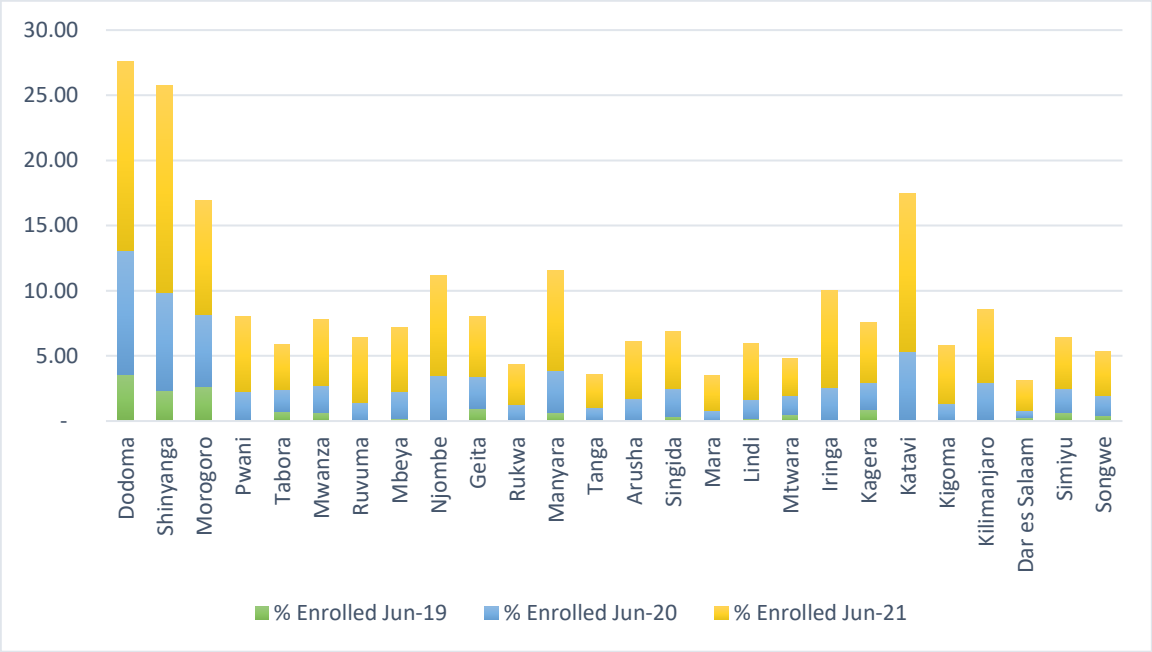
Figure 5: iCHF cumulative enrolment trends 2018/19 to 2020/2021



Further analysis indicates regional variations; enrolment has increased more steadily in regions that were supported by the first and second phases of the HPSS project. For example, cumulative increased enrolment over the three year period (2019 to 2021) in Dodoma, Shinyanga and Morogoro with coverage of 3.9% to 15%, 2.3 to 16% and 2.6 to 9% respectively compared to Dar es Salaam, Simiyu, Songwe with coverage of 0.3 to 2%, 0.6 to 4%, 0.5 to 3% respectively (Figure 5). Although during data collection in sampled regions we noted HPSS pilot regions of Dodoma and Shinyanga Dodoma and Shinyanga had more experience and investment compared to all the other 4 regions because they were pilot regions were receiving similar TA, better performance in these regions suggests long time accrued experiences for the past ten years whereas other regions have started implementing iCHF from July 2018 and with limited investment. Nevertheless, it is worth noting that "new regions" such as Katavi, Iringa and Njombe to cite a few are also closing the gap very steadily after gaining experience

(See Figure 6). It can be postulated enrolment rate will change dramatically if the mandatory UHI act is enacted and implemented this or next year.

Figure 6: iCHF cumulative enrolment trend 2018/19 to 2020/2021 by % and regions



Source: IMIS, June 2021

Rate of active clients in iCHF

Active membership, referring to families/households whose policies are still active at the time of reporting, either new enrollees or those who have renewed their policies and remain active increased from 1.07% in 2019 to 2.84% by April 2021, but is still below the target of 5% (Figure 5) Active clients are enrolled members who have renewed their premiums. What factors attract members to renew or not? Possibly because of satisfaction by services- package received. Data from visited regions revealed Non-Government Organizations (NGOs) are supporting enrollment of members to iCHF. For example, in Kigoma World Vision and Plan International were supporting families from vulnerable groups.

"on the side of enrollment of members, it is good. And it is good because, we have stakeholders here who support either children living in vulnerable situations but also, they support children in schools. I think they are Plan International and others.
For instance we have just recently received TZS 50 or so million from Dar-es-Salaam, World Vision; you find it is these partners who give support on social issues. So, we have become number one because we have these stakeholders who help to pay for them through iCHF. But if it was left to us alone without the stakeholders it would've been a challenge"
KI- Kigoma RHMT

In Manyara, PharmAccess is supporting enrolment of pregnant women through MomCare project. The MomCare aims at demonstrating a quality improvement for maternal and childcare services through demand side financing. The model increases accountability, good governance, improving system responsiveness to women who receive RCH services and increase health seeking behaviors by empowering women accessing maternal care. At Magugu health centre, women attending services shared positive things to say about the

services they received. In Kigoma region, lack of medicines and commodities has been a major constraint for enrolling to iCHF as was cited by a health facility respondent:

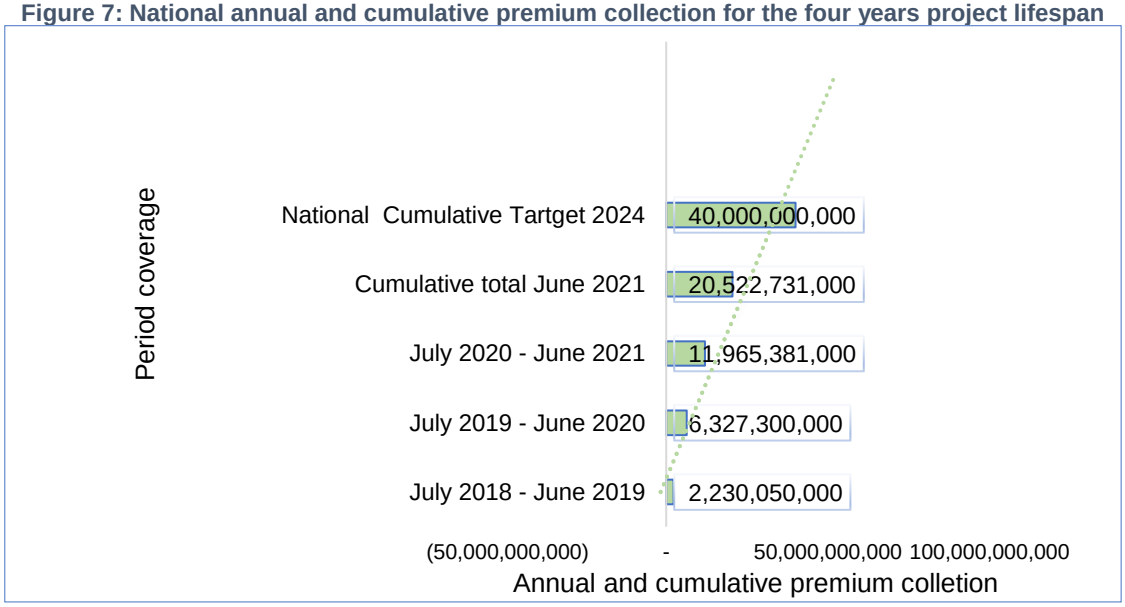
"when a pregnant woman comes, she needs surgery, she has to buy everything. They are only supplied with few equipment that are available but most of them they have to buy. It can cost them over 50,000. They are complaining a lot what is the use of 30,000 they pay for insurance"

KI-Health Facility -Buhigwe DC

Collection from iCHF and amount paid to health facilities plus matching funds

The amount of funds collected nationally has increased from Tsh. 2.2 billion in FY 2018/19 to Tsh. 11.9 billion in FY 2020/21, more than fivefold over time and reaching half of the four years target of Tsh. 40 billion. The target for the project is TZS 40 billion as the cumulative amount from Nov 2019 to October 2023. By June 2021, the cumulative amount collected was TZS 20.5 billion implying the project is likely to achieve or perform over the set national target as linear line forecast if situation remains constant, as portrayed in Figure 6.

Figure 7: National annual and cumulative premium collection for the four years project lifespan



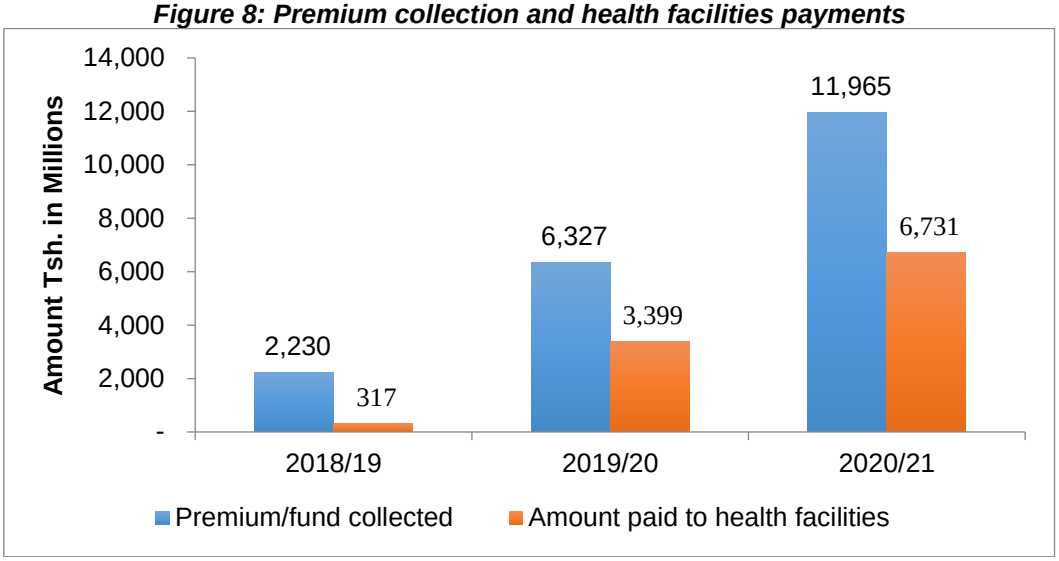
Source: IMIS, 2021

The amount of funds paid to health facilities is about half that collection over the three years. The cumulative collection over the period stands at Tsh. 20.5 billion, while the payments are at 50.9% or Tsh10.4 billion. Dar es salaam region lies on the extreme side with a cumulative collection of Tsh. 3.2 billion but only paid about 24% of that amount, Tsh. 0.76Billion. (Figure 7). The case of Dar es salaam needs to be viewed from different angles. Firstly, the regional collection of Tsh 3,159,788,000 is equivalent to 15% of the national total collection while the Tsh 768,194,505 is equivalent to 7% of Tsh 10B paid to health facilities. Secondly, it should be noted that, the CHF performance in the region is shaped by the unique social and demographic characteristics (dense population and low poverty level but with high absolute number) compared to other regions of Tanzania. Thirdly, as per the formula, Dar es Salaam is paying according to the requirement. There was augment that, the only issue here is that

the region has received a relatively larger volume of premiums from October 2020, which is in harmony with the spread within membership period (to cover membership for 12 months) and thus allocation for HF reimbursement is also spread in that respect. In this regard, the amount collected does directly link to the amount paid during the given time frame, of which the data were collected.

Figure 9 shows funds collected per region. Da es Salaam has the highest funds collected followed by Dodoma, Morogoro, and Shinyanga. Again, the HPSS project former pilot regions appeared to perform much better than other regions. Mara, Simiyu, Songwe, and Rukwa have the lowest of funds collected.

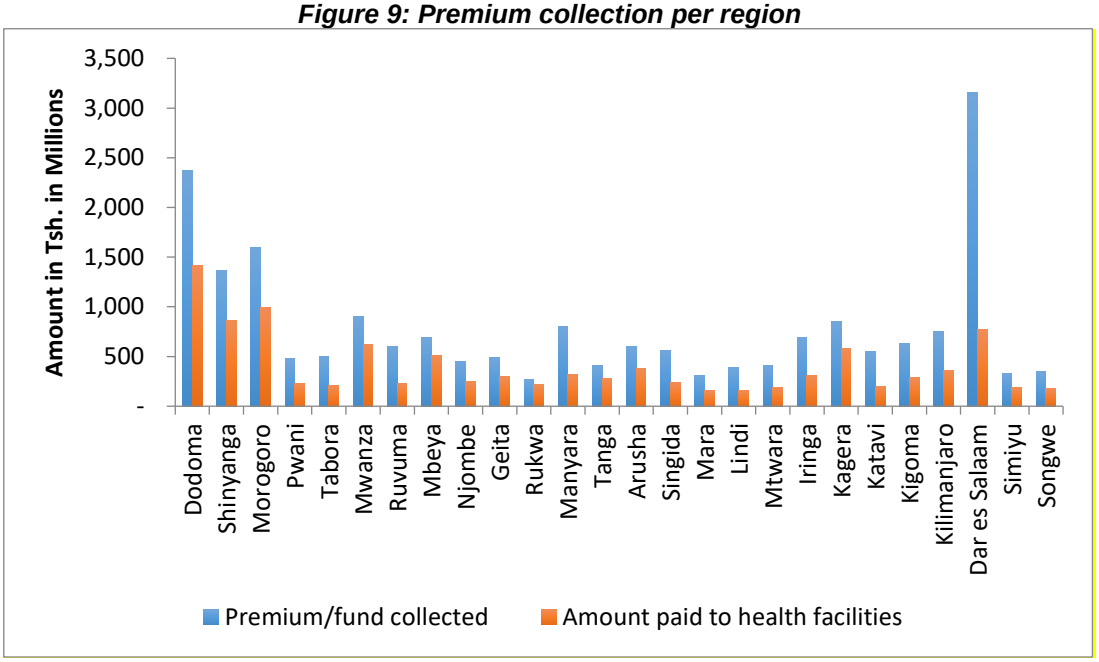
Figure 8: Premium collection and health facilities payments



Furthermore, the majority of former donor-supported regions by Health System Strengthening Project (HPSS), PharmAcess (Manyara) have been doing relatively better as compared to the new rollout regions in implementing iCHF. Regions without donor support have found it challenging to initiate the iCHF because of the high initial investment cost in terms of awareness building and equipment as shown in Table 5. The latest scorecard indicates regions with the highest administrative cost share as a percentage of income, which might jeopardise the funds collection liquidity. For example, the administrative cost as percentage of income for Simiyu was 24%, and Kigoma was 30%, both above the set 20% threshold.

Although interviews with KIs commended portability across the region, there were some reservations at tertiary levels as the scheme by design doesn't include the really cost of services provided. According to the scheme design, the premium is set at Tzs 30,000.00 per family with a maximum of 6 individuals (family members) and the government matches with Tzs 30,000. However, findings from this MTR revealed that since its operationalisation, the Government has not disbursed the matching fund as expected. The government is supposed to add the same amount of funds collected at health faciity level. In our view the fact that the scheme is running on 50% of the projected funds, this has increased burden and lessened liquidity of pooling at the regional level.

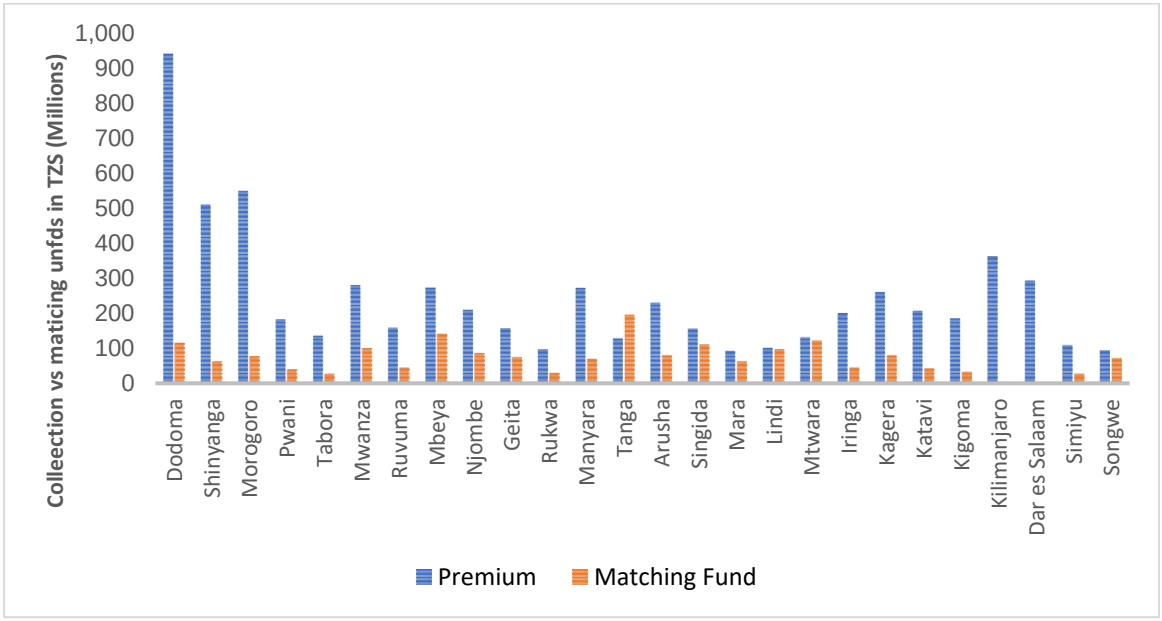
Figure 9: Premium collection per region



Source: Project Report, 2021

Lack of adequate matching funds and future capacity of the government to meet her obligation with a potential increase in enrollment was argued as not healthy for the pooled fund liquidity. In other words, it is presupposed that the government will keep increasing the matching funds as enrollment increases, but this has not been the case. This MTR observed that not only is the matching fund not equivalent to the amount collected, but the latest payment was made in 2019/20 financial year as presented in Figure 10.

Figure 10: Collected premium against received matching funds by region 2019/20



Source: Independent Verification of Health Service Results Supported by the Health Basket Fund, 2021

"So, they lose all the user fees as was before the iCHF and then paid very little and remember it's never on time so they are making lose because the government is unable to make the other sufficient funds the 30,000. I was reading somewhere that the iCHF

insurance has covered only 5% of the population country wide and the government cannot afford to pay the 50% percent of the matching fund so it's up to you and me to ask ourselves what if we push it to 20% -30%? The hospitals will literally refuse"

KI-HPSS Basel

Data obtained from recent the Internal Auditor General verification report for disbursement of the HBF observed that a total of TZS 1.83 billion (29.1 percent) was released out of TZS. 6.32 billion requested in financial year 2019/20 (Figure 9)

The improved Community Health Fund provides an opportunity for accessing services at regional referral hospital level. While satisfaction was generally observed at primary health care levels, reservations were made about payment for services rendered at tertiary facilities at Regional Referral Hospital levels. In Kigoma, one respondent from the RHMT expressed similar views on costs incurred for promoting and managing the funds:

"…but the management of it poses that challenge. Even when you have enrolled 100 people with iCHF, meaning you get 100 times Tsh 30,000 which is approximately three million. So, the person starts reasoning the mobilization that I have been doing and at the end of the day I don't get back what I worked for, the service providers start thinking that it doesn't pay"

Kigoma RHMT

Because of relatively high levels of operational and administrative expenditure, the challenge may even be worse with regions with lower populations and/or higher poverty levels, which implies that even if enrolment rate is high, fewer members are contributing to meet fixed and administrative cost and procurement of services provided at facilities. As an example, further analysis of recent highest expenditure in the relatively highest poverty index and/or low population regions (Katavi, Njombe, and Kigoma) is shown in Table 3. According to the recent Household Budget Survey (HBS, 2019) Kigoma is one of the poorest regions; second to Mwanza- with basic poverty and leading food poverty in Tanzania with one third of population living below the poverty line.

Table 3: Enrollment Rate and other Social Demographic Variables in selected regions

Region	Population	Basic Poverty	HH population	HH Size	Active		Active %		TZS collection in	Admin cost
					2020	2021	2020	2021		
Dodoma	2,492,989	23.2	534,976	4.7	35,984	28,863	6.73	5.40	2,242,480	7.7
Rukwa	1,270,050	45	254,010	5.0	2,003	4,049	0.79	1.83	240,320	23
Dar	6,813,287	8	1,310,248	5.0	6,481	23,005	0.50	1.76	2,943,808	4.5
Kilimanjaro	1,864,329	10.5	433,565	4.3	17,187	12,015	3.96	2.77	692,050	1.8
Kigoma	2,616,200	34.5	458,932	5.7	13,807	13,480	3.00	2.95	589,330	48.0
Lindi	977,738	38	257,299	3.8	6,633	7,124	2.58	2.77	369,310	-
Njombe	803,299	13	198,192	4.1	7,109	8,188	2.16	2.71	422,460	70.9
Katavi	738,237	29	131,828	5.6	9,581	5,762	7.27	4.30	415,170	68.6

Source project data and Household Budget Survey, 2019

Based on the iCHF design document, all provider payments are based on capitation. Ten percent of the premiums collected from beneficiaries is expected to be deducted to compensate enrolment officers as payment for services, nine percent is spent for administrative costs and 80 percent for capitation (MOHCDGEC, 2018b). The remaining one percent is set aside as reserves for the iCHF capitation formula. Of the government matching funds, 15 percent is used for administrative costs and 80 percent for capitation (see Figure 3). The remaining five percent is set aside for reserves (MOHCDGEC, 2018b).

Of the pooled funds set aside for capitation, 65 percent is allotted to primary healthcare facilities and 35 percent to hospitals. Under the iCHF design, capitation payments flow directly to facilities accounts instead of passing through district accounts. At public facilities, capitation rates are not intended to cover the whole cost of providing services as salaries and overhead costs are paid for through supply side financing from the government.

Under capitation funding modality, payments to health facilities is not based on the actual cost of services provided i.e. reimbursement but health care facilities receive fixed monthly payment that covers health services costs adjusted for rates of service utilization. 80% of collected fund goes back to health facilities under calculated formula. Criteria depends on utilization volume of number of cases. As such, unlike NHIF's itemized claims, iCHF does not use a cost reimbursement modality.

iii. Conclusion

Evidently, this MTR shows that irrespective of the iCHF implementation challenges, significant achievements of HPSS's project TA within this exit phase are clearly notable. This includes high level government ownership and leadership in rolling out the scheme to all 26 regions and ensuring committed staffing at all levels (national, regional, districts, councils, ward, and village level) and the acceptability of the scheme in the community. In addition, a fivefold increase in enrolment deserves to be commended.

Conclusively, findings of this MTR suggest the project will likely achieve set goals. The ongoing efforts of strengthening iCHF are laying a good foundation for more room for the Switzerland's TA and future financial support for the envisioned Mandatory Universal Health Insurance.

iv. Recommendations

For the remaining interim project exit period:

- Increase more efforts on unfinished business for remaining period including policy guidelines and interoperability of the digital solution.

- Advocate for the government's commitment to match funds for the government's commitment that is lacking or the implementation/honouring of the commitment

- Further research: Despite growing policy and programme interest in iCHF, there is very little research on which to base an assessment of iCHF's impact on providers performance, particularly at tertiary (regional referral hospitals) and zonal levels of the health system.

Several issues warrant further investigation to respond to the following:

- It is therefore an opportune moment not only to review developments in CHF markets, but also to consider the effects of iCHF on health system performance.
- The purpose of measuring health system performance will be to generate reliable information for policy development and to foster accountability by enabling stakeholders more participation in the process and to make informed decisions.

Long-term recommendations:

While we acknowledge that the good progress in iCHF performance and a need for evidence generation for advocacy, it is our opinion that support for iCHF is still required to further enhance its management and business operations. It is our understanding that the current policy direction of UHI of which iCHF is a part, will implemented soon. We anticipate that the government will implement some structural and design changes of the scheme, hence, in this respect, support to iCHF should continue in the following areas:

- Management and coordination of the scheme, especially through establishing a strong “iCHF Unit” at PORALG
- Customers relations, communicating with iCHF client
- Branding, marketing and promotion of iCHF
- Restructuring of the enrolment personnel into an effective sales agent model
- Empowerment of elected councilors and of administrators by establishing an easily accessible iCHF monitoring tool through an online portal with customized dashboards
- Establishing iCHF as a pro-poor financing mechanism through subsidizing health insurance for TASAF members (and possibly extending this social protection to other vulnerable groups)
- Offering iCHF health insurance for small and medium scale businesses and associations
- Given Switzerland’s niche and experience in health care financing it is therefore recommended that the SDC continue providing technical support

3.1.2. Implementation of a complementary supply system for health commodities-Jazia Prime Vendor System

Output 1.2. The GoT has in place the required structures, staff capacity and tools for effectively implementing and managing the Jazia Prime Vendor System	

i. National Technical Assistance and Rollout to Subnational level

With regards to structures and staffing, coordinators for PORALG and MOHCDGEC were appointed. The MOHCDGEC is working on development of national policy and guidelines while the PORLAG counterpart is responsible for daily operationalization of Jazia-PVS. Findings from this MTR revealed all required staff are in place from national and health facility levels. Similarly, all regions, councils, and public health facilities are implementing Jazia-PVS. All regions, in line with the circular number one for implementation of JAZIA prime vendor system, have vendors supplying medicines and facilities are procuring whenever they have a stock out list from MSD.

ii. Project Performance

The key indicator for this output is the number of regions that are operating the Jazia PVS according to national guidelines/SOPs. Five deliverable elements for this output included: a) Jazia-PVC responsible staff placed at national and regional levels, b) National Jazia-PVS and vendor guidelines, c) Standardized National Auditing tool, d) Training module on eLIMIS and, e) revised Standard Treatment Guidelines. In addition, this output is measuring two variables: available tracer medicines, and total value of all purchases from Jazia-PVS in each region and for the whole country. The ultimate national target is to have fully functional MSD with no need for complementary Jazia-PVS.

In terms of expected deliverables for this output, 'findings from this MTR revealed that expected deliverables for this output were lagging. For example, the National Jazia PVS guidelines and vendor guide are in the final stages of the draft version but is yet to be finalized and approved. The approval and endorsement of the Jazia-PVS guidelines has been delayed by almost one year now. Review of the approved micro activity plan shows this activity was planned to be finalised by December 2020. In addition, the Standardized National Auditing Tool was planned to be completed by end of April 2021 but was still in development stages. Another tool which was lagging is the training module on eLIMIS for dispenser students which is scheduled to be developed in this year. The Pharmacy Council of the MOHCDGEC had not yet approved the training module. A recent progress report indicated that the working session for the revised STGs stratified by level of care that was to enable stratification and support to digitalize Jazia PVS order processes, monitoring and reporting, by leveraging existing national IT systems (DHIS2 and eLMIS) had not taken place. The prerequisite for implementation of this activity is hinged on signed PVS-Jazia guidelines. In addition, although the Jazia digital solution was developed it was not operational at the time of this MTR, activity for development of Jazia PVS digital system started in year 1, with higher user requirement to stakeholder's business mapping activities. The system has not been developed to date like other activities pending approval of the guidelines.

Availability of Tracer Medicines

Jazia PV system has significantly reduced drug shortage in most facilities. For example, in Dar es Salaam, it was reported that PVS-Jazia has significantly contributed to the availability of health commodities at health facilities. Other visited regions attested to improvements in availability of medicines and supplies through Jazia-PVS complementary modality.

> *"by referring to the percent, we are at 83% in availability of essential medicines whereby before JAZIA we never reached 70%. But also I see a bright future ahead as we are continuing to improve JAZIA. We had one Prime vendor in the region. For the time of his/her service we identified some challenges, the ability of serving all pharmaceuticals, medical equipment and laboratory supplies is heavy [challenging]. This time we are allowed to have four prime vendors in order for another to deal with one category and another with another category. So we are expecting to rise from 83% to 100% in achieving regional goals"*
>
> ***KI- RHMT Dar es Salaam***

In Dodoma, HPSS was acknowledged for the more than three years of technical support. Jazia is being run by the government in the region while HPSS offers technical support and finances for a few things. Similar positive achievements were reported at facility levels.

"the prime vender system was designed for bringing services nearer to the facilities so it was an alternative to MSD, instead of waiting for MSD for 3-4 month. The MSD is providing services to the whole country, so if we have the prime vendor to the regions, who we can face physically and is easy to press orders and get medicine why can't we use them to make the facility services easier?"

KI- Health Facility Shinyanga

in Shinyanga PVS improved availability and shortened time spent for requesting out of stock commodities at facility level. In Kigoma, interviews with respondents reported that the quality of health services provided, particularly drug availability was very poor. When iCHF members visit health facilities, they do not always find the required drugs. Similarly, in most cases, laboratory services were lacking. As a result, some CHF members were told to buy drugs from private vendors and other members were given referrals to nearby health facilities. This situation discourages members and thus they sometimes decide not to seek health care services. Due to this problem, some members planned not to renew their CHF cards upon expiry. This was attested to in an interview with a health official in Kigoma.

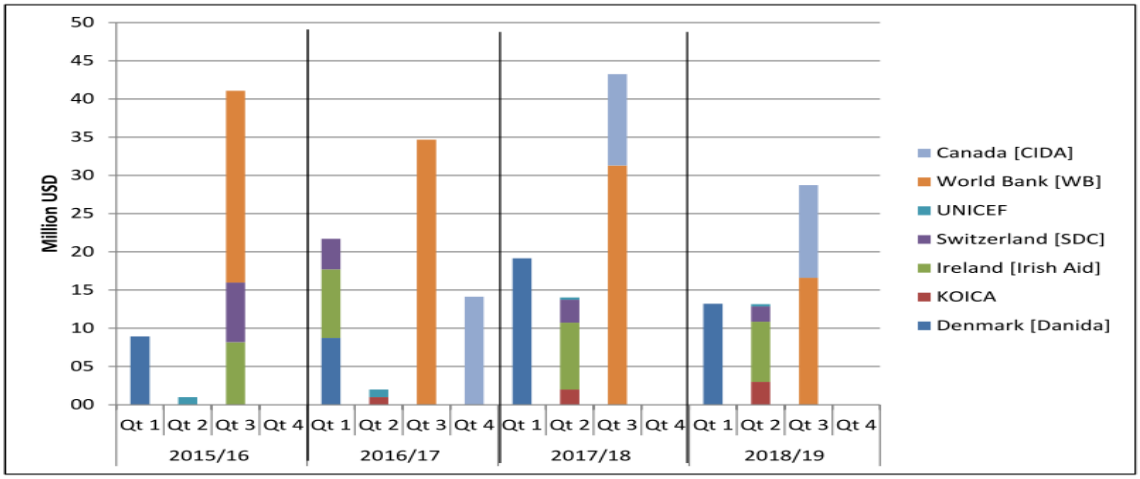
"Now we don't have confidence to stand in the public and promote insurance. People might throw stones to you. They won't even listen to you. So, we expect a big number of dropouts this year"

KI Health Facility- Muyama HC, Buhigwe, Kigoma

Total value of all purchases

The value of health commodities procured through Jazia vendor system has been unsteady due to delayed disbursement of basket funds at primary health care levels. It should be noted that PHC facilities especially dispensaries and health centres largely depend on HBF as a source of funding for medicine and supplies. Only one DP has consistently been able to disburse in first quarter (Figure 11), it is unclear why the Government has not been disbursing funding timely.

Figure 11: ***Development parterns disbursements to HBF Holding Account by quarter***



Source: MoHCGEC 2019

Delayed disbursement of HBF for more than three quarters in 2020 has been observed. Similar delays in disbursement was documented by the recent HBF review that revealed various explanatory factors . One factor could be late disbursement to the Holding Account by DPs. The delays in DP disbursement is to some extent dependent on the late signing of the annual Side Agreement, which is a prerequisite for DPs to be able to disburse

The HBF has been increasingly one of the major sources of funding at primary health facility level. For example, the same report showed that, the HBF contribution enabled procurement of medicines, infrastructure improvement, supportive supervision and capacity building (Table 4 shaded in green). At health centers and dispensaries visited in the field, it was estimated that more than 80% of the medicines procured by health facilities in 2018/19 were funded by the HBF rather than by user fee collections.

Table 4: Sources of funds by source and health facility level 2017/18 - 2018/19

Health Facilities Level	2017/2018					2018/2019				
	HBF	**NHIF**	**CHF**	**User fees**	**Total**	**HBF**	**NHIF**	**CHF**	**User fees**	**Total**
	Million TZS					Million TZS				
Council/DDH Hospitals	1211	664	348	1066	3288	1274	427	294	1277	3273
Health Centers	532	188	88	336	1145	611	340	46	397	1394
Dispensaries	106	25	26	30	187	109	27	11	20	167
Total - DDHF	1849	877	461	1433	4620	1994	794	352	1694	4834
	Percentages					Percentages				
Council/DDHs	37%	20%	11%	32%	100%	39%	13%	9%	39%	100%
Health Centres	46%	16%	8%	29%	100%	44%	24%	3%	28%	100%
Dispensaries	57%	13%	14%	16%	100%	65%	16%	7%	12%	100%

Source: HBF MTR, 2020

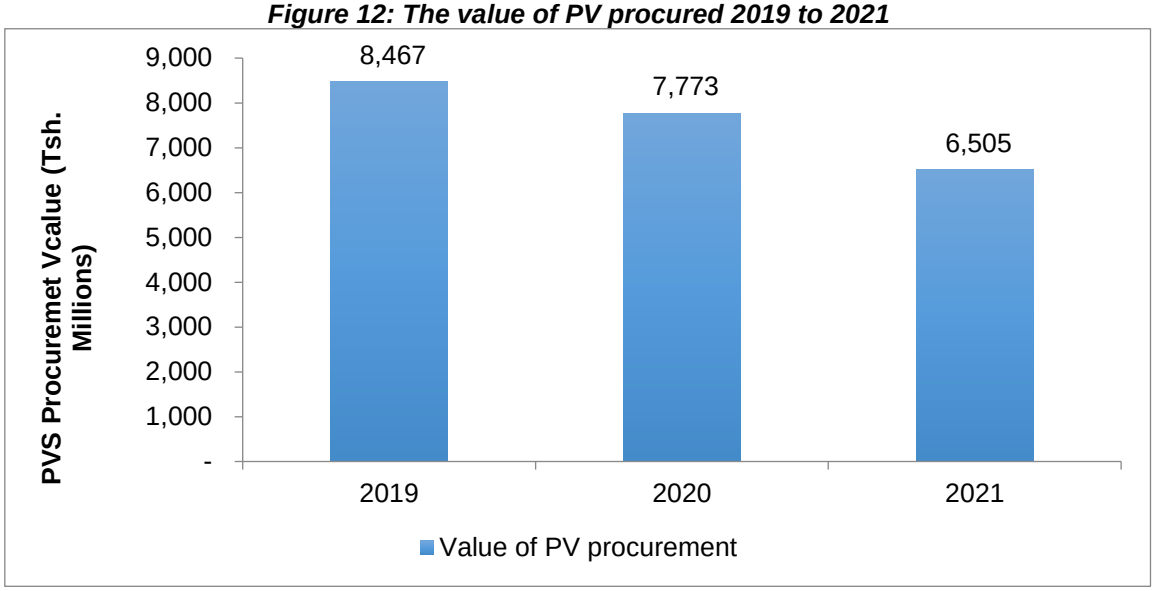
In addition, Regional Referral Hospitals (RRH) which were the biggest purchasers at some time have stopped using PVS due to an unexpected increase in prices because of the Covid-19 pandemic. This situation might partly explain the relative decrease in value of procured commodities for the past three years as presented in Figure 10. Regardless of some of these shortcomings, Jazia PV system has reduced drug shortage in most facilities. Tracer medicines availability is at 80% and on track to the target of 100%. However, in Kigoma and Mwanza, hesitancy of prime vendors to supply facilities and corruption of DMOs was noted:

"another challenge was in pricing. The prime vendor was requesting an increase in the prices due to COVID. So, we sat together as a region and agreed on the price. There was a time she refused to sell us drugs due to the prices and that was not nice. So, for more than three or four months she didn't provide services but later on we sat and agreed on a price. We set a standard price according to the market and for her according to COVID-19 so it was all set and we started back again. But also, there was a challenge not here but we were cautioned that some of the DMO's have been asking for bribes. She is the one who submitted that to TAMISEMI. They ask for bribes"

RHMT- Kigoma

It is unquestionable that the essential medicines availability has of recent improved. The 10 tracer medicines and essential medicines for acute infectious diseases, pain relief, noncommunicable diseases and one vaccine are tracked in DHIS2 through routine data collection.

Figure 12: The value of PV procured 2019 to 2021



As most routine data indicates adequate availability of commodities, a different picture was observed during the field visit of this MTR. At sampled dispensary and health centre levels in Buhigwe District Council a serious shortage of medicine and supplies was reported.

"Also, facilities don't have medicines because they don't have money to purchase from prime vendors since contributions are being deposited to regional account and when we request, we receive small amount of money. It even de-motivates morale of mobilizing people to join.

There are no medicines. It's like we harass people. They complain that they would have been told so that they don't join and use their money which they paid for contribution to buy medicines"

KI- Buyenzi Dispensary, Kigoma

Again, this was attributed to delayed and declining HBF disbursements and medicine and supplies. In addition, the issue of lack of medicine and enrolment of new clients, and imbalance between serviced provided and claims payments was reported.

"At the beginning were receiving 19 million, then it decreased to 14 million then it decreased again now we get 6 million. That is a very small amount to health facility. There are a lot of services to do so when funds come, they don't cover all the requirements. There was a time they delayed to be deposited, we were in a worse situation. They were deposited February this year. We were requesting medicines from MSD and given only Alue for malaria and ARV, no other medicines.
Also, the deposited amount doesn't reflect with the service we provided. Previously they told us to make sure we claim but it doesn't help"

KI- Muyama HC, Buhigwe DC

Similarly, during an interview, one of the KIs expressed reservations about what we see in routine data reports and what is practically happening at the facility levels. This was flagged out by the Chief Medical Officer (CMO).

*"Takwimu na taarifa haziwi na uhalisia, Kukosekana kwa fedha 2019/2020 – kulipunguza kasi ya mnyororo wa ugavi – athari ni kubwa, Maoteo: Uhalisia wake ni mdogo (accuracy level below **67%**), Udokozi/wizi/Upotevu wa bidhaa za afya vituoni, and Medicine/drug audit za kila robo hazifanyiki (hafifu)"*

"The report and reality on the ground does not reflect reality. Lack of budget for 2019/2020 slowed the procurement and logistic speed-serios effect, projections accuracy very low at 67% stalking/theft/loss of health product at health facilities, and medicine/drug audit are not conducted on quarterly basis"

RMO and DMOs Meeting, 2021

This challenge of stockout and the discrepancy between budget allocation and actual release for medicine and supplies cannot be overemphasised. Recent data from the MOHCDGEC indicates that apart from the year 2015/16 and 2020/21, release of funding for medicine and supplies has been below 50% as summarised in Table 5.

Table 5: Government budget and release by financial year

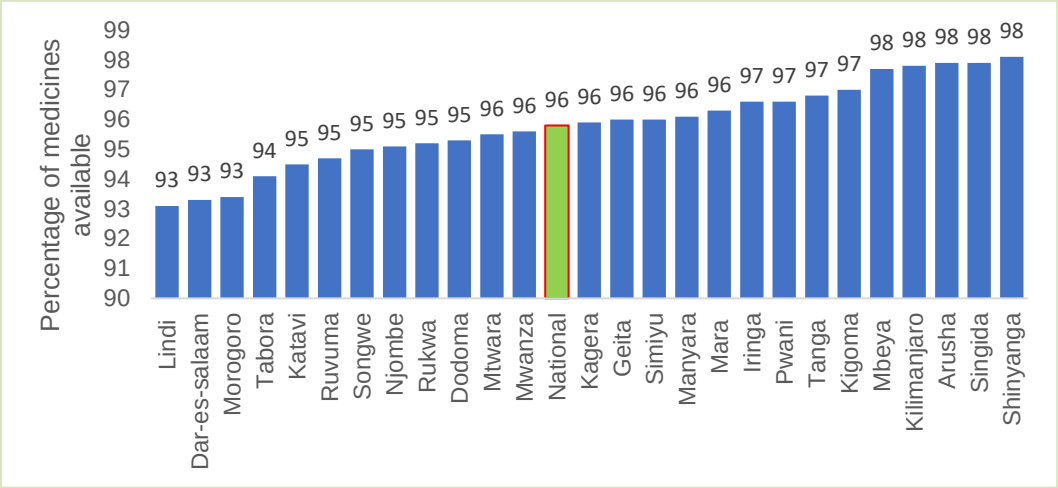
Financial year	Budget (TZS Billion)	Released (TZS Billion)	% o
2015/16	29.25	35.2	121
2016/17	251.5	121.08	48.1
2017/18	260	80	30.7
2018/19	260	80	30.7
2019/20	200	0	0
2020/21	200	152.3	76.15
2021/22	218	10	4.6

Source: CMO Presentation to the RMOs and DMOs meeting, 2021

iii. Conclusion

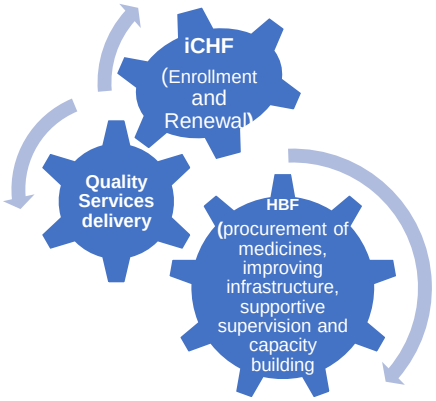
Although gaps were noted in this MTR, It is unquestionable that the PVS-Jazia has significantly contributed to recent increased availability of essential medicines. The ten tracer medicines and essential medicines for acute infectious diseases, pain relief, noncommunicable diseases and one vaccine are tracked in DHIS2 through routine data collection. The availability of tracer medicines was generally high and increased during HSSP IV: 88.3%, 82.2%, 91.6% and 95.9% in 2015, 2016, 2017 and 2018 respectively. This improvement is observed in all regions. The five best performing regions in 2018 were Shinyanga, Singida, Arusha, Kilimanjaro and Mbeya. The variation between regions is small, with Lindi and Dar es Salaam only 5% below the best performing regions as shown in Figure 13.

Figure 13: Tracer Medicines and Supplies 2018



However, this MTR observed that gaps still exist, including critical shortage of tracer medicine and reported incidences of corruption. This should also be explored further. Furthermore, strong complementarity and synergy coherence exists between the HBF and iCHF performance including enrolment and renewal of members as portrayed in Figure 13.

Figure 14: HBF Complementarity and synergy with CHF at Primary Health Care Level



iv. Recommendations

- Increase efforts in unfished business for the remaining period including policy guidelines, digital solution functionality, and SOPs

- Given the strong HBF and PVS-Jazia complementarity, it is recommended that the SDC spearheads evidence-based advocacy among HBF partners and government on timely allocation and disbursement of the HBF to health facility levels.

3.1.3. Implementation of the Health Technology Management

Output: The GoT has in place the required structures, staff capacity, tools and procedures for effectively implementing Health Technology Management	

i. National Technical Assistance and Rollout to Subnational level

It is worth noting from the outset discussion of this component that, unlike CHF, PVS-Jazia, and Health Promotion component, the context of this component was planned to be

implemented for only two years. However, due to the delayed implementation of the component activities, implemntation was extended for another six months to give more time for the completion of the planned activities.

The review of this component focused on the status of the regions in the handing over of this component and the exit plan. With respect to staffing, at the time of this MTR, 18 (69%) of the 26 regions had at least 1 Biomedical Engineers and Technicians. Although in each visited region the structure and HTM focal point was in place, staff qualification variations were noted. For example, in Shinyanga region, an Electrician with NECTA certificate holder was managing the workshop, in Kigoma region, a Degree holder in Biomedical Technology was managing the workshop while in Manyara region the region has two Biomedical Technicians. It was noted in most visited regions a Laboratory Technologist were HTM Focal Point at RHMT (Kigoma, Mwanza and Manyara). It was reported there is no adequate human resources for this technical component that needs a lot of support. It was noted this component has a lot to do with very minimal resources in terms of both materials and human resources.

"*what has been done is the establishment of national workshop and also zonal workshop and also creation of MEIMIS though it's not yet very strong* at the development stage, to precise at pilot stage*. Another thing is we have been able to teach the electrical experts how to repair medical equipment for example hospital beds have been repaired, so there is a high possibility of saving equipment's complete damage"*

KI-PORALG

ii. Project Performance

This output had to three deliverable elements: the level of functioning structures for HTM as per policy guidelines and operating manual; the number of regions that have functional maintenance workshop; and the level of utilization of the openMEDS digital solution by region.

Functioning HTM Structures

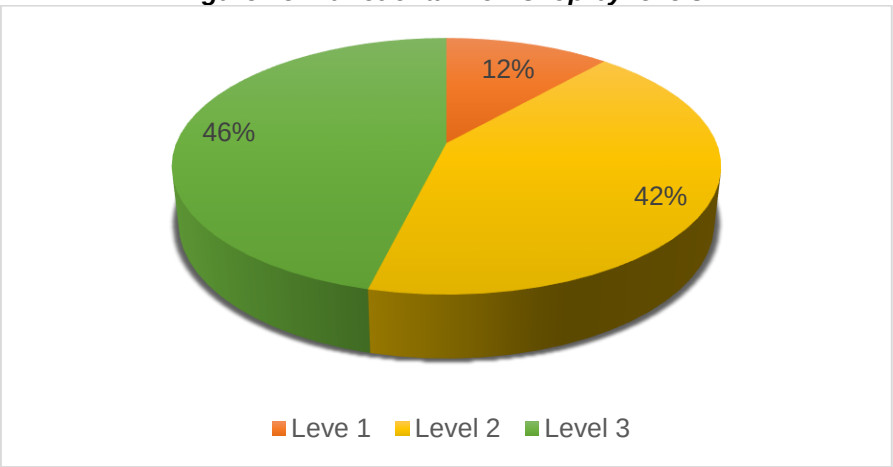
The Technical Assistance Facility is on track to reach its target from a baseline of 20% in 2019 to 80% in April 2021 of functioning HTM structures at regional level. We further noted and commend the increased number of repaired equipment. A total of 3,107 equipment repaired in 2019 increased to 8,764 in 2020. Recording of the repaired equipment is still a challenge. Furthermore, the team verified completion of the

Number of regions that have functional maintenance workshops

It terms of functioning workshops, only 3(12%) out of 26 regions had a level 1 workshop (Dodoma, Shinyanga and Mara) at level 3 have a standard functioning workshop; Level 2 regions Kagera,Tabora, Mwanza, Arusha, Mara, Morogoro, Iringa, Dar es Salaam, Mtwara ,Lindi and Tanga have workshops with basic tools as presented in Figure 15. The rest of the regions are at level 1 and with no maintenance rooms.

In Dodoma, maintenance repair, installation, and funds for buying spare parts was acknowledged as support received from HPSS. The region is providing technical support to lower-level health facilities. However, since HPSS stopped the exercise of maintenance the region is facing funding challenges especially in the districts concerning spare parts and repairs.

Figure 15: Functional Workshop by levels[9]



In Kigoma, we noted that although a qualified biomedical engineer was in place, his skills and knowledge were not optimised. Lack of support and budget were also reported to undermine the effort for implementation of the HTM in the region:

"There is a day I sat with them and I told them do you know why they call you a welder? You are not doing that which you studied. If you did, they won't call you an electrician. Alright Engineer, you are embarrassing for not working in line with your professional training. Because we have a lot [of] broken equipment you have just stored them and you have a degree, how can we not call you an electrician if they are not working? So, he faces a challenge from not getting support from the management of the hospital. So, you will just find him idle and wasting away his knowledge if he was able to fix it here even others would ask for him"

KI-RHMT-Kigoma

[9] level 1: room with basic tools , level 2: a workshop with basic tools, level 3:a workshop with standard tools as per operating manual

It was interesting to note that although HPSS has invested and renovated the workshop, the staff managing it was an electrician. Notwithstanding background of some biomedical technicians, HPSS was commended for providing short courses and orientation to the HTM.

The challenge of capacity to manage the workshop (Figure 15) was echoed in Shinyanga. Given the workshop in-charge education and qualification background, it was difficult to manage some of newly installed equipment.

"it is true that sometimes we do not have the knowledge about some equipment especially the new ones. You are using a lot of time and energy to study them by using the equipment manual and so on. And when they are not working, we are told to do the maintenance and use them. Sometimes we have to ask for an expert from Bugando Hospital Mwanza region.
I am an electrician, I did my studies at Moshi technical and later I went VETA but about biomedical, there was a time we went for seminars and we were trained on that which gave me an idea of using new equipment. But sometimes there are big problems above my knowledge"

KI- Shinyanga Regional Referral Hospital

Level of Utilization of OpenMEDIS

With reference to utilization of OpenMEDIS, discussions with national level respondents revealed appreciation of the training support provided through HPSS, specifically, medical equipment inventories, and training of the HTM focal point at regional level. Although efforts

Figure 16: Refurbished Health Technology Workshop in Shinyanga

to create the system of registering all equipment was ongoing, the digital solution was reported to have not started operating. When we inquired if the system is linked to the Health Facility Registry system, it was reported not to be integrated with the HFRS.

> *"not yet, it has no connection but the main goal is to be able to integrate, but this system is operating in dispensaries, health centers and central district hospitals so I believe when it's completed, there will be a room for integration with the government system"*
>
> ***KI-MOHCDGEC***

We noted that, HPSS had already shifted from supporting openMEDIS to Medical Equipment and Infrastructure Management (MEIM). MEIM is the web-based system which counts as module within the National Health Facility Registration System (HFRS) special for Government health facilities in Tanzania mainland. We noted basically the system development was completed. MEIMIS is planned to be launched as the national inventory management system by the MoHCDGEC before end of 2021. Once full functional, MEIMIS will perform several functions including: Inventory Management, Maintenance Management, Stock Management and Infrastructure Management. MEIMIS provide medical equipment reports such as inventory reports, spare parts/consumables stock reports, equipment, infrastructure maintenance report etc

iii. Conclusion

Unlike other components, HTM is in its infancy stage, having been implemented for only eighteen months. What is remarkable achievement from this MTR about the HTM is completion of users' manual and development of the digital solution in this sort time. It is anticipated during the next financial year; the system will be integrated with HFR and with GoTHOMIS and AfyaCare systems. This will be one of the great achievements given ongoing government and private sector investment in new technology for diagnosis, treatment, and prevention of health conditions. We noted from the field visit, management is not planning and providing financial resource for HTM interventions.

Our experience observed from the visited regions is how high the demand is for the necessary human and financial resources for implementation and coping with recurrent malfunctioning biomedical equipment, especially the new ones.

Given the high demand we observed in the field closure of the HTM may be premature. It should be noted that, of recent the government has invested in and imported highly specialised diagnostic technology as well as surgical related equipment through domestic resources and HBF. However, this investment has not been aligned with investment in human resource training and absorption.

iv. Recommendations

Short term

- HPSS is commended for significant achievement in this intervention. Effforts should be increased on ensuring the system is full functional and is rolled out nationally, support dissemination and use of policy guidelines, and advocate for employment of qualified Biomedical Engineers, Technicians and Artisans available in the market.

Long term

- Given the short implementation period and high demand due to increasing investment in biomedical technology, it is recommended to stay longer in this component. Specifically, support should be provided on timely data entry on equipment and infrastructure, training on new technology.
- It is also recommended to leverage national and international (including from Switzerland) expertise and experience from the private sector through PPP.

3.1.4. Implementation of Health Promotion

Output 1.4. The GoT has in place the required structures, staff capacity, tools and procedures for effectively implementing and managing community and school participatory health promotion	

We noted that this component was planned to be implemented for the first two years of the exist phase and no cost extension was extended at a no-cost for 6 months.

i. Technical Assistance and Rollout to Subnational levels

Concerning number of regions with required coordination and supportive structures as per the national policy guidelines and implementation guide, MTR appraisal of progress reports and discussion with KI at national and subnational levels disclosed that by year one of project roll-out all regions had a Health Promotion Coordinator Focal point.

ii. Project progress

Deliverable elements for health promotion interventions included staffing at national and regional levels; availability of health promotion implementation guidelines and supportive supervision. Specifically, the following indicators were used to measure progress around this output: number of regions with required coordination and supportive structures as per the national policy guidelines and implementation guide; number of regions with staff trained on health promotion techniques and are using the skills by UDOM and Zonal Training centers and the level of application of Community Participatory Health Promotion approach in the regions according to the national guidelines/guide/SOPs.

Training on health promotion techniques by UDOM and Zonal Training centres was temporarily postponed due to COVID-19 pandemic, while the level of application of Community Participatory Health Promotion approach in the regions according to the national guidelines/guide/SOPs was attained by reaching out to 50% of targeted regions.

Discussion at national level acknowledged information collected to implement different changes of policy and guide.

"For example, we have made supervision check list which deals with system and through supervision checklist you can rank the status of which councils is on which stage of planning, stage of council and the stage of community to show how are the activities and it will be easy to intervene and know which place is weak and how is promotion performing. You have the indicators which you score and check per status;
for us implementers if we make our own guidelines the ministry of health, they have a hundred percent go ahead. For us, we have to implement the system first and see if it helps first, do you understand?"
KI-PORALG

iii. Conclusion

The project implementation of this component is on track. Like output two and three (Jazia-PVC and HTM), development and functionality of an innovative digital solution for health promotion is lagging. During the time of this MTR, support provided to develop the digital observatory of health promotion to enhance M&E, analysis, planning & support was at the preparatory stage. The government at the national level expressed the need for an extension of the project period to accomplish the unfinished business for this component. However, discussion with HPSS indicated optimism for completion of remaining activities within remaining time.

iv. Recommendations

Although this initiative comes to an end this year, it is recommended HPSS is engaged with NCD TWG to ensure implementation of health promotion is mainstreamed within the next five years by seizing health promotion leadership opportunity for implementation of the HSSP V. The HSSP V has underscored human centred approach for its implementation.

3.1.5. Implementation of Evidence Generation

Output 3.1: Evidence base is created through research and analysis of best practices and knowledge gaps to inform policy and future adaptations in the fields of iCHF development, Jazia PVS, health technology management and health promotion	

i. Performance

Indicators for this output include number of study reports and publications per each component, and number of meaningful gender-informing issues analysed and recommendations for action made. Although it was envisaged to have at least one publication per each component yearly by the end of April 2021 which can be translated to eight publications. However, during the time of this MTR five publications were made four were on the medicine's component and one on health promotion with the following titles:

a) Adherence to standard treatment guidelines among prescribers in primary healthcare facilities in the Dodoma region of Tanzania,
b) Acceptability of a Prime Vendor System in Public Healthcare Facilities in Tanzania,
c) The effects of medicines availability and stock-outs on household's utilization of healthcare services in Dodoma region, Tanzania,
d) The role of accountability in the performance of Jazia prime vendor system in Tanzania, and
e) Impact of hand hygiene intervention: a comparative study in health care facilities in Dodoma region, Tanzania using WHO methodology

Further review of the five papers didn't not show gender equality analysis. Most of research papers employed quantitative approach and methods which could not dig down on gender equality and equity issues. This also applies to performance reports including sex segregation.

Regarding capitalization products generated from existing data sources, review of project progress documents showed a capitalisation protocol for development, dissemination of

products was to be developed in the next semester and first products were to be drafted during that period. The following can be recorded as achievements: policy briefs on Community Participatory Health Promotion Support to Tanzania, HPSS Support to Disease Outbreak and Pandemic Response two presentations. Either the project was engaged during the Tanzania Health Summit November 2020 and papers on Jazia PVS was presented at the SDC Health Network webinar series on PSE in April and June 2021.

It is difficult to explain why this component is not moving as planed irrespective of presence of highly qualified and experienced researchers at national and zonal project levels supported by experts based in Basel. It was also difficult to tell who is making research agenda if the research advisory committee with researcher/academicians and senior government level officials of MOHCDGEC and PORALG was meeting regularly to guide and advise the project on research activities and ensure buy-in and support of the Government.

ii. Conclusion

In view of the current policy and legal framework changing context, it can be stated as a lost opportunity to provide evidence-based advocacy for policy and legal changes. Furthermore, there was no evidence of GE analysis as a baseline and specialised GE human resource for this project. Unless concerted efforts are put in place, it will not be easy to achieve results on this output. Lack of evidence generated from this component has denied the HPPS project and SDC capacity to provide evidence-based advocacy for policy changes.

Delay in this section can be partly explained by the project's capacity to deliver because of staff attrition. During the time of this MTR, we observed that two (Communication and IT) senior staff had just left HPSS. The new staff were there for almost one quarter. Staff leaving the project might be due to job security or a competitive market.

iii. Recommendations

Given the importance of this component it is recommended:
To expedite the processes, hiring of highly qualified private research individuals or consultancy firms with comparative advantage in the given thematic areas to be considered to undertake some studies instead of relying on public and academic institutions.

We recommend consideration of the short-term to long-term TA Consultancy support to the M&E Research Component at Dodoma project office. This will allow the coordinator to focus on regular project M&E responsibilities. It is recommended that the TA work within the current project organization modality i.e., technically answerable to Basel based Research Coordinator and administratively working with HPSS project in Dodoma.

3.2. Relevance of HPPS Project to national and global priorities

RELEVANCE:	**IS THE INTERVENTION DOING THE RIGHT THINGS?** **Examine: The extent to which the intervention objectives and design respond to beneficiaries',5 global, country, and partner/institution needs, policies, and priorities, and continue to do so if circumstances change.**

This section responds to the following MTR question: What is the government's priorities in this field and how does the current set up of the HPSS fit? The focus in this section was to

examine the extent to which the intervention objectives and design respond to the country policies and priorities and beneficiaries' needs.

3.2.1. HPSS Relevance to National Priorities

Without a doubt, HPSS is supporting national efforts to realise national priorities. Our review of project documents indicates that the HPSS project design and priorities, budget and programs have been responding to national priorities, and aligned to Mission Strategic Plan as well as national and local priorities in Tanzania regions. Furthermore, the project is it is aligned to Mission Strategic Plan as well as national and local priorities in Tanzania regions. Furthermore, the project is aligned to international development policies including Paris Declaration, Switzerland's development cooperation, National Health Policy draft (2020), the national Health Strategic Plan III 2010-2015, IV 2015-20 and the current generation HSSP V 2021-2026.

Historically SDC support through HPSS was initiated following request from senior government officials (Chief Medical Officer) on iCHF and Jazia PVS. The Chief Medical Officer of the Ministry of Health and Social Welfare requested that the Government of Switzerland support the planned reforms. The reforms aimed at addressing access barriers to primary health care services by poor rural populations. The access barriers identified were shortages of medicines, dysfunctional equipment, inability to pay user fees in case of sudden illness and prevention of communicable diseases. The HPSS project was launched in July 2011.

Furthermore, evidently HPSS's interventions are very well articulated and mainstreamed into existing government processes. It is for this reason HPSS layered /different levels of the health system approach was very successful for TA concentrating supporting the GoT mainly at the national and regional and council/district levels to enable government structures to implement the project's innovations sustainably.

Specifically, HPSS's initiatives are well articulated in the GoT and CCM ruling party manifesto

> *"…Kuimarisha mfumo wa bima ya afya nchini ikiwemo mifuko ya bima za afya (NHIF na CHF) ili kufikia lengo la Serikali la kuwa na bima ya afya kwa wananchi wote;…Kuimarisha mfumo wa mshitiri ili kuhakikisha kuwa bidhaa za afya zinapatikana kwa uhakika na kwa gharama nafuu katika ngazi zote za huduma"*
>
> *"To strengthen insurance system including health insurance schemes (NHIF and CHF) to achieve the government goalof mandatory health insurance for all citizen; to strengthen prime vendor system to ensure availability of medicine and supplies at an affordable cost at all level of service delivery"*
>
> ***CCM Manifesto, iCHF section 83: e and Jazia-VPS and section 83 aa***

HPSS's initiatives are also well articulated in the national policy including the next five year development plan, HSSP V, and the draft National Health Policy 2021. Government partners were involved from the beginning.

> *"Among the things we are proud of is implementation of CHF, in particular digital solution for iCHF"*

KI-MOHCDGEC

3.2.2. Government Future Direction on Health Insurance and Jazia PVS

i. Key findings: Paradigm Shift to Universal Health Insurance

Further discussion on the future of the Single National Health Insurance with the high-level KI respondents from the MOH (Minister, Director of Policy and Planning and others) revealed that, unlike the long-term proposed Single National Health Insurance, there are no plans for merging health insurance schemes, instead the government has taken the direction of Universal Health Insurance. One of the senior MOHCDGEC respondents revealed that within the Universal Health Insurance (UHI) framework the government will establish a scheme, subsuming both iCHF and NHIF without merging the two schemes. Some of the cited reasons for not merging then into Single National Health Insurance was to ensure each scheme is growing without affecting the other:

"it is because of the attempt of unifying, to merge. That has been a big challenge in the government. Because the leaders want to be satisfied with the outcome. When you put together the weak. They are worried that it will make even NHIF weak"

KI-MOHCDGEC

Government subsidy

In terms of government subsidy to poorer households, the review team was informed that the government will establish a mechanism to identify those in need of health services, identify vulnerable groups, such as children, pregnant women, people with chronic diseases, and elderly, and ensure that they are incorporated in the insurance schemes. Furthermore, the proxy-means testing approach used by TASAF will be explored for use as a mechanism for identification of those unable to pay for health services who will progressively be supported by the government to access health insurance cover.

UHI Ongoing Process

Regarding the process toward UHI, changes in legislation will be made through tabling of the UHI Bill this year. In addition, the government will work with stakeholders to expand the scope of health insurance. The government will mobilise citizens to join health insurance schemes to ensure that every citizen has access to health care without financial constraints. For people who do not have formal employment, the improved Community Health Fund (iCHF) benefit package includes critical primary health care interventions such as treatment for severe acute malnutrition and transport to maternity waiting homes.

Innovative methods of payment for iCHF (e.g., through labour or in-kind) will be investigated. It was observed that the National Health Insurance Fund (NHIF) is gradually expanding its services to cover people with informal employment. Following the introduction of mandatory insurance, once the Bill currently under development is passed, work will initially focus on strengthening and expanding coverage under the existing schemes. According to the MOHCDGEC respondents, subsequent studies will chart the way forward to increase pooling under one regulatory body.

Future national health insurance framework

Further information gathered from this discussion showed that legislative changes will include amending the Tanzania Insurance Regulatory Authority to be mandated to regulate all health insurance schemes. According to TIRA establishment Act, 2009, the authority is charged with the responsibility of coordinating policy and other matters relating to insurance in the United Republic. However, social health insurance was not part of TIRA mandate.

ii. Conclusion

Findings from this MTR is consistent with a study by which showed availability of medicines, timely delivery and higher order fulfilment rate, increased purchasing power of the districts, and efficiency gains in the procurement process as factors for strong government system ownership. Although the iCHF is highly prioritised and well-articulated in national policy and strategies, it is evident from this MTR the government is in transition with potential future changes and an unclear picture of the future health insurance framework. Expected changes are in terms of administration and management of health insurance system in Tanzania. A high level of government ownership and leadership will hopefully ensure the iCHF is safeguarded.

iii. Recommendations

- SDC should continue with environmental scanning on how the UHI discussion evolves and re-adjust accordingly while taking a lead on digital solution.

- Take the wait-and-see approach through regular environmental scanning on how the discussion around health insurance is evolving during discussion in the National Parliament this November, 2021. This my entail follow-up on UHI Bill legislation changes.

> *"If I were SDC, I would wait and see what comes out of the Universal Health Insurance Bill. We don't know what the structure will look like"*
>
> ***KI-Hon. Dr. Dorothy Gwajima- Minister MOHCDGEC***

3.2.3. Relevance to Targeted Beneficiaries – Users and Providers

Tanzania, like most countries in Sub-Saharan Africa, faces the twin pressures of a) a tight public health care budget and b) unmet need to improve access to health services especially for the poor and those working in the rural areas and/or the informal sector. As part of wider reforms in health care financing, Tanzania introduced user fees in 1993 following the government failure to provide free health care to all its citizens through tax financing. The Community Health Fund (CHF) was introduced in Tanzania as part of the Ministry of Health's (MOH) endeavour to make health care affordable and available to the rural population and the informal sector in 1996 in response to the existing challenges in the health financing system, which included low economic growth, constraints on the public sector and low organizational capacity. The CHF mechanism provides an opportunity for community members (households) to finance or co-finance costs associated with health services, offering them greater involvement in the management of community financing scheme and organization of health services. As such, this MTR finds iCHF scheme as a step towards closing gaps towards

access to health services in line with the UHC in response to the widely acknowledged difficulties which exist in tax financing and social health insurance.

Few interviewed respondents were complaining that compared to other insurances e.g., NHIF, they are not given the best services, for instance they experience more delays in seeing the doctors and receiving other services. The same applies to the health workers in providing services; they tend to ignore the iCHF users compared to NHIF due to the same reason commonly referred to as *Bima Ndogo*. As noted by one KI in Manyara:.

"Most of the time when a patient comes we tend to ask what type of insurance one is using, whenever its iCHF due to the complexity of reimbursement we normally ask them to wait, because in real sense everything with iCHF whenever it comes to returns is a waste of time, so unless its an emergency that is when we have no choice"

KI – Manyara Facility

It should be noted that, in terms of premium collection NHIF has a much higher member contribution than the iCHF. Their revenues are generated from deductions of salaries, which is a stable and transparent monthly fund flow. In contrast to iCHF, the NHIF reimbursements are based on actuarial calculations meant to achieve full cost recovery. The funding provided by the GoT to NHIF through salary deductions of government employees is not matched to a comparable funding of the iCHF clients.

3.2.4. Relevance to Embassy of Switzerland Mission

Findings from the field visit and review of progress reports indicate that Switzerland has been supporting the Tanzania health sector from 1960s. The HPSS project contributes to the Swiss Agency for Development and Cooperation (SDC) results on new Cooperation Programme for Tanzania 2021-2024 and Swiss Overseas Development Assistance (ODA), as well as Switzerland's International Cooperation Bill 2021-2024 which pursues four key objectives: (i) Contributing to sustainable economic growth, market development and the creation of decent jobs (economic development); ii) Addressing climate change and its adverse effects and managing natural resources sustainably (the environment); iii) Saving lives, ensuring basic services, especially in relation to education and healthcare, and reducing the causes of forced and irregular migration (human development) and iv) Promoting peace, the rule of law and gender equality (peacebuilding and governance).

Specifically, the HPSS Project focuses on outcome 1 (State institutions are more efficient and effective, inclusive and increasingly free of corruption) where it is aligning with the MoHCDGEC, PORALG and MoFP capacities to deliver high-quality basic social services in health, social protection and Vocational Skills Development (VSD) that leave no one behind, and strengthening their systems to make them efficient and effective institutions in advancing digitization and e-government initiatives.

3.3. How well does the HPSS Project Fit in?

COHERENCE:	HOW WELL DOES THE INTERVENTION FIT? Examine: the compatibility of the intervention with other interventions in a country, sector or institution.

i. The synergy, convergence and complimentarily of the HPSS project

Firstly, this MTR assessed how the HPSS project approach was employed in designing and implementing the programme's support in Tanzania and how it fits into the health financing initiatives. Secondly, the focus was on the coherence between the various facets of the programme including iCHF, Jazia-Prime Vendor System, Health Promotion, and Heath Technology Management and how the coordination mechanisms and challenges are adding value while avoiding duplication of effort. Specifically, this section examined the synergy, convergence and complimentarily of the HPSS project implementation approach and ongoing four areas of interventions as further discussed in the following sections. Guided by the OECD criteria, this section responds to the following question: what are the strategies of other donor partners in the field of health financing, and how can HPSS ensure complementarity and synergies with them?

ii. Conclusion

The HPSS TA support to the health system in Tanzania has significantly contributed to the success and achievements made to strengthening implementation of rollout of iCHF countrywide. All regions have structures in place. According to our respondents at regional and district levels, there are CHF coordinators responsible for coordinating the implementation of the scheme at ward and village levels.

IMIS digital solution has improved the data management system. Members are registered using smart phones and their membership information is stored digitally. This allows reliable storage and means easy review, update, and retrieval of member information when needed. iCHF coordinators at regional, district and health facility levels reported that the new system had made it easier to detect expired CHF cards and thus beneficiaries could be reminded to renew their membership on time.

iii. Recommendations

Given the current discussion on Universal Health Insurance and irregular dialogue among eHealth Development Partnership, it is recommended that SCD take the lead in convening meetings and coordinating the UHI development agenda, including dialogue and advocacy with government counterparts (MOH for policy and PORLAG for implementation).

In the same vein, SDC should take the lead in the review of the stalled Health Care Financing Strategy and ensure it is harmonised with the on-going UHI discussion. The eHealth stakeholders include:

E-Health Partnership members
Digital Square Director
PATH
USAID TZ
PharmAccess,
GIZ -Currently coordinating
Others
UNICEF Chief Health
NHIF Director General
P4H partners
KfW who are planning an IT project with NHIF,
ILO planning to support e.g., institutional studies,

WB is about to share their Benefit Incidence Analysis etc.

Government Partners

Zanzibar:

Director for Digital Development, Revolutionary Government of Zanzibar
Permanent Secretaries MOF and MoH, Revolutionary Government of Zanzibar
Director IT of relevant ministries Other iCHF implementers /support PharmAccess,

Mainland:

E-Government Focal Point, Prime Minister's Office
National Planning Commission, E-Government Focal Point
MOFP, Digital System focal point.

SECTION FOUR
RESULTS AND FINDINGS
APPRAISAL OF IT ARCHTECTURE IN TANZANIA

4.0. Introduction

RELEVANCE:	**IS THE INTERVENTION DOING THE RIGHT THINGS?** **Examine: The extent to which the intervention objectives and design respond to beneficiaries',5 global, country, and partner/institution needs, policies, and priorities, and continue to do so if circumstances change.**

Tanzania envisions implementation of the Universal Health Coverage (UHC), with discussions still in progress. The MoHCDGEC is expecting to table the Cabinet Paper and the Bill to the Parliament in September 2021. With the outcome of the UHC still not clear, the Swiss Development Corporation sees the opportunity to invest in the design and development of digital tools and infrastructure that will eventually support the future design of health insurance in Tanzania. With this in mind, SDC sees an opportunity to look into the experience of iCHF, especially in enrolling the informal sector and rural population. Whatever strategy or direction the GoT will take regarding health insurance implementation, it is expected to have a mechanism to enrol and renew members in formal and informal sectors with much focus on the rural population.

The Health Promotion and Systems Strengthening Project phase three aims at achieving the following outcomes based on its objectives:

a) A Technical Assistance Facility (TAF) effectively supporting national implementation of iCHF, Jazia PVS, openMEDIS and Community Participatory Health Promotion.
b) The GoT effectively develops and implements digitalisation solutions regarding openIMIS, Jazia PVS, openMEDIS and health promotion, aligned with the national IT landscape.
c) Data and findings generated by HPSS are effectively used to develop evidence-based capitalisation products for informing policy decisions of GoT.

In this regard, the HPSS project has been providing resources to the MOHCDGEC, PORALG and MoFP and the E-Health Partnership responsible for the e-government policy setting and implementation of ICT architecture. The objective of provision of such resources was to ensure the digital innovations developed by the project such as IMIS, JAZIA PVS System, OpenMEDIS are fully integrated with other government ICT infrastructure and systems, including DHIS2, EPICOR, GEPG, PLANREP, GOTHOMIS and iCHF, whilst NHIF has in place the claims verification and payment system, an IT system for cashless payment and rapid reimbursements of health services provided by clinics under iCHF insurance coverage.

The Government Electronic Payment Gateway (GePG) is a crucial element for cashless operations of government services and the cashless operations of iCHF need to be aligned with the GEPG. Concerning medicine supplies, the electronic logistic management information

system (eLMIS) of the Medical Stores Department (MSD), a MoHCDGEC related parastatal, integrates the Jazia PVS digital elements. The HPSS developed an insurance management information system (IMIS) for iCHF which has a module for members' verification. These systems must be integrated with the government's electronic patient file (GoTHOMIS light) and automated as much as possible to ensure rapid claim settlements. The PORALG IT department is a project partner for this initiative and HPSS was expected to provide resources towards this integration effort in collaboration with other partners including PS3, PATH, JSI, D-Tree, pharmaccess, Global Health Supply Chain Technical Assistance - Tanzania project, MoHCDGEC and NHIF.

Such a holistic approach to the healthcare digital innovation investment requires mobilisation of resources from all partners in the country's healthcare system. SDC sees this as a unique opportunity to redirect investment into the E-Health Partnership to make the underlying data systems more functional. Regardless of any future social health insurance adopted by the GOT, it will still require sound, solid, real-time and integrated digital systems to make the SNHI work as intended and produce progress towards UHC.

This section identifies immediate and health insurance relevant gaps in the Tanzania Health Enterprise Architecture that HPSS can address through its comparative advantage, and that have a high likelihood to increase iCHF coverage. Specifically, this section responds to the following MTR question: What are investment opportunities in the health insurance related digital system development by the E-Health Partnership in mainland, given the slow progress in iCHF coverage to-date and the stalled health insurance policy dialogue?

4.1. Government IT eHealth Priorities

The GOT has put more focus on digitization, and there is a significant investment in Information and Communication Technology as a tool to enhance socio-economic development. This is witnessed by the recent establishment of the ICT Ministry which will formulate and monitor policies on information and communication technologies and postal services. The Ministry is expected to drive the digital transformation agenda in Tanzania amid the global fourth phase of industrial revolution. The government recognised the importance of leveraging ICT as a catalyst to develop all economic endeavours to strengthen the industrial and agricultural-based economy. The National ICT Policy focused on ensuring Tanzanians become economically, socially and culturally enriched and become an ICT-enabled knowledge society.

The current eHealth Strategy has an ambitious aim to ensure delivery of a safe, high-quality, equitable, efficient and sustainable health system that is equipped to respond to emerging health sector cost and demand pressures. The MoHCDGEC has recognised the potential of ICT in ensuring the realisation of its vision. At the core of its strategy, the MoHCDGEC has emphasised that implementation of the enterprise architecture ensures alignment of health sector information systems with its mission, goals, and objectives and leverage information and communication technology in service delivery. This was necessitated due to several challenges including scaling up the silo-ed health information systems, limited point-to-point integration, key architectural gaps, and limited governance of individual systems. Most of the data from different sources were also manually aggregated and not error corrected. As a result, it was hard to make informed and reliable service delivery and management decisions.

The government has been making significant strides in the implementation of digital technology in the health sector. This is in line with the 2019-2024 digital health strategy, which has the vision to accelerate the transformation of the Tanzanian health system through innovative, data-driven, client-centric, efficient, effective, and integrated digital health solutions. The digital transformation seen in the health sector has affected almost all pillars of the health system, including;

a) Medical products and technology – implementation and rollout of electronic logistics management system (eLMIS). This is the cost-effective system of health data management that ensures greater commodity security and better health outcomes. eLMIS links health facilities with the central store to collect and distribute logistics data in real time. Knowing which medicines are used and which medicines are required helps supply chain managers provide continuity of supply for patients. Through the HPSS project the government has piloted the National Medical Equipment and Infrastructure Management Information System which tracks the status and condition of medical equipment at health facilities. The system was piloted in six regions and plans are underway to roll it out nationally.
b) Health workforce – implementation and rollout of Human Resource for Health Information System which is the system for collecting, processing, managing and disseminating data and information on human resources for health information system (HRHIS).
c) Healthcare financing – implementation and rollout of NHIF service portal for National Health Insurance clients. The NHIF Service Portal is designed, developed and hosted by National Health Insurance Fund (NHIF). The Portal's main objective is to have a one-stop centre interface for health care services delivery in a transparent, easy and cost-effective manner from various accredited health facilities for the benefit of its beneficiaries.

4.2. HPSS Current and Future Contribution

The implementation of openIMIS coupled with integration with the mentioned key ICT systems will benefit the future SNHI in whatever design the government will agree to. Health care costs are growing significantly in the world currently, posing a challenge to many health financing schemes. Information systems have proven to be key tools in lowering such costs. Interoperability between clinical, financial and public health systems such as CRVS and National ID systems allows for the assessment of effectiveness and the monitoring of cost. Using public health data to forecast health care resources, clinical data to assess outcomes and financial data to track cost, provides the critical information infrastructure which can easily drive the UHC.

Two key digital tools currently operating in administering health insurance in Tanzania include the OpenIMIS application developed by HPSS and currently used for the Community Health Fund and NHIF web portal. HPSS has invested in IMIS and has helped it become one of the outstanding digital innovation tools developed under the project. However, more features need to be added and close attention given to the integration and interoperability with other systems in the health sector. The NHIF digital tool has been developed to cater for the formal sector while OpenIMIS tool currently suits the informal sector, with Swiss TPH working to improve it so that it can work in the formal sector as well. The openIMIS is not yet integrated with most of the information systems operating in the health sector. Recently the application was

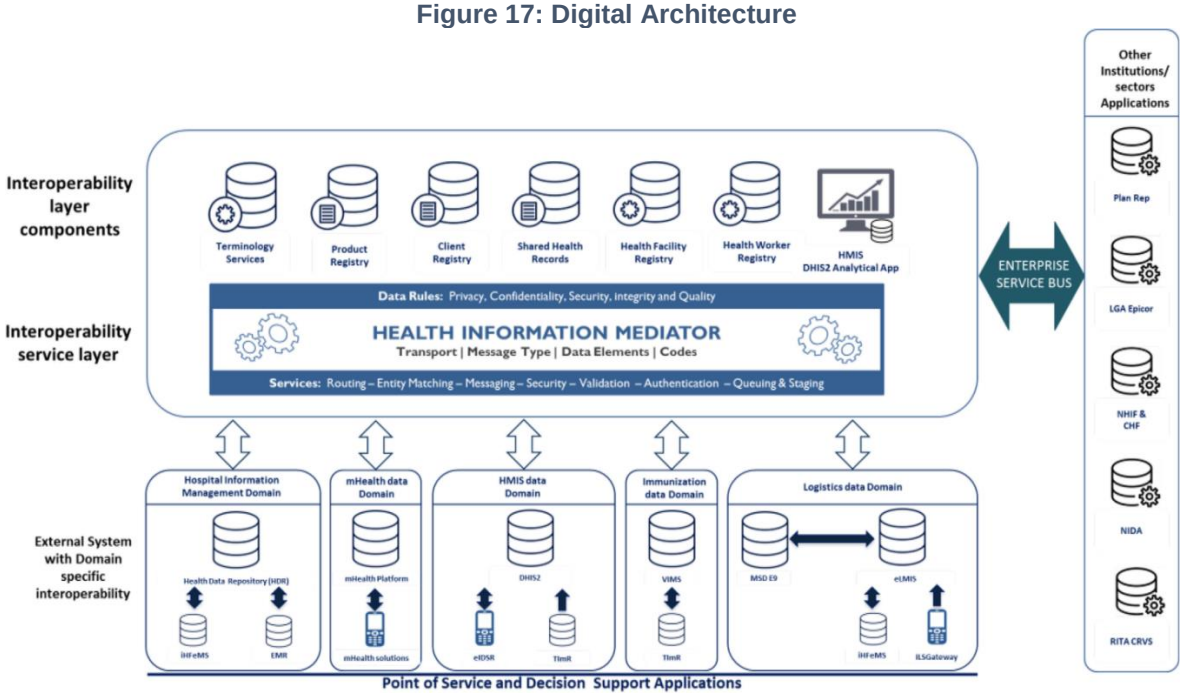
integrated with the Government Electronic Payment Gateway (GEPG) to facilitate electronic collection of revenue by members. Efforts are ongoing to ensure the system exchanges data with Government of Tanzania Health Operations Management Information System (GoTHoMIS) which will remove most of the current bottlenecks facing the claims process in the CHF scheme. Considering the full adoption of openIMIS as a national digital tool for the rollout of iCHF scheme, there is a need to invest more in the system.

4.3. Identified gaps

How well does the current digital enterprise architecture function to support health insurance?

The MoHCDGEC is developing the Health Information Mediator as a tool towards implementation of the Tanzania Health Enterprise Architecture (TZHEA). The TZHEA is expected to define the structure and operation of the health sector and enable streamlining the silo-ed developed information systems to better address the health system outcomes. The overall objective is to ensure the health sector gains maximum benefit from the implementation of various digital technologies. The systems connected to the openHIM include eLMIS, HFR, HRHIS, DHIS2, Client Registry (NHCR), FFARS, MUSE, EPICOR, THSCP, Wadau Portal. In its digital investment roadmap, the MoHCDGEC identified the development of standards for health insurance eClaims as one of the investments requiring relatively short time to complete at low cost. However, during the discussion with one of the key stakeholders of the implementation of Enterprise Architecture (Figure 17), it was found that this was among the recommendations that has not yet been selected by any stakeholder and is yet to be implemented. In ensuring successful implementation of health insurance schemes, integration of the system to most clinical information systems is essential. The most effective way of achieving this is through integration to the Health Information Mediator.

Figure 17: Digital Architecture



HPSS could do the following to ensure the digital tool (OpenIMIS) reaps the benefit of the enterprise architecture to support health insurance in future:

- Integration of the payer-side (OpenIMIS) and other providers' side systems such as Health Facility Registry, Human Resource for Health Information System, so that they can transact business electronically including eligibility checking, claims transmission.
- Developing standards of interoperability, common coding systems for Health Insurance Information Systems (eClaims) which will allow these systems to talk to each other but also talk to other systems in health sector.

"*We now have 13 systems exchanging data and starting to improve decision making for health workers at all levels, to sustain these achievements and momentum, we – in collaboration with partners – will continue to operationalize the shared vision of the Tanzania Health Roadmap and strive to have a shared health record for all 7,500+ health facilities in the next few years.*"

KI-MOHCDGEC

The MoHCDGEC has made significant strides towards integration of key digital systems to support delivery of efficient clinical services. This has been largely contributed by the implementation of openHIM. GoTHoMIS has been integrated with key information systems including NHIF claim management system making claims of NHIF funds from facilities more efficient. Moreover, the system has already been integrated to other Hospital Management Information Systems operating at consultant and specialized hospitals like MEDIPRO making claims from these hospitals also efficient. Despite all this automation at the provider side, l the GOTHOMIS system is yet to be linked to the openIMIS making it difficult to automatically get the standard treatment costs (from NHIF portal) and the patients' electronic file system. Once claims are entered into the system the payment is automatically effected from the system by the regional office. Health facilities are not able to obtain the treatment costs and the standard treatment protocols from the NHIF portal. Currently the Facility Financial Accounting Reporting System is already integrated with the openHIM and it therefore exchanges data with other systems connected to the application. The GoTHoMIS system is yet to be connected making extraction of useful clinical data challenging.

It is important to note that notwithstanding the delayed integration process, HPSS is in the process of supporting PORALG to integrate CHF-IMIS with GoTHOMIS and to facilitate PORALG and MoHCDGEC in the integration of CHF-IMIS and Afya Care. Integration of CHF-IMIS with HIM like MEDIPRO will depend on decision of the government on coverage of CHF services once the Minimum Benefit Package is defined. However, we were informed that this work is not foreseen in the workplan of HPSS and cannot be delivered without additional resources.

4.4. Recommendations

4.4.1. Short term recommendations

Below are the key immediate investment recommendations to the OpenIMIS digital tool:

- Investing in the technical hosting infrastructure of OpenIMIS. In particular, building a data centre with data back-up plans (on-site and in another physical building) is essential. The current risk of losing all data on the central server is very high.

- While it is understandable that integration of IMIS with GoTHOMIS and AfyaCare are already in the HPSS workplan and the GoT policy on iCHF at the moment applies a capitation formula for paying health care providers (as such a fee for service reimbursement is not applied but is possible in IMIS); it is recommended that consideration should be made to adopt and improve the eClaim module of the system by ensuring that claims made by health facilities include the price list which will in turn calculate the total amount of funds they expect to be reimbursed based on the clients they have serviced. This can be achieved by integrating the Health Management Information System (GOTHOMIS and AfyaCare) and the openIMIS system.
- There is also an urgent need to ensure capacity is built for the PORALG team to ensure that they can adapt the system in the future if needed and especially to fix minor technical hick-ups on their own first. To this end, it is necessary to establish a permanent IT team that can devote itself full-time to IT tasks. The motivated Swiss developers can only ensure the sustainability of knowledge transfer if it is expected that the local IT specialists will not leave their position again after a few months. Establishing an IT service centre to take care of various digital Social Health Protection areas on a national level can make sense.

4.4.2. Long-term Recommendations

Which digital systems in support of a future UHI are least developed and require intensified support over the next 5 years?

Digital innovations in health can play a key role in ensuring the achievement of UHC. Optimizing existing ICT infrastructure and making strategic new investments in digital health solutions may accelerate UHC in terms of which people, what services and how much of the costs are to be covered. There are significant opportunities looking into the digital health investment roadmap in Tanzania for timely and innovative use of ICT, but solutions must be harnessed strategically to deliver cheaper and faster UHC in the right context at the right time. Some of the key investment recommendations in digital health solutions which could play a vital role in future support for UHI include the following:

i. Social Registries

The issue of patient registration is considered very important as there is generally a higher domestic migration of the younger generation. For the health insurers, this means that a person moves back and forth between the formal and informal sectors more often in the course of his or her life and must therefore be covered several times by different health insurance schemes. In its simplest form, a register is a list of people with specific characteristics, such as gender, age group, marital status, or place of residence. By tracking characteristics, services can be provided to a specific target group. In the field of social (health) protection, a fundamental distinction is made between the following registers:

- Beneficiary registers: Registers supporting benefit management systems (often called “programme MIS”) to carry out the decision-making, enrolment and notification stages along the benefit chain for a social programme.

- Integrated Beneficiary Registries/Client Health Registers: Integration of data from beneficiary registers/MISs of several different programmes. In practice, they provide a consolidated overview of data collected by different programmes, show who receives what benefits and focuses exclusively on beneficiaries. They can serve as powerful tools for monitoring and coordinating the “supply” of social programmes by assessing

gaps and overlaps in the coverage of crucial benefit bundles and services tailored to the specific needs of profile groups.

- **Integrated Social Registries:** These are Information systems that support outreach, intake, registration and determination of potential eligibility for one or more social programmes. In practice, social registries centralise data integration upstream by collecting/compiling data for a register of potential beneficiaries that specific programmes and services then draw on.
- They can serve as powerful tools for assessing the 'demand' for social programmes by profiling different population groups' specific needs and conditions. Both CHF and NHIF, and TASAF have their beneficiary databases and are not linked to each other. This results in the following challenges:
- Difficult to track beneficiaries of the three schemes.
- Duplicate enrolment may not be detected.
- Health care providers cannot quickly determine where the patient is covered by using one digital tool.

For the future implementation of UHI in Tanzania the following is recommended for the project in digital technology implementation considering experience globally:

Some Health insurance operators have already recognised that a joint beneficiary registry in which a citizen's primary demographic data and insurance coverage status are stored for social health protection delivery can generate advantages for all stakeholders in the health sector. A good way forward would be to define the technical requirements that such a registry should have. This should be done step by step. While the idea of a National Social Registry sounds exciting, it should be noted that it would require massive financial and human resource investment. The establishment of a joint beneficiary registry between CHF and NHIF as a first step seems more appropriate.

ii. Assessing the quality of care

Concerning the management of service providers, it was noticed that there are no digital tools that allow clients to assess the quality of services provided by health workers on time. Reports are produced by CHF and NHIF staff to assess the performance of service providers manually - but these do not include the experience of service beneficiaries. There is a register of health facilities in the country, but there is a lack of information on updating the data and who is responsible for updating the register. This register is also not yet linked to the existing OpenIMIS.

A register of health facilities serves as a central authority to uniquely identify all places where health services are provided in the country. It addresses the question of where precisely a health facility is located in the country. In addition to the essential facility data, the health facility register should also receive the GPS data to display it on digital maps. The maps offer additional services to the client, such as a "find your nearest provider" app. Likewise, in the event of a disaster (earthquake), the nearest emergency facilities can be found more quickly. From the health insurance company's point of view, such an application is also of interest because it can also contain additional functions to improve the referral mechanism. Functions such as the display of opening hours or waiting times are also conceivable. A Health Worker Registry is the central place for maintaining the unique identities of health care providers in

the country - it answers the question “by whom”. A digital health worker registry should ideally be established by the Ministry of Health, as it will also regulate the accreditation and licensing of health workers in the country. From a health insurer’s point of view, this register is essential, for example, to develop digital products that enable customers to find the best possible doctor. This register is also necessary for the expansion of telemedicine services in future that could be billed via the health insurance funds. The current OpenIMIS solution allows the addition of accredited facilities and the management of price lists. However, the possible extensions towards better contract management, such as maintenance of contracts, history of tariffs, accreditation ratings and terms, and sanctions, could also be valuable.

iii. CRVS and National ID

A weak population registration system limits the ability of governments to use data to plan and deliver government services, including national health insurance. This results in public funds being wasted on investments in systems that are not being put to good use. The population under the age of 16 is particularly affected as they often cannot obtain a national identity card, and the allocation of a life-long ID number does not work correctly.

A weak registration system poses the most significant risk for this population group of not having a state-recognized identity. The government has already recognised the importance of lifelong identities. Some of these problems are mentioned in the Health Sector Strategic Plan V. In particular, the health facilities are of great importance because it is there where new-borns can be registered and where the link to the civil registration database could be quickly established. This report already mentioned no link between the respective databases of beneficiaries at NHIF/CHF/TASAF and other social protection implementers. Additionally, none of the organisations are linked to a Civil Registration and Vital Statistics (CRVS) system or generates the national ID or citizen card. This means that:

- There is no automatic information on new-borns or deceased persons.
- Family composition is stored redundantly in NHIF and CHF/TASAF and at the health facility level.

The population does not see the benefits of registration, and the registration process is perceived as cumbersome by the authorities and citizens. The lack of the required documents, especially the father’s proof of citizenship, and the lack of support from family members in obtaining the required documents for the population are obstacles to registration. The Government of Tanzania should continue to push for reforms to bring registration and identity management in line with global trends. These reforms are a complete overhaul of the identity management system and the introduction of the chip-enabled national identity card, which is gradually being issued to citizens across the country. Paper-based manual registration should be replaced by digital registration as much as possible. It is necessary to involve the health service providers to create digital links between their patient registration systems and the CRVS system.

iv. Telemedicine

The MoHCDGEC is implementing telemedicine services to ensure access to specialised health services to the communities in rural areas. One of the key gaps in reaching the targets of the HSSP IV was the poor infrastructure and equipment. The GOT has constructed health care facilities to cater for all populations in the country; however, some citizens still travel long

distances to access the services. Inequitable access to health care for several groups in the population due to epidemiological and geographical factors is still a notable challenge. In order to address this issue, the MoHCDGEC has adopted the implementation of telemedicine services to leverage technology in increasing access to quality health services to Tanzanians. The MoHCDGEC is looking to connect all hospitals to telemedicine services and establish strategic medical centres of excellence (hubs) to provide services to regional referral hospitals and primary healthcare facilities. A centre of radiology and imaging excellence has been established at the Muhimbili Orthopaedic Institute, which provides radiology and imaging interpretation services to other connected hospitals. Other hubs planned to be established are the: Cardiology hub at JKCI, Oncology and Pathology at MNH and ORCI, Radiology, Pathology and Maternal and Child Health at MNH.

Most telemedicine services have been unsustainable, making most of the projects implemented not reach the maturity stage. There have been talks to ensure teleconsultation services are covered in insurance schemes to make the service sustainable. The MoHCDGEC is looking to invest more in telemedicine services financing and mainstreaming in health system structure studies. Furthermore, there is development of tools that will allow the exchange of medical data across healthcare system structures (from primary health facilities to consultant health facilities) to facilitate electronic referral of patients and subsequently could be billed through the health insurance funds. The study and developed telemedicine tools could also serve as an attraction to iCHF clients as they can access consultant services that would be difficult to get in remote facilities.

SECTION FIVE
RESULTS AND FINDINGS

PRELIMNARY APPRAISAL ON SDC FUTURE NICHES OF ENGAGEMENT AFTER HPSS

5.0. Introduction

RELEVANCE:	IS THE INTERVENTION DOING THE RIGHT THINGS? Examine: The extent to which the intervention objectives and design respond to beneficiaries',5 global, country, and partner/institution needs, policies, and priorities, and continue to do so if circumstances change.

Social protection has become an integral part of development policies to mitigate economic imbalances and facilitate sustainable development. Social health insurance is advocated in response to the view that financing health care through out-of- pocket payment is expensive and exposes many people, particularly from poor communities to severe financial shocks during sickness. While in Tanzania mainland social health insurance was established two decades ago and current legal and policy discussion on Universal Health Insurance is ongoing, in Zanzibar the government is envisioning the creation of the universal health insurance.

In line with the MTR objective three, this section explores and identifies opportunities within the existing financial envelope to engage with Zanzibar in developing a digital basic health insurance scheme. The section responds to the following MTR question: What are potential partnerships between and with the Government of Tanzania and Switzerland that will leverage Switzerland's key innovations[10]and bilateral investments to enhance efficient corruption free state institutions government accountability (human resource management, distant learning (professional development, accreditation, education, and professional skills development), health insurance, social protection, public finance management)

5.1. Zanzibar Universal Health Coverage Priorities

5.1.1. Social Economical Context

Like Mainland Tanzania, Zanzibar has made progress in terms of life expectancy and reduction of maternal and newborn death. However, Zanzibar's population is rapidly increasing with a lower life expectancy (61) compared to Mainland (66). In addition, Zanzibar has a high fertility, and low use of modern FP (14% highest Unguja and 7% lowest in Pemba). Like the Mainland, Zanzibar also experiences severe shortages of health care workers, with substantial shortages of all cadres at the primary health care unit level. Further, approximately 60% of HRH is geographically skewed in urban settings[11].

5.1.2. Health outcomes at a glance

Although progress has also been made in Zanzibar in under-five mortality and malaria has almost been eliminated, like the Mainland, neonatal death remains stagnantly high at 29 per 1000 with similar concerns with quality of care. Unlike Tanzania`s mainland where there are

[10]including IMIS, ICHF, Jazia PVS, MEMIS, school health, and digital innovation capacity embedded in a complex and interraled systems that are part of health system architecture)
[11]Zanzibar HSSP IV 2021-26

increasing institutional deliveries, in Zanzibar, delivery in health facilities with skilled workers has remained low (67% in 2018[12]). Antenatal coverage is also poorer than on the Mainland; coverage for at least one visit is 86% but only 30% of pregnant women or girls make four visits. Immunisation coverage of 78% in 2018 didn't meet the target of 86%. Finally, while Zanzibar has the country`s lowest HIV prevalence at just 1%, HIV is concentrated among key populations where the HIV prevalence of 12%. While undernutrition is declining, anemia among pregnant women remains a real problem and now both overweight among adult and underweight among children are high at 39%. Zanzibar is similarly observing an increasing burden of non-communicable diseases.

With such high fertility rates, it is easy to understand that Zanzibar is an island with a very young population: 49 per cent being under 18, and 16 per cent being children under-five. According to UNICEF, the government on Zanzibar really needs to increase the proportion of the budget dedicated to social welfare, child protection, education, nutrition and health, in order to have the resources available to fulfil the basic rights of children. Especially now in times of crisis, UNICEF is flagging that the basic rights of children are in jeopardy and need extra attention. Affected by the high maternal and child mortality rates, life expectancy is relatively low at 65 years on the islands. This can partly be traced back to the poor human resources for health on the island: 0.08 physicians per 1000 population and 0.7 nurses for the same amount of people, and the sub-standard maternal and childcare. In a situation like this, it is vital to make sure that the nurses and doctors on the island get the right equipment, supplies and training that they need to carry out their work as efficiently as possible.

5.1.3. Policy and Legal Framework

Even if UHI is currently advocated for in Zanzibar, the Social Protection Policy provides guidelines and the way for implementation of social health insurance. Other policy and legal documents governing practice of health care in Zanzibar include various Acts and Laws governing the health sector in different aspects of health as follows: the Medical practitioners and dentists Act no.12 of 1999; an act to provide for protection and management of public and environmental health risks and related matters; the mental health Act no.1 of 2001; The Zanzibar food, drugs and cosmetics act, number 2 of 2006 and its amendment Act number 2 of 2006; Zanzibar Nurses and Midwives Council Act number 5 of 2014; Public and Environmental Health Practitioners Act number 15 of 2012; An Act number 3 of 2016 to establish Mnazi Mmoja Hospital as a semi-autonomous institutions and other matters related there to; Private Hospital Act (Regulations) number 4 of 1994; The traditional and Alternative Medicine Act number 8 of 2008; The Act number 10 of 2011 for establishment of the Chief Government Chemist Laboratory; An Act number 10 to provide the registration and Regulation of medical laboratory Practitioners and other matter related there to; The establishment of the Chief Government Chemist Laboratory Act no 10 of 2011; and An Act to Establish Zanzibar Health Research Institute and other matters connected therewith.

Health care delivery in Zanzibar is delivered through the public, private and traditional and alternative medicines. Currently, there are 344 facilities providing health services to the community. Of these 167 are public health facilities, 123 are privately owned including 18 facilities are owned by faith-based organisations and 35 are traditional clinics. The public health care system is organised into primary, secondary and tertiary levels. At the primary

[12]Zanzibar Health Bulletin 2018

level services are delivered through the Primary Health Care Centres (**2**), designated Primary Health Care Unit Plus (32) and Primary Health Care Units (127). At the secondary level services are provided through the District hospitals (4) and a Regional Hospital (1) while at the tertiary level services are delivered through a tertiary hospital. In all these levels services are provided according to the Zanzibar Health Policy of 1999 and its amendment od 2011 and the Essential Health Care Package of 2007 and its revision of 2019.

5.2 Current and Upcoming National and International Initiatives: Key Findings from Zanzibar Fact-finding Mission

During the MTR Team visit to Zanzibar it was realised the GOZ has formulated a technical team which was tasked with the pre-design of a health insurance scheme to operate in Zanzibar. The team has completed the pre-design of health insurance scheme as well as the draft implementation roadmap. The Zanzibar Health Insurance Scheme is expected to include both the formal and informal sectors and other groups within the society and will cover high, middle, low income and destitute population groups to improve financial protection and achieve universal health coverage. The details of emerging issues from both high-level Universal Health Insurance and findings from KI interviews are presented in the following sections.

5.2.1. Emerging Issues from High level Zanzibar UHI Meeting

Zanzibar subscribes to international commitments including the International Health Financing Plans: Abuja Declaration of 2001 calling for a 15% government budget on health spending, SDGs target 3.8: achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all, and the World Health Organization (WHO) recommendation for US$ 60 annual health expenditure per person as part of aggregate national health expenditure (government, individual/family contributions, donor baskets.

Adequate financing is the leading determinant of establishing an effective and sustainable UHI. Establishment of an adequate system design is the engine of the UHI financing strategy based on international and national health financing policy. This reform is implemented through smooth mobilisation of resources through contributory arrangements, investment and income, and financing options from fiscal space and other avenues as portrayed in Figure 13. It was underscored that, issues of economic growth, demographic changes because of aging and rapid urbanisation will be considered for analysis. In terms of sustainability, it is commonly known that health care outgrows economic growth. Taking note of population migration and movements to and from Zanzibar. Most critical dynamics to be considered when selecting systems design include: awareness of senior policy markers which requires advocacy, development of the HI may take 18-1=24 months. It was also noted no minimum promises of level of minimum package, will depends on strong proposition whether integrated or parallel.

The details of expected Health Insurance in Zanzibar are presented in Figure 17. These elements are part of the pre-designed health insurance that were discussed by number of key participants. Among the key elements discussed in detail is number of dependents for polygamous families. In Tanzania, like many other African countries, polygamy is commonly practiced in some parts of the country. Polygamy has implications for the frequency of sexual activity and the fertility rate (number of children).

Figure 18: **Details of key elements of proposed health insurance in Zanzibar**

Elements	Details
Sources of finance	Taxes, Government subsidies for those who cannot afford to pay premium and another sources Premium from those who can afford, Co-payment, Earmarked
Pooling Options	Two Pools (Formal and Informal)
Benefit package	Comprehensive and Basic
Subsidising the destitute	Social Mapping, Categorisation, development of social economic status data base and Registration of economic status
Administration and management	ZSSF
Guiding Documents	Referral Protocol, Price list, List of essential Drugs, Quality Assurance guideline and others.
Level of compulsion	Compulsory for all residents of Zanzibar and visitors who don't have acceptable insurance cover
Referral Protocol	Comprehensive scheme no referral up to District Hospital, applied to Referral Hospital Basic scheme referral applied from PHCU&PHCU+ to Referral Hospital
Dependents	Spouse/s, children below 18 years and above up to 21years if still in school + college, parents, adopted children below 18 years up to 21 if still in school +college
Gate Keeping	Referral Protocol, Co– payment and Approval of high cost specialised services (e.g MRI)
Contribution Rate	to be determined by actuarial valuation study
Accreditation of Service Providers	Zanzibar Social Security Fund (ZSSF)
Provider payment mechanisms	User fee
Contributing population	Formal Sector Employees and Informal Sector Employee and other groups
Retirement of the Principal member	The principal member and dependents will continue to receive the service while contributing through pension
Death of the Principal member	Six month no contribution for the dependents, then the dependents shall enroll in a formal or informal pool
Premium Collection	Formal Sector through: ZSSF Informal Sector: Mobile Money services, Banks branches, Agents and others
Enrolment Process :	Formal employees through employers and informal Sector: Individual and through Organised groups such as Cooperative Societies and others

Zanzibaris are considered a polygamous community (see Table 7). The latest DHS revealed that, while in Mainland about 9% of married men have more than one wife, about 30% or more of married women in Kusini Pemba live in polygamous arrangements.

Table 6: **Percent distribution of currently married women age 15-49 by number of co-wives in Zanzibar by regions**

Region	Number of Co-Wives		
	O	**2**	**2+**
Kaskazini Unguja	75.2	20.1	4.7
Kusini Unguja	73.2	23.8	3.1
Mjini Magharibi	71.6	25.8	2.5
Kaskazini Pemba	71.6	21.9	6.5
Kusini Pemba	69. 9	24.8	5.3

Source: Tanzania DHS-MIS 2015-16

Furthermore, only 10% of married women in households in the highest wealth quintile have co-wives, compared with 29% of married women with co-wives in households in the lowest wealth quintile. Similar to women, older men (age 35-49), men in rural areas, men with no education or primary incomplete education and men in households in the lowest wealth quintile

are more likely to have two or more wives than other men. This implies that the issue of social and cultural factors should be considered during design of the health insurance in Zanzibar.

5.2.2. Current and Future Zanzibar Health Financing: Commitments, Partners, and Workplan

The health system is currently largely financed through Ministry's Annual Budget Expenditures and off budget financial support, Health Basket Fund from one partner namely DANIDA whose programme is coming to an end, and Out of Pocket (OOP), off-budget projects funding.

The paradigm shift from free health care to cost sharing approach for those who can contribute and a hgh level of people understanding and demand for high quality services. Zanzibar health insurance scheme -ongoing. Put in place mechanism for UHI. The workplan for implementation of the Zanzibar has been developed. Figure 18 presents funding commitment status of key activities.

Figure 19: Zanzibar Health Insurance Workplan Funding Status

Area	Financial commitment Status
Assessment of ZSSF to manage the scheme	Work in Progress by Pharm Access
Actuarial Valuation	Already have commitment
ICT Solution	No commitment
Household categorisation	Already have commitment
Predesign of the Scheme	Completed
Advocacy for Pre design	Already have commitment

Source: High level Meting Government presentations, September, 2021

During the meeting it was found that PharmAccess has been supporting the government of Zanzibar in the development of a documented Health Financing Strategy which itemised alternative financing options for healthcare in Zanzibar and in the establishment of a defined health insurance scheme. In addition, PharmAccess is supporting introduction of a unique identification number for every Zanzibar resident as a measure to increase transparency and tracking of services, efficiency and accountability on health resources spending.

The Health Financing Strategy is expected to address the whole spectrum of financing i.e., collection, pooling, purchasing and payment. This support is provided in collaboration with MoHSWGEC and UNICEF including development of the concept note. It was also reported that PharmAccess facilitated development of the draft design document, development of draft concept for a visitors scheme, and customising of the OPEN-IMIS system for registration and collection of utilisation data.

Other observed active Health Insurance partners in Zanzibar include Jakaya Mrisho Kikwete Foundation working in collaboration with Zanzibar Research Centre for Policy analysis (ZRCP) the MOHSWGEC and financial and technical support from SDC.

5.3. Emerging Issues from Meeting with Zanzibar KI

During the field visit to Zanzibar and discussions with senior Ministry of Health Social Welfare Gender Elderly and Children officials the following were mentioned as key priorities of the President of the Revolutionary Government of Zanzibar:

5.3 1 Systems strengthening

This includes empowering human resources for health to improve their performance efficiency and accountability for productivity during service delivery. It was cited that currently there is no system in place to capture healthcare worker productivity. Everything is done manually making it difficult to assess the health workforce performance. Improving the systems in the health sector is aimed at ensuring efficiency and accountability and subsequently delivery of quality health to Zanzibaris

5.3.1 Expansion of the Health System

Even though distance to health facilities is not a challenge, population diversity in Zanzibar, including people's movements, lack of qualified personnel, geographical location in Islands especially in Pemba, lack of commodities and relatively high out of pocket funding has made the health system relatively distant to the population. The only well-staffed facility is Mnazi Mmoja Hospital. Specifically, Pemba was cited by the PS as a "crying island" because of lack of high quality and referral system in the island. Pemba is described as unique, composed of solitary and scattered islands This scenario has led to congestion and low-quality service delivery at the hospital. Due to the ever increasing population in Zanzibar, which also includes a massive number of tourists, there is a need to expand health services. In line with the expansion of health services there is a need to decongest the Mnazi Mmoja hospital in Unguja by strengthening the referral system and improving services at other lower level facilities.

5.3.2 Increase sustainability

Ensure service delivery is of high-quality including health technology management; most of the visited health facilities had unused and non-functioning machines including those of diagnostics (imaging, telemedicine, and laboratory). Ensure mixed skills trained healthcare workers. In this case the government is envisioning an improvement in the existing healthcare workers skills, bringing back highly skilled personnel (notable staff movements from Zanzibar to Mainland and elsewhere because of relatively low payment), and establishment and creation of a new nursing and midwifery department at the Ministry of Health headquarters. The president has identified the need to sustain the health service particularly through introduction of health insurance schemes as well as privatisation of health services in Zanzibar.

5.3.3 Decrease Gender Based Violence

GBV is highly prevalent in Zanzibar. The current government is focusing on reducing gender-based violence and indiscriminate harmful practices in the islands.

5.3.4 Healthcare Funding

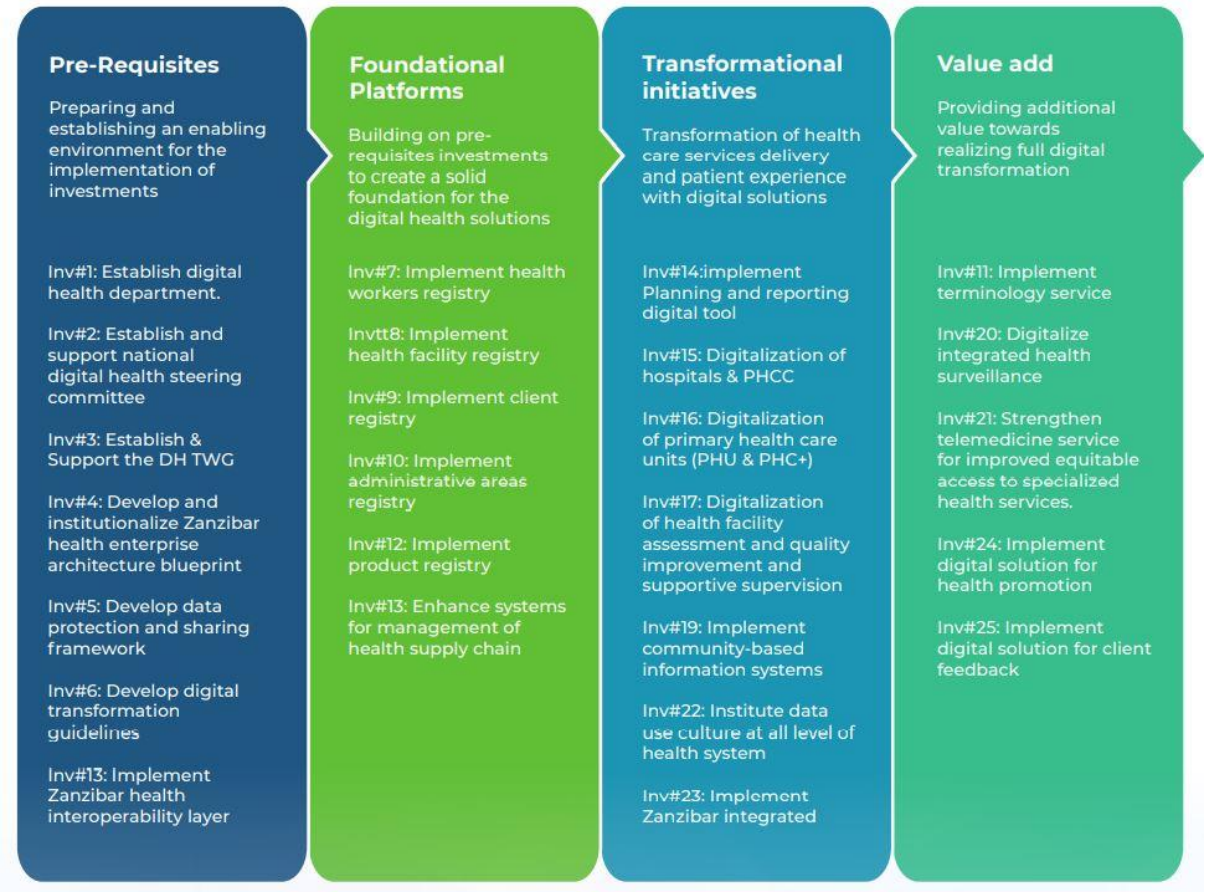
A shift from currently free service policy to social health insurance. The universal health insurance implementation is still at the infant stage with His Excellency President Hussein Mwinyi giving it his full political backing. Although the government policy is to provide free health care, escalating costs of health services due to emerging of high technology in diagnostic and treatment services is currently obvious. Out of pocket (OOP) expenditure is high (19%), which translates into catastrophic situations among population without having mechanism to protect the poor.

5.4. Digital Health Strategies in Zanzibar

This section responds to the following MTR question: Is the level of digitisation of government systems sufficient to administer efficiently and effectively a UHI?

The GOZ through the Ministry of Health is making significant strides in implementation of eHealth in the health sector. Recently the government launched its 2020/21 – 2024/25 digital health strategy. The strategy's main objective is to develop appropriate digital health solutions for better health to all Zanzibaris. The strategy was developed to address challenges facing digital implementation in health system, which include inadequate ICT expertise and computing infrastructure; limited financial resources; poorly designed digital solutions; suboptimal data quality and limited data use culture throughout the health system; inadequate digital health capacity and reluctance of some users to adopt digital health solutions in their day to day operations. Another challenge identified includes the presence of fragmented digital health systems that are not interoperable.

Figure 20:Categories of the Digital Investment



Implementation of the same is still not sufficient to effectively and efficiently administer UHI. The government has not yet implemented the HMIS in most facilities in Zanzibar. HMIS is one of the fundamental information systems in implementing a health insurance scheme. Health Management Information Systems (HMIS) is one of the six building blocks essential for health system strengthening. HMIS is a data collection system specifically designed to support planning, management, and decision making in health facilities and organisations. HMIS has the potential to improve the efficiency health system through automation and generating

necessary reports for managing operations, performance, quality, planning, decision-making and reporting for projects. Lack of HMIS at facilities in Zanzibar will have a negative impact on the implementation of UHI. Public Sector Systems Strengthening (PS3) have shown interest in supporting the GOZ in implementing the GoTHoMIS in primary healthcare units (PHU & PHC+). This will still leave a gap in the implementation of digitisation of hospitals & PHCC.

The government of Zanzibar has developed the 2020/2021 – 2024/25 Digital Health Investment Roadmap through the Ministry of Health, Social Welfare, Elderly, Gender and Children which is the blueprint for driving digital solutions in health sector. The following are the key priorities (See Figure 19) in the roadmap for the next five years.

6. Recommendations

Given the findings in mainland, what can Zanzibar learn for its own development of a UHI. Based on the experience in mainland and the President's vision, there several areas Zanzibar can learn from the implementation of iCHF in mainland which include:

6.1 Holistic Approach to Health System Strengthening

Looking at the HPSS project implementation in all phases and the major achievement to date, which was building systems for the government to adopt as well as capacity building and knowledge transfer to key government personnel in the implementation of health insurance system, the GOZ can largely learn from the implementation of HPSS project from the view of system building. His Excellency President Hussein Mwinyi sees the lack of an efficient system as one of the stumbling blocks in ensuring better health delivery to the Zanzibaris. The HPSS project design looked to ensure other health systems components are well functioning to ensure successful implementation of a health insurance scheme. The same design and lesson can be adapted to the GOZ as they look to implement the health insurance scheme as means to achieving Universal Health Coverage in Zanzibar.

In order to administer a well-functioning social health insurance, a properly and strong health system consisting of trained and motivated health workers, a well-maintained infrastructure, and a reliable supply of commodities and appropriate technologies is required. It is therefore essential that while implementing the health insurance scheme the health system can respond to the demands of the clients. This will include:

- Constant and adequate supply of commodities
- Stable health financing, including covering those who needs healthcare most, the poor and vulnerable groups.
- Multi skilled human resource capacity building
- Health technology management
- Health promotion in response to the current shift in demographic and diseases for more urbanised and high prevalence of non-communicable diseases.

6.2 Guiding Health Policy and Implementation Guidelines

Given strong experience in the Mainland, it is highly recommended that a secular UHI, and other accompanying policies be developed in advance of the reviewed national health policy.

6.3. Digitalisation

Considering the pre-design scheme, the GOZ should invest in the ICT infrastructure (hardware, software and connectivity) that will be ready to facilitate operationalisation of the

health insurance scheme by focusing on integrating the payers' and providers' side systems. The GOT of Tanzania is implementing the openHIM, which tries to integrate the critical ICT systems in the health sector. The GOZ has developed the enterprise architecture which is the blueprint of implementation of health information systems looking at a health sector in a more holistic approach. In order to achieve this the GOZ has to do an initial assessment of the key information systems that can impact the implementation of health insurance scheme.

While implementing the Health Insurance Information Systems below are the key recommendations to take into consideration:

6.3.1 Coordination of activities

Various Development partners would like to support the Government of Zanzibar in implementing digital interventions soon. However, skilled local staff/consultants are needed to ensure proper coordination of these investments to achieve the desired health outcomes. Especially considering that the Ministry has already identified 25 investment areas (see chart 15), sequencing of activities is vital. It is essential to avoid redundant digital interventions. Similarly, inadequate sequencing of interventions can cause significant delays in the implementation of digital projects.

Experience in other countries has shown that an international advisor with relevant experience in health financing, health insurance but also experience in working with ministries in low-resource settings can be a great added value for the project.This is specifically to support the Ministry in decision-making and support the aforementioned sequencing of activities in introducing health insurance. The goal is not for the international advisor (ideally an "embedded advisor") to act as a gatekeeper but as a facilitator between government institutions and development partner interests.

6.3.2 In-depth assessment of available digital tools

A thorough evaluation of all digital solutions used in the health system must be made before successful implementation of the health insurance system. It is imperative to look beyond the health sector and assess the completeness of registries (e.g., CRVS) or online payment systems. In this way, the implementation of the health insurance information system can be ensured from a holistic point of view, instead of looking at it from the perspective of an isolated implementation.

6.3.3 Capacity Building

Capacity building for the Ministry of Health, Social Welfare, Elderly and Children (MoHSWEGC) is necessary. This is the only way to ensure that digital systems for health purchasers (e.g., health insurance) and digital systems for health service providers are used in a customer-oriented manner and are interlinked.

6.3.4 Electronic payments

The integration of the health insurance system should be preceded by an analysis of potential contribution, collection and provider payment solutions. It has been shown in other countries that well-designed electronic payment gateways can significantly support the contribution collection process by addressing the individual needs of specific groups of insured persons. An example of this is seasonal payment by farmers.

6.3.4 Health Insurance Operational Software

Implementing a digital health insurance information system to support the planned health insurance in Zanzibar is the core piece for any health insurance operator. It is essential to consider the country context and choose a software solution that can be adapted to the specificities of Unguja and Pemba. OpenIMIS is an existing open-source product that offers a high degree of flexibility and customisation possibilities.

The Ministry of Health is also recommended to look at the IT solution for the pension system in Zanzibar and learn from it.

Some of the key considerations for designing the IT system for the health insurance operator include:

- An IT solution for health insurance should put the beneficiary or patient first and not start with the M&E side. This mistake could be observed again and again in other countries. Successful monitoring of the health financing parameters through dashboards requires the delivery or connection of operational IT systems for the health insurance and the service providers (e.g., Patient Registration Systems & Electronic medical records).

- Operational software for health insurance should cover the essential business processes of a health insurer. These are in particular:
    - the member enrolment
    - the collection of premiums
    - the claim management
    - fraud & abuse control
    - financial management
    - monitoring and evaluation
    - reporting

- A “bridge” between payer and provider side systems is imperative to enable them to conduct business electronically, including eligibility verification, claims submission and more. This should be done by using standard protocols for data transmission such as HL7 FHIR.

6.3.5 Registries

Another important point is the connection of operational systems to existing registries such as the Civil Registration and Vital Statistic System. This makes it possible to identify any deceased persons and integrate new-borns into the family’s insurance coverage as quickly as possible.

The establishment of facility registries and health worker registries also makes sense. Other countries are already working on so-called available drug registries in which, for example, innovative solutions are used to identify genuine/fake drugs.

Added value can be achieved by the introduction of a joint beneficiary registry as this allows the identification of the citizen across the social protection organisations and checking of entitlement to benefits. The establishment of a social registry is also conceivable. However, data privacy guidelines must not be ignored in this context.

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Reviewed documents:

- HPSS phase 3 Prodoc
- MTR Health Sector Strategic Plan IV
- E-health strategy
- Documentation and websites for the IT systems supported by HPSS
- Project performance reports and publications
- Zanzibar Digital Strategy
- Tanzania Mainland DIGITAL STRATEGY
- Zanzibar Social Protection Strategy

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Yusufu H. Iddi		In charge Curative Pepmba			

Annex 2. Terms of Reference

TERMS OF REFERENCE
FOR THE
EXTERNAL MID-TERM REVIEW OF THE PHASE 3 (EXIT PHASE) OF THE HEALTH PROMOTION AND SYSTEM STRENGTHENING PROJECT (HPSS) BEING IMPLEMENTED IN TANZANIA
FROM NOVEMBER 2019 – OCTOBER 2023

Abbreviations

SDC	Swiss Agency for Development and Cooperation
ODA	Overseas Development Assistance
VSD	Vocational Skills Development
CSOs	Civil Society Organizations
HPSS	Health Promotion and System Strengthening Project
MoHCDGEC	Ministry of Health, Community Development, Gender, Elderly and Children
PORALG	President's Office for Regional Administration and Local Government
MoFP	Ministry of Finance and Planning
iCHF	improved Community Health Fund
PVS	Prime Vendor System
GoT	Government of Tanzania
TAF	Technical Assistance Facility
TA	Technical Assistance
SoP	Standard Operating Procedures
NHIF	National Health Insurance Fund
TAMISEMI	President's Office for Regional Administration and Local Government (in Swahili)
SNHI	Single National Health Insurance
UHC	Universal Health Coverage
IMSC	Inter-Ministerial Steering Committee
ILO	International Labor Organization
LMICs	Low and Middle Income Countries
MTR	Mid Term Review
GePG	Government Electronic Payment Gateway
eLMIS	electronic Logistical Management Information System
CFAO	Chief of Finance and Administration Officer
PMU	Project Management Unit
GIZ	German Development Cooperation
HTMS	Health Technology and Management System

1.0 Purpose of this document

This document contains the requirements relating to the mandate for "Health Promotion and System Strengthening Project (HPSS) Mid Term Review." It serves as a template for the bidder to submit his or her offer. Contracts are awarded according to the invitation to tender procedure according to Art. 35 of the FOPP.

2.0 Goal and content of the Mandate

2.1 SDC Country Strategy 2021-2024

Switzerland, through the Swiss Agency for Development and Cooperation (SDC) has finalized its new Cooperation Programme for Tanzania 2021-2024. It is aimed at continuing the efforts of SDC in the country, which dates back to the early 1960. Swiss ODA, based on the values of participation, accountability and a rule-based administration, has significantly contributed to poverty reduction and sustainable development in Tanzania, most notably in malaria control and basic health services.

The new Cooperation Programme is anchored in Switzerland's International Cooperation Bill 2021-2024 which pursues four key objectives: (i) Contributing to sustainable economic growth, market development and the creation of decent jobs (economic development); ii) Addressing climate change and its adverse effects and managing natural resources sustainably (the environment); iii) Saving lives, ensuring basic services, especially in relation to education and healthcare, and reducing the causes of forced and irregular migration (human development) and iv) Promoting peace, the rule of law and gender equality (peacebuilding and governance).

The overall goal of the Swiss Cooperation Programme Tanzania 2021-2024 is **to empower young Tanzanians, especially young women, to advance socially and economically, thus enabling them to be a main driver of Tanzania's move to an equitable and stable middle-income country, and contributing to regional stability and prosperity.** To reinforce coherence, Swiss cooperation in Tanzania will pursue three cross-sectoral portfolio outcomes that aim to strengthen state institutions, protect and promote civic space, and improve youth livelihoods:

Outcome 1: State institutions are more efficient and effective, inclusive and increasingly free of corruption.

Tanzanian civil service is more efficient and effective and perceived corruption is decreasing. Basic social services coverage is progressing, but challenged by quality and equity issues, population growth and urbanization, and acutely threatened by the government's preference for spending on large infrastructure projects.

This outcome therefore aims at strengthening central state institutions and local authorities to be more efficient and effective in using limited public resources, to be more responsive and accountable to - young - men's and women's needs and less prone to corruption. A mix of Swiss sector budget support and technical assistance for key state institutions, including oversight bodies, will help inform government policies and foster the ability and capacities of the public sector to deliver high-quality basic social services in health, social protection and VSD that leave no one behind.

Outcome 2: Civic space is protected and enables all Tanzanians and especially young women to influence local and national policymaking and implementation and protect their human rights.

The traditionally fairly open civic space in Tanzania has significantly shrunk in recent years. Too many young people lack the necessary skills and avenues to create and access information, voice their interests and concerns. They remain unrepresented and unable to participate in decisions that affect the society, their communities and human rights.

This outcome therefore aims at protecting and promoting the space that enables young Tanzanians, especially young women, to express themselves freely and to shape and influence social, political and economic matters concerning them. Advocacy activities of Swiss-supported accountability actors (mainly CSOs and media) and human rights defenders will preserve and open new spaces for all Tanzanians, especially youth, to engage with and influence state and private institutions at national and local levels. The likelihood is thus greater that policies, structures and processes take into account the needs and aspirations of young people, whether from rural or urban areas, and that human rights are better protected.

Outcome 3: More youth, especially young women, benefit from gainful income-generating opportunities and sustainable livelihoods.

Poverty is more prevalent among women-headed households and young people. Tanzanian youth and particularly young women are often stuck in low-paid informal or nonpaid work where they face limited prospects in terms of economic opportunities. Moreover, negative gender norms and traditions, as well as sexual and reproductive ill health hampers their economic development.

Switzerland recognizes that the growing population in Tanzania is a huge opportunity for accelerating growth and shared wealth. This outcome therefore aims at improving the livelihoods of youth, in particular young women, by expanding their access to (i) quality and relevant basic and vocational skills, innovations and financial services, (ii) youth-friendly sexual and reproductive health services, and (iii) social protection. Combined, public investments and private engagement in these areas will expand the economic options of youth - provided sufficient and attractive market opportunities exist - and allow them to pursue more gainful income-generating opportunities, thus supplementing and stabilizing existing income flows, and which ultimately lead to sustainable livelihoods and reduced income poverty.

The HPSS Project is focusing on outcome 1 where it is aligning with the three government Ministries – MoHCDGEC, PORALG and MoFP in strengthening their systems to make them efficient and effective institutions in advancing digitization and e-government initiatives.

2.2 Background Information

The project was initiated by the Chief Medical Officer of the Ministry of Health and Social Welfare and requested the Government of Switzerland to support the planned reforms. The reforms aimed at addressing access barriers to primary health care services by poor rural populations. The access barriers identified were shortages of medicines, dysfunctional equipment, inability to pay user fees in case of sudden illness, prevention of communicable diseases. The HPSS project was launched in July 2011. It started as a pilot project to develop and implement innovative health system solutions addressing the access barriers. The four project components were health promotion, health financing (improved community health fund - iCHF), medicines supply and management (Jazia Prime Vendor System-Jazia PVS) and health technology management (openMEDIS). The project is now in its third and exit phase with a budget of approximately US$ 9m (for 4 years, 11.2019-10.2023), to support the government of Tanzania to implement these interventions nationwide. The policy dialogue on a single national health insurance has been stalled for the past 3 years due to a financing shortfall of government in support of universal health insurance.

2.3 HPSS Project Phase 3 (see more information in the Prodoc)

Phase 3 is conceived as an exit phase with the objective to ensure full system compatibility and operational integration of the outputs of phases 1 and 2. It is conceptualized in a way that will lead to a sustained logical conclusion of the HPSS project with its aim to strengthen the health system in the whole of Tanzania. This is expected to support the country's progress towards its Development Vision 2025, and the health-related Sustainable Development Goal of Universal Health Coverage.

In the **exit phase**, the project has undergone **a change of role** from a facilitation role **to the role of providing technical assistance to the Government of Tanzania (GoT)** with the objective of mainstreaming HPSS project interventions into existing government operational structure and processes. The project is concentrating on supporting the GoT in the consolidation and nationwide implementation of system strengthening interventions developed by the HPSS project. The project design has evolved from a project to generate solutions working in 3 regions to a technical assistance program supporting government structures and agencies in adopting and implementing these access enhancing reforms.

The **project goal** for phase 3 is:

The health system of Tanzania is strengthened through adoption and implementation of reforms related to the iCHF health insurance, the Jazia PVS medicines management, the health technology management, and participatory health promotion at community level.

The three objectives of the phase 3 of the HPSS Project are:

1. The establishment of a Technical Assistance Facility (TAF) for the GoT coordinated through the Health Systems Strengthening Resource Centre (HSSRC) located at PORALG. The TAF is supporting i) the nationwide scale up ofiCHF, openMEDIS, Jazia Prime Vendor System (PVS), equipment repair and maintenance system, and community participatory health promotion; ii) the development and dissemination of standard operating procedures (SOP) and guidelines and manuals related to the effective deployment of interventions piloted by HPSS, as well as iii) the deployment of an innovative capacity building system that ensures that field operations are compliant with SOPs and guidelines;
2. The provision of specialized technical assistance (TA) to the GoT (MoHCDGEC, PORALG, and MoFP) digitization effort of e-government. The TA will ensure system compatibility and effective integration of the HPSS derived interventions such as the health insurance management information system (IMIS) for iCHF including connectivity to the cashless payment function of the Government Electronic Payment Gateway (GEPG), as well as the IT systems related to procurement of medicines and medical devices through Jazia PVS, and the IT infrastructure around equipment maintenance (openMEDIS) and health promotion;
3. The creation of a nationalthink-tank or center of excellence that identifies and prioritizes knowledge gaps relevant to the nationwide deployment of Universal Health Coverage priority interventions such as the establishment of a national health insurance scheme. The project will support the Think Tank with suitable consultants.

Phase 3 aims at achieving the following **outcomes**, based on the above objectives:

1. A Technical Assistance Facility (TAF) effectively supports national implementation of iCHF, Jazia PVS, openMEDIS and Community Participatory Health Promotion.
2. The GoT effectively develops and implements digitalization solutions regarding openIMIS, Jazia PVS, openMEDIS and health promotion, aligned with the national IT landscape.
3. Data and findings generated by HPSS are effectively used to develop evidence based capitalisation products for informing policy decisions of GoT.

The HSSRC coordinates TA deployment through **joint work plans with agreed budgets** with PORALG and MoHCDGECsupporting the nationwide implementation of iCHF, Jazia PVS, HTM systems and Health Promotion approaches.

The project is providing resources to the MoHCDGEC, PORALG and MoFP and the E-Health Partnership responsible for the e-government policy setting and implementation of an IT architecture. This is in order to ensure the **integrationof digital processes** related to iCHF,

Jazia PVS and HTM systems with other government systems such as DHIS2[13], EPICOR, Planrep, GoTHOMIS and NHIF IT system for cashless payment and rapid reimbursements of health services provided by clinics under iCHF insurance coverage. The Government Electronic Payment Gateway (GePG) is an important element for cashless operations of government services and the cashless operations of iCHF needs to be aligned with the GEPG. With regard to medicine supplies, the electronic logistic management information system (eLMIS) of the Medical Stores Department (MSD), a MoHCDGEC related parastatal, is the integrating system for the Jazia PVS digital elements. The HPSS developed insurance management information system (IMIS) for iCHF and the NHIF based claims verification and payment system is in place and in use. These systems must be integrated with the government's electronic patient file (GoTHomis light) and automated as much as possible to ensure rapid claim settlements. The PORALG IT Department is project partner for this initiative and HPSS will provide, jointly with other partners (e.g. PS3plus[14]) resources towards this integration effort.

2.4 Organizational structure of the HPSS Project

The organizational structure of the HPSS Project has changed in this exit phase. The current HPSS office in Dodoma is now the HPSS Project Management Unit (HPSS PMU). It provides human resources, financial management and procurement services to the four project components. The PMU is minimally staffed with a technically oriented Project Manager (PM) and by a Chief Financial and Administrative Officer (CFAO). Both report to the HPSS Project Director at the Swiss TPH. Each project component is administered through the PMU.

2.5 HPSS Project Intervention Approach

Phase 3 is designed as a consolidation phase of the innovative health system strengthening solutions at national level, and as an exit phase for the project. The establishment of the Technical Assistance Facility (TAF) is very important in enhancing the national roll out of the innovative solutions. The TAF consists of technical and administrative staff from HPSS phase 1 & 2 paid by the HPSS Project to provide operational and technical expertise in implementing iCHF, Jazia Prime Vendor, openMEDIS, and community participatory health promotion. The TAF expertise represents all levels of operations (community, district, region, zones, national, IMIS). The TAF is managed by the Project Manager reporting operationally to the Director Health Services (PORALG) and to the HPSS Project Director. In addition to the Dodoma based senior TAF experts, the project has deployed eight zonal experts and support teams for rapid response to the regions consisting each of 2 to 3 staff. The focus of the zonal teams is to monitor iCHF, Jazia Prime Vendor, HTMS and health promotion implementation in the regions and the provision of technical support to the regions. The zonal teams also ensure operational synergies with public finance management programs such as USAID PS3, PharmAccess and GIZ.

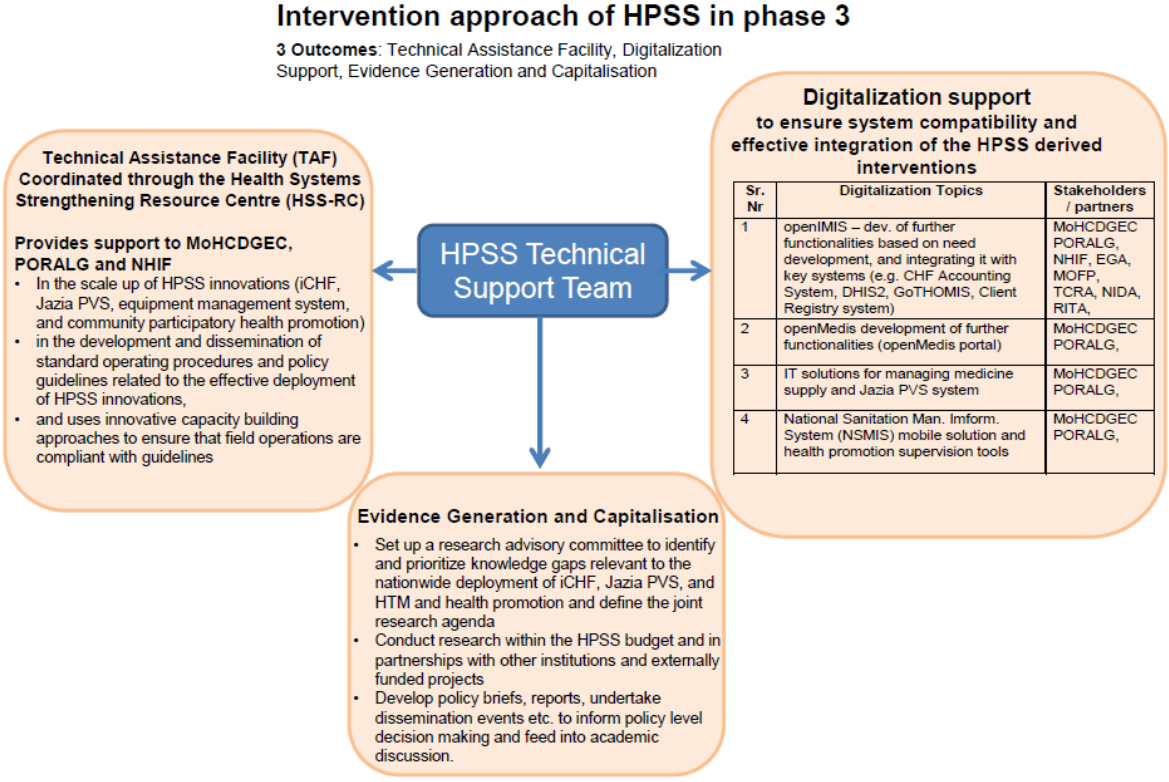
The roll out of the project components will be **phased out in stages.** The **Health Promotion** and **Health Technology and Management** components are being implemented for 18 months and will be closed on 30th April 2021.The phasing out of these two components will then enable the HPSS project to concentrate on the two big components of the health financing (build up of the national health insurance for the informal sector and rural population which contributes to the development of the Single National Health Insurance - SNHI) and medicines management and supply (improving medicine availability as an essential

[13]District Health Information Software 2 (DHIS2) is an open source, web-based platform most commonly used as a health management information system (HMIS). Today, DHIS2 is the world's largest HMIS platform, in use by 73 low and middle-income countries. Approximately 2.4 billion people live in countries where DHIS2 is used. Including NGO-based programs, DHIS2 is in use in more than 100 countries.

[14] This is a USAID funded project that is supporting the area of public financial management.

component of quality of care through Jazia Prime Vendor System as a supplementary supply chain).

The element of evidence generation and capitalization is implemented for the whole phase of four years.



3.0 Health Insurance context in Tanzania

The government of Tanzania is implementing the improved community health fund (iCHF) as a short-term health insurance solution for informal sector whilst developing a compulsory single national health insurance strategy in support of UHC.

Since 2015, the Tanzania health sector through an inter-ministerial technical committee (IMTC) has been engaged in the definition of a future compulsory single national health insurance as the backbone of the health financing strategy. Different studies were carried out to inform on the development of the financing strategy. A cabinet paper has been drafted based on this strategy to be presented in Parliament. The Cabinet Paper that is spearheaded by the MoHCDGEC has gone through many content changes. The Health Financing Technical Working group has been following up on this document. Unfortunately, no member from the Development Partners has seen this document as it has not been shared for discussion or comments by the MoHCDGEC. It has been rescheduled so many times to be presented in Parliament. It was scheduled to be presented in the September 2020 Parliamentary session but this still did not happen. The Single National Health Insurance (SNHI) cabinet paper has not been processed for lack of identified government financing. The ILO and MoHCDGEC now initiated a new institutional feasibility and ability-to-pay study to support the development of a SNHI concept. It is still not clear when the Cabinet Paper will be discussed in Parliament. At the earliest, a Single National Health Insurance in operations will be ready by 2025.

The social health insurance context in Tanzania is characterized by high volatility. Senior policy makers in the MoHCDGEC have very different views on social health insurance from those of the health service provider President's Office for Regional Administration and Local

Government (PORALG and in Swahili it is best known as TAMISEMI[15]). Since July 2018, TAMISEMI is implementing the iCHF, a comprehensive social health insurance scheme including all services of governmental health care providers in mainland Tanzania at primary level (dispensaries, health centers), secondary level (district hospitals) and tertiary level referral services at Regional Referral Hospitals[16], with a TZS 30'000 premium for six members of a household for 12 months. Membership is portable and allows access to more than 6,000 mostly government operated health facilities across mainland Tanzania, irrespective of where members have been enrolled. The iCHF management and pooling of funds occurs at regional level. In 2020, all 26 regions of mainland Tanzania were implementing the iCHF. In parallel, the MoHCDGEC is implementing the National Health Insurance Fund (NHIF), a health insurance scheme for the civil servants[17] but which nowadays is also targeting large private sector employers and independent individuals (minimum premium TZS 1'200'000). The NHIF presently reports 4,856,062 members[18], equivalent to 8.4% of the population of Tanzania. As per January 2021, the iCHF reports a number of 1.8 million persons with active policy, equivalent to 3.5% of the population of Tanzania.

Phase 3 of the HPSS project concentrates on capacitating the GoT to operate independently a health insurance system adopted to the needs and specific situation of rural population and population living in the informal sector. The project renders support on all key aspects of operating and managing such an insurance system (support of SOPs, manuals, teaching and training tools etc,). One area of focus of the project's work is also to capacitate the GoT to independently operate and further develop the IT system operating the insurance scheme.

The "Insurance Management Information System" (IMIS, or openIMIS expressing the opensource character)is a comprehensive system for managing a health insurance scheme with its key elements of beneficiary management, health service claims generation, transmission and review. "By applying industry standards, openIMIS provides a seamless exchange of beneficiary, health service provider and scheme operator data."[19]This IT capacity building of TAMISEMI and MoHCDGEC will be supportive of any future design of a Single National Health Insurance System. IMIS has been developed in Tanzania and is presently embedded as an open source global initiative(openIMIS) to benefit other countries worldwide.

4.0 HPSS Project MTR

4.1 Rational

The planned MTR takes place around one year and a half of implementation of phase three. The remaining 30 months of HPSS project implementation will allow to make a significant contribution towards the further development of a specific health insurance system for UHC which may be integrated into a **single national health scheme** later if the GoT so wishes.

In the current context, digitization has become a priority area of focus for the government of Tanzania. The Single National Health Insurance (SNHI) discussions are in progress. The Cabinet Paper and the Bill to the Parliament is planned to be tabled in September 2021. SDC's view is that the 30 months project exit phase can still make a substantial contribution towards creating understand of the future design of the national health insurance and to inform the development of the It system which will support its operations. In this respect, it will be relevant to look into the experience of iCHF **especially on enrolling the informal sector and rural population.** Whaterver strategy of insurance will be developed by the government it should have a mechanism to enrol and renew people in the informal and rural population which is a challenge.

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[15] TAMISEMI and PORALG are used interchangeably

[16] http://www.chf-iliyoboreshwa.or.tz/en/chf-benefit-package, (website of TAMISEMI)

[17] The civil servants are deducted 3% from their salaries and the employer co-contributes 3% (total contribution is 6%) covering 6 members of the household for a period of 12 months.

[18] https://www.nhif.or.tz/pages/profile#gsc.tab=0, as per 08th Nov. 2020

[19] https://openimis.org/

Such a redirection would enhance effectiveness and attractiveness to providers and clients of any future governmental health insurance strategy. More broadly, such an investment would strengthen health governance more broadly, accountability of health insurance premiums and e-government efficiency in general. Such a redirected investment into the E-Health Partnership is expected to make the underlying data systems more functional. Any future social health insurance will require solid, real-time and integrated digital systems to make the SNHI work as intended and produce progress towards UHC. The contribution of developing IMIS and integrating it with the key IT systems therefore is expected to benefit a future SNHI in whatever organizational form the GoT choses.

4.2 Objectives of the MTR

This External Mid-Term Review (MTR) comes at the start of the second year of implementation of the HPSS project in phase three. It will cover the period from November 2019 to March 2021.

4.3 Overall objective

The MTR is to provide an external view allowing the priority setting of the US$ 9m investment over the remaining period of the HPSS project phase 3 (around 30 months at the time of the review) and to identify options for the Swiss Agency for Development and Cooperation for investments at the interface between digital health and social protection beyond the end of phase 3 of HPSS project.

The review shall **namely focus**

- **how HPSS can contribute towards the generic health system management related IT architecture**, with
- focus **on making any future health insurance as efficient and effective as possible**. The review will also briefly appraise progress to-date of specific activities of HPSS phase 3: medicine management, health promotion, health technology management. This translates in the following three main objectives to be answered by the MTR

2. Assess the **project's performance in operating a TAF during the first 16 months of HPSS** phase 3 supporting the nationwide implementation of the reforms generated by HPSS phase 1 and 2 (iCHF, PV-Jazia, OpenMEDIS, Health Promotion; details see attached annual report);
3. Appraisal of the **present contributions and objectives of HPSS to**
    3.4. **strengthen the IT health systems architecture in Tanzania** through the countrywide introduction of IMIS for health insurance management, its linking up with health facility management systems (GotHOMIS and AfyaCare), with the government accounting system (MUSE), and with reporting, analysis, and monitoring tools such as DHIS2.
    3.5. Appraisal of the contriutions of HPSS to the IT infrastructure of the governmentl health systems with its support of IT systems in the fields of supplementary medicine supply, health technology management, and health romotion supervision.
    3.6. Appraisal of options to strengthen such support activities of the advancement of the health system IT architecture in Tanzania e.g. through the E-Health Partnershipfor future SDC investments into digitization and digital systems that make state systems more efficient and corruption free (Outcome 1 of the Cooperation Programme 2021-2024)
4. Preliminary appraisal on SDC future niches of engagement after HPSS (ideally building on investments made under point 2)

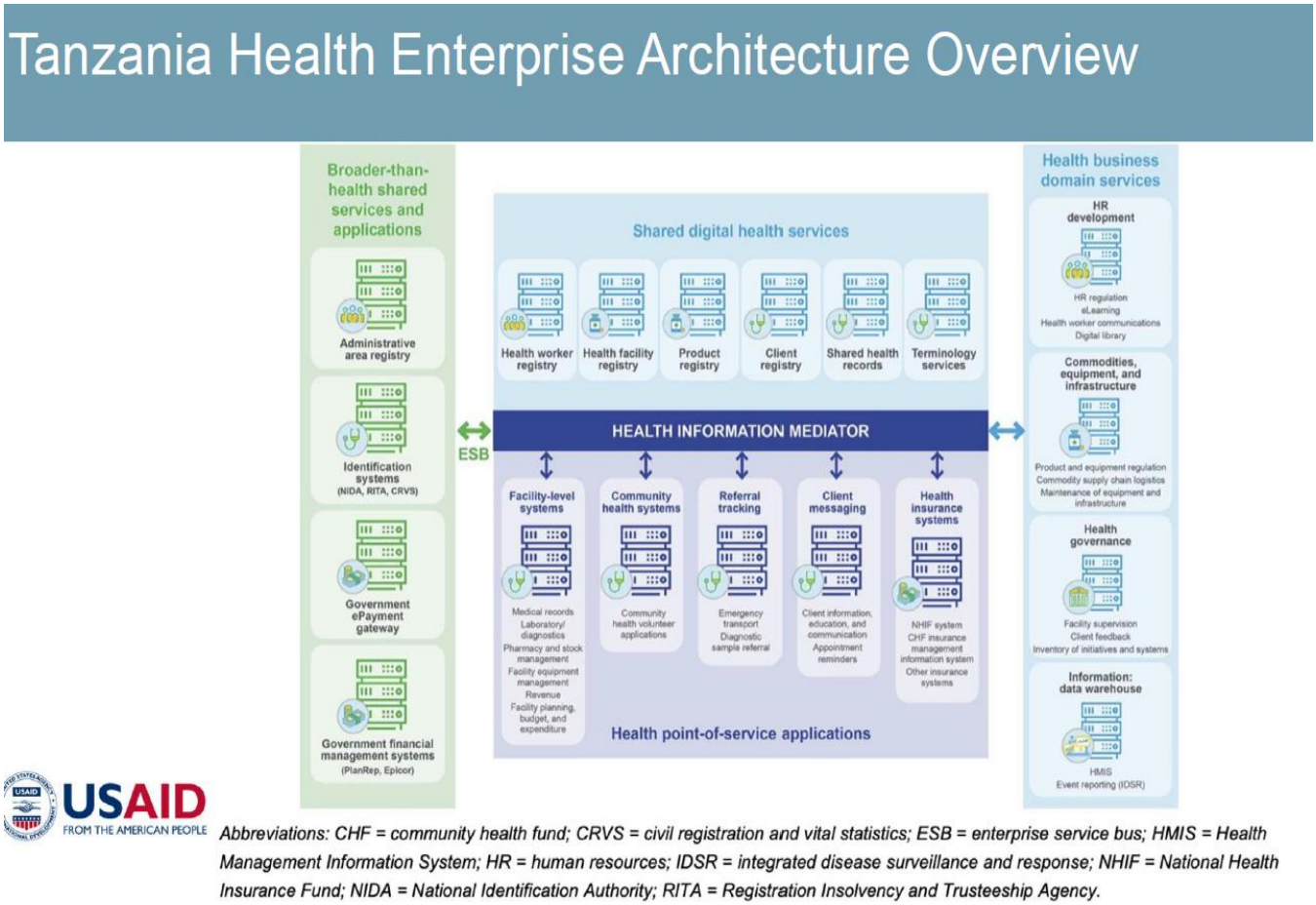
4.4 MTR Specific Questions

The specific questions in respect to **the first objective of the MTR** (performance, achievements and gaps of TAF during phase 3) are:

- Is HPSS project phase 3 on track with providing relevant TA to GoT for the nationwide implementation of iCHF, PV, Healtjh Promotion and openMEDIS as described in the ProDoc and logical framework?;
- Have the outputs of HPSS project phase 3 resulted so far in increasing coverage with iCHF and reducing stock outs nationwide? An analysis of bottlenecks to achieve impact is expected.
- What is the perception of intended beneficiaries at PHC clinic, LGA, regional and national level with regard to results achieved, through TAF, so far in phase 3?
- What achievements and bottlenecks are being identified namely in respect to community health insurance and the health insurance management system (and to a smallerextent on medicine management, health promotion, health technology management)?
    - What is the government's priorities in this field and how does the current set up of the HPSS fit?
    - What are the strategies of other donor partners in the field of health financing, and how can HPSS ensure complemetarity and synergries with them?
    - Based on the above, what are the necessary adjustments of HPSS phase 3 to ensure high value for money of the TAF and without causing disruption in the implementation of the phase 3?

The specific questions in respect to **the second objective of the MTR** (Identify options to direct some remaining project resources into the advancement of the health insurance related IT architecture in Tanzania through the E-Health Partnership) are:

- What are investment opportunities in the health insurance related digital system development by the E-Health Partnership in mainland, given the slow progress in iCHF coverage to-date and the stalled health insurance policy dialogue.
- Identify immediate and health insurance relevant gaps in the Tanzania Health Enterprise Architecture that HPSS can address through its comparative advantage, and that have a high likelihood to increase iCHF coverage.
- Identify opportunities within the existing financial envelope to engage with Zanzibar on developing a digital basic health insurance scheme.



Abbreviations: CHF = community health fund; CRVS = civil registration and vital statistics; ESB = enterprise service bus; HMIS = Health Management Information System; HR = human resources; IDSR = integrated disease surveillance and response; NHIF = National Health Insurance Fund; NIDA = National Identification Authority; RITA = Registration Insolvency and Trusteeship Agency.

The specific questions in respect to **the third objective of the MTR**(Provide a high-level appraisal on niche for future SDC investments into digitization and digital systems that make state systems more efficient and corruption free (Outcome 1)) are:

- What are potential Partnerships between with the Government of Tanzania and Switzerland that will leverage Switzerland's digital innovation capacityand bilateral investments to enhance efficient corruption Free State institutions (human resource management, distant learning (professional development, accreditation, education, professional skills development), health insurance, social protection, public finance management, government accountability)?
- What are national and international initiatives (both current and upcoming) in social protection, health insurance or E-Health with focus on UHC where bilateral investments in Tanzania would have high value added and effectively leverages Swiss digital innovation capacity?

5.0 Methodology

The external review team submits a proposal of the planned design and methodological approach for conducting the Mid-Term Review in the inception report. The review team will use existing data and project information sources in a preliminary document review and realize field and stakeholders visits with interviews and discussions with key stakeholders for their analysis.

The external review consultant will perform desk reviews including the project's literature (project document, credit proposal, progress reports, baseline report etc.) and relevant national policy document (HSSP4 Mid Term Review (2019), E-Health strategy, other relevant recent (2015) national policy documents).

The consultant will hold discussions and interviews with differernt stakeholders. Duty travel to Tanzania will be necessary (unless the Covid 19 situation evolves in a way that this is not possible). Some of the stakeholders include the GoT counterparts, specific stakeholders of the HPSS project, other donors involved in similar/complementary supports, (especially the P4H partners that are active in the field of health financing)SDC staff in Dar Es Salaam, with members of the E-Health Partnerships, and with the management of the HPSS project oth in Tanzania and Switzerland.

6.0 Review Team

The External Review Team will be composed by a team **of three to four national or international consultants.** The number is determined by the team's expertise to address the MTR objectives. SDC expects a gender balanced team.

6.1 Consultant Team Profile

The review team is expected to have expertise in:

- ✓ **A specialist with documented experience of performance evaluations of Technical Assistance Facilities/Technical Assistance provision systems for governments in LMICs to serve national, regional and district interlocutors.**
- ✓ One or several specialist with health system IT architecture experience in LMICs in supporting the development of digitization strategies for governments with superior documented experience in digital government systems for social protection and welfare. The expert needs to have a strong familiarity with Switzerland's digital innovation expertise with impact on systems serving the social sector or the commercial insurance system.
- ✓ **The Review Team Leader can be any of the above and must have documented experience in leading a team of professionals in a developing country to successful completion of an MTR**. The evaluation team should have a deep understanding of the social and political background of Tanzania and the functioning of the health insurance and digitization landscape and key actors in Tanzania;
- ✓ Knowledge and proven expertise in health insurance approaches, management and design for UHC in LMICs, especially with regard to coverage for rural populations and members of the informal sector;
- ✓ A good understanding and expertise in digital health;
- ✓ **A capacity to analyze the outcomes/outputs of the HPSS project with a LNOB/gender lens**
- ✓ **Good analytical skills and report writing skills as demonstrated by a successful record of previous work on related topics;**
- ✓ **Good communication skills and ability to interact with different stakeholders.**

6.2 Roles and Responsibilities

6.2.1 The Consultant Review Team Leader

- ✓ Managing the review following the scope of work and work plan approved by SDC;
- ✓ Preparing and submitting all deliverables as per the contract;
- ✓ Updating SDC regularly on progress of the review;
- ✓ Ensuring the quality assurance of all deliverables.

6.2.2 SDC

SDC Programme Officer in charge of the review will be responsible for the following:

- ✓ Managing the Consultant's contract;

- ✓ Acting as the main contact person for the Consultant;
- ✓ Sharing deliverables with key stakeholders;
- ✓ Collecting stakeholders' comments on the draft review report;
- ✓ Including the management response in the final Review Report;
- ✓ Disseminating the review.

6.3 Start-up Meeting

The Consultant must attend (in person or via a tele- or video-conference) a start-up meeting with the Health Domain Team of SDC. The purpose of this meeting is to ensure that:

The consultant understands (1) SDC expectations concerning the quality of evaluation deliverables, and (2) processes and timelines; and 3) the Consultant has the opportunity to ask for clarifications on the mandate.

6.4 Evaluability Assessment

The evolving COVID 19 pandemic may affect the availability of key informants and ability to carry out data collection in the field. The Consultant must thoroughly assess these constraints through an evaluability assessment in order to inform the evaluation's feasibility as well as the methodological choices, which may require greater reliance on certain lines of evidence, minimized travel to the field, increased use of information and communication technologies (ITC), etc.

Note: the use of local expertise cannot be ethically justifiable to replace international expertise if both bear or create the same COVID-19 related risks (getting or propagating the virus). However, there may be circumstances where international expertise is barred from reaching a country or where local expertise is more appropriate for local interactions due to language etc., etc. It is important to restate for all evaluations, regardless of the COVID-19 situation, that i) local expertise is always strongly encouraged and ii) ethical norms always have to be maintained regardless of conditions.

Based on the evaluability assessment, the evaluation may be

- delayed or cancelled, or
- conducted with a narrower scope, or
- re-purposed: There may be cases where field data constraints and contextual changes are so important that it may be preferable to completely repurpose the evaluation to respond to the evaluations users' needs. This may require different methodological approaches.

7.0 Deliverables

The review team shall present an inception report outlining approach and methodology, including timetable, organizations to be included and assessment tools within 10 days of signing the contract. After receiving comments from SDC, the draft will be finalized latest 2 weeks after the beginning of the assignment. The review team shall present a final analytical report of the HPSS project presenting the findings, conclusions and recommendations of the review in a concise report, written in English and of maximum 30 pages main body of text (without the annexes). The recommendations should consider short-term and medium-term steering implications. The report should be in Arial font size 11.

The report should be presented in the following format:

1. Cover page, table of contents, list of acronyms

2. Executive summary

3. Introduction

4. Objectives

5. Methodology including reflection on limitations of the methodology

6. Results/ findings

7. Analysis and interpretation (including tables/graphics and text)

8. Conclusion and recommendations

9. Annexes - The annexes should include a list of documents consulted and persons interviewed, as well as the PowerPoint presentation used for the debriefing

The report should be delivered in 2 paper copies and an electronic version by email.

7.1 Time frame and target dates

The review will take place in the months of April and June 2021. The review is to take place over a period of 50 working days (10 days for Zanzibar), and shall be completed not later than June 15th2021.

Deadline	Activity
08.03.2021	Publication of the mandate on: www.eda.admin.ch
12.03.2021	Questions by email
15.03.2021	Answers to all bidders who have expressed an interest
31.03.2021	Deadline for submitting offer
12.04.2021	Awarding of mandate and notice to unsuccessful bidders
15.04.2021	Signing of contract and beginning of mandate
26.04.2021	Presentation of inception report
03.06.2021	Submission of draft report
11.06.2021	Submission of final report

8.0 Formal aspects of the invitation to tender

8.1 Contracting authority

Embassy of Switzerland in Tanzania

Swiss Agency for Development and Cooperation

79, Kinondoni Road

P. O Box 23371

Dar es Salaam, Tanzania

www.eda.admin.ch/daressalaam

All bids should be sent by e-mail by (31stMarch 2021) to:

Jacqueline Matoro with e-mail: jacqueline.matoro@eda.admin.ch

The Subject of the E-mails should be **MTR HPSS Project** written in Capital and Bold.

Postal Submissions are not accepted.

8.2 Type of procedure

Procurement in the invitation to tender is in accordance with the Federal Ordinance of 11 December 1995 on Swiss Office of Public Procurement, FOPP, SR 172.056.11.The submitted bids must meet the requirements and instructions provided here in.

8.3 Composition and content of the offer

Chapter	Contents
1a	Technical Proposal, containing Curriculum Vitae of the consultants to be involved, SC1 and SC2, AC1 and AC2
b	Financial proposal: submit the financial proposal in accordance with your submitted proposed time/ days. Currency to be used: US Dollar (US$), see AC5

8.4 Budget

Please prepare a budget based on your estimations of time and the fees of the involved consultants. The mandate is estimated not to exceed 50 working days in total. No reimbursement can be made for the bidder's work in preparing and submitting his or her offer.

8.5 Contractual terms

The contract to be concluded is subject to the general terms and conditions of doing business [which are supplied in the Annexes]. The general terms and conditions are considered to be accepted when an offeris submitted.

They can also be found under:
https://intraweb.deza.admin.ch/de/Home/Leitdokumente/Arbeitshilfen/Arbeitshilfe_Vertragserstellung_und_verwaltung/Standardvertraege/Auftraege

9.0 Suitability criteria

The bids can be submitted by companies/firms or by individuals/groups of individuals. The bidder able to meet both suitability criteria (SC) listed below has to specify that and clearly state he/she/it is applying to carry on the entire assignment alone. Capability and ability to fulfil the mandate shall be confirmed with a self-declaration.

No.	Suitability criterion	Verification
SC1	**A specialist with documented experience of performance evaluations of Technical AssistanceFacilities/Technical Assistance provision systems for governments in LMICs to**	The technical proposal attached with CVs of the consultants to be involved, containing at least 1 with

	serve national, regional and district interlocutors. One or several specialist with E-government experience in LMICs in supporting the development of digitization strategies for governments with superior documented experience in digital government systems for social protection and welfare. The expert needs to have a strong familiarity with Switzerland's digital innovation expertise with impact on systems serving the social sector or the commercial insurance system.	relevant project evaluation within last 5 years
SC2	**Experience and understanding in the area of health insurance approaches, management and design for UHC in LMICs, especially with regard to coverage for rural populations and members of the informal sector;** A good understanding and expertise in digital health;	The technical proposal attached with CVs of the consultants to be involved, containing at least 1 with relevant project evaluation within last 5 years

9.1 Award criteria

Of the valid offers submitted, the contract will be awarded to the technically and economically most favorable bid.Offers will be assessed according to the following award criteria and weighting:

No.	**Award criterion**	**Weighting 100%**
	Quality criteria	**Totaling 80%**
AC1	Experience with similar projects	40%
AC2	Experience in the Region	20%
AC3	Technical Adequacy	10%
AC4	General Qualifications	10%
	Price criteria	**Totaling 20 %**
AC5	Financial Proposal	20%

Award Criteria are evaluated on a scale of 0 to 5.

Score	**Fulfilment and quality of the criteria**

0	Cannot be established	- Information not available
1	Very bad fulfilment	- Information is incomplete - Data quality is very poor
2	Bad fulfilment	- Information relates inadequately to the requirements - Data quality is poor
3	Average fulfilment	- Information globally responds inadequately to the requirements - Data quality is adequate
4	Good fulfilment	- Information focuses well on requirements - Data quality is good
5	Very good fulfilment	- Information clearly relates to the achievement of outputs - Data quality is excellent

9.2 Financial Proposal

The financial proposal must be presented through one of the budget templates provided by SDC below.

The submission of any other format will disqualify the proposal. The format should be duly filled in all its relevant parts. Please submit the financial proposal using **USD Currency**.

In case the team is entirely formed by **local consultants** (is considered local any consultant not coming from **an OECD country**) please use the Local Mandate Form in attachment to the e-mail.

Please note that a consultant - either individual or a company - with Tanzanian nationality will be subjected to a withholding tax of 5% (on fees) while Non-Tanzanians will be charged with 15% tax (on fees).

For the case of **international consultants - individuals or companies -** (from any OECD country)please use the Mandate B form provided in the e-mail. Note also that the withholding tax is not applicable.

10.0 Additional points to be noted by the bidder

10.1 Negotiations

Remain reserved.

10.2 Confidentiality

All information of any kind that comes to the attention of the bidder in connection with the tendered mandate of the awarding authority is to be treated as confidential. The content of the present tender may only be made available to persons taking part in the preparation of the bid.

The tender documentation may not be used for any other purposes than preparation of the bid, even in extracts.

Bidders treat facts as confidential that are not public knowledge or publicly available. In cases of doubt, facts are to be treated as confidential. This obligation to secrecy remains valid even after conclusion ofthe tender procedure.

The awarding authority undertakes to maintain confidentiality about this bid towards third parties subject to the reserve of statutory publication requirements.

10.3 Integrity clause

Bidders undertake to take all necessary measures to avoid corruption, especially not to offer or accept payments or other advantages.

Bidders who violate the integrity clause are required to pay a contractual penalty to the contracting authority amounting to 10% of the contract sum.

The bidder notes that a violation of the integrity clause leads as a rule to the cancellation of the award or to early termination of the contract by the contracting authority for important reasons.

The Parties shall inform each other in case of any well-founded suspicions of corruption.

10.4 Protected rights

All protected rights that arise from executing the mandate shall be transferred to the contracting authority.

11.0 Additional documents provided to the bidders upon expression of interest:

- SDC's General Terms and Conditions of Business for Type A & B Mandate

- Project Document for HPSS project with Logframe and Budget

12.0 Reference Documents

- HPSS phase 3 Prodoc
- MTR Health Sector Strategic Plan IV
- E-health strategy
- Documentation and websites for the IT systems supported by HPSS

Annex 1: List of stakeholders to be interviewed

For **first** MTR objective regarding the TAF performance, in particular with:

Deputy Permanent Secretary Health and Director Health PORALG

Officer in Charge of health facilities (5 random dispensaries, 3 random health centers, 1 district and 1 regional hospital from one region in each of the 5 zones (Central, Coastal, Lake, Northern, Southern)

If possible iCHF card holders, (10 sequential interviews at a health center/district hospital)

Dr. Dorothy Gwajima, Minister of Health

Permanent Secretary and Chief Medical Officer MoHCDGEC

Regional Administrative Secretaries (from 2 to 3 regions)

iCHF implementing offices (iCHF Coordinators) of the GoT at regional and council level

iCHF implementation unit at PORALG and ICT Department PORALG

Other iCHF implementers /support organisations (Pharmaccess, GIZ, others in Mbeya region)

UNICEF Chief Health

NHIF Director General

NHIF IT Director

HPSS project team in Dodoma

HPSS Management Team SwissTPH (Project Director Manfred Störmer, IT experts, iCHF Component expert and openIMIS coordinator, and international experts guiding the development of the Jazia Prime Vendor System and the Health Promotion Component)

Swiss Agency for Development and Cooperation (Donor of the project)

For the **second**MTRobjective regarding the potential of HPSS to strengthen the Health Enterprise Architecture in Tanzania, especially with regard to health insurance, in particular with:

Mainland:

Deputy Permanent Secretary Health and Director Health PORALG

IT Director PORALG

Permanent Secretary MOHCDGEC

IT Director MOHCDGEC

Dr Faustine Ndugulile, Minister of IT and Communication

E-Health Partnership members

Digital Square Director

Henry Mwanyika, PATH Regional Digital Health Director

Jemma Bisimba, Health System Director, USAID TZ

Zanzibar:

Director for Digital Development, Revolutionary Government of Zanzibar

Permanent Secretaries MOF and MoH, Revolutionary Government of Zanzibar

Director IT of relevant ministries

For the **third** MTRobjective regarding potential Swiss niches in the digital space in support of efficient and corruption-free state institutions, in particular with:

Mainland:

E-Government Focal Point, Prime Minister's Office

National Planning Commission, E-Government Focal Point

MOFP, Digital System focal point

Deputy Permanent Secretary Health and Director Health PORALG

IT Director PORALG

Permanent Secretary MOHCDGEC

IT Director MOHCDGEC

Dr Faustine Ndugulile, Minister of IT and Communication

E-Health Partnership members

Digital Square Director

Henry Mwanyika, PATH Regional Digital Health Director

Dr Daudi Mboma, Dar es Salaam Computing Center

P4H partners - KfW who are planning an IT project with NHIF, ILO planning to support e.g. institutional studies, WB is about to share their Benefit Incidence Analysis etc.

Zanzibar:

Dr Juma Malik Akil (PhD), Deputy Executive Secretary, Zanzibar Planning Commission

IT Directors relevant Ministries