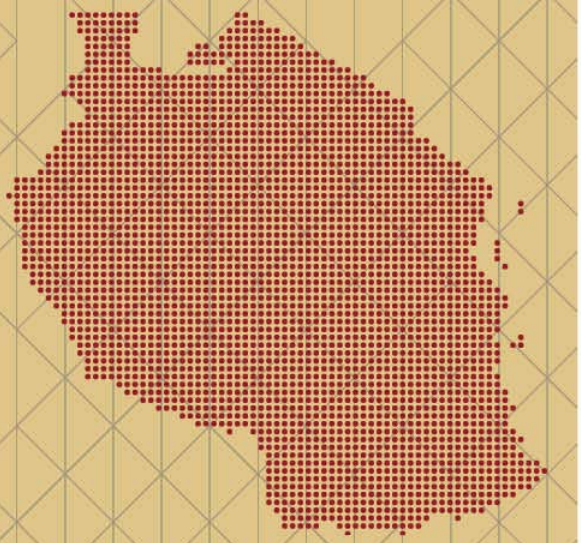
TANZANIA

COUNTRY CONSULTATION REPORT



Key Findings

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This report was prepared as part of the 5-country consultation for the African Collaborative for health financing Solutions project (ACS). This report was produced thanks to the contribution of a team of editors, analysts, and members of the ACS team who traveled to Tanzania for the purpose of conducting individual interviews. Kathleen Axelrod, Nicole Davis, and Katie Van Es provided background and writing support while Jonathan Gonzalez-Smith coded interviews.

Executive summary

The United Republic of Tanzania, which comprises Tanzania mainland and the islands of Zanzibar, is an East African country with a population of about 53 million. The public health system in Tanzania is organized as a hierarchical pyramid with dispensaries being at the lowest level and national referral hospitals offering the most specialized services. Oversight of health service provision is split between the Ministry of Health which oversees higher-level facilities and President's Office- Regional and Local Government (PO-RALG) which oversees facilities at the community level. The private sector, consisting of private for-profit, faith-based organizations or non-profit providers manages 40 percent of all hospitals in Tanzania.

Tanzania has anchored aspects of Universal Health Coverage (UHC) within its national policy framework including the Tanzania Development Vision 2025 (Vision 2025), the Health Sector Strategic Plan 2015-2020 (HSSP IV) and the National Strategy for Growth and Poverty Reduction (MKUKUTA). Tanzania's health sector strategy (HSSP IV) is informed by the Sustainable Development Goals (SDGs) and national plans such as Vision 2025 and the Big Results Now initiative (BRN). From the 2017 health sector review, limited levels of financing to the sector and the current health financing arrangements were noted as impeding financial access of the population to healthcare services. It is in this context that Tanzania developed its draft health financing strategy in 2015 which is currently pending approval by the cabinet.

The African Collaborative for Health Financing Solutions project (ACS) conducted a detailed consultation phase as a way to hone in on core challenges faced by countries in moving forward UHC, elucidate potential solutions, and ultimately inform framing of the ACS implementation approach. Tanzania was one of five countries visited in December 2017, and this report outlines the key findings of this mission around; the understanding of UHC, current health financing priorities, mechanisms for dialogue on UHC, barriers to advancing UHC and the potential areas that ACS could support Tanzania.

Some key findings of the consultation include the fact that there is a shared understanding of the concept of UHC among most stakeholders. This shared definition has universal access to quality, affordable services at its core. However, respondents noted that in Tanzania multiple definitions and approaches towards achieving UHC currently underpin implementation; the implementation and operational practices of these UHC concepts need to be easily translated and understood by the general population.

Stakeholders identified improving service delivery, improving access to and affordability of care, and convening stakeholders to collaborate on UHC efforts as key priorities. These priorities reflect the need to enhance healthcare service delivery in tandem with addressing technical health financing priorities to ensure that the health system is ready to meet the needs of users. At the community level, the consensus of the 4 focus group discussions was that the health system requires to be more responsive to the needs of users in terms of increasing availability of services, improving quality and enhancing value for those covered by insurance schemes.

Collaboration within the health sector and adoption of a multi-sectoral approach were identified as ways to accelerate UHC progress. Stakeholders saw a role for ACS in supporting this dimension through integrating UHC in existing dialogue platforms, strengthening linkages between ongoing initiatives and supporting a multi-sectoral approach for UHC. The need to strengthen collaboration with the private sector and the need to include them at all stages of policy formulation was underscored by multiple respondents. Other opportunity areas identified were around learning and knowledge sharing including sharing best practices and helping translate international examples for adoption in Tanzania. There is an appetite among stakeholders in Tanzania for greater collaboration with regional organizations with a couple of practical ways proposed to foster this collaboration, for example through regional organizations supporting countries to track their progress towards UHC.

Tanzania appears to be at an important inflection point on the journey to achieving Universal Health Coverage. This view is evidenced by the status of health financing policy reform, the interest in more inclusive stakeholder dialogue towards a common implementation plan for UHC and the clustering of stakeholder views around a number of priority areas that if addressed could potentially contribute to advancing UHC in Tanzania. The consultation mission valued the insights of stakeholders on the current state of the health financing discourse and UHC implementation progress in Tanzania. It is hoped that the findings in this report contribute to the ongoing dialogue on health financing and UHC in Tanzania.

List of Abbreviations

BRN	Big Results Now Program
CHF	Community Health Fund
CHW	Community Health Worker
CSO	Civil Society Organization
DFF	Direct Facility Financing
FBO	Faith-based organization
FGD	Focus Group Discussion
FFS	Fee-for-service
HFS	Health Financing Strategy 2015-2025
HIV	Human Immunodeficiency Virus
HSSP	Health Sector Strategic Plan 2015-2020
M&E	Monitoring and Evaluation
MOH	Ministry of Health
MOHCDGEC	Ministry of Health, Community Development, Gender, Elderly and Children
NCDs	Non-communicable diseases
NGOs	Non-Governmental Organizations
NHIF	National Health Insurance Fund
NSSF	National Social Security Fund
PFM	Performance-based management
PO-RALG	President's Office- Regional and Local Government

PPP	Public-Private-Partnership
RBF	Results-Based Financing
RMNCH	Reproductive, maternal, neonatal, and child health
TB	Tuberculosis
TIKA	Tiba Kwa Kadi
UHC	Universal Health Coverage
WHO	World Health Organization

Background: Tanzania Health System and Policy Landscape

The United Republic of Tanzania, which comprises Tanzania mainland and the islands of Zanzibar, is an East African country with a population of about 53 million and a population growth rate of 3.1 percent.[1,2] Most of the population (about 70.4 percent) lives in rural areas.[3] Currently, Tanzania's government expenditure on compulsory financing schemes represents approximately 10 percent of general government expenditure.[4]

Table 1: Tanzania General Health Statistics

Indicator	Statistics	Year
Infant Mortality Rate (death per 1,000 live births)	41.5	2015 (1)
Under Five Mortality Rate (death per 1,000 live births)	58.8	2015 (1)
Maternal Mortality Rate (deaths per 100,000 live births)	398	2015 (1)
Total Fertility Rate	5.2	2013 (1)
Modern Contraceptive Prevalence Rate among MWRA	34.4	2010 (1)
Unmet Need for Family Planning (%of MWRA, ages 15-19)	16.3	2010 (1)
Prevalence of HIV, female (% ages 15-49)	5.8	2016 (2)
Prevalence of HIV, male (% ages 15-49)	3.6	2016 (2)
Prevalence of HIV, total (% of population ages 15-49)	4.7	2016 (2)

Sources: (1) WHO Country Statistics, (2) UNAIDS Country Statistics

According to Tanzania Vision 2025, the country's health priorities include universal access to primary health care, universal access to quality reproductive health services, and reducing infant and maternal mortality.[5] Voluntary health insurance as a percent of current health expenditure expenditure stands at approximately 2 percent while out of pocket as a percentage of current health expenditure is at 26 percent, with 25.8 percent of the population being covered by public health insurance schemes.[6,7]

Tanzania is a presidential democratic republic, and its health system is decentralized as part of the post-1990s health sector reforms.[8,9] The public health system in Tanzania is organized as a hierarchical pyramid[10] with dispensaries constituting the lowest level of care followed by health centers and district hospitals - all these operate within the local government level. Health centers may refer patients to regional hospitals which can, in turn, refer patients to national/referral hospitals that lie at the top of the pyramid and are overseen by the central health ministry. The private sector, consisting of private for-profit, faith-based organizations or non-profit providers manages 40 percent of all hospitals in Tanzania.[11]

Tanzania demonstrates an interest in achieving Universal Health Coverage (UHC) through anchoring aspects of universal coverage within its national policy framework including the Tanzania Development Vision 2025 (Vision 2025), the Health Sector Strategic Plan 2015-2020 (HSSP IV) and the National Strategy for Growth and Poverty Reduction (MKUKUTA). Vision 2025 is the country's long-term economic and social development plan, and one of its three main objectives is to "achieve quality and a good life for all."[12] Under this objective, there are multiple health goals such as access to primary healthcare for all, which is a critical component of UHC.[13] Previous national growth strategies have also embodied principles of social protection.[14] For example, the National Poverty Reduction Strategy (1998) through which the Tanzania Social Action Fund (TASAF) was founded in 2000. TASAF is currently in its third phase, and the purpose of the program is to raise income and consumption. By doing so, TASAF bolsters the ability of individuals and families in the lowest quintiles to survive shocks with a special focus on protecting children. [15]

Tanzania's health sector strategy (HSSP IV) is informed by the Sustainable Development Goals (SDGs) and national plans such as Vision 2025 and the Big Results Now initiative (BRN).[16] The BRN was enacted as a transformational strategy to help Tanzania achieve middle-income nation status by 2025 by helping the government move away from the dependency on aid and addressing constraints in priority areas such as education, human capital, primay health care, and maternal and neonatal child health .[17,18] HSSP IV aims

to improve quality of services, increase equity of access, achieve active community partnership, and address the social determinants of health. Thus, the HSSP IV addresses all three components of the WHO definition of UHC: access, quality, and cost. (See Annex 4 for graphic)[19,20] HSSP IV also integrates a focus on primary healthcare with the Primary Health Care Services Development Programme (MMAM 2007–2017) highlighted as one of its framing policies.[21]

The implementation of HSSP IV is driven by the sectoral ministry - Ministry of Health, Community Development, Gender, Elderly and Children (MOHCDGEC). From the council level down, service delivery is the mandate of Local Government Authorities (LGAs) which are overseen by the President's Office - Regional Administration and Local Government (PO-RALG) in line with the Decentralization-by-Devolution (D-by- D) approach[22]. The D-by-D approach is an initiative undertaken by Tanzania during the 1990s to transfer decision making authority and resources from the central government to local authorities to improve service delivery within the public sector[23].

The most recent Tanzania health sector review (2017) notes that both limited levels of financing to the sector and the current health financing arrangements impede financial access of the population to healthcare services[24]. Table 2 below shows the main health insurance schemes in Tanzania. There are also a number of micro-insurance schemes which have even lower coverage levels than private health insurance schemes and often are not financially sustainable[25].

Table 2: Health insurance schemes in Tanzania

National Health Insurance Fund (NHIF)	Community Health Fund (CHF)	Tiba kwa Kadi (TIKA)	Social Health Insurance Benefit (SHIB)	Private Health Insurance Schemes
Mandatory scheme	Voluntary scheme piloted in 1996 and established in 2001 CHF Act	Similar to CHF, but with an urban focus, launched in 2009	NSSF is mandatory but members have to register for SHIB	Voluntary schemes managed by private for-profit insurers
Employees and employers equally contribute a premium equal to six percent of the employee's salary	Premiums paid per household and defined by respective Local Government Authorities (LGAs) The government matches all contributions through a matching grant	Membership fee of 5,000-10,000 Tanzanian shillings.	No specific contribution as costs of health services obtained are deducted from NSSF contributions	Financed through premiums paid by the user of the insurance
Covers civil servants, spouses and dependents nationally	Designed for rural populations and for the informal sector	Targets urban populations	Covers private and parastatal employees and up to 5 dependents	Covers both individual and corporate clients
Benefits package includes preventive and curative services	Benefit package is at the discretion of the district.	Benefit package is at the discretion of the urban council.	Outpatient and inpatient care to specified limit	Plan dependent but typically includes inpatient and outpatient services

Approximately 2.5 million beneficiaries in 2012 (~5% of the population)	Membership is approximately 18% of the population	18 urban councils have introduced a scheme Covers about 4% of the population[26]		All the private schemes combined cover 1.4% of the population

In 2015, Tanzania developed a draft national health financing strategy (HFS). The purpose of the HFS is to provide equitable access to affordable, quality healthcare.[27] Additionally, a goal of the HFS is to create a comprehensive social health protection system for Tanzania.[28] The draft HFS includes plans to: introduce a single National Health Insurance (SNHI) scheme that will eventually be mandatory; develop a minimum benefits package that is available to all Tanzanians; improve public financial management; and select the most suitable provider payment mechanisms for the country.[29] The draft HFS is currently awaiting approval from the Cabinet.[30]

CONSULTATION FINDINGS

The African Collaborative for Health Financing Solutions project (ACS) conducted a detailed consultation phase as a way to hone in on core challenges faced by countries in moving forward UHC, elucidate potential solutions, and ultimately inform framing of the ACS implementation approach. Tanzania is one of five countries that was visited during this phase; a number of regional and global actors were also consulted. A multi-disciplinary team of seven ACS staff and consultants conducted 36 interviews and four focus group discussions between 4th to 13th December 2017, meeting with a broad array of stakeholders from across sectors and levels of implementation (see Annex 1 and 2 for stakeholder categories). The following results were elucidated:

- Understanding of UHC as a concept, priorities around UHC and healthcare financing in Tanzania, and progress in implementing UHC related policies;
- Attitudes towards the inclusiveness of and mechanisms for dialogue on UHC policies and plans;
- Barriers to advancing UHC and innovative solutions to accelerate implementation of UHC related policies and programs; and
- Potential areas in which the ACS Project can support Tanzania on its journey towards UHC.

Background on UHC in Tanzania

KEY FINDINGS: UHC Definition and Priorities

- Stakeholders interviewed (with the exception of community members) have a similar understanding of key elements of the UHC concept, with universal access to quality, affordable services forming the foundation of this shared definition.
- Different actors, based on their technical focus or expertise, placed varied emphasis on different elements such as financing, accountability and reaching vulnerable groups within their definitions of UHC.
- As different stakeholders emphasize different elements of the UHC concept in their own definitions of UHC, this presents a challenge when translating the concept of UHC to the end user of health services at the community level.
- Top priorities highlighted were: improving service delivery, improving access to and affordability of care, and convening stakeholders to collaborate on UHC efforts
- The stated priorities reflect the need to enhance healthcare service delivery in tandem with addressing technical health financing priorities to ensure that the health system is ready to meet the needs of users.
- Some perspectives need to be better integrated into the UHC discourse - specifically citizen voices and private sector actors.

Definitions of Universal Health Coverage

While the stakeholders the ACS team met did not have a singular definition of UHC, there were broad similarities in their definitions of UHC. Overall, a majority of stakeholders defined UHC in terms of accessibility, quality and affordability. All stakeholders stated that UHC means access to care for all and included an element of financial protection in their definitions (for example touching on terms such as affordability, reduced financial burden, etc.). Both private sector and public-sector implementers emphasized access to affordable and high-quality services as necessary components of UHC. Additionally, most stakeholder groups included equity within their UHC definitions.

Some stakeholders defined UHC through the lens of specific policy and/or technical frameworks. For example, multilateral donors stated that there was a precise definition in the Tanzania Health Sector Strategy: everyone can access the services that they need without constraints. Respondents from civil society cited the World Health Organization (WHO) definition of UHC in their responses. All the definitions provided by all stakeholder groups, with the exception of community members, demonstrate an understanding of both the Tanzanian health policy and WHO definitions of UHC whose key facets include access, quality, equity, and affordability.

Different stakeholders placed higher or lower emphasis on different elements of the UHC concept. For example, civil society stakeholders mentioned financing the least in their definitions of UHC compared to other stakeholder groups, with some civil society actors emphasizing that UHC is more than health financing. On the other hand, donors particularly emphasized financing as a key component of UHC. Definitions from politicians and public-sector stakeholders had a greater focus on access and service quality as compared to financing. Civil society was also the only stakeholder group to identify accountability of the government as a part of achieving UHC. Private sector implementers and donors were the only two stakeholder groups to mention access to the minimum basic healthcare package as an element of UHC. A few stakeholders from civil society and implementing partners mentioned reaching

poor and marginalized groups. Although all stakeholder groups shared similar elements in their UHC definitions, the elements of particular focus are reflective of their roles in or relationships with the health system. (Annex 4 is a table showing the definitional elements that each stakeholder group primarily focused on. Note the stakeholder groups are not evenly weighted.)

In addition to being asked about how they would define UHC, stakeholders from civil society were specifically asked about the level of community knowledge of UHC. Respondents stated that not everyone is aware of the concept of UHC, but there is some knowledge of free services that are available to citizens, such as HIV testing and medication. Respondents highlighted the ambiguity of the definition of UHC as a challenge to communicating the concept to communities. An additional challenge noted was the difficulty in translating elements of UHC – both literal and conceptual translation - into language that the community could understand.

This difficulty in translation of the UHC concept was reflected in the Focus Group Discussion (FGD) participants' responses when they were asked to define health coverage (as a proxy for UHC). There was no consistent description with one FGD group made up of mothers stating that they were unable to describe the concept of health coverage at all. The other three groups all dealt with access to healthcare in one form or another, with one group stating that everyone should have access regardless of economic status. Two other groups added that health coverage entails services such as delivery being free and the availability of services, providers and equipment. Whilst a technical definition of health coverage is not expected at individual patient level, the seeming lack of language to describe health coverage in one group may point to potential challenges that could come up when discussing UHC at community level. The variability in responses may also indicate either a differential understanding of key concepts across various community members or a difference in the expectations of the users of services; both of these aspects will need to be considered during the formulation of communication to the general population as Tanzania moves towards UHC.

There is a shared understanding of key elements of the UHC concept among a majority of stakeholders interviewed in Tanzania with universal access to quality, affordable services forming the foundation of this shared definition. Different actors bring the lens of their expertise or focus area to their definition with varied emphasis placed on elements such as financing, accountability and reaching vulnerable groups. Tied to the multiple definitions of UHC was the notion that this presents a challenge when translating the concept of UHC to the end users of health services at the community level. This translational challenge was reflected in the responses of the different community members who had difficulty defining the concept of health coverage within their context.

Box 1. Definition of UHC

"It is the responsibility of the government to ensure everyone in the country has access." ***CSO***

"UHC has two dimensions - financial protection and accessibility to quality care…UHC is a process, not just a defined concept. It is an interesting journey but very challenging." ***Development partner***

"Governments may not invest, someone must fill the gap. Free healthcare doesn't exist. Someone has to be paying for it – you pay or it has to be subsidized." ***Public implementer***

UHC and Health Financing Priorities

According to the stakeholders interviewed, the major priorities to advance health financing and achieve UHC in Tanzania were; improving the delivery and quality of primary and preventative healthcare services, improving access to and affordability of care, and bringing stakeholders together to collaborate on UHC efforts. Stakeholders from civil society, implementing partners, the public sector, as well as politicians, included improving the quality of care among their top priorities. These responses reflect a dual prioritization of improvement of health services (in terms of coverage and quality) coupled with an emphasis on addressing the financial barriers to accessing healthcare in Tanzania.

Community members noted the need for a consistent supply of medicines, provision of adequate medical equipment and improvement in the quality of services as their top health priorities. The focus groups with community leaders also highlighted that health facilities in their communities were not enough with one group stating that a dispensary was the only available point of care in their area. This mirrors the responses of other stakeholder groups who highlighted the improvement of service delivery including access to care as key priorities.

Collaboration was another important theme for a majority of stakeholders, and interestingly, their responses included putting forward ideas on potential ways to get different actors to work in partnership. Many stakeholders highlighted the importance of improving systems of collaboration within the health sector, including public-private partnerships, to achieve UHC. For example, one respondent stated that UHC cannot be achieved through the Ministry of Health alone. Donors, technicians, and the public sector included strengthening of public-private partnerships in their top priorities.

Different stakeholder groups focused on varied dimensions of collaboration in their responses. The private sector highlighted the importance of working with the government to include citizen perspectives into their work and to improve efficiency in the health sector. The private sector, public sector, and technician stakeholders specifically mentioned collaboration among different partners as well as coordination between partners in the public and private sectors as top work priorities. Multilateral donors and some technicians highlighted reducing fragmentation of donor support as a top priority. One suggestion for reducing this fragmentation was to develop codes of conduct for working together. Other stakeholders mentioned that developing mechanisms to follow-through with political and organizational commitments to achieve UHC from multiple groups, such as the government, the private sector, and CSOs, would provide an entry point for developing a multi-sectoral approach as would working with sectors outside of health around achieving UHC.

Policy and strategy development related to key technical and supportive functions, such as service delivery, financing, and advocacy for policy, was highlighted as a way to accelerate achievement of UHC. Private sector, donor, public sector, implementing partner, and technician stakeholder groups all had a greater focus on health financing and public-private partnerships in their responses. However, each stakeholder group saw policy development and partnership achieving slightly different goals. For example, the private sector highlighted the partnership with government and policy change as a way to better define the role of the private sector in health while enabling them to provide quality health services that complement services provided by the public sector. Conversely, donors saw policy development and partnership as a way to reduce fragmentation across groups.

The stakeholders interviewed perceived the adoption of the draft health financing strategy and advocacy for its implementation as a mechanism of improving access to and affordability of healthcare. In terms of specific strategy development, health financing policy design, advocacy for health financing, and modalities to enhance insurance coverage and products were highlighted. These were the top work

priorities for the private sector, donor, implementing partner, and researcher respondent groups. These work priorities not only align with stakeholder perceptions of UHC but also align with UHC-related priorities included in policies such as the draft HFS and Tanzania's HSSP IV.

Reaching the informal sector and low-income populations coupled with the need to decrease out-of-pocket (OOP) payments also featured in the list of priority areas to enable UHC progress. Development partners, researchers, and the public sector were the only stakeholder groups to explicitly mention the broader themes of poverty reduction and social protection as priorities for achieving UHC.

The majority of stakeholders stated that they determined and aligned their organizational priorities around UHC and health financing with the country's priorities as stated in the Health Sector Strategic Plan and other country development plans. Stakeholders that work both in Tanzania and within the region had international/global priorities as an additional factor that determines their organizational focus areas.

The priorities identified by stakeholders reflect the need to improve healthcare service delivery in tandem with working on technical health financing priorities. This will ensure that the health system is ready to meet the needs of users, especially those currently facing financial or other barriers to accessing care, as well as better serving specific segments of the population such as vulnerable groups. In order to tackle the multiple priorities around advancing UHC in Tanzania, stakeholders felt that improving collaboration platforms and integrating multi-sectoral perspectives was crucial. Expanding on the theme of collaboration, it was noted that there are perspectives that need to be better integrated into the UHC discourse, such as citizen voices and private sector actors.

Organizational Activities related to UHC

In order to better understand how the priorities stated in the previous section translate into practice, the team asked each stakeholder to name the main activities that their organizations implement related to UHC. Among all stakeholders, the top UHC-related activities mentioned were capacity building, service delivery, health financing, and supporting collaboration between stakeholders. The primary means of both capacity building and collaboration are training and knowledge dissemination. Additionally, many stakeholders focused on policy formulation or identification and advocacy.

While almost all categories of stakeholders participated in the top UHC-related activities listed, there was variation within each stakeholder group in the types of activities that each organization focused on. For example, some respondents from the public sector identified advocacy, capacity building, and training as key activities, while others in the same stakeholder group identified partner coordination and policy development as key activities. The different activities within the same stakeholder category demonstrate the different ways organizations choose to work towards achieving their priorities. In the case of the public sector, it might also be a reflection of different mandates of different units. Development partners were one of the stakeholder groups whose key activities span across multiple levels in the health system. They provide support to the public sector for policy development, knowledge sharing, and policy, strategy and tool development while funding implementing partners who work at service delivery level and with communities.

There was also complementarity in the range of activities carried out by the organizations in each stakeholder category. For example, implementing partners activities ranged from participating in policy development, health financing and insurance, capacity building, to service delivery activities. Civil society activities ranged from implementing service delivery and community-based educational programs to training and collaborating with the private sector. Additionally, certain stakeholder categories showed a specialization in the UHC-related activities that they do is based on technical expertise. For example, researchers', technicians' and academics' primary activities consist of research, evaluation, training and knowledge dissemination on UHC and health financing. Interestingly, private sector activities centered around service delivery and health insurance, alluding to key competencies in these areas.

The UHC-related activities mentioned reflect most of the organizational priorities described above, and, therefore by extension, the national priorities related to achieving UHC.

Collaboration, Learning and Accountability Focus

Furthermore, stakeholders were asked how their organizations participate in and support activities related to multi-sectoral collaboration, learning and knowledge management, and accountability. These are the three core themes of the ACS approach. The most common strategy highlighted across all three topics was convening and engaging stakeholders at both central and local levels.

The majority of activities related to learning and knowledge management included holding workshops and sharing research findings through publications. The most common participants and target audiences are the public sector (government agencies and the MOH), the private sector (through PPPs), civil society, and grassroots level (citizens). Many events have representation from across multiple stakeholder groups and sectors. Many respondents emphasized multi-sectoral approaches as being important to accountability. Based on these responses, most actors address the ACS core themes by utilizing events as convening platforms to share knowledge and work with other stakeholders.

Stakeholder Dynamics

KEY FINDINGS

- There is a vibrant SWAp process in Tanzania that forms the major coordination framework for UHC and health financing.
- Challenges remain around increasing efficiency and effectiveness of coordination platforms including moving their focus from strategy to action.
- Private sector and non-health sectors were mentioned as actors many stakeholders would want to collaborate with more.
- Stakeholder platforms need to balance being more inclusive with ensuring that the actors at the table are relevant for the initiatives being undertaken
- Multiple forums and groupings create awareness around UHC, but stakeholders noted the ongoing debate and lack of definitive direction from any of these forums on how to advance UHC in Tanzania.
- There is an appetite among stakeholders in Tanzania for greater collaboration with regional economic communities and regional networks.

Stakeholder Collaboration

Many stakeholders spoke of collaborations with other actors outside of their stakeholder group. The most common collaborators cited were the public sector in general (for example government agencies), the Ministry of Health, and NGOs. Additionally, certain stakeholder groups appear to engage with a diverse set of partners. From the interviews, civil society, implementing partners, public sector and donor stakeholder groups mentioned the widest range of collaborators. The actors they work with include community-level organizations and representatives, local and national government, development partners, NGOs, interest groups, and the private sector. However, not all stakeholders interviewed are engaged in collaboration or have the same level of engagement on UHC-related activities. Notably, the private sector and other sectors outside of health were not featured in interviewee responses on collaborating partners.

With a view to sparking greater collaboration, respondents were asked which actors that they do not currently work with, but would like to engage. It is notable that respondents from most stakeholder groups were interested in increasing collaboration with the private sector. Suggestions for collaboration included establishing platforms and a mutual accountability framework to encourage dialogue and increase trust with the private sector. Stakeholders from the public sector, researchers, and donors stated an interest in engaging academic and research organizations in UHC-related activities. Civil society actors stated an interest in engaging more with the media. Both private sector and public-sector actors expressed an interest in collaborating with government ministries outside of the Ministry of Health.

From the focus group discussions, a majority of the community members noted that there were meetings held quarterly that were attended by ward and district level government officials from different sectors such as health, environment and community development. During these meetings, community members noted that very little time was spent on health issues. In addition, while the FGD participants saw the meetings as an avenue to voice their concerns around health, they felt that their opinions were not taken into account when decisions were being made by the government. All the focus groups proposed that community meetings be held that were dedicated to health issues.

Stakeholders also reflected on why they do not currently engage with specific actors, and there were varied responses provided. One common challenge noted was a perceived lack of commitment from other stakeholders to collaborate and work on UHC-related activities. For example, implementing partners perceived the MOH to be less committed to collaboration because of a history of avoiding discussion and lack of action after convening. Politicians stated that the central government interacts more with other stakeholders than the local and regional governments. Additionally, many stakeholders highlighted the lack of a common definition of UHC and the absence of a common plan to achieve it as barriers to collaboration. Other aspects cited as impediments to collaboration were bureaucracy, lack of financial transparency, and lack of resources to support engagement. Respondents proposed some solutions to these challenges with academia and public-sector groups suggesting that collaboration processes be more formalized in order to address some of the challenges cited. In terms of achieveing a common definition of UHC, some respondents proposed that having greater policy coherence around UHC would lead to a common definition while most stakeholders wanted opportunities for involvement in defining the plan for implementation of UHC in Tanzania.

Based on these responses, there are existing collaborative initiatives between different actors in Tanzania around UHC and health financing. The stakeholder groups most commonly cited as collaborators may either be those that are central to the process of advancing UHC (in the case of the public sector) and/or may be those more open to collaborating with diverse groups (NGOs). Despite few groups currently collaborating with the private sector and non-health sectors, it is important to note that they were mentioned as actors many stakeholders would want to collaborate with more. Some stakeholders did note that they indirectly work with the private sector through work with the MOH, but would like to increase direct collaboration with the sector. Others perceived the private sector as experienced in improving quality of care and specifically mentioned private sector providers, such as FBOs, as actors that need more engagement. While it is clear that most stakeholders see the value of greater private sector partnerships, it was not clear from the interviews why this collaboration has not been more actively sought after. There may be a need to address the lack of a common approach towards progressing UHC in Tanzania as well as the perceived lack of commitment around collaborating on UHC which were the most commonly cited challenges.

Box 2. Stakeholder dynamics

The more stakeholders you have the more points of view and perspectives you'll get. You cannot have a party alone" ***Private sector***

"Yes, involving a broader range of stakeholders can result to better responsiveness to consumers' needs bringing solutions for reducing costs and innovations. On the other hand, the problem is not involvement but the level of involvement and well as integrated solutions." ***Private sector implementer***

"A more systematic effective multi-sectoral approach needs to be defined which will depend on person/individual at the front of the project. The leader needs to be open to vision of UHC and open to innovation in delivery of care leveraging the multiple sectors in an official way" ***CSO***

Donor Coordination

Stakeholders from the academic, public sector, politician, and technician groups identified key activities to support donor coordination and alignment. The overall observation was that there is a need for activities to harmonize and coordinate across multiple donors. All these stakeholders stated that the government should play a greater role in facilitating coordination with and across donors. The public-sector respondents resonated with this sentiment but noted that government capacity to coordinate

needs to be strengthened given that coordination for UHC often requires incentivizing participation across multiple sectors as well as continuous communication with donors. One respondent expounded on this by stating that there is a need to improve the skills of the public sector to undertake dialogue with multiple donors including bolstering the capacity of the team to balance the diverse interests of various groups. Representatives from the academic and technician groups (working outside the health sector) had a different perspective, being of the view that the Planning Commission need to be active in donor coordination. Respondents also cited examples of specific initiatives that

'could result from greater coordination - such as the inclusion of more partners in the basket fund and increased information sharing between donors and the government.

Box 3. Donor coordination

"Donor coordination is very political. Every donor wants to do things that they plan and align with their agenda. Coordination can be done by the government" – ***Academic***

"Donor Coordination is not an easy thing. Everyone is here for their own agenda, interest and deliverable. All the donors are driven by meeting metrics." – ***Public Sector***

The Nature of Country Platforms for UHC

There is a high awareness of existing country coordination platforms that are linked to UHC. All stakeholders interviewed participated in one or more country platforms for UHC. The most common platforms cited were those within the Sector-Wide Approach (SWAp) which are convened by the MOH. The majority of stakeholders participate in different Technical Working Groups (TWGs). Other frequently cited platforms include the Development Partners Group (DPG), Public-Private Partnership (PPP) forums and the Joint Sector Annual Review Forum.

Although many different stakeholder groups found platforms such as the Health Financing Technical Working Group and Joint Sector Annual Review effective, most stakeholders could identify challenges to the effectiveness of platforms in-country. In particular, respondents from civil society and implementing partners stated that progress in moving from discussion to action is slow. Poor communication among stakeholders, limited coordination across different platforms, and slow implementation of strategies and programs were recurring themes across stakeholders. One cause of ineffective implementation was that following discussion no official decisions were made and roles and responsibilities were not delineated. Other stakeholders stated that there are too many groups, causing duplication and inefficiencies. Stakeholders from academia were of the view that there are too many committees and that the committees do not necessarily have the right people on them.

There was a perception that not all coordination platforms are inclusive, with some stakeholder groups stating they do not receive invitations to forums. For example, respondents from both the private sector and donor groups suggested that the private sector is often not fully engaged perhaps due to mistrust between the public and private sector. They added that the private sector is sometimes not involved at all stages of policy formulation - from strategy design through to implementation. Private sector stakeholders highlighted that if they had been involved in policy formation, then they would know how to complement basic services with secondary services that the government could not cover in order to increase access to care. Respondents from both groups stated that the PPP forum needed to be strengthened.

Furthermore, some platforms, such as technical working groups, vary in effectiveness depending on who is leading the group, and there is a need for follow-up. Researchers thought that meetings were effective, but that there was a lack of commitment to creating action after the meetings. On the other hand, the public sector indicated that some forums do plan for follow-up meetings to assess project and idea development as well as implementation. Private sector respondents stated that while the multiple groups and forums created an awareness of UHC, there was no clear guidance provided from any of the groups as there is still debate about what direction to take in regard to planning for UHC advancement.

There is a vibrant SWAp process in Tanzania that forms the major coordination framework for UHC and health financing. A majority of stakeholders participated in one or more coordination platforms with those convened by the Ministry of Health being the most cited. Challenges remain around increasing efficiency and effectiveness of these coordination platforms and moving from strategy to action. There is also a need to balance inclusivity of the platforms with having the right stakeholders at the table for key initiatives. Respondents noted the benefits of multiple forums and groupings in creating awareness around UHC but noted that there is no definitive direction from any of these forums on how to advance UHC in Tanzania.

Box 4. Nature of Stakeholder dynamics

"We're invited to the meeting but no clarity on what the bill entails and the benefits to the clients will be so that private sector can design products that are complementary to what the government will provide." ***Private sector***

"TWGs are stronger than (other) UHC platforms." ***Implementing Partner***

"Everyone is waiting for what will be launched in order to determine the next step on how to stay in business or reach the unreached. The result would have been better if the private sector was engaged from the beginning…" ***Private Sector***

Regional Organizations or Initiatives for UHC

In addition to collaborating with stakeholders in-country, most stakeholders collaborate with regional organizations. The most common types of regional organizations mentioned were regional economic communities and regional networks. Many stakeholder groups cited collaboration with the East African Community (EAC). Another regional body mentioned was the Southern African Development Community (SADC). The regional networks mentioned include the African Budget Network, the African Accountability Health Platform and the East African Healthcare Federation (EAHF).

Stakeholders from civil society had varying levels of collaboration with regional organizations with some stating that their organizations were not actively involved in regional collaboration due to capacity constraints. Respondents from the politician group did not state specific collaborations with regional organizations, while public sector implementers mentioned working with a wide range of regional actors.

The primary means of collaboration between stakeholders and regional organizations was knowledge sharing and learning. The main mechanisms to facilitate learning were idea exchange or participation in forums and events and through sharing expertise on policy development or strategic planning. In terms of the thematic areas of collaboration with regional actors, stakeholders from the technician group specifically mentioned PPPs, implementing partners mentioned accountability, and donors highlighted advocacy as a specific area for collaboration.

In addition to discussing existing collaborations with regional organizations, almost all stakeholders stated ways that regional organizations could play a greater role in advancing UHC in Tanzania and mentioned their desire for increased partnership with regional organizations or economic bodies, such as the EAC. Although many stakeholders highlighted supporting convening platforms and knowledge sharing as mechanisms for increased engagement, responses varied across stakeholders. Respondents from civil society stated that regional organizations should track countries' progress towards UHC and strategically engage with local organizations. Stakeholders from the development partners and multilateral donor groups stated that regional organizations should play a greater role in supporting the development of insurance and advocating its potential use across borders. Respondents from the media and technician groups proposed that regional organizations could help mobilize resources for UHC. Technician and academic stakeholders highlighted capacity building as points of increased regional involvement, and researchers stated that regional organizations should bring their own competencies to countries to help progress UHC.

While there is a level of collaboration with regional economic communities and regional networks, there is an appetite among stakeholders in Tanzania for greater collaboration. This is especially so for the topic of UHC. Some broad themes for potential collaboration include sharing learning from other countries, resource mobilization and support in tracking key metrics to enhance accountability.

Barriers and Challenges

KEY FINDINGS

- The main barriers identified by stakeholders were related to service delivery, funding, lack of clear strategy/roadmap, collaboration, coordination within the system, and lack of awareness on UHC.
- The most commonly cited policy related to UHC was the draft health financing strategy. Respondents also mentioned the Health Sector Strategic Plan, National Strategy for Growth and Poverty Reduction (MKUKUTA) and Vision 2025 as key policies supporting Tanzania's progress towards UHC.
- While most respondents were positive about the right policies being in place for UHC, most expressed concern about the slow implementation of key policies.
- Majority of barriers and challenges highlighted focus on supply-side challenges with the only demand-side focused barrier noted being the lack of awareness of UHC among the population
- The focus group discussions flagged the need for the health system to be more responsive to users in terms of increasing availability of services, improving quality and enhancing value for those covered by insurance schemes

Service delivery: A number of barriers were mentioned within service delivery, the most common of which was around human resources for health. A number of respondents noted that there was a need for more health workers. In addition, stakeholders highlighted the need to train the existing healthcare providers as well as address the current distribution of the workforce which is clustered in urban areas. This was corroborated by the findings from the focus group discussions where participants also noted that there were insufficient numbers of healthcare workers serving their community. In addition, respondents noted the need to address a common challenge, which was resistance to change. During transitions of power or changes in government policy, healthcare workers were said to have a tendency to resist policy changes. Other challenges frequently mentioned include lack of drugs and equipment, as well as poor quality of services and systems. The FGD participants' views were similar as they noted that the health services they received were sometimes of low quality, specifically citing the care pregnant women and children receive. Interviewees also mentioned limited infrastructure, especially in rural areas, as a challenge to ensuring adequate access to care by communities. Community members specifically mentioned that in addition to limited numbers of facilities, the poor quality of roads impedes access to health facilities.

Funding: One of the most commonly mentioned barriers was low investment in health and insufficient resources. This lack of funding was noted as especially affecting resourcing of commodities and health system improvements. Some respondents noted that funding services for the poor and vulnerable groups might pose a challenge given the size of the country's economy. Other stakeholders were of the view that there are adequate resources though these are currently not well allocated or managed. A few stakeholders, therefore, questioned the sustainability of proposed health financing schemes. At the user level, the FGD participants noted that while it cost them a significant amount to purchase health insurance, there was a perception that cash paying patients received priority at health facilities.

Lack of clear strategy/roadmap: One of the most commonly cited barriers was a lack of a common definition and approach towards achieving UHC in Tanzania. A majority of stakeholders mentioned that there is no clear roadmap towards achieving UHC. Other stakeholders also noted that this lack of clarity is accompanied by the implementation of multiple approaches to health financing that sometimes lead to duplication of effort. One example cited was the multiple approaches to improving the CHF scheme with at least three parallel approaches currently being implemented. The three approaches to iCHF that the respondent mentioned are the iCHF implementation projects supported by PharmAcccess, GIZ, and Swiss Development Cooperation (SDC). A related issue mentioned by some stakeholders was the change in policy direction and priorities occasioned by the transition to a new president; this has led to unclear direction on how to progress UHC in Tanzania.

Collaboration: The most common obstacles cited related to collaboration were poor donor coordination, lack of clear leadership by government, limited involvement of non-state actors and limited public-private sector collaboration. Some stakeholders noted that the lack of private sector collaboration might be a missed opportunity in the push towards UHC as the government could draw on private sector resources and expertise to ensure sustainability of health financing initiatives.

Coordination within the system: A few respondents mentioned that there was limited coordination between the central level and local levels within the health system. Some respondents postulated that this lack of coordination could be due to the fact that healthcare facilities at the various tiers of care are managed by different units – the Ministry of Health and Local Government Authorities under PO-RALG. This issue was also raised by community members who highlighted that at times patients insured under the CHF program had difficulty accessing services when referred to higher levels of care. For example, they noted that patients referred to the district hospital were at times made to buy medicines at private pharmacies despite these being available at the health facility.

Lack of awareness on UHC: A significant number of stakeholders noted that there is limited awareness of the concept of UHC among the general population. Some stakeholders mentioned that this would pose a challenge, especially when requiring communities and individuals to adapt to new financing mechanisms such as uptake of health insurance. Some respondents felt that there was limited outreach to communities in rural areas with information on UHC. Additionally, while respondents from civil society did articulate their programs at community level, these focused on service delivery and advocating for higher quality of care with no explicit mention of education of communities on UHC.

Box 5. Barriers and challenges

"System elaborated well, but implementation is not functioning due to bottlenecks, for example in authorizing funding." – ***Donor***

"There is a disconnect between NHIF and CHF. NHIF is compulsory, and CHF is voluntary. This yearly registration is a barrier. Administrative – who is providing the insurance? How are the insurance systems coordinated?" – ***Public Sector***

"Demographic patterns – have a big number of people in the informal sector (30% under poverty line)." – ***Implementing Partner***

A majority of barriers and challenges highlighted focus on supply-side challenges currently faced by Tanzania's health system. The only demand-side focused barrier noted by stakeholders at the national level was the lack of awareness of UHC among the population. In contrast, the views expressed by community members involved in the focus group discussions highlight a need for the health system to be

more responsive to the needs of users in terms of increasing availability of services, improving quality and enhancing value for those covered by insurance schemes. With this in mind, there may be a need for stakeholders to reorient ongoing health financing initiatives to include a greater focus on addressing the demand side challenges to achieving UHC in Tanzania.

Perception of Key Policies and Strategies:

The most commonly cited policy related to UHC was the draft health financing strategy. Respondents also mentioned the Health Sector Strategic Plan, National Strategy for Growth and Poverty Reduction (MKUKUTA) and Vision 2025 as key policies supporting Tanzania's progress towards UHC. Other legislation mentioned included the Tanzania Investment Act, the PPP Act, and the Companies Act which were viewed as contributing to the broader governance framework necessary for UHC implementation.

Respondents also anecdotally identified a number of key national health and financing developments that they believed were relevant in supporting progress towards UHC. The examples that were most commonly mentioned were NHIF and CHF. While the NHIF and CHF are not policies, respondents mentioned them as key schemes in place that are instrumental in the push for UHC. During the focus groups, while the majority of community members could not point out any specific policies they were aware of, they noted that they were aware of various government commitments around healthcare but felt that these commitments were not well implemented at their level.

When interviewees were asked about the implementation status of key policies and strategies in place, responses were mixed with slightly more respondents expressing a positive outlook. The positive responses recognized that key policies were in place to support Tanzania's progress towards UHC. Respondents cited how UHC is anchored in the national health sector strategy, Vision 2025 and the draft health financing strategy.

While most respondents were positive about the right policies being in place for UHC, most expressed concern about the slow implementation of key policies. One example that was cited by a number of stakeholders was the time it has taken for the draft health financing strategy to be approved. Other respondents mentioned that the new health policy and implementation plan of the improved Community Health Fund (iCHF) are both not approved. The iCHF is a voluntary, district-owned insurance scheme that would combine what has worked well in the CHF with what has worked well in the Kilimanjaro Native Cooperation Union Health Plan to try to expand access further and to improve the benefits package.[31]

Lastly, interviewees at the national level discussed the need to improve and broaden the awareness and understanding of technical strategies for UHC. An example shared by one stakeholder was around the introduction of the concept of cost sharing which faced significant initial resistance. However, when the population understood the approach, they became advocates for it. Consequently, there needs to be better advocacy and explanation of terminology around UHC and health financing to get the population on board with policy changes needed to progress UHC.

Inclusive Design Process

When interviewees were asked about whether they believed policymakers and implementers account for stakeholder views when designing and implementing UHC-related policies, there was a mixed response. The primary reasons stakeholders felt there was a lack of inclusion was due to insufficient engagement and a lack of communication. One stakeholder elaborated on this by emphasizing how NGOs and local communities need to be better engaged throughout design and implementation.

One example cited as a positive, inclusive process was the Direct Facility Financing (DFF) where health facility plans are developed with input from the community. Some respondents felt that community engagement is further in the health sector as compared to other industries.

However, there were also many stakeholders who believed that the current process of developing of UHC-related policies was inclusive. The main reason interviewees felt the process was inclusive was due to the engagement of local leaders. For example, one implementing partner mentioned that the use of Village Development Committees has been instrumental in creating community-level platforms for consultation.

At the community level, all the four groups that took part in the FGDs felt that their voices are not taken into account by policy makers. They also did not feel like they necessarily have a voice at the community meetings. The community members felt that when they are able to voice their opinions, they do not receive feedback or see results or changes based on their proposals.

Among the stakeholders interviewed, the draft health financing strategy emerged as the policy most closely linked to progressing UHC in Tanzania. Stakeholders also highlighted how UHC is embedded in the broader policy framework both at health sector level and nationally. Due to the fact that the health financing strategy has been pending approval for an extended period, respondents concluded that the policy framework for UHC and health financing is only partially in place. There are also concerns about the rate of implementation of key policies and strategies. Additionally, stakeholders expressed the need to achieve broader buy-in for policy changes to support UHC, including from the end users of services. This point is reinforced both by the mixed responses from national stakeholders on how inclusive the current policy-making process is and by the feedback from community members that they do not feel their views are taken into account during policy making.

Solutions and Innovations

KEY FINDINGS

- There was no clear consensus on what constitutes an example of innovation in UHC with examples tending to focus on successfully implemented programs or initiatives within the public sector.
- Examples of the UHC-related innovations in Tanzania mentioned were: health committees, Community Health Fund, and the 'Tumaini la Mama' program.
- Stakeholders proposed many ideas about where innovations are needed to accelerate progress towards UHC. The most commonly cited areas that could benefit from innovation were engaging local players, mobilizing existing resources, and extending coverage.
- Stakeholders in Tanzania have limited awareness of health financing related innovations in the region, though interestingly, the few examples highlighted were all from countries that share a physical border with Tanzania.

Country Level Innovations

While it was hard to discern general trends in innovations around UHC that exist in Tanzania, interviewees provided anecdotal evidence about different innovations that they were excited about. To note, stakeholders were not provided with a definition of innovation or examples what types of interventions

would be considered innovative. Each interviewee therefore identified what they perceived as innovative leading to the wide range of responses. One innovation an interviewee from civil society mentioned was health committees. Health committees are formed by health facilities to provide a setting for discourse on important health issues such as mobilizing community members to join a health insurance like the Community Health Fund. Similarly, one public-sector stakeholder mentioned the progress that the NHIF is having in one region through the 'Tumaini la Mama' program.

However, not all developments with regards to innovation have been positive. For example, a civil society member also mentioned the Tanzania Accountability Framework, which in their opinion, has been ineffective in improving governance despite being developed through evidence-based research and through input from high-level politicians.

In addition to the innovations mentioned above stakeholders discussed many recommendations about where innovations are needed, which in their opinion, would accelerate progress towards UHC. The most common responses were engaging local players, mobilizing existing resources, and extending coverage. For example, one implementing partner mentioned the sequential decision map developed to enable Tanzania to establish SNHI to help advance UHC but also discussed the need to build provide capacity and mapping to consolidate this progress. The same interviewee also recommended improving the fragmented health management system, setting a common language for service delivery roles, and using results-based financing to motivate the health system rather than as the only source of funding for facilities. Similarly, a civil society member mentioned using CHWs to progress other aspects of UHC, mainly to raise awareness as well as to educate. Local government representatives can also be leveraged to achieve this goal. Lastly, a public-sector interviewee mentioned how NGOs, FBOs, and private for-profits should interact more with the communities to see what the needs are. This would lead to a more inclusive approach that would increase efficacy.

However, one interesting finding was how the interviewees had differing views about the effectiveness of community health funds, which many stakeholders considered an innovation. While most stakeholders noted this as a positive innovation to avail prepaid care to rural populations; some stakeholders highlighted the fragmented insurance approach that the government has undertaken through having multiple public sector-driven schemes. In relation to this, one stakeholder stated that when countries have insurance schemes such as through the CHF or NHIF, governments think they have achieved UHC. Thus, according to this stakeholder, it will be necessary for the Tanzanian context to evaluate the reasons why the community health fund is still necessary and what other strategies need to be implemented to progress towards UHC.

Box 6. Solutions and Innovations

"Direct Facility Financing (DFF) – good initiative to disconnect the district bureaucrats from the facility. Funds bypass district and go straight to the facility." - ***CSO***

"M-technology in Kenya… [We are] considering methods of adapting MPesa technology as a means to digitize CHF." - ***Implementation partner***

Regional Level Innovations

There was a wide variety of responses when stakeholders were asked to describe important regional level innovations and how regional organizations and networks could support stakeholders' work. Interviewees had different understandings of the word regional. Some stakeholders believed regional referred to the

district level within a country, while others believed it referred to innovation across countries. Due to this, it is hard to discern major trends, but it does provide good anecdotal evidence on regional innovation.

An implementing partner mentioned the strength of m-health innovations in Kenya as examples of regional innovation. Another stakeholder also mentioned the success of performance-based financing (PBF) in Uganda as an example of regional innovation. There are some examples of PBF in Tanzania as well but this did not emerge as an innovation among stakeholders. On a similar note, a number of stakeholders mentioned the progress Rwanda has been able to make around health financing, but also stated how the example of Rwanda is country-specific and would be hard to replicate in Tanzania. Additionally, one interviewee mentioned the strength of South Africa's regional advocacy for UHC.

Furthermore, stakeholders also discussed recommendations about potential innovations that would help address many of the issues surrounding UHC in Tanzania. An example provided by one stakeholder mentioned is the plan to integrate mobile payments for CHF premiums in one region; this is based on a similar program in Kenya. In addition, a few stakeholders mentioned the possible plan at EAC level towards allowing portability of social insurance schemes across East Africa.

Stakeholders in Tanzania have limited awareness of health financing related innovations in the region. One interesting highlight is that all the examples of innovations provided were from countries that share a physical border with Tanzania and this may point to the fact that innovations from countries perceived to have a similar context may be more acceptable.

ACS Approach

KEY FINDINGS

- Collaboration emerged as a recurring theme throughout the interviews with most stakeholders highlighting the need to improve collaboration and coordination in order to progress UHC.
- A number of stakeholders proposed integrating excluded stakeholder groups into existing collaboration platforms as well as ensuring that the UHC discussion is moved from the national level into stakeholder platforms at local level.
- The main area that stakeholders see ACS supporting advancement of UHC in Tanzania is by disseminating knowledge and helping to bring together multiple actors.
- The three main challenges that ACS may face are negotiating an entry point, articulation of tangible value-add, and managing stakeholder relationships.

Stakeholders were asked to reflect on the status of the three pillars of the ACS approach (accountability, learning and collaboration) in the Tanzanian context. A significant number of stakeholders stated that there are currently systems to ensure accountability within the health system though almost all respondents had suggestions on how this could be improved. The suggestions provided included; improving monitoring and evaluation (M&E) practices, strengthening community-level involvement and leadership as well as increasing transparency. Other proposals were regular audits and further decentralizing the onus of accountability to the local level.

A majority of stakeholders noted that the culture around learning and knowledge sharing on UHC and health financing needs to be strengthened in Tanzania. In terms of ongoing initiatives, stakeholders shared examples of platforms for knowledge sharing such as the regional and district medical officers' meetings, Technical Working Groups and conferences on specific themes such as Human Resources for Health

(HRH). The public sector was cited as the primary convener of a majority of these platforms. While these platforms exist, stakeholders cited challenges around the limited number of opportunities available for knowledge sharing, the absence of systematic processes coupled with ineffective communication mechanisms to disseminate learning. Stakeholders suggested increasing funding to move ad hoc learning events into regular meetings, broadening the conveners of platforms beyond the public sector and setting up mechanisms to share best practices among different regions in Tanzania.

Collaboration emerged as a recurring theme throughout the interviews with most stakeholders noting the need to improve collaboration and coordination. Respondents noted that certain stakeholder groups were often excluded from the discussion on UHC and health financing citing private sector, civil society, local leaders and representatives from sectors outside of health, as most often left out. A number of stakeholders proposed integrating excluded stakeholder groups into existing collaboration platforms as well as ensuring that the UHC discussion is moved from the national level into stakeholder platforms at local level. Additionally, enhancing multi-sectoral collaboration was proposed as a way to attain progress towards UHC.

Based on the responses received, there are ongoing activities in Tanzania around the three core ACS pillars. Stakeholders also shared potential ways to enhance accountability, strengthen the culture of learning and knowledge sharing as well as widen collaboration within and outside the health sector. These suggested activities may present a starting point for mapping out ACS engagement in Tanzania. Beyond the specific questions asked, a significant number of stakeholders appreciated the ACS approach of undertaking a consultation mission to understand the Tanzanian context prior to engaging in any project implementation.

Box 7. ACS Approach: Accountability, Learning and Knowledge Sharing, Collaboration

"No, this [accountability] isn't really happening. They have signed, but when asked why they're not getting to the 15% budget commitment, there's no answer." – ***Public Sector***

"The culture of learning and sharing can be increased by creating an incentive for people to be involved in UHC." – ***CSO***

"Need a multi-sectoral approach, not just the MOH." – ***Private Sector***

ACS Support Areas

ACS is seen as a useful project by the stakeholders interviewed because of the varied ways it can help Tanzania progress towards achieving UHC. Overall, the main areas that stakeholders see ACS supporting advancement of UHC in Tanzania include the dissemination of knowledge and helping bring together multiple actors.

Learning and knowledge sharing

Sharing of best practices: In terms of disseminating knowledge, stakeholders were most concerned with how ACS could support the spreading of best practices to Tanzania. Additionally, some respondents proposed mapping out current efforts or gaps to international examples of success in order to facilitate learning of best practices in specific technical areas. The highlighting of these best practices would help anchor evidence-based best practices into policy in Tanzania.

Translating international examples for adoption: Respondents also discussed the need to share international best practices so that Tanzania could learn from the broader region as well. A frequent

response on how ACS could support Tanzania was to help translate international approaches for adoption into other countries including Tanzania. This could also help broaden regional learning if the approaches were from the African continent.

Improving capacity building for advocacy and accountability: While respondents acknowledged the need for greater learning and knowledge sharing, interviewees discussed the lack of understanding and training on how to best share knowledge as well as how to effectively advocate for a solution such as UHC were common barriers. Thus, a frequent ask from stakeholders was that ACS could help build capacity in Tanzania to more effectively use evidence, increase citizen engagement, and collaborate.

Collaboration

Build on existing platforms as an entry point: In terms of uniting different stakeholders, interviewees had many different suggestions on how ACS could help support this goal. For example, one suggestion was to build on existing forums and integrate the agenda into new forums such as the National HRH alliance and White Ribbon Alliance. Furthermore, there was a recommendation that space be negotiated with the Ministry of Finance gatekeepers as there is a new initiative there to help achieve the sustainable development goals. If ACS could align around the sustainable development goals, it would be easier to include the Ministry of Finance in the discussions.

Strengthen linkages between existing approaches: Beyond just including the Ministry of Finance, one interviewee highlighted the need to link UHC interventions at the service provision level to payers (insurance funds). The respondent stated that these are currently fragmented, leading to inefficiencies. Similarly, a stakeholder demonstrated the need to integrate private sector initiatives with broader government initiatives. An example cited was Jamii Africa which is a private micro-insurance scheme that has had significant success since launching, but the respondents felt that the initiative's impact could potentially have been greater if a public-private partnership was developed.

Support multi-sectoral approaches: Respondents noted that a multi-sectoral approach with a variety of different types of representatives needs to be included in the discussion on how to achieve UHC. Furthermore, one interviewee highlighted the need to also include non-health workers at the grassroots level who have an impact on health.

Use a Common language for UHC: In addition, interviewees frequently recommended that ACS help with strengthening communication and collaboration. For example, an implementing partner mentioned how ACS could help coalesce partners around common language for UHC, which would clarify the diverse messages being spread. On a similar note, another recommendation was that ACS could help come up with more user-friendly information and ensuring that healthcare agreements understood the audience. The urban-rural divide will influence how citizens understand the information revealed and decisions made in an agreement. This was emphasized by a majority of stakeholders who noted the need to integrate improved community involvement in the ACS support areas.

Challenges

Drawing on their broad range of experience working in and with the health system in Tanzania, the respondents were asked to reflect on potential issues that the ACS project would need to bear in mind should the team have the opportunity to support Tanzania. Stakeholders identified three main areas that the project should take into account.

Negotiating an entry point: A majority of respondents noted that ACS would need to understand the structure of decision making around UHC and the relationships among different actors. Some of the key actors cited by respondents were PO-RALG, NHIF, MOH and Local Government Authorities. For example, one stakeholder noted that there would be a need to straddle the existing balance of power among different actors. This was also highlighted by another interviewee who mentioned the split of roles between the NHIF and CHF as a dynamic to be considered. Stakeholders noted that this would be a critical dimension to bear in mind to avoid being in a position where ACS could be pigeon-holed into supporting only one insurance scheme or financing approach.

Articulation of tangible value-add: Similarly, another challenge stakeholders mentioned was the need to demonstrate the tangible value that ACS would bring to Tanzania while at the same time articulating how the project builds on existing efforts. Demonstrating tangible value was deemed as important because stakeholders stated that the government had expressed a weariness in the constant discussion of problems and advocating for solutions rather than the demonstration of actual results. Similarly, a public-sector stakeholder mentioned how key decision makers would ask numerous questions to ensure the proposed project truly helped Tanzania. Thus, in the opinion of this stakeholder, it is critical that ACS be at the implementation level which is where changes made trigger policy shifts. One suggestion a civil society stakeholder had was to build ACS on existing opportunities that exist in Tanzania, which would in, turn, demonstrate how the project fits into the existing ecosystem.

Managing stakeholder relationships: Respondents also noted that ACS could face a challenge around ensuring involvement of all key stakeholders and institutions. In particular, stakeholders mentioned that both the MOH and the Presidential Office - Regional and Local Government (PO-RALG) would need to be adequately informed on what ACS plans to do and why this is important for Tanzania. Furthermore, an implementing partner mentioned how it would be critical to balance discussions with the various stakeholders to ensure that ACS does not disrupt the current hierarchy and balance of power. Another related point raised by a number of stakeholders is that the project would need to bear in mind the current political and policy context occasioned by the recent transition to a new government in Tanzania. Another dimension raised by respondents is that the stakeholders currently excluded from the UHC dialogue such as the private sector, civil society, local leaders, and non-health actors would be critical to achieving the goals set out by ACS. Thus, while stakeholders mentioned how ACS would be helpful in involving a diverse set of stakeholders, balancing the current stakeholder dynamics with the need to support the inclusion of additional actors may present a challenge which ACS will have to work through.

Conclusions

Tanzania is at an important inflection point on the journey to achieving Universal Health Coverage. The country has a number of key polices which embed the concept of UHC and this sentiment was echoed by the stakeholders to whom the ACS consultation team spoke. A majority of stakeholders did point out that the draft health financing strategy which is currently pending cabinet approval is an important component for the policy framework that will guide the country as it seeks to advance its UHC goals.

While stakeholders essentially agreed that the core elements of UHC being universal access to quality and affordable services, most respondents cited a lack of a common definition of UHC as a potential barrier the country faces. This was emphasized when respondents pointed out that beyond agreeing on a UHC definition for technical and implementing partners, this concept would need to be shared with the

community. Multiple definitions of UHC present a challenge when translating the concept of UHC to the end user of health services at the community level. Stakeholders also noted the difficulty in translating elements of UHC – both literal and conceptual translation - into language and actionable initiatives that the community could understand. Discussions with community members during focus groups reinforced the need to engage the end users of services more when defining the direction that health financing in Tanzania will take.

A related issue that came through the interviews was the need to broaden the platforms for coordinating UHC strategy and implementation. Actors that were often cited as missing include the private sector, citizens and non-health sectors. Respondents noted that Tanzania has a vibrant SWAp process which forms the major coordination framework for UHC and health financing. A majority of the stakeholders interviewed at the national level participate in one or more technical working groups but a significant number noted that while they were participants, they did not always feel fully engaged and specifically in the case of the private sector, they were not involved in the full policy-making cycle. From the responses, a vast majority of stakeholders looked to the SWAp forums for direction on the next steps around health financing but due to limited communication and coordination, felt excluded from the current discourse.

There is a need to move from strategy definition to action. This was underlined by the fact that the top two priority areas for UCH were improving health service delivery and affordability of healthcare. A number of respondents noted that there is slow implementation of key policies supporting UHC. An example highlighted is the draft health financing strategy that has been pending approval for a number of years. Additional contextual factors noted were the change in policy direction with successive governments, a feeling that health workers resist policy change and the fact that it takes significant effort to communicate the implication of policy changes to the broader population. Challenges were also noted around increasing the efficiency and effectiveness of coordination platforms to moving their focus beyond strategy development into guiding implementation.

Based on the interviews conducted, there is a tension between focusing on supply-side driven interventions and integrating a user-centric approach to Tanzania's UHC and health financing rollout. To note, the main barriers to UHC highlighted by stakeholders at the national level were all supply-side focused. The only demand-side focused barrier they noted was the lack of awareness of UHC among the population. In contrast, the focus group discussions highlighted a need for the health system to be more responsive to the needs of users in terms of increasing availability of services, improving quality and enhancing value for those covered by insurance schemes.

While recognizing areas that require greater focus, it was promising that stakeholders had clear ideas on the main strategies to accelerate progress towards UHC in Tanzania. Improving collaboration emerged as a recurring theme throughout the interviews with most stakeholders highlighting the need to improve collaboration and coordination within the health sector. A number of stakeholders proposed integrating excluded stakeholder groups into existing collaboration platforms as well as ensuring that the UHC discussion is moved from the national level into stakeholder platforms at local level. Multi-sectoral collaboration was repeatedly cited as a strategy to advance UHC in Tanzania. There is also appetite among stakeholders in Tanzania for greater collaboration with regional economic communities and regional networks.

The respondents interviewed resonated with the three pillars of the ACS approach - accountability, learning and collaboration. The main area that stakeholders see ACS supporting advancement of UHC in Tanzania is by disseminating knowledge and helping to bring together multiple actors. Specifically, around

learning, stakeholders see a role for ACS in sharing best practices as well as helping translate international examples for adoption in Tanzania. ACS could also support this dimension by providing capacity building for advocacy and accountability. In terms of supporting collaboration, stakeholders were of the view that ACS could help integrate UHC into existing platforms while linking ongoing UHC initiatives. The project could also support multi-sectoral approaches for UHC and contribute to defining a common definition of UHC in Tanzania.

Finally, stakeholders highlighted three main challenges that ACS may face as a new entrant into the Tanzanian health financing discourse. These challenges include negotiating an entry point, articulation of tangible value-add, and managing stakeholder relationships.

The consultation mission valued the insights of stakeholders on the current state of the health financing discourse and UHC implementation progress in Tanzania. The challenges noted as well as a majority of the solutions proposed by stakeholders on how to accelerate UHC progress align with the thematic focus of the ACS project. This includes broadening existing coordination platforms, including more actors from within and outside the health sector in the dialogue and ensuring that the planned financing and health system changes respond to the critical needs of users. There is also an opportunity for ACS to contribute to the evidence base guiding UHC implementation in Tanzania by fostering regional learning and adoption of best practices.

Annexes:

Annex 1: Stakeholder composition

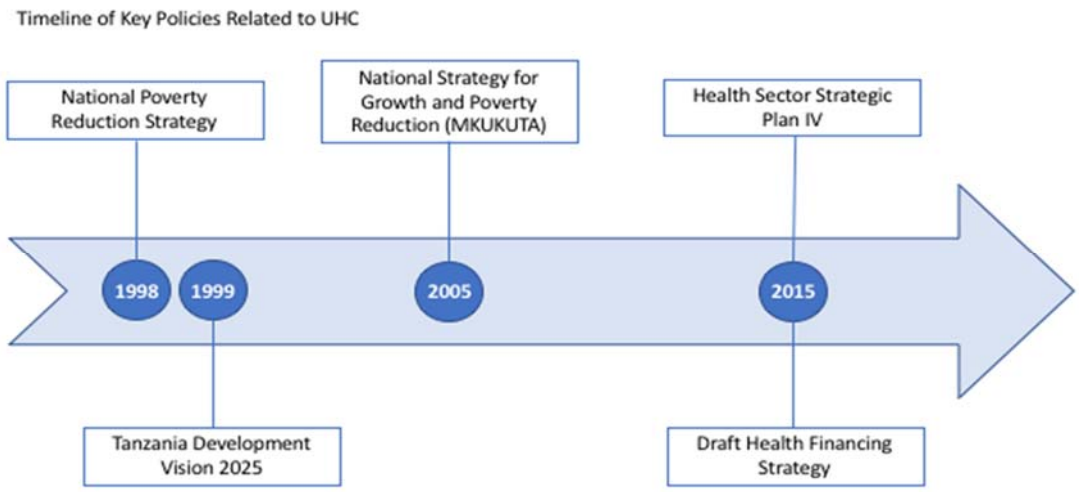
Stakeholder Category	Total #
Civil Society Organizations	5
Development Partner	5
Implementing Partner	3
Media	1
Politician	1
Private Implementer	6
Public Implementer	5
Researcher	3
Technician	7
TOTAL	**36**

Annex 2: Focus Group Discussion composition

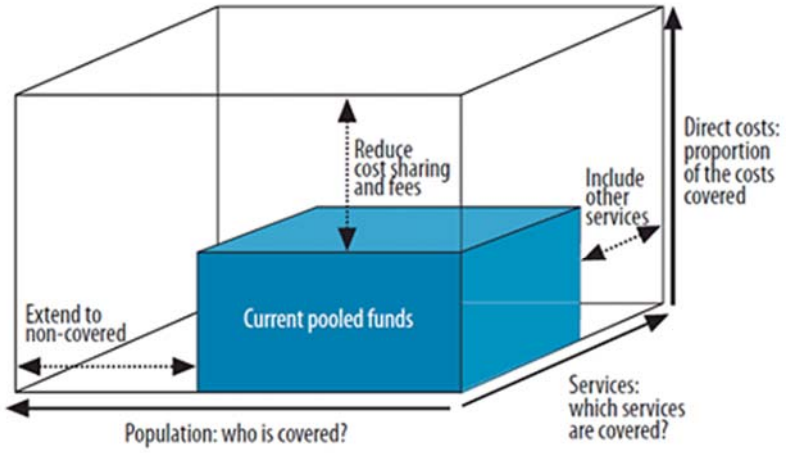
There were 4 focus group discussions held in two regions of Tanzania. In each area, one focus group consisted of women with children (mothers) while the other group was made up of community leaders (both male and female).

Region	Number of FGDs	Participant numbers	
		Male	Female
Morogoro	2	4	14
Pwani region	2	8	18
		12	32

Annex 3: Key policies/reforms related to UHC in Tanzania



Annex 4: WHO universal coverage – three dimensions[32]



Three dimensions to consider when moving towards universal coverage

Annex 4: Stakeholder mentions of UHC Definition Elements

Stakeholder Type	Most Mentioned UHC Definition Element				
	Financial Protection/Affordability	Health Access	Universal Provision	Equity	Quality
Civil Society	2	1	**4**	0	2
Development Partners/Donors	**5**	4	**5**	1	2
Implementing Partners	2	**3**	**3**	2	2
Academics/Researchers	**3**	2	1	1	1
Private Sector Implementers	1	1	**2**	1	**2**
Politicians	0	1	**2**	0	1
Technicians	**2**	**2**	0	0	1
Public Sector Implementers	2	2	**4**	0	2

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