EVANGELICAL LUTHERAN CHURCH IN TANZANIA

HEALTH POLICY

September, 2013

FOREWORD

As a response to the national health sector reforms, the Evangelical Lutheran Church in Tanzania (ELCT) developed a strategic and innovative approach in health service delivery with the main goal of having an improved quality health services. A health policy, therefore, to guide the strategic approach and process became necessary. The Church developed the policy to guide health service delivery in the ELCT Health Sector so that the overall goal to make services accessible, affordable and of acceptable quality can be reached with good impact.

The policy captures the context within which ELCT health sector is functioning. Health service delivery in the Church health facilities is done within the national policy framework and guidelines. The emphasis, on the other hand, is put on core values of the Church such as compassion and love and the Church's commitment to serve the underserved, disadvantage and vulnerable groups.

A policy statement is not static. Hence, the overall context and contents of this policy should be reviewed from time to time, subject to the changing environment, new government directives, emerging and re-emerging diseases, and changes in science and technology and overall circumstances within which the service delivery operates.

It is expected that all stakeholders will use this policy and its operational guidelines effectively. It is anticipated that the availability and subsequent use of this policy at all levels of implementation in the Church will generate constructive ideas to be utilized when next review process is due.

Mr. Brighton Killewa
Secretary General
September, 2013

ACKNOWLEDGEMENT

The review and ultimate preparation of this document involved discussion, consultation and documentation by different health stakeholders. The Evangelical Lutheran Church in Tanzania (ELCT) wishes to recognize and acknowledge her sincere appreciations to all those who were involved in the preparation of this policy. It is practically not possible to remember and mention each and every person who participated in the exercise however, I thank you all.

The Health Department of ELCT wishes to appreciate the work done particularly by the national ELCT Managed Health Care Program (MHCP) Team comprising of different health programs and projects including; the PHC project, MEMS, Health Advocacy, Palliative Care, Health Technical Services, Medical ICT project, ART, and HIV/AIDS prevention program for their active participation in the policy review as well as sorting and preparation of the operational guidelines.

Special appreciation goes to health colleagues the Medical Officer I/Cs and Medical Secretaries from ELCT hospitals and Dioceses who participated in one way or another during joint technical forums and partners meetings deserve special thanks too whose comments helped to shape the final operational guidelines.

I am also very thankful to Dr. Vishnu Mahamba, a health policy analyst, Dr. John Hillary the ELCT health Advocacy Officer and Dr. Paul Mmbando the ELCT Palliative Care manager who jointly participated in the final scrutiny and putting up together this policy.

Last but not least, I would like to extend appreciation to our development partners including Finnish Evangelical Lutheran Mission (FELM), Church of Sweden (CoS), Dan Mission and Danish Mission Council Development Department (DMCDD) whose financial support to the ELCT MHCP helped to finance the process of preparation of these policy documents.

I am also grateful to those who are not mentioned but have contributed in one way or the other in making this work possible,

On behalf of ELCT Health department, I wish to take this opportunity to thank all for making this work possible!

Dr. Geofrey Nimrody Sigalla
ELCT Health Director
September, 2013

TABLE OF CONTENTS:

ACRONYMS:

AIDS	Acquired Immunodeficiency Syndrome
CBHS	Community Based Health Services
CSSC	Christian Social Services Commission
ELCT	Evangelical Lutheran Church in Tanzania
FBO	Faith Based Organization
HBC	Home Based Care
HCTS	Health Care Technical Services
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
ICT	Information and Communication Technology
MEMS	Mission for Essential Medical Supply
MSD	Medical Stores Department
MoHSW	Ministry of Health and Social Welfare
PC	Palliative Care
PHC	Primary Health Care
PPP	Public Private Partnership
RCH	Reproductive and Child Health
STD	Sexually Transmitted Disease
TDHS	Tanzania Demographic Health Survey
VA	Voluntary Agency
WHO	World Health Organization
WCC	World Council of Churches

OPERATIONAL TERMS

The Church:

For the purpose of this policy, the Church will mean the Evangelical Lutheran Church in Tanzania

Church district:

This refers to second level administration after the Diocese and usually comprises 4-5 congregations

Disadvantaged and vulnerable groups:

This include children under 5 years of age, pregnant women, disabled individuals

Health sub-systems:

These refers to department, church district, committees and congregation within the ELCT Church

Advocacy

Refers to a process where an individual or organization aims at influencing public policy and resource allocation decisions within a certain system. In this policy, advocacy will refer to influencing the government for more funding to the Church health facilities and also refers to promotion of patient rights in health facilities

Cross cutting issues:

This refers to issues pertaining relief, human rights, HIV/AIDS, gender and environment.

ELCT HEALTH POLICY

1 INTRODUCTION AND CONTEXT

1.1 BACKGROUND INFORMATION

Generally, health means the state of physical, social and mental well being and not merely the absence of disease or infirmity. A good health is human capital input in facilitating development to an individual, family and the nation, specifically in attaining better life and hence poverty reduction. In this regard, health aims at enhancing sustainable development to the community; through self initiatives maximising on the ability and opportunities available. The maintenance of a good health needs community empowerment through participation in decision making, planning and implementation of their strategies for development.
Soon after independence 1961, health services in Tanzania were provided according to National Policy Directives till 1990. During the 1990s, the health sector in Tanzania faced a period of comparative stagnation and even decline. The health services were characterized by severe shortages of essential drugs, equipment and supplies and deteriorating infrastructure and were also plagued by poor management, lack of supervision and lack of staff motivation. There was little cooperation or coordination in health service delivery between the public sector, Faith Based Organizations (FBOs), and private-for-profit service providers. The government responded by formulating strategies to improve the situation, one of the strategies was to encourage the Public –Private – Partnership (PPP) in health care service delivery. This strategy was included in the National Health Policy and called for the private sector to compliment the health care service provision, including Faith Based organizations and other not-for-profit organizations.

The Evangelical Lutheran Church in Tanzania has been providing health care services in the country since its existence. This work in Tanzania began as a pioneer work of Missionaries, at the turn of the Century. Health care services have been an integral part in this mission as the Lord declares Himself as "The Lord that heals", and commands the believers to heal the sick. Wherever the Church started or extended its missionary work, medical and health care services followed.

Today, the faithe based health facilities provide about 40% of health care services in the Country and the services are more in the rural than in urban areas. ELCT alone provides at least 15% of total health care in the country, which is estimated through the bed capacity/number of all facilities and catchment area. Indirectly, the Church influences all other health care providers through its practices, training institutions and standards it sets. Currently the Church has 24 hospitals and these include one national referral hospital,

4 regional referral hospitals, 7 District Designated Hospitals, 3 Council Designated Hospitals and one specialised Mental hospital. The Church has extensive Primary Health Care (PHC) and Community Based Health Care (CBHC) services, other health promotion activities and over 140 Health Centres and Dispensaries all over Tanzania. Among others, the services provided in almost all of the Church health facilities include

- **Health Promotion services and** activities which aim at behavior change and prevention of Non-communicable conditions to ensure that life styles of individuals are conducive to personal development and environmental safety;
- **Preventive health services** which aim to prevent diseases by promoting optimal nutrition and control of infectious diseases transmission, curtail epidemics and improvement of working environment to maintain highest standards of occupational health;
- **Curative services** which aim to treat correctly diseases or conditions to reduce the likelihood of complications or death by improving quality and quantity of care to patients and ensuring availability of basic services and supplies;
- Provision of **palliative care services** which aims at providing holistic care to patients with life threatening conditions;
- Provision of **Spiritual services to** all patients and people around Health Facilities;
- **Rehabilitation services** to patients such as physical rehabilitation, mental rehabilitation and psychological support to vulnerable groups;
- Some health facilities provide **Medical Education Trainings** for different cadres.

The Church is committed to providing holistic affordable and accessible quality health care services, which will result in healthy individuals and communities whereby physical, emotional, mental and spiritual needs are met and balanced.

The ELCT Mission states;

> *"To make people know Jesus Christ and have life in its fullness by bringing them the good news through words and deeds, based on the Word of God as it is in the Bible and the Lutheran teachings guided by the ELCT constitution*".

The Church believes that once these are attained, individuals and communities will have peaceful and joyful life. To do this amidst the changes currently taking place and the growing demand for health services would need very careful planning and mobilization of communities and all People of goodwill to participate in realising this mission. Such planning and mobilization and allocation of resources need guidance. For this

reason, the Church Health and Diaconal Directorate initiated the process of making a health policy which would guide health care services for the entire Church.

1.2 HEALTH POLICY CONTEXT AND PROCESS

Tanzanian's health status is relatively poor due to high burden of diseases, poverty and low level of education. The health services offered to address this burden is insufficient. The average life expectancy at birth is estimated to be 51years, for males and 54 years for females (TDHS 2010).

Tanzania faces a number of disease with high mortality including Malaria, HIV/AIDS, Tuberculosis, obstetric conditions, other communicable and non - communicable diseases. An increasing number of these diseases is caused by changing life styles, poor living conditions and environmental mis-management. The Socio-economical environment in Tanzania has been changing very fast and impacting upon the health care sector. The deteriorating economy has made it difficult for the Government and other providers to meet the rising costs of provision of health care.

Increasing costs are being passed to individual citizens whose ability to pay is greatly impaired by poverty. Poverty is closely related to many killer diseases such as HIV/AIDS, TB, diarrhoeal diseases and pneumonia in children. Poverty is associated with poor nutrition, poor housing, poor sanitation, and even low productivity, all of which contribute to poor health. The high morbidity is to a large extent caused by communicable diseases, which are related to poverty and ignorance. Most of these diseases are preventable. To overcome this challenge a comprehensive health care system is needed. In addition, non-communicable, neglected diseases and chronic diseases are increasing and have resulted into double burden situation to the communities and the health care system.

Unemployed youth and communities exposed to different cultures have led to social breakdown resulting into eroded morals. This in turn has compounded health problems with drug abuse, early and unwanted pregnancies and child birth; STDs and HIV/AIDS.

Resources for health care services are limited with increasing number of people who cannot afford the costs of health care in Tanzania. Government budget allocation for health care services has been declining yearly, which would almost amount to abdication of responsibility in health care. For a long time external sources have been a major supplement to health care funding for both the Government and the Church hospitals. These sources are also declining or becoming more complex to obtain because of change in donor policies. Increasingly the health providers have to contend with finance.

In responding to these challenges and increased demand to health care services, the government has developed different policies and strategies in attempt to address the situation. The Vision 2025 identifies health as one of the priority sector contributing to higher quality livelihood for all Tanzanians. In addition the National Strategy for Economic Growth and Poverty Reduction (MKUKUTA) aims to foster collaboration among all sectors and stakeholders mainstreaming cross cutting issues hence addressing improvement of quality of life and social wellbeing. Then National Health Policy also aims at the nation to have healthy society and improving social wellbeing and provision of basic health services. In all these strategies and policies, collaboration with the private sector in the provision of health care services is emphasised as it complements the government efforts in providing health care services to all citizens. The ELCT Health System is among potential Health Care Provider and a stakeholder in the country, providing a sizeable health services in collaboration with the state, other like minds and communities.

1.3 A NEED FOR A HEALTH POLICY

In view of the above, the Church needs a policy in order to direct how health care services will be organized, provided, and managed. In addition, the policy is needed so as to ensure that each individual receives equitable, accessible and affordable quality health care services that are fairly distributed. The policy has taken into account the past and present practices, experiences, future perspectives and changing environment. The health policy recognises that health people are an investment to economic growth and poverty reduction. Moreover, the Church through this health policy aims in empowering communities and involving them in health services provision.

The Church recognises that there are several ongoing social and economic reforms, emerging of new diseases, developments in science and technology and global trends in new health care reforms. Therefore the Church commits to regular policy reviews to cater for areas that are not addressed in the previous versions. The current Church health policy review will allow for incorporating health issues which are currently high priority in addressing new challenges for instance issues related to Public Private Partnerships, Health Advocacy, Palliative care services, Quality Improvement and Health Care Financing.

1.4 THE POLICY REVIEW PROCESS

The health policy formulation and review process has gone through several inter-related phases. The first draft policy document was shared and reviewed by relevant individuals in ELCT Health Sub-units and projects in series of meetings. Additional meetings were held with key stakeholders for revising and sharing while progressively incorporating stakeholders' inputs and clarifying its inspiring principles and goals, as

well as the operational implications of the chosen goals and approaches. A precondition to success is the shared commitment to this health policy by all stakeholders engaged in the health sector. This health policy draws attention to nationally agreed priorities and strategies, on which the efforts of all concerned partners shall concentrate. The policy is planned to be reviewed from time to time, preferably after every 5 years.

1.5 GUIDING PRINCIPLES

There will be principles guiding the ELCT Health Policy. These include the following:

1.5.1 Health as a Universal Human Right

Access to health care is a universal human right within the means that community can sustain.

Health is a precondition for individual and societal development. Recognizing the value of health care, the Church is committed to compliment the government's efforts in health sector development in serving the under-served and reaching the rural population.

1.5.2 Focus on Equity, Gender and Poverty

Equity, social justice and good governance are essential for health and social improvements.

Every individual shall access good quality health services, irrespective of socio-economic status, origin, gender, and geographic location. Recognition shall be given to the special needs of the most vulnerable. User-friendly services shall be equally accessible to everyone regardless of their gender. The Church will ensure that health care services are delivered on an equitable and affordable basis to all communities and persons, especially to the poor and vulnerable members of the community and to women and children.

1.5.3 Accountability

Adequate financial, administrative and communication instruments are needed to ensure the accountability and transparency of health sector decisions and operations.

1.5.4 Primary Health Care

Primary Health Care shall be the foundation of the health system and a model for improving health care delivery. The PHC approach focuses on promoting good physical and mental health and preventing illness, but it also includes basic quality curative care at the level closest to users, where they have first contact with health care system. The PHC approach places citizens and patients on an equal partnership with health professionals in decision-making about health.

1.5.5 Public Private Partnership

The Church will effectively manage the diverse set of health sector partners who are motivated by a range of different mandates, interests, resources and ways of working. The Church needs effective partnerships that are characterized by continuous and frank consultations, information sharing, clear rules of engagement,

transparent transactions, and explicit incentives. Partnerships for health shall be guided by the Government to ensure that their actions are coherent with the principles of the national health policy.

2 ELCT HEALTH POLICY VISION, MISSION AND OBJECTIVES

2.1 VISION

The vision of the Church Health Policy is to have a healthy society with healthy individuals and communities where-by physical, emotional, mental and spiritual needs are met and balanced, resulting in peaceful and joyful life.

2.2 MISSION

The mission of the Church Health Policy is to witness and glorify God through provision of holistic equitable, affordable, accessible and sustainable quality health care services, in partnership with community and other stakeholders.

Pursuant to this mission, the Church aims to:

2.2.1 Provide health care services to all people irrespective of creed, status or social inclination.

2.2.2 Honour human life as sacred, sustain and enrich it.

2.2.3 Elicit the participation of individuals and communities in taking responsibility for their own health through education and actual performance of those activities, which have direct or indirect consequences on health.

2.2.4 Emphasize Biblical teachings on caring for the body (the temple of God) and addressing conditions that enable individuals and communities to improve their health status.

2.2.5 Provide health care services appropriately to communities with special emphasis on disadvantaged and vulnerable groups within the community

2.2.6 Empower disadvantaged groups to promote equity and ensure access of health service by vulnerable groups at all levels.

2.2.7 Take into account sustainability of health care through ensuring institutional legitimacy, organisational competence and sustainable funding base.

2.2.8 Exercise good stewardship through organisational, technical and financial accountability.

2.2.9 Strengthen preventive services in order to control incidences of communicable, non-communicable diseases

2.2.10 Strengthen rehabilitation and restoration services

2.2.11 Advocate for effective partnership with committed stakeholders especially for Public Private Partnerships

2.2.12 Facilitate human resource development through trainings, thus contributing to overall national human resource for health with required skills mix and experience.

2.3 GOAL, AIM AND POLICY OBJECTIVES

Goal

A community with healthy individuals, living a peaceful and joyful life and contributing effectively to national development.

Aim

To provide quality health care services that are integrated within the national health system, services of good quality, affordable, equitable, and sustainable and gender sensitive.

Objectives

2.3.1 To prevent and control communicable and non communicable diseases thus reducing disease incidences, disabilities and deaths and hence improve the life expectancy

2.3.2. To improve social welfare services for all people especially those disadvantaged vulnerable groups and underserved people residing in rural areas, through advocacy and protection of their rights

2.3.3 To improve and strengthen public private partnership in health services provision

2.3.4 To facilitate production of human resource for health of different categories taking into consideration aspects of gender and requirements of staff at different health services level.

2.3.5 Provide a framework for analysis, planning and advocacy of health work within the Church and its institutions.

2.3.6 To provide guidance on decision making and implementation of health care services.

2.3.7 To provide a basis for monitoring and evaluation of health services practices, performance and progress.

3 ORGANISATION FOR PROVISION OF HEALTH CARE SERVICES

3.1 ORGANIZATIONAL STRUCTURE

The Church aims at provision of essential and quality health care services to the community with specific focus to the underserved population. To achieve this, there shall be health boards at different levels with clear mandate as well as duties and roles assigned to each level. The aim of these health boards shall be to facilitate provision of quality health care services at different levels that are integrated within the national health system. In that respect, Church health services are expected to be of good quality, affordable, equitable, sustainable and gender sensitive.

3.1.1 National Level: Health Board of the Church

There shall be a **Health Board for the church** that shall report to the Church Executive Council. The board shall have a minimum of 6 and maximum of 10 competent and committed members. The Board members shall be elected by the General Assembly through its election procedures. Duties and roles of the Board are stipulated in the Church constitution.

3.1.2 Diocese Level: Diocesan Health Board

There shall be health board in every Diocese and its members shall be elected by the Diocesan Executive Council using Council's election procedures. The Diocesan Health Secretary shall be the secretary to the Board who shall be responsible for management of health services in the Diocese. Where there is a Church Health Training Institution in the Diocese, the Principal of the school shall be a member of the Diocesan Health Board.

Duties and Roles of the Diocese Health Board (*Under Sect.2.2 of the Guidelines*) shall include reviewing and approving plans and budgets related to health care services and development. The board is also responsible for running of health facilities in the Diocese as well as perform other duties in accordance to Diocesan constitution.

3.1.3 Health Facility level: Hospital Board

There shall be a hospital board in every hospital whose members shall be elected by the Diocesan Executive Council. The board shall have a minimum of 6 and maximum of 10 members comprising of a Diocesan representative, (Diocesan Health Secretary, and where the secretary is not available another representative shall be elected). Board members must include representation from government bodies and shall have adequate gender balance. The doctor in charge shall be the secretary to the board. Duties and Roles of the hospital board shall include reviewing and approving hospital plans and

budgets, financial and other reports. In addition the hospital board shall oversee management of resources of the health facility including facility land and estates.

3.1.4 Health Facility level: Health Centres and Dispensary Boards

There shall be Facility board in every Church Health Centre and Dispensary whose members shall be elected by either the Church district or Congregational Executive Councils. The board shall have a minimum of 6 and maximum of 10 members comprising of a district/congregational representatives, Board members must include representation from government bodies and shall have adequate gender balance. The In Charge of the facility shall be the secretary to the board. Duties and Roles of the boards shall include reviewing and approving hospital plans and budgets, financial and other reports. In addition the boards shall be responsible for overseeing the management of the health facility resources including facility land and estates.

3.2 OVERVIEW OF CHURCH HEALTH CARE SERVICES

The Church recognises and appreciates the existence of many partners, inside and outside Tanzania contributing towards the improvement of health in the community. The Church further appreciates the close collaboration in health issues among the entire faith based communities through the coordinative activities of the Christian Social Service Commission. Therefore,

3.2.1 The Church will relate positively to these institutions and organisations in pursuing its mission.

3.2.2 The Church health services will be guided by relevant national policies and health strategies including the National Health Policy in all areas of its operation while observing the vision, mission and Christian ethics

3.2.3 The Church health system is an integral part of the Church and its Mission. The Church health system exists to accomplish the healing ministry of the Church through:

- Promotion of health in a holistic manner
- Prevention of diseases and infirmity
- Curative services
- Palliative services
- Facilitate and provide different types of trainings
- Promoting Public Private Partnership

- Promotion and coordination of research activities
- Strengthening advocacy strategies
- Provision of Diaconal and Spiritual services

The Church health system will complement the healing ministry through the following functions:

- Conducting health education on prevailing health problems
- Promotion of food security, nutrition, safe water and sanitation
- Provision of Reproductive and Child Health services.
- Health promotion activities including prevention of non communicable diseases and neglected diseases
- Prevention and control of endemic diseases
- Provision of appropriate treatment of common diseases
- Provision of essential drugs
- Improving and maintaining a functioning referral system of complicated cases
- Provision of rehabilitation, Home based care and Palliative Care and social support services
- Quality assurance and Quality improvement monitoring
- Supporting initiatives to develop alternative health care financing

In order to achieve this, all Church health units shall formulate appropriate strategies and plans to sustain their intention to provide Comprehensive health care services.

3.2.4 The Church will coordinate its health system which comprises of subsystems and units at different levels with their autonomous governing boards under the trusteeship of the respective Church structures.

3.2.5 Subsystems and units will operate as one health care system through appropriate directives, coordination, support and control mechanisms.

3.2.6 The health services will be categorised according to existing government and Church regulations and the organisation structure will take cognisance of the local environment where the subsystem exists.

4. HEALTH POLICY ISSUES AND STATEMENTS

4.1 PRIMARY HEALTH CARE

A healthy person is a "whole" person and the Church is providing "holistic" care for the whole person. The Church aim is to have people remain healthy. For this matter, the efforts in promoting health through Primary Health Care services on the same continuum of care as our health efforts to heal the sick. As opposed to emphasis on the curative services in the past, increasing emphasis will be put on health promotion and preventive services. The Primary Health Care (PHC) strategy is the cornerstone for ensuring the provision of essential health care services for all citizens and PHC remains the guiding principle for achieving sectoral, national and international health targets. The strategy has facilitated successful coordination of health service provision by various stakeholders.

In order to achieve a level of service for providing accessible and sustainable Primary Health Care services for all citizens, the Church shall:

4.1.1 Advocate the community to be involved in all stages of health care services provision, from planning, implementation, monitoring and evaluation. This is due to the fact that it is the right and the duty of the community to take responsibility of its own health and engage itself to a learning process on health.

4.1.2 Provide health care services at sustainable costs and individuals and communities will be educated to share these costs. Communities shall be encouraged to extend a loving care to members of their community who are unable to pay and raise funds and resources to cover the costs. The Church shall also support initiatives to develop health insurance schemes to cover Primary Health Care services for rural communities whose members are farmers, peasants or small scale entrepreneurs without formal employment.

4.1.3 Address the main culture-related health problems in the community. The health care provision has to consider cultural issues. The aim is to create a culture in which good acceptable healthy practices become a norm.

4.1.4 Address Non-communicable diseases through health promotion activities and campaigns and furthermore support for the enhancement of beliefs, knowledge, behaviours and practices responsible for prevention of such conditions.

4.1.5 Address the issue of traditional health care services in the community. As it is known that there are some helpful practices that contribute to health yet some are harmful to health and contrary to the Christian faith. The Church will endeavour to further understand unknown practices and react appropriately. The Church shall encourage positive practices and discourage negative ones.

4.1.6 Encourage community multi-professional health team in enabling inter-sectoral collaboration. The Church health system shall be sensitive and actively relate to community development activities contributing to health. These include activities such as education, water and sanitation, improved agriculture and housing.

4.2 HUMAN RESOURCES DEVELOPMENT

The Church recognise that the human resources are the most valuable resource in the health sector. There has been a deliberate effort to develop the capacity of health sector personnel so as to have different skills. However, there is still a need to strengthen more training programs to cater for existing and envisaged new personnel.

In order to have sufficient human resources for health with the required skills mix and experience, who will be able to manage and provide quality health services in a sustainable manner, the Church shall:

4.2.1 Execute programs that ensure training, acquisition, and retaining / keeping personnel with right attitudes and professional competence in its health units.

4.2.2 Monitor performance of human resource for health and monitor health sector training curriculum as per national guidelines and approved standards for training in the public and private institutions.

4.2.3 Endeavour to see to it that, there will be a deliberate human resource plan, health education and training and appropriate management of human resources. The planning will be such that the health subsystems will be equipped with qualified and proficient workers placed at the right places and in right numbers according to standards acceptable in the country. These will be supplemented and complemented by volunteers and interns from abroad and inside the country.

4.2.4 Have its training institutions according to need and abilities. In addition to this, health workers will be educated and trained in other appropriate health training institutions both within and outside the country.

4.2.5 Provide employment opportunities and place the qualified personnel to positions according to their qualification and skills depending on health sector needs. The Church will ensure upkeep of professionalism and ethical standards through continuous training, coaching, mentoring and assessments as well as guidance and counselling,

4.2.6 Endeavour to take good care of its health care workers through good remuneration packages, staff motivation and good working environments. In addition, the Church shall ensure appropriate contractual arrangements as well as suitable staff terminal benefits. Consequently,

staff performance shall be the emphasis criterion at all facility levels. Failure to perform will lead to termination of contract. Above all, the Church will see to it that there are appropriate staff regulations and codes of conduct to all health workers.

4.3 RESEARCH IN HEALTH CARE PROVISION

The Church recognizes the importance of research and the use of research findings with the purpose of improving the health care services. However, the culture of doing research according to priorities and national health problems has not been given the required attention. Most of researches done have geared to identifying problems instead of giving solutions to problems facing communities. Furthermore, many researches have been prepared to cater for needs of training institutions or external institutions.

In order to strengthen research system which will help to improve the provision of health care services in health facilities, the Church shall:

4.3 1 Strengthen the research system and use it as a tool for analysis and planning while utilizing research findings in planning and implementation of strategies and health plans.

4.3.2 Monitor and coordinate all research activities and operational research; and emphasize more on ethical issues that will relate to Christian faith and medical practices.

4.3.3 Collaborate with research institutions in carrying out research activities that will generate data and information that will contribute to improvement of health care services.

4.3.4 Emphasize the research to concentrate on areas that will contribute to health of the community, health systems management, health care provision, clients experiences and satisfaction with the health care provided or health care workers training in collaboration with other actors in health research. The research findings and results have to be disseminated and communicated for utilisation.

4.4 DRUG SUPPLIES AND MANAGEMENT

Constant availability of quality drugs and medical supplies is essential for effective provision of health care services. There has been a mechanism to monitor and control standards and quality of commodities manufactured within the country and those imported from other countries. This mechanism is mostly controlled by the government. The Church faces the challenge of proper monitoring, supervising and ensure quality and performance of the commodities. Constant availability of drugs is a major indicator of quality, key to customer satisfaction, and an incentive for the communities to utilize health care services. About 40% of all

costs of health care in the Church health facilities are absorbed by drugs. Therefore, improvement in management of drugs is bound to have a significant effect on health care.

In order to ensure quality and availability of sufficient drugs and other medical supplies that are safe and meet the national and international standards at all health facilities, the Church shall:

4.4.1 Improve drug acquisition mechanisms as per national standards and needs, storage; distribution and prescription are properly planned for, monitored and controlled.

4.4.2 Adopt a common system of procurement of drugs and medical supplies for all of her units and other faith based and non- for –profit health facilities in the country and participate in national and regional pool procurement initiatives to benefit from economies of scale.

4.4.3 Provide training to health care workers in inventory management and quality assurance issues.

4.4.4 Encourage and support Drug Revolving Funds within health subsystems.

4.4.5 Promote rational drug use practices such as use of generic drugs and provision of appropriate patient information to improve compliance. In addition, the Church shall endeavour to reduce drug costs through various mechanisms such as non medical treatment, encouraging, compounding and simple formulations in health units.

4.5 HEALTH CARE TECHNICAL SERVICES

In the past the Church health care facilities have experienced great shortage of medical equipment. In some cases, existing equipment has been non-functioning because of lack of regular maintenance. The Church health facilities have not performed well as far as upkeep of equipment is concerned. The Church will see to it, that health subsystems and units are equipped with technically appropriate, affordable, standard, effective and sustainable equipment. In view of the above, the Church shall:

4.5.1 Employ qualified technicians who will oversee hospital and medical equipments installation, maintenance and repair in order to have effective functioning equipment. Whenever necessary the Church shall sub-contract qualified individuals or companies to execute maintenance activities which are beyond the capacity of the employed technicians.

4.5.2 Purchase standard equipment to be used in health facilities according to international and national standards. The health facilities shall consult HCTS for professional technical guidance during procurement process.

4.5.3 Ensure planned preventive maintenance (PPM) of equipment and annual validation and certifications of relevant and specific equipment is done timely. In addition, HCTS and health facilities management teams shall make sure the equipment inventory is updated on

yearly basis. Moreover, HCTS shall provide guidelines for equipment which need to be disposed adhering to the national standards on safe disposal.

4.5.4 Collaborate with partners through coordinative activities of Christian Social Services Commission (CSSC) and other stakeholders in health care provision in sharing success, challenges and way forward to improve reliable and affordable hospital and medical equipment maintenance.

4.5.5 Promote HCTS to network with other international and national professional organization. In addition to this HCTS shall organize and conduct technical seminars as per demand

4.6 ADVOCACY ON HEALTH ISSUES

The government is the principle duty bearer of all health care services in the country. It is thus responsible for the overall accountability in provision of preventive, curative and rehabilitative health services for its population. The government however recognises and appreciates the existence of other complementary health care providers including FBOs and other private health care providers. However, the costs for running and managing of health facilities is continuously growing day after day causing a big burden to FBOs and Voluntary Agencies who have volunteered to provide health services to especially rural and hard to reach areas.

The Church together with other FBOs and Private Health providers have recognised the need to advocate and lobby for government support (technically, financially, and materially) for the smooth running and management of FBO and Private health facilities. In addition, the government has enacted a Private Public Partnership (PPP) bill in response to the same. The policy on PPP calls for collaborations and partnerships in delivering quality, affordable and accessible health services to its citizens as their human rights. In this regard, The Church shall:

4.6.1 Strategically strengthen PPP in health sector to ensure effective government support to Church health facilities at national, district and community levels

4.6.2 Strategically and steadily continue to identify health issues that call for advocacy at national and lower levels

4.6.3 Collaborate and network with other FBOs, VAs and Private health providers and stakeholders to advocate and lobby for government support in providing quality health care in their facilities

4.6.4 Advocate for equitable quality health services among communities in the country

4.6.5 Continue its promise and commitment to the provision of quality services by availing of its services to the public, describing the roles of its health care providers and those of their clients as stipulated in the Church's Health Service Charter

4.6.6 Support Diocesan level advocacy teams to function at their jurisdiction levels

4.6.7 Advocate for continued support and partnerships with Development and implementing Partners and the International Community for health service delivery to the poor, disadvantaged and vulnerable communities in Tanzania

4.6.8 Collect relevant information including government and global policies and guidelines and share them widely with Church health facilities, other interest groups and other stakeholders

4.6.9 Promote the rights of patients by informing, educating and displaying the patient charter in all its health care facilities

4.7 GENERAL MANAGEMENT OF HEALTH FACILITIES

Management is enabling the available and allocated resources to produce worthwhile results. In the health system where the human and financial resources are scarce, experience shows that these resources have not been utilised efficiently and effectively. Both the political and the Church environment surrounding the hospitals stifled initiatives in optimal use of resources at the health subsystems and units. The need for increased initiative and planning and control of activities is called for, particularly at this age of stiff competition. The Church faces challenges in proper and close monitoring, supervising and control its activities. This calls the need of good management and effective health boards which will govern and monitor all activities so as the main goal is achieved. In this regard,

4.7.1 The Church will create an environment conducive to efficient and effective management within its health system.

4.7.2 Effective functioning health boards for all health subsystems shall be established and strengthened. These boards will approve plans, budgets, review financial and other reports, and make decisions relating to overall resources.

4.7.3 There will be a different health boards at different levels. At the national level, there shall be ELCT health board where members shall be selected by the Executive Council of ELCT. At the Diocese level, the Health Board shall be selected by the Diocesan Executive Council and at the Health Centre and Dispensary level the boards

shall be selected by congregational councils, which shall then be approved by the Diocesan Medical boards. *(This is also stipulated under section 3, 3:1 of this policy)*

4.7.4 The health boards shall have competent and committed members so as to be more effective. The board shall comprise 6 to 10 members and shall include a theologian, a financial expert, a management expert and a health professional. These people shall be carefully selected from the community and relevant organisations on the basis on their ability to contribute effectively to the performance of the unit.

4.7.5 Health boards at all levels shall have workable long and short-term plans with clear specific objectives. All the health subsystems and units should adopt 3-5 year plan and budget broken into annual and quarterly rolling plans. Implementation of the plan and budget shall follow regulations and procedures stipulated by the Church Health Secretariat.

4.7.6 To make sure Boards continue to function properly, there shall be a system to evaluate performance of these Boards.

4.7.7 The subsystems and units should adopt reporting systems according to the Church Health Management Information System. The Church HIMS provides the basis for analysis at different levels on implementation of the health policy.

4.7.8 The facilities at the hospital level shall be managed by qualified and skilled personnel with academic background in administration and public health so as to promote the specialization. This means the clinicians shall manage the clinical component of the health system and administration to be conducted by managers.

4.8 FINANCIAL MANAGEMENT

The financial resources available to the overall health system are limited, and this applies to both public and private sectors. Besides patient fees and government grants there still a need to raise funds from other sources from in and outside the country. Generally, the budget is still insufficient in relation to actual demand. In view of this, The Church needs to adopt strategies for fund raising locally, from the government and overseas. In addition, the Church needs to develop mechanisms which will guide the management of finances at all levels to ensure compliance with government and development partners. In this regard:

4.8.1 All subsystems and units will adopt ELCT/ Dioceses Health System accounting manuals and financial regulations, to ensure good financial management.

4.8.2 Administration of financial resources through budgeting, actual receipts, expenditure and periodic audits.

4.8.3 Transparency and accountability (organisational, technical and financial) in all finance related issues shall be emphasized

4.8.4 Strategies to have an effective, well performing and controlled finance system shall be adopted at all levels. These strategies shall include:

- Staffing standards and appropriate use of Human Resource Information Management System
- Annual audits by qualified, professional and ethical auditors (both internally and externally)
- Cost effective drug management and appropriate use of Stock Management System
- Appropriate use of Health Management Information System,
- Contracting out of selected services.
- Exploration of alternative models for health care financing, such as cost sharing and risk sharing mechanisms such as community health funds for both facility-based and home based services.

4.9 INFORMATION AND COMMUNICATION TECHNOLOGY

The church recognizes that information and communication technology is an important tool in enhancing the overall development particularly in strengthening the system of service delivery in the health sector that improves performance and productivity. Of recent, there have much emphasis on the use of ICT to improve health care service through the strategy known as electronic Health (*e*Health). This strategy is intended to lay a solid foundation for making the best possible use of Information and Communications Technology (ICT) resources in Tanzania's health and social welfare sector. This strategy envisions modernising and increasing the whole sector's performance. However due to budget constraints and shortage of information and communication experts like any other developing countries our country has failed to use this technology effectively.

In order to increase productivity, performance and quality health services, the Church is emphasizing the following components:

4.9.1 Utilization of low-cost connectivity, the gradual expansion of infrastructure, and development of the ICT support structure addressing the needs of eHealth.

4.9.2 The Church will establish sustainable system of ICT which in turn will help in generation of reliable data by health facilities and other organizations to improve their own management and compilation of data and information. The information and data generated can then be utilized during planning and monitoring sessions locally and at the national level.

4.9.3 Improved human resource management and development of blended-learning or eLearning for in-service and pre-service training.

4.9.4 Establishment of collaborative networks of telemedicine, ranging from the health centres to specialised hospitals, in order to broaden the quality and accessibility of health services at lower costs, while strengthening the referral system.

4.9.5 Improve health promotion, disease prevention and environmental health; assure a stronger involvement of the communities in promoting ICT for preventative health, patient and community empowerment and improving affordable access to health services and counselling.

4.9.6 Deploy ICT with the specific aim of increasing the accessibility and use of health research findings while intensifying the use of ICT in local research activities.

4.9.7 *e*Health innovations are closely followed and when cost effective solutions for current or emerging problems are available they will be implemented in the Church health facilities.

4.10 QUALITY ASSURANCE

The government has set minimum standards in the health service delivery to guide the quality of care. The Church considers the quality of care a priority in health care service provision at all levels. Quality of care is a degree of performance in relation to a defined standard of intervention, known to be safe and have the capacity to improve health within available resources. However, these standards have not been attained. In addition, there is a great shortage of health professionals at all levels, shortage of drugs, medical equipment, pharmaceutical supplies, and dilapidated buildings which have affected the provision of quality health services. In order to promote and improve health services to attain the agreed minimum standards and provision of quality care in a conducive environment, the Church shall:

4.10.1 Ensure availability of adequate medical supplies, reagents, drugs and equipments for improved quality of services.

4.10.2 Acquire and adopt international and local guidelines, service charters which are applicable to The Church setting.

4.10.3 Strengthen the system of supportive supervision and monitoring of the quality of health care at all levels.

4.10.4 Promote use of service charter by both clients and staff.

4.10.5 Advocate for adoption of recommended hospital architectural building designs from the MoHSW so as to improve the health care services.

4.10.6 Ensure adequate financial resources for renovation and maintenance of the hospitals premises.

4.10.7 Support strategies to implement and monitor quality improvement of health care services with a view to certification and ultimately accreditation by recognised national and international bodies

4.11 INFECTION PREVENTION:

Implementing proper infection prevention practices is one of the prerequisites for ensuring safe health care delivery and therefore improving quality of health services and preventing nosocomial infections. Prevention is control of diseases by interfering different modes of their transmission. Prevention is always better than cure since it reduces pains inflicted by diseases and costs associated with the treatment of the diseases. In order to strengthen preventive services for controlling diseases incidences and disability, the Church shall:

4.11.1 Promote on-job training on infection prevention to all health care providers.

4.11.2 Establish and strengthen active quality improvement teams in all health care facilities.

4.11.3 Conduct supportive supervision, mentorship and provide guidance on infection prevention to all health facilities.

4.11.4 Facilitate the survey of nosocomial infections in all health facilities and utilize the information gathered.

4.11.5 Emphasize community involvement in disease infection prevention, this will include strengthening of health education to the community.

4.12 REPRODUCTIVE HEALTH AND FAMILY PLANNING

Reproductive health is concerned with the ability to have safe sexual life and right to decide on reproduction. Reproductive health entails sexual health, antenatal care, prenatal, postnatal and neonatal care; child care, adolescent health and family planning and prevention and treatment of reproductive tract infections including STDs and HIV/AIDS. In order to improve quality and coverage of reproductive health care services for all groups, the Church shall:

4.12.1 Promote the implementation of reproductive and child health package as per national guidelines.

4.12.2 Establish friendly programs for youth sexual health and encourage male involvement.

4.12.3 In collaboration with the respective districts shall ensure provision of vaccines and family planning within their catchment areas.

4.12.4 Continue to collaborate with various stakeholders to improve reproductive health services for women, men, youth and the elderly.

4.12.5 Encourage the religious leaders and clergy to advocate for good Christian morals including abstinence, avoiding premarital sex, multiple sexual partners so as to improve the reproductive health.

4.13 OCCUPATIONAL HEALTH

The government continues to ensure workers' protection against all occupational hazards in their work places. The Church continues to support these efforts in every aspect so as to improve the working environment for health care workers. Despite of all these efforts, occupational hazards of various forms are on the increase due to poor working environment, outdated working tools and insufficient protective gears. Moreover, the working environment is poor and sometimes becomes dangerous to health care workers. This situation has caused ill-health and suffering to health care workers including deformity, diseases such as, Cholera, HIV/AIDs, Tuberculosis and even deaths. In order to protect, improve and sustain health care worker's health status in their working environment, the Church shall:

3.13.1 Ensure that the workers are protected by being provided with quality preventive and curative services in their working places in collaboration with stakeholders and the concerned community

3.13.2 Supervise and monitor implementation of laws, regulations, guidelines, procedures and standards as per national standards for protecting and developing worker's health in their working places.

3.13.3 Ensuring safe working environment and providing emergency health care to their employees.

3.13.4 Promote post event counselling and provide Spiritual services to health care workers who become affected at work.

3.13.5 Emphasize development of different workplace policies

3.13.6 Ensure fire risks are minimized to patients, clients and staff working in Church health facilities including fire through employment of appropriate fire fighting appliances in all health facility buildings.

4.14 HEALTH CARE FINANCING

Due to economic constrains, since 1980 to date the cost of health services delivery has greatly increased. In addition, the limitation and decrease of government budget allocated to the health sector which led the health sector to depend much more on development partners. In addition, inadequate participatory approach to the community has caused un-sustainability in the health services delivery. Due to this fact, the government decided to introduce people's participation through cost sharing policy. In addition, the government is advocating alternative mechanisms which could finance the heath care services. The Church has been implementing some complementary financial options (user fees), yet there is still a growing demand in financing the health sector.

Therefore, in order to strengthening complementary financial options for the purpose of improving health service, reduce dependency and improve participation and management of the community, the Church shall:

4.14.1 Prepare, improve and monitor cost sharing guidelines of health services including income and expenditure of the cost sharing fund.

4.14.2 Establish conducive environment to the community to participate in cost sharing.

4.14.3 in collaboration with other stakeholders will continue to create new financial options which a sustainable and beneficial to the community.

4.15 PALLIATIVE CARE, REHABILITATION AND SPIRITUAL CARE

Palliative care refers to an approach that improves the quality of patients and their families facing the problems associated with life-threatening illness, through the

prevention and relief of suffering by means of early identification and treatment of pain and other problems, physical, psychosocial and spiritual. Throughout the world, many patients present late to the health care system with advanced disease. Therapies to control their disease are frequently ineffective, associated with multiple side effects that cause increased suffering and are expensive. Unfortunately, although the knowledge and experience to control pain and diminish suffering exist, the tragedy for most of the world's population is that palliative care is not available to them. In Tanzania, this service has not been fully established and utilized despite the dramatic increase on the need of palliative care. In addition, provisions of rehabilitation and Spiritual services have not been fully utilized. These services focus more on helping people who have disabilities achieve their personal, career, and independent living goals hence improve their quality of life.

In regard to this, the Church shall:

4.15.1 Provide quality holistic care which focus on the all aspects of palliative care guidelines including management of pain and symptom in its totality. This shall be integrated with home based care services at all levels.

4.15.2 Establish the palliative care services as an integral part of general hospital services rather than a vertical program. This will include employing qualified staff in palliative care in all facilities.

4.15.3 Ensure availability of effective drugs for pain and other symptom relief, and education on their use, shall be available throughout her health system.

4.15.4 Ensure that advocacy at national and local government authorities is done for further recognition of the PC and HBC services. The aim shall be to sustain the services and gain support from the government as well as health insurance companies to promote sustainable local and better financial support of PC services.

4.15.5 Emphasize each Diocese to identify rehabilitation needs and establish community based rehabilitation services according to needs in collaboration with PHC program.

4.15.6 Promote equitable and appropriate utilization of the existing rehabilitation institutions and centers by all Dioceses.

4.15.7 Promote ethics and pastoral care services at all health facilities guided by Christian Ethics and Pastoral care guidelines for the health sector.

4.15.8 Emphasize Spiritual care providers to appropriately support clients from all denominations (including Christian and Non-Christian clients) who receive care from Church's facilities.

5. POLICY IMPLEMENTATION

5.1 The policy development involves all actors (policy makers, community, technocrats, donors, Government) involved with health care services provision

5.2 As much as possible the policy will be made clear to give the right images and impressions to the participants to facilitate serious and critical discussions. This is an ongoing process whose effect is to produce understanding, acceptance and commitment to the policy. The underlying principle is that policy is dynamic, it continue to evolve with time.

5.3 Having gone through the stages, the policy will be adopted and used as a guide in planning, implementation and monitoring of Church activities. In addition the policy will be utilized in developing SOP and relevant guidelines and by-laws which may be required from time to time.

5.4 The Church's health system should have a mechanism that is sensitive to change in context, processes and contents of the policy. This is ongoing process and will culminate into a complete review of the policy document every **five** years.