Using Health Intervention and Technology Assessment (HITA) to Inform the Healthcare Investment in Tanzania: A Scoping Visit

APRIL 8 – APRIL 11, 2015
DOUBLE TREE HOTEL
DAR ES SALAAM, TANZANIA

Disclaimer: The activities and the report were supported through funds provided by the Access and Deliver Partnership (ADP) Project. The ADP Project is five-year (2013-2017) initiative funded by the Government of Japan that aims to help LMICs enhance their capacity to access and introduce new health technologies for TB, malaria and NTDs. The project is led and coordinated by United Nations Development Programme (UNDP), with collaboration from the World Health Organization Special Programme for Research and Training in Tropical Diseases (WHO TDR) and PATH. The opinions herein are those of the author(s) and do not necessarily reflect the views of the Government of Japan, UNDP, WHO TDR, or PATH.

Table of Contents

Executive Summary

The scoping visit to Tanzania aims to explore the potential areas for introducing health intervention and technology assessment (HITA)[1] to support health resource allocation, focusing on the investment and disinvestment of health technologies. A number of approaches were used to understand the situation and analyse potential areas for the introduction of HITA in Tanzania. This include a document review, in-depth interviews, and a two-day workshop, with a wide range of health system stakeholders. An interpretive approach was used to analyse the data. The potential areas identified for HITA include the following:

1. Introducing HITA for the revisions of the essential medicines list (EML);
2. Supporting Country Coordinating Mechanism (CCM) in introducing HITA as part of priority setting for health programs and procurement of commodities;
3. Using HITA to support local health authorities for health priority setting or evaluation of health investments;
4. Using HITA for the development of the Essential Health Package, including health check-ups.

Main conducive factors include the availability of a few well trained health economists and well-established research institutes, strong commitment from particular government officials who are responsible for the development of the EML in Tanzania, and accumulative interest in health priority setting among academics (e.g. in health research priority setting) in the last decade. The potential challenges include a decentralized health system and local authorities' inadequate capacity in health priority setting, no standardized method for HITA which may lead to low quality or bias results, no local funding sources are available for HITA and most health research have been invested according to funding offered by external donors. The future process of introducing HITA needs to take into account the commitment of local partners, the timeline of the project (2-3 years), the financial requirement, the availability of technical support from experts with relevant expertise as well as the potential impact in resource allocation.

[1] HITA and HTA (health technology assessments) are used interchangeably in this report; however, HITA is used in this report to be in line with the World Health Assembly (WHA) resolution on HITA for Universal Healthcare Coverage (UHC). HITA is regarded as an analytical tool for supporting evidence-based priority setting.

World Health Organization (WHO), World Health Assembly (WHA), *Health Intervention and Technology Assessment (HITA) in Support of Universal Health Coverage (UHC)*, A/RES/67/24/15.7 (24 May 2014), available from http://apps.who.int/gb/ebwha/pdf_files/WHA67/A67_R23-en.pdf

Introduction

Governments worldwide are facing the challenge of balancing limited resources and the increasing need for healthcare of their population. Universal Healthcare Coverage (UHC) is introduced to ensure equitable access to essential health services doubles the challenge for the government, especially in resource-limited settings. As a result, priority setting for health system is an inevitable task. The World Health Assembly (WHA) endorses Health Intervention and Technology Assessments (HITA)[2] as a priority-setting tool and process for supporting governments to make systematic, participatory, and evidence-based resource allocation.

A two-day introductory workshop on health technology assessment was held in Dar es Salaam, Tanzania, through the collaboration between the Ministry of Health and Social Welfare (MOHSW) and PATH during 9th-10th April 2015. The workshop aimed to provide a forum for key Directorates and Departments of MOHSW, key government agencies engaged in health policy development and academia to learn about the HTA process, its need, and applications with examples in developing/low-resource settings.

The Health Intervention and Technology Assessment Program (HITAP) partnered with PATH to provide technical assistance to the Tanzanian government. The objectives of HITAP team's scoping visit were as follows:

- To understand the health system context in Tanzania and to identify the potential areas of using Health Interventions Technology Assessment (HITA) to guide policy healthcare resource allocations
- To demonstrate and identify appropriate mechanisms for future updating and refining of the essential medicines list as well as other government healthcare programs, with an eye towards achieving Universal Healthcare Coverage (UHC)

The technical team's findings outlined in this report are analysed from document reviews, in-depth interviews with key stakeholders, and workshop or expert consultation results. The report reflects HITAP's viewpoint of the current situation and potential applications of HITA in Tanzania.

[2] HITA is a systematic analysis of health economics, social, and ethical implications of introducing medicines, vaccines, medical devices, as well as other public health programs or interventions in the health system. HITA appreciates limited resources and ensures the best use of these resources.

Main Findings

Document review

The document review (please consider the list of references in Appendix 2) inform on the interests of academics in health priority setting as well as illustrate some barriers of making evidence-informed policy development in Tanzania, which includes the lack of capacity for generating and using HTIA evidence compounded by a decentralized system of government. Interviews with key informants show both potential and difficulties of introducing HITA, including commitment to Universal Healthcare Coverage, donor-driven priority setting, and inadequate coordination between government agencies and academics.

The review of the 4th edition of the EML shows that the list is very comprehensive containing more than 500 medicines. However, it includes some controversial anti-cancer drugs such as bevacizumab for cancer treatment (even though there is no cost-effective evidence that supports the use of this drug for cancer treatment for low- and middle-income countries) or the recommendation of using ranibizumab for the treatment of macular diseases (given that it is a high cost medicine and some high-income countries still cannot afford it).[3] Many medicines included in the EML are not included in the WHO essential medicines list, which contradicts the information provided in the foreword and introduction that indicates that the inclusion of the WHO medicines list is a major criteria of selecting medicines for the Tanzanian EML. For example, atorvastatin for hyperlipidemia is included in the Tanzanian EML but not on the current version of the WHO essential medicines list.

[3] ADAMS, B. 2015. The BMJ weighs in on Avastin/Lucentis debate [Online]. Available: http://www.pmlive.com/pharma_news/the_bmj_weighs_in_on_avastinlucentis_debate_699646 [Accessed 11th April 2015].
TORJESEN, I. 2012. Why using Avastin for eye disease is so difficult.

Interview

The interview with Juma Chum, the Deputy Director of the Global Fund (GF) Country Coordinating Mechanism (CCM) in Tanzania, showed that the organization is active in the program implementation through regular quarterly meetings with the support from technical groups (they often hold more meetings than the CCM itself). Involvement of civil society organizations (CSOs) is a major challenge for the CCM as representatives from CSOs often bring their own agendas to the meetings. The CCM relies heavily on technical groups from the MOHSW in their decisions on procuring medical devices and other commodities. This area requires priority setting evidence, which is still lacking. According to Mr Chum, an HTA champion should be in the Department of Health Planning; however, it should be embedded in all levels of the government.

Dr Leonard Mboera, the director, and Dr Elizabeth Shayo, a researcher, from the National Institute for Medical Research (NIMR) shared their experiences in setting research priorities using a systematic and participatory approach. However, priorities have not been seriously implemented as research has focused mainly on donor-funded priorities; however, this issue was denied by both interviewees when questioned. NIMR seems to have a very strong multi-disciplinary research team with more than 800 staff, including local enumerators. NIMR hosts around 5 trained health economists and Dr Mboera expressed his strong interest in the area of health information systems.

Two-day workshop

The Director of Health Quality Assurance Department from the Ministry of Health and Social Welfare (MOHSW or MOH), Dr. Mohamed Ally Mohamed opened the workshop and followed by Ms Mutsumi Metzler from PATH providing background information about the Access Development Partnership (ADP) project and the objectives of the workshop, which aims to introduce concepts of HITA and sharing experiences of using HITA for priority setting in Thailand and South Africa. In addition, the workshop will gather the viewpoint of various stakeholders who participated in the workshop about the potential use, barriers, and key stakeholders of introducing HITA in Tanzania. Dr Yot Teerawattananon and Ms Shelley McGee gave a background on HITA, the applications of HITA on making coverage decisions of medicines and public health interventions as well as price negotiations. In Thailand, HITA has been introduced to support the development of the national list of essential medicines, which is the only pharmaceutical reimbursement list in the country, and the UHC benefit package. The process involved multiple stakeholders in nominations, assessment, and appraisal of health interventions and technologies. The use of HITA evidence for price negotiations resulted in significant reduction in medicine prices, leading to the savings of more than a billion Thai baht annually. PRICELESS was established in 2009, with the aim of improving value for money and reducing equities in the South African healthcare system. Its current work includes priority setting for maternal and child health interventions, fiscal intervention to improve behaviour (e.g. imposing taxes on sugar-sweetened beverages), and recently, PRICELESS also joined the iDSI to establish the HITA network in Sub-Saharan Africa. Ms McGee presented the results of a web-based search on the number of individuals in each Sub-Saharan African countries that published economic evaluation studies. The search found that there were 62 individuals in Tanzania that fit the criteria; it is the 5th country with the highest number of researchers conducting economic

evaluations. South Africa, with 151 scholars, is the first, and followed by Kenya, Uganda, and Ghana.

Chief pharmacist, Dr Henry Irunde, informed on the development of the national list of essential medicines, which now consists of more than 500 items and is linked with the public health insurance (covering approximately 19% of the population). The list is scheduled to be revised this year, 2015, and incorporating the interest of using HITA for selecting essential medicines in Tanzania as well as making the process more transparent and participatory.

Professors Peter Kamuzora and Dr Elizabeth Shayo presented research results on priority setting that incorporates district level authorities' involvement. They found that local authorities were lack of capacity for setting their own health agendas, coupled with inadequate support from the central government, including the MOH. Accountability for reasonableness (A4R), consisting of relevance, publicity, appeals, and enforcement, was discussed because it was used as a framework for analysis of the fair decision-making process in the research studies. They concluded that the A4R concept should be implemented and HITA had potential to facilitate the introduction of A4R in the decision making process at every level.

For group exercises, participants identified HITA that that government should invest in or disinvest, the selection criteria, the stakeholders, and the barriers. The HITA investments were as follows: larvicide as a preventive intervention, rehabilitative care, telemedicine, screening for non-communicable diseases, and investment in the health information system. The barriers to investment are: financial constraints, unclear or unknown benefits, lack of skilled human resources, infrastructure, conflict of interest, governance, political will, community acceptability, and sustainability. They also said that the criteria for investment should be how well the intervention matches with the burden of disease, the efficient integration into the current system, effectiveness, and acceptance by the communities.

For disinvestment topic, the group identified the following interventions: health days for diseases, out-of-country patient care for government officials, abdominal x-ray for women, short courses healthcare workers, car purchases, and (changing the current) procurement act. This group said that the criteria for disinvestment should be safety of the technology or intervention, future cost savings, alternative options, and relevance of benefit. Barriers for disinvestment include political or donor investment in certain interventions, regulation/legislation, lack of infrastructure, and insufficient evidence. Both groups identified similar stakeholders for the process, namely, the MOH, the Ministry of Finance (MOF), the beneficiaries, the civil society organizations, professional associations, academicians, politicians, district health offices, healthcare providers and development partners.

The participants:

The second day of the workshop began with the recap of the first day's working group exercise. Major observations include:

- Given that a long list of interesting health interventions and technologies were listed by participants for investment and disinvestment considerations, it proves that the local stakeholders are the most appropriate persons to be involved in priority setting process. In addition, the list confirmed significant potential of making health system in Tanzania to be more efficient.
- This exercise also shows that the priority setting cannot be done properly by outsiders, including international development partners. However, this may not be the case in Tanzania, where about 48% of total health expenditure comes from external donors.
- Criteria for the identification and assessment of interventions and technologies should be designed by local authorities. Budget and human resource requirements are major concerns for investment in Tanzania, whereas politics and conflict of interest (COI) are main barriers for disinvestment. Interestingly, the lack of good quality evidence was identified by investment and disinvestment groups as one of the major barriers for evidence-informed policy decision making.
- There was a consensus in both groups that many stakeholders should be involved in the priority setting process. A few stakeholders outside the health sector such as the Ministry of Education, Ministry of Finance, and local authorities were mentioned as key stakeholders.

Ms Janet Kimambo presented the progress towards UHC in Tanzania by informing the current situation of public health insurance coverage at 19% - 12% is covered by the Community Health Fund (rural voluntary health insurance) and TIKA (urban voluntary health insurance) and 7% is covered by the National Health Insurance Fund (NHIF) for civil servants. For NHIF, up to 4 dependents are eligible for inclusion. Government officials pay 3% of their salaries for the health insurance premium, to which the government tops up a similar amount to NHIF. There are about 1-2% of Tanzanians with private health insurance. The National Health Accounts illustrate that external donors are major sources of health financing (48%) followed by out-of-pocket payments (27%) and government expenditure (21%). As a result of government commitment to UHC, the Health Financing Strategy developed by the inter-ministerial steering committee in 2013 aims to reduce out-of-pocket expenditure and provide equitable, cost-effective health interventions as part of the health benefit package with a view of establishing a single national health insurance for risk pooling by 2020.

Then the participants were divided into two groups to discuss three questions:

1. What are the potential applications of HITA for evidence-based policy development in Tanzania?
2. What are the conducive factors and barriers of introducing HITA in Tanzania?
3. Who are the key stakeholders in supplying HITA and the target users?

In the afternoon, the workshop started with a report back from the working groups that encourages further discussion regarding the potential use of HITA and key players. This includes an exercise that aims to motivate the participants to deliberate about the potential introduction of HTA in their health system. The working questions include; (i) what are the potential applications of HTA in evidence informed policy making? (ii) what are factors that conducive to HTA introduction? (iii) what are barriers to HTA introduction? and (iv) who are suppliers and users of HTA? Participants were divided into two groups and were encouraged by PATH, HITAP and PRICELESS staff to work through the four questions. At the end of the session, group representatives presented results to all participants and discussions was carried out.

Pictures to illustrate the discussion's atmosphere:

Participants identified a number of important potential applications of HTA. The development of the EML, and the optimal benefit package (at district and national levels) were predominantly proposed by both groups. Other similar applications that were proposed by both groups were the development of the National Health Strategy and Plan, price negotiation for medical products, and the use of HTA evidence to inform R&D research and investment of local manufacturers in medical products. Other identified applications included the use of HTA evidence to support the development of population screening package (health check-up), inform the Public Private Partnership plans, investment in high-cost technologies, quality control of private facilities, and pharmaceutical vigilance.

Concerning the conducive factors to the introduction of HTA in Tanzania, infrastructures, e.g. databases, guidelines and human resources were mentioned. In addition, political stabilisation and the demand for high-cost technologies from users and providers were suggested as a noble atmosphere and motivation to support the use of HTA in Tanzanian health care system. Supports from global movements in HTA including the WHO resolution, and availability of international network to provide technical supports for HTA were also acknowledged by the participants. Even though infrastructures and human resource were listed as a conducive factors; the participants were aware of the inadequacy of those resources and the need for further development to be able to catch up with the required HTA activities that were previously identified. Furthermore, a lack of funding support and a standardised method for HTA to be performed by various professionals throughout the country was also concerned.

An extensive list of potential HTA producers was shared by participants. Two main organizations include research institutes and university (see details in table 1). Additionally the latter was expected to carry out HTA training courses to help build in-country capacity for HTA studies. Users of HTA evidence were mainly identified from the MOHSW's agencies such as the Department of Policy and Planning, the Pharmaceutical Unit, the Medical Stores Department, Manager of the NHIF, the Preventive Services. Participants stressed that users should include those from both national and district levels. Development partners as well as health facilities (both public and private) were also important users who should be informed about the HTA evidence of the country.

Table 1: Full results from the group exercise

Questions	Group 1	Group 2
POTENTIAL APPLICATION OF HTA	• Essential Medicines List (EML) • Medical equipment list • Health check-up package development (services, frequency, age group) • HTA to inform investment of local manufacturers • Price negotiations at central and district levels • District health package • National Health Strategy Plan • Quality control of private health	• Develop optimal benefit package • Essential drugs and commodities procured by government • National Health Plan • Informed product registration (criteria for inclusion and price negotiation) • Budget (informing PLANREP, CCHP, information package) • Supply chain management • Training for health REQs • Pharmaceutical vigilance

Questions	Group 1	Group 2
	facilities (hospitals and providers) • Public private partnership (hospitalisation)—control of fee that are charged by private facilities to insurance • Investment in high-cost technologies • Scaling-up of new technologies/introduction	• R&D research priorities
CONDUCIVE FACTORS	• Existing fund (?) • Existing structures for process (supportive and failed) • Guided by WHO (WHA resolution) • Supporting existing databases • External technical support • Potential for development partners support • Demand for high cost technologies (from users and providers) • HTA champion exist • Existing skills	• Guidelines and standard • Research university and units • Human resource • Stable political situation • Good governance • Health system design • Collaboration with development partners
BARRIERS	• Lack of training on HTA (need to pull disciplines together) • No standardised methods • Lack of clear HTA system design • Inadequate communication between research and policy • Inadequate funding	• Lack of data (inadequate quality)/not consolidated/completed—cost, effectiveness and coverage • (Survey) Tools • Lack of funding for HTA • Unstable power (and water) supply • COI in policy development • Industries • Inadequate professionals for HTA • Donor dependency
SUPPLIERS OF HTA	• Research institutions including NIMR, IHI and TFNC • Training institutions including MUHAS, UDSM, KCMC, UDOM, BUGANDO, SUA, and Open University, NHLQATC	• NIMR, MUHAS, IFAKARA • BUCHS (medical university), NHL, COSTECH
USERS OF HTA	• Referral hospitals • Decision and policy makers for EML and medical equipment list • Department of Policy and Planning, MOHSW • NHIF manager • TFDA • Director of Preventive Services • Section for PPP's (Director of Curative Services) • Medical Stores Department	• MOHSW (MSD) • Health facilities • Community/local authorities • Development partners; UNDP, WHO, USAID, USS, UNFPA, SICA, SIDA, other UN agencies, EU AID agencies, CIDA, NORAD

Questions	Group 1	Group 2
	• Pharmaceutical Services Unit • Professional bodies (guidelines)	

Results from this exercise suggested an important and potential areas for the introduction of HTA in Tanzania. The development of EML and the benefit package, in response to the development towards the Universal Healthcare Coverage, were the most probable channels that urgently require the use of HTA evidence. The identified list of institutions that are likely to be HTA evidence producers provided useful information to further step to create collaborative project for in-country capacity building initiatives. The identified information were derived from the participants in this workshop who were mainly from the MOHSW, NHIF, and universities; thus their knowledge and experiences are likely to influence the discussion results into a specific direction.

After the exercise reports, HITAP shared the experience of early establishment of the HITA system in Thailand ten years ago. Dr. Teerawattananon informed that the HITA system in Thailand then was not much different from the current situation in Tanzania, where there is no HITA focal point, with a lack of linkage between HITA and policy making. The turning point came in 2003 when the government decided to include antiretroviral treatment as part of the one year old UHC scheme in Thailand. The inclusion of the antiretroviral treatment was purely based on politics as Thailand had very strong HIV activists, putting pressure on the government to include the treatment in the benefit package even though it was excluded from UHC. Because of this, other patient representatives, health professional associations and industries put pressure in the government to include other treatments and one of the significant issues is the inclusion of renal dialysis. At the time, the government realised that they could not make coverage decisions without evidence because renal dialysis was regarded as one of the most expensive health interventions in healthcare systems around the world. The then government commissioned the first policy-informed HITA work. The result of the studies were very helpful in informing the first peritoneal dialysis policy. HITA received recognition as a good tool for policy making, and the government decided to significantly invest in HITA system development by establishing HITAP in 2006. The presentation encouraged participants to begin establishment of an HITA system in Tanzania.

The last section was led by Ms Mutsumi Metzler and Dr Henry Irunde who gave commitment to participants that the ADP project would provide support to the policy demand of establishing HITA in Tanzania in the next 3 years of the project. However, the specific HITA work needs to be decided together between the Tanzanian MOH and ADP project leads. In addition, Ms Metzler encouraged participants to think about the long-term vision of HITA beyond project timelines of ADP.

Discussion

The main findings were used to create the following SWOT analysis for Tanzania's HITA development.

The strengths include:

- A government policy committed to UHC, which could pave the way for the introduction of evidence-based resource allocation across healthcare programs. HITA stands out as a potential tool to respond to this policy demand given the use of HITA in many countries that have already achieved UHC.
- Tanzania has well-trained and skilful local scholars with some strong research institutes and university units. Many of them have experiences in conducting economic evaluation, analysis of current priority-setting mechanism at both national and local levels. If this human resource can be drawn upon to provide support for the use of HITA in policy decision making, there will be a high chance of producing robust results.
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The weaknesses include:

- Most of the research organizations are driven by external donor or funding support, therefore it is difficult to find a research institute to commit to HITA. It is also very challenging for the long-term sustainability of using HITA to support public health resource allocation, unless the MOH or NHIF have committed resources for HITA though this situation may not be seen in the near-future.
- Because HITA alone cannot make impact as it depends on policy implementation, the impact of the work relies on effective procurement and delivery. In addition, the coverage of public insurance is low and as such, the impact of HITA may not be significant unless the country commits more resources to health spending or can negotiate with health funders to use the available resources for HITA.
- The quality of local data might affect the quality of HITA. HITA without using local information may not be relevant and considered by policy makers. Additionally, HITA using low quality of local data will not yield robust results; therefore, investment in the development of local database should be ensured.
- A decentralized and fragmented health system with inadequate capacity of local authorities is perceived as an obstacle in making impact of evidence-informed policy development as it is difficult to implement a centralized policy (based on HITA results). On the other hand, there is no clear mechanism to introduce HITA in the local authority level given the lack of interest, inadequate capacity, and unclear accountability mechanism.

Opportunities

- Tanzania will become a graduating country from global donors in the near future because its current GDP per capita per year is above $1,500. This will result in the shift of financial responsibility from financial donors to the government.
- The country is enjoying a stable political situation, which fosters the chance for research and good policy implementation.
- The ADP project is committed to support HITA development in the country until 2018, which means that there will be external technical and financial support to push HITA development forward.
- PRICELESS seems to be keen on expanding their work and reputation in the region and can be a valuable technical resource given the geographical advantage and a better understanding of the regional context, strengths, and challenges.
- With the Essential Medicines List (EML) upcoming revision and also with an unsatisfactory previous version, this provides an opportunity to conduct HITA in this area as the model for future use of HITA.

Threats

- Though PRICELESS has a comparative advantage in the region, it also has limited capacity with only 3 research staff and is likely to be over-committed with other projects (e.g. iDSI and domestic work).
- Industries' and professional groups' resistance to HITA development is an obstacle because they may perceive that HITA introduction aims to control costs and to limit their clinical autonomy, respectively.

Having done the SWOT analysis, what are the options for ADP for establishment of HITA in Tanzania? The following options were identified from discussions and group work during the workshop:

1. Introducing HITA for the revisions of EML
   Given that the Pharmaceutical Services Division is due to revise the current version of the EML and the chief pharmacist, Dr Irunde, is very committed to HITA, this can be a good potential work that demonstrates the benefit of HITA and may lead to sustainable development of the HITA system in Tanzania. However, it is uncertain whether Dr Irunde correctly estimates the magnitude of technical analysis necessary for the development of the EML. His reasoning is that his division houses enough staff to conduct the work; however, from the interview, the number of staff is limited to only 15 people and their skill in conducting HITA is yet to be developed. If this choice is selected, a strong local research partner(s) such as MUHAS, IFAKARA, or NIMR should complement the technical capacity with external support (from HITAP or PRICELESS).
2. Supporting CCM in introducing HITA as part of priority setting for health programs and procurement of commodities
   Given that the Global Fund strategy 2012-2016 indicates Investing for Impact and expresses interest in introducing value for money measure coupled with the interest of the chairman of CCM, there is an opportunity to pilot the use of HITA in supporting

Global Fund's investments in Tanzania. However, for this option to be viable, there needs to be a strong commitment from the CCM because they need to take the challenge of overcoming politically sensitive issues as the status quo is that the coverage decisions are made by the MOH, relying on selective expert groups appointed by each MOH department in practice. The advantage of working with CCM is that the HITA work will focus on either HIV, TB, and/or malaria, which are the central focus of the ADP programme and if successful, this is likely to make a significant impact given the level of investment of Global Fund in Tanzania (more than $300 million from June 2015 to December 2017).

3. Using HITA to support local health authorities for health priority setting or evaluation of health investments

   Given that a priority setting capacity of local authorities who are responsible for primary healthcare is of major concern among workshop participants, building up local authorities' capacity on HITA would be a sustainable development. However, this option requires an innovative approach (as opposed to introducing HITA at the central government that most countries experienced). Also, it can be a costly, time-consuming, and external staff intensive option because they may require close supervision and support and HITA work will need investment in local data collection. As a result, it may take time for HITA work and to see the impact of HITA. Also, it is uncertain whether scaling up is possible at regional or national levels. An example of this work includes the development of the district health package or impact evaluation of the current health program in particular local authorities.

4. Using HITA for the development of the Essential Health Package, including health check-ups

   Given that it is currently of public and political interest to develop the package for health screening for Tanzania, it can be a timely introduction of HITA for development of the package. HITAP's experience of development of population-based health screening in Thailand and found that HITA is useful to inform disinvestment of many unsafe, cost-ineffective health screening. However, if the development aims for comprehensive and need-based health screening package, this work needs significant resources and good quality of epidemiological information in the country, which may be lacking in Tanzania. Also, it is uncertain whether it will be financially and practically feasible to implement the package once it is developed.

The future process of introducing HITA needs to take into account the commitment of local partners, the timeline of the project (2-3 years), the financial requirement, the availability of technical support from experts with relevant expertise as well as the potential impact in resource allocation.

Appendix 1: Agenda

Day 1

Time	Sessions	Lead/Facilitator
8:30 – 9:00	Registration & Welcome introduction of participants	MOHSW and PATH
9:00 – 9:30	Opening Speech	Permanent Secretary, MOHSW
9:30 – 10:00	Session 1: Setting the context - Access and Delivery Project Overview - Health Technology Assessment (HTA) and Health Technology Management for new technology adoption - Evidence based decision making and priority setting for health systems strengthening	PATH
10:00 -10:30	Tea Break	
10:30 -11: 15	Session 2: Introduction to HTA (Concepts and Practice Overview) - Definition/Dimensions/Components - Principles - Process/Structure - Need/Demand/Supply based on country context - Using HTA to inform policy decisions on various issues - Q&A	Yot Teerawattananon, HITAP
11: 15 - 12:45	Session 3: Introduction of PRICELESS - Making smart decisions for healthcare investment - Q&A	Shelley McGee, PRICELESS, South Africa
12:45 – 13:45	Lunch	
13:45 – 15:00	Session 4: Tanzania's experience in health technology assessment and adoption **Presentations:** Health care priority setting in Tanzania: challenges and opportunities for implementing fair and sustainable process Challenges to fair decision making in health care service: involvement of stakeholders Decision making process for selection of Essential Medicines List **Q&A and Discussions**	 Dr. Stephen Maluka, Institute of Development Studies, University of Dar es Salaam Dr. Elizabeth H. Shayo, NIMR Dr. Henry Irunde, Pharmacy Service Section, MOHSW Facilitated by Clint Pecenka, PATH

Time	Sessions	Lead/Facilitator
15:00 – 15:30	Tea break	
15:30 – 16:45	Session 5: Topic selection - Process and stakeholders - Group exercise	Facilitated by HITAP, PRICELESS, and PATH
16:45-17:00	Conclusion and setting the stage for Day 2	PATH/HITAP

Day 2

Time	Sessions	
9:00 – 9:30	Recap from Day 1	PATH + HITAP
9:30 – 10:30	Session 1: Institutionalizing HTA – learning from other countries - Examples of HTA structures from a few countries - Applications of HTA for policy making o Action research o Clinical guideline development o Reimbursements for UHC	Yot Teerawattananon, Jomkwan Yothasamut, Alia Luz, HITAP
10:30 – 12:30 **(Take a tea break at an appropriate timing)**	Session 2: Group Discussion – Need of HTA services in Tanzania **Presentation**: Progress toward universal coverage and utility of HTA in relation to UHC **Discussion:** - Why is priority setting important considering the goal of and progress toward universal health coverage in Tanzania? - What factors should be considered for priority setting? - How could establishing systematic HTA contribute to this end? - What types of technologies/program interventions do we want to evaluate if we do a pilot assessment?	Mariam Ally, Policy and Planning, MOHSW Facilitated by HITAP, PRICELESS, and PATH
12:30 – 13:30	Lunch	
13:30 – 14:15	Session 3: Establishment of HTA in Thailand: learning from nine-year experiences of HITAP - History of HTA development in Thailand - The contribution of HITAP's five management strategies to HTA institutionalization in Thailand - Lessons learned and ways forward - Q&A	Jomkwan Yothasamut, HITAP
14:15 – 15:00	Session 4: Global movement on HTA and International Support - WHA Resolution on Health Intervention and Technology Assessment in support of UHC - Existing international networks - International Decision Support Initiative (iDSI) - HITAP International Unit - Q&A	Alia Luz, HITAP
15:00 – 15:30	Tea break	

Time	Sessions	
15:30 – 16:30	Session 5 (Recap): Summarize group discussions and identify short- to medium-term plans - What is the vision for HTA in Tanzania? - What are critical factors to achieve the vision? - Who are key stakeholders? - What are the major next steps and timelines?	Facilitated by HITAP, PRICELESS, PATH
16:30 – 17:00	Closing remark	Director of Quality Assurance, MOHSW

Venue: Double Tree Hotel, Dar es Salaam
Date of mission: April 9th – April 10th, 2015
Responsible agency: PATH and Health Intervention and Technology Assessment Program (HITAP)
Counterparts: Ministry of Health and Social Welfare, Tanzania

List of HITAP, PATH, and PRICELESS experts:

	Name	Designation / Title
1	Dr. Yot Teerawattananon	Program Leader, HITAP
2	Ms. Jomkwan Yothasamut	Researcher, HITAP
3	Ms. Alia Luz	Project Coordinator, HITAP
4	Mrs. Mutzumi Metzler	Commercialization Officer, PATH
5	Mr. Jay Ward	Project Administrator, PATH
6	Ms. Shelley McGee	Health Economist, PRICELESS

List of participants:

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