THE UNITED REPUBLIC OF TANZANIA

MINISTRY OF HEALTH

NATIONAL INFECTION PREVENTION AND CONTROL PROGRAMME REPORT: 2021–2025.

MAY, 2026

***Recommended Citation*:**
Health Quality Assurance Unit–Ministry of Health (HQAU–MoH). National Infection Prevention and Control Programme Report: 2021-2025. Signed on 31st May, 2026.

TABLE OF CONTENTS

FOREWORD

Infection Prevention and Control (IPC) is a cornerstone of safe, high quality healthcare delivery and an essential component of health system resilience. Effective IPC programmes not only protect patients and healthcare workers from avoidable infections, but also strengthen overall health service quality, occupational safety, and preparedness for public health threats. This report presents a comprehensive assessment of the implementation and performance of Tanzania's national IPC programme over the period from 2021 to 2025. It highlights progress made in expanding programme coverage, strengthening healthcare associated infections (HCAIs) surveillance, building the capacity of healthcare workers, and improving data quality and reporting systems across health facilities.

The findings demonstrate notable achievements, including the expansion of IPC implementation to an increasing number of health facilities, improvements in selected IPC outcomes, and substantial investments in workforce training and mentorship. At the same time, the report identifies persistent challenges, particularly in surveillance performance, adherence to reporting timelines, healthcare waste management practices, and compliance with IPC standards.

The need for strengthening IPC implementation has been part of the Health Sector Strategic Plan: July 2021 – June, 2026 (HSSP-V); which recognized implementation of IPC as an essential element in preparedness and response to "*health epidemics, emergencies and disasters*"[1]. Lessons from previous implementation – as assessed through the trend of compliance to IPC standards from 2010 to 2017[2], and the analysis of the star rating assessment dataset for the Fiscal Year 2015/2016 and reassessments in the Fiscal Year 2017/2018[3], have informed the implementation efforts in 2021-2025. During the Coronavirus Disease 2019 (COVID-19), the need for further strengthening of IPC implementation was evident[4,5,6]. Compliance to IPC standards in 26 referral hospitals in 2021 was found to be

[1] Ministry of Health, Community Development, Gender, Elderly and Children. Health Sector Strategic Plan July 2021 – June 2026 (HSSP V); Leaving No One Behind. Available at: https://mitu.or.tz/wp-content/uploads/2021/07/Tanzania-Health-Sector-Strategic-Plan-V-17-06-2021-Final-signed.pdf.

[2] Hokororo J, Eliakimu E, Ngowi R, German C, Bahegwa R, Msigwa Y, Kazaura K, Simbeye D, Komba A. Report of Trend for Compliance of Infection Prevention and Control Standards in Tanzania from 2010 to 2017 in Tanzania Mainland. *Microbiol Infect Dis.* 2021; 5(3): 1-10. Available at: https://www.scivisionpub.com/pdfs/report-of-trend-for-compliance-of-infection-prevention-and-control-standards-in-tanzania-from-2010-to-2017-in-tanzania-mainland-1598.pdf

[3] Kinyenje, E., Hokororo, J., Eliakimu, E., Yahya, T., Mbwele, B., Mohamed, M., & Kwesigabo, G. (2020). Status of Infection Prevention and Control in Tanzanian Primary Health Care Facilities: Learning From Star Rating Assessment. *Infection prevention in practice*, *2*(3), 100071. https://doi.org/10.1016/j.infpip.2020.100071

[4] Gomes, D. J., Hazim, C., Safstrom, J., Herzig, C., Luvsansharav, U., Dennison, C., Ahmed, Y., Wesangula, E., Hokororo, J., Amone, J., Tekle, B., Owiso, G., Mutayoba, R., Lamorde, M., Akello, E., Kassa, G., Feleke, B., Ndegwa, L., Kazaura, K., Musisi, D., … Bancroft, E. (2022). Infection Prevention and Control Initiatives to Prevent Healthcare-Associated Transmission of SARS-CoV-2, East Africa. *Emerging infectious diseases*, *28*(13), S255–S261. https://doi.org/10.3201/eid2813.212352

[5] Powell-Jackson, T., King, J. J. C., Makungu, C., Spieker, N., Woodd, S., Risha, P., & Goodman, C. (2020). Infection prevention and control compliance in Tanzanian outpatient facilities: a cross-sectional study with implications for the control of COVID-19. *The Lancet. Global health*, *8*(6), e780–e789. https://doi.org/10.1016/S2214-109X(20)30222-9

[6] Mghamba, J. M., Oriyo, N. M., Bita, A. A. F., Shayo, E., Kagaruki, G., Katsande, R., Hussein, A., Kishimba, R. S., Urio, L. J., Lema, N., Camara, N., Makundi, V., Mengestu, T. K., Saguti, G. E., Habtu, M. M., Kwesi, E., Bakari, M., Mfaume, R., Makubi, A., & Subi, L. (2022). Compliance to infection prevention and control

inadequate[7]. During the Marburg Outbreak in Kagera Region from 21 March to 01 June, 2023, "*the critical importance of strict adherence to IPC practices in controlling highly infectious diseases*" was demonstrated[8].

The collaborative efforts of all stakeholders in the implementation of various IPC activities enabled the realization of the achievements contained in this report. Also, the implementation has been guided by the World Health Organization (WHO) IPC core components[9]. Documentation of the implementation in collaboration with the supporting partners – the "USAID Medicines, Technologies, and Pharmaceutical Services (MTaPS) Programme, through the Management Sciences for Health, showed that using a multi-component approach was very instrumental in ensuring proper implementation of IPC interventions in health facilities[10].

The insights presented in this report will guide the efforts to strengthen IPC implementation in the next strategic period (2026/2027-2030/2031) as outlined in IPC action Plan (2026-2031). The recommendations provided emphasize the need to further institutionalize IPC practices, improve data use for decision-making, enhance workforce capacity, and ensure sustained improvements in healthcare quality and patient safety. As part of improving data use for decision making, the team that worked on this report (**listed in Annex 1**) has proposed to share the findings in terms of nine (09) publications as listed in **Annex 3**. The report, as well as the publications process have and will serve as part of building capacity for "*Tanzania Field Epidemiology and Laboratory Training Programme (TFELTP)*" Residents from the Muhimbili University of Health and Allied Sciences (MUHAS) who have been assigned to Health Qulity Assurance Unit (HQAU), namely - **Melkizedeki A. Kwizombe** (Cohort 17 – Second Year TFELTP) and **Hajrat M. Abdulrahman** (Cohort 18 – First Year TFELTP).

---

interventions for slowing down COVID-19 in early phase of disease transmission in Dar es Salaam, Tanzania. *The Pan African medical journal*, *41*, 174. https://doi.org/10.11604/pamj.2022.41.174.31481

[7] Bahegwa, R.P., Hokororo, J.C., Msigwa, Y.S., Ngowi, R.R., German, C.J., Marandu, L., Nassoro, O.A., Kinyenje, E.S., Degeh, M.M., Masuma, J.S., Lutkam, D.S. and Eliakimu, E.S. Infection prevention and control compliance during COVID-19 pandemic era: assessment of 26 regional referral hospitals in Tanzania. *Discov Health Systems* 3, 21 (2024). https://doi.org/10.1007/s44250-024-00078-6

[8] Kinyenje, E., Hokororo, J., Ngowi, R., Kiremeji, M., Mnunga, E., Samwel, A., Sylvanus, E., Mnken, E., Yango, M., Mtalika, M., Mmbaga, V., Saitoti, N., Malecha, A., Kundy, F., Rwabilimbo, M., Kaniki, I., Mwisomba, G., Charles, E., Mughanga, P., Kitambi, M., … Nagu, T. (2024). Infection prevention and control of highly infectious pathogens in resource-limited countries: an experience from Marburg viral disease outbreak in Kagera Region - Tanzania. *BMC infectious diseases*, *24*(1), 628. https://doi.org/10.1186/s12879-024-09508-5 Mwisomba, G., Charles, E., Mughanga, P., Kitambi, M., … Nagu, T. (2024). Infection prevention and control of highly infectious pathogens in resource-limited countries: an experience from Marburg viral disease outbreak in Kagera Region - Tanzania. *BMC infectious diseases*, *24*(1), 628. https://doi.org/10.1186/s12879-024-09508-5

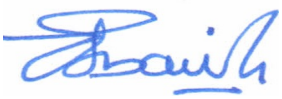
[9] Guidelines on core components of infection prevention and control programmes at the national and acute health care facility level. Geneva: World Health Organization; 2016. Licence: CC BY-NC-SA 3.0 IGO. Available at: https://iris.who.int/server/api/core/bitstreams/d811a2ad-3c7f-48a2-b88b-4935da71a87b/content

[10] Lutkam, D., Konduri, N., Hokororo, J. C., Eliakimu, E. S., Alombah, F., Simba, S., Muiva, C., Ngowi, R. R., Bahegwa, R. P., Msigwa, Y. S., Schwarz, D., Lusaya, E., & Joshi, M. P. (2025). Multi-pronged system strengthening approach to improving infection prevention and control practices in Tanzania. *Infection prevention in practice*, *7*(3), 100477. https://doi.org/10.1016/j.infpip.2025.100477

Throughout 2021-2025, implementation of "virtual *IPC sessions using Project ECHO Platform*" has been very essential in enhancing the knowledge of health care workers[11,12]. In the context of changing global health funding landscape, the use of the platform has been instrumental in building capacity of health care workers.

The Ministry of Health acknowledges the dedicated efforts of healthcare workers, health facility teams, Regional and Council Health Management Teams, Development and Implementing Partners who have contributed to the implementation of IPC activities across the country. Their commitment has been central to the progress achieved to date. It is our hope that the evidence presented in this report will inform strategic planning, foster accountability, and accelerate efforts toward achieving safer healthcare services for all.

I am optimistic that all stakeholders will continue to support implementation of IPC activities at all levels of health service delivery in order to keep our people and communities safe; and ensure resilience of our health facilities during disease epidemics. Identified factors affecting compliance to IPC practices (guidelines, standards, and standard operating procedures)[13],[14] will be addressed in the Fiscal Years 2026/2027 – 2030/2031. The recent (declared on 15th May, 2026) Ebola outbreak in the Democratic Republic of Congo[15,16,17] is an indication that we need to ensure sustained implementation of IPC practices in our health facilities at all levels.



Dr. Eliudi S. Eliakimu
DIRECTOR OF HEALTH QUALITY ASSURANCE UNIT

---

[11] Ngowi, R., Simba, S., Eliakimu, E., Hokororo, J., Lutkam, D., Kinyenje, E., German, C., Bahegwa, R., Msigwa, Y., Nassoro, O., Marandu, L., Mwaisengela, S., Degeh, M., Yahya, T., Lusekelo, J. and Lusaya, E. (2024) Evaluation of Infection Prevention and Control Extension for Community Healthcare Outcome Clinic in Referral Hospitals in Tanzania. *Journal of Service Science and Management*, **17**, 248-268. doi: 10.4236/jssm.2024.173012.

[12] Ngowi, R., Simba, S., Hokororo, J., Lutkam, D., Kinyenje, E., German, C., Bahegwa, R., Msigwa, Y., Nassoro, O., Marandu, L., Machibya, M., Mwaisengela, S., Degeh, M., Yahya, T., Peter, D., Lusekelo, J., Lusaya, E. and Eliakimu, E. (2025) Usefulness of IPC ECHO Clinic in Tanzania—Experience from Its Evaluation in 10 Referral Hospitals. *Health*, **17**, 1299-1318. doi: 10.4236/health.2025.1710086.

[13] Bahegwa, R. P., Hussein, A. K., Kishimba, R., Hokororo, J., German, C., Ngowi, R., Eliakimu, E., & Ngasala, B. (2022). Factors affecting compliance with infection prevention and control standard precautions among healthcare workers in Songwe region, Tanzania. *Infection prevention in practice*, *4*(4), 100236. https://doi.org/10.1016/j.infpip.2022.100236

[14] Okomo, U., Fitzgerald, F., Feasey, N., Mehtar, S., & Dramowski, A. (2026). Infection prevention and control in low- and middle-income countries: policy, practice, and implementation challenges in sub-Saharan Africa. *Clinical microbiology reviews*, e0014222. Advance online publication. https://doi.org/10.1128/cmr.00142-22

[15] WHO. Epidemic of Ebola Disease caused by Bundibugyo virus in the Democratic Republic of the Congo and Uganda determined a public health emergency of international concern; 17th May 2026. World Health Organization, Geneva, Switzerland. Available at: https://www.who.int/news/item/17-05-2026-epidemic-of-ebola-disease-in-the-democratic-republic-of-the-congo-and-uganda-determined-a-public-health-emergency-of-international-concern

[16] Baraniuk C. (2026). Ebola: WHO declares emergency as strain with no vaccine kills 100 in DRC and Uganda. *BMJ (Clinical research ed.)*, *393*, e313572. https://doi.org/10.1136/bmj-2026-313572

[17] Lang K. Ebola: What you need to know and what to do about suspected cases BMJ 2026; 393: e166095. doi: https://doi.org/10.1136/bmj-2026-166095

ACKNOWLEDGEMENT

The Ministry of Health expresses its profound appreciation to all regions, councils, health facilities, implementing partners, technical experts, and programme staff whose collective commitment made the 2021–2025 IPC implementation data review, analysis, and preparation of this report possible. This work stands as a testament to the unwavering dedication of frontline health workers, quality improvement teams, IPC focal persons, and surveillance staff, whose meticulous documentation, vigilance, and routine reporting provided the foundation for this comprehensive national analysis. The Ministry further extends sincere gratitude to the Prime Minister's Office - Regional Administration and Local Government (PMO-RALG) for their steadfast collaboration and strategic support in advancing IPC implementation across all levels of the health system.

The Ministry accords exceptional and distinguished recognition to the Center for International Health, Education and Biosecurity (CIHEB) - Tanzania, under the *Usalama wa Afya Duniani project*, for its outstanding financial support, without which this work would not have been realized. CIHEB's sustained investment, technical partnership, and commitment to strengthening health security and the IPC programme have been instrumental in enabling this nationwide effort. Their contribution extends beyond funding, reflecting a high-impact partnership that has significantly enhanced the quality, scope, and credibility of this report.

The Ministry also acknowledges the invaluable technical contributions from the University of Dar es Salaam (UDSM) – District Health Information System-2 (UDSM) – District Health Information System-2 (DHIS2) Lab, whose expertise in data management was critical, alongside support from academic institutions, the National Institute for Medical Research (NIMR), and participating health facilities.

The Ministry also acknowledges the financial and technical support from the various Development and Implementing Partners (from 2021 to 2025) including World Health Organization; the United States Centre for Disease Control and Prevention (US-CDC); CDC Global Health; Africa CDC; the Global Fund; Amref Health Africa – Tanzania; Management Sciences for Health through the "Medicines, Technologies, and Pharmaceutical Services (MTaPS) Programme; Tanzania Health Promotion Support (THPS); Korea Foundation for International Healthcare (KOFIH), Medipeace; ICAP at Columbia University (originally called the International Center for AIDS Care and Treatment Programmes (ICAP)); Water Aid; Management and Development for Health (MDH); GIZ Health Focus; Catholic Relief Services (CRS); Clinton Health Access Initiative (CHAI); Médecins Sans Frontières (French for Doctors Without Borders) (MSF); and Americares. Also, the following supported the programme in implementing IPC activities to their health facilities - Bank of Tanzania (BoT); Private Hospitals Advisory Board (PHAB); North Mara Gold Mining Medical Center[18]. Their support has contributed to achievements contained in this report. In addition, we acknowledge all the Directorates, Departments, Units, Sections and programmes of the MoH, PMO-RALG, Regions, Councils, health facilities and all health workers at large for their

[18] Hokororo, J. Marandu, L., Ngowi, R., Bahegwa, R., Msigwa, Y., German, C., Nasoro, O., Kinyenje, E., Mwaisengela, S., Degeh, M., Mazengo, R., Ndauzi, I. and Eliakimu, E. (2024) Training of Infection Prevention and Control to Healthcare Workers of Mining Health Facilities: A Shared Responsibility for Improving Safety of Mining Communities. *Occupational Diseases and* Environmental *Medicine*, 12, 243-264. doi: 10.4236/odem.2024.124018.

collaboration both financially and technically in the implementation of IPC in the country. Also, the Ministry acknowledges the support from the US-CDC in the development and finalization of the "National IPC Action Plan: 2026-2031". Their continued support will help to ensure success in the implementation of the plan.

Special gratitude is extended to the Health Quality Assurance Unit (HQAU) staff, namely: Erick S. Kinyenje, Dr. Chrisogone J. German, Dr. Omary A. Nassoro, Laura E. Marandu, Mwajabu H. Machibya, Dr. Radenta P. Bahegwa, Ruth R. Ngowi, and Dr. Mbwana M. Degeh, for their vision and for providing strategic guidance in implementation of IPC activities; as well as, for their tireless efforts throughout the process of data analysis and writing of this report. We further acknowledge the contributions of Dr. Pius Kagoma, Clinical Services Coordinator at PMO-RALG; Dr. Siril Kulaya, Deputy Chief of Party– *Usalama wa Afya Duniani Project;* and Dr. Christina Mmasa, IPC Manager – *Usalama wa Afya Duniani Project*, whose technical leadership, oversight, and unwavering commitment were pivotal in driving this work to fruition. Furthermore, special thanks go to all others who contributed to the writing of this report, as listed in **Annex 1**.

Dr. Joseph C. Hokororo
HEAD OF IPC SUB-UNIT IN HQAU & NATIONAL COORDINATOR OF IPC

EXECUTIVE SUMMARY

Tanzania's national Infection Prevention and Control (IPC) programme is a key pillar for patient safety, healthcare quality, occupational health, and health security. This report presents a retrospective assessment of IPC programme implementation and performance from 2021 to 2025, focusing on programme coverage, healthcare-associated infection (HCAI) surveillance, workforce capacity building, compliance with IPC standards, and routine reporting systems.

The analysis demonstrates substantial expansion of IPC implementation during the reporting period. The number of participating health facilities in IPC M&E increased from 19 facilities in 2021 to 148 facilities in 2025, reflecting progressive scale-up across referral and primary healthcare levels.

Capacity building efforts also expanded considerably, with 1,013 healthcare workers from 148 facilities trained on IPC monitoring and evaluation (M&E) and DHIS2 reporting between 2021 and October 2025. In addition, the number of healthcare workers receiving at least three days of basic IPC training reported by the health facilities increased markedly from 1,363 in 2021 to 19,511 in 2025.

Availability of IPC guidelines at departmental level improved from 73.7% in 2021 to 97.6% in 2025, demonstrating improved institutionalization of IPC practices. Despite internal trainings coordinated by reporting health facilities, IPC training conducted by the MoH increased from 1,153 healthcare workers (HCWs) in 2021 to 8,630 HCWs in 2025 in all regions (4,223 through physical training and 4,407 through virtual training).

Capacity building on HCAIs was conducted to 119 HCWs from 39 HFs in 2021 and increased to 437 HCWs from 94HFs. Findings from HCAI surveillance showed mixed progress. Surgical service coverage increased substantially, with procedures rising from 9,616 in 2021 to 127,039 in 2025. Over the same period, overall SSI rates declined from 3.7% in 2022 to 1.7% in 2024 before increasing to 2.4% in 2025, indicating initial improvements followed by a recent reversal. Neonatal sepsis rates also improved modestly, declining from 12.2 to 10.9 cases per 1,000 live births between 2021 and 2025, although higher-level facilities continued to report persistent challenges.

Healthcare worker safety indicators showed important gains but also highlighted remaining gaps. Hepatitis B vaccination coverage among healthcare workers increased from 4% in 2021 to 31% in 2025, though coverage remains below recommended targets. Reported occupational HIV exposures and uptake of HIV PEP increased steadily over time, while PEP protection rates remained consistently high at above 85%. However, completion of the full PEP regimen declined from 69.3% in 2021 to 62.5% in 2025, indicating challenges in adherence and follow-up. The proportion of infectious healthcare waste remained consistently above the WHO-recommended threshold of 20%, despite a gradual decline from 42.2% to 35.5%, suggesting persistent weaknesses in waste segregation practices.

Assessment of IPC compliance and mentorship among 10,462 healthcare workers over five years revealed variable performance across healthcare facilities. Mean IPC compliance scores were 62% using both the Standards-Based Management and Recognition (SBMR)

tool and the WHO Infection Prevention and Control Assessment Framework (IPCAF), indicating moderate implementation of IPC standards across assessed facilities.
Reporting completeness improved substantially from 58.5% in 2021 to approximately 75% from 2022 onwards, while data accuracy remained relatively high and stable at around 88–92%. However, only 93 of the expected 148 facilities were regularly reporting IPC indicators by 2025, highlighting ongoing gaps in reporting coverage and system functionality.

Overall, the findings indicate that Tanzania's IPC programme achieved substantial expansion and measurable improvements in selected IPC outcomes during the review period. Nevertheless, progress remained uneven due to persistent system challenges, including shortages of trained human resources, inadequate HCAI surveillance capacity, infrastructure and Water, Sanitation and Hygiene (WASH) gaps, weak follow-up systems, fragmented data management processes, and supply chain limitations. Priority actions for the next strategic period include strengthening routine HCAI surveillance, improving data quality and reporting performance, expanding workforce training and mentorship, increasing Hepatitis B vaccination coverage, reinforcing healthcare waste management practices, strengthening accountability and compliance mechanisms, and continue to integrate IPC activities more effectively into routine health system planning, financing, and supervision frameworks.

ABBREVIATIONS AND ACRONYMS

AfyaSS	Afya Supportive Supervision System
CCHP	Comprehensive Council Health Plan
CHMT	Council Health Management Team
CHOP	Comprehensive Hospital Operational Plan
CIHEB	Center for International Health, Education and Biosecurity
CS	Caesarean Section
DHIS2	District Health Information Software 2
HCAIs	Healthcare-Associated Infection(s)
HCWs	Healthcare Worker(s)
HFs	Health Facility / Health Facilities
HFR	Health Facility Registry
HMT	Hospital Management Team
I&ESS	Internal and External Supportive Supervision
IPC	Infection Prevention and Control
IPCAF	Infection Prevention and Control Assessment Framework
IPCFP	Infection Prevention and Control Focal Person
MoH	Ministry of Health
NIMR	National Institute for Medical Research
PEP	Post-Exposure Prophylaxis
PMO-RALG	Prime Minister's Office - Regional Administration and Local Government
QI	Quality Improvement
QIT	Quality Improvement Team
RHMT	Regional Health Management Team
RRH	Regional Referral Hospital
SBMR	Standards-Based Management and Recognition
SSI	Surgical Site Infection
UDSM	University of Dar es Salaam
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization
WIT	Work Improvement Team

TERMS AND DEFINITIONS

For the purpose of this report,

Infection Prevention and Control (IPC) refers to evidence-based measures designed to prevent or reduce the spread of infections within health care settings.

Healthcare-Associated Infections (HCAIs) refer to infections acquired during the process of receiving care that were not present or incubating at the time of admission or first contact with a health service.

Standards-Based Management and Recognition (SBMR) refers to the national standards-based assessment approach used to measure compliance against expected IPC practices.

Infection Prevention and Control Assessment Framework (IPCAF) refers to the WHO Infection Prevention and Control Assessment Framework used to assess facility progress across the core components of IPC programmes.

Data Quality refers to the extent to which data are accurate, complete, timely, and consistent, ensuring that reported information is reliable and fit for decision-making.

Infection Prevention and Control Assessment Tool (IPCAT): refers to a standardized assessment instrument used by healthcare facilities and regulatory bodies to evaluate the effectiveness of Infection Prevention and Control (IPC) programmes to identify gaps in hospital safety protocols and ensure that facilities meet international standards set by WHO.

LIST OF FIGURES

LIST OF TABLES

1. INTRODUCTION

1.1 Overview of the National Infection Prevention and Control Programme in Tanzania

Tanzania's national IPC programme forms a central pillar of patient safety, quality of care, occupational health, outbreak preparedness, antimicrobial resistance containment and general health system strengthening. The programme operates through national leadership, subnational management structures, and health facilities at different levels. In practical terms, the programme seeks to ensure that all health facilities have the governance arrangements, workforce competencies, surveillance systems, commodities, infrastructure, and reporting mechanisms needed to prevent avoidable infections among patients, visitors, and health workers and community at large. Ultimately, IPC intend to provide safe environment for health provision.

The programme aligns with the World Health Organization's core IPC components at national and facility levels and uses the IPCAF and IPCAT methodologies to assess institutional progress. In the Tanzanian context, these global principles are operationalized through routine reporting, standards-based assessment, supportive supervision, mentorship, action planning, and progressive institutionalization of IPC within health facility management structures.

1.2 Objectives of the Report

The overall objective of this report is to account the implementation and performance of the national IPC programme from 2021 to 2025 and to identify the priority actions required to strengthen programme effectiveness in the next strategic period. Specifically, this report aims:

i. To account the coverage of IPC programme implementation across participating regions, councils, and health facilities.
ii. To account the performance of HCAI surveillance, including reporting coverage and trends where available.
iii. To narrate the compliance with IPC standards as assessed through SBMR and IPCAF performance scores
iv. To report the performance of IPC routine reporting in DHIS2 and the quality of programme data.
v. To share the progress in capacity building for healthcare workers, including training and mentorship on IPC.
vi. To report key programme bottlenecks and recommend priority actions for improvement.

1.3 Significance of this Report

A retrospective report of this kind serves three purposes. First, it provides accountability for national IPC programme implementation across a defined period. Second, it translates dispersed routine data into a single narrative that can support strategic review and resource prioritization. Third, it creates a bridge between routine monitoring and the next programme cycle by highlighting where progress has occurred, where performance has plateaued, and where system weaknesses are preventing scale, quality, or sustainability.

2. SCOPE AND METHODOLOGY

2.1 Scope of the Report

This report presents the implementation of the Infection Prevention and Control (IPC) programme from October 2021 to December 2025, covering 148 health facilities trained on IPC indicator reporting. These included 15 health facilities at national, specialized, and zonal levels, as well as all 28 Regional Referral Hospitals (RRHs) across 26 regions. In 13 of these regions, the intervention was further expanded to 105 Primary Health Care (PHC) facilities, including district hospitals, health centres, and dispensaries.

Before the establishment of the IPC M&E system in 2021, indicators such as neonatal sepsis and post-exposure prophylaxis (PEP) services were monitored at health facility level. Hence, in this report, additional facilities outside the 148 health facilities were included. 2.2 Data Sources

This report is based on a retrospective review of routine programme data drawn from national electronic systems, particularly DHIS2, AfyaSS, and the IPC training database. Overall, 26 IPC-related indicators are reported through DHIS2. Of these, 21 indicators are directly monitored under the national IPC programme, while the remaining 5 are monitored and reported under other programmes/divisions (National AIDS, STIs and Hepatitis Control Programme (NaSHCOP); Reproductive, Maternal, Newborn, Child, and Adolescent Health Division (DRMNCAH); and the Environmental Health and Sanitation Section under the Preventive Services Division). Of the 21 IPC programme indicators, 8 are reported monthly and 13 quarterly.

IPC Monthly Indicators:

i. Surgical Sites Infection (SSI) of patients operated in the reporting Health Facilities (HFs)
ii. SSI of patients operated outside HFs
iii. SSI due to Caesarean section
iv. Hours used by Quality Improvement Team (QIT) on implementing IPC activities
v. Amount of Chlorine used by HFs
vi. Amount of soap used by HFs
vii. Percentage of Infectious Waste produced in a month
viii. Hours used by IPCFP in implementing IPC.

IPC Quarter Indicators:

i. Percentage of staff who have completed the full course of Hepatitis B vaccinations
ii. Percentage of staff who have received IPC training
iii. Percentage of departments with IPC guidelines
iv. Percentage of departments with active Work Improvement Teams (WITs)
v. Percentage of facility taken samples for culture (swabbing) from high-touch surfaces
vi. Percentage of departments within the facility with improved latrines/toilets
vii. Functionality of QIT (Total number of meetings held between the QIT and the Health Management Team (HMT))
viii. Functionality of WIT (Total number of meetings held between the facility's QIT and departmental Work Improvement Teams (WITs) to discuss IPC activities)
ix. Functionality of IPC Committee (Number of meetings conducted by the IPC Committee)

x. Average percentage score achieved after internal assessment using IPC Standards
xi. Percentage of facilities with reliable water sources (piped water or borehole)
xii. Percentage of departments within the facility with a functional piped water system, and
xiii. Percentage of departments within the facility with hand hygiene facilities/supplies

2.3 Analytical Approach

Data for the review period (2021–2025) were extracted from DHIS2, AfyaSS, and the IPC training database, then cleaned and analysed using R (version 4.5.2). Descriptive analysis generated frequencies, proportions, percentages, and temporal trends by facility category, ownership, and year. Regional and zonal distribution of outcomes was examined through spatial mapping. Linear regression was used to assess temporal trends in neonatal sepsis and surgical site infection (SSI) rates over time, with 95% confidence intervals computed by normal approximation. PEP uptake and completion, and healthcare waste management indicators were analysed descriptively.

2.4 Methodological Limitations

The use of archived routine data introduces important methodological limitations. Some facilities reported inconsistently, submitted incomplete data, or applied denominators that varied over time, affecting comparability. In some instances, these inconsistencies resulted in implausible values (e.g., proportions exceeding 100%), reflecting challenges in indicator definition, reporting practices, or data aggregation. In addition, certain indicators may reflect reporting effort rather than actual programme performance. While these limitations do not invalidate the findings, they necessitate cautious and transparent interpretation. The results should therefore be understood within the context of these data quality constraints, and conclusions drawn with appropriate consideration of their potential influence on observed trends and performance estimates.

3. RESULTS

3.1 Training on Monitoring and Evaluation of IPC Indicators

Surveillance is one of the key pillars of Tanzania's IPC Programme, providing critical insight into the occurrence of HCAI and the effectiveness of prevention efforts. From 2021 to October 2025, a total of 1,013 healthcare workers (HCWs) from 148 health facilities (HFs) were trained on IPC M&E including how to report IPC indicators through DHIS2. As of 2025, HCWs from 148 HFs were trained these included 43 referral hospitals in all regions and 105 primary health care facilities (PHCFs) across 13 regions. Furthermore, capacity building on HCAIs was done to 389 HCWs from 98 HFs (40 referral hospitals and 58 PHCFs).

3.2 Indicators Performance

3.2.1 Monthly Indicators

The National IPC Programme maintains a regular monthly surveillance framework through eight IPC indicators to ensure clinical safety and institutional accountability. At the surgical level, the Ministry monitors Surgical Site Infections (SSIs) occurring both within and outside healthcare facilities, with a special focus on post-Caesarean section complications to ensure safe maternal health.

Furthermore, the programme tracks environmental safety through the percentage of infectious waste generated, ensuring effective segregation protocols. To sustain these efforts, the report quantifies the dedicated time invested by Quality Improvement Teams (QIT) on systemic enhancements and the specific hours logged by IPC Focal Points (IPCFP) in executing frontline programme activities. Together, these indicators provide the precise data necessary for the MoH to evaluate the operational integrity of the national healthcare infrastructure.

3.2.1.1 Surgical site infections

This section presents an analysis of SSIs surveillance data in Tanzania, highlighting the overall burden, distribution, and trends over the past five years. It examines SSI patterns across different procedure types, including Cesarean and Non-Cesarean surgeries, and provides insight into the proportion and trends of specific SSI categories to inform targeted prevention and control strategies.

The overall summary of Surgical procedures and SSIs

Table 1 shows that the overall SSI rate increased from 3.1% in 2021 to 3.7% in 2022, then declined to 1.7% in 2024 before rising to 2.4% in 2025. Non-C/S procedures recorded higher SSI rates than C/S in the early years, peaking at 5.1% in 2022, before dropping sharply to 0.9% in 2024 and slightly increasing to 1.3% in 2025. In contrast, C/S SSI rates remained relatively stable, ranging between 1.5% and 2.1% throughout the period. Overall, SSI trends improved after 2022, though the 2025 increase indicates some reversal of progress.

Table 1: The overall summary of surgical procedures and SSI, from 2021 to 2025

Year	# of HFs	Overall Surgical Procedures			Non-Caesarean Section			Caesarean Section		
		Procedures	SSI Cases	SSI Rate (%)	Procedures	SSI Cases	SSI Rate (%)	Procedures	SSI Cases	SSI Rate (%)
2021	17	9,616	274	3.1%	5,714	190	3.3%	3,900	71.0	1.8%
2022	67	84,802	3,091	3.7%	27,993	1,440	5.1%	47,304	1,005.0	2.1%
2023	110	116,174	2,733	2.4%	37,915	752	2%	65,571	1,166.0	1.8%
2024	131	124,869	2,112	1.7%	45,996	420	0.9%	68,814	1,007.6	1.5%
2025	126	127,039	2,911	2.4%	42,883	558	1.3%	73,322	1,473.0	2%

The five-year trends of SSIs (2021 – 2025)

Figure 1 shows trends in surgical procedures and surgical site SSI rates from 2021 to 2025. While the number of surgical procedures increased substantially from 9,616 in 2021 to 127,039 in 2025, SSI rates initially rose from 3.1% in 2021 to 3.7% in 2022, then declined to 1.7% in 2024, indicating could be due to improvement in IPC. However, the rate increased again to 2.4% in 2025, suggesting a modest reversal in progress despite continued growth in surgical volume.

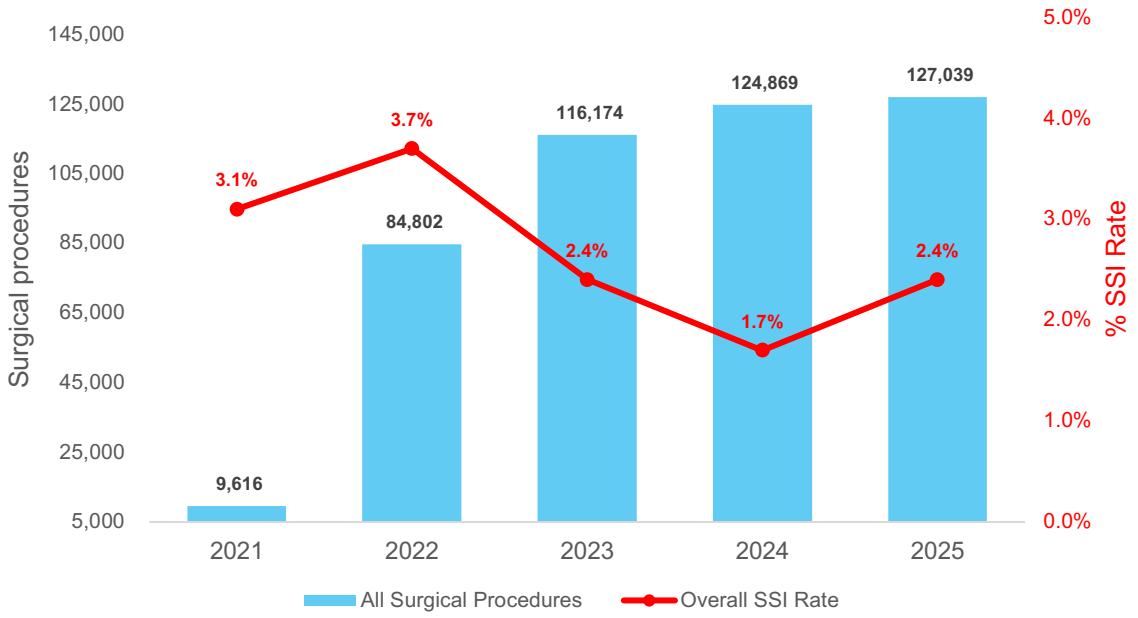


Figure 1: The five-year trends of Surgical Site Infections (2021 – 2025)

The distribution of surgical procedure types and associated SSIs

From 2021 to 2025, the proportion of Cesarean (C/S) procedures increased from 37.9% in 2021 to 60.3% in 2025, overtaking Non-C/S procedures, which declined from 62.1% to 39.7% over the same period. Correspondingly, the share of SSI cases attributed to C/S rose markedly from 27.3% in 2021 to 65.3% in 2025, indicating that over time, the burden of surgical site infections became increasingly concentrated among Cesarean procedures.

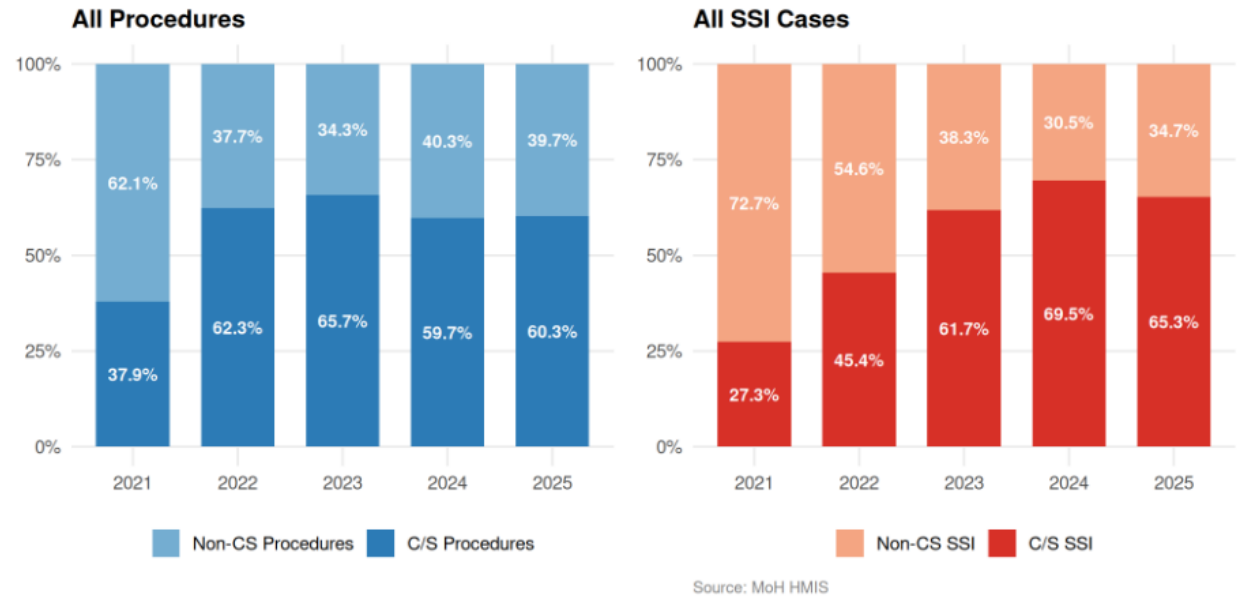


Figure 2: The distribution of surgical procedure types and associated SSIs, 2021–2025

Distribution of SSIs Within and Outside/Referral Facilities, 2021–2025

The distribution of SSI cases shifted markedly toward within-facility infections over time, increasing from 45.3% in 2021 to 82.3% in 2025, with a peak of 84.0% in 2024, as shown in figure 3. Conversely, outside/referral facility SSI cases declined from 54.7% to 17.7% over the same period. This trend suggests that a growing proportion of SSI cases are being identified and managed at the facility where surgery was performed, potentially reflecting improved postoperative follow-up, surveillance, and reporting systems within facilities.

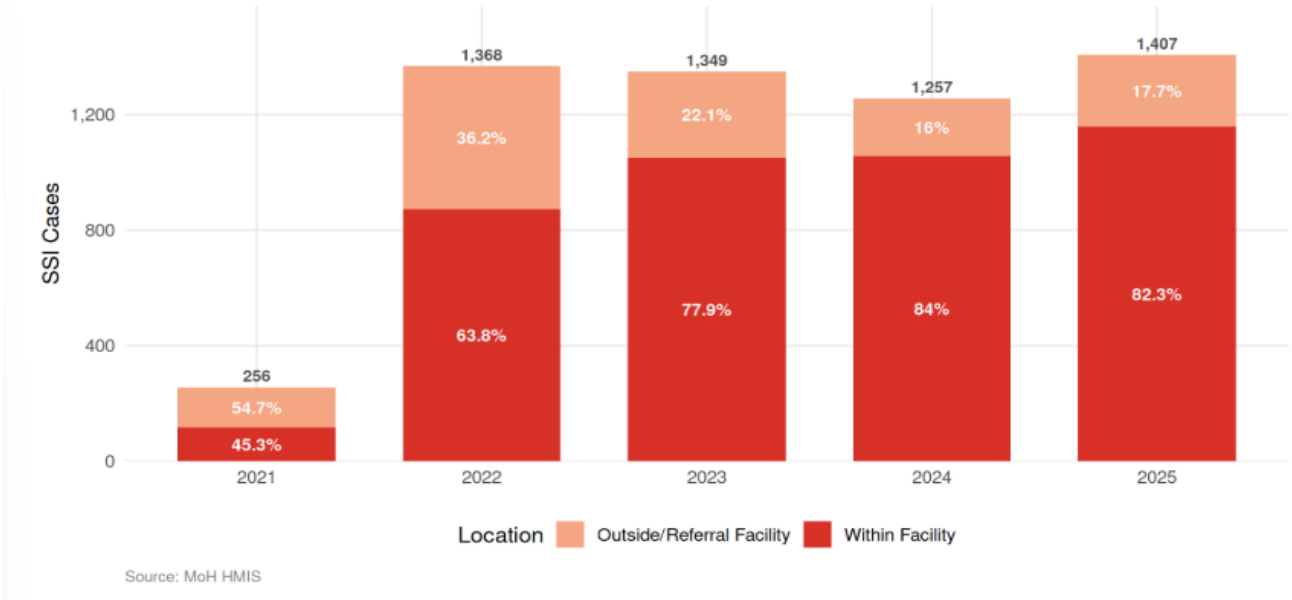


Figure 3: Distribution of SSIs Within and Outside/Referral Facilities, 2021–2025

Trends in SSIs among Cesarean vs. Non-Cesarean procedures, 2021–2025

There was a fluctuating SSI trend between C/S and Non-C/S procedures over the five years. Non-C/S procedures recorded notably higher SSI rates in 2021 (3.3%) and peaked at 5.1% in 2022, before declining sharply to 0.9% in 2024 and slightly increasing to 1.3% in 2025. In contrast, C/S SSI rates remained relatively stable, ranging from 1.5% to 2.1%, with a slight upward trend in 2025 (2.0%). Overall, Non-C/S procedures showed greater variability, while C/S procedures maintained comparatively stable SSI rates throughout the period (Figure 4).

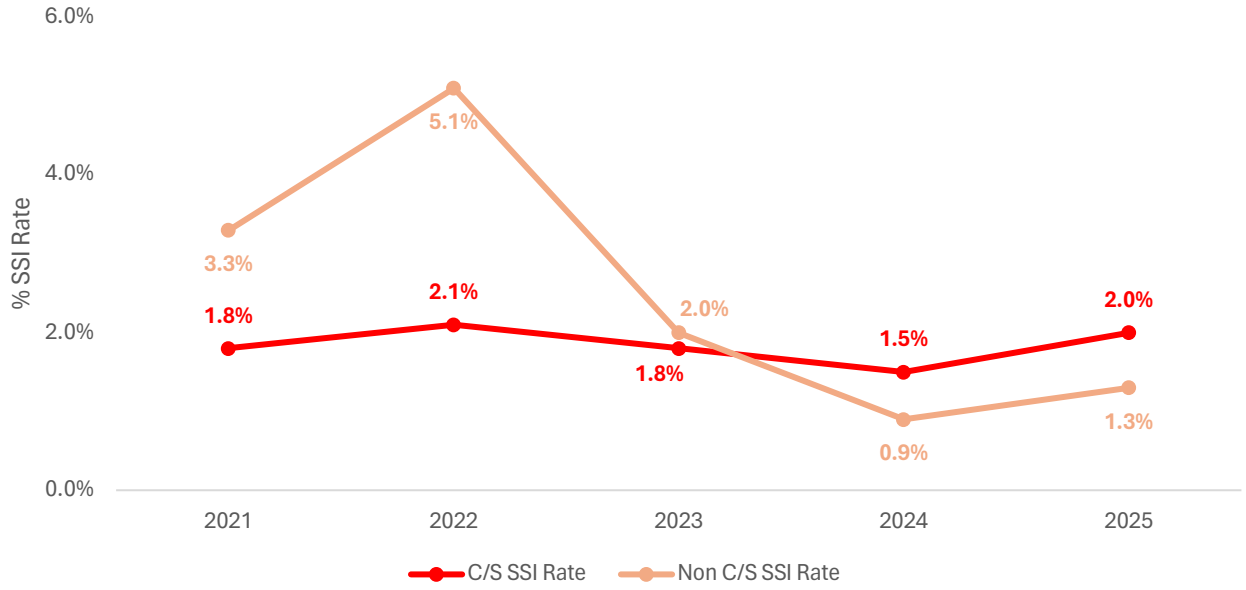


Figure 4: The five-year Trends of SSIs among Cesarean vs. Non-Cesarean procedures, 2021 - 2025

Proportion of surgical site infection cases by type (Caesarean section excluded)
Across 2021–2025, superficial SSIs increased in proportion from 29.8% in 2021 to 46.8% in 2025, peaking at 52.0% in 2023–2024 (Figure 5). In contrast, organ/space SSIs steadily declined from 25.0% to 7.3% over the same period. Deep SSIs remained relatively stable, fluctuating between 36.3% and 45.9%. Overall, the pattern suggests a shift from more severe toward less severe SSI types over time. C/S were not included in this analysis because SSI type variable was not included in C/S data collection tools.

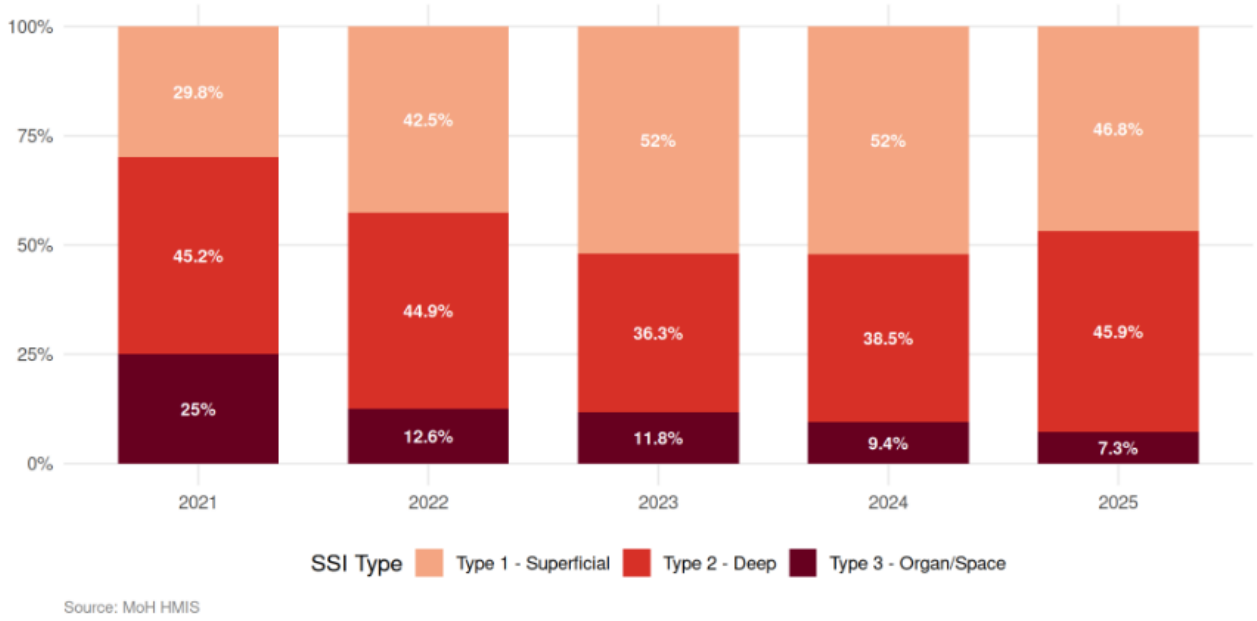


Figure 5: Proportion of surgical site infection cases by type (2021–2025)

Trends analysis of surgical site infection cases by type

Over the 2021–2025 period, Ordinary Least Squares (OLS) trend analysis showed no significant change in infection rates for Type 1 (superficial) and Type 2 (deep) surgical site infections. However, Type 3 (organ/space) infections demonstrated a statistically significant decrease, with rates declining from 0.6% to 0.1% (slope: -0.11 percentage points per year; 95% CI: -0.20 to -0.01; $p<0.05$) as shown in Table 2.

Table 2: The Trends analysis of surgical site infection cases by type (2021 – 2025)

	Rate (%) and 95% CI by Year		OLS Trend on Year							
	2021	2022	2023	2024	2025	Change 2021–2025 (Diff, 95% CI)	Slope (pp/yr)	95% CI	p-value	Interpretation
Type 1 (Superficial)	1.4 (1.1–1.7)	2.7 (2.5–3.0)	2.7 (2.5–3.0)	1.6 (1.4–1.7)	1.8 (1.6–2.0)	0.4 (0.1–0.8)	-0.03	-0.78 to 0.71	0.899	No significant trend
Type 2 (Deep)	2.1 (1.7–2.5)	2.9 (2.6–3.1)	1.9 (1.7–2.1)	1.2 (1.0–1.3)	1.8 (1.6–1.9)	-0.3 (-0.8–0.1)	-0.24	-0.81 to 0.33	0.276	No significant trend
Type 3 (Organ/ Space)	1.2 (0.9–1.5)	0.8 (0.7–0.9)	0.6 (0.5–0.7)	0.3 (0.2–0.4)	0.3 (0.2–0.4)	-0.9 (-1.2–-0.6)	-0.23	-0.34 to -0.12	0.006	**Significant decrease**

The proportion of Surgical Site Infections in Caesarean Section

The proportion of SSIs following Caesarean Section (C/S) showed a gradual upward trend, increasing from 2.2% in 2021–2022 to 2.8% in 2025. Although C/S procedures remained consistently high over the period, the SSI rate steadily rose and remained above the WHO benchmark of 2% throughout. This suggests a persistent burden of post-caesarean infections and highlights the need for strengthened perioperative infection prevention measures.

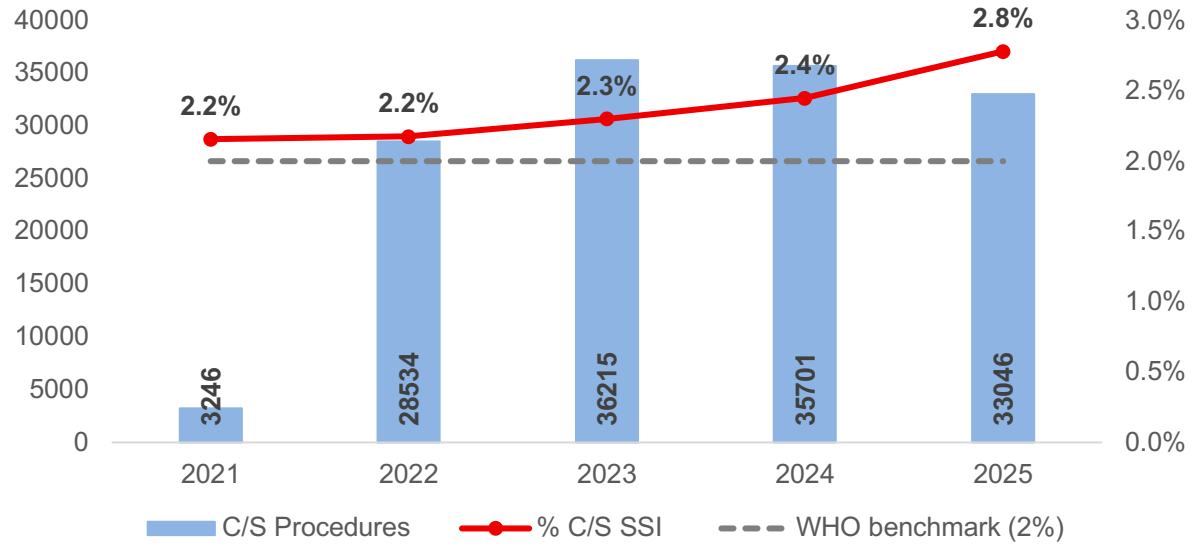


Figure 6: The proportion of SSIs in Caesarean Section (2021 – 2025)

Regional Performance on Surgical Site Infection

Regional SSI rates varied considerably across Tanzania, ranging from 1.3% to 5.5%. The top five highest-burden regions recorded SSI rates between 4.0% and 5.5% *(Songwe, Katavi, Simiyu, Manyara, and Kagera)*. In contrast, the five lowest-burden regions had SSI rates ranging from 1.3% to 1.5% *(Arusha, Ruvuma, Tanga, Singida, and Mara)*. Overall, high-volume regions such as Dar es Salaam, Mwanza, and Mbeya maintained relatively moderate SSI rates (2.4%–2.7%) despite large surgical caseloads (Figure 7).

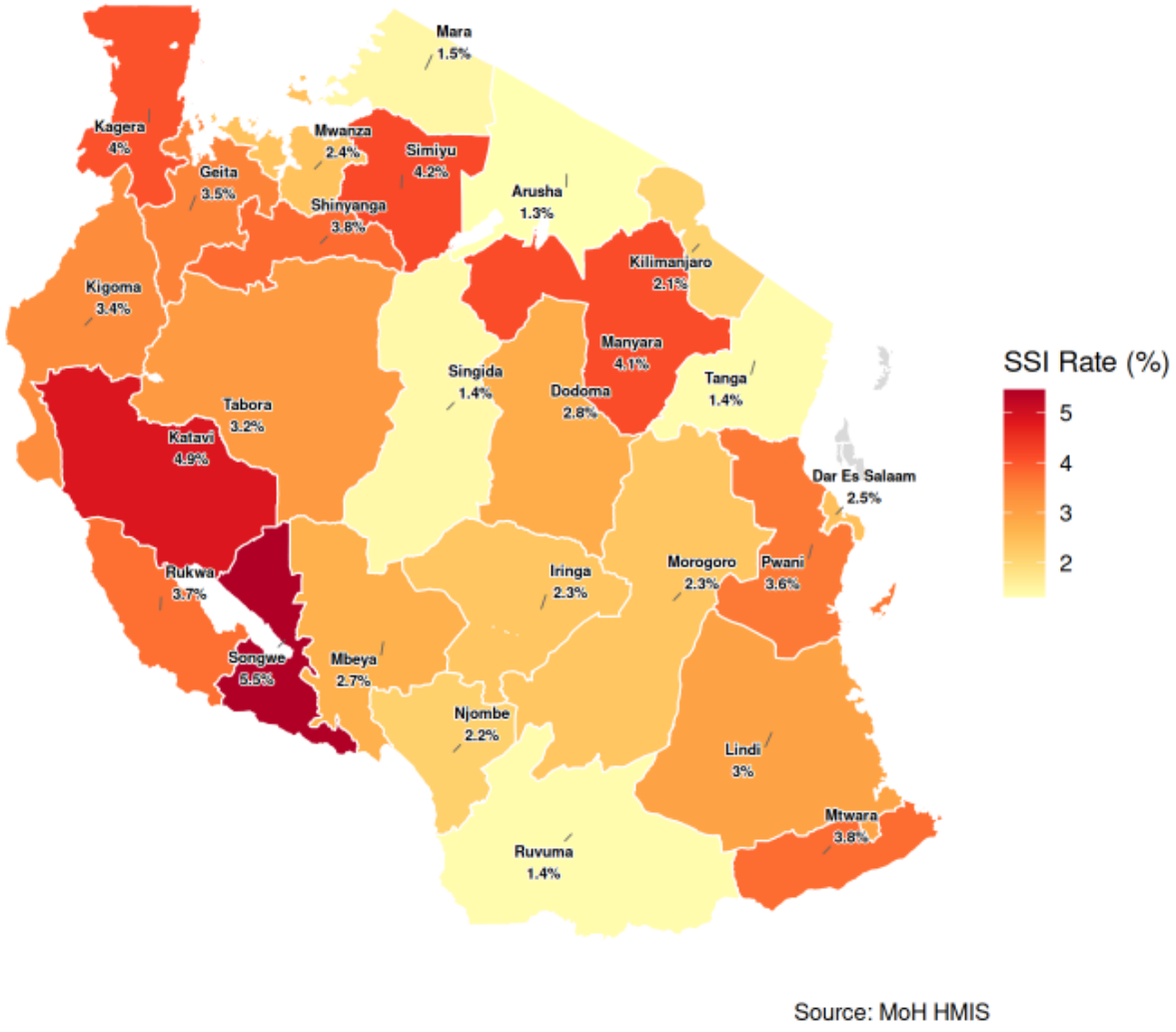


Figure 7: Regional Surgical Site Infection rate (pooled 2021-2025)

Temporal Trends in SSI Rates by Procedure Type

Monthly SSI rates showed temporal fluctuations over the review period, with occasional spikes observed in specific months for both Caesarean Section (C/S) and non-C/S procedures. However, these increases were irregular and did not recur consistently during the same periods across successive years, suggesting the absence of a clear seasonal pattern. Overall, the observed variations are more likely attributable to localized changes in reporting, surveillance intensity, case mix, or facility-level practices rather than true seasonality in SSI occurrence (Figure 8).

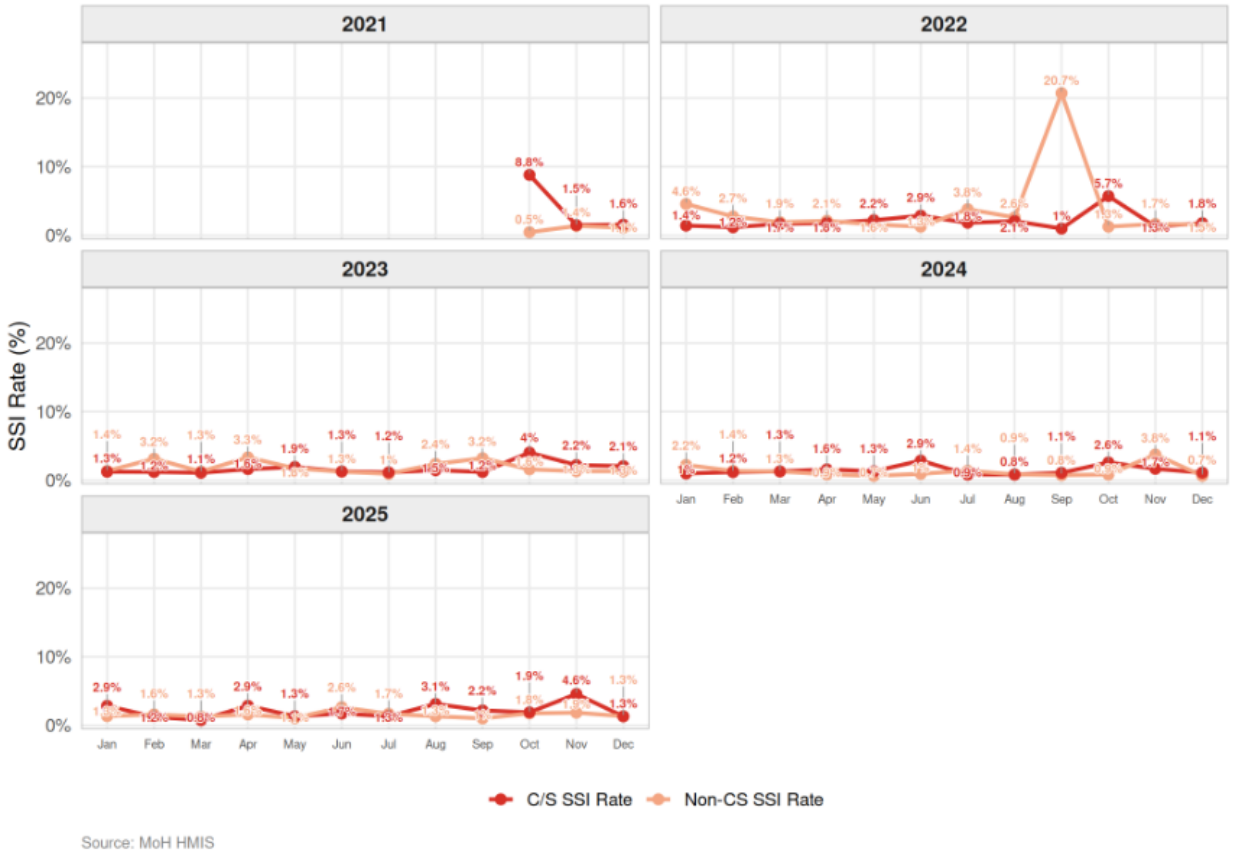


Figure 8: Temporal Trends in SSI Rates by Procedure Type

Proportion of surgical procedures vs SSI cases by age group across five years

Figure 9 shows the distribution of surgical procedures and surgical site infections (SSIs) by age group from 2021 to 2025. SSI cases were consistently concentrated among adults aged 25–49 years, increasing from 45.6% in 2021 to 57.3% in 2025, making this the most affected age group throughout the period. The 15–24 age group remained relatively stable, contributing 26.6%–37.4% of SSI cases, while children aged 0–14 years consistently accounted for the smallest proportion (1.6%–9.6%). In contrast, the 50+ age group showed a marked decline, from 26.2% in 2021 to 7.5% in 2024–2025, indicating a reduced share of SSI burden over time.

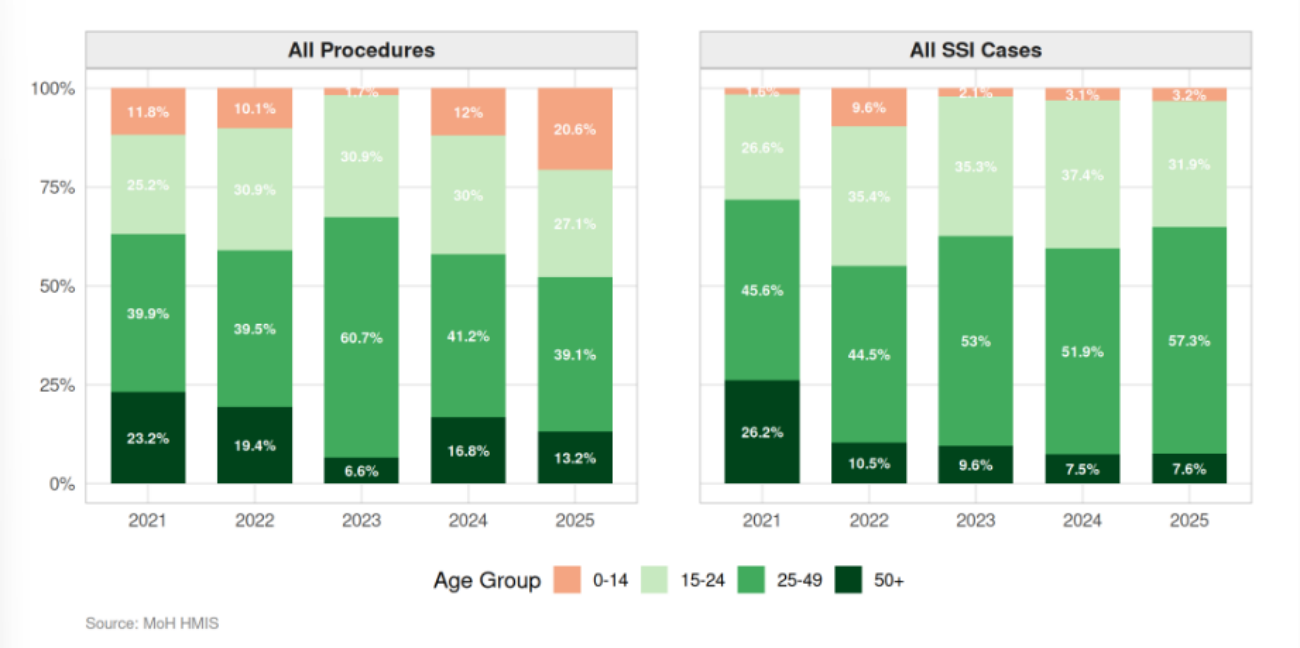


Figure 9: Proportion of surgical procedures vs SSI cases by age group (2021 – 2025)

3.2.1.2 Neonatal Sepsis

Figure 10 presents live births and neonatal sepsis rates per 1,000 live births in Tanzania from 2021 to 2025. Over the period, the number of live births increased steadily, from 1,848,439 in 2021 to 2,446,300 in 2025. In contrast, the neonatal sepsis rate showed an overall decline, decreasing from 12.2 per 1,000 live births in 2021 to 10.9 in 2025, despite a slight increase to 12.0 in 2023. This trend suggests that although the population of newborns increased over time, the relative burden of neonatal sepsis has gradually reduced, potentially reflecting improvements in maternal and newborn care, infection prevention, and early case management.

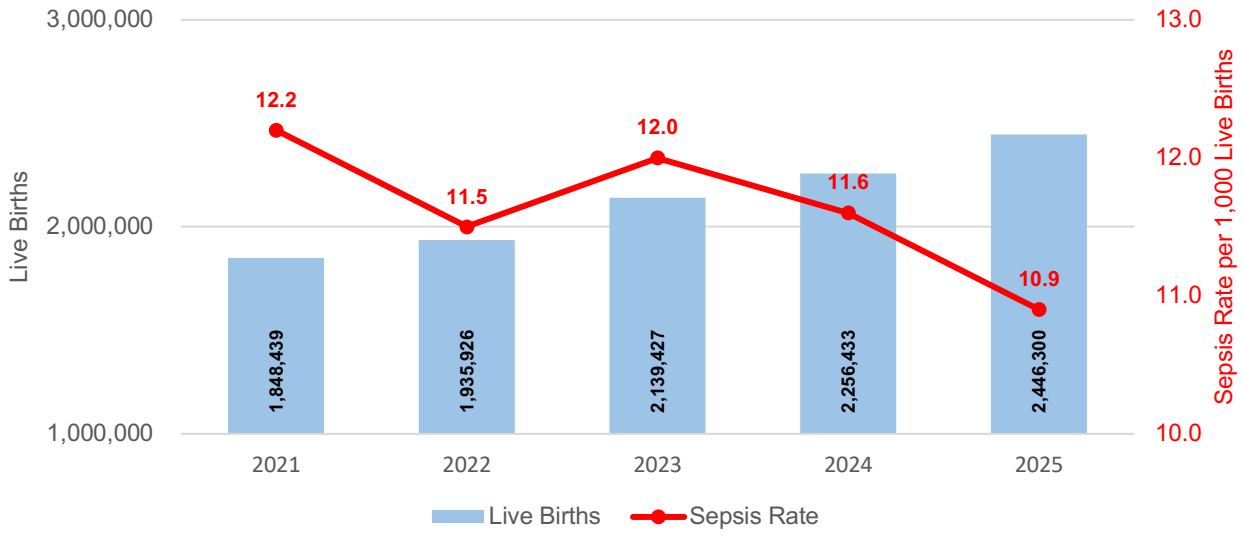


Figure 10: The Overall Neonatal Sepsis Rate, 2021 - 2025

Neonatal Sepsis Rate by Facility Levels and Ownership

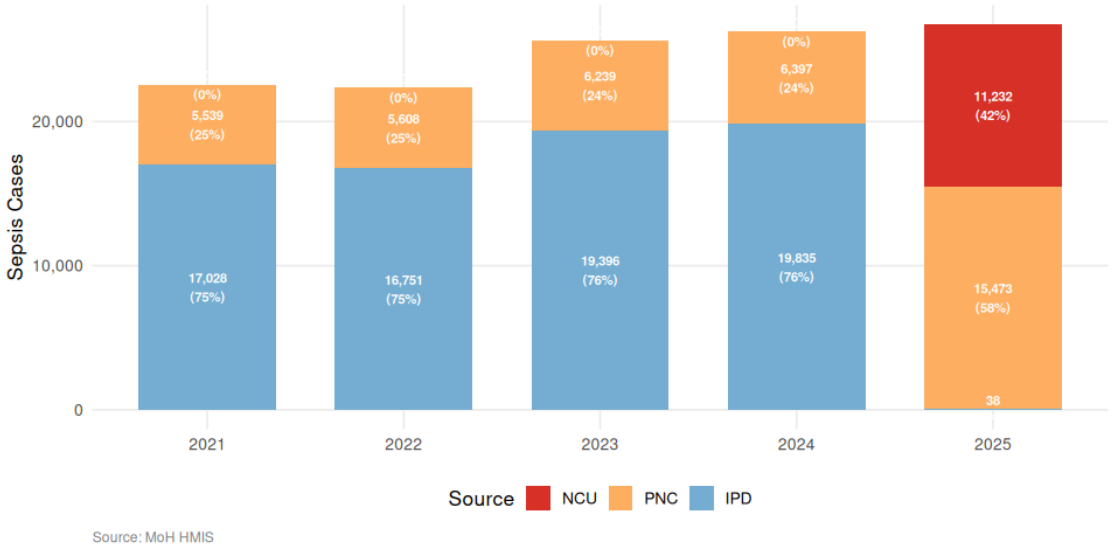
Between 2021 and 2025, the overall neonatal sepsis rate in Tanzania declined significantly by 1.3 points (95% CI: -1.5 to -1.1). However, this overall improvement masks important differences: secondary facilities achieved a dramatic reduction of 22.2 points, while tertiary facilities saw a significant increase of 2.0 points and primary facilities a small but significant increase of 0.6 points. Private facilities improved substantially (down 4.0 points), while public facilities showed only a tiny decline (down 0.4 points). Male and female rates both declined modestly but significantly, as shown in Table 3. Thus, the overall positive trend is driven almost entirely by improvements in secondary-level facilities, not by universal progress across all facility types.

Table 3: Neonatal Sepsis Rate (per 1,000 Live Births) with 95% Confidence Interval

Rate (per 1,000) and 95% CI by Year						
	2021	2022	2023	2024	2025	Change 2021-2025(Diff, 95% CI)
Overall						
Overall	12.2 (12.1–12.4)	11.5 (11.4–11.7)	12.0 (11.8–12.1)	11.6 (11.5–11.8)	10.9 (10.8–11.1)	-1.3 (-1.5–-1.1)
Level of Health Facility						
Tertiary	7.9 (6.9–8.8)	14.0 (12.7–15.2)	7.7 (6.8–8.7)	22.3 (20.6–24.0)	9.8 (8.7–11.0)	2.0 (0.5–3.5)
Secondary	64.1 (62.8–65.4)	65.7 (64.4–67.1)	76.8 (75.3–78.2)	78.1 (76.6–79.7)	41.9 (40.7–43.1)	-22.2 (-24.0–-20.4)
Primary	11.7 (11.5–11.9)	10.8 (10.6–11.0)	11.8 (11.6–12.0)	12.4 (12.2–12.6)	12.4 (12.2–12.5)	0.6 (0.3–0.9)
Facility Ownership						
Public	10.9 (10.8–11.1)	10.0 (9.9–10.2)	10.9 (10.8–11.1)	10.3 (10.1–10.4)	10.5 (10.4–10.7)	-0.4 (-0.6–-0.2)
Private	18.4 (17.9–18.9)	19.5 (19.0–20.0)	18.3 (17.8–18.8)	21.2 (20.7–21.8)	14.3 (13.9–14.8)	-4.0 (-4.7–-3.4)
Sex						
Female	5.8 (5.7–5.9)	5.5 (5.4–5.6)	5.7 (5.6–5.8)	5.5 (5.4–5.6)	5.3 (5.2–5.4)	-0.5 (-0.7–-0.4)
Male	6.4 (6.3–6.5)	6.0 (5.9–6.1)	6.3 (6.2–6.4)	6.1 (6.0–6.2)	5.7 (5.6–5.7)	-0.7 (-0.9–-0.6)

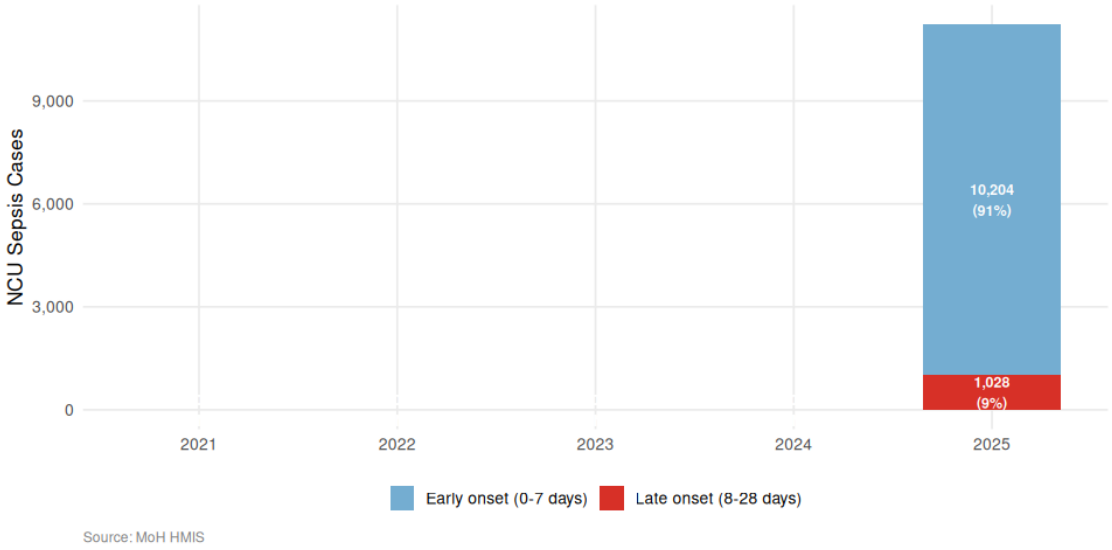
Sepsis by Source: There was slightly increases of neonatal sepsis rate at IPD 75% in the year 2021 to 76% in the year 2021 to 2024. In terms of PNC there was a decrease in neonatal sepsis from 25% in the year 2021 to 58% in the year 2025. However, there was an introduction of NCU (IPD and OPD) HIMS tools, which was introduced in the year 2025 which introduced NCU data sources and showed the sharply increase of NCU neonatal sepsis rate of 42% in the year 2025.

From 2021 to 2024, the neonatal sepsis rate at IPD increased slightly from 75% to 76%. In contrast, the PNC neonatal sepsis rate decreased from 25% in 2021 to 24% in 2024. Additionally, the NCU HIMS tools (covering IPD and OPD) were introduced in 2025, bringing in new NCU data sources that revealed a sharp increase in NCU neonatal sepsis, reaching 42% in 2025.



Sepsis by onset (NCU only)

Early-onset = Days 0–7; Late-onset = Days 8–28. NCU cases only. Note: data collection started in 2025 under this category



By 2025; 91% of neonatal sepsis in NCU were occurring within 7 days.

Neonatal sepsis by region

Regional neonatal sepsis rates varied widely, with an average rate of 12.4 per 1,000 live births across regions. The five highest-burden regions recorded rates ranging from 18.7 to 21.3 per 1,000, led by Lindi (21.3), Manyara (20.5), Iringa (19.9), Mtwara (19.5), and Morogoro (18.7). In contrast, the five lowest-burden regions had rates between 4.5 and 8.0 per 1,000, namely Rukwa (4.5), Geita (4.9), Mara (6.0), Simiyu (7.2), and Katavi (8.0). This substantial regional variation suggests differences in newborn care quality, IPC practices, and case detection/reporting across regions (Figure 11).

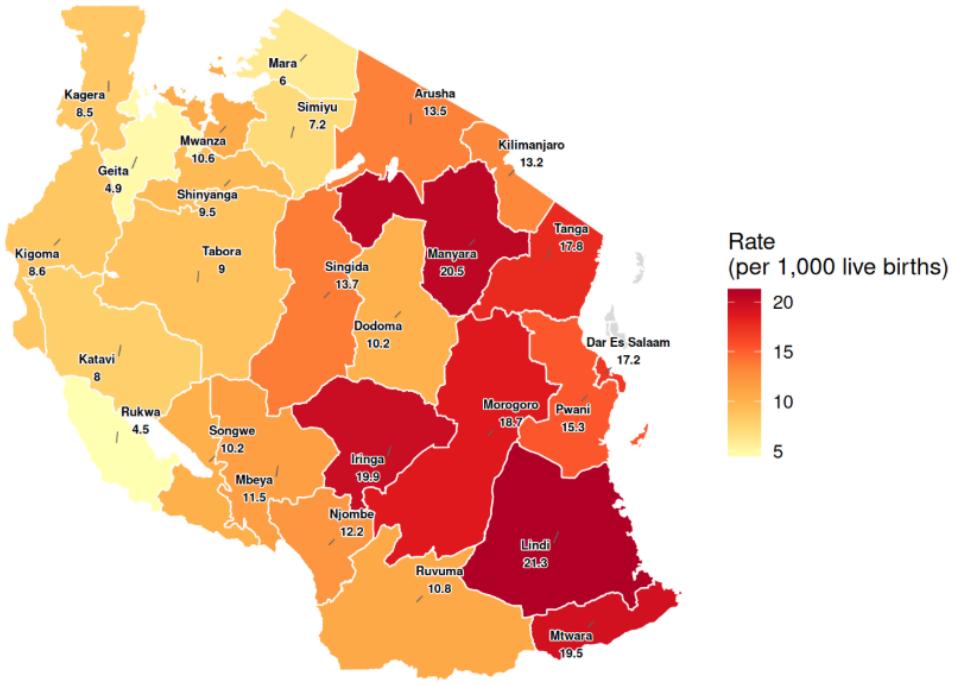


Figure 11: Neonatal Sepsis rate per 1,000 live births by region (pooled 2021 2025)

3.2.1.3 Time used by Quality Improvement Team to oversee IPC

Annual Average Time in Hours by QIT, 2021 – 2025

Between 2021 and 2025, the average annual hours used to oversee IPC increased steadily from 48.3 to 49.1 hours. As a percentage of the expected 60 hours, this rose from 80.5% to 81.8%, indicating a modest but consistent improvement in meeting the target. However, the percentage dipped to 74.9% in 2022, then recovered to 81.8% by 2025. This initial drop likely reflects the inclusion of many facilities that had newly started QIT implementation and had not yet reached full operating capacity (Figure 12).

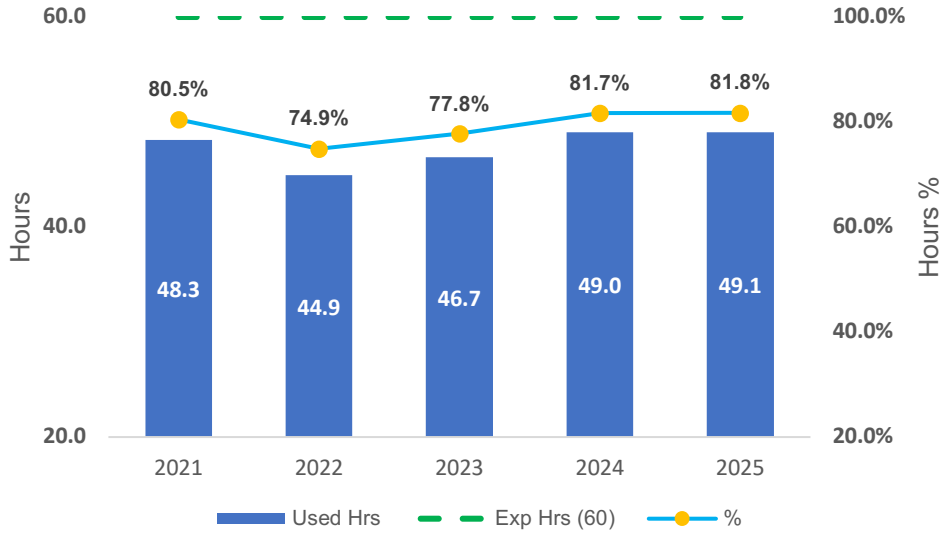


Figure 12: Annual Average hours used by QIT to oversee IPC, 2021 - 2025

Annual pooled average QIT hours used to oversee IPV per facility category
Between 2021 and 2025 (pooled average), secondary facilities recorded the highest average annual hours at 65.4 (109% of the expected 60 hours), followed by tertiary facilities at 55.2 hours (92%), and primary facilities at 38.1 hours (63.5%). Only secondary facilities exceeded the 60-hour target. This highest performance in secondary facilities can be attributed to the presence of staff dedicated to QIT issues, unlike primary facilities, where staff shortages are common.

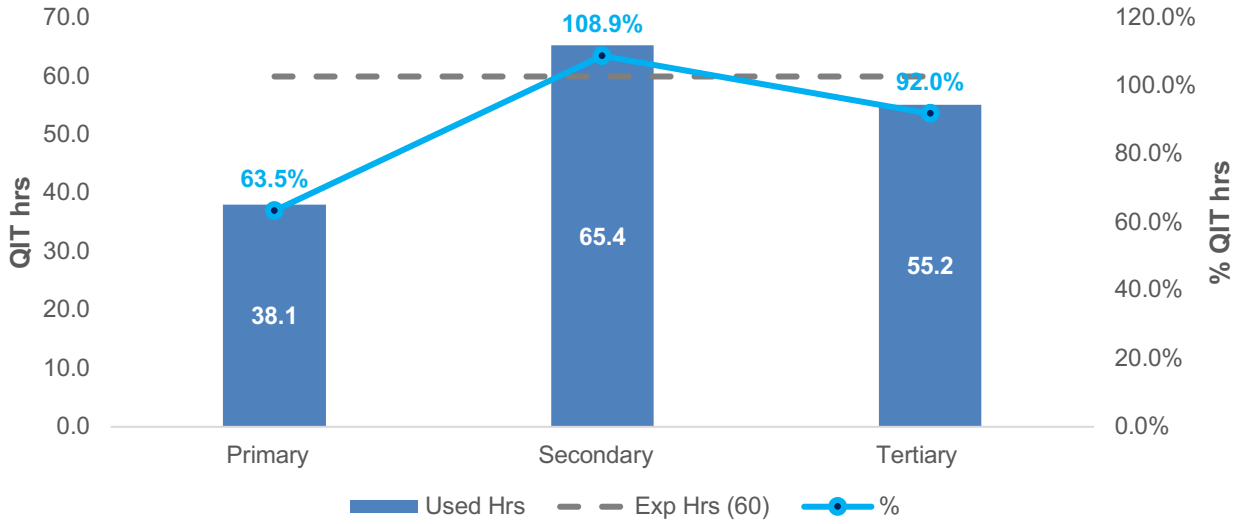


Figure 13: Five-year average hours (QIT) use to implement IPC per facility category

Overall five-year average QIT hours to oversee IPC per facility, Level 2021 – 2025
Figure 14, when analyzed by facility level, the same pattern was observed as facility category, with higher-level facilities recording greater QIT hours than lower-level facilities. Specialized Hospitals (112.1%) and Regional Referral Hospitals (108.9%) exceeded the expected target, while Zonal Hospitals (74.7%) remained below target, likely reflecting differences in facility workload and dedicated focus on QIT activities.

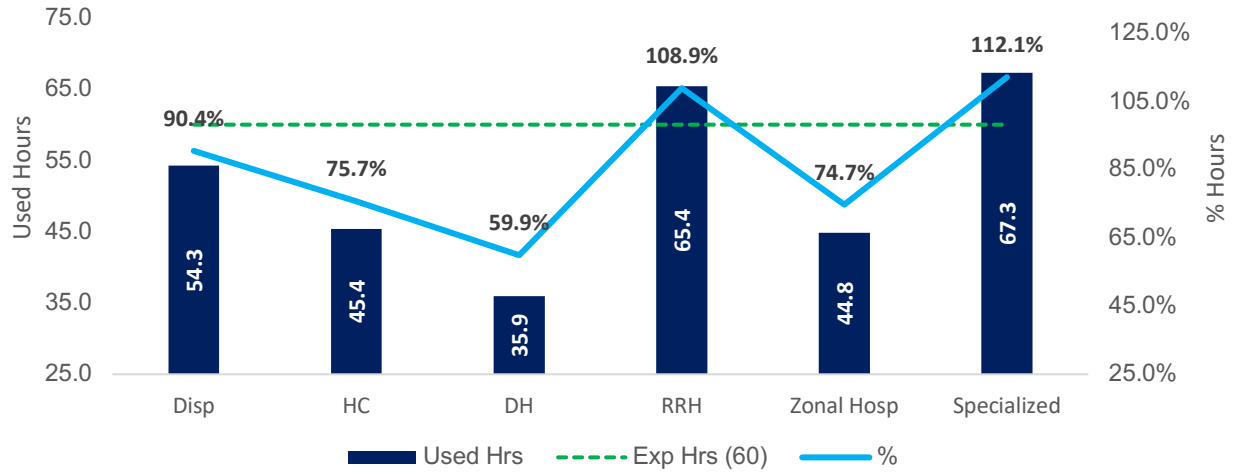


Figure 14: Overall average QIT hours by facility level

Annual average QIT hours to oversee IPC by ownership category
Public facilities consistently showed higher QIT hours than private facilities from 2021 to 2025, achieving 78.4%–85.5% of the expected target compared with 38.9%–59.1% in private facilities, Figure 15. This higher performance may reflect the generally greater availability of staff in public facilities compared to private facilities.

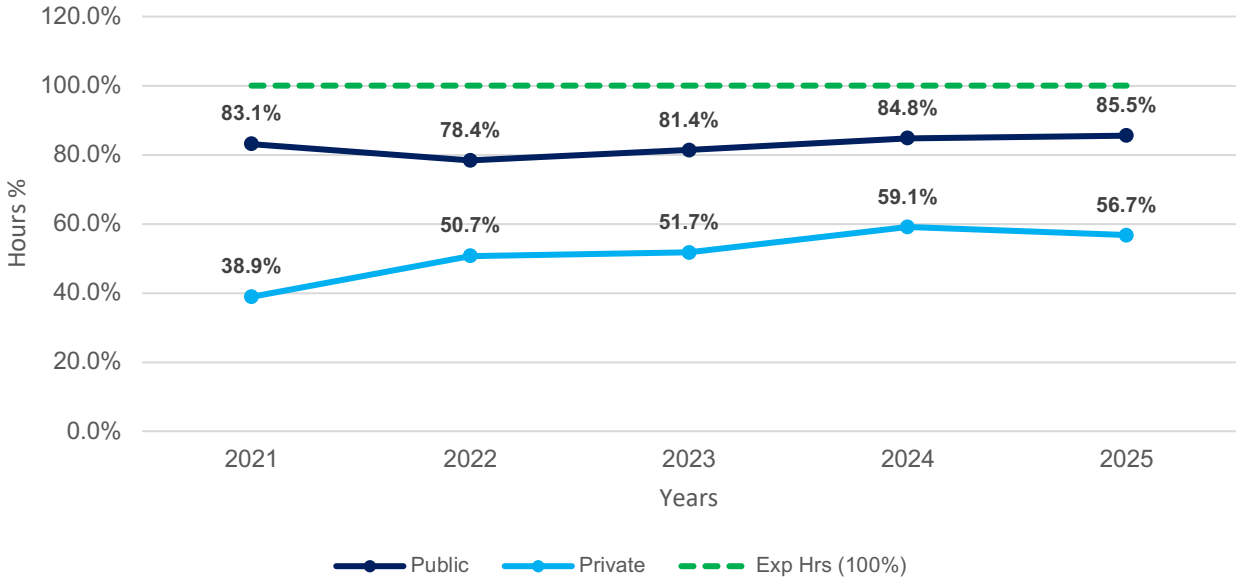


Figure 15: Annual average QIT hours to oversee IPC by facility ownership, 2021 - 2025

3.2.1.4 Time spent by IPC Focal Person to implement IPC

Overall hours spent by the IPC focal person to implement IPC by year
The hours spent by IPC focal persons in implementing IPC increased substantially after 2021, rising from 23 hours (38.3% of the expected 60 hours) in 2021 to a peak of 49 hours (82.0%) in 2023. Although average hours declined slightly thereafter, they remained relatively high at 47 hours (77.7%) in 2024 and 44 hours (73.3%) in 2025 (figure 16). Across all years, the expected benchmark of 60 hours was not fully met, but performance improved markedly compared with the 2021 baseline.

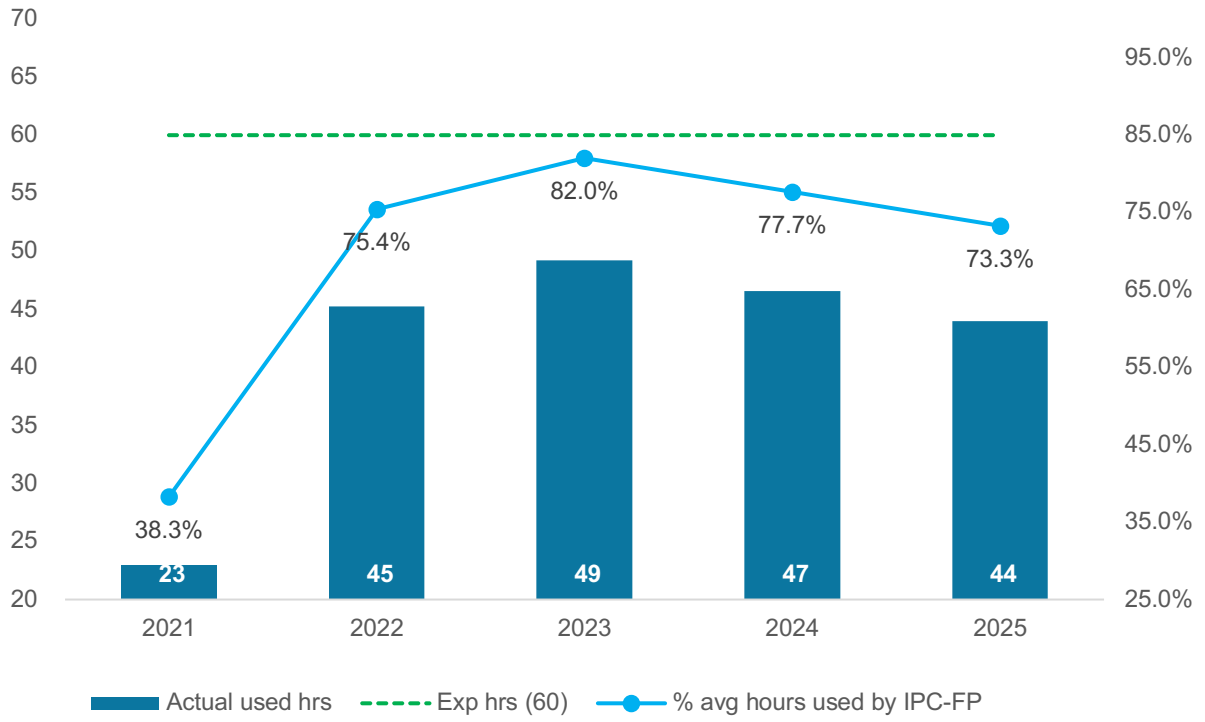


Figure 16: Overall Hours spent by the IPC focal person to implement IPC by year

Overall hours spent by the IPC focal person to implement IPC by Facility categories
Tertiary facilities recorded the highest average hours, increasing from about 22% in 2021 to exceed the expected benchmark (100%) in 2023–2024, peaking at around 121% in 2024, before slightly declining to just below target in 2025. Secondary facilities consistently performed at moderate levels, improving from 42% in 2021 to about 84% in 2022, then gradually declining to around 73% by 2025, remaining below the expected benchmark throughout. In contrast, primary facilities recorded the lowest time commitment, rising from near zero in 2021 to about 60% in 2023, with slight fluctuations thereafter, indicating persistent under-allocation of IPC focal person time at lower-level facilities (Figure 17).

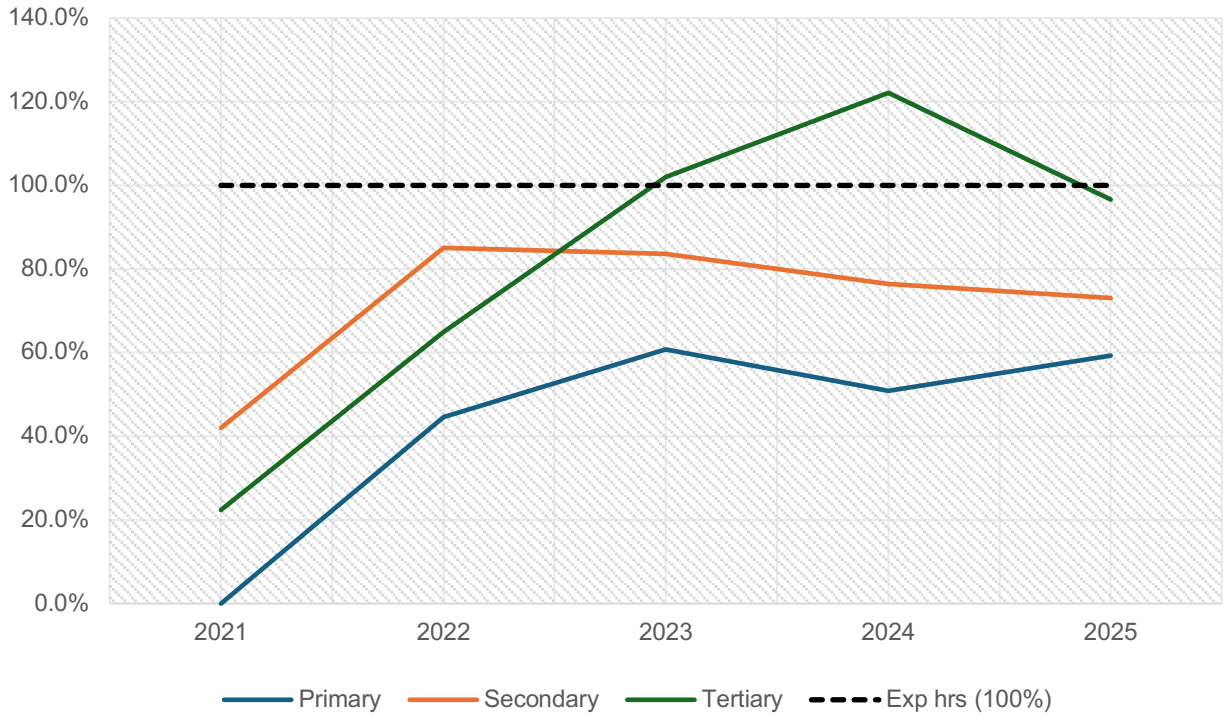


Figure 17: Hours spent by the IPC focal person to implement IPC by Facility categories

Overall hours spent by the IPC focal person to implement IPC by facility level
National hospitals consistently recorded the highest average hours, exceeding the expected benchmark in 2023–2025 (127.9%–153.9%), followed by Regional Referral Hospitals (RRHs), which also surpassed the benchmark from 2023 onward (106.0%–142.8%). Zonal hospitals showed steady improvement, reaching 87.0% in 2024, but remained slightly below the target overall. In contrast, lower-level facilities (Dispensaries, Health Centres, and District Hospitals) showed more inconsistent performance, with Dispensaries fluctuating markedly (0.0%–151.1%), while HCs and DHs generally remained below the expected 100% benchmark, indicating lower and less stable IPC focal person time allocation at primary care levels (Figure 18).

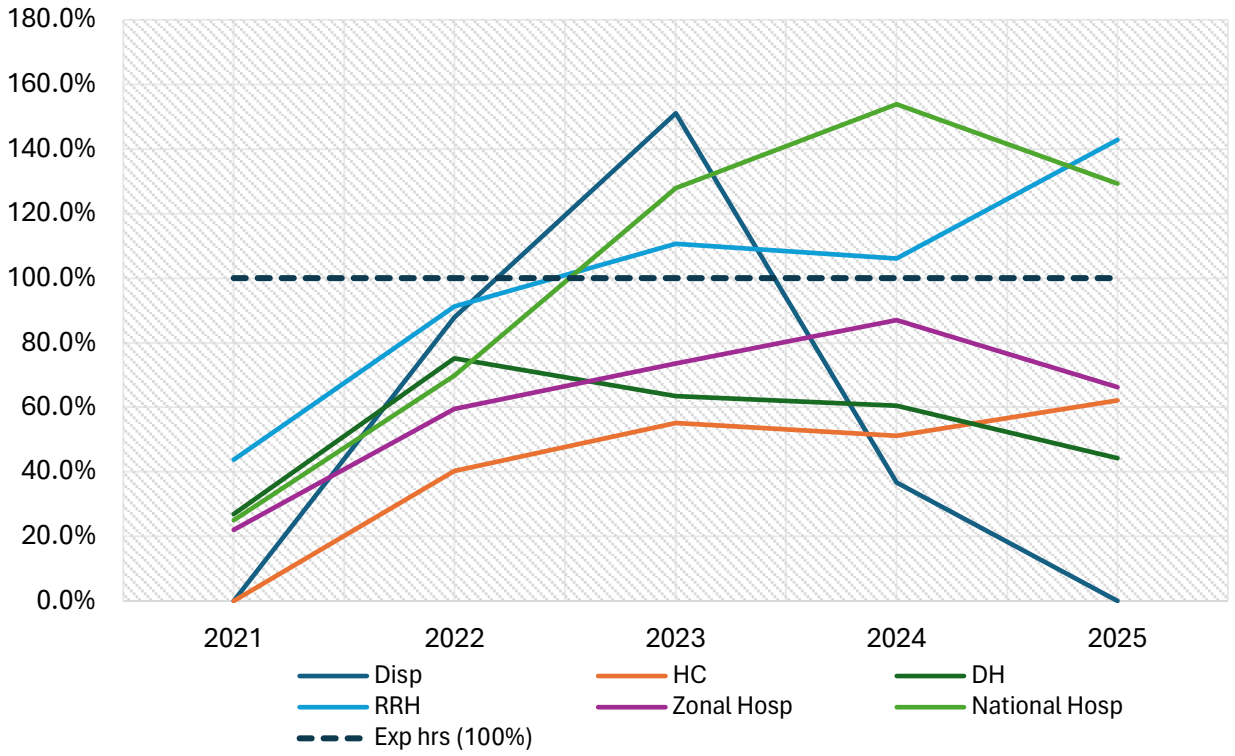


Figure 18: Hours spent by the IPC focal person by facility level

Overall hours spent by the IPC focal person by facility ownership

IPC focal person time commitment to implement IPC was consistently higher in public facilities than private facilities throughout 2021–2025, with public facilities reaching 89.5% in 2023 and maintaining relatively strong performance thereafter (Figure 19). In contrast, private facilities remained substantially below the expected benchmark, ranging from 34.9% to 66.7%. This lower time allocation in private facilities may partly reflect higher staff turnover and smaller staffing levels compared with public facilities, which can limit dedicated time for IPC coordination and implementation.

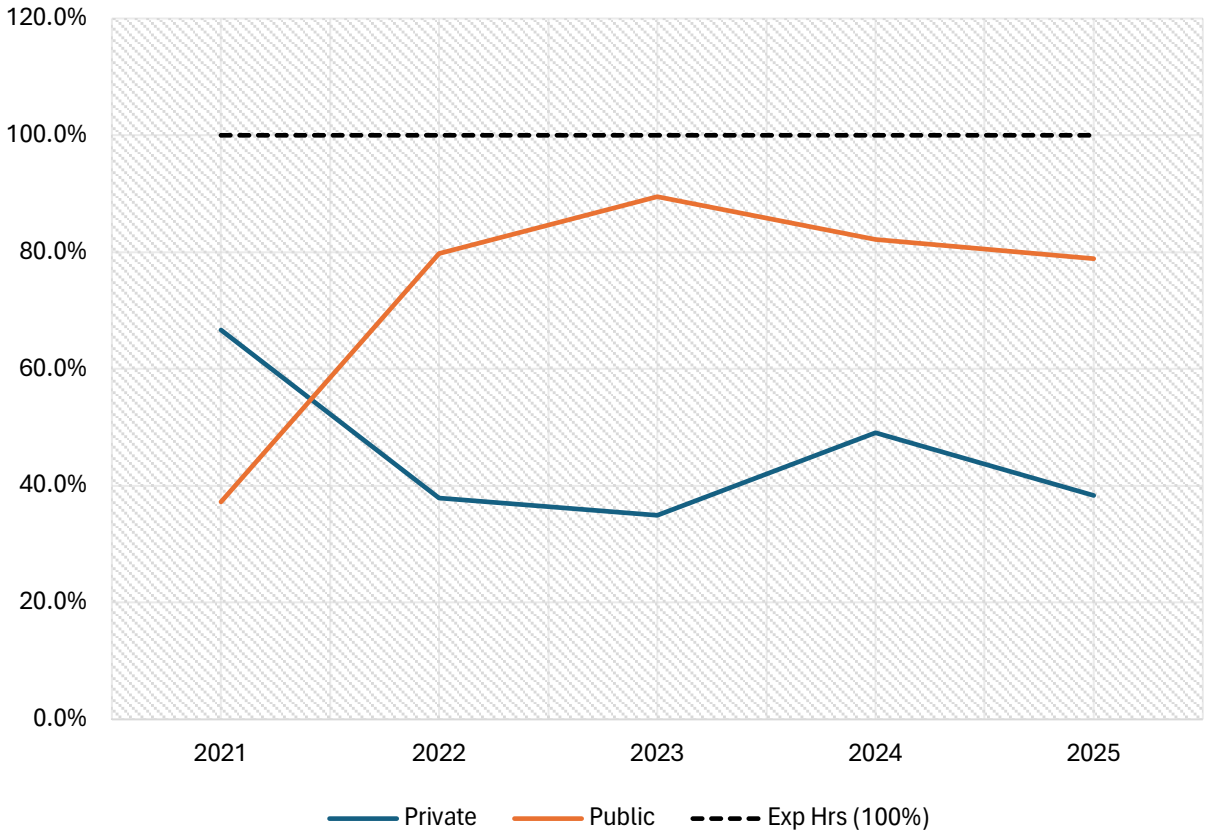


Figure 19: Hours spent by the IPC focal person by facility ownership

3.2.1.5 Percentage of Infectious Wastes

From 2021–2025, the proportion of infectious waste remained consistently above the WHO benchmark (20%), though it declined from 42.2% to 35.5% over time. Meanwhile, total healthcare waste increased markedly, peaking in 2023 before slightly declining (Figure 20). Overall, the trend suggests some improvement in waste segregation, but infectious waste levels remain higher than recommended, indicating persistent segregation gaps.

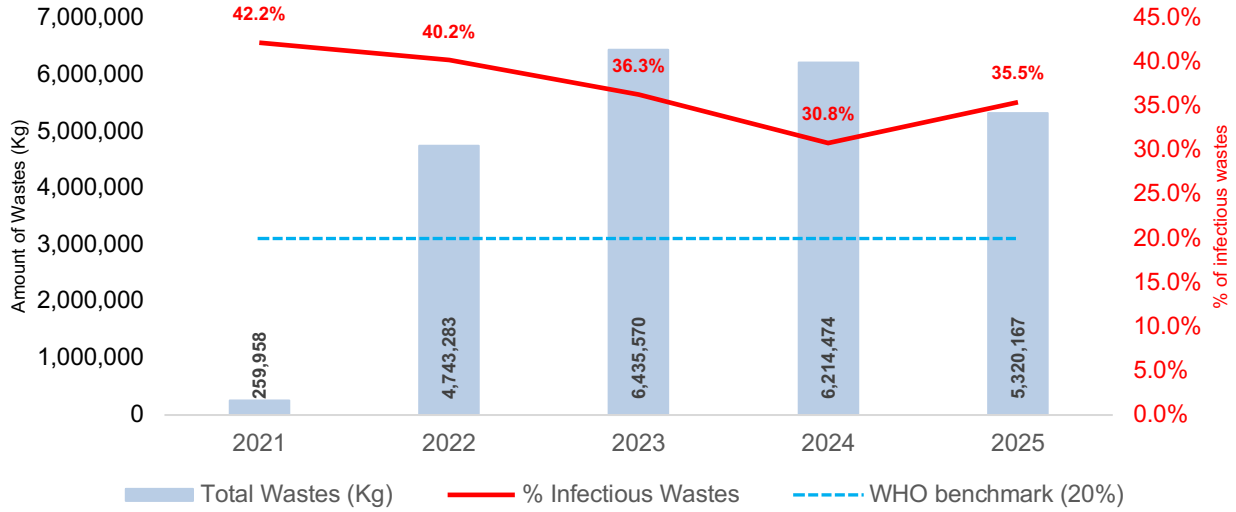


Figure 20: Percentage of infectious waste (2021 – 2025)

The monthly waste production and segregation

Total waste generation showed some monthly fluctuation, peaking in May 2024 (1.7 million kg), but generally remained high throughout 2023–2025 (Figure 21). Over the same period, the proportion of hazardous waste consistently remained above the recommended standard (≤20%), mostly ranging between 30% and 50%, although there was a notable dip below the benchmark in May 2024 (14.3%) as shown in figure 22. Overall, while waste reporting has strengthened over time, the persistently high hazardous waste proportion indicates continued challenges in effective waste segregation.

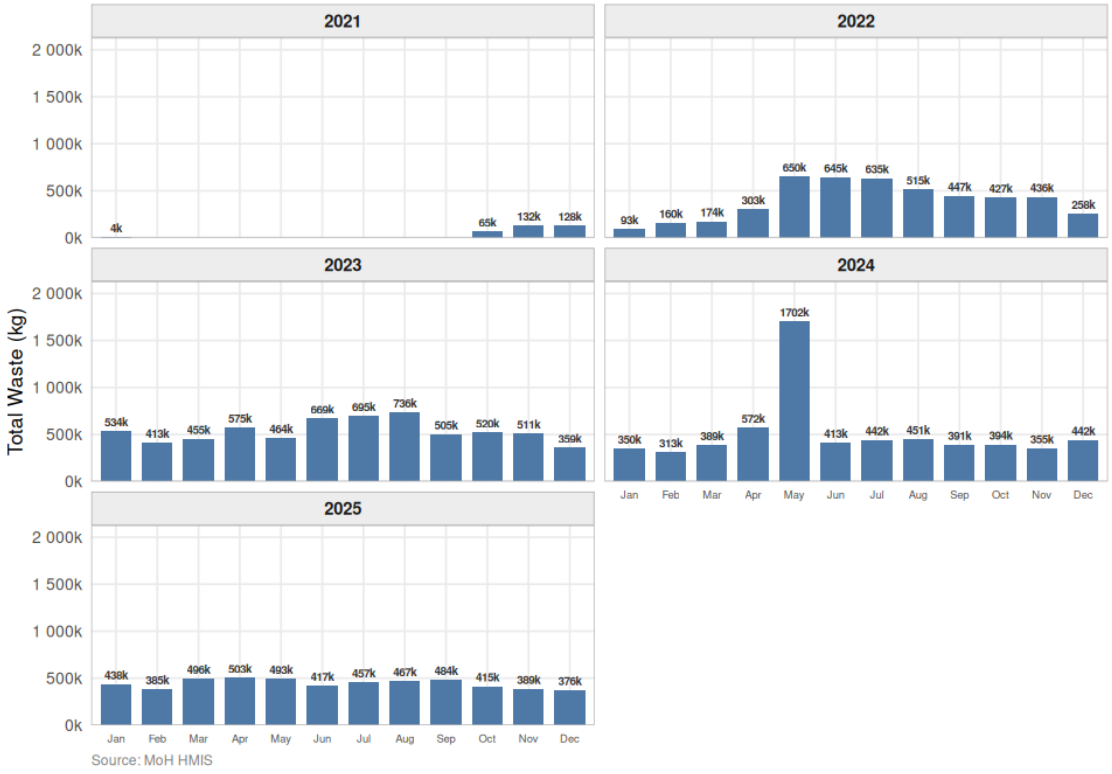


Figure 21: Monthly total waste collected in the healthcare facilities, 2021 – 2025

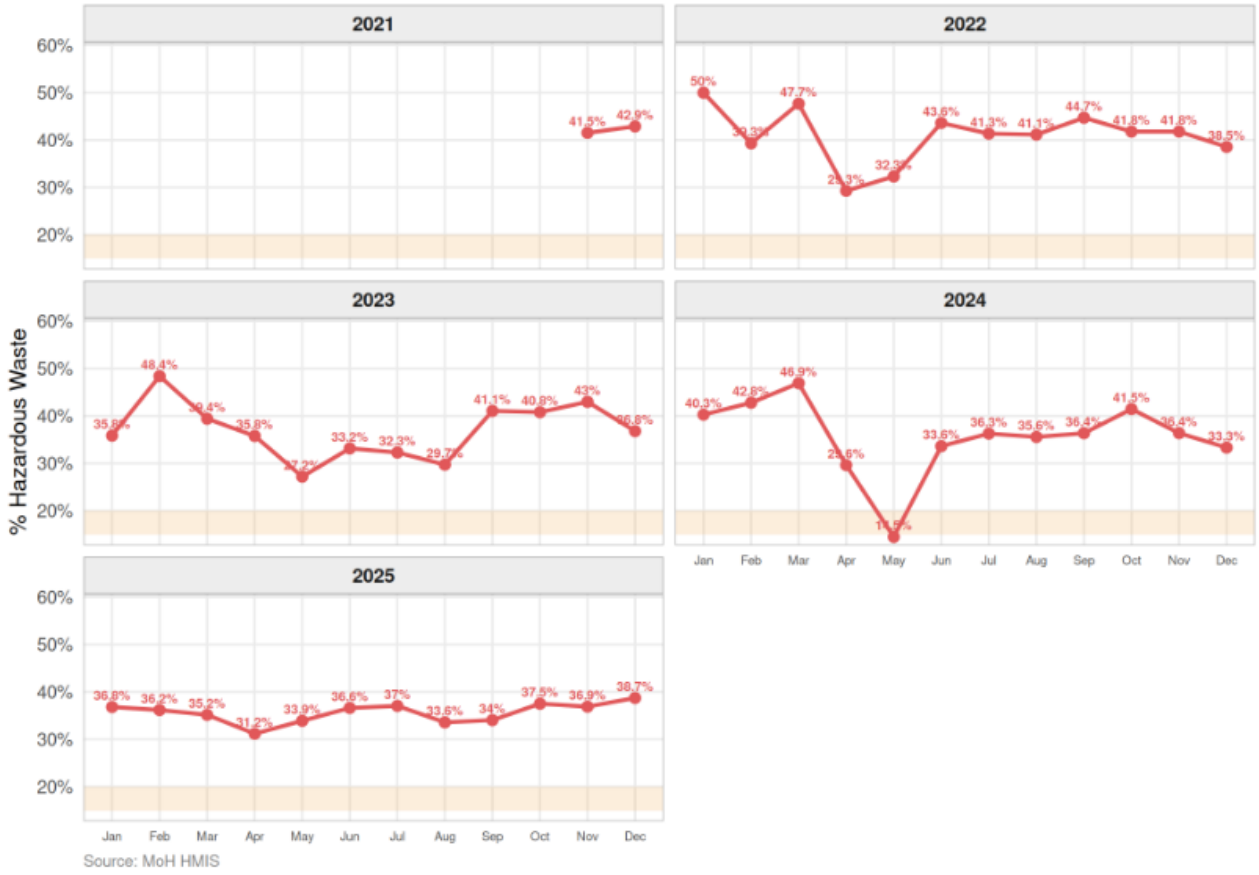


Figure 22: Monthly hazardous waste collected in the healthcare facilities, 2021 – 2025

Top 20 facilities with higher total waste production

The top 20 waste-generating facilities showed considerable variation in both total waste volume and the proportion classified as hazardous. Notably, some facilities generated very large amounts of waste while maintaining relatively low hazardous waste proportions, suggesting better waste segregation practices. In contrast, other facilities produced lower total waste volumes but had a high percentage of hazardous waste, indicating possible over-classification of waste or weaker segregation efficiency (Figure 23).

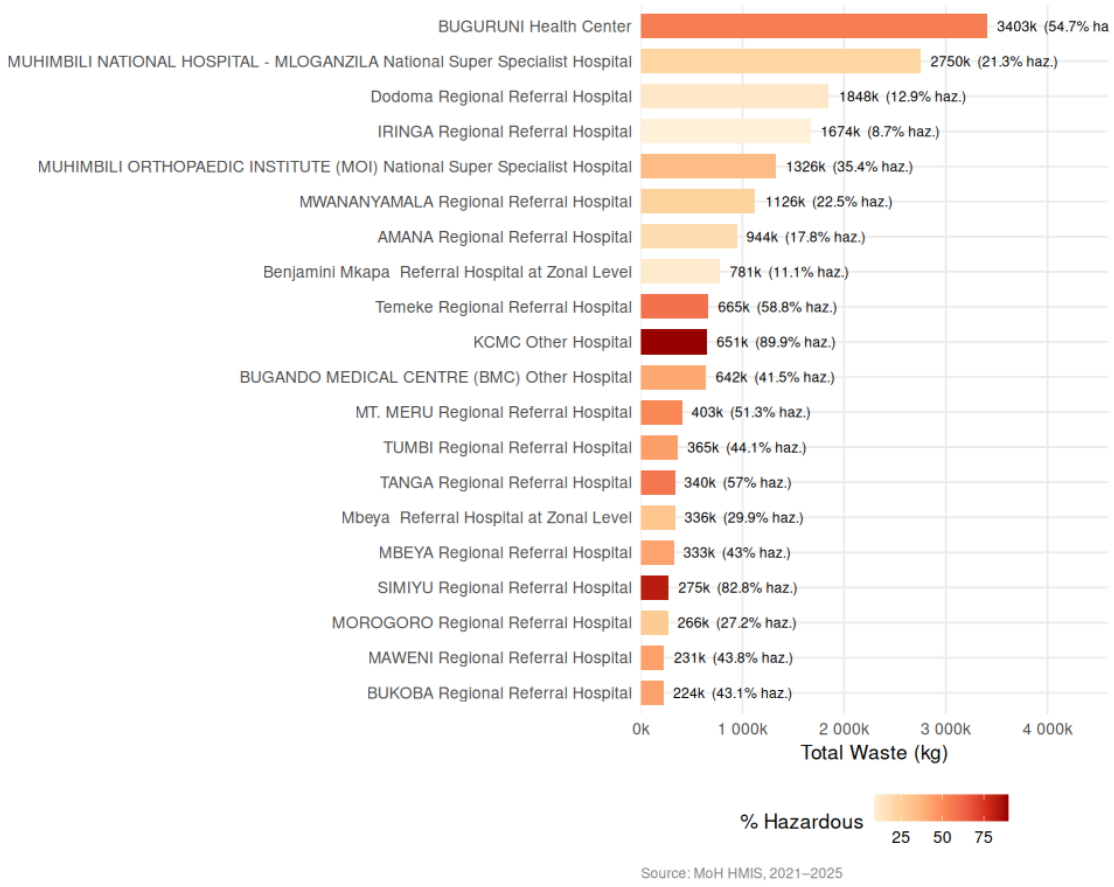


Figure 23: The top 20 facilities with higher total waste production

Top 20 Facilities with higher hazardous waste production

The top 20 facilities by hazardous waste proportion reported very high hazardous fractions, ranging from 58.0% to 95.5%, far exceeding the recommended benchmark of ≤20%.

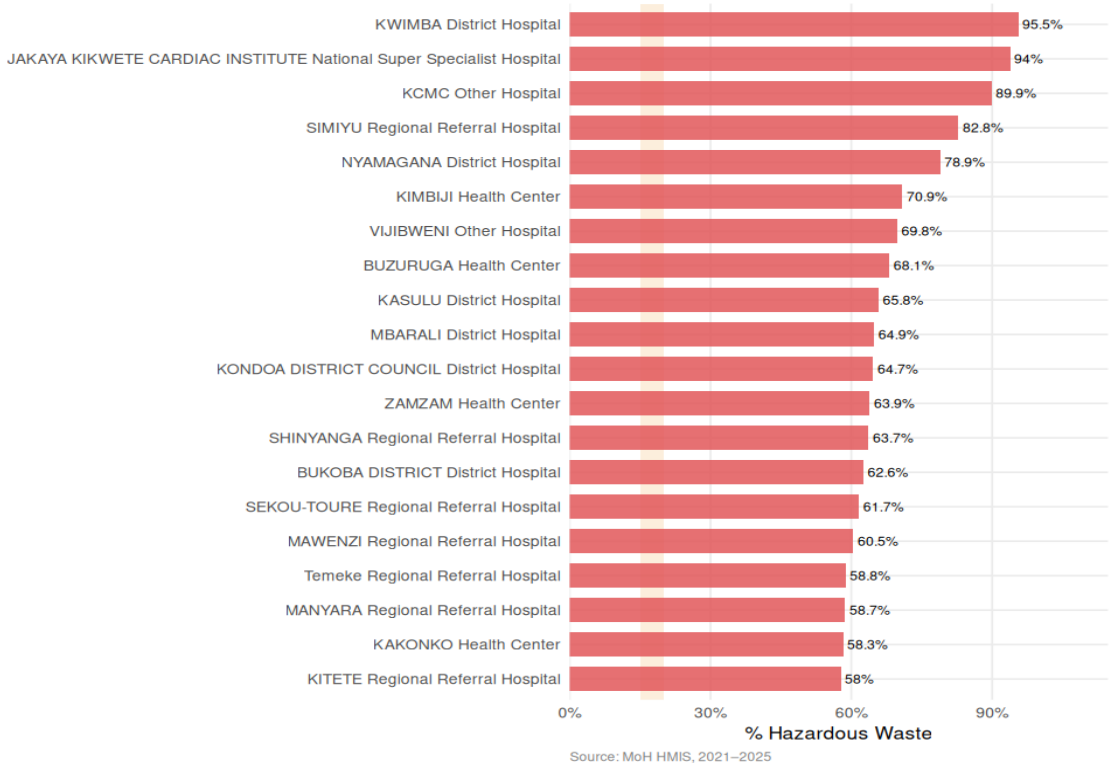


Figure 24: The top 20 facilities by hazardous waste proportion (pooled 2021-2025)

Hazardous waste by region

Regional hazardous waste segregation averaged 42.6%, more than double the recommended standard (≤20%), indicating that most regions exceed the acceptable proportion of hazardous waste. The highest levels were observed in Simiyu (82.8%), Kilimanjaro (75.6%), Shinyanga (63.7%), Tabora (58.0%), and Tanga (57.0%), suggesting poor segregation efficiency. In contrast, Iringa (12.8%) and Dodoma (13.8%) were the only regions below the 20% standard, indicating better waste segregation practices and more appropriate classification of hazardous waste (Figure 25).

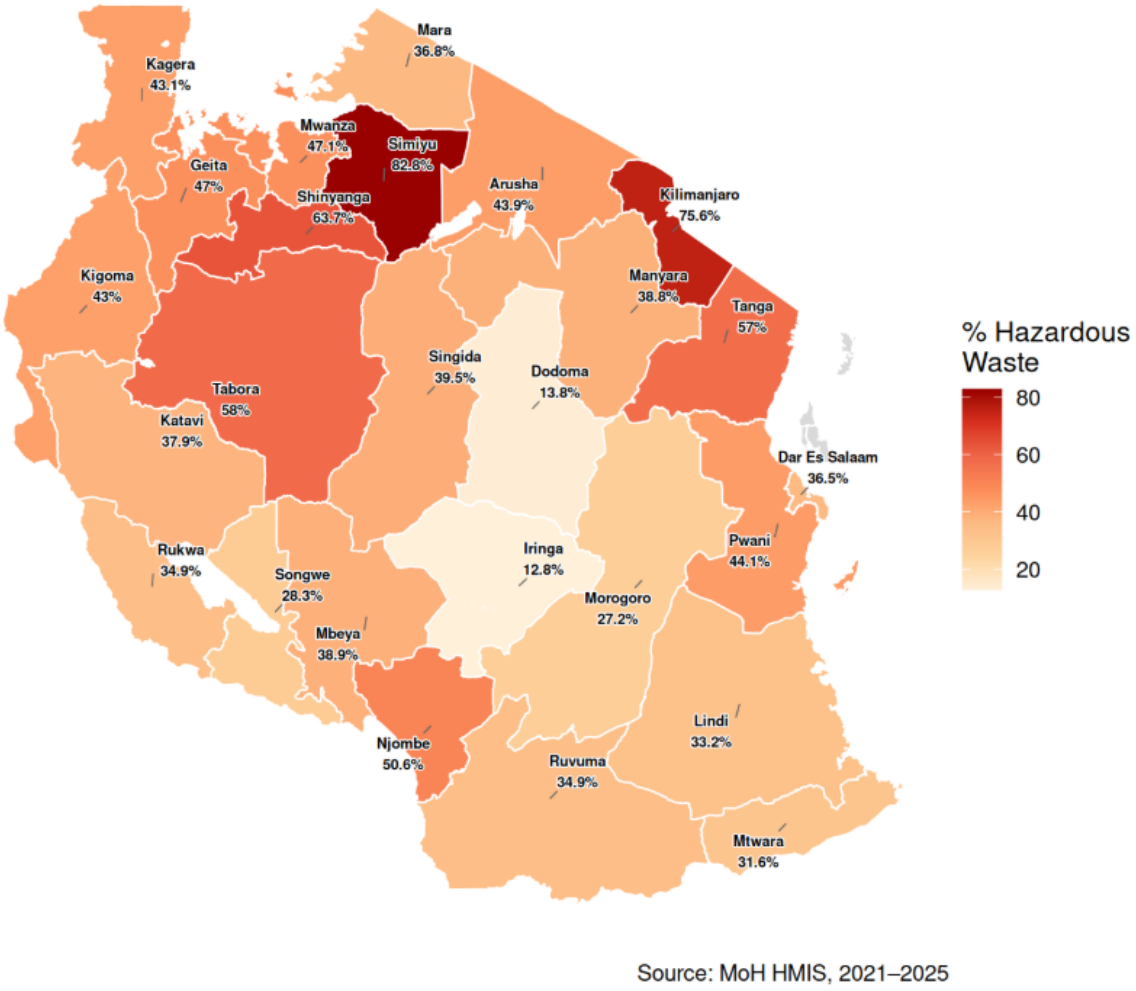


Figure 25: Spatial analysis: Hazardous waste segregation by region

3.2.1.6 HIV PEP uptake and effectiveness

PEP remains a highly effective intervention to prevent transmission after exposure. Uptake is generally strong, especially in well-supported occupational settings. However, completion of the 28-day regimen remains suboptimal. When fully adhered to, PEP is highly protective, with seroconversion rates approaching zero. Most failures stem from incomplete courses or re-exposure rather than drug inefficacy.

Overall HIV PEP Uptakes

This analysis shows a steady increase in both reported HIV exposures and PEP uptake from 2021 to 2025. Reported exposures rose from 1,465 in 2021 to 4,128 in 2025, while PEP uptake increased from 1,457 to 3,918 over the same period, figure 26. The gap between reported exposures and PEP given was minimal in 2021 but widened slightly in 2022 and 2023, before narrowing again in 2024 and 2025. Overall, the trend indicates consistent growth in exposure reporting alongside a corresponding increase in PEP uptake, with PEP provision closely tracking reported exposures over time. The remaining gap may be accounted for by various reasons; some exposed individuals may have presented late (>72 hours) for PEP, or may have already been HIV positive.

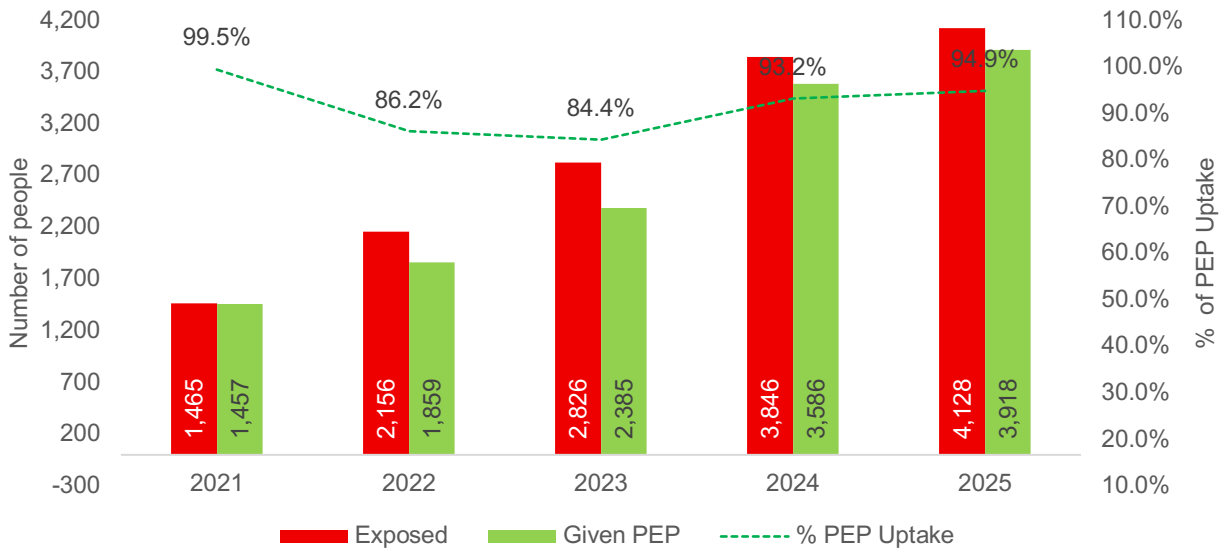


Figure 26: Overall PEP uptake among exposed 2021 - 2025

The trend of HIV PEP Uptakes by Occupational Categories

Figure 27, when disaggregated by occupational categories, the trends follow the same pattern as the overall data, with the largest proportion attributed to non-occupational exposures, followed by occupational exposures.

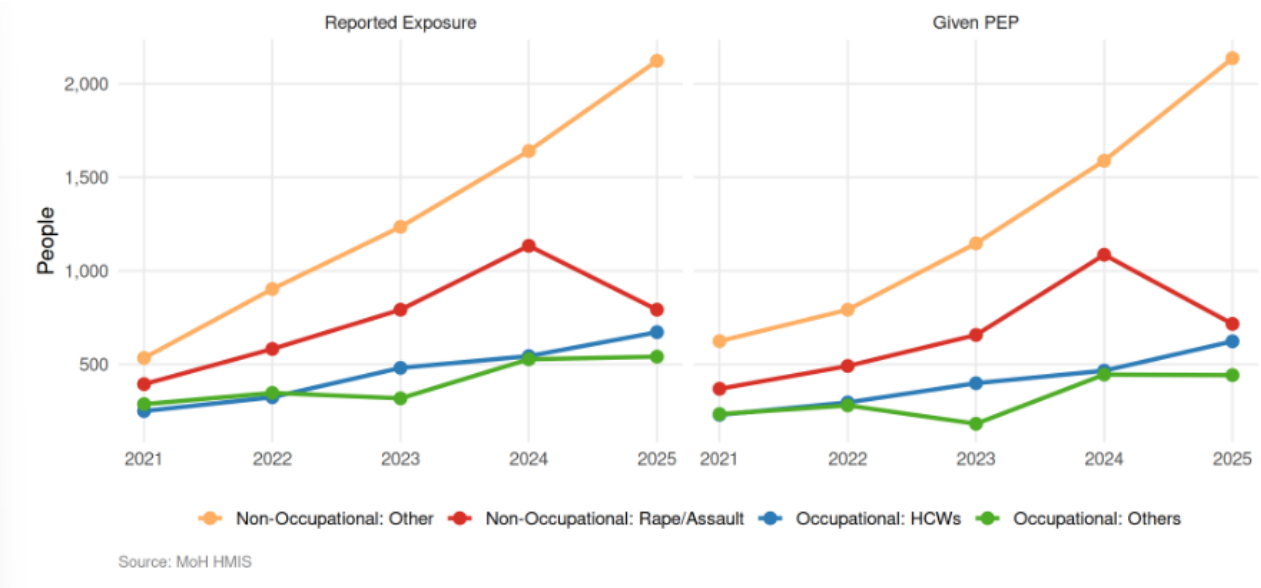


Figure 27: Overall PEP uptake among exposed by work categories, 2021 - 2025

HIV PEP Uptakes by gender

Figure 28, when disaggregated by gender, males accounted for a disproportionately higher share of both HIV exposures and PEP uptake across most categories, except rape/assault. This large proportion of male exposure may be attributed to their work-related risks

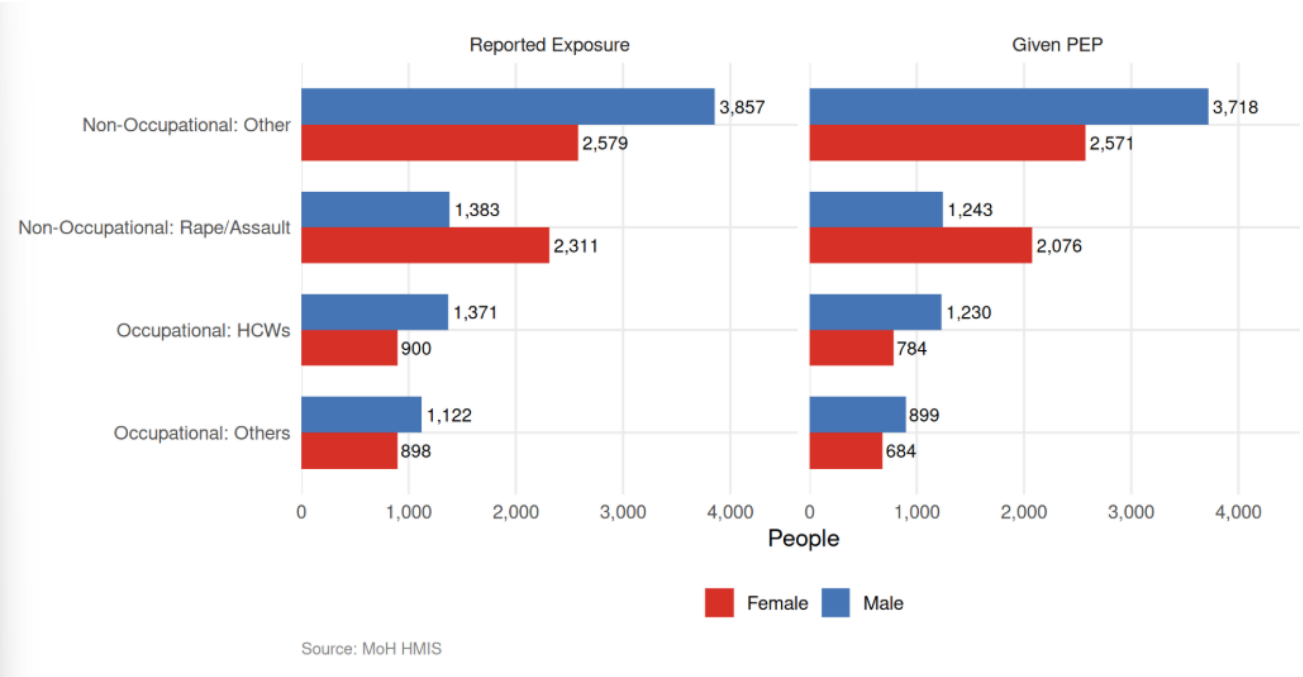


Figure 28: HIV PEP uptake among the exposed by work category and gender (pooled, 2021 – 2025)

HIV PEP Uptakes by Cadres among health services providers

Figure 29 shows that HIV PEP uptake following occupational exposure was highest among the "Others" cadre, accounting for 1,476 cases (38.1%), followed by Nurses/Nurse Assistants with 815 cases (21.1%) and Clinicians with 757 cases (19.6%). Laboratory staff contributed 331 cases (8.6%), while students and interns accounted for relatively smaller proportions (5.4% and 3.3%, respectively).

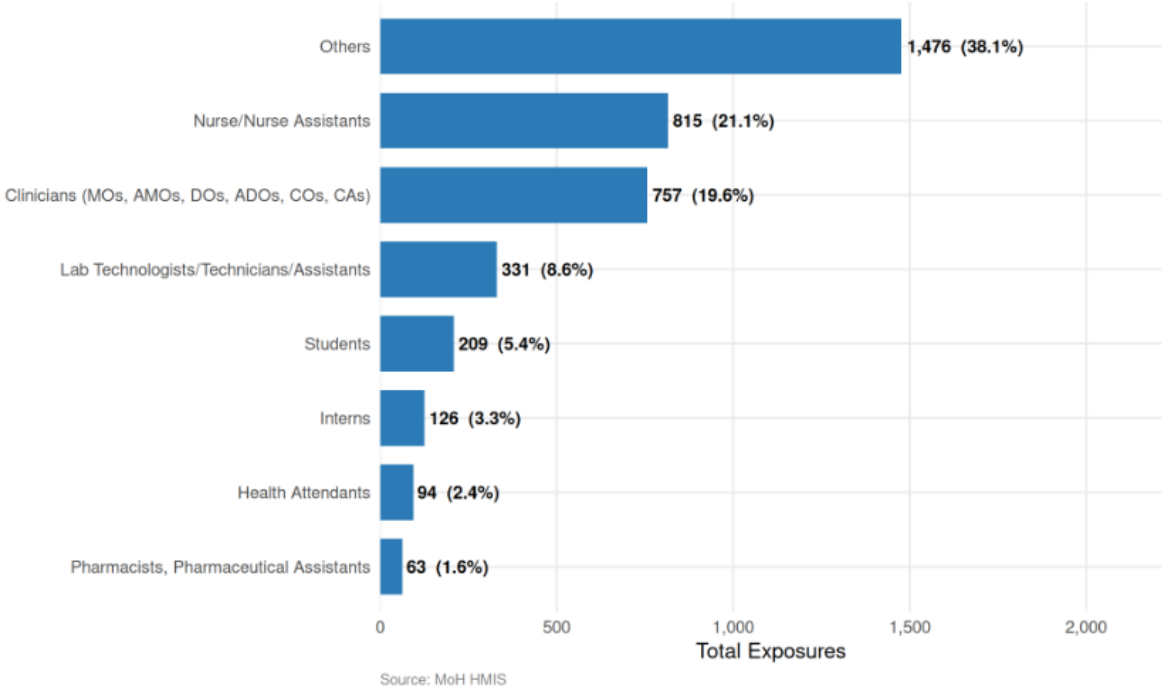


Figure 29: HIV PEP uptake by cadres among health service providers, pooled (2021-2025)

Cause of HIV Exposure among Healthcare Workers

The figure 30, shows that "Other" exposures accounted for the largest share (35.4%), followed by hollow needles/cannulas from other procedures (23.3%) and phlebotomy (22.5%). Solid needles (10%) and splash exposures (8.8%) contributed smaller proportions. Overall, needle-related injuries remain the leading cause of HIV exposure among healthcare workers.

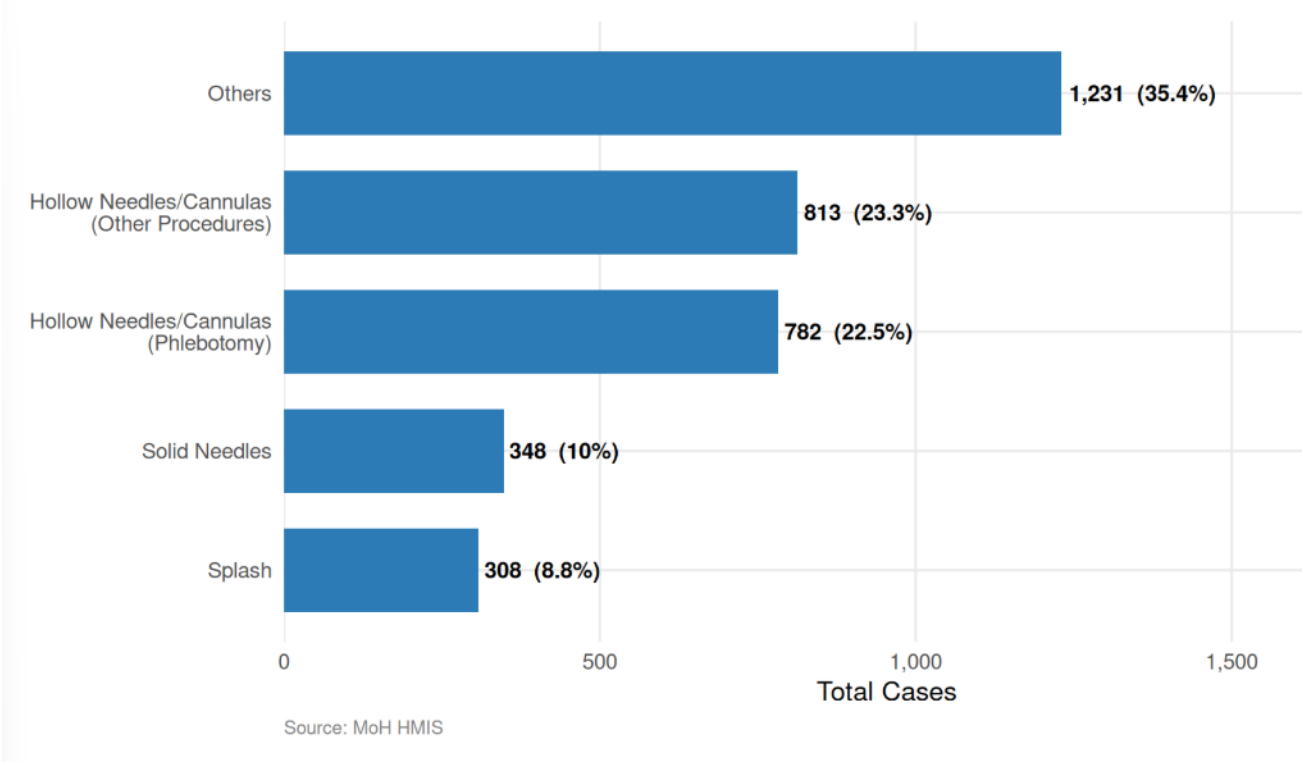


Figure 30: The cause of HIV exposure among health services providers, pooled, 2021 – 2025)

Annual reported HIV exposure due to Rape/Assault

The figure 31 shows that reported HIV exposure due to rape/assault increased steadily from 2021 to 2024, followed by a decline in 2025, with a similar pattern observed in PEP uptake, suggesting that most reported survivors received PEP. Notably, children under 15 years consistently accounted for a substantial proportion of cases, nearly one in every three to two reported cases, highlighting the significant burden of sexual violence among children and the need for strengthened child protection and timely access to post-exposure care.

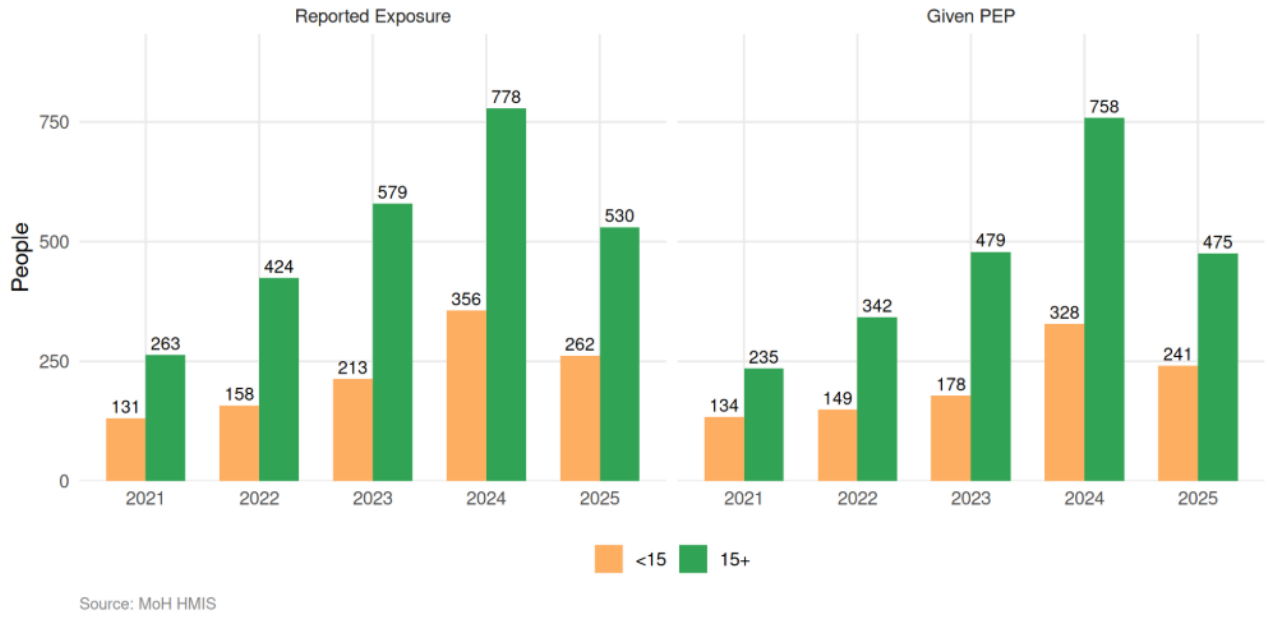


Figure 31: HIV Exposure due to rape/ assault by age (2021 - 2025)

PEP uptake among Rape/ Assault cases by Gender and Age

Figure 32, shows differing age patterns among rape/assault survivors receiving PEP by gender. Among females, girls under 15 years consistently accounted for a substantial share of cases, indicating a notable burden of child sexual violence (left). In contrast, among males, survivors were predominantly aged 15 years and above, with boys under 15 representing a smaller proportion (right). Overall, the burden is more evenly distributed by age among females, but concentrated in older age groups among males.

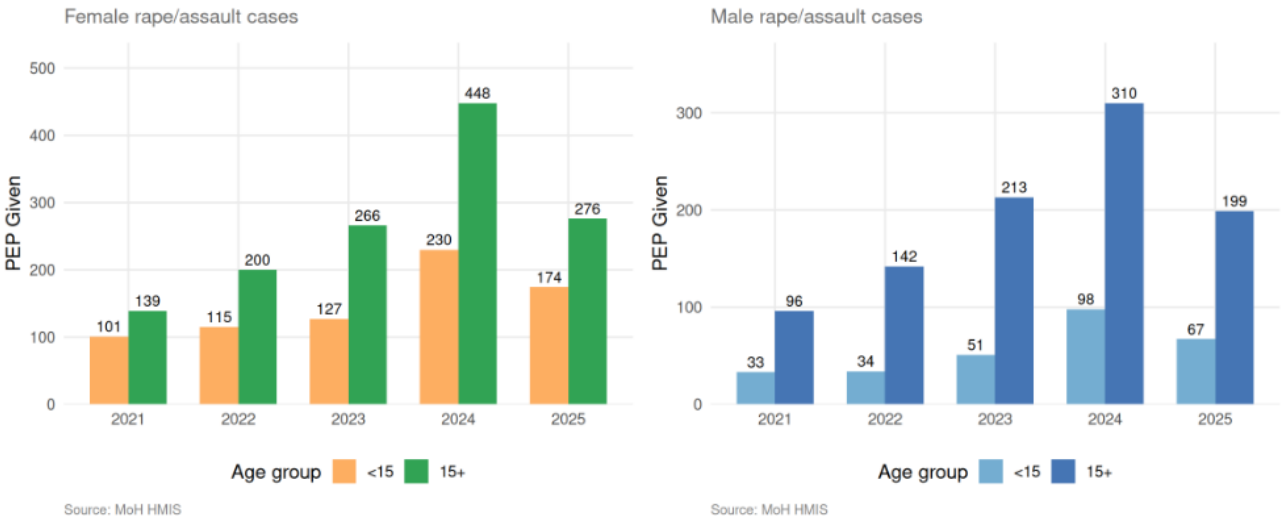


Figure 32: PEP uptake due to Rape/ Assault among females

HIV PEP effectiveness

The protection rates remained consistently high, ranging from 85.7% to 89.2% between 2021 and 2025, while PEP completion rates were notably lower and declined over time, from 69.3%

in 2021 to 62.5% in 2025, with the lowest level recorded in 2024 (59.8%). This gap suggests that although most exposed individuals received initial protection, a substantial proportion did not complete the full PEP course, highlighting challenges in treatment adherence and follow-up.

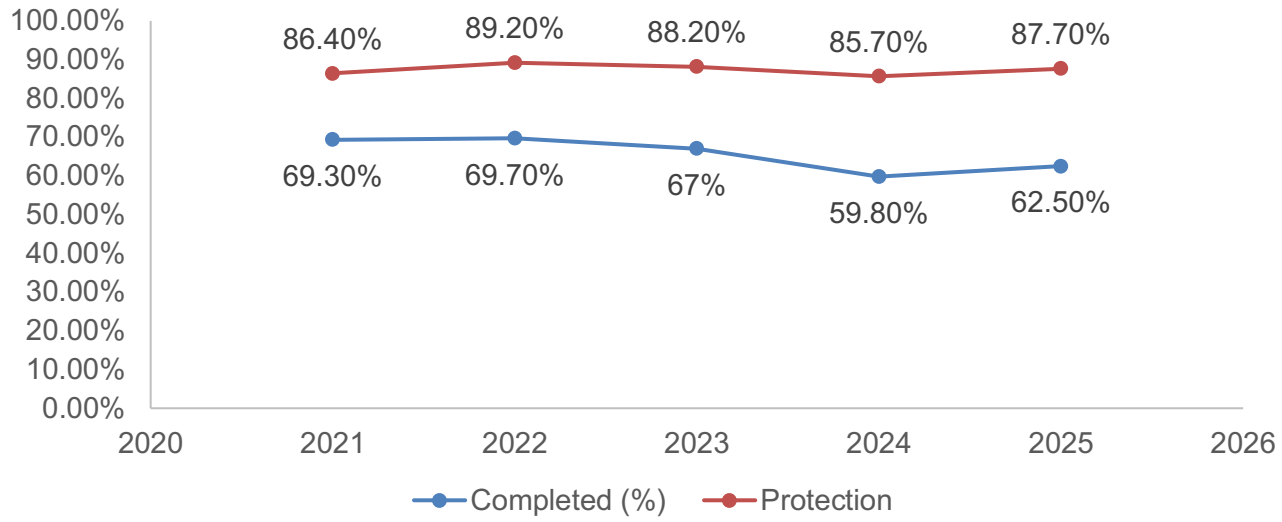


Figure 33: HIV PEP effectiveness

3.2.1 Quarterly indicators

3.2.1.1 Hepatitis B vaccination among healthcare workers

Hepatitis B vaccination completion among healthcare workers increased steadily from 4% in 2021 to 31% in 2024, remaining unchanged at 31% in 2025, as shown in Figure 34. While the number of staff completing vaccination rose substantially over time, overall coverage remains low, with fewer than one-third of healthcare workers fully vaccinated by 2025.

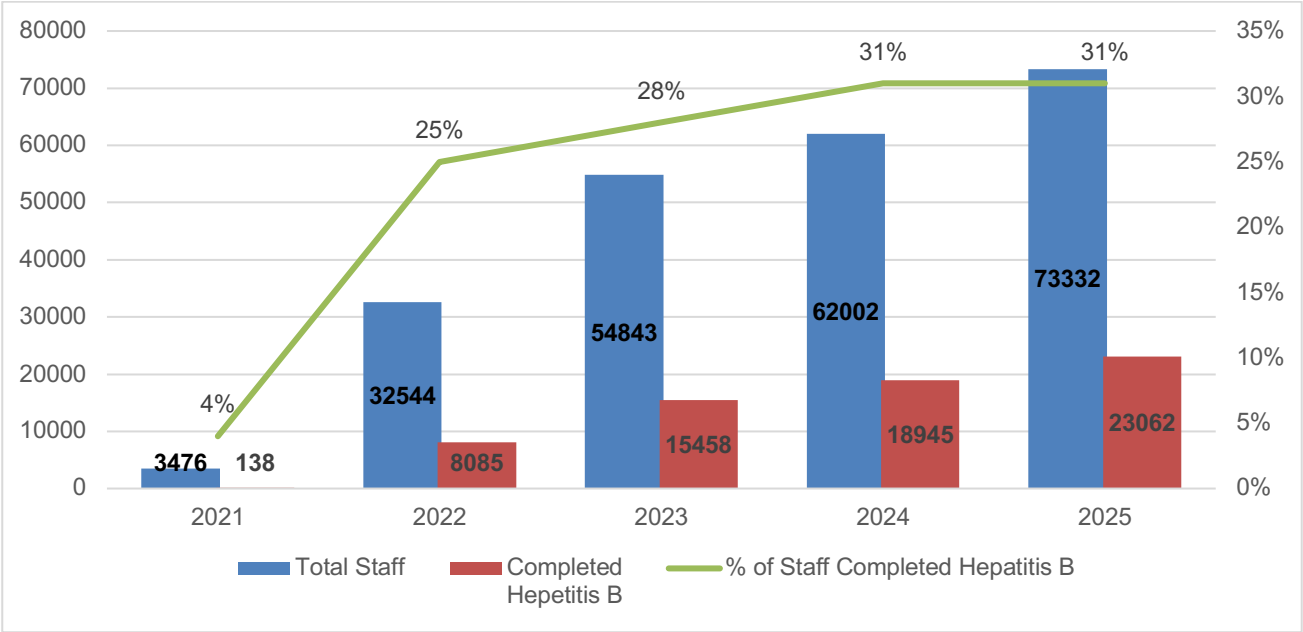


Figure 34: Trends of Hepatitis B vaccine uptake and completion among HCWs from 2021 to 2025

Trends of Hepatitis B vaccine coverage among healthcare workers' quarterly

Figure 15 shows fluctuating but gradually improving Hepatitis B vaccination coverage among healthcare workers over time. Coverage increased from near zero in 2021 to peaks above 35% (e.g., 37.5% in 2022Q4 and 37.3% in 2025Q3), though with intermittent declines (e.g., 22.7% in 2024Q1 and 24.7% in 2025Q1). Overall, despite variability, the trend indicates progressive improvement in vaccination uptake, though coverage remains below optimal levels.

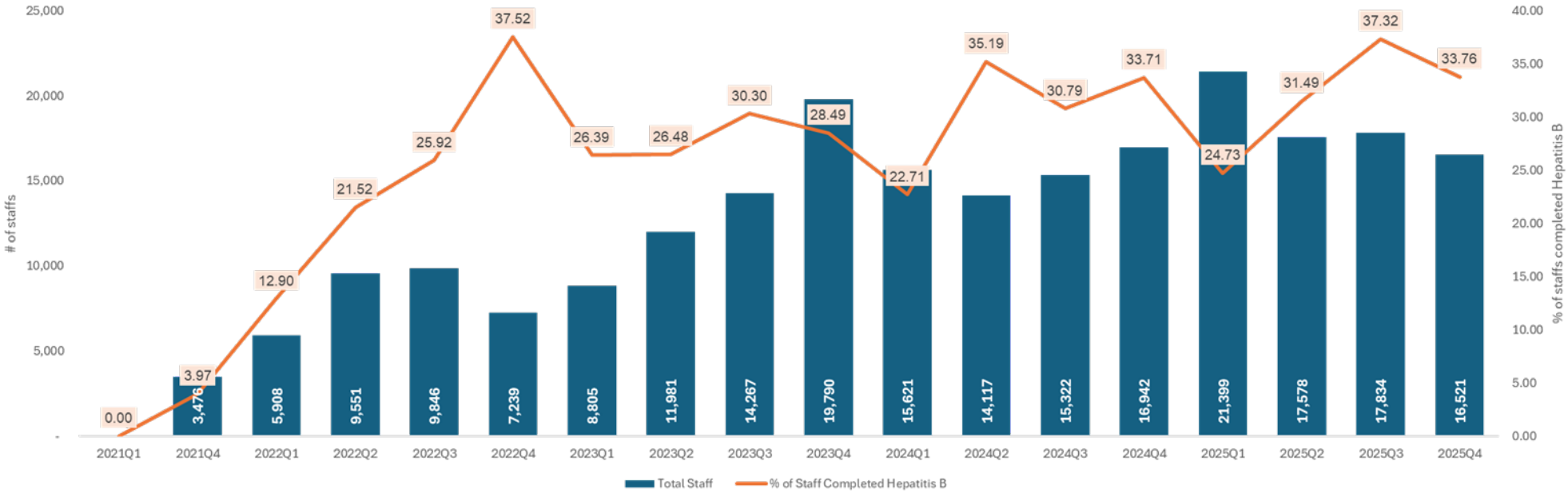


Figure 35: Trends of Hepatitis B vaccine coverage among healthcare workers by quarter

3.2.1.2 Capacity building for healthcare workers

IPC training and mentorship

The number of participating health facilities over time, accompanied by a corresponding rise in the absolute number of staff trained in IPC. Figure 36 shows that the total number of staff who received at least three days of basic IPC training, either within or outside the reporting facilities, increased from 1,363 in 2021 to 19,511 in 2025. Similarly, the number of facilities reporting these data increased from 11 to 159 over the same period.

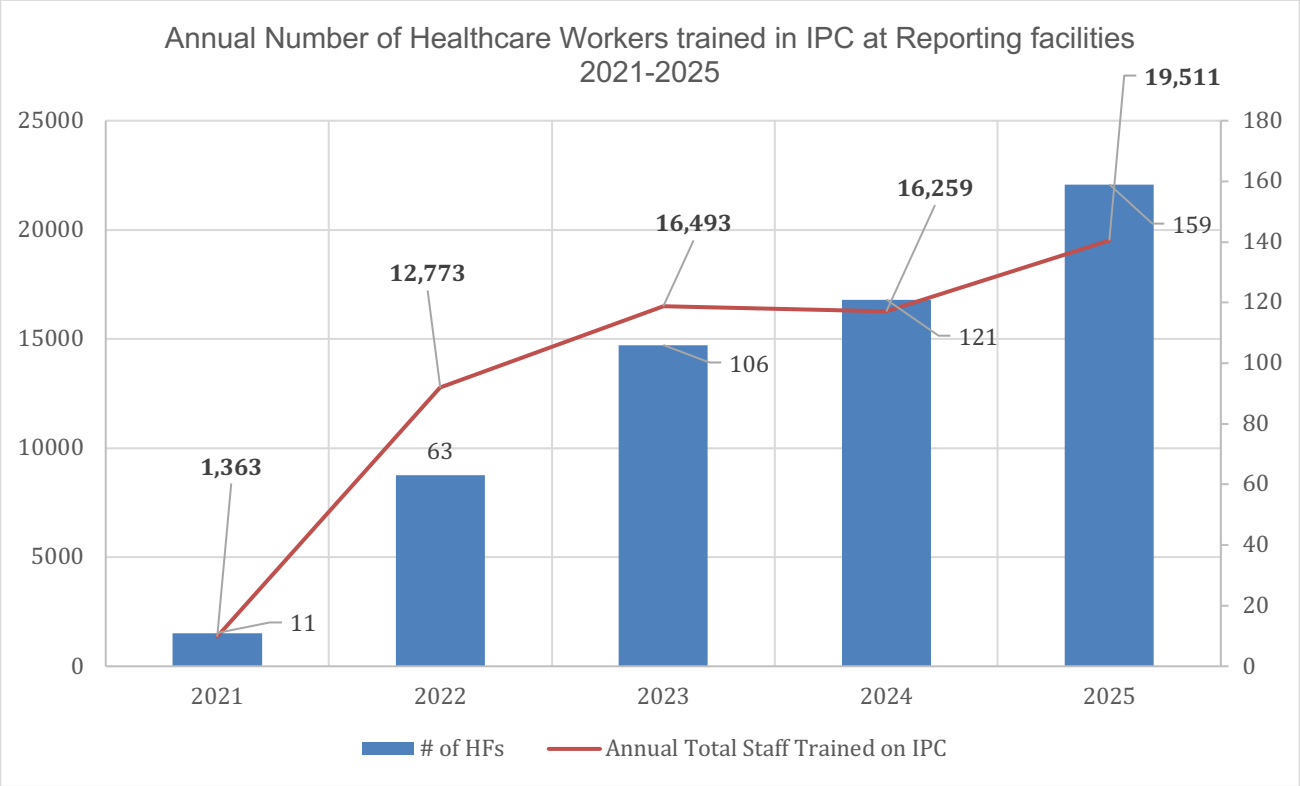


Figure 36 Annual Number of Healthcare Workers trained in IPC at Reporting facilities 2021-2025

3.1.2.2 Percentage of the department with IPC guidelines Per year

Table 4 below presents the proportion of departments with IPC guidelines (2021–2025). The number of facilities and units assessed increased markedly over time, with a corresponding rise in units reporting the availability of IPC guidelines. Coverage improved from 73.7% in 2021 to near-universal levels, reaching 97.6% in 2025, with consistently high levels maintained above 89% from 2023 onwards. These findings indicate substantial progress toward institutionalization of IPC guidelines across departments, reflecting strengthened governance and standardization of IPC practices at the facility level.

Table 4: % of department with IPC guidelines

Year	HFs	Units	Units with IPC guidelines	Percent
2021	11	285	210	73.68
2022	63	1415	1417	100.14
2023	106	2101	1897	90.30
2024	121	2400	2145	89.38
2025	159	2478	2419	97.63

By facility level

Availability of IPC guidelines at the health facility level

The availability of IPC guidelines improved across all levels of HFs, with secondary and tertiary facilities achieving near-universal coverage at or near 100% throughout the period. District-level hospitals also demonstrated high and sustained coverage, generally exceeding 90%. In contrast, lower-level facilities, particularly dispensaries and health centres, showed greater variability, with comparatively lower and less consistent coverage over time. Notably, substantial gains were observed across most facility levels by 2025, indicating progressive standardization of IPC guidelines. Overall, the pattern reflects a gradient in IPC guideline availability by level of HFs, with persistent gaps at primary-level facilities, underscoring the need for targeted support to achieve equitable implementation across the health system.

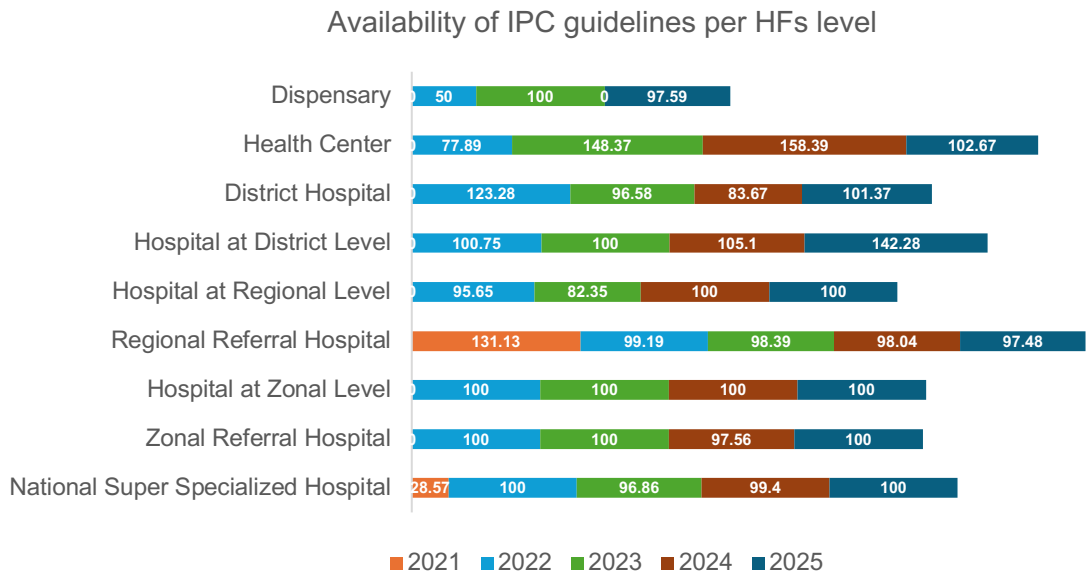


Figure 37: Availability of IPC guidelines by health facility level (2021–2025).

3.2.1.3 Percentages of departments with Working Improvement Teams

The proportion of departments with WITs remained high but declined from 97.2% in 2021 to 84.7% in 2023, followed by a modest increase to 87.9% in 2025. Although the absolute number of units with WITs increased alongside programme expansion, proportional coverage did not keep pace with the growth in facilities and service units. These findings indicate sustained but incomplete coverage, underscoring the need to strengthen functionality and ensure consistent establishment of WITs across all units.

Table 5: below presents the proportion of departments with Work Improvement Teams (2021–2025).

Year	HFs	Units	Units with WITs	Percent
2021	11	285	277	97.2
2022	63	1415	1362	96.3
2023	106	2101	1780.3	84.7
2024	121	2400	2048	85.3
2025	159	2478	2177	87.9

3.2.1.4 Percentage of Health Facilities with improved toilets

Figure 38, shows that the number of health facilities with improved toilets increased steadily from 279 in 2021 to 2,326 in 2025, closely tracking the rise in reporting facilities. The proportion remained high throughout (above 93%), peaking at 105.0% in 2024 before declining slightly to 93.9% in 2025. Overall, this indicates consistently high coverage of improved sanitation, though values above 100% suggest minor inconsistencies in reporting or denominators.

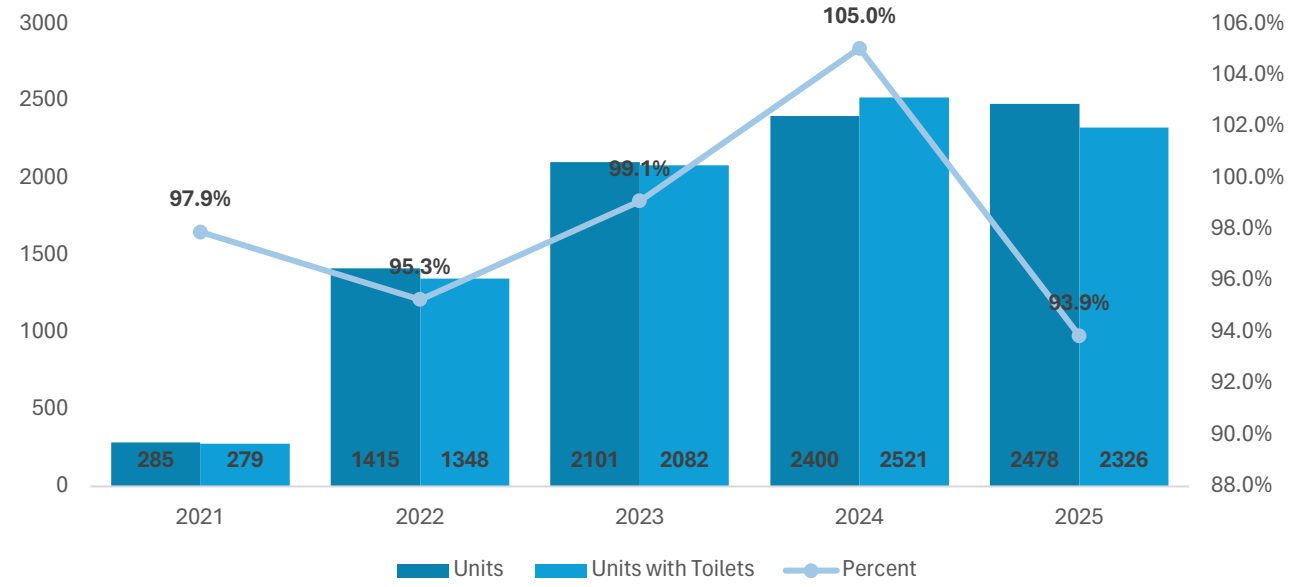


Figure 38: Number and Proportion of Health Facilities with Improved Toilets, 2021–2025

3.2.1.5 Average Percentage score of IPC standards

Facility compliance with IPC standards in Tanzania is measured through both SBMR and IPCAF-related assessment processes. SBMR provides a national standards-based management perspective, while IPCAF reflects progress against the WHO IPC core components. Although this indicator requires facilities to report their own assessment scores following internal evaluations, the reported data were of insufficient quality; therefore, external assessment scores were used for this analysis.

From 2021 to 2025, IPC assessments, data quality audits (DQAs), and mentorship activities were conducted results are as shown in Table 6 bellow:

Table 6 Average performance compliance to IPC standards, 2021-2025

	Average performance compliance to IPC standards, 2021-2025			
SN	Number of Health Facilities assessed	**SBMR**	**IPICAF**	**HCWs mentored**
1	2021 - n=124(1 NH, 5Sp.H, 4ZRH, 28RRH, 33DHs, 48HC, 5 Disp) for SBMR & n=10 (3ZRH, 8RRH) for IPCAF	43%	67%	2542
2	2022 - n=37 for Both SBMR & IPCAF (1NH, 2Sp.H, 5 ZRH, 28RRH, 1DHs	62%	68%	1993
3	2023 - n=100 for Both SBMR & IPCAF (1NH, 3Sp.H, 3 ZRH, 7RRH, 49DHs, 37HCs, 1 Disp)	60%	52%	2751
4	2024 - n=28 for Both SBMR & IPCAF (4ZRH, 23RRH, 1HC,)	75%	69%	2526
5	2025 - n=6 for Both SBMR & IPICAF (1SP, 2ZRH, 2RRH, 1DH)	72%	53%	650
	5 years status	62%	62%	10,462

3.2.1.6 Percentage of Health Facilities with reliable water sources

The figure shows a steady increase in the number of health facilities with reliable water sources, rising from 264 in 2021 to 5,392 in 2025, alongside growth in reporting facilities. However, the proportion exceeds 100% from 2022 onward (e.g., 266.3% in 2024), suggesting inconsistencies in the denominator or possible data quality issues. Overall, while access to reliable water appears to have improved, the unusually high percentages suggest minor inconsistencies in reporting or denominators.
(Figure 39).

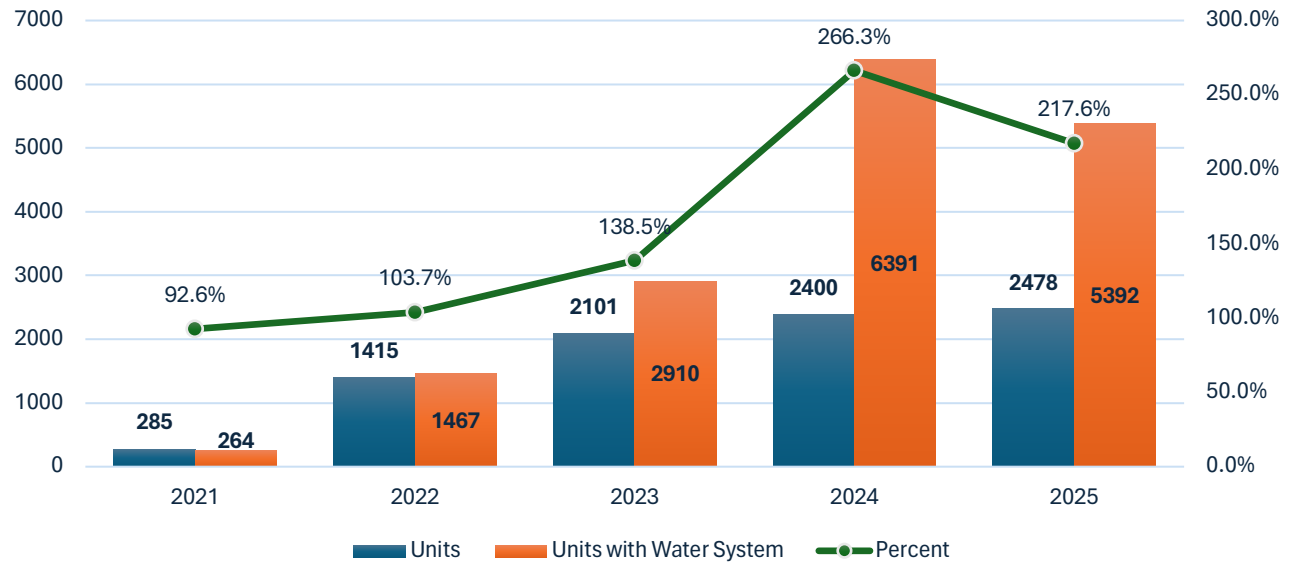


Figure 39: Number and Proportion of Health Facilities with Reliable Water Sources, 2021–2025

3.2.1.7 Percentage of departments with hand hygiene facilities/ supplies

Figure 40 shows a substantial increase in the number of departments with hand hygiene facilities, rising from 264 in 2021 to 5,392 in 2025. However, the reported percentages exceed 100% from 2022 onward (e.g., 266.3% in 2024), indicating likely inconsistencies in the denominator or reporting structure. Overall, while the availability of hand hygiene facilities appears to have improved, the inflated proportions suggest minor inconsistencies in reporting or denominators.

.

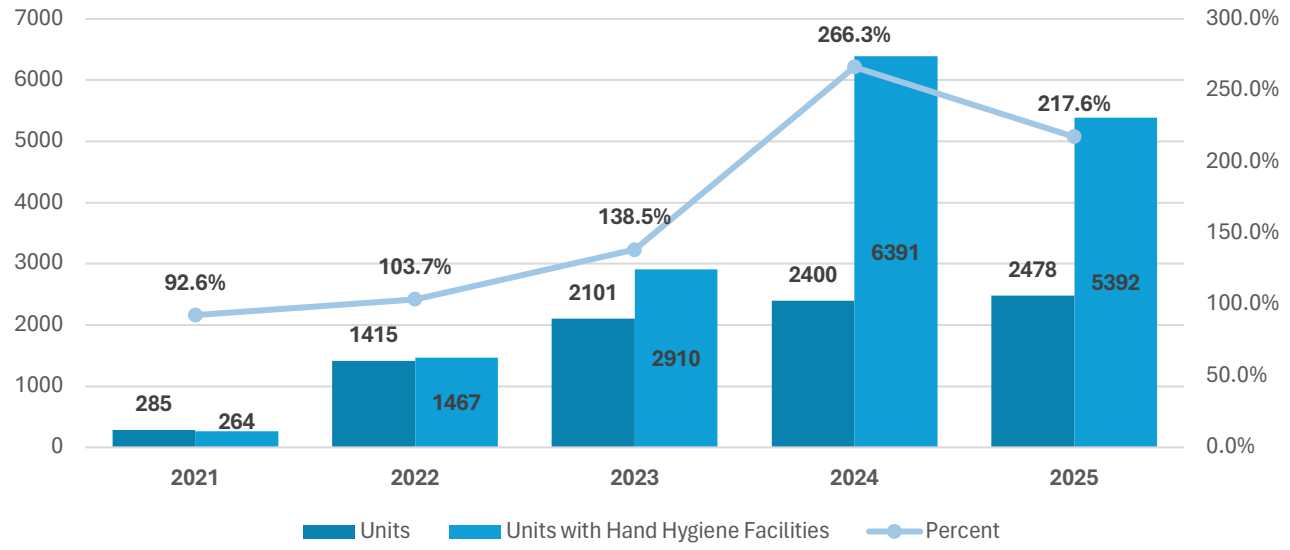


Figure 40: Number and Proportion of Departments with Hand Hygiene Facilities, 2021–2025

3.3 IPC Monitoring and Evaluation

The national IPC programme uses a combination of electronic systems, particularly DHIS2 and AfyaSS, to support reporting, supervision, and performance review.

3.3.1 Reporting rates and trends

3.1.2.3 Overall IPC reporting rate

Figure 41 shows a marked improvement in IPC quarterly reporting rates, increasing from 27.0% in 2021 to 63.7% in 2022, and remaining relatively stable at around 61–65% through 2025. While the number of actual submissions steadily increased over time (10 in 2021 to 354 in 2025), reporting coverage plateaued after 2022, suggesting that further efforts are needed to improve the completeness of reporting among eligible health facilities.

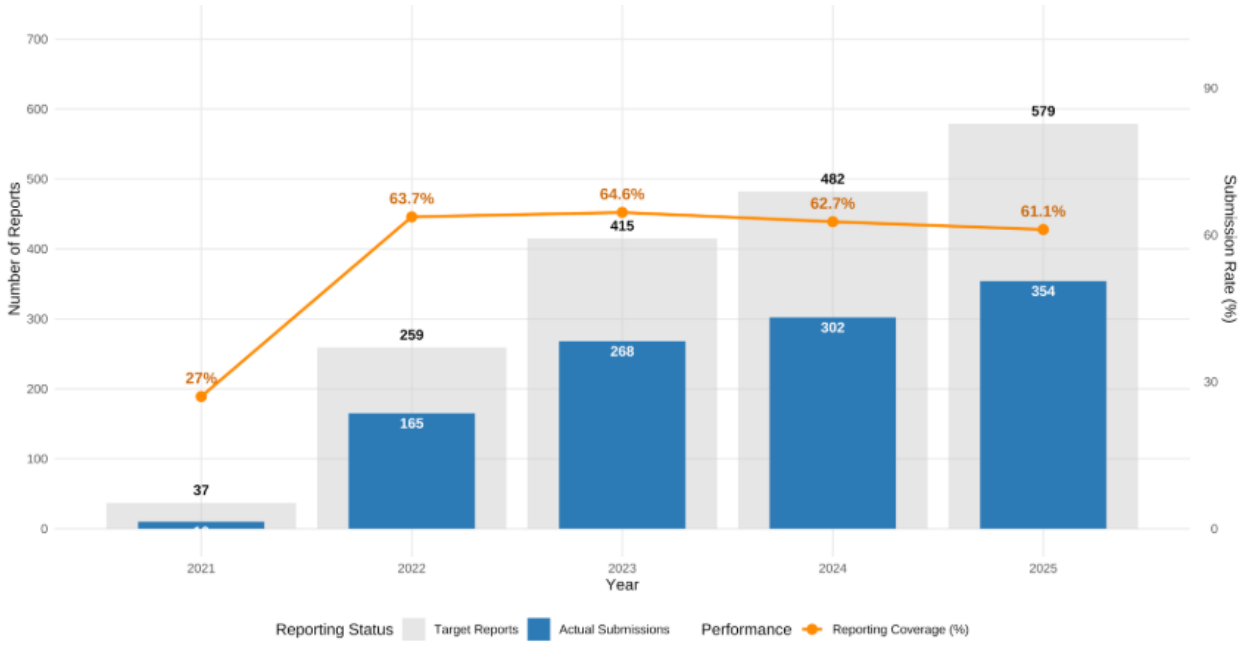


Figure 41: IPC Annual reporting rate among eligible health facilities

Quarterly reporting rate

When analysed by quarter, IPC reporting increased substantially from 2021Q3 to 2022Q2, followed by relatively stable performance with moderate fluctuations through 2025. Although submitted reports improved over time, reporting levels consistently remained below expected reporting targets across all quarters (Figure 42).

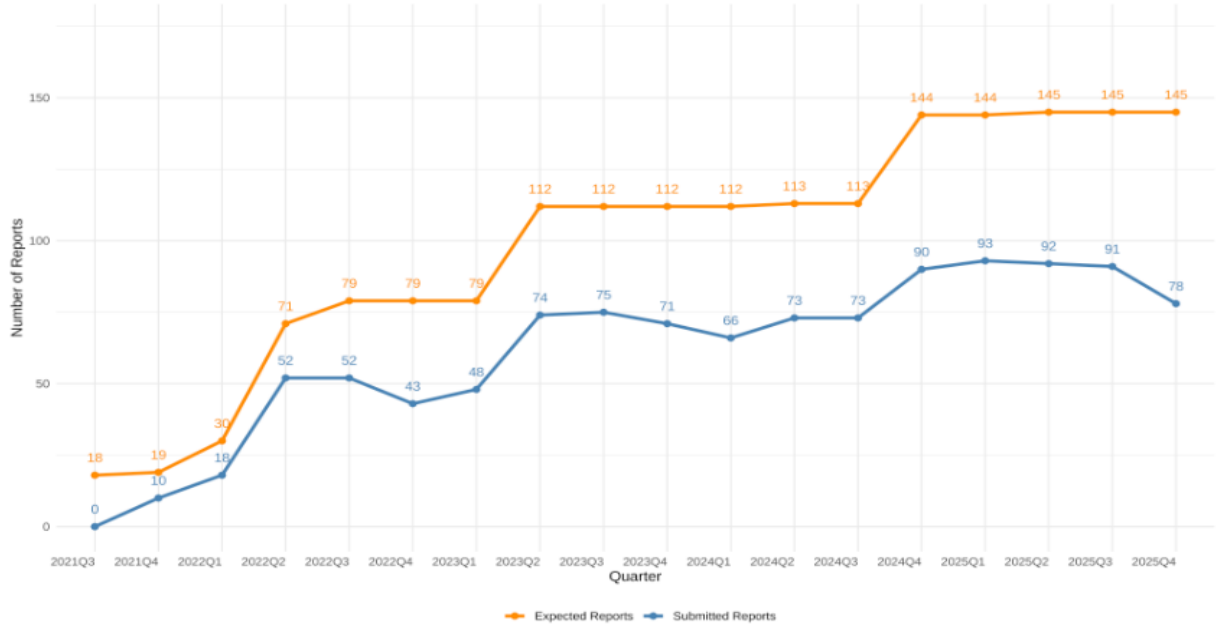


Figure 42: IPC quarterly reporting rate among eligible health facilities

3.4 Data Quality

This section provides data on completeness, timeliness, consistency, and accuracy, and presents these dimensions separately for monthly and quarterly reporting where relevant.

3.4.1 The Overall IPC Report Submission Rate

Table 7 presents the overall IPC reporting performance from 2021 to 2025, showing a steady increase in the number of eligible health facilities and in the number of submitted reports. Eligible facilities increased from 19 in 2021 to 148 in 2025, with high participation in report submission (e.g., 143 facilities submitted reports in 2025).

However, the submission rate remained low, improving from 4.4% in 2021 to 27.1% in 2025, indicating that only a small proportion of expected reports were submitted. Overall, 5,726 out of 26,975 expected reports (21.2%) were submitted, highlighting persistent gaps in reporting completeness despite increased participation.

Table 7: IPC Report Submission Trends and Overall Performance, 2021–2025

Combined IPC Reports Submission

Pooled Data (2021 - 2025)

Year	Eligible HFs	HFs Submitted Reports	Total Expected Reports	Total Submitted Reports	Submission Rate (%)
2021	19	17	1,327	58	4.4%
2022	80	72	4,899	754	15.4%
2023	117	113	6,503	1,392	21.4%
2024	148	143	7,123	1,595	22.4%
2025	148	143	7,123	1,927	27.1%
Total	**148**	**144**	**26,975**	**5,726**	**21.2%**

3.4.2 Completeness

Completeness is the proportion of expected reports that were submitted, calculated as submitted reports divided by expected reports (%), and assessed over time to track reporting performance.

Figure 43 shows that data completeness improved substantially from 58.5% in 2021 to 74.8% in 2022, then remained relatively stable, fluctuating slightly between 71.4% and 75.2% through 2025. Although the number of submitted reports increased markedly over time, completeness plateaued around the overall average of 73.1%, indicating room for further improvement in reporting coverage.

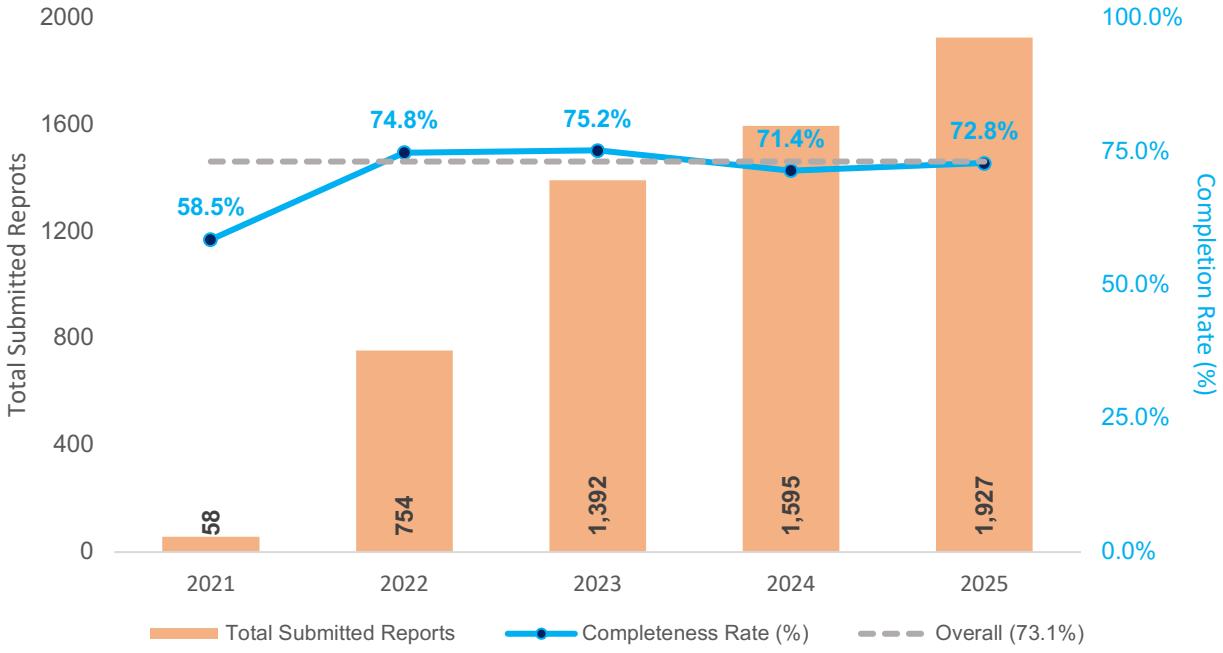


Figure 43: Trends in Data Completeness of IPC Reporting, 2021–2025

3.4.3 Timeliness

Timeliness is the proportion of reports submitted within the expected reporting period, calculated as on-time reports divided by total submitted reports (%), and assessed over time to evaluate adherence to reporting deadlines.

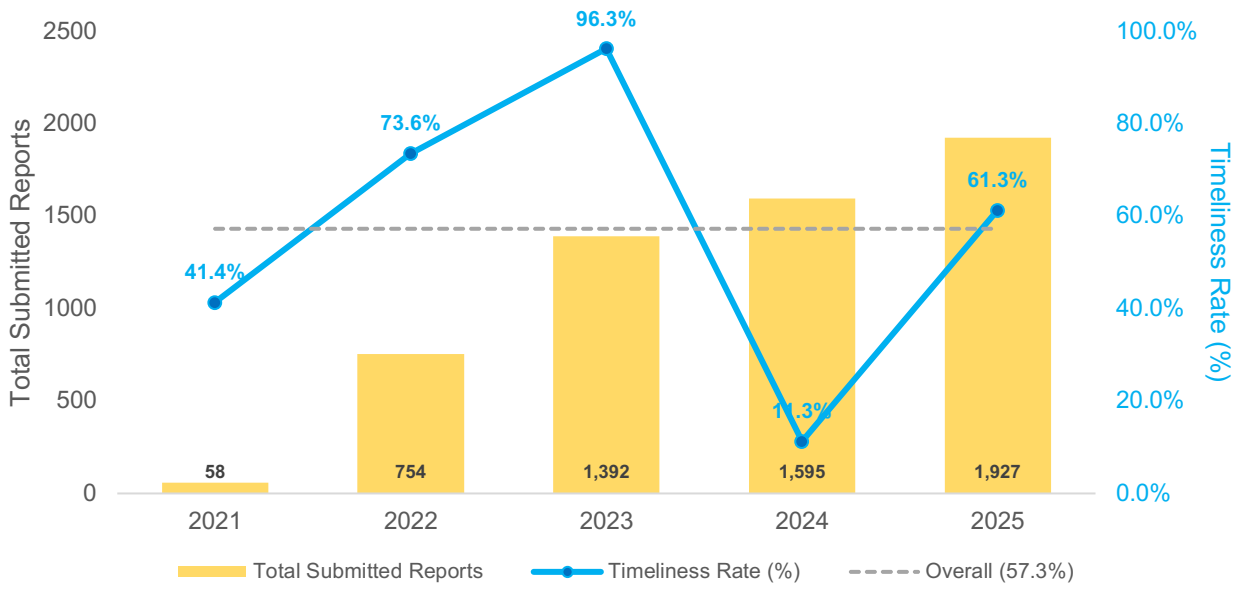


Figure 44: Trends in Timeliness of IPC Reporting, 2021–2025

Figure 44 shows that the timeliness of reporting improved markedly from 41.4% in 2021 to 96.3% in 2023, indicating better adherence to reporting deadlines. However, there was a sharp decline to 17.3% in 2024, followed by a recovery to 61.3% in 2025. Despite the steady increase in the number of submitted reports over time, timeliness remained inconsistent, with an overall average of 57.3%, highlighting gaps in on-time reporting.

3.4.4 Accuracy

Figure 45 shows that data accuracy remained relatively high and stable over time, ranging from 92.3% in 2021 to 87.5% in 2025, with a slight decline after 2021. Despite the increasing number of submitted reports, accuracy consistently stayed around the overall average of 88.4%, indicating generally reliable data with minor fluctuations across the years.

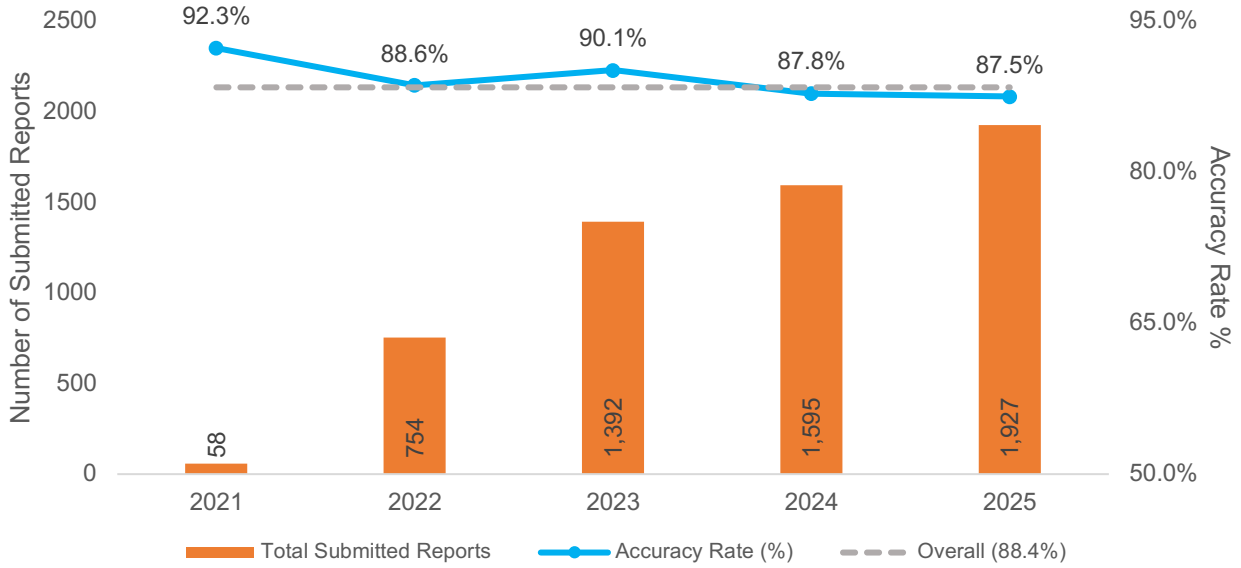


Figure 45: Trends in Data Accuracy of IPC Reporting, 2021–2025

4. CROSS-CUTTING PROGRAMME CHALLENGES AND GAPS

4.1 Human resource gaps

Staff shortages affect multiple dimensions of IPC implementation at the sub-national level at large. Regions and Councils with a limited number of staff often struggle to exempt some healthcare workers as co-members or co-opted members of Regional Health Management Teams (RHMTs) and Council Health Management Teams (CHMTs) with a specific duty on Quality Improvement issues. Also, contributes to improper completion of IPC activities from the action plans prepared during assessment after internal and external Supportive Supervision (I&ESS) and assessment. At the programme level, human resource gaps can also weaken mentorship and supervision coverage.

4.2 Infrastructure and built environment limitations

Infrastructure and built environment limitations in Tanzania remain a fundamental barrier to the implementation of IPC practices. Despite progress in establishing national policies, many healthcare facilities, particularly at the primary level, suffer from inadequate WASH facilities or structures that hinder compliance to IPC standard precautions, which contribute to high rates of HCAIs.

4.3 Weak surveillance functionality

Where surveillance systems are incomplete or weakly embedded, HCAI data may be underestimated, insufficiently classified, or inconsistently followed up. Weak surveillance also reduces the ability of facilities to learn from trends and target preventive measures. Strengthening surveillance, therefore, requires both technical training and institutional follow-through. A low percentage of SSI data may also indicate fear of reporting among healthcare workers or facilities

4.4 Supply chain and commodity constraints

Detergents, Disinfectants, Antiseptics, personal protective equipment, waste handling supplies, vaccination inputs, and data tools are all required to translate policy into practice. Supply interruptions weaken compliance, distort reporting, and frustrate frontline teams.

4.5 Financial constraints

Financial constraints affect training, supervision, facility-level improvements, action-plan completion, and regular monitoring. Emphasize is to integrate IPC annual workplans, facility quality improvement plans, and domestic resource allocation into the Comprehensive Council Health Plans (CCHPs), Comprehensive Hospital Operational Plans (CHOP) and Health Facility Plans.

4.6 Waste management challenges

Safe segregation, transportation, treatment, and final disposal of health care waste remain practical test points for IPC functionality. Waste management challenges pose both environmental and occupational safety concerns, with implications for compliance, staff risk, and public confidence in healthcare services.

5. RECOMMENDATIONS AND FUTURE IMPROVEMENTS

The recommendations below are organized to support the next strategic period and to provide a practical agenda for programme consolidation rather than simple continuation.

i. Institutionalize a structured data quality improvement cycle, including routine checks for completeness, timeliness, consistency, and indicator plausibility within DHIS2 and AfyaSS.
ii. Reporting facilities have to report based on defined and standardized programme denominators across all reporting streams.
iii. Strengthen HCAI surveillance through simplified case definitions, stronger classification support, routine data review, dissemination of HCAIs protocol, and better linkage between surveillance findings and facility quality improvement action.
iv. Improve assessment coverage especially at private health facilities and PHCFs and interpretation by consistently pairing planned-versus-conducted assessment data with SBMR and IPCAF scores and follow-up action-plan completion.
v. Scale up of IPC M&E system to private health facilities and the remaining PHCFs.
vi. Expand and target IPC training and mentorship based on facility performance, data quality findings, and surveillance gaps rather than using uniform approaches for all facilities.
vii. Accelerate Hepatitis B vaccination among healthcare workers through catch-up strategies, tighter workforce tracking, and stronger coordination between occupational health, supply chain, and facility management functions.
viii. Integrate IPC priorities more explicitly into facility and council annual workplans, quality improvement plans, and domestic financing discussions.
ix. Strengthen waste management, commodity security, and infrastructure planning as enabling conditions for sustained IPC compliance.
x. Develop an external-facing annual IPC results dashboard that can summarize programme performance for government, partners, and international technical audiences.

5.1 Priority Actions for Strengthening IPC Programme

Priority Action	Rationale	Implementation Level	Lead Actor	Timeline	Indicator
Strengthen HCAI surveillance	Improve detection, reporting, and prevention of infections	Facility / subnational	Facilities / RHMTs	Medium-term (1–3 years)	% of facilities routinely reporting HCAI indicators (e.g., SSI, sepsis)
Improve data quality	Increase confidence in routine data for decision-making	All levels	Programme M&E team	Short-term (0–1 year) and ongoing	Completeness (%), Timeliness (%), Accuracy (%) of IPC reports
Scale up HCW vaccination (Hepatitis B)	Protect healthcare workers and reduce occupational risk	Facility / national	MoH / Facility management	Medium-term (1–3 years)	% of healthcare workers fully vaccinated against Hepatitis B
Strengthen IPC compliance and follow-up actions	Ensure adherence to IPC standards and improve facility performance	Facility / subnational	Facilities / RHMTs	Medium-term (1–3 years)	% of facilities implementing corrective actions from IPC assessments
Improve WASH and waste management systems	Reduce infection risk and improve environmental safety	Facility / national	MoH / LGAs / Facilities	Long-term (3–5 years)	% of facilities meeting WASH/HCWM standards; % infectious waste within WHO threshold (≤20%)
Scale up IPC M&E System	Improve data decision making through monitoring and of IPC interventions	Facility	MoH	Long-term (3–5 years)	% of health facilities reporting IPC indicators in DHIS2
Increase time for QIT and IPC team to oversee IPC	Every HF need to have functional QIT and IPC committee/FP	Facility	CHMTs, Facility directors/In charges	Short term (within a year)	% of HFs with functional QIT and IPC team

6. CONCLUSION

Between 2021 and 2025, Tanzania's national IPC programme demonstrated substantial progress, with expanded implementation, improved surveillance, and measurable gains in key outcomes, including reductions in SSIs and neonatal sepsis, as well as increased uptake of occupational protection measures. However, progress remains uneven, with persistent challenges in IPC outcomes, healthcare waste management, and data quality, particularly in reporting completeness, timeliness, and consistency.

While the programme has established a strong foundation for IPC implementation, systemic constraints such as human resource gaps, infrastructure limitations, and weak surveillance systems continue to affect performance. Moving forward, sustained impact will depend on consolidating gains through strengthened HCAI surveillance, improved data quality and use, enhanced compliance with IPC standards, and targeted investments in workforce capacity, infrastructure, and essential commodities.

Overall, the programme is well-positioned to advance, provided that these gaps are addressed through coordinated, data-driven, and system-wide interventions.

REFERENCES

1. World Health Organization. Guidelines on core components of infection prevention and control programmes at the national and acute health care facility level. Geneva: WHO; 2016. https://iris.who.int/server/api/core/bitstreams/d811a2ad-3c7f-48a2-b88b-4935da71a87b/content

2. World Health Organization. Infection prevention and control assessment framework at the facility level (IPCAF). Geneva: WHO; 2018. https://www.who.int/publications/i/item/WHO-HIS-SDS-2018.9

3. World Health Organization. Improving infection prevention and control at the health facility: interim practical manual supporting implementation of the WHO guidelines on core components of infection prevention and control programmes. Geneva: WHO; 2018. https://www.who.int/publications/i/item/WHO-HIS-SDS-2018.10

4. World Health Organization. Global strategy on infection prevention and control. Geneva: WHO; 2023. Licence: CC BY-NC-SA 3.0 IGO. https://www.who.int/publications/i/item/9789240080515

ANNEXES

Annex 1: List of Main Contributors

SN	Name	Title	Work station
1.	Eliudi Eliakimu	DHQAU	MoH Dodoma
2.	Joseph Hokororo	Head of IPC Sub-Unit & National IPC Coordinator	MoH Dodoma
3.	Radenta Bahegwa	Epidemiologist	MoH Dodoma
4.	Chrisogone German	M&E Expert	MoH Dodoma
5.	Erick Kinyenje	Epidemiologist	MoH Dodoma
6.	Ruth Raymond	IPC Programme Officer	MoH Dodoma
7.	Yohanes Msigwa	Lab Scientist	Mbeya
8.	Pius Kagoma	CSCo	PMO-RALG
9.	Oliver Chalilah	M & E Officer	MoH Dodoma
10.	David Lenga	M & E Officer	MoH Dodoma
11.	Syabo Mwaisengela	Ass. Lecturer	Mzumbe University
12.	Jimmy Mbelwa	DHIS2 Expert	UDSM-Dar es Salaam
13.	Hassan Muhomi	DHIS2 Expert	UDSM-Dar es Salaam
14.	Henry Mkama	DHIS2 Expert	UDSM-Dar es Salaam
15.	Henry Kalist	DHIS2 Expert	UDSM-Dar es Salaam
16.	Furahini Mbise	Research Officer	NIMR - Dar es Salaam
17.	Lackson David	Data Analyst	MUHAS- Dar es Salaam
18.	Imaculata Marwa	IPCFP	Maweni RRH
19.	Cecilia Charles	Epidemiologist	Katavi RRH
20.	Melkizedeki A. Kwizombe	TFELTP Resident (02nd Year)	MUHAS

SN	Name	Title	Work station
21.	Calvin Swai	St. John's University of Tanzania	Dodoma
22.	Jonhas Malija Masatu	Epidemiologist	DED- Muheza DC Tanga
23.	Granford Mwapili	HMIS FP	DED Busega, Simiyu
24.	Jenifer Assey	QIFP	RS- Lindi
25.	Adolf Mwakitaluma	QIFP	DED Mtama DC, Lindi
26.	Elford Mkerebe	HMISFP	RS- Manyara
27.	Jemael Samson	QI	DED- Kankonko, Kigoma
28.	Marwa Mwikabe	MO	DED Malinyi DC, Morogoro
29.	Haile Sanga	QIFP	DED Mpanda MC, Katavi
30.	Janeth Msuma	IPC Expert	WHO Country Office, Tanzania
31.	Kokuhabwa Mukurasi	Epidemiologist	Centers for Disease Control and Prevention (CDC) Tanzania
32.	Siril Kulaya	Deputy Chief of Party	*Usalama wa Afya Duniani project*
33.	Hassan Chaula	M&E Manager	*Usalama wa Afya Duniani project*
34.	Christina Mmasa	IPC Manager	*Usalama wa Afya Duniani project*
35.	Upendo Msajila	M &E Officer	*Usalama wa Afya Duniani project*
36.	Jumanne Kakwaya	IPC Programme Officer	*Usalama wa Afya Duniani project*
37.	Adam Kamese	M &E Officer	*Usalama wa Afya Duniani project*
38.	Nuru Beda	IPC Programme Officer	*Usalama wa Afya Duniani project*
39.	Andrew Kigombola	Clinical Service Coordinator	*Usalama wa Afya Duniani project*

Annex 2: List of Eligible Healthcare Facilities for IPC M&E by 2025

S/N	Name of Health Facilities	Health Facility Registry (HFR) Code
1	Ligula RRH	103503-9
2	Mawenzi	104514-5
3	Temeke RRH	107806-2
4	Mwananyamala RRH	105905-4
5	Amana RRH	100097-5
6	Geita RRH	101192-3
7	Iringa RRH	101854-8
8	Manyara RRH	104279-5
9	Mbeya RRH	104602-8
10	Mt. Meru RRH	105316-4
11	Simiyu RRH	113724-9
12	Shinyanga RRH	107423-6
13	Singida RRH	107485-5
14	Sokoine RRH	107517-5
15	Songwe RRH	120626-7
16	Sumbawanga RRH	107663-7
17	Tanga RRH	100405-0
18	Tumbi RRH	107942-5
19	Bukoba RRH	102162-5
20	Katavi RRH	121927-8
21	Maweni RRH	108713-9
22	Mwalimu Nyerere Memo RH (Musoma)	105721-5
23	Morogoro RRH	105299-2
24	Sekouture	107354-3
25	Njombe RRH	113689-4
26	Songea RRH (Ruvuma RRH)	107543-1
27	Tabora RRH (Kitete RRH)	107703-1
28	Dodoma RRH	100991-9

S/N	Name of Health Facilities	Health Facility Registry (HFR) Code
29	Benjamin Mkapa	111841-3
30	ORCI	106880-8
31	MOI	105267-9
32	MNH - Upanga	105651-4
33	MNH - Mloganzila	111890-0
34	KCMC	102525-3
35	lMtwara Zonal	120486-6
36	Chato Zonal	120343-9
37	DCMC	100960-4
38	Kibong'oto	110886-9
39	JKCI	111836-3
40	Mbeya Zonal	104601-0
41	Bugando Zonal	100438-1
42	Mirembe	104962-6
43	Highdom Hospital	101335-8
44	Buguruni HC - Ilala MC	100463-9
45	Mnazi Mmoja DH - Ilala MC	105242-2
46	KIMBIJI Health Center - Kigamboni	102905-7
47	Vijibweni Hospital - Kigamboni	108256-9
48	Bunju HC - Kinondoni	100577-6
49	Tandale HC - Kinondoni	107738-7
50	Tegeta Dispensary	107799-9
51	Mbagala Rangi tatu DH	104547-5
52	Mbagala Round table HC	110276-3
53	Kimara HC - Ubungo	102900-8
54	Mbezi HC - Ubungo	108687-5
55	Sinza HC - Ubungo	107495-4
56	Chanika HC	100738-4
57	Kinyonga DH	102980-0
58	Mtama DH/Lindi DC	120686-1

S/N	Name of Health Facilities	Health Facility Registry (HFR) Code
59	Ruangwa DH	114821-2
60	Nachingwea DH	106063-1
61	Liwale DH	120901-4
62	Nyangao CDH	107643-9
63	Town HC	103562-5
64	Mnero DH - Nachingwea DC	109262-6
65	Bukoba DH	114500-2
66	Rubya DH	107125-7
67	Biharamulo DH	114841-0
68	Murugwanza DH - Ngara DC	105701-7
69	NYAKAHANGA CDH - Karagwe DC	106656-2
70	NKWENDA HC	106558-0
71	Mugana DH - Misenyi DC	105623-3
72	Zam Zam HC - Bukoba MC	108406-0
73	Bitale HC - Kigoma DC	100377-1
74	Uvinza DH - Uvinza DC	114480-7
75	Kakonko HC	102211-0
76	Kibondo DH	102618-6
77	Kasulu DH	114046-6
78	Kasulu TC	102453-8
79	Buhigwe DH - Buhigwe DC	120359-5
80	Babtist CDH - Kigoma MC	100318-5
81	Masasi DH - Masasi DC	113932-8
82	St. Benedict Hospital - Masasi DC (NDANDA)	107571-2
83	Mkomaindo DH - Masasi TC	105093-9
84	Nanguruwe DH - Mtwara DC	106181-1
85	Nanyamba DH - Nanyamba TC	113747-0
86	Mangaka DH - Nanyumbu DC	104244-9
87	Mchemo DH - Newala DC	120544-2
88	Newala DH - Newala TC	106320-5

S/N	Name of Health Facilities	Health Facility Registry (HFR) Code
89	Tandahimba DH - Tandahimba DC	107736-1
90	Misungwi DH (Misungwi DH iwekewe fomu kwenye mfumo)	121768-6
91	Nyamagana DH	106688-5
92	Ukerewe DH - Nansio	108053-0
93	Magu DH	103990-8
94	Buzuruga HC	100642-8
95	Sengerema CDH (other hosp)	120763-8
96	Buchosa DH	113707-4
97	Kwimba DH (Ngudu DH)	106426-0
98	Busekelo DH	113925-2
99	Chunya DH	100890-3
100	Kyela DH	103430-5
101	Mbarali DH	115154-7
102	Igawilo CH	101535-3
103	Tukuyu DH	107897-1
104	Mbalizi CDH	108676-8
105	Tosamaganga Hosp	107867-4
106	Mafinga DH	103877-7
107	Frelimo DH	101153-5
108	Ilula DH	101768-0
109	Lugoda DH	103646-6
110	Kilolo DH	114061-5
111	Kasanga HC	102400-9
112	Inyonga B Health Center	101816-7
113	Usevya Health Center	108171-0
114	Katumba HC	102489-2
115	Tanganyika District Hospital	114004-5
116	MPANDA DH	105336-2
117	UDOM Hospital	108009-2
118	Chemba DH	114015-1

S/N	Name of Health Facilities	Health Facility Registry (HFR) Code
119	Uhuru DH	114711-5
120	Mvumi DH	105775-1
121	Kongwa DH	103311-7
122	Kondoa DH	120346-2
123	Kondoa TH	103297-8
124	Chamwino DH	113853-6
125	Bahi DH	113978-1
126	ST Gema DH	107590-2
127	Hanang DH - Tumaini DH	109266-7
128	Babati DH	120367-8
129	Mbulu DH	114048-2
130	Mbulu Town Council Hospital	111321-6
131	Babati Town Hospital	100211-2
132	Kiteto DH - Kibaya DH	102590-7
133	Simanjiro DH	113966-6
134	Arusha CC Hospital	112384-3
135	Oltrumet DH	106922-8
136	Karatu DH	113964-1
137	Longido DH	120431-2
138	Meru DH	100184-1
139	Monduli DH	105287-7
140	Ngorongoro DH	113930-2
141	St. Joseph CDH	107597-7
142	Hai DH	101295-4
143	Rombo DH	113986-4
144	Kibosho DH	102621-0
145	Same DH	123119-0
146	Siha DH	109265-9
147	Usangi Hospital	108166-0
148	Vwawa DH	108289-0

Annex 3: List of Proposed Manuscripts Based on the Analysed Data in the Report

S/N	Proposed Title of the Manuscript	Name of the Lead Author
1	Surgical Site Infections in Tanzania: 5-Year Trend and Variation Analysis	Cesilia Charles
2	Hepatitis B vaccine coverage among health service providers: A trend of five years from 2021 to 2025 in mainland Tanzania	Melkizedeki Kwizombe & Siril Kulaya
3	Trends, Distribution, and Variations in Neonatal Sepsis Rates in Tanzania Health Facilities: Analysis of DHIS2 Data from 2021 to 2025	Jonhas Masatu
4	Occupational Exposure and Post-Exposure Prophylaxis for HIV among Healthcare Workers: A 5 Year Retrospective Analysis of DHIS2 Data in Tanzania.	Andrew Kigombola
5	Compliance with Hazardous Waste Segregation Standards in Tanzania's Healthcare Settings: An Empirical Analysis of Prevalence and Determinants	Syabo Mwaisengela
6	Data quality	Chrisogone German
7	Association Between Quality Improvement Team Activities and IPC Outcomes in Tanzanian Healthcare Facilities: A Five-Year Longitudinal Study (2021–2025)	Erick Kinyenje
8	The Influence of IPC training coverage on healthcare workers Practices in Health Facilities in Tanzania: Analysis of Routine DHIS2 Data from 2021 to 2025	Elford Mukerebe
9	Trends and Patterns of Non-Occupational Exposure and Post Exposure Prophylaxis Utilization	Hajrat Mohamed