

## United Republic of Tanzania



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The United Republic of Tanzania (URT) is composed of Tanzania Mainland and the state of Zanzibar.. Consequently, in the URT there are two independent Ministries of Health and Social Welfare, each with a Cabinet Minister. In Tanzania Mainland, health services follow the administrative organization with 21 Regions, 113 districts and 133 local authorities; in Zanzibar, there are two health zones with ten districts.

Since independence URT has enjoyed political stability, and economic growth. By 2006, the country had achieved an increase in GDP of 6.7% per annum thereby increasing the total government budget. The GDP per capita has been increasing from US\$ 277 in 2003, US\$ 324 in 2006 and US\$ 414 in 2007 based on current prices. The country has invested substantially in the public sector including health reforms that have embraced public-private partnership and decentralization of the entire public sector.

### HEALTH & DEVELOPMENT

- Tanzania's population is young ; 44% being children under the age of 15 years. The fertility rate is high at 5.7 given unmet needs for family planning standing at 22% for Mainland and 31% for Zanzibar and low contraceptive prevalence. With a predominantly rural population the country has recently made **impressive gains in reducing infant and under-five mortality rates** despite 57.8% of the population estimated to live under the poverty line of 1 USD per day.
- Malaria is a leading public health problem in Tanzania Mainland contributing to 39.4% of the total OPD attendances and a leading cause of deaths below and above 5 years of age: The Tanzania HIV/AIDS and Malaria Indicator Survey (THMIS) 2007/08 indicates that malaria prevalence in Tanzania mainland has declined from 20% in 2006 to 18% and similarly anaemia has fallen from 10% to 8% over the same period. Ownership of mosquito nets has increased significantly over the years from less than 15% in 1999 to nearly 60% in 2007. Zanzibar has shown a marked decline in malaria incidence since the scaling up of multiple interventions [ACTs since 2003, free access of Long Lasting Insecticide Treated Nets (LLINs) to the vulnerable groups and the deployment of Indoor Residual Spraying (IRS)]; Malaria prevalence in Zanzibar stands at 0.8% in under-fives.
- Trends in child health have been positive – gradual increase in exclusive breast feeding from 23% of infants in 1991/1992 to 41% in 2004/05; decline in underweight prevalence from 25% of under fives in 1991/1992 to 17% in 2004/5; decline in infant mortality from 99 in 1999 to 68 per 1000 in 2004/5 and further decline to 58 in 2008.
- HIV prevalence among 15-49 years age group has shown a marked decline from 7% in 2003 to 5.7% in 2007 for Tanzania Mainland while the prevalence in Zanzibar has remained below 1% in the general population. The level of knowledge of HIV prevention methods is high. Action to fight the HIV/AIDS problem has been boosted by high level political support.
- TB case notifications have stabilized at 50% of expected WHO estimates; the treatment success rate has surpassed the WHO Global TB control target of 85%.

Total population millions (projected 2008)	URT	39.9
% Pop under 15 years	URT	44
%Rural population	URT	77
Life expectancy at birth		
Men	URT	51.4
Women	URT	53.6
Infant mortality	Mainland Zanzibar	58 54
Neonatal mortality	Mainland	29
Under fives mortality	Mainland	91
Maternal Mortality	Mainland Zanzibar	578 362
DPT-HB3 coverage in Children 12-23 months	Mainland	83%
Malaria prevalence	Mainland Zanzibar	18% 0.8%
HIV/AIDS Prevalence (15-49 years)	Mainland Zanzibar	5.7% 0.8%
Tuberculosis Case Detection rate	URT	51%
Tuberculosis treatment success rate	URT	87.4%
Births assisted by skilled personnel	Mainland Zanzibar	46% 51%
Vitamin A supplementation level (% children 6-59 months)	Mainland	85%
Stunting (chronic malnutrition)	Mainland Zanzibar	38% 23%
Access to clean and safe water within 30 minutes spent collecting water (% population)	Rural Urban	37% 77%

OPPORTUNITIES	CHALLENGES
<ul style="list-style-type: none"> <li>High level political commitment to support health translating into gradually increasing health budget</li> <li>Decentralization by devolution empowering local authorities enables planning for Primary Health Care implementation.</li> <li>Pro-poor policy framework – National Strategy for Growth and Reduction of Poverty and a Health Sector Strategic Plan supported by a wide range of stakeholders.</li> <li>Nationwide health infrastructure with a broad primary health facilities base.</li> <li>A large pool of health training resources (tertiary education and Allied Health Schools).</li> <li>Strong government ownership of the health reform agenda and formal commitment to gradually increasing the funding of the sector over the next five years</li> <li>Institutionalization of health policy analysis and training in the new MOH Centre for Health Systems Development</li> <li>Pooling of funds at the national level provides new opportunities for improving equality of resource allocation and reducing the financial burden of care for the poor</li> <li>Establishment of professional associations for professional development and to increase quality of care</li> <li>Development of Community Action for Health, to empower communities to control social determinants of health</li> <li>Good childhood immunization programmes sectors and regions to promote equitable and sustainable economic growth, improving health, education and well being for everyone.</li> <li>Evolving processes of Alignment and Harmonization with Government planning and budgeting cycles</li> <li>An advanced SWAPs mechanism in the health sector</li> <li>Evolving 'One UN Reform' – Delivering as One through Joint Programmes</li> </ul>	<ul style="list-style-type: none"> <li>Human resources for health development, management and retention in a sector running with less than half of required health workforce</li> <li>Persistently high maternal mortality</li> <li>Improving quality, reliability, completeness of health data and coordination of sources</li> <li>Double burden of disease (CDs and NCDs) with occurrence of drug resistance in some CDs</li> <li>Adherence to standards to uphold quality health service delivery</li> <li>Procurement and forecasting weaknesses have continued to affect regularity of medicines and supplies at health facilities</li> <li>Health care financing on equitable base and allocative efficiency within an environment of rising costs of medicines and care</li> <li>Low population coverage with unequal access to adequate health services, clean water and sanitation.</li> <li>Inadequate health information systems for monitoring and analysis of health indicators.</li> <li>Immature HR capacity development throughout the health sector. Intensive recruitment of national staff to fill of the established posts well advanced.</li> <li>Reliance on external cooperation: during the past years about 40% of the Ministry of Health (MOH) budget has been financed through bilateral/multilateral agencies; this will fall in future years.</li> <li>Sector coordination while making an effort to meet competing agendas of partners</li> <li>Meeting performance expectations of multitude of partners</li> <li>Providing leadership to positively influence sustainability of Development Partners activities</li> </ul>

## PARTNERS

Bilateral Partners include Swiss Development Cooperation, DANIDA, The Netherlands, Irish Aid, GTZ, KfW, CIDA Canada, JICA, USAID, and indirectly The European Union. Key multilateral partners include the African Development Bank, The World Bank, UNICEF, and UNFPA. WHO is the leading partner in health on behalf of the UN under the One UN initiative: Other UN Agencies that indirectly or directly support health include UNAIDS, UNDP, WFP and FAO.

Government, Development Partners and Private funds form dominant expenditures in the health sector. Domestic funds support the recurrent budget including wages and other recurrent costs, while the development budget is more heavily supported by foreign funding. Basket funding is increasingly playing an important role in health as a pooled fund from subscribing Development Partners. In addition to bilateral and multilateral development assistance, URT receives funds from Global Initiatives such as the GFATM and GAVI, and other mechanisms which largely operate outside the framework of Alignment and Harmonization (Paris Declaration).

## WHO STRATEGIC AGENDA (2010-2015)

- 1. Supporting the progress towards the achievement of the health related MDGs within a framework of strengthening health systems and service delivery**
  - Human Resources for Health
  - Health Financing
  - Health Information Systems
  - Scaling up of Health Services Delivery
  - Community based health services and health promotion
- 2. Support to national priority programmes**
  - Reduction of maternal, newborn, and child mortality
  - Combating communicable and noncommunicable diseases
  - Epidemic Preparedness and Response
- 3. Supporting actions on social determinants of health**
  - Addressing the risk factors for noncommunicable diseases
  - Contribution to Government and other partners' efforts towards Promotion of Food Safety and Reduction of Malnutrition
  - Integrate gender equality and rights into the health programmes
  - Support Tanzania to ensure environmental sustainability for better health
- 4. Supporting partnership for health development**
  - Leadership role in technical matters related to health
  - Health coordination among UN and other Health Development Partners
  - Foster partnership to deliver the MDGs
  - Public Private Partnership (PPP) strengthening
  - Advocate for conduction of Health Impact Assessments
  - Strengthening inter-sectoral collaboration for health



HE President Jakaya Mrisho Kikwete launching the Health Sector Strategic Plan and presents copies to representatives of the public & private sector

## ADDITIONAL INFORMATION

WHO country office web site <http://www.who.int/countries/tza/en/>

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