WORLD HEALTH ORGANISATION

COUNTRY OFFICE FOR AFRICA

Health Systems Profile

United Republic of Tanzania

October, 2004

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FOREWORD

1 GENERAL SITUATION AND TRENDS

1.1 General context and demography

The United Republic of Tanzania (URT) is a Union of two formers states Tanzania Mainland (formerly called Tanganyika) and Zanzibar that united in 1964. It is situated on the eastern shores of Africa, and is bordered by Kenya and Uganda to the North, Democratic Republic of Congo, Rwanda, Burundi and Zambia to the West and Malawi and Mozambique to the South. URT located between longitudes 28°E and 40°E; latitudes 1°S and 12°S.

URT has a total area of 947,480Km^2, of which 883,000Km^2 constitutes land. The country is formed by two states. Tanzania Mainland occupies 881,000Km^2 and the islands making up the state of Zanzibar occupy 2,000Km^2. The state of Zanzibar includes the islands of Unguja and Pemba.

Tanzania has largely savannah climatic pattern, with two rainy seasons (short rains in November/December and long rains from March to May). The cold season begins in June/July and ends in August and a hot period extending from October through to February. The average temperature ranges from 20^{o}C to 30^{o}C, but varies greatly between the colder mountainous regions and warmer coastal belt.

The population size of the country has grown at a rate of 2.9% from 1988 to 2002 and stood at 34.6 million, according to the latest Census in 2002. However, the rate of population growth differs according to the 26 regions. The regions that show high rates of growth are predominantly in urban areas, such as Dar es Salaam, but also in areas of high refugee influx, namely Kigoma. Males are 48.9% of the population while females are 51.1%. Infants and children under-five form 5% and 20% of the total population respectively and the total fertility rate is 6.3 children. The life expectancy at birth for Tanzanians is 54 years (52 years for men, 55 years for women). Due to HIV/AIDS life expectancy as almost remain stagnant.

The demographic profile of URT or population pyramid is show in the figure below:

The wide base of the pyramid is characteristic of a population with a high fertility rate and a high child mortality rate. The majority of the population are children (<18 years).

The population of Zanzibar stands at 1.0 million and exhibits a growth rate of 3.1%, higher than that of the mainland (2.9%).

The national population density stands at 39 people per Km^2; however, this varies considerably from region to region. The Dar es Salaam and Urban West regions exhibit particularly high population densities of 1793 people per Km^2 and 1700 people per Km^2, respectively, compared to the rest of the country. Zanzibar also has a high population density of 400 people per Km^2.

Tanzania's 120 ethnic groups are unified through Kiswahili, the official language that has contributed considerable national social cohesion. English language is also used, especially when handling foreign engagements.

1.2 Economy and literacy

The latest per capita income is at US$ 260, (2002 Bank of Tanzania 2002 report) making Tanzania one of the poorest countries in Africa. Since the adoption of economic recovery program in 1985 the country has witnessed good progress in terms of economic growth. An average growth rate of 4.0% was recorded between 1992 and 1998 compare to 2.5% in a period prior to that. Every sector contributed to the growth of the economy in 1998; especially high growth rates were observed in mining, manufacturing, construction, transport and communications.

In 1999, the country's GDP grew by 4.8%. This was mainly due to growth in agriculture and trade sectors, which observed higher growth rates than in 1998. Growth in most other sectors was lower than the previous year. Gross domestic produce increased to 59,861 million in 1999 and the income per capita increased to shs.193,409 (1999 prices), a 13.3% increase since the previous year. The growth in the agricultural sector contributed about 48.9% of the GDP, suggesting that Tanzania is heavily dependent on its under-developed agricultural sector.

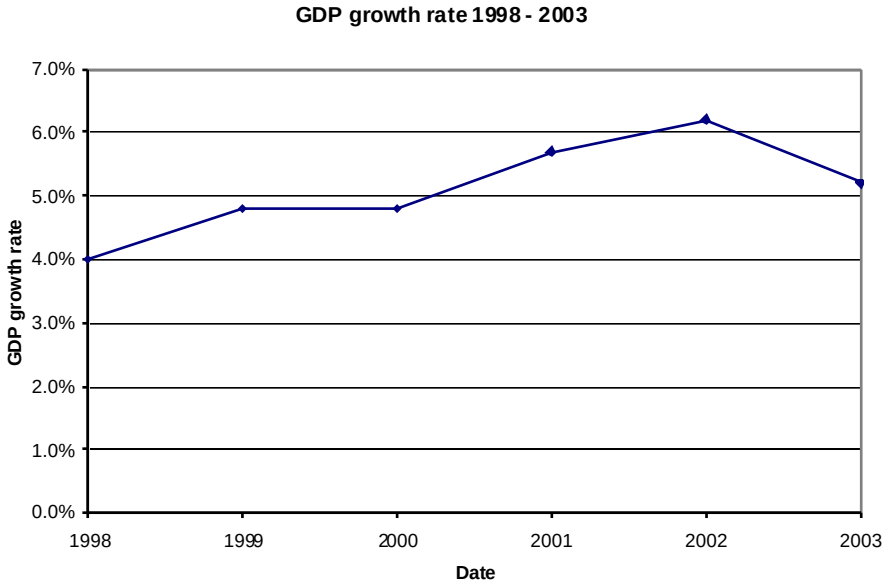
The NCP index for 1999 showed an average inflation of 7.8% compared with 12.9% in 1998. This was attained through better control of money supply and government expenditure restraining policies. Unfortunately, the reduced inflation did not contribute to significant economic growth.

The current situation has been shaped by socio-economic reforms, launched in 1986, focusing on market economy and participation of the private sector and civil society (NGOs, research and training institutes, religious mission). In 1999, the Tanzanian Development Vision 2025 was launched, which will attempt to achieve:

- Higher quality of livelihood
- Peace, stability and unity

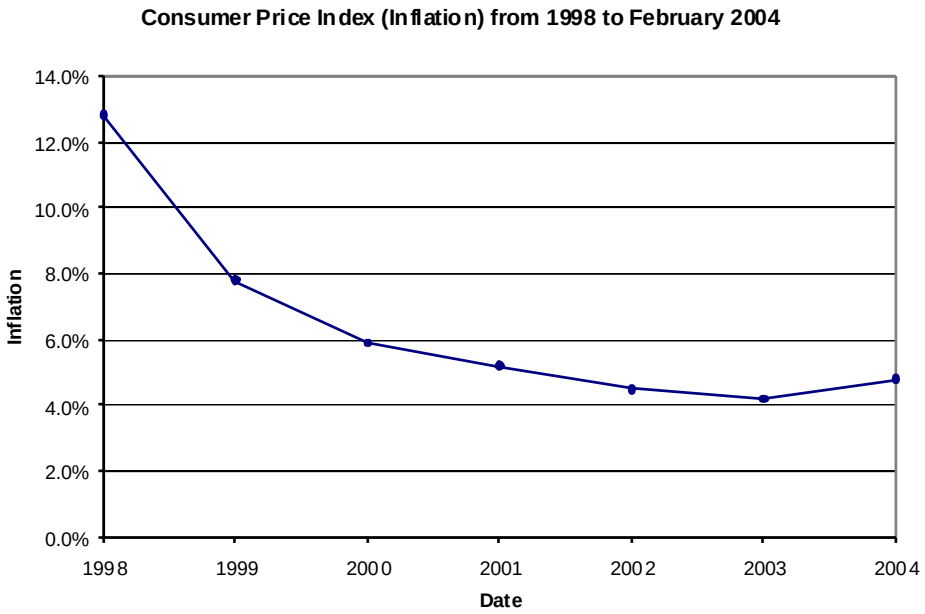
- Good governance
- A well-educated and learning society
- A competitive economy capable of producing sustainable growth and shared benefits.

The Tanzanian economy continued to improve during 2002, recording a GDP growth rate of 6.2%, the highest level attained in many years. Agriculture, still contributing most significantly to GDP, grew at a rate of 5.8%, which was slightly below the 6.5% from 2001. Growth in agriculture was held back mainly by poor weather, lack of credit and investments, under-developed infrastructure, inefficient marketing channels and a lack of production facilities. The GDP growth rate decreased to 5.2% in 2003.



Source: adapted from the Economist Intelligence Unit 2003

During June 2003, consumer price inflation stood at 4.3, a slight increase from 4.2 during March 2003. This low rate of inflation was due to a combination of tight monetary policy and the implementation of a cash budgeting system by the government. In February 2004, inflation increased to 4.8%, mainly due to raised prices of food, fuel, power and water subgroups.



Source: adapted from the Economist Intelligence Unit

In May 2004, the Government passed a supplementary budget to help to cover both the costs of rebuilding food stocks and rising energy cost. The country's strong relations with the IMF were apparent in its latest review of the country's PRGF facility. However, the Fund emphasised the need for reform in the energy sector. The Bank of Tanzania has successfully managed to reduce the headline prime-lending rate. With support from donors, the Government of Tanzania is in the process of conducting a major survey to try to quantify accurately the impact of HIV/AIDS on the economy.

In Zanzibar, the GDP growth rate was slow from 1995 to 2000, and has oscillated between extremes of 7.1% in 1996 and 0.5% in 1998[1]. This was due to a number of factors, most notably the retraction of aid and development assistance during political tensions in 1995-2002. Development aid was resumed and the 'Development Vision 2020' was launched in 2002, focusing on the eradication of absolute poverty and the creation of a suitable environment.

Until recently, the government refrained entirely from domestic borrowing in line with the objective of sustaining macro-economic stability. The primary macro-economic concern arising from Tanzania's fiscal situation relate to the effects of increased aid flows. These are in two areas; one is hampering the competitiveness of the economy and second is the aid dependency and related risk to sustainability of current expenditure levels.

The Ministry of Finance's strict control of the fiscal deficit has underpinned Tanzania's solid macroeconomic performance over recent years. The fiscal policy will continue to be guided by the prudent expenditure commitments outlined in the poverty reduction strategy, focussing on expenditure

[1] Zanzibar Poverty Reduction Plan (ZPRP)-Thematic Papers for the launching of Zanzibar Poverty Reduction Plan, May 1998

on 'priority sectors'. These include agricultural development, the provision of education and health facilities and infrastructure development. However, implementation will still be constrained by a lack of capacity. On the revenue side, the government will continue to try to widen the tax base, improve tax administration and eliminate taxes that impede business. To-date, monetary policy has set targets for the rate of money supply growth; most recently, in June 2003, set a growth rate of 10-12% for broad money??? for the year ending June 2004, in order to achieve its initial inflation target of 4%. Subsequently, due to drought and rising food prices, the Bank of Tanzania has informally increased its inflation target to 5%. All the same, inflation is expected to remain moderate and fairly stable.

URT's macroeconomic growth has not been successfully translated into microeconomic development. This means that the poorest and most vulnerable groups do not benefit from its countries economic performance. The 2001 Household Budget survey (HBS 2001) indicated that there has been little reduction in basic needs and income poverty –i.e. 36% of the population could not meet their basic needs, compared to 39% ten years earlier, and 19% did not have an income high enough to meet the basic daily caloric requirement, falling from 22% ten years earlier. Other data also correlate this finding that, despite impressive levels of growth, many Tanzanians are not benefiting from the wealth gained by their country's economy.

Total debt stock stood at US$ 8,679.4 million at the end of February 2004, out of which US$ 7,825.2 million was external (90.2%) and US$ 854.2 million was domestic debt (9.8%). The country's huge external debt has had a negative impact on its economy and continues to hinder the government's ability to fight poverty and improve public health. URT has become the fourth country to access full HIPC facility under the Enhanced Debt Relief Framework. This has stimulated the beginning of debt reduction, which will continue over a 20-year period by which time external debt will be reduced by approximately US$ 3,000 million.[2]

The impact of HIV/AIDS is also acting as an external shock to URT's economy and is the single biggest threat to socio-economic development. HIV/AIDS is currently imposing a burden on the country's financial resources through augmented medical expenditures, absenteeism from work, reduction in workforce numbers and training costs in re-building the labour force. The HIV pandemic is hindering the countries ability to improve the health and well being of its people and is a responsible factor in the country's high mortality and morbidity, and poverty[3].

With the introduction of public sector reforms and restructuring, unemployment levels have increased by 3.6% (rural) and 11% urban[4].

[2] Budget speech by the MOF/Mainland, 2002/2003.
[3] WHO Country Cooperation Strategy: Tanzania 2002
[4] A survey undertaken by Bureau of statistics Tanzania in 1991.

The gross primary school enrolment ratio for 1997-2002 was 63 for both males and females, with an attendance rate of 47% for males and 51% for females. The percentage of primary school entrants reaching grade 5 increased from 82% in 1995-1999 to 96% in 1995-2002. However, gross secondary school enrolment has not had similar success, with an enrolment ratio of 6 in males and 5 in females.[5]

Adult literacy rates, from 2000, are 84 for men and 67 for women, thus showing differences in education levels between adult males and females. Although girls under 14 have higher attendance rates at school[6], adult women have lower levels of education than their male counterparts.

1.3 Environmental Health

There is a lack of a single comprehensive Public Health Legislation in country. The existing legislation is scattered under different authorities and is out-dated for present times and the standards for the protection of the environment are inadequate as a basis for implementing legislation of the control of human health hazards. Furthermore, there is inadequate enforcement of the existing legislation, due the lack of legal background amongst personnel employed by the enforcing authorities. This means there is deterioration in environmental health and sanitation services, causing the spread of communicable disease and a failure to prosecute those responsible.

Tanzania's water sources include surface water, ground water and rain water. Due to socio-economic, geographical and demographic condition most of the water supply can be categorised as unsafe. About 20% and 68% of people living in urban and rural areas respectively do not have access to clean water according to the WHO Department of Health Action in Crisis. The National Water Policy of 1991 states that safe water should be available within a radius of 400m from the home. One water point should serve safe water to 250 people with an average consumption of 40 litres per person per day. The National Environmental Policy states that the implementation of water sources, as well as other development programs, should be carried out in an integrated manner and protects water catchments areas and their vegetation cover. However there are many problems affecting the provision of safe water to communities, as highlighted by National Environmental Health and Sanitation Policy Guidelines (April 2002), including inadequate operation and maintenance, low coverage especially in rural areas (30%) and unplanned settlements, pollution and contamination of water sources and a high leakage rate (50%). According to the Household Budget Survey 2000/01 sanitation service levels were gauged at 90% but hygiene practices such as population washing hands after toilet visit were poor (33%).

[5] Bureau of Statistics 2002
[6] Executive summary: The policy implications of Tanzania's mortality burden, Volume 1: A Ten-Year Community-Based Perspective. Adult Morbidity and Mortality Project, Ministry of Health URT, DIFID, University of Newcastle Upon Tyne.

Tanzania has a National Environmental Policy (1997) that emphasises the promotion of safe water, environmental infrastructure to protect waste disposal services, the development of urban and rural waste management systems and the review of the laws governing hazardous wastes. Nevertheless, solid waste management has become an increasing problem, especially in urban areas where there are many sources of waste and few effective disposal methods. Only a small population are served by the central sewage system. Most solid waste is buried or burnt on-site, disposed of at road sides, on open areas or in valleys and storm water drains. Wastes containing hazardous components and hospital wastes are also disposed of in the same sites. There is no defined management of domestic and agricultural wastes in rural areas.

Few industries are associated with the municipal sewage system. Instead, industries are expected to have a pre-treatment plant, but again this is rarely the case. Other industries discharge wastewater and even products directly into rivers or leave them to percolate underneath soil.

There is inadequate legislation protecting public health and the environment from chemicals that have otherwise either been banned or are strictly regulated in developed countries. Registration of industrial and consumer chemicals is not yet in place in Tanzania; and the amount of such chemicals that are imported for local use and those manufactured locally is unknown. Government is currently drafting a bill to protect the public from chemicals that have been banned elsewhere.

The problems associated with environmental health have been attributed to many factors, such as inadequate resources, poor public awareness and participation, lack of strategies and integrated plans on management, inadequate policies governing waste disposal and hazardous chemicals, inadequate laws and regulations and weak enforcement of existing laws.

Shelter in urban and rural settlements varies widely, but for the majority of people, housing is inadequate which has lead to non-sanitary situations that threaten the health and productivity of its inhabitants.

1.4 Healthy lifestyles, food and nutrition

In 1980, the country saw a dramatic rise and fall in alcohol consumption during difficult economic times. However, since 1990, alcohol consumption has levelled off at approximately 6 litres per capita per year in adults (+15) and remains relatively constant[7].

The annual adult consumption, per capita, of tobacco has remained steady since the early 1980s at approximately 370 cigarettes per year. In 1990, adults in rural areas had varied rates of smoking between 28% and 43% in men, but were much lower (<4%) in women[8]. In the same areas, 7.3% of boys aged 15-19 years smoked, while almost no girls of the same age group smoked. Tobacco control

[7] Alcohol in Developing Countries: A Public Health Approach. Pg 40-50.
[8] Tobacco or health: a global status report. WHO Geneva. Pg 131-133.

measures in Tanzania are weak. The anti-tobacco legislation of 2003 prohibited smoking in public places and advertising without warning on health side effects. Neither alcohol nor tobacco consumption are considered major causes of morbidity or mortality, relative to other causes of illness.

Although there are no conclusive national figures available, drug abuse is considered a major social problem, especially among young people in Zanzibar and Dar es Salaam. In 2000 a KAP survey in Dar es Salaam and Stone town, Zanzibar, showed that 2.0% of the population used cannabis. The use of heroin has also increased since 1994. Drug abuse prevention organisations have been set up and are actively engaged in both Mainland Tanzania and Zanzibar.

Protein-energy malnutrition (PEM) is a significant public health problem, especially among children and women[9]. About 16% of children are born with a birth weight of under 2500 grams and 44% of children under 5 have stunted growth, implying significant chronic PEM and 30% are under weight (acute malnutrition). The rural population has more pronounced PEM. Micronutrient deficiencies are also common in children and women. Poor food safety, inadequacies in feeding and micronutrient deficiencies, such as iron, iodine and vitamin A, and frequent illness put children at high risk of suffering from and eventually dying from PEM. The high rate of micronutrient deficiencies in women manifests approximately 14% of women in the high land and 80% in costal areas being anaemic during pregnancy, and about 25% of maternal deaths being associated with anaemia: Nearly 70% of women are vitamin A deficient, despite the apparent high rate of vitamin A supplementation coverage of over 90% in 2002.

2 COUNTRY HEALTH STATUS

2.1 Mortality

The charts[10] below show that there is a high mortality rate in all ages in the Tanzanian population.

There are inequalities in morbidity rates between age groups and a swell in mortality rate between ages 20 and 50 that is likely to be caused by HIV/AIDS, a problem described as a national emergency. Although it is clear that these high rates of preventable mortality remain a huge burden on the country, trends in mortality rates have shown an overall decrease since the mid-1990s.

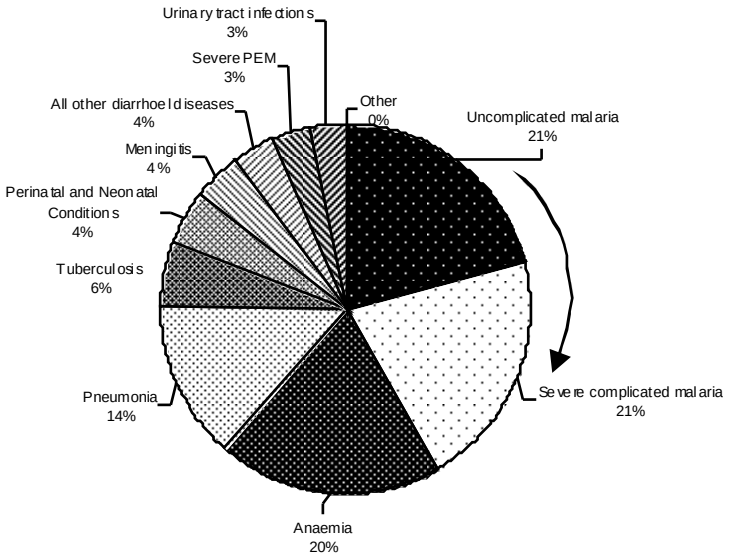
There are also significant geographic inequalities in mortality, as well as in their causes. The age-adjusted death rate, which allows areas to be compared despite differences in age-structure, is higher in Dar es Salaam than in rural areas (Hai and Morogoro)[11].

[9] Second Health Sector Strategic Plan (HSSP), July 2003 – June 2008, Ministry of Tanzania, page vii.
[10] Executive summary: The policy implications of Tanzania's mortality burden, Volume 1: A Ten-Year Community-Based Perspective. Adult Morbidity and Mortality Project, Ministry of Health URT, DIFID, University of Newcastle Upon Tyne. Pg 31.

The main causes of mortality among the Tanzanian population, in all ages and in children under-five years are shown in the figures below.

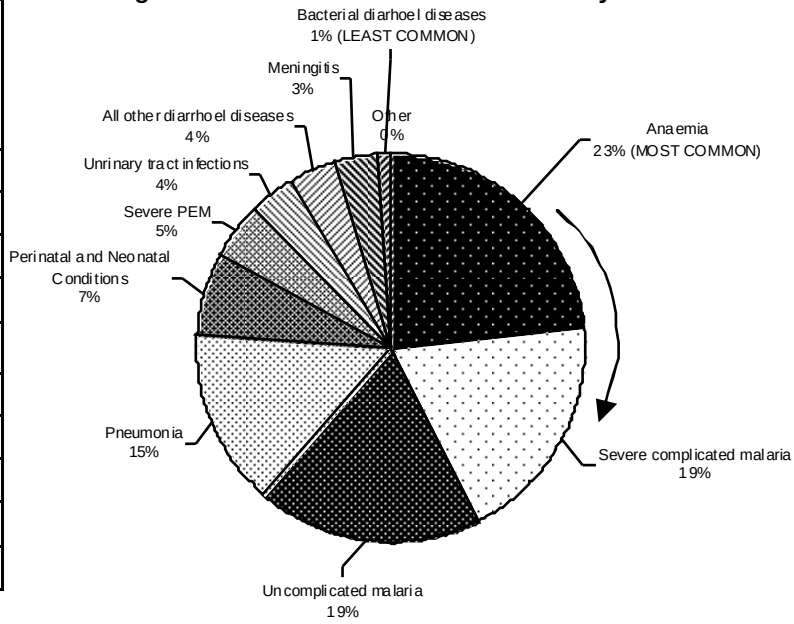
Ranking (leading causes) in ALL AGES	Disease
1	Uncomplicated malaria
2	Severe complicated malaria
3	Anaemia
4	Pneumonia
5	Tuberculosis
6	Perinatal and Neonatal Conditions
7	Meningitis
8	All other diarrhoeal diseases
9	Severe PEM
10	Urinary tract infections

10 leading causes of death in ALL AGES, in 2000



Ranking (most common) in children UNDER-FIVE	Disease
1	Anaemia
2	Severe complicated malaria
3	Uncomplicated malaria
4	Pneumonia
5	Perinatal and Neonatal Conditions
6	Severe PEM
7	Urinary tract infections
8	All other diarrhoeal diseases
9	Meningitis
10	Bacterial diarrhoeal diseases

10 leading causes of deaths of children under-5 years in 2000



Source: adapted from Health Statistics Abstract 2002. Health Information and Research Section, Planning and Policy Department, Ministry of health.

[11] The policy implications of Tanzania's mortality burden, Volume 1: A Ten-Year Community-Based Perspective. Adult Morbidity and Mortality Project, Ministry of Health URT, DIFID, University of Newcastle Upon Tyne. Pg 114.

Malaria remains a serious significant public health problem and is the number-one cause of mortality in the general population and a major childhood killer. The estimated number of malaria cases per year is about 14-19 million, causing about 100,000 deaths per year, of which 70,000 are children under-five[12]. The effects of malaria are most devastating in pregnancy or when complicated by HIV/AIDS.

The infant mortality rate for 2002 was 104, which was a substantial decrease from 142 in 1960. Likewise, the under-five mortality rate dropped to 165 in 2002 from 241 in 1960. Nevertheless, it is estimated that one out of seven children die before the age of five and two-thirds of deaths are occurring before the age of two. About 75% of these deaths are caused by preventable diseases/conditions including malaria, pneumonia, malnutrition and diarrhoea. Tanzania is not on track to meet the 2015 target of reducing under-five mortality by two thirds within the first year after birth.

The maternal mortality rate is high at 529 per 100,000 live births[13]. This means that 9000 women die annually due to pregnancy related causes, while a further 250,000 become disabled from the same causes (op cit). Early and frequent pregnancies have additional risk to maternal mortality and morbidity – 26% of adolescent girls have their first birth by 19 years, which may have contributed to the high maternal mortality rate. The poor national maternal health is not only an indication of poor reproductive health, but also of women's low status in Tanzanian society and poor access to basic health services. Nevertheless, trends in maternal mortality rate suggest that it is decreasing slowly. Maternal mortality rates have decreased (1992-1999) in Dar es Salaam, however only at the 90% significance level, and have decreased insignificantly in the Hai and Morogoro districts[14].

HIV/AIDS is acting as a significant threat to public health and underlies many of the 10 leading causes of death. The NACP reported a cumulative total of 144,498 known AIDS cases by the end of the year 2001. It has also been noted by the NACP that only 1 out of 5 AIDS cases is reported. At the end of 2003, about 1.6 million people were living with HIV/AIDS, of which 1.5 million were adults and 500,000 were children. The overall prevalence rate of HIV/AIDS is 9.6 (2003). On mainland Tanzania, 15% of people aged 15-49 years are infected with HIV and 60% of new HIV infections occur among young people (15-24 years). Overall prevalence of HIV among blood donors for the year 2001 was 11% with greater prevalence amongst females; the latter acquire HIV infection at an earlier age. Zanzibar is also experiencing a rapid spread of HIV/AIDS with 2011 cases in October 2001, from only 3 cases in 1986. There is a greater prevalence rate amongst females compared to their male

[12] President Benjamin Mkapa's monthly address on 1 August 2004.
[13] Second Health Sector Strategic Plan (HSSP), July 2003-June 2008.
[14] Robert Mswia et al. Community-based monitoring of safe motherhood in the United Republic of Tanzania. Bulletin of the World Health Organisation 2003, 81 (2).

counterparts. The major mode of transmission is heterosexual and it has been noted that transmission is still rising rapidly despite high level of awareness on condoms.

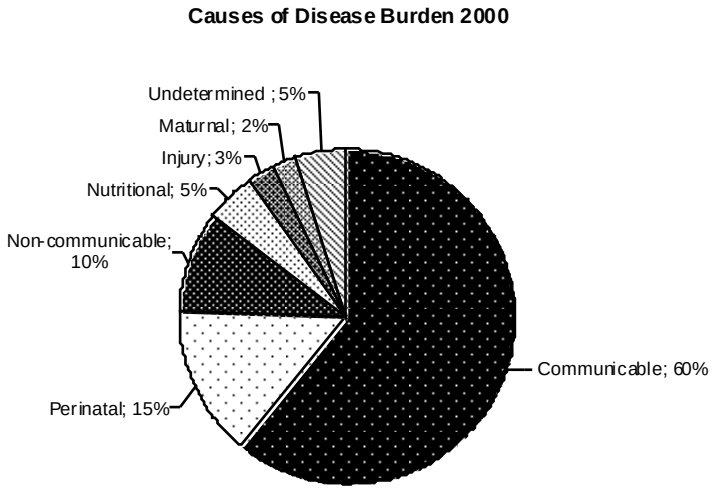
HIV/AIDS has had a significant impact on children directly, via vertical transmission from mother to child, as well as by orphaning children from their HIV+ parents, exposing them to vulnerability situations (sex abuse, child labour, stigma, marginalization etc) that are detrimental to their health. In 2001, there were about 815,000 child orphans.

During 2004, it was estimated that only 1650 people are receiving ART, out of 260,000 who are in need of medicines. Only a few Tanzanians can afford ART.

The Tanzanian government has acknowledged the HIV/AIDS pandemic as a national emergency and has formed the Tanzania Commission for AIDS (TACAIDS) to spearhead bold multisectoral measures to fight it.

2.2 Morbidity, disability and major health problems

The majority of the causes of morbidity are communicable diseases[15], as opposed to non-communicable diseases.



Source: adapted from Health Statistics Abstract 2002. Health Information and Research Section, Planning and Policy Department, Ministry of health.

In 2000, 16% of the population were under-five years; yet about 55% of the disease burden in the total population affected children under-five (although this burden had decreased by 7% from 1999). About 2.3% of the total burden of disease was experienced in maternity.

[15] Health Statistics Abstract 2002. Health Information and Research Section, Planning and Policy Department, Ministry of health.

Approximately 30% of the total burden of disease of the whole population is caused by acute febrile illness (predominantly malaria) according to the Bureau of Statistics (2002)???. About 66% of those with acute febrile illness are children under-five and 10% are women (aged 15-49). Malaria accounts for the top 33% of admissions and of outpatients. Following resistance to Choloquine, Fansidar was introduced as a first line drug. However resistance to this has also developed, causing health services to resort to combination therapy including Artemissin, a more expensive option.

Sexually transmitted infections (STIs), including HIV/AIDS, accounted for about 10% of the total disease burden for 2000. This was an increase by 7% from the previous year.

Tuberculosis, accounted for 7% of the burden of disease in 2000, which had increased since the previous year by 5%. The increase in tuberculosis morbidity is mainly due to the rising prevalence of HIV/AIDS.

3 RESPONSE OF THE NATIONAL HEALTH SYSTEM

3.1 National Health policies and plans

The aim of the National Health Policy is to improve the health and well being of all Tanzanians, with a focus on the most at risk groups of people and to address the unmet needs of the population.
The main priorities of the policy and plan of 1990 were as follows

- Reduce infant and maternal mortality and morbidity and to raise the population's life expectancy. The plan will attempt to reach these goals through the provision of better maternal and child health services, promotion of nutrition, control of communicable diseases and the integrated treatment of common conditions.
- Increase the availability and accessibility of health services to all people at no cost.
- Training cadres at all levels, from community to national level, to allow greater self-sufficiency in trained personnel.
- Mobilise the community on how to prevent common health problems and increase the capacity for communities to assess and analyse problems so that effective action may be implemented through greater community participation.
- Promote awareness among at the community level that health problems can be managed successfully through multi-sector cooperation, such as education, water and sanitation, community development, women's organisation, agriculture, NGO's and the Government.

However, there has since been developments in this policy. Private medical practice was re-legalised a year later and a cost-sharing system was introduced in the public health facilities in July

1993. A common framework for a comprehensive Health Sector Reform was formulated, focusing on an Inter-Ministerial Technical Committee and a Working Group in Office of the Ministry of Health (MOH). The working group included technical representation from other ministries, which acted by coordinating sector studies, developing a Health Sector Strategy and preparing a Health Sector Plan. In 1994 the Government prepared the Social Sector Strategy which, with respect to health, proposed a restructuring of the ministry with a focus on the provision of basic and preventative health services, decentralisation of services with greater independence given to district health authorities, greater attention to policy formulation, quality control and promotion of private investment in the sector.

In the Joint Ministry of Health and Donors Health Sector Reform mission of 1995, a donor statement was produced underlying the principles of the reform:

- Adjustment of the Government's function in the health sector, due to liberalisation of the economy, including its interface with the private sector and changes in services such as logistics, pharmaceuticals and human resources.
- The new role for the Ministry of Health in policy, sponsorship and regulation of the health sector.
- Financing of provision of essential cost-effective health packages.
- Decentralisation of the public sector health system, with an emphasis on the production unit on a district level.
- Reallocation of Government funds in favour of the essential health packages, with donor support, and development of the financing services not included in the health packages.
- Distribution of resources to areas on the basis of population, weighted for socio-economic factors.
- Continual improvement in the central drugs and supplies system.

The Joint Mission allowed the realisation that to implement the governments plan required regular review of the Three-year Government Action Plan (within the Strategic health plan), which had the following features. Firstly, to review basic governing principles to allow continued relevance to a changing environment, secondly, to allow agreement on the next steps in implementing reforms and on the tasks to be undertaken during the next period, such as sequencing and costs, and finally agreement on the implementation mechanisms as well as on the monitoring and evaluation of the action plan for the next review.

In 1996, the Health Sector Reform Plan of Action (1996-1999) formed the basis for implementation of the health sector/donor support in the reform process. Improved health of the family became a major strategy for reform in the health sector. The MOH coordinated this initiative, and provided increased emphasis on the provision of health, mainly through nutrition and family planning

intervention. Greater community-based health care was also highlighted as an integral part of the reform plan.

The National Health Policy (1990) was reviewed in 2002 and is now subject to government approval. The Proposal for Health Sector Reform of 1994, the Tanzanian Development Vision 2025, Poverty Reduction Strategy 2000, gender mainstreaming, the importance of vulnerable groups and HIV/AIDS have been incorporated in the updated Health Policy.

The main focus points of the Health Sector Reform Strategic Plan 2002-2007 (Zanzibar) and the Medium-Term Strategic Plan 2002-2004 (Mainland) are as follows:

- To improve access, quality and efficiency of district primary health services.
- To improve the management, quality, efficiency and financial viability to support primary-level services, teaching and research, in Level Two and Level Three hospital services.
- To improve the capacity for the MOH in sector-wide management, policy development, analysis and national planning; development of guidelines; performance monitoring, evaluation and regulation of service delivery and practice.
- To develop human resources for health by improving skills and building management capacity at all levels of the health system.
- To strengthen the national support systems for drugs and other medical supplies and equipment, physical infrastructure, health management information systems and transport.
- To improve health financing and financial management.
- To promote the participation of the private sector in the provision of health services.
- To develop and implement a system for donor and government involvement, coordination, monitoring and evaluation.

However, reforms have not responded fully to the health needs of the Mainland and Zanzibari population. Access to quality health services, especially among poor and rural communities, remains low. In fact, according to the World Health Report 2000, Tanzania is performing poorly, specifically in attaining fairness of financial contribution to health costs.

Floods and drought account for 38% and 33% of all emergencies respectively. Policies and strategies on the issue of national disasters and emergency situations are weak judging from recent experiences. Regional and Local Authorities are required to have Disaster Management Committees and an Emergency Preparedness Unit has been set up at the MoH to cater for management of emergencies. In the case of a large humanitarian emergency, the country has limited capacity to manage the event independently and greatly depends on the international community for assistance.

Reaching the Millennium Development Goals[16]

Despite improvements and progression towards reaching the Millennium Development Goals, much work still remains to be done. About 48% of the Tanzanian population is living below the basics needs poverty line. Poverty is widespread over the whole country, but is particularly prevalent in rural areas. Young children, youths, women, the elderly, those in large households, subsistence farmers, herders and small-scale fishermen are most at risk of falling below the basic needs poverty line. The country has been able to work towards the eradication of poverty by successfully maintaining a stable macroeconomic growth.

Between 1990 and 1999, HIV prevalence increased from 5.5% to 9.4%. In 2002, the prevalence fell to 7.8%, thus reaching the development goal of <8% by 2015.

While 92% of urban households were using safe water in 2000, this figure was only 56% in rural households. This means in order for the national average to reach the millennium goal of 82% using safe water, this disparity in clean water access must be addressed.

It is unlikely that Tanzania will halve the proportion of people suffering from hunger by 2015. The number of moderately and severely underweight children has risen between 1991 and 1999, from 28.8% to 29.4% respectively. Zanzibar, on the other hand is set to reach the goal if it continues to reduce hunger at its present rate.

Between 2001 and 2002 there was a large increase in net primary school enrolment and girl-boy ratios in primary schools were almost one, implying gender equity in this aspect. Indeed the poorest areas observed greater improvements than the least poor and in some cases were equal to the least poor. The country is likely to eliminate disparities in primary and secondary education by 2015. However, in order to achieve universal primary education, much progress is still needed in the set programme.

Child and infant mortality rates have dropped in both the poorest and least poor groups between time periods 1994-1999 and 1998-2002. However, the country is unlikely to reduce the under-five mortality rate to below 48 per 1000 live births. The proportion of orphaned children has increased between 1994 and 2001 by about 15% to 20% due to HIV/AIDS related deaths. This occurred mainly in the poorest groups with a huge rise of 73% in the Morogoro district and a 13% rise in Dar es Salaam. Nonetheless, there was an improved ratio of school attendance among the orphaned children compared to non-orphans (aged 10-14) from 16% to 28% between 2001 and 2002. This improvement was more pronounced in the poorest areas in both sexes.

There was improved maternal health between 1994 and 2001, reflected by a fall in maternal mortality ratios, an increase in births taking place in health facilities, and a drop in fertility rates. However, in 2001 and 2002 women of working age formed the largest proportion of the unemployed population in Dar es Salaam (this was worse in poorer groups) and the numbers of employed women

[16] Source: IDT/MDG progress, URT. UNDP

remained the same between 2001 and 2002. The current maternal mortality rate of 529 per 100,000 live births is unlikely to fall to the development goal of 133 by 2015.

The country may potentially reach the development goal of reversing the loss of environmental resources by 2015, but without significant progress to reduce poverty, it will be challenging to reach this goal.

3.2 Organisation and management structure of the National Health System

The National Health System is based on a central-district government structure. The MOH, President's Office Regional Administration and Local Government (PORALG) are jointly responsible for the delivery of public health services. The central Ministry of Health is responsible for policy formulation and the development of guideline to facilitate policy implementation. Regional Health Management Teams (RHMTs) interpret these policies and monitor their implementation in the districts they supervise. The District Health Management Team (DHMT) is responsible for Council health services including dispensaries, health centres and hospitals in a given district. The District Medical Officer (DMO) heads the DHMT as in charge of all Council Health Services. The DHMT follows guidelines for planning and management of district health issued jointly by MOH and PORALG. The DMO is accountable to the Council Director on administrative and managerial matters, and responsible to the RMO on technical matters. The Regional Medical Officer (RMO) heads the RHMT and reports directly to the Ministry of Health on issues related to medical management and PORALG through the Regional Administration Secretary (RAS) on issues related to health administration and management.

A dispensary provides preventative and curative outpatient services to the local communities and normal deliveries. Health Centres have 25 – 30 inpatient beds. They cater for inpatients and outpatients, deliveries, receive referrals from dispensaries, as well as conduct preventive service activities including outreach. Hospitals provide similar services to dispensaries and health centres but at a greater level of expertise given a higher level of clinical and nursing care capability and laboratory/radiology diagnostic capacity. Hospitals also provide surgical including emergency obstetric care. The referral system is made up of three levels: dispensaries, health centres and hospitals (district, regional and consultant).

The MOH also oversees autonomous agencies, such as the Food and Drugs Authority, Medical Stores Department, the Chief Government Chemical Laboratory, National Institute for Medical Research and the Tanzania Food and Nutrition Centre. The MOH collaborates with donors and non-governmental organizations on the implementation of public health programmes such as the Expanded Programme on Immunisation (EPI), Reproductive and Child Health (RCHS), National AIDS Control

Programme (NACP) Malaria Control Program (MCP) and the National Tuberculosis Leprosy programme (NTLP).

Health Services Boards and various community health committees (Health Facility Governing Committees, Community Health Fund Committees etc) have been formed to make use of community involvement in health service delivery and also contribute to the formulation, monitoring and evaluation of health plans.

The liberalization policy during the 1980s resulted in the MOH allowing 'private-for-profit' practice to complement Faith-Based Organisations (FBOs) working within the private health sector. Non-governmental organisations also operate in the private health sector. The Government has supported the work of voluntary agencies through substantial subsidies. Voluntary agencies run nearly half of all hospitals and provide half of hospital beds. The private organisations also provide care in health centres and dispensaries, although to a lesser extent. Since the Government's re-legalised private medical practice, the for-profit private sector has grown considerably since 1994.

Inter-sectoral collaboration for health development is achieved through coordination of planning, implementation and evaluation of health related activities. Sectors and organisations, such as donors, NGOs, Education, Agriculture, Water and Community development work together in preparing and implementing joint action plans for health promotion. Current emphasis (of TACAIDS for example) is to make multisectoral collaboration work at Councils.

With regard to the public-private mix in the health system, it is common that government health workers own or manage private health facilities, such as pharmacies and clinics. This has caused some conflict of interest between the public and private as hospital staff delay the availability of public medicines which would otherwise reduce profits from their privately owned pharmacies.

The informal health sector has provided Tanzanians, especially those in the least poor quartile of the population, with access to traditional medicines since the colonial period. Traditional medicine has continued to be practised separately from allopathic medicine, but has been threatened by its lack of written documentation on its practice, making its promotion difficult. The number of traditional medicine practitioners has declined as a result[17]. The Medical Practitioners and Dentists Ordinance states, "Nothing contained in this ordinance shall be construed to prohibit or prevent the practice of systems of therapeutics according to native methods by persons recognised by the community to which they belong". The Traditional Medicine Research Unit was established in 1974 and works to promote and standardize traditional medicine. However, there has been no attempt to incorporate traditional medicine into the training curricula of allopathic medical training.

[17] Mhame P. Development of national policy on traditional medicine and strategies for integrating traditional medicine into health systems. Presented at the WHO consultative meeting on strategy for traditional medicine for the African region 2001-2010. Harare, Zimbabwe, 13-15 December 1999.

3.3 Physical resources

3.3.1 Infrastructure

The health care delivery system has been marked by reform and improvement. There has been an expansion of health services to the rural areas facilitating greater access to the rural population. By 1980, about 45% of the population lived within 1km of a health facility, 72% within 5km and 93.1% within 10km of a facility[18]. However, there are still geographical inequalities in access to health services that can be attributed to its under-developed infrastructure.

Due to reduced expenditure since 1980s, there has been deterioration in the health infrastructure, and performance given poor or no maintenance of equipment, inefficient drug supply, low salaries, unmotivated staff, inadequate supervision and poor management. These issues are being addressed under the current Health Sector Reform as outlined in the HSSP (2003-2008).

Dispensaries serve a population of 6 -10 thousand people, a health centre 50 thousand and a district hospital 250 thousand people. The regional hospital serves as a referral centre to between 4 and 8 district hospitals and the four consultant hospitals serve several regional hospitals.

Table 1: Health facilities in Tanzania Mainland according to ownership

Facility Ownership	**Consultant Specialized**	**Regional Hospital**	**District Hospital**	**Other Hospital**	**Health Centre**	**Dispensary**
Government	6	15	39	4	211	2019
Parastatal	0	0	1	3	3	110
Private	1	0	0	33	11	396
Total	**2**	**15**	**40**	**40**	**225**	**2,525**

Source: HMIS Annual Report – 1997

Table 2: Health facilities in Zanzibar according to ownership

Facility Ownership	**Consultant Specialized**	**Regional Hospital**	**District Hospital**	**Other Hospital**	**Health Centre**	**Dispensary**
Government						
Parastatal						
Private						
Total						

[18] MOH, 1979. Inventory of Health Facilities in Tanzania.

3.3.2 Equipment

The Medical Stores Department (MSD) is lacking in certain major equipment, namely dental chairs and maternity beds, and there are long delays of up to 1-year in acquiring basic equipment. Council Health Management Teams do not have direct access to their drugs and equipment budget; this is disbursed direct to MSD, limiting Councils flexibility to purchase from other sources during the same budget year. However, councils are able to include the same item under 'other expenditure' in the following year to get permission to buy the item outside of the MSD. The process of purchasing essential equipment is therefore inefficient, and the equipment is occasionally of poor quality.

Distribution of equipment is uneven between the regions as can be observed from the following table.

Table 2: Distribution of some essential equipment by region:

Region	Motor Vehicles	Microscopes	Sterilizers	X-Ray machines
Dodoma	20	61	321	6
Arusha	34	102	612	29
Kilimanjaro	51	189	0	20
Tanga	0	0	0	0
Morogoro	34	28	10	0
Coast	0	0	0	0
DSM	6	74	248	11
Lindi	16	48	329	16
Mtwara	21	65	214	7
Ruvuma	16	30	521	11
Iringa	52	165	455	20
Singida	24	24	355	9
Mbeya	25	25	494	11
Tabora	21	20	269	9
Rukwa	0	0	0	0
Kigoma	25	25	258	6
Shinyanga	42	42	474	7
Kagera	47	47	435	13
Mwanza	2	2	468	15
Mara	26	26	539	8
Total	462	973	6002	198

Source: adapted from Health Statistics Abstract 2002. Health Information and Research Section, Planning and Policy Department, Ministry of health.

3.3.3 Medicines and medical supplies

Tanzania's National Drug Policy was completed in 1991. The policy necessitated the need to develop the Pharmaceutical Master Plan (1992-2002) as an implementation framework and suggested the creation of environment suitable domestic pharmaceutical industries to grow. This also stimulated the founding of institutions ensuring quality and procurement of safe efficacious drugs. The Medical Stores Department (MSD) is the sole provider of drugs and supplies to the public health care system. The policy allows for private sector suppliers to cater for private providers.

Medicine and medical supply availability is adequate. However, on the district level, there is oversupply of some essential drugs and undersupply of other medicines. This is mainly due to the standardised composition of the drug kits, as well as the limitation for councils to use health basket funds to buy medicines outside of the MSD. The MSD is also occasionally out-of-stock, effectively

leaving the health care services without a provider of specific drugs or supplies. While the MSD is able to buy essential drugs at low prices and from an efficient provider, councils request the authority to buy drugs outside of the MSD in case of an emergency or when the MSD is out of stock. The logic of the monopoly position held by the MSD is therefore debatable. However, decentralisation of the drug budget management can potentially lead to a misuse of funds and biased procurement of medicines.

Communication between health facilities and the district centre via a two-way radio system has been effective and efficient, and is used for patient care, referrals and administrative communication. The cascade supervision system and ambulance referral system also depend on this form of communication, however the cost-effectiveness of the two-way radio system is unknown.

3.4 Human resources for health (HRH)

With one doctor for every 20,000 people, there is a great need for human resource development in Tanzania. The situation in Zanzibar is worse than the Mainland. HRH development has to be addressed as a priority in order to respond adequately to improvements in health services. More specifically, there is a need for the right sizing and multi-professional workforce, better quality of staff training, a more balanced approach to the allocation of human resources across service levels and geographical areas, and workforce incentives and remuneration packages.

The number of staff working in the Council Health Management Team (CHMT), the Regional Medical Officer's (RMO) workplace and in health facilities is not according to approved staffing levels[19]. The Government-established patterns[20] are adhered to by the CHMT, despite different patient loads in different health facilities, leading to overstaffing in certain health facilities at the expense of other more needy health facilities. The health workforce is unevenly distributed in favour of large urban centres and the public sector. Tertiary and secondary health institutions consume most of the services of staff with significant gaps in staffing pattern.

Although districts have begun training initiatives, these are often based on locally perceived needs - districts could not provide training plans or an overview of what training had been completed the previous year. At the CHMT and Regional level, few vacancies are reported and capacity varies considerably, which is often associated with previous and ongoing CHMT and RMO capacity building projects. Detailed task analyses of the CHMT exist but no assessment of current capacity to undertake increasing tasks has been carried out. Also, there is little incentive for Councils to manage human resources efficiently.

The Selective Accelerated Salary Enhancement (SASE) scheme is limited in application and hence demotivating to staff not included. There is no structured performance based reward system for

[19] Technical Review of Health Service Delivery at District Level. Health Research for Acton (HERA). March 2003.
[20] Latest MOH guidelines on facility based staffing norms date from 1999/2000.

facility staff. Allowances only benefit staff whose frequency in the various workshops is already high anyway; these staff would usually have other work incentives, such as SASE etc. Other aspects of staff motivation, such as good work recognition, helping to perform better, improving working environment are used in some districts, but without any comprehensive strategic approach.

It has been concluded by research[21] that significant increases (up to 50%) in staff productivity can be made. However, despite these productivity increases, the number of staff needed is estimated to double in 2007 and triple by 2015. Interventions relating to HIV/AIDS are expected to take about 40% of staff's time.

[21] C Kurowski et al. Human Resources for Health: Requirements and Availability in the Context of Scaling-up Priority Interventions in Low Income Countries, case Studies from Tanzania. January 2003.

Category	Dodoma	Arusha	K'njaro	Tanga	Morogoro	Coast	DSM	Lindi	Mtwara	Ruvuma
Medical Doctors	9	36	23	18	17	0	28	11	12	9
Specialist Doctors	1	18	10	12	7	0	12	0	3	4
Dentists	0	1	3	1	1	0	8	1	1	2
Specialist Dentists	1	0	0	0	1	0	0	0	0	0
Pharmacist	2	5	4	3	0	0	8	1	1	1
Laboratory technicians	5	16	15	5	8	0	7	2	5	12
Radiographers	1	8	1	13	6	0	4	1	1	2
All others	1453	2694	3127	3427	1931	0	1567	976	1564	1924

Category	Iringa	Mbeya	Singida	Tabora	Rukwa	Kigoma	Shinyanga	Kagera	Mwanza	Mara	TOTAL number in profession
Medical Doctors	14	6	10	8	2	10	6	16	17	6	258
Specialist Doctors	5	4	3	1	0	3	1	0	11	2	97
Dentists	1	0	0	1	0	0	1	1	2	1	25
Specialist Dentists	0	0	1	1	0	0	0	0	0	0	4
Pharmacist	2	1	1	0	0	2	2	1	7	1	42
Laboratory technicians	10	25	9	4	3	9	7	9	44	4	199
Radiographers	3	1	6	2	0	2	1	1	6	2	61
All others	1231	1616	1527	1632	954	1477	1722	1699	2902	1641	35064

Source: adapted from Health Statistics Abstract 2002. Health Information and Research Section, Planning and Policy Department, Ministry of health.

Total number of Health Workers in URT = 35,750 (listed professionals + 'all others')

3.5 Health Financing:

Tanzania is following a mixed type of financing the health system. It is largely using tax financing which dominates about 70% of public financing. Taxation is complemented by user fees in the form of cost sharing in government health facilities. It has also introduced Community Health Fund and National Health Insurance Scheme. Regarding resource allocation, the health sector has devised a formula to ensure geographical equity in the distribution of the resources. It is now working on mechanisms that will provide for effective distribution of resources within the sector.

Domestic funds drive the recurrent budget, while the development budget is more heavily influenced by foreign funding. Off-budget funds are predominantly foreign, with the domestic contributions made by cost-sharing schemes in the sector (excluding NHIF) contributing only 2.4% of total projected off-budget resources.

The government funding is channelled through four sources, namely the Ministry of Health Budget, the Ministry of Local Government budget, revenues of the District and Urban Councils from development levy and other locally generated sources and finally the Prime Minister's budget.

The health expenditure constitutes 4.5%[22] of the GDP. This is about 10% of public expenditure and corresponds to US$ 6 per capita per annum; the recommended per capita expenditure by the World Development Report 1993 is US$ 12 per capita while the Commission for Microeconomics and Health recommends US$ 40 per capita. The Abuja target for health expenditures is 14% of government expenditure. All of the standards set by international organisations suggest a shortfall in health expenditures.

Below are selected national health account indicators:

Public health expenditure	
General Government expenditure on health as % of total expenditure on health, 2001	46.7%
General Government expenditure on health as % of total general government expenditure, 2001	12.1%
Per capita government expenditure on health in international dollars, 2001	US$ 12
Sources of public health expenditure	
Social security expenditure on health as % of general government expenditure on health, 2001	0.0%
External resources for health as % of total expenditure on health, 2001	29.5%
Private health expenditure	
Private expenditure on health as % of total expenditure on health, 2001	53.3%
Sources of private health expenditure	
Prepaid plans as % of private expenditure on health, 2001	4.4%
Out-of-pocket expenditure on health as % of private expenditure on health, 2001	83.10%

[22] Draft Tanzania National Health Accounts report, Ministry of Health 2000.

Health Sector Financial Data

Recurrent	**Expenditure 2000/2001**
Ministry of Health:	
- Government funds	Shs. 39,885,344,271
- Donor basket funds	Shs. 4,364,216,238
Regional Administration	
- Government funds	Shs. 5,614,804,137
Urban councils	
- Government funds	Shs. 6,067,256,194
- Donor basket funds	Shs. 1,626,738,540
District councils	
- Government funds	Shs.23,333,303,942
- Donor basket funds	Shs. 4,655,181,282
Total Recurrent	**Shs. 85,546,844,604**

Development	**Expenditure 2000/2001**
Ministry of Health:	
- Government funds	Shs. 3,253,939,506
- Foreign (non-basket)	11,583,576,639
Regional Administration	
- Government funds	Shs. 361,419,503
- Foreign (non-basket)	Shs. 1,024,583,643
Total Development	Shs. **16,223,519,291**
Total on Budget	Shs. **101,770,363,895**

Off Budget Expenditure	**Expenditure 2000/2001**
Cost Sharing	
- Cost sharing with hospitals	Shs. 1,421,254,371
- Community health fund	Shs. 438,258,582
Other foreign funds	Shs. 75,000,000,000
Total off budget	Shs. **76,859,512,953**

Grand total of health sector expenditure	*Shs. 178,629,876,848*

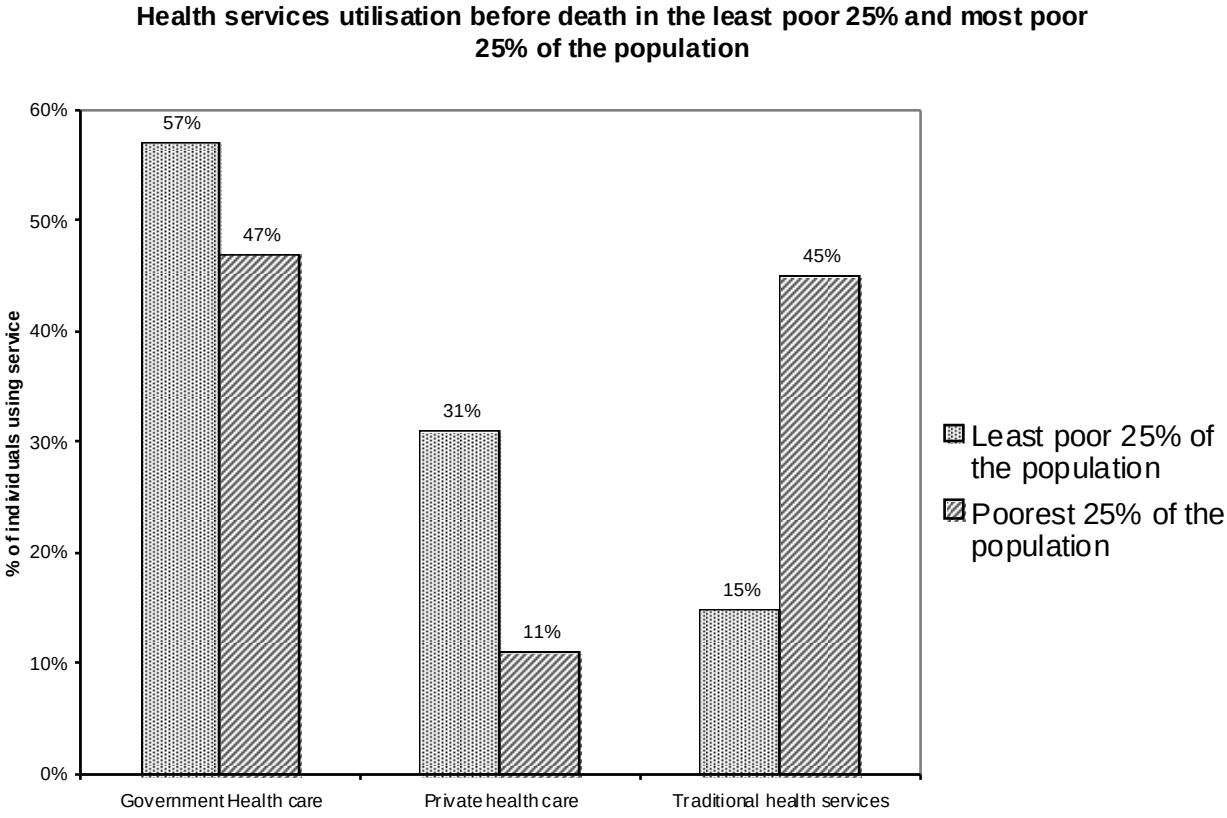
The government's policy on the provision of health services includes a user-fee, which was introduced in 1993 as a cost-sharing programme. This user-fee was introduced at regional and referral hospitals for curative services only, in order to pay for the increased health expenditure as the population grows and as health services develop. All preventative services, including immunisation, continue to be

universally free to all Tanzanians. The user-fee was expected to improve the quality of services provided and to reduce the waiting time for services. However, a user-fee restricts access to those who cannot afford curative services.

3.6 Health services access and utilisation

Geographical inequalities in health service access and utilisation exist. There is a declining ability for residents in the poorest geographical areas to access and use health services. In 2000 it was estimated that 85% of the disease burden could be addressed by available, cost-effective interventions. However, access to health care is constrained mainly by long distances to health facilities, poor road infrastructure and a lack of vehicles for transportation. Most public dispensaries lack access to funds to provide appropriate services; some have funds accruing from cost sharing but are not authorised to utilise these collections directly.

There are also socioeconomic/income inequalities in the access and utilisation of health services:



Source: adapted from The policy implications of Tanzania's mortality burden, Volume 1: A Ten-Year Community-Based Perspective. AMMP

The chart above highlights the inequalities in health services utilisation before death. Out of the 25% of least poor people, 57% had access to and utilised the governmental/formal health service before

death, whereas only 47% of the poorest 25% of people had access to and used this sector. Even greater inequalities are observed in private health care as 31% of the least poor 25% had access and used private services, whereas a small 11% of the poorest 25% used these services. Instead, the 25% poorest people turned to traditional health services (45%), where as only 15% least poor used these services before they died.

Access to health service utilisation is also cause-specific. There are fewer inequalities in children's access to immunisation services, due to continued commitment of the Government and NGOs to vaccinate all children free of charge. On the other hand, there are clear inequalities in the access to and utilisation of services relating to AFI/malaria, HIV/AIDS, tuberculosis and diarrhoeal disease. Targeted primary prevention and scaled-up primary health care services that address diseases associated with the highest mortality burdens may aid in reducing geographical inequalities. Strategies, such as IMCI, will allow greater utilisation of available preventative and curative services to children, especially those in the poorest areas.

The country has achieved high rates of coverage of antenatal care (90%), immunisation, and vitamin A supplementation (over 90% in 2002). Despite impressive gains, the general health and nutrition status of most Tanzanians remains poor. Reforming the National Health Service is greatly required to allow better access and utilisation of health service. Access to the most vulnerable groups, namely pregnant women, infants and children under-five and AIDS orphans is essential to the overall health of the country.

3.7 Monitoring and evaluation of the national health system

The Second HSSP (2003-2008) has allowed the development of appropriate indicators at key levels to facilitate monitoring of performance based on service outputs and outcomes. At the secondary health service level, annual and periodic performance indicators have been laid down to assess the progress of the health sector towards meeting the objectives and the improvement of service delivery. Improved health sector poverty monitoring indicators have also been defined, and updated in February 2003. However, these indicators are spread broadly over the main areas of health, and hence cannot provide a detailed picture of health care delivery, but instead act as a proxy measure of the direction of change.

- The monitoring of HSSP implementation progress is carried out through the fulfilment of key process outputs of its three main components.
- Health sectoral performance monitoring is undertaken annually as part of the review of sectoral MTEFs and annual plan of action.
- The Council health service performance is monitored through 19 council indicators, including inputs, process, output and outcomes.

The sources of data available for monitoring and evaluation come from the Health management Information System, National Sentinel Surveillance System, National Population Census, Demographic and Health Surveys, household budget surveys, periodic health service delivery survey and other surveys and national program/project reports.

4 CONCLUSION

Tanzania is macro-economically stable, mainly due to strict control of its fiscal deficit. However, despite her impressive macroeconomic performance, the country fails to transform macroperformance into microlevel developments and hence remains one of the poorest and underdeveloped African countries. Tanzania relies heavily on weather dependent Agricultural sector. Lack of credit and investments, under-developed infrastructure, inefficient marketing channels and a lack of production facilities are additional factors contributing to slow GDP growth rate. The country's huge external debt also has had a negative impact on its economy and continues to hinder the government's ability to fight poverty and improve public health.

HIV/AIDS is the greatest single threat to the country's public health, social development and economy. About 1.6 million people were living with HIV/AIDS in 2003. New cases are predominantly among young people (15-24 years) reflecting the need for aggressive education and prevention interventions among this age group. The number of AIDS orphans is growing, putting more children at risk of illness and abuse.

Infants and children under-five remain a vulnerable group, accounting for 55% of the total population's burden of disease. Infant and under-five mortality, despite falling figures, still have high mortality rates, and 75% of these causes of death are from preventable diseases. Protein-energy malnutrition (PEM) is a significant public health problem, especially among children and women and among rural populations. The malnourished are left more vulnerable to further illness.

Poor maternal health suggests a greater need for reproductive health as well as general health interventions targeting this vulnerable group.

Approximately 30% of the total burden of disease of the whole population is caused by acute febrile illness (predominantly malaria). Malaria is a major cause of death especially among children under-five and complicates pregnancy, due to its associated anaemia. There is hence a greater need for access to preventative measures, especially insecticide-treated nets.

Reform in the national health service is greatly required to allow better access and utilisation of health service. Access to the most vulnerable groups, namely pregnant women, infants and children under-five and AIDS orphans is essential to the overall health of the country.

Inequalities in the access and utilisation of health services, namely geographical and income disparity, prevent the improvement of the Tanzanian population and should therefore be tackled.

Access to health care is also constrained by distance to facilities, poor road infrastructure and a lack of vehicles for transportation. Most public dispensaries are lacking in appropriate supplies, equipment and funds.

The Medical Storage Department supplies health facilities with equipment and medicines at acceptable prices. However, the logic of its monopoly position is debatable. The MSD is slow to deliver, lacking in certain essential equipment, occasionally out-of-stock and while medicine availability is adequate, over-provide essential medicines and under-provide other medicines. It is suggested to allow councils to buy essential drugs outside of the MSD in case it is out-of-stock or in emergency situations. It is against the spirit of decentralisation to keep the district drug budget entirely at MSD, out of control of the councils. However, a risk of decentralisation of the drug budget management is misuse of funds and biased procurement of drugs.

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6 GLOSSARY

7 ANNEXES

7.1 Map of national health infrastructures and Organisational Chart of Ministry of Health

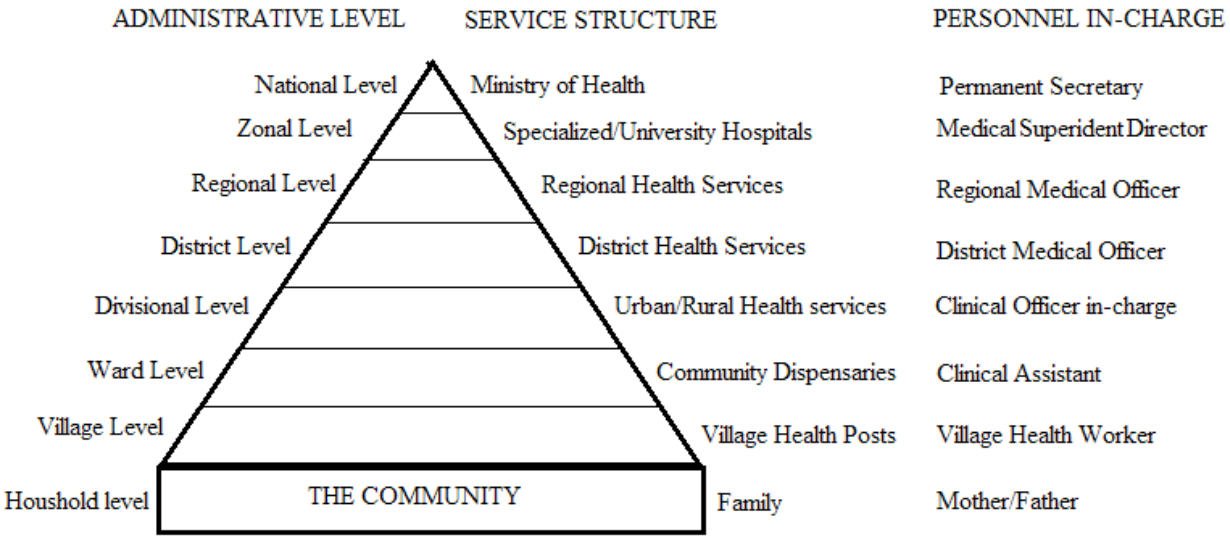
7.2 Selected health indicators

Table 7.2.1

7 ANNEXES

7.1 Map of national health infrastructures and Organisational Chart of Ministry of Health

7.1.1 Organisational Pyramid of the Tanzanian national health infrastructure



7.1.2 Organisational Chart of Ministry of Health

7.3 Selected health indicators

Table 7.2.1

UNITED	**REPUBLIC OF TANZANIA**
Capital city:	Dodoma
Official Language:	Swahili
Surface Area:	945,000Km^2 (883,000Km^2 constituting land)
Population density – per square km (2002)	39 people per km^2
Ministry of Health Web Page:	

Table 7.2.2

Demographic indicators	**Data**	**Year**	**Source**
Population - Total - Male - Female - Children aged 0 to 1 year - Children aged 0 to 5 years	34.6 million 16.9 million 17.7 million	2002	2002 census
Under 15 years as a % of total population			
65 years and over as a % of Total population			
Life expectancy at birth - total - Male - Female	53.75 years 52.4 years 55.1 years	2002	2002 census
Total fertility rate	5.2	2002	2002 census
Annual population growth rate (%)	2.9%	1990 to 2002	2002 census
Percent urban population	34	2002	2002 census
Crude birth rate (per 1000 population)	40	2002	2002 census
Crude death rate (per 1000 population)	18	2002	2002 census
Infant mortality rate (per 1000 live births)	104	2002	2002 census
Under 5 mortality rate (per 1000 live births)	165	2002	2002 census
Maternal mortality ratio (per 100,000 live births)	1500	2000	2002 census

Table 7.2.3

Socio-economic Indicators	**Data**	**Year**	**Source**
Gross Domestic Product per capita (US$) adjusted for purchasing power parity			
Annual GDP growth rate (%)	5.3%	2003	Economist Intelligence Unit
Adult Literacy rate - Male	84%	2000	2002 census

- Female	67%		
Percent of population living in poverty (income below $1)	20%	2002	2002 census
Human Development Index	0.400	2003	WHO Dept. of Health Action in Crisis

Table 7.2.4

Health and Environment indicators	**Data**	**Year**	**Source**
Percentage of population with sustainable access to an improved water source in an - Urban area	80%	2003	WHO Dept. of Health Action in Crisis
- Rural area	42%		
Proportion of population with access to improved sanitation - Urban area	98%	2003	WHO Dept. of Health Action in Crisis
- Rural area	86%		

Table 7.2.5

Nutritional Status Indicators	**Data**	**Year**	**Source**
Percent of life births weighing less than 2500	16%	2002	2002 census
Percentage of underweight children among children under five years of age	36%	1998-2002	2002 census

Table 7.2.6

Health Resources Indicators	**Data**	**Year**	**Source**
Number of physicians per 10,000 population	N/A		
Number of midwives per 10,000 population	N/A		
Number of pharmacists per 10,000 population	N/A		
Number of dentists per 10,000 population	N/A		
Number of nurses per 10,000	N/A		
Number of Hospital Beds per 10,000 population	0.09	2003	WHO Dept. of Health Action in Crisis
Total national health expenditure as percentage of GDP			
Total government health expenditure as percentage of GDP			
Total government health expenditure as a percentage of total government expenditure			
Percent of national health expenditure devoted to tertiary institutions			
Percent of national health expenditure devoted to secondary and primary level			
Percent of out-of-pocket in total health expenditure			
Percent of recurrent government expenditure going to drugs			

Proportion of population with access to affordable essential drugs on a sustainable basis			
Amount of international aid received as % of total government health expenditure			
Total health expenditure per capita (US$)			
Total government health expenditure per capita (US$)			

Table 7.2.7

Table 7.2.8

HIV/AIDS, Malaria and TB indicators	**Data**	**Year**	**Source**
HIV prevalence among young people aged 15 to 24 years	15%	1987 - 2000	2002 census
Contraceptive prevalence rate	22%	1995 - 2001	Multiple Indicator Cluster Surveys
Number of children orphaned by HIV/AIDS	815,000	2001	2002 census
Number of AIDS patients with access to ARV	700 - 1500	2001	UN office for Coordination of Humanitarian Affairs, Tz.
Male to Female ratio on HIV	47		
Prevalence rate associated with malaria	1,131,655	2003	WHO Dept. of Health Action in Crisis
Death rates associated with malaria			
Proportion of population in malaria-risk areas using effective malaria prevention and treatment measures			
Prevalence rate associated with tuberculosis	159.6 per 10,000	2003	WHO Dept. of Health Action in Crisis
Death rate associated with tuberculosis			
Proportion of tuberculosis cases detected and cured under DOTS: - detected - cured	 47% 79%	2001	UNICEF

Table 7.2.9

Table 7.2.10