World Health Organization

Country Cooperation Strategy at a glance

United Republic of Tanzania

http:// www.who.int/countries/en/

WHO region	Africa
World Bank income group	Low-income
Child health	
Infants exclusively breastfed for the first six months of life (%) (2014)	41.1
Diphtheria tetanus toxoid and pertussis (DTP3) immunization coverage among 1-year-olds (%) (2016)	97
Demographic and socioeconomic statistics	
Life expectancy at birth (years) (2015)	63.8 (Female) 59.9 (Male) 61.8 (Both sexes)
Population (in thousands) total (2017)*	52554.6
% Population under 15 (2015)	45.2
% Population over 60 (2015)	4.8
Poverty headcount ratio at $1.25 a day (PPP) (% of population) (2007)	67.9
Literacy rate among adults aged >= 15 years (%) (2007-2012)	73
Gender Inequality Index rank (2014)	125
Human Development Index rank (2014)	152
Health systems	
Total expenditure on health as a percentage of gross domestic product (2014)	5.58
Private expenditure on health as a percentage of total expenditure on health (2014)	53.59
General government expenditure on health as a percentage of total government expenditure (2014)	12.31
Physicians density (per 1000 population) (2014)	0.022
Nursing and midwifery personnel density (per 1000 population) (2014)	0.416
Mortality and global health estimates	
Neonatal mortality rate (per 1000 live births) (2016)**	25 [17.2-27.6]
Under-five mortality rate (probability of dying by age 5 per 1000 live births) (2016)*	67 [46.2-70.7]
Maternal mortality ratio (per 100 000 live births) (2016)**	556 [281 - 570]
Births attended by skilled health personnel (%) (2016)**	64
Public health and environment	
Population using safely managed sanitation services (%) (2016)**	19
Population using safely managed drinking water services (%) (2015)	34 (Urban)

* Tanzania National Bureau of Statistics
**Tanzania Demographic and Health Survey of 2015/16
Global Health Observatory May 2017
http://apps.who.int/gho/data/node.cco

HEALTH SITUATION

Tanzania has made progress in some of health indicators including attaining MDG targets for child mortality and halting the progression of HIV, TB and Malaria. Over the past decade life expectancy at birth has increased from 51 to 62 years (Population and Housing census, 2012). Communicable diseases and maternal, newborn and childhood illnesses remain the major causes of morbidity and mortality. Other important conditions are neglected tropical diseases (NTDs), non-communicable diseases (NCDs) and malnutrition. Tanzania is among the 22 countries in the world with high tuberculosis burden, and ranks sixth in Africa with a case notification of 65,908 in 2016 which is 41% of the estimated annual TB incidence. Similarly, multi-drug resistance TB is on the rise, with an estimate of 850 cases in a year and case detection of 196 in 2016. The TB/HIV co-infection rate is estimated at 34% (Annual NTLP Report 2016). About 1.4 million people in Tanzania are living with HIV of whom 11% are aged 15–24 years and 58% are women (Spectrum 2016 Tanzania). There has been a steady decline in HIV prevalence from 7% in 2003 to 4.7% in 2017 among adults (Tanzania HIV Impact Survey, 2016-17) . Similarly the burden of malaria has steadily declined from a prevalence of 18% in 2007 (Tanzania HIV and Malaria Indicator Surveys) to 14% in 2015 (Demographic and Health Survey 2015/16). Maternal mortality ratio has increased from 454 in TDHS 2010 to 556 per 100,000 live births in TDHS 2015-16 which is unacceptably high.

The regulatory framework for medicines and medical devices has improved over the years. However substandard and falsified products are still found on the market. There are gaps in efforts to reduce malnutrition which is responsible for stunting and underweight. There are also challenges with low quality maternity services and identification of tuberculosis cases. Disease outbreaks such as cholera remain a threat owing to the persistence of risk factors such as poor access to improved drinking water and sanitation. Road traffic injuries have been on the increase and continue to claim lives. Data from the Traffic Department indicate that from January to December 2016, road crashes claimed 3,381 lives and caused 9,549 injuries.

HEALTH POLICIES AND SYSTEMS

The Country Cooperation Strategy (CCS III) was developed simultaneously with the national Five Year Development Plan (FYDP II) 2016/17–2020/21. The Country Cooperation Strategy (CCS III) has therefore been aligned to FYDP II objectives. The theme of Five Year Development Plan II is "nurturing industrialization for economic transformation and human development". The Five Year Development Plan (FYDP II) aims, among other things, to lower the under-five mortality rate to about 45 deaths per 1000 live births; maternal mortality to below 250 deaths by 2021, and the prevalence of HIV to 3%, and to raise life expectancy at birth to 66 years. It also aspires that by 2021 access to clean and safe water reaches 85% in the rural areas and 90% in the urban areas. CCS III is again aligned with the Health Sector Strategic Plan IV, 2015–2020 (HSSP IV), and United Nations Development Assistance Plan II, 2016–2020 (UNDAP II). In addition, it reflects the priorities identified in the 12th Global Programme of Work (GPW), 2014–2019 approved by the 66th World Health Assembly in 2013.

Health services are organized in a pyramidal structure with the primary care facilities at the base, the district hospitals at the next level, and the referral hospitals at the apex. Primary care services and district hospitals are managed by the local government authorities while regional and national/tertiary hospitals are under the central government. Dispensaries provide preventive and curative outpatient services, while health centres also admit patients and might provide minor surgical services. Non-governmental organizations and community-based organizations also provide outreach services. The Ministry of Health, Community Development, Gender, Elderly and Children (MOHCDGEC) has developed a curriculum and training materials for a community health worker cadre based on the community health services guidelines developed in 2013.

COOPERATION FOR HEALTH

WHO Country Office, UN agencies, development partners, faith-based organizations and other stakeholders, and government ministries, departments and agencies work with the Ministry of Health, Community Development, Gender, Elderly and Children (MOHCDGEC) through the Sector Wide Approach (SWAp) framework. The technical committee for SWAp is multisectoral with representation from the MOHCDGEC, the President's Office, Regional Authorities and Local Government, the Ministry of Finance, Development Partners, Faith-Based Organisations and CSOs. Implementation of health sector milestones is determined by the SWAp technical committee and approved by the SWAp policy meeting annually. The SWAp technical working groups monitor the implementation of the programmes.

Annual and mid-term reviews evaluate progress towards the milestones and Health Sector Strategic Plan (HSSP) respectively. WHO Country Office participates in the key decision-making bodies such as the technical working groups, joint annual health sector reviews, technical committee for SWAp meetings and the Development Partners Group for Health (DPG-Health). Development partners provide funding to the health sector through general budget support, Health Basket Fund or projects. The UN agencies and programmes provide support through United Nations Development Assistance Plan (UNDAP). The agencies are committed to Delivering as One through harmonizing their programmes and human and financial resources. This avoids duplication and allows focusing on areas where they have the most impact.

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Country Cooperation Strategy *at a glance*

WHO COUNTRY COOPERATION STRATEGIC AGENDA (2016–2020)	
Strategic Priorities	**Main Focus Areas for WHO Cooperation**
STRATEGIC PRIORITY 1: Reducing the morbidity and mortality caused by communicable diseases through appropriate and effective interventions, including strengthening the health system and addressing environmental issues.	• Strengthened intersectoral capacities for the management of environmental threats to health. • Increased access to prevention, diagnostics, care and treatment and interventions for tuberculosis, HIV and malaria. • Increased and sustained access to safe and quality essential medicines for NTDs.
STRATEGIC PRIORITY 2: Reducing the burden of NCDs through health promotion, and reduction, prevention, treatment and monitoring of their risk factors.	• Increased evidence to use for advocacy, leadership and multisectoral response on injuries, with a focus on risk factors, road safety, child injuries and violence against children, women and youth. • Increased access to interventions to prevent and manage NCDs and monitoring of their risk factors. • Improved capacity for surveillance and interventions for reduction of nutritional risk factors.
STRATEGIC PRIORITY 3: Contribute to RMNCAH and well-being and promote health through addressing the social determinants of health.	• Increased access to high quality, reproductive, maternal, newborn, child and adolescent health interventions. • Increased vaccination coverage for hard-to-reach populations and communities. • Enhanced capacity for intersectoral collaboration to address the social determinants of health.
STRATEGIC PRIORITY 4: Strengthening health systems to improve quality, equity in access and utilization of health services.	• Strengthened capacity to develop and implement appropriate policies and legislation for Human Resources for Health (HRH) planning, management, production and retention and to adopt innovative health financing that ensures increased quality, access and equity of health services. • Built capacity of the civil registration and vital statistics systems, including to support the strengthening of Health management Information system (HMIS), reviews, assessments, surveys, research and evaluation, to generate evidence for policy. • Increased access to, and rational use of safe, efficacious and quality medicines and health technologies.
STRATEGIC PRIORITY 5 : Providing support for developing the minimum IHR (2005) core capacities and strengthening the capacity to implement disaster risk management.	• Built core capacities required for IHR (2005) in MOHCDGEC and local government authorities for all-hazard alert and response. • Increased capacity to manage health risks of emergencies and build resilience, including adequate preparedness for rapid and effective response to health-related disasters and emergencies and major epidemics and pandemics using the One Health approach. • Strengthened surveillance systems to identify paralysis due to wild poliovirus or type-2 vaccine-related poliovirus.

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