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REPRODUCTIVE HEALTH *at a* GLANCE

TANZANIA

June 2011

Country Context

Tanzania is among the most politically stable countries in Africa and, since 2000, has maintained a robust annual rate of economic growth of 5 to 7 percent.[1] Prudent macroeconomic policies, market–oriented reforms and debt relief have resulted in a suitable environment for Tanzania's steady growth. Despite the high rate of economic growth in recent years, poverty remained high at 33.6 percent.

Tanzania's large share of youth population (44 percent of the country population is younger than 15 years old[2]) provides a window of opportunity for high growth and poverty reduction—the demographic dividend. For this opportunity to result in accelerated growth, the government needs to invest more in the human capital formation of its youth. This is especially important in a context of decelerated growth rate arising from the global recession and the country's exposure to high volatility in commodity prices.

Gender equality and women's empowerment are important for improving reproductive health. Higher levels of women's autonomy, education, wages, and labor market participation are associated with improved reproductive health outcomes.[3] In Tanzania, the literacy rate among females ages 15 and above is 66 percent.[2] Girls enrollment in primary schools is comparable to boys with a 99 percent ratio of female to male primary enrollment.[2] Eighty-nine percent of adult women participate in the labor force[2] that mostly involves work in agriculture. Gender inequalities are reflected in the country's human development ranking; Tanzania ranks 138 of 157 countries in the Gender-related Development Index.[4]

Greater human capital for women will not translate into greater reproductive choice if women lack access to reproductive health services. It is thus important to ensure that health systems provide a basic package of reproductive health services, including family planning.[3]

Tanzania: MDG 5 Status

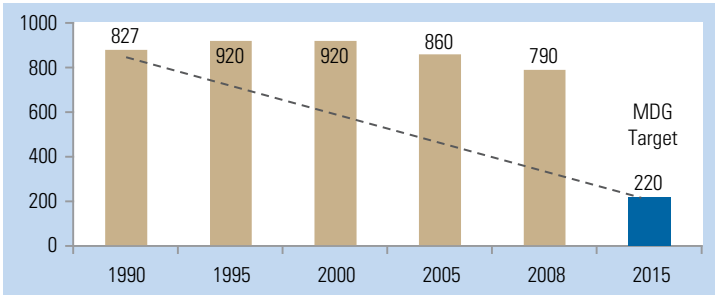
MDG 5A indicators	
Maternal Mortality Ratio (maternal deaths per 100,000 live births) *UN estimate*[a]	790
Births attended by skilled health personnel (percent)	50.6
MDG 5B indicators	
Contraceptive Prevalence Rate (percent)	34.4
Adolescent Fertility Rate (births per 1,000 women ages 15–19)	116
Antenatal care with health personnel (percent)	95.9
Unmet need for family planning (percent)	25.3

Source: Compiled from multiple data sources.
[a] 2010 DHS estimated MMR at 454 per 100,000 live births.

MDG Target 5A: Reduce by Three-quarters, between 1990 and 2015, the Maternal Mortality Ratio

Tanzania has made insufficient progress over the past two decades on maternal health and is not on track to achieve its 2015 targets.[5]

Figure 1 ▪ Maternal mortality ratio 1990–2008 and 2015 target



Source: 2010 WHO/UNICEF/UNFPA/World Bank MMR report.
The 2010 DHS estimated MMR at 454 per 100,000 live births.

World Bank Support for Health in Tanzania

The Bank's new ***Country Assistance Strategy*** under preparation (P122530) is scheduled to be approved by the Bank's Executive Board on June 7, 2011.

Current Project:
P105093 TZ-Health Sector Dev II – Add Fin (FY08) ($60m)
P119067 TZ-Health Sector Dev II – Add Fin (FY10) ($40m)

Pipeline Project:
P125740 Basic Health Services Project ($100m)

Previous Health Project:
P082335 TZ-Health Sector Development II (FY04) ($65m)

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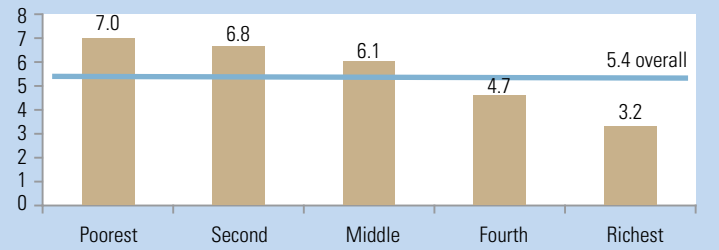
Key Challenges

High fertility

Fertility remains high. Total fertility rate (TFR) fell slightly from 6.3 births per woman in 1991–92 to 5.6 in 1999 but remained the same till 2007–2008; it then decreased slightly to 5.4 in 2010.[6, 7] TFR among women in the lowest wealth quintile is more than twice those in the highest wealth quintiles (Figure 2).[6] Disparities exist between women in rural areas at 6.1 births per woman compared to 3.7 for those in urban areas, and vary by education levels at 7.0 births per woman with no education, and 3.0 with secondary education or above.[7]

Figure 2 ▪ Total fertility rate by wealth quintile



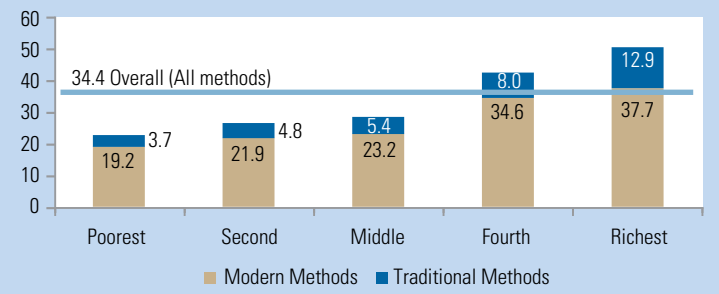
Source: DHS Final Report, Tanzania 2010 .

Adolescent fertility rate is high affecting not only young women and their children's health but also their long-term education and employment prospects. Births to women aged 15–19 years have the highest risk of infant and child mortality as well as a higher risk of morbidity and mortality for the young mother.[3, 8] In Tanzania, there are 116 reported births per 1,000 women aged 15–19 years.[7]

Early childbearing is high and more frequent among the poor. Forty four percent of women are either mothers or are pregnant with their first child by age 19. Teenagers in the lowest wealth quintile are more than twice as likely to start childbearing early as women in the highest wealth quintile (28 percent and 13 percent, respectively).

Use modern contraception has been increasing. Use of modern contraception among married women has increased from 7 percent in 1991 to 20 percent in 2004 and to 27 percent in 2010.[7] Injectables are the most commonly used method among married women at 11 percent followed by the pill at 7 percent.[7] Use of long-term methods such as intrauterine device and implants are negligible. There are socioeconomic differences in the use of modern contraception among women: it is 18 percent of women with no education use modern contraception as compared to 35 percent of women with secondary education or higher, and 25 percent for rural women versus 34 percent for urban women.[7] Use of modern contraceptives is 38 percent among women in the highest wealth quintile and 19 percent among those in the poorest quintile[7] (Figure 3).

Figure 3 ▪ Use of contraceptives among married women by wealth quintile



Source: DHS Final Report, Tanzania 2010.

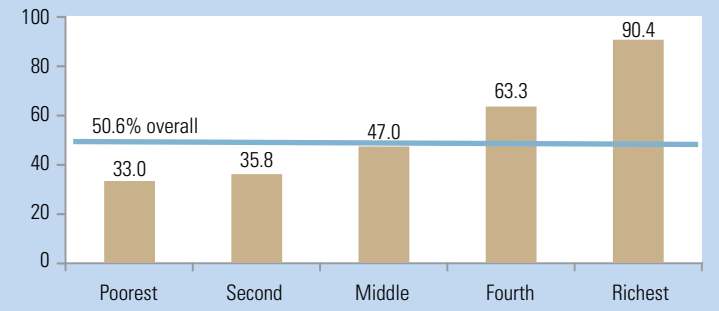
Unmet need for contraception is high at 25 percent[7] indicating that women may not be achieving their desired family size.[9]

Fear of side effects and opposition to use are the predominant reasons women do not intend to use modern contraceptives in future. Twenty-eight percent of women not intending to use contraception indicated fear of side effects or health concerns as the main reason while 25 percent expressed opposition to use, primarily by themselves, their husband, or due to their religion.[10] Cost and access are lesser concerns, indicating further need to strengthen demand for family planning services.

Poor Pregnancy Outcomes

While majority of pregnant women use antenatal care, institutional deliveries are less common. Over 95 percent of pregnant women receive antenatal care from health professionals (doctor, clinical officer/assistant clinical officer, nurse or midwife, and MCH aide) with 43 percent having the recommended four or more antenatal visits.[7] However, a smaller proportion, 51 percent deliver with the assistance of skilled medical personnel predominantly in the public sector.[7] While 93 percent of women in the wealthiest quintile delivered with skilled health personnel, only 33 percent of women in the poorest quintile obtained such assistance (Figure 4).[7] Additionally, 34 percent of women with no education delivered with skilled health personnel as compared

Figure 4 ▪ Birth assisted by skilled health personnel (percentage) by wealth quintile



Source: DHS Final Report, Tanzania 2010.

to 86 percent of women with secondary education or higher while 83 percent of urban as 42 percent of rural women delivered with skilled health personne.[7] Further, 58 percent of all pregnant women are anaemic (defined as haemoglobin < 110g/L) increasing their risk of preterm delivery, low birth weight babies, stillbirth and newborn death.[11] According to the 2010 DHS, nearly two-thirds of women percent never received postnatal care.

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Nearly half of women who indicated problems in accessing health care cited concerns regarding inability to afford the services or long distance (Table 1).[10]

Table 1 ▪ Barriers in accessing health care (women age 15–49)

Reason	%
At least one problem accessing health care	35.5
Getting money needed for treatment	24.1
Distance to health facility	19.2
Not wanting to go alone	10.5
Getting permission to go for treatment	2.4

Source: DHS Final Report, Tanzania 2010.

Human resources for maternal health are limited with only 0.008 physicians per 1,000 population but nurses and midwives are slightly more common, at 0.242 per 1,000 population.[2]

The high maternal mortality ratio at 790 maternal deaths per 100,000 live births indicates that access to and quality of emergency obstetric and neonatal care (EmONC) remains a challenge.[5]

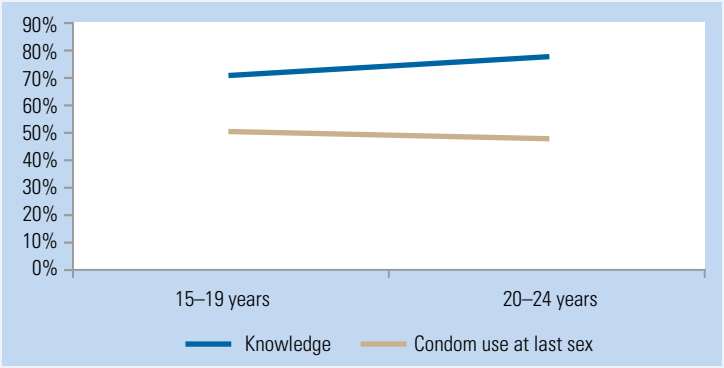
STIs/HIV/AIDS is a public health concern

HIV prevalence is moderately high in Tanzania but women are one of the most vulnerable groups. The adult population that has HIV is 5.7 percent; prevalence among females is significantly higher than among males (6.6 percent and 4.6 percent, respectively).[6]

Eighty-nine percent of women and 81 percent of men know that HIV can be transmitted through breast milk. Seventy-five percent of women and 67 percent of men know that the likelihood of passing HIV from mother to child can be reduced by drugs.[7]

There is a large knowledge-behavior gap regarding condom use for HIV prevention. While most young women are aware that using a condom in every intercourse prevents HIV, about 50% percent of them report having used condom at last intercourse (Figure 5). This gap widens among older aged women likely due to the fact that the chances of using condoms as a form of contraception diminishes with marriage.

Figure 5 ▪ Knowledge behavior gap in HIV prevention among young women



Source: DHS Final Report, Tanzania 2010 (author's calculation).

Technical Notes:

Improving Reproductive Health (RH) outcomes, as outlined in the RHAP, includes addressing high fertility, reducing unmet demand for contraception, improving pregnancy outcomes, and reducing STIs.

The RHAP has identified 57 focus countries based on poor reproductive health outcomes, high maternal mortality, high fertility and weak health systems. Specifically, the RHAP identifies high priority countries as those where the MMR is higher than 220/100,000 live births and TFR is greater than 3.These countries are also a sub-group of the Countdown to 2015 countries. Details of the RHAP are available at *www.worldbank.org/population*.

The Gender-related Development Index is a composite index developed by the UNDP that measures human development in the same dimensions as the HDI while adjusting for gender inequality. Its coverage is limited to 157 countries and areas for which the HDI rank was recalculated.

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Key Actions to Improve RH Outcomes

Strengthen gender equality

- Support women and girls' economic and social empowerment. Increase school enrollment of girls. Strengthen employment prospects for girls and women. Educate and raise awareness on the impact of early marriage and child-bearing.
- Educate and empower women and girls to make reproductive health choices. Build on advocacy and community participation, and involve men in supporting women's health and wellbeing.

Reducing high fertility

- Address the issue of opposition to use of contraception and promote the benefits of small family sizes. Increase family planning awareness and utilization through outreach campaigns and messages in the media. Enlist community leaders and women's groups and emphasize community-based distribution
- Provide quality family planning services that include counseling and advice, focusing on young and poor populations. Highlight the effectiveness of modern contraceptive methods and properly educate women on the health risks and benefits of such methods.
- Promote the use of ALL modern contraceptive methods, including longterm methods, through proper co1unseling which may entail training/re-training health care personnel.
- Strengthen post-abortion care (treatment of abortion complications with manual vacuum aspiration, post-abortion family planning counseling, and appropriate referral where necessary) and link it with family planning services.

Reducing maternal mortality

- Promote institutional delivery through provider incentives and possibly, implement risk-pooling schemes. Provide vouchers to women in hard-to-reach areas for transport and/or to cover cost of delivery services.
- Target the poor and women in hard-to-reach rural areas in the provision of basic and comprehensive emergency obstetric care (renovate and equip health facilities).
- Address the inadequate human resources for health by training more midwives and deploying them to the poorest or hard-to-reach districts.
- Strengthen the referral system by instituting emergency transport, training health personnel in appropriate referral procedures (referral protocols and recording of transfers) and establishing maternity waiting huts/homes at hospitals to accommodate women from remote communities who wish to stay close to the hospital prior to delivery.
- During antenatal care, educate pregnant women about the importance of delivery with a skilled health personnel and getting postnatal check. Encourage and promote community participation in the care for pregnant women and their children.

Reducing STIs/HIV/AIDS

- Integrate HIV/AIDS/STIs and family planning services in routine antenatal and postnatal care.
- Lower the incidence of HIV infections by strengthening Behavior Change Communication (BCC) programs via mass media and community outreach to raise HIV/AIDS awareness and knowledge.

References:

1. The World Bank, Tanzania: Country Brief. <http://web.worldbank.org/WBSITE/EXTERNAL/COUNTRIES/AFRICAEXT/TANZANIAEXTN/0,,menuPK:287345~pagePK:141132~piPK:141107~theSitePK:258799,00.html>.
2. World Bank. 2010. World Development Indicators. Washington DC.
3. World Bank, Engendering Development: Through Gender Equality in Rights, Resources, and Voice. 2001.
4. Gender-related development index. http://hdr.undp.org/en/media/HDR_20072008_GDI.pdf.
5. Trends in Maternal Mortality: 1990–2008: Estimates developed by WHO, UNICEF, UNFPA, and the World Bank.
6. Tanzania Commission for AIDS (TACAIDS), Zanzibar AIDS Commission (ZAC), National Bureau of Statistics (NBS), Office of the Chief Government Statistician (OCGS), and Macro International Inc. 2008. Tanzania HIV/AIDS and Malaria Indicator Survey 2007-08. Dar es Salaam, Tanzania: TACAIDS, ZAC, NBS, OCGS, and Macro International Inc.
7. National Bureau of Statistics (NBS) [Tanzania] and ICF Macro. 2011. Tanzania Demographic and Health Survey 2010. Dar es Salaam, Tanzania: NBS and ICF Macro
8. WHO 2011. Making Pregnancy Safer: Adolescent Pregnancy. Geneva: WHO. http://www.who.int/making_pregnancy_safer/topics/adolescent_pregnancy/en/index.html.
9. Samuel Mills, Eduard Bos, and Emi Suzuki. Unmet need for contraception. Human Development Network, World Bank. Available at http://www.worldbank.org/hnppublications.
10. National Bureau of Statistics (NBS) [Tanzania] and ORC Macro. 2005. Tanzania Demographic and Health Survey 2004-05. Dar es Salaam, Tanzania: National Bureau of Statistics and ORC Macro.
11. Worldwide prevalence of anaemia 1993–2005: WHO global database on anaemia/Edited by Bruno de Benoist, Erin McLean, Ines Egli and Mary Cogswell. <http://whqlibdoc.who.int/publications/2008/9789241596657_eng.pdf>.

TANZANIA REPRODUCTIVE HEALTH ACTION PLAN INDICATORS

Indicator	Year	Level	Indicator	Year	Level
Total fertility rate (births per woman ages 15–49)	2010	5.4	Population, total (million)	2008	42.5
Adolescent fertility rate (births per 1,000 women ages 15–19)	2010	116	Population growth (annual %)	2008	2.9
Contraceptive prevalence (% of married women ages 15–49)	2010	34.4	Population ages 0–14 (% of total)	2008	44.7
Unmet need for contraceptives (%)	2010	25.3	Population ages 15–64 (% of total)	2008	52.3
Median age at first birth (years) from DHS	2010	19.5	Population ages 65 and above (% of total)	2008	3.1
Median age at marriage (years)	2010	18.9	Age dependency ratio (% of working-age population)	2008	91.4
Mean ideal number of children for all women	2010	4.9	Urban population (% of total)	2008	25.5
Antenatal care with health personnel (%)	2010	95.9	Mean size of households	2004/05	5
Births attended by skilled health personnel (%)	2010	50.6	GNI per capita, Atlas method (current US$)	2008	440
Proportion of pregnant women with hemoglobin <110 g/L	2008	58.2	GDP per capita (current US$)	2008	496
Maternal mortality ratio (maternal deaths/100,000 live births)	1990	880	GDP growth (annual %)	2008	7.5
Maternal mortality ratio (maternal deaths/100,000 live births)	1995	920	Population living below US$1.25 per day	—	—
Maternal mortality ratio (maternal deaths/100,000 live births)	2000	920	Labor force participation rate, female (% of female population ages 15–64)	2008	88.8
Maternal mortality ratio (maternal deaths/100,000 live births)	2005	860	Literacy rate, adult female (% of females ages 15 and above)	2008	66.3
Maternal mortality ratio (maternal deaths/100,000 live births)	2008	790	Total enrollment, primary (% net)	2008	99.6
Maternal mortality ratio (maternal deaths/100,000 live births) target	2015	220	Ratio of female to male primary enrollment (%)	2008	98.6
Infant mortality rate (per 1,000 live births)	2008	67	Ratio of female to male secondary enrollment (%)	—	—
Newborns protected against tetanus (%)	2008	81	Gender Development Index (GDI)	2008	138
DPT3 immunization coverage (% by age 1)	2010	86.1	Health expenditure, total (% of GDP)	2007	5.3
Pregnant women living with HIV who received antiretroviral drugs (%)	2005	5.6	Health expenditure, public (% of GDP)	2007	3.5
Prevalence of HIV, total (% of population ages 15–49)	2007	6.2	Health expenditure per capita (current US$)	2007	21.7
Female adults with HIV (% of population ages 15+ with HIV)	2007	58.5	Physicians (per 1,000 population)	2006	0.008
Prevalence of HIV, female (% ages 15–24)	2007	0.9	Nurses and midwives (per 1,000 population)	2006	0.242

Indicator	Survey	Year	Poorest	Second	Middle	Fourth	Richest	Total	Poorest-Richest Difference	Poorest/Richest Ratio
Total fertility rate	DHS	2010	7.0	6.8	6.1	4.7	3.2	5.4	3.8	2.2
Current use of contraception (Modern method)	DHS	2010	19.2	21.9	23.2	34.6	37.7	27.4	–18.5	0.5
Current use of contraception (Any method)	DHS	2010	22.9	26.7	28.6	42.6	50.6	34.4	–27.7	0.5
Unmet need for family planning (Total)	DHS	2010	30.8	27.3	29.0	23.5	16.3	25.3	14.5	1.9
Births attended by skilled health personnel (percent)	DHS	2010	33.0	35.8	47.0	63.3	90.4	50.6	–57.4	0.4

Tanzania Policies and Strategies that have Influenced Reproductive Health

- Population issues have been included as a substantive thematic area in the new MKUKUTA structure and subsequent dialogue structure allowing government, development partners, private sector, civil society and academia to engage in its performance and public expenditure review on an annual basis.
- Government efforts to slow population growth by expanding family planning services though re-launching its Green Star National Family Planning campaign and adopting innovative ways which include community based distribution programmes, social marketing and franchising, public private partnerships and linking family planning with HIV prevention efforts with dual protection strengthening Contraceptive Logistic Management System for contraceptive supplies and increased allocation of funds under the contraceptive budget line of the MOHSW's MTEF.
- Tanzania has effective health system that reaches down to and engages meaningfully the community including young people and Tanzania continues to invest in implementing its Health Sector Strategic Plan III and health sector reforms with a focus on strengthening Primary Health Care. Challenges in the health system particularly in the areas of human resources for health, health management information systems and health care financing are being addressed.
- The Government has finalized and is implementing the National HIV prevention strategy and its corresponding two-year action plan (2009/10–2011). Preventing new infections among young people is key to ensuring an AIDS free generation.
- Tanzania has achieved improvements in educational enrollment and retention, especially for girls at the secondary and tertiary level and for older Tanzanians, adult education programmes especially for rural women helps correct past inequalities. The government would be passing legislation that will amend the 1971 Marriage Act and bar marriage before age 18 and efforts to integrate population and family life education (POP-FLE) including sexuality and life skills education in the schools system with complementary outreach programmes for out-of-school youth are underway
- Tanzania, in its efforts to empower women and ensure gender equality has economic strategies, structures, policies and laws that recognize women as vital in development. Job creation including equal access to employment for male and female youth is a priority.
- Tanzania's National Population Policy Implementation Strategy (2007) provides an effective framework for the needed multi-sectoral, multi-dimensional and integrated approach to population and development.
- Reactivation of the Parliamentary Committee on Population and Development and the Tanzanian Council on Population and Development has begun to create accountability for the Policy's implementation.

Development Partners Support for Reproductive Health in Tanzania

The DPs in the health sector actively coordinate sector dialogue and activities through the Health Sector WG. Under the Sector-Wide Approach, eleven members contribute to the Health Basket Fund: Canada, Denmark (Lead from July 2011), Germany, Ireland, Netherlands, Norway, Switzerland, One UN, UNFPA, UNICEF, and World Bank (Lead until June 2011).

Japan, USA, and WHO also participate in the WG. USA as well as the Global Fund for AIDS, Tuberculosis, and Malaria contribute a substantial sum to disease targeted programs. In 2010/11 financing from the Global Fund amounted to approximately US$225 million or 49 percent of the total MoHSW budget.

US Government funding for PEPFAR is not included in the government budget, and was expected to reach US$358 million for the USG fiscal year which ended September 30, 2010. Other USG commitments are expected to total US$80 million, for an overall USG total of US$438 million. FY11 funding is expected to remain at similar levels.

WHO: safe motherhood

UNFPA: Reproductive health and rights

UNICEF: child protection; under-5 mortality

USAID: Health systems strengthening; skilled birth attendance and HIV/AIDS

SIDA: Women's rights; Girls' education

CIDA: Healthcare workforce and HIV

AUSAID: Safe Motherhood (EMOC)

GIZ: Gender mainstreaming

WB: Safe motherhood (EMOC) and Health financing, support to secondary education

SDC: Safe motherhood (EMOC) and health Financing

HMIS and decentralization

DANIDA: Pharmaceutical and strengthening + HIV/AIDS

JICA: Strengthening health management at regional level

Pooling partners (WB, RN, Ireand, UNFPA, CIDA, GTZ, DANIDA, Norway, UNICEF, CDC): Health system strengthening and improvement of service delivery