**Evaluating Equity in the Provision of**

**Primary Health Care in Tanzania**

by

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**Abstract**

Equitable access to primary health care is vital to the overall health and development of a country. Since its independence in 1967, Tanzania has established a clear objective of achieving primary health care for all. Yet achieving the goal of health care for all is especially difficult considering Tanzania’s poverty and rural population base. This essay 1) explores the extent to which equitable primary health care services are available to all citizens in Tanzania and 2) explores the changes in health status of key primary health care-related health indicators to assess the effectiveness of Tanzania’s efforts. To conduct this analysis, a desk-based literature review was performed examining relevant peer-reviewed research in addition to government reports and polices from Tanzania’s Ministry of Health and Social Welfare. Ultimately, this review found that the Tanzanian government has utilized various PHC strategies—decentralization, user fee abolition, and contracting out of services—with varying degrees of effectiveness in their quest for health care for all. Decentralization and the use of non-governmental actors to extend services can be seen as strengths, while the government’s ability to enforce user fee exemptions and waivers at facilities was found to be a weakness. This proves that while PHC strategies are supported by health policy, policy goals are not always realized. Consequently, in the midst of a decentralized health system, local autonomy is needed to ensure that efforts across all levels are working towards improved access in the delivery of PHC.

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# Abbreviations

|  |  |
| --- | --- |
| ANC | Antenatal Care |
| APHFTA | Association Of Private Health Facilities In Tanzania |
| CHF | Community Health Fund |
| CHMT | Council Health Management Teams |
| CSSC | Christian Social Service Commission |
| DHMT | District Health Management Team |
| FBO | Faith-Based Organization |
| HSR | Health Sector Reforms |
| LGA | Local Government Authorities |
| MOHSW | Ministry Of Health And Social Welfare |
| NGO | Nongovernmental Organization |
| NHIF | National Health Insurance Fund |
| NSSF | National Social Security Fund |
| OOP | Out-Of-Pocket |
| PEPFAR | President’s Emergency Plan For AIDS Relief  |
| PHC | Primary Health Care |
| PMI | President’s Malaria Initiative  |
| PNC | Postnatal Care |
| PPP | Public-Private Partnership |
| RHMT | Regional Health Management Teams |
| THE | Total Health Expenditure |

# Introduction

The United Republic of Tanzania is one of East Africa’s most populous countries, with a population of nearly 44 million (World Bank, 2009). The United Republic of Tanzania is also among the poorest countries in the world—with a per capita gross national income of US$600—and is ranked 162 out of 177 countries on the Human Development Index (World Bank, 2009). Regardless of this poverty, Tanzania is considered politically stable in relation to many of its sub-Saharan African counterparts. Within the context of a peaceful, impoverished country, the Tanzanian government is one of the main players in determining the distribution of scarce resources like health care.

Poor access to health care is one of the major impediments to balanced growth in rural communities worldwide (Marrone, 2007). Consequently, equitable access to primary health care is a vital component to the overall health and development of a country. Since its independence in 1961, Tanzanian health policy has established a clear objective of achieving primary health care for all. Achieving this goal is especially difficult considering the immense poverty, the high percentage of citizens who live in rural areas, and health care as a scarce resource.

 To aid in achieving primary health care for all the Tanzanian government has made it a priority to ensure everyone in the population is within 5km of a health center (National Institute for Medical Research, 2008). However, close proximity to a health center is only one factor contributing to a healthy population. Cost of health services also presents a major barrier to adequate health care. After the introduction of user fees in the 1990s, Tanzania determined that certain services should be provided free of charge, including certain preventive and maternal and child health services. This cost exemption, however, is not uniformly applied across health facilities, and varies whether a patient is visiting a private, government-run, or faith-based medical facility.

Consequently, equitable health care distribution is not simply an issue left to the government to decide. While the Tanzanian government owns about 64% of all total health facilities, other major players control the remaining facilities. These players are made up of both private-not-for-profit and private-for-profit organizations, and the private providers rely largely on government financing.

The objective of this essay is to explore the extent to which equitable primary health care (PHC) services are available to all citizens in Tanzania. Equity can be viewed in terms of equity of health service delivery and equity of health financing. For purposes of this essay, both forms are examined. A secondary objective is to explore the changes in health status of key PHC-related health indicators to assess the effectiveness of Tanzania’s efforts.

What follows is a brief background on the Tanzanian health care system followed by a description of PHC and what other countries have done to achieve the goal of PHC for all. This literature review includes a review of equity, as discussed in health policy literature. In addition to peer-reviewed research, this essay relies on government reports and quantitative data from the 2006 Tanzania Service Provision Assessment Survey.

Ultimately, this review found that the Tanzanian government has utilized the various PHC strategies of decentralization, user fee abolition, and contracting out of services. What remains is the question of where the Tanzanian government goes from here in their quest for PHC for all? In terms of equity in access, faith-based organizations have been found to be most effective, while government facilities are the most comprehensive in their provision of basic PHC services. Since faith-based organizations tend to be located in rural, hard to reach areas, they can be seen as a viable way for the government to expand services, particularly reaching out to rural areas. Service level agreements formalize this arrangement by ensuring these private-not-for-profit facilities provide the necessary PHC services, incentivized through government funding.

In terms of user fee abolition, the effectiveness of this strategy for equity in PHC remains unclear. User fee exemptions and waivers are a step towards improved financial equity and Tanzania has shown a clear decrease in out-of-pocket expenditure as a percentage of private expenditure; however, research suggests that many users still end up paying for services that are “exempt” through unofficial provider payments. Government facilities appear to be the most equitable in their user fee exemptions and waivers, although consumer preference for faith-based organizations demonstrates the need for further research on the quality of services in these organizations. This shows that even with policy in place, continued efforts are needed at all levels to ensure policy goals are being met and realized.

# Background on Tanzania’s Health System

## Health Policy

In Tanzania, PHC has had a long history in policy and programs reinforced by international efforts. Tanzania gained independence from British colonial rule in 1961. At this point the health care system was small and fragile. Tanzania had gained independence through a peaceful process, unlike some of its counterparts who found independence through insurgency (e.g. Kenya and Mozambique) (Young, 1986). Since its independence, Tanzania has had a strong focus on achieving primary health care for all. Policy in the 1970s, as a result of the Arusha Declaration in 1967, worked towards a socialized health system with elements such as the elimination of private-for-profit health providers; however, sole public provision of health services proved unsustainable going into the 1980s.

 PHC for Tanzania was first conceived in 1967 and further expanded through the Decentralization Act of 1972 (Ministry of Health and Social Welfare, 2009), resulting in the establishment of numerous health facilities throughout the country. In 1992, PHC was revised and aimed at enhancing the management of most health program activities at the district level.

The last few decades have seen continued health policy change, beginning with the Ministry of Health and Social Welfare’s (MOHSW) National Health Policy in 1990, which was subsequently revised in 2003 and 2007 (MOHSW, 2009). The National Health Policy Plan outlines specific governmental objectives such as improving the partnership between public, private and faith-based sectors. This collaboration between sectors was initiated in 1994 with Health Sector Reforms (HSR), which specifically addressed improving access, quality and efficiency in health service delivery.

The preferred method to achieve this efficiency, in the most cost-effective way, was through the use of PHC (MOHSW, 2009). Other major aspects of HSR in 1994 were: decentralization of health services, introduction of user-fees in government-run facilities, introduction of health insurance plans, and encouragement of public/private partnerships.

 More recently, the MOHSW developed the Primary Health Care Service Development Programme in 2007 as a means of accelerating the delivery of primary health care services for all (MOHSW, 2009). While the national health policy has given broad guidelines on the health services delivery system in Tanzania, the PHC strategy has outlined how the policy is to be implemented. One of the main elements of this program was to improve health service access through the construction of more PHC facilities and improving the communication within the referral system. The strategy for doing this was by having a dispensary in each village and a health center in each ward. The Primary Health Care Service Development Programme also addresses the revised National Health Policy and its efforts towards the international Millennium Development Goals surrounding maternal health, child health and priority diseases.

 Another element to the National Health Policy is the Tanzanian Development Vision 2025, which aims to achieve high quality of life for all Tanzanians through certain development strategies including quality primary health care for all (National Institute for Medical Research, 2008). The Vision 2025 is in accordance with the Poverty Reductions Strategy as the MOHSW recommends increased equity in allocation of public services, targeting those most at risk.

## Health System Structure

The Tanzanian health care system is highly decentralized into three levels: district level, secondary/tertiary level, and the central level. Responsibilities at each level are outlined in Table 1.

Table 1 Tanzanian Health System Levels and Responsibilities

|  |  |
| --- | --- |
| **Level** | **Responsibilities** |
| ***District & Local*** | The district hospital, health centers, dispensaries, and community health services |
| ***Secondary & Tertiary*** | Secondary and tertiary hospitals, providing specialty care, and other tertiary-level institutions (teaching institutions); |
| ***Central*** | Provides support services such as policy-making, donor coordination, and monitoring and evaluation. |

The Tanzanian government is focused on integrating the three levels to work towards reducing disease prevalence and cost, particularly the burden from HIV/AIDS and malaria, as a means of strengthening the entire health system (United States Agency for International Development, 2007). At the district level of the MOHSW there is a District Health Management Team (DHMT), which determines the health priorities for their district (MOHSW, 2009).

Within the public sector, there are 78 hospitals, 409 health centers, and 2,450 dispensaries as of 2007 (USAID, 2007). The private sector, as of 2007, had 126 registered private health centers (70 belonging to voluntary agencies, 50 private-for-profit, and 6 belonging to parastatal organizations) (USAID, 2007). Out of the 1,340 registered private dispensaries, 561 are private for-profit and 250 belong to parastatal organizations. The Tanzanian government is the provider of health services in Tanzania and owns about 64 % of all total health facilities (USAID, 2007).

Since over 70% of Tanzania’s population lives in rural areas, 56% of the 121 private, mostly not-for-profit hospitals are located in rural areas (USAID, 2007). Over half (52%) of the registered health centers are also located in rural areas (USAID, 2007). For the most part, access to health care has focused on ensuring that as many people as possible are close to health facilities. Access to primary facilities has certainly grown, with 95% (National Institute for Medical Research, 2008) of the Tanzanian population within five kilometers (three miles) from a dispensary or health center. The location of hospitals, however, remains favored towards urban areas.

# Primary Health Care: A Review of the Literature

*Essential health care…made universally accessible to individuals and families in the community through their full participation and at a cost that community and country can afford to maintain at every stage of their development in the spirit of self- determination.*

*-Definition of primary health care, Alma Ata Declaration Article VI*, (WHO, 1978)

 The year 1978 marked a victory in the health rights of individuals worldwide with the Alma Ata Declaration for PHC (World Health Organization, 1978). This conference noted the importance of PHC access because it is often the first point of contact with a health system (WHO, 2008). This is especially significant in the sub-Saharan African context where there is a high burden of infectious, controllable disease (Dambisya & Ichoku, 2012). Consequently, the push for PHC was selected as an ideal means for achieving “Heath for All by the Year 2000”, a goal that had been set in 1975 by the World Health Assembly (International Conference on PHC, Burkina Faso).

Founded on the concept that health is a fundamental human right, PHC can be seen as a vital tool in guiding health policy in a government’s approach to achieving universal and equitable access to health care. Subsequently, PHC has been adopted as a strategy for enhancing overall efficiency and health system performance and as a critical tool in improving health outcomes of a population (International Conference).

## Equity

The Alma Ata Declaration marked the first notable concern for health equity with its petition for “health for all”. The Declaration further deemed primary health care as the most efficient (financially and distributional) way to reduce health inequities. Equity as it relates to health has various components including equity in health service delivery, and equity in health financing (Bravement, 1998).

Health inequalities are not always regarded as inequities; inequities specifically refer to group disparities (i.e. income, geographic location), whereas inequalities are the result of inevitable and unavoidable conditions (i.e. biological variations) (Whitehead, 1992). In other words, health inequality is a positive or descriptive notion of what exists, while health equity is a normative notion of what should be (Ong, Kelaher, Anderson, & Carter, 2009). While no single definition of equity exists, it is helpful to specify how equity is achieved. Ong et al. (2009) state that equity in health is achieved via the opportunity to achieve health potential, which is determined through factors such as access, utilization and quality. It is important to note that inequities, as specified by the International Society for Equity in Health, are capable of repair.

Equity in the provision of healthcare is to ensure access to a minimum standard of healthcare according to need for all (Zere, Moeti, Kirigia, Mwase, & Kataika, 2006). In other words, it means *equal access for equal need*. Achieving equity of access to health services is process oriented. Zere et al. (2006) further define access as the removal of barriers (e.g. geographical and financial) that disadvantaged groups often face in obtaining health care. Consequently, one way to measure equity in health *provision* is by comparing socio-economic status to health status, analyzing the degree of inequality in between.

Based on the review of other country’s efforts, it is determined that the main PHC strategies for achieving equity can be defined as: decentralization, user fee abolition, and contracting out services. In addition to these PHC strategies, the literature dictates equity goals of cost, access (geographical and financially), and service provision. These PHC strategies and equity goals serve as a guide to evaluate and measure the effort of the Tanzanian government in providing PHC services.

No discussion on equity is complete without distinguishing between vertical and horizontal equity. As defined in the literature, vertical equity is subject to value-based judgments that imply preferential treatment for those deemed worse off. Horizontal equity, on the other hand, presents equal access to all (Goddard & Smith, 2001).

## Primary Health Care in Other Countries

Over 30 years since the Alma-Ata declaration of “health for all”, many countries have put time and energy into establishing a strong primary health system based on equitable distribution of health services to meet goals of social justice, responsiveness, financial protection and solidarity—particularly for vulnerable groups in rural areas (Rawaf, Maeseneer, & Starfield, 2008; Biswas, et al., 2009; Kruk, et al., 2010). Rawaf, Maeseneer, and Starfield (2008) identify four essential features of a primary health care system: accessibility, person-focused, comprehensive, and universal.

Investing in the affordability and quality of primary health care has been shown to be one of the most sustainable solutions for a health system (Biswas, et al., 2009). Research at the macro level is overwhelmingly supportive of primary health care initiatives, showing that needs-based, comprehensive health care systems produce better health outcomes at a lower cost. The literature also tells us that a strong primary care system reduces social inequalities in health (Biswas et al., 2009; Kruk, et al., 2010).

In particular, low- and middle-income countries have made primary care a keystone of their health systems as a way of expanding coverage to a range of preventive and curative services. Cuba, Iran, and Sri Lanka are all historic examples of primary care expansion that have resulted in near universal access to health care (Kruk et al., 2010). The establishment of a primary care facility network in Iran led to coverage of 85% of the rural population within twenty years (Kruk et al., 2010). Sri Lanka, a relatively poor country recovering from extensive conflict, universally covers its population with primary care and has utilization levels comparable to industrialized countries.

Latin American reforms have focused on equity in service utilization (i.e. ensuring that health services are utilized by all income groups) and equity in health outcomes. In order to reduce the gap in access to services between rich and poor, Costa Rica and Brazil chose economically disadvantaged areas of their countries for the implementation of their primary care initiatives (Rosero- Bixby, 2004). In Mexico, the poor have enrolled disproportionately in the health insurance program Seguro Popular, a health insurance program covering primary care consultations and medicines (Gakidou et al., 2006). Thailand has focused its primary care efforts on rural areas (i.e. physician supply, rural health insurance, and increasing the number of rural clinics). Vapattana-Wong et al. (2007) found among the poorest children in Thailand, relative mortality fell much faster than among richest children, decreasing the poor-rich gap in mortality by more than half between 1990 and 2000.

The Australian landscape is such that diverse rural and remote communities face a lack of health care access (Humphreys & Wakerman, 1008). In their quest for achieving health equity, the Australian government determined that a “one size fits all” approach is insufficient to meet the diverse needs of its people. Consequently, their reform has focused on service models that ensure key service requirements and community needs are met by taking into account the specific geographical, social, economic and cultural contexts that differentiate the many rural and remote communities. Focusing on rural areas and other vulnerable groups provides a common strategy to reduce inequities through the local delivery of health services (Kruk, et al. 2010).

In Brazil, reform policies have also been combined with the decentralization of health services delivery. This model focuses more on prevention and promotion (Atkinson, Fernandes, Carpara, & Gideon, 2005). Decentralization has been the key to giving local health providers discretion to meet local needs and promote intersectoral collaboration while acting under the helm of a central policy focused on incentives.

The onset of structural adjustment programs in the 1980s and 1990s brought an influx of user fees in health care services in Africa. These have proved to be a significant financial barrier to accessing services, and many countries have taken action to address this (Ridde & Morestin, 2010). Fortunately, international aid agencies have been on board with fee abolishment and through their extensive study, researchers Ridde and Morestin (2010) found that the abolition of user fees has had positive effects on service utilization. Meessen et al. (2011) found that local African leaders in the sub-Saharan African countries of Burkina Faso, Burundi, Ghana, Liberia, Senegal, and Uganda are also willing to take action to remove financial barriers that impact vulnerable groups, especially pregnant women and children. Specifically in Uganda, Moat and Abelson (2011) discovered the importance of interactions between formal and informal institutions to abolish user fees for health services in 2001.

As another PHC strategy, contracting out of PHC services has become increasingly popular in low- and middle-income countries. This method helps to alleviate pressure on government facilities to provide all the PHC services. Liu, Hotchkiss and Bose (2008) found that contracting out PHC services to nongovernmental providers improves access; however, the effects on equity, quality, and efficiency were unclear (Liu, Hotchkiss, & Bose, 2008).

 As the objective of this essay is to explore the extent to which equitable primary health care (PHC) services are available to all citizens in Tanzania, the following elements of the Tanzanian health care system are examined: decentralization, user fees, and service provision (including contracting of services and access).

# Methods

 Since this is a theoretical essay, the research was dependent on secondary sources and studies. The methods are three-fold including: a comprehensive literature review, a review of Tanzanian health policies and programs, and a review of quantitative data related to health service provision in Tanzania.

 A comprehensive review of the literature included searching for published and unpublished studies focused on PHC and health policy in Tanzania. The review was of the published and grey literature using databases and information systems including Google Scholar, PubMed, EQUINET, World Bank reports, and WHO Statistical Information System (WHOSIS). Search strings were composed of permutations of “primary health care”, “health systems”, “health policy”, and “health reform” all within a Tanzanian context. Additionally, all Tanzanian government reports made available online from the MOHSW within the last two decades were reviewed. These include the National Health Policy, the Health Sector Strategic Plan, the National Strategy for Growth and Reduction of Poverty, and the National Package of Essential Health Intervention reports.

 The analysis is a review of Tanzania’s efforts towards achieving equity in PHC, as identified in the literature. This includes an analysis of the Tanzanian health care system are under the subsections of decentralization, user fees, and service provision.

 In addition to a review of Tanzanian health policy, quantitative data from the 2006 Tanzania Service Provision Assessment Survey (National Bureau of Statistics (NBS) [Tanzania] and Macro International Inc., 2007) is supplied to examine the distribution of health facilities (i.e. public, private, and FBO) and the PHC-related services they provide. These minimum health services have been agreed upon since the mid-1990s as essential within the international health community and typically include maternity care, family planning, childhood immunizations, treatment of common childhood illnesses, and the prevention and treatment of malaria, tuberculosis, HIV/AIDS (Disease Control Priorities Project, 2007).

# Findings

The presentation of findings incorporates all three methods discussed in the previous section. A description of the main players involved in provision of PHC services is below.

## Main Players

Since the government is not the sole provider of PHC services, this essay distinguishes between three main providers: government, including parastatal organizations (i.e. organizations partially owned by the government); private-not-for-profit providers, primarily made up of faith-based organizations (FBOs); and private-for-profit practitioners and facilities (Adjei, et al., 2009).

### Government

The government has historically been the main provider of health services, even prior to Tanzania’s independence. Within the public system, Tanzania’s decentralization consists of district, regional, and national levels. However, the district assumes the majority of responsibilities and curative services are provided primarily through district hospitals (and FBOs in some areas). At the sub-district level, community health centers and dispensaries provide both curative and preventive services, with parastatal organizations being under the control of government (National Bureau of Statistics (NBS) [Tanzania] and Macro International Inc., 2007).

### Faith-Based Organizations

 FBOs have long been involved in the provision of health services in sub-Saharan Africa (Dambisya & Ichoku, 2012). Their work can be traced back to European Christian missionaries who established hospitals and schools as part of their missionary work. Lipsky (2011) notes that unlike other nongovernmental organizations (NGOs), FBOs follow the direction of the organization, but also place a heavy emphasis on religion and following God. The role of FBOs has historically been important in providing health services to the underserved. At the time of independence, approximately half of health services in Tanzania were provided by FBOs (Dambisya & Ichoku, 2012). This has dropped only slightly in the twenty-first century, with about 41% of hospitals and 21% of health centers owned by FBOs.

Green, Shaw, Dimmock and Conn (2002) explain that the importance of FBOs in health service delivery is three-fold: First, they are a distinct actor in a more complex grouping of health care providers (i.e. private for-profit, local authorizes, and secular NGOs); secondly, most are now managed by a national church structure rather than an international missionary organization; and finally, funding for FBOs is now more secular based, including international donors and national governments.

### Private Sector

 Private-for-profit practitioners have been in existence in Tanzania since the colonial period. They mainly provide curative and preventive health services (National Bureau of Statistics (NBS) [Tanzania] and Macro International Inc., 2007). Following independence, private-for-profit providers continued to provide services, but the idea of making a profit using human health came into question after the Arusha Declaration (The United Republic of Tanzania, 2011). In Tanzania’s move towards socialism in the 1970s, the government decided that health services could be provided equitably without for-profit institutions, and effectively banned for-profit providers in 1977 under the Private Hospitals Regulation Act.

 In the early 1980s, Tanzania suffered from drought, war and poor economic performance. It was decided that the government could no longer provide quality health services to all under the economic erosion occurring at the time (The United Republic of Tanzania, 2011). To improve the situation the law prohibiting for-profit medical practice was repealed. This paved the way for private practice in medicine and also ended free medical care.

 Private health service providers refer to for-profit providers including private hospital groups, medical practitioners, and pharmacies, and private insurance. Dambisya and Ichoku (2012) point out that the term private can include a number of unregulated, small-scale health service suppliers. This informal private sector typically consists of traditional healers and informal drug sellers (Foster, 2012), however due to research limitations these are not discussed. According to National Health Account Data, private health insurance constitutes a small portion of total health expenditure (THE) at 3.2% (Foster, 2012).

It is through this separation of providers that the three core elements of equity in PHC (cost, access, and services provision) are examined. For a breakdown of facilities by provider type, see Appendix 1.

## Findings: Tanzania’s Health Care System

### Decentralization

Tanzania’s health care system has a history of decentralization dating back to the Decentralization Act of 1972. This setup allows for non-governmental actors to be included as active partners in local level planning with the potential for greater involvement in policy and resource allocation (Green, Shaw, Dimmock, & Conn, 2002). The benefit to users is greater access to existing services as well as access to new services. Improving collaboration between governmental and non-governmental health services providers improves accountability and quality assurance at all facilities.

The MOHSW and the Prime Minister’s Office Regional Administration leave the decentralization of health services to Local Government Authorities (LGAs) (National Institute for Medical Research, 2008). This devolution of services allows for diversification of roles in the delivery of health care. At the top is the MOHSW, with the responsibility of policy formulation and the development of guidelines. The regional level falls next in line where Regional Health Management Teams (RHMTs) interpret these policies and supervise their implementation at the district level. DHMTs oversee council health services including health centers, dispensaries and district hospitals. At the lowest level is Council Health Management Teams (CHMTs). This structure enables healthcare to be initiated at the local level, allowing districts certain flexibility to cater to local needs (National Institute for Medical Research, 2008).

Advances in health policy in Tanzania means that more public resources are delegated to districts as part of the government’s commitment to decentralization. Block grants and basket funds are the methods in which resources are allocated from the central government to district and local levels. Consequently, the local level has benefited from the decentralization of services and push for PHC by receiving an increase in donor funding funneled through health baskets. Eight international donors, mostly based in Western Europe and including the World Bank, comprise the Health Sector Basket Fund to join funds and allocate to lower levels (Maluka et al., 2010).

Block grants are the means by which the central government allots funding to districts and local councils. The allocation of block grants between facilities at the district level is coordinated with stakeholders, but a minimum and maximum is set to ensure that around 50 to 70% of the funding goes to district managing organizations and the hospitals, while the rest is divided between health centers and dispensaries. The allocation formula applied to the health block grant distributes the grant among local governments based on four allocation factors: population size, poverty count, district vehicle route, and under-five mortality (Mbuyita & Makemba, 2007). These factors are weighted, with the population size determining about 70% of the funding amount (Maluka et al., 2010). This ensures that resources are allocated to areas with the highest need to support access and use of health services by poor communities, keeping in line with national policies (MOHSW, 2009).

The decentralized system also supports coordination of services between non-governmental actors. Local governments can select faith-based hospitals to act as the designated district hospital in areas where there is no government-run hospital. Within this method, FBO facilities can benefit from block grants. These hospitals receive about 35% of basket funds to take on this role (Maluka et al., 2010). Consequently, FBOs have made it a priority to increase negotiations with local government to build partnerships and essentially receive a larger percentage of the funding. Other non-governmental entities can receive international funds through health baskets.

Tanzania’s decentralized system is also conducive to prioritization of health care services. Out of this, the Accountability for Reasonableness has developed as a guiding framework for priority setting, with fairness identified as one of the key goals. In practice, Maluka et al. (2011) found Tanzania’s decentralized health system for district level priority-setting to be not as participatory as suggested by the government. Priority-setting usually occurred in the context of budget cycles and the process was driven by historical allocation rather than negotiations between stakeholders. One of the main reasons for minimal stakeholder involvement at the local level was due to the lack of formal mechanisms for communication. Maluka et al. (2011) found that priority-setting decisions (but not the rational behind them) were simply publicized through circulars and notice boards.

### User Fees

Health care financing in Tanzania uses a combination of financing sources to support the health system (Adjei, et al., 2009). About 70% of financing comes from public sources, of which taxation comprises the majority. Government funds are allocated towards public facilities through block grants, while the health basket funding is available for both public and private facilities. Health insurance plans and out-of-pocket payments, such as user fees, in the informal sector are very regressive (Macha, et al., 2012).

Cost-sharing policy was introduced in the early 1990s through the introduction of user fees (Mtei et al., 2007). The scope of commercial health insurance is very limited in Tanzania; instead the focus has been growing community-based pre-payment programs. The Community Health Funds (CHF), introduced in 1996, is a community-based insurance plan that focuses on primary health care centers. The goal of the CHF, devised in conjunction with the World Bank’s International Development Association, is to improve financial stability in the health sector (Dambisya & Ichoku, 2012). The CHF was designed primarily for rural communities based on the concept of risk-sharing and community empowerment and aims to provide basic health care for poor and vulnerable populations within rural Tanzania. Overall, the CHF contributes only about 15% to the total revenue within the Tanzanian health sector (Macha, et al., 2012). Consequently, enrollment in CHF is rather low across the country due to barriers such as high CHF membership fees compared to small user fees in public facilities (Macha, et al., 2012; Mtei, Mulligan, Ally, Palmer, & Mills, 2007).

 In 2001, Tanzania instituted the first phase of a mandatory health insurance system known as the National Health Insurance Fund (NHIF). This made it compulsory for all public workers to become a member the NHIF (Mtei, Mulligan, Ally, Palmer, & Mills, 2007). This health insurance program is funded by a 6% payroll contribution, split evenly between the employer and employee, and covers the public employees, spouses, and up to four other dependents.

In addition to the CHF and NHIF health insurance programs, the National Social Security Fund (NSSF) is a pre-payment program available for formal sector employees to contribute towards their own health and that of their families (MOHSW, 2009). According to the 2002 census, approximately 5.6% of the population was enrolled in the NSSF (MOHSW, 2009). Conversely, enrollment voluntary health insurance programs like the CHF remain low; in some areas enrollment rates are less than 2% in this voluntary insurance program (Mtei et al., 2007).

 Regardless of health insurance programs, out-of-pocket payments are high compared to other sources of health care financing. In 2006, about 47% of health care financing came from household out-of-pocket-expenditures (Mtei & Borghi, 2007). Public financing accounts for about 43%, relatively evenly split between the government budget and donor support. As a whole, public health financing remains only 10% of total public financing, below the Abuja target of 15%.

Makawia, Macha, Ally, and Borghi (2010) note that health care services overall in Tanzania benefit the rich more than the poor, as the poorest 20% receive less benefit than they need. In terms of *equal access for equal need*, Figure 1 shows that there are large improvements to be made. The lowest income quintile is far from receiving their fair share of benefits in comparison to need.

Figure 1 Comparison of health consumption of benefits versus need by income quintile, 2008

Graph Note: The Poorest 20% received approximately 10% of health benefits

Source: Makawia et al., 2010

The poorest 20% are also less likely to be enrolled in a health insurance program and end up paying more out-of-pocket as a proportion of their income for health care services (see Figure 2).

Figure 2 Household Health Care Financing as Proportion of Income, 2008

Graph Note: Tax and OOP are generally the main burden of health care financing, with little enrollment in insurance plans. Membership in CHF (and the respective proportion of income allotted to CHF) is limited; hence it’s low visibility

Source: Mtei and Borghi, 2010

Figure 3 shows that since 1995 there has been an overall decrease in out-of-pocket (OOP) expenditure as a percentage of private expenditure in health care spending. This can be contributed to a combination of user fee exemptions and waivers for certain health services implemented in the mid-1990s (Health Research for Action, 2006).

Figure 3 Expenditure on Health as Percentage of THE in Tanzania

Source: WHO, Health Systems 20/20 Database (USAID)

Since user fees are typically charged in public and private facilities, exemptions were created based on priority health services to vulnerable groups. These services were authorized to be maternity care during pregnancy and child birth, preventive and curative care for children under five, and treatment for certain diseases including HIV/AIDS, TB, Leprosy, and cancer (Health Research for Action, 2006). In practice, exemption policies are typically followed, however there is often inconsistency with some of the diseases between facilities and issues with reimbursement for exempt services at non-governmental facilities (Health Research for Action, 2006).

Unlike exemption policies, waivers at health facilities are extended for the poor, emergency patients, health workers, elderly, and the disabled. In practice, these are less commonly used than exemptions due to inconsistent waiver registers and unclear definitions of eligibility for waivers. As a result of these inconsistencies, waivers are supposed to be issued at the local and district levels. Barriers to receiving waivers continue due to lack of information (poor unaware of their rights to waivers), fear of stigmatization, and difficult registration procedures for waivers (Health Research for Action, 2006).

Table 2 is a comparison of user fee charges by facility type. The effect of user fees is a double-edged sword: on the one side they help increase funds available to the facility, and on the other side they may deter poor clients from using services (National Bureau of Statistics (NBS) [Tanzania] and Macro International Inc., 2007). Health policy dictates that all facilities should charge some form of user fees, with the exception of service exemptions and waivers. While antenatal care (ANC) services are to be provided free of charge at all government facilities, there are still some discrepancies with about two percent still charging for these services. In contrast, private for-profit facilities (60%) and FBOs (33%) are more likely to charge for ANC services.

Table 2 User Fee Charges, 2007

|  |
| --- |
| **Comparison of user fee charges by facility**  |
|  | **Percentage of facilities:** |
|   | With any routine user fee for adult curative care | With discount or exemption for some clients\* | Where clients can prepay for multiple visits or for one service\* | With user fees for ANC |
| **Government** | 70 | 81 | 58 | 2 |
| **Private-for-profit** | 95 | 71 | 19 | 60 |
| **Faith-based** | 99 | 77 | 29 | 33 |
| \*Among facilities charging user fees for adult curative care, percentage that use systems to decrease OOP fees for clients or to reimburse deferred client fees, and percentage that publicly post fees.  |

Table Note: 70% of all government facilities charge any routine user fee for adult curative care

Source: National Bureau of Statistics [Tanzania] and Macro International Inc. (2007

While user fee exemptions and waivers are a step towards improved financial equity, research suggests that users still end up paying for services through unofficial provider payments (Kruk, Mbaruku, Rockers & Galea, 2008; Maestada and Mwisongob, 2011). Kruk et al. (2008) found that three-quarters of women still end up paying for delivery services regardless of the exemption. In their study, they also found that out-of-pocket payments for facility delivery were substantial, often driven by high transportation costs, unofficial provider payments, and preference for mission facilities, which levy user charges (Kruk et al., 2008).

These unofficial provider payments are found via informal payments or “tips” to health providers where patients pay their providers for seemingly “free” services. In their study, Maestada and Mwisongob (2011) found that health workers at all levels receive informal payments in a number of different contexts. While health workers sometimes share the payments received, it is only partially. They suggest that health workers are involved in ‘rent-seeking’ activities, such as creating artificial shortages and deliberately lowering the quality of service, in order to extract extra payments from patients or to bargain for a higher share of the payments received by their colleagues (Maestada & Mwisongob, 2011). As a result, the distributions of informal payments are unfair and negatively affect those already in poverty. Maestada and Mwisongob (2011) also found that informal payments negatively impact the quality of health care through rent-seeking behaviors and through frustrations created by the unfair allocation of payments.

The need for additional research on unofficial payments at health facilities remains, as does the need for improved transparency in user fees (Health Research for Action, 2006). Government-run health facilities do not typically have prices and fees visible, nor are they required to show which services are exempt. Consequently, this shows the necessity for improved regulation and administration of user fee exemptions and waivers even with the policy in place.

### Service Provision—Public-Private Partnerships

The Prime Minister’s Office identifies the primary actors in the Tanzanian health care system as the government, the private sector, and non-state actors. These actors play vital roles in public-private partnerships (PPPs), and are identified below:

**(a) The Government**

Will facilitate implementation of the PPPs by putting in place the appropriate enabling environment. This includes favorable policies, implementation strategy, legal and institutional framework.

**(b) The Private Sector**

The Private Sector will take the leading role in identifying and implementing PPPs including carrying out of feasibility studies, mobilizing resources, risk sharing, monitoring and evaluation, and providing technical expertise and managerial skills.

**(c) Non-State Actors**

Other stakeholders include financial institutions, academic institutions, NGOs, FBOs, employees, trade unions, environmentalists, political leaders, community groups, sector interest groups and public in general. This category is expected to support the implementation of PPPs through monitoring and evaluation, dissemination of information in order to create an understanding the nature and benefits of PPPs in their areas of interest.

*PPP History*

Prior to the 1980s, church-based health care was largely provided separately from the State sector (Green, Shaw, Dimmock, & Conn, 2002). It was after the Alma Alta Declaration in 1978 that multisectoralism and collaboration was stressed as part of a broader concept of health. What has resulted is a formalized service agreement between FBOs and the government in many African countries (Green, Shaw, Dimmock, & Conn, 2002).

During the 1990s, the government recognized the need to partner with FBOs and the private sector to “achieve greater efficiency and responsiveness to the public’s needs” (Lipsky, 2011). As Green et al. (2002) note, greater collaboration between FBOs and the government presents a unified policy front. By engaging NGOs in policy planning, relationships and partnerships are strengthened versus the government taking a narrow public service focus. To ensure collaboration, dialogue must occur between government and FBOs about roles and relationships. Additionally, there is a need for support on the part of MOHSW support and willingness by FBOs to fully support national health plans and policies.

Prior to policy legislating the use of PPPs, public-private arrangements were implemented through existing laws such as the Public Corporation Act of 1992 and through the mandate emanating from structural reform policies that occurred in the 1990s. One of the National Poverty Reduction objectives occurs through the creation and delivery of competitive and sustainable PPPs.

 According to the Vision 2025 implemented in 2000, the government is to support and encourage multi-actor participation in economic growth through investments in the private sector (i.e. infrastructure and service development) (Prime Minister's Office, 2009). PPPs were identified as an effective way to achieve this. According to the Prime Minister’s Office, PPPs are an effective alternate source of financing, management and maintenance of public sector projects, including health services. PPPs also allow the Government to streamline responsibilities in providing social services, effectively enhancing efficiency, accountability, quality of service and wide outreach (Prime Minister's Office, 2009).

The National Health Policy of 2007 recognized the contribution of the private sector in health service provision. Out of this, stemmed the objective to increase participation of the private sector in achieving access to health services at all levels. The PPP steering committee was established to propose a regulatory policy, dictating the involvement and cooperation of providers to ensure that capacities in private institutions are used to improve the health of the people. The PPP steering committee identified two major umbrella organizations in the private sector (previously identified above): the CSSC, representing a large number of Faith Based Organization, and the APHFTA, representing a smaller number of private hospitals and clinics, mainly based in urban areas. The Ministry, acting as the policy broker, was established to chair the PPP steering committee, collaborating with representatives from the private sector. At the time, it was decided that the service agreements would regulate collaboration between service providers and Councils and that further strengthening of the PPP forums at district level would remain a focus.

At the end of 2007, the MOHSW, the CSSC, the APHFTA, and several other organizations finalized the national template for the Service Agreement between the government and service providers. These Service Agreements allow non-governmental facilities (both private-for-profit and private-not-for-profit) to access public financing, in a type of performance-based financing (Adjei, et al., 2009). These contracts indicate certain outputs to be achieved (e.g. number of pregnant mothers or children under five being served years; essential drugs provision; number of trainees).

*PPPs Today*

In Tanzania, the efforts of FBOs can be seen as complementary to public efforts as indicated by their government subsidization. Dambisya and Ichoku (2012) note the significance of FBOs in rural, hard-to-reach areas. Lipsky (2011) identifies the comparative advantages of FBOs in health delivery as having greater flexibility than the government and understanding local context, which ultimately leads to improved responsiveness to local needs. She also identifies their capacity to build social capital through volunteerism and community mobilization as an advantage. She follows that since “governments are unable to provide everything to their citizens [they] therefore, must seek partnership with other entities to provide some of those services and access necessary resources” (2011, p.27).

Designated District Hospitals in Tanzania provide a coordinating relationship between FBOs and the government (Green, Shaw, Dimmock, & Conn, 2002). This status allows church hospitals to supervise community health services in its area. As a coordinated supervision of services, both the hospital and government are committed to PHC, and the church health services are even involved in District Health planning (Green, Shaw, Dimmock, & Conn, 2002).

PPPs can be seen as essential to the administration of health services due to the fact that such a high number of health facilities are owned by the private sector (both FBOs and for-profit), which was about 40% in 2009 (MOHSW, 2009). A National PPP Steering Committee was established in the early 2000s along with zonal and regional PPP forums in a number of zones and regions. There are council services at the district level to help facilitate PPP collaboration. However, the Ministry had no guiding policy how to put the PPP concept in practice.

The MOHSW acknowledged the inadequate conceptual recognition and understanding of PPPs, particularly the view that the private sector is regarded as a separate system co-existing with the public in provision of health services, rather than one system with equal actors providing complementary services (MOHSW, 2009).

Recognizing that the capacity of private providers was not exhaustively utilized and that national health programs were often absent in private facilities, the MOHSW saw a need to merge efforts stating “the capacity of the MOHSW, the regional level, the district and the private stakeholders in managing negotiations and contractual arrangements in the policy and Service Agreement template is inadequate”.

 As of 2011, the MOHSW proposed merging the functions and activities performed under the Public Health Section and Voluntary and Private Health services Section, forming one Section to be called Public and Private Health Services (President's Office Public Service Management, 2011). The identified reason was the fact that both Public and Voluntary Health Services are to be governed by the same principles and guidelines, and a merger would minimize cost and duplication of efforts. While they all have the same functions and responsibilities, the difference between the two lies only on the basis of ownership.

*PPP Access*

Since the Tanzanian government has made a goal of close proximity to health care services (within 5km of a health facility), access to primary facilities has certainly grown over the last few decades. Hospital allocation, however, remains favored towards urban areas. Additionally, there is a major disconnect between equity of access between facilities. Figure 4 shows the difference between the population private hospitals take in versus government and faith-based organizations. Private-for-profit facilities disproportionately serve a large number of the top income quintile and often reject those that cannot pay, while the FBOs appear to have the most equitable distribution of benefits across income quintiles.

Makawia et al. (2010) suggest that greater availability of faith-based providers in rural areas and their flexible pricing strategies lead to a more even share of health care benefits

**Figure 4 Distribution of benefits according to income quintile and facility-type, 2008**

Graph Note: 7% of benefits in the public facilities are received the poorest 20%. Overall, the poorest 20% receive just over 10% of all benefits.

Source: Makawia et al., 2010

To assess the provision of PHC services, Table 3 displays services offered by facility, including childhood immunizations, family planning, ANC, postnatal care (PNC), maternity, tuberculosis, and HIV/AIDS. From the standpoint of service provision, government facilities by far provide the most comprehensive access to PHC-related services. The percentage of private-for-profit facilities, on the other hand, that provide all basic services (as defined by the survey) and other PHC-related services appears grossly inadequate. Since both private-for-profit facilities and FBOs receive government funding in their provision of health services, this raises the question of how in line this is with achieving PHC for all? Should government money continue to be funneled to private-for-profit facilities if only a small percentage provide the necessary PHC services?

Table 3 Provision of PHC, 2007

|  |
| --- |
| **Provision of PHC-related services by facility type** |
|  | **Percentage of facilities that provide:** |
|   | All basic services\* | Child immun-ization | All basic child health services | Any modern contracep-tive method | ANC | PNC | Normal delivery services | ANC & normal delivery | Any TB diagnostic services | An HIV testing system | Anti-retroviral Treatment | **Average %** |
| **Government** | 91 | 94 | 93 | 97 | 96 | 79 | 91 | 90 | 44 | 22 | 3 | **73** |
| **Private-for-profit** | 23 | 24 | 24 | 32 | 30 | 15 | 18 | 12 | 32 | 33 | 2 | **22** |
| **Faith-based** | 49 | 78 | 78 | 39 | 83 | 59 | 73 | 73 | 40 | 32 | 9 | **56** |
| \*Outpatient services for sick children and for adult STIs, temporary methods of family planning, antenatal care (ANC), immunization, and child growth monitoring. |

Table Note: 91% of all government facilities provide all basic services

Source: National Bureau of Statistics (NBS) [Tanzania] and Macro International Inc. (2007)

## Findings: Changes in Health Status

To evaluate their use of scarce resources in the improvement of health, below is a collection of tables reflecting trends in health status. These health indicators have been chosen because of their relation to PHC services. In general, PHC services focus on maternal and child health, family planning (i.e. contraceptives) and certain diseases such as HIV. The availability of data also limited which health indicators are displayed.

Since 1967, there have been clear improvements in both life expectancy and infant mortality rates. Additionally, the positive trends in women’s health (contraceptive use and antenatal visits) and decline of HIV prevalence since the 1990s demonstrate overall improvements in the health status of Tanzanians. Short of increases in external funding, public policy and health trends demonstrate that Tanzania is on a positive path towards increasing primary health care for all.

As shown in Figure 5, life expectancy saw some stagnation in the 1990s, but has shown improvement since 2002. Infant mortality (Figure 5) has also seen positive gains, decreasing from 147 deaths/1,000 live births in 1999 to 112 deaths/1,000 live births in 2005. Under-five mortality (not shown) also decreased between 1978 and 2002, from 231 to 162 per 1,000 live births. Mtei and Borghi (2007) suggest that the declining trend in child mortality could be attributed to improved malaria control – both the increased use of mosquito nets as well as improved curative care through more effective drug treatment. Malaria and anemia remain the main causes of under-five child mortality at 48% and 10% respectively in 2004.

Figure 5 Life Expectancy and Mortality Rates in Tanzania

Source: World Development Indicators (WDI), Health Systems 20/20 Database (USAID)

Tanzania’s HIV prevalence rate saw a peak in the latter part of the 1990s (see Figure 6), but has shown significant decline since. This can be largely attributed to the extensive donor funding geared toward HIV and AIDS control. The country received approximately $130 million in Fiscal Year (FY) 2006 from the President’s Emergency Plan for AIDS Relief (PEPFAR) and approximately $27 million for FY 2007 from the President’s Malaria Initiative (PMI).

Figure 6

Source: UNAIDS, Health Systems 20/20 Database (USAID) (USAID, 2012)

Women’s health in Tanzania has also seen improvements (see Figure 7) in terms of contraceptive prevalence and pregnant women who received at least one antenatal visits. However, the existing data on antenatal visits is somewhat old (2004). While the contraceptive use data is relatively up to date (2010), there is certainly room for improvement as it is still below 40%.

Figure 7

Source: Demographic and Health Surveys (DHS) and World Development Indicators (WDI), Health Systems 20/20 Database (USAID)

## Findings: Comparison to Other Sub-Saharan African Countries

Tanzania has certainly seen improvements in health indicators related to PHC, but how do they compare to other sub-Saharan African countries? To get a clearer picture of Tanzania’s success in improving health, data from 13 other sub-Saharan African countries was evaluated based on percent change from 1990 to 2009. These sub-Saharan African countries were chosen because their GDP fell within $100 (plus and minus) of Tanzania’s GDP in 2009. Due to data limitations, only life expectancy, infant mortality, under-five mortality, maternal mortality, and HIV prevalence were evaluated. In all of the indicators but maternal mortality and HIV prevalence, the year 1990 was chosen as a baseline because the PHC strategies of decentralization, user fee abolition, and contracting out of services was not yet in full force.

Out of 14 countries, Tanzania’s life expectancy change was 6th highest between 1990 and 2009 reaching 56.59 years. Their under-five mortality rate change was the highest, dropping to 80.4 per 1,000 births in 2009. Tanzania’s infant mortality rate also showed great improvements in comparison to the other 13 countries, again ranking highest in their change between 1990 and 2009 (52.5 infant deaths per 1,000 live births in 2009).

The change in maternal mortality ratio per 100,000 live births was fairly dismal in comparison to the other countries, with just a small decrease since 2000 and still an overall high ratio. The year 2000 was used as a baseline to due lack of data for 1990. Kruk et al. (2009) looked at the extent in which women in rural western Tanzania bypass their nearest primary care facilities to deliver at more distant health facilities; typically preferring NGO-run or faith-based health clinics over government-run facilities. The researchers found that 44% of women who delivered in a health facility bypassed their nearest facility (Kruk et al., 2009). Bypassing is costly and inefficient for the individuals and the health system. This creates more inequity as NGO and faith-based facilities are typically more expensive, which results in more money spent on user fees for rural individuals. In addition to obstetric risk factors, a major reason for this appears to be a concern about the quality of care at government dispensaries and health centers.

For comparison of HIV prevalence, the year 2000 was used as a baseline since HIV was just barely emerging in many sub-Saharan African countries in 1990. Consequently, a comparison of 1990 to 2009 would show an increase across the board in all countries. Looking at the HIV prevalence among individuals ages 15-49, Tanzania had the third largest change in the country comparison. Additionally, at 5.6% (UNAIDS, 2011), Tanzania’s HIV prevalence among this age group is on the lower end of the spectrum (Lesotho, in comparison, has a prevalence of 23%).

The last country comparison was not a health indicator, but rather an equity indicator. For OOP expenditure as a percentage of total health expenditure (THE), Tanzania has not only shown the greatest improvement, but also has the smallest OOP expenditure as a percentage of THE compared to the other 13 countries at 17.19% (WHO, 2011). By decreasing this percentage, the financial burden on individuals and families is reduced. See Appendix 3 for the complete data tables.

## Findings: Limitations

The cross country comparison is by no means an exhaustive country comparison, as external factors such as population size, political climate, donor funding levels, and health financing were not controlled for. However, these improvements in health indicators demonstrate the success of the Tanzanian government in implementing PHC strategies. Additionally, the large decrease (47.26% to 17.19%) in OOP expenditure as a percentage of private expenditure suggests improvements in cost as an equity goal. The equity goals of access and service provision were not factored into the country comparison due to data limitations.

 This theoretical examination of the Tanzanian health care system is reliant on the use of secondary data collection. Due to cost and travel limitations it was not feasible for the researcher to collect primary data through surveys or interviews. As a result, certain confounding elements may not be controlled for and certain gaps remain in the data. In addition, this examination does not fully capture the health status of Tanzania. Health care access and utilization are simply a piece of the health status puzzle when studying the social determinants of health.

# Conclusion—Lessons learned from Tanzania

Distribution of scarce resources can be difficult to manage on an equitable basis, and health care remains no exception. This essay sought to consider the extent to which health care is available to all citizens by exploring the provision of PHC services in Tanzania; in particular, how does the Tanzanian government meet goals of equity in their provision of PHC? To meet goals of equity through the delivery of PHC services, the Tanzanian government has instituted a wide range of policies and programs that incorporate effective PHC strategies including decentralization, user fee abolition, and contracting out of services.

The success to which the Tanzanian government has utilized decentralization, user fee abolition and the contracting out of services, however, varies. The Tanzanian government’s efforts have been strongest in the strategies of decentralization and contracting out of services and the weakest in their abolition of user fees. In particular, Tanzania has as history of decentralization in their health care system, which provides allocated roles at the various points from the central level down to district and local levels. This decentralized system allows for flexibility towards local health needs. Tanzania has focused on the growth of PPPs in distributing health services, which has been proven to be an effective method for extending the availability of PHC services to all citizens.

The overall financial burden is relatively progressive as a result of taxation and health insurance programs. The OOP costs reflect a marginally pro-rich finance structure; however, there has been an overall decrease in OOP expenditure as a percentage of private expenditure since the 1990s. This demonstrates the need for further examination of user fee exemptions and waivers as research suggests that many users still end up paying for “exempt” services through unofficial provider payments. Government facilities appear to be the most equitable in their user fee exemptions and waivers, although consumer preference for FBOs demonstrates there may be differences between facilities in terms of quality of health services.

In terms of access, PPPs prove to be an effective means of extending and contracting out services. Consequently, the Tanzanian government must decide whom to extend health services through. While government facilities provide the most comprehensive list of PHC services, FBOs appear to be the most equitable in their provision of services across income quintiles.

FBOs also have several strengths in addition to their equitable provision of services. First, they tend to be located in rural locations, providing services to those that might otherwise fall through the cracks. As a second strength, various studies have shown a consumer preference for FBO-provided services over that of government-provided services. Finally, while government facilities overall are more comprehensive in their provision of PHC-related services, FBOs show definite strengths in the provision of children’s health and delivery services.

The 2007 National Health Policy acknowledges the strengths of the private sector and suggests areas for improvement through the use of government service level agreements. These agreements could potentially strengthen PHC services gaps in the private sector; government funding would essentially dictate which services a facility must provide. In working towards goals of equity and universal health care, policy recommendations would focus on strengthening PPPs between the government and FBOs rather than private-for-profit providers because of their existing efforts towards equity. Currently, there is inadequate mainstreaming of PPP at all levels.

This review of the Tanzanian government’s efforts towards meeting the goals of access through the delivery of PHC services shows definitive strengths (decentralization and the use of non-governmental actors to extend services) and considerable weaknesses (the government’s ability to enforce user fee exemptions and waivers at facilities). It might even be argued that Tanzania’s strength of decentralization might inherently affect its ability to enforce policy at the local level. This shows that even with policy in place, policy goals are not always realized. Consequently, in the midst of a decentralized health system, local autonomy is needed to ensure that efforts across all levels are working towards improved access in the delivery of PHC.

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# Appendices

## Appendix 1: Number of Health Facilities by Type and Provider, 2006



Source: Adjei, et al., 2009

## Appendix 2: Timeline of PHC Policy

|  |  |
| --- | --- |
| Timeline of Primary Health Care Related Policy in Tanzania |  |
| **Year** | **Policy or Program** | **Description** |
| 1967 | Arusha Declaration  | Put PHC and rural health on the policy radar |
| 1972 | Decentralization Act of 1972 | Shifted power towards Regions and Districts; more flexible to local needs, but also increased regional disparities |
| 1977 | Private Hospitals Regulation Act | Private-for-profit providers could no longer operate in Tanzania |
| 1978 | Alma Alta Declaration  | International decree for Primary “Health Care for All” |
| 1982 | Local Government Authorities Act | Transferred authority to lower levels of government, allowing for more participation in planning, implementation and evaluation |
| 1990 | National Health Policy | Overarching framework and policy detail for Tanzanian health system |
| 1991 | Private-for-Profit ban lifted | Private providers could begin charging service fees again |
| 1992 | Health Management Teams  | Creation of Health Management Teams at the District and Regional levels (DHMT, RHMT) |
| 1993 | Introduction of user fees | National structure created for user fees; certain exemptions given for maternal and child health care services |
| 1994 | Health Sector Reform | Aimed at improving efficiency, equity and resource mobilization through leadership, accountability and partnerships at all levels in the health system. Primary health care was adopted as the most cost-effective strategy to do this. Focus on decentralization of health services and financial reforms. |
| 1996 | Local Government Reform Programme | Instituted political, financial and administrative accountability at the district level |
| 1998 | National Poverty Eradication Strategy | Poor health and nutrition identified as key components of poverty |
| 1999 | National Health Insurance Fund (NHIF) | Health insurance program created for civil servants |
| 2000 | National Package of Essential Health Interventions | Prioritizing health services to reduce burden of disease, increase efficiency an and effectiveness |
| 2000 | Vision 2025 | Long term national development plan; health sector critical to attaining high quality of life; improved access to PHC |
| 2001 | Community Health Fund (CHF) | Health insurance program targeted at the poor and those living in rural areas |
| 2003 | National Health Policy | Revision of 1990 NHP |
| 2005 | National Strategy for Growth and Reduction of Poverty | Provides the overall direction for the achievement of the Millennium Development Goals (MDGs) |
| 2007 | National Health Policy | Revision of 2003 NHP, recognizing the contribution of the private sector in health service provision.  |
| 2007 | Primary Health Care Service Development Programme | Main goal to accelerate the provision of primary health care services for all by 2012 |
| 2011 | Public and Private Health Services Section | Merger of the Public Health Section and Voluntary and Private Health Services sections within the MOHSW. |

## Appendix 3: Comparison of Select Tanzanian Health Indicators to Other Sub-Saharan African Countries

Sources: World Development Indicators, 2011; UNAIDS, 2011; World Health Organization, 2011

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Country** | **Life expectancy at birth in years, 1990** | **Life expectancy at birth in years, 2009** | **Increase**  | **% Change** |
| Lesotho | 59.33 | 46.67 | -12.66 | -21% |
| Kenya | 59.34 | 55.84 | -3.5 | -6% |
| Zambia | 47.48 | 47.81 | 0.33 | 1% |
| Mauritania | 55.94 | 57.92 | 1.98 | 4% |
| Comoros | 55.6 | 60.23 | 4.63 | 8% |
| Gambia | 53.13 | 57.84 | 4.71 | 9% |
| Ghana | 56.84 | 63.39 | 6.55 | 12% |
| Nigeria | 45.64 | 50.95 | 5.31 | 12% |
| **Tanzania** | **50.6** | **56.59** | **5.99** | **12%** |
| Uganda | 47.36 | 53.07 | 5.71 | 12% |
| Benin | 48.65 | 55.17 | 6.52 | 13% |
| Mozambique | 43.18 | 49.28 | 6.1 | 14% |
| Sudan | 52.53 | 60.79 | 8.26 | 16% |
| Guinea | 43.67 | 53.17 | 9.5 | 22% |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Country** | **Infant Mortality Rate per 1,000 Live Births, 1990** | **Infant Mortality Rate per 1,000 Live Births, 2009** | **Decrease** | **% Change** |
| **Tanzania** | **95.2** | **52.5** | **-42.7** | **-45%** |
| Uganda | 105.8 | 65 | -40.8 | -39% |
| Guinea | 135.4 | 83.6 | -51.8 | -38% |
| Mozambique | 146.2 | 94.6 | -51.6 | -35% |
| Zambia | 109.2 | 71.5 | -37.7 | -35% |
| Ghana | 76.7 | 51.3 | -25.4 | -33% |
| Benin | 107 | 74.7 | -32.3 | -30% |
| Nigeria | 126 | 90.4 | -35.6 | -28% |
| Comoros | 87.9 | 64 | -23.9 | -27% |
| Gambia | 78.3 | 57.8 | -20.5 | -26% |
| Sudan | 78.4 | 66.9 | -11.5 | -15% |
| Kenya | 64.3 | 56.3 | -8 | -12% |
| Lesotho | 72 | 67 | -5 | -7% |
| Mauritania | 80.3 | 75.4 | -4.9 | -6% |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Country** | **Maternal mortality ratio per 100,000 live births, 1990--WDI-2011** | **Maternal mortality ratio per 100,000 live births, 2008--WDI-2011** | **Decrease** | **% Change** |
| Guinea | 1,200 | 680 | -520 | -43% |
| Mozambique | 1,000 | 550 | -450 | -45% |
| Benin | 790 | 410 | -380 | -48% |
| Gambia | 750 | 400 | -350 | -47% |
| Ghana | 630 | 350 | -280 | -44% |
| Nigeria | 1,100 | 840 | -260 | -24% |
| Uganda | 670 | 430 | -240 | -36% |
| Mauritania | 780 | 550 | -230 | -29% |
| Comoros | 530 | 340 | -190 | -36% |
| **Tanzania** | **880** | **790** | **-90** | **-10%** |
| Sudan | 830 | 750 | -80 | -10% |
| Zambia | 390 | 470 | 80 | 21% |
| Kenya | 380 | 530 | 150 | 39% |
| Lesotho | 370 | 530 | 160 | 43% |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Country** | **HIV prevalence total (% ages 15-49), 2000--UNAIDS** | **HIV prevalence total (% ages 15-49), 2009--UNAIDS** | **Decrease** | **% Change** |
| Kenya | 9 | 6.3 | -2.7 | -30% |
| Guinea | 1.7 | 1.3 | -0.4 | -24% |
| **Tanzania** | **7.3** | **5.6** | **-1.7** | **-23%** |
| Ghana | 2.3 | 1.8 | -0.5 | -22% |
| Benin | 1.4 | 1.2 | -0.2 | -14% |
| Uganda | 7.3 | 6.5 | -0.8 | -11% |
| Nigeria | 3.9 | 3.6 | -0.3 | -8% |
| Zambia | 14.4 | 13.5 | -0.9 | -6% |
| Lesotho | 24.5 | 23.6 | -0.9 | -4% |
| Comoros | 0.1 | 0.1 | 0 | 0% |
| Mauritania | 0.6 | 0.7 | 0.1 | 17% |
| Mozambique | 8.6 | 11.5 | 2.9 | 34% |
| Sudan | 0.3 | 1.1 | 0.8 | 267% |
| Gambia | 0.5 | 2 | 1.5 | 300% |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Country** | **Out-of-pocket expenditure as % of total expenditure on health, 2000--WHO** | **Out-of-pocket expenditure as % of total expenditure on health, 2009--WHO** | **Decrease** | **% Change** |
| **Tanzania** | **47.26** | **17.19** | **-30.07** | **-64%** |
| Benin | 56.14 | 41.53 | -14.61 | -26% |
| Lesotho | 35.94 | 21.91 | -14.03 | -39% |
| Zambia | 39.2 | 27.22 | -11.98 | -31% |
| Gambia | 35.66 | 24.2 | -11.46 | -32% |
| Ghana | 46.65 | 36.78 | -9.87 | -21% |
| Comoros | 45.9 | 38.4 | -7.5 | -16% |
| Guinea | 87.16 | 84.29 | -2.87 | -3% |
| Mozambique | 12.57 | 10.68 | -1.89 | -15% |
| Nigeria | 61.65 | 60.9 | -0.75 | -1% |
| Sudan | 66.08 | 69.84 | 3.76 | 6% |
| Kenya | 43.81 | 51.24 | 7.43 | 17% |
| Uganda | 41.5 | 52.97 | 11.47 | 28% |
| Mauritania | 21.1 | 37.4 | 16.3 | 77% |