Introduction
The government, with the assistance of non-governmental organisations (NGOs) and international donors has made tremendous efforts towards curbing the spread of malaria, HIV/AIDS, pneumonia, tuberculosis and other ailments that afflict Tanzanians. A number of achievements have also been realised especially increased accessibility and provision of preventive and promotive health care to the rural poor. However, despite the availability of sound health policy, shortage of resources available to health sector is evident.

The National Health Policy
Tanzania seeks to improve the health and well being of all Tanzanians with a special focus on those most at risk, and to encourage the health system to be more responsive to the needs of the people. The policy recognizes that, good health is a major resource essential for poverty eradication and economic development. The policy seeks to facilitate meeting the key health related targets of the MDGs, which are also enshrined in the NSGRP. These are reduction of maternal and infant mortality, provision of adequate and equitable maternal and child health services. The policy also provides for more resource allocation for the prevention of HIV and AIDS and other diseases such as malaria and immunization of children under 2 years of age, as well as enhancing the provision of reproductive and Child Health including family planning. In this respect the policy provides for promotion of youth – friendly services so as to improve access to reproductive health information and services for young people.

The newly initiated Primary Health Service Development Programme, (PHSDP/MMAM) 2007-2017, addresses the delivery of health services to ensure fair, equitable and quality services to the community and is envisioned to be the springboard for achieving good health for Tanzanians.

Health Services Delivery
The Ministry of Health and Social Services takes charge of health sector services throughout the country.
The health system and especially the government’s referral system assume a pyramidal pattern of a referral system recommended by health planners, that is from dispensary to Consultant Hospital. The structure of health services at various levels in the country is as follows:

**Village Health Service**
This is the lowest level of health care delivery in the country. They essentially provide preventive services which can be offered in homes. Usually each village Health post have two village health workers chosen by the village government amongst the villagers and be given a short training before they start providing services.

**Dispensary Services**
This is the second stage of health services. The dispensary cater for between 6,000 to 10,000 people and supervise all the village health posts in its ward.

**Health Centre Services**
A health Centre is expected to cater for 50,000 people which is approximately the pop. of one administrative division.

**District Hospitals**
The district is a very important level in the provision of health services in the country each district is supposed to have a district hospital. For those districts which donate have Government normally negotiates with religious organizations to designate voluntary hospitals get subventions from the Government to contract terms.

**Regional Hospitals**
Every region is supposed to have a hospital. Regional Hospital offer similar services like those agreed at district level, however regional hospitals have specialists in various fields and offer additional services which are not provided at district hospitals.

**Referral/Consultant Hospitals**
This is the highest level of hospital services in the country presently there are four referral hospitals namely; the Muhimbili National Hospital which cater the eastern zone; Kilimanjaro Christian Medical Centre (KCMC) which cater for the northern zone, Bugando Hospital which cater for the western zone; and Mbeya Hospital which serves the southern Highlands.

**Treatment Abroad**
Other diseases and cases require special treatment whose facilities and equipment are not available in the country. Depending on the foreign exchange position, some patients have to be sent for treatment abroad.

**Human Resources**
The available number of professional health workers is about 37,000. The government is the main employer of health workers. Through special agreements, some of its employees are allocated to faith based health facilities. The majority of health staff, about 74%, work in the government health facilities; followed by faith-based facilities with a share of 22%. Private facilities employ about 3% and parastatal owned facilities have 1% of total workforce in the health sector.

Budget allocation for human resources is still limited, production capacity of training institutions are insufficient and HRH management capacity remains low. The World Health Organization estimates the current deficit of health workers in Tanzania to be around 90,000.

The ratio of doctors to inhabitants is 1:50,000.

**Malaria situation**
Every year, 14 million to 18 million new malaria cases are reported in Tanzania, and 100,000-125,000 deaths occur. Of those deaths, 70,000-80,000 occur in children less than five years of age. The annual incidence rate is between 400 and 500 per 1,000 people, and this number doubles for children less than five years of age. These high rates imply multiple episodes of malaria in a single year for many individuals.

Malaria is the leading cause of outpatients, deaths of hospitalized people, and admissions of children less than five years of age at medical facilities. As a result, it is considered the major cause for the loss of economic productivity of those between 15 and 55 years old, and an impediment to the learning capacity of people between 5 and 25 years of age. The disease represents one of the most important obstacles to economic development in Tanzania.

Tanzania has made some progress in the fight against malaria through a combination of effective interventions such as use of Long lasting insecticide nets, effective treatment with WHO recommended artemisinin based
combination therapies (ACTs), and effective environmental action including indoor residual spraying. Tanzania’s Isle of Zanzibar has reduced the burden of malaria by over 50% between 2000 and 2007 using these interventions.

The Tanzanian government is currently mooting plans to distribute over 7 million long-lasting treated nets free of charge to all children under five and subsequently to mount a campaign for universal coverage of at least two long lasting nets per household – amounting to about 14.6 million nets to 8.7 million households.

Maternal, New Born and Child Health (MNCH)

Maternal deaths are caused by factors attributable to pregnancy, childbirth and poor quality of health services. Newborn deaths are related to the same issues and occur mostly during the first week of life. Child health depends heavily on availability of and access to immunization, quality management of childhood illnesses and proper nutrition.

In Tanzania 13,000 women die each year from pregnancy related causes and another 157,000 children die before their first birthday.

From 1999 to 2007 under-five mortality in Tanzania has dropped from 147 to 91 per 1000 live births. Similarly infant mortality has declined substantially from 104 to 68 live births between 2003 and 2008. Possible contributing factors may be related to general development efforts and cost-effective public health interventions. Neonatal mortality which is estimated at 32 per 1,000 live births has remained stagnant as did maternal mortality which persists at a high level (578 per 100,000 live births). High Maternal and Neonatal death rates reflect poor access to and poor quality of care during antenatal, perinatal and postnatal periods.

Less than 50% of women in Tanzania deliver with the attendance of a skilled professional and availability of basic equipments and supplies for conducting normal deliveries are available in only 13% of facilities offering delivery services. The gains in child mortality are currently threatened by a consecutive drop in immunization coverage.

Reporting shows drop in DPT-HB3 coverage from 94% in 2004 to 83% in 2007. Child and maternal health is further undermined by high levels of malnutrition with more than one third of children stunted and more than two thirds suffering from anaemia and other micronutrient deficiencies. One MNCH Plan has been developed to accelerate the attainment of MDG 4 and 5, if the above challenges are not addressed, Tanzania will not be able to attain the objectives.

HIV/AIDS situation

The HIV epidemic has stabilized around 6% since 1997. The current national HIV prevalence of 5.7% shows a 1.3% decline from the THIS 2003-2004 survey.
HIV/AIDS in Tanzania is a generalized epidemic. By early 2008 it was estimated that 1.3 million people including adult and children in Tanzania were living with HIV and 10% are children. Adults in the age group of (35 - 39) are more likely to be infected than the other age groups. Knowledge changes were noted in the Tanzania HIV/AIDS and Malaria Indicator Survey (THMIS) 2007 - 2008 but risky sexual acts still prevail among men and women of various age and socio-economic groups. Some of the driving factors includes poverty, pervasive socio-cultural practices and promiscuity.

Tanzania launched a HIV/AIDS Care and Treatment plan in October 2003 and since 2004 a rapid and large scale roll-out of antiretroviral treatment has been ongoing. The operational target was to provide ART drugs to 440,000 AIDS patients by the end of 2008. To achieve this objective, the Ministry of Health and Social Welfare established Care and Treatment Centers (CTC) starting from referral hospitals followed by regional and district hospitals and then to health centres and dispensaries. As of March, 2009, the cumulatively reported number of patients ever started on ART was 235,012 and a total of 454,681 patients were reported to have been enrolled in care, representing 21.5% of the 2,113,158 estimated people living with HIV (PLHIV).

While there has been a positive trend among women accessing services at CTC, the number of children accessing these services represented only 9% of the total CTC clients by December 2008, way below the 20% target set by the Ministry of Health and Social Welfare. There are also major challenges in the area of early identification and enrollment of infected children into care. So far there are only 509 (15%) out of 3,420 PMTCT centres conducting HIV Early Infant Diagnosis (HEID). In 2008, 10,376 children were tested and by September 2009, 11,289.

By December 2008, the percentage of HIV positive pregnant women who received antiretroviral to reduce the risk of MTCT was 68%. It is estimated that 70,000 to 80,000 newborn infants are at risk of acquiring HIV every year.

It is estimated that 2 million children have been orphaned as a result of the disease.

The National Voluntary Counselling and Testing Campaign (2007 - 2008) has provided a unique stimulus to the general HIV/AIDS response in the country. While more than 4 million people have tested in all districts of the country, the campaign also served to augment the scope and scale of other intervention components of the national response. The areas that have benefited from the campaign include advocacy, general behaviour change communication, community mobilization and reduction of stigma, strengthening of laboratory services and training of health care workers. Overall, awareness of AIDS is high, amongst men and women in all age groups, and across background characteristics, with at least 90 % of people having heard of AIDS.

**Development of the sector**

During 2009, the government in collaboration with various stakeholders continued to implement a special programme on Primary Health Care. The emphasis was directed towards strengthening and improving child and maternal health to reduce mother and child mortality. A programme aimed at collecting and analyzing health statistics was improved, to ease the process of collecting accurate data related to the health sector.

Centers that provide health services increased to 6,385 compared to 5,901 in 2008, an increment of 7.6%. Among those, the government had 292 hospitals, 431 health centers and 3,526 dispensaries, whereas government parasitats had 15 hospitals, 41 health centers and 1,477 dispensaries. The private sector and charity organizations had 163 hospitals, 163 health centers and 1,477 dispensaries.

Environmental health service education was given to improve people’s health through 52 radio programmes. There was a distribution of 190,000 leaflets and 120,000 banners were designed to sensitize the public against contracting the dreadful HIV/
Aids, tuberculosis, Malaria, Incommunicable diseases and other related disasters.

Training on new techniques related to availing information concerning home care service to people living with HIV/AIDS was conducted to regional doctors and coordinators of Arusha, Dar es Salaam, Coastal, Lindi, Manyara and Iringa regions.

The second phase of tetanus immunization campaign was undertaken to 957,983 women in Bariadi, Bunda, Bukombe, Hanang, Kahama, Kibondo, Kiteto, Meatu, Mpanda Urban, Ngoro, Rorya, Simanjiro, and Tarime districts.

A total of 146 care givers were trained on sexually transmitted diseases (STDs), maternal health, and peer education for youths. 126 coordinators were also trained on passing information related to STDs.

**Health Sector Challenges**

Despite all these efforts, morbidity and mortality due to communicable and non-communicable diseases remain serious challenges. The following is a summary of the findings:

- Weak health system support for human resource gap of more than 10,000 and infrastructure renewals at the dispensary and health centres are a priority;
- Low and ineffectual scaling up of well known and effective interventions (rebuilding and equipping the dispensaries) to respond to maternal, neonatal, child survival and nutrition are urgent;
- The unchanged maternal mortality ratios – 580/100,000 since the past decade, dire need to reach the MDG number 5 through expansion and support to FANC for improved and skilled birth attendance;
- Poor behavioural change and communication to promote care-seeking, including facility based delivery etc.

**Challenges facing health sector**

- Tanzania faces a serious human resources crisis with a health worker shortage estimated at 60% of projected requirements and with an inequitable distribution of health workers.
- Health conditions are particularly poor in rural areas because of the lack of frontline community health workers and access to clean water.
- Poor transport to health centres and hospitals has denied many Tanzanians health services, especially pregnant women who fail to access clinical services.
- Health sector is currently challenged by existing demands and new demands. It is becoming increasingly more costly to provide health care – new vaccines, more expensive and effective anti-malaria drugs, essential commodities, ARVs and scaling up cost effective interventions.

**Conclusion**

At the moment, the greatest challenge facing the health sector in Tanzania is inadequate human resources to deliver quality health services to the population. Since the 1990s, Structural Adjustment Policies (SAPs) and HIV/AIDS have greatly reduced the health-sector workforce. While services may be available, the human and physical infrastructure is in need of improvement to allow for better quality patient care. Although some progress has been made in HR, it is however not commensurate with the magnitude and urgency of the crisis. Filling the estimated deficit of 90,000 health workers therefore still remains a major challenge that the government needs to deal with.

Furthermore, the resources are not adequate especially when health care needs are increasing and costs are escalating.