**THE UNITED REPUBLIC OF TANZANIA**

MINISTRY OF HEALTH

ANNUAL HEALTH SECTOR PERFORMANCE PROFILE 2024

July, 2025

FOREWORD

The Annual Health Sector Performance Profile Report (AHSPPR) provides a summary of the progress achieved in the health sector, based on the evaluation of indicators outlined in the Fifth Health Sector Strategic Plan 2021–2026 (HSSP V). It also presents updates on the implementation of health services within the framework of the Sustainable Development Goals (SDGs).

This report presents the progress, status, and gaps in delivering quality and standard health care services for all in 2024. In line with the identified gaps, it sets forth a summary of recommendations to guide policy improvements and actions. The report is structured around the six health system building blocks defined by the World Health Organization (WHO) and reflected in HSSP V, enabling comprehensive monitoring of key health sector indicators. It draws on data from multiple sources, including DHIS2, program data, and surveys, as primary inputs.

The report calls on key health sector stakeholders to support the government in achieving the goals of HSSP V, thereby contributing to the overall attainment of the Sustainable Development Goals (SDGs 2030) and Tanzania's Development Vision 2025. The recommendations outlined will serve as a framework for developing evidence-based interventions to address existing challenges and gaps in the health sector.

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ACKNOWLEDGMENT

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We are grateful for the dedication and contributions of officials from the Ministry of Health (MoH) and the President's Office – Regional Administration and Local Government (PO-RALG). Our heartfelt thanks also extend to development partners, implementing partners, faith-based organizations, private sector entities, civil society organizations, and other institutions for their unwavering support in strengthening the health sector.

We would also like to recognize the guidance and support provided by the Minister, Deputy Minister, Permanent Secretary, and Deputy Permanent Secretary throughout the preparation of this report.

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ABBREVIATIONS AND ACRONYMS

AHSPP	Annual Health Sector Performance Profile
MoH	Ministry of Health
PO-RALG	President's Office – Regional Administration and Local Government
HSSP V	Health Sector Strategic Plan V (2021–2026)
DHIS2	District Health Information Software 2
HMIS	Health Management Information System
Got-HOMIS	Government of Tanzania Hospital Management Information System
CCHP	Comprehensive Council Health Plan
PlanRep	Planning and Reporting Tool
NBS	National Bureau of Statistics
TDHS	Tanzania Demographic and Health Survey
MCCD	Medical Certification of Cause of Death
ICD-10	International Classification of Diseases, 10th Revision
VA	Verbal Autopsy

CRVS	Civil Registration and Vital Statistics
RITA	Registration, Insolvency and Trusteeship Agency
U5BRI	Under-5 Birth Registration Initiative
EMR	Electronic Medical Records
NCDs	Non-Communicable Diseases
RMNCAH	Reproductive, Maternal, Neonatal, Child and Adolescent Health
PMTCT	Prevention of Mother-to-Child Transmission (of HIV)
RHCA	Reproductive Health for Cancer
CECAP	Cervical Cancer Prevention Program
VIA	Visual Inspection with Acetic Acid
ANC	Antenatal Care
FANC	Focused Antenatal Care
PPFP	Post-Partum Family Planning
GBV	Gender-Based Violence
VAC	Violence Against Children
NTDs	Neglected Tropical Diseases
PCT	Preventive Chemotherapy
LF	Lymphatic Filariasis
STH	Soil-Transmitted Helminths
SCH	Schistosomiasis
MDA	Mass Drug Administration

NTDCP	Neglected Tropical Diseases Control Programme
MMDP	Morbidity Management and Disability Prevention
TT	Trachomatous Trichiasis (surgery)
IDSR	Integrated Disease Surveillance and Response
iCCM	Integrated Community Case Management
IRS	Indoor Residual Spraying
EMC	End Malaria Council
IPTsc	Intermittent Preventive Treatment of malaria in school-aged children
PMC	Perennial Malaria Chemoprevention
ASAQ	Artesunate-Amodiaquine
SMI	Safe Motherhood Initiative
EMS	Emergency Medical Services
NEMS	National Emergency Medical System
BMH	Benjamin Mkapa Hospital
KCMC	Kilimanjaro Christian Medical Centre
MNH	Muhimbili National Hospital
EMD	Emergency Medicine Department
ICU	Intensive Care Unit
PHEOC	Public Health Emergency Operations Centre
VIMS	Vaccine Information Management System
IPC	Infection Prevention and Control

OPD	Outpatient Department
IPD	Inpatient Department
RRH	Regional Referral Hospital
DH	District Hospital
DDH	Designated District Hospital
HC	Health Centre
ISO	International Organization for Standardization
SADCAS	Southern African Development Community Accreditation Service
KENAS	Kenya Accreditation Service
AfSBT	African Society for Blood Transfusion
AAR	After Action Review
IAR	Intra-Action Review
AIDS	Acquired Immune Deficiency Syndrome
AMR	Antimicrobial Resistance
ALS	Advanced Life Support
BLS	Basic Life Support
CDR	Crude Death Rate
CTX	Cotrimoxazole
COVID-19	Coronavirus Disease 2019
EBS / eEBS	electronic Event-Based Surveillance
EDPs	Extremely Dangerous Pathogens

EHS	Essential Health Services
EID	Early Infant Diagnosis
FP	Family Planning
GePG	Government e-Payment Gateway
HIDU	High Dependency Unit
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HCWs	Health Care Workers
ICU	Intensive Care Unit
ICT	Information and Communication Technology
IDSR / eIDSR	electronic Integrated Disease Surveillance and Response
IPTp	Intermittent Preventive Treatment in pregnancy
ITN	Insecticide Treated Net
JEE	Joint External Evaluation
JKCI	Jakaya Kikwete Cardiac Institute
LAN	Local Area Network
LGA	Local Government Authority
M&E	Monitoring and Evaluation
MCCD	Medical Certification of Cause of Death
MDA	Mass Drug Administration
MOI	Muhimbili Orthopaedic Institute

MUSE	Medical User System for Electronic payments/claims
NAPHS	National Action Plan for Health Security
NaPA	National Payment Application
NGO	Non-Governmental Organization
OHCD	One Health Coordination Desk
PHEM	Public Health Emergency Management
PHEOC / RPHEOC	Regional Public Health Emergency Operation Centre
PMC	Perennial Malaria Chemoprevention
PMTCT	Prevention of Mother-to-Child Transmission
PWID	People Who Inject Drugs
RCCE	Risk Communication and Community Engagement
RHMT	Regional Health Management Team
RVF	Rift Valley Fever
SBA	Skilled Birth Attendant
STH	Soil-Transmitted Helminthiases
STIs	Sexually Transmitted Infections
TB	Tuberculosis
TOTs	Training of Trainers
UNICEF	United Nations International Children's Emergency Fund
VPDs	Vaccine Preventable Diseases
WHO	World Health Organization

EXECUTIVE SUMMARY

This report aims to provide an assessment of the annual implementation of the Health Sector Strategic Plan (HSSP V 2021/22–2025/26) for the year 2024. The evaluation is based on a set of 50 selected health sector indicators agreed upon by Sector-Wide Approach (SWAp) members. These indicators cover impact, health coverage, risk factors, health system outputs including access and quality and health system inputs.

Overall, significant progress is observed across the implemented health interventions. While some indicator targets have been fully achieved and others are making good progress toward attainment, a few indicators still lag behind, requiring collective efforts to realize them. The majority of evaluated indicators are derived from routine Health Information Systems, the Population and Housing Census, health surveys, and UN estimates. However, some key indicators dependent on surveys were not available during the preparation of this report. The Ministry of Health remains committed to allocating resources to conduct surveys necessary for evaluating the progress of all HSSP V selected indicators.

For each indicator, a thorough analysis and detailed report are provided to elaborate on achievements, identify gaps, and offer policy recommendations aimed at accelerating progress toward the set targets. The table below presents a summary of key achievements for 2024.

Health indicators status for the HSSP V and SDGs set targets year 2024

No.	Key Selected Indicators	End of HSSP II 2009	End of HSSP III 2015	End of HSSP IV 2020	Status as of 2021	Status as of 2022	Status as of 2023	Status as of 2024	HSSP V Target 2025/26	Source of data
	Impact Indicators									
1	Life expectancy at birth (years)	51.5	61.8	66	66.9	67.8	67.8	67.8	68	Census 2022
2	Total fertility rate	5.7	5.2	4.9	4.9	4.8	4.8	4.8	4.2	TDHS -MIS 2022
3	Maternal Mortality Ratio/ 100,000 live births	578	454	556	556	104	104	104	232	TDHS -MIS 2022

No.	Key Selected Indicators	End of HSSP II 2009	End of HSSP III 2015	End of HSSP IV 2020	Status as of 2021	Status as of 2022	Status as of 2023	Status as of 2024	HSSP V Target 2025/26	Source of data
4	Under-five Motality/1,000 live births	112	81	67	67	43	43	43	38	TDHS -MIS 2022
5	Neonatal Mortality Rate/1,000	45	32	25	25	24	24	24	15	TDHS -MIS 2022
6	Teenage girls (15-19) who are pregnant or have born a child (%)	22	19	16.5	16	16	16	14.9	12	HMIS/TDHS 2022
7	HIV incidence per 100 adults and young people (15-24)	ND	1.00%	0.60%	ND	ND	0.18 (15+)	0.18%	0.30%	THIS-2022/23
		ND	3.20%	2.40%	ND	ND	0.17(15-24)	0.17%	0%	THIS-2022/23
8	PMTCT: Newborns with HIV infection	ND	ND	11.1%	10.89%	6.9%	8.1%	8.1%	<4%	HMIS 2024
9	Malaria parasite prevalence among children 6-59 months (%)	18.1%	14.8%	7.5%	7.5%	8.1%	8.1%	8.1%	<3.5%	TDHS-MIS 2022
10	TB incidence per 100,000 population	452	306	222	208	195	183	183	162	WHO GTR 2024
11	Mortality due to NCD (cardiovascular, cancer, chronic respiratory disease, and diabetes) at 30-70 years (%)	ND	ND	18%	ND	ND	37.8%	43.4%	16.20%	HMIS 2024
	Health Coverage Indicators									
1	Early antenatal care coverage among pregnant women< 12 weeks	14%	15%	27%	37%	38%	42.9%	43.7%	60%	HMIS 2024
2	Demand satisfied with modern FP methods among currently married women 15-49	54%	61%	53%	ND	53%	53%	53%	62%	TDHS -MIS 2022

No.	Key Selected Indicators	End of HSSP II 2009	End of HSSP III 2015	End of HSSP IV 2020	Status as of 2021	Status as of 2022	Status as of 2023	Status as of 2024	HSSP V Target 2025/26	Source of data
3	Institutional deliveries (complemented by SBA rate)	51%	54.70%	83%	81%	81%	85.8%	87.5%	85%	HMIS 2024
4	Full immunization coverage among infants	71%	75%	88%	96 (PENTA 3)	107%	122%	97%	85%	VIMS 2024
5	Use of ITN among children under 5 / among pregnant women	64%/57%	54%/55%	56%/51%	ND	64%/66%	64%/66%	64%/66%	80%/80%	2022 TDHS-MISS
6	IPTp2 doses among pregnant women	57%	33%	79%	78%	60.1%	89.3%	90%	85%	2022 TDHS-MIS
7	ART coverage among people living with HIV, with viral load suppression	ND	60%	85%	95.10%	94.3%	96%	98%	95%	2022-23 THIS
8	TB treatment coverage	ND	37%	64%	65%	78%	78%	76%	90%	WHO TB Global report 2024
9	Cervical cancer screening coverage among women aged 30-50 years in the last 3 years	ND	65%	79%	70%	85%	72.5%	75.7%	60%	HMIS 2024
10	Adults 15-59 years with hypertension who are on (successful) treatment	37% (2007)	ND	7.3% (2012)	ND	ND	ND	ND	>25%	
11	Adults 15-59 years with diabetes who are on (successful) treatment	ND	ND	9.10%	ND	ND	ND	ND	>25%	
12	Viral hepatitis treatment coverage (B and C)	ND	ND	5% (for each)	ND	ND	ND	ND	50%	
13	Prevalence of blindness	ND	ND	2.80%	ND	ND	ND	ND	1%	

No.	Key Selected Indicators	End of HSSP II 2009	End of HSSP III 2015	End of HSSP IV 2020	Status as of 2021	Status as of 2022	Status as of 2023	Status as of 2024	HSSP V Target 2025/26	Source of data
	Risk Factor Indicators									
1	Early initiation of breastfeeding among all newborn children	50.80%	53.50%	53.50%	53.50%	70%	70%	70%	65%	2022 TDHS-MIS
2	Children under 5 years who are stunted	34.70%	31.80%	32%	32%	30%	30%	30%	20%	TDHS -MIS 2022
3	Anaemia prevalence in women 15-49 years/ adolescents 15-19 / under-fives 6 – 59 Month	ND	45%(WRA)	45%	45%	42%	42% (15-49 years)	59%	25% reduction for all groups	TDHS-MIS 2022
			ND (ADO)	ND	ND	ND	ND	ND		
			58%(US)	58%	58%	58%	58%	59%		TDHS-MIS 2022
4	Overweight or obesity among adults Women of Reproductive Age 15-59 years	29.70%		31.7% WRA	31.7	36%	36%	36%	≤ 31.7%	TDHS-MIS 2022
	Obesity among adults 15-59 years	29.70%	8.7% Both Sex (2.5% Males & 15% Females)	ND	ND	ND	10.1% Both Sexes (6.2% Males & 14.2% Female)	ND	≤ 11.5%	TDHS-MIS 2022/STEP SURVEY 2012 & 2023

No.	Key Selected Indicators	End of HSSP II 2009	End of HSSP III 2015	End of HSSP IV 2020	Status as of 2021	Status as of 2022	Status as of 2023	Status as of 2024	HSSP V Target 2025/26	Source of data
5	Relative Reduction of Tobacco use among persons aged 15-49 years	ND	14.10% (Both Sexes)	ND	ND	ND	10% (Both Sexes)	ND	30%	STEP Survey 2012 and 2023
		ND	26% Males 2.9% Females	ND	ND	ND	19.9% Males 0.8% Females	ND	30%	
6	Households with adequate sanitation facilities	ND	ND	24% TMIS 2017	ND	66.5%	72.3%	77.5%	>50%	NPS 2022
7	Households with safe drinking water source	ND	ND	60% (TMIS 2017)	ND	78.8%	86(Urban) 72.3 (Rural)	90(Urban) 79.6 (Rural)	>80%	NPS 2022
Health system outputs indicators, including access and quality										
1	OPD utilization per person per year	0.85	0.9	0.85	0.67	0.67	0.78	0.8	1.2	HMIS 2024
2	Number and distribution of health facilities per 10,000 population	1.6	1.8	2.1	1.4	1.5	1.97	2.1	2.5	HMIS 2024
3	Hospital admissions per 100 persons per year	0.03	0.05	3.2 (AARC - 0.2%)	2.68	2.74	2.98	3.1	4.2	HMIS 2024

No.	Key Selected Indicators	End of HSSP II 2009	End of HSSP III 2015	End of HSSP IV 2020	Status as of 2021	Status as of 2022	Status as of 2023	Status as of 2024	HSSP V Target 2025/26	Source of data
4	Essential medicines (tracers) availability	28%	76%	96%	90.5%	95% (30 Items)	76% (290 Items)	85%	>95%	eLMIS 2024
5	Percent of hospitals providing essential /comprehensive surgical services with tracer items on the day of the assessment	ND	ND	5% (SARA 2017)	ND	ND	66%	66%	>75%	SARA 2023
6	Caesarean Section Delivery 100 live births	10%	10%	8.00%	11	11.6%	11.6%	11.4%	10%	HMIS 2024
7	Percentage of adults and children with HIV known to be on treatment 12 (24; 60) months after initiation of ART	13%	50%	84%	87%	89%	92%	95%	95%	HMIS 2024
8	Emergency preparedness average of 13 core capacities defined by IHR	ND	ND	54%	56%	58%	63%	63%	70%	Annual Filled SPAR 2020, 2021,2022,2023-Published in WHO Website
9	Quality of care: primary health facilities with three stars (% of all facilities)	ND	18%	21%	14%	14%	ND	ND	80%	DQA 2022
	Health System Inputs indicators									
1	Domestic General Government Health Expenditure (GGHE-D) as	ND	ND	2.60%	2%	2%	2%	2%	5%	PER 2024

No.	Key Selected Indicators	End of HSSP II 2009	End of HSSP III 2015	End of HSSP IV 2020	Status as of 2021	Status as of 2022	Status as of 2023	Status as of 2024	HSSP V Target 2025/26	Source of data
	percentage of Gross Domestic Product (GDP)									
2	Government share of the total health budget from all sources (%)	12	12	10%	9.00%	9.1%	8%	7%	12%	PER 2024
3	Health insurance coverage as % of total population (all schemes)	4%	9%	14%	14.7%	15.3%	15.3%	15.3%	58%	NHIF 2022
4	Health workforce density per 10,000 population and distribution by major cadre (details in HRH plan)	5	5.1	6	6.8	8.9	8.4	11.44	22	HRHIS 2024
5	Data accuracy for tracer indicators (Data agreement between source and report documents)	ND	45%	81%	81%	82%	88%	92%	85%	AIG Report (2024)
6	Birth registration: percent of newborns / under fives	3%	26%	47%	65%	65%	68%	41%	90%	RITA 2024
Key										
1					Target Achieved					
2					Good progress likely to be achieved					
3					Far from the target					
4					No data					

CHAPTER ONE
1.0. INTRODUCTION

BACKGROUND

To enhance the health of all Tanzanians and improving life expectancy the Government of Mainland Tanzania is committed to provide quality health services that respond to the needs of the population. This commitment is anchored in two fundamental documents: the Health Policy of 2007 and the Health Sector Strategic Plan(s) (HSSPs). The Health Policy provides the overall framework for government priorities in the health sector and serves as a guide for programs and strategies. These strategies are designed to establish realistic targets, emphasize evidence-based interventions, and promote the efficient utilization of available resources. In turn, the Health Sector Strategic Plan(s) provide direction for monitoring and evaluating sector performance against agreed targets within the specified timeframe. The Ministry of Health (MoH) plays a central role in offering leadership and oversight of health sector performance assessments, while the President's – Office Regional Administration and Local Government (PO-RALG) acts as a key implementing body for HSSPs and other health initiatives.

1.1. HEALTH SECTOR STRATEGIC PLAN V (HSSP V) CONTEXT

The Health Sector Strategic Plan V (HSSP V) serves as the primary reference document for developing five-year strategic plans at the national, regional, council, and hospital levels. It provides direction for designing specific programmes and plans, including annual operational plans across all levels of the health system. The document outlines the range of services offered within the health sector, along with the respective roles and responsibilities at each level. In addition, it presents strategies that address priority areas as well as cross-cutting issues, highlighting approaches to ensure quality, equity, gender responsiveness, and good governance. Therefore, HSSP V stands as a key instrument in achieving the following sector's vision and mission:

1.1.1. VISION
To have a healthy and prosperous society that contributes fully to to the development of individuals and the nation.

1.1.2. MISSION
To provide sustainable health services with standards that are acceptable to all citizens without financial constraints, based on geographical and gender equity.

1.1.3. GOAL

According to the Tanzania Vision 2025, health is identified as one of the priority sectors contributing to high quality livelihoods for all Tanzanians. This will be achieved through realization of the following health services goals:

- Access to quality health care for all individuals of appropriate ages;
- Access to quality reproductive health services for all individuals of appropriate ages;
- Reduction in infant and maternal mortality rates by three quarters of baseline levels;
- Universal access to clean and safe water;
- Life expectancy comparable to the level attained by typical middle-income countries;
- Food self sufficiency and food security; and
- Gender equality and empowerment of women in all health parameters.

1.2. DATA SOURCES

The information used in compiling the 2024 AHSPPR is from routine activities and surveys. For routine activities, the DHIS2 under the M&E Unit is the main source of statistical data. Population figures were based on the 2022 population census from the National Bureau of Statistics. However, few indicators do not have new data as they rely on household surveys especially the Tanzania Demographic Health Survey (TDHS).

Components of the DHIS2 are the health facility monthly and annual reports. These reports are, like any sources of data, prone to errors associated with incomplete or inaccurate reporting. Other key sources of information include:

i.   Sentinel Panel of Districts (SPD)
ii.   Human Resources Information System
iii.   Disease specific programmes
iv.   Annual Health Sector Perfomance Reports
v.   Population and Housing Census
vi.   Tanzania HIV Impact Survey
vii.   Tanzania Demographic and Health Survey reports

1.3. POPULATION HEALTH GROUPS IN TANZANIA

A substantial number of indicators in this report use Population values as their denominators, whereby the major population groups for this report includes Under 1 year, Under 5-years, Adolescents (age 10 – 19 years), Young population (age 15-24 years) as per WHO, Women of Reproductive Age (15 – 49 years), and Elderly (60+ years) population (Table 1). The Tanzania's Population size was reported to reach 64,241,822 people by the year 2024 as projected from 2022 census (National Population projections 2023-2050). The

under-five years population constitute 14.7 percent of the all population of Tanzania mainland, while the under one-year population is 3.3 percent of the all population.

On the other hand, the woman of reproductive age (15-49 years) was 40.3 percent of the female population.

Table 1: Population Age Groups, 2024

Selected Age Group	Both Sexes	Male	Female	Percentage
Under 1 year	2,374,531	1,200,046	1,174,485	3.3
Under 5 years	10,726,740	5,416,806	5,309,934	14.7
Adolescents (10 - 19)	14,761,734	7,424,445	7,337,289	20.3
Young Population WHO (15- 24)	12,114,659	5,897,908	6,216,751	16.6
Women of Reproductive Age (15 - 49) *	29,349,438	14,091,649	15,257,789	40.3
Elderly (60+)	3,463,958	1,583,502	1,880,456	4.8
Total Population	**72,791,060**	**35,614,356**	**37,176,704**	

Source : *Population and Housing Census 2022*

1.3.1. POPULATION DISTRIBUTION BY REGION

Planning in health sector uses population projections to allocate resources for various interventions including infrastructure development, medical supplies forecasting and human resource for Health. It is important to note that the following criteria are critical for allocation of resources; (i) population size – a greater number of people will present with a greater health needs; (ii) age and sex profiles of populations – the very young and very old have greater health needs than the general population, women have greater health needs than men; (iii) degree of relative/absolute poverty – poverty causes ill health and vice versa; and a 'health-related need' which constitutes a gap between actual and desirable health states. In this view, regions with highest Population such as Dar es Salaam, Mwanza and Tabora (Figure 1 and 2) will require more resources compared to Njombe which has the least population.

Figure 1:Distribution Of Population By Region(X1,000,000), Tanzania Mainland 2024
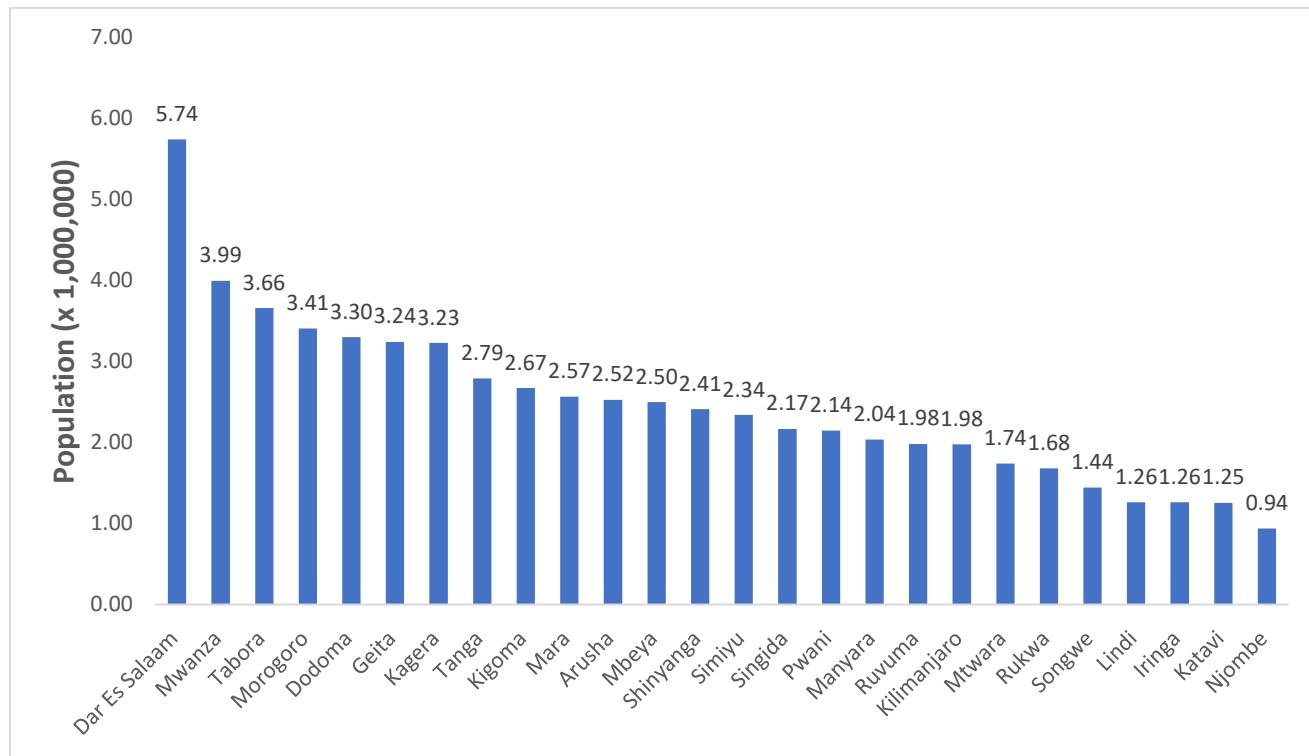
Source: NBS-PHC 2022

1.3.2. HEALTH STATUS OF THE POPULATION

The overall goal of the health sector is to improve the health status of the population which is assessed using demographic indicators. Table 2 shows a health status based on selected indicastors.

Table 2:Demographic Indicators, Tanzania Mainland 2024

Indicators	2023	2024
Mortality		
Male Life Expectancy	65.2	65.5
Female Life Expectancy	70	70.4
Total Life Expectancy	67.6	68
Infant Mortality Ratio	24	24
Total fertility rate	4.8	4.8

Figure 2:Trend of Fertility and Mortality Rate; 1999 – 2022
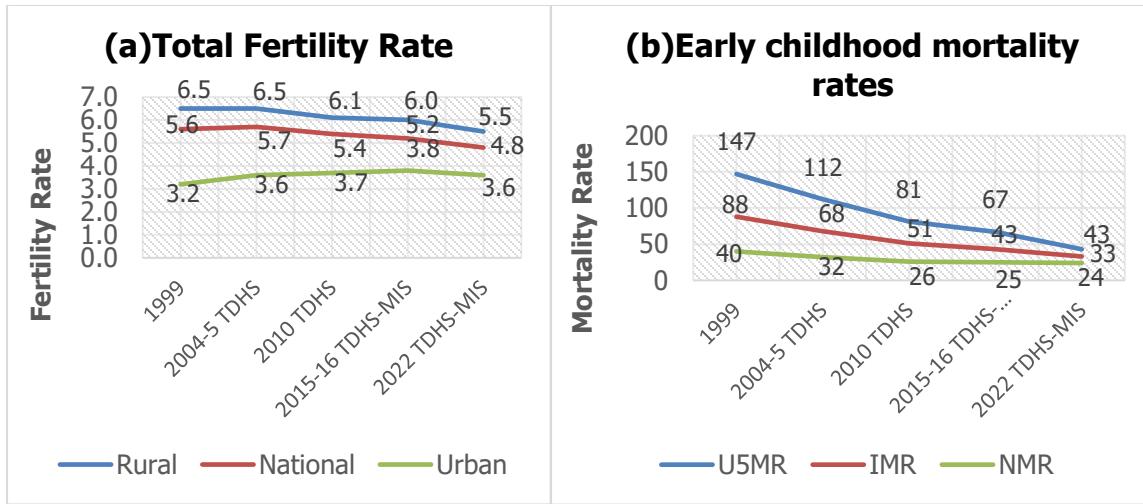
CHAPTER TWO
2.0. HEALTH INFRASTRUCTURE AND HEALTH SERVICES

A well-established infrastructure forms the backbone of a resilient and responsive healthcare system. In the health sector, this extends beyond just physical facilities to include digital technologies, communication networks, and medical equipment. It acts as a foundational support system, driving improvements in care quality and elevating the overall standard of health services. To progress toward Universal Health Coverage, it is essential not only to ensure the availability of quality health services but also to guarantee fair distribution across regions and deliver services efficiently to all populations.

2.1. HEALTH FACILITIES, HOSPITAL BEDS AND EQUIPMENT.
2.1.1. HEALTH FACILITIES.

The total number of health facilities increased from 11,805 in 2023 to 12,846 in 2024. This expansion included 462 hospitals, 1,254 health centers, 8,328 dispensaries, 1,013 various types of clinics, 1,676 diagnostic service units, and 113 other types. In terms of ownership, government institutions accounted for the majority with 7,545 facilities (58.73%), followed by the Private sector managing 4,123 facilities (32.10%), Faith-Based Organizations with 1,096 (8.53%) and Parastatal bodies with 82 (0.64%).

Table 3:Number Of Health Facilities, Tanzania Mainland; 2024

DISTRIBUTION OF HEALTH FACILITIES YEAR 2024					
Function Health Facilities	**Government**	**Parastatal**	**FBO**	**Private**	**Total**
National Hospital	1	0	0	0	1
Specialized Hospitals	6	0	0	0	6
Zonal Referral Hospital	5	0	0	0	5
Hospital at Zonal Referral Hospital	1	0	4	8	13
Regional Hospitals	28	0	0	0	28
Hospital at Regional level	0	0	21	27	48
District Hospital	182	0	0	0	182
Hospital at District level	13	5	98	63	179
Total Hospital	**245**	**5**	**123**	**89**	**462**
Health Centre	951	7	163	133	1,254
Dispensaries	6,327	67	729	1,205	8,328
Total Health Facility (Hospital, Health Centre and Dispensary)	**7,523**	**79**	**1,015**	**1,427**	**10,044**

DISTRIBUTION OF HEALTH FACILITIES YEAR 2024					
Function Health Facilities	**Government**	**Parastatal**	**FBO**	**Private**	**Total**
Health Clinics	12	3	72	926	1,013
Diagnostics (with standalone Laboratory)	2	0	7	1,667	1,676
Other Health Facilities	8	0	2	103	113
Total -Health Facilities functional	**7,545**	**82**	**1,096**	**4,123**	**12,846**

Source: Health Facility Registry (HFR)

The data indicates a steady upward trend in the number of health facilities in Tanzania mainland over the five-year period from 2020 to 2024. The total facilities increased from 9,813 in 2020 to 12,846 in 2024, representing an overall growth of approximately 31%. This consistent rise reflects a deliberate and sustained investment in strengthening the health system infrastructure, aimed at improving accessibility and availability of healthcare services across diverse geographical areas (Figure 3).

Figure 3:Trend Of Health Facilities In Tanzania Mainland; 2020 − 2024
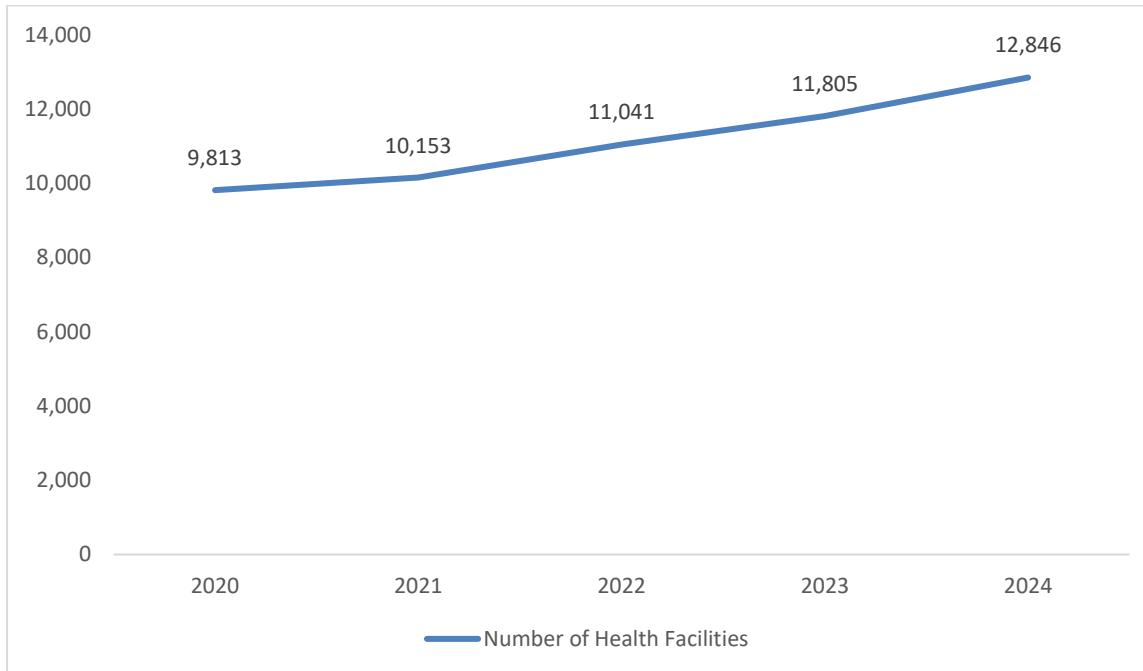
Source: Health Facility Registry (HFR)

In 2024, the distribution of operational health facilities across Mainland Tanzania reveals that facilities at the tertiary level—including (National Hospital, National Specialized Hospitals, Zonal Referral Hospitals, and hospitals at zonal level) accounted for 0.2 percent. Those at secondary

level, such as (Regional Referral Hospitals and hospitals at regional level) made up 0.6 percent. The vast majority, 99.2 percent, were at the primary care level, comprising (District Hospitals, Health Centers, Dispensaries, Clinics, Maternity/Nursing Homes, and other facilities) (Figure 4).

Figure 4:Distribution Of Functional Health Facilities By Level Tanzania Mainland 2024
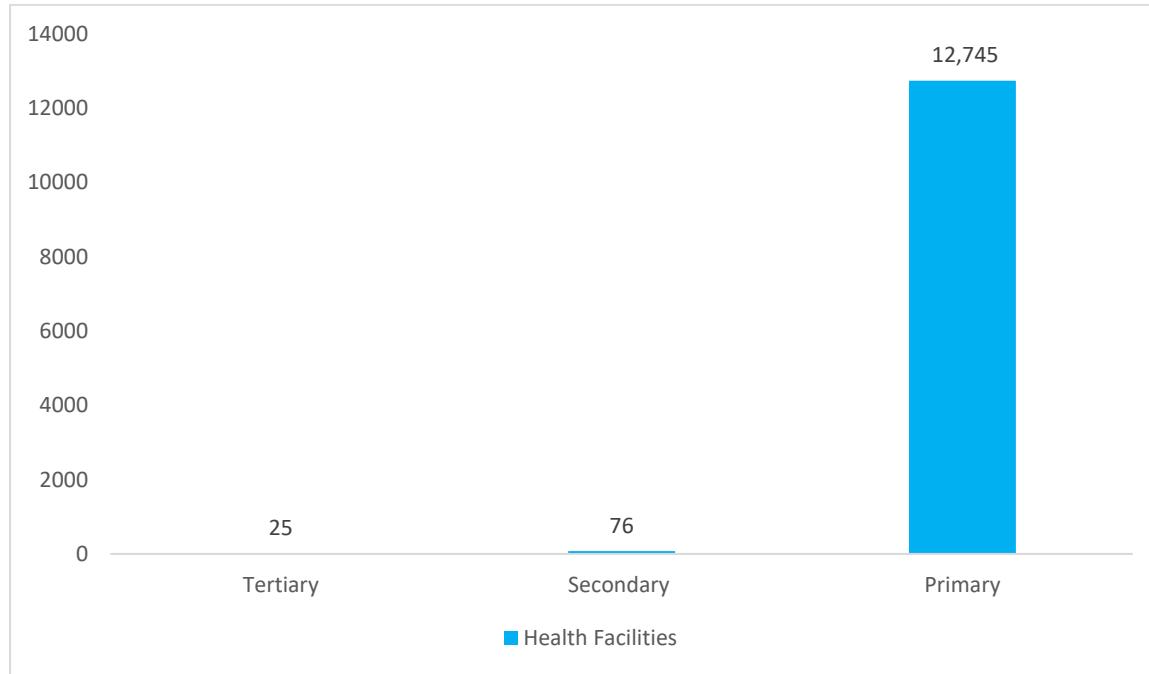
Source: Health Facility Registry (HFR)

In 2024 the   distribution of operational health facilities by ownership shows that the majority are publicly owned, with the government managing 7,545 facilities, representing 58.7 percent. Private sector ownership accounts for 4,123 facilities (32.1%), while Faith-Based Organizations (FBOs) operate 1,096 facilities (8.5%). Additionally, 82 facilities (0.6%) are under the ownership of parastatal institutions (Figure 5).

Figure 5:Number Of Facilities By Ownership Tanzania Mainland, 2024
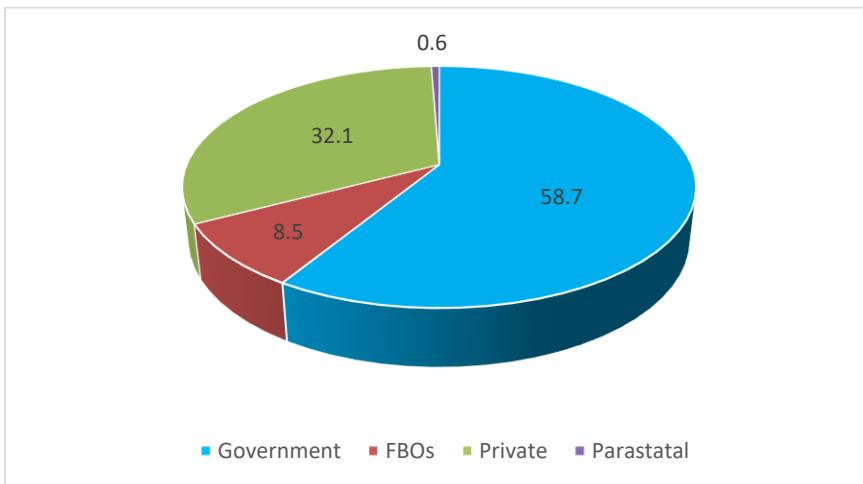
2.1.2. DISTRIBUTION OF FUNCTIONAL HEALTH FACILITIES BY REGION IN 2024

The data for 2024 indicates that Dar es Salaam had the highest number of functional health facilities, totaling 1,539 (12%), followed by Morogoro with 762 (5.9%) and Mwanza with 736 (5.7%) facilities. Katavi recorded the lowest number, with 178 (1.4%) health facilities, followed by Rukwa with 270 (2.1%) and Songwe with 283 (2.2%), as illustrated in Figure 6.

Figure 6:Regional Distribution Of Functional Health Facilities In Mainland Tanzania, 2024
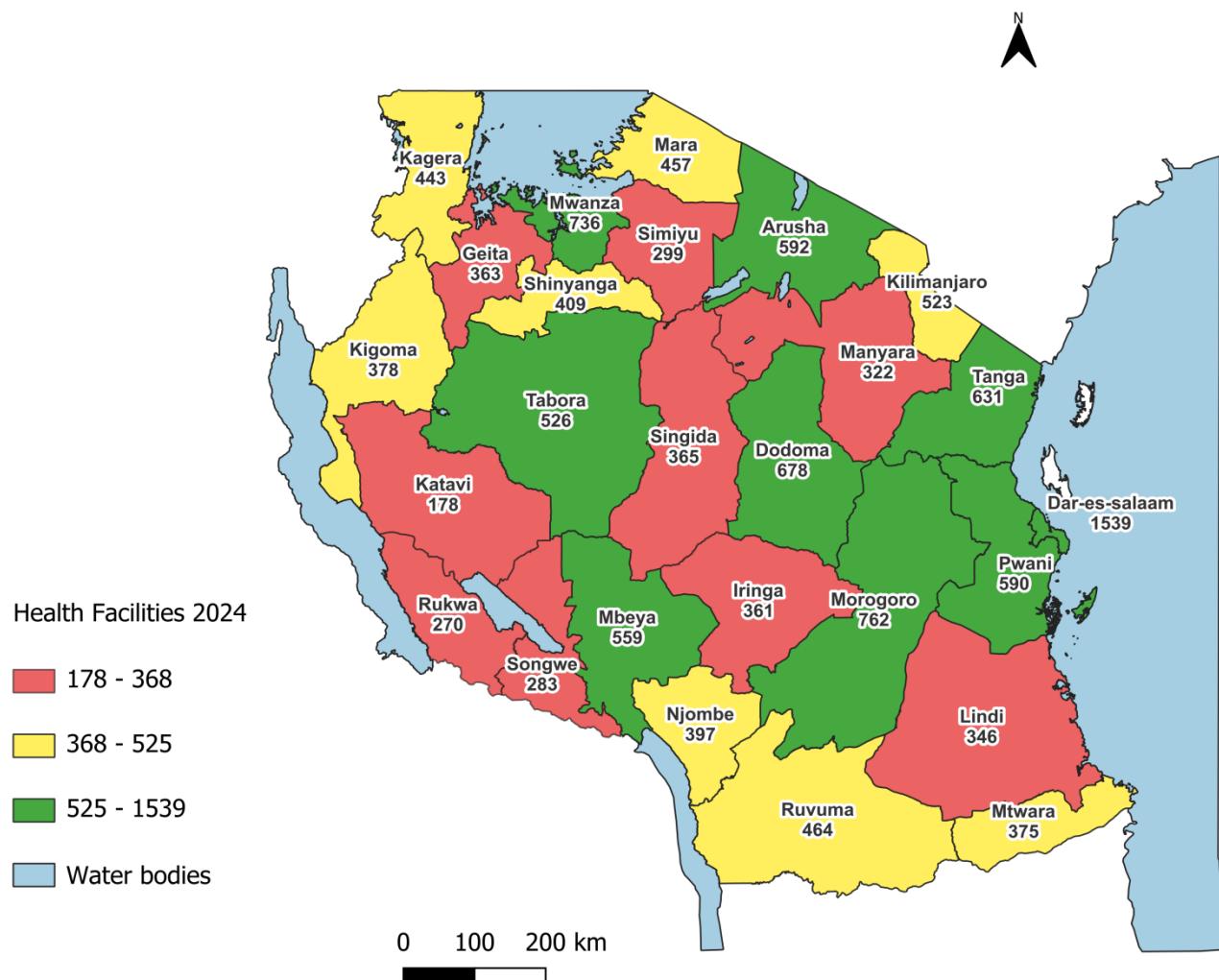
2.1.3.   HEALTH FACILITIES MEDICAL EQUIPMENT

Medical equipment is used for the specific purposes of diagnosis and treatment of disease or rehabilitation following disease or injury. Use of medical equipment in hospitals is of greatest importance. They can be used alone or in combination with any accessory, consumable or other piece of medical equipment. The use of equipment allows the medical professions using medical equipment to assess a patient's medical needs.

The total of 1,330 medical equipment across National and National Specialized Hospital, Zonal Hospital and Regional Referral Hospital, of which 1,215 are functional and 115 are non-functional (Table 4) shows that there is 283 Dialysis Machines of which 10.6% are not functional, 39 functional CT scan machine while 2.5 % not function, there is 35 functional of oxygen plant in the country, also there is one PET CT at Ocean Road Cancer Institute.

Table 4 :Health Facilities Medical Equipment Status 2024

SN	Medical Equipment name	National & Super specialized Hospital			Zonal Hospital			Regional Referral Hospital			Grand Total		
		Functional	Non-Functional	Sub Total	Functional	Non-Functional	Sub Total	Functional	Non-Functional	Sub Total	Functional	Non-Functional	Sub Total
1	CATHLAB (Angio suit)	2	0	2	1	0	1	0	0	0	3	0	3
2	PET CT	1	0	1	0	0	0	0	0	0	1	0	1
3	MRI	6	0	6	7	0	7	0	0	0	13	0	13
4	CT -SCAN	5	1	6	7	0	7	27	0	27	39	1	40
5	DIGITAL FLUOROSCOPY	0	1	1	4	0	4	8	0	8	12	1	13
6	CR-XRAY	1	1	2	0	0	0	0	0	0	1	1	2
7	X- RAY MACHINE	15	1	16	19	0	19	44	1	45	78	2	80
8	PERIAPICAL XRAY	3	0	3	4	0	4	15	0	15	22	0	22
9	DIGITAL C-ARM	5	3	8	4	0	4	1	2	3	10	5	15
10	DIGITAL MAMMOGRAPHY MACHINES	1	1	2	3	0	3	1	0	1	5	1	6
11	OPG	2	0	2	5	0	5	13	0	13	20	0	20
12	ULTRASOUND MACHINE	28	0	28	18	0	18	115	4	119	157	8	165
13	SIMULATOR	3	0	3	0	0	0	0	0	0	3	0	3
14	CT-SIMULATOR	1	0	1	0	0	0	0	0	0	1	0	1
15	RADIOTHERAPY MACHINE (COBALT 60)	2	0	2	0	0	0	0	0	0	2	0	2
16	BRACHYTHERAPY SYSTEM	1	1	2	0	0	0	0	0	0	1	1	2
17	ARCHITECH MACHINE CI 4100	8	0	8	4	0	4	30	0	30	42	0	42
18	CHEMISTRY ANALYZER	16	2	18	17	3	20	53	8	61	86	13	99
19	HEMATOLOGY ANALYZER	14	0	14	16	3	19	56	8	64	94	3	97
20	BIO-SAFETY CABINET	25	3	28	19	3	22	40	5	45	84	11	95
21	VIRAL LOAD MACHINE	9	0	9	16	1	17	27	3	30	52	4	56
22	ANESTHESIA MACHINE	44	2	46	52	8	60	102	25	127	198	35	233
23	DIALYSIS MACHINE	54	0	54	78	5	83	124	22	146	256	27	283
26	OXYGEN PLANT	2	0	2	7	0	7	26	2	28	35	2	37
	Total	248	16	264	281	23	304	682	80	762	1215	115	1330

2.1.3. BED AVAILABILITY IN HEALTHCARE INSTITUTIONS 2024

Across Mainland Tanzania, every health facility is assigned a bed capacity consistent with its level of care and infrastructure design. Bed capacity denotes the maximum number of beds a facility can support. The availability of beds in both public and private institutions serves as an indicator of inpatient service provision. The Ministry of Health is fully responsible for supervising, inspecting, and ensuring that all beds in health facilities are durable, safe, and appropriate for clinical use.

In 2024, the total bed capacity across health facilities stood at **147,159**, while the number of available beds was **140,352**, resulting in a shortfall of 6,807 beds. The available beds were distributed as follows: **66,139** in general and **35,970 in** maternity wards, examination beds are **22,488 and in** delivery beds are **12,767**, **1,403** in Neonatal Intensive Care Units (NICUs), and **1,585** in Intensive Care Units (ICUs). Among all facility types, dispensaries accounted for the highest number of beds (Table 5).

Table 5:Distribution Of Facilities Beds By Type Of Health Facility – 2024

SN	Facility level	Bed capacity	Available Beds						
			IPD General Ward	IPD Maternity Ward	Delivery Ward	ICU	NICU	Examination Beds	Total
1	National Hospital	2,064	2,040	295	20	31	24	238	2,648
2	Specialized Hospital	1,847	864	-	-	8	-	45	917
3	Zonal Referral Hospital	5,001	3,405	340	69	60	62	200	4,136
4	Hospital at a zonal level	3,449	2,877	271	38	68	16	266	3,536
5	Regional Referral Hospital	9,753	5,586	1,518	189	400	478	529	8,700
6	Hospital at Regional Level	5,595	3,994	866	134	211	322	608	6,135
7	District Hospital	25,488	11,358	5,343	865	289	383	1,462	19,700
8	Hospital at District Level	18,055	11,809	3,639	646	196	151	1,662	18,103
9	Health Centre	35,924	15,573	11,521	3,059	22	109	4,638	34,922
10	Dispensary	38,027	7,587	12,045	7,683	114	36	11,505	38,970
11	clinics	1,956	1,046	132	64	4	4	1,335	2,585
	Total	**147,159**	**66,139**	**35,970**	**12,767**	**1,403**	**1,585**	**22,488**	**140,352**

Table 6:Distribution Of Facilities Beds By Regions – 2024

SN	Regions	Bed capacity	Available Beds						
			IPD General Ward	IPD Maternity Ward	Delivery Beds	ICU	NICU	Examination Beds	Total
1	Arusha	6486	3306	1786	485	63	35	1204	6879
2	Dar es salaam	17110	10094	2941	607	309	510	3425	17886
3	Dodoma	7208	2831	1582	599	44	26	1031	6113
4	Geita	4134	1834	1064	446	4	18	598	3964
5	Iringa	3891	2081	1282	443	55	43	750	4654
6	Kagera	7796	3155	1843	608	42	20	970	6638
7	Katavi	2141	779	559	248	31	31	330	1978
8	Kigoma	3321	1457	884	276	27	27	438	3109
9	Kilimanjaro	8716	4473	1978	618	113	49	1094	8325
10	Lindi	1750	1002	713	360	18	34	433	2560
11	Manyara	3884	1728	1090	350	30	54	512	3764
12	Mara	7830	3069	1737	643	41	67	934	6491
13	Mbeya	6893	3468	1270	418	56	87	787	6086
14	Morogoro	6463	3321	1800	630	55	38	989	6833
15	Mtwara	4637	1735	1057	433	27	75	714	4041
16	Mwanza	6865	2993	1553	559	98	63	967	6233
17	Njombe	5941	3052	1300	606	1	22	846	5827
18	Pwani	6324	1896	1538	491	25	11	927	4888
19	Rukwa	3940	1337	1049	410	23	11	528	3358
20	Ruvuma	4373	2053	948	346	6	8	562	3923
21	Shinyanga	3667	1391	1401	487	43	30	672	4024
22	Simiyu	3163	1200	1088	386	51	65	486	3276
23	Singida	5970	2390	1880	651	40	99	939	5999
24	Songwe	2819	969	597	311	25	25	434	2361
25	Tabora	5737	2021	1340	592	139	60	722	4874
26	Tannga	6100	2504	1690	764	37	77	1196	6268
	Total	**147,159**	**66,139**	**35,970**	**12,767**	**1,403**	**1,585**	**22,488**	**140,352**

Distribution of beds year 2024 by regions it shows that Dar es salaam is the region with the largest number of beds (17886) because of the higher number of health facilities. It also shows that songwe is the region with the least number of beds in (2361).

2.2. HEALTHCARE FACILITY SERVICES

The government holds the mandate to ensure the delivery of quality and accessible healthcare services to all citizens. This commitment aims to enhance the overall health and well-being of the population, empowering individuals to contribute effectively to both personal welfare and national development. This section presents data on reported cases among outpatients and inpatients, along with commonly diagnosed conditions. Table 7 highlights key health system outputs, including access and service utilization—such as the number of health facilities per 10,000 population, outpatient department (OPD) visits per person per year, and hospital admissions per 100 people annually.

Table 7:Health System Outputs Including Accessibility And Utilization,2020-2024

Indicator	Baseline 2020	Target 2025	2023	2024
Distribution of health facilities per 10,000 population	2.1	2.5	1.97	2.1
OPD utilization per person per year	0.85	1.2	0.78	0.8
Hospital admissions per 100 people per year	3.2	4.2	2.98	3.1

2.2.1. OUTPATIENT ATTENDANCE (OPD)

The term "outpatient" refers to a person who seeks medical care without requiring an overnight stay at a healthcare facility. Outpatients receive diagnosis or treatment and return home the same day. In 2023, the total number of outpatient visits was 46,522,958, while in 2024, this figure increased to 47,982,589, as illustrated in Figure 7.

Figure 7:Attendance Of Outpatients For Tanzania Mainland 2023 – 2024
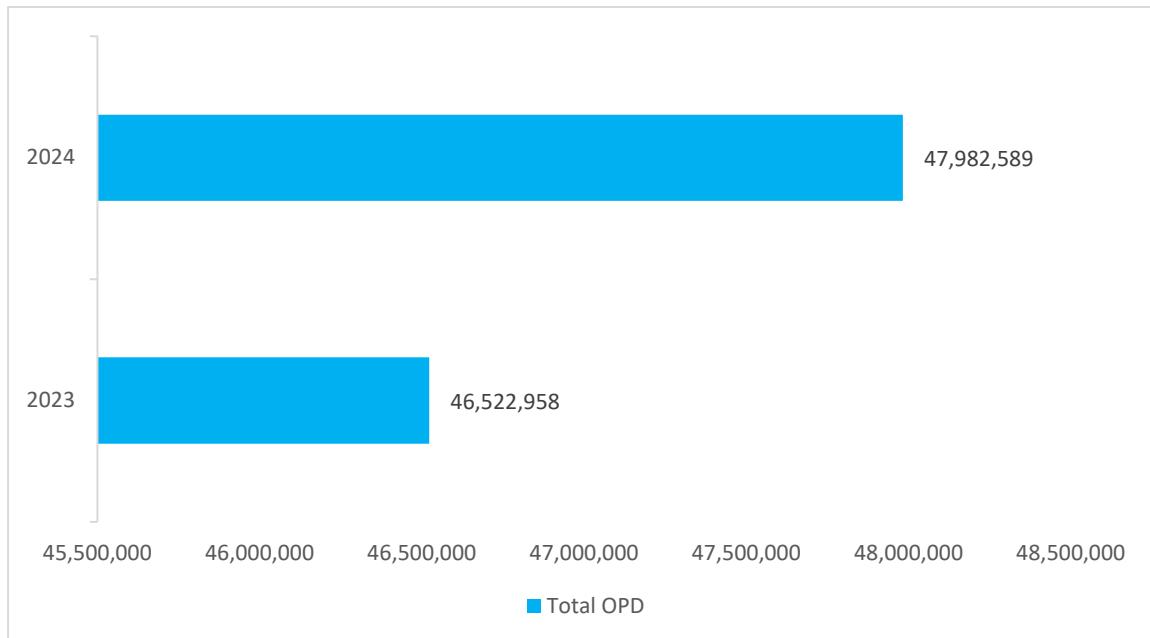
Source: DHIS2

Additionally, outpatient attendance varied across different age groups. As shown in Table 8, the highest number of visits was recorded among individuals aged 5 years to under 60 years, followed by children aged 1 year to under 5 years.

Table 8:Distribution Of Outpatients By Age Groups, 2023-2024

Age Group	2023	2024
Under 1 month	546,071	547,662
1 month - < 1year	5,211,864	5,764,455
1year - < 5year	10,735,557	11,133,635
5 years - < 60 years	24,484,238	24,535,032
60 years and above	5,545,228	6,001,805
Total	**46,522,958**	**47,982,589**

Source: DHIS2

2.2.2. INPATIENTS ATTENDANCES (IPDS)

The term "hospital admission" refers to the process by which a patient is formally accepted into a healthcare facility for treatment that requires at least one overnight stay. Admitted patients

receive continuous medical care, monitoring, or procedures that cannot be managed on an outpatient basis. In 2023, the number of hospital admissions was 1,782,466, which increased to 1,875,063 in 2024, as shown in Figure 8.

Figure 8:Number Of New Patients Who Were Hospitalized In Year 2023- 2024
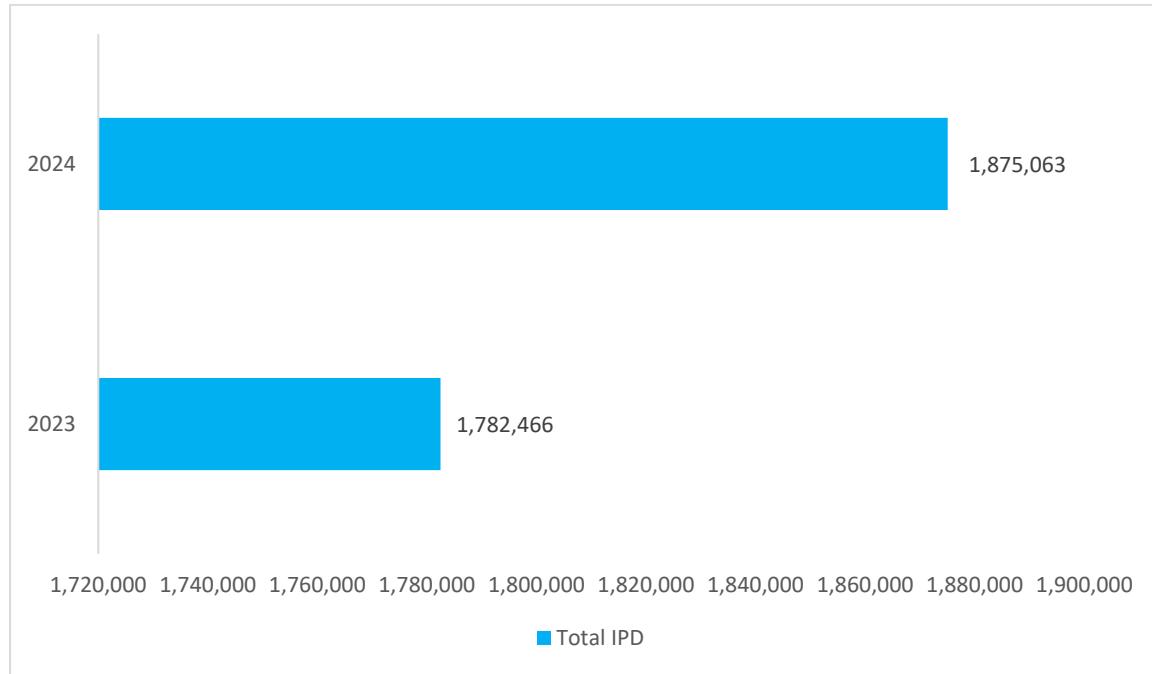
Source: DHIS2

Also, hospital admissions varied across different age groups. As presented in Table 9, the highest number of admissions was recorded among individuals aged 5 years to under 60 years, followed by children aged 1 year to under 5 years.

Table 9:Distribution Of Inpatients By Age Groups, 2023-2024

Age Group	2023	2024
Under 1 month	89,683	96,915
1 month - < 1year	152,209	160,779
1year - < 5year	287,109	307,173
5 years - < 60 years	1,046,356	1,075,066
60 years and above	207,109	235,130
Total	**1,782,466**	**1,875,063**

2.2.3. MOST DIAGNOSED DISEASES

The most recorded diagnoses in health facilities play a critical role in identifying and responding to the community's health needs. This section presents the top 10 diagnoses for both outpatient and inpatient cases, reflecting the variety of conditions treated across healthcare settings. Monitoring these patterns is essential for guiding the efficient allocation and utilization of healthcare resources.

2.2.4. TOP TEN LEADING OUTPATIENT DIAGNOSES

Table 10 presents the top ten leading outpatient diagnoses (across all age groups) for the consecutive years 2023 and 2024, with Upper Respiratory Infections, Urinary Tract Infections, and Malaria ranking among the most frequently reported conditions.

Table 10: Top Ten Causes Of Outpatient Attendance All Ages 2023-2024

Rank	Diagnosis	2023	%	Diagnosis	2024	%
1	Upper Respiratory Infections	11,250,766	25.23	Upper Respiratory Infections	11,603,152	25.49
2	Urinary Tract Infections	5,652,407	12.67	Urinary Tract Infections	5,521,749	12.13
3	Malaria (BS +Ve, mRDT +Ve & Clinical)	3,537,459	7.93	Malaria (BS +Ve, mRDT +Ve & Clinical)	3,358,789	7.38
4	Pneumonia, Severe & Non-Severe	1,889,341	4.24	Diarrhea With No Dehydration	1,871,862	4.11
5	Diarrhea With No Dehydration	1,750,802	3.93	Pneumonia, Severe & Non-Severe	1,850,186	4.06
6	Hypertension	1,602,784	3.59	Hypertension	1,758,881	3.86
7	Other Non-Infectious GIT Diseases	1,490,976	3.34	Other Non-Infectious GIT Diseases	1,687,070	3.71
8	Intestinal Worms	1,108,642	2.49	Peptic Ulcers	1,131,892	2.49
9	Peptic Ulcers	1,056,307	2.37	Intestinal Worms	1,102,596	2.42

| 10 | Skin Infection, Non-Fungal | 1,022,596 | 2.29 | Skin Infection, Non-Fungal | 1,016,097 | 2.23 |

Source: DHIS2

Table 11 illustrates that Upper Respiratory Infections, Malaria and Diarrhea with no dehydration consistently remained the leading outpatient diagnoses among children under five years of age in both 2023 and 2024.

Table 11:Top Ten Leading OPD Diseases Among Under Fives 2023 – 2024

Rank	Diagnosis	2023	%	Diagnosis	2024	%
1	Upper Respiratory Infections	5,897,827	38.65	Upper Respiratory Infections	6,409,377	39.8
2	Malaria (BS +Ve, mRDT +Ve & Clinical)	1,611,431	10.56	Malaria (BS +Ve, mRDT +Ve & Clinical)	1,557,744	9.67
3	Diarrhea With No Dehydration	1,290,019	8.45	Diarrhea With No Dehydration	1,400,755	8.7
4	Urinary Tract Infections	1,155,583	7.57	Pneumonia, Severe & Non-Severe	1,141,393	7.09
5	Pneumonia, Severe & Non-Severe	1,119,399	7.34	Urinary Tract Infections	1,108,229	6.88
6	Skin Infection, Non-Fungal	589,557	3.86	Other Non-Infectious GIT Diseases	675,673	4.2
7	Other Non-Infectious GIT Diseases	581,158	3.81	Skin Infection, Non-Fungal	608,666	3.78
8	Intestinal Worms	441,462	2.89	Intestinal Worms	467,901	2.91

9	Diarrhea With Some Dehydration	352,029	2.31	Diarrhea With Some Dehydration	388,732	2.41
10	Skin Infection - Fungal	341,837	2.24	Skin Infection - Fungal	369,918	2.3

Source: DHIS2

Table 12 shows that Upper Respiratory Infections, Urinary Tract Infections consistently and Malaria remained the leading outpatient diagnoses among aged five years and above during both 2023 and 2024.

Table 12:Top Ten Leading Opd Causes Of Diseases Among Five Years And Above 2023 – 2024

Rank	Diagnosis	2023	%	Diagnosis	2024	%
1	Upper Respiratory Infections	5,352,939	18.89	Upper Respiratory Infections	5,193,775	18.28
2	Urinary Tract Infections	4,496,824	15.87	Urinary Tract Infections	4,413,520	15.54
3	Malaria (BS +Ve, mRDT +Ve & Clinical)	1,926,028	6.8	Malaria (BS +Ve, mRDT +Ve & Clinical)	1,801,045	6.34
4	Hypertension	1,593,592	5.62	Hypertension	1,748,226	6.15
5	Peptic Ulcers	1,056,291	3.73	Peptic Ulcers	1,131,884	3.98
6	Other Non-Infectious GIT Diseases	909,818	3.21	Other Non-Infectious GIT Diseases	1,011,397	3.56
7	Pneumonia, Severe & Non-Severe	769,942	2.72	Diabetes Mellitus	803,732	2.83
8	Diabetes Mellitus	724,889	2.56	Pneumonia, Severe & Non-Severe	708,793	2.5
9	Intestinal Worms	667,180	2.35	Rheumatoid And Joint Diseases	665,847	2.34
10	Rheumatoid And Joint Diseases	603,692	2.13	Intestinal Worms	634,695	2.23

Source: DHIS2

2.2.5. TOP TEN LEADING ADMISSION DIAGNOSES

Table 13 indicates that Malaria, both Severe and Non-Severe Pneumonia, as well as Severe and Mild/Moderate Anemia, consistently remained the leading causes of hospital admissions over the two consecutive years, 2023 and 2024.

Table 13:Top Ten Leading Causes Of Admission All Ages 2023-2024

Rank	Diagnosis	2023	%	Diagnosis	2024	%
1	Malaria (BS +Ve, mRDT +Ve & Clinical)	204,347	16.57	Malaria (BS +Ve, mRDT +Ve & Clinical)	206,593	16.33
2	Pneumonia, Severe & Non-Severe	180,282	14.62	Pneumonia, Severe & Non-Severe	175,689	13.89
3	Anemia, Severe & Mild/Moderate	101,442	8.23	Anemia, Severe & Mild/Moderate	114,259	9.03
4	Urinary Tract Infections	86,625	7.03	Urinary Tract Infections	93,244	7.37
5	Acute Diarrhea (<14 Days)	76,614	6.21	Acute Diarrhea (<14 Days)	90,614	7.16
6	Hypertension	65,272	5.29	Hypertension	76,885	6.08
7	Upper Respiratory Infections	54,140	4.39	Peptic Ulcers	55,859	4.42
8	Peptic Ulcers	50,539	4.1	Upper Respiratory Infections	52,486	4.15
9	Gynecological Diseases	43,026	3.49	Gynecological Diseases	46,713	3.69
10	Diabetes Mellitus	36,156	2.93	Diabetes Mellitus	40,293	3.18

Source: DHIS2

Table 14 shows that Pneumonia (both Severe and Non-Severe), Malaria, Acute Diarrhea, and Anemia (Severe and Mild/Moderate) consistently ranked among the top causes of hospital admissions for children under five years of age in both 2023 and 2024.

Table 14:Top Ten Leading Causes Of Admission Among Under Fives 2023 – 2024

Rank	Diagnosis	2023	%	Diagnosis	2024	%
1	Pneumonia, Severe & Non-Severe	118,507	28.15	Pneumonia, Severe & Non-Severe	118,282	27.09

	Diagnosis	2023	%	Diagnosis	2024	%
2	Malaria (BS +Ve, mRDT +Ve & Clinical)	83,143	19.75	Malaria (BS +Ve, mRDT +Ve & Clinical)	85,023	19.47
3	Acute Diarrhea (<14 Days)	56,128	13.33	Acute Diarrhea (<14 Days)	63,216	14.48
4	Anemia, Severe & Mild/Moderate	35,023	8.32	Anemia, Severe & Mild/Moderate	39,102	8.95
5	Upper Respiratory Infections	23,924	5.68	Low Birth Weight and Prematurity Complication	24,510	5.61
6	Low Birth Weight and Prematurity Complication	22,503	5.34	Upper Respiratory Infections	23,906	5.47
7	Birth Asphyxia	14,117	3.35	Birth Asphyxia	14,808	3.39
8	Urinary Tract Infections	13,736	3.26	Urinary Tract Infections	14,532	3.33
9	Burn	5,386	1.28	Sickle Cell Disease	5,822	1.33
10	Sickle Cell Disease	5,234	1.24	Burn	5,505	1.26

Source: DHIS2

Table 15 shows that Malaria and Urinary Tract Infections consistently ranked among the leading causes of hospital admissions for children aged five years and above in both 2023 and 2024.

Table 15: Top Ten Leading Causes Of Admission Among Five Years And Above 2023 – 2024

Rank	Diagnosis	2023	%	Diagnosis	2024	%
1	Malaria (BS +Ve, mRDT +Ve & Clinical)	121,204	14.93	Malaria (BS +Ve, mRDT +Ve & Clinical)	121,570	14.68
2	Urinary Tract Infections	72,889	8.98	Urinary Tract Infections	78,712	9.5
3	Anemia, Severe & Mild/Moderate	66,419	8.18	Hypertension	75,798	9.15
4	Hypertension	64,370	7.93	Anemia, Severe & Mild/Moderate	75,157	9.07
5	Pneumonia, Severe & Non-Severe	61,775	7.61	Pneumonia, Severe & Non-Severe	57,407	6.93
6	Peptic Ulcers	48,679	5.99	Peptic Ulcers	54,106	6.53
7	Gynecological Diseases	41,461	5.11	Gynecological Diseases	45,292	5.47
8	Diabetes Mellitus	35,431	4.36	Diabetes Mellitus	39,608	4.78
9	Fractures	30,508	3.76	Fractures	33,305	4.02

10	Upper Respiratory Infections	30,216	3.72	Road Traffic Accidents	29,951	3.62

Source: DHIS2

Challenges

- Despite ongoing interventions, Upper Respiratory Infections and Malaria (confirmed by blood smear, mRDT, or clinical diagnosis) continue to be among the most frequently reported causes of outpatient visits and hospital admissions.
- Hypertension, diabetes mellitus, and injuries also remain prevalent and continue to pose significant public health challenges.

Policy Recommendations

- Greater focus and investment are needed to enhance the prevention and control of infectious diseases, non-communicable diseases (NCDs), and injuries in response to their increasing trends.
- It is essential to strengthen both technical and clinical supportive supervision across all levels of health facilities and intervention areas to accelerate disease prevention and control efforts.

CHAPTER THREE
3.0. REPRODUCTIVE, MATERNAL, NEONATAL CHILD AND ADOLESCENT HEALTH (RMNCAH)

INTRODUCTION

The Government of Tanzania has been strengthening and improving access and quality of Reproductive, Maternal, Neonatal Child and Adolescent Health (RMNCAH) services that appeal to women, men and young people. This is demonstrated by the positive changes in service utilization along the continuum of care especially in Antenatal fourth visits, institution delivery, PMTCT, postnatal, immunization and family planning services.

3.1. REPRODUCTIVE HEALTH FOR CANCER (RHCA)

Reproductive cancers are among the commonest cancers in the country. Table 16 shows decrease in the percentage of women aged 30 – 49 years screened for cervical cancer from 53.2% in 2023 decreasing to 38.3% in 2024. The decrease is attribute to stock out of acetic acid and breakdown of machines used for treatment. Furthermore, the percentage of women treated for precancerous lesions decreased from 75.6% in 2023 to 46.8 in 2024.

Table 16: Indicators Of Reproductive Health For Cervical Cancer 2023-2024

S/N	INDICATOR	2023	2024
1	Number of women screened (total)	601,922	732,132
2	Number of women aged 30-49 years screened for cervical cancer for the first time	320,545	489,587
3	Percentage of women aged 30 – 49 years screened for cervical cancer for the first time	53.2%	38.3%
4	Percentage CECAP First visit clients with VIA positive results	2.1%	2.8%
5	Percentage of all VIA positive clients treated	75.6%	46.8%
6	Percentage of all screened clients with suspected cervical cancer	2.6%	2.6%

Source: *DHIS2*

Figure 9, presents cervical cancer screening coverage among women aged 30–49 for the years 2023 and 2024 across regions. The data show that no region achieved the 80% target in either year. In 2023, the highest-performing regions were Manyara 67.2%, Singida 66.8%, Pwani 64.0%, Ruvuma 64.1%, Iringa 61.6%, Geita 59.9% and Njombe 59.8%. In 2024, several regions showed declines, including Arusha from 54.5% to 39.5% and Dodoma from 58.9% to 35.7%, while Kilimanjaro showed a slight increase from 42.2% to 46.0%. In 2024, all regions reported coverage below 50%.

Figure 9:Percentage Of Women Aged 30-49 Years Screened For Cervical Cancer For The First Time 2023-2024
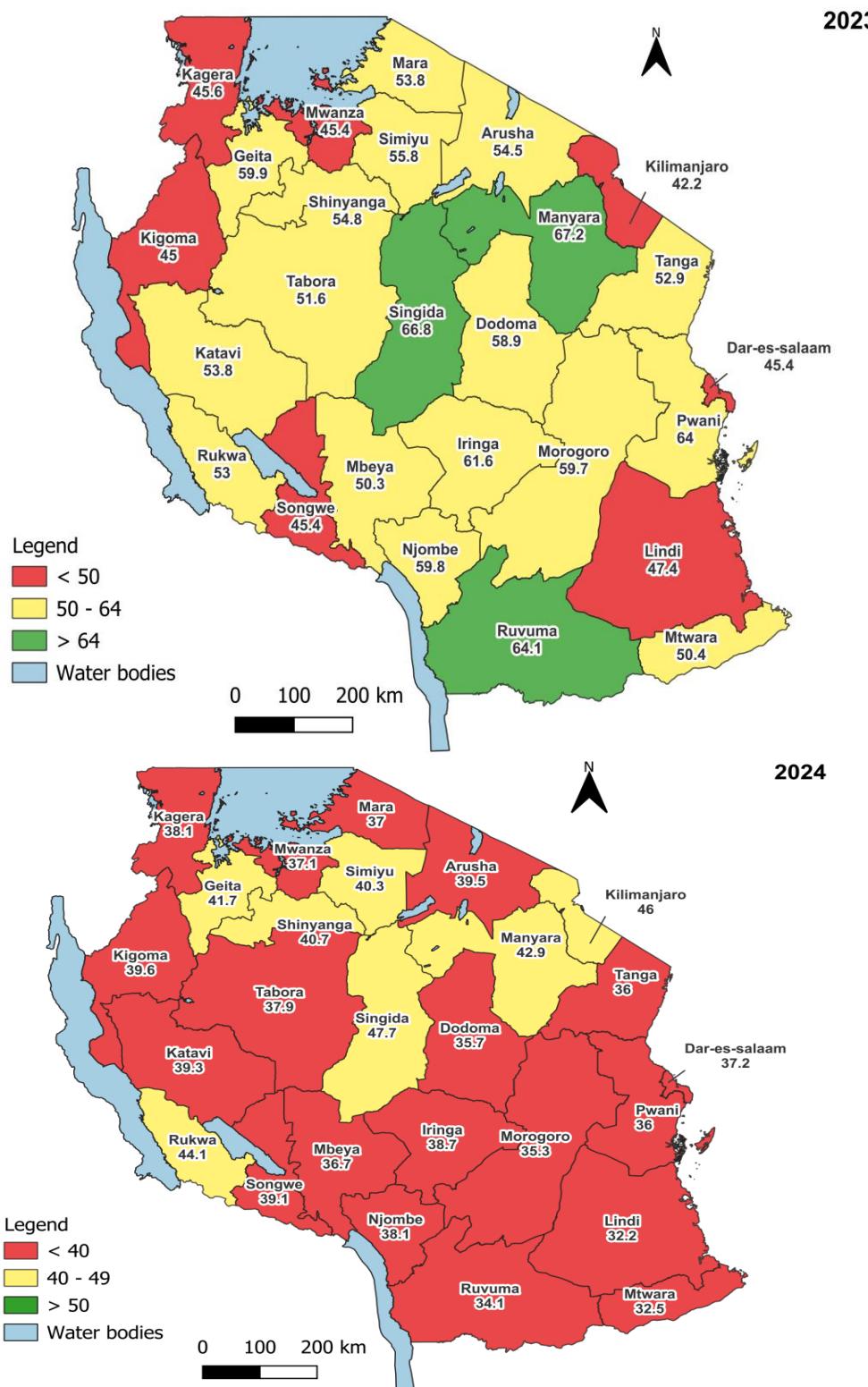
Source: DHIS2

Figure 10 , presents cervical cancer screening and treatment for VIA-positive (V+) to women between 2023 and 2024. Kilimanjaro saw a sharp increase in V+ rates between years from 1.5% in 2023 to 6.0% in 2024 while the treatment coverage dropped from 92.4% in 2023 to 17.2% in 2024. Other regions, like Geita and Iringa, also experienced declines in treatment rates. Regions such as Kagera and Tabora, maintained high treatment coverage.

Figure 10:Percentage Of All Via Positive Clients Treated (Both Cryotherapy And Leep) 2023-2024
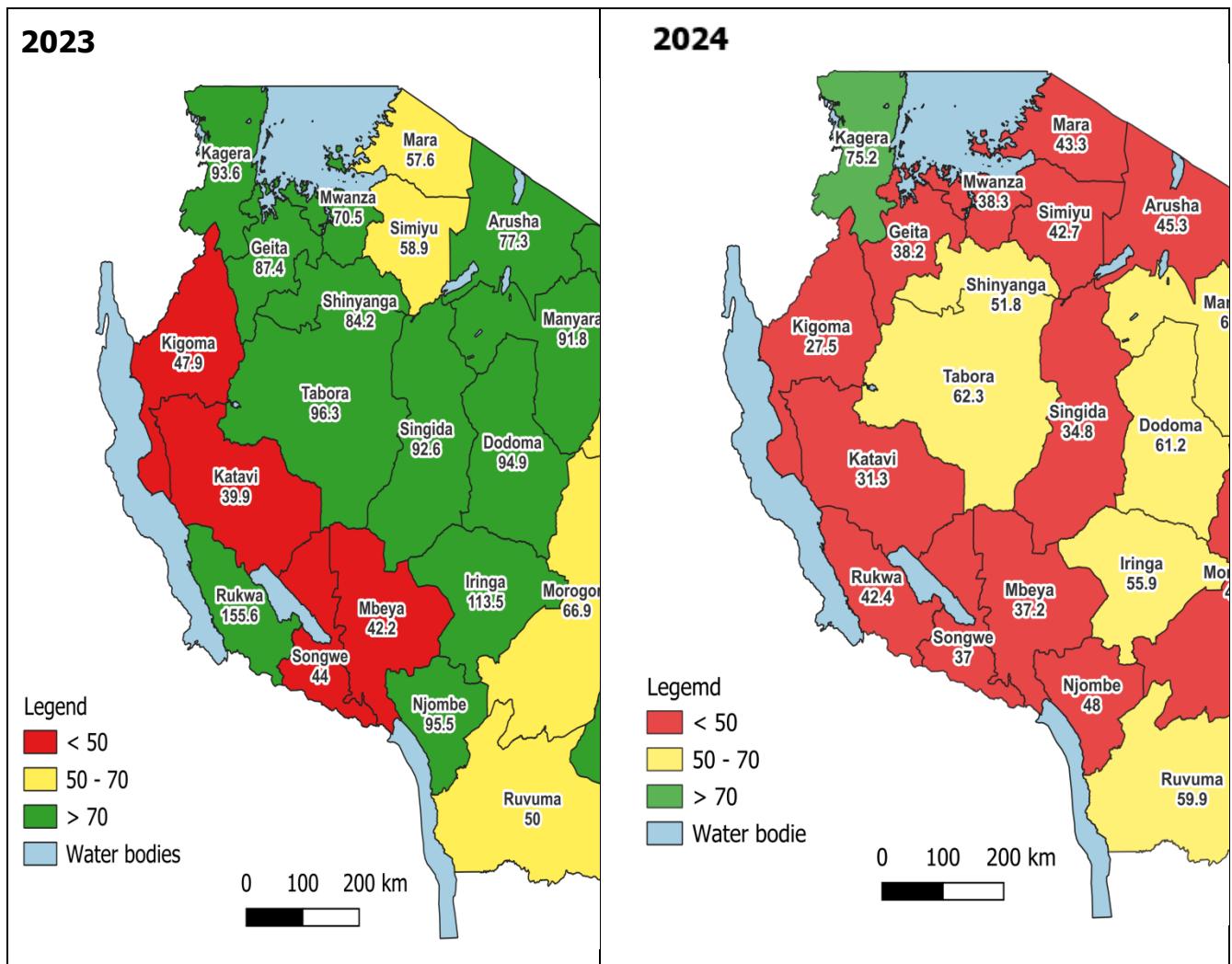
Source: DHIS2

3.2. ADOLESCENT REPRODUCTIVE HEALTH (ARH)

Figure 11 shows a slight increase in the percentage of pregnant adolescent women attending ANC visits, rising from 11.5% in 2023 to 11.9% in 2024. Similarly, the proportion of adolescent deliveries increased from 14.4% in 2023 to 14.9% in 2024 over the same period.

Figure 11: Percentage Of Women Delivered Who Were 10 - 19 Years Of Age And Adolescents Who Were Pregnant Or Started Childbearing In Tanzania, 2023 And 2024
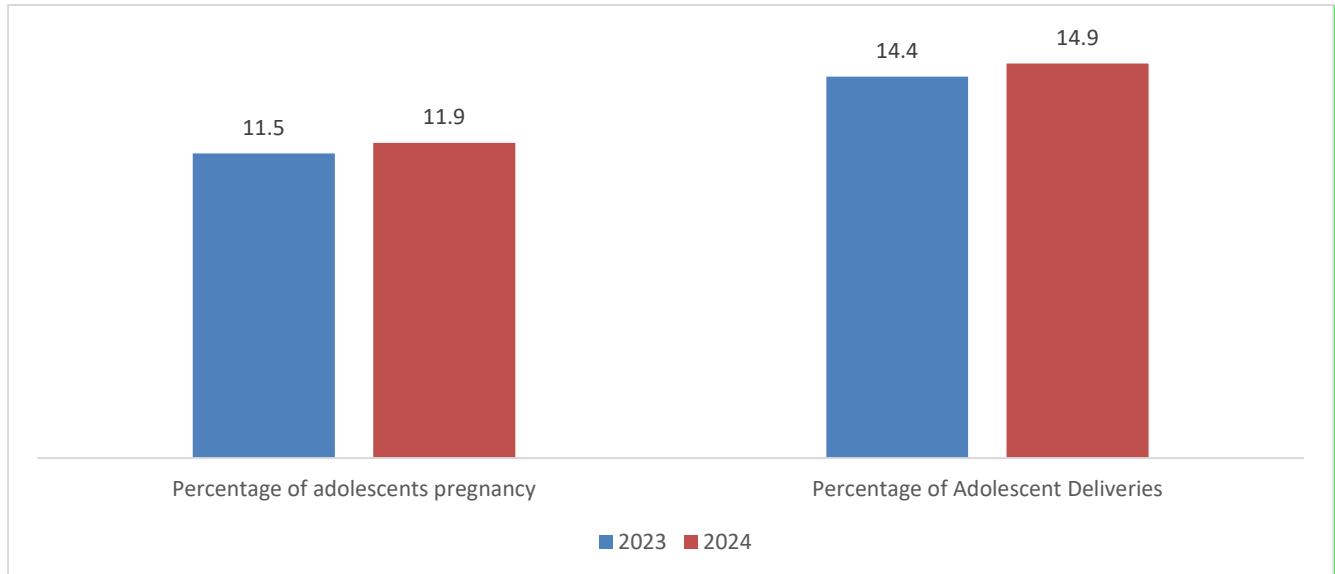
3.3. PREVALENCE OF TEENAGE PREGNANCIES BY REGION FOR THE YEAR 2023 - 2024

Table 17 adolescent data from 2023 and 2024 shows the percentage of pregnant adolescent women attending their first antenatal care (ANC) visit and the proportion of women who gave birth while being less than 20 years old by regions. Focusing on the proportion of women delivered who are less than 20 years in 2024, the regions with the highest rates of adolescent mothers are Songwe 21.4%, Rukwa 20.9%, Tabora 20.5%, Ruvuma 20.3%, and Katavi 19.9%. While, the regions with the lowest proportions of adolescent mothers are Kilimanjaro 4.4%, Dar es Salaam 6.4%, Arusha 8.4%, Iringa 11.2% and Pwani 11.8%.

Table 17:Percent Of Pregnant Adolescent Women Attending ANC 1 And Those Delivering At Health Facilities By Regions; 2023-2024

SN	Region	2023		2024	
		Percentage of pregnant adolescent women attending first ANC visit	Proportion of women delivered who are less than 20 years	Percentage of pregnant adolescent women below 20 years attending first ANC visit	Proportion of women delivered who are less than 20 years
1	Arusha	11.1	9.1	8.5	8.4
2	Dar Es Salaam	7.8	6.1	5.2	6.4
3	Dodoma	18.0	17.1	13.4	17.5
4	Geita	17.1	16.2	14.8	16.6
5	Iringa	11.4	10.4	7.2	11.2
6	Kagera	14.4	13.5	9.1	13.7
7	Katavi	19.5	19.5	24.9	19.9
8	Kigoma	10.0	11.6	8.7	12.4
9	Kilimanjaro	6.2	5.7	3.4	4.4
10	Lindi	18.4	18.7	13.6	19.2
11	Manyara	15.1	13.0	11	12.7
12	Mara	17.7	16.7	13.6	17
13	Mbeya	16.8	15.7	13	16.7
14	Morogoro	17.2	16.3	13.2	16.9
15	Mtwara	18.7	19.0	9.7	19.7
16	Mwanza	15.3	14.2	10.2	14.1
17	Njombe	11.5	11.9	7.4	12.2
18	Pwani	13.1	12.0	12.3	11.8
19	Rukwa	20.9	19.7	19	20.9
20	Ruvuma	20.2	19.8	16.6	20.3
21	Shinyanga	18.5	17.5	12.8	18
22	Simiyu	16.5	15.2	12.9	15.7
23	Singida	15.2	13.1	13.2	13.4
24	Songwe	20.9	20.7	15.4	21.4
25	Tabora	20.0	19.0	20.2	20.5
26	Tanga	13.1	12.1	10	12.4

Challenges

 i. Inadequate integration of Adolescent and Youth Friendly Reproductive Health into other services.

 ii. Inadequate multisectral approach towards health for adolescents including those with special needs

 iii. Inadequate education and health promotion activities to empower community to understand health impact of community social-cultural norms and practices that hinder adolescents' access to quality Adolescent Development Health Services (ADH)

Policy recommendation

 i. To strengthen the integration of Adolescent Sexual Reproductive Health interventions into school, college, and University curricular

 ii. To improve multisectral approach towards health for adolescents including those with special needs

 iii. To reinforce eradication of undesirable community social-cultural norms and practices that hinder adolescents' access to quality Adolescent Development Health Services (ADH)

3.4. SAFE MOTHERHOOD INITIATIVES (SMI)

Timely postnatal care can treat complications arising from delivery and teach mothers how to care for themselves and their infants.

3.5. ANTENATAL CARE SERVICES (ANC)

Antenatal care attendance at least once has been sustained at 100% over the two-year period (2023- 2024). The number of pregnant women attending the first ANC visit was observed to be higher than the estimated population of pregnant women. This might be due to the factor (0.04) used to obtain the estimated population of pregnant women which may underestimate the true value.

Figure 12 shows that the percent coverage of ANC 4 plus in 2024 was 124 percent, which is above the National target of 80%. This might have been attributed to adopting the monthly ANC visit strategy and moving away from the focused antenatal care (FANC) strategy. The results show that the percentage of pregnant women attending the first Antenatal Care visit before 12 weeks of gestation had increased from 42.9% in 2023 to 44% in 2024.

Figure 12:Percentage Of Anc First Visit, Anc 4 Plus Visit Coverage And Anc 1st Visit Before 12 Weeks 2023-2024
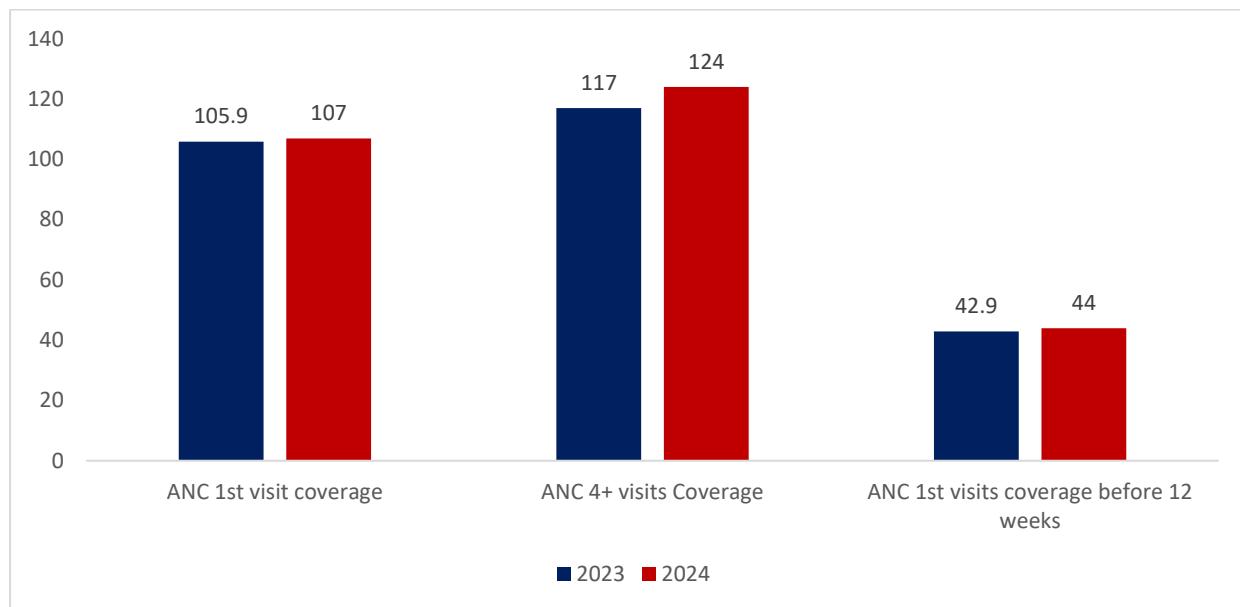
Source: DHIS2

3.5.1. ANC 4+ VISITS COVERAGE BY REGIONS

Table 18 shows the regional performance of first, four or more Antenatal Care Visits and early ANC booking. More than 92.3% (24) regions had more than 90 percent coverage of ANC 4-plus visits in 2024, as it was observed in 2023. This might have been attributed by population immigration and health education provided into some regions.

3.5.2. COVERAGE OF EARLY ANTENATAL CARE ATTENDANCE BY REGIONS

More than half of the regions (about 57.69%) recorded an increase in the percentage of pregnant women attending the first ANC visit within the first 12-weeks of gestation in year 2024 compared to year 2023. In 2024, eight regions reported coverage of 50% and above, these were Kilimanjaro, Kagera, Kigoma, Njombe, Iringa, Ruvuma, Mtwara and Dodoma regions, these were the best performers in terms of early ANC attendance. Tabora and Katavi had coverage below 30%.

Table 18:Percent of Pregnant Women Attending Anc 1st And 4+ Visits and ANC Visit Before 12 Weeks of Gestation by Region, 2023 – 2024

SN	Region	2023			2024		
		ANC 1st visit coverage	ANC 4+ visits Coverage	ANC 1st visits coverage before 12 weeks	ANC 1st visit coverage	ANC 4+ visits Coverage	ANC 1st visits coverage before 12 weeks
1	Arusha	106.4	116.7	37.8	118	135	44
2	Dar Es Salaam	86.2	158.5	31.6	79	152	42
3	Dodoma	100.2	115.5	49.4	105	121	50
4	Geita	133.0	103.9	38.1	132	110	32
5	Iringa	78.9	102.5	47.1	81	105	58
6	Kagera	94.4	145.7	63.5	101	167	70
7	Katavi	187.9	139.8	48.3	192	162	27
8	Kigoma	100.3	117.6	65.0	102	115	67
9	Kilimanjaro	84.0	111.3	66.3	96	127	81
10	Lindi	95.0	128.1	28.7	89	127	33
11	Manyara	100.9	108.2	33.2	105	123	36
12	Mara	113.3	117.1	46.4	115	113	43
13	Mbeya	98.3	107.7	42.0	100	109	43
14	Morogoro	105.8	118.5	35.6	100	116	37
15	Mtwara	71.0	112.9	36.4	65	105	52
16	Mwanza	103.7	106.0	32.2	102	122	36
17	Njombe	75.5	93.3	48.6	73	99	65
18	Pwani	130.2	144.1	46.4	125	161	40
19	Rukwa	133.2	144.0	64.6	137	149	49
20	Ruvuma	100.0	103.1	55.7	103	109	54
21	Shinyanga	126.6	96.8	33.1	127	111	31
22	Simiyu	116.7	135.3	59.7	114	143	48
23	Singida	114.6	91.4	40.7	126	100	39
24	Songwe	105.4	88.1	36.5	109	95	36
25	Tabora	142.3	90.3	28.0	145	105	25
26	Tanga	87.4	88.5	26.1	91	99	33
	National Average	**105.9**	**117**	**42.9**	**107**	**124**	**44**

3.5.3. ANTENATAL CARE INTERVENTIONS

Figure 13 shows an increase in uptake of both IPTp2 and IPTp3 in 2024 (90% and 73.2%) compared to 2023 (89% and 70.9%).

Figure 13:Percentage Uptake of IPTp2 And IPTp3 Doses for Prevention of Malaria in Pregnancy,2023-2024
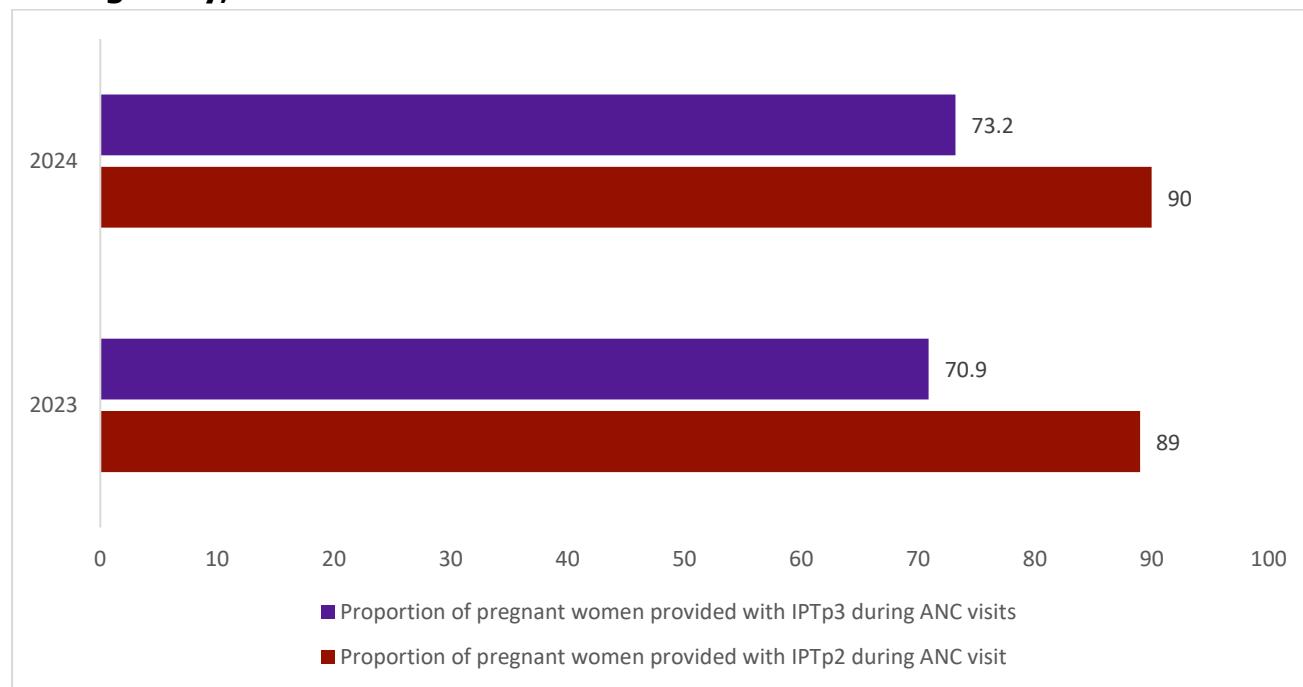
Source: *DHIS2*

Regional coverage of IPTp2 and IPTp3 in 2023 and 2024 is presented in Figure 14 and 15 below. As shown, an increase from 89% to 90% for IPTp2 and 70.9% to 73.2% for IPTp3 in 2023 and 2024 respectively was recorded. An overall increase in number of regions with desirable coverage (>=80%) and decrease in number of regons with poor coverage (<60%) is clearly shown.

Figure 14:Percentage of pregnant women who received IPTp2 in 2023-2024
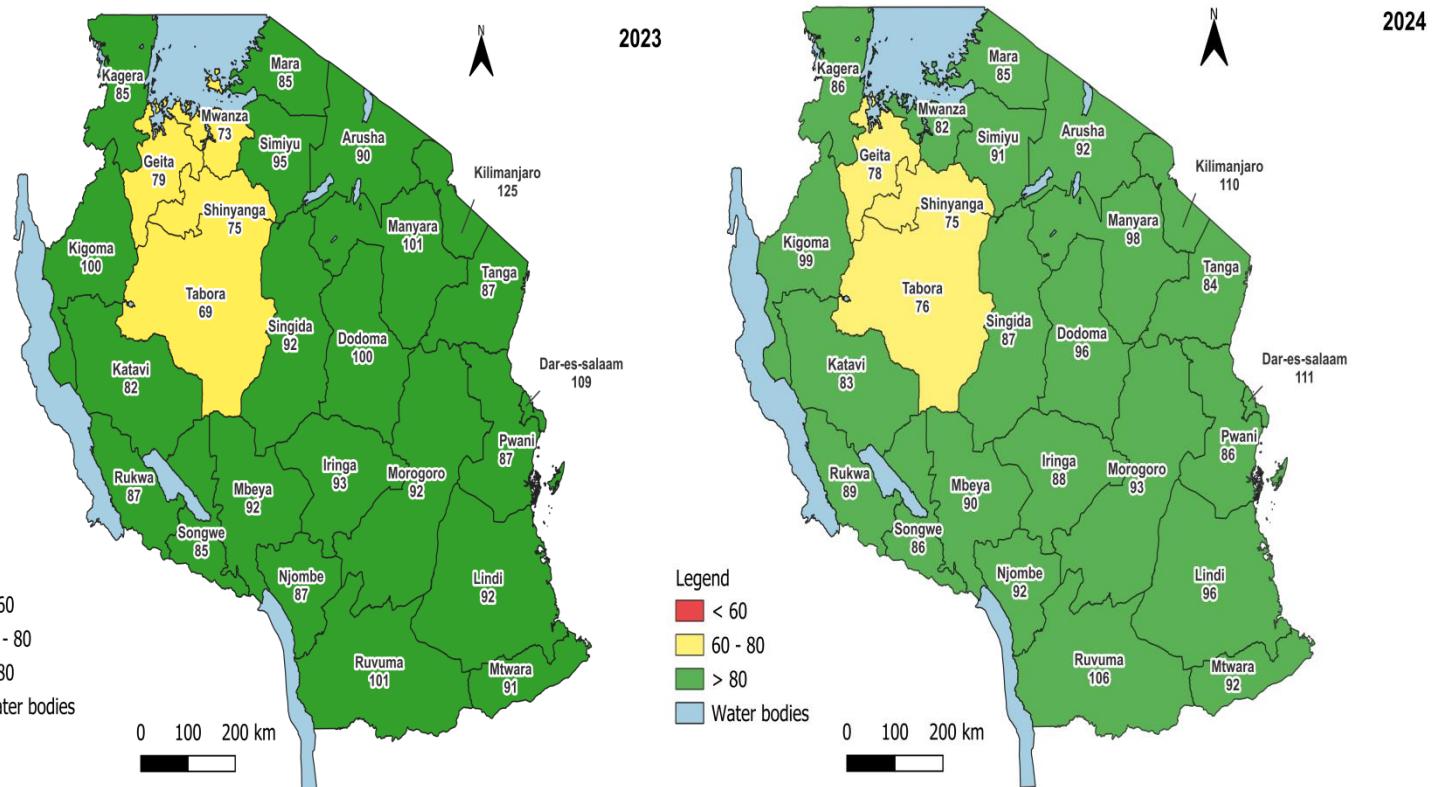
Source: *DHIS2*

Figure 15:Percentage of pregnant women received IPTp3 in 2023-2024

2023

Legend
- 🟥 < 60
- 🟨 60 - 80
- 🟩 > 80
- 🟦 Water bodies

0   100   200 km

2024

Legend
- 🟥 < 60
- 🟨 60 - 80
- 🟩 > 80
- 🟦 Water bodies

0   100   200 km
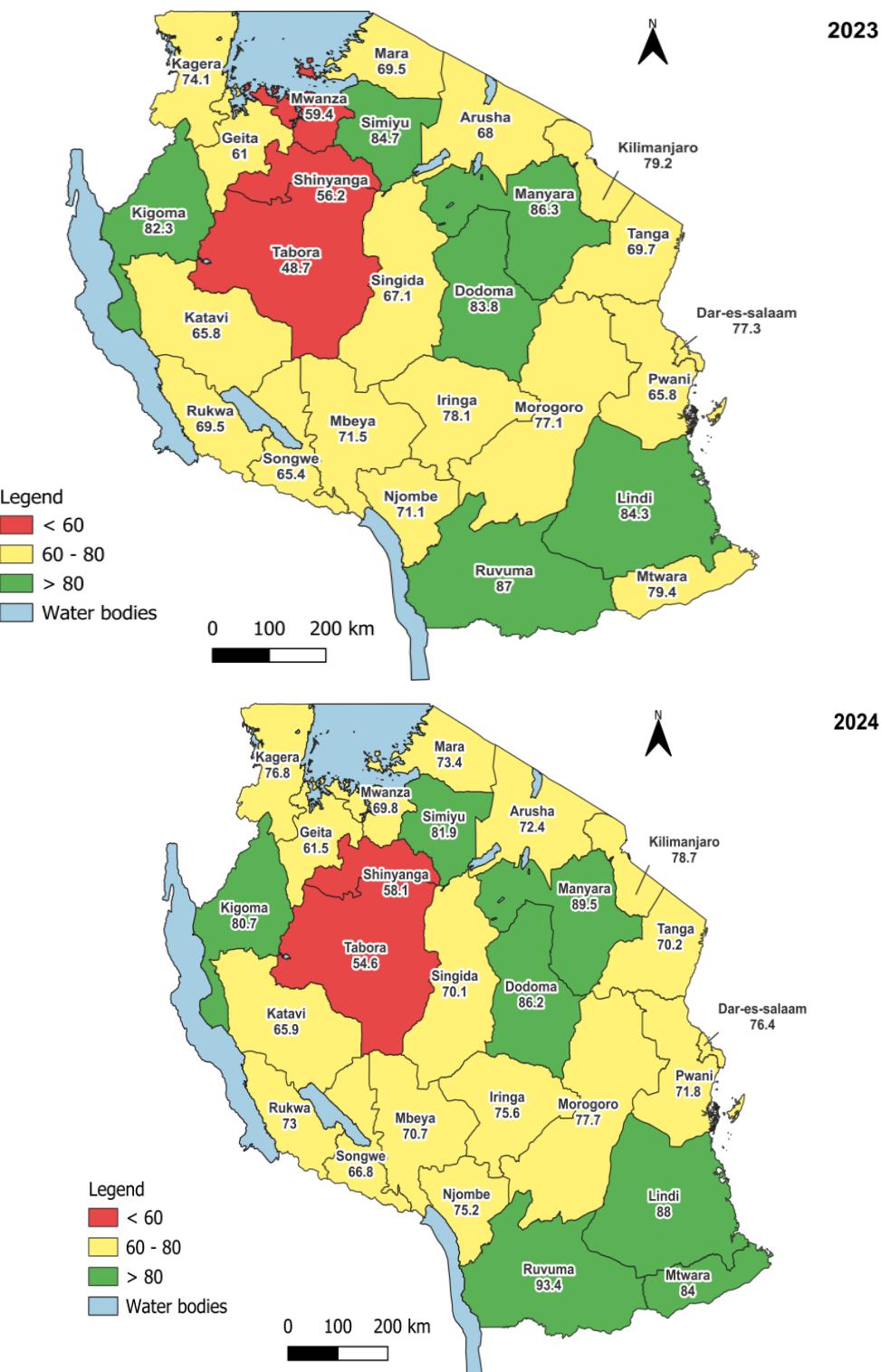
Source: DHIS2

3.5.6. ANAEMIA IN PREGNANCY

Figure 16 shows the percentage of pregnant women tested for anaemia increased from 82% in 2023 to 94% in 2024, percent of pregnant women receiving adequate quantity of Iron and Folate tablets until the next ANC visit increased from 95% in 2023 to 97% in 2024 and percentage of pregnant women with severe anemia (<8.5 g/dl) increased from 1.5% in 2023 to 1.9% in 2024.

Figure 16: Haemoglobin Tests Conducted, FEFO And Anaemia Among Pregnant Women In   2023-2024
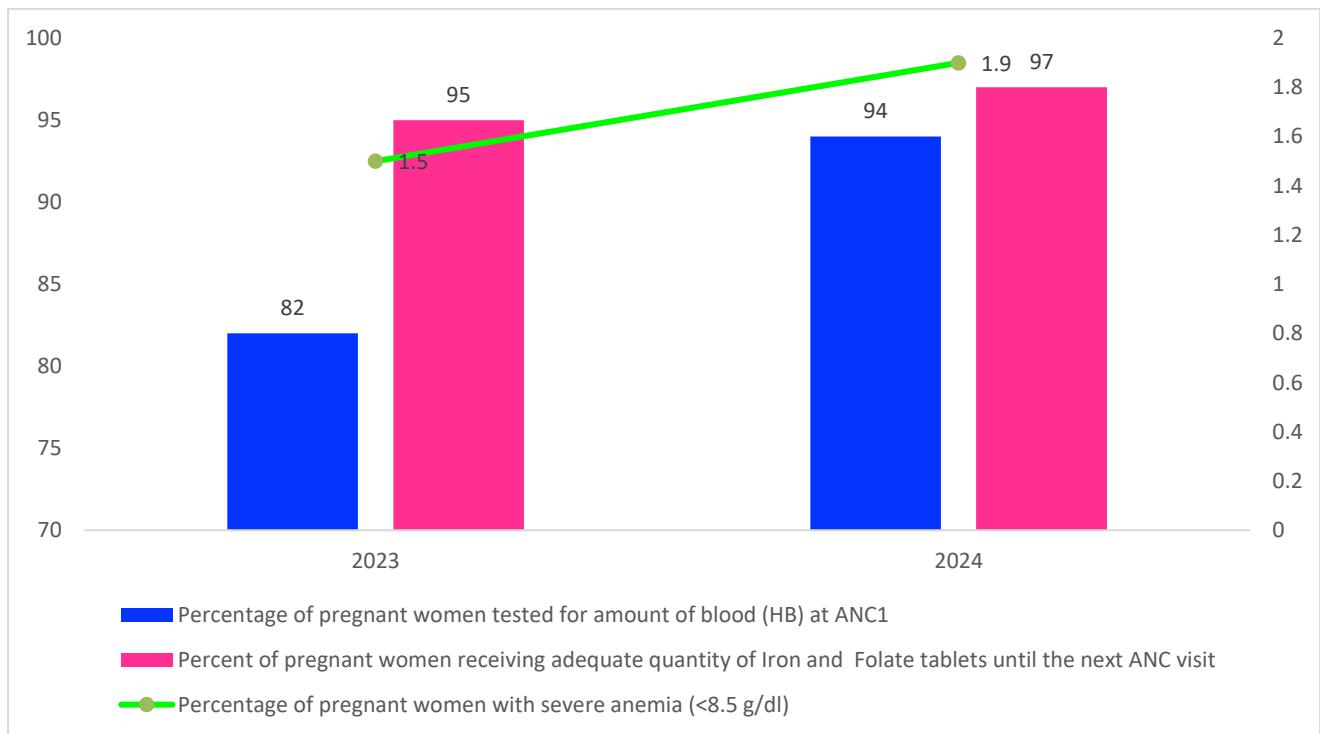
Source: DHIS2

Figure 17 shows that Haemoglobin tests conducted among pregnant women by region have improved from 2023 to 2024. In 2024, Hb testing was above 60% in all regions which marks improvement compared to 2023 where by Rukwa region was 59.6% which was below target and remarkably increased to 77.2% in 2024.

Figure 17:Haemoglobin Tests Conducted Among Pregnant Women By Region; 2023- 2024

2023

Kagera 80
Mara 81.4
Mwanza 82.5
Simiyu 95.1
Arusha 84.2
Kilimanjaro 97.4
Geita 73.8
Shinyanga 78.7
Manyara 70.1
Kigoma 82.6
Tabora 70
Tanga 65.3
Singida 86.9
Dodoma 96.3
Dar-es-salaam 101.4
Katavi 66.9
Pwani 95.6
Rukwa 59.7
Mbeya 91.3
Iringa 76.5
Morogoro 89.8
Songwe 63.3
Njombe 75.2
Lindi 78.2
Ruvuma 65.7
Mtwara 88.6

Legend
- < 60
- 60 - 80
- > 80
- Water bodies

0 100 200 km

2024

Kagera 92.7
Mara 88.5
Mwanza 95.3
Simiyu 99
Arusha 93.8
Kilimanjaro 99
Geita 87.9
Shinyanga 96.2
Manyara 87.7
Kigoma 90.4
Tabora 99.8
Tanga 81.8
Singida 92.9
Dodoma 98.2
Dar-es-salaam 102.3
Katavi 85
Pwani 97.1
Rukwa 77.2
Mbeya 97.4
Iringa 86.6
Morogoro 95.4
Songwe 81
Njombe 90
Lindi 89.3
Ruvuma 101.3
Mtwara 98.7

Legend
- < 60
- 60 - 80
- > 80
- Water bodies

0 100 200 km

3.6. DELIVERY SERVICES

This section presents information on utilization of health facilities for child-birth by pregnant women, extent of child-delivery by skilled human resources for health, child-birth by adolescents and magnitude of low birth weights in Tanzania. It highlights percentages of geographical and effective coverage of labour and delivery services at national and regional level. A total Number of deliveries has increased from 2,151,672 in 2023 to 2,259,642 in 2024.

3.6.1. INSTITUTIONAL DELIVERY, SKILLED BIRTH ATTENDANT, UTEROTONICS USE AND CAESAREAN SECTION

Figure 18. show that, institutional delivery has increased from 85.8% in 2023 to 87.5% in 2024 while skilled birth attendants have increased from 92.4% in 2023 to 93% in 2024. The use of uterotonics also increased from 97.6% in 2023 to 98.3% in 2024. The high performance displayed by these labour and delivery indicators is an indication of an increased trust in the health system by the population and good progress towards maternal mortality reduction.

Figure 18:Percentage of Institutional Delivery, Skilled Birth Attendant, Deliveries by Caesarean Section and Uterotonics use in Tanzania Mainland; Year 2023 – 2024
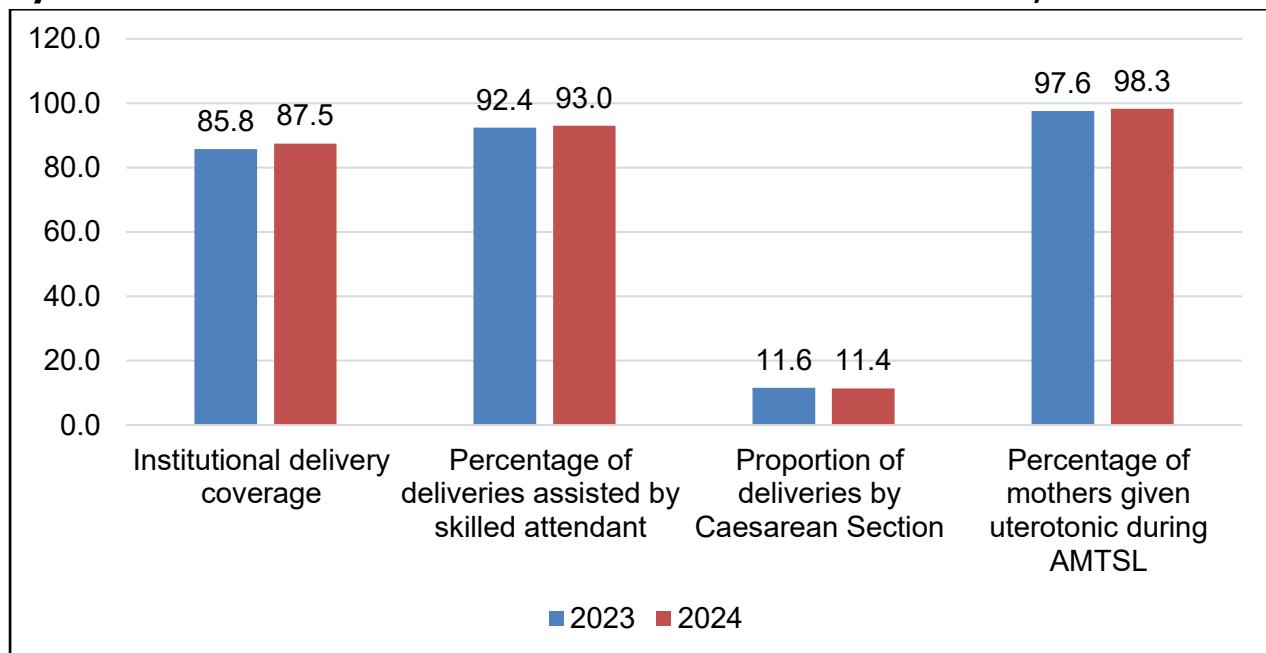
Figure 19:Number of total deliveries and live birth in Tanzania Mainland; Year 2023 − 2024
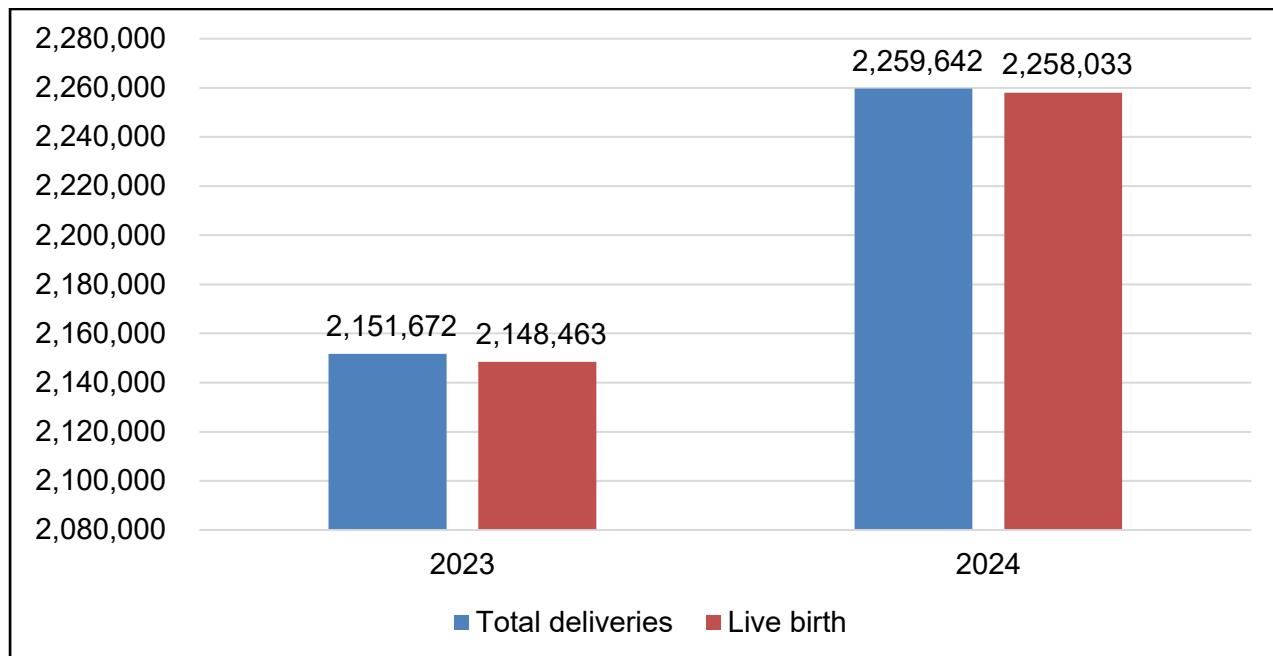
3.6.2. COVERAGE OF INSTITUTIONAL DELIVERY AND DELIVERIES BY SKILLED BIRTH ATTENDANTS

Figure 20. displays the regional performance of institutional deliveries and deliveries by skilled attendants and mothers given uterotonic within 1 hour after delivery in 2023 and 2024. In 2024, seven regions including Pwani, Rukwa, Katavi, Simiyu, Geita, Tabora and Shinyanga had reported 100% or more institutional delivery. Skilled birth attendants in these regions were also high. Mtwara, Dar es Salaam and Njombe regions had the lowest performance in institutional delivery in 2024.

Figure 20:Coverage of Institutional Delivery by Region 2023 and 2024
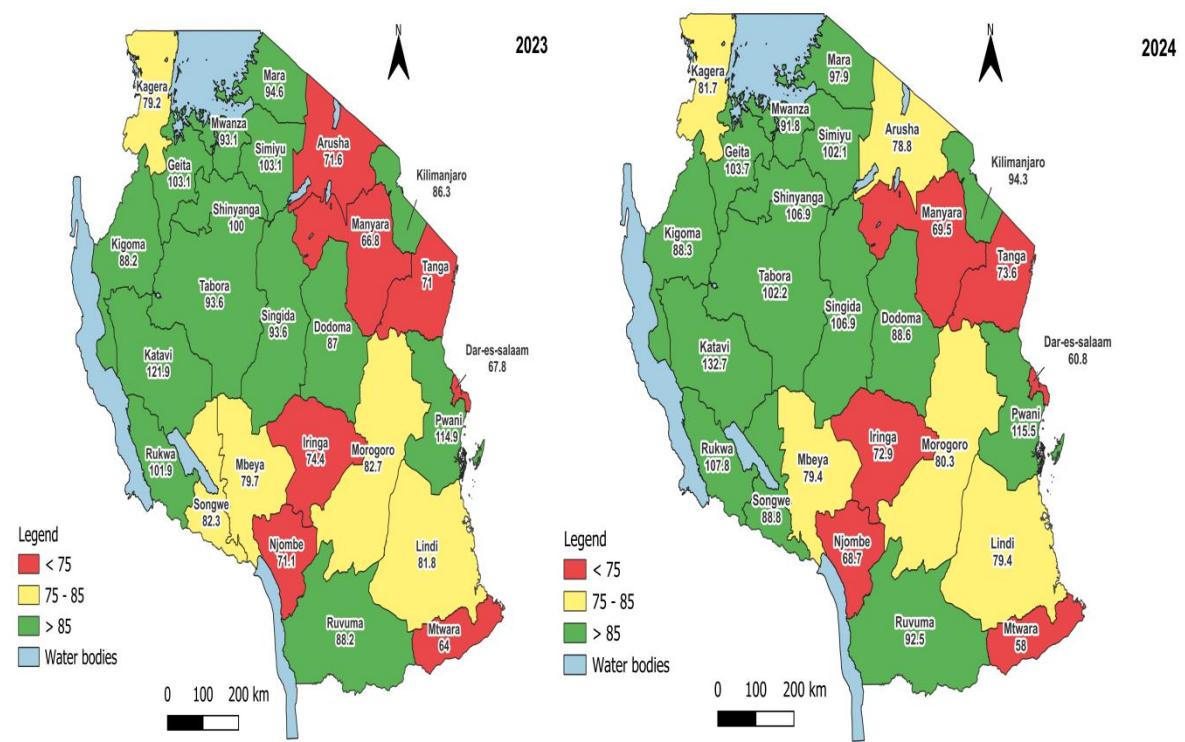
Source: *DHIS2*

Figure 21:Percentage of Delivery by Skilled Birth Attendants by Region, 2023 and 2024
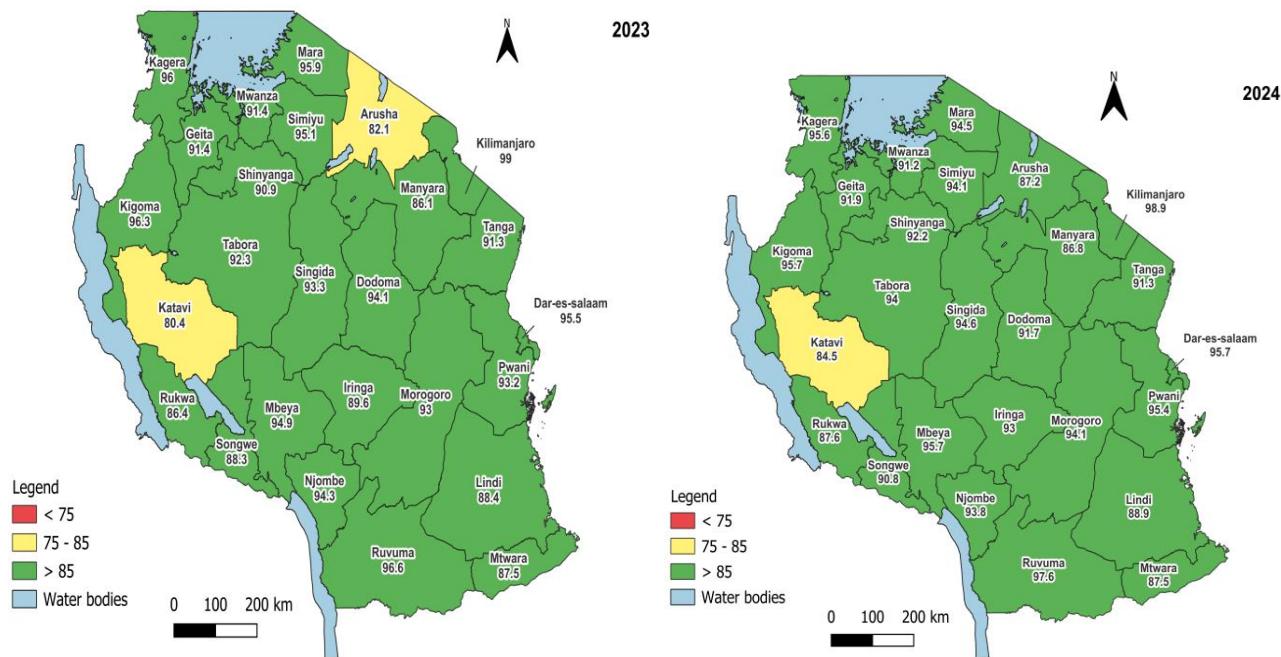
Source: DHIS2

Challenges

i. Despite the improved health facility delivery, there is inadequate provision of quality of care in the new CEmONC facilities. This is caused by among other factors as follows:
   - Insufficient number and skills of Health Care Workers
   - Inadequate Infrastructures to fully support CEmONC services
   - Gap in the community linkage on Maternal Health.
   - Lack of follow-up actions after conducting regular maternal and perinatal death reviews.at regional, district and facility level.

ii. Insufficient uptake of LLINs to Pregnant women and infants during first antenatal care visit and MR1 immunization following limited availability of LLINs in Private Health Facilities due to lack of MSD account code.

iii. Low uptake of IPTp2 and IPTp3 to pregnant women as a measure to ensure early booking among pregnant women and availability & provision of SP at ANC.

Policy recommendation

i. There is a need to mobilize resources to expand CEmONC services to cover all Health Centers

ii. Some efforts to equip CEmONC facilities with equipments and skilled personnel as required.

iii.   There is a need for arrangements to refurbish and provide essential BEmONC equipment to dispensaries.

iv.   To strengthen community health services

3.7. FAMILY PLANNING UPTAKE

There has been an increase in the annual utilization of modern family planning methods from 2020 to 2024. In 2024, the estimated population of women aged 15-49 years was 15,487,565 of whom 9,491,378 (61.3%) were utilizing family planning services. Out of these, 3,806,173 (40.1%) were continuing clients, while 5,685,205 (59.9%) were newly registered during the year. The average national utilization rate for new acceptors of modern family planning was 43.9% in 2024 hitting the national target of 42% set for 2025 (as outlined in One Plan III), as depicted in Figure 22.

Family planning outreach services continued to be provided across all regions in Tanzania to reach clients in underserved and marginalized areas. The national coverage of family planning services through outreach was 20.4% in 2024 indicating an increase from 19.9% in 2023.

Figure 22:Trend Coverage of Family Planning New Acceptors Tanzania Mainland 2020 to 2024
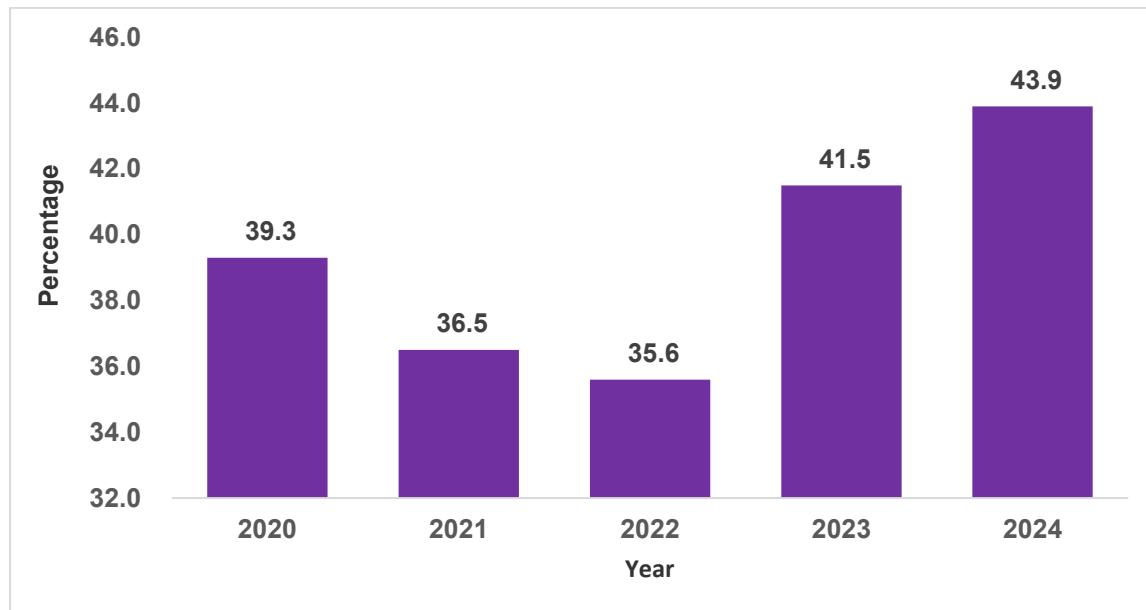
Source: DHIS2

3.7.1. COVERAGE OF NEW ACCEPTORS FOR MODERN FAMILY PLANNING

The trend in modern family planning coverage for new acceptors has been fluctuating over the past five years. It increased from 37.2% in 2019 to 39.3% in 2020, then declined to 36.5% and 35.6% before rising again to 41.5% in 2023 and 43.9% in 2024, as depicted in Figure 23.

Regions with higher coverage of modern contraception for new acceptors included Kigoma (74%), Mara (70%), and Kilimanjaro (69%). Eleven regions reported utilization of modern family planning services above the national average of 43.9%, while fifteen regions had less coverage. The regions with the lowest coverage were Songwe (25.1%), Lindi (23.3%), and Mtwara (20%).

Figure 23:Coverage of New Acceptors for Modern Family Planning 2024

Source: DHIS2 2024

3.7.2. ADOLESCENTS FAMILY PLANNING COVERAGE

Adolescents across all regions in Tanzania have access to family planning services, yet the overall coverage of these services for adolescents remains very low. Fourteen regions have higher coverage rates than the national average of 28.2%, while 12 regions fall below it. Regions with high coverage include Lindi (48.5%), Mtwara (47.4%), and Ruvuma (42.5%). Conversely, regions with low coverage are Kilimanjaro (13.5%), Iringa (19.9%), and Kagera (22.3%) as portrayed in Figure 24.

One hundred and two (102) councils reported coverage rates for new family planning among adolescents above the national average of 28.2%, while 82 councils report rates below this average.

Figure 24:Adolescents Family Planning Coverage by Regions 2024

The trend in modern family planning coverage for adolescents remained consistently low over the five-year period from 2020 to 2024 as illustrated in Figure 25.

Figure 25:Trend of Adolescents Received Family Planning Methods Tanzania Mainland 2020 to 2024
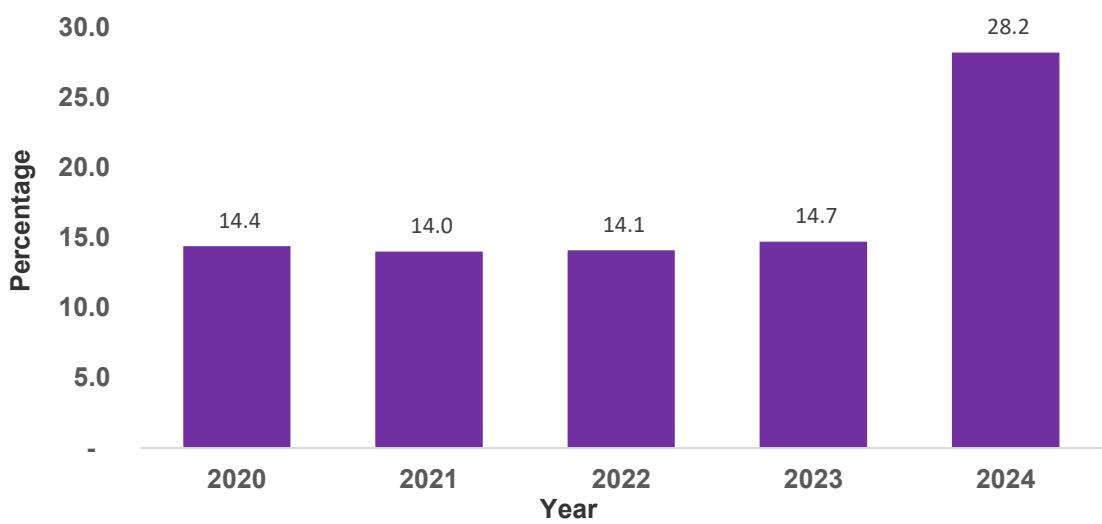
3.7.3. FAMILY PLANNING OUTREACH SERVICES

Family planning outreach services were consistently provided across all regions in Tanzania to extend services to underserved and marginalized areas. Nine regions exceeded the national average of 20.4% for outreach family planning services, while 17 regions fell below it. Regions with a high proportion of clients receiving family planning services through outreach included Mara (43%), Geita (30.7%), and Njombe (26.7%). Conversely, Lindi region had the lowest proportion, serving only 4.4% of clients, followed by Mtwara (7%), and Ruvuma (10.6%) as illustrated in Figure 26.

Figure 26:Family Planning Outreach Coverage by Regions 2024
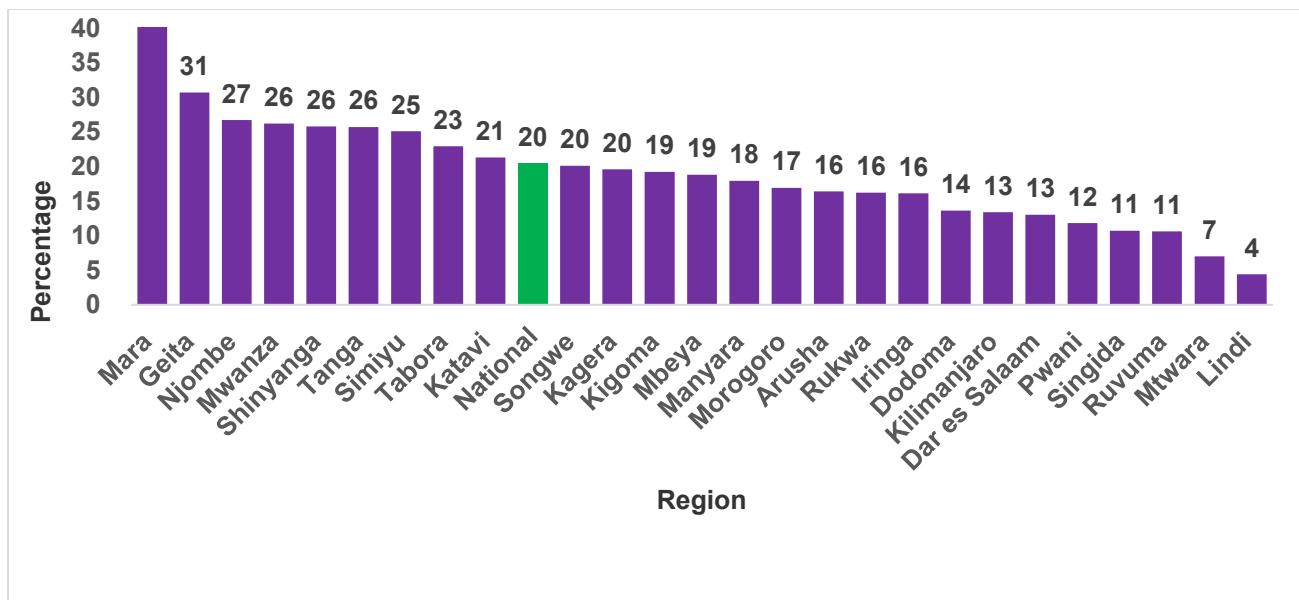
Source: DHIS2 2024

The trend in outreach family planning coverage remained consistently low over the five-year period from 2020 to 2024 as depicted in Figure 27.

Figure 27:Outreach Family Planning Clients Tanzania Mainland 2020 to 2024

Source: DHIS2 2024

3.7.4. POST-PARTUM FAMILY PLANNING UPTAKE

Postpartum Family Planning (PPFP) services continued to be provided across all regions in Tanzania, primarily at the labor wards. Twelve (12) regions exceeded the national average of 49.6% for PPFP coverage, while 14 regions fell below this standard. Regions with a high number of clients receiving PPFP services included Dodoma (82.2%), Mara (72.4%), Kilimanjaro (71.8%), and Arusha (66.1%). On the other hand, Ruvuma region had the lowest number of clients receiving family planning services through PPFP (9.8%), followed by Mtwara (19.6%), Pwani (21.4%), and Kagera (21.7%).

Eighty-eight (88) councils reported PPFP coverage rates above the national average of 42%, while 96 councils reported rates below this average as shown in Figure 28.

Figure 28: Postpartum Family Planning Coverage by Regions 2024

The trend in PPFP coverage shows a gradual increase from 2020 through 2024. It was notably low in 2020 (9%), followed by a significant rise to 30% in 2021. Thereafter, it gradually increased to 34% in 2022 and reached 49.6% in 2024, as depicted in Figure 29.

Figure 29: Coverage of Post-Partum Family Planning Tanzania Mainland 2020 to 2024
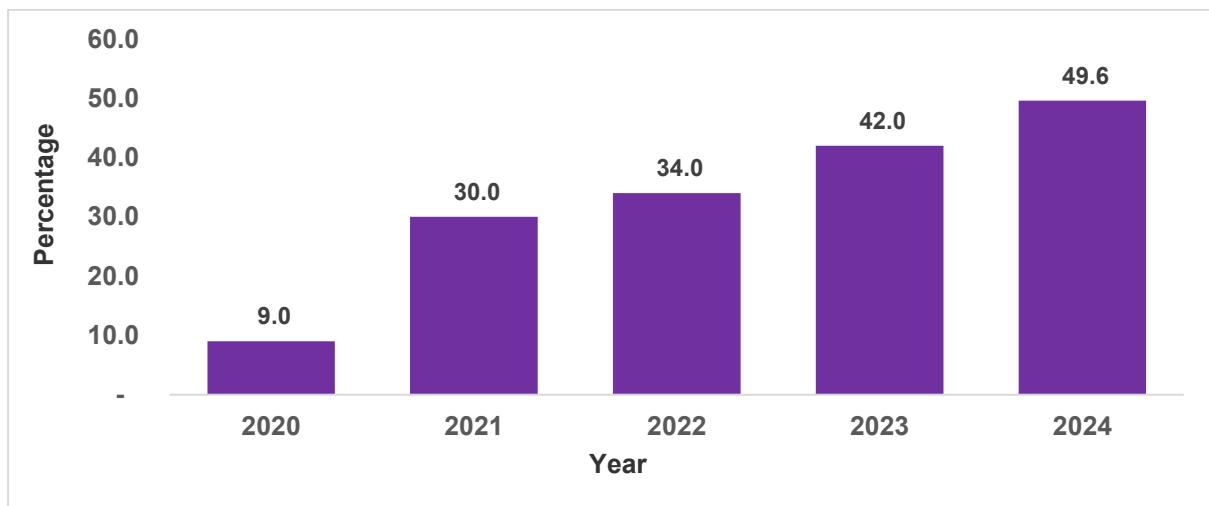
3.8. GENDER BASED VIOLENCE AND VIOLENCE AGAINST CHILDREN IN TANZANIA MAINLAND

Gender Based Violence (GBV) and Violence against Children (VAC) are common public health issues in Tanzania. TDHS 2022 showed that 27% of women aged 15-49 years has experienced physical violence and 12% experienced sexual violence.

The data from DHIS2 show that reported GBV/VAC cases increased from 253,441 in 2022 to 266,410 in 2023 and increased to 274,004 in 2024.The percentage of survivors reporting within 72 hours for accessing timely medical and psychosocial support remains below the national target of 60%. In 2024, only 31.3% of cases were reported within 72 hours, which is an increase compared to 30.2% in 2023. Moreover, only 21 out of 184 councils (11.4%) met the national target, leaving 88.6% below standard. The trends in sexual violence among females show a declining from 7% in 2023 to 3% in 2024, while among males, there is a slight decrease from 7% in 2023 to 5.9% in 2024. Physical violence among females dropped from 37% in 2023 to 17.9% 2024 whereas for males, it remained at 38% in 2023 and 36.3% in 2024. Among VAC cases, the number of neglected children continued to rise, from 9,754 in 2023 to 9,769 in 2024, while children living in risk environments increased from 8,771 in 2023 to 8,857 in 2024

as shown in Table 19. Region comparison, Dar es Salaam recorded the highest number of GBV/VAC 21,726, Shinyanga 19,759 and Geita 7,734 in 2024 as shown in Table 20.

Table 19:Proportions Of GBV/VAC Reported Cases Tanzania Mainland From 2020 to 2024

No.	INDICATORS	2020	2021	2022	2023	2024
1	Percentage of female assaulted sexually clients amongst all females	8	8	7	7	3
2	Percentage of female assaulted physically clients amongst all females	39	37	37	37	17.9
3	Percentage of male physically assaulted clients amongst all males	35	36	38	38	36.3
4	Percentage of Male Sexually assaulted clients amongst all males	6	6	6	7	5.9
5	Number of neglected children	6,312	6,998	9,050	9,754	9,769
6	Number of children living in risk environment	5,935	8,499	7,857	8,771	8,857

Source: DHIS2

The data from DHIS2 show that reported GBV/VAC cases increased from 253,441 in 2022 to 266,410 in 2023 and increased to 274,004 in 2024.

The percentage of survivors reporting within 72 hours for accessing timely medical and psychosocial support remains below the national target of 60%. In 2024, only 31.3% of cases were reported within 72 hours which is an increase compared to 30.2% in 2023. Moreover, only 21 out of 184 councils (11.4%) met the national target, leaving 88.6% below standard. The trends in sexual violence among females show a declining from 7% in 2023 to 3% in 2024, while among males, there is a slight decrease from 7% in 2023 to 5.9% in 2024. Physical violence among females dropped from 37%i n 2023 to 17.9% 2024 whereas for males, it remained at 38% in 2023 and 36.3% in 2024. Among VAC cases, the number of neglected children continued to rise, from 9,754 in 2023 to 9,769 in 2024, while children living in risk environments increased from 8,771 in 2023 to 8,857 in 2024. Region comparison, Dar es Salaam recorded the highest number of GBV/VAC 21,726, Shinyanga 19,759 and Geita 7,734 in 2024.

Table 20:Number of GBV/VAC Reported Cases and Cases Reported Within 72 Hours by Region From 2020 to 2024

No.	Region	GBV/VAC cases	% Reported within 72hrs	GBV/VAC cases	% Reported within 72hrs	GBV/VAC cases	% Reported within 72hrs	GBV/VAC cases	% Reported within 72hrs	GBV/VAC cases	% Reported within 72hrs
		2020		2021		2022		2023		2024	
1	Arusha	4,537	35	5,500	24	8983	32	8542	35	10,483	48
2	Dar es Salaam	14,267	32	19,612	31	28417	36	25586	45	21,726	46.2
3	Dodoma	4,226	37	5,922	33	6396	31	10460	19	17,929	18.9
4	Geita	1,101	39	9,887	28	18737	27	18020	33	7,734	40.8
5	Iringa	11,263	43	9,387	43	8158	37	6978	36	10,941	26.4
6	Kagera	6,872	22	10,530	22	14634	36	13753	33	14,895	39.6
7	Katavi	1,441	19	877	24	2704	35	3902	39	5,519	32.6
8	Kigoma	7,119	33	6,779	37	11932	54	12152	54	16,379	36.6
9	Kilimanjaro	3,878	32	3,475	30	13301	18	9757	57	8,733	79.2
19	Lindi	2,553	19	1,639	13	2605	24	2144	29	2,341	29.3
11	Manyara	5,203	39	9,269	17	6855	18	11438	15	11,932	17.2
12	Mara	13,461	34	18,619	24	17900	31	17820	26	15,606	24
13	Mbeya	5,812	19	7,382	25	9363	34	12081	27	9,166	33.1
14	Morogoro	7,574	30	5,237	29	4674	24	5912	27	5,957	34.5
15	Mtwara	2,804	20	2,928	10	2974	14	2231	13	2,970	10.9
16	Mwanza	12,446	23	11,410	21	16899	14	16938	18	16,841	23.7
17	Njombe	4,076	40	3,657	41	4632	29	6689	45	7,422	47.3
18	Pwani	6,468	32	7,156	39	8061	35	9849	31	10,518	42.9
19	Rukwa	5,728	7	3,527	21	7307	32	4504	50	6,732	53.8
20	Ruvuma	9,548	8	4,902	6	3941	15	10829	6	10,397	5.4
21	Shinyanga	13,731	15	15,060	15	19290	15	20986	11	19,759	10.9
22	Simiyu	3,627	46	5,786	45	5165	25	4900	25	6,028	22.9
23	Singida	2,499	36	2,887	44	4121	39	5397	42	4,678	44.2
24	Songwe	1,304	41	2,489	49	3066	48	3268	57	3,826	34.7
25	Tabora	9,013	18	19,215	19	19205	15	14032	13	12,250	10.7
26	Tanga	1,978	45	3,954	42	4121	43	8242	44	13,242	32.7
	National	**162,529**	**28**	**197,086**	**27**	**253,441**	**28**	**266,410**	**30**	274,004	31.3

Source: DHIS2

3.9. TANZANIA IMMUNIZATION PROGRAM
3.9.1. KEY INDICATORS AND STATUS OF IMMUNIZATION

Tanzania continues to make significant progress toward achieving the goals outlined in the Immunization Agenda 2030 (IA 2030), demonstrating substantial improvements in immunization performance across various antigens in 2024. The National Immunization Program set ambitious targets, aiming to vaccinate 3,172,712 surviving infants and 5,138,338 girls aged 9 to 14 years with the HPV vaccine.

The program achieved remarkable results in 2024, with 3,060,371 children receiving the DTP-HepB-Hib third dose, corresponding to a 96% coverage rate. Additionally, 3,166,006 children were vaccinated with the MR first dose (representing 99.8% coverage), while 2,974,813 children received the MR second dose (94% coverage). The HPV vaccination surpassed the target, with 5,478,165 girls vaccinated, achieving 107% coverage. Notably, all other antigens reported coverage rates of above 90%, except for Td2+, which recorded 88% coverage. These impressive achievements reflect the continued efforts of the immunization program and its commitment to safeguarding public health.

However, there are limitations affecting the accuracy and quality of immunization data. One key challenge faced on 2024 immunization data is the lack of age disaggregation in the numerator in the current data collection tools, which prevents routine examination of whether children are vaccinated within the recommended age for scheduled vaccines or receive vaccinations later than intended. This limitation hampers accurate monitoring of adherence to vaccination schedules. Moreover, the reliance on paper-based data collection tools, such as tally sheets and registers, compromises data quality as these primary collection tools often encounters challenges during the transfer of data to monthly reporting tools. This process introduces errors and inconsistencies, affecting the accuracy of reported coverage rates.

To address these data-related challenges, the IVD program has implemented a new version of the monthly report form in the VIMS system which disaggregates data based on the age of the child receiving immunization services. These new forms will be starting January, 2025. The development and deployment of TImR child electronic register tool is also expected to significantly enhance data accuracy by facilitating age-disaggregated reporting and improving the consistency of data across all levels.

Table 21: National immunization Coverage 2024

National immunization Coverage 2024

Vaccine (or Supplement)	Description of Denominator	Number in Target Group (Denominator)	Number of doses administered through RI (Numerator)	Coverage (%)
BCG	Live births	3,360,060	3,857,918	114.8%
DTP-HepB-Hib - 1	Surviving infants	3,172,712	3,038,288	95.8%
DTP-HepB-Hib - 2	Surviving infants	3,172,712	2,993,785	94.4%
DTP-HepB-Hib - 3	Surviving infants	3,172,712	3,060,371	96.5%
HPV – 1	Girls 9-14 years	5,138,338	5,478,165	106.6%
IPV	Surviving infants	3,172,712	3,090,375	97.4%
MR – 1	Surviving infants	3,172,712	3,166,006	99.8%
MR – 2	Surviving infants	3,172,712	2,974,813	93.8%
PCV-13 - 1	Surviving infants	3,172,712	3,024,555	95.3%
PCV-13 - 2	Surviving infants	3,172,712	2,989,957	94.2%
PCV-13 - 3	Surviving infants	3,172,712	3,047,154	96.0%
Rota- 1	Surviving infants	3,172,712	3,015,407	95.0%
Rota- 2	Surviving infants	3,172,712	2,966,163	93.5%
Rota- 3	Surviving infants	3,172,712	2,983,816	94.0%
bOPV – 1	Surviving infants	3,172,712	2,950,836	93.0%
bOPV – 2	Surviving infants	3,172,712	2,904,718	91.6%
bOPV – 3	Surviving infants	3,172,712	2,953,048	93.1%
Td2+	Live births	3,360,060	2,974,469	88.5%

Source: *VIMS database 2024*

3.9.2. DTP3 DISTRICT COVERAGE

In the 2024 reporting period, a total of 110 districts (56.4%) successfully achieved the target coverage of 95% or higher for the DTP-HepB-Hib third dose. This reflects commendable efforts by immunization teams and local health authorities in the 110 districts, demonstrating robust vaccination outreach and service delivery. However, there are still notable gaps that require attention. Specifically, 26 districts reported coverage rates between 90% and 94%, indicating a need for targeted interventions to close the gap to 95%, 29 districts achieved coverage rates between 80% and 89%, suggesting moderate performance but room for improvement and 30 districts reported coverage rates between 50% and 79%, highlighting significant challenges in reaching target populations and maintaining consistent vaccination services.

3.9.3. VACCINATED AND UNDER-VACCINATED STATUS DTP VACCINE (2020 – 2024)

The number of under-vaccinated children in Tanzania has shown a consistent downward trend over recent years, reflecting the success of targeted immunization efforts. In 2020, the number of under-vaccinated children stood at 104,453, which decreased to 83,392 in 2021. This positive trend continued in 2022, with the number further declining to 82,837, and in 2023, it dropped significantly to 10,053.

This remarkable progress can be attributed to the program's continuous efforts in conducting Periodic Intensification of Routine Immunization (PIRI) activities and strengthening routine immunization services. As a result of these concerted efforts, no under-vaccinated children were recorded in 2024, marking a major milestone in the country's immunization program. Sustaining these achievements will require ongoing commitment to routine immunization, continued community engagement, and diligent monitoring to promptly address any emerging challenges.

Figure 30:Vaccinated and under-vaccinated, DTP Vaccine 2020 to 2024
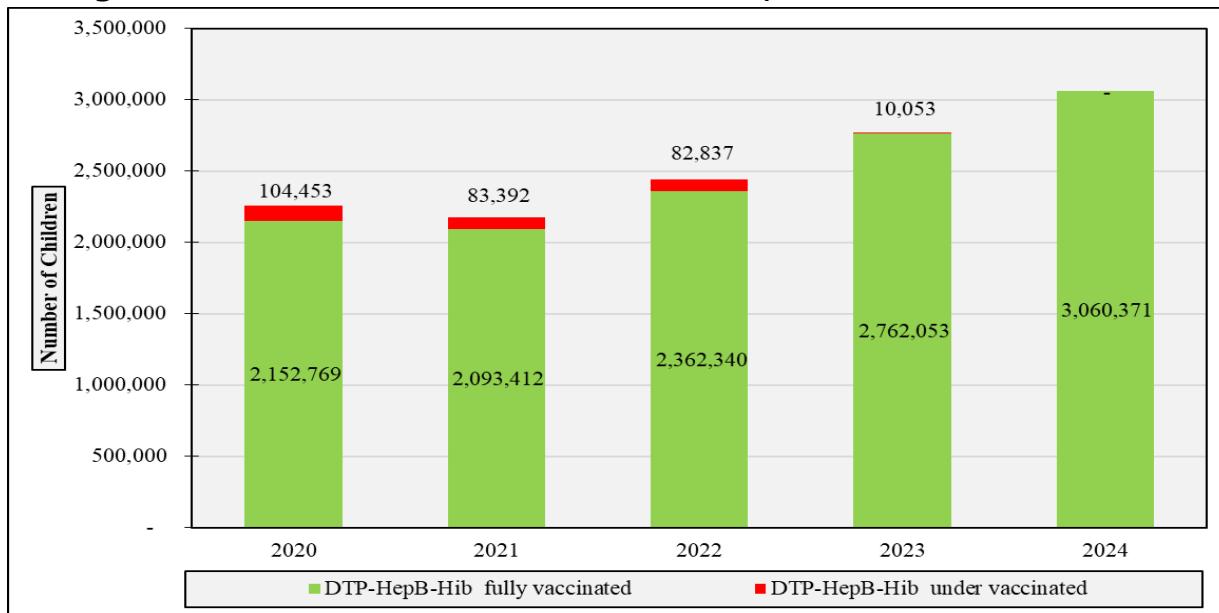
3.9.4. FULLY VACCINATED AND UNDER-VACCINATED, MR VACCINE 2020 TO 2024

Between 2019 and 2022, Tanzania experienced an increase in the number of MR under-vaccinated children, reflecting challenges in maintaining consistent immunization coverage during that period. However, a slight decrease was observed in 2022, with the number of MR under-vaccinated children recorded at 288,664. This reduction indicated some progress in addressing gaps in routine immunization, but significant challenges remained.

Remarkably, in 2023, Tanzania reported no recorded cases of MR under-vaccinated children, a milestone achievement compared to the previous three years. Further, Key initiatives included the proactive identification of under-vaccinated children, intensified vaccination activities during Periodic Intensification of Routine Immunization (PIRI), and swift responses to measles outbreaks, in turn affected routine coverage as most antigens reached extreme coverage (%) beyond 100%. These coordinated actions significantly contributed to bridging immunization gaps and protecting children from vaccine-preventable diseases but affected quality of data as data collection tools were not designed as per PIRI requirement.

Despite the success achieved in 2023, the situation shifted again in 2024, when the number of under-vaccinated children rose to 191,193. This resurgence underscores the need for sustained and enhanced efforts to maintain high immunization coverage.

Figure 31:Fully and under vaccinated MR Vaccine 2020 to 2024
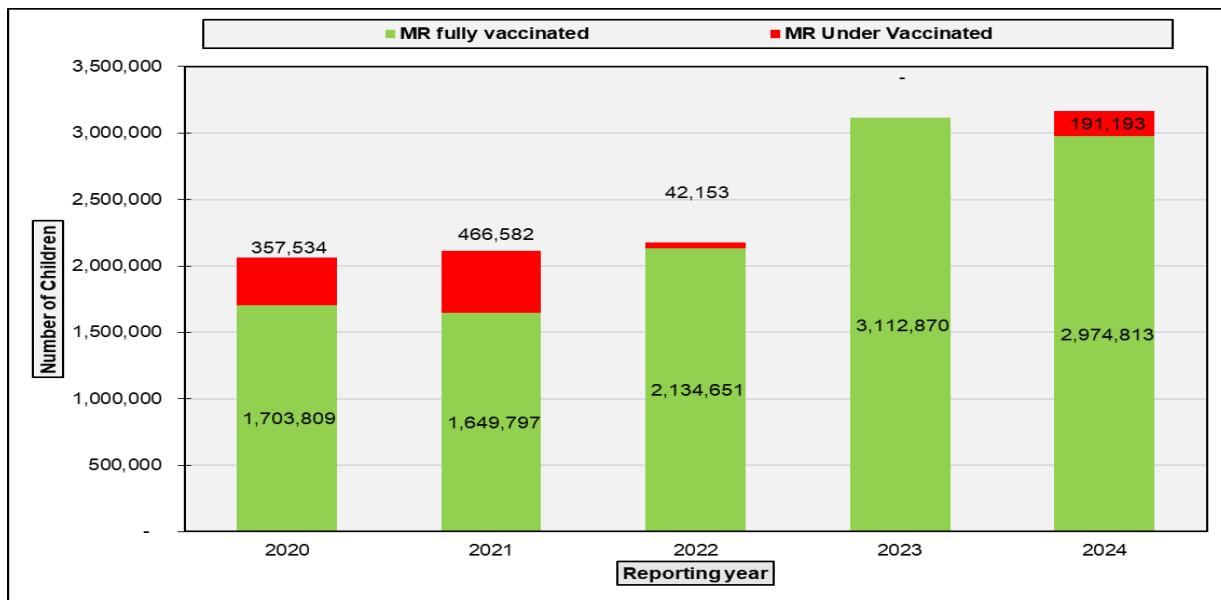
3.9.5. VACCINE PREVENTABLE DESEASE SURVILLANCE

In the country, Polio surveillance, Measles rubella surveillance as well as Neonatal and maternal Tetanus surveillance are integrated at regional and council level, in line with the current advocacy for integration of Polio surveillance with other VPD surveillance.

3.9.6. KEY AFP SURVEILLANCE PERFORMANCE INDICATORS

Tanzania maintains well established sensitive AFP surveillance system country wide supplemented with 16 Environmental Surveillance (ES) sites in 11 regions Arusha, Dar es salaam, Dodoma, Kagera, Kilimanjaro, Mbeya, Morogoro, Mtwara, Mwanza, Tanga, Rukwa and Zanzibar. At National level the country has consistently attained the set target indicators for the past 5 years.

Figure 32:Trend of target and reported AFP cases, 2020 to 2024
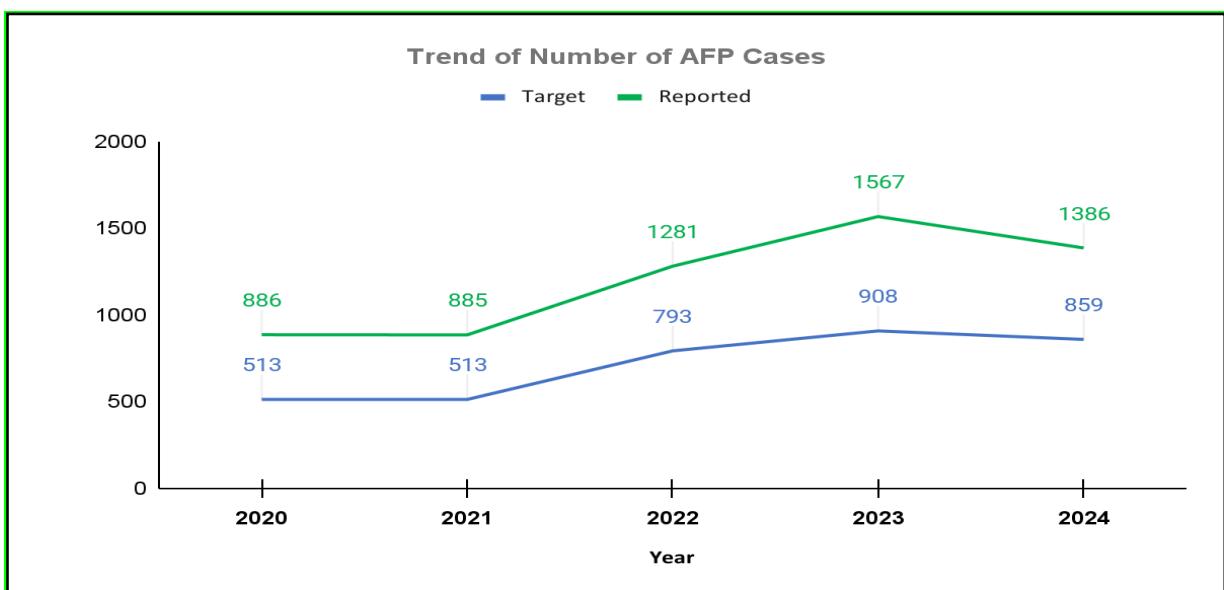
In 2024, a total of 1,386 AFP cases were reported. Case notification and investigation were conducted in a timely manner, with rates of 95% and 96%, respectively. However, only 64% of samples reached the national level (IVD – Dar es Salaam) within three days of collection, indicating delays in sample transportation. 2% of the reported cases were inadequate indicating the possibility of existing knowledge gaps on VPD surveillance among health care workers and lack of updated surveillance guidelines and SOPs. Isolation of Non-Polio enteroviruses (NPENT) was 5.12% remaining below target (Tareget 10%). No confirmed Polio case was reported in 2024.

At national level, Tanzania has maintained an adequate non-Polio AFP rate and stool adequacy since certification in November 2015. During 2020 -2024, the non-Polio AFP rate remained above the target rate of 3 for five years consecutively. In 2023 there was a slight increase to 4.9 as a result of programmatic efforts in polio activities including outbreak response activities.

Figure 33: Graph showing NP AFP and Stool adequacy at National level, Jan - Dec 2024

AFP perfomance indicators- 2020-2024

	2020	2021	2022	2023	2024
AFP detection rates	3.5	3.5	4.9	5.2	4.3
Non-AFP rate	3.5	3.4	4.8	4.9	4.2
Stool adequacy (%)	99	98	98	97	98
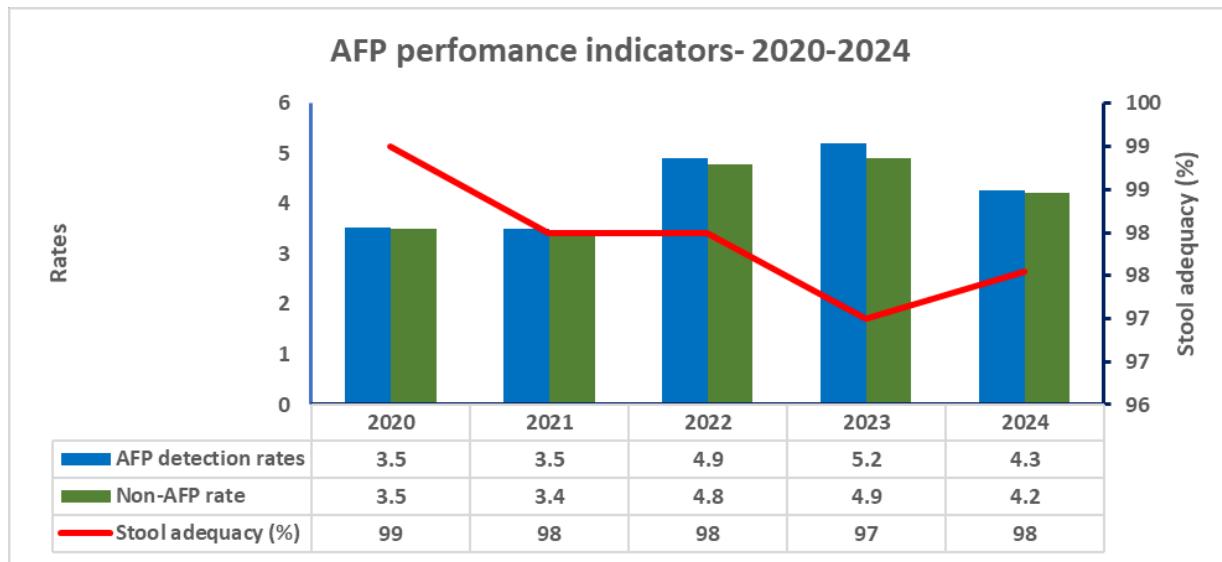
All regions met target indicators for the expected number of AFP cases to be reported. At council level, all councils (195) reported AFP cases with variation in performance indicators observed country wide. About 28 councils (14%) of Councils did not meet the target performance for Non-Polio AFP (NP AFP) rate while 10% did not meet the target performance for stool adequacy.

Challenges

i. There was out of stock of vaccine for 2019 – 2022 which led to high vaccination rate in year 2023.

Policy recommendations

i. Strengthen catch-up plan to target unvaccinated and under-vaccinated children, resulting in improved vaccination coverage.

ii. Ensure all stakeholders value, seek out, and actively support immunization services

Ensure the availability and utilization of high-quality data to facilitate evidence-based decision making at all levels.

CHAPTER FOUR

4.0. COMMUNICABLE DISEASES

Communicable diseases continue to pose a major global and national public health challenge. In Tanzania, they remain among the leading causes of morbidity and mortality, with malaria, HIV/AIDS, and tuberculosis (TB) contributing significantly to the disease burden. Emerging and re-emerging infectious diseases, coupled with antimicrobial resistance (AMR), have intensified the need for coordinated, multi-sectoral public health responses.

4.1. HIV/AIDS

Tanzania remains among the countries with the highest burden of HIV in Eastern and Southern Africa (EASA). According to the Tanzania HIV Impact Survey (THIS) 2022/23, the national HIV prevalence among adults aged 15–49 years is 4.4%, translating to an estimated 1,548,000 people living with HIV (PLHIV) in 2023. The epidemic continues to show heterogeneity, with significant disparities across age groups, sex, regions, and key populations.

Encouragingly, HIV incidence has declined in recent years. Among individuals aged 15–49 years, incidence dropped from 0.24% in 2016/17 to 0.21% in 2022/23. For adults aged 15 years and above, incidence fell from 0.29% to 0.18% during the same period. These declines reflect the continued impact of national efforts in prevention, testing, treatment, and retention in care.

Programmatic data as of December 2024 show strong performance in treatment coverage. A total of 1,529,567 individuals were receiving Antiretroviral Therapy (ART), representing approximately 90% of the estimated 1.7 million PLHIV in Tanzania. This high ART coverage reflects the government's ongoing efforts to expand access to HIV care and treatment services, improve retention, and sustain viral suppression rates.

Among those on ART, 47,305 were children aged 0–14 years, accounting for 3.1% of all ART recipients. However, national estimates from Spectrum 2023 suggest that approximately 64,668 children in this age group are living with HIV, indicating a persistent gap in pediatric case identification and linkage to care that requires urgent and innovative responses.

4.1.1. NATIONAL HIV RELATED IMPACT AND OUTCOMES

Tanzania has adopted the UNAIDS Fast-Track Strategy aimed at achieving the 95-95-95 targets by 2025 and ending AIDS as a public health threat by 2030. According to THIS 2022/23, Tanzania recorded a strong performance:

- 83% of PLHIV knew their HIV status

- 98% of those who knew their status were on ART

- 94% of those on ART were virally suppressed

This represents significant progress from the 2016/17 baseline (61-94-87), though challenges remain in closing testing gaps, particularly among men, adolescents, children, and key and vulnerable populations.

Tanzania's multisectoral approach under the National AIDS, STIs and Hepatitis Control Strategy (NASHCoP Strategic Plan) integrates HIV with STIs and Viral Hepatitis, reflecting a shift toward a more comprehensive, people-centered health response.

Ending the HIV epidemic involves three outcome measures illustrated in the table below. Table 22. illustrates the country's progress as of 2024 for the three listed epidemiological impacts.

Table 22:Country's Standoff on HIV Impact Outcomes 2024

2020 Target: NMSF IV 2018 – 2023	Status as of 2024
New HIV infections were reduced by 75% in 2020, and by 85% in 2025 from the 2010 baseline • Among children, reduced to less than 5% by 2025 and below 2% by 2030	Approximately 60,000 people acquired HIV infection in 2023, 30% of the new infections are among young people, and 71% of the new infections among young people are AGYWs. • Equivalent to a 46% decline from the 2010 baseline of 110,000, 21% increment among young people • MTCT has dropped to 8.1% in 2024, down from 18% in 2010 and 11% in 2021, yet off a target of ≤4%
AIDS related deaths reduced by 50% in 2020, 70% in 2025, and 80% by 2030	Estimated 25,000 lives were lost to AIDS related illnesses, • A 61% decline from the 2010 (64,000) baseline. An 18% decrease among children from 22% in 2024.

HIV related stigma reduced to <5% by 2025 from the 2013 baseline of 28% and 20.5% for external and internal stigma, respectively. Attain < 5% stigma and discrimination by 2030	5.5 % PLHIVs experienced external stigma (Stigma Index Survey 2.0, 2021)

4.1.2. UNAIDS SUSTAINABLE DEVELOPMENT GOALS

Tanzania has demonstrated a strong commitment to ending the HIV epidemic in line with the Sustainable Development Goals (SDGs) and the UNAIDS 95-95-95 targets, as outlined in the Health Sector HIV Strategic Plan V (HSHSP V, 2022–2026). Through robust national efforts and strategic partnerships, the country has made remarkable progress toward achieving epidemic control.

By December 2024, Tanzania had almost reached all three 95-95-95 targets, reaching 92% of people living with HIV (PLHIV) aware of their status, 99% of those diagnosed on antiretroviral therapy (ART), and 98% of those on ART achieving viral load suppression.

This progress places Tanzania among the leading countries globally in the fight against HIV, reflecting the effectiveness of coordinated public health interventions, scale-up of HIV testing and treatment services, and sustained stakeholder engagement. Figure 34 illustrates the national performance as of end 2024.

Figure 34:Programmatic Performance on UNAIDS SDG from 2021-2024

95-95-95 status

Chart showing Performance Percent % on the y-axis (0 to 120) and Reporting Years on the x-axis (2021, 2022, 2023, 2024).

Year	1st 95	2nd 95	3rd 95
2021	85	99	96
2022	94	99	97
2023	97	96	95
2024	92	99	98

Legend: 1st 95, 2nd 95, 3rd 95, Linear (1st 95), Linear (1st 95)
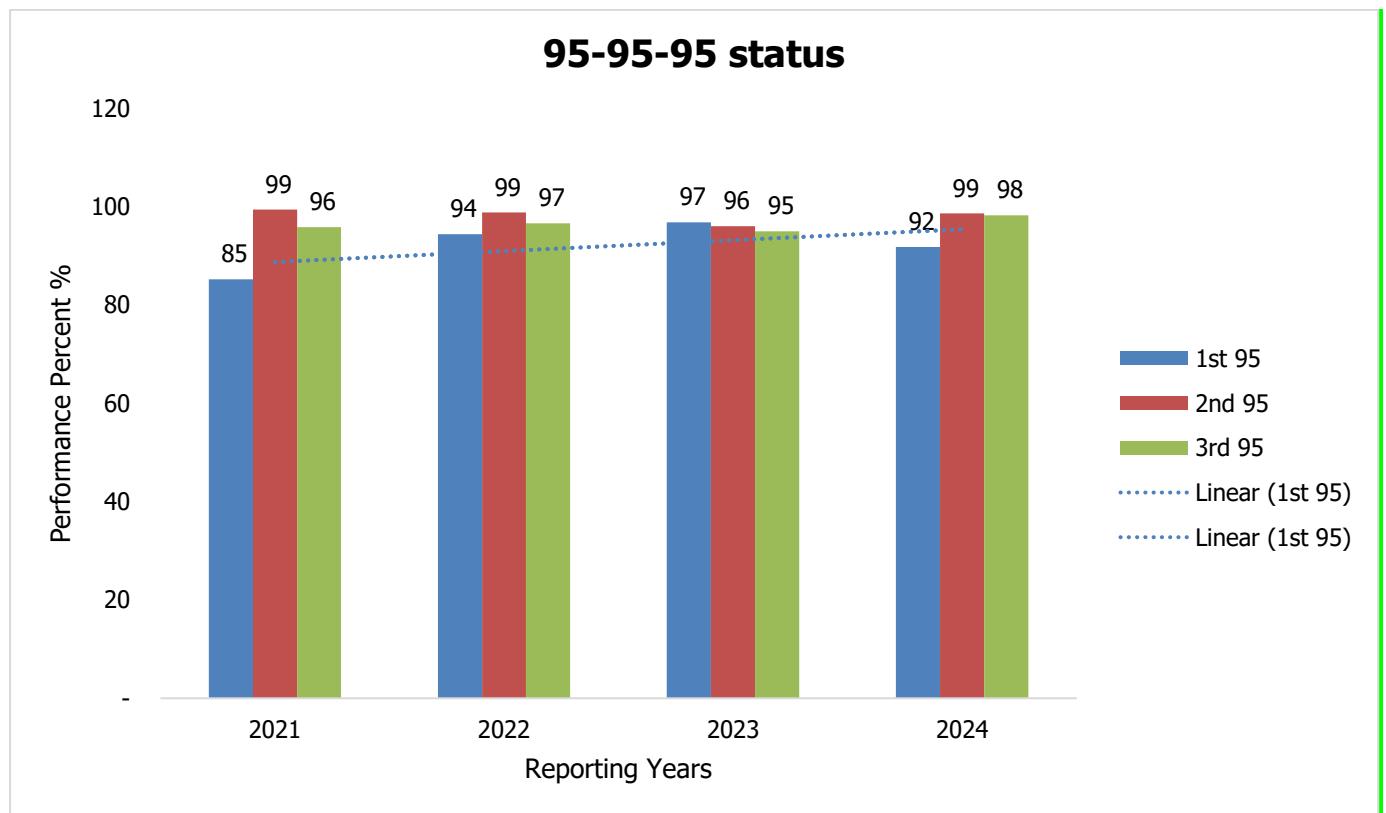
Source: HMIS-DHIS2, 2024

Figure 35:95-95-95 Status According to This 2022/23
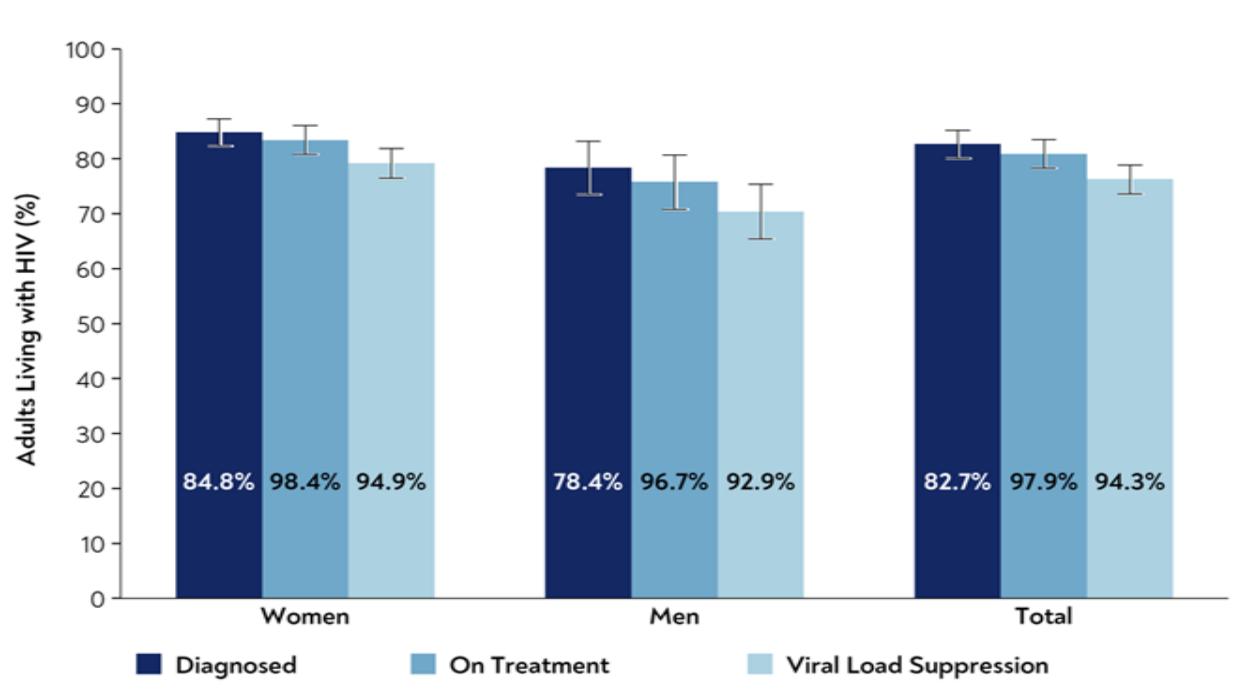
The Figure 35 above shows that, according to the Tanzania HIV Impact Survey (THIS) 2022/2023, 82.7% of adults aged 15 years and older living with HIV are aware of their HIV-positive status. Among those diagnosed, 97.9% are receiving antiretroviral therapy (ART), and of those on treatment, 94.3% have achieved viral load suppression.

4.1.3. PLHIV IDENTIFICATION

Despite ongoing efforts by the Government to identify individuals living with HIV and link them to care, treatment, and support services, critical gaps remain, particularly among children under 15 years. This age group continues to be inadequately reached by current identification strategies. To address this, there is a pressing need for innovative and targeted approaches, especially in high-burden and underserved areas, to ensure no population is left behind in the national HIV response.

Figure 36:Country performance on UNAIDS 95-95-95, PLHIV identification gaps highlighted across sub populations; 2021-2024
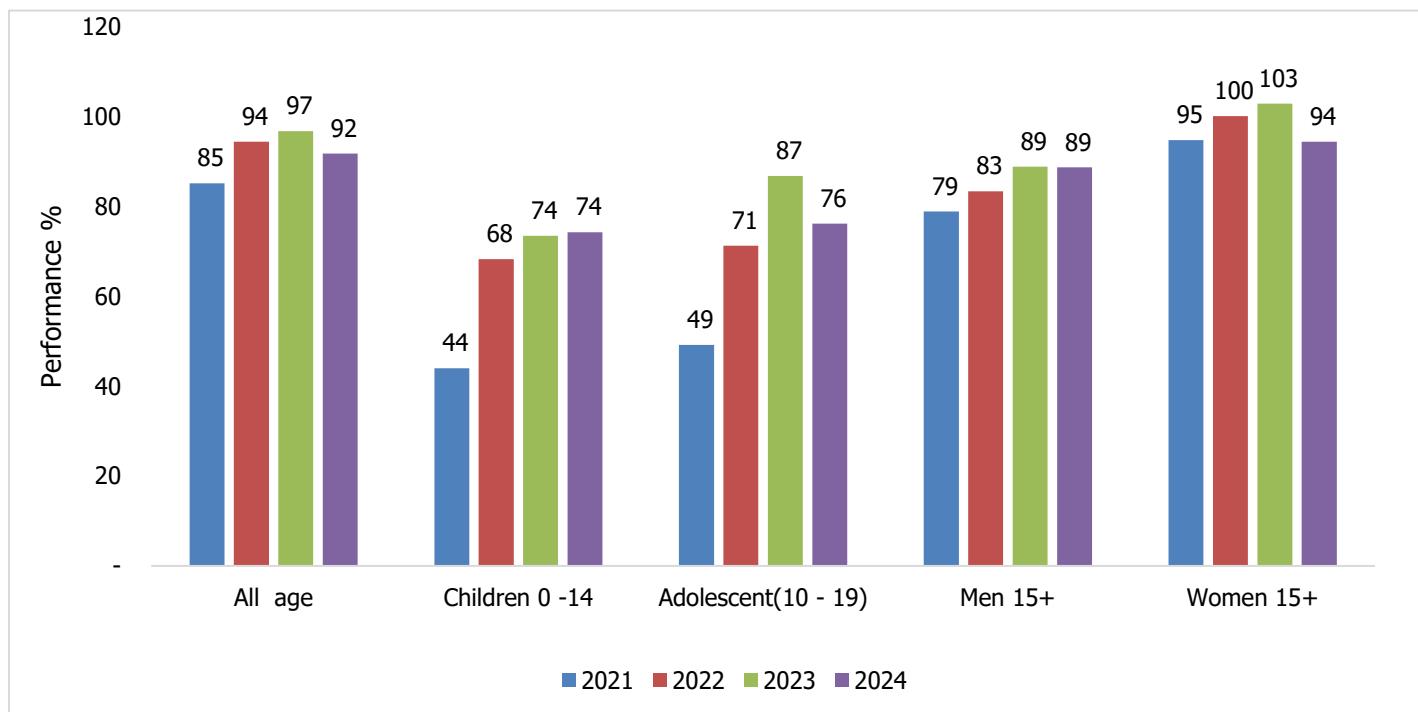
Source: DHIS2, 2024

4.1.4. REDUCTION OF NEW HIV INFECTIONS

It is estimated that about 6,500 new HIV infections occur among children under 15 years old. Moreover, about 50% of all new infections are from the 15 – 29 years age group. Although generally, new HIV infections have significantly dropped over the recent years (Figure 37), program data have indicated the existence of new HIV Infection pockets.

Figure 37:Slow reduction of new HIV infection far above the target, 2010 to 2024
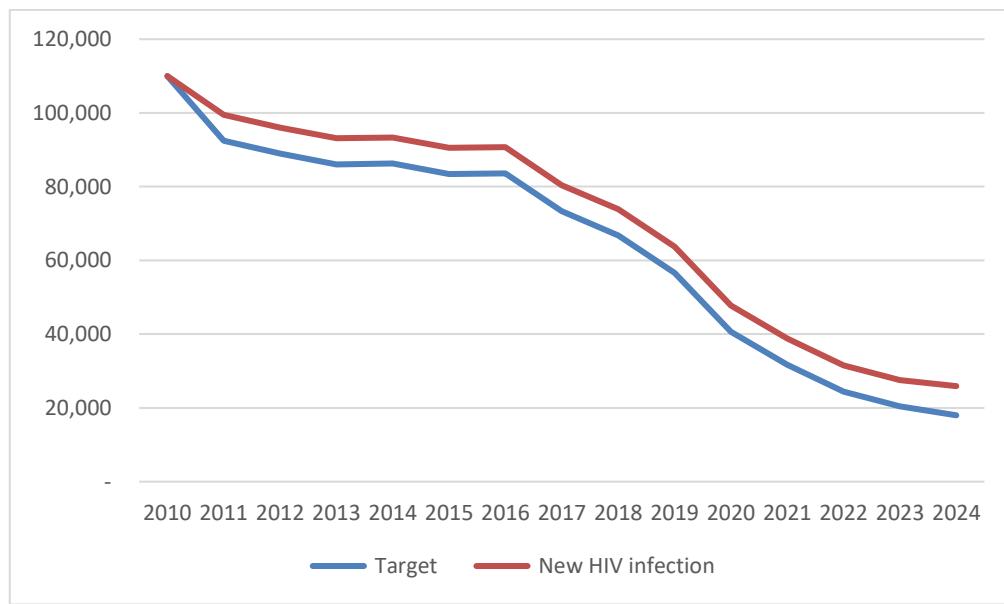
Source: Spectrum Estimate, 2024

4.1.5. COVERAGE OF HIV EARLY INFANT DIAGNOSIS (HEID)

Mother to Child transmission of HIV (MTCT), including during the breastfeeding period, remains a critical public health challenge in Tanzania, with the current final transmission rate standing at 8.1%. While over 95% of HIV-exposed infants (HEIs) consistently received ARV prophylaxis in recent years, a notable drop occurred in 2022, highlighting programmatic gaps.

Efforts to enrol HEIs in care have shown fluctuating performance. In 2024, 88.8% of an estimated 67,861 HEIs were enrolled in care, a decline from 95.9% in 2023. Additionally, the proportion of HEIs tested for HIV within two months of birth, a key milestone for early detection, has stagnated at around 79.5%, falling short of the national target of 95% by 2025. Testing at 18 months has gradually improved, from 22,888 infants in 2022 to 31,878 in 2024. Uptake of cotrimoxazole prophylaxis (CTX) has also significantly increased, reaching 93.0% coverage in 2024.

Despite high coverage of initial services, the persistent gaps in timely diagnosis, particularly at 9, 12, and 18 months, pose a risk of undetected infections and continued HIV transmission through breastfeeding. Strengthened follow-up systems and integrated maternal-child health services are essential to closing these gaps and achieving EMTCT targets.

Table 23:Early infant diagnosis towards elimination of Mother to child transmission of HIV 2021 to 2024

Indicators	2022	2023	2024
Number of HEI (proxy of total HIV+ pregnant women)	69,250	64,977	67,861
Number of HEI Enrolled into Care (first test for EID)	58,247	62,301	60,259
Number of HIV exposed children tested at ≤ 2 Months	45,825	50,085	47,895
Number of HIV exposed children tested at 18 Months	22,888	28,699	31,878
Number of HEI received ARV Prophylaxis	57,082	56,301	55,223
Number of HEI received CTX	44,093	58,849	56,017
Proportion of HEI enrolled (%)	84.1	95.9	88.8
Proportion of EID Testing at ≤ 2 Months (%)	78.7	80.3	79.5
Proportion of EID Testing at > 2 Months (%)	21.3	19.7	20.5
Proportion of HEI received ARV prophylaxis (%)	98.0	90.4	91.6
Proportion of HEI received CTX (%)	75.7	94.5	93.0

Denominator has been adjusted by 25% to control for double reporting emanating from old and new PMTCT MC Cohort reporting forms

4.2. VIRAL HEPATITIS INFECTIONS (HBV AND HCV)

i. Despite longstanding public health efforts, viral hepatitis remains a significant burden in Tanzania. According to the THIS 2022/23 report, the national prevalence of Hepatitis B Virus (HBV) stands at 3.5%, and Hepatitis C Virus (HCV) at 0.2%, with higher prevalence among priority and at-risk populations such as people who inject drugs (PWID), healthcare workers, and incarcerated individuals. These figures underscore the persistence of the disease and emphasize the need for expanded screening and linkage to care, particularly in underserved areas.

ii. Tanzania has set clear targets to reduce the annual incidence of HBV and HCV infections by 40% and associated mortality by the same margin by 2025 (baseline 2022). This translates to lowering HBV-related deaths to fewer than 7 per 100,000 population and HCV-related deaths to fewer than 3 per 100,000 population. However, the country still

faces challenges related to limited access to affordable diagnostics, low awareness of viral hepatitis among the general population, and poor integration of hepatitis services into existing HIV and primary health care platforms.

4.3. SEXUALLY TRANSMITTED INFECTIONS (STIS)

i. Sexually transmitted infections (STIs) continue to be a major public health concern in Tanzania. The THIS 2022/23 findings indicate that the prevalence of untreated STIs among the general population is 7.4%, with higher rates reported in key populations and among adolescent girls and young women (AGYW). Among adult men aged 15 years and older, 5.3% reported abnormal penile discharge, and 7.4% reported genital ulcers or sores within the 12 months preceding the survey.

ii. The burden of untreated STIs not only contributes to infertility and poor reproductive health outcomes but also facilitates increased risk of HIV and viral hepatitis acquisition and transmission. Despite efforts to scale up syndromic management and STI service integration within reproductive and HIV care, challenges remain around stigma, insufficient diagnostic capacity, and limited partner notification systems.

Challenges

i. PLHIV Identification Gaps: Programmatic data reveals persistent gaps in identifying people living with HIV (PLHIV), especially among adult men, AGYW, children, and key populations. These groups often remain unreached due to inadequate mapping and tailored outreach to their respective hotspots.

ii. Integration and Coordination: Services for HIV, STIs, and viral hepatitis remain inadequately integrated across care platforms, affecting continuity of care and efficiency in service delivery.

iii. Low Awareness and Testing Uptake: Misconceptions, stigma, and poor risk perception contribute to low uptake of testing services, particularly for STIs and hepatitis among the general population and at-risk groups.

Policy Recommendations

i. Expand Targeted HIV Testing and Identification: Strengthen the identification and linkage of at-risk groups (e.g., AGYW, adult men, and children) through differentiated service delivery models and hotspot mapping, including the scale-up of HIV self-testing and index testing.

ii.   Enhance ART Adherence and Optimization: Improve retention and adherence to ART, especially for children and adolescents, by optimizing regimens and implementing differentiated service delivery models (e.g., community ART groups and multi-month dispensing).

iii. Strengthen STI and VH Service Integration: Ensure full integration of STI and viral hepatitis services into HIV, maternal health, family planning, and TB services. This includes expanding access to diagnostics, improving partner management, and leveraging community-based platforms.

iv.   Scale-Up Hepatitis B and C Screening and Treatment: Expand nationwide HBV and HCV screening, especially among pregnant women, blood donors, healthcare workers, and high-risk populations. Facilitate access to treatment for those diagnosed and invest in local laboratory capacity for viral load and genotype testing.

v.   Community Engagement and Behavior Change: Intensify community sensitization to reduce stigma, increase health-seeking behavior, and promote early diagnosis and treatment for HIV, STIs, and VH. Special focus should be given to culturally embedded practices and gender-sensitive interventions.

4.4. TUBERCULOSIS AND LEPROSY CONTROL

Tanzania is among the 30 high TB and TBHIV burden countries with estimated 122,000 TB incidence and 18,400 TB deaths both HIV negative and positive as per the WHO Global TB Report 2024. The report also shows that Tanzania has reduced the TB incidence rate by 40% from 306/100,000 per population in 2015 to 183/100,000 in 2023 and number of TB deaths reduced by 68% from 55,000 in 2015 to 18,400 in 2023. Based on the above data, Tanzania is on track to reach the 2025 End TB target milestone of reducing the TB incidence rate by 50% and number of TB deaths by 75%. 76% of TB patients were diagnosed and received treatment, with 24% missed TB cases. This has put Tanzania among the 3 countries with high TB burdens on track to reach the END TB milestone 2025 of reducing the Incidence rate by 50% in 2025 and among 13 countries in reducing the number of TB deaths by 75%

Tanzania achieved leprosy elimination target since 2006, thus mean less than 1 case of leprosy per 10,000 population. In 2024, 1,255 new cases were reported, translating to a leprosy detection rate of 20 per 1,000,000 population and the rate of children detected among newly leprosy cases was 0.5 per 1,000,000 population. Additionally, the Grade 2 Disability (G2D) rate was 1.8 per 1,000,000 population among new cases. While leprosy has been eliminated at the national level, new cases are still concentrated in specific councils with five regions continue to have endemic councils that have not yet achieved leprosy elimination target.

4.4.1. KEY INDICATORS AND STATUS

As shown in Table 24 below, the country is progressing well in TB control; most key TB indicators such as TB Incidence rate and TB Treatment success rate are performing well. The

TB treatment coverage for the year 2024 is not yet available, but the year 2023 treatment coverage of 76% which was below the 2023 target (85%). The leprosy indicators are performing well. The grade 2 disability was 9% against the target of 6%. This necessitates the injection of more resources to boost Leprosy elimination initiatives in the country.

Table 24:HSSP Targets & Indicators

S/N	Indicators	Baseline 2020	Achievement 2024	Target 2024	Target 2025	Comments	Data Source
1	TB treatment coverage	59%	76% (2023)	85%	90%	Progressing well, data for 2024 not available	WHO TB Global report 2024
2	TB incidence rate per 100,000 population	273	183 (2023)	178	150	Target achieved,	WHO TB Global report 2024
3	TB Treatment success rate	93%	96%	>90%	>90%	Target achieved	DHIS2-ETL
4	Grade 2 disability among newly diagnosed leprosy cases	7%	9%	6%	5%	Not achieved	DHIS2-ETL

Source: *DHIS2-ETL & WHO TB Global Report 2024*

Figure 38 shows the performance in TB case notifications rate per 100,000 population in 2023 and 2024 by region. The top three regions with high TB notification rates are Dar es Salaam, Dodoma and Pwani in both years 2023 and 2024, Regions like Tabora, Mwanza, Ruvuma, Tanga, Shinyanga, Mara, Songwe, Kagera and Kigoma had low TB case notification rate in 2024 while in 2023 Songwe, Mwanza, Kagera, Rukwa and Kigoma had low TB notification rate. However, all regions except Dar es Salaam, Pwani, Dodoma, Morogoro, Katavi, Geita, Manyara and Arusha have their TB notification rate declined in 2024 compared to that of 2023.

Figure 38: Performance in TB Notification rate per 100,000 population by region, 2023 and 2024
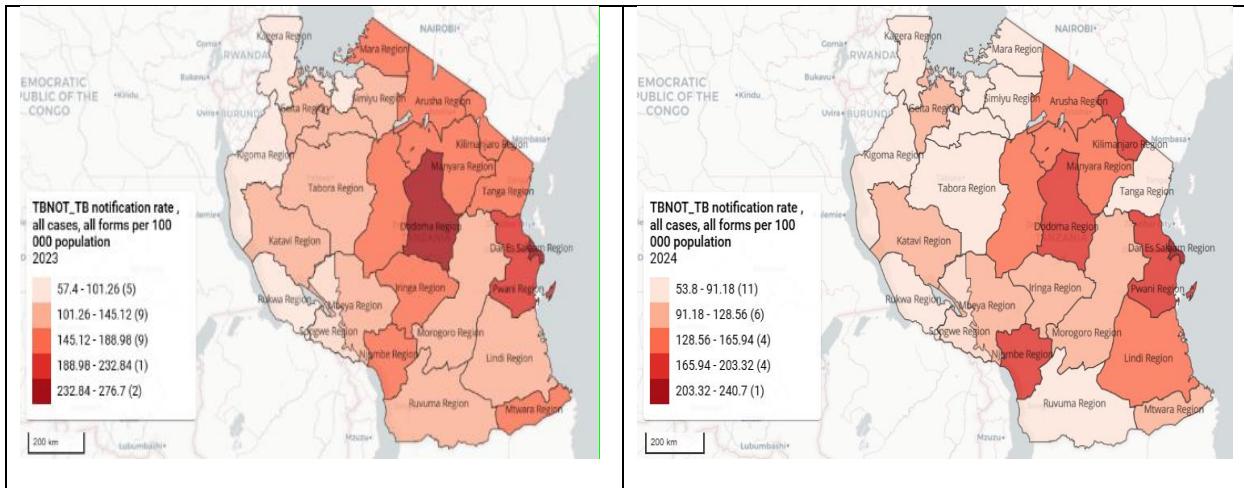
Source: DHIS2-ETL

Figure 39. shows TB treatment success rate by Region for TB patients started treatment in 2022 and 2023. At the national level, the treatment success rate has slightly decreased to 95.8 % in 2023 compared to 96.2% for TB cases notified in 2022. All regions surpassed national target of above 90%.

Figure 39:TB treatment Success Rate by Region
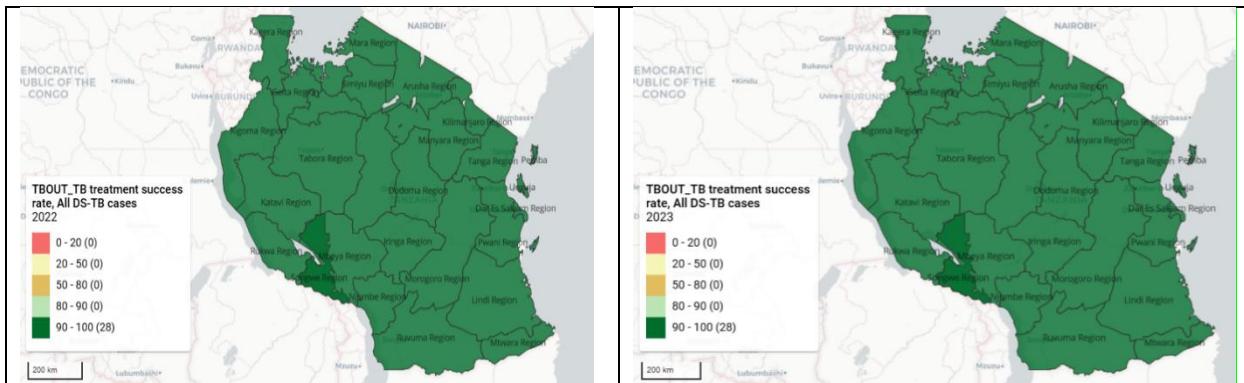
Source: DHIS2-ETL

Figure 40 presents the regional distribution of newly diagnosed leprosy cases in 2023 and 2024. Morogoro recorded the highest number of notifications, followed by Lindi, Dar es Salaam,

Mtwara, Kigoma, Tabora, Tanga, Geita and Ruvuma in both 2023 and 2024, fifteen region (15) regions reported the lowest leprosy case, whereas Manyara had no reported cases in 2024.

Figure 40:Number of new Leprosy cases diagnosed in 2023 and 2024
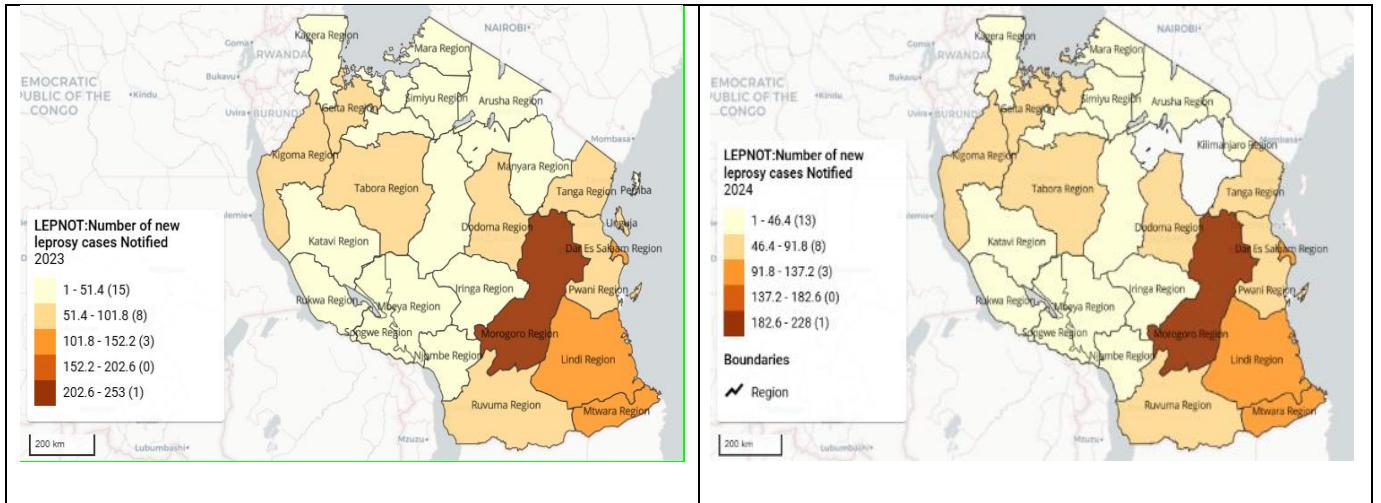
Source: *DHIS2-ETL*

Figure 41 depicts the number of new leprosy cases with Grade 2 Disability (G2D) per region. The Tanga region had the highest number of G2D cases, followed by Morogoro, Geita, Dar es Salaam, Tabora, and Pwani. This pattern was consistent in both 2023 and 2024. Regions of Simiyu, Shinyanga, Rukwa, Njombe, Manyara, Kilimanjaro, Iringa, and Arusha reported zero new leprosy cases with G2D.

Figure 41:Number of new leprosy cases with Grade 2 Disability by region 2023 and 2024
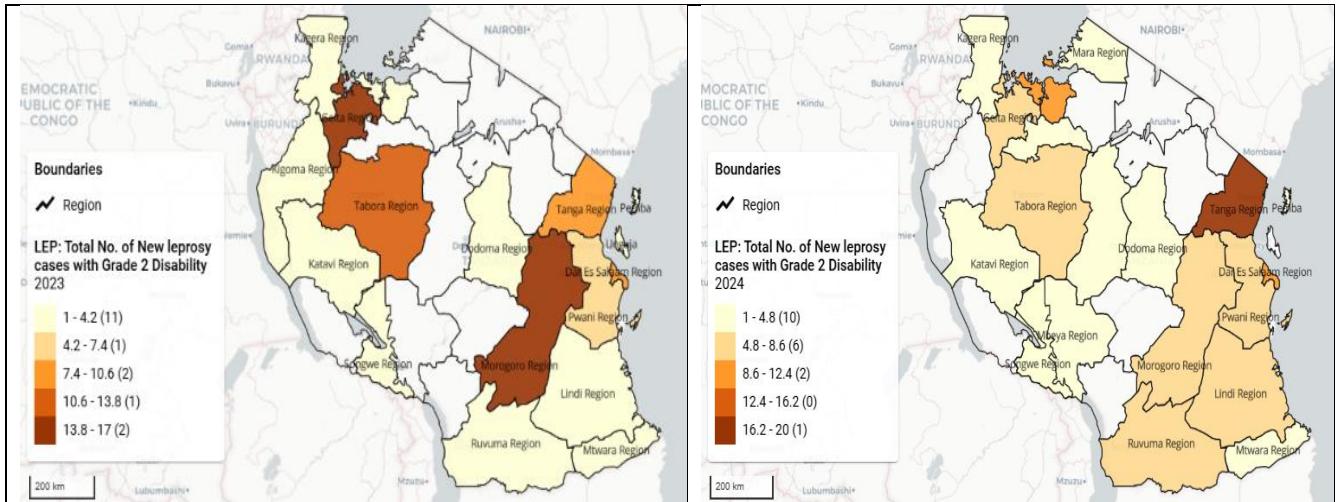
Source: *DHIS2-ETL*

Figure 42. depicts the leprosy cases detection rate per 1,000,000 population the higher number of detections indicates great transimission of disease, more effective case detection and greater

awareness of the Communities/health care providers on leprosy detection. In 2024, Lindi and Morogoro region had the highest Leprosy detection rate, followed by pwani, Mtwara, Kigoma, Rukwa, Dar es Salaam and Tanga while in 2023 Lindi had the highest followed by Morogoro, Pwani, Mtwara, Geita, Katavi, Kigoma, Rukwa, Ruvuma and Tanga. The pattern was consistently in both 2023 and 2024 for Regions of Lindi, Pwani, Kigoma, Mtwara, Rukwa, Ruvuma and Tanga

Figure 42:Leprosy detection rate per 1,000,000 population by region, 2023 and 2024
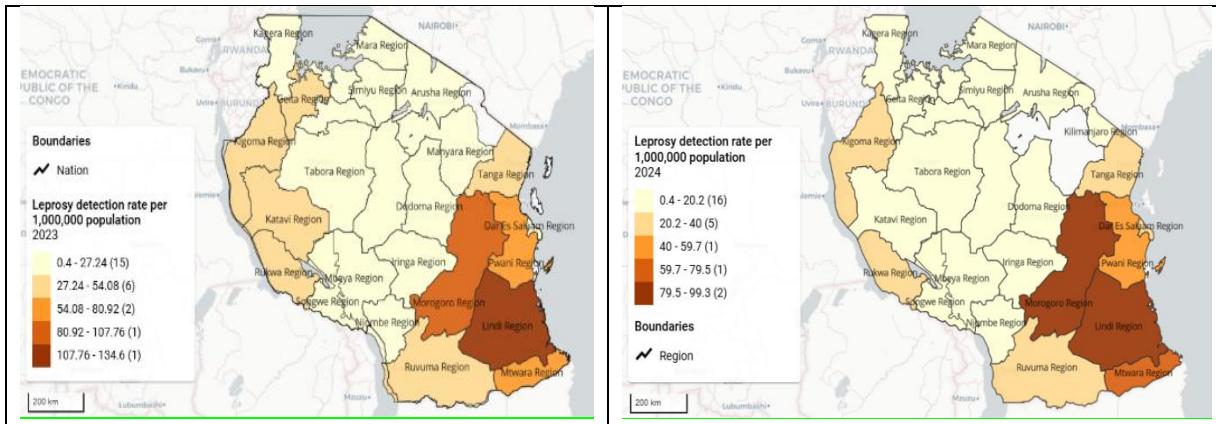
Challenges
i. Low awareness and knowledge of community and health services providers on Tuberculosis and Leprosy diseases
ii. Inability to afford initial costs for services, including consultation fees and diagnostic investigations such as X-rays.
iii. Inadequate skills and knowledge in the management of Leprosy patients among the health care providers
iv. Inadequate financial resources to support Tuberculosis and Leprosy activities.

Policy recommendations
i. Expansion of TB and Leprosy services to reach more people through improving diagnostics services in health facilities and optimizing Integrated Sample Referral System
ii. To expand models of health financing and social protection to address barriers to TB services access, such as consultation fees and other indirect costs.
iii. Engage more Implementing partners (IPs) to support TB and Leprosy control interventions
iv. Enforce the use of National Operational Guideline for Community based Tuberculosis and Leprosy intervention.

4.5. MALARIA

In the last 10 years, approximately one third of the country consistently showed a very low (<1%) Malaria prevalence and remained moderate to high (10% and above) prevalence in another one third of the country. The remaining third of the country had a low prevalence (1 - <10%) fluctuating between the two above extremes as depicted by Figure 44. The dynamics of the proportion of population living in the four endemicity levels are extrapolated from three successive Malaria Indicator Surveys (MIS) conducted between 2008 and 2017 (Figure 43). All MISs have demonstrated an increase in the proportion of people living in very low transmission areas and conversely a decrease of the population living in the highest transmission settings. Furthermore; the MIS conducted in 2017, revealed 59% decline in prevalence of Malaria in Tanzania Mainland from an average of 18.1% in 2008 to 8.1% in 2022.

Figure 43:Trend in Malaria Prevalence among 2 – 59 months Children (MIS) from 2008 to 2022
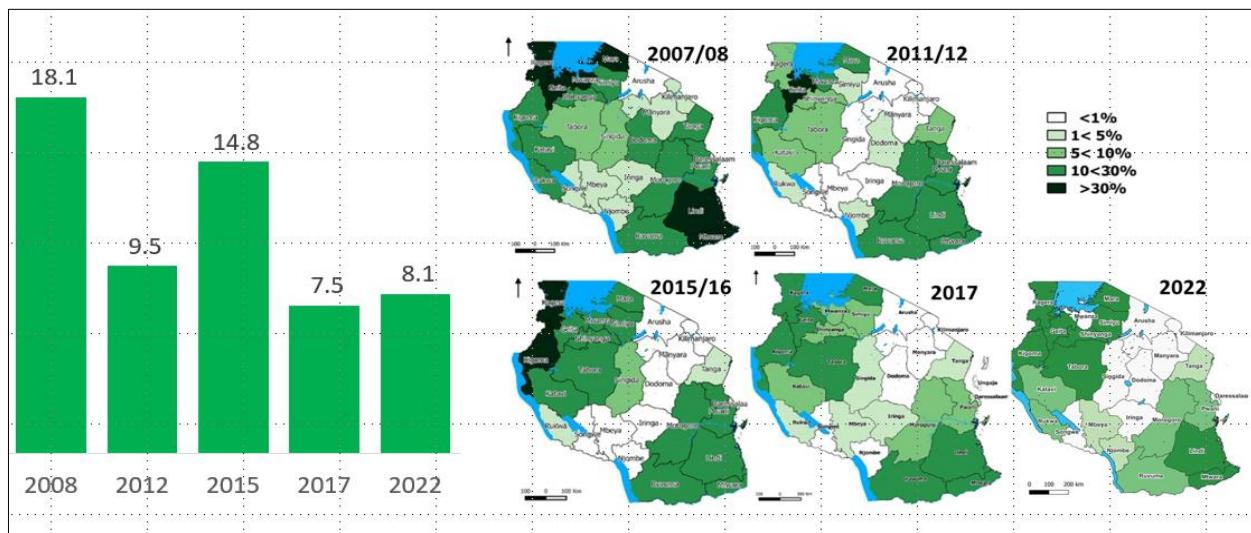
Source: *TDHS-MIS*

The School Malaria Parasitological Survey (SMPS) though is higher than MIS, there was a decrease in malaria prevalence among school aged children of 5 – 16 years from 21.6% in 2015 to 11.1% in 2023 (Figure 44). The population of school children shows a progressive increase in number of Councils with very low endemicity (less 1%) from 45 in 2015 to 59 in 2019; decreasing to 50 councils in 2023. The population also shows a progressive decrease in number of Councils with highest endemicity class from 64 in 2015 to 22 in 2023 as depicted by Table 25.

Figure 44:Trend in Malaria Prevalence among School Aged Children (5 − 16 years old), 2015 to 2023
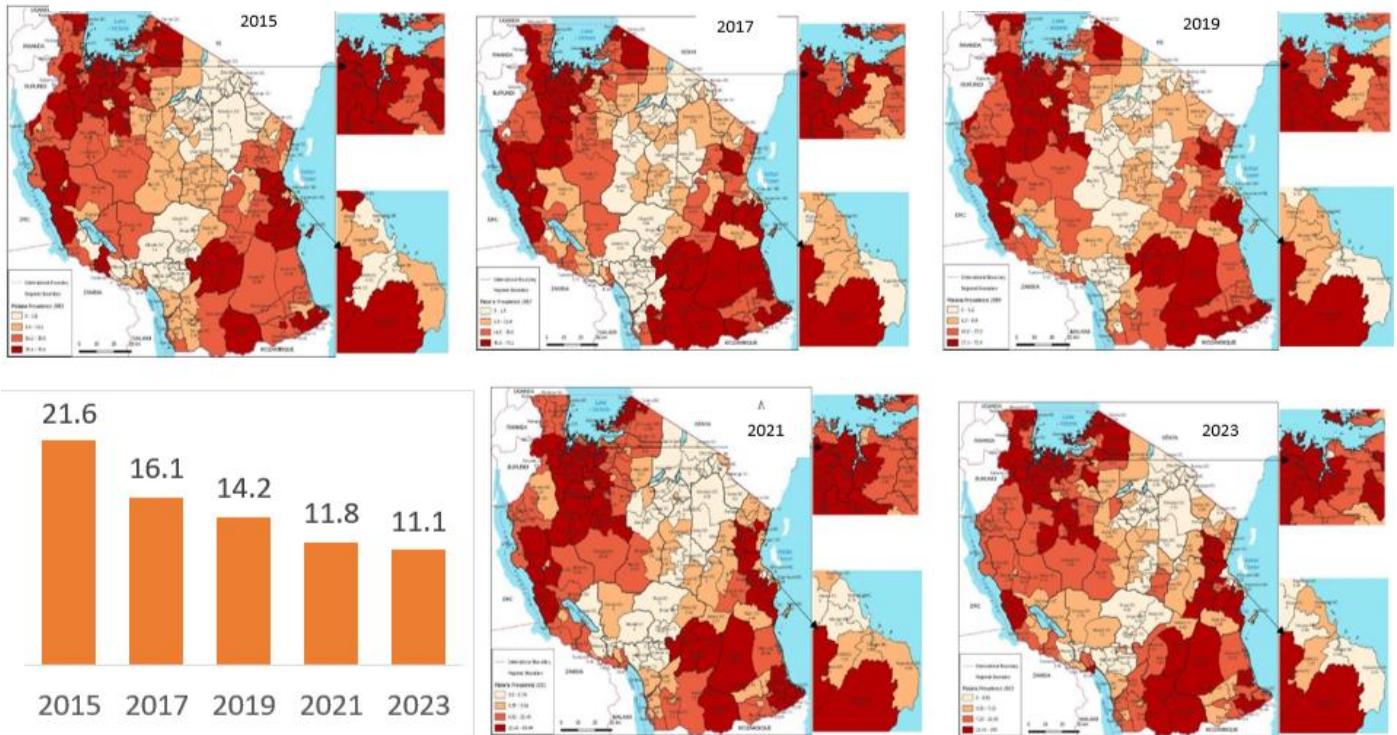
Table 25:Trends in number of Councils by mean prevalence among school children in different strata (2015 - 2023)

Prevalence Rate	Number of Councils				
	2015	2017	2019	2021	2023
<1%	45	45	59	58	50
1-<5%	19	29	15	27	39
5-<10%	13	13	15	22	20
10-<30%	40	40	51	46	53
>30%	64	57	44	31	22
Total number of Councils	181	184	184	184	184

4.5.1. MALARIA PREVALENCE AMONG PREGNANT WOMEN

Pregnant women are among the sentinel population, which is monitored to inform the country on malaria prevalence. Findings show a progressive increase in the number of Councils with very low endemicity (less 1%) from 55 in 2023 to 61 in 2024; whereas a progressive decrease in the number of Councils with the highest endemicity class (>10%) from 40 to 32 has been observed, see Table 26 and Figure 45 provides a summary of trends in parasite positivity rate among pregnant women and its heterogeneous distribution across the country from 2020 to 2024.

Table 26:Trends in number of Councils by prevalence of malaria for pregnant women 2020-2024

Prevalence	2020	2021	2022	2023	2024
<1%	44	40	52	55	61
1-<5%	45	49	48	44	51
5-<10%	36	37	43	45	40
>10%	59	58	41	40	32
Total	184	184	184	184	184

Figure 45:Malaria positivity rate among pregnant women 2020 – 2024 (Source: HMIS-DHIS2)
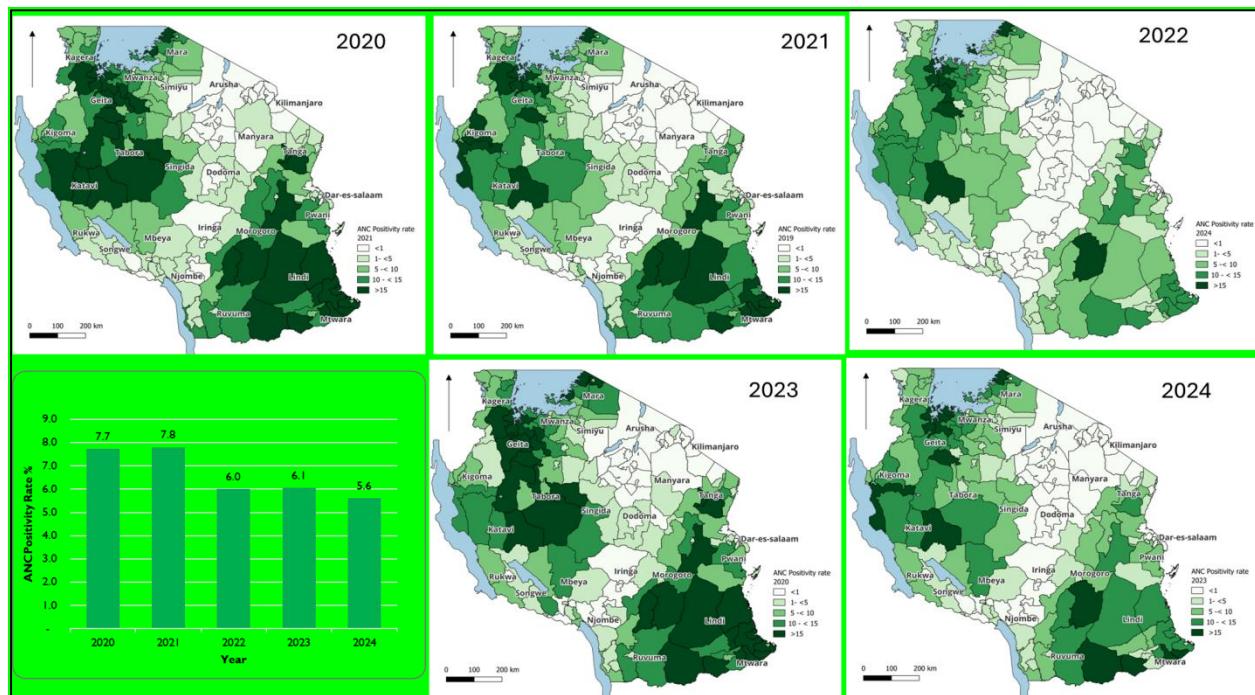
4.5.2. MALARIA INCIDENCE

The malaria case distribution among outpatient department (OPD) attendees across various age groups from 2023 to 2024, alongside the incidence of malaria per 1,000 individuals annually. The percentage of children under five years old among OPD malaria cases exhibits a downward trajectory, decreasing from 9.8% in 2023 to 8.9% in 2024. Similarly, the proportion of malaria cases across all age groups concerning total OPD attendance demonstrates a decline from 7.6% in 2023 to 7.0% in 2024. Overall, the incidence rate per 1,000 individuals at risk per year drops by 8.6% from 58 in 2023 to 53 in 2024.

Table 27:Trend of Malaria Incidence 2020 to 2024

Year	OPD Attendance		OPD Malaria Cases		Malaria burden (%)		Malaria Incidence per 1000 (all age groups)
	all age groups	< 5	all ages groups	< 5	all age groups	< 5	
2020	43,175,396	15,697,704	5,998,540	2,669,098	13.9	17.0	106
2021	41,475,952	14,091,536	4,410,290	1,960,528	10.6	13.9	76
2022	41,604,259	14,263,957	3,484,408	1,581,523	8.3	11.1	58
2023	46,517,000	16,491,089	3,536,947	1,610,704	7.6	9.8	58
2024	47,977,849	17,441,237	3,357,685	1,557,182	7.0	8.9	53

Source: DHIS2

The distribution of malaria cases across different councils reveals notable variations (Figure 46). In 2024, there was a noticeable decrease in the number of councils experiencing a malaria incidence rate above 100 cases per 1000 population, as compared to the previous four years. The central corridor consistently exhibited areas with low malaria incidence (below 50 cases per 1000 population), while the Northwest and Southeast zones consistently displayed higher incidence rates (above 150 cases per 1000 population). However, Councils in Ruvuma Region have demonstrated a noticeable decrease in incidence as compared to previous years.

Figure 46:Annual malaria Incidence by council per 1,000 population in 2020 – 2024 (Source: HMIS-DHIS2)
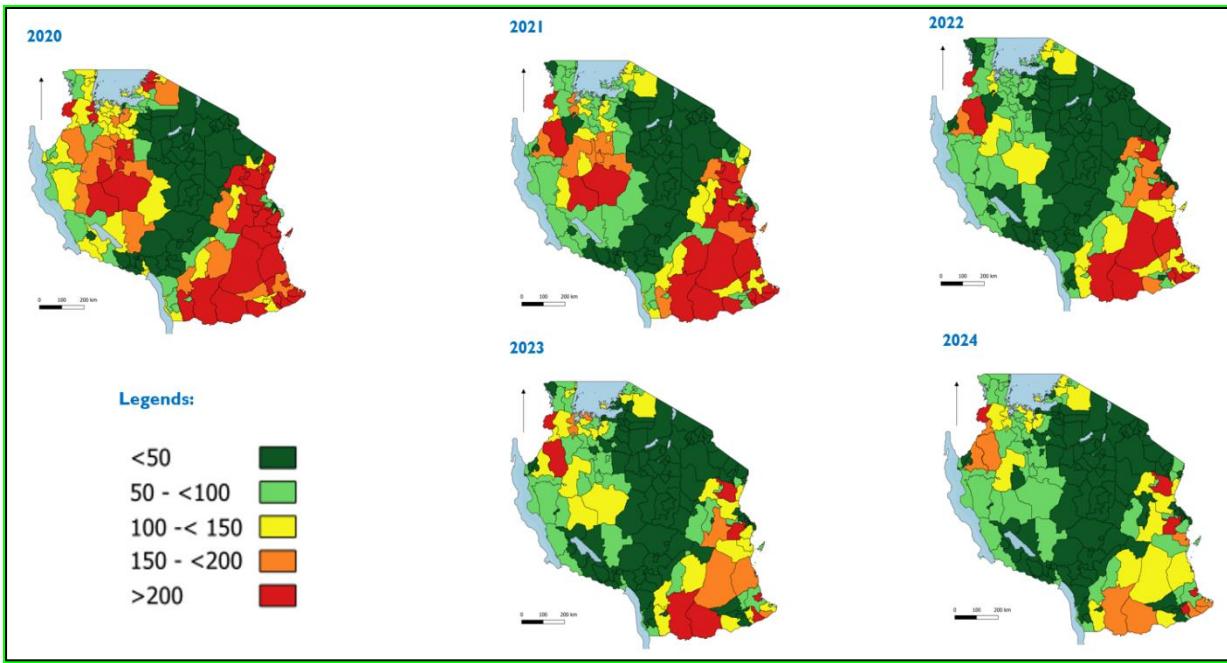
4.5.3. MALARIA MORTALITY RATE

According to Figure 47 there is a notable reduction of malaria mortality rate from 2020 to 2024, specifically, a significant decline by 25% from 3.2 deaths per 100,000 population in 2023 to 2.4 deaths per 100,000 population in 2024.

Figure 47:Malaria death rate per 100,000 population 2020 – 2024
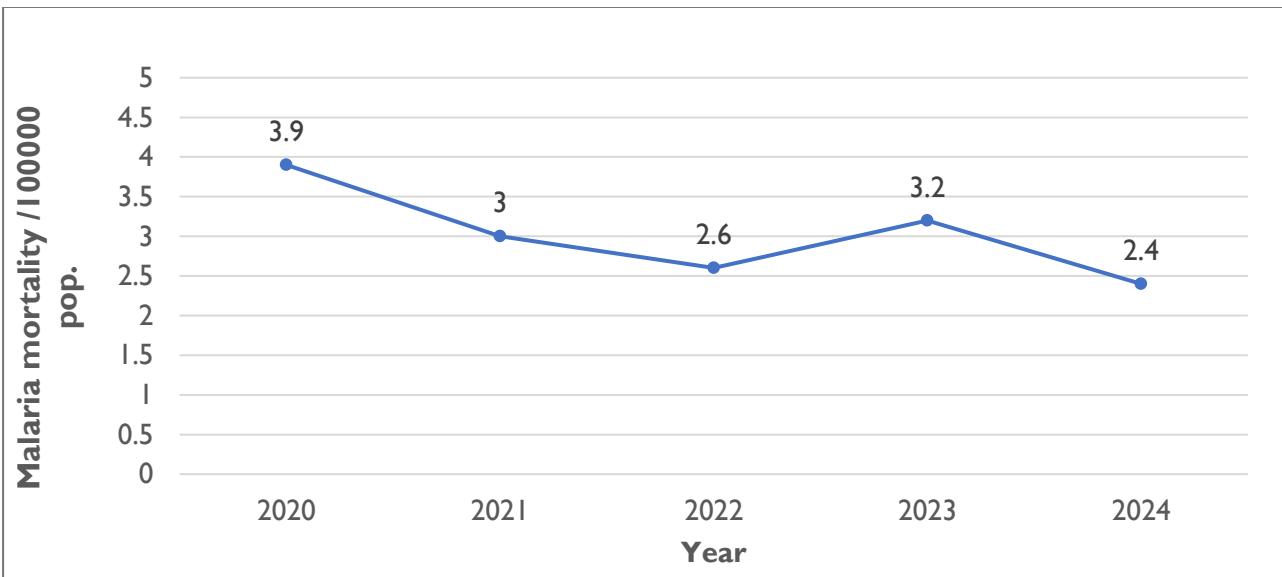
Source: HMIS-DHIS2

Challenges

i. Inadequate inventory management and control as a result of inadequate availability of the tools, inadequate documentation, irrational use of malaria commodities as well as not adhering to the guides by health care workers in different levels of supply chain.

ii. Data quality: Inconsistence between HMIS tools, DHIS2 and eLMIS data reported by the same health facilities which affect the quantification needs.

iii. There is a funding gap to support NSP 2020-2025, which specifically led to the non-implementation of IRS in the 56 eligible councils.

iv. There is an imminent threat of invasion by a new malaria vector, known as Anopheles stephensi. This species poses a significant danger as it is an efficient vector for urban malaria transmission.

v. ACT partial resistance has been observed in some parts of Kagera Region as well as from bordering countries such as Rwanda and Uganda which poses a great concern in sustaining gains in Malaria control. The country is aware, and the transition plan to Artesunate Amodiaquine (ASAQ) is underway.

Policy recommendations

i. To continue conduct population-based surveys to enrich routine health facility data for evidence-based planning and allocation of interventions.

ii. The MoH to Advocate for mobilization of domestic resources at the National and LGAs levels through the implementation of an End-Malaria Council (EMC) and the allocation of malaria interventions in CCHPs.

iii. To scale up chemo-preventive strategies; Intermittent preventive treatment of malaria in school-aged children (IPTsc) and Perennial malaria chemoprevention (PMC) as these have the potential to accelerate malaria burden reduction and as well as being able to improve access to care in hard-to-reach communities.

iv. To ensure intoperability of the available information systems (DHIS2/HMIS, GotHOMIS and AFYA Care) where a single digital reporting tool can be used to capture all data at the health facilities to increase efficiency and minimize transcription errors while documenting and reporting.

v. The Ministry of Health (MoH) and the PO-RALG should enhance the utilization of the micro-planning tool integrated into the plan-rep for both councils and health facilities. This tool should encompass malaria interventions within their comprehensive plans

vi.   To accelerate implementation of integrated Community Case Management for Malaria (iCCM) in five (5) Regions of Kagera, Kigoma, Geita, Katavi and Ruvuma to achieve burden reduction in areas with moderate and high malaria transmission risk.

4.6. PREVENTION AND CONTROL OF OTHER COMMUNICABLE DISEASES

4.6.1. NOTIFIABLE DISEASES

Epidemiology and Diseases control plays important role of disease control and prevention using Integrated Disease Surveillance and Response (IDSR) approach for all programs. This can only be successful when detection of the targeted diseases is done as well as obtaining laboratory confirmation of the disease and using thresholds to initiate timely action at the Community, Facility, District, Regional and the National levels.

Integrated disease surveillance systems provide necessary technical support for strengthening national communicable disease surveillance systems through the implementation of the national strategy for Integrated Disease Surveillance and the International Health Regulations (IHR). In 2014, Tanzania started using mobile technology, known as eIDSR (electronic IDSR) to enhance early reporting of diseases and events. This system is linked to DHIS2 to improve reporting and sharing information among stakeholders.

Indicators

i.   To have 90% of facilities reporting accurate and complete information on notifiable diseases and events in a timely manner.
ii.   To have less than 1 percent (<1) of case fatality rate of cholera
iii.   To have zero cases of Influenza A H1N1, Rift Valley Fever and Dengue Fever

4.6.1.1. CHOLERA CASE FATALITY RATE (CFR)

The cholera case fatality rate (CFR) has remained 1.9 percent in year 2023 while in 2024, CFR dropped to 1.0 percent. A total of 11,401 cases with 117 deaths were reported from 23 regions except Kilimanjaro, Iringa and Njombe with zero cases in the year 2024 as compared to 1,040 cases with 20 deaths that were reported from 11 regions in the year 2023 from Arusha, Mara, Singida, Kigoma, Simiyu, Katavi, Rukwa, Kilimanjaro, Dar es salaam, Ruvuma na Kagera regions. The Cholera incident cases were equal the 1.0% CFR in 2024, that was due to aggressive response to contain the disease.

Figure 48: Show the distribution of Cholera Cases by Regions in 2023 and 2024
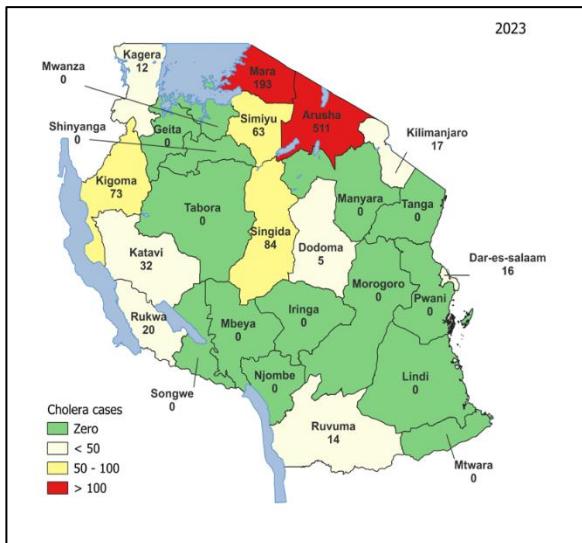
Figure 48A: Distribution of Cholera cases by regions in 2023
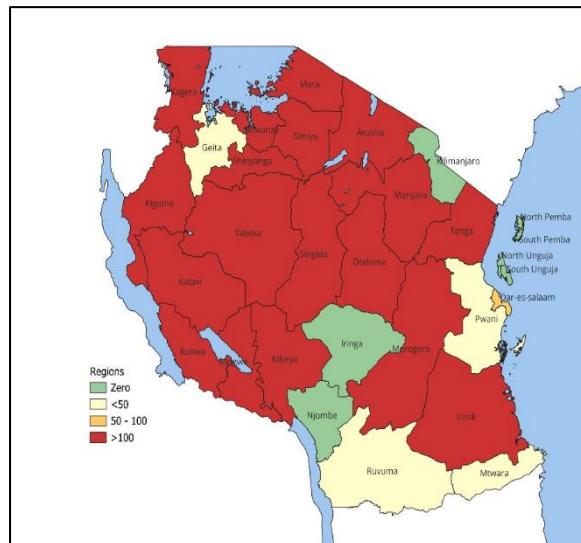
Figure 48B: Distribution of Cholera cases by regions in 2024

4.6.2. EMERGING AND RE-EMERGING DISEASES.

Emerging diseases are a global threat to human existence. Every country is exposed to the potential emergence of infectious diseases. Factors such as changes in ecology, climate and human demographics play different roles in a complex mechanism contributing to the occurrence of infectious diseases. Examples of diseases which have newly emerged in Tanzania are Rift Valley fever (2007), influenza A H1N1(Swine flu) (2009), and Dengue fever (2010). Important aspects of control in case of outbreaks are surveillance, preparedness and early response. The IDSR strategy and other stakeholders are key stakeholder spearheading the country's response and preparedness for emerging and re- emerging diseases.

4.6.2.1. INFLUENZA A H1N1 (2009) AND RIFT VALLEY FEVER

Despite of occurrence of outbreak of AHIN1 in 2009, in 2023 there was no case but in 2022 there were 3. In 2007, Rift Valley Fever occurred but in year 2023 and 2024 there were no cases.

4.6.2.2. PERCENTAGES OF COMPLETENESS AND TIMELINESS OF REPORTING

Figure 49: Percentage of Timeliness of Health Facilities reporting by week, from 1st to 52nd Week in 2023 and 2024
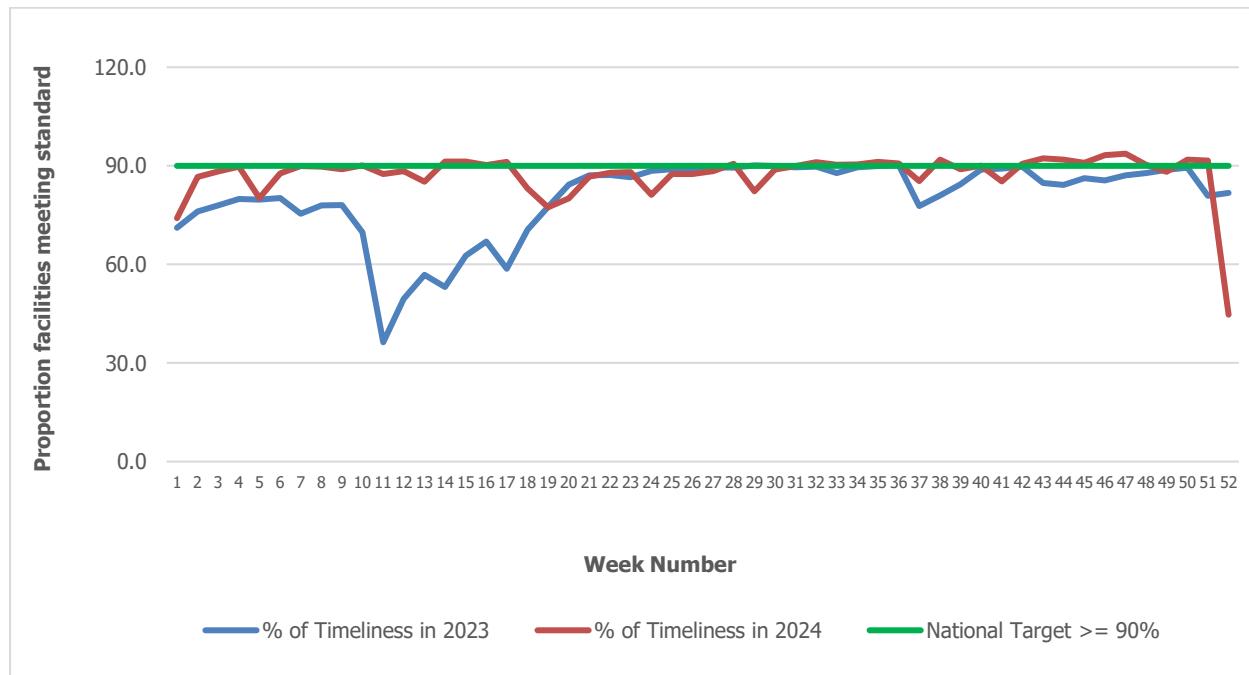
Source: *IDSR*

The overall timeliness of health facilities reporting from all 26 regions are presented in Figure 50. Almost the above half of the timeliness in the year 2023 was below the National Target of >=90%, except 20 weeks of the timeliness were above the national target. But in 2024 the timeliness fluctuates almost around the national target of > = 90% except in 52nd dropped much to 44%.

Figure 50: Percentage of Completeness of Health Facilities reporting by week, from 1st to 52nd Week in 2023 and 2024
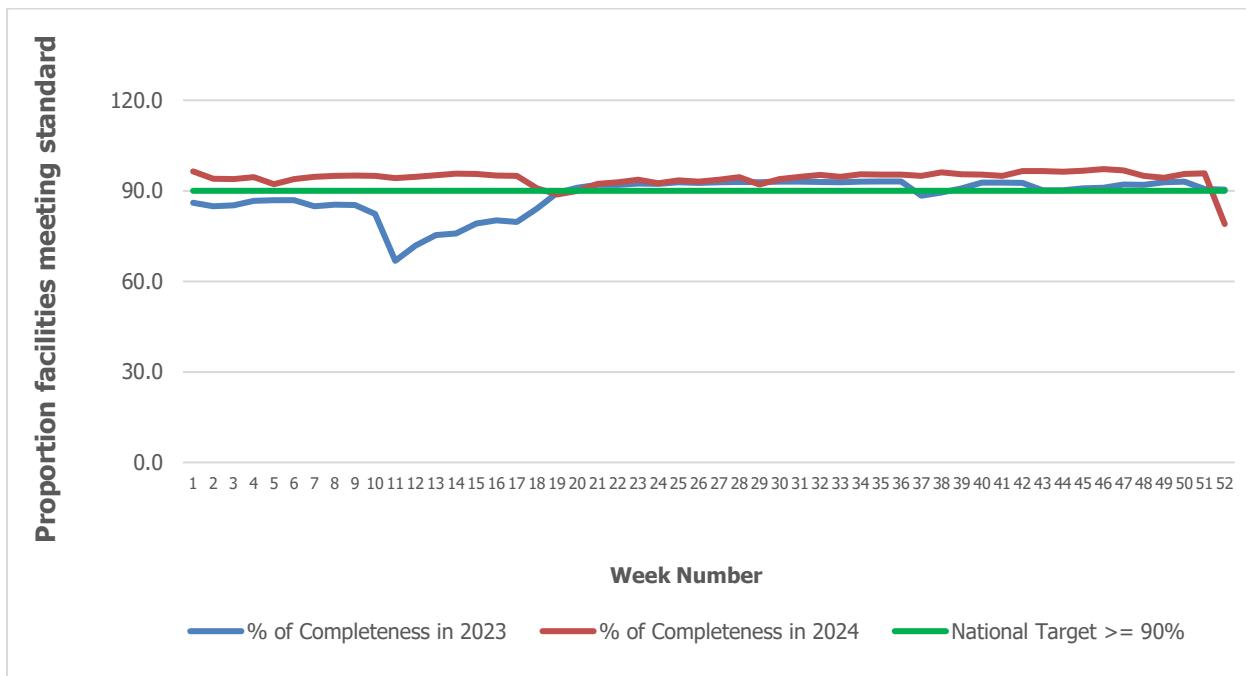
Source: *IDSR*

In 2023 and 2024, the overall completeness of health facilities reporting from all 26 regions as presented in Figure 51. Only in year 2024 the completeness met the national target >= 90% except 19th and 52nd weeks were slight below the National Target. But in 2023 from 1st to 19th, 38th and 39th were below the National Target >=90%.

Table 28:Summary of Key Indicators and their Achievements

Indicators (HSSP V)	Set target	2022	2023	2024
Number of incident cholera cases notified	0	513	1,040	11,401
Cholera case Fatality Rate (%)	<1	0%	1.9%	1.0%
Number of incident Dengue Fever cases notified	0	0	139	33
Number of incidents of Rift Valley fever notified	0	0	0	0

Number of influenza A H1N1 cases notified	0	3	0	0
Percentage of districts (N=184) submitting weekly on time to next level.	>90%	74.4%	81.8%	87.4%
Percentage of districts (N=184) submitting weekly on Complete to next level.	>90%	82.8%	90.1%	94.2%

Source: DHIS2/IDSR

Success

i. **Faster Data Transmission**: Electronic reporting reduces delays compared to manual paper-based systems.
ii. **Real-Time Alerts**: Automated triggers for outbreak-prone diseases enable quicker public health responses.
iii. **Early Warning Systems**: Detects unusual disease patterns before they escalate into outbreaks.
iv. **Reduced Manual Errors**: Digital forms minimize mistakes from handwriting or manual calculations.
v. **Automated Validation Checks**: Systems can flag incomplete or inconsistent data before submission.
vi. **Standardized Reporting**: Ensures uniformity in case definitions and data formats.
vii. **Availability Analytics**: Supports trend analysis and visualization (Dashboards, maps).
viii. **Reduced Paperwork**: Saves time and costs associated with printing, transporting, and storing paper reports
ix. **Optimized Human Resources**: Frees up health workers from tedious manual data entry for more critical tasks.
x. **Mobile Reporting Tools**: Community health workers (CHWs) can submit data via SMS or mobile apps, improving grassroots surveillance.
xi. Real time capturing of signals: The use of electronic Event Based Surveillance used by CHW and HCW facilitate reporting of health threat alert.

Challenges

xii. **Inadequate Supervision & Feedback**: Limited monitoring and feedback mechanisms reduce accountability in reporting.
xiii. **Operational cost**: SMS cost, hosting fee and infrastructure maintenance cost but also regularly training to health care workers

xiv. **High Staff Turnover**: Frequent changes in personnel mean continuous retraining is needed.

xv. **Insufficient linkage with system**: Several systems are not linked with eIDSR system with keys system such as Laboratory, Animal, Environmental, Meteorological etc

Policy Recommendations

i. Enforcement of Public Health Act 2009 on Communicable Diseases Prevention and Control

ii. Advocate installation of mobile networks towers all over the country to easy electronic communication

4.7. NEGLECTED TROPICAL DISEASES

Tanzania is endemic to a number of Neglected Tropical Diseases (NTDs) affecting most marginalized individuals in the country thus, aggravating the vicious cycle of poverty and diseases. These diseases include the five Preventive Chemotherapy targeted NTDs (PCT), namely, Schistosomiasis (bilharzia), Soil-transmitted Helminths (intestinal worms), Lymphatic Filariasis (elephantiasis), Onchocerciasis (river blindness) and Trachoma as well as case management diseases such as Human African Trypanosomiasis (HAT), Rabies, Tick borne Relapsing fevers, Echinococcosis (hydatid), Taeniasis (cysticercosis), Brucellosis, Plague, Leprosy and Snake bite. A large part of the population is at risk of co-infection with two or more of these diseases.

Tanzania is implementing the Integrated Neglected Tropical Disease Control program (NTDCP) aiming at eliminating/controlling the five Ppreventive Chemotherapy-NTDs which are Lymphatic Filariasis (LF), Onchocerciasis, Trachoma, Schistosomiasis (SCH) and Soil-Transmitted Helminths (STH).

Table 29. Preventive Chemotherapy (PCT) against NTDs in the form of Mass Drug Administration (MDA) has reached all endemic districts countrywide from 2016. This means that, PCT is provided in all endemic councils requiring MDA for Lymphatic Filariasis, Onchocerciasis and Trachoma. There have been interrupted MDAs for Schistosomiasis and STH due to financial resources. Referring to NTD Strategic Master Plan 2021-2026, Lymphatic Filariasis, Trachoma, Schistosomiasis and STH are targeted for elimination as Public Health Problem and Onchocerciasis is

targeted for elimination (interruption of transmission), thus, striving to reach stop MDA implementation across all endemic councils.

Table 29:Number of councils requiring Preventive Chemotherapy for 5 NTDs in year 2020-2024

Source: *MOH/NTDCP (2024)*

Disease specific	Baseline 2020	Target 2025/26	Achievement 2024	Councils require PC 2024
Trachoma	69	68	61	7
Lymphatic filariasis	119	115	114	5
Onchocerciasis	28	17	5	25
Schistosomiasis	184	58	7	177
Soil Transmitted Helminthes	184	58	52	132

4.7.1. TRACKING PERFORMANCE OF PREVENTIVE CHEMOTHERAPY

Two indicators for tracking performance of coverage of preventive chemotherapy are *geographical and epidemiological coverage of MDAs*. Despite of each ever-endemic

district has been reached with PCT against 5 NTDs, inconsistence MDAs for Schistosomiasis and STH MDA is becoming a challenge to maintain geographical coverage.

4.7.2. GEOGRAPHICAL COVERAGE OF PREVENTIVE CHEMOTHERAPY

Table 30. shows the mass drug administration geographical coverage report for year 2024. The geographical coverage was maintained 100% for the Lymphatic Filariasis(LF), Onchocerciasis and Trachoma. Also of note, there is increasement of geographical MDA coverage for Schistosomiasis and STH from 25% both diseases in year 2023 to 97% and 87% respectively in year 2024.

Table 30:Trend in Geographical Coverage of Preventive Chemotherapy for selected NTDs year 2023 and 2024

Year	2023			2024		
	No of Councils		**Geographical**	**No of Councils**		**Geographical**
Diseases	**Target**	**Reached**	**Coverage**	**Target**	**Reached**	**Coverage**
Lymphatic Filariasis	7	7	100%	2	2	100%
Onchocerciasis	29	29	100%	25	25	100%
Trachoma	9	9	100%	7	7	100%
Soil-Transmitted Helminthiases+	179	45	25%	179	155	87%
Schistosomiasis+	179	45	25%	155	150	97%

Source: NTDCP Report (2024)

+ The 5 urban councils in Dar es salaam region are excluded from MDA plan.

Figure 51:Trend in Geographical Coverage of Preventive Chemotherapy for PCT NTDs year 2023 and 2024
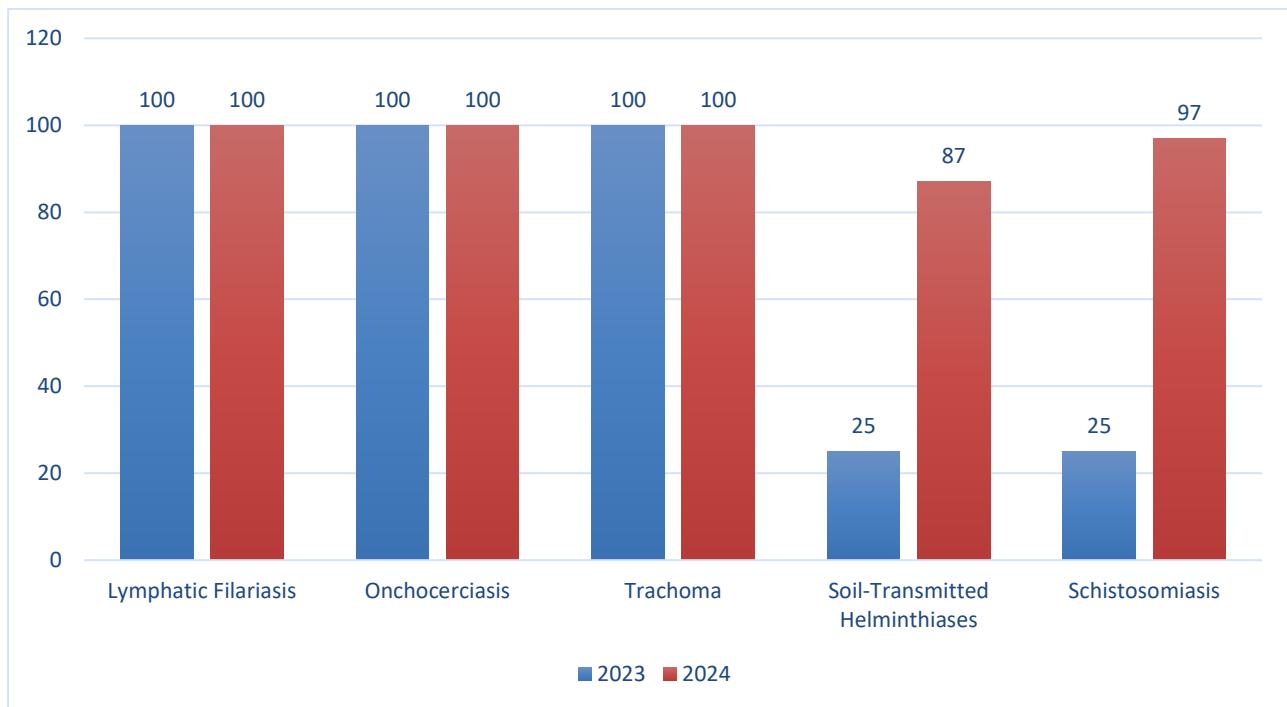
4.7.3. EPIDEMIOLOGICAL COVERAGE OF PREVENTIVE CHEMOTHERAPY

Table 31 shows the Mass Drug Administration epidemiological coverage reports for year 2024. The epidemiological coverage in 2024 was similar compared to 2023 in Trachoma and STH except the LF, Onchocerciasis, and Schistosomiasis although still is above minimum coverage threshold of 65%, 80% and 75% respectively.

Table 31:Trend in Epidemiological Coverage of Preventive Chemotherapy for selected NTDs year 2023 and 2024

Year	2023			2024		
	No of people		**Epi.**	**No of people**		**Epi.**
Diseases	**Population at risk**	**Treated**	**Coverage (%)**	**Population at risk**	**Treated**	**Coverage (%)**
Lymphatic Filariasis	962,687	909,569	95	331,521	257,243	78
Onchocerciasis	5,409,586	5,250,194	97	6,883,457	5,910,635	88
Trachoma	2,251,842	1,838,142	82	1,967,143	1,603,419	82
Soil-Transmitted Helminthiases*	3,634,940	3,170,887	88	10,145,972	8,931,365	88
Schistosomiasis*	2,716,317	2,334,753	86	7,734,005	6,345,744	82

Source: NTDCP Report (2024)

*The Epi. Coverage of Soil-Transmitted Helminthiases and Schistosomiasis MDA was calculated based on targeted school aged children (5-14 years) in geographical area reached with annual MDA.

Figure 52:Trend in Epidemiological Coverage of Preventive Chemotherapy year 2023 and 2024
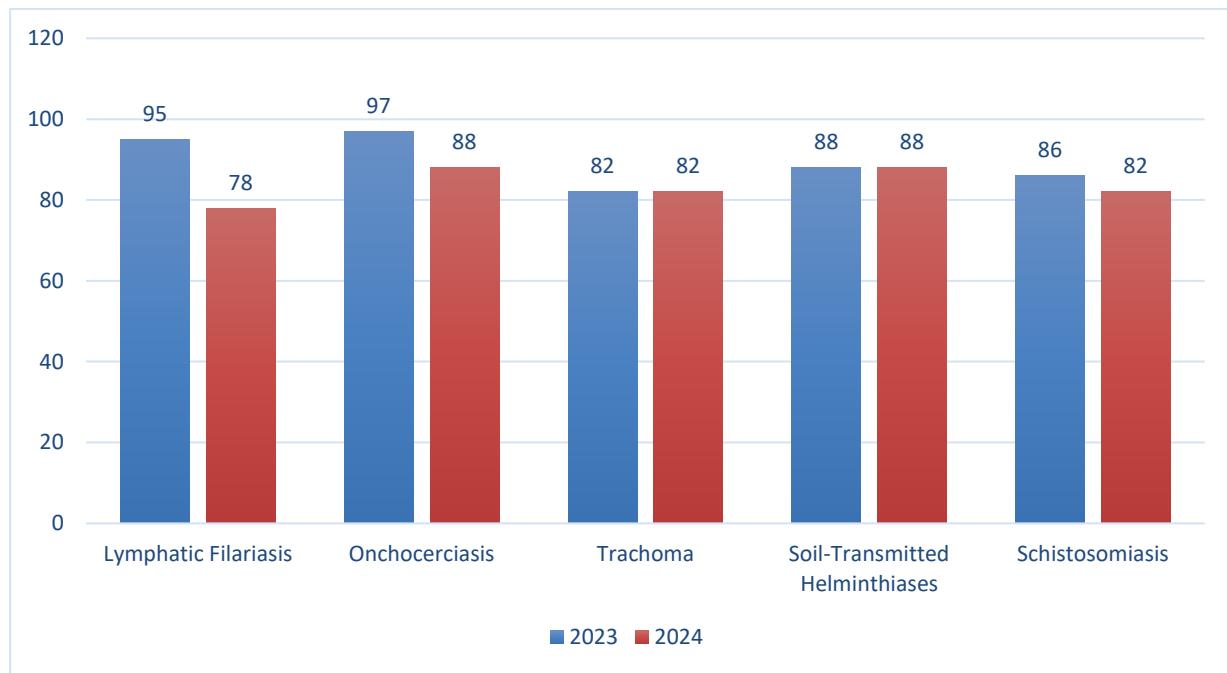
4.7.4. MORBIDITY MANAGEMENT AND DISABILITY PREVENTION SERVICES AND REPORTED CASES FOR NEGLECTED TROPICAL DISEASES YEAR 2023 AND 2024

Table 32. shows the morbidity management (MMDP) services provided against lymphatic filariasis and trachoma in the year 2023 and 2024. Number of people received hydrocele and TT surgeries increased in 2024 compared to 2023.

Table 32: Number of people received MMDP services and reported neglected tropical diseases cases year 2023 and 2024.

MMDP Services	2023			2024		
	Target	Received	%	Target	Received	%
Lymphatic Filariasis						
Hydrocele operated	1,200	1,358	113	1,200	1,772	148
Patients training for Lymphoedema management	400	32	8	400	40	10
Community Health Workers training for lymphoedema management	200	208	104	200	200	100
Trachoma						
TT treatment camp (Surgeries)	3,823	3,530	92	2,800	2,673	95
Eye surgical Entropion correction	4,000	2,869	72	3,500	2,729	78

Source: NTDCP Report (2024)

Table 33 shows the number of neglected tropical cases reported in the year 2023 and 2024. There has been a decrease in the number of OPD cases for Onchocerciasis, Schistosomiasis and Intestinal worms/STH - from 990 cases, 23,197 cases and 1,111,414 cases in 2023 to 476 cases, 22,667cases and 1,105,343 cases in 2024 respectively. However, in year 2024 there is increment of reported cases in Trachoma compared to year 2023.

Table 33:shows the number of neglected tropical cases reported in the year 2023 and 2024

Diseases		2023	2024

	Target	Reported Cases	Reported Cases
Trachoma TF	<500	759	873
Trachoma TT	<1,000	2,003	2,452
Onchocerciasis OPD	<500	990	476
Intestinal worms OPD	<1,000,000	1,111,414	1,105,343
Soil-Transmitted Helminthiases IPD	<2,000	2,772	2,747
Schistosomiasis OPD	<20,000	23,197	22,667
Schistosomiasis IPD	<500	945	763

Source: DHIS2 Report (2024)

Challenges

i. Inadequate resources and funding for morbidity management and disability prevention include surgery services to people with hydrocele, trachomatous trichiasis (TT), and manage lymphoedema.

ii. Inadequate funding for implementation and monitoring of 5 PCT NTDs Mass Drug Administration.

iii. Inadequate resources for implementation of programmatic NTDs impact surveys.

iv. Limited integration of non-routine/community NTD data in Unified Community System (UCS) and Composite Management Information System (CMIS) housed in DHIS2.

v. Persistent and/or recrudescence of NTDs in hotspots at endemic districts.

Policy Recommendations

i. Prioritizing and budgeting resources and funds for NTD Control Programme from both domestic and development partners.

ii. Integration of NTD interventions in the health system structure and strengthen of coordination and resources mobilization.

iii. Strengthening NTD monitoring & evaluation, operation research and surveillance for early detection of NTDs and any recrudescence.

CHAPTER FIVE

5.0. NON-COMMUNICABLE DISEASES

5.1. CHRONIC NON-COMMUNICABLE DISEASES

Non-communicable diseases (NCDs) represent a silent but escalating global health crisis. Unlike infectious diseases, NCDs are not contagious; they develop gradually and persist over time, often demanding lifelong attention and care. These conditions stem from a complex interplay of genetic predispositions, physiological changes, environmental exposures, and lifestyle behaviors. Once considered problems of high-income nations, NCDs are now increasingly prevalent in low- and middle-income countries, including Tanzania, where they pose serious threats to public health and national development. The growing burden of diseases such as cardiovascular disorders, diabetes, cancers, and chronic respiratory conditions is overwhelming already strained health systems and undermining economic progress. With rising morbidity, disability, and premature deaths, NCDs are not only medical challenges but also significant social and economic concerns that demand urgent, integrated, and sustained action.

5.2. KEY PERFORMANCE INDICATORS AND TARGETS

1. Adult 15-59 years with Hypertension who are on (successful) treatment by 60% in 2025
2. Adult 15-59 years with Diabetics who are on (successful) treatment by 25% and above by 2025
3. Cervical Cancer Screening coverage among women 30-50 years by 25% and above in 2025
4. Number of patients with SCD attended at OPD

Table 34: Indicators

Data/Period	2020	2021	2022	2023	2024
Number of clients with High Blood Pressure/Hypertension in OPD	1,171,840	1,345,866	1,393,836	1,602,774	1,758,881
Proportion of cardiovascular clients in OPD	0.4	0.48	0.5	0.5	0.6
Proportion of hypertension in OPD	2.7	3.2	3.4	3.2	3.7
Number of patients with Rheumatic Fever <15 in OPD	27,289	25,489	34,222	29,160	46,959
Diabetes case detection rate in OPD	0.91	1.1	1.1	1.2	1.3
Number of Diabetic clients in OPD	513,526	644,583	679,090	734,310	823,038
Number of sickle cell diseases patients in OPD	55,965	61,257	74,124	87,953	88,567
Proportion of sickle cell diseases patients in OPD	0.13	0.15	0.18	0.2	0.2

5.3. INDICATORS FOR TRACKING PERFORMANCES

1. Number of patients with Bronchial Asthma attended at OPD who are on (successful) treatment
2. Number of patients with Cancer attended at OPD.
3. Number of patients with Diabetes attended at OPD who are on (successful) treatment
4. Number of patients with Hypertension attended at OPD who are on (successful) treatment
5. Number of patients with SCD attended at OPD

5.4. TREND OF PROPORTION OF NCD AT OPD

The prevalence of non-communicable diseases (NCDs) has shown a steady increase since 2020, when patients with NCDs accounted for 11.5% of all outpatient department (OPD) visits. This upward trend continued, reaching 12.8% by 2024, as illustrated in Figure 53.

Figure 53:Proportion of trend of all NCD patient at OPD, 2020 to 2024
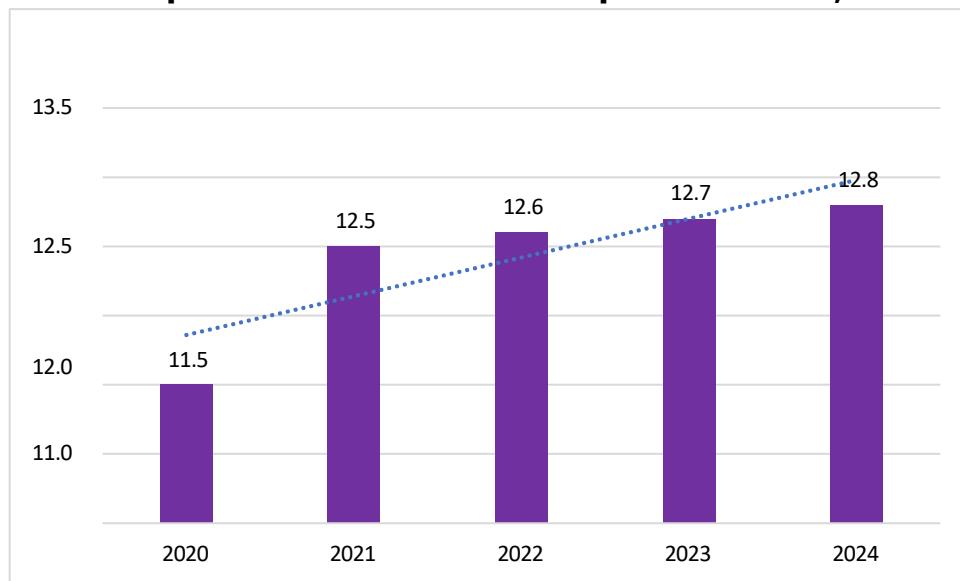
As illustrated in Figure 54, the number of reported cancer cases decreased significantly in 2024, totaling 55,845, compared to 59,138 cases in 2023. This decline may be attributed to early detection resulted from improvements in diagnostic screening techniques and the expansion of nationwide screening programs. Furthermore, the reduction could also reflect increased community awareness, likely driven by ongoing non-communicable disease (NCD) education and sensitization campaigns.

Figure 54:Trend of cases of Cancer in 2020 to 2024
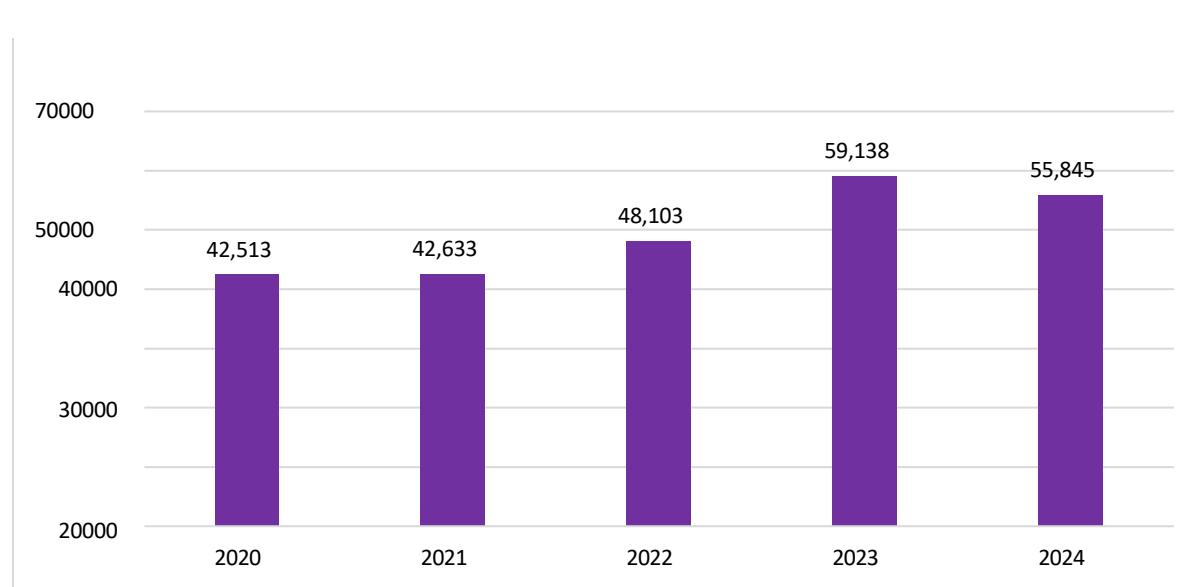
Source: DHIS2

Figure 55 illustrates a significant and consistent rise in Diabetes Mellitus cases over the five-year period from 2020 to 2024. The data shows a steady upward trend, indicating a continuous increase in the number of reported cases each year.

Figure 55:Trend of cases of Diabetes Mellitus in 2020 to 2024
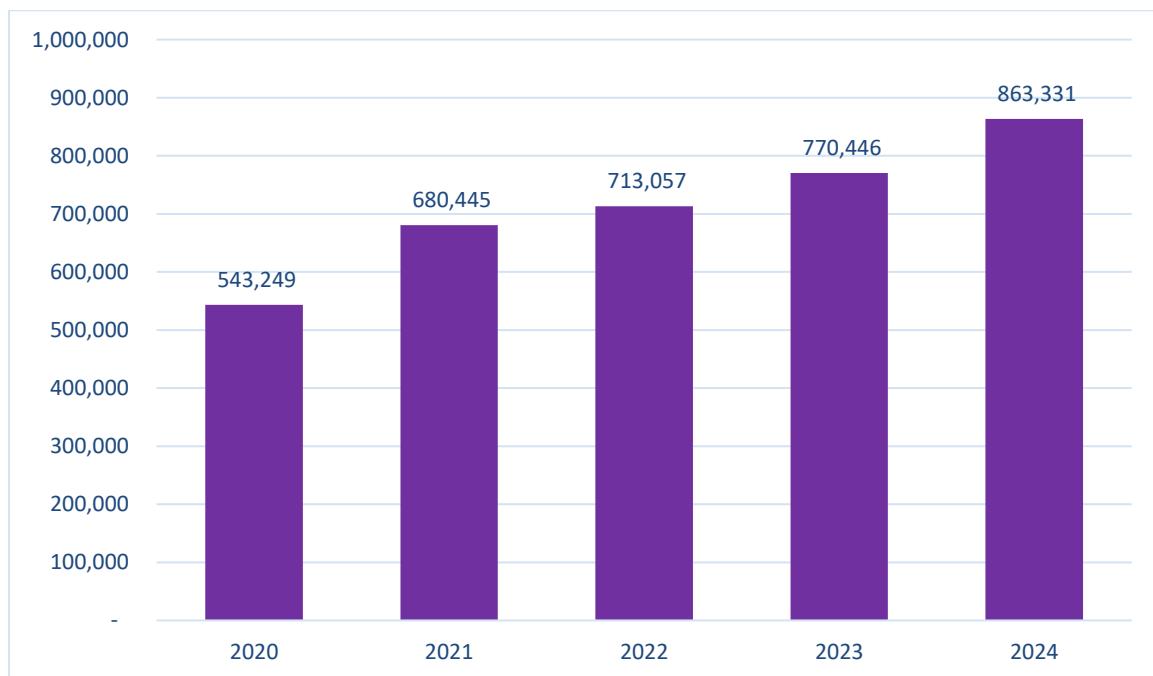
Source: DHIS2

Figure 56 shows a similar upward trend in hypertension cases, with a steady increase over time. In 2023, the number of reported cases was 1,668,046, which rose to 1,835,766 in 2024, reflecting a notable year-on-year rise.

Figure 56:Trend of cases of hypertension in 2020 to 2024
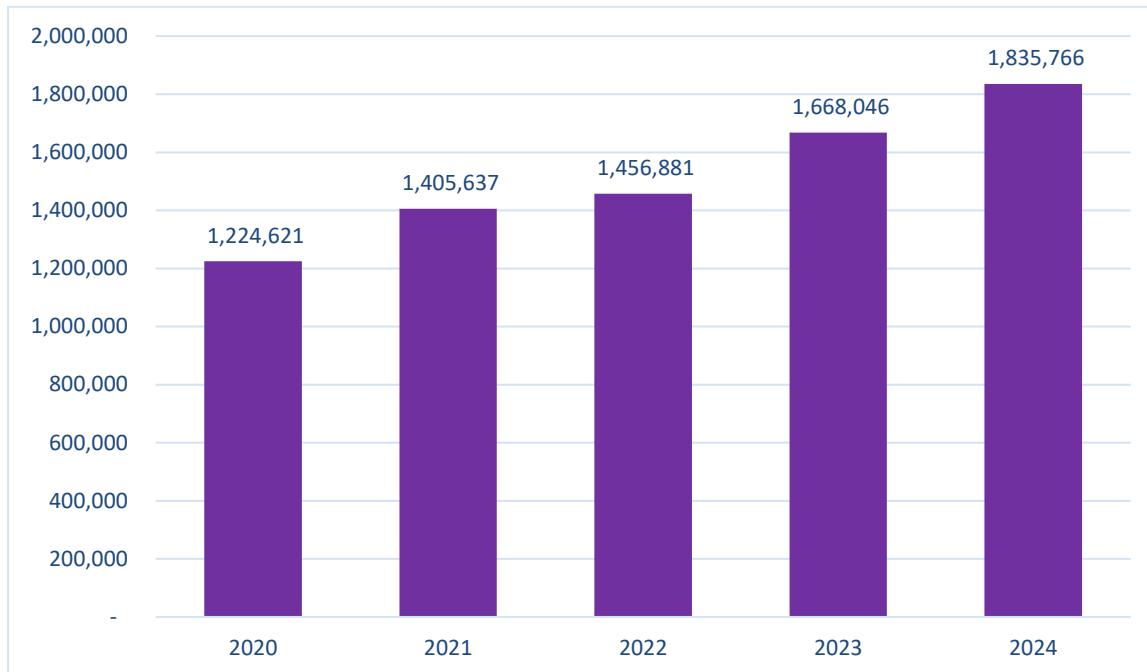
Source: DHIS2

CHAPTER SIX
6.0. EPIDEMICS AND DISASTER PREPAREDNESS AND RESPONSE
INTRODUCTION

The Ministry has been steadily putting various interventions in place to improve its capacity to prepare for, detect, respond to, and recover from epidemics and disasters in the country as well as to strengthen multisectoral collaborations and stakeholder engagement in disaster preparedness and response. Key functions like preparedness, detection, response, recovery, linkage and disaster management are closely coordinated by the Emergency Preparedness and Response Unit (EPRU) in collaboration with the individual regional and district health departments.

6.1. PREPARE

Tanzania continues to face a serious growing challenge of emerging and re-emerging diseases. This is Given its geographical location with Long porous international borders connecting eight (8) countries. The interconnection facilitates the movements of people, animals and other commercial goods across the official and porous borders, level of sanitation and the interconnected world, all this increases the opportunities for infectious diseases to emerge and spread globally.

Building the IHR core capacities to enable the country to prepare, promptly detect and respond to public health events, Tanzania joined the GHSA agenda in 2015, and in February 2016, Tanzania was the first country globally to volunteer to do a joint external evaluation (JEE) and the first to use the recommendations for priority actions from the JEE to develop a National Action Plan for Health Security (NAPHS) in 2017. Five years of implementation of the NAPHS have elapsed and the country has conducted the second Joint External Evaluation on August 2023.

The country's August 2023 joint External Evaluation has recorded a remarkable improvement in many technical areas supported by the Global Health Security Project. A total of 56 indicators were assessed, 41 scored demonstrated capacity (level 3-4) while two indicators from immunization scored sustainable capacity (level 5). The overarching strengths include high political commitment, good governance, and partnerships as shown in Table 35.

Table 35: Joint External Evaluation scores for Tanzania Mainland in 2023

Technical areas	Indicator number Indicator	Scores
Prevent		
P1. Legal instruments	P.1.1 Legal instruments	2
	P.1.2 Gender equity and equality in health emergencies	1
P2. Financing	P.2.1 Financing for IHR implementation	2
	P.2.2 Financing for public health emergency response	2
P3. IHR coordination, National IHR Focal Point functions and advocacy	P.3.1 National IHR Focal Point functions	3
	P.3.2 Multisectoral coordination mechanisms	4
	P.3.3 Strategic planning for IHR, preparedness or health security	4
P4. Antimicrobial resistance (AMR)	P.4.1 Multisectoral coordination on AMR	4
	P.4.2 Surveillance of AMR	4
	P.4.3 Prevention of MDRO	1
	P.4.4 Optimal use of antimicrobial medicines in human health	3
	P.4.5 Optimal use of antimicrobial medicines in animal health and agriculture	3
P5. Zoonotic disease	P.5.1 Surveillance of zoonotic diseases	2
	P.5.2 Response to zoonotic diseases	3
	P.5.3 Sanitary animal production practices	2
P6. Food safety	P.6.1 Surveillance of foodborne diseases and contamination	4

	P.6.2 Response and management of food safety emergencies	1
P7. Biosafety and biosecurity	P.7.1 Whole-of-government biosafety and biosecurity system is in place for human, animal, and agriculture facilities	2
	P.7.2 Biosafety and biosecurity training and practices in all relevant sectors (including human, animal, and agriculture)	3
P8. Immunization	P.8.1 Vaccine coverage (measles) as part of national program	5
	P.8.2 National vaccine access and delivery	4
	P.8.3 Mass vaccination for epidemics of VPDs	5
Detect		
D1. National laboratory systems laboratory	D.1.1 Specimen referral and transport system	4
	D.1.2 Laboratory quality system	3
	D.1.3 Laboratory testing capacity modalities	4
	D.1.4 Effective national diagnostic network	4
D2. Surveillance	D.2.1 Early warning surveillance function	4
	D.2.2 Event verification and investigation	3
	D.2.3 Analysis and information sharing	3
D3. Human resources	D.3.1 Multisectoral workforce strategy	2
	D.3.2 Human resources for implementation of IHR	3
	D.3.3 Workforce training	4
	D.3.4 Workforce surge during a public health event	1

Respond		
R1. Health emergency management	R.1.1 Emergency risk assessment and readiness	3
	R.1.2 Public health emergency operations centre (PHEOC)	3
	R.1.3 Management of health emergency response	4
	R.1.4 Activation and coordination of health personnel in a public health emergency	1
	R.1.5 Emergency logistic and supply chain management	4
	R.1.6 Research, development, and innovation	3
R2. Linking public health and security authorities	R.2.1 Public health and security authorities (e.g. law enforcement, border control, customs) are linked during a suspect or confirmed biological, chemical or radiological event	3
R3. Health services provision	R.3.1 Case management	4
	R.3.2 Utilization of health services	1
	R.3.3 Continuity of essential health services (EHS)	2
R4. Infection prevention and control (IPC)	R.4.1 IPC programs	3
	R.4.2 HCAI surveillance	3
	R.4.3 Safe environment in health facilities	3
R5. Risk communication and community engagement (RCCE)	R.5.1 RCCE systems for emergencies	3
	R.5.2 Risk communication	4
	R.5.3 Community engagement	3

IHR Related Hazards and Points of Entry and Border Health		
PoE: Points of entry and border health	PoE.1 Core capacity requirements at all times for PoEs (airports, ports and ground crossings)	3
	PoE.2 Public health response at PoEs	4
	PoE.3 Risk-based approach to international travel-related measures	4
CE. Chemical events	CE.1 Mechanisms established and functioning for detecting and responding to chemical events or emergencies	3
	CE.2 Enabling environment in place for management of chemical event	2
RE. Radiation emergencies	RE.1 Mechanisms established and functioning for detecting and responding to radiological and nuclear emergencies	3
	RE.2 Enabling environment in place for management of radiological and nuclear emergencies	3

Source: *JEE report 2023*

6.2. COUNTRY HEALTH RISK PROFILE ASSESSMENT

According to the Health Risk Profile Assessment conducted in September 2022, Tanzania was found to be prone to about 23 types of public health hazards and its associated health risks. Out of all 23 hazards, COVID-19 was ranked very high risk and 9 hazards with high risk which are Cholera/ Acute Watery Diarrhea, Pandemic Influenza, Earthquake, Storm, Ebola virus disease, Yellow Fever, Aflatoxicosis, Drought and Transportation accidents as shown in Table 36 and Table 37. The Health Risk Profile and risk calendar need to be updated in every two years.

Table 36:Country risk profile result for assessment conducted in 2022

Impact	Very Low	Unlikely	Probable	Very Low	Almost sure
Critical					
Severe		Tsunami	Pandemic Influenza; Earth Quake; Yellow Fever; Chemical agent; Transportation accidents	Cholera/Acute Watery Diarrhea; Storm; Ebola Virus disease	COVID-19
Moderate		Volcanic activity	Flood; Landslide; Monkeypox; Rift Valley fever; Radiation agents; Cyber-attack; Mining hazards	Aflatoxicosis; Drought	
Minor			Poliomyelitis	Plague; Anthrax	
Negligible					

Likehood

Table 37:Country risk calendar for assessment conducted in 2022

United Republic of Tanzania   Subnational area(s)   Assessment Date

Legend: No Seasonality | Lowest | Moderate | High | Peak

Specific Hazard	Risk level	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
COVID-19	Very high												
Cholera/ Acute Watery Diarrhea	High												
Pandemic Influenza	High												
Earthquake	High												
Storm	High												
Ebola virus disease	High												
Yellow fever	High												
Aflatoxicosis	High												
Drought	High												
Transportation accidents	High												
Plague	Moderate												
Anthrax	Moderate												
Flood	Moderate												
Landslide	Moderate												
Tsunami	Moderate												
Monkeypox	Moderate												
Rift Valley fever	Moderate												
Chemical agents	Moderate												
Radiation agents	Moderate												
Cyber attack	Moderate												
Mining hazards	Moderate												
Poliomyelitis	Low												
Volcanic activity	Low												

Source: *MoH. Strategic Risk Assessment Report, 2022*

6.3. REGIONAL PHEOC ESTABLISHMENT STATUS IN TANZANIA MAINLAND 2023

Tanzania Mainland has one National Public Health Emergency Operation Centre (PHEOC) at the Ministry of Health headquarters. To enhance preparedness and strengthen coordination during outbreaks and epidemics at the sub-national level, ongoing efforts are focused on scaling up the establishment of Regional Public Health Emergency Operation Centres (RPHEOCs).

As of 2024, a total of twenty (20) RPHEOCs have been established across twenty (20) regions in the Tanzania Mainland. The initiative began in 2020 with the establishment of four (4) RPHEOCs in Kigoma, Kagera, Mwanza, and Dar es Salaam. In 2022, two (2) additional centers were set up in Arusha and Kilimanjaro. This was followed by five (5) more RPHEOCs in 2023 in Iringa, Songwe, Katavi, Dodoma, and Mtwara. In 2024, four (4) new centers were established in Manyara, Tabora, Morogoro, and Lindi, as illustrated in Figure 58.

These efforts have been made possible with support from partners including the U.S. Centers for Disease Control and Prevention (US-CDC), Africa CDC, the World Health Organization (WHO), and the Global Fund.

In addition to infrastructure development, continuous training on Public Health Emergency Management (PHEM) and the Incident Management System (IMS) has been provided to core PHEOC staff in 18 regions, along with emergency simulation exercises. However, there is a need to cascade this training to the council level for broader capacity building.

Furthermore, Intra-Action Reviews (IARs) and After-Action Reviews (AARs) have been conducted for various health threats, including Ebola, Marburg, Mpox, cholera, and Rift Valley Fever (RVF). To guide these initiatives, comprehensive guidelines for the establishment and operationalization of regional PHEOCs have also been developed.

Figure 57: Regional PHEOC Establishment Status from 2020 to 2024, Tanzania Mainland
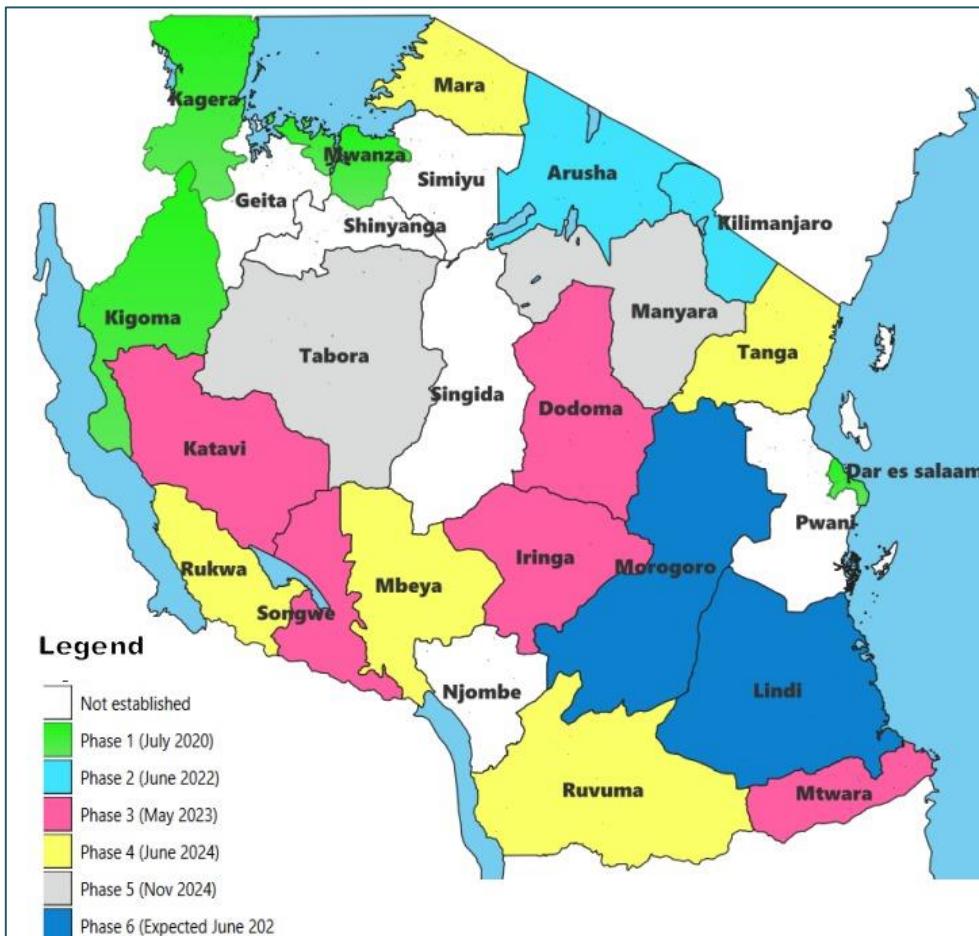
6.4. DETECT

Tanzania has implemented the electronic Integrated Disease Surveillance and Response (eIDSR) system across all 26 regions, covering approximately 35 priority diseases under the IDSR strategy, including selected Extremely Dangerous Pathogens (EDPs). This system has significantly improved the timeliness of outbreak detection and response, reducing the average response time from 72 hours to between 24 and 48 hours.

To strengthen early warning capabilities, an electronic Event-Based Surveillance (eEBS) system has been developed to support real-time alert reporting from all levels, starting from the community level. This system is currently being piloted in five regions—Arusha (Ngorongoro), Mbeya, Katavi, Mara, and Kagera.

The eIDSR system has also been enhanced with the integration of an Outbreak Management and Contact Tracing module, enabling a more efficient and coordinated response to disease outbreaks when they occur.

To support data sharing and communication, Tanzania has established a National Public Health Bulletin, which complements existing weekly and monthly surveillance bulletins. These platforms facilitate the dissemination of information on disease surveillance, outbreak response activities, and feedback to stakeholders.

Despite these advancements, challenges remain, particularly in supporting outbreak investigations, scaling up the implementation of event-based surveillance, and operationalizing the National Alert Desk. There is also a need to deploy dedicated volunteers to the Alert Desk to support triage and verification of alerts from various sources.

6.5. LINKAGES

To enhance coordination and collaboration during disasters, the Ministry engages with various partners, drawing on their technical expertise, skills, and experience to promote synergy and improve the effectiveness of implementation for better outcomes. Capacity-building initiatives are ongoing, with the involvement of PORALG in training trainers (TOTs) at the sub-national level to ensure broader reach at grassroots levels. Additionally, the Ministry works closely with the One Health Coordination Desk (OHCD) under the Prime Minister's Office to bring together multiple stakeholders in advancing a One Health approach to preparedness, detection, and response to public health emergencies. Prioritizing the mapping of key stakeholders and assessing their capacities is essential, with resource tracking tools playing a vital role in maintaining up-to-date information on available resources.

6.6. EMERGING AND RE-EMERGING DISEASES

Tanzania continues to face significant public health challenges from both emerging and re-emerging infectious diseases. Several diseases that have emerged in Tanzania include HIV/AIDS (the 1980s), Rift Valley fever (2007, 2008, 2009), dengue fever (2010), multi-drug resistant TB (2007–2010), COVID-19 (2020 – 2021) and Leptospirosis (2022), Marburg Virus Disease (MVD) (2023) (2025), Cholera (September 2023-Current), Emerging diseases such as COVID-19 and Mpox (Monkeypox) have highlighted the need for strong surveillance and rapid response systems. At the same time, re-emerging diseases like cholera, dengue fever, Rift Valley Fever (RVF), and viral hemorrhagic fevers such as Ebola and Marburg persist as recurring threats, often linked to climatic changes, cross-border movement, and human-animal interactions.

The country's diverse ecosystems and increasing urbanization contribute to the risk of zoonotic disease outbreaks. Factors such as population mobility, weak sanitation infrastructure in some

areas, and climate variability further exacerbate vulnerability. Tanzania's commitment to a One Health approach integrating human, animal, and environmental health remains key in addressing these complex threats.

Through strengthened surveillance systems like eIDSR, improved laboratory capacity, public health emergency operations, and intersectoral collaboration, Tanzania is working to detect, respond to, and manage these diseases more effectively. However, continued investments in preparedness, early warning systems, and community-level engagement are crucial to reduce the impact of emerging and re-emerging diseases on public health and development.

Implemented Interventions and Achievements Attained in 2024

i. Responded against deadly Marburg Virus Diseases in Biharamulo District, Kagera Region (March 2024).

ii. Establishment of Public Health Emergency Operations Centres of Manyara, Tabora, Morogoro, and Lindi.

iii. Advocacy sessions on PHEOC to Regional Administrative Secretaries (RAS), Regional Health Management Teams (RHMTs), and PHEOC staff in four (4) Regions of Manyara, Tabora, Morogoro, and Lindi.

iv. Orientation sessions on PHEOC and Incident Management System (IMS) to Incident Managers of 7 Regions (Mara, Tanga, Mbeya, Rukwa, Ruvuma, Lindi and Morogoro)

v. Responding to Cholera Outbreak in 23 Regions (September 2023- Current)

vi. Establishment of twenty (20) Public Health Emergency Operation centres (PHEOC) and training of staff who would be working in those centres

vii. Procurement of 603 special medical Emergency response bags for paramedics in all 26 regions with medical suppliers and medicines for trauma and other medical emergencies (Activity on progress)

viii. 270 community volunteers were trained, including the police force, SUMA JKT, Fire and rescue brigade on first aid.

ix. Procurement and installation of 50 first aid Kits for Ministry of Health vehicles to provide emergency medical services during medical emergencies or trauma while travelling or during an event.

x. Development of a plan for operationalization of EMS services (Draft in place).

xi. Development of a Trauma Module and integration into a National Emergency Medical System (NEMS) by using 115 as a Toll-free number. Online training for the regional dispatchers done.

xii. Coordination of the distribution of the procured ambulances across the country

xiii. Establishment of the skills training centre in Benjamin Mkapa Hospital (BMH), KCMC, and MNH for emergency care training for both in-hospital and pre-hospital

services, especially emergency care departments (EMD) and Emergency Medical Services (EMS) (drivers, bodaboda, Police, Special community groups).

xiv. Establishment of a trauma registry to be used in all emergency departments and incorporated into the hospital management systems.

xv. Completed community driver's application to be used for emergency transportation of causes related to pregnant women and children from the community to the facility

xvi. Distributed 368 ambulances in all regions at the level of Council level, and the distribution plan for the rest of the country is complete.

Interventions done in 2024

Coordination of preparedness interventions in responding to emergency events:

i. Orientation sessions on PHEOC and Incident Management System (IMS) to 40 core PHEOC staff of Kigoma and Kagera Regions.

ii. Endorsement of guidelines for establishing a Public Health Emergency Operations Centre at Regional Levels, Mpox Response Plan, and National Guideline for the management of Mpox Disease.Printing and distribution of 20,000 copies of the Mpox National Guideline to 26 regions

iii. Capacity building of case management and IPC through virtual and physical trainings to 1,150 Health care workers from Geita, Morogoro, Katavi, Mbeya, Ruvuma, and Tanga regions

6.7. PUBLIC HEALTH EMERGENCY PREPAREDNESS RESILIENCE

Over the past decade, the importance of resilience, public health emergency preparedness and response operations has gained significant attention in the global health community. In Tanzania, where public health emergencies have posed significant challenges, efforts have been made to establish structures like the Public Health Emergency Operating Centre (PHEOC), EMDs, ICUs, and EMS. This also includes strengthening the health system to facilitate efficient response, like the establishment of Oxygen Plants to ensure accessibility of oxygen to all who need it, improving diagnostic services through the provision of MRI, CT Scan, Ultra-sound and digital X-Rays etc

6.7.1. STATE OF EMERGENCY AND CRITICAL CARE IN THE COUNTRY

The sixth phase government under the leadership of Hon. President Dr. Samia Suluhu Hassan has continued to strengthen emergency medical services. In 2022, there were 700 EMD beds in 7 EMD centers nationwide. By 2023, the number of EMD beds increased to 1,684 in 116 EMD

centers, including 82 newly established EMD departments in council hospitals from 2022 to 2023. As of June 2024, a total of 124 out of 228 government hospitals equivalent to 55%—had functioning EMDs.

Additionally, the number of ambulances has increased from 761 in December 2022 to 1,167 in June 2024.

Before 2022, only eight public ICUs were available, with 183 ICU beds, far below the WHO's recommendation of 8,500 beds for critically ill patients. The government then constructed 44 new ICU buildings, increasing the number of ICU beds to 988. This expansion, including new facilities at national, zonal, special, and regional referral hospitals, significantly boosted the country's capacity to manage medical emergencies, demonstrated effectively during the Katesh landslide and floods.

Essential services like Emergency Medicine departments, led by emergency physicians, along with intensive care units, theaters, x-ray, CT scan, and a blood bank, underscored the hospital's capacity to handle various medical emergencies. X-ray and CT scans facilitated rapid diagnosis, while emergency departments with efficient triage systems, and staff training in emergency response protocols provided immediate care. Intensive care units and theatres were crucial for managing severe injuries, allowing timely surgical interventions and the presence of a blood bank ensured vital blood transfusions.

6.7.2. AMBULANCES FOR PRE-HOSPITAL EMERGENCY MEDICAL SERVICES (EMS) AND REFERRALS

In 2022, a nationwide assessment of ambulances was conducted to evaluate the status of pre-hospital Emergency Medical Services (EMS) and referral systems, in line with existing guidelines and standards. The assessment revealed that the Tanzania Mainland had a total of 761 ambulances. Of these, 221 ambulances (29%) were non-functional, leaving only 540 (71%) operational. This represented just 39.7% of the total estimated national requirement of 1,361 ambulances.

Among the functional ambulances, 81 (15%) were classified as Basic Life Support (BLS), 12 (2%) as Advanced Life Support (ALS), and the remaining 447 (83%) were categorized as transport vans due to the absence of essential medical equipment such as oxygen supplies, medical lockers, and other standard items required for basic ambulance functionality.

In 2023, a total of 613 new ambulances were procured through collaborative efforts between the Ministry of Health and the President's Office Regional Administration and Local Government (PORALG). These included 393 ambulances funded through the International Monetary Fund (IMF), 210 through the Global Fund, and 10 donated by the Government of India. As a result,

the number of functional ambulances increased to 1,153, improving ambulance availability from approximately 40% to 84.7% of the national requirement. The number of BLS ambulances rose from 528 in 2022 to 1,071 in 2023, while ALS ambulances increased from 12 to 82, as reflected in Table 38.

In 2024, an additional 46 ambulances were procured through the Global Fund, with distribution currently underway. This brings the total number of ambulances procured between 2022 and 2024 to 1,199 equivalent to a 48% increase in ambulance availability, raising national coverage from 40% in 2022 to 88% by 2024.

Table 38: Ambulance Status from 2022/23 to 2024/2025

Type of Ambulance	Functional during the 2022 assessment	New in 2023	New 2024	Total in 2024
Basic Ambulance (BLS)	528	543	46	1,117
Advanced Ambulance (ALS)	12	70	0	82
Total	**540**	**613**	**46**	**1,199**

6.7.3. DEVELOPED NATIONAL EMERGENCY MEDICAL SERVICES FOR OPERATING EMERGENCIES

- The Trauma module and ambulance management module have been incorporated into the national emergency medical services system (NEMS). Therefore, the system can now coordinate emergency care and referrals for all kinds of emergencies
- The Drivers application (*Drivers App*) has been developed and linked with the NEMS for real-time identification of drivers, and dispatching them (community and Ambulance drivers). The application also works for private ambulances, in case the private ambulance operators are to be incorporated into the system.
- The procurement of Ambulance trackers for 300 Ambulances is in progress; this is part of the institutionalisation of the National Emergency Medical Services system.

6.7.4. STATE OF HUMAN CAPITAL FOR EMERGENCY PREPAREDNESS AND RESPONSE

i. The Ministry has continued to provide training to the available HCWs at Health facilities to build capacity to be able to provide hospital out-of-hospital services

(EMS). A total of 809 experts (Clinicians 214, Nurses 325, Health Officers, Police & Fire and rescue brigade 125, and SUMA JKT guards 20) were trained.

ii. The Ministry conducted preparedness training for council and regional teams, with a particular focus on regions that are geographically at high risk. A total of 3,264 service providers from 30 councils received training to enhance their capacity to respond effectively to emergencies and disasters.

iii. In collaboration with partners, the Ministry has also strengthened Regional Public Health Emergency Operation Centres (RPHEOCs). Four new RPHEOCs have been established in the regions of Manyara, Tabora, Morogoro, and Lindi, equipped with essential supplies and staffed with 60 trained personnel. This brings the total number of operational RPHEOCs in the Tanzania Mainland to twenty (20). Additionally, the National Public Health Emergency Operation Centre has been upgraded with improved ICT infrastructure to enhance coordination and response capacity at the national level.

iv. Furthermore, the Ministry, in partnership with stakeholders, coordinated six (6) emergency preparedness simulation exercises to test and strengthen outbreak response mechanisms. These exercises involved the regions of Geita, Kigoma, Katavi, Rukwa, Dodoma, Dar es Salaam, and Arusha.

6.7.5. CHALLENGES THAT HINDERED TARGETS FROM BEING ACHIEVED

i. Increase in Epidemics and Disasters in the country.
ii. Shortage of Human resources and medical equipment to cover all designated and new health facilities
iii. Inadequate skills and knowledge of HCWs in managing critically ill patients and those who require oxygen therapy.
iv. Shortage of HIDU, especially in high-risk regions
v. Limited Financial support to strengthen preparedness interventions nationwide

CHAPTER SEVEN
7.0. CIVIL REGISTRATION AND VITAL STATISTICS
INTRODUCTION

This Civil Registration and Vital Statistics (CRVS) chapter provides a detailed analysis of the registration status of vital events (births and deaths) along with causes of death statistics for the year 2024. This section thoroughly examines three major areas: birth registration, death registration, and causes of death data.

7.1. BIRTH REGISTRATION
7.1.1. SUMMARY STATISTICS OF BIRTHS REGISTERED

Table 39 summarizes registered births between 2023 and 2024 regardless of the age at which the registration took place. The results reveal an increase in registered births from 1,279,946 in 2023 to 1,682,214 in 2024, indicating positive progress in the CRVS system. However, continued efforts are needed to improve coverage and ensure the entire population is registered and issued birth certificates. Of the births registered in 2023-24, most were for children under age five, the group targeted by U5BRI, which was implemented in 26 regions of Mainland Tanzania. The slight improvement in birth registration observed in 2024 was partly attributed to linking birth certificates with other citizen entitlements such as National ID, higher education loans, passports, etc. These results highlight the importance of linking birth registration certificates with other governmental services to increase the perceived value of birth registration.

Table 39: Summary of Registered Births by Specific Age Group and Sex

Age Group	2023			2024		
	Male	Female	Total	Male	Female	Total
Total	**654,922**	**625,024**	**1,279,946**	**864,112**	**818,102**	**1,682,214**
0-4	391,986	409,812	801,798	548,312	561,398	1,109,710
5-17	67,175	71,183	138,358	77,902	81,106	159,008
18-25	138,408	99,896	238,304	160,439	115,035	275,474
26+	57,353	44,133	101,486	77,459	60,563	138,022

Source: CRVS system 2024

7.1.2. BIRTH REGISTRATION COMPLETENESS RATE

Table 40. presents the number of registered births and levels of completeness by regions in Mainland Tanzania, from 2023 to 2024. The data indicate that the percentage of births registered within the year of occurrence remained relatively low, at approximately 12 percent in both two years. This suggests a persistent gap in achieving full birth registration completeness in Mainland Tanzania. This indicates a major challenge in ensuring that all births are promptly recorded, which can have long-term consequences for national data accuracy and social services.

In 2024, the completeness of birth registration was higher in Dar es Salaam (30.5%) and Iringa (26.0%) regions. On the other hand, birth registration completeness was low in Tabora (1.7%) and Rukwa (3.3%) regions. The comparisons suggest that more targeted efforts are needed to improve birth registration, especially in regions with extremely low completeness. Nevertheless, it is important to point out technical and logistical factors that contribute to low levels of completeness. Oftentimes, due to network disruptions, malfunctions in mobile registration steps, financial constraints and coordination difficulties, events that are recorded may fail to be effectively uploaded and registered in the civil registration system. Such events may be registered eventually, but not within a year of their actual occurrence.

Table 40: Completeness of Birth Registration by Region

Region of Occurrence	2023			2024		
	Estimated Births	Number registered	Completeness (%)	Estimated Births	Number registered	Completeness (%)
Mainland Tanzania	**2,203,244**	**266,031**	**12.1**	**2,215,146**	**264,571**	**11.9**
Dodoma	110,198	5,065	4.6	110,617	11,058	10
Arusha	82,414	9,081	11	81,487	12,768	15.7
Kilimanjaro	57,837	4,314	7.5	57,676	10,295	17.8
Tanga	89,742	6,228	6.9	89,891	7,077	7.9
Morogoro	107,580	7,670	7.1	106,671	16,513	15.5
Pwani	69,267	4,450	6.4	68,262	12,740	18.7
Dar es Salaam	181,230	80,389	44.4	177,350	54,056	30.5
Lindi	35,592	536	1.5	34,965	4,822	13.8
Mtwara	50,837	2,475	4.9	50,062	8,792	17.6
Ruvuma	64,168	3,812	5.9	63,615	3,717	5.8
Iringa	38,019	1,939	5.1	37,556	9,758	26
Mbeya	81,649	11,499	14.1	80,933	11,444	14.1
Singida	74,309	1,589	2.1	75,604	10,054	13.3
Tabora	133,988	4,305	3.2	136,650	2,299	1.7
Rukwa	69,183	2,541	3.7	70,843	2,305	3.3
Kigoma	98,467	52,397	53.2	100,691	10,892	10.8
Shinyanga	86,619	1,640	1.9	87,699	7,152	8.2
Kagera	116,496	41,641	35.7	118,096	6,930	5.9
Mwanza	143,965	3,635	2.5	145,293	10,905	7.5
Mara	94,178	6,547	7	96,246	7,847	8.2
Manyara	70,251	3,644	5.2	71,231	6,428	9
Njombe	27,811	507	1.8	27,454	6,133	22.3
Katavi	50,031	529	1.1	51,121	2,690	5.3
Simiyu	92,387	1,083	1.2	95,301	18,434	19.3
Geita	125,764	4,385	3.5	128,425	4,924	3.8
Songwe	51,262	2,607	5.1	51,407	4,538	8.8

Source: CRVS system 2024

7.1.3. TIMELINESS OF BIRTH REGISTRATION

The proportion of births that were registered and certified within 90 days decreased from 53.8 percent in 2023 to 40 percent in 2024 (Table 41). The results also show that in 2024, regions that performed well in terms of the timeliness of registration are Dar es Salaam with 82.2 percent, followed by Kigoma with 61.1 percent region. Regions reporting the lowest levels of

timeliness in 2024 were Shinyanga 10.3 percent and Singida 15.7 percent. Despite decentralization of birth registration up to ward and health facility levels, many regions still struggle to register birth events within the legal timeframe. The decline of the timeliness suggests significant challenges in the efficiency of the CRVS system. The delay in uploading records into the system is a primary factor, highlighting potential gaps in the infrastructure or processes that support timely data entry.

Table 41: Timeliness of Birth Registration and Certification

Region	2023			2024		
	Within 90 days (%)	After 90 days (%)	Total	Within 90 days (%)	After 90 days (%)	Total
Mainland Tanzania	**53.8**	**46.2**	**264,506**	**40.0**	**60.0**	**264,571**
Dodoma	26.0	74.0	5,066	31.3	68.7	11,058
Arusha	79.6	20.4	9,081	37.2	62.8	12,768
Kilimanjaro	48.9	51.1	4,314	51.7	48.3	10,295
Tanga	79.6	20.4	6,227	41.9	58.1	7,077
Morogoro	39.2	60.8	7,670	21.5	78.5	16,513
Pwani	56.0	44.0	4,450	30.1	69.9	12,740
Dar es Salaam	63.4	36.6	80,389	82.8	17.2	54,056
Lindi	55.5	44.5	535	17.6	82.4	4,822
Mtwara	32.6	67.4	2,474	18.9	81.1	8,792
Ruvuma	73.8	26.2	3,812	26.8	73.2	3,717
Iringa	77.0	23.0	1,939	27.8	72.2	9,758
Mbeya	78.5	21.5	11,499	24.7	75.3	11,444
Singida	29.2	70.8	1,589	15.7	84.3	10,054
Tabora	57.8	42.2	4,611	42.5	57.5	2,299
Rukwa	42.1	57.9	2,541	43.2	56.8	2,305
Kigoma	40.7	59.3	52,398	61.1	38.9	10,892
Shinyanga	46.0	54.0	1,334	10.3	89.7	7,152
Kagera	42.5	57.5	41,641	36.5	63.5	6,930
Mwanza	60.9	39.1	3,635	30.2	69.8	10,905
Mara	26.9	73.1	6,547	21.4	78.6	7,847
Manyara	73.8	26.2	3,644	19.0	81.0	6,428
Njombe	58.8	41.2	507	23.2	76.8	6,133
Katavi	68.8	31.2	529	49.4	50.6	2,690
Simiyu	23.9	76.1	1,082	18.5	81.5	18,434
Geita	36.9	63.1	4,385	28.4	71.6	4,924
Songwe	86.3	13.8	2,607	19.5	80.5	4,538

Source: CRVS system 2024

7.1.4. BIRTH REGISTRATION COVERAGE AND CERTIFICATIONS FOR CHILDREN 0-4 YEARS (UNDER-FIVE BIRTH REGISTRATION)

In Table 42. reveals the birth registration completeness for under-five years of age in the years 2023 and 2024. There was a concerning trend in under-five birth registration coverage decrease from 43.8 percent in 2023 to 41.1 percent in 2024 and this might be attributed to the aging of the under-five registered children into the 5-17 age group.

Table 42:Birth Registration Coverage and Certifications for Children 0-4 Years

Region	2023			2024		
	0-4 Years	0-4 Births registered[1]	Percent	0-4 Years	0-4 Births registered[2]	Percent
Mainland Tanzania	**10,374,918**	**4,542,512**	**43.8**	**10,726,740**	**4,407,526**	**41.1**
Dodoma	519,408	201,948	38.9	537,664	202,188	37.6
Arusha	400,635	197,801	49.4	409,307	197,837	48.3
Kilimanjaro	258,431	122,817	47.5	272,706	122,618	45.0
Tanga	421,250	184,040	43.7	437,575	184,143	42.1
Morogoro	511,021	229,561	44.9	525,395	228,402	43.5
Pwani	306,317	111,387	36.4	320,482	110,859	34.6
Dar es Salaam	740,531	549,809	74.2	794,755	547,508	68.9
Lindi	169,459	99,182	58.5	175,144	99,237	56.7
Mtwara	228,173	99,177	43.5	238,796	99,085	41.5
Ruvuma	296,954	91,271	30.7	308,823	91,287	29.6
Iringa	176,813	70,238	39.7	181,627	70,057	38.6
Mbeya	387,330	121,542	31.4	397,533	121,205	30.5
Singida	373,717	149,561	40.0	381,584	149,808	39.3
Tabora	673,607	255,895	38.0	682,584	232,328	34.0
Rukwa	315,205	92,039	29.2	329,422	93,635	28.4
Kigoma	492,629	319,986	65.0	504,858	318,323	63.1
Shinyanga	421,051	82,434	19.6	429,384	82,467	19.2
Kagera	550,521	333,981	60.7	570,036	334,132	58.6
Mwanza	671,597	286,544	42.7	695,473	286,433	41.2
Mara	440,880	192,519	43.7	457,491	192,541	42.1
Manyara	350,208	181,776	51.9	358,976	182,058	50.7
Njombe	127,683	60,478	47.4	131,650	60,436	45.9

Region	2023			2024		
	0-4 Years	0-4 Births registered[1]	Percent	0-4 Years	0-4 Births registered [2]	Percent
Katavi	242,301	22,066	9.1	247,874	46,368	18.7
Simiyu	447,749	168,228	37.6	461,193	168,435	36.5
Geita	604,312	126,079	20.9	623,098	126,206	20.3
Songwe	247,136	59,855	24.2	253,310	59,930	23.7

Source: CRVS system 2024

7.2. DEATH REGISTRATION

This section presents data on deaths registered in Tanzania Mainland for years 2023 and 2024. Just like births, death registration has been taking place since the German era and later British rule in 1921, where at that time the registration was guided and managed by the Births and Deaths Registration Act (Cap. 108 R.E 2002). Table 43. below presents summary statistics of deaths registered at the national level from 2023 to 2024. Registered deaths increased from 34,224 in 2023 to 39,089 in 2024. Overall, the results show that the more deaths were registered for males than for females among all age groups in 2023 and 2024.

Table 43:Summary Statistics on Registered Deaths

Age group	Year and Sex					
	2023			2024		
	Male	Female	Total	Male	Female	Total
Mainland Tanzania	**23,730**	**10,494**	**34,223**	**27,602**	**11,487**	**39,089**
0-4	597	483	1,080	621	476	1,097
5-17	278	209	487	263	177	440
18-25	438	341	779	495	370	865
25+	22,416	9,461	31,877	26,223	10,464	36,687

Source: CRVS System 2024

7.2.1. DEATH REGISTRATION COMPLETENESS RATE

The completeness rate of death registration was calculated to assess system improvements and enable the adjustments that are used when calculating mortality indicators. The computation of completeness is based on the number of registered deaths in a particular period divided by the expected number of deaths for that period, based on projections derived from analysis of data from the 2022 Tanzania Population and Housing Census.

As presented in Table 44, the completeness of death registration in 2024 was at 3.2 percent, which is lower than the 4.4 percent recorded in 2023. This indicates that there has been little improvement in capturing death events in Mainland Tanzania which is essential for generating accurate mortality data in health planning and policymaking. Table 42 also presents the total number of registered deaths and levels of completeness by region of residence in Mainland Tanzania. Analysis at the regional level for 2024 indicates that levels of death registration completeness was Dar es Salaam (8.9%), Arusha (5.6%), Iringa (8.5%) and Kilimanjaro (5.5%). Efforts should be intensified to understand and address the factors undermining death registration.

Table 44: Completeness of Death Registration by Region

Region	2023			2024		
	Estimated Deaths	Registered death	Completeness (%)	Estimated Deaths	Registered death	Completeness (%)
Mainland Tanzania	**336,905**	**14,744**	**4.4**	**415,458**	**13,170**	**3.2**
Dodoma	12,671	730	5.8	21,419	609	2.8
Arusha	6,160	666	10.8	10,075	563	5.6
Kilimanjaro	10,903	934	8.6	14,156	781	5.5
Tanga	13,384	895	6.7	18,377	672	3.7
Morogoro	13,384	716	5.3	21,870	591	2.7
Pwani	7,920	583	7.4	15,612	409	2.6
Dar es Salaam	40,623	4,619	11.4	35,568	3,152	8.9
Lindi	6,250	258	4.1	9,239	240	2.6
Mtwara	9,069	408	4.5	13,538	247	1.8
Ruvuma	9,779	420	4.3	14,418	360	2.5
Iringa	9,752	132	1.4	11,148	947	8.5
Mbeya	15,451	180	1.2	19,016	361	1.9
Singida	9,673	282	2.9	11,949	257	2.2
Tabora	18,758	392	2.1	23,046	320	1.4
Rukwa	8,381	182	2.2	11,560	144	1.2
Kigoma	16,475	468	2.8	16,217	631	3.9
Shinyanga	8,758	390	4.5	15,711	333	2.1
Kagera	24,769	251	1.0	24,512	489	2.0
Mwanza	18,221	848	4.7	22,960	899	3.9
Mara	14,374	485	3.4	17,043	372	2.2
Manyara	10,125	242	2.4	9,780	204	2.1
Njombe	6,940	120	1.7	9,345	93	1.0
Katavi	7,753	37	0.5	8,670	55	0.6
Simiyu	12,489	199	1.6	12,696	183	1.4
Geita	16,970	245	1.4	16,900	189	1.1
Songwe	7,873	62	0.8	10,633	69	0.6

Source: Data from CRVS System 2024

7.2.2. TIMELINESS OF DEATH REGISTRATION

The timeliness of death registration and certification within 30 days of the event in Mainland Tanzania was 59.7 percent in 2023 and 59.6 percent in 2024 (Table 45). This points out the room for improvement in ensuring more timely death registration in Mainland Tanzania. In 2024, the timeliness of death registration was highest in Iringa (90.4%) and Dar es Salaam (77.1%) regions. On the other hand, late death registration (after 30 days) was especially prominent in Songwe (75.4%), Mtwara (69.2%) and Katavi (69.1%) regions. The significant regional variations in death registration timeliness highlight disparities in the effectiveness of the CRVS system across different regions.

Table 45:Timeliness of Death Registration by Region

Region	2023			2024		
	Within 30 days (%)	After 30 days (%)	Total	Within 30 days (%)	After 30 days (%)	Total
Mainland Tanzania	**59.7**	**40.3**	**14,744**	**59.6**	**40.4**	**13,170**
Dodoma	44.1	55.9	730	68.5	31.5	609
Arusha	52.3	47.7	666	41.6	58.4	563
Kilimanjaro	60.9	39.1	934	64.3	35.7	781
Tanga	96.5	3.5	895	45.2	54.8	672
Morogoro	59.6	40.4	716	58.9	41.1	591
Pwani	51.5	48.5	583	56.2	43.8	409
Dar es Salaam	73.1	26.9	4,619	77.1	22.9	3,152
Lindi	32.6	67.4	258	39.6	60.4	240
Mtwara	99.5	0.5	408	30.8	69.2	247
Ruvuma	46.2	53.8	420	43.3	56.7	360
Iringa	93.9	6.1	132	90.4	9.6	947
Mbeya	96.1	3.9	180	51.8	48.2	361
Singida	52.1	47.9	282	37.7	62.3	257
Tabora	42.9	57.1	392	41.3	58.8	320
Rukwa	34.1	65.9	182	37.5	62.5	144
Kigoma	40.4	59.6	468	47.7	52.3	631
Shinyanga	98.5	1.5	390	57.4	42.6	333
Kagera	39.0	61.0	251	45.2	54.8	489
Mwanza	56.3	43.8	848	55.1	44.9	899
Mara	49.7	50.3	485	44.9	55.1	372
Manyara	33.1	66.9	242	43.6	56.4	204
Njombe	3.3	96.7	120	53.8	46.2	93
Katavi	43.2	56.8	37	30.9	69.1	55

Region	2023			2024		
	Within 30 days (%)	After 30 days (%)	Total	Within 30 days (%)	After 30 days (%)	Total
Simiyu	55.3	44.7	199	46.4	53.6	183
Geita	98.4	1.6	245	50.3	49.7	189
Songwe	4.8	95.2	62	24.6	75.4	69

7.3. CAUSES OF DEATH
INTRODUCTION

This section presents in detail the data analysis on the causes of deaths that happened both in health facilities and communities. It describes the top 20 causes of death for all ages and sexes, under-five causes of death. Broad group categories of causes of death. The list has been produced by combining related individual causes to identify the leading underlying causes of death across various age groups. In addition, this section describes the initiatives taken to improve the quality and collection of data on the causes of deaths in communities in the year 2024.

7.3.1. LEADING CAUSES OF DEATH

This section provides a detailed explanation of the leading causes of death. Each bar represents the percentage of total mortality attributed to a specific condition, based on medical certification of the cause of death conducted at health facilities for deaths occurring within them during the specified year.

7.3.2. TOP 20 LEADING CAUSES OF DEATH FOR ALL AGE GROUPS

In 2024, conditions arising during the perinatal period emerged as the leading contributors, accounting for 8.7% (CSMF), followed by "birth asphyxia and birth trauma" at 7.3%. Lower respiratory infections (7%), hypertensive disease (4.8%), and HIV (4.4 %) were also among the top five causes. Non-communicable diseases, including cerebrovascular disease (4.3%), nephritis and nephrosis (3.9%) and diabetes mellitus (2.7%), remained among the top 20, although at lower proportions compared to the leading perinatal and infectious causes. Road traffic accidents (2.4%) continued to be a notable contributor, highlighting the increasing impact of injuries on overall mortality.

Figure 58:Top 20 leading Causes of Death
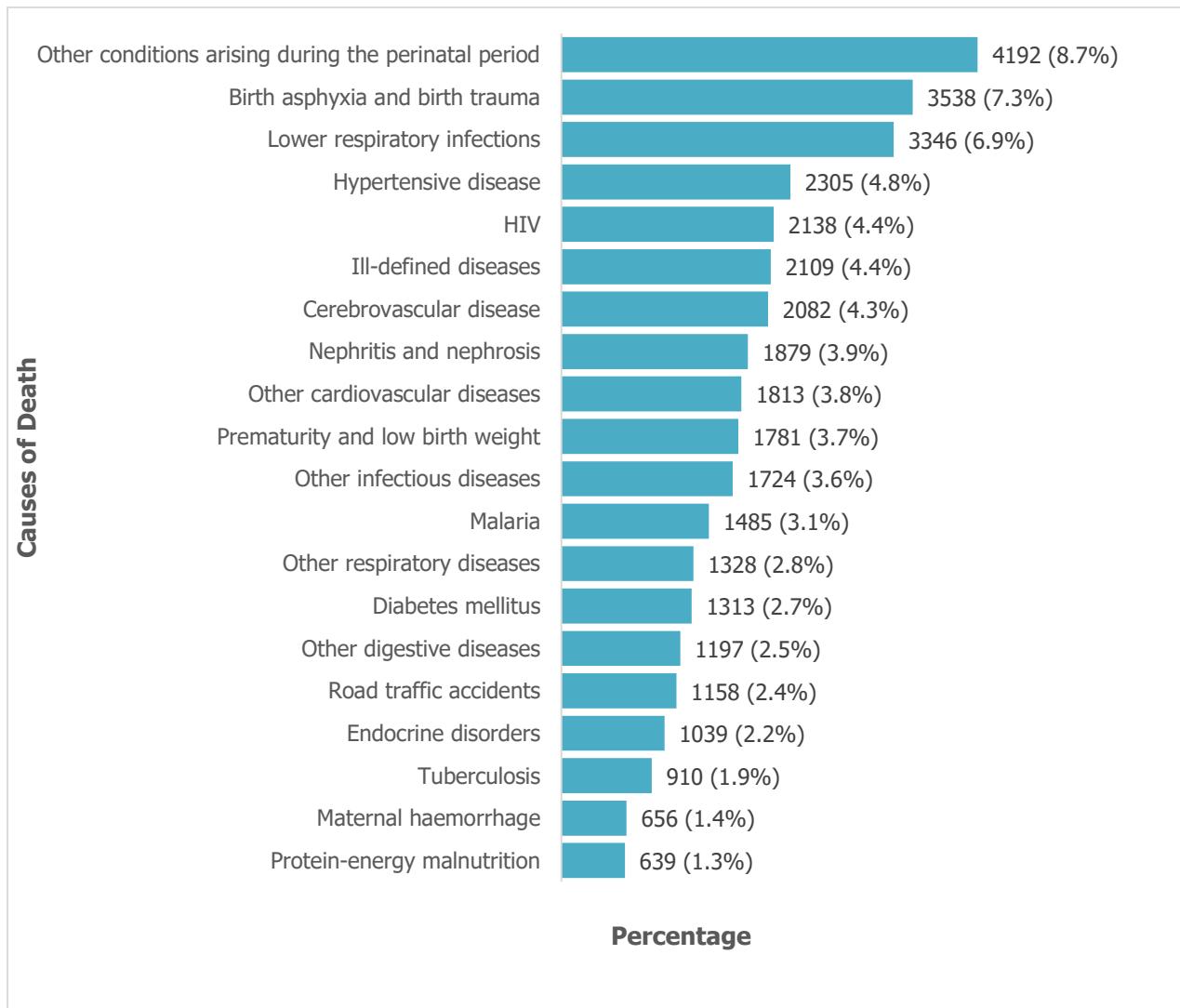
Source: DHIS2 and other EMRs Databases 2024

7.3.3. LEADING CAUSES OF DEATH FOR UNDER-FIVE CHILDREN

The Figure 59 highlights that mortality among children under five is overwhelmingly dominated by perinatal and neonatal conditions. Other perinatal conditions (26.9%), birth asphyxia and trauma (22.7%), and prematurity/low birth weight (11.4%) together accounted for over 60% of all deaths, underscoring the importance of maternal and newborn care.

Respiratory infections were also major contributors, with lower respiratory infections (9.1%) ranking fourth, while upper respiratory and other respiratory diseases added about 1.8% combined. Preventable infectious and nutritional causes remained significant: malaria (4.0%), protein-energy malnutrition (3.3%), Diarrhoeal diseases (1.8%), and other infectious diseases (2.5%).

Chronic and congenital conditions, though less common, were still relevant, including congenital heart anomalies (1.9%) and other congenital anomalies (1.8%). Nephritis/nephrosis (0.7%) and endocrine disorders (1.1%) reflected additional vulnerabilities. Injuries contributed minimally, with unintentional injuries (0.4%) and road traffic accidents (0.2%) appearing in the top 20.

Overall, under-five mortality is heavily concentrated in preventable and treatable perinatal, infectious, and nutritional causes, with congenital conditions also contributing, pointing to priorities in maternal health, neonatal care, infection control, and nutrition interventions.

Figure 59: Top 20 Leading Causes of Death for Under-Five Children
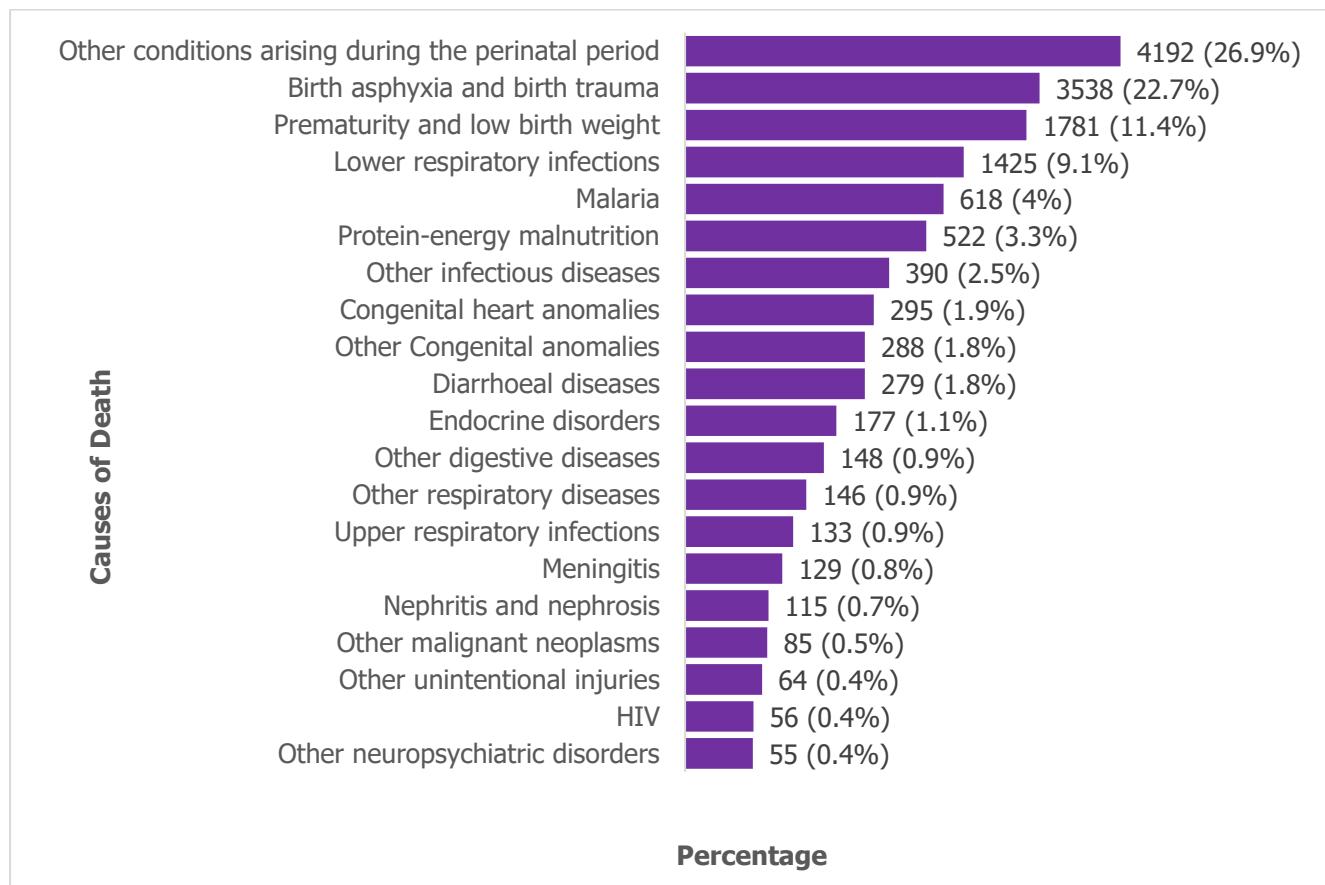
Source: DHIS2 Database 2023

7.3.4. BROAD GROUP CATEGORIES OF CAUSES OF DEATH

Figure 60 presents the total burden of disease in Mainland Tanzania in 2024, categorized into four groups. Group I includes communicable, maternal and nutritional conditions; Group II covers noncommunicable diseases, and Group III comprises external causes and injuries (i.e road traffic crashes, falls, self-inflicted, etc.). Group IV represents undetermined causes by available methods, accounting for about 4.6% of the total. Communicable diseases contributed the largest share at 48.4%, followed by noncommunicable diseases at 43.4%, while injuries accounted for 4.3% of the total mortality burden in 2024.

Figure 60: Broad Group Categories of Causes of Death 2023 and 2024
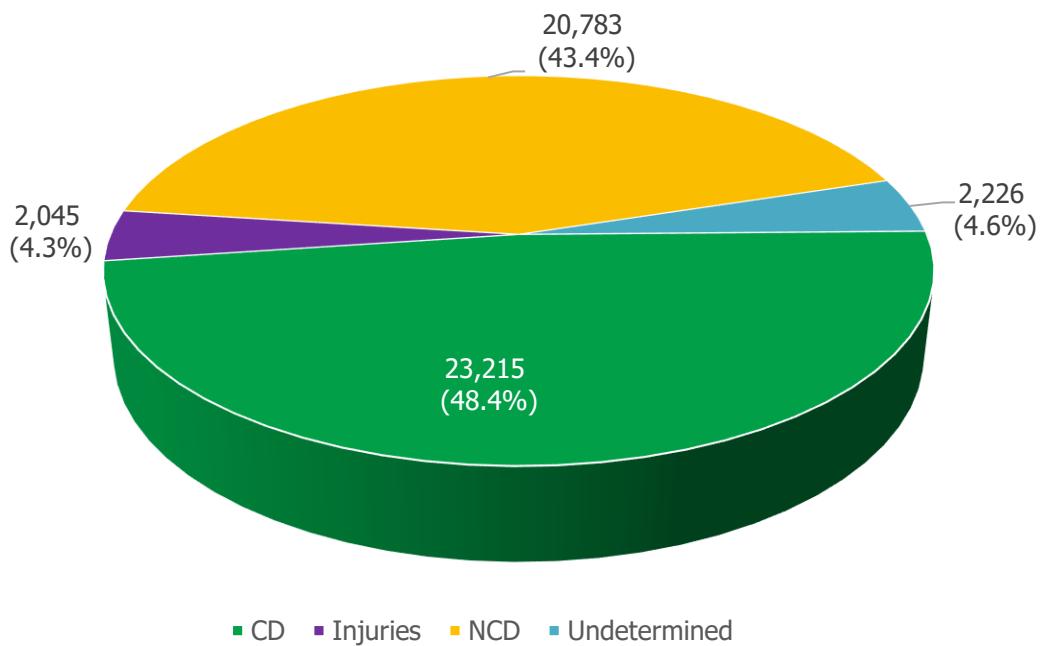
Source: DHIS2 and other EMRs Databases 2024

7.3.5. COMPLETENESS OF MEDICAL CERTIFICATION OF CAUSES OF DEATH (MCCD) DATA

It is very important that all the people responsible for the documentation and registration of deaths provide accurate, comprehensive, reliable, complete and timely information, and that they record all deaths. This statistical data is used by the health sector to develop public health policies and goals for decision-making. In addition, mortality data is critical for measuring and comparing health status at local, national and international levels, because they are regularly and extensively collected in every developed country and most developing ones.

Table 44 below shows that a total of 48,269 deaths were medically certified and captured through the DHIS2 system, and through EMR systems in the year 2024 in Mainland Tanzania. Compared to the estimated total number of deaths in Tanzania in 2024, 14.6% received an MCCD. Of note, it's estimated that 30% of the deaths that occurred in Mainland Tanzania in 2024 happened in health facilities, while 70% occurred in the community. This suggests that approximately half of the deaths in health facilities are getting MCCD.

The completeness and quality of CoD data from health facilities can be improved by providing refresher training to physicians, strengthening electronic data collection systems and increasing the number of supportive supervisions (e.g., by following up to ensure that every facility-reported death gets an MCCD).

Table 46: Completeness of MCCD data in year 2024

Region	Total Population	CDR	Estimated Deaths	Total # of Deaths	Total # with MCCD	Proportion of deaths with MCCD (%)
Tanzania	63,632,240	5.2	330,888	49,471	48,269	14.6
Arusha	2,498,127	5.2	12,990	1,926	1,926	14.8
Dar	5,757,488	5.2	29,939	11,556	11,556	38.6
Dodoma	3,278,498	5.2	17,048	3,119	3,119	18.3
Geita	3,157,254	5.2	16,418	853	853	5.2
Iringa	1,270,481	5.2	6,607	1,824	1,824	27.6
Kagera	3,185,122	5.2	16,563	1,814	1,814	11.0
Katavi	1,221,095	5.2	6,350	926	926	14.6
Kigoma	2,615,705	5.2	13,602	1,088	1,088	8.0
Kilimanjaro	1,988,804	5.2	10,342	2,600	2,600	25.1
Lindi	1,274,561	5.2	6,628	723	723	10.9
Manyara	2,005,076	5.2	10,426	952	952	9.1
Mara	2,520,567	5.2	13,107	822	822	6.3
Mbeya	2,491,317	5.2	12,955	2,767	1,565	12.1
Morogoro	3,402,216	5.2	17,692	2,672	2,672	15.1
Mtwara	1,751,331	5.2	9,107	1,122	1,122	12.3
Mwanza	3,929,138	5.2	20,432	4,289	4,289	21.0
Njombe	949,784	5.2	4,939	724	724	14.7
Pwani	2,149,395	5.2	11,177	1,474	1,474	13.2
Rukwa	1,632,123	5.2	8,487	561	561	6.6

Region	Total Population	CDR	Estimated Deaths	Total # of Deaths	Total # with MCCD	Proportion of deaths with MCCD (%)
Ruvuma	1,978,114	5.2	10,286	730	730	7.1
Shinyanga	2,375,329	5.2	12,352	575	575	4.7
Simiyu	2,266,681	5.2	11,787	736	736	6.2
Singida	2,135,179	5.2	11,103	1,640	1,640	14.8
Songwe	1,427,308	5.2	7,422	648	648	8.7
Tabora	3,587,736	5.2	18,656	1,685	1,685	9.0
Tanga	2,783,811	5.2	14,476	1,645	1,645	11.4

Source: DHIS2 Database and NBS Projections of 2022 Population and Housing Census

7.3.6. VERBAL AUTOPSY IMPLEMENTATION

Verbal Autopsy is practical and can be used to estimate specific mortality fractions of the underlying cause of death at community level in Tanzania, where medical certification is not currently possible. Figure 61 shows councils implementing verbal autopsy (VA) through the VA national representative sample, which comprises of 258 wards in 29 councils of Tanzania. Based on previous experiences and given the large proportion of deaths in Mainland Tanzania that occur outside the formal health systems, through the Ministry of Health, the government aims to scale up the verbal autopsy intervention to all regions in the country. The programe has been scaled up to 50 percent of the sampled 258 wards by December 2024 where by, over 2,170 deaths received a cause of death classification trough verbal autopsy (962 Males and 1,208 Females) had been captured in the Verbal Autopsy Manager System. Therefore, the results presented in section 6.7 is from analysis of partial data collescted from the implementation of VA.

Figure 61: Map of Tanzania showing Regions Implementing Verbal Autopsy
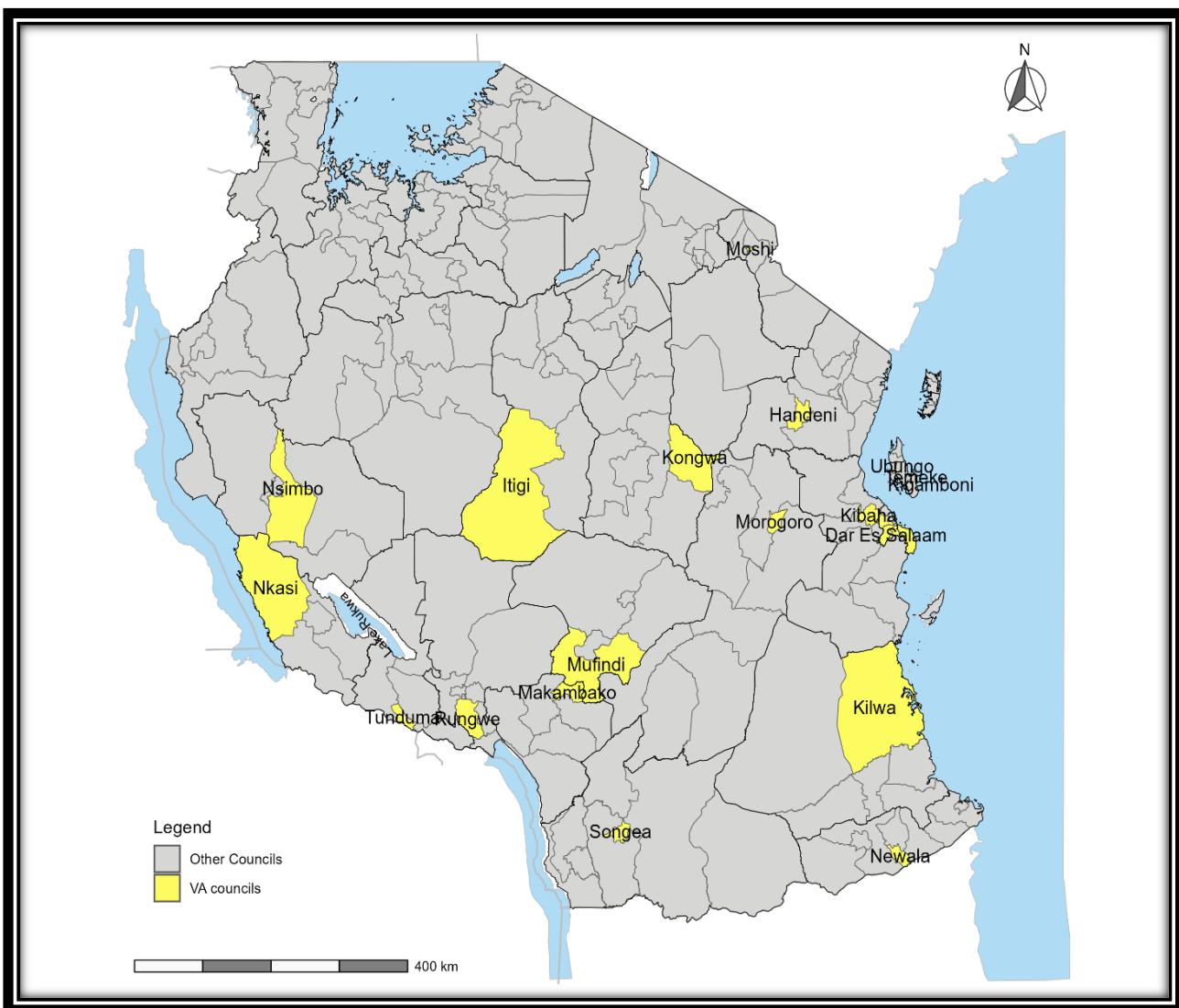
Challenges

i. The use of a hybrid system (both paper and electronic) for medical certification of causes of death, as well as for birth and death registration, which leads to data transfer errors.

ii. The existence of non-integrated systems within the health sector, systems such as MCCD, DHIS2, and other electronic medical records are not interoperable. There is also a lack of integration between the health sector and the civil registration system.

iii. Implementing verbal autopsies to determine the causes of community deaths is very costly, which has limited their coverage to only a few areas through a nationally representative sample.

Recommendations

i. The government should invest in system data linkage to enable real time data transfer from the health sector to RITA, thereby facilitating more efficient and timely birth and death registration processes.

ii. The Government, through RITA, should review the decentralization of birth registration through U5BRI to enable timely registration of every birth event occurring in health facilities and communities.

iii. In collaboration with PoRLAG and MoH, RITA should finalize the integration of the CRVS system with the health facility systems to ensure every live birth and death events occurring are registered and certified.

iv. RITA, in collaboration with key stakeholders, conducts community awareness campaigns on the importance and value of registering and certifying vital events. The use of a nationally representative sample approach should be strengthened to better ascertain cause-of-death data from community settings.

CHAPTER EIGHT
8.0. NUTRITION

This section presents the progress in addressing malnutrition across the country via targeted nutritional interventions. It uses key performance indicators to provide a data-driven assessment of how programs have helped reduce all forms of malnutrition namely; undernutrition, micronutrient deficiencies, and over nutrition (overweight/obesity). These indicators are crucial for tracking the effectiveness and impact of national nutritional strategies,

highlighting both successes and areas needing further attention to guide policy and resource allocation for ongoing improvements in public health.

8.1. EARLY INITIATION OF BREASTFEEDING

Early initiation of breastfeeding refers to placing the new born baby at the mother's breast in the first hour following delivery. This early contact is essential because it triggers milk production, helps the baby maintain proper body temperature and glucose levels, and strengthens the mother-child bond. This practice is an important measure of effective new born care and is linked to decreased new born mortality and better breastfeeding outcomes over time. The Ministry collects data on this practice at health facilities as part of routine monitoring of maternal and child health services.

Figure 62. presents the proportion of children who were breastfed within one hour after birth for the years 2022, 2023, and 2024. The data shows a steady increase in early initiation of breastfeeding over the three-year period. In 2022, 91.4% of new-borns were breastfed within the first hour of life. This figure rose to 92.4% in 2023 and further improved to 93.3% in 2024, reflecting continued progress in promoting timely breastfeeding practices at birth. This improvement is largely attributable to the increased proportion of births occurring in healthcare facilities, alongside positive advancements in other nutrition-related interventions, such as advocacy for the Baby Friendly Hospital Initiative and its Ten Steps to Successful Breastfeeding.

Figure 62: Proportion of Children who were Breastfed within One Hour after Birth; 2023-2024
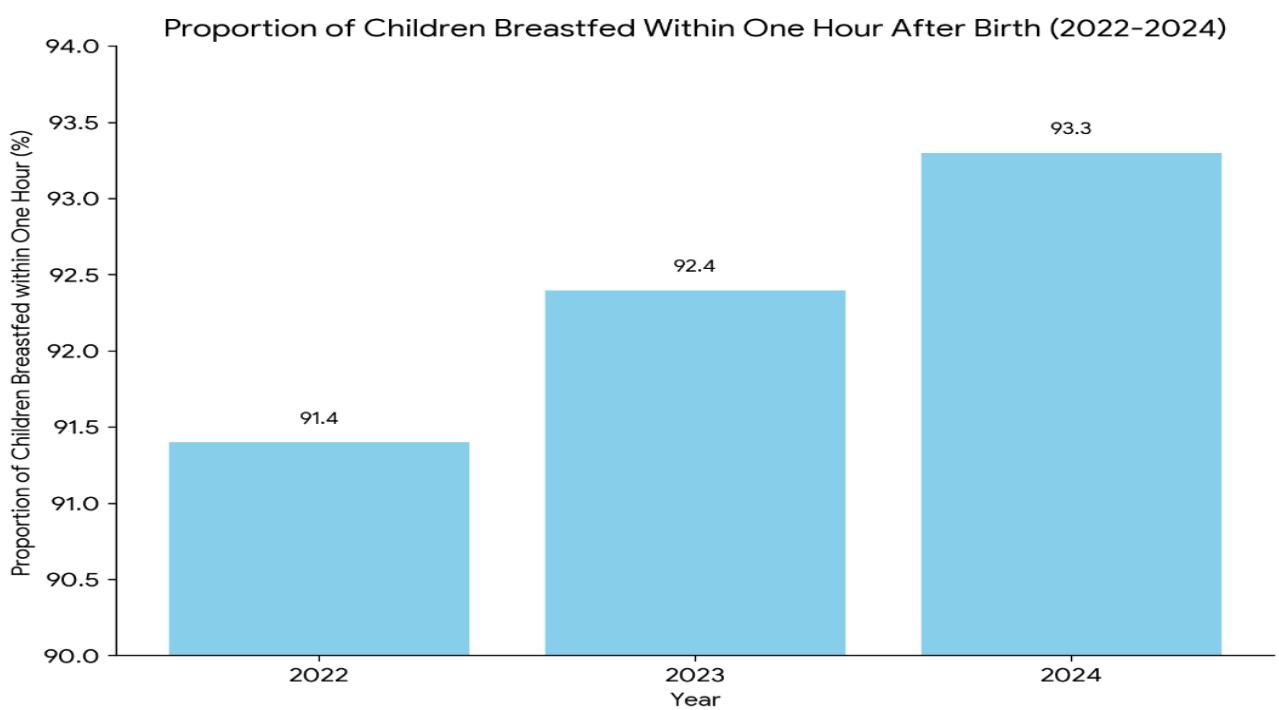
Source: DHIS2

Figures 63; highlights regional differences in the proportion of children breastfed within one hour of birth across Tanzania in 2024 compared to 2023. Of the 26 regions, 13 surpassed the national average of 93.3 percent. Kilimanjaro recorded the highest rate at 97 percent, followed by Mbeya, Simiyu, Kigoma, Singida, Geita, Manyara, and Rukwa, each at 95 percent. Iringa, Dar es Salaam, and Njombe had the lowest rates, all below 86.5 percent. In 2023, Kilimanjaro also led at 97.9 percent, followed by Kagera at 96.6 percent, while Lindi had the lowest at 86.5 percent.

Figure 63: Proportion of Children who were Breastfed within One Hour after Birth; 2023-2024
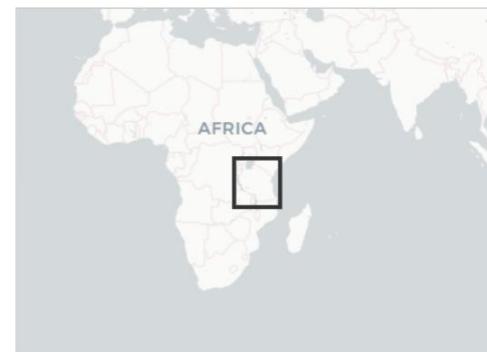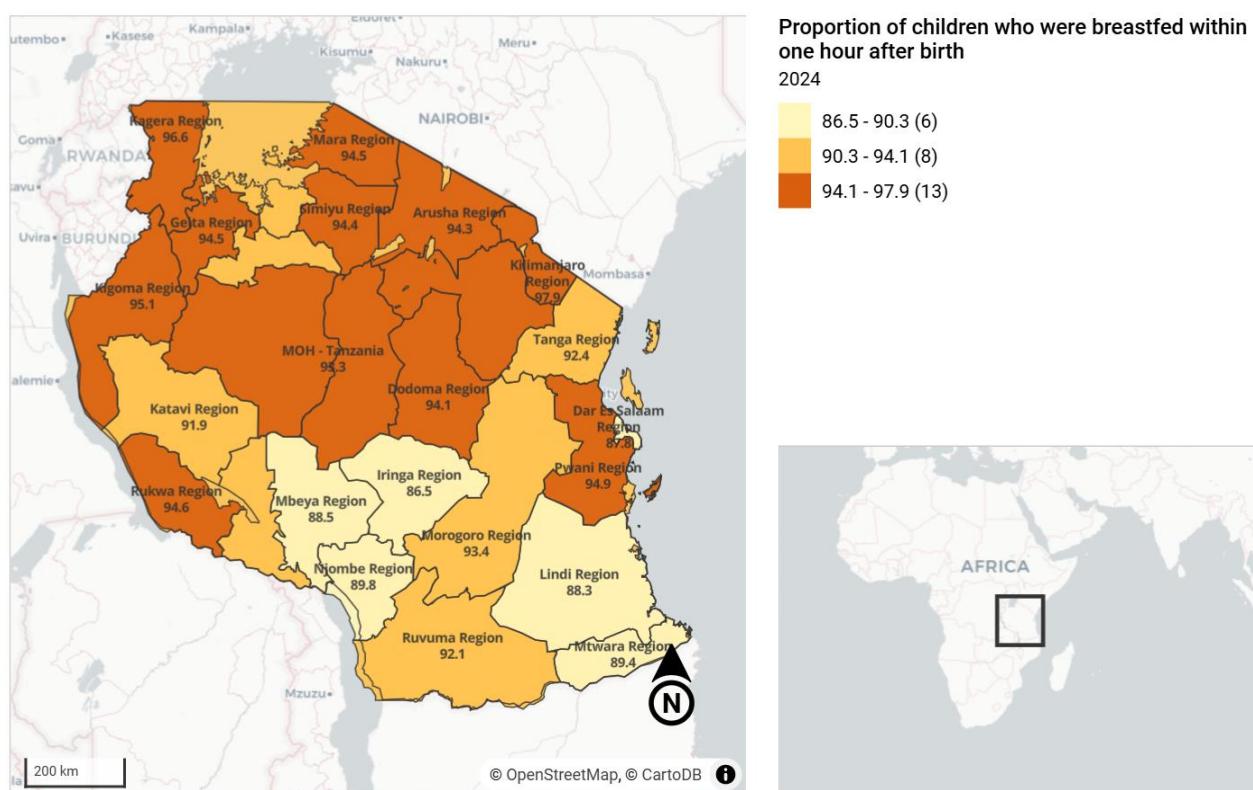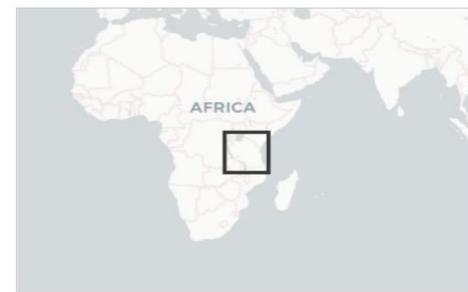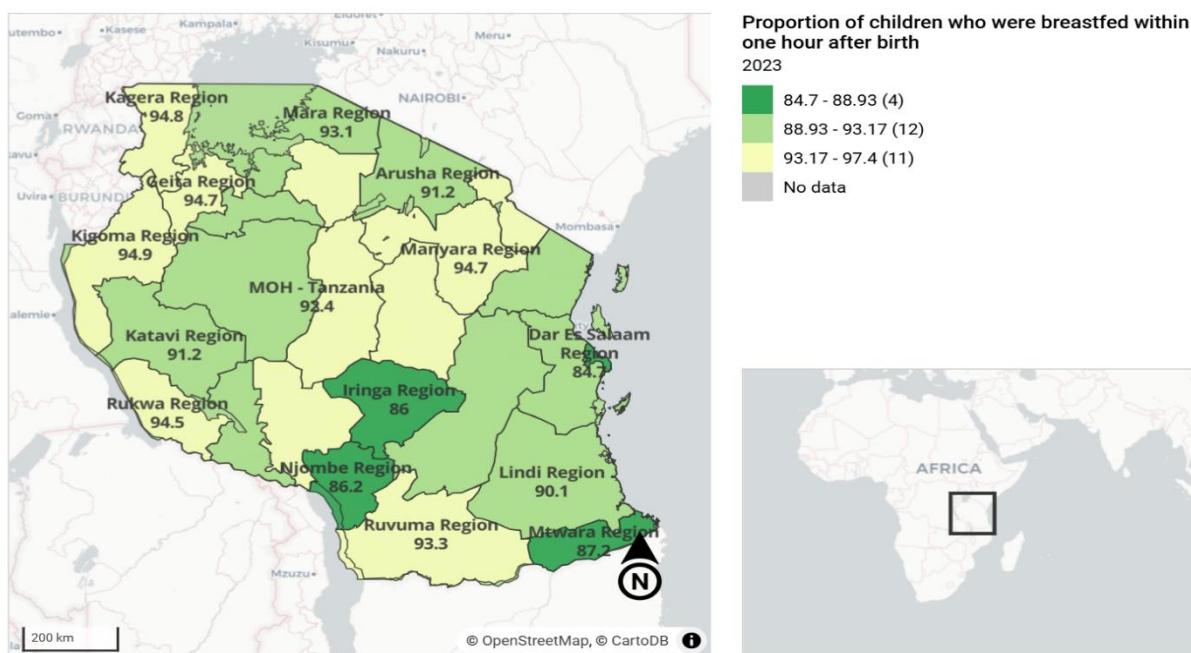
Source: DHIS2

8.2. LOW BIRTH WEIGHT

Low birth weight (LBW), defined as a birth weight of less than 2,500 grams, is a significant concern in maternal and child health. It is frequently linked to factors such as preterm birth, inadequate maternal nutrition, and limited access to prenatal care, all of which can compromise infant survival and development.

Figure 64: The data shows the proportion of newborns with low birth weight (LBW) for the years 2022, 2023, and 2024, as reported by the Ministry of Health (MOH) in Tanzania. In 2022, the LBW rate was 5.6%, which slightly decreased to 5.5% in 2023. In 2024, the proportion further dropped to 5.1%. Overall, the data reflects a steady decline in the percentage of newborns with low birth weight over the three-year period.

Figure 64: Percentage of New-born alive with Birth-weight Less than 2.5Kg; 2022-2024
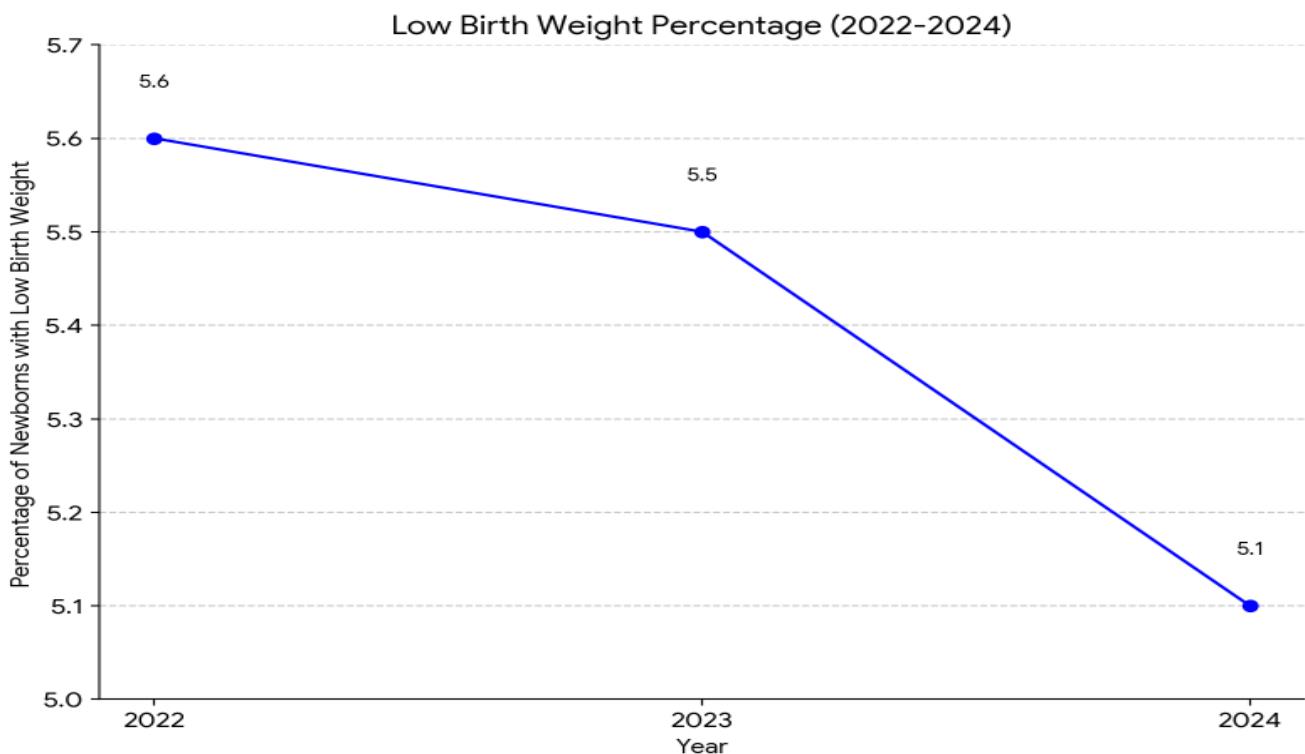
Source: DHIS2

The distribution of low birth weight (LBW) in Tanzania varies considerably by region. The Ministry of Health reports a national average of 5.1%. Regions with the highest rates of LBW

births are Lindi (8.2%), Mtwara (7.8%), Njombe (7.8%), and Morogoro (7.7%). Conversely, Rukwa (2.2%), Simiyu (2.8%), Kilimanjaro (2.9%), and Tabora (3.5%) have the lowest. This regional variation underscores the importance of focused public health efforts to address high LBW rates, especially in southern and coastal areas, and to continue the positive trends in regions with lower rates.

Figure 65: Percentage of New-born alive with Birth-weight Less than 2.5Kg by Region in Tanzania
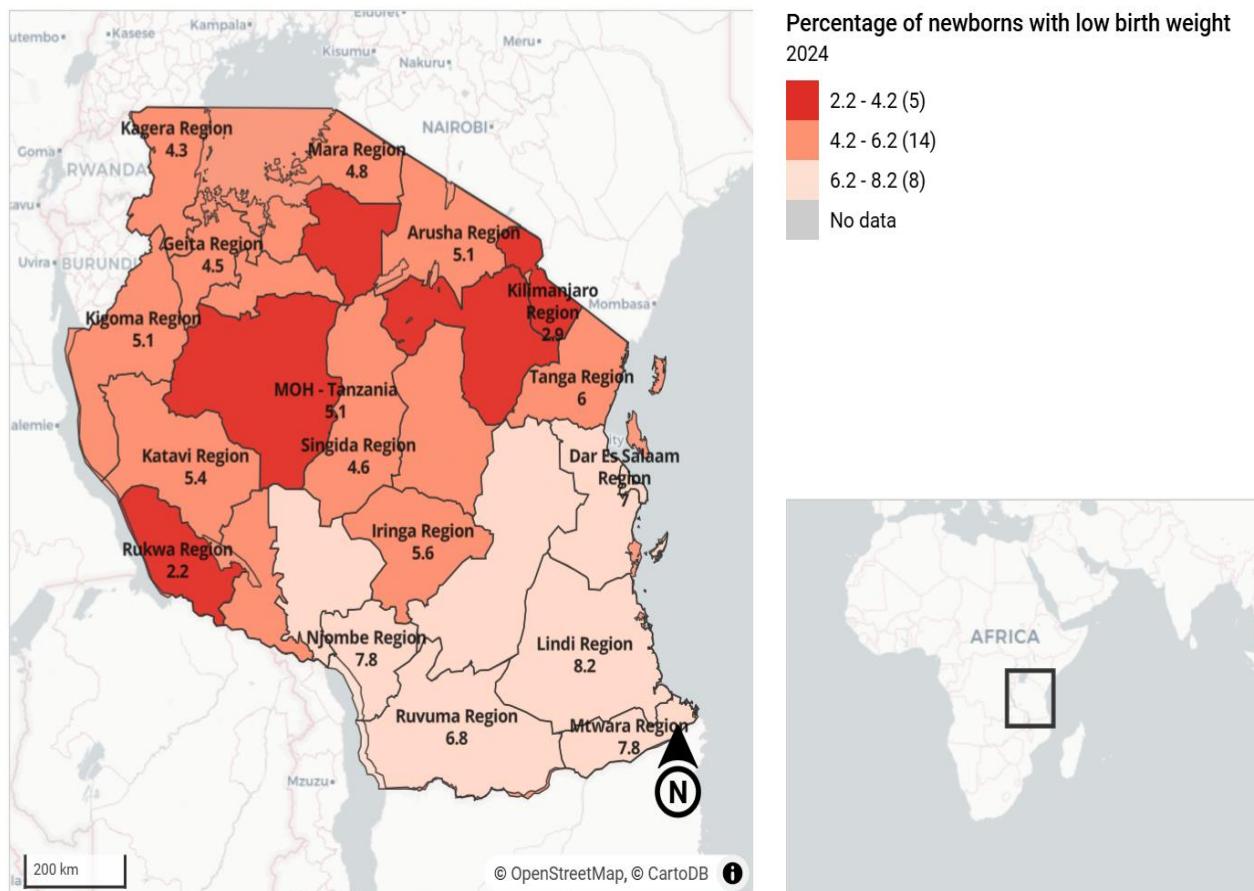
8.3. UNDERWEIGHT AMONG CHILDREN AGED 0 – 59 MONTHS

Underweight in children aged 0–59 months is a key indicator of child malnutrition, reflecting both acute and chronic nutritional deficiencies. It is defined as a weight-for-age measurement that is more than two standard deviations below the median on the WHO Child Growth Standards. This condition can arise from insufficient food intake, recurrent infections, or inadequate maternal health and feeding practices.

Underweight children face a higher risk of illness, developmental delays, and increased mortality. Therefore, monitoring the prevalence of underweight in this age group is essential for evaluating the effectiveness of nutrition programs and guiding policies aimed at improving child health and nutritional status.

Figure 66: Proportion of children aged 0-59 months who are underweight from 2022 to 2024.
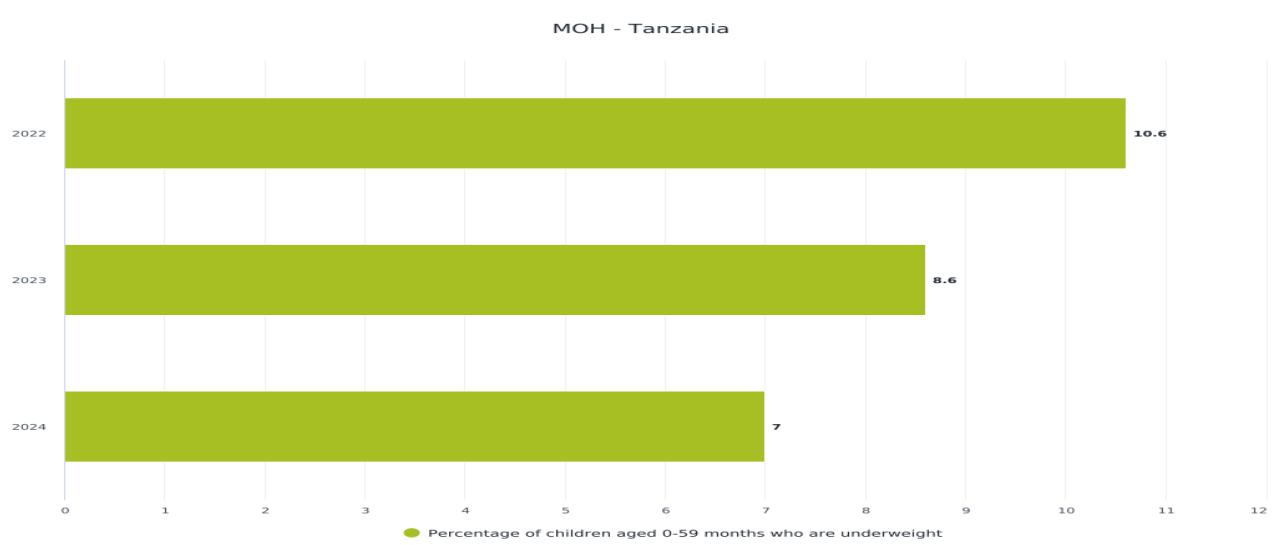
Figure 67 above show the percentage of Children aged 0-59 months who are underweight by region from 2022 to 2024; as reported by the Ministry of Health (MOH) in Tanzania. In 2022, the prevalence of underweight was 10.6 percent, which slightly decreased to 8.6 percent in 2023. By 2024, the proportion further dropped to 7 percent. Overall, the data reflects a steady decline in the percentage of underweight among under-five children over the three-year period.

Figure 67: Percentage of Children aged 0-59 months who are underweight by region, 2024
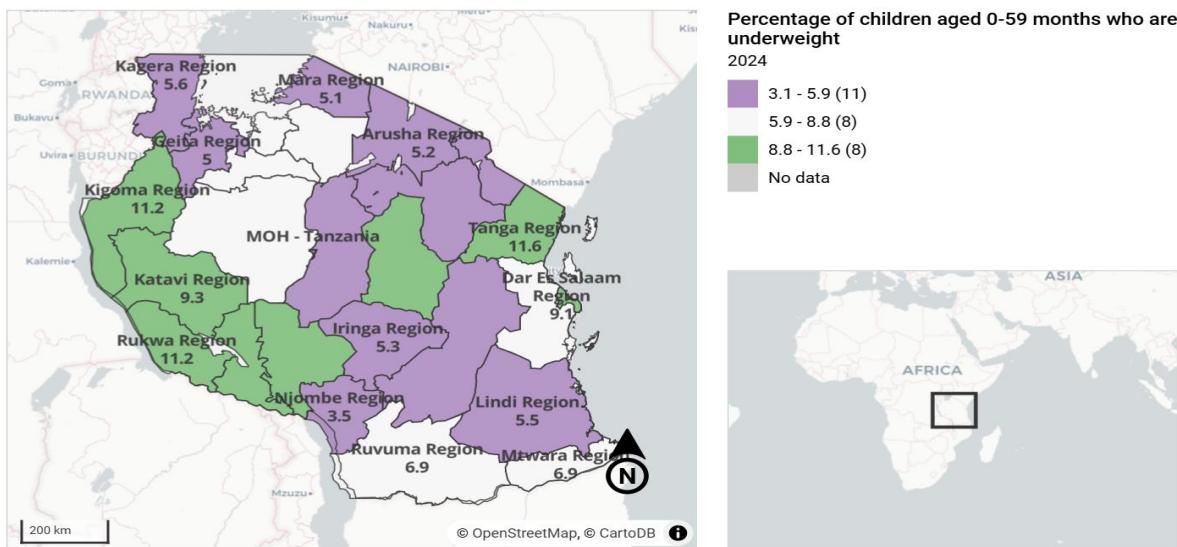
Source: *DHIS2*

The distribution of underweight in Tanzania in 2024 varies significantly by region. According to the Ministry of Health, the national average stands at 7.0%. Several regions report higher rates, including Lindi (7.4%), Simiyu (8.5%), Mbeya (8.8%), Dar es Salaam (9.1%), Katavi (9.3%), Dodoma (9.9%), Songwe (11.0%), Kigoma (11.2%), Rukwa (11.2%), and Tanga (11.6%). In contrast, 16 regions reported a lower prevalence of underweight compared to the national average. Overall, the data indicate notable improvements in underweight levels across many regions, reflecting the impact of ongoing nutrition interventions and public health efforts.

8.4. STUNTING

Stunting is a major global health issue where children's height-for-age falls below WHO standards due to chronic undernutrition during the first 1000 days of life. It is driven by poor maternal nutrition, inadequate feeding, frequent infections, poor sanitation, and poverty. Stunting impairs physical and cognitive development, weakens immunity, and limits future economic potential. Prevention requires early, multi-sectoral interventions including better nutrition, healthcare, education, and sanitation.
Regular assessments help track progress, guide policy, and engage communities in addressing child undernutrition.

Figure 68: Stunting prevalence among children aged 0–59 months
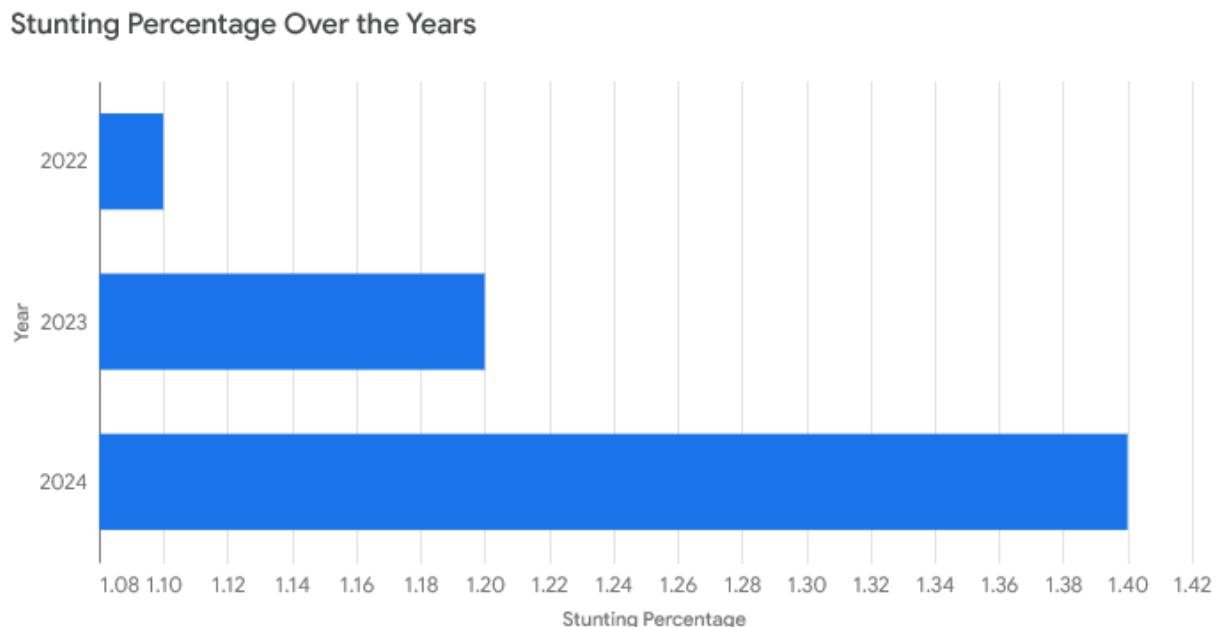
Source: DHIS 2, TDHS 2015-16, TNNS 2018 & TDHS-MIS 2022

Figure 68. The data from 2022 to 2024 shows a gradual increase in stunting prevalence among children aged 0–59 months, rising from 1.1% to 1.4% over the three-year period. In comparison, survey data indicates that the percentage decreased from 34 percent in 2015-2016 to 31.8 percent in 2018, and further to 30 percent in 2022. However, despite this decrease, the results indicate that the level of stunting among children under the age of 5 in Tanzania is still considered to be "very high" according to the new WHO-UNICEF prevalence thresholds for stunting, which are set at 30 percent and above.

Figure 69: Percentage Variation of children under age 5 who are stunted by Region
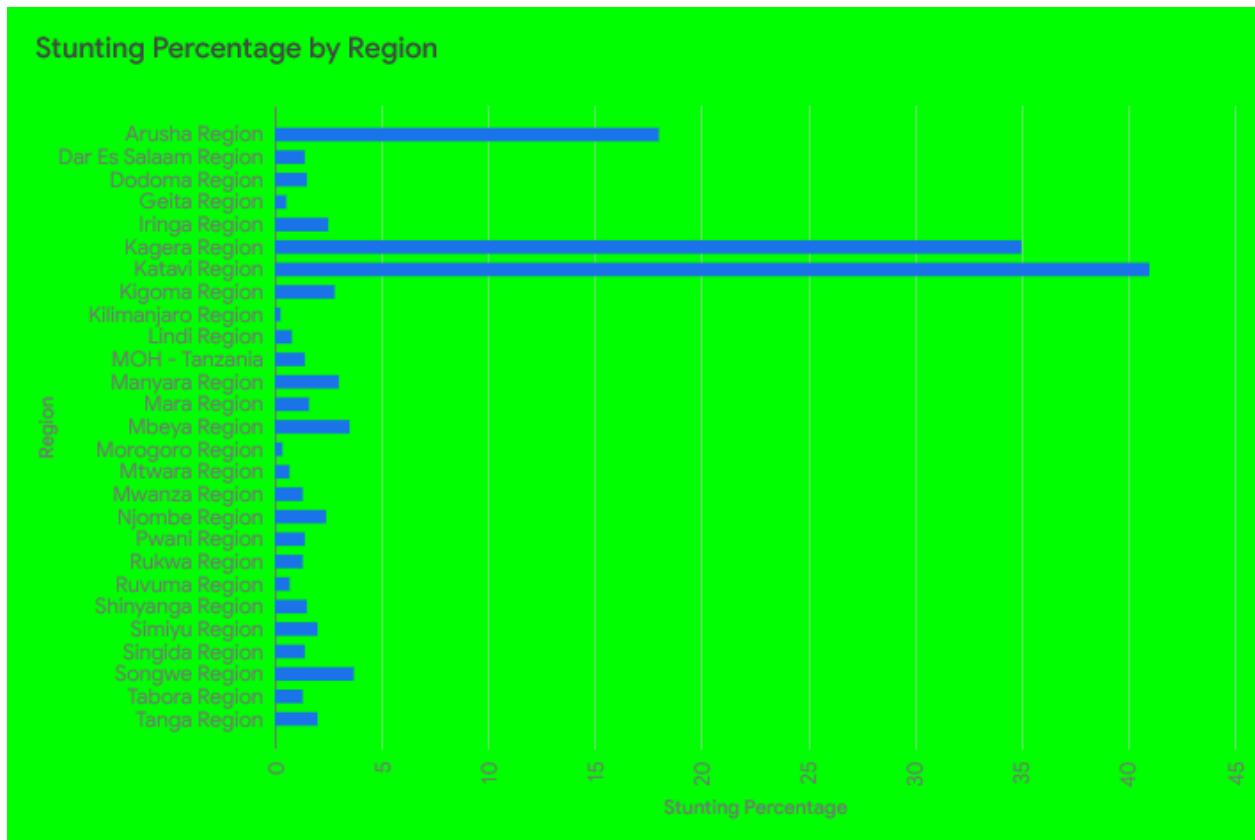
Based on the 2024 data in the graph, the percentage of children aged 0-59 months who are stunted varies across regions. Some regions with notable stunting percentages include Katavi Region (41%) and Kagera Region (35%). Regions with lower stunting percentages include Dar Es Salaam Region (1.4%), Pwani Region (1.4%), and Kilimanjaro Region (0.26%).

8.5. FERROUS AND FOLIC ACID SUPPLEMENTATION

Maternal health is a cornerstone of public health and a critical determinant of a nation's well-being. Iron and folic acid deficiencies during pregnancy are among the leading causes of maternal anemia, low birth weight, preterm delivery, and increased risk of maternal and infant mortality. In recognition of the vital role these micronutrients play in ensuring safe pregnancies and healthy fetal development, ferrous and folic acid supplementation has been globally endorsed as an essential component of antenatal care.

To address micronutrient deficiencies among women of reproductive age (WRA), Tanzania provides ferrous and folic acid (FeFo) supplements to all pregnant women, and data is systematically collected to inform health policy and program improvements.

Below is the data on FeFo (Iron and Folic Acid) supplementation among pregnant women in Tanzania from 2022 to 2024. The data shows a steady increase in the proportion of pregnant women receiving supplementation over the three years. In 2022, 92% of pregnant women received FeFo supplements, rising to 95% in 2023 and in 2024 indicates a further increase to 97%.

Figure 70: Proportion of Pregnant Women Receiving Fefol Supplementation (2022-2024)

Proportion of Pregnant Women Receiving Fefol Supplementation (2022-2024)
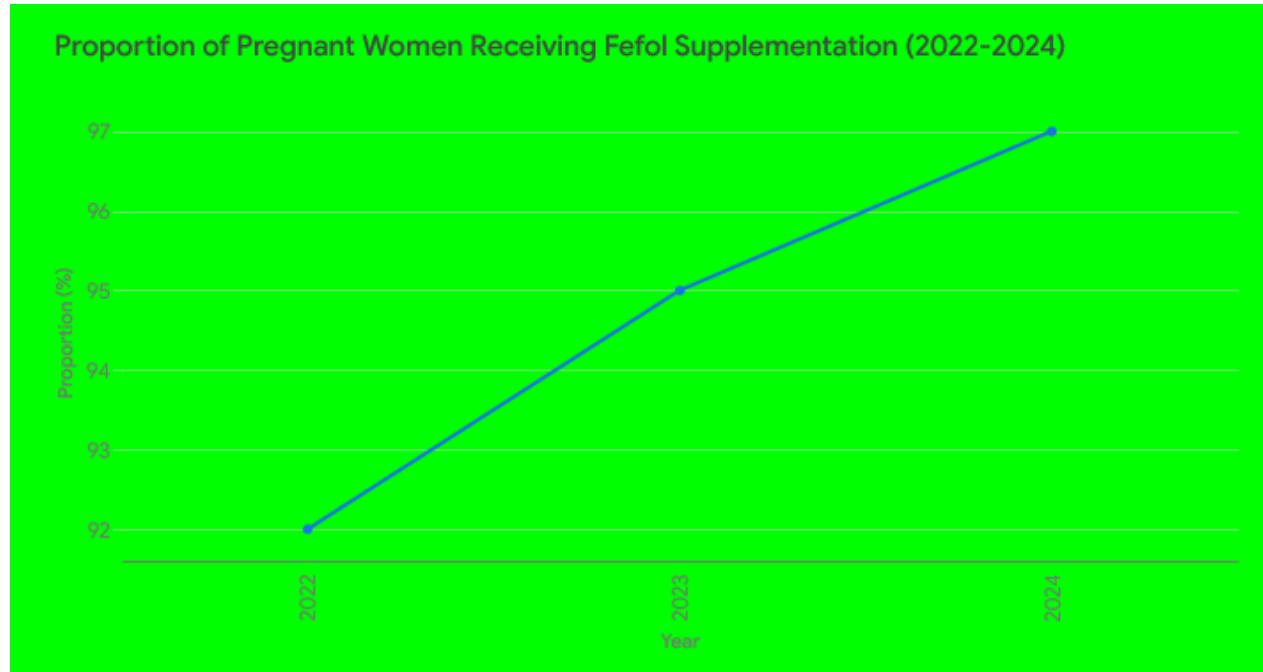
Source: DHIS 2

8.6. DISTRIBUTION BY REGION IN 2024

The map Figure 71. below indicates a generally high proportion of pregnant women receiving FeFo supplementation across most regions of Tanzania in 2024, with many regions falling into the highest category of more than 98 percent. Very few regions fall on the lowest category.
The high prevalence of Fefol supplementation among pregnant women in Tanzania is likely attributable to several contributing factors. Strong governmental and health initiatives, as indicated by the involvement of the Ministry of Health, suggest a focused effort to promote and track Fefol distribution. The emphasis on maternal and child health, given the crucial role of iron and folic acid in preventing anemia and neural tube defects, likely drives these initiatives. Furthermore, the detailed data collection and monitoring, evident in the provided table and

map, point to the existence of specific targets and systems aimed at ensuring widespread coverage and progressive improvement in Fefol supplementation across the regions.

Figure 71: Proportion of pregnant received Fefol (Iron Folic) supplementation
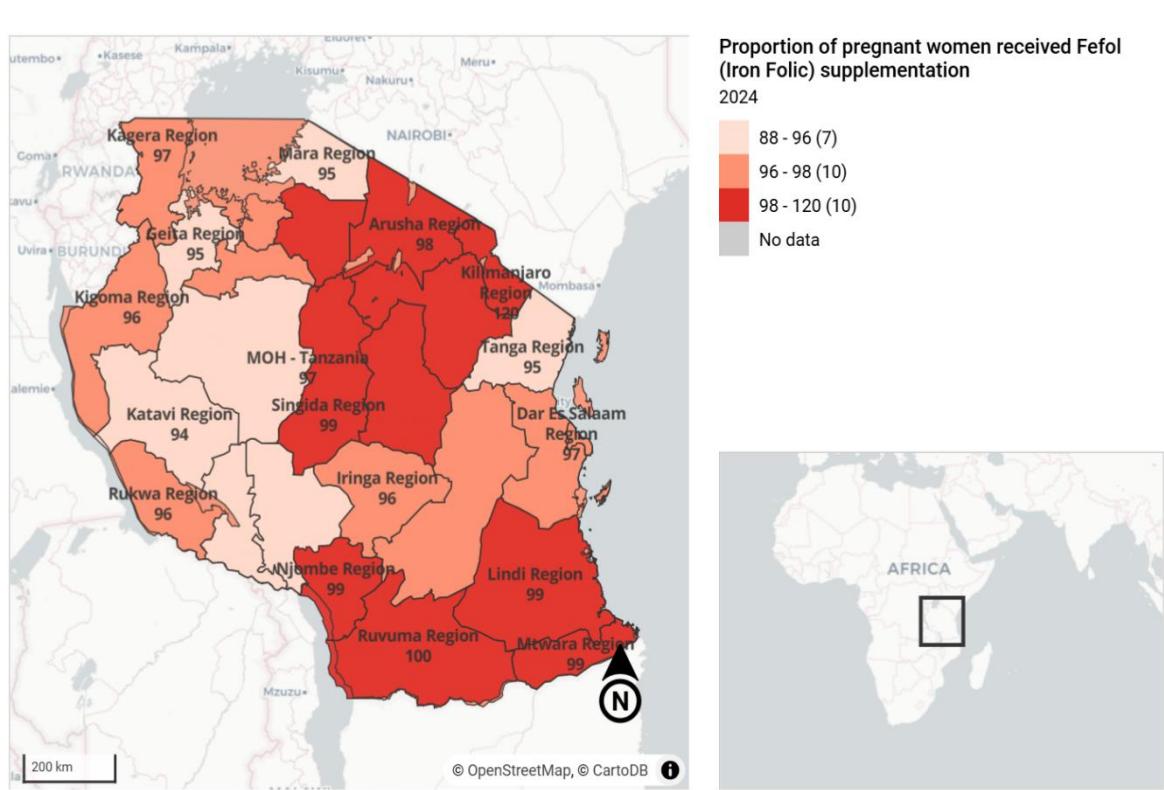
8.7. IMPLEMENTED INTERVENTIONS AND ACHIEVEMENTS

Tanzania has implemented various nutrition interventions aimed at improving the health and well-being of its population, particularly focusing on reducing the triple burden of malnutrition namely; under-nutrition, micronutrient deficiencies, and over-nutrition (Overweight & Obesity) and their associated health consequences.

Some of the key interventions and notable achievements include:

1. Scaling Up Nutrition (SUN) Movement

Tanzania joined the SUN Movement in 2011, demonstrating a national commitment to address malnutrition through a multi-sectoral approach involving government, civil society, donors, and the private sector.

2. National Multi-Sectoral Nutrition Action Plan (NMNAP)

Tanzania launched its first NMNAP (2016–2021) and continues implementation in its second phase (2021–2026). The plan integrates nutrition-sensitive and nutrition-specific interventions, focusing on maternal, infant, and young child nutrition, adolescent nutrition, and non-communicable disease prevention.

3. Micronutrient Supplementation and Fortification

- **Vitamin A supplementation** for children under five has seen national coverage rates improving steadily.
- **Iron and folic acid supplementation** for pregnant women is promoted through antenatal care.
- Mandatory **fortification of wheat and maize flour** with iron, zinc, folic acid, and vitamin B12 has been implemented to combat widespread micronutrient deficiencies.

4. Community-Based Nutrition Programs and Village Health and Nutrition Days

The commemoration of Village Health and Nutrition Days (VHNDs) serves as a vital platform for implementing and strengthening community-based nutrition programs. Through these quarterly outreach sessions, frontline health workers such as CHWs, Extension workers and village & ward leaders engage with families directly in their villages, promoting key messages around breastfeeding, complementary feeding, maternal nutrition, multisecterol interventions and hygiene practices. These grassroots-level interventions enhance nutrition awareness, improve child and maternal health outcomes, and foster community participation in long-term behavioral change. VHNDs thus play a pivotal role in bringing essential health and nutrition services closer to underserved populations, reinforcing the objectives of national nutrition missions.

5. School Feeding Programs and Nutrition Education

Tanzania has expanded school feeding programs, particularly in rural and food-insecure areas, to improve children's nutritional status and support better learning outcomes. In addition to providing meals, the government has integrated nutrition education into school curricula to instill lifelong healthy eating habits among students. Furthermore, nutrition promotion and awareness are actively encouraged through the establishment of nutrition clubs, as well as school gardening and small animal keeping initiatives, which help students gain practical knowledge on food production, healthy diets, and sustainable agriculture.

6. Growth Monitoring and Promotion (GMP)

Regular monitoring of children's growth through community and health facility services enables early detection and management of malnutrition cases.

7. Policy and Legislative Frameworks

Tanzania has developed a range of supportive policies and strategic frameworks; including the Food and Nutrition Policy, Health Sector Strategic Plans, and the Agricultural Sector Development Strategy. All of which are aligned to improve nutritional outcomes through coordinated, multi-sectoral efforts.

Key Achievements

1. Reduction in stunting rates among children under five (from 42% in 2010 to 30% in 2022).
2. Enhanced coordination among sectors working on agriculture, health, education, and water to address malnutrition holistically.
3. Improved coverage of Vitamin A supplementation and deworming interventions.

CHAPTER NINE
9.0. HEALTH CARE FINANCING

9.1. HEALTH FINANCING

Healthcare financing is a growing policy priority in Tanzania, evidenced by ongoing efforts to strengthen health insurance through the Universal Health Insurance Act. This chapter outlines the public health financing landscape in the country, detailing funding sources, budget and expenditure trends, fund allocation, and policy implications. Total health expenditure (THE) has risen significantly from Tshs 5.4 trillion (US$2.4 billion) in 2020/21 to Tshs 6.8 trillion (US$3.0 billion) in 2022/23, a 21% increase. Consequently, per capita health spending increased from Tshs 94,292 (US$41) to Tshs 114,290 (US$49) during this period. The share of THE in GDP also grew from 4% in 2020/21 to 4.9% in 2022/23. Furthermore, the government's health expenditure as a proportion of total government spending increased from 6% to 7% between 2020/21 and 2022/23.

9.2. HEALTH FINANCING SOURCES

Adequate health financing is a critical enabler for a health system to effectively operate and achieve its objectives. Tanzania's health sector is funded through a mix of sources, including the government, health insurance schemes, households, and donors. A significant trend is the substantial growth in the government's contribution to healthcare financing, increasing from 23% in 2020/21 to 36% in 2022/23. The role of health insurance in funding has seen some volatility, peaking at 17% in 2022/23 after starting at 12% in 2020/21 and then settling at 23% in 2022/23. Foreign financing, while remaining a key contributor, has generally been on a downward trajectory (33% in 2020/21 to 23% in 2022/23), with a minor uptick to 24% in 2022/23. Worryingly, out-of-pocket payments have consistently increased over the last three years (24%, 27%, and 28% from 2021/22 to 2022/23). The observed increase in government funding (from 23% to 36%) is increasingly important for stable financing given the complexities of the global health financing landscape. Figure 72 presents the breakdown of health expenditure by funding source.

Figure 72: Trend of Share of Source of Funds
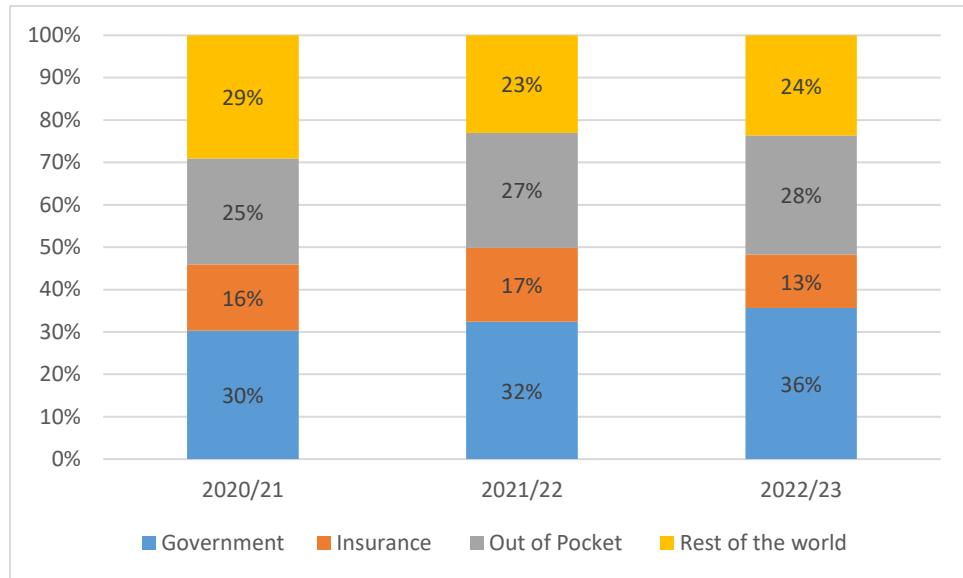
9.3. EXPENDITURE BY HEALTH CARE PROVIDERS

In Tanzania, healthcare providers comprise a range of facilities, including National Hospitals, Zonal Referral Hospitals and Regional Referral Hospitals. Additionally, the healthcare system incorporates primary healthcare facilities, such as District Hospitals, Health Centers and Dispensaries. The analysis of health expenditures by providers extends to include retailers of medical goods, providers of preventive care, institutions responsible for administering and financing healthcare systems, as well as funds managed directly by the respective agents themselves. Figure 73; show the shares of CHE by providers, respectively.

Figure 73: Share of Health Expenditure by Providers
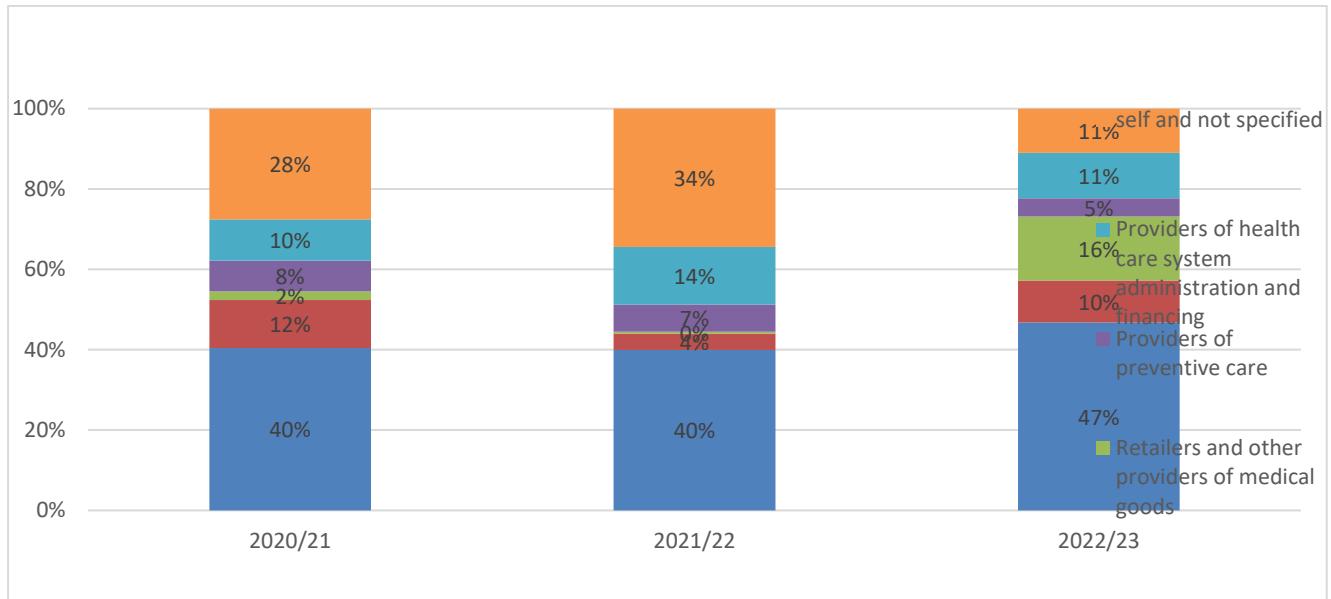
Between 2020/21 and 2022/23, Tanzania's healthcare expenditure distribution by provider shifted notably, with hospitals consistently receiving the largest share, increasing from 40% to 47%. Concurrently, spending on primary health care providers fluctuated, dropping from 12% to 4% before recovering to 10%, while expenditure on retailers and medical goods providers saw a significant jump from 2% to 16%. Conversely, preventive care's share steadily declined from 8% to 5%. The "self and not specified" category also decreased sharply from 28-34% to 11%, suggesting improved data categorization. These trends imply an increasing reliance on hospital-based care and potentially the private retail sector, while primary and preventive healthcare may be facing underinvestment or instability, with potential long-term implications for public health outcomes and system sustainability.

9.4. EXPENDITURE BY HEALTH CARE FUNCTIONS

These functions include curative services, prevention services, governance, and administration, as well as other unclassified services. Figure 74. illustrates the distribution of the total healthcare expenditure.

Figure 74:Function by Share
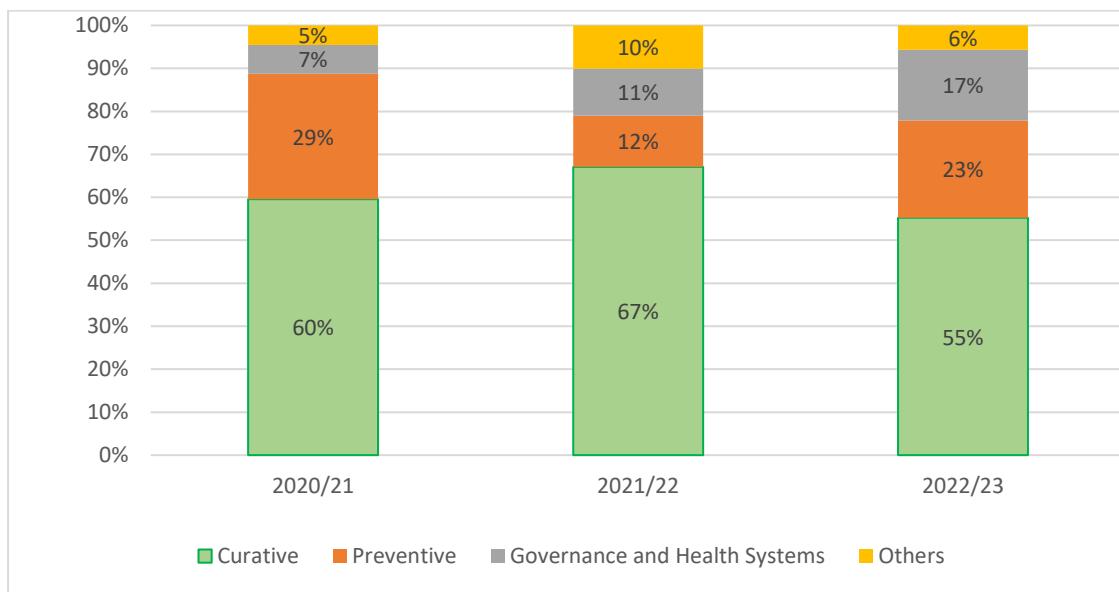
Current Health Expenditure (CHE) in Tanzania from 2020/21 to 2022/23 shows that curative care consistently accounts for the largest share, fluctuating from 60% in 2020/21 to a peak of 67% in 2021/22, before dropping to 55% in 2022/23. Meanwhile, preventive care experienced significant volatility, decreasing sharply from 29% in 2020/21 to 12% in 2021/22, then rebounding to 23% in 2022/23. Notably, expenditure on governance and health systems demonstrated a steady upward trend, increasing from 7% in 2020/21 to 17% in 2022/23, indicating growing investment in strengthening health sector management and infrastructure. The "Others" category also varied, from 5% to 10% and then back to 6% over the same period. This trend suggests a potential need to rebalance spending to prioritize sustained preventive measures alongside continued health system improvements.

9.5. EXPENDITURES BY DISEASES

Diseases/conditions are typically classified into seven main groups, including infectious diseases, reproductive health issues, nutritional deficiencies, non-communicable diseases, injuries, non-disease-specific categories, and other and unspecified diseases/conditions. It's important to note that expenditure on diseases primarily reflects the burden of diseases at the facility level, due to the methodology used in estimating disease-specific expenditure. Figure 75; illustrates the distribution of CHE across disease categories.

Figure 75:Share of Disease in CHE
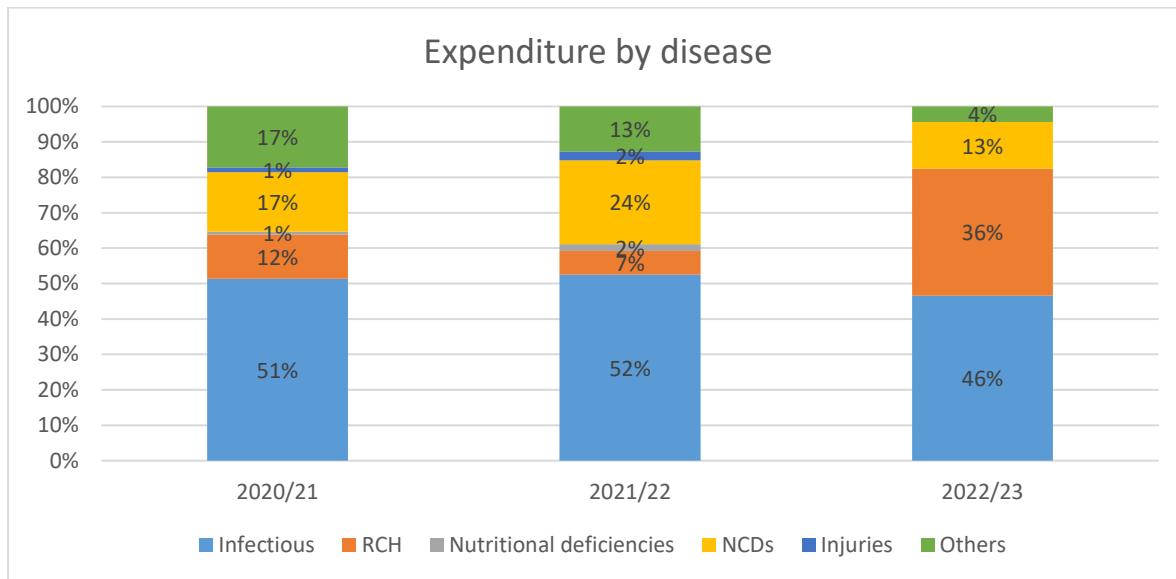
The stacked column chart illustrates the distribution of healthcare expenditure across various disease categories in Tanzania over three fiscal years: 2020/21, 2021/22, and 2022/23.

In 2020/21, infectious diseases accounted for the largest share at 51%, followed by Reproductive and Child Health (RCH) at 12%. Expenditure on nutritional deficiencies and injuries was minimal, each at 1%, while Non-Communicable Diseases (NCDs) and other categories each made up 17%. The following year, 2021/22, saw a slight increase in infectious disease expenditure to 52%, while RCH declined to 7% and nutritional deficiencies rose to 2%. NCDs remained significant at 24%, injuries stood at 2%, and expenditure on other categories dropped to 13%. By 2022/23, a noticeable shift emerged, with infectious disease expenditure declining to 46%, while RCH surged to 36%. Nutritional deficiencies remained at 2%, NCDs dropped to 13%, injuries increased to 4%, and other categories fell to 4%. This trend highlights a gradual decrease in funding for infectious diseases, a substantial rise in RCH expenditure, and fluctuations across other categories over the three-year period.

Healthcare expenditure in Tanzania has shifted, with declining infectious disease funding and a sharp rise in Reproductive and Child Health (RCH) investment. Non-Communicable Diseases (NCDs) show funding fluctuations, requiring stable resource allocation. Nutritional deficiencies and injuries remain underfunded, demanding greater attention. Prioritizing balanced funding and regular assessments will optimize healthcare impact.

Challenges

i)   Insufficient Public health expenditure to achieve universal health coverage

ii)   Dependency on foreign financing

iii)   Vulnerability to catastrophic and impoverished health spending

Policy Recommendation

i)   To fast tracking roll out of Universal Health Insurance Act

ii)   To increase the share of domestic resource for health financing

iii)   To promoting preventive services

CHAPTER TEN
10.0. ENVIROMENTAL HEALTH AND SANITATION

10.1. INTRODUCTION

Good health depends on clean air, a stable climate, a preserved natural environment, as well as access to adequate water, sanitation and hygiene. It also requires protection from harmful radiation, unsafe chemical management and unhealthy working conditions. A healthy environment could prevent nearly a quarter of the global disease burden. The WHO report in 2016, 13.7 million of deaths, representing 24% of global fatalities, were attributed to modifiable environmental risks. This means nearly one in four global deaths are linked to environmental health conditions.

The Sustainable Development Goals (SDGs) of the 2030 Agenda has five key goals that addresses the environmental determinants of health and contribute directly and indirectly to SDG 3 which focused on "health" - ensuring healthy lives and promoting well-being for all at all ages. These SDGs address the issues of water, sanitation and hygiene, air quality, chemical safety, and climate action.

To achieve environmental health objective, as country need to evaluate possible health problems attributable to environmental factors; develop inclusive and equitable public health

interventions to protect all people from environmental hazards; and ensure compliance with those interventions. This is achieved through participation of key stakeholders at national, regional and local government authorities.

10.2. INDICATORS

The indicators presented in this part are drawn from the HSSP V (2021-2026), the National Environmental Health, Hygiene and Sanitation Strategy (2020–2025) and Sustainable Development Goals 2030 for interest of the government and Development partners to reflects WASH interventions.

Table 47:Summary of Indicators, Baseline and Targets for Year 2023 and 2024

No.	Key Indicator	Baseline 2023	Target 2024	Achievement 2024
1.	Percentage of households with toilets (all type)	98.6	100	98.4
2.	Percentage of households with improved toilets	77.5	100	79.7
3.	Percentage of household with access to improved sanitation	72.3	75	79.7
4.	The number of villages declared Open Defecation Free (ODF)	20,000	5,148	1.6
5.	Number of health facilities supported with WASH infrastructures	1,902	2,636	2,740
6.	Percentage of people with access to improved water sources (Urban).	86	100	90
7.	Percentage of people with access to improved water sources (Rural)	72.3	85	79.6
8.	Percentage of household with functional Handwashing points	50	54.5	48.8
9.	Number of Points of Entry enhanced with Core capacities at 80% and above for the implementation of IHR, 2005	5	40	13
10.	Number of healthcare facilities with workplace improvements program	100	73	73
11.	Number of Regional Referral Hospital with H-Tech incinerators	28	28	28
12.	Number of National, zonal and specialized hospital with Hi-Tech incinerators	11	11	11

10.3. SANITATION AND HYGIENE AT HOUSEHOLD LEVEL

In Tanzania households with any form of toilets has not show any progress in reducing the percentage as in 2023 households with any form of latrine was 98.6% while in 2024 the number decrease to 98.4%. The reasons behind this situation could be that, most of people build temporaly sanitation and hygiene facilities and during rain season it collapse that explain this phenomenoane. On the other hand, households with improved toilets increased from 77.5% (2023) to 79.7% (2024), *Mtu ni Afya* campaign that is implemented countrywide with the emphasise to household build improved latrine and other key messages on nutrition, physical excerses, hand washing etc. Also, in 2024 households with no latrine from these finding has increased to 1.6% from 1.4% in 2023.

Speaking on the coverage of hand washing, there is a decrease in households with hand washing point from 54.5% in 2023 to 48.8% in 2024. The decrease of handwashing points at households from the NSMIS data was due to increase of coverage of household visited and data quality issues in the data collecting sytem. The safely managed sanitation is the highest level of access to improved sanitation, in 2023, the proportion of households with access to safely managed sanitation was 32.6%, lower than the average compared to the reported 34.8% in 2024. **Table 48** below shows the progress on indicators

10.4. IMPLEMENTATION OF THE SUSTAINABLE RURAL WATER SUPPLY AND SANITATION PROGRAM

The Government of Tanzania through the Ministry of Health; Ministry of Water; Ministry of Education, Science and Technology and PO-RALG is implementing a Sustainable Rural Water Supply and Sanitation (SRWSS) program for five-year 2020 - 2025. The program is designed to increase and sustain access to improved Water, Sanitation and Hygiene services in rural settings in 25 Regions of Tanzania Mainland except Dar es salaam and 137 councils. The program has managed to reach 6,610,198 new constructed improved latrines, 555 Open Defecation Free villages, 2740 health care facilities constructed with water tanks, improved toilets, incinerators, hand washing facilities at point of use. Also, the program has increased households with hand washing point to the 48.8%.

As it is shown in the table below, the program has achieved remarkable achievement whereby out of five (5) indicators three (60%) of them were implemented beyond the target. Due to this achievement during this period, World Bank and Government increased the project coverage from 17 regions to 25 regions and 86 districts to 137 councils.

Table 48: Summary of Indicators, Baseline and Targets for Year 2023 and 2024

Indicator	First Year 2019/20		Second Year 2020/2021		Third Year 2021/22		Fouth Year 2023/24		Target for 4 years
	Target	Success	Target	Success Cumm.	Target	Success Cumm.	Target	Success Cumm.	
People with access to improved latrine	400,000	2,602,308	1,300,000	4,669,918	2,200,000	6,610,198	9,040,260	10,112,878	4,000,000
Open defecation free villages	50	72	350	245	650	555	1,746	941	1,250
Number of health facilities rehabilitate/constructed with WASH infrastructures	100	0	450	873	800	1,534	2,636	2740	1,500
Number of Districts with good quality sanitation and hygiene data	86	0	86	5	86	62	80	58	86
Percentage of households with hand washing points	10	38.5	15	42.2	20	41.3	80	48.8	30

Source: *SRWSS Program 2024 – MoH*

10.5. NATIONAL CLEANLINESS COMPETION

In 2024, the Ministry organized competitions and announced the winners at the climax of the National Health Week celebrations on April 8, 2025. The overall regional winner of these competitions was Njombe Region. Additionally, Tanga City emerged as the winner in the City-level competitions, Njombe District at the District Council level, Moshi Municipality at the Municipal Council level, and Njombe Town at the Town Council level. The Ministry encourages councils and citizens to enhance sanitation and hygiene services, as more than 70% of patients visiting healthcare facilities suffer from infectious diseases caused by poor hygiene. This highlights the urgent need for improved cleanliness and public health awareness to reduce the spread of such diseases.

10.6. MENSTRAUL HEALTH AND HYGIENE

Menstruation is one of the Ministry's priorities, and to make it sustainable, the Government, through President of the Regional Administration and Local Government (PO-RALG) office continues to allocate 10% of the school operational grants (capitation fund) to enable schoolgirls to access sanitary pads. Additionally, stakeholders are being engaged to contribute to these services and distribute sanitary pads in schools. In the fiscal year 2023/2024, the Government, in collaboration with stakeholders forming the Safe Menstruation Platform, coordinated the availability of 5 million sanitary pads and distributed them to primary and secondary schools in Dodoma. In the fiscal year 2024/2025, 2,847 private rooms were constructed in primary and secondary schools, and about 2,248,591 sanitary pads were distributed to the targeted 2,830,850 beneficiaries.

10.7. ENVIRONMENTAL PROTECTION AND POLLUTION CONTROL

Access to Inceraror and Biodigestor: The Government continues to face challenges in maintaining a healthy and environmentally friendly atmosphere within health facilities, aiming to protect both human health and the environment from the harmful effects of hazardous waste. To address this, significant efforts have been directed toward the prevention and mitigation of healthcare waste risks. Notable progress has been achieved in recent years - by 2023, all 28 Regional Referral Hospitals (RRHs) were equipped with functional incinerators, reaching 100% coverage, a remarkable increase from only 21 RRHs (17.9%) in 2022. Similarly, the number of Council Hospitals with incinerators rose from 33 in 2022 to 58 (31.5%) in 2023, and further to 64 (35%) out of 184 facilities in 2024.

Figure 76:Incinerator Coverage in Health Facilities 2022 to 2024
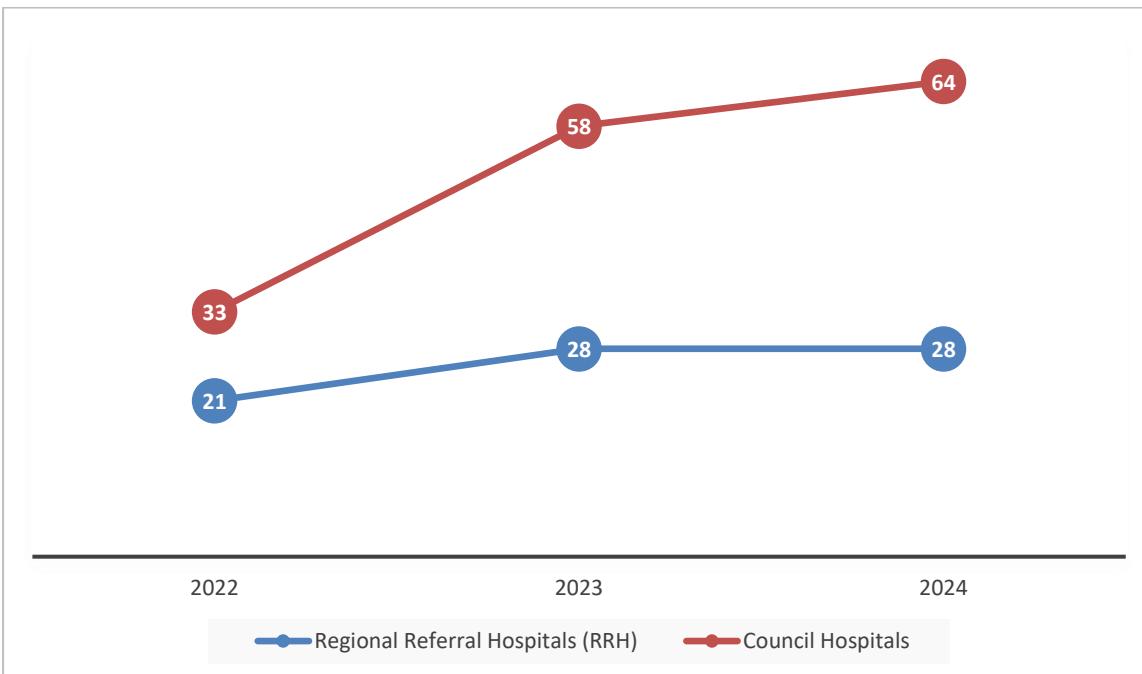
On the other hand, for the digestible health care waste, construction of Biodigester has increased from 9% in 2023 to 17% in 2024. The target is to reach 100% for all RRH in 5 years. At facilities, the Biodigester offers management of healthcare as well as the production of energy in HCFs.

Environmental Social Safe Guard: In strengthening infrastructures, the conditional survey to capture environmental risks and impacts was done in 25 regions targeted to cover 15 Hospitals, 75 Health centres and 76 Dispensaries, up to now 31 hospitals has already carried EIA. In 2024/2025 financial year, the government continued its efforts to strengthen environmental sustainability in the healthcare sector by expanding Environmental Impact Assessments (EIAs).

Climate Change in Health: In the year 2023, The Government developed a Climate Change Dashboard, a technology for forecasting climate change-related diseases e.g. malaria, dengue, cholera and other diarrhoea diseases. The dashboard provides early warning indicators for climate-related diseases and at this point it is pilot phase and finally, it will be operationalized in 184 councils for enhancing preparedness. A nationwide transition to clean cooking solutions has been launched across public and private institutions, including Regional Referral Hospitals (RRHs) and various health facilities. This initiative aligns with the National Clean Cooking Strategy (2024–2034), which aims to ensure that 80% of the population has access to clean cooking energy by the year 2034.

10.8. IMPLEMENTATION OF THE WORKPLACE PROGRAMME

The Ministry has developed programme to support workplace improvements in health care facilities and to sanitation workers to improve their workplace health conditions. In the health sector between the year 2023 to 2024 with the use of national guideline on health and safety of health workers have trained CHMT in 73 councils in 10 Regions from Mbeya, Kigoma, Tabora, Kilimanjaro, Iringa, Mwanza, Mtwara, Dodoma, Ruvuma and Singida with 1035 beneficiallies healthworkers. One the other hand, the workplace improvement was also done to sanitation workers where by the Ministry has developed the National guideline on health, safety and dignity of sanitation workers and its training materials and was launched in Shinyanga on September 2024 and about 115 sanitation workers was trained. The aim of these is to advocacy on improving working contions in various sectors.

A comparison of reported cases of occupational health from health facilities in the year 2023 and 2024 as shown in Figure 77 below.

Figure 77: Occupational Health Issues Reported Quartery in the year 2023 compared to 2024
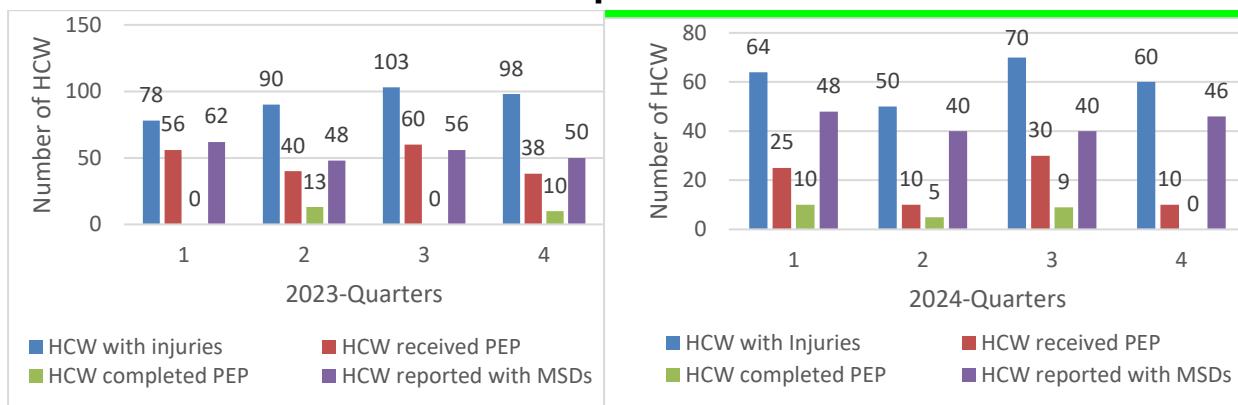
10.9. IMPLEMENTATIONS OF PORT HEALTH SERVICES

Port Health Stations are part of a comprehensive system that serves to limit the introduction and spread of contagious diseases in Tanzania.The port health services are established to operationalize the International Health Regulation (IHR) 2005 and the Public Health Act (2009) that target control diseases in points of entry. To fully achieve control of disease at points of entry (PoE), the IHR 2005 requires countries to build and maintain capacity to prevent and respond to public health events. In this regard, in the year 2024 the following investment and achievements have been made.

Port Health Services has continued to control entry and exit of infectious diseases including Ebola, Murburg, Mpox, COVID 19 and others through Airports, ports and ground crossing by conducting a health screening of travellers incoming and exiting traveller. For the year 2024, a total of 11,005,877 travellers were screened of which 2,930,807 (26.6%) were international travellers and 8,075,070 (73.4%) were domestic travellers. A total of 18 travellers were suspected to have infectious diseases but after further investigations, none of the travellers was found to have dangerous infectious disease. There is increased number of travellers screened compared to year 2022 to 2023 as a total of 8,375,047 travelers were screened of which 1,733,502 (20.7%) were international travelers and domestic travelers were 6,641,545 (79.3%), none of the travellers was found to have dangerous infectious diseases. (Figure 78).

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Figure 78: Number of travelers screened for the year 2023 and 2024
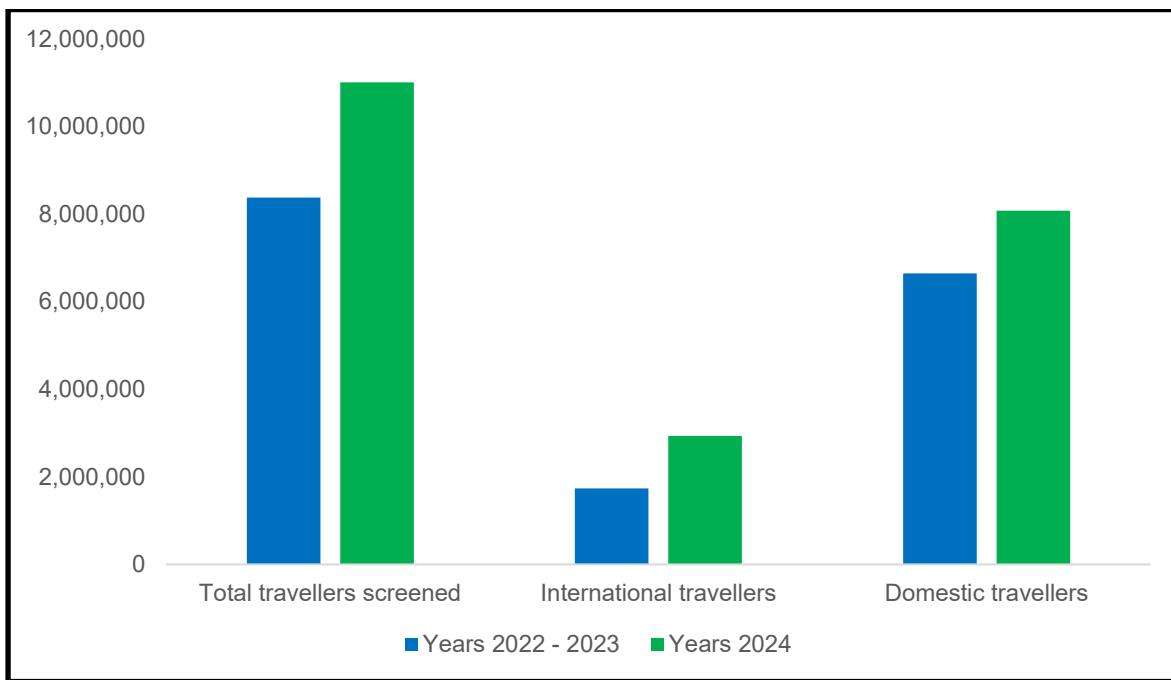
On the other hand, for the ***control Yellow Fever disease at points of entry***, in the year 2024, a total of 6,941,522 travellers screened, the number is high compared to 5,642,611 travellers who were screened in 2023. These are travellers who came or transited from yellow fever endemic countries and are screened for their vaccinated status against yellow fever disease of those screeds, in 2024 travellers 15,212 who lacked proof of vaccination were vaccinated against the disease as compered to 11,747 travellers who were vaccinated during the year 2023.

Enhancement of the core capacity of port of entry, to enhance the capacity of ports of entry on transportation of suspected or ill travellers, the Ministry has purchased and distributed 8 ambulances to Julius Nyerere International Airport, Kilimanjaro International Airport, Songwe Airpoprt, Mwanza Airport Holili border, Namanga OSBP, Tunduma OSBP and Mutukula OSBP. The capacity of ports was also enhanced with human resource for health, where by 201 permanent staff were employed and deployed to all Port Health Offices in the Country. This this made an increase of Port Health Staff from 300 in 2023 to 501 in 2024. An increase of new Port Health Officers will strengthen Port Health services operations and has facilitated the establishments of new Port Health Offices in 10 Points of Entry of Pangani, Kagunga and

Bagamoyo ports, Kilambo, Mkunya, Mkenda na Kyaka borders, Songea Airprt and SGR stations of Dodoma, Morogoro na Dar es Salaam to make 54 Port Health offices with staff directly employed with Ministry.

The Strategic Risk Assessment and updation of existing contingency plan to multi hazard at high-risk ground crossings of Mutukula OSBP and Horohoro OSBP. Inadditional, the Ministry conducted Population Conectivity Across Borders (PoPCAB) at Songea and Nyasa Districs, Ruvuma region to enhance prevention and control of Cholera, TB and other Public Health Events of International Concern (PHEICs) from Mozambique and Malawi while joint PoPCAB exercises were performed at borders between Tanzania and Countries of Uganda and Kenya. PoPCAP highlighted rooutes, stop overs, regions which are at risk of getting crossborder diseases outbreaks and human activities that facilitate crossborder interactions hence development of strategic interventions for the prevention and control of infectious diseases across borders. Furthermore, the Ministry conducted joint core capacity assessment at borders between Tanzania na Burundi which generated joint action plan for the improvement core capcity requrements for Points of Entry and Border Health as per IHR, 2005.

Challenges
  i).   For quite a number of years, the proportion of households without latrines has not fallen below 1%, and as of 2024, it remains at 1.6%. Similarly, the percentage of households with handwashing facilities has consistently remained below 50%. Despite significant investments in the National Sanitation Campaign, including the nationwide implementation of the "Mtu ni Afya" initiative, these figures have shown little to no improvement over the years.
 ii).   About 14 out of 26 our urban authorities in Tanzania have sewerage system and the system can only provide services to less than 10% of the need geographical area (Tabora, Arusha, Mbeya, Tanga, Songwe, Shinyanga, Dodoma, Dar es Salaam, Morogoro, Mwanza, Moshi, Singida, Iringa and Mara). Majority of the urban househods relay on onsite sanitation services.
 iii). Nationwide, just roughly one-third of the solid waste generated is getting collected, the remained two-third of Tanzania's MSW is disposed of in an inadequate way.
 iv).   An ongoing prevelance of cholera in several regions because of inadequate safe water supply to communities and communities rely on raw water from unprotected water sources

v). Insufficient resources to support the healthcare facilities' workplace improvement progr ams.

vi). In adequacy of resources to facilitate the achievement of the clean cooking adoption targets set by the country National Clean Cooking Strategy

vii). Despite growing recognition of the need to adopt clean cooking solutions, RRHs and other health facilities facing financial constraints,

viii). Because health facilities lack the necessary supplies for the prevention and control of work-related illnesses and injuries, as well as an unsatisfactory working environment and insufficient human resources for health to support the high demands of work, health workers suffer from occupational health-related diseases and injuries.

ix). Inadequate enforcement of regulations made under the Public Health Act, 2009 that would facilitate implementation of various Public Health intervention in the country.

x). Inadequate resources allocated to make routine maintenance of medical equipments such as incinerators.

xi). Inadequate adherence of SoP for Health care waste management at health facilities.

xii). Inadequate office building and space as well as permanent facilities for health screening of travellers and isolation of suspected travelers with infectious diseases at Points of Entry.

xiii). Inadequate facilities for implementation of vector control program, water quality and environmental contaminants monitoting, conveyances inspections and provision of Ship Sanitation Certificates at Points of Entry.

xiv). Inadequate funding for clean cooking technologies in health sector budgets.

Policy recommendations

i). To examine and improve the enforcement of Public Health Regulations in order to facili tate the Public Health Act 2009's implementation, which regulates a number of public h ealth issues and aids in the prevention and management of infectious diseases.

ii). To strengthen port health services to prevent the importation and exportation of diseases of international concern.

iii). To improve health facilities management skills to optimize management responsibilities in improving workplace environment for workers in healthcare service delivery.

iv). To close the gaps in community sanitation and hygiene by putting Social Behavioural Communication models, best practices, and techniques into practice.

v). To scale up safe water supply and waste water management infrastructures to all underserved rural areas and peri urbans.

vi). To leverage on financial incentives such as grants, low-interest loans, or subsidies to ease the cost of clean cooking technology to health institution

CHAPTER ELEVEN
11.0. HUMAN RESOURCE FOR HEALTH

11.1. INTRODUCTION

Tanzania is one of the developing countries faced by critical shortage of Human Resources for Health (HRH). According to the Staffing levels guideline (2017-2022), the minimum number of health workers required to provide services in the Health Sector in financial year 2022/23 was 348,923. The actual number of health workers available was 126,925, which explains a shortage of 221,998 (64%) workforce.

For the year 2023/2024, the total Human Resources for Health requirement was 391,950, the number of Human Resources in the health service delivery facilities was 177,340 compared to 2023 and the shortage was 214,610 (55%).

As shown in Figure 81, in year 2021/2022, out of a total requirement of 348,923 health workers, only 119,728 were available, resulting in a shortage of 229,195 personnel (34% shortage). The situation slightly improved in 2022/2023, with available staff increasing to 126,925, reducing the shortage to 221,998, though the percentage shortage rose to 36%. By 2023/2024, the total requirement increased significantly to 391,950, with 177,340 health workers available, leading to a shortage of 214,610 and a marked rise in the percentage shortage to 55%. This trend underscores the growing gap between demand and availability of health personnel despite marginal improvements in absolute staffing numbers.

Among whom, 138,059 were in the local government facilities about 78% and 39,281 about 22% in Regional Referral, Zonal, Specialized, National Hospitals, training institutions and ministry headquarter and other institutions.

11.2. THE HRH INDICATORS

The HRH indicators for Medical Officers, Assistance Medical Officers, Nurses of all categories, Laboratory Staff and pharmaceutical staff in the country for 2024 is as shown in the Table 49.

Table 49: Number of Health Workers (Specific Cadre) Per 10,000 Populations 2020 to 2024

	Performance Indicator	2020	2021	2022	2023	2024
1	Medical Specialists	-	-	-	0.39	0.49
2	Number of Medical Doctors (MD) per 10,000 population	1.03	1.03	0.74	1.09	1.22
3	Number of Assistant Medical Officers (AMO) per 10,000 population	0.31	0.31	0.34	0.54	0.52
4	Number of AMOs/MDs per 10,000 population	1.34	1.34	1.08	1.63	1.84
5	Number of Nurse/Midwives per 10,000 population	4.1	4.1	6.8	7.24	9.6
6	Number of Pharmaceutical Staff per 10,000 population	0.34	0.34	0.35	2.76	2.96
7	Number of Health Laboratory Staff per 10,000 population	0.96	0.96	0.8	1.19	1.23

Source: HRHIS population 2024

Figure 79:Number of Human Resources in the Health Service Delivery Facilities, 2021/22 to 2022/24
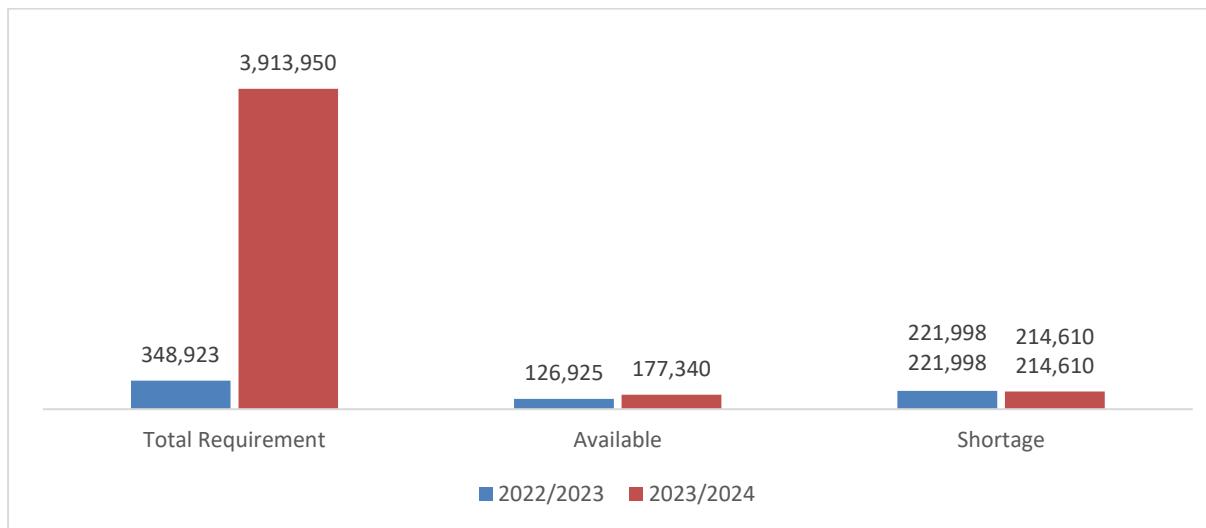
11.3. HUMAN RESOURCES FOR HEALTH DISTRIBUTION
11.3.1. HRH DISTRIBUTION BY REGION

Table 50 and Figure 80 show the Human Resources for Health distribution by regions. The peripheral regions still face a critical shortage of Human Resources for Health compared to the regions like Mbeya, Kilimanjaro, Dar Es Salaam and Dodoma where the workforce shortage is below 33 percent.

Table 50: HRH Distribution by Region, 2024

REGIONS	REQUIRED 2024	AVAILABLE 2024	SHORTAGE 2024	%SHORTAGE	%AVAILABILTY
Njombe	17,226	3,531.07	13,695	80%	20%
Songwe	8,122	1,866.53	6,256	77%	23%
Kagera	23,145	6,425.44	16,719	72%	28%
Mbeya	24,260	6,810.02	17,450	72%	28%
Katavi	23,933	6,931.86	17,001	71%	29%
Simiyu	17,066	5,134.02	11,932	70%	30%
Lindi	16,485	5,377.89	11,107	67%	33%
Shinyanga	12,343	4,236.41	8,106	66%	34%
Kigoma	23,485	8,076.91	15,408	66%	34%
Mtwara	12,700	4,798.86	7,901	62%	38%
Ruvuma	12,365	5,039.62	7,326	59%	41%
Singida	14,229	6,252.36	7,977	56%	44%
Rukwa	11,570	5,364.45	6,206	54%	46%
Geita	24,375	11,519.79	12,855	53%	47%
Tabora	3,181	1,621.10	881	28%	51%
Mara	13,708	7,186.19	6,522	48%	52%
Morogoro	10,064	5,314.75	4,749	47%	53%
Tanga	7,708	4,268.29	4,497	58%	55%

Arusha	16,447	9,582.82	5,865	36%	58%
Pwani	11,140	6,560.14	4,580	41%	59%
Kilimanjaro	17,342	10,657.70	6,684	39%	61%
Mwanza	12,448	7,827.02	4,621	37%	63%
Dodoma	9,628	6,088.76	3,539	37%	63%
Manyara	13,852	8,836.85	4,015	29%	64%
Iringa	17,369.60	11,723.07	5,647	33%	67%
Dar es Salaam	17,759	12,308.32	5,451	31%	69%

Source: *HRHIS 2024*

Figure 80:Availability of Human Resource for Health by region, facilities as per manning level; 2024
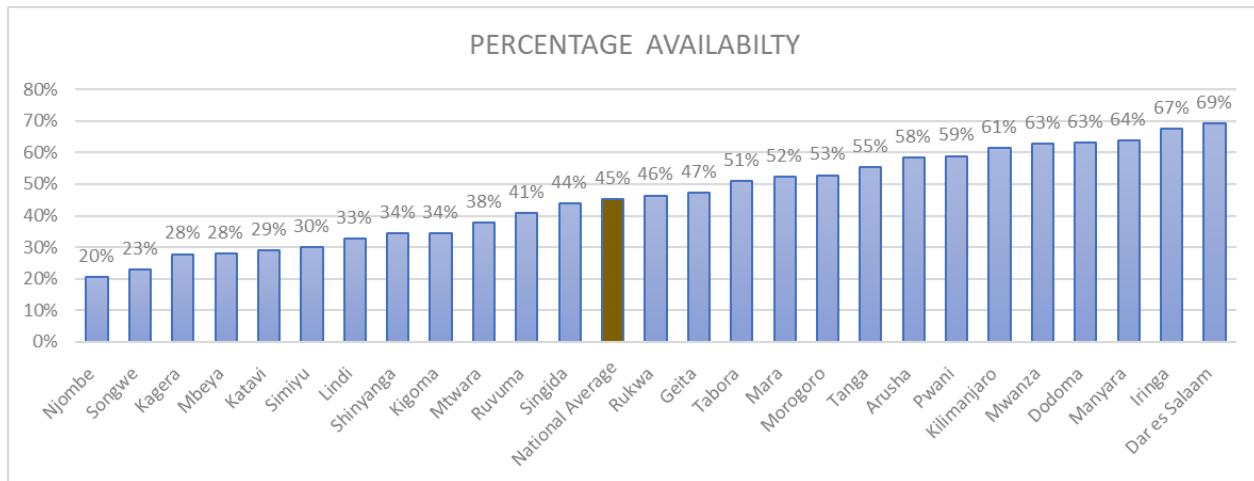
Source: HRHIS 2024

11.3.2. RURAL VERSUS URBAN HRH DISTRIBUTION

The total number of health workers available in 2023/2024 was 177,340 among them 28,551 (16.1%) are not working directly in health service delivery facilities, rather they are working in the Ministry, Training Institutions, agencies etc. The distribution of Health Care Workers (HCWs) in rural and urban settings shows that, HRH 46.1 percent are in urban settings and 53.9 percent are in Rural areas in 2024 as shown in the Figure 81.

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Figure 81: Urban and Rural HRH Distribution

URBAN AND RURAL HRH DISTRIBUTION

46.1
53.9

■ RURAL
■ URBAN
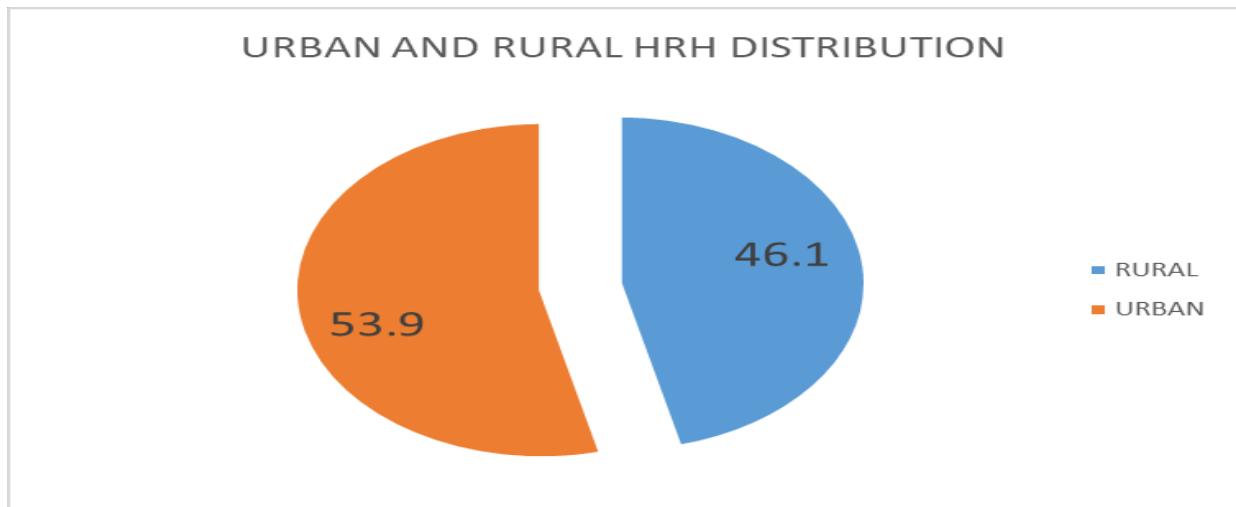
Source: HRH

11.3.3. HRH DISTRIBUTION AT FACILITY LEVEL

The Dispensaries experience four times shortage than in the Regional Referral Hospitals. The Health Training Institutions experiences extreme shortage of Tutors for about 69 percent. For the year 2022/23 and 2023/24, the HRH distribution by facility levels is as shown in the Table 51.

Table 51: HRH Distribution by Type of Facility 2023 and 2024

Facility Level	2023				2024				
	HRH Required	HRH Available	Shortage	% Available	HRH Required	HRH Available	Shortage	% Available	% Shortage
Dispensary	100,646	33,122	67,524	33%	123,857	43,122	80,735	35%	65.18%
Health Centre	68,204	27,287	40,917	40%	75,477	45,496	29,981	60%	39.72%
District Hospital	123,624	29,451	94,173	24%	125,264	37,945	87,319	30%	69.71%
Other Hospital	16,324	12,278	4,046	75%	21,829	17,278	4,551	79%	20.85%

Regional Referal Hospital	27,941	19,444	8,497	70%	29,536	22,588	6,948	76%	23.52%
National, Zonal & Specialised Hospital	2,637	1,856	781	70%	3,145	2,955	190	94%	6.04%
Health Training Institutions	9,547	3,487	6,060	37%	12,842	7,956	4,886	62%	38.05%
Grand Total	**348,923**	**126,925**	**221,998**	**3**	**391,950**	**177,340**	**214,610**	**45%**	**55%**

Source: *HRHIS*

11.4. TRAINING AND DEVELOPMENT FOR LOWER AND MIDLEVEL CADRE

The enrolment has been fluctuating from 2020 to 2024 as shown in the Figure 82 below.

Figure 82:Enrolment and Graduate Trend for the year 2020 to 2024
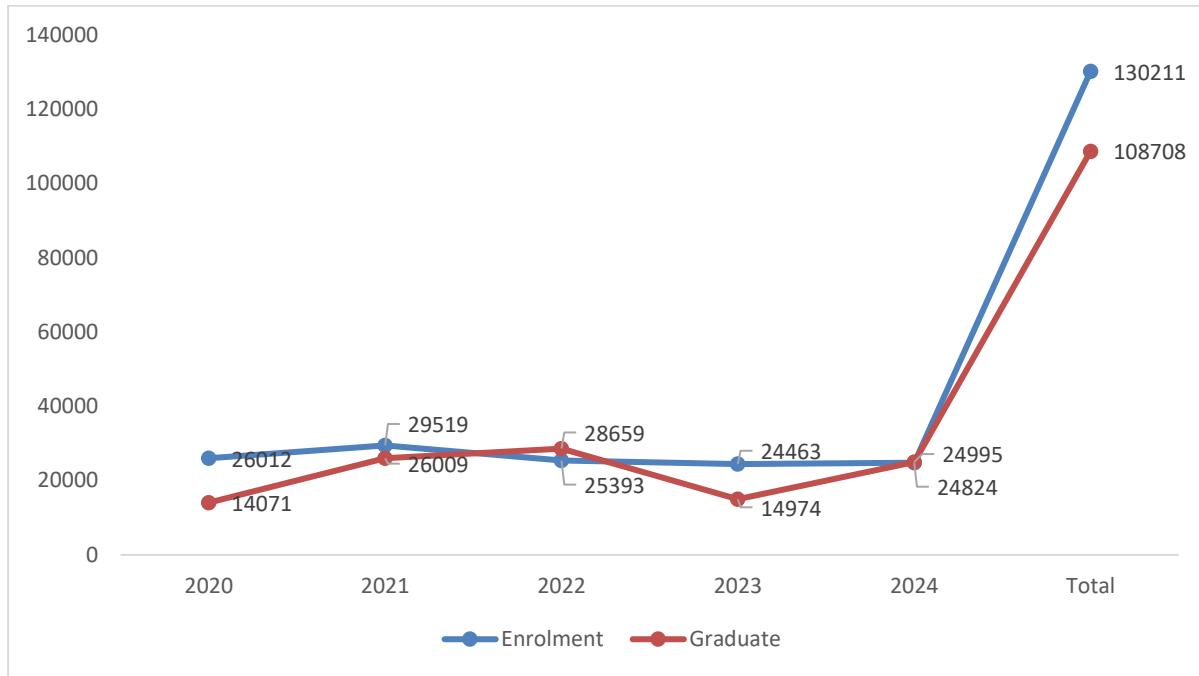
Source: *NACTVET/HRHIS*

11.5. TRAINING AND DEVELOPMENT FOR POSTGRADUATE

The Ministry has increased sponsorship of postgraduate students from 502 in 2020 up to 1,373 in 2024. The focus is to reduce gaps of specialists and super specialists for the National, Zonal, Specialized and Regional Referral Hospitals throughout the country. The number of beneficiaries has been fluctuating due to varying costs of the scholarship abroad.

Figure 83: Showing Post Graduate Studies

RECIPIENTS OF SCHOLARSHIP
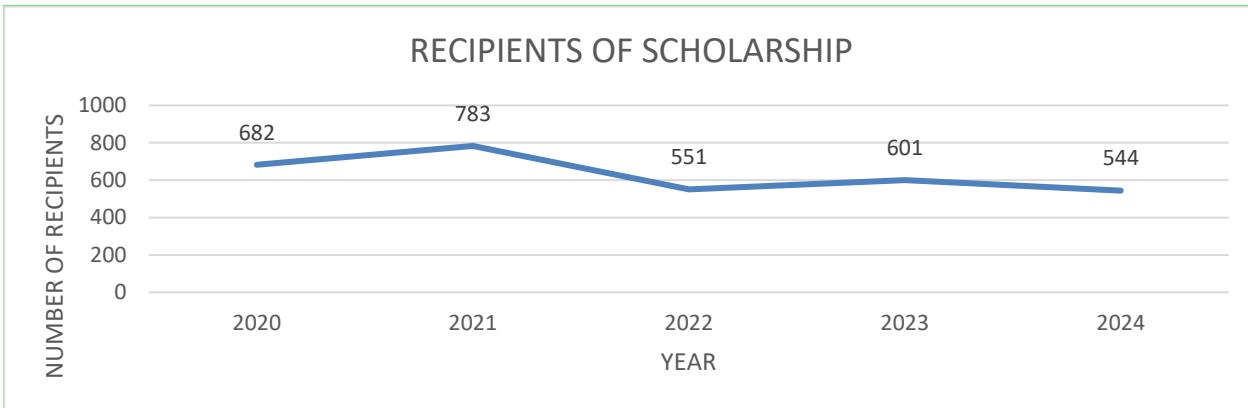
Source: HRHIS 2024

11.6. CONTINUOUS PROFESSIONAL DEVELOPMENT

Continuous Professional Development (CPD) is the organized process of continually improving and developing knowledge, understanding and professional skills. It refers to the process of certified training through independent, participation-based or interactive learning methods.

The Ministry of Health has established the National e-learning platform for health as one of cost-effective strategy in providing CPD for Healthcare workers. The main expected outputs of the eLearning are to increase the number of healthcare workers with improved capacity in provision of quality health services. In the year 2023 of National eLearning Platform for healthcare workers had more than 298 modules and frequency of active users increased from 94,734 in 2023 to 129,664 in 2024 with increase number of modules by 136 percent.

In addition,apart from eLearning Platform,Ministry of Health through Professional Health Regulatory Councils Namely Health Laboratory Professional Councils (HLPC),Medical Council of Tanganyika (MCT),Tanzania Nursing and Midwife Council (TNMC) and Pharmacy Council (PC) has managed to accredit 212 active CPD Providers who conduct CPD activities virtually and in physical sessions to enhance health Practioners to get CPD points for professional development and practicing Licenses renewal.

11.7. HUMAN RESOURCE FOR HEALTH RECRUITMENT

The government through MoH and PORALG has recruited a total of 43,774 health care workers in six years' time from 2017 up to 2024. In the year 2024, the government planned to hire 13,187, but in the implementation of the process there were hired a total of them 13,193 new

health care workers throughout the country, but the attrition caused by different factors reached 761 health Care Workers. The factors which contributed to attrition include retirement (595 staff), death (87), leaving the job for unknown reason (56), summary dismissal (9) and fake certificates (14). The recruitment trend is as shown in Figure 84.

Figure 84: Number of Recruited Health Care Workers, 2019 to 2024

Source: HRHIS

11.8. HUMAN RESOURCE FOR HEALTH RETENTION

For 2023/24, a total of 7,438 houses were built around dispensaries and Health Centre's to accommodate and retain Human Resource for Health. However, other factors include death, summary dismissal, leaving the job as a result of difficult working environments. Overcoming this challenge, the government provides recruitment permits to fill the gaps (HRH replacement). In 2023/24, the government provided a permit to recruit 1,434 new Health Care Workers to fill the gap.

Planned interventions

  i. To increase enrolment of students resulting from increase of Health Training Institutions and expansion of health training programs in 2024/25
 ii. To introduce one new training program in health training institutions of radiology.
iii. To implement National Health Workforce Volunteering Guideline 2021 in all facilities
 iv. To recruit of 17,222 new health care workers

Achievements

 i.   The public and private health training institution has enrolled 24,463 students in 2024
 ii. The number of health training institutions graduates increased from 11,704 in 2019 to 14,974 in 2024.
 iii. The government also recruited 13,193 new health workers for 2024 as shown in the graph above (Figure 84)

11.9. HUMAN RESOURCE FOR HEALTH INDICATORS

The HRH Indicators measure the number of health workers available per 10,000 populations in a given geographical area. This indicator is very useful in making comparison of HRH available in different regions. The WHO recommends HRH density indicator of 22.8 clinicians and nurses per 10,000 populations. The currently respective indicator for our country in 2024 was 11.44 clinicians per 10,000 populations, same as 50.17 percent of the WHO target

Health Laboratory Staff Per 10,000 population has increased rate from baseline except for Medical Doctors who surpassed the 2023 targets due to the recruitment of the 13,193 HCWs among whom were Medical Doctors in 2024 (Table 49).

Figure 85:HRH Distribution for Clinicians and nurses cadres Per 10,000 Population by Region 2024
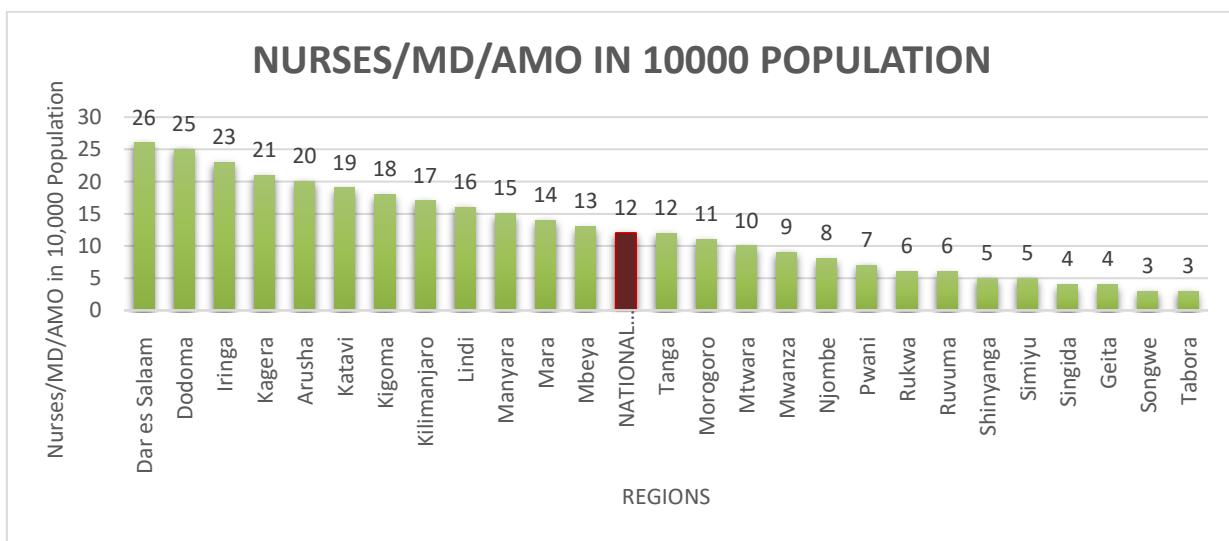
Source: HRHIS 2024

The regions with HRH per 10,000 populations regions above national average includes, Dar Es salaam, Dodoma, Iringa, Kagera, Kigoma, Kilimanjaro Lindi, Manyara, Mara, and mbeya Lindi, Manyara Mara and Mbeya. These regions have favourable conditions of work and living environment. Regions such as Tabora, Songwe, Geita, Singida, Shinyanga, Ruvuma, Rukwa, Njombe, Mwanza, Mtwara, Morogoro and Tanga are below National average of 21 health workers per population as shown in Figure 85.

11.10. ACCREDITATION STATUS OF HEALTH TRAINING INSTITUTIONS

The proportion of health training institutions with full accreditation, which is proxy for the quality of institutions, is shown in the Table 52.

Table 52: Proportion of Training Institutions with Annual Accreditation 2020 to 2024

| Indicators (HSSP IV) | Baseline | | |
	2020	2023	Achievement (2024)
Percent of Health Training Institutions with accreditation	219 out of 219 (100%)	All 219 Health Training Institutions have full accreditation (100%)	222 (100%)

Challenges

  i.   Shortage of human resources for health by 64 percent.
 ii.   Unsatisfactory infrastructure (Electrical, clean water and sewerage systems)
iii.   Unsatisfactory Classrooms, laboratory, Library, offices, staff houses etc
 iv.   Dilapidated buildings
  v.   Unfinished buildings
 vi.   Shortage of funds for;

1) Expansion, rehabilitation, maintenance of sewerage system and completion of unfinished buildings
2) HRH Training and Development
3) Running of Health Training colleges

   a.   Postgraduates' sponsorship within and outside the country

vii.   There is a need to establish and expand training program of some cadres which are not available in the market for recruitment e.g. Biomedical Engineers, dental technologist, dental surgeons, and occupational therapists, Oral Health Nurses and Speech therapists and Dental Technologists.
viii.   HRH shortage in Health service delivery and Health Training colleges which is affecting quality of graduates
ix.   Old and unfinished infrastructure for health service delivery and training institution
x.   Restriction from POPSM in recruitment plans due to wage bill
xi.   Inadequate funds for HRH development and management
xii.   Unavailable retention plans
xiii.   Many HRH players with different roles in HRH
xiv.   Establishment of Projects/programs without proper plans of increasing and recruiting of HRH rather than shifting from existing facilities.

Policy Recommendation

i.   To increase production and recruitment of HRH Rare cadres especially specialist and super specialist
ii.   To prioritize recruitment to regions (areas) with lowest HRH density and not considering shortage by considering absolute numbers only.
iii.   To strengthen HRH retention by providing essential services for health care workers such as house, electricity, water etc and other financial motivation.

To strengthen health service delivery facilities and health training institutions construction or expansion plans should take into consideration of HRH recruitment plan National Health Programs/Projects should plan and consider HRH in their plans

CHAPTER TWELVE
12.0. HEALTH COMMODITIES

12.1. INTRODUCTION

The government and various stakeholders are prioritizing continuous availability of health commodities at health facilities, aligning with the Health Sector Strategic Plan V (HSSP V) to ensure sufficient supplies and reduce wastage. Measurement of health commodity availability is based on 290 priority health commodities, with the Ministry refining its methodology for accurate assessment across all facility levels: 101 for Dispensaries, 181 for Health Centers (HC), 207 for District Hospitals (DH), 212 for Regional Referral Hospitals (RRH), and 238 for National and Zonal Hospitals. Certain hospitals, due to specialized services, are monitored using specific lists: Mirembe (192), JKCI (161), Kibong'oto (228), MOI (194), and ORCI (169). For the case of Medical Stores Department (MSD) a list of 382 priority health commodities is used to measure performance in health commodities availability.

Availability of 290 priority health commodities increased by 9%, from 76% in 2023 to 85% in 2024. This improvement in availability is attributed to:

i. Government commitment with monthly disbursements of receipt-in-kind funds, totaling TZS 103 billion for FY 2023-2024 equivalent to 50.24% of the allocated budget. Additionally, TZS 116.57 billion equivalent to 58% of the total allocated budget has been released for FY 2024/25 (July - December 2024). Apart from that the government has also provided 100 billion to MSD as a recapitalization to improve MSD capital.

ii. Facilities on average utilized 158 billion equivalents to (31%) of collected own source of funds to procure health commodities in 2024.

iii. Improved availability of priority health commodities at MSD level from 57% (2023) to 64% (2024) (Target is to reach 85%)

iv. Increased local production capacity of essential health commodities by MSD

v. Enhanced management and accountability through routine medicines and financial tracking at facilities, along with the IMPACT approach

vi. Mentorship and Data quality assessments conducted to 1,185 health facilities and 2203 health facilities staff were mentored on various areas on management of health commodities via the redesigned logistics system (RLS).

vii. Implementation of bottom-up quantification approach for demand forecast on time.

viii. Efforts to improve medicine quality include updating Standard Treatment Guidelines and the National Essential Medicines List; Medical Therapeutics Committee (MTC) guidelines, and training healthcare workers in public hospitals. However, challenges persist due to inadequate of resources.

12.2. AVAILABILITY OF 290 PRIORITY HEALTH COMMODITIES BY REGIONS

The availability of 290 priority health commodities has increased from 76% in 2023 to 85% in 2024 (**Figure 86)**. In 2024, the availability at Primary Health Facilities (PHFs) varies by regions, ranging from 67% in Songwe and Tabora region to 82% in Lindi region (**Table 54**)

Table 53: Availability of 290 priority health commodities by level of facilities, in 2024

Facility Level	24-Jan	24-Feb	24-Mar	24-Apr	24-May	24-Jun	24-Jul	24-Aug	24-Sep	24-Oct	24-Nov	24-Dec	Average
Dispensary	77%	77%	75%	75%	76%	76%	77%	77%	76%	77%	76%	75%	76%
Health center	71%	74%	70%	71%	70%	72%	72%	72%	75%	75%	77%	78%	73%
District Hospital	73%	77%	79%	79%	80%	82%	83%	83%	78%	80%	78%	79%	79%
Regional Referral Hospital	99%	93%	99%	96%	97%	100%	97%	96%	99%	97%	98%	97%	97%
National, Special & zonal Hospitals	86%	94%	98%	98%	98%	98%	98%	99%	98%	99%	99%	99%	97%
Average	81%	83%	84%	84%	84%	85%	85%	85%	85%	86%	86%	86%	**85%**

Table 54:Availability of 290 Priority Health Commodities at PHCs (Dispensaries, Health Centers, District Hospitals) by Regions in 2024

SN	Region	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sept-24	Oct-24	Nov-24	Dec-24	Average
1	Arusha	85%	83%	83%	86%	81%	79%	86%	82%	85%	78%	77%	72%	81%
2	Pwani	82%	72%	79%	69%	81%	79%	83%	81%	79%	79%	78%	73%	78%
3	Dar Es Salaam	88%	85%	88%	85%	83%	83%	80%	84%	88%	81%	80%	77%	83%
4	Dodoma	77%	64%	72%	55%	79%	77%	79%	77%	75%	76%	79%	75%	74%
5	Geita	75%	77%	73%	70%	71%	72%	76%	74%	74%	80%	77%	80%	75%
6	Iringa	81%	83%	74%	82%	80%	79%	78%	79%	74%	77%	76%	72%	78%
7	Kagera	61%	69%	63%	67%	73%	84%	89%	77%	60%	75%	80%	74%	73%
8	Katavi	73%	80%	70%	78%	67%	80%	69%	75%	70%	73%	71%	71%	73%
9	Kigoma	74%	78%	65%	78%	63%	62%	67%	69%	81%	71%	69%	78%	71%
10	Kilimanjaro	89%	91%	85%	90%	80%	74%	79%	83%	85%	80%	78%	71%	82%
11	Lindi	86%	77%	85%	79%	76%	72%	74%	76%	85%	76%	79%	73%	78%
12	Manyara	90%	68%	84%	76%	84%	77%	82%	86%	86%	76%	80%	74%	80%

1 3	Mara	75%	65%	71%	62%	71%	71%	74%	72%	73%	78%	72%	74%	72%
1 4	Mbeya	75%	79%	70%	76%	69%	72%	73%	71%	76%	76%	76%	79%	74%
1 5	Morogor o	67%	81%	70%	80%	75%	78%	75%	76%	73%	81%	77%	78%	76%
1 6	Mtwara	71%	76%	66%	77%	73%	73%	73%	78%	66%	77%	78%	79%	74%
1 7	Mwanza	86%	76%	84%	77%	77%	77%	77%	78%	84%	79%	76%	74%	79%
1 8	Njombe	74%	79%	70%	79%	80%	75%	80%	81%	74%	77%	80%	77%	77%
1 9	Rukwa	71%	62%	69%	60%	74%	73%	80%	76%	69%	72%	81%	78%	72%
2 0	Ruvuma	78%	70%	74%	69%	80%	81%	78%	82%	74%	74%	77%	73%	76%
2 1	Shinyang a	70%	81%	72%	80%	72%	70%	74%	74%	72%	75%	72%	80%	74%
2 2	Simiyu	73%	78%	68%	77%	73%	75%	70%	73%	71%	75%	76%	83%	74%
2 3	Singida	81%	88%	80%	88%	80%	82%	80%	80%	80%	76%	79%	72%	81%
2 4	Songwe	67%	46%	56%	53%	65%	75%	74%	65%	56%	73%	80%	77%	66%
2 5	Tabora	72%	63%	71%	64%	61%	65%	66%	76%	74%	80%	71%	78%	70%
2 6	Tanga	80%	87%	82%	89%	76%	73%	77%	75%	83%	76%	66%	70%	78%

							77%						
Average	77%	76%	74%	75%	75%	75%	77%	77%	76%	77%	76%	75%	76%

Figure 86: Availability of 290 priority health commodities at PHFs by region, in 2023 and 2024
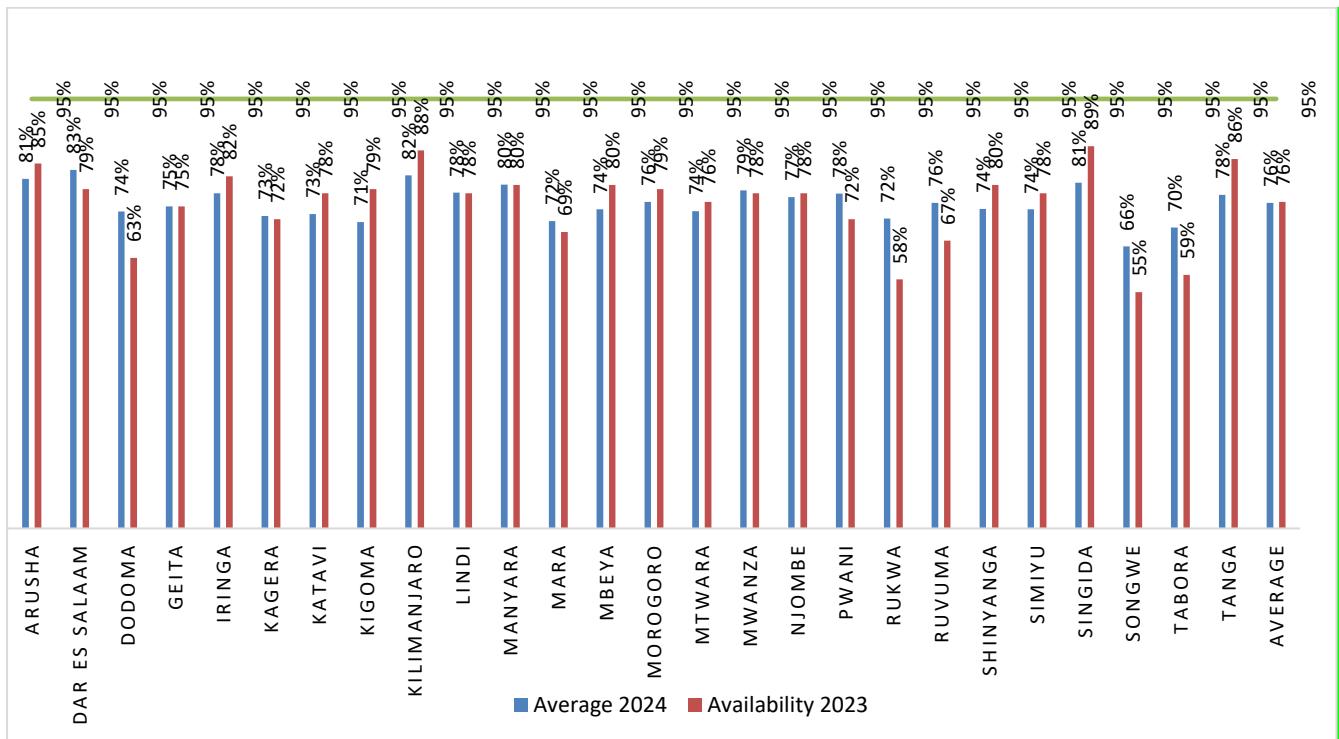
2.3. AVAILABILITY OF 382 PRIORITY HEALTH COMMODITIES AT MSD

Figure 87. below shows the availability of 382 priority health commodities at MSD from 2022 to 2024. The average availability of health commodities has improved from 56% in 2022 to 64% in 2024.

Figure 87 :Availability of 382 priority health commodities at MSD 2022 to 2024
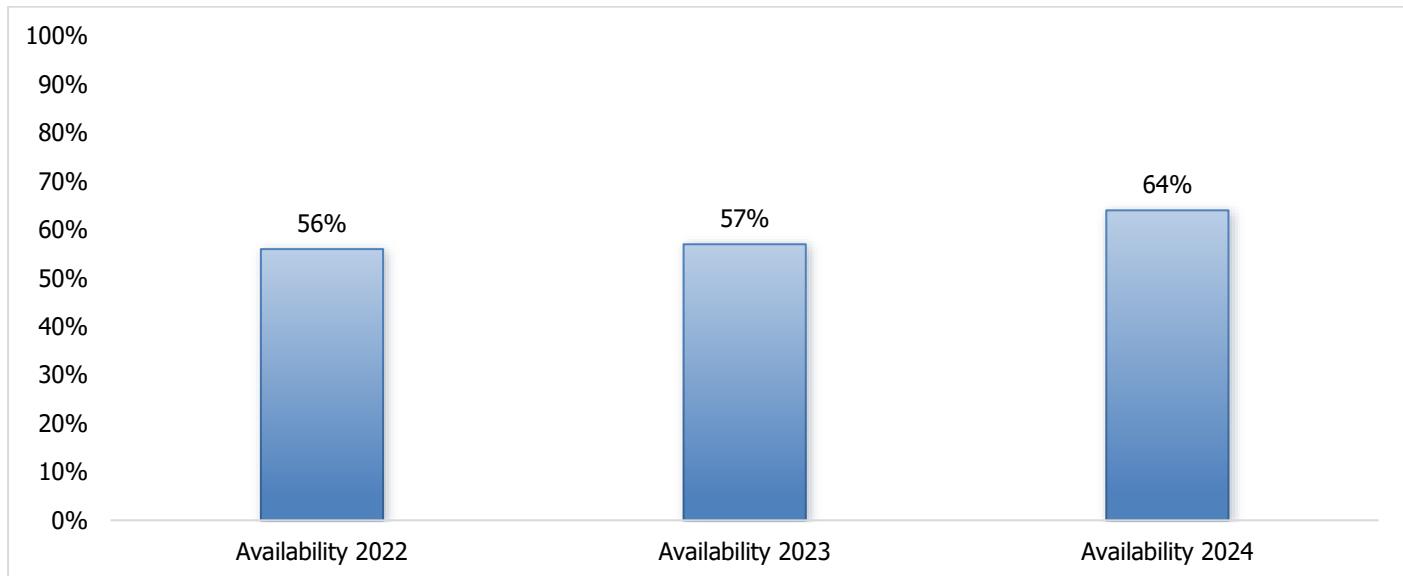
Source: E10

This better performance of MSD is a result of ongoing improvements in areas such as procurement, storage, distribution, and manufacturing of health commodities. Additionally, the improvement has been contributed by procuring commodities based on an improved supply plan and ensuring that all priority health commodities have framework agreements. These agreements help ensure the timely accessibility of commodities at an affordable price.

12.4. AVAILABILITY OF VERTICAL PROGRAM COMMODITIES AT HEALTH FACILITIES

The availability of vertical health commodities has decreased in 2024 compared to previous years, with the exception of IVD, which performed 100% throughout. Decrease in NASHCoP commodities was due to inconsistent availability of HIV RTKs in health facilities. NMCP was affected by unavailability of some of the ALU categories at the facilities though clients were served with the available category at the facility. However, Reproductive, Maternal and Child Health (RMCH) commodities recorded a decrease in availability from 94% in 2023 to 84% in

2024. This decrease in the availability of RMCH commodities was due to gap of donors in Co-Financing Reproductive and child health commodities. Other reasons for the drop in percent availability were due to inconsistent commodity availability at the central MSD, poor consumption-based forecasting and insufficient quality of facilities reports.

Figure 88:Availability of vertical program priority items, 2023 and 2024
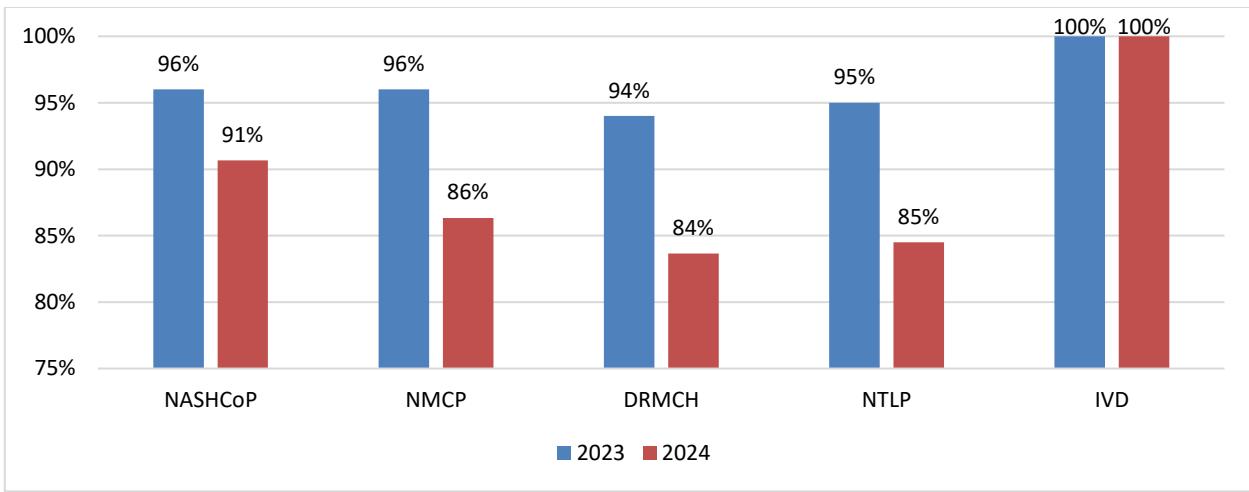
Source: e-LMIS & DHIS2

12.5. PROMOTION OF DOMESTIC PHARMACEUTICAL MANUFACTURING

The Ministry of Health, in collaboration with stakeholders, is promoting domestic investment in pharmaceutical manufacturing. In 2024, twelve (12) pharmaceutical manufacturing facilities were in operation, and eight (8) were under construction. These facilities are expected to reduce the reliance on imported health commodities, which currently stands at 80% for medicines and medical equipment, and 100% for reagents and vaccines

Key milestones in the promotion of domestic pharmaceutical manufacturing include:

1. Provision of exemption of VAT on raw materials for the production of medicines such as packaging and molds used in medicines manufacturing.
2. Establishment of Gloves manufacturing at Idofi
3. Production of essential health commodities at Keko pharmaceutical
4. Investment in the production of therapeutic water, which has been successful and is now able to meet the needs of the country.

Challenges

i. Provision of health services through a block payment system that hinders effective revolving of health commodities funds.
ii. Health facilities' failure to adhere to guidelines on effective utilization of cost-sharing funds in the procurement of health commodities for example, facilities rely on health commodities funds for other expenditures.
iii. Reliance on imported health commodities, which currently stands at 80% for medicines and medical equipment, and 100% for reagents and vaccines.
iv. Around 50% of the health facilities operating without fully functioning electronic systems.

Policy Recommendations

i. Health commodities funds (receipt in kind) should consistently be disbursed on time and according to the budget to increase the availability of health commodities in the supply chain.
ii. To strengthen supportive supervision and health commodities tracking for optimal utilization of existing systems.
iii. To ensure effective implementation of Health Commodities Revolving Fund guidelines.
iv. Review business environment to facilitate domestic pharmaceutical production, reduce dependency of imports and open opportunities for export
v. All healthcare facilities should be equipped with user-friendly electronic systems to manage health products (EMR).
vi. To increase human resources in the supply chain area, specifically pharmacists and laboratory experts.

CHAPTER THIRTEEN
13.0. DIAGNOSTIC SERVICES, BLOOD SAFETY SERVICES AND PUBLIC HEALTH LABORATORIES

13.1. DIAGNOSTIC SERVICES
13.1.1. MEDICAL LABORATORY SERVICES

Medical laboratories in Tanzania have always played an essential role in determining clinical decisions and providing clinicians with information that assists in the prevention, diagnosis, treatment, and management of diseases and outbreaks. From 2010 to 2024 the Government has installed various laboratory equipment at all levels of the health system in the country, beginning with the most challenge machines at Health facilities, such as Chemistry, Haematology and Urine analysers. Figure 89. shows that the Ministry has installed a total of 2,611 equipment, 1017 Haematology analysers, 830 Chemistry analysers and 764 Urine analysers. On the other hand, among more than 900 health facilities installed with this equipment; are 8 Dispensaries, 686 Health Centres, 121 District Hospitals, 39 Designated District hospitals, 29 Military Hospitals, 28 Regional Referral Hospitals and 5 Hospitals.

Figure 89 : Types and installation of analysers by health facilities level from 2010 to 2024
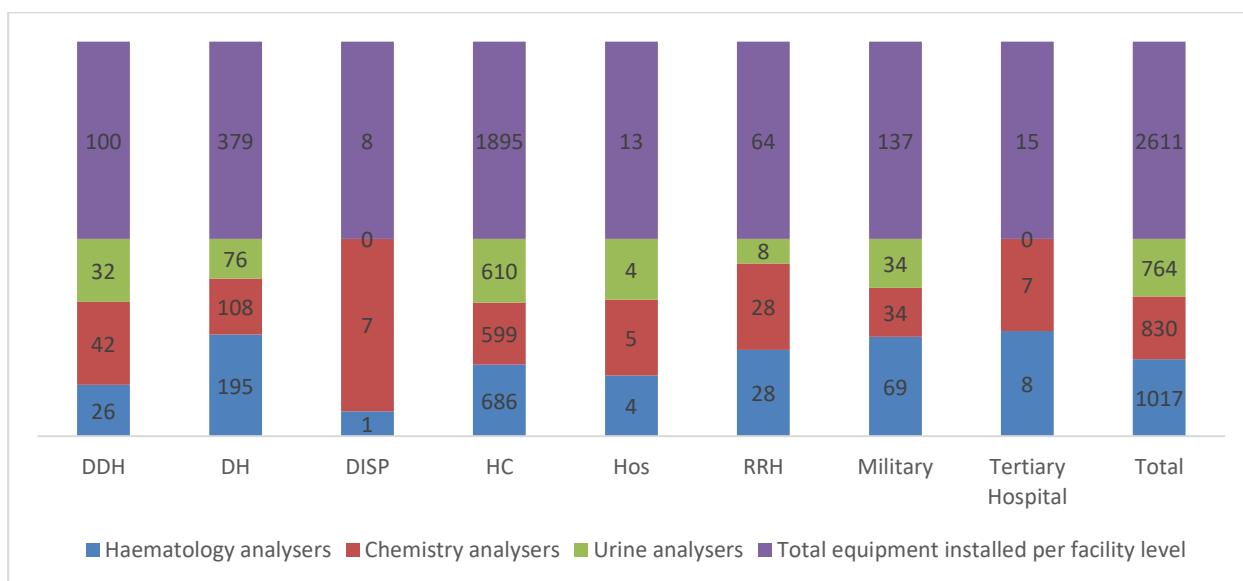
DDH: Designated District Hospital. DH: District Hospital. HC: Health Centre. RRH; Regional Referral Hospital. DISP: Dispensary

13.1.2. QUALITY MANAGEMENT SYSTEM AND ACCREDITATION (ISO 15189)

The measures that follow have been undertaken by the government in order to implement Quality Management System and accreditation for proficiency in rendering specific laboratory services at all levels. In 2024, thirteen (18) laboratories were accredited making a total of eighty three (83) health laboratories that have been accredited on ISO 15189 by internationally recognised organisations which are; SADCAS and KENAS since year 2010. Additionally, a total of six (6) blood transfusion centre laboratories have been accredited on African Society for Blood Transfusion (AfSBT) international standards for blood transfusion services.

13.2. RADIOLOGY SERVICES

The government through the Ministry and President's Office Regional Administrative and Local Government from 2010 to 2024 procured 32 CT scan, 7 MRI, 201 digital X-ray in order to improve diagnostic services. As in Table 55 below, 45 health facilities have CT installed and are providing services. 13 facilities have MRI installed and providing services. Also, 559 facilities have X-ray installed and providing services. Teleradiology has been installed to 25 health facilities to increase access to quality diagnostic services and reduce referral system although still below the targets by 2025 as depicted in Table 55.

Table 55:Key Indicators

Indicator(s)	Target 2025	Achievements	
		2023	2024
CT scan services at National, Zonal, Specialised and Regional referral hospitals	41	45	45
MRI services at National, Zonal and Specialized	11	13	13
X-ray services at National, Zonal, Specialized, RRH, Council hospitals and health centres	1,408	346	559
Radiotherapy services at specialized and zonal hospitals	8	2	2
Tele-radiology coverage at National, Zonal, Specialized, regional referral hospitals and council hospitals	41	23	25
Radiology and imaging facility met radiation safety requirements	1,408	1400	
Ultrasound services at National, Zonal, Specialized, RRH, Council hospitals, health centres and dispensaries	9,489	512	970

13.3. HEALTH CARE TECHNICAL SERVICES

As in the Table 56 below, in 2024 Healthcare technical services have increased and improved in different levels of health facilities. The Government through the Ministry of Health have established mechanisms to ensure proper management of medical devices and machineries through installation services, preventive maintenance, and repair services to all levels of health facilities. The Ministry has been working with Government institutions and collaborating partners in health sector to enhance the provision of timely and effective healthcare technical services, which leads to the delivery of quality health services like diagnosis, treatment, and rehabilitation. The government has increased the number of Biomedical engineers and technicians from 497 in 2023 to 578 in 2024 which makes the present number of 48 Biomedical Engineers and 326 Biomedical Equipment Technicians.

Table 56 shows that the performance on Maintenance contracts to facilities with high valued diagnostic and treatment equipment (Regional referral Hospitals, Zonal, Specialized and National) was 41 in year 2024 compare to 39 in 2023, this is a great achievement. The availability of equipped biomedical workshops for repair and maintenance services was 14 very low compared to targets of 41 by 2025. This means at each health facility from District to Tersiary level you can find an inhouse team of biomedical engineering with at least either a workshop or a room with basic working tools dedicated for maintentance and repair intervention.

Table 56:Key indicators

Indicator(s)	Target 2025	Achievements	
		2023	2024
Maintenance contracts to facilities with high valued diagnostic and treatment equipment (Regional referral Hospitals, Zonal, Specialized and National)	41	39	41
Availability of equipped biomedical workshops for repair and maintenance services	41	9	14
Strengthening the use of medical equipment and Infrastructure management information system at all levels of health facilities.	249	146	224

Medical oxygen production and sustainability plans have been established to ensure a consistent and reliable supply of oxygen therapy at or near health facilities. The number of oxygen production plants has significantly increased from 9 in 2023 to 49 in 2024

13.4. BLOOD SAFETY SERVICES
13.4.1. KEY PERFORMANCE INDICATORS AND STATUS

The key blood safety indicators in HSSP V includes: Strengthening the availability of safe blood and other blood products by establishing an effective and sustainable system for the collection, care and distribution of safe blood in the country.

13.4.2. STATUS OF THE PERFORMANCE ON BLOOD UNITS COLLECTED

Table 57. indicates the number of individuals who appears for blood donation, the number has been increasing slightly overtime from 531,000 in 2023 to 578,827 in the 2024. The increase is being due to ongoing advocacy, awareness campaigns and increase in the number of blood collection sites at council level.

The collection of 578,827 blood units in 2024 covers 98 percent of the required blood units of 590,000 in the country per year. NBTS screens all individuals for eligibility before blood donation. All individuals deferred from donation during screening are referred to the nearest health facility for further diagnostic and treatment. During the 2024 reporting period, a total of 7,627 individuals (1.3%) were deferred from donating blood due to medical conditions and high-risk behaviors, compared to 5,027 individuals (0.94%) in 2023.

During the 2024 reporting period, there was a significant decrease of Replacement donors (49.20%) compared to the year 2023 (54.5%). The experience shows that young age of 18-25 years (45.90%) are prominent contributors of blood. Male donors contributed more than 86 percent of all blood donations and only 9 percent of the blood donors were in the category of Repeat donors.

Table 57: Characteristics of Blood Donors During the Year 2024

Category	Variables	Total	Percentage
Gender	Male	498,949	86.20%
	Female	79,878	13.80%
Age group	18-20	151,074	26.10%
	21-25	114,608	19.80%
	26-35	169,596	29.30%
	36-65	143,549	24.80%
Donor types	Voluntary	294,044	50.80%
	Replacement	284,783	49.20%
Frequency of donation	First time	527,311	91.10%
	Repeat	51,516	8.90%

Source: NBTS 2024

13.4.3. STATUS OF THE PERFORMANCE ON COMPONENTS PRODUCTION IN 2024

In 2024, a total of 72,353 (12.5%) whole blood units collected were processed into components. This is is a 28.4% increase from 56,307 (11%) blood components that were processed in 2023. In the review period, a total of 107,082 blood components were produced, of which 72,353 were Packed Red Blood Cells (PRBCs), 6,209 platelets and 29,520 were Fresh Frozen Plasma (FFP) compared to 2023 where 85,270 blood components were produced, of which 56,307 were PRBCs, 6,225 platelets and 22,738 FFP.

During the reporting period NBTS mentored and equipped Muhimbili National Hospital, Benjamin Mkapa Hospital and three (3) Regional Referral Hospitals in Njombe, Kigoma and Iringa, together with their Medical Officer In charges (MOIs) at Zonal Referral Hospital in the area of produce, storage and distribution of components production.

13.4.4. STATUS OF THE PERFORMANCE ON BLOOD UNITS DISCARDED

A total of 69,459 (12%) blood units were discarded due to Transfusion-Transmissible Infections (TTIs). This is a slight increase from 61,716 (12%) discarded blood units in 2023. The percentage contribution of discards by TTIs type is as follows: HBV 24,890 (4.3%), HIV 14,471 (2.5%), Syphilis 18,522 (3.2%) and HCV 11,577 (2.5%) **(Figure 90)** where by in 2023 discards

by TTI type were as follows; HBV (4.7%), HIV (2.2%), Syphilis (3.2%) and HCV (2.3%). From the report, we note that donations from Family Replacement donors had higher proportion of TTIs compared to donations from voluntary non-remunerated blood donors (VNRBDs). The differences were noted in all four TTIs types (HBV, HCV, SYPHILIS, and HIV).

Figure 90:Proportional of Blood Units Discarded Due to TTIs for the Year 2024
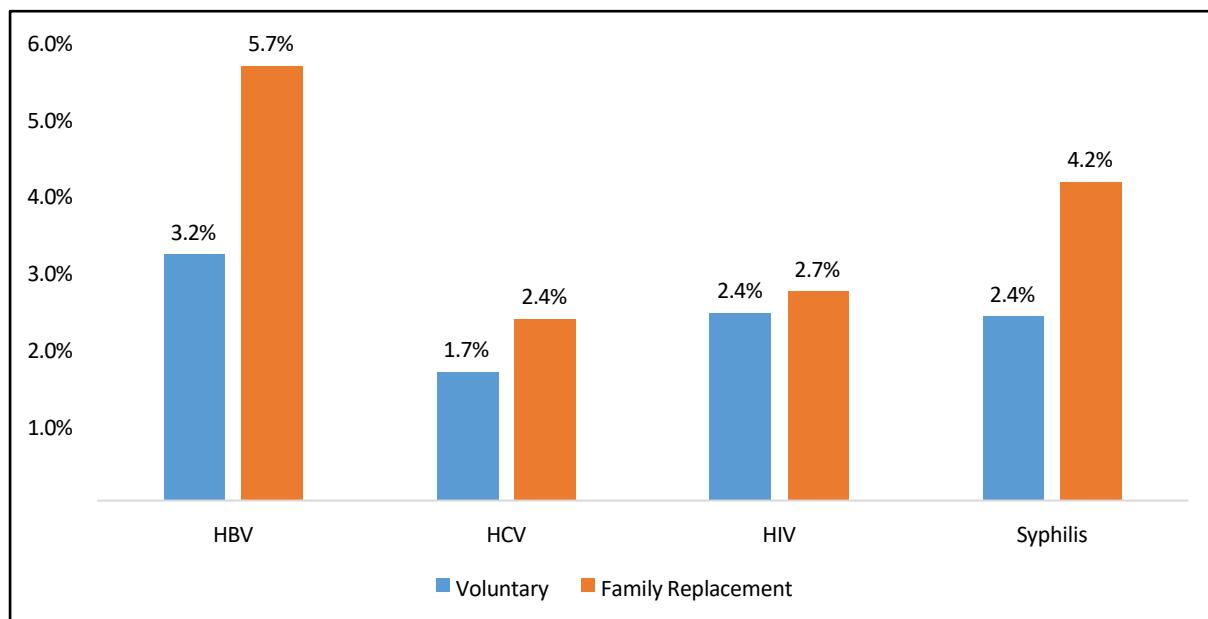
13.5. NATIONAL PUBLIC HEALTH LABORATORY

13.5.1. STATUS OF THE PERFORMANCE ON SAMPLE TESTING

NPHL is implementing a key function at responding to outbreaks, disease surveillance, receiving and testing samples for Quality check, Referral services and confirmation of unusual pathogens. In 2023 samples tested were 15,273 compared to 2024 whereby NPHL received total of 35,082 of samples for confirmation of outbreaks, quality check and referral service from different health facilities within the country.

13.5.2. EXPANSION OF SENTINEL SITES

The NPHL as a National program for Influenza surveillance has increased number of sentinel sites for detection, identification and samples transportation from fifteen sentinel sites (15) for the year of 2023 to 30 sentinel sites in 2024, whereby 21 sites covering five regions in Tanzania mainland which are Mbeya, Arusha and 9 in Tanzania Island.

However, sentinel sites for dengue fever increased from Eight (8) in 2023 to Eleven (11) in 2024 and all these sites for dengue are in Dar es Salaam.

Challenges

i. Inadequate skilled human resource capacity is affecting the quality and the pace of workload created by demands of safe blood at all levels.
ii. Tanzania meets only 9 whole blood unit per 1,000 population falling substantially below the WHO threshold of 10 whole units per 1,000 populations.
iii. High rate of blood units discarded due to TTIs especially HBV.

Policy recommendations

i. To establish the blood safety cost sharing mechanism to ensure sustainability of blood safety activities
ii. To promote blood collection so that all blood recipient in Tanzania receive blood collected from the safe pool of voluntary non-remunerated blood donor and screened in quality assured manner
iii. To prevent the spread of HBV, HCV and other TTIs among the community.
iv. Blood components production and utilization should be scaled up to minimize the use of whole blood for those who need blood components

CHAPTER FOURTEEN
14.0. INFORMATION AND COMMUNICATION TECHNOLOGY

14.1. INTRODUCTION

Tanzania's Ministry of Health (MOH) embarked on a Digital Health Strategy in 2019, with the aim to enhance healthcare through digital solutions, focusing on governance, service efficiency, data-driven decision-making, and interoperability. Key goals include improving client experience, empowering healthcare providers, ensuring resource availability, and strengthening disease surveillance. The strategy emphasizes innovation, digital tools like telehealth, and robust governance to drive sustainable health improvements.

This chapter describes how the Digital Health strategy (2019–2024) and Draft Digital Transformation Strategy (2025–2030) have improved health care delivery, data supply and demand, system performance and resource management (human, financial and supply chain). In 2024, the Ministry upgraded ICT infrastructure in Regional Referral Hospitals, Zonal and Specialized Hospitals. Additionally, Health Information Mediator and Muungano Gateway linked major digital platforms for easy data transmission.

14.2. DIGITAL HEALTH COVERAGE OF EMR IN TANZANIA

Electronic MedicaL Record (EMR) coverage is 100% in National (1 Hospital), Specialized (5 Hospitals), Zonal (4 Hospitals) as well as RRH (28 Hospitals) while 98.93% in District hospitals (covering 185 District hospitals), 86.66% in Health centres (covering 799 Health Centres), 67.64% in Dispensaries (covering 3,529 Dispensaries) and 30% in clinics (Covering 3 clinics).

The widespread use of EMR systems has greatly improved the accuracy and accessibility of medical records by streamlining the management of patient data. Because medical professionals can now easily access thorough patient histories, patient care has improved. Additionally, EMRs improve data analysis, allowing health authorities to base their decisions on current data.

Figure 91:Percentage of EMR coverage in Health Facility for the year 2024
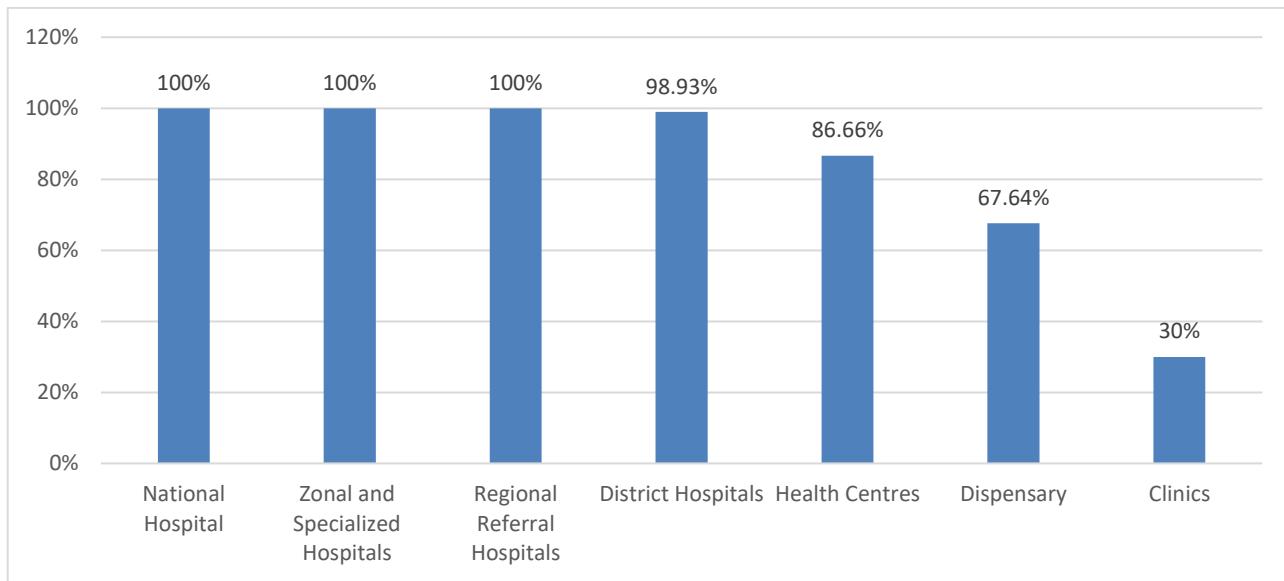
The integration of these new facilities into the existing digital framework is a priority for the upcoming years to ensure consistent data management across all levels of healthcare system.

14.3. INTEROPERABILITY STATUS

The health sector has enhanced systems to communicate to each other. Up to this reporting time 36 systems communicate to each other and 106 use cases have been implemented to enable interoperability between systems.

14.4. ENHANCEMENT OF CONTINUUM OF CARE AND IMPROVEMENT OF REFERRAL CHAIN

The health sector has integrated Electronic Medical Records (EMR) across all tertiary hospitals through the Health Data Universal (HDU) system to improve the continuum of care and strengthen the referral chain. Currently, the sector is working on integrating HDU with Primary Health Care (PHC) facilities through a Health Data Wallet intervention. This initiative enhances the effectiveness of the existing system by enabling secure, real-time access to patient data across multiple healthcare providers. The digital solution facilitates seamless sharing of medical records, supporting telemedicine, remote consultations, and improved referrals, especially in rural areas. By linking healthcare facilities through interoperable systems, Patient Summaries contribute to greater efficiency, faster decision-making, and reduced duplication of medical procedures.

14.5. IN RESPONSE TO THE COVID-19 EPIDEMIC, VARIOUS MEASURES TO ASSIST THE FIGHT AGAINST THIS EPIDEMIC HAS BEEN DEVELOPED

Electronic Event-Based Surveillance (EBS) system captures health-threatening rumours. This system collects rumours from the community, media scanning software, call center, health facilities and regions. By identifying potential outbreaks early, the EBS system helps in prompt response and containment efforts.

Introducing public messaging as part of EBS where citizens are allowed to send normal sms to 199 and report the rumours they have by starting with word "TETESI" e.g there are children with high fever with fainting episodes in Ubungo "TETESI Ubungo Watoto wanapata homa kali na kuzimia". This initiative empowers the community to participate actively in monitoring public health threats, thereby enhancing the overall surveillance network.

Table 58: Implementation Summary of Hospital Management Information System by Levels for the year 2024

No.	Level	Available	No. of Facilities
1	National Level	JEEVA	2
2	Specialized Hospital and Zonal Hospitals	MediPro; eMedical; Inaya; eHMS; AfyaCare and CareMD	13 out of 13 (100 %)
3	Regional Referral Hospitals	AfyaCare, GoTHoMIS and eHMS	28 out of 28 (100%)
4	District Hospitals, Health Centres, Dispensaries and Clinics	GoTHoMIS	Covering 4,523 health facilities (62.467%)

These systems' deployment has improved patient record-keeping, decreased paperwork, and expedited hospital operations. Hospitals at the national level that use JEEVA have reported improved administrative and patient management efficiency. Significant operational improvements have also been observed in specialized and zonal hospitals using MediPro, eMedical, Inaya, eHMS, AfyaCare, and CareMD. Regional Referral Hospitals' dedication to digitizing healthcare services is demonstrated by their 100% implementation of AfyaCare, GoTHoMIS, and eHMS. The lower adoption rate in District Hospitals, Health Centers, and Dispensaries, however, suggests that more work is required to develop digital health infrastructure at these levels.

14.6. IMPLEMENTATION OF TELEMEDICINE SERVICES

Telemedicine services have been rolled out to 7 Hubs and 19 Regional Referral hospitals by implementing Tele-radiology and Tele-consultation services. This enables specialized services to be accessed in remote areas through ICT innovations.

14.7. OTHER DIGITAL SYSTEMS WHICH HAVE BEEN IMPLEMENTED IN 2024

i. Health professionals can apply for postgraduate sponsorship through the Postgraduate Sponsorship application system in order to attend local and international universities. 764 of the 942 applicants who applied for sponsorship in 2024 fulfilled the requirements.

ii. MUSE was introduced in four zonal hospitals and all 28 RRHs.National Hospitals (Muhimbili and Mloganzila), JKCI, MOI, Mbeya Zonal, Manyara RRH, Ruvuma RRH, and Iringa RRH have all adopted the MEIMIS system.

iii. MMAMA has been implemented throughout Tanzania, including Zanzibar: The goal of the m-mama emergency transport system (EmTS) is to decrease maternal and newborn deaths by increasing access to high-quality emergency care. Through HIM, M-mama was able to integrate with other payment systems like MUSE, GePG, and NaPA.

Challenges

Notwithstanding these successes number of obstacles hindered the effective adoption of digital solutions:

i. Users' and decision-makers' limited eHealth proficiency.

ii. Opposition to eHealth solutions as a result, differing opinions or unfavorable perceptions of ICT systems in medical facilities.

iii. Attempts to reach additional facilities are hampered by inadequate PCs, printers, and other LAN installation equipment.

iv. Insufficient electric power in certain places.

v. Insufficient funds

vi. Insufficient ICT staff

vii. A number of disjointed electronic health information systems that are not in line with the workflow of healthcare.

Policy Recommendations

To enhance the transformation of the Tanzania health care system through innovative, data-driven and integrated digital health solutions, the following actions are recommended:

i. To improve investment in ICT infrastructure

ii. To provide comprehensive training for health workers to improve computer literacy and eHealth skills.

iii. To develop and implement standards for interoperability among different HISs to ensure seamless data flow and integration.

iv. To engage with private sector partners to leverage resources and expertise in implementing digital health initiatives.

v. To allocate adequate financial resources to support ongoing and future digital health projects.

vi. To implement alternative power solutions, such as generator and inverters power supply in areas with unreliable electricity supply.

vii. To conduct awareness campaigns to change negative perceptions and attitudes towards digital health solutions.

CHAPTER FIFTEEN
15.0. COUNCIL LEVEL MANAGEMENT
15.1. INTRODUCTION

Health Services in Council level is organized at four levels, namely Community, Dispensaries, Health Centres and level 1 hospital (District Hospital/Hospital at the District level). Chronologically, dispensaries, health centres and Level 1 hospitals are the first points of contact for health services provision to the community mandated to provide Primary Health Care services. CHMTs are Overseers of technical and sector-specific administrative performances.

Indicators

i.   Percentage of councils whose annual plans were approved in the first round of CCHP's assessment criteria

ii. Percentage of councils whose annual CCHPs' implementation technical & financial reports (Technical & Financial) submitted and assessed

Targets

i.   All Councils (184) are approved annual plans after the assessment

ii. 87% of the HFGCs to be fully functional by 2025

iii. The coverage of health services in remote areas is increased through the implementation of construction and rehabilitation by 2025

iv. The number of health facilities providing comprehensive health services based on the National Essential Health Care Interventions Package (NEHCIP) is increased.

v.   The accreditation system for health facilities in place.

vi. Decentralization of management (planning, budgeting, financial management, implementation and monitoring) from council level to health facility and community level in place.

vii. All health programmes' activities incorporated in CCHPs and services in health facilities provided in an integrated way

15.2. PLANNING AND BUDGETING PERFORMANCE

The quality of CCHPs is on track to reach the HSSP V target of having 100 percent CCHPs approved at first round assessment. CCHPs are approved for funding if they score 70 percent or above. Some government directives usually are used during the budget preparation. Assessors are usually provided with electronic version of CCHP guidelines, ceilings for all LGAs and other appropriate documents. The percentage of CCHPs approved for funding at first round of assessment has increasd slightly from 96.5 percent in 2023/24 to 97.3 percent for 2024/2025.

Table 59:Ten Best Performing Councils and Poorest Performing Councils During CCHP First Assessment; 2024/2025

Best Performing Councils			Poorest Performing Councils	
No.	Council	Score (%)	Council	Score (%)
1	Makete DC	98	Pangani DC	69.5
2	Kibaha DC	97.5	Nyasa DC	69.5
3	Singida MC	97	Musoma DC	68
4	Mpimbwe DC	94.5	Iramba DC	66
5	Kishapu DC	94.5	Nzega DC	64.5
6	Kigamboni MC	94.5	Morogoro DC	62.5
7	Kongwa DC	94	Iringa DC	62
8	Itilima DC	94	Mufindi DC	60
9	Longido DC	93.5	Nzega TC	57.5
10	Korogwe TC	93.5	Korogwe DC	42.5

Source: *PORALG implementation report 2024*

The Councils which scored below 70% were asked to correct their plan and resend for second assessment until all score 70% and above.

15.3. DECENTRALIZATION OF MANAGEMENT FROM COUNCIL LEVEL TO HEALTH FACILITY AND COMMUNITY LEVEL

The government has decentralized management of health services (governance and financial management) from the Council level to the Health facility level (Health Centres and Dispensaries) since 2017/18 and the following has been achieved with regards to decentralization to the health facility level:
  i.   All public health facilities at the Council level (i.e. 7,448 HFs - Council hospitals, Health centres and Dispensaries) opened and started operating bank accounts
  ii. Contract employment of 517 assistant accounts for the Health Centres

iii. Financial tracking, reporting and analysis were done and worked on the identified challenges for improvement

iv. Automation and application of the new resource allocation formula for 2024/2025plan

v. The DHFF process has elevated the level of morale among the health facility staff

vi. Through Health Facility Governing Committees, community participation in planning and budgeting and service delivery has improved

vii. Improved planning and budgeting of facilities through proper use of data

viii. Improved financial management through the use of PlanRep and FFARS systems

Challenges

i. Low geographical coverage in terms of availability of health facilities and improved referral system particularly in the remote areas.

ii. Shortage of skilled HRH needed for provision of health services at council level

iii. Delayed funding, delays in procurement process, inadequate transport facilities and ad hoc activities resulting in partial or non-implementation of activities

iv. The number of clients joining the iCHF is low despite continuous sensitization.

v. Unsatisfactory quality of health services.

vi. Few CHSBs and FHGCs receive orientation on their functions and responsibilities.

vii. Unreliable availability of electricity, internet connectivity affecting ability of health facility staff to work of ICT systems such as FFARS

viii. Low expenditure of facility funds due to various reasons including; cumbersome procurement procedures

ix. Inadequate funding to finance health services provision

Policy Recommendations

i. To strengthen the decentralized health systems beyond the council/ district, while, capacitating the CHMTs, facility teams and health facility governing committees.

ii. To strengthen supportive supervision and outreach services in order to improve quality of services.

iii. To strengthen capacity building on using the FFARS and using the system frequently

iv. To strengthen monitoring of DHFF implementation by MoH and PO-RALG to ensure proper utilization of funds by facilities and improvement of services.

v. To raise public awareness on the importance of CHSBs/FHGCs in the councils.

vi. To build capacity on Human and Financial Management to the health Facilities.

CHAPTER SIXTEEN
16.0. SERVICE UTILIZATION IN NATIONAL, SPECIALIZED AND ZONAL REFERRAL HOSPITALS 2023 AND 2024.

The OPD data shows a general increase in patient attendance across all hospital levels from 2023 to 2024. Zonal Referral Hospitals had the highest OPD cases, rising from 953,922 in 2023 to 1,025,754 in 2024. Specialized Hospitals also recorded growth from 647,986 in 2023 to 689,773 in 2024. while the National Hospital experienced the highest relative growth rising from 241,559 in 2023 to 264,632 in 2024 patients. This upward trend indicates an overall rising demand for health services, possibly due to population growth and improved access.

The IPD data show trends across hospital levels between 2023 and 2024. Zonal Referral Hospitals registered a slight increase in admissions, rising from 92,611 in 2023 to 94,580 in 2024. Specialized Hospitals recorded the most growth, with admissions increasing from 25,933 in 2023 to 32,298 in 2024. While National Hospital experienced a small decline, with dropping from 61,590 in 2023 to 60,763 in 2024 which may indicate stabilization of admissions or a shift of some patients to other facilities.

16.1. SPECIALIZED AND SUPERSPECIALIZED HEALTHCARE SERVICES

The Government has continued to improve specialized and primary healthcare services to ensure these services are available within the country. These services are provided at Muhimbili National Hospital, Muhimbili Orthopaedic Institute (MOI), Jakaya Kikwete Cardiac Institute (JKCI), Ocean Road Cancer Institute, regional referral hospitals, and private hospitals including Aga Khan and Saifee. During the year 2024, a total of 10,675 patients received primary specialized treatment compared to 10,023 patients in 2023 in various medical fields, as shown in Table 60.

Table 60: Specialized and Super Specialized Services 2024.

Na.	Specialized services provided in the country	2023	2024
1	Cochlea Implant	11	22
2	Kidney Transplant	25	25
3	Intragastric balloon placement	90	20
4	Complex heart surgery without opening the chest (Cardiac catheterization	2,156	2,695
5	Open-heart surgery	562	587

Na.	Specialized services provided in the country	2023	2024
6	Brain surgery	2,036	2,030
7	Spine surgery	352	406
8	Hip replacement surgery	203	237
9	Cervical cancer Treatment	1,341	1,378
10	Breast cancer Treatment	467	555
11	Oesophageal Cancer Treatment	374	364
12	Skin cancer Treatment	113	132
13	Prostate Cancer Treatment	248	188
14	Knee Replacement Surgery	189	232
15	Aneurysm repair	7	19
16	Transsphenoidal tumour excision	14	2
17	VP shunt/ETV & Spina Bifida	563	471
18	Acetabular Reconstruction	110	130
19	Arthroscopy	402	300
20	Interventional Radiology	760	882
	TOTAL	**10,023**	**10,675**

## 16.2 SERVICE UTILIZATION IN REGIONAL REFERRAL HOSPITALS IN 2023 AND 2024.

The OPD data for Regional Referral Hospitals shows a slight decline in outpatient attendance between 2023 and 2024. In 2023, these hospitals recorded 3,275,508 OPD cases, while in 2024 the number dropped to 3,257,404, reflecting a decrease of 18,104 patients.

The IPD data for Regional Referral Hospitals shows a very slight decline in inpatient admissions between 2023 and 2024. In 2023 were 313,887, while in 2024 they decreased marginally to 313,031, representing a reduction of only 856 patients.

16.3. SPECIALIZED SERVICES IN REGIONAL REFERRAL HOSPITAL

As a result of ongoing investment in Regional Referral Hospitals, various specialized medical services have been provided, including 639,532 cases of internal medicine, 104,259 cases of obstetrics and gynecology, 224,033 emergency life-saving services (EMD), and 77,530 pediatric cases, among others, as shown in Figure 92.

Figure 92:Specialized Services at Regional Referral Hospitals,2024
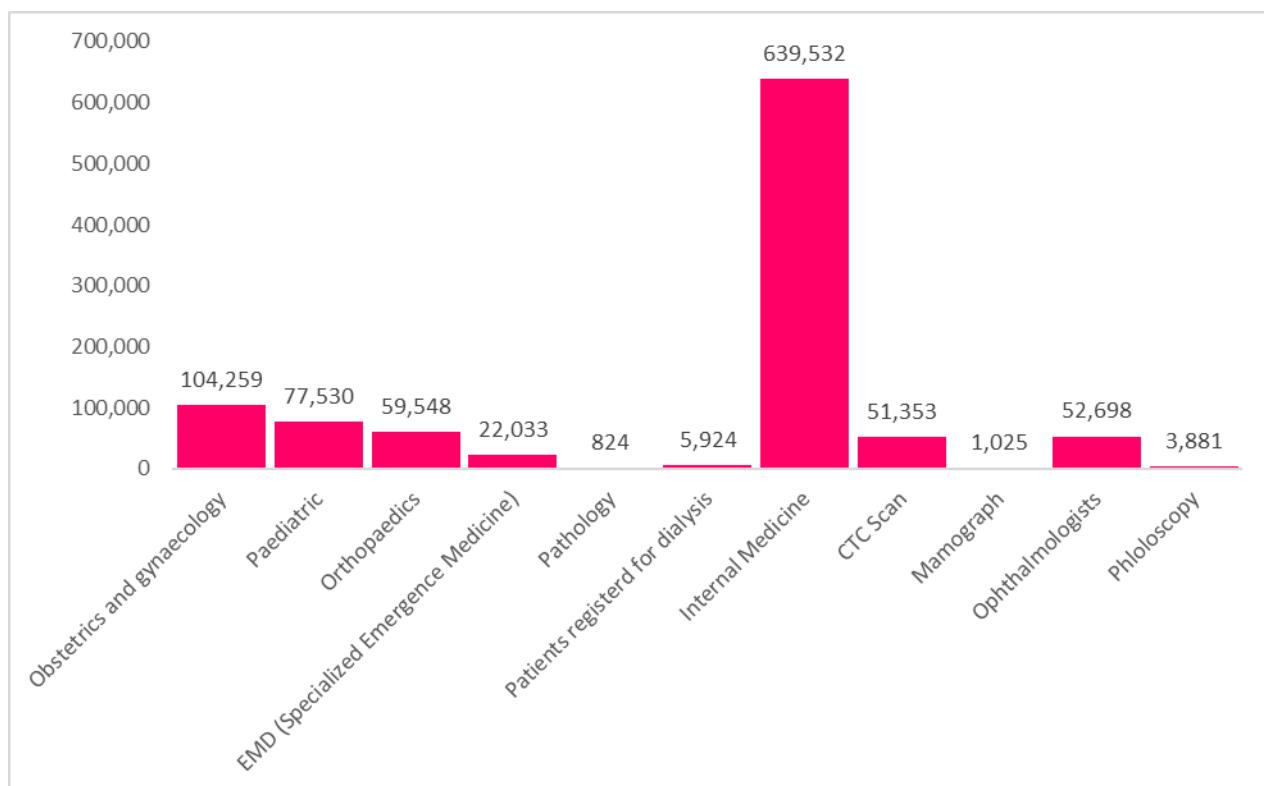
16.4. DIAGNOSTIC SERVICES

The Government has continued to strengthen the availability of medical equipment and disease diagnostic services to ensure appropriate treatment based on the specific illness. By December 2024, the Ministry had procured and distributed diagnostic equipment as shown in Table 61.

Table 61: Availability of diagnostic services equipment 2023 and 2024

No.	Equipment	2023	2024
1	MRI	7	13
2	CT SCAN	32	45
3	Digital X- Ray	344	491
4	Utra Sound	494	970
5	PET Scan	1	1
6	Fluoroscopy	4	13
7	Cath Lab	3	4

Key Challenges

1. **Rising Demand for Health Services**

   o Significant increase in outpatient (OPD) and inpatient (IPD) utilization at national, zonal, and specialized hospitals, straining existing infrastructure and staff capacity.

2. **Uneven Distribution of Specialized Services**

   o While superspecialized services are concentrated at MNH, MOI, JKCI, Ocean Road, and a few private hospitals, regional hospitals provide limited advanced interventions.

3. **Stagnant or Declining Utilization in Some Facilities**

   o Regional referral hospitals saw a slight decline in OPD and IPD utilization, which may indicate patient preference for higher-level facilities or gaps in service delivery quality.

4. **Capacity Gaps in Advanced Care**

   o Some critical services (e.g., kidney transplants, brain surgeries, oncology treatments) remain limited in volume compared to demand.

5. **Specialized Workforce Shortages**

- o Increasing demand for advanced procedures (e.g., cardiac, neurosurgery, oncology, radiology) requires more skilled specialists, but training and retention remain challenges.

6. **Health Financing Burden**

   - o High reliance on costly superspecialized services, often subsidized by government, creates sustainability concerns.

Policy Recommendations

1. **Expand Specialized Services Beyond Dar es Salaam**

   - o Strengthen capacity of zonal and regional referral levels both public and private hospitals with advanced diagnostic and treatment technologies (oncology, cardiac, renal, neurosurgery).

   - o Establish satellite centers for high-demand services to reduce patient congestion at national hospitals.

2. **Strengthen Human Resources for Specialized Care**

   - o Invest in training and retention of superspecialists (cardiologists, neurosurgeons, oncologists, interventional radiologists).

   - o Introduce incentive packages to retain professionals in regional and zonal hospitals.

3. **Improve Service Quality at Regional Referral Hospitals levels**

   - o Standardize specialized services to reduce patient bypass to national-level hospitals.

   - o Expand internal medicine, emergency, obstetrics, and pediatric services with modern equipment.

4. **Enhance Health Financing Mechanisms**

   - o Strengthen health insurance coverage both Public and private insurances (NHIF, iCHF, UHC basket) to reduce out-of-pocket expenditure for costly procedures.

   - o Promote public–private partnerships to co-finance specialized equipment and treatment centers.

5. **Introduce Digital Health & Referral Systems**

- o Use electronic referral tracking and telemedicine platforms to improve coordination between lower-level facilities and tertiary hospitals.

6. **Expand Preventive and Early Detection Programs**

- o Enhance screening for cancers, kidney diseases, and cardiovascular conditions to reduce late-stage, high-cost admissions.