HEALTH POLICIES AND PRACTICES TO ADDRESS SOCIAL DETERMINANTS OF HEALTH INEQUITIES - TANZANIA CASE:

1. Introduction

The Tanzanian health sector has been undergoing far-reaching reforms since the mid-1990s and has adopted a Sector-Wide Approach (SWAp). The reforms are being implemented at all levels and involve fundamental changes in many critical areas of the sector. The complexity of the current reforms and the challenges ahead are quite immense. Therefore, close monitoring and evaluation of the health sector’s performance overtime is quite imperative. To this effect, the health sector stakeholders have agreed to a set of indicators for the monitoring of the Health Sector Strategic Plan (HSSP) whilst at the same time also directly linked to the implementation of the Poverty Reduction Strategy (PRS) (National Strategy for Growth and the Reduction of Poverty (NSGRP)).

Health Sector is now facing challenges to demonstrate tangibly that it is moving in the right direction, making progress towards improved service delivery focused on addressing equity issues and health outcomes (MDGs, PRS goals, HSSP goals).

2. Social Health determinants

Health has many determinants, and only a few of these can be directly influenced by health systems.

Today it is widely acknowledged that poverty is a major factor influencing health. These are social issues leading to Millennium Development Goal No.1 where income poverty translates itself to food poverty and the resultant various forms of malnutrition. We all know that the underlying course of ill health and mortalities in poor countries in malnutrition. There has been with the exception of Dar es Salaam, Mwanza and Arusha which are the three major cities in Tanzania, only little reduction in income poverty. The picture is the same for food poverty. In spite of exemption policies this has implications for the access and use of health care. In Tanzania we are aware that access and use of health care is a function availability of quality health services. While we are battling with equity issues, we need to focus more squarely on the availability of services. The relationship with food poverty on the prevalence on malnutrition is also obvious. This is somewhat in contrast to the fact that there has been since the mid-1990s a steady growth of the GDP, which is 5% since 2002 in line with the PRSP targets.

Roads do not just play a role in the access to markets, but they are also a determinant in access to referral services, for example in the context of obstetrical care. Unemployment in Tanzania a largely urban phenomenon has implications on health as well, as it is linked to poverty. Studies are showing that while the access of the services by user fees may be a concerned, the cost of transport by far out weighs the medical costs.
There have been stagnant primary school enrolment ratios in the late 1990s, which have improved substantially in the past years. However, in the short run, the bill for the stagnant enrolment in the 1990s, and in particular the decrease of the enrolment of girls (the ratio girls/boys decreased from 0.97 to 0.94) will have to be paid, when the girls of those generation come into the reproductive age. The low figures of female literacy particularly in rural areas, are not promising knowing the close link between maternal education and child health. The target should be to complete full secondary education, if the health sector has to realize the dividends through decreased mortalities and morbidities especially for children.

Although improvements in the use of safer water sources have taken place, there have been little changes in distance to water sources and average water consumption has not increased. The hygiene component in MDG 7 needs to be emphasized. Malaria, Bilharzias, Typhoid, Onchocerciasis, trachoma, Cholera and diarrhoeas are all related to this MDG, either through water born or water washes or water related diseases.

SOCIAL PROTECTION
- Issues of social protection
- Housing and overcrowding
- Transport to health facilities

CONSTRAINTS
- Human resources development
- Under-Funding
- Management capacity
- HIV and AIDS
- Community Participation

The overall impression is that health has significantly improved in Tanzania since 2001. To put it in more positive terms, it has not deteriorated what could have been expected on the background of the HIV and AIDS epidemics. The findings of the DHS 2005, shows that there is a sharp decrease in IMR from 99 per 1000 (1999) to 68 per 1000 (2005). For under five from 147 per 1000 (2002) to 112 per 1000 (2005).

Policy Developments in Tanzania.

- Vission 2025
- PES 2010
- NSGRP 2005
- NHP
- CCHP for 113 councils for the last 4 years
- MTEFs
- Decentralisation

Sector Reviews
- PERs
- NHA
- Milestones
- Multisectoral approach spec for health

- Measures taken to address disparities and inequities (including gender imbalances) in accessing public health care services

- Poor – rich inequalities
Socio-economic differences account for most of the inequality and inequities in accessing health care have been demonstrated for a long time in Tanzania. These inequities have been successfully addressed through the exemption schemes in place. The voucher system has been introduced in ensuring the poor access to health in general terms, the voucher system is working fine in the context of ITN-distribution.

- **Gender inequalities**
  
  Gender related inequalities are not widely recognized. However, there is multiple evidence for gender inequalities having an impact on health in Tanzania. Female Genital Mutilation is widespread and even though not according to law the practice to force pregnant girls out of school is frequent. Sexual and gender-based violence is widespread, for example, but not only in the multiple refugee communities. The high MMR reflecting at least in part the difficulties women have in accessing health care is a striking point in case.

- **Urban-rural inequalities**
  
  Inequalities are striking and well documented. They are in favour of the urban environment. However, little is known about intra-urban differentials, where – as experience from other countries indicates - the urban poor are sometimes even more disadvantaged than the rural population in general.

**Best practices/successes and future challenges**

**Best practices**

In this context only a selection of best practices can be presented. This list is by no means exhaustive, but reflects only that numerous laudable initiatives are going on in Tanzania:

- The overall planning capacity of the various stakeholders in the regions and districts has improved.
- The successful, albeit still slow scaling up of social marketing of ITN and the impact on Malaria
- Burden if disease focussed planning has shown impact: Burden of disease based budget allocation has shown a dramatic positive impact in reducing infant and under five mortality in the observed districts. Allocation procedures are further refined by applying additional criteria, such as distance and poverty indices in order to channel resources to the districts, which are most in need.
- Commitment of the GoT and SWAp of the donor community has improved the funding basis of the health system.
- Some vertical programmes, like the TB-programme have had a very positive impact and are international landmarks of good practice
- The successful introduction of iodised salt to fight goitre
• Last but not least it is a good practice of the GoT to have climbed on the bandwagon of fighting tobacco. This will help not only to avoid that economic growth evaporates in smoke but also will have a positive impact on the health status of the Tanzanian population.

**Challenges**

Challenges are lying ahead is how to reduce morbidity/mortality related issues, service delivery issues, and last but not least equity and the strive to reduce disparities issues. All this will take place in the context of the general social and economic development of Tanzania, which is in itself an even larger challenge.

To ensure equity in terms of (financial, geographic and cultural) access will be probably the largest challenge as it is linked to the above mentioned factors as well as to changes in culture and attitude when it comes to a gender balanced development.