2022 TANZANIA DEMOGRAPHIC AND HEALTH SURVEY AND MALARIA INDICATOR SURVEY

Policy Implications

1.0 Introduction

It is obvious that the 2022 TDHS-MIS data is rich in informing policy processes in terms of formulation, reviews, implementation as well as monitoring and evaluation. This data can also be utilized to make informed decisions in planning interventions that will yield better results in the short-, medium- and long-term periods. In line with the ongoing global movement in utilizing data for policy and decision making, this chapter therefore highlights key policy issues that need to be noted to inform policy makers and planners to make informed decisions in health and other related sectors. Some of the key issues include:

1.1 Education

Education level of household members and women in particular demonstrate to be a powerful influential tool of various health indicators. Most notable ones are:

i. For women aged 25 - 49, there is almost a 6-year difference in the median age at first marriage between those with no education and women with secondary or higher education (18.1 years versus 23.7 years).

ii. The data indicate that among both women and men, higher level of education is associated with later age at first sexual intercourse, and this association is strongest among women. Among women age 25–49, there is a 2.6-year difference in the median age at first sex between women with secondary or higher education and those with no education (18.7 versus 16.1). The difference in age at first sex between the two levels of education for men age 25–49 is 0.5 years (18.3 versus 18.8).

iii. Total Fertility Rate (TFR) declines with increasing education, from 6.3 children per woman for women with no education to 3.8 children per woman for women with secondary or higher education. Generally, women with no education have 2.5 more children than women with secondary or higher education.

iv. Women aged 25 – 49 with secondary or higher education begun childbearing 4 years later than women aged 25 – 49 with no education.

v. As education levels increase, the ideal number of children decreases. The ideal number of children decreases from 6.5 children among women with no education to 4.0 children among women with secondary level education or higher.

vi. Teenage pregnancy decreases as the level of education increases from 53% among women age 15–19 who have ever had a live birth with no education to 9 % among women age 15–19 who have ever had a live birth with secondary and higher levels of education.

vii. The percentage of women aged 15 - 49 who received ANC from skilled providers increases with increasing level of education.

viii. The percentage of births that occurred in a health facility increases with the level of education —from 66% of births to mothers with no education to 94% of births to mothers with secondary education or higher.

ix. Stunting was more prevalent among children of mothers who had no formal education (36%) compared to those with complete primary (30%) and secondary education level or higher (21%).

x. Malaria prevalence is low among children whose mothers completed primary and secondary education (6% and 4%, respectively), compared to children whose mothers had no formal education or only a limited formal education (10% and 12%, respectively).

xi. Women's participation in decision making increases with increasing education and wealth. Forty four percent of women with no education participate in all three decisions, as compared with 63% of women with secondary or higher education.

xii. Women's knowledge of FGM increases steadily with increasing education, from 72% among women with no education to 95% among those with secondary or higher education. A similar pattern is observed among men.

The above health indicators point to a strong link between education and health outcomes, and therefore the ongoing government efforts of investing in education and review of the Education Policy 2014 is in the right direction. Extending basic education from primary to

Form IV as proposed in the new policy direction need to start now and indeed education expenditure should be viewed as more developmental than recurrent, as the long-term positive impacts will be seen in other sectors including health. In line with an ongoing initiative of "health in all policies", education sector has to be viewed as key and important partner to push the health agenda.

2.0 Health Care Financing

Tanzania is moving towards Universal Health Care (UHC) target. This is being done through health care reforms by introducing the mandatory health insurance. Current data show that out of 10 women (94%) and men (93%) age 15-49 in Tanzania do not have any health insurance and it is only five percent of children (0-14 years) who have health insurance cover. Furthermore, data show that the most frequently mentioned problems in accessing health care is getting money for treatment and there have been instances where women were denied medical services due to lack of money and others were prevented leaving the health facility due to inability to complete settling the medical bill. Four percent of women reported being denied medical services due to lack of money, and 4% were prevented leaving the health facility due to lack of payment.

There is therefore an urgent need to finalize the Mandatory Health Insurance Bill to include the entire population into pre-paid health services mechanism. This should go hand in hand with reviewing of Social Security Policy 2003 to include both contributory and non-contributory mechanisms into health insurance. Initiatives such as Productive Social Safety Net (PSSN) under TASAF should be shaped in a way that it includes health insurance to cover respective target households through all its components of cash transfer, public works and livelihoods enhancement.

3.0 Non-Communicable Diseases (NCDs) Risks

Data shows that over weight and obesity among women, men and adolescents is increasing overtime. At the same time, significant differences in the prevalence of hypertension are found among both sexes according to their body mass index (BMI). Hypertension levels are higher among the overweight/obese than among those of normal weight. The rate of hypertension among obese men for example is 17% and 18% for women, much higher than those with normal BMI (Data). This trend demonstrates a pure "double burden of diseases" narrative and possesses risk in the already over burdened health system and further increase the cost of health care.

With the ongoing effort toward UHC, this pattern of alarming increase of NCDs can cause trouble in the insurance schemes to be designed and defeat the purpose of UHC. Health care

policies, strategies and plans should give more attention to preventing this trend by investing more on public education and implement other strategies in relation to NCDs. (Henceforth, the implementation of the Food-Based Dietary Guidelines (FBDGs), National Multisectoral Nutrition Action Plan II (NMNAP II), National Non-Communicable Diseases Research Agenda (NNCDRA), and Guidelines on Physical Activity and Sedentary Behavior are expected to create awareness on healthy lifestyle, foster conducive environment for multisectoral approach and accountability and to identify research areas of priority for prevention.

4.0 Towards Achieving Health Targets

4.1 Infant and Child Mortality

The Tanzania Health Sector Strategic Plan V (2021 – 2026), The National Reproductive, Maternal, Newborn, Child and Adolescent Health & Nutrition (2021 - 2025) and one Plan III are key policy documents, with their implementation demonstrating clear results. There has been an increase in the percentage of women who attended the recommended four or more ANC visits, the percentage of women seeking ANC during the first trimester, as well as the percentage of births with skilled assistance during delivery.

Both neonatal and under five mortalities have decreased and the targets of reducing under-5 mortality to less than 25 per 1,000 live births by 2030 seem to be achievable. However, neonatal mortality has almost remained the same for the past 12 years (26 per 1,000 live births-TDHS 2010 to 24 per 1,000 live births TDH-MIS 2022) which call for government and stakeholders to invest more in addressing issues that will lead to reducing neonatal mortality including infrastructure (Neonatal Intensive Care Units - NICU) to attain the SDG goal of neonatal mortality rate to less than 12 per 1,000 live births.

4.2 Maternal Mortality

Data show that there is a sharp decline in Maternal Mortality Ratio (MMR) from 530 to 104 maternal deaths per 100,000 live births between 2015 - 2016 TDHS-MIS to 2022 TDHS-MIS surveys (based on re calculated estimates with reference of 7 years before the survey). This can be attributed to a number of factors, among others, improvement in ANC attendance, reduction in teenage pregnancies, increased delivery in health facilities and assisted delivery by health professionals. These have been possible as the country continue implementing policies and strategies that are more targeted to vulnerable

population groups across the country. MMR decline is on course towards achieving the SDG target of 70 deaths per 100,000 live births by 2030.

To sustain gains achieved, more need to be done especially in strengthening health care delivery through building more infrastructures, invest in more diagnostics equipment and other health commodities, increasing the number of health care workers at the facilities which the government has constructed over the past few years. Increasing population call for increase in human resources and other essentials to provide quality services. Other non-health related infrastructures such as road network, in particular rural roads, access to energy and water are also key to reach the facility as well as smooth operation of the available facilities.

5.0 Triple Burden of Malnutrition

Tanzania is implementing the NMNAP II which is a triple duty strategy that addresses undernutrition, overnutrition and micronutrients malnutrition. Data are clearly showing that NMNAP approach is justified as stunting rates are still high (30%) albeit reduction from 34% in 2015 – 16 TDHS-MIS; overweigh and obesity among women and men as well as women adolescents are on the increase and micronutrients deficiencies remain high despite supplementation efforts. Anaemia among women of reproductive health remains high at 42% and 59% among children under age 5.

Results from operational surveys, National Nutrition Surveys, and review of literatures, NMNAP II has revealed that Tanzania is facing significant health and economic challenges from overweight and obesity, which cause the loss of about 2.8 per cent of its annual GDP. Designing and implementing strategies which can be applied in the prevention, control, and management of overweight and obesity (which are the risk factors of non-communicable diseases such as diabetes, high blood pressure, cardiovascular diseases and some cancers) is paramount. Some of Strategies are to strengthen health-care infrastructures, establishment and strengthening interventions targeting overweight and obesity at the workplace and community levels, advocacy of fiscal policies on sugar and sweetened beverages (SSBs), strengthening partnerships, including public–private sector engagement, and Implementing National Food Based Dietary Guidelines (NFBDGs).

Implementing the second generation of National Multi-sectoral Nutrition Action Plan (NMNAP II) along with other nutrition sensitive sector strategies need to be given more weight to help preventing nutrition related mortalities and morbidities. A holistic approach is feasible considering life cycle approach and ensuring inclusivity of key sector such as

education, health, social protection, WASH, agriculture and food in delivering and ensure accountability in implementing nutrition interventions. It is of paramount importance that we consider both facility, community and workplace as the levels.

In addition, the NFBDGs (which will be launched this year) is one of the tools to facilitate success of the NMNAP II. Therefore, its implementation follows a multi-sectoral approach already stipulated in the exiting NMNAP II, and with regard to the inter-sectoral nature of the nutrition as a cross-cutting issue, several ministries and departments need to incorporate the FBDGs in their policies and translate them into action. Moreover, activities to fulfil the NMNAP II strategies to prevent, manage and control overweight and obesity are clearly stipulated.

6.0 Water and Sanitation

Water and Sanitation are important for the health of the population. While accesses to water and sanitation have improved with time, two thirds of the population do not treat their water prior to drinking. Boiling water and straining through cloth are the most common types of water treatment. Moreover, households using open defecation remain high at 10%. Unclean water pose high risks of water- borne diseases which increase stress of the health care delivery and associated costs.

The health Policies should advocate for increased access to safe water and treatment at source as well as advocating for by-laws that mandate every household to have minimum accepted toilet facility. Health in all policy strategies should include all pertinent sectors to help achieving better in health indicators.

7.0 Female Genital Mutilation

Although prevalence of Female Genital Mutilation dropped from 10% recorded in in 2015–16 TDHS to 8% in 2022 TDHS, FGM is still practiced and is most prevalent in Manyara and Arusha with 43% of women aged 15-49. There is a dramatic decrease in the prevalence of FGM/C among women age 15–49 in Dodoma, from 47% in 2015–16 to 18% in 2022. Furthermore, FGM is more common in rural areas (three times higher compared to urban) and most were circumcised when they were less than 5 years of age (34%) or after they reached puberty. Twenty-eight percent of circumcised women underwent the procedure from 10–14 years of age, and 20% were circumcised at the age of 15 or older.

Despite existence of legal frameworks that protect female children and adults against FGM ***[The Tanzania's Penal Code CAP 16 (RE 2022) Section 169A*** *(URT, 2022)] and* ***Sexual Offences Special Provision Act 1998,*** *the practice is still common in some regions. While*

it is important to continue with mass national campaigns and awareness raising against FGM, there should be special emphasis in more prevalent regions of Manyara and Arusha, drawing lessons from successful regions notably Dodoma that recorded sharp decline in FGM between two TDHS. In addition, enforcements of the above-mentioned legal instruments need to be strengthened along with using influential leaders at community level such as religious leaders and others to educate public on the effects of FGM to women.