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Tanzania

This brief compares Tanzania's health system with that of its peers in sub-Saharan Africa and other low-income countries. Additionally, it presents an overview of the Tanzanian health system's strengths and weaknesses in order to highlight some of the challenges faced by HIV/AIDS and malaria programs.

Tanzania, with more than 37 million people, is a low-income country (gross domestic product [GDP] per capita of $313) located in East Africa. While troubled by challenges in health similar to those of other sub-Saharan African countries, Tanzania's government has made a strong commitment to reduce poverty and improve health status. In recognition of the population's health needs, Tanzania's Ministry of Health (MoH) established the Second Health Sector Strategic Plan (2003-2008), the main focus of which is to provide quality health services to the population.

A lack of qualified human resources is a major limiting factor for implementing effective health policies and reforms. Tanzania is experiencing a severe shortage of human resources in health.

Donors too have responded with a rapid increase in financial assistance for health. Due to Tanzania's high HIV prevalence rate of 6.5% in the 15-49 age group (compared with a sub-Saharan Africa average of 5.9%) and 9 out of 10 people at risk for malaria, the country received approximately $130 million in FY 2006 from the President's Emergency Plan for AIDS Relief (PEPFAR) and approximately $27 million for FY 2007 from the President's Malaria Initiative (PMI). Yet, despite national commitment and donor assistance, the health status of the Tanzanian population remains one of the poorest in the region and in need of further efforts.

HEALTH SYSTEMS STRENGTHS AND WEAKNESSES

According to the Second Health Sector Strategic Plan, the health system is organized into three components: the district component (the district hospital, health centers, dispensaries, and community health services), secondary and tertiary hospitals and other tertiary-level institutions (teaching

Country Brief

Health Systems Country Briefs *assess a country's health system to identify "best buys" for health systems strengthening – limited investments in health systems activities that are certain to realize important gains. Information in this Brief comes from review of secondary data sources, country reports, and communication with country experts. Data for comparisons with peer countries come from internationally comparable datasets of the World Bank, World Health Organization, and others; where more recent data are available from the country, those data are used.*

HEALTH SYSTEMS 20/20

TABLE 1: TANZANIA HEALTH SYSTEM – STRENGTHS AND WEAKNESSES

Health System Function	Data/Evidence	Strengths and Weaknesses
Health Financing	• Household out-of-pocket expenditures on health in 2003 accounted for 81.1% of total private health expenditures. • Tanzania has introduced community-based insurance to increase the rural population's access to care. • Tanzania has introduced a cost-sharing strategy for operating hospitals, to increase their resources and to improve the quality of services they deliver.	**Strengths** • Donors are increasing their support, especially for HIV/AIDS and malaria. • Districts are encouraged to incorporate innovations in their health centers. • District levels have a virtual network for knowledge-sharing. Weaknesses • The current health financing arrangement does not cover the entire population. • Per capita spending on health is extremely low compared with other countries in sub-Saharan Africa and in the low-income group.
Governance	• Tanzania scored better than about 40% of the countries surveyed and better than the average score for its regional and income-group peers in voice and accountability, and regulatory quality. • Tanzania performed best in government effectiveness, where it ranked slightly higher than 40% of the countries surveyed, while its sub-Saharan Africa and low-income peers ranked higher than only 27% and 22%, respectively.	**Strengths** • The government's commitment to good governance in health is reflected in Tanzania's performance vis-à-vis its sub-Saharan Africa and low-income group peers. • Tanzania has a donor coordination mechanism in place. **Weaknesses** • The evidence presented suggests that greater efforts are needed in governance.
Service Delivery	• In 2004, 95% of one-year-olds received DPT3 immunization, much higher than other countries in sub-Saharan Africa (71%) and in the low-income group (73%). • Health care delivery is decentralized, with village health centers, dispensaries, and district hospitals playing a significant role.	**Strengths** • Health facilities are almost evenly distributed among rural and urban areas. **Weaknesses** • The high maternal mortality (1,500 per 100,000 live births) suggests the existence of many barriers to health care access.
Human Resources	• Physician density is 2 per 100,000 compared with the World Health Organization recommendation of 20 per 100,000. • In 2004, Tanzania had only 822 physicians.	**Strengths** • Potential to experiment with incentive systems in order to increase retention of health staff **Weaknesses** • Severe shortage of trained health professionals • Inadequate capacity to train and retain health workers
Health Information Systems	• A new, integrated health information system was established in 1993.	**Strengths** • The system is used in all health facilities, in both the public and the private sectors. • The system design eliminates duplicative reporting. **Weaknesses** • Data are not used timely and efficiently for decision-making. • Data quality and accuracy are weak.

institutions), and the central level which provides support services such as policy-making, donor coordination, and monitoring and evaluation. Through its strategic plan, Tanzania intends to better integrate the three components in order to reduce the disease burden, especially from HIV/AIDS and malaria, and to strengthen its health system. Furthermore, it continues to support Community Health Funds (CHF), a community-based insurance scheme, in primary health care centers, and the Health Service Fund, a cost-sharing mechanism in operating hospitals. These two strategies have increased both access to health care, especially in rural areas, and the resources available to health facilities. The MoH also intends to better integrate vertical programs into the health service delivery system.

According to the 2006 World Health Report, Tanzania is still highly dependent on donor funding. Tanzania's total expenditure on health has been stable at around 4% of GDP between 1999 and 2003. However, external funding accounted for almost a quarter (22%) of Tanzania's total health spending and has been steadily increasing since 2002. In the same period, external funding was less than one fifth (between 16% and 18%) of total health spending for sub-Saharan African countries and other low-income countries.

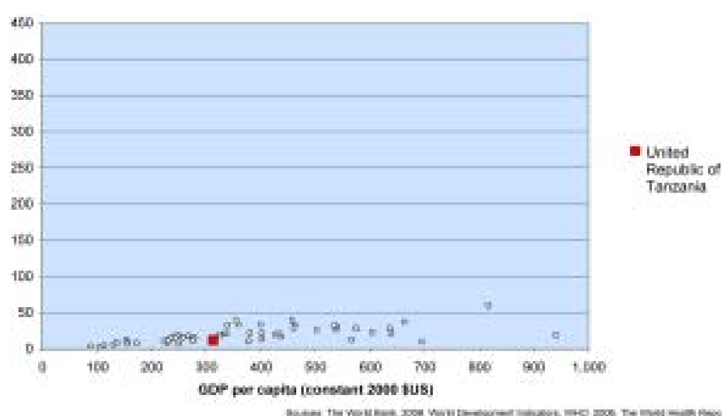
Tanzania's health status indicators (see Annex 1 for complete list) suggest that further investments in health, and the health system, are necessary: In 2004, the life expectancy at birth (46 years) was lower than the average in sub-Saharan Africa (49 years) and in other low-income countries (53 years). Less than half of births (46%) were attended by skilled personnel in 2004, slightly less than in sub-Saharan Africa countries (52%) and other low-income countries (48%). Tanzania's fertility rate is high at 4.9, but this is equivalent to that of other low-income countries (also 4.9) and lower than that of sub-Saharan Africa (5.2). Under-5 mortality in Tanzania, although high at 126 per 1,000, is lower than the average in sub-Saharan Africa and in other low-income countries (151 per 1,000 and 131 per 1,000, respectively).

These health status indicators provide the context for the health systems strengths and weaknesses summarized in Table 1. The five health systems functional areas (health financing, governance or stewardship, health service delivery, human resources, and health information systems) are discussed in greater detail below.

Health Financing

Tanzania spends less on health, in total and per capita expenditures, than its sub-Saharan African peers and other low-income countries. In 2003, the country's total health expenditure was 4.3% of GDP as compared with 4.9% in sub-Saharan Africa and 5.2% in other low-income countries. Tanzania's per capita health expenditure was only $12, less than half of the average $49 per capita in sub-Saharan Africa and the average $26 per capita in other low-income countries.

FIGURE 1: PER CAPITAL TOTAL HEALTH EXPENDITURE FOR TANZANIA AND LOW-INCOME COUNTRIES



In 2003, Tanzania's government spent almost 13% of its total expenditures on health, a higher percentage than other countries in sub-Saharan Africa and in the low-income group (9.0% and 8.7%, respectively). Along the same lines, more than half (55%) of total health spending is public, which is close to the average 50% in sub-Saharan Africa and more than the average 46% in other low-income countries. Household out-of-pocket expenditures in Tanzania constitute four fifths (81%) of private health expenditures, similar to other countries in sub-Saharan Africa and in the low-income group (81% and 85%, respectively). According to Tanzania's 2000 National Health Accounts (NHA), households contribute almost half (47%) of total health expenditures. Almost three quarters (72%) of out-of-pocket expenditures in health were spent on services from public providers (13% and 15% were spent on services from private for-profit and not-for-profit providers, respectively).

In 1999, the MoH approved the National Health Insurance Fund Act, which establishes a compulsory social health insurance scheme for formal sector employees. This fund currently covers 3% of the population. CHFs, established in 2001, bring community-based insurance to 48 districts, mostly in rural areas. Churches, informal sector groups, cooperatives, and mutual health organizations run micro-insurance schemes for those employed in the informal sector. Private health insurance is limited, but available for those who choose to pay.

Governance

The World Bank's 2004 Worldwide Governance Indicators evaluate countries based on five governance characteristics. The voice and accountability percentile rank indicates the extent to which citizens participate in selecting their government. Political stability describes the perceptions of the likelihood that a country's government will be destabilized or overthrown by unconstitutional or violent means. Government effectiveness indicates the quality of public services and of the civil service. Regulatory quality refers to the government's ability to formulate and implement sound policies and regulations. The rule of law describes the extent to which citizens have confidence in and abide by the rules of society. Finally, the control of corruption indicates the extent to which public power is exercised for private gain.

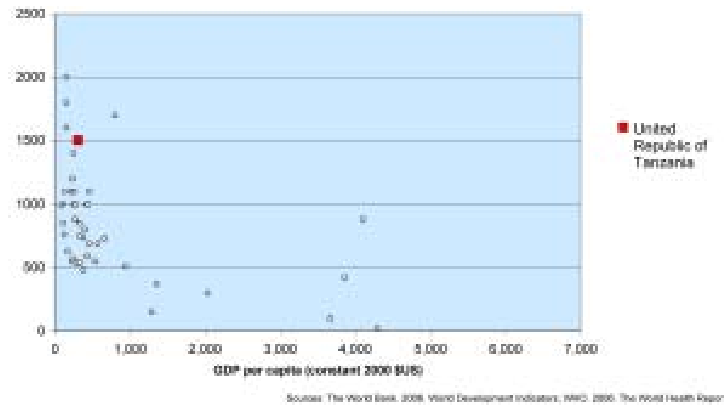
Tanzania scored better than almost 40% of the countries surveyed in voice and accountability, government effectiveness, and regulatory quality, while sub-Saharan Africa and other low-income countries scored, on average, better than 25-30%. Tanzania scored better than 36% of the countries surveyed in control of corruption. In the same category, other sub-Saharan Africa and low-income countries scored better than 29% and 24%, respectively. Tanzania also performed slightly better than its peers in political stability, where it scored better than 35% of the countries surveyed. Other sub-Saharan Africa and low-income countries scored better than 33% and 26%, respectively. In regulatory quality, Tanzania scored better than 29% of the countries surveyed. Although Tanzania performed worse in this category than in its other government rankings, it was similar to the average in sub-Saharan Africa and other low-income countries, which scored 29% and 25% better than other countries surveyed, respectively.

Service Delivery

In terms of service delivery indicators, Tanzania performed better than its sub-Saharan Africa and low-income peer countries. For example, in 2004, 95% of one-year-olds received DPT3 immunization. This figure is significantly higher than in sub-Saharan Africa and other low-income countries, where an average of only about 72% of one-year olds received DPT3 immunization. Similarly, 96% of pregnant women received at least one antenatal visit in Tanzania, compared to 80% in sub-Saharan Africa and 74% in other low-income countries. In contrast, maternal mortality continues to be very high: In 2000, Tanzania's maternal mortality ratio was 1,500 per 100,000 live births, compared with 855 and 738 for sub-Saharan Africa and other low-income countries, respectively.

Tanzania has 26 administrative regions and 130 administrative districts. Health services in Tanzania are organized in a hierarchical structure. The village health service is the lowest level of health care delivery. From there, patients are referred to dispensaries, health centers, district hospitals, regional hospitals, and, finally, to referral hospitals.

FIGURE 2: MATERNAL MORTALITY RATIO FOR TANZANIA AND SUB-SAHARAN AFRICA



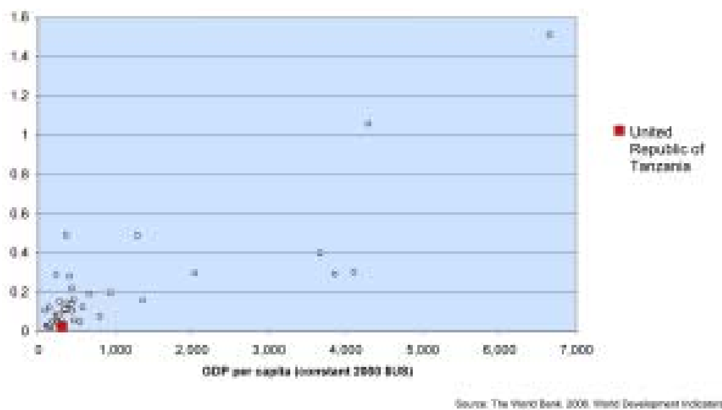
In the public sector, Tanzania has 78 hospitals, 409 health centers, and 2,450 dispensaries. Currently, Tanzania has 126 registered private health centers, of which 70 belong to voluntary agencies, 50 are private for profit, and 6 belong to parastatal organizations. There are 1,340 registered private dispensaries, of which 561 are private for-profit and 250 belong to parastatal organizations.

Because 70% of Tanzania's population is rural, 56% of the 121 private, mostly not-for-profit hospitals are located in rural areas. More than half (52%) of the registered health centers are also located in rural areas. The majority of pharmacies are privately owned, by individuals or organizations.

Human Resources

A severe shortage of qualified human resources for health is a major limiting factor for implementing effective health policies and reforms. According to the 2006 World Health Report, in 2002, Tanzania had only 822 physicians, with a physician-to-population ratio of 2 per 100,000. Not only is this much lower than in other sub-Saharan Africa and low-income countries (19 per 100,000 and 42 per 100,000, respectively), it is significantly lower than the World Health Organization's recommendation of 20 per 100,000.

FIGURE 3: PHYSICIAN DENSITY FOR TANZANIA AND SUB-SAHARAN AFRICA



Considering the population's current health status and the high burden of disease, especially due to the HIV/AIDS and malaria epidemics, the need for qualified health professionals will very likely continue to increase. Therefore, Tanzania needs to invest significant efforts in human resources development in order to create incentives for health professionals to remain in the country and to work in the areas with the greatest unmet health needs.

Health Information Systems

Robust health information systems are an indispensable tool for tracking resources and for evidence-based decision-making. Tanzania's Health Management Information System (MTUHA in Kiswahili) is currently used by all health facilities (including government, private, and nongovernmental and parastatal organizations). When this system was established in 1993, it incorporated all previously existing systems, including the Expanded Program for Immunization and the programs for tuberculosis, leprosy, and AIDS control. Within the current system, information is integrated, has a bottom-up flow of information, and health workers are less burdened by the filling out of separate forms for different programs.

In spite of these successes, the health information system can be further strengthened. Information is not sufficiently used in decision-making, especially at the local level. Data quality and accuracy, as well as timely reporting could be improved. Lastly, better management of software and hardware problems would eliminate inefficiencies at the regional and central levels.

RECOMMENDED BEST BUYS

Improve district-level health planning and spending. The decentralized districts lack simple tools for planning, budgeting, and spending health funds received from various sources: MoH, CHFs, donors, fees, and revolving funds for items such as bed nets. The MOH's Tanzania Essential Health Interventions Project, Ministry of Finance, and Ministry of Local Government will roll out PlanRep2, an easy-to-use tool that provides a graphical analytical summary of district health priorities, partners, sources of funds, total financial resources budgeted and spent, and other key health care data. PlanRep2 can support the impact of PEPFAR and PMI by showing the disease burden of malaria and HIV/AIDS compared with planned expenditures. It also can improve district absorption and management of PEPFAR and PMI funds and interventions. The best buy for US programs is to support the national roll-out and link the NHA framework with PlanRep2, so that NHA can be produced more easily and regularly, and districts and other stakeholders can access NHA data.

Roll out IDSR strategy. Tanzania's Integrated Disease Surveillance and Response (IDSR) strategy, already implemented in 12 districts, should be rolled out nationwide so that all levels of the health system have high-quality data for monitoring disease trends and quickly detecting and responding to outbreaks. IDSR is the backbone of public health and a platform to target HIV/AIDS, malaria, and TB by improving data recording and management, epidemiology skills and systems, epidemic preparedness, and outbreak management and supervision. By integrating multiple systems and forms, IDSR leads to more efficient use of human and financial resources. IDSR also includes functional laboratories and networks that solve obstacles to communications with remote areas. Expected results include effective monitoring of resistance to antiretroviral drugs, integrated surveillance for HIV and TB, and reliable tracking of malaria incidence and death rates among target groups such as children under 5 years and pregnant women.

ANNEX 1: KEY HEALTH SYSTEM INDICATORS FOR TANZANIA AND PEER COUNTRIES

Health systems data		Country level data		Average value for regional comparator[1]		Average value for income group comparator[2,3]		
				Sub-Saharan Africa		Low-income economies		
		United Republic of Tanzania	Year of data	SSA	Year of data	LI	Year of data	Source of data
Core Module								
Indicator 1	Population, total	37,626,920	2004	14,785,627	2004	39,904,246	2004	The World Bank. 2006. World Development Indicators.
Indicator 2	Population growth (annual %)	1.90	2004	2.22	2004	2.19	2004	The World Bank. 2006. World Development Indicators.
Indicator 3	Rural population (% of total)	63.55	2004	63.02	2004	67.40	2004	The World Bank. 2006. World Development Indicators.
	Urban population (% of total)	36.45	2004	36.98	2004	32.60	2004	The World Bank. 2006. World Development Indicators.
Indicator 4	Contraceptive prevalence (% of women ages 15-49)	25.40	1999	23.36	-	26.25	-	The World Bank. 2006. World Development Indicators.
Indicator 5	Fertility rate, total (births per woman)	4.90	2004	5.24	2004	4.89	2004	WHO. 2006. The World Health Report.
Indicator 6	Pregnant women who received 1+ antenatal care visits (%)	96.00	1999	79.71	-	74.25	-	WHO. 2006. The World Health Report.
	Pregnant women who received 4+ antenatal care visits (%)	69.00	1999	51.42	-	46.49	-	WHO. 2006. The World Health Report.
Indicator 7	Prevalence of HIV, total (% of population aged 15-49)[4]	6.50	2005	8.44	2003	4.76	2003	The World Bank. 2006. World Development Indicators.
Indicator 8	Life expectancy at birth, total (years)	46.19	2004	49.07	-	53.27	-	The World Bank. 2006. World Development Indicators.
Indicator 9	Mortality rate, infant (per 1,000 live births)	78	2004	93	2004	84	2004	The World Bank. 2006. World Development Indicators.
Indicator 10	Mortality rate, under-5 (per 1,000)	126	2004	151	2004	131	2004	The World Bank. 2006. World Development Indicators.
Indicator 11	Maternal mortality ratio (per 100,000 live births)[5]	1,500	2000	855	2000	738	2000	WHO. 2006. The World Health Report.
Indicator 12	GDP per capita (constant 2000 US$)	313	2004	879	2004	373	2004	The World Bank. 2006. World Development Indicators.
Indicator 13	GDP growth (annual %)	6.28	2004	5.06	-	5.49	-	The World Bank. 2006. World Development Indicators.
Indicator 14	Per capita total expenditure on health at international dollar rate	29.00	2003	103.56	2003	72.74	2003	WHO. 2006. The World Health Report.
Indicator 15	Private expenditure on health as % of total expenditure on health	44.60	2003	49.99	2003	53.81	2003	WHO. 2006. The World Health Report.
Indicator 16	Out-of-pocket expenditure as % of private expenditure on health	81.10	2003	81.10	2003	84.67	2003	WHO. 2006. The World Health Report.
Indicator 17	Gini index	34.62	2003	40.19	-	38.23	-	The World Bank. 2006. World Development Indicators.
Governance Module								
Indicator 1	Voice and accountability							
	Point estimate[6]	-0.4	2004	-0.6	2004	-0.8	2004	The World Bank. Governance Indicators: 1996-2004.
	Percentile rank[7]	38.30	2004	31.84	2004	27.52	2004	The World Bank. Governance Indicators: 1996-2004.
Indicator 2	Political stability							
	Point estimate[6]	-0.4	2004	-0.6	2004	-0.8	2004	The World Bank. Governance Indicators: 1996-2004.
	Percentile rank[7]	35.00	2004	32.67	2004	25.88	2004	The World Bank. Governance Indicators: 1996-2004.
Indicator 3	Government effectiveness							
	Point estimate[6]	-0.4	2004	-0.8	2004	-0.9	2004	The World Bank. Governance Indicators: 1996-2004.
	Percentile rank[7]	40.40	2004	26.54	2004	21.96	2004	The World Bank. Governance Indicators: 1996-2004.
Indicator 4	Rule of law							
	Point estimate[6]	-0.5	2004	-0.8	2004	-0.9	2004	The World Bank. Governance Indicators: 1996-2004.
	Percentile rank[7]	39.60	2004	26.84	2004	22.57	2004	The World Bank. Governance Indicators: 1996-2004.
Indicator 5	Regulatory quality							
	Point estimate[6]	-0.6	2004	-0.7	2004	-0.8	2004	The World Bank. Governance Indicators: 1996-2004.
	Percentile rank[7]	29.10	2004	28.70	2004	24.63	2004	The World Bank. Governance Indicators: 1996-2004.
Indicator 6	Control of corruption							
	Point estimate[6]	-0.6	2004	-0.7	2004	-0.8	2004	The World Bank. Governance Indicators: 1996-2004.
	Percentile rank[7]	36.00	2004	29.17	2004	24.12	2004	The World Bank. Governance Indicators: 1996-2004.

Health Financing Module								
Indicator 1	Total expenditure on health as % of GDP	4.30	2003	4.89	2003	5.18	2003	WHO. 2006. The World Health Report.
Indicator 2	Per capita total health expenditure, at average exchange rate (US$)[8]	12	2003	49	2003	26	2003	WHO. 2006. The World Health Report.
Indicator 3	Government expenditure on health as % of total government expenditure	12.70	2003	9.07	2003	8.68	2003	WHO. 2006. The World Health Report.
Indicator 4	Public (government) spending on health as % of total health expenditure	55.40	2003	50.01	2003	46.19	2003	WHO. 2006. The World Health Report.
Indicator 5	Donor spending on health as % of total health spending	21.90	2003	15.93	2003	18.26	2003	WHO. 2006. The World Health Report.
Indicator 6	Out-of-pocket expenditure as % of private expenditure on health	81.10	2003	81.10	2003	84.67	2003	WHO. 2006. The World Health Report.
Service Delivery Module								
Indicator 1	Number of hospital beds (per 10 000 population)	NA	NA	6	-	26	-	WHO. 2006. The World Health Report.
Indicator 2	Percentage of births attended by skilled health personnel per year	46.00	2004	51.74	-	47.57	-	The World Bank. 2006. World Development Indicators.
Indicator 3	DTP3 immunization coverage: one-year-olds immunized with three doses of diphtheria, tetanus toxoid (DTP3) and pertussis (%)	95.00	2004	71.48	2004	73.40	2004	WHO. 2006. The World Health Report.
Indicator 4	Contraceptive prevalence (% of women ages 15-49)	25.40	1999	23.36	-	26.25	-	The World Bank. 2006. World Development Indicators.
Indicator 5	Pregnant women who received 1+ antenatal care visits (%)	96.00	1999	79.71	-	74.25	-	WHO. 2006. The World Health Report.
Indicator 6	Life expectancy at birth, total (years)	46.19	2004	49.07	-	53.27	-	The World Bank. 2006. World Development Indicators.
Indicator 7	Mortality rate, infant (per 1,000 live births)	78	2004	93	2004	84	2004	The World Bank. 2006. World Development Indicators.
Indicator 8	Maternal mortality ratio (per 100,000 live births)[3]	1,500	2000	855	2000	738	2000	WHO. 2006. The World Health Report.
Indicator 9	Prevalence of HIV, total (% of population aged 15-49)[4]	6.50	2005	8.44	2003	4.76	2003	The World Bank. 2006. World Development Indicators.
Human Resources Module								
Indicator 1	Physicians (density per 1,000 population)	0.02	2002	0.19	-	0.42	-	WHO. 2006. The World Health Report.
Indicator 2	Nurses (density per 1,000 population)	0.37	2002	1.21	-	1.14	-	WHO. 2006. The World Health Report.
Indicator 3	Midwives (density per 1,000 population)	NA	NA	0.09	-	0.22	-	WHO. 2006. The World Health Report.
Indicator 4	Pharmacists (density per 1,000 population)	0.01	2002	0.09	-	0.08	-	WHO. 2006. The World Health Report.
Indicator 5	Lab technicians (density per 1,000 population)	0.04	2002	0.10	-	0.07	-	WHO. 2006. The World Health Report.
Pharmaceutical Management Module								
Indicator 1	Total expenditure on pharmaceuticals (% total expenditure on health)	10.40	2000	27.53	2000	27.04	2000	WHO. 2004. The World Medicines Situation.
Indicator 2	Total expenditure on pharmaceuticals (per capita at average exchange rate) in US$	1	2000	9	2000	5	2000	WHO. 2004. The World Medicines Situation.
Indicator 3	Government expenditure on pharmaceuticals (per capita at average exchange rate) in US$	1	2000	6	2000	2	2000	WHO. 2004. The World Medicines Situation.
Indicator 4	Private expenditure on pharmaceuticals (per capita at average exchange rate) in US$	1	2000	6	2000	4	2000	WHO. 2004. The World Medicines Situation.
Health Information System (HIS) Module								
Indicator 1	Maternal mortality ratio reported by national authorities[9]	580	2001	560	2001	518	2001	UNICEF. 2006. The State of the World's Children 2006.
Indicator 2	Mortality rate, under-5 (per 1,000)	126	2004	151	2004	131	2004	The World Bank. 2006. World Development Indicators.
Indicator 3	HIV prevalence among pregnant women aged 15-24	7	2002	12	-	10	-	UNICEF. 2006. The State of the World's Children 2006.
Indicator 4	Proportion of children under 5 years who are underweight for age	29	1999	25	-	29	-	WHO. 2006. The World Health Report.
Indicator 5	Number of hospital beds (per 10,000 population)	NA	NA	6	-	26	-	WHO. 2006. The World Health Report.
Indicator 6	Contraceptive prevalence (% of women ages 15-49)	25.40	1999	23.36	-	26.25	-	The World Bank. 2006. World Development Indicators.
Indicator 7	Percentage of surveillance reports received at the national level from districts compared to number of reports expected	86.55	2005	91.90	2005	92.35	2005	WHO. 2005. Annual WHO/UNICEF Joint Reporting Form.

NOTES:

NC: Not Calculated because the regional comparator includes both high income countries as well as some countries that have a population of less than 30,000, which are not classified by the World Bank.

NA: Data Not Available

- : No specific year is noted here since the average is calculated across different countries, where the data is reported in different years

1- The geographic classifications used by the World Bank are for low-income and middle-income economies only. Low-income and middle-income economies are sometimes referred to as developing economies. The use of the term is convenient; it is not intended to imply that all economies in the group are experiencing similar development or that other economies have reached a preferred or final stage of development. The countries are divided into 6 regions: East Asia and Pacific (EAP), Europe and Central Asia (ECA), Latin America and the Caribbean (LAC), Middle East and North Africa (MENA), South Asia (SA), Sub-Saharan Africa (SSA). Countries noted with * in the spreadsheets indicate high-income countries (with the exception of South Africa classified as an Upper-middle income country) which are not part of the World Bank geographic classification.

2- The classification of countries by income group is based on the World Bank classification which classifies member economies, and all other economies with populations of more than 30,000. The countries which are not in a category have a population of less than 30,000.

3- Economies are divided according to 2004 GNI per capita, calculated using the World Bank Atlas method. The groups are: LI (low income), $825 or less; LMI (lower middle income), $826 - $3,255; UMI (upper middle income), $3,256 - $10,065; and (HI) high income, $10,066 or more (the HI countries are further divided between OECD and non-OECD, noted n-OECD).

4- The following countries report "<0.1" : Azerbaijan, Bosnia and Herzegovina, Brunei Darussalam , Bulgaria, Croatia, Egypt, Iraq, Japan, Jordan, Mongolia, Philippines, Republic of Korea., Romania, Slovakia, Slovenia, Sri Lanka, Syrian Arab Republic, Tajikistan, The former Yugoslav Republic of Macedonia, Tunisia, Turkmenistan

5- Estimates derived by regression and similar estimation methods for the following countries: Afghanistan, Albania, Algeria, Angola, Armenia, Bhutan, Bolivia, Botswana, Burundi, Cape Verde, Comoros, Congo, Cote d'Ivoire, Democratic Republic of Korea, Democratic Republic of Congo, Djibouti, Dominican Republic, El Salvador, Equatorial Guinea, Fiji, Gambia, Georgia, Ghana, Guinea Bissan, Indonesia, Iraq, Kazakhstan, Kyrgyzstan, Lau People's Democratic Republic, Lebanon, Lesotho, Liberia, Libyan Arab Jamahiriya, Maldives, Mozambique, Myanmar, Namibia, Nicaragua, Niger, Nigeria, Oman, Pakistan, Papua New Guinea, Senegal, Sierra Leone, Solomon Islands, Somalia, South Africa, Sudan, Swaziland, Syrian Arab Republic, Tajikistan, Timor-Leste, Turkey, Turkmenistan, United Arab Emirates, Uzbekistan, Viet Nam.

6- Ranges from -2.5 to 2.5. Higher values indicate better governance ratings.

7- Percentile rank indicates the percentage of countries worldwide that rate below the selected country (subject to margin of error)

8- Democratic People's Republic of Korea reports "<1000" for the per capita total expenditure on health at average exchange rate (US$)

9- Data refer to the most recent year available during the period 1990-2004. Several countries either have data that refer to years or periods other than 1990-2004, differ from the standard definition, or refer to only part of a country. These countries are Dominican Republic, Ghana, Lebanon, Papau New Guinea, Solomon Islands, Syrian Arab Republic, Turkey.

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Health Systems 20/20

Health Systems 20/20, a five-year (2006-2011) cooperative agreement funded by the U.S. Agency for International Development (USAID), offers USAID-supported countries help in solving problems in health governance, finance, operations, and capacity building. By working on these dimensions of strengthening health systems, the project will help people in developing countries gain access to and use priority population, health, and nutrition (PHN) services. Health Systems 20/20 integrates health financing with governance and operations initiatives. This integrated approach focuses on building capacity for long-term sustainability of system strengthening efforts. The project acts through global leadership, technical assistance, brokering and grant making, research, professional networking, and information dissemination.

Why Health Systems?

The delivery of all health services, including the priority PHN services, depends on the underlying health system. To combat malaria, TB, HIV, and maternal and child health problems, the health system needs adequate and appropriately allocated financing, inclusive decision making and accountability, and financial and human resource management systems that deliver inputs where and when needed. A smoothly functioning health system maximizes the delivery of effective and life-saving technical interventions.

How to Access Health Systems 20/20

USAID missions and bureaus can access Health Systems 20/20 by obligating funds to cooperative agreement No. GHS-A-00-06-00010-00. The project can accept all types of USAID funding, including PEPFAR, POP, CS, EFS, as well as funds through EGAT and D&G. As a Leader with Associate mechanism, missions and bureaus can also negotiate and manage separate Associate Awards for which they will designate a CTO.

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