What is Chronic Poverty?

The distinguishing feature of chronic poverty is extended duration in absolute poverty. Therefore, chronically poor people always, or usually, live below a poverty line, which is normally defined in terms of a money indicator (e.g. consumption, income, etc.), but could also be defined in terms of wider or subjective aspects of deprivation.

This is different from the transitorily poor, who move in and out of poverty, or only occasionally fall below the poverty line.

Background Paper for the Chronic Poverty Report 2008-09

PRS Assessment on Chronic Poverty in Tanzania: Focusing on the Health and HIV/AIDS Sector

Tamahi Yamauchi

The research for this Background Paper was made possible by funding from the Japan International Cooperation Agency (JICA).
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1 Introduction

Since the mid-1990s when poverty reduction became the goal of the development agenda through various international conferences (Conference in Cairo, 1994), poverty reduction has come to the policy agenda also in Tanzania, as seen in National Poverty Eradication Strategy (1997)\(^1\) and Tanzania Development Vision 2025 (1998)\(^2\). The latter Vision 2025, developed by Planning commission at that time\(^3\), has become the long term development vision in Tanzania, which aims that by 2025 Tanzania will become the middle-income, semi-industrialized country without poverty, and has advocated widely to the general public through national campaign up to the grass roots level. The former which was formulated by Vice-president’s office in centre, which has undertaken the poverty reduction agenda since 1994, and has had support from UNDP since then, targets to halve the income poverty by 2010, among other poverty reduction objectives, and developed a set of indicators called ‘Poverty and welfare monitoring indicators’\(^4\)\(1999\), in broad consultation with stakeholders. These indicators are extensive, but were not utilized in practice (2003, Enoki).

In 1995 when Mkapa took up the presidency which has continued up to 2005, several public sector reforms such as privatization, local government reform, public financial management reform, public sector management reform, which have taken up since mid-1980s, have also continued to take up.

\(1\) Mid-term strategy for eradicating poverty. It aims to halve poverty by the year 2010, compared to 1990.
\(2\) Long-term development vision. It aims Tanzania becomes a semi-industrialized country without poverty.
\(3\) President’s office, Planning and privatization (by 2005) now ?
\(4\) It is composed of 73 indicators which are to be monitored at various levels: national, regional, and district levels.
Encountering the tension between Tanzanian government and donors caused by the severe government budget deficit and corruption on one hand, and aid fragmentation on another, around 1994-5, the efforts which review the aid relationship was initiated with the Helleiner report (1995). This report suggests the aid coordination, alignment to the government processes, national ownership of the development and technical assistance, which later Tanzanian government and aid agencies have agreed to take up to follow and monitor the aid practices. After monitored by Helleiner for several years it was succeeded by the independent monitoring group. In the meantime the government and aid agencies aimed to formulate the plan to develop the agreed aid practices on aid coordination, alignment, harmonization issues, to be followed by the aid agencies. The plan is later called ‘Tanzania Assistance Strategy (TAS) (2002)’. Several working groups were formulated to develop TAS, which continued to work even during and after the formulation of PRS.

2 Objectives of this research

This research addresses to find out how PRS policy implementation through focusing on basic health services and HIV/AIDS care and prevention has reached chronically poor and what the drivers / obstacles toward it in Tanzania are. The reason for focus is due to the recent stagnant situation in health of Tanzanian people, and HIV/AIDS is the threat to the people as the most impoverishing force in Tanzania (Tz Participatory Poverty Assessment 2002/3). In focusing on implementation of some PRS prioritized policies targeting to population in general and specifically to vulnerable groups, the research looks at the coverage and quality of these, unpacks PRS process in terms of PRS-sector policy linkage and its implementation process through budgeting and descentralization, and looks at what the drivers and obstacles toward implementation are. It also looks at the effective social protection programmes. Through this it aims to address how the PRS and social protection could effectively reach the chronically poor
to assist their poverty reduction. It also aims to fill the gap on research on chronically poor in Tanzania.

1) Core objective:

Through interviews to government officials and other key stakeholders and project officers at both central and local level, as well as utilizing exiting data of LADDER in Morogoro region in 2001, conducting community wealth ranking and FGDs to vulnerable groups and HH / individual interviews, the research attempts to look at how the PRS policy implementation focusing on health and HIV/AIDS, and social protection has reached the chronically poor in Tanzania, what the major drivers and obstacles to reach them are.

From the findings, the research aims to make recommendations to Ministry of Planning, Economy and Empowerment, Ministry of Health, TACAIDS (Tanzania Aids Commission) and Presidents office – Local Government and other stakeholders (donors and CSOs) on how they could implement policies better and effectively to reach the chronically poor in Tanzania.

2) Specific objectives:

The followings are the specific objectives:

To examine how the PRSP and health and HIV/AIDS sector priority policies and process and address measures to reach its policy implementation to the chronically poor in Tanzania.

- Utilizing LADDER data, to find out how the implementation of the PRS policies in health and HIV/AIDS, social protection assistance in Morogoro region have reached to the chronically poor and how these have related to the change of their lives.
- To analyse what the drivers and obstacles of PRS policy implementation to reach the chronically poor are.
To suggest recommendations on how the PRS policy implementation and processes could reach the chronically poor to assist their poverty reduction.

To feed into the next Chronic Poverty Report 2007/8.

3 Background of the Tanzanian context

Tanzania is in majority an agrarian society, whose major proportion of population (around 80%) is engaged in agriculture, and about half of GDP comes from agricultural sector. The prevalence of poverty is still high in Tanzania, and poverty is overwhelmingly concentrated in rural areas where 87% of the poor population live, and it is highest among household who depend on agriculture. Poverty headcount ratio is 27% compared to 13.2% in urban, according to HBS 2000/1. HBS 2000/01 suggests the growing inequality between rural and urban areas since 1991/2, measured by its Gini coefficient from 0.34 to 0.35. Especially in Dar es Salaam the poverty headcount ratio (food poverty line) was reduced dramatically from 13.6 % to 7.5%, while in rural areas it fell only slightly from 23.1% to 20.4%. On HIV/AIDS the adult prevalence rate is 7% based on population sample estimate, which is lower than the estimate among the blood donors. The number of people living with HIV is at about 1.1 million.

Tanzanian PRS 2, National Strategy for Growth and Reduction of Poverty (NSGRP, 2005) states the target of income poverty (basic needs poverty) to 24% in rural area is ambitious (p.4), and it suggests that it requires higher and faster growth rate of GDP in rural than in urban areas. But it also states that the modest decline in poverty in 1990s was achieved by per capita growth which was made by faster growth of activities in urban areas (manufacturing, construction, mining and quarrying, wholesale, retail and hotel) than in agriculture. In this situation NSGRP aims to emphasize in raising productive capacities of rural population.

Non-income poverty is also severe. Illiteracy remains high with 28.6% of the total population, and women (38.6%) are more illiterate than men (20.4%). There are still
high rate of infant and under-five mortality rate (68 and 112, respectively), although the recent DHS 2004 showed the big improvement in those (IMR 99 per 1,000 live births to 68, Under-five MR 147 to 112), whose decrease was analyzed due to through interventions, such as improved breastfeeding practices, increased vitamin supplementation, and reduction of poverty, leading to reductions in malnutrition (Stunting: from 46.7 in 2001 to 37.7 in 2004). Access to clean and safe water is also a challenge, where 47% of HHs use the unprotected water for drinking in rural areas (2001 HBS). A majority of rural households lack proper hygienic use and maintenance of latrines.

PRS (2000) identified vulnerability as an issue to tackle to achieve poverty reduction. Tanzania Participatory Poverty Assessment 2002/3 was conducted to grasp the situation of vulnerability, and analyze the impoverishing forces and response options to the vulnerable people. It suggests people’s concerns on wrong policies and effects on environment, bad governance and the macro economy, where the pace, manner in which privatisation and trade liberalization, such as agricultural marketing, specific sector reforms such as in health and education, affect the living of the rural poor in loss of jobs, markets and sales and worse welfare. It also suggests that HIV/AIDS is the most severe impoverishing force to HHs in Tanzania.

But neither PRS nor NSGRP address the duration of poverty or chronic poverty. This is due to lack of panel data which do unable us to know the dynamic situation of the living of each HH and individual in rural areas. Only recently, with increasingly recognized importance on understanding poverty dynamics which poor has experienced in order to prescribe better poverty reduction policies, there have been several attempts to create panel data in Tanzania (Kagera HDS, Urban poverty study using HBS samples). This research attempts to fill the gap in research on chronically poor in Tanzania, in assessing how PRS implementation has reached them and its drivers / obstacles for it.
Chronic poverty is determined to be long duration of poverty. Chronically poor tend to suffer multi-dimensional (e.g. chronic illness, disability, illiteracy, landlessness, etc.), long duration of poverty (Chronic Poverty Research Centre, 2005).

3.1 Chronic poverty

Chronic poverty is an absolute poverty for an extended period of time. In the analysis of poverty dynamics chronically poor includes always poor and usually poor, whose mean poverty score over all periods is less than the poverty line, and who are poor in every period.

![Figure 1.1 The chronically poor, transitory poor and non-poor – a categorisation](image)

Source: Chronic Poverty Report 2004-05, p.5

And chronic poverty is caused not only due to monetary poverty, but is often the combination of capability deprivation, low levels of material assets, and social or political marginality. There are structural factors (labour and product markets, ethnicity, race, caste, gender, religion, class, disability, refugee status, geographic location), life cycle factors (widowhood, household composition, being young or elderly) and idiosyncratic factors (natural disaster, ill health, impairment, robbery) that create and maintain poverty. Commonly chronically poor are engaged in casual labour, live in
households with high dependency ratios, and those with few assets (human and social, as well as physical or financial), and those live in remote rural areas tend not to escape poverty. Hence the Chronic Poverty Report tests the multi-dimensionality of deprivation (severe stunting, the under five mortality, female illiteracy, the life expectancy (probability of dying before the age of 40), monetary income (% of population of income less than US$1 / day) for different countries (p.11).

With absence of comparative data of the above assets throughout the world, Chronic Poverty Report 2004/5 estimates that based on the monetary dimension (income less than US$1/day) between 300 and 420 million people are chronically poor. It also estimates that based on this estimate from 30.0% to 40.0% of the Sub-saharan African population are assumed chronically poor over a five year period (p.9).

3.2 Who are the CPs in Tanzania (from PPA, field study)?

In Tanzania the chronically poor have not been identified, and neither PRS1 nor NSGRP address the duration of poverty or chronic poverty. It is partly due to the absence of panel data which makes impossible to know the poverty dynamics of people. It also reflects the absence of the concept of the chronic poverty in poverty analysis, hence the lack of the attention among policy makers on the chronic poverty and on the disaggregation of poor into chronically poor and transitory poor. Only recently, with increasingly recognized importance on understanding poverty dynamics which poor has experienced in order to prescribe better poverty reduction policies, there have been several attempts to create panel data in Tanzania (Kagera HDS, Urban poverty study using HBS samples).

But on the other hand, in Tanzania vulnerability has been in focus as an important aspect in poverty reduction which Tanzania Poverty Reduction Strategy Paper (PRS1, 2000) has identified as an important issue to do research on the causes and realities on vulnerability in Tanzania during the PRS1 period.
1) **PPA**

Hence Tanzania Participatory Poverty Assessment (TzPPA) 2002/3 was conducted to grasp the situation of vulnerability, and analyze the impoverishing forces and response options to them. The results suggest the people’s concerns on wrong policies and negative effects of environment, bad governance, inappropriate taxation, lack of physical security, HIV/AIDS, malaria and ageing on their lives. It also suggests that among these impoverishing forces, HIV/AIDS is the most severe impoverishing force at individual / household level in Tanzania, in contrast to the widely influencing forces like macro-economic conditions and governance issues.

TzPPA 2002/3 categorizes key impoverishing forces into the following dimensions:

Table 1: Key impoverishing forces in Tz PPA 2002/3

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Environment</td>
<td>These include shocks (like flooding) and stresses (as in the case of gradually degrading forests, soils, fisheries and pastures). Environment-related impoverishing forces not only affect people’s material wellbeing, but also their health and sense of confidence in future wellbeing.</td>
</tr>
<tr>
<td>2. Macro-economic conditions</td>
<td>National macro-economic decisions (such as privatization of parastatal industries, elimination of subsidies for agricultural inputs, the introduction of cost-sharing into the health care system and a reduction of agriculture/livestock extension officers) impact on employment levels, the profitability of rural livelihoods, the cost of accessing crucial services, etc. As a result of globalization, macroeconomic decisions made by other countries (such as their choice to subsidise local agricultural production) are increasingly being felt by ordinary Tanzanian as shocks and stresses.</td>
</tr>
<tr>
<td>3. Governance</td>
<td>Many impoverishing forces are directly linked to the responsibilities of Government and the practice of governance. These include shocks (such as extortion and other forms of corruption) and stresses (like stifling taxation</td>
</tr>
</tbody>
</table>
4 Ill-health

Malnutrition, injury, disease (especially HIV/AIDS) and other forms of physical and / or psychological ill-health often undermine people's material, bodily and social wellbeing.

5 Lifecycle-linked conditions

People experience some types of ill-health, health risks, social marginalization and diminished personal security, etc. as a direct result of their place in the lifecycle. Thus, for example, the reduced strength and energy of old age is a lifecycle-linked impoverishing force. Childhood diseases and maternal welfare are also lifecycle-linked issues.

6 Cultural beliefs and practices

Some impoverishing forces are the result of cultural traditions/norms that, among other things, diminish people's freedom of choice and action. These forces are widespread but highly differential in impact. Many forces privilege men over women and adults over children and youth.

(Source: Tanzania PPA: p. 20)

During the Tanzanian PPA exercise the stakeholders identified vulnerable groups listed as: children, youths, elderly, women, especially widows, people with disabilities, and people with chronic illness including HIV/AIDS. Vulnerable people sometimes fall into chronic poverty.

Disability:

Among those characteristics, there is only disability data available from the Census 2002. From 2002 Census the proportion of people with disabilities out of total population in Tanzania are 2.0 %, higher compared to corresponding prevalence rates in other neighboring countries: Sudan (1.6%), Uganda (1.2%), and Zambia (0.9%) (20002 Population and Housing Census).
Table 2: Disabled persons by type of disability: 2002

<table>
<thead>
<tr>
<th>Type of Disability</th>
<th>Number</th>
<th>Percentage (1)</th>
<th>Percentage (2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total population</td>
<td>34,443,603</td>
<td>100.0</td>
<td>-</td>
</tr>
<tr>
<td>Disabled</td>
<td>676,502</td>
<td>2.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Physically impaired</td>
<td>323,773</td>
<td>0.9</td>
<td>47.9</td>
</tr>
<tr>
<td>Visually impaired</td>
<td>56,227</td>
<td>0.2</td>
<td>8.3</td>
</tr>
<tr>
<td>Dumb/Hearing impaired</td>
<td>88,832</td>
<td>0.3</td>
<td>13.1</td>
</tr>
<tr>
<td>Albinos</td>
<td>6,924</td>
<td>0.02</td>
<td>1.0</td>
</tr>
<tr>
<td>Intellectually impaired</td>
<td>110,574</td>
<td>0.3</td>
<td>16.3</td>
</tr>
<tr>
<td>Multiple impaired</td>
<td>90,172</td>
<td>0.3</td>
<td>13.3</td>
</tr>
<tr>
<td>Not disabled</td>
<td>33,767,101</td>
<td>98.0</td>
<td>-</td>
</tr>
</tbody>
</table>

Source: The United Republic of Tanzania 2002 Population and Housing Census.

Note: Percentage (1) is the percentage distribution of the total population by types of disability; Percentage (2) is the percentage distribution of persons disabled by types of disability.

Poor nutrition:

Chronic Poverty Report 2004/5 suggests that the stunting under five years of age is expected to be strongly associated with chronic poverty, for there is considerable evidence that the long term and intergenerational poor nutrition relates to physical and mental health, mortality and chronic poverty (Chronic Poverty Research Centre, 2005, p.8). With the absence of panel data the rate of stunting of children under five years could be taken up as a macro level proxy indicator for chronic poverty. At the national level 37.7%⁵ is stunted in 2004, which is a relatively high prevalence rate compared to other developing countries. When analyzed in the wealth levels, stunting is almost three times more frequent among the lowest wealth quintile, than the highest wealth quintile.

⁵ Who is below -2 Standard Deviation from the median of the reference population in terms of height-for-age
quintile. According to PHDR 2005 ‘children from roughly 30% of the poorest households did not show any improvement in their nutritional status’ (p.30).

Table 3: Stunting ratio of children under 5 in 2004/5

<table>
<thead>
<tr>
<th>Wealth quintile</th>
<th>Height for Age (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lowest</td>
<td>44.9</td>
</tr>
<tr>
<td>Second</td>
<td>42.8</td>
</tr>
<tr>
<td>Middle</td>
<td>40.9</td>
</tr>
<tr>
<td>Fourth</td>
<td>37.5</td>
</tr>
<tr>
<td>Highest</td>
<td>15.7</td>
</tr>
</tbody>
</table>

Source: DHS 2004-2005

In the geographical distribution the poverty map is shown as follows which has a regional variations in changes in stunting, hence the intervention against the nutrition is also to be considered in locality. Between 1996 and 2004 in the Central and Western regions the stunting rate has no improvement or remained the same, compared to mainly the Coast and North-eastern region with improved their nutritional status.

Figure 2: Map of children stunted by region, 1996 and 2004
Source: PHDR 2005
2) Field Study

With the absence of panel data at the national level, this research attempts to follow up the Livelihoods and Diversification Directions Explored by Research (LADDER) study conducted by University of East Anglia, UK and Sokoine University of Agriculture, Tanzania, in 2001 in Morogoro region in Tanzania. It is attempted to address to identify the chronically poor people, their socioeconomic characteristics, their recent experience in changes in access to health and HIV/AIDS services (during the PRS1 period) compared to people in other categories of poverty level, and the reasons why (impoverishing forces) they are chronically poor.

The characteristics of the chronically poor (they are called ‘poorest’) are the followings in the different sub-villages:

Nyandira sub-village, Lundi village:

Characteristics of the poorest (in the last five years)

- Elderly, disabled people live in the family
- Shortage of land which is not enough for the family sustenance
- They are doing casual labour
- They have low level of understanding for development
- They have low exposure to seminars / outside knowledge
- They are lazy, don’t want to work.

In contrast, in community discussions one of the reasons of the upward mobility from the poor to rich was due to the diligence and high eagerness to work.

In Nyandira wealth ranking exercise the chronically poor are 10 HHs, the majority, while unchanged middle are 9, and downward from rich to middle are 7, downward (transitory) poor 1 HH, out of 35 HHs.
Table 4: Wealth ranking in Nyandira Lundi

<table>
<thead>
<tr>
<th>Wealth Rank in 2006</th>
<th>Unchanged</th>
<th>Upward</th>
<th>Downward</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rich</td>
<td>2</td>
<td>1</td>
<td>-</td>
<td>3</td>
</tr>
<tr>
<td>Middle</td>
<td>9</td>
<td>5</td>
<td>7</td>
<td>21</td>
</tr>
<tr>
<td>Poor</td>
<td>10 (CP)</td>
<td>-</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td>Total</td>
<td>21</td>
<td>6</td>
<td>8</td>
<td>35</td>
</tr>
</tbody>
</table>

Source: Wealth ranking exercise in Lundi

Gudugudu sub-village, Mlali

Criteria for the poorest (in the last five years)

- Disabled
- With chronic disease
- Lack of access to basic requirements, to agricultural inputs, and to livestock even small like chickens)

Same as Nyandira with the hypothesis that other things are constant, in Gudugudu wealth ranking the no. of the chronically poor are 11 out of 30HHs.

Table 5: Wealth ranking in Mlali Gudugudu

<table>
<thead>
<tr>
<th>Wealth Rank in 2006</th>
<th>Unchanged</th>
<th>Upward</th>
<th>Downward</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rich</td>
<td>5</td>
<td>0</td>
<td>-</td>
<td>5</td>
</tr>
<tr>
<td>Middle</td>
<td>5</td>
<td>2</td>
<td>5</td>
<td>12</td>
</tr>
<tr>
<td>Poor</td>
<td>11(CP)</td>
<td>-</td>
<td>2</td>
<td>13</td>
</tr>
<tr>
<td>Total</td>
<td>21</td>
<td>2</td>
<td>7</td>
<td>30</td>
</tr>
</tbody>
</table>

Source: Wealth ranking data in Gudugudu Village
In Darajani wealth ranking the no. of the chronically poor are 4 HHs and downward poor are two out of 21 HHs.

Hence in general, the poorest people in those three sub-villages in the last five years are: **people with disability and/or chronic diseases, people with low assets, people with low access to services, etc.** This relates to their vulnerability and their poverty severity.\(^6\)

In looking at the poverty composite index which is comprised of the following items: family size; adults education level reached; remittances from relatives; gender analysis; roof material; livestock; assets; land area; health of HH head; when the characteristics of the chronically poor HH is analyzed, the relationship between the chronically poor and the downward mobility of poverty is mostly related to the health status/disabled of the household head (60% of the chronically poor HH and downward mobilized HHs are with unhealthy/disabled HH head.).

### 4 Research methodology

#### 4.1 Research methodology

The research methodology is mixed with quantitative and qualitative study. The analysis is made at macro- (policies and their implementation), meso- (service delivery, planning and budgeting at the local levels) and micro- (interviews with the village officials, etc. and PRA exercises and household interviews) levels. The methodology at each level is as follows:

\(^6\) Tanzania's PRSP does refer to poverty severity. But there is no poverty monitoring indicator related to this in order to follow up the changes.
1) Macro level

The analysis of the PRSP, Health Sector Policy and Health Sector Strategic Plan and National HIV/AIDS Policy and National Multisectoral Strategic Framework, the health sector and HIV/AIDS sector PERs and other research documents on health and HIV/AIDS is conducted at the policies and their implementation level in order to find how Tanzanian PRSs and health and HIV/AIDS sector policies are addressing the needs of the chronically poor people, and how they have been implemented and how policies related to social protection address measures to reach its implementation to chronically poor.

2) Meso level

The interviews at the local government level (regional, district level) corresponding to the three sub-villages in the Mlali and Mgeta wards were conducted to analyze how they have been service delivery, planning, and budgeting targeted to chronically poor at the local government level, how these have changed through descentralization, and if these have changed already, what have been the effects, especially in relation to the PRS priority policy implementation in health and HIV/AIDS, and the ones related to the chronically poor, and if there were no changes, what the obstacles against it were.

3) Micro level

In order to identify the chronically poor households, the three sub-villages are picked up from the LADDER sampled sub-villages. They are: Mlali Gudugudu in Mlali Ward and Nyandira Lundi in Mgeta Ward in Mvomero district and Chanzuru Darajani in Kilosa district. The semi-structured interviews with the key stakeholders at the village level (Ward Executive Officers, Village Executive Officers, sub-village chairmen, divisional secretaries, doctors at the dispensaries, and the traditional healers) in these sub-villages are conducted, as well as the village community discussions, group discussions with the vulnerable people, PRA wealth ranking exercises and the village
mapping, and the 23 household semi-structured interviews (10 in Mlali Gudugudu, 5 in Nyandira Lundi, and 8 in Chanzuru Darajani). The sampled households are picked up from the sampled households in LADDER study in order to conduct the PRA wealth ranking exercise and for the household semi-structured interviews.

The objectives of this study are: how the communities have experienced changes in accessing service delivery in health and HIV/AIDS; whether it has reached to the chronically poor; if so, how their lives have changed, if not, what the problems in reaching the chronically poor were; how social protection measures like TASAF and other projects have reached the chronically poor; how they changed the lives of the chronically poor.

4.2 Research questions

The concrete research questions at each level are the followings:

Macro level

- **PRSP and Policies**
  
  How do the PRSs and health / HIV/AIDS policies address the problem of chronic poverty, and measures to reach the policy implementation towards them? Especially assess health policies on user fees and exemption for vulnerable groups to access primary health care and function of community health funds, and care and treatment for HIV/AIDS affected people and support for their families.

  What kind of impacts have been of these policies and the social protection programmes to vulnerable groups / chronically poor?

- **PRS – Policy and budget linkages**
  
  How does PRS reflect in the health and HIV/AIDS sector policies, in relation to the chronically poor? Have the budget reflected the priorities of the PRSs and these policies, especially in relation to the chronically poor? How were they assessed/ monitored, by whom?
• **Policy implementation through decentralization**

How was the budget composition and sectoral allocation in health and HIV/AIDS sectors after the implementation of PRSs at the local government (district) level? How did change the planning mechanism at the local government (district) level? Whether the communities’ demands/plans were incorporated into the budget and were they implemented? Who was present in participation? How do local governments perceive towards these descentralization?

---

Meso-level

• What are the major events in the area in recent years? Have those events changed the situation of the area?

• What are the major changes of the area (district/ward) in recent five years? Since when those changes were made? How? Who benefited and are affected by those?

(Desenctralization)

• What have been the major changes in administration, fiscal isssues since 2001? How has increased block grants impacted in making sectoral plans and budgets? Have the services reached to the poorest and remote areas than before?

• What has been done in terms of increasing accountability to the people in service delivery?

• Has there been any problem of budget constraint, institutional constraints, or capacity?

(Health and HIV/AIDS)

• What have been major changes in activity plans in health and HIV/AIDS since 2001? Have those reached to the poorest, remote areas? What has the major hindrance towards expansion of coverage of quality service?

• Has the descentraliation process impacted to the change in service delivery in health and HIV/AIDS?

• Has there been any change in the way of developing activity plans in health and HIV/AIDS recently?

• Has there any health / HIV/AIDS programme been conducted targeting to vulnerable groups? By which organization, who were targeted and beneficiaries? Do they have any problems or good effects?
• Have they perceived any change in people going to health clinic in recent years? If so, what are the reasons? If not, what are the reasons that they’ve heard? How do the people treat illness?

(In relation to health and HIV/AIDS)

• What were major activity plans in health and HIV/AIDS in recent five years? Have they changed recently from previous period?

• How were these plans made in recent years?

• Have these services reached poorest / vulnerable areas and/or people?

• How do people in the district perceive the cost for health services (including user fees and annual health tax, for drugs, transport, etc.)? Do people in the district know the exemption system? How has it been applied?

• How do people participate to the community health fund? If they not, what do they think were the reason?

• Do you have any request to central ministry?

• Has there any health and HIV/AIDS programmes been targeting to vulnerable groups? What kinds of activities were conducted? Who were targeted and beneficiaries? Do they have any problems or good effects? Do they know of any such kind of support elsewhere?

• (Ask for the recent council health plans / budgets/expenditure since 2002 - 2006 )
4.3 Limitation of the field study

On the field work the key-informant interviews and community discussions and PRA exercises (wealth ranking and village mapping), and household level surveys and in-depth interviews were conducted utilizing a research assistant who translates between Kiswahili and English. Hence the quality of interviews and the above exercises mattered due to the translation by him. Also it was attempted first to conduct oral history interviews at the household level to capture the changing lives that the household had experienced in recent years. But through translation it was difficult to take up the informants’ words literally because of Kiswahili, which was not enable me to conduct nuanced translation by myself, by always using translator. Also sometimes the translator summarized the informants’ narratives which might miss the important
point for collecting and analyzing information of their living and perception, which also limits the real information from the informants.

And due to the limited human resources (one team composed of one researcher and one research assistant) all the ten original baseline (LADDER) studied sub-villages were not visited, resulting only three out of them were visited, which also limits our data collection for this follow-up study. Also the number of the samples of this study is very limited (23 households), hence the quantitative analysis of the data could not be achieved. And the number of data is limited compared to the baseline study so that the generalization of the findings of this research has to be applied under this consideration.

5 Tanzanian PRS and Chronic Poverty

5.1 PRS1

In the introduction of Poverty reduction strategy by WB/IMF as a HIPC condition in 1999 Tanzania developed its first PRS in 2000 with donor support, utilizing the already elaborated documents such as Tanzania Development Vision 2025 (1998) and the National Poverty Eradication Strategy (1997) and its indicators as background documents and information, and the already progressed aid coordination initiatives such as drafting exercises of Tanzania Assistance Strategy (2002)\(^7\). But due to its rather quick formulation of PRSP there have not been extensive consultation activities, which resulted to raise complaints by the CSOs that their voices have not been sufficiently heard in developing the document.

\(^7\) Tanzanian government document for national development which aimed to formulate with the agreed aid practices on aid coordination, alignment, harmonization issues, to be followed by aid agencies.
Tanzanian 1st PRS (1st PRS) defined the seven priority sectors: basic education; primary health care; water and sanitation; agriculture; rural roads; justice and legal systems; HIV/AIDS; which have been prioritized in budget allocation. 1st PRS has promoted the public administrative and financial reforms as drivers of policy implementation. Aid supported the 1st PRS implementation, with increased aid volumes, alignment to national processes and harmonization between the processes, including increasing trends towards the General Budget Support (Poverty Reduction Budget Support) which disburses money directly into the Tanzanian government budget.

1st PRS also has special attention in vulnerability and cross-cutting issues, such as gender and environment. The policies which have specific attention to vulnerable people in the 1st PRS are:

- **Extreme vulnerability:** FFW, WB TASAF, Equalization Fund for disadvantaged areas, Food security (community managed irrigation in arid area, improve access to food supplies, development of drought-resistant crops, re-afforestation)

- **Agriculture:** Encourage farmers to organize in groups / cooperatives to facilitate access to credit and to carry out research

- **Employment creation:** to assist vulnerable groups (through training)

- **Education:** Abolition of primary school fees

- **Health:** More effective support of primary health care, essential health package delivery

- **Environment:** poorest / poor depend on environment resources (forest products, woodland resources) for sale and for own consumption → Protect environment is pro-poor
Among the above policies this research looks at the health policies: effective support to primary health care, equity in essential health package delivery; as well as the PRS priority areas in HIV/AIDS since the people living with HIV/AIDS and their families are also vulnerable group.

But since there is no concrete policy framework for social protection, these policies should have been incorporated into each sector, for the extreme vulnerability, the food security is managed by the Ministry of Agriculture and Food Security.

Regarding vulnerability, 1st PRS suggests to study the situation of the vulnerable groups and the causes of vulnerability, the countermeasures to be undertaken by the government as well as CSOs and other stakeholders.

5.2 Policies targeted at chronically poor in this research

As mentioned above Tanzanian PRS defines health and HIV/AIDS sectors as priority sectors in budget allocation. Among the health sector the primary health care (provision of quality health service, personnel training, etc.) is the priority item, while the HIV/AIDS sector has awareness campaigns, development of strategic plans for combating HIV/AIDS, preventive measures, monitoring / surveillance of the incidence and impact of the pandemic, as well as actions taken to fight it, as priority items, as prioritized in budgeting.

Hence in this research the PRS priority policies are analyzed in access to the primary health care and HIV/AIDS care and prevention: the quality health services accessible to all Tanzanians and responsive to their needs; accessible quality maternal and child care to all Tanzanians; and provide HIV/AIDS awareness creation activities and provide care to the people living with HIV/AIDS.

This research also takes up the social protection activities for the most vulnerable people and chronically poor. Given social protection activities being multi-sectoral and
the ministries related to these activities (former Ministry of Children, Gender and community development, and the one of Youth and labour) being small and weak, they have not been well-coordinated and not well-implemented. Hence various initiatives to contain vulnerability are being carried out in Tanzania by donors (like TASAF (Tanzania Social Action Fund)) and other organizations, individuals, households, communities, albeit most are small scale and location-specific focusing on particular social or vulnerable groups (Study on Social Protection Programmes on vulnerability, 2004).

5.3 Chronically poor in Tanzanian PRSs

There is no such articulation on chronically poor in Tanzanian PRSs, neither PRS1 and NSGRP (PRS2). It is because, as mentioned above, there is not enough panel data set to analyze poverty dynamics in Tanzania, the dissaggregation of poverty analysis being limited.

Also the human capacity of the Vice president’s office with responsibility for poverty reduction or PRS is weak being relatively new institution, and institutionally also weak compared to ministry of finance, who manages the budgeting of all the ministries. Also like the ministries of Youth, labour and development, and the one of Children, youth and community development, the former ministries relating to social protection and welfare are also institutionally and politically weak, as usual in other countries.

The government-donor agenda around improving public administration, budgeting and financial management is dominating the better articulation of complex, potentially sensitive policy issues and priorities such as tackling exclusion or discrimination.
6 Basic status at the beginning of PRS 1 (2000/01)

6.1 Poverty status / health / HIV/AIDS indicators

According to the two Household Budget Surveys (1991/92, 2000/01) over the 1990s the poverty headcount ratio is regarded as remained roughly the same as a percentage of the population, from 38.6% to 35.3%, which could be interpreted as roughly no difference, because of the small sample size in 1991/92 and some sampling errors in 2000/01. However, there was a significant reduction of 10% in the poverty gap (average distance of the poor to poverty line) at the national level and the 20% reduction of the poverty severity (squared) at the same level.

Table 6: HBSs 1991/92 and 2000/01 reported the following income poverty levels:

<table>
<thead>
<tr>
<th>Country level</th>
<th>Dar Salaam</th>
<th>Other urban</th>
<th>Rural</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of population below the basic needs Poverty line 1991</td>
<td>38.6%</td>
<td>28.1%</td>
<td>28.7%</td>
</tr>
<tr>
<td>% of population below the basic needs Poverty line 2001</td>
<td>35.4%</td>
<td>17.6%</td>
<td>26.0%</td>
</tr>
</tbody>
</table>

And there are large regional differences in the above poverty levels as following map (insert poverty map in the PHDR 2005). In northern highlands and lake zones, and some southern districts poorer regions are concentrated compared to other zones. According to the World Bank’s Country Economic Memorandum (2005) draft comparing the change of the geographical poverty levels from 1991/92 to 2000/01, in addition to Dar, a significant decline in poverty occurred in the Southern Highlands, both in urban and rural areas. In the Northern Highlands, poverty increased in rural areas but remained constant in urban areas, while the opposite occurred in the Lake districts. In the case of the Southern Highlands, this was quite a reversal in fortune. In sum, the
extent of poverty reduction during the 1990s seems to be uneven, with major gains in some areas and an overall worsening in others. Understanding the sources of these differences and analyzing them could yield insights into the effects on households of the economic rollercoaster of the 1990s.

Health indicators

Several new sources of information about health, nutrition and HIV/AIDS have been made available recently, including new analysis of data from the 2002 population census, data from the 2003 HIV/AIDS indicator survey, and the 2003/04 demographic and health survey. They are summarized in the table below.

Table 7: Health outcome data in Tanzania: 1999 – 2004

<table>
<thead>
<tr>
<th></th>
<th>1999</th>
<th>2002</th>
<th>2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevalence of stunting under 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infant Mortality Rate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DHS</td>
<td>99</td>
<td>68</td>
<td></td>
</tr>
<tr>
<td>Census</td>
<td></td>
<td>95</td>
<td></td>
</tr>
<tr>
<td>Under–five Mortality Rate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DHS</td>
<td>147</td>
<td>112</td>
<td></td>
</tr>
<tr>
<td>Census</td>
<td></td>
<td>162</td>
<td></td>
</tr>
<tr>
<td>Life expectancy at birth</td>
<td></td>
<td></td>
<td>51</td>
</tr>
<tr>
<td>Female</td>
<td></td>
<td>52</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td></td>
<td>50</td>
<td></td>
</tr>
<tr>
<td>Children 12–23 months immunized against:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>Measles</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DHS</td>
<td>78</td>
<td>80</td>
<td></td>
</tr>
<tr>
<td>DPT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DHS</td>
<td>81</td>
<td>86</td>
<td></td>
</tr>
<tr>
<td>HIV prevalence among pregnant women</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ANC surveillance</td>
<td>9.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>THIS</td>
<td>6.8</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


There was a reduction in stunting rate and mortality rates, with a particularly sharp drop in the most recent few years. According to the Tanzania Reproductive and Child Health Survey 1999 and DHS 2004 stunting of children under five fell from 44% to 38%, infant mortality fell from 99 to 68 and under-five mortality fell from 147 to 112 during the same period. Much of these declines may be due to the reduction of income poverty level, or to the improved malaria control - both increased use of preventive mosquito nets and improved curative care through a more effective drug treatment (PHDR 2005).

But looking closely at the stunting rate, recent study by REPOA (2005) indicates a widening gap between the poorest and the least poor between 1991/92 and 1999. It indicates an increase of roughly 8% in prevalence of stunting in children from the poorest households, and a large decrease of about 20% in those from the least poor households. It shows that children from roughly 30% of the poorest households did not show any improvement in their nutritional status. Rather, the prevalence of stunting
worsened in this group. It shows that the chronically poor remained poor or worsened their poverty level in this period.

Figure 3: Proportion change in the prevalence of stunting by income/poverty percentile (concentration index growth curve), 1991 - 1999

Source: PHDR 2005, p.28

6.2 Health indicators in Morogoro

According to Morogoro Health Abstract 2005/6 based on the Health Management Information System the data at the Mvomero district (Mlali Gudugudu and Nyandira Lundi sub-villages) and Kilosa district (Chanzuru Darajani sub-village) in the Infant Mortality Rate and Under 5 Mortality Rate, and Maternal Mortality Rate compared to the total country level are in the following table. But this comparison can not be compared, for the Health Management Information System’s data are generally less confident than the DHS data at the country level.
### Table 8: Child and maternal mortality ratio at the district and country level

<table>
<thead>
<tr>
<th>Area</th>
<th>Infant Mortality Ratio per 1,000 live birth</th>
<th>Under 5 Mortality Ratio per 1,000 live birth</th>
<th>Maternal Mortality Ratio per 100,000 live birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mvomero District (2005)</td>
<td>149</td>
<td>188</td>
<td>748</td>
</tr>
<tr>
<td>Kilosa District (2005)</td>
<td>114</td>
<td>190</td>
<td>528</td>
</tr>
<tr>
<td>Country level (2004)</td>
<td>68</td>
<td>112</td>
<td>578</td>
</tr>
</tbody>
</table>

Source: Morogoro Health Abstract 2005/6, DHS 200-5

### LADDER Study

With the combination of the quantitative (household level) and qualitative (village observation, PRA wealth ranking, household interviews), LADDER study results suggested that the rural poverty is strongly associated with lack of land and livestock, as well as inability to secure non-farm alternatives to diminishing farm opportunities. The findings of the selected asset levels by income tercile are as followings;
It also suggests the doubts about the current and future rural tax regimes, and the motivation of district councils to deliver improved services. It concludes that the PRSP process needs to address these disjunctures between its macro level goals and debilitating local level institutional contexts if real gains in rural poverty reduction are to be realized.
6.3 Health system

6.3.1 Policy and health status

The National Health Policy of 1990 was reviewed and finalized in 2002. New developments such as Proposal for Health Sector Reform of 1994, Tanzania Development Vision 2025, Poverty Reduction Strategy 2000, have been integrated in the new policy documents. The Health Policy, implementing linked with local government reform, public service reform, and health sector HIV/AIDS strategy are formulated to facilitate the provision of equitable, quality and affordable basic health services, which are gender sensitive and sustainable, delivered for the achievement of improved health status.

On the National Health Policy the government jointly with the development partners formulated the Programme of Work (1999 – 2002) and the second Health Sector Strategic Plan (2003 – 2008). The plan stipulates the future priorities as: assuring providing essential health package: the role of central level as setting policy, governance, regulations, legislation, financing, monitoring and quality assurance; and human resource development. And the Plan carries forward nine strategic areas: (1) district health services; (2) hospital services; (3) role of central ministry; (4) human resource development; (5) Central support services; (6) health sector financing; (7) public-private partnership; (8) MoH and donor relationship; and (9) HIV/AIDS.

At the district level the plan identifies the key constraints as the lack of progress in some of the district HSR strategies, which also results from the differing calendars for phased implementation of government reforms (local government reform, health sector reform, public sector reform), and the shortage of numbers and skills in district health staff, difficulty to capture all available health resources during the planning process, and difficulty to implement the essential health package according to the local burden of disease (needs). These constraints limit the provision of primary health care services at the district level.
The technical review document presented in the Annual Health sector review which was held in March 2006 (Health research for action, 2006) points out that the worrisome developments concerning maternal and obstetric care, which results stagnating Maternal Mortality Ratio. It advises to focus more attention to the maternal and obstetric care and to secure the right mix of skills and equipment for the basic emergency obstetric care. The document points out that the human resource problem and it recommends to train and upgrade the health workers, to provide incentives and hardship allowances to health workers who work in rural areas, and to recruit more manpower. Also regarding quality of care it recommends to monitor and supervise the supervision, to strengthen District Health Board and Facility Health Committee role in performance monitoring and to provide community feedback on quality.

6.3.2 Exemption and waiver system

General user fees are charged in a large number of public health centres and dispensaries and in practically all public hospitals. Exemption and waiver system aims to protect the vulnerable and poor from the adverse impact of user fee. The exemption system is applied to the people with chronic diseases and pregnant women and children under five. Waiver is applied to the elderly (above sixty years of age), the poor (with appropriate documentation), the disabled, emergency patients (temporary waiver), health workers, and the prisoners. But the study based on literature on exemption and waiver system (ETC Christal, Equity implications of health sector user fees in Tanzania) mentions that the exemption and waiver systems are not implemented appropriately because: (1) exemption schemes are implemented in informal and ad hoc ways; (2) exemptions based on the ability to pay are extremely uncommon in practice; (3) decisions to exempt are often left to the discretion of local service providers; (4) absence of specialized staff hampers the effectiveness of the waiver procedure; (5) there can be a negative attitude of health staff towards policies for protecting the poor as waivers mean less income and more work; (6) the distribution of cards for a waiver or exemption are often cumbersome and lead to high
administrative costs, delay and retention of cards; (7) financial incentives or staff performance are linked to successfully collecting fees; (8) the characteristics of the poor are generally not defined in a clear fashion; (9) poor people do not know about exemptions or do not bother because of administrative barriers; and (10) exemption schemes can be stigmatizing and dehumanizing.

6.4 HIV/AIDS sector system

In 1988 the government with technical support from the WHO Global Programme on AIDS formed the National HIV/AIDS Control Programme (NACP) under the Ministry of Health in order to scale up the Health Sector response to HIV/AIDS and strengthen the health system capacity to support HIV/AIDS interventions. Initially HIV/AIDS was perceived purely as a health problem and the campaign to deal with it involved the health sector only through the NACP. But HIV/AIDS needing multi-sectoral response and being a social, cultural and economic problem, Tanzania Commission for AIDS (TACAIDS) was established by President in December 2000. The Commission was established to provide strategic leadership and coordinate and strengthen all multi-sectoral stakeholders involved in the fight against HIV/AIDS. The Multisectoral Policy Guidelines on HIV/AIDS is now in place.


National Multisectoral Framework stipulates the decentralized system to implement the national response up to the grass roots level. It sets up the organizational structure from the national level as TACAIDS to coordinate the national level to the village level.
where it sets up the Aids Control Coordinators who supersedes the activities preventing the spread of HIV/AIDS and sets up the multisectoral committee at each level. Because of descentralized system the districts have the budget for activities, such as holding awareness raising seminars, holding coordination meetings among the CSOs related to HIV/AIDS, making materials / textbooks, etc. Normally the community development officers become the Aids control coordinators.

Figure 5: Recent organizational Structure of TACAIDS at the local level

At the village level the village Aids control coordinator attends the village meetings to raise awareness and provide knowledge about the prevention of HIV/AIDS.
7 PRS and policies and policy processes in health and HIV/AIDS sectors

7.1 PRS and health sector

7.1.1 Policy

1st PRS (2000) sets health sector as one of the priority sectors and the primary health care as its priority policy items, through essential health package delivery, personnel trainings; nutrition education, especially to mothers, and reinforcement of reproductive health and family planning, active HIV/AIDS awareness campaigns, and increasing the coverage of births by trained personnel, etc.

Hence the first poverty monitoring indicators set in the Poverty monitoring master plan (2001) included the followings: infant and under 5, and maternal mortality rates, life expectancy, children under 2 years immunized against both measles and DPT, and births attended by a skilled health worker, districts covered by active HIV/AIDS awareness campaigns.

On public expenditure the National Health Policy sets targets the share of the budget for health being 11% in 2000 set to rise to 14%, and the per capita public health spending was US6$ in 2001 to increase up to US 9$ in 2004 and thereafter to US 12$. The PRS has been planned that for ‘the primary health care’ it would be increased about 1.6 times (from 42,314 Tsh. to 68180Tsh.) from 2000/01 to 2002/3 fiscal year budget.

The National Health Policy (2002), in line with the proposal for Health Sector Reform of 1994, Tanzania Development Vision 2025, the focus on vulnerable groups and HIV/AIDS, and the gender mainstreaming, PRS 1, puts is objective to reduce the burden of disease, maternal and infant mortality and to increase life expectancy through the provision of adequate and equitable maternal and child health services, to
ensure the availability of drugs, reagents and medical supplies and infrastructures, and to ensure that the health services are available and accessible to all the people in the country (urban and rural areas) (National Health Policy 2002).

The 2\textsuperscript{nd} Health Sector Strategic Plan (2003) stipulates that the Ministry of Health in collaboration with PMO-RALG\textsuperscript{8} coordinates maintenance / improvement of structures, supply of hospital equipment and other logistics, leading to improvement of quality, quantity, accessibility and sustainability of the district health services and infrastructure.

On relationship with the stakeholders, policy dialogue in the health sector is well structured, including through annual multi-sectoral Health Sector Review meetings and Health sector basket fund committee. The Health sector review meeting is organized by the Ministry of Health and Social Welfare with the Prime Minister’s Office – Regional Administration and Local Government and the Ministry of Finance. On the meeting the MTEFs and PERs are also discussed as well as technical review of the health sector performance.

7.1.2 Public expenditure

Since the late 1990s the health sector has organized itself the public expenditure review. Although the health sector is regarded as a priority sector in PRS and hence in its budget allocation, health sectoral spending as % of total government budget has increased from FY 2000 to FY 2002 topping at 11%, but later it has been a little decreased and stagnant around 10% (10.1% in FY 2005 budget). The government budget and donor allocation (budget and off-budget) to health per capita in FY 04 was US$8.12, hence it raised high concerns among stakeholders that the budget should increase in the health sector. Hence finally in FY05 it was budgeted at US$11.57 (PER FY05 update p.41), which could surpass finally the target set at 2004 with public

\textsuperscript{8} In the new government since 2006 the ministry responsible for local governments are under Prime Minister’s Office, hence called PMO-RALG.
spending of US$9 per capita, but it would not still surpass the sectoral spending per total GOT budget at 11% in FY02.

Figure 6:

Sectoral spending as a proportion of the total GOT budget, FY00–FY05

<table>
<thead>
<tr>
<th>%</th>
<th>FY00actual</th>
<th>FY01actual</th>
<th>FY02actual</th>
<th>FY03actual</th>
<th>FY04actual</th>
<th>FY05budget</th>
</tr>
</thead>
<tbody>
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<tr>
<td>8.8</td>
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<tr>
<td>10.6</td>
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<tr>
<td>11</td>
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<td>10.4</td>
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<td>9.7</td>
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<tr>
<td>10.1</td>
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</tbody>
</table>

(Health sector PER FY05 update final report)

Figure 7:

Public health expenditure: Total on budget

<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>0</td>
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<td></td>
</tr>
<tr>
<td>50</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>100</td>
<td></td>
<td></td>
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<tr>
<td>150</td>
<td></td>
<td></td>
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<tr>
<td>200</td>
<td></td>
<td></td>
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<tr>
<td>250</td>
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<td>300</td>
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<tr>
<td>350</td>
<td></td>
<td></td>
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</tbody>
</table>

(Health sector PER 05 update final report)
If we look at recurrent spending related to PRS priority items, the following table shows the priority items spending, however, with some inconsistencies between years regarding allocation to drug kits and the indent system at primary level facilities.

Table 9: Recurrent spending on PRS priority items FY02 to FY05 (Tsh million)

<table>
<thead>
<tr>
<th></th>
<th>FY 2002</th>
<th>FY 2003</th>
<th>FY 2004</th>
<th>FY 2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total subvention to LGAs</td>
<td>35,393</td>
<td>43,548</td>
<td>42754</td>
<td>63503</td>
</tr>
<tr>
<td>Preventive service subvotes at RAS</td>
<td>302</td>
<td>304</td>
<td>310</td>
<td>330</td>
</tr>
<tr>
<td>LGAs drugs budgeted under MoH</td>
<td>9,108</td>
<td>12,478</td>
<td>15,812</td>
<td>15,592</td>
</tr>
<tr>
<td>MoH HQ preventive service subvote</td>
<td>7,574</td>
<td>7,253</td>
<td>15,187</td>
<td>16,072</td>
</tr>
<tr>
<td>Total health priority items</td>
<td>52,376</td>
<td>63,582</td>
<td>74,063</td>
<td>95,496</td>
</tr>
<tr>
<td>Total priority sector spend/ budget</td>
<td>141,330</td>
<td>175,638</td>
<td>222,520</td>
<td>312,811</td>
</tr>
<tr>
<td>Priority items as % sectoral spend</td>
<td>37%</td>
<td>36%</td>
<td>33%</td>
<td>31%</td>
</tr>
</tbody>
</table>

(Health sector PER PY05 update, final report)

As shown above, although the total priority sector spending / budget increased during these four years, priority items as percentages of the total sectoral spending have been decreasing (from 37% in FY02 to 31% in FY05).
7.1.3 Incentive towards the PHC

Although the PRS1 has put emphasis on the universal primary health care, why the public expenditure has not been put prioritized (increased) out of total health expenditure in recent years? The Acting Director of Department of Policy and Planning in Ministry of Health and Social Welfare mentioned the various issues including secondary and tertially health care as the key pillars of the health policy and budget allocation, which is the realization of the National Health Policy. It shows that the implementation of the PRS, the primary health care, could not be put prioritized among these other priorities. At this level the PRS priority is not prioritized in its real budget allocation. It was found that in order to address the needs of the chronically poor / extremely poor the PRS priority has to be put more emphasis and be put more awareness on the policy implementation and budget allocation.

Not to put much emphasis on the priority on the primary health care / prevention on the policy implementation and budgeting as mentioned above, may be due to that the government-health donors’ agenda is around improving public administration, budgeting and financial management, including for the implementation of the sector basket funding is dominating the better articulation of the politically sensitive policy issues and priorities. It may also be due to the lack of data relating to the geographical or socio-economic dissaggregation to identify the implementation or outcome / impact of the service delivery in the analysis of the dissaggregated level.

7.2 PRS and HIV/AIDS sector

7.2.1 Policy and institutional framework

Although the 1st PRS does not have a section as one of the Strategy for poverty reduction on HIV/AIDS, but has it under the health sector. It aims that special efforts will be made to raise the share of districts with active HIV/AIDS awareness campaigns
to 75% by 2003, and promotion of peer education in schools. But under the expenditure priority items, HIV/AIDS is included separately.

National policy on HIV/AIDS (2001) sets the framework for leadership and coordination of the National multisectoral response to the HIV/AIDS epidemic. The specific objectives of the policy are: 1) prevention of transmission of HIV/AIDS, through awareness creation, and safer sex and making safe blood; 2) promotion of early HIV testing with pre-and-post test counseling; 3) care for people living with AIDS, through counseling, combating stigma and adequate treatment; 4) sectoral roles and financing, through ensuring strong and sustained political and government commitment, leadership and accountability at all levels; 5) research, and 6) legislation and legal issues.

National policy has a chapter on the rights of persons living with HIV/AIDS, whose objective includes: people living with HIV/AIDS are entitled to all basic needs and all civil, legal, and human rights without any discrimination based on gender differences or sero-status.

TACAIDS (Tanzania Commission for HIV/AIDS) was established in 2000 in order to provide strategic leadership and to coordinate the implementation of a national multi-sectoral response to HIV/AIDS leading to the reduction of further infections associated diseases and the adverse socio-economic effect of the epidemic. It leaves the Ministry of Health to focus on the health sector response. However, there are still major challenges in the area of collaboration and integration within the sector and between sectors, and in implementing community involvement.

TACAIDS developed the National Multi-sectoral Strategic Framework on HIV/AIDS (NMSF, 2003), which translates the National policy on HIV/AIDS by providing strategic guidance to the planning of programmes, projects and interventions by various stakeholders in the fight against HIV/AIDS. It also contains a monitoring and evaluation system and the institutional, coordination and financial frameworks of the National
response to HIV/AIDS. The financial monitoring is mainly through the Public Expenditure Review (PER) for HIV/AIDS.

Linkage between PRS and policy processes has been made through each year’s sectoral reviews which review the previous year’s policy implementation performance including based on the output / outcome indicators defined by PRS, and through sectoral Public expenditure reviews, and through budget process.

On the health sector each year the annual health sector reviews have been conducted around April / May before the budget session where the donors also pledge the plan for next fiscal year’s disbursement. In the same meeting the sectoral PER also is informed with the MTEF (Medium-term expenditure framework)⁹


7.2.2 Public expenditure

HIV/AIDS PERs have been conducted only recently. Because of much off-budget related projects and initiatives, it has been very difficult to grasp how the public expenditure on HIV/AIDS was composed, although the gradual effort to be captured these off-budgeted programmes / initiatives to be on-budgeted.

⁹ Three-year budget plan
### Table 10: Summary of HIV Spend: GOT, Aid 2001/2 – 2004/5

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A   GOT recurrent</td>
<td>2,296</td>
<td>7,050</td>
<td>14,500</td>
<td>14,582</td>
<td>+0.5%</td>
</tr>
<tr>
<td>B   GOT dev’t</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>-</td>
</tr>
<tr>
<td>C   Aid via govt systems</td>
<td>N/a</td>
<td>4,460</td>
<td>8,600</td>
<td>40,381</td>
<td>+369.5%</td>
</tr>
<tr>
<td>D   Total recorded by Acc’t General</td>
<td>11,510</td>
<td>23,100</td>
<td>54,964</td>
<td>+137.9%</td>
<td></td>
</tr>
<tr>
<td>E   Other aid to govt.</td>
<td>N/a</td>
<td>16,137</td>
<td>18,500</td>
<td>13,161</td>
<td>-28.9%</td>
</tr>
<tr>
<td>F   Total Aid to public sector</td>
<td>9,948</td>
<td>20,597</td>
<td>27,100</td>
<td>53,542</td>
<td>+97.6%</td>
</tr>
<tr>
<td>G   Total public sector expenditure</td>
<td>12,244</td>
<td>27,647</td>
<td>41,600</td>
<td>68,124</td>
<td>+63.8%</td>
</tr>
<tr>
<td>H   Aid to NGOs</td>
<td>4,546</td>
<td>19,365</td>
<td>26,100</td>
<td>12,561</td>
<td>-51.9%</td>
</tr>
<tr>
<td>I   Total expenditure</td>
<td>16,789</td>
<td>47,012</td>
<td>67,700</td>
<td>80,685</td>
<td>+19.2%</td>
</tr>
<tr>
<td>J   Aid Total</td>
<td>14,494</td>
<td>39,962</td>
<td>53,200</td>
<td>66,103</td>
<td>+24.3%</td>
</tr>
<tr>
<td>K   Government Total</td>
<td>2,296</td>
<td>7,050</td>
<td>14,500</td>
<td>14,582</td>
<td>+0.5%</td>
</tr>
</tbody>
</table>

**Key:**

- D = A+B+C
- F = C+E
- G = A+B+F
- I = G+H
- J = F+H
- K = A+B

**Source:** Multi-sectoral PER for HIV/AIDS, 2005
Total planned expenditure on HIV/AIDS for FY 2004/5 has reached Tshs 80.7 billion. This includes 12.6 billion aid to NGOs. Taking the government portion alone (domestic and aid-financed), the total has risen from 41.6 billion to 68.1 billion. This represents an increase of 64% over the previous year. All of the increase has come from aid resources. Funding modalities of foreign aid are through: project funding; multi-sectoral HIV basket fund; health sector basket fund; and HIV Direct Budget Support. The big players like PEPFAR, the Global Fund and TMAP account for the bulk of external assistance for HIV. Meanwhile domestic financing for HIV has remained flat, at 14.6 billion after having doubled the year before.

In spite of the centrality of local government on the National Multi-sectoral Strategic Framework, the vast majority of government expenditure is incurred by central ministries. The 10% or so spent by local government is almost entirely aid-funded. Given recent capacity developments at the local level, a sharp increase in funding for the local government level is desirable.

Among the central government votes, TACAIDS makes up 55%, health makes up 36% of the budgeted funds. However, the TACAIDS channels through it the funds to other government departments. 56% of the budget The functional analysis of prospective HIV spending is as following figure.
The high 'multi-purpose' proportion reflects activities of a cross-cutting nature. Care and treatment is more than three fold than for prevention, but this estimate excludes some important elements of prevention (condom procurement and promotion, control of sexually transmitted infections), hence if they are included the proportion for prevention becomes much higher.

In order to contain the prevalence of HIV/AIDS HIV preventive measures should be the top expenditure priority, also for that this represent the most cost-effective intervention and to contain the future costs of care and treatment. Capacity-building for a multi-sectoral response is now well-advanced, but level of spending by other ministries, departments and agencies (MDAs) remains very small. Domestic financing for action at the local government levels is negligible. Much of the aid funding now available is inequitably distributed across district councils and is difficult to access and account for. It is recommended that government institute a block grant system for HIV action at council level through TMAP resources.
As mentioned above, since the TACAIDS is still new organization and has just begun to establish its decentralized system, and the National Multisectoral Strategic Framework has just begun to be implemented, and the many projects by the different stakeholders support, HIV/AIDS sector is still to be in the beginning stage of coordination. Also this sector is very much affected by the donors' initiatives, irrespective of the country’s context. Hence the government’s coordination of the HIV/AIDS sector is difficult further. From the figure 8 above, we can’t see the planned activities in detail (multi-purpose occupies 56%).

In terms of chronically poor perspective, the budget for care and treatment for HIV/AIDS affected people should also be prioritized as well as the socio-economic support for them. For the latter, the activities are categorized as the ‘multi-purpose’ which we can not see how much they are allocated in the budget.

But HIV/AIDS indicator survey 2004 shows the interesting data that there is the positive relationship between HIV prevalence rates and wealth (3.4% in the poorest quintile vs. 10.5% in the least poor quintile). And it is reported that this difference may further be under-estimated because of higher non-response rate among the least poor quintile (PHDR 2005). Hence the HIV affected people are not necessarily chronically poor. Consequently it can hence be said that the preventive activities must be the top priority for the poor not being falling down poorer, as well as some priority care and treatment for HIV affected people not falling down in poverty.

7.3 Institutional structure for policy implementation

In Tanzania PRS has been said that it has been mainly implemented through priority budgeting in priority sectors. PRS technical committee comprised of the Directors of policy and planning of the priority sectors (in PRS1) has been gathered has the mandate to formulate the PRS Annual Progress Reports (APRs) which has the public expenditure reviews and next three years' budget planning (Medium Term Expenditure
Framework: MTEF) before next year’s budget session. This is supposed to be the place that the priority budget could be prioritized beforehand to the other sector’s budget.

Although as the above figure 7 shows, the absolute on-budget total public health expenditure has been increased, as the health sector PER report shows, the proportion of the health sector expenditure out of total government budget has been stagnant since 2001. Hence it can not be said that it has been prioritized in total budgeting. On this, it has been analyzed by Booth (2005: p.4) that there are other mechanisms (patrimonial system) rather than bureaucratic system that have been functioning in the political arena in Tanzania even in like the PRS era under the sights from donors through the HIPC initiative pressures.

Figure 9:

(Health sector PER 05 update)

And among total government health spending, the proportion of preventive / primary health care spending also has been stagnant since FY01, as shown in Figure 9. Hence total preventive / primary health care also has not become prioritized even through
PRS process. On the other hand, the central spending, like administration, National Institute of Medical Research, and Tanzania Food and Nutrition Center have received more budget since FY01.

In conclusion the health sector as a priority sector in PRSP has not been prioritized among out of total budgeting, nor the preventive / primary health care out of total public health expenditure.

7.4 Monitoring

On budgetary and fiscal monitoring the PERs in key sectors and the PEFAR (Public Funding and Financial Accountability Review) are conducted annually. In the key PRS priority sectors which have the Sector-wide approaches their results are discussed in their sector reviews. On outcome and impact monitoring the poverty monitoring system is effective, which produces quality bi-annual Poverty and Human Development Report which reports poverty outcomes and key policy researches.

Overall the strength of incentives for agencies to prepare budget reports, and for actors to respond to information in those reports does not appear strong.

Sector reviews are one entry point for decision making. Whilst sector reviews have not been used as a focal point for reviewing of routine agency performance reports, reports on aspects of sector performance, including public expenditure reviews are discussed. Some stakeholders complain that sector reviews have yet to fostering improved decision making systematically. For example, PER reports are used as a basis for lobbying for additional funding, rather than how to improve the efficiency of existing spending within sectors.

Despite the ability of the poverty monitoring system to flag issues relating to poverty, the policy response to those issues does not appear to have been particularly strong. The lack of a high level entry point for decision making forum to discuss NSGRP
performance is one reason. Audit reports appear to result in few decisions, in part because the Parliament the incentives for parliament are weak

7.5 Accountability to the chronically poor (vulnerable groups)

Poverty monitoring system holds annual Poverty Policy Week and several meetings to discuss on the poverty-related policy issues among the domestic as well as external stakeholders. They raise awareness of the poverty-related policies, their implementation, and the key issues among them, but the discussion there tend not to link up with the political decision making process.

Several poverty studies were held to hold accountability to the people of the process of Tanzanian 1st PRS period. The first is Tanzanian Participatory Poverty Assessment 2002/3 and the second is the Policy and Service Satisfaction Survey to hear the voices of the people. Especially the results of the Tanzanian PPA were presented and discussed by the different vulnerable themes at the Poverty Policy Week 2003 to reflect the later policy implementation and to develop the second PRS.

The accountability to the vulnerable groups was enhanced in the PRS review process, for the broad PRS consultation activities were held in the PRS review in the year 2004. It was reflected the rapid development and the awareness toward lack of accountability to Civil Society Organizations (CSOs) of the Tanzania 1st PRS in 2000. Hence the vulnerable groups were mostly satisfied that their voices / demands were heard and included in developing the NSGRP. The implementation of the NSGRP has been through SBAS (Strategic Budget Allocation System), the computer software to highlight the NSGRP prioritized budget lines in making budget, in order to link the NSGRP prioritized policies with the budget. The PEFAR 2006 suggests that the NSGRP’s cluster for social sector (notably education and health) receives much more budget
than before, i.e. 3.6% in 2000/01 to 5.5% in 2004/5. But the evaluation of the budgeting under NSGRP on services toward vulnerable groups is still to be evaluated, for no documentation has yet mentioned about whether the budget under NSGRP has prioritized the budget lines for the vulnerable groups.

There are also apparent problems of donor demands for accountability overwhelming rather than reinforcing the weak domestic voices demanding accountability. Donor participation in NSGRP and sector processes is heavy. Meanwhile donor reporting instruments (e.g. the Performance Assessment Framework) are not fully aligned with government instruments. Whilst donors tend to get relatively free access to information and personnel, domestic civil society groups and research institutions do not. Hence it is recommended to develop clear rules of game for civil society engagement.

8 Effect of implementation of PRS1 on Chronically Poor on health and HIV/AIDS

8.1 Macro level

From DHS, IMR and U5MR declined recently, from 99 in 1999 to 68 in 2004, and from 148 to 112 per 1,000 live birth, respectively. If this trends continue MDGs are within reach. Much of this decline is likely to be the result of improved malaria control – both increased use of preventive mosquito nets and improved curative care through a more effective drug treatment (PHDR 2005, p.23).
Table 11: Percentage of stunting children by wealth quintiles

<table>
<thead>
<tr>
<th>Wealth quintile</th>
<th>Stunting(^{10}) rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lowest</td>
<td>44.9</td>
</tr>
<tr>
<td>Second</td>
<td>42.8</td>
</tr>
<tr>
<td>Middle</td>
<td>40.9</td>
</tr>
<tr>
<td>Fourth</td>
<td>37.5</td>
</tr>
<tr>
<td>Highest</td>
<td>15.7</td>
</tr>
<tr>
<td>Total</td>
<td>37.7</td>
</tr>
</tbody>
</table>

Source TDHS 2004-05

Through they have geographical disparities between regions and districts, and between urban / rural. Those in the rural areas had higher mortality rates per 1,000 live births: for IMRs are 78 versus 99 in urban and rural areas, and for U5MR, 123 versus 162, respectively (DHS 2004/5). Also the percentage of under-fives reported to have had fever in the two weeks prior to the survey, a proxy indicator for malaria, declined from 35% in 1999 to 23% in 2004 (TDHSs). There is an increase in under fives sleeping under nets, and in particular those sleeping under treated nets, from 46% in 2001 to 53% in 2003, and 15% to 26% over the same time period, respectively (joint Health Sector Review Meeting 2005).

Child immunization coverage continues to be high compared to other sub-Saharan countries. The 2004 coverage rates are 80% for measles and 86% for DPG3, exceeding the 85% DPG target set for 2003, and both of which increased from 1999. However, there is urban / rural differences, in rural areas coverage levels for both vaccinations is lower by about 10% points in the urban areas (PHDR p.25).

\(^{10}\) Height for age. Percentage below -2 standard deviation of the total.
Malnutrition continues to be a major cause of morbidity and mortality in under-fives in Tanzania. This is likely to be caused by inappropriate feeding practices and repeated incidences of childhood illnesses. After the unchanged status during 1990s there is an improvement in under-five nutrition from 1999 to 2004. The prevalence of stunting, which indicates the chronic malnutrition, went down from 44% in 1999 to 38% in 2004. And compared to its slight increase rate in urban areas, in rural areas it declined from 48% to 41% during the same time period. But there is a study that indicate a widening gap in stunting between this poorest and least poor between 1991/2 and 1999 (PHDR 2005), where the poorest had worsened in nutrition while the least poor improved. In geographical variations, major improvements can be observed in Iringa, Morogoro, Coast, Arusha and Kilimanjaro between 1999 and 2004 (PHDR 2005: p.30).

Relating regional poverty estimates (Figure 10) with the change in under five stunting prevalence (Figure 2), the PHDR 2005 reports that it becomes clear that regions with lower rates of poverty showed higher rates of improvement in stunting, compared to poorer regions. It shows the widening gap between the wealthier and poorer in nutrition as well as income poverty.
On HIV/AIDS the recent Tanzania HIV/AIDS indicator survey (2003/4), the first to produce reliable national and regional level estimates on the prevalence of HIV/AIDS in Tanzania, indicates that the overall prevalence rate is 7%, 7.7% in females and 6.3% in men. Data also indicate and average prevalence in pregnant women of 6.8% which is lower than 7.7% among all women. According to blood donor data, the percentage of the 14-24 year age group which is HIV positive has been on the decline since 2001,
implying a decrease in new infections in both males and females. The risk of being HIV positive is twice as high for residents of urban areas than for the rural residents, the overall urban infection rate is 12.0%, compared to 5.8% in the rural. Also the poorest group has least prevalence rate than the least poor group.

On knowledge about HIV/AIDS national survey data suggests that at least one-third of the adults know the major facts about HIV transmission and prevention, although the level of understanding is a concern.

On maternal health TDHS 2004/5 show that pregnancy related mortality has not improved over the last two decades. The MMR for the period 1995 to 2004 was 578 per 100,000 live births, not significantly different from the 1987 to 1996 ratio of 529 per 100,000 live births. While a proxy indicator for maternal mortality is the percentage of births taking place in a health facility showed a slight improvement from 44% in 1999 to 47% in 2004, but there is considerable urban/rural and regional variation. Urban women are twice as likely as rural women to have delivered at a health facility (about 80% versus 39%).

In terms of quality health care, there remain many obstacles: long distances to health facilities, unaffordable transport systems, poor quality of care, poor governance and accountability mechanisms and poorly implemented exemption and waiver schemes. Access to primary health care facilities in rural areas has worsened during 1990s, in percentage of population within 5 Kms of a health centre or dispensary from 77% in 1991/2 down to 68% in 2000/01 (HBSs). And exemption and waiver schemes are not effective because of the absence of clear policy guidelines and the difficulties in defining who is poor or not, communities well not informed of the schemes and facilities not having incentives due to no compensation for resulting loss in user fees.

As a result poor households resort to a number of short-term survival strategies to pay for health care, especially in emergencies and for chronic illnesses: using their own savings, engaging in petty trade, borrowing money, taking a loan, selling critical assets,
taking children out of school, reducing the number of meals taken in a day, etc.. This further impoverishes them and exacerbates the risks of long-term vulnerability (PHDR 2005, p. 37).

Deployment of available health workers is highly imbalanced. The workers in urban areas represent a disproportionately share of high skilled cadres, while in rural areas they are mainly constituting low skilled.

8.2 Meso level

8.2.1 Decentralization (Meso level)

In 1998 the Government published its Policy paper on Local Government reform. However, the implementation set-up was not in place before 2000. In the health sector Plan of Work 1999 – 2002 was developed to promote the decentralization in the health sector and the Health Sector Basket Fund has supported the capacity building of the local governments. In order to reduce the regional inequality since FY 2003/4 the formula based allocation system has been introduced: 70 % on population, 10% on poverty index; 10% on under five mortality rate; and 10% on distance to health facilities11.

Among the fiscal descentralization process, since 2005/6 multi-sectoral Local Government Capital Development Grant12 was developed to promote the descentralization of the planning activities at the local government level and the health

11 In order to assure sustainability if the allocation to the local government is lower than the previous budget, it remains the same amount ‘held harmless’.

12 The objective of the grant is to improve the provision of the infrastructure and services to people by Local governments. The former project was of WB. The fund is now coming from Tanzanian government, WB/IDA loan, and LGRP common basket fund.
sector local budget allocation was also integrated into this. Among the expenditure of the total LGCDG FY05 14% was utilized for the health.

Under the LGCDG system introduced in 2005/6 budget in Kilosa district 64% of the health sector budget was provided by the block grant (LGCDG) and in Mvomero district 46% was provided by it.

8.2.2 Bottom-up planning through O&OD

Meanwhile the PMO-RALG (Prime-minister’s office – Regional administration and Local government) with collaboration of other ministries and UNICEF, has developed participatory O&OD (Opportunities & Obstacles to Development) methodology in order to enhance ‘Good governance and community participation’, whose guideline was distributed to all the ministries, regional government authorities, and district authorities. Its characteristics are: 1) bottom-up planning from the village level, 2) focusing on local resources, 3) aligning to local government processes, 4) targeting to attain Vision 2025, 5) not binding to the specific sectors. With the own resource and external funds from UNICEF and others, by February 2006 the O&OD was rolled out to 66 LGAs (Local government authorities) out of the total 121 LGAs. The source of financing of the plans developed by O&OD could also come from half of the LGCDG allocated to the LGAs, which is stipulated to be utilized to the village level. O&OD exercise is the condition for permission of the LGCDG allocation to the LGA. But because of the high cost (Training of trainers, allowances / transport for about two months per one LGA) for implementing O&OD exercise has become a problem in terms of sustainability of the exercise.

On the fiscal descentralization the public allocation to the district has increased in the absolute amount in the last three years, but not increased at such rate compared to the central level (2.6 times versus 2.1 times)(Figure 11). The recurrent expenditure also has substantially increased at the central and preventive levels (Table 12).

13 It can be assumed that some of the donor funds are off-budget, hence not counted into this.
Figure 11: Proportion of actual expenditure by level, FY-2 - 04

![Proportion of actual expenditure by level, FY02–FY04](image)

Table 12: Total GOT public allocation to health per capita (Tsh.)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Level</th>
<th>Baseline</th>
<th>FY04</th>
<th>FY05</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Budget</td>
<td>Actual</td>
</tr>
<tr>
<td>Total GOT public allocation to health per capita</td>
<td>Central</td>
<td>1,245</td>
<td>2,699</td>
<td>2,799</td>
</tr>
<tr>
<td></td>
<td>Regional</td>
<td>172</td>
<td>356</td>
<td>351</td>
</tr>
<tr>
<td></td>
<td>District</td>
<td>848</td>
<td>1,442</td>
<td>1,375</td>
</tr>
<tr>
<td>Per capita GOT recurrent expenditure broken down by level</td>
<td>Central</td>
<td>190</td>
<td>565</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hospital</td>
<td>1,077</td>
<td>1,716</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preventive</td>
<td>894</td>
<td>1,678</td>
<td></td>
</tr>
</tbody>
</table>

(Health sector PER update FY05)
The Figure 11 shows the proportion of actual expenditure by administrative level. This does not show the funds going to the local level. But the overall increase in on-budget expenditure was 25% from FY03 to FY04. The Central spending was increased by the National Health Insurance Fund and the GoT recurrent OC allocation. While also at the local government level the absolute growth in expenditure was higher than the average the basket allocation to district councils (28%) due to the application of the resource allocation formula.

8.2.3 Service delivery

**Accountability**

Through descentralization process it has been found out that the bottom-up accountability has risen up. All the DEDs (District Executive Directors) interviewed mentioned that in recent years through the participation mechanism in planning, implementation, and evaluation, like O&OD exercises contributed to the increased bottom-up accountability from the grass roots level. Through increased accountability people assume ownership as they participate in identifying, planning and implementation. On the participation of the people in the projects, the WEO of the Chanzuru rated involvement of people at 70% in planning activities.

But in the health facility level we find only one sub-village that there has been health facility committee, which is responsible for management of the dispensary, supervision of cleanliness in the village and informing / instructing communities on issues related to health issues. While in another sub-village there is no committee at the health facility level, hence the health issue has been discussed in the village council (where the sub-village leaders attend) among other sectors’ topics.

Accountability on health and HIV/AIDS services to the people seems to have been strengthened through the descentralization process, through participation to the health committees, to the HIV/AIDS control committees, to the village councils, and through the limited fiscal descentralization to the health facility level, and through the increased
ability to order much needed drugs through the new indent system for online ordering of drugs to the Medical Stores Department.

On service delivery, through decentralization, service delivery has come closer to the people at the grass-roots. Children are getting vaccinations, vitamins in villages not at district levels as it used to be before. Besides, decentralization has increased transparency to some extent through which there has been feedback on implementation of HIV/AIDS related matters. Various committees on health and HIV/AIDS, which constituted different stakeholders, have been formed to plan and address health and HIV/AIDS in villages at ward and village levels.

Misuse of drugs

On the use of drugs many people in the two researched sub-villages perceived doubt about the transparency of the use of the drugs in the dispensary, mentioning the possibility of the misuse of the drugs by the doctors in the dispensary, for the non-availability of the drugs in the latter half of each month has become worse than in the previous years. The doctors have the drug shop nearby, where they suspected that the drugs are deviated from the dispensary which is supposed to provide to the patients free of charge.

The health service issues have been discussed in the village councils. And it neither does allow the close monitoring of the health system in detail, including the above misuse of drugs.

Financial accountability

And the financial accountability at the district level has somewhat improved over the last few years. A MoHSW and PMORALG audit of the Council Health Basket Fund
reported the reduced numbers of desclaimers issued during the January 2003 to June 2004 than the previous 12 months period. But the accountability can not be ensured in detail for the expenditure tracking survey has not been executed.

Meanwhile many people in the village complained about the utilization of user fees at the dispensary level, mentioning that the use of this money was not accountable to them. In Mlali Gudugudu sub-village people have to pay to a consultation at the dispensary at Tsh.100/- for the salary for the security guard, while more than enough money would have been collected and the extra money was not known for its uses.

Other problems on accountability

There are also other several problems against accountability. 1) There is low level of participation among communities in public activities because they put more efforts in their individual activities for their livelihood. 2) The understanding capacity of some community members was low coupled with illiteracy problem. 3) It was difficult to mobilize people in the villages who interacted with urban dwellers who suggested that the villages should not do self-reliance as that was the responsibility of the government. 4) Due to political problem, especially before election time, problems occurred in mobilizing people and materials of people’s contribution for community development, for political opponents say to people not to participate to these community development activities, saying they could bring development without their contribution. 5) Some of the village leaders in the village committees were ignorant of their roles and responsibilities, also due to their low level of education and understanding. 6) Some village governments have low capacity to plan, supervise, follow up on key development issues, and as a result communities complained about their low performance.
8.3 Micro level

Fair’s fair (2006) reports its preliminary analysis that the regional mortality associates with malnutrition, anaemia and adult educational attainment. It also reports that the disadvantaged groups (the poor, the less well-educated and rural residents) tend to consume less health care than others in both preventive and curative services. The mismatch between health needs and health care consumption shows the ‘inverse care law’ and in particularly related to use and quality of maternal health services across socio-economic groups. It also reports that the poor are less likely to receive a quality service even if they reach a facility. It suggests that since the supply factors in health care that stands out most in Tanzania is the human resources it is important to introduce an incentive package to redress the mal-distribution of skilled human resources (more urban, less rural) as the pro-poor policy measure.

There is a limitation of analysis of correlation between the PRS, policy level and the field level study, especially this study has very limited field level study, i.e. three sub-villages in Morogoro region. But it attempts to suggest some findings of the micro level.

8.3.1 Community level discussions

In the community level discussions it was found that the eagerness to work and exposure to the seminars / outside world were mentioned as the causes of the upward mobility. On the contrary, the drought / bad or unusual weather were most mentioned by the villagers as the impoverishing forces. Also the diseases / ill health, un-eagerness to work were mentioned next as the impoverishing forces.

And it was found in Mlali Gudugudu sub-village that the presence of HIV/AIDS is acknowledged as a bigger problem than previously. They also noted changes on awareness raising through seminars / announcements of issues related to HIV/AIDS and the presence of Voluntary Counselling and Testing (VCT) Centre in the nearby village.
8.3.2 PRA

Wealth ranking

Methodology:

The objective of the activity was to re-categorize thirty five sampled households in LADDER study (2001) and follow up on the changes of their lives since 2001. Four villagers per sub-village who are knowledgeable about the villagers and the village, were selected to do this exercise as key informants.

The first task is to discuss and agree by them on the main characteristics of the poor in the sub-village and the criteria of them classifying into three wealth groups (rich / middle / poor). The second is also to identify the criteria of the poorest group.

Using the cards bearing each household name the key informants are asked to classify each 35 sampled household into three wealth groups according to the agreed criteria. Then on each household’s wealth / poverty level compared the one in 2001, they discussed about the main reasons for these changes of the wealth / poverty levels.

From the households classified as poor they also picked up the poorest households and discussed why they are poorest.

Findings:

The criteria of each wealth / poverty level in Mlali Gudugudu and Nyandira Lundi sub-villages are shown as per following tables, which is similar among the three sub-villages. The common criteria are: land ownership, food security, type of houses, ability to send children to school, livestock ownership.
Table 13a: Criteria Used For Wealth Ranking: Lundi Sub-Village – Nyandira Village

<table>
<thead>
<tr>
<th>CRITERIA</th>
<th>RICH (GROUP I)</th>
<th>MIDDLE (GROUP II)</th>
<th>POOR (GROUP III)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Housing condition</td>
<td>Good/modern house with - Block or burnt bricks (walls) - Plastered - Cemented (floor) - Roofed with iron sheet</td>
<td>Ordinary house with un-burnt bricks thatched with iron sheet</td>
<td>- Un-burnt bricks thatched with grasses - Small house (few rooms) for family members</td>
</tr>
<tr>
<td>2. Land ownership (Mashamba)</td>
<td>- Own 1-6 acres of land - Conduct irrigation approximately 3 acres</td>
<td>Possession of land 1-3 acres 1 acres under irrigation</td>
<td>Practice unimproved farming Possess $\frac{1}{2}$ - 1 acre of land (vegetable, maize, fruits, beans)</td>
</tr>
<tr>
<td>3. Livestock ownership</td>
<td>Goats 1-10, pig 1-5, chicken 1-20</td>
<td>Goats 1-3, pigs 1-2 and chicken 1-10</td>
<td>Goats 1-2 (local) Pigs 1 and chicken 0-3</td>
</tr>
<tr>
<td>4. Education</td>
<td>Able take/provide education to all children up to university level</td>
<td>Able to afford education for children from primary to form 6 level</td>
<td>Primary to form 4 (four)</td>
</tr>
</tbody>
</table>
## PRS Assessment on Chronic Poverty in Tanzania

<table>
<thead>
<tr>
<th></th>
<th>Treatments / health care</th>
<th>Affordable at all levels (dispensary to National Hospital of Muhimbili).</th>
<th>Can afford treatment up to the region hospital level</th>
<th>Afford dispensary to at least health center. (Langali center). Many opt traditional healers</th>
</tr>
</thead>
</table>
| 6. | Food security and meals  | - Available throughout a year  
- Able to take 3 standard diet meals a day | Uncertain for the whole year, afford 2 meals per day | Not enough for the whole year. One to 2 meals per day with uncertainty |
| 7. | Clothing                 | Afford to buy all types of clothes (fashions) for the family members | Normal clothing | How level std second hand of low quality and prices. |
| 8. | Agricultural inputs     | Able to buy all types (required) of inputs | Manage to purchase some inputs | Unable to purchase required inputs (seeds, fertilizer, pesticide). |
| 9. | Labour                  | Hire and able to pay hired labour (farming etc) | Sometimes hire labour | Occasionally sell their labour for income earning |

**NOTE:** Under 2 above crops cultivated include cash: vegetables and fruit etc, food: maize and beans
Table 13b: Wealth ranking criteria for 30 hhs at Gudugudu sub village, Mvomero district

<table>
<thead>
<tr>
<th>CRITERIA</th>
<th>GROUP I (rich) 5 HHS</th>
<th>GROUP II (Middle) 11 HHS</th>
<th>GROUP III (poor) 13 HHS</th>
<th>Chronically Poor 4HHS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Land ownership</td>
<td>Have 5 and above acres of land</td>
<td>Own 1-3 acres of land located in different areas</td>
<td>Have 1 or less acres of land</td>
<td></td>
</tr>
<tr>
<td></td>
<td>an acre = approx. (70m x 70m)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Food security</td>
<td>Secured as food is available throughout a year</td>
<td>Uncertain about food security i.e. (inadequate food)</td>
<td>Have no food security at all and can go without food</td>
<td></td>
</tr>
<tr>
<td>3. Type of house</td>
<td>Improved/modern house(s) with cemented floor, roofed with</td>
<td>Ordinary house status – cemented floor, mud bricks for walls</td>
<td>Low standard</td>
<td>Very poor houses</td>
</tr>
<tr>
<td></td>
<td>cemented floor, mud bricks for walls and roofed with iron</td>
<td>and roofed with iron</td>
<td>Floor: mud</td>
<td></td>
</tr>
<tr>
<td></td>
<td>and walls made of blocks/plastered</td>
<td></td>
<td>Walls: mud bricks or poles with mud</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Roof: thatch with grasses / banana leaves or part with</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>iron</td>
<td></td>
</tr>
<tr>
<td>4. Education</td>
<td>Able to take/send children to schools (primary education</td>
<td>Children to go school up to primary education level</td>
<td>Unable to educate children, buying uniforms is a problem</td>
<td></td>
</tr>
<tr>
<td></td>
<td>to secondary to college/university)</td>
<td></td>
<td>Children have not gone (do not go) to school</td>
<td></td>
</tr>
<tr>
<td>5. Livestock</td>
<td>Majority own animals like goats (5 or more), pigs (5 or</td>
<td>Pigs: 1</td>
<td>Chicken 1-2</td>
<td></td>
</tr>
<tr>
<td>ownership</td>
<td>more)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Farming and agricultural inputs</td>
<td>Own a pump worth/value Tshs. 300,000/= for irrigation of their fields and rent to others. Afford to purchase inputs</td>
<td>Unable to own pumps and can averagely afford inputs (fertilizer, seeds, pesticides)</td>
<td>Cannot afford</td>
</tr>
<tr>
<td>---</td>
<td>---------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
<td>--------------</td>
</tr>
<tr>
<td>6.</td>
<td>Health facilities (treatments)</td>
<td>Have easy access to health facilities/treatments for their family members</td>
<td>Can access to treatment</td>
<td>Cannot easily access due to costs</td>
</tr>
<tr>
<td>7.</td>
<td>Labour</td>
<td>Have ability to hire labour from other groups</td>
<td>Do not sell their labour, are committed and use their own (family) labour for everything</td>
<td>Sell labour for their survival / dependant</td>
</tr>
</tbody>
</table>
Causes of changes on wealth/ poverty levels:

The various causes of downward movement (impoverishment) were mentioned. The first was prolonged drought that hindered some households’ progress. This hit almost the whole country early this year with no exception of Darajani people but coping strategies varied from household to another and some households found falling down in their endeavors. Majority of them could not afford irrigation system, hence they harvest very little barely for subsistence.

Low income among households under this category was another factor that has been frustrating their struggle for better life. As a result they faced difficult conditions in carrying out agricultural activities, lacked money for hiring enough land for more production.

Land was singled out as another crucial factor, which hampered their advancement. On average the majority owned inadequate land (1-3 acres) obtained through inheritance. The same households had low income that cannot help them to rent land. In Chanzuru Darajani where there is a big area of Sizal plantation both inadequate land and low income compel some households to spend most of their time and energy selling their labour instead of investing on their own development initiatives.

‘People with money are very clever we work for them, they pay us little and we remain stagnant, while they move forward.’

They meant that selling labour was exploitative somehos because they were not satisfied with payment. They payable amount varied with size of the area cultivated by the labourer but ranged between Tshs 500.- to 1,000.- per square unit (piece) paid on daily basis. On that basis some hard workers could complete 2 or 3 square a day and some could only do a single square a day.
Some households were driven poorer by loss of their partners (husbands or wives) especially widows. It was because men are the main bread winners and particularly so where there was no external support from relatives.

The reason for upward movement (becoming rich) was mentioned caused by change in agriculture through production of new / additional crops which were not produced before such as tomato or sim sim as cash crops.

Remittance or other form of support from relatives contributed to uplift the living standards. Some received cash for different uses while some were assisted materials like food, construction of houses, etc.

Another factor for positive change was related to individual’s development effort, commitment and reduction of unnecessary expenses which contributed to personal savings. A combination of all these pushed some of the households to a better off position.

The forth reason for positive movement was attributed to labour utilization in the sub-village. Some of those who shifted up had an advantage of employing their family labour in production and other development activities but also had the capacity to hire additional labour simultaneously. This increased production area and produce but also improved their timing of activities (e.g. planting, weeding, etc.), that is activities were implemented according to schedule, and element which is important in agriculture.

Village map:

The village maps were drawn by the key informants in each sub-village like following map in Mlali Gudugudu, which facilitates the community group discussion concerning the characteristics of the village and the conditions of sampled households.
8.3.3 Household interviews

The household asset survey and semi-structured interviews are conducted with the 23 sampled households.

Below is the summary of an interview with HIV/AIDS-suspected widow in Nyandira Lundi sub-village which could show how the HIV/AIDS-affected (suspected) widow has been falling down the poverty level.
Box 1: An interview with HIV/AIDS-suspected widow in Nyandira Lundi Sub-village

<table>
<thead>
<tr>
<th>Mary Pius was categorized poor in 2001 and remained in the same category of poor in 2006. She is 55 years old, a widow living with her two children. Both of her children have finished standard seven and support their mother in farming. Their health was good. The other two small children are dependent on their elders. Three other children are out of the home and engaged in farming activities and another child is doing petty business.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HIV/AIDS</strong></td>
</tr>
<tr>
<td>Mary Pius said herself as a HIV/AIDS victim.</td>
</tr>
<tr>
<td>‘My problem is HIV/AIDS disease. As you see how my condition is, when I met visitors (white people) in 2004 I was diagnosed and given medicine to use. They came to SUA (a centre for agriculture at Nyandira Village) representing a certain religion. So there are medicines which I am now collecting from the dispensary.’</td>
</tr>
<tr>
<td><strong>Support</strong></td>
</tr>
<tr>
<td>However, she has not received any support from the external sources other than from her two children. Hence her source of income is no other things as her cultivation of green peas at a small scale and she got only 1/2 kilogramme for buying salt because her health has been poor.</td>
</tr>
<tr>
<td><strong>Assets</strong></td>
</tr>
<tr>
<td>On viewing trends of her income over past five years, she said that the income level had dropped or there was no change given the current situation of life. She attributed problem to weather fluctuation (not her health) as a contributing factor to unimproved life.</td>
</tr>
</tbody>
</table>
She possessed land of 4 pieces (she could not estimate in terms of acres). Because of her health she could not utilized all of her land but she did not rent out her land. She has two houses both with good conditions which were constructed when her husband was alive (he died in 2003). No changes were registered on assets over the past five years.

Service at dispensary

When got sick, she said that people in the village went to the dispensary (including her), and if they did not get cured, they went to the hospital / health centre at Mgeta (neighboring town). But she complained the lack of medicine at the dispensary and has to buy them. ‘And if she (you) has no money, she (you) keep(s) suffering’.

On her mother’s (elderly) case the exemption system was not applied.

‘Aah no. No exemption, I have my old mother who is sick since last year, is weak and up to now she is weak and without a shilling no medicine and she was instructed to buy drugs, she failed to purchase and personally I have no money (to help her).’

On the reason why there is no medicine at the dispensary, she answered;

‘they are clever because they have their own chemist and make business to get their livelihood in our days, medicine were brought in the dispensary but were taken away’.

Hence she suggested that the government should take responsibility of supplying more medicines and improve treatment in all heath facilities, including the appropriate application of the exemption system (to elderly, etc.).
In the three villages, it was found that the health and HIV/AIDS services were gradually improved, such as the construction of the health centres with human personnel at the village level, construction of the Voluntary counseling and testing centres at the village level, the provision of treated mosquito nets to mothers with children under five for discounted price (Tsh. 300) and their prevalence to the houses, and the holding of the HIV/AIDS awareness raising seminars and workshops at the village level. These benefits also have reached to the chronically poor somehow as well.

The second founding is that the accountability of the use of drugs in the health centres is very low to the people in the villages. Many people in the villages mentioned the doubt about the misuse of the drugs in the health centres, for the half of the month there is no drugs available in the health centres and they receive the prescription from
the doctors there and buy the drugs from the drug shops nearby which the doctors in the health centers own. Hence the people ask the monitoring of the use of the drugs.

The third finding is that the exemption system is not functioning well. Among the three villages in the field study only one sub-village in Kilosa district applied the user fees which are intended to serve to supply the necessary drugs and equipments and tools for primary health care services at dispensary. Hence the exemption and waiver system for this user fees were also applied only in this sub-village. The qualification for the exemption system is as follows:

- elderly
- disabled
- people with chronic diseases (e.g. TB, heart disease, etc.)
- children under five
- pregnant women

But process for applying exemption is complex, bureaucratic, and arbitrary, for it is difficult to prove whether they are qualified, especially on poverty level (Msongwe’s report). It is applied arbitrary even when they are clearly qualified, e.g. elderly, for they are not treated sometimes with exemption. And sometimes the villagers don’t feel like it has been started / effective. However, according to the clinical officer in Chanzuru Darajani, there are positive impacts appeared of exemption system among the people in the villages. Primarily, the exemption system has reduced some minor health problems/ illnesses because the people go to dispensary free of charge, the second is saving, in the sense that the money which the exempted people could otherwise use for treatment was now deviated and saved for other purposes.

The forth finding is on the Community Health Fund (CHF).

CHF is not well known to the people and the key stakeholders even to the health workers. The participation rate is very low, because people are not used to the
insurance system, and they do not see such a benefit of paying Tsh. 5,000.-/year &
family. This is, first, because due to the fact that the primary health care is given free
even without CHF for children under 5 and pregnant women, who are the most
vulnerable for being ill and need health care. This is also due to that the dispensary
does not provide good and satisfactory services, e.g. they don’t have medicines,
neither have laboratory, so that even the CHF member has to go to the private
dispensary to pay for the laboratory as well as the cost for drugs. They also pointed out
that there is sometimes ill treatment of CHF members compared to cash payers.
Additionally men pointed out problem that CHF did not cover all health problems, e.g.
fracture. However, women insisted that CHF was very important for it can serve a lot
during emergency cases. Men also acknowledged it, but felt discouraged by the poor
health service provided in the health facilities.

Hence they prefer paying user fees (Tsh. 100 ~ 1,000/-) when they need the health
care, to being a member of CHF. User fee is decided at the health facility level,
supervised by the health facility committee or village social committee. Hence the
recommendation is to lower the participation fee, and to revise the health fee system in
total.

Role of the traditional healers

In the three surveyed sub-villages people first resort to the public health services when
they fall ill. When they are asked about the traditional healers people first reacted
frightened why we ask about them, for saying that ‘they are not scientific. They do not
test or examine the health conditions.’. But when we ask further to confirm that there
are the traditional healers in their sub-villages they began to talk about the role of the
traditional healers. People go to traditional healers when they don’t get cured after they
went to the public health services, believing that they are ‘bewitched’, hence they can’t
get cured in the scientific way. In the surveyed sub-villages there are 4 – 5 traditional healers.

The treatment of the traditional healers is used with herbs, trees, etc. The regional health authority tries to register them, hence there are their associations which they belong to and pay association fee and gather sometimes to discuss the issues concerning the way of treatment, etc. The cost for treatment is not uniform. People pay to them as much they can afford and / or like to do so, from Tsh. 500 – 2,000.-, etc. Hence the literature mentions that poor people who can not afford to pay to the public health services they go to traditional health services. Also in the poorest group discussion in Gudugudu in Mlali although there is no user fee, where people only pay the cost for guardians and / or receptionist, and/or for the notebook, for half a month they have to buy the drugs, for there is no available drugs at the dispensary, they can not afford to pay for the drugs sometimes. It shows that the very poor / chronically poor are facing difficulty to access to the public health services.

Stigma / discrimination on HIV/AIDS

In the three surveyed sub-villages there is stigma on HIV/AIDS among patients. They don’t want to be seen by others. They often take the disease in town out of the villages and after they find illness they’ve been back to the village.

According to the World Vision Tanzania which supports the awareness raising activities in the communities in Mlali ward through the awareness raising in the village level the stigma / discrimination on HIV/AIDS has been reduced for they know about the disease and how to survive
Quality of health service

In the surveyed sub-villages some people complain about the behavior of the health workers at the health facilities, especially during at nights and weekends when they are not open, when no workers attends to the emergency like deliveries. One elderly woman mentioned that she is treated badly because she is illiterate. Also the small number of health workers at the dispensaries is also mentioned by some people to be increased. It shows that filling many vacant posts at the health facilities should be the priority to improve the services.

Poverty levels

The following table 14 shows the socio-economic status of the sampled HHs in the surveyed sub-villages. They are compared with the same samples of the LADDER study which included the wealth ranking exercises conducted in 2001. It shows that the wealth ranks ranked by the wealth ranking exercise somehow reflects the socio-economic characteristics of each HH. Especially chronically poor or downward poor are ranked relatively lower than the other HHs. But the differences of the sums of the indicators of socioeconomic statuses between the HHs seem to reflect the potentials of the HH’s wealth and/or vulnerability.

On the analysis of LADDER study data (F. Ellis and N. Mdoe, 2002) out of five asset levels (HH size, Area owned, Livestock, Education, Tools), livestock relates most to the poverty levels of the whole sampled HHs. In our sampled data, the assets (ownership of radio and bicycle) seem to relate most to the poverty levels of the sampled HHs, although the criteria/ranking of our sample data differ from the LADDER study.
Table 14: Socio-economic indices’ data of the sampled HHs in the surveyed sub-villages

<table>
<thead>
<tr>
<th>Poverty level in the wealth ranking exercise</th>
<th>Family size</th>
<th>Education</th>
<th>Remittances</th>
<th>Gender</th>
<th>Healthy/Sickness</th>
<th>Roof</th>
<th>Livestock</th>
<th>Assets (bicycle, radio)</th>
<th>Land area</th>
<th>Sum</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mlali Gudugudu</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hadija Rajabu</td>
<td>CP</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Sherua Maulid</td>
<td>CP</td>
<td>-1</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td>Selemani Kidazu</td>
<td>CP</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Zena Ramadhani</td>
<td>CP</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td>Charles Bemde</td>
<td>Downward poor</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Malki Josephat</td>
<td>Downward poor</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Scolastica Raphael</td>
<td>Downward Middle</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>0</td>
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</tbody>
</table>

78
<table>
<thead>
<tr>
<th>Name</th>
<th>Status</th>
<th>0</th>
<th>1</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>2</th>
<th>1</th>
<th>3</th>
<th>1</th>
<th>11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wilkista Wilbread</td>
<td>Constant Middle</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td>Sijari Mokola</td>
<td>Upward middle</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td>Khalifa Kiponza</td>
<td>Constant Rich</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>14</td>
</tr>
<tr>
<td>Nyandira Lundi</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mary Pius</td>
<td>CP</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td>2</td>
<td>1</td>
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<td>1</td>
<td>1</td>
<td>0</td>
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<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
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<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
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<tr>
<td>Rita Wahindi</td>
<td>Constant Middle</td>
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<td>1</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>5</td>
<td>15</td>
</tr>
</tbody>
</table>
### Chanzuru Darajani

<table>
<thead>
<tr>
<th>Name</th>
<th>Socio-economic Level</th>
<th>Family Size</th>
<th>Education of HH Head</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hussein Virungo</td>
<td>Downward middle</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Hadija Kilongola</td>
<td>CP</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Juma Chidama</td>
<td>CP</td>
<td>1</td>
<td>0</td>
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<tr>
<td>Ramadhan Joseph</td>
<td>Upward rich</td>
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<td>0</td>
</tr>
<tr>
<td>Akisa Muhimili</td>
<td>Downward poor</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Abdallah Viungo</td>
<td>Constant middle</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Amina Yahaya</td>
<td>Downward middle</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Seleman Emil</td>
<td>Constant Rich</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Socio-economic Levels based on the following criteria:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family size: Over 10 members = -1, 6-10 members = 0, 1-5 members = 1</td>
</tr>
<tr>
<td>Education of HH head: Reached to secondary = 3, reached to Std. 7 = 1, no education = 0</td>
</tr>
</tbody>
</table>
Remittances: over Tsh. 5,000 = 2, less than Tsh. 5,000 = 1, no received = 0

Gender of the HH head: Female HH head = 0, male head = 1

Health status of the HH head: Healthy = 2, unhealthy / disabled = 0

Roof material: Iron sheets = 2, grass / leaves = 0

Livestock: No. cattle = No. x 3, No. goats or sheep, pigs = no. x 2, No. of chickens (1~10 chickens = 1, 11~20 chickens=2, 21~30 chickens=3)

Assets: Radio owned= 1, bicycle owned=1

Land area: Over 5 acres=5, 1-4 acres=3, 1 acre under=1
As mentioned above, other than these socio-economic data, the chronic poverty seems to correlate much to the health status of the household head. That means if the household heads are ill or disabled, these households tend to be chronically poor households. This is probably because the agriculture is the main occupation in the three surveyed villages, and other business opportunities are very limited. Hence the health status of the household heads rather than, for example, the education level of the head, relates directly to the poverty level of the households.

9 Conclusion and policy recommendation- What is driving force for implementation? What are the obstacles against implementation?

Concerning policies for chronically poor, the Tanzanian 1st PRS regards vulnerability as the most important policy for poverty reduction and the NSGRP places mainstreaming attention to vulnerable groups in its policy matrices.

The implementation of PRS into policy actions has been through the sector policies. In the health sector National Health Policy (2003) and its implementation plan, the second Health Sector Strategic Plan (2003 – 2008) are the guiding policy documents to implement the policy actions in health. The Policy identifies PRS1 as the guiding documents hence the objective of the policy will be targeted at strengthening of the essential clinical and public health packages, under which the Strategic Plan also identifies the provision of the quality district health services as its priority. This includes accelerating the process of decentralization of health services focusing on quality service delivery.

But in its implementation the proportion of the primary health care / prevention out of total health budget has not been increased in its budget allocation since 2002. It implies that the enough political attention has not been put in PRS. Hence it can be said that neither policy for chronic poverty has also been put on focus. As Booth (2005) suggests, the politics in Tanzania are dominated by the ‘patrimonial’ system, not the bureaucratic one, hence the PRS has not been on the centre of the political stage, but tending to divide the resources by the patronage system. It also implies that there are other priorities in the sector in the sector political setting which hinders the PRS priorities-primary health care- put on focus. Hence as the first policy recommendation the PRS priorities should be put prioritized in the political setting as the basic stand point. Further, there is no expenditure tracking survey in health so far, hence we can not say that the health budget has been properly utilized in an accountable manner.

And in the outcome level the drop of the stunting rate of children under 5 in rural areas in recent 5 years implies the reduction of income poverty as well as improvement of other socio-economic poverty levels of the people in the rural areas. But the widening gap of the prevalence of stunting between the poorest and the least poor during 1990s and the data
that the regions with lower rates of poverty shows higher rates of improvement in stunting, imply the prevalence of the chronically poor. Hence it can be said that the effort of reduction of poverty and improvement of primary health services have not been reached to the chronically poor.

In the HIV/AIDS sector National HIV/AIDS policy is the policy document with strong policy commitment by the President under which the National Multisectoral Strategic Framework has been formulated to put strategically against HIV/AIDS throughout sectors. In these documents, as the PRS put priority on, HIV/AIDS care and prevention activities are set on as the priority.

In the HIV/AIDS sector the public expenditure is difficult to be grasped because of the multi-sectoral as well as big portion of un-captured many stakeholders’ activities. The Multi-sectoral Public Expenditure Review for HIV/AIDS 2005 report (2005) mentions that the three donors (USAID, Canadian Development Cooperation, and Global fund(GFATM)) presently account for between two thirds and three quarters of total aid for HIV/AIDS. On the top of that in 2006 World Bank starts the big care and preventive project (Tanzania Multisectoral Aids Project) with large amount of funds. The vast majority of donor funding is planned and very little of these aid resources flows through the exchequer system. For the effective utilization and better coordination of aid resources it is expected to be devised streamlined, multi-donor funding mechanisms for HIV/AIDS that will channel resources through the Exchequer system and to be well coordinated among them.

On the meso level the decentralization has been proceeded at the local government level, which has promoted the efficiency, effectiveness, and accountability of the services provided. But the low capacity of the local government and of the people hinders effective implementation of the decentralization process. Hence the further capacity development of the local government and providing education / awareness raising towards people on community development are needed.

On the micro level the political problem (opponents to the village leaders) sometimes hinders people’s participation / contribution towards the community development activities. The power politics among the villagers (the people with power always have the voice in community development) also hinders equity of benefit in community development. The chronically poor are not benefited from these politics, for they normally don’t have the voice.

The chronically poor tend not to have access even to the quality primary health care for the cost of the drugs, for when they find the drugs are not available at the dispensary they sometimes can’t afford to pay. They are treated sometimes badly compared to the well-off patients so that they don’t want to go to the health facilities.

Because of the seminars / awareness raising activities the knowledge about HIV/AIDS and its prevention is mostly prevalent even at the grass roots level. But due to lack of Voluntary
Counselling & Testing Centres in the nearby village level and due to the people’s fear of knowing results of test the appropriate prevention of HIV/AIDS is not effective. The stigma on HIV/AIDS is mostly high among the HIV/AIDS patients and the villagers in general. More awareness raising on HIV/AIDS and informing the way of treatment of HIV/AIDS is needed to reduce stigma and for more effective HIV/AIDS prevention.

Because of stigma the HIV/AIDS patients tend to desire to hide themselves from the people, hence can not work. In the surveyed villages, however, there is social safety net to provide support from the family members, relatives and the neighbors. It provides them to buy food and get drugs. But the social protection activities towards them are needed by the government or organizations, for the support by the relatives and neighbors is not enough to sustain their living hence they and their families tend to fall into chronic poverty.

**Recommendation**

Tanzanian PRS2 (NSGRP) has mainstreamed policies targeted to the vulnerable groups. Hence the implementation of the priority policies targeted by NSGRP has to be ensured first, which could enable to cover the benefit to the vulnerable people including the chronically poor. Hence the budgeting towards the appropriate allocation to each policy actions in the Annex of the NGSRP has to be planned and ensured each year.

But in terms of chronically poor perspective, the above implementation does not still ensure its service delivery to reach the chronically poor specifically to overcome their chronic poverty. Social protection programme provides the most vulnerable with desperately needed money, to provide money to buy food, to reduce the needs to sell off precious assets such as livestock and land, to stimulate local economy and to encourage the farmers to produce more. Hence the social protection policies pinpointing to them is needed, such as cash transfer or income transfer, food for work, support to HIV/AIDS affected people and families, etc. But the targeting is very difficult. It has to be developed very clear criteria for targeting (e.g. elderly, widows, orphans, children under 5, etc.).

On whether cash or in-kind transfer issue, distributing money rather than food could be better measures for social protection in terms that it enables households to choose how to spend cash – whether on food or long-term food security strategies (e.g. investing in livestock or tools, etc.). In the Ethiopian case (Ethiopian Red Cross Society, 2003) the people prefer cash to food aid. While in terms of child nutrition the food aid could be better measure due to the direct support to nutrition of the households. Hence the socio-economic characteristics of the villages targeted is the determinants for either cash or food transfer to the vulnerable groups.

The Committee for Social Protection has been established in order to proceed to discuss about and formulate the National Social Protection Programme. But the leader government institution has not yet been decided, which probably the Ministry of Planning, Economy and Empowerment would assume later. It is reported that the Action Plan for developing the
National Social Protection Policies would be formulated soon. It would be deserved to be formulated sooner for the chronically poor to overcome their chronic poverty.

1) Health Policies

Quality primary health service provision is prioritized in policy document and the absolute amount of health budget has been increasing. But the proportion of the preventive/primary health care out of total public health expenditure has not been increasing, hence the prioritization in the health sector can not be said that is there. It should be prioritized in the budget allocation more clearly and the primary health services are expected to reach to the poorest/chronically poor.

Governance

In the three surveyed sub-villages many villagers expressed concerns about the misuse of the drugs by the doctors in the dispensary. It was expressed that the stock-outs of the drugs in the dispensary is worse than before. It seems funny that since the indent system was introduced the stock-outs of the drugs have more frequently happened. It might happen due to the mis-estimation of the drug necessity by the dispensary, but if it happens every month as the villagers suspected there is the misuse of the drugs by the doctors who have the drug shop and earn money from the cost of the drugs. Hence the monitoring system of the use of the drugs in the dispensaries by the villagers is needed to avoid the corrupt behaviour of the doctors in the dispensaries. This kind of corrupt behaviour or mismanagement of the public service causes the obstacle against appropriate implementation of the policies.

2) HIV/AIDS

HIV preventive measures must remain the top priority. The awareness raising activities like seminars and meetings at the village level should be promoted more. The local level activities should be done through the recently-established decentralized multi-sectoral system under TACAIDS.

For awareness raising and prevention of HIV/AIDS the building of the Voluntary and Counselling and Testing centres at the village level and their activities should also be enhanced.
10 Interviewed people

1. Mrs. R. Kikuli, Acting Director of Department of Policy and Planning, Ministry of Health and Social Welfare
3. Mr. Mbando, Commissioner of TACAIDS
4. Dr. Servacius Likwelile, Executive Director, TASAF
5. Dr. Mbando, TACAIDS commissioner
6. Dr. Meshack Massi, Regional Medical Officer, Morogoro
7. Ms. Servus Amo Sagday, Senior Economist / Programme Officer, Ministry of Planning, Economy and Empowerment
8. Dr. B. Cooksey, TADREG Researcher
9. Ms. Valerie Leach, Policy Analysis Coordinator, REPOA
10. Mr. Hisahiro Ishijima, JICA expert on health sector cooperation & planning
11. Mr. Shinnichi Takenaka, JICA expert on HIV/AIDS project chief adviser
12. Mr. Abdul Jetha, Country Programme Director, Help Age International, Tanzania
13. Ms. Heather Kindnss, Save the Children UK, Tanzania
14. Mr. Emmanuel Mtango, Programme officers at World Vision Tanzania HIV/AIDS project
15. Mr. Tomohiko Sugishita, Ms. Erika Fukushi, Mr. Nobuyuki Goto, Experts in JICA Morogoro Health Project
16. Mr. Takahiro Moriya, Assistant Resident Representative, health & HIV/AIDS sector, JICA Tanzania Office
17. Mr. Kikswesha, Acting Regional Administrative Secretary, Morogoro region
18. Prof. N. Mdoe, Professor of Economics, Sokoine University of Agriculture
19. Prof. F. Ellis, Professor of Economics, Overseas Development Group, University of East Anglia
20. Dr. Yusef Hemed, Regional SAVVY adviser, MEASURE Evaluation
21 Mr. Kikwesha, Acting Regional Administrative Secretary – Morogoro region
22 Mr. Uledi Hassan, Economist – Morogoro
23 Mr. C.Lyimo Regional HIV/AIDS Control Coordinator, Morogoro
24 Ms. Mwajuma, Community Development Officer, Mvomero
25 Mr. Mohamed Ali Kilango, Mlali Gudugudu Sub-village chairman
26 Mr. A. Mshamu, District Executive Director, Kilosa District Council
27 Mr. Mlashi, Community Development Officer, Kilosa
28 Mr. M. Mwemsanga, Medical Officer in Charge (Ag. Medical Officer)
29 Mr. Robert Mwambalaswa, District Health Officer / HIV /AIDS – Coordinator
30 Mr. Willy Chiwaya, TASAF Coordinator, Kilosa District
31 Mr. Gideon Duge, Ward Executive Officer, Chanzuru ward, Kilosa
32 Mr. Julius Lumambo Former Ward Executive Officer (transferred)
33 Ms. Julita Kapembe Village Executive Officer, Chanzuru village, Kilosa
34 Mr. Abdallah Virungo Sub-village chairman, Darajani sub village, Kilosa
35 Dr. A. Siaga, Clinical Officer, Chanzuru dispensary, Kilosa
36 Mr. E. Dionis, Village Executive Officer, Nyandira Lundi Village
37 Mr. Y. Msimbe, Chairman, Nyandira Lundi Village
38 Mr. Fidelis Masednga, Nyandira Lundi Sub-village chairman
39 Mr. Mayunga William, Clinical Officer, Nyandira Dispensary
40 Ms. Henriette Kolb, European Union, Tanzania
41 Ms. Sarah Fuller, Swiss Development Corporation, Tanzania
42 Dr. Ibrahim Kabole, AMREF Tanzania
43 People in Mlali Gudugudu Sub-village
44 People in Nyandira Lundi Sub-village
45 People in Chanzuru Darajani Sub-village
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