UNIVERSITY OF DAR-ES-SALAAM

WORKSHOP ON "ECONOMIC POLICY ENVIRONMENT IN TANZANIA IN THE TWENTY FIRST CENTURY: LESSONS FROM THE NYERERE LEGACY"

TITLE: PROVISION OF HEALTH SERVICES IN TANZANIA IN THE TWENTY FIRST CENTURY: LESSONS FROM THE PAST.

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Paper presented at a workshop on Economic Policy Environment in Tanzania in the twenty - first century: Lessons from the Nyerere legacy held from 30th March to 31st March 2000 in Dar-es-Salaam.

Abstract

The health services during the colonial period and immediately after independence were seriously deficient in providing basic health facilities to the **majority** of Tanzanians. The health service before independence had been geared towards servicing a small elite group, mainly for colonial administrators and a few others and as result at independence in 1961 the health status of the majority of Tanzania's population was poor. Realizing the seriousness of the problem, Tanzania under the leadership of the late Mwalimu Julius K Nyerere declared in no uncertain terms that disease and ill health were among the enemies that had to be fought and conquered in order to consolidate Tanzania's hard won independence. This has been an on-going battle that still continues today.

The 1967 Arusha Declaration sought to restructure the health sector as part of a comprehensive strategy to ensure sustainable development based on the principles of socialism and self-reliance. The Arusha Declaration set in motion an agenda to reverse the predominantly curative orientation of the pre-1967 period towards preventive and public health measures. Steps were taken to abolish existing rural-urban bias to establish a viable rural health care network within the spirit of self-reliance. But perhaps the most significant outcome of the Arusha Declaration in the field of health were efforts to make health care comprehensive, universally accessible, and free of out of pocket payments to the general public.

With the push of the Arusha Declaration and Nyerere's steadfast belief that health is the cornerstone of human existence "Mtu Ni Afya", Tanzania was able to establish a health care network unprecedented in countries of her economic status during the 1970s and 1980s. While the Twenty first century offers both opportunities and challenges, a number of important lessons can be learnt from the Nyerere era that can contribute to improving policy making in general and designing the way forward for Tanzania in the twenty first century. It is becoming increasingly clear that renewed efforts are urgently required in order to provide better health services to all Tanzanians which was undoubtedly one of Mwalimu Nyerere's most cherished dreams. A number of lessons can be learnt from the Nyerere legacy.

Among the important lessons that can be drawn from the past is the necessity of providing a conducive socio-economic environment for a comprehensive and universally accessible health care system. That provision of health care cannot be separated from overall economic and social development is perhaps the most important lessons that we can learn from the Nyerere legacy. The achievements of the Nyerere era proved to be unsustainable because of absence of effective economic policies. The economy failed to produce the necessary wealth to sustain the health reforms. During the Nyerere era, health was made to be basic right to all and this must remain the underlying ideology for provision of health care in Tanzania. Other lessons that can be learnt include providing safety guards for the poor and other disadvantaged groups, particularly women and children so that their health needs can continue to be met. Provision of health services to rural areas was given top priority and this must continue to be so in this era the free market economy.

This paper examines Mwalimu's role and contribution to efforts aimed at improving the health of the Tanzanian people and health services in Tanzania since independence to the mid 80s when the late Mwalimu J.K. Nyerere stepped down as president of Tanzania. We shall in particular be trying to highlight the gains and lessons from the Nyerere era that can be used to push the on-going health sector reforms in a direction that will eventually lead to provision of better health services to all Tanzanians in the twenty first century and beyond. The paper also attempts to identify some of the missing links in health sector policy formulation and implementation so as to come up with viable policies to meet the present needs in this era of rapid social and economic change.

1. Introduction:

The widely agreed definition of health is that of The World Health Organization (WHO) which states that "Health is the state of complete physical mental, and social well-being and not merely the absence of disease." Health is thus considered the very center of persons' well being and development. It is today widely acknowledged that health is an important component of the development process in the sense that it can help or hinder national development, and that other forces of development can add to or detract from health.

The late Mwalimu Nyerere was one of the few leaders in the third world to realize that health is an important and necessary component of the development processes. With this realization Nyerere dedicated the best part of his life to improving the general wellbeing and in particular to the provision of better health services to all in Tanzania. The late Mwalimu Nyerere realizing that Tanzania was a very poor country directed that the country's meager resources be channelled to improving the wellbeing of the general population so that the would be healthy and able to contribute effectively to the development of the country.

Today, the twenty-first century poses great obstacles to the goal of sustained development particularly provision of improved social services including health and education to the majority of Tanzania's population. According to World Bank studies conducted in 1993, the literacy level in Tanzania is estimated to have declined from 85% achieved in the 1970s and 1980s to 68% during the early 1990s, the most affected are the low-income families who are the majority population in the country. The primary school gross enrolment rate dropped from 93% in 1980 to 63% in 1990. The enrollment rate continues to drop with increasing dropout of pupils unable to complete their studies. The country has ratios of one hospital bed per 1,000 people and one doctor per 33,330 people. This is in light of increasing health needs of a country characterized by a high population growth rate of more than 2.8%. With liberalization and on-going sectoral reforms, Tanzania is forced to cut down public expenditure on health and education and cannot employ more teachers or more doctors. But perhaps the greatest obstacle to sustainable development is increasing mass poverty. Growing poverty in Tanzania exposes millions of people to the hazard of infectious diseases in their everyday lives. More than 40% of Tanzanians live in extreme poverty (Bagachwa 1988; World Bank, 1990; etc). Half of Tanzania's population lacks regular access to the most

needed essential drugs. Continuing population growth and rapid urbanization are forcing many city dwellers to live in overcrowded and unhygienic conditions, where lack of clean water and adequate sanitation are breeding grounds for infectious disease and ill health.

Having made extensive progress towards provision of health for all in Tanzania in the 70s and 80s during the Nyerere era, Tanzania faces a severe challenge to continue providing health services to the bulk of its population. We can without doubt learn important lessons from the legacy of the late Mwalimu J.K. Nyerere in the provision of health for all.

2. Health and Development in Tanzania: An Overview.

The death of Mwalimu Julius K. Nyerere last October at the age of 75 robbed Tanzania of its most adherent health advocate. Mwalimu Nyerere, founder and father of modern day Tanzania, dedicated the best part of his life to the service of the Tanzanian people, Africa and the world in general. One of Nyerere's greatest concerns was improving the health and general wellbeing of the people of Tanzania.

Soon after gaining independence in 1961 Mwalimu Nyerere directed his government to put special emphasis on improving health and social services. This was due to the reality that a large segment of Tanzania's population, particularly those in rural areas were poor and had only limited access to basic health services or no access at all. The few available services located mainly in urban areas were often provided in a narrow mainly curative-and-isolated manner. There was an apparent lack of proper balance among promotive, preventive, curative, rehabilitative, and sociomedical care. Most people could not afford the costs of medical care or had no access to health facilities and thus depended to a large extent on traditional medicine or at the mercy of God. Relationships with other sectors contributing to human wellbeing and with other community resources were almost non-existent. For instance, there was no relationship between health and the educational sector. All of these problems culminated in provision of poor health services and welfare of the general public.

In the immediate post-independence period, as a result of strong budgetary limitations the government concentrated on economic projects and education. In the period 1961-64 economic projects including agriculture were given 60% of the budget, while education got 15% of the budget (van Etten,

1976). Health services were only allocated 4% of the budget. The money that was allocated was aimed at improving hospital services, particularly in towns and urban areas. Rural health services had very little support from the central government.

The newly independent government under the leadership of the late Mwalimu J.K. Nyerere in recognition of the stiff challenges towards development embarked upon formulation of five-year Plans for overall socio-economic development. In the First Five-Year Plan of 1964-69 the proposals of the Titmuss Committee were accepted as the basics of policy for the health service. This called for the establishment of a countrywide system of rural health centres, each providing integrated health care and supervising a number of satellite dispensaries. The aim was to extend the health services into the rural sectors with particular emphasis on preventative aspects. But rural health services were under the control of local government and this made worse the shortage of funds for the development of the sector. During the First Five-Year Plan only 2.2 per cent of the total Central Government was allocated to health, while a small proportion of this allocation was implemented (Kilama, W. et al, 1974). Overall the results of the First Five-Year Plan were disappointing and in fact within the health sector there was no significant improvement due to the lack of resources, planning machinery and staff (Kahama, 1999). This led to re-assessment of Tanzania's development goals and new policy initiatives, which culminated in the introduction of the Arusha Declaration.

In 1967 Tanzania took a huge step towards restructuring of its economy and a new ideological approach based on the principles of socialism and self-reliance. With the introduction of the Arusha Declaration in 1967, Tanzania pursued a health policy aimed at providing equal and free access to health facilities and services to the entire population. This was indeed a bold and revolutionary step and stemmed from Mwalimu Nyerere's basic principle and conviction that improving the health and wellbeing of all Tanzanians was the way forward to sustainable development. Health care provision was aimed at reaching rural and urban communities to include the poor who could not afford the cost of health care and those who could afford to pay for their health care. Health services were provided free of charge by government institutions while voluntary agencies charged modest fees. Given the reality that over 80% of the population lived in rural areas, development of the rural health infrastructure was given high priority. Hospitals were built in each region and there was also a shifting of emphasis from curative to preventive

care. These measures allowed the majority of Tanzanians to have access to health services and improve the quality of life. For instance, by 1992 about 72% of the population lived within 5 km of a health facility and 93% lived within 10 km (URT, 1995).

Much of these achievements can to a large extent be attributed to the relentless and untiring efforts of the late Mwalimu Julius Nyerere. It is however important to point out that the road towards improved health services has been long and bumpy with a lot yet to be done to ensure that Nyerere's efforts to improve the general welfare of the Tanzanian people are not in vain. This is clear when we examine the development of the health sector during the post independence period.

3. Health policies and Progress during the Post-Arusha Period:

The Arusha Declaration of 1967 was a turning point in Tanzania's history and formed the basis of defining future development objectives. The Second Five-Year Plan (1969-74) came two years after the Arusha Declaration. In an address to Parliament convened to debate the Plan, Mwalimu Nyerere said: "The priorities have been decided upon in the light of our objectives, which are: firstly, providing an adequate and balanced diet for our people -which means health bodies" (Mwalimu J.K. Nyerere, *Introduction to the Second Five-year Development Plan*). Indeed Mwalimu's call set not only the tune for the Plan, but also for its implementation. The Second Five-Year Plan was geared towards rural development and the satisfaction of basic needs such as housing, water supply and health care. The Plan set its major goals in preventive medicine as better nutrition, better environment sanitation, better maternal and child health and better control of communicable diseases (Kilama, et. all, 1974).

With the Arusha Declaration the health sector was given a new sense of priority and direction. Allocations of the budget to health increased dramatically from Tsh. 31m ($4.3m) in the First Five-Year Plan to Tsh.93m ($13.m) in the Second Five-Year Plan. Rural health services and preventative medicine were allocated Tsh.31m in the Second Plan of which Tsh.27m was allocated to rural health centres (van Etten, 1976). The delivery of health services was to be through health centres and dispensaries, village health centres and mobile health services. The emphasis was on the expansion of health facilities and areas hitherto unreached by the government and other agencies, such as the missionaries.

Mwalimu Nyerere was indeed the driving force behind the Arusha Declaration and other development initiatives that followed thereafter. He was relentless in his efforts to ensure better welfare and improved health services for the Tanzanian population. For instance, in September 1971, at the bi-annual conference of TANU under the chairmanship of the late Mwalimu Nyerere, health service were assigned even greater priority and the need for rural development specifically directed at health services, water supplies and education was emphasized. Various steps were taken to put into effect the directives of TANU conference.

For instance, In 1972 the Ministry of Health headquarters took over national projects and was responsible for providing policy direction and overall sectoral coordination. The new consultant hospitals at Moshi and Mwanza became operational. The ministry also increased its grants-in-aid support to the voluntary agency hospitals. Meanwhile the planning and implementation of local health programmes was the responsibility of lower levels of government. There was community participation in the promotion of health services. The impressive performance by the Ministry of Health is shown in table 1 below.

Table 1: Curative Services During the 1969/1974 Development Plan

Type of Facility	1969	1970	1971	1972	1973/74	Increase Since 1970
Number of Hospitals	121	124	126	128	130	9
Number of Hospital Beds	16,400	16,940	17,990	18,300	18,600	2,200
Number of Dispensaries	1,356	1,400	1,445	1,494	1,594	238
Number of Rural Health Centres	50	69	87	100	135	85

Source: Cited from Kilama, W. et. al (1974) "Health Care Delivery in Tanzania"

P.196

As shown in the table above, there has been an increase of 2,200 beds in government hospitals during the period 1969-74. It is believed that countrywide the bed number increase was much higher, especially when the contribution by the voluntary agency hospitals is considered. The number of dispensaries and rural health centres also increased indicating significant improvement of health service facilities, particularly in rural areas.

The cornerstone of rural development in the 1970's was the establishment of Ujamaa villages. This policy, as Kahama (1999) notes, was significant in relation of health services for it meant that the

delivery of health services would be made much easier by collecting together scattered households into villages. The Arusha Declaration was the precursor to the Primary Health Care (PHC) strategy, which is the basis of the Health Public Policy.

In September 1973 at another TANU conference, Nyerere's commitment to the health sector was once again clear when he said:

> "We must determine to maintain this national policy and not again be tempted by offers of a big new hospital, with all the high running costs involved-at least until every one of our citizens has basic medical services readily available to him"(cited from Gish, 1975).

Nyerere's main concern was clearly on provision of basic health services to rural areas where the majority of the population lived. The impact of the government's efforts under the leadership of Mwalimu Nyerere to provide improved health services to the general public was slowly becoming visible. This is well illustrated in table 2 below showing the overall changes in hospital services between 954 the year TANU was born, 1961 the year Tanzania won her independence and 1972, five years after the Arusha Declaration.

Table 2: Curative Services in 1954, 1961 and 1972 Compared.

Type of Facility or personnel	1954	1961	1972
No. of Hospital (Govt. + V. A)	86	98	128
No. of Hospital Beds.	8,395	11,166	18,213
No. of Rural Health Centres.	-	22	100
No. of Rural Dispensaries.	764	975	1,594
No. of Citizen Doctors. (i)Registered. (ii)Licenced	29 2 27	44 12 32	335 195 140
No. of Medical Assistants	130	200	335
No. of Rural Medical Aids	200	380	578

*Figures are as at 31st December of each year shown.
Source: Cited from Kilama, W. et. al (1974) "Health Care Delivery in Tanzania" p.197.

Table 2 above further indicates a rapid increase in the provision of health services in the country between 1954 and 1972. There was rapid increase in the number of hospitals, rural health centres and dispensaries as well as in the number of medical personnel. This progress continued during the 1970's and early 1980's.

The Government's efforts through The Second Five-Year Development Plan 1969-74 and Third - Five Year Development Plan 1975-80 were most favourable to the Ministry of Health. They were indeed people oriented. These Plans, which came after the Arusha Declaration, were aimed at bringing benefit to

all. The Central Government would cater for such rural based health facilities as dispensaries and rural health centres.

The period from 1969 - to the mid 80s thus witnessed further progress in the provision of essential health care for the Tanzanian population. A study in 1972 found that 50% of the outpatients at a government hospital and 37% at a private hospital traveled less than 9 miles. They went even shorter distances to get to health centres which provided more basic facilities, with 50% of heath centre patients travelling less than 5 miles and another 30% travelling between 5 and 10 copies (Gish 1975). The percentage of pregnant women visiting modern hospitals or clinics rose from 33% in 1961 to 67% in 1970 (Akin 1992). By 1980 it was estimated that 72% of the total population lived within 5 km of the nearest health facility (Matomora 1989). A UNICEF study in 1980 found that of the total population, 76% had access to health services (defined as within one hour by public transport), and now 99% of the urban population and 72% of the rural population have such access (UNICEF 1991).

National health education programme such as "Mtu Ni Afya" (man is health) and "chakula ni uhai" (food is life) were launched through the media and through community discussion groups. These were aimed at improving health through increased awareness and through self-help measures such as building latrines and mosquito control. These programs seem to have been relatively successful in increasing public awareness and leading to some change in behaviour.

From the above one can not fail to observe that the decade of the 1970s was one of great successes for the health sector in Tanzania. The 1980s were different. Tanzania got into serious economic difficulties, which in turn had a devastating impact on the provision of health services in the country. Lack of resources and sufficient investment in the health sector as well as lack of dynamic policies led to unsustainability of the health sector. Todate provision of essential health services remains inadequate and often poor health in most parts of the country. We have to take a critical look at existing health policies and attempt to find new methods of providing an equitable and efficient system of health care. From the Nyerere era we saw successful attempts to provide an equitable system of health services which gave emphasis to rural areas and was based on the principle that health was a basic right. This is an important lesson that can be built upon in the twenty first century. We also note that the health system was not very efficient and was characterized by mismanagement and bureaucratic tendencies. This evidenced by the

number of long queues at hospitals, lack of essential medicine in hospitals while there are pileups at government health stores and huge administrative costs. These mistakes must be avoided and the aim must be to establish an efficient health system that is still geared towards providing health services to all. This is of the utmost importance as provision of health services is slowly becoming a privilege for those who can afford to pay.

4. Present State of Health and Challenges in Tanzania.

The gains of the 70s and 80s in the provision of essential health services to all are in danger of being eroded in the twenty-first century. The present health situation in the country leaves much to be desired. Health in Tanzania is best reflected by the situation of women and children. About 200,000 children under five die every year from preventable diseases in combination with malnutrition. The 1996 TDHS survey indicates that diarrhoeal and respiratory illness are common causes of child death. In the two weeks before the 1996 TDHS survey, 14 percent of children suffered diarrhoea and 13 per cent were ill with acute respiratory infections (ARI). Pneumonia kills about 38,000 children each year. This is generally a result of poor living conditions and lack of essential health services. Malnutrition is yet another scourge causing illness causing illness and death not only among children but also among the adult population. 43 percent of Tanzanian children under five are classified as stunted (low height- for - age) and 18 percent are severely stunted. Seven percent of children under five are wasted (low weight-for-height); 1 percent are severely wasted (TDHS, 1997). Most malnutrition is caused by not so much by lack of food as by repeated infections which burn up calories, depress the appetite, drain away nutrients in vomiting or diarrhoea. The observation has been made that very few children die from measles alone or even from respiratory infections or dehydration alone. They die from the sheer frequency of the assaults on their growth during their most vulnerable years. Each infection whether it is measles or diarrhoea or whooping cough, lowers the child's nutritional status, and leaves the child weaker and more susceptible to further infection.

What is noticeable from the above data is the poor state of health, particularly the health of women and children. A major reason has been the inability to continue sustaining existing health facilities due to lack of resources and poor management. Today most government hospitals and dispensaries are

characterized by rundown buildings, lack of essential drugs and medical personnel. The economy has been performing badly since the early 80s and the health sector was one of the most affected sectors. Even with the introduction of structural adjustment programmes that were introduced to rescue the economy, the health sector remains in poor shape. The share for the budget as a percentage of the total government budget fell continuously from 7.1% in 1977/78 to 3% in 1984/85. This trend was reversed after 1993/94 with a sharp increase as indicated in table 3 below.

Table 3: Total Government Expenditure and Health sector Expenditure as % of Government Expenditure, 1977/78 - 1996/97.

Year	Govt. Expenditure Mill. Tshs.	Health Expenditure Mill. Tshs	Health %
1977/78	8894.1	669.2	7.5
1978/79	13035.4	688.0	5.5
1979/80	13969.9	720.6	5.1
1980/81	15320.0	791.7	5.2
1981/82	18399.1	992.1	5.4
1982/83	20017.0	1037.8	5.2
1983/84	21460.9	1170.8	5.4
1984/85	26720.0	1328.7	4.9
1985/86	33219.3	2446.3	7.7
1986/87	51142.1	2122.6	4.3
1987/88	76911.5	3908.9	3.9
1988/89	78911.5	3908.9	3.9
1989/90	112284.8	6998.4	5.9
1990/91	143812.3	8561.6	4.9
1991/92	173107.1	8561.6	4.9
1992/93	220706.6	9763.7	4.4
1993/94	349738.0	39803.0	11.4
1994/95	361239.0	42024.0	11.6
1995/96	371183.0	44923.0	12.1
1996/97	38764.0	47589.0	12.3

Source: MOH, 1998.

Total government expenditure on health remains inadequate thus limiting the provision of health services to the general public. To make matters even worse, most of the government budget went mostly to curative services in the form of health service facilities. Table 4 below shows the situation of health facilities in Tanzania in 1996.

Table 4: Health Facilities in Tanzania, 1996.

	Government	Voluntary Agencies	Parastatal	Private	Total
Hospital	66	38	8	48	205
Health Centres	273	16	11	18	318
Dispensaries	2,303	675	185	1,224	4,387
Total	2,642	774	204	1,290	4,910

Source: MOH, **Health Statistics Abstracts 1997**, p.88.

The actors in the first two decades of independence in the provision of health services were the government, voluntary agencies (Vas), mainly Christian mission hospitals, local governments (dispensaries and health Centres) and some private practitioners especially in the urban areas. The emphasis was the expansion of health facilities and services to areas hitherto unreached by the government and other agencies, such as the missionaries.

By 1996 the direction of the Ministry of Health (MOH) was for cost sharing and increasing the role of the private sector. This is indicated in the health sector reforms, which among other things introduced a Plan of Action. The Plan of Action (1996-99) of May 1996 states that the national budget will be increased to at least 14% and reformulated to support cost-effective health packages. It also states that cost sharing will be extended to the health center and dispensary levels, and communities would be expected to take full responsibility for financing their health services through formal and informal risk pooling mechanisms e.g. community Health Fund[1]. The vision of the government of Tanzania after the reforms is of a health sector, which is efficiently managed, well organized and restructured. It is expected that the required drugs and medical supplies will be available at all health facilities for a reasonable price. It is also expected that a sustainable health financing would have evolved and that the health workforce would be motivated and productive (HSR Plan of Action, 1996, p. 1).

The vision is sound but the problematic is whether the reforms would adequately confront the entrenched weaknesses in the heath sector without marginalising from health services large sections of the Tanzania's population. From present day evidence, the health sector reforms appear to be marginalising an increasing number of people, particularly the poor and other disadvantaged groups. There are no adequate

[1] MOH, **Health Sector Reform Plan of Action**, 1996-1999 p. v.

safety nets to ensure that the most vulnerable have access to essential health services.

From the above one can conclude that the provision of health services remains a major challenge. Problems of providing essential health services have become even more difficult in the present era of rapid economic and social change. This makes it more imperative to learn from our past successes and failures in the health sector.

In order to successfully address the increasing health problems facing the country it is first necessary to identify key obstacles facing the health sector and to draw lessons from the past.

5. Obstacles and Lessons Learnt in the Provision of Health services in Tanzania.

In its efforts to improve health care for its population the government is still struggling to setup basic health facilities in the form of hospitals, dispensaries and health centers in all districts of the country. The government is also encouraging the private sector to provide essential health care to the Tanzania population. All these steps have to be critically examined to determine the extent to which they can contribute to addressing the problems facing the health sector.

The biggest obstacle hindering the provision of essential health services is without doubt poverty, which is widespread in both rural and urban areas. The WHO report of 1995 correctly points out that the world's biggest killer and the greatest cause of ill-health and suffering across the globe is listed almost at the end of the International Classification of Diseases. It is given the code Z59.5 - extreme poverty.

The late Mwalimu Julius K. Nyerere had no doubt about the seriousness of the poverty problem and its impact on the health of the Tanzanian population, particularly children. Nyerere notes that in 1997, 46% of Tanzania's Debt was owed to Bilateral (or Paris Club) Creditors; and 37% to Multilateral Financial Institutions, basically the IMF, the World Bank and the African Development Bank; and 10% to the non-Paris Club Creditors. Debt Service payments falling due in 1997 amounted to US $275 million or 35% of total export earnings of Tanzania. Nyerere correctly observes that the price Tanzania pays in trying to

service this debt is very heavy[2].

Even after retiring as head of State in 1985 Nyerere continued to advance the case for equitable distribution of resources that would lead to better welfare of the African people. To every audience he spoke he put the question: DO WE HAVE TO STARVE OUR CHILDREN IN ORDER TO SERVICE OUR DEBT? It is clear that to Mwalimu, debt was a health issue. The lesson that we must learn from this is that No discussion of health in Tanzania and Africa in general can neglect the variety of ways debt has been translated into higher food prices, poorer medical services and worsening health. Nyerere points to The United Nations estimates that indicate that because of paying debts, 19,000 children are dying every day in Africa alone. Money, which according to Mwalimu Nyerere, should be spent on health care, education and poverty eradication is eaten up by debt repayments. UNICEF has calculated that a sum of US $ 9 billion additional investments in Social Development in Sub-Saharan Africa (where most of HIPCs are) would save the lives of 21 million people. And that is only a fraction of the 13billion US dollars, which that region pays out annually to service debt.

The transition from socialism to multi party democracy and a market economy is proving more difficult and costly than any one imagined. The costs have been not only economic, from the dramatic decline in GDP. They have also been human, from falling wages, growing crime and loss of social protection. The health sector has been one of the most affected.

Economic hardships as a result of slow economic growth and social sector spending cuts as a result of SAPs have also had a significant impact on the health of the general population in Tanzania. With declining incomes, many families are unable to provide basic necessities of live including food and health care The hardest hit have been women and children. The Gender Profile of Tanzania states that costs of medical care for Malaria at a low cost Private hospital and pharmacy are equivalent to nearly half of a monthly wage (TGNP, 1993). This implies that many people are unable to go to hospital for treatment. Malaria now kills more than one million people every year in Tanzania the majority being children (MOH, 1999).

The impact of dwindling economic resources and poverty on the health of people has been devastating. For Instance, about 52 per cent of pregnant women suffer from protein/energy malnutrition.

[2] Address by Mwalimu J.K. Nyerere, to the Jubilee 2000 Rally in Hamburg, Germany, 27 April 1999.

Tanzania women are 200 times more likely to die as a result of childbearing in their lifetime than women in the North. More and more children are going hungry and suffer from malnutrition.

The major result of the economic crisis to the health sector has been the introduction of patient user charges in an attempt to recover costs. This policy of cost recovery has been fairly controversial as it goes so strongly against all that Tanzania has held to be so important. The key aspect that health is a basic right for all appears to have been cast aside in the midst of the on-going health sector reforms. The existing situation forces us to look again at existing policies and to find sustainable methods of providing an equitable and efficient system of health care. This includes amongst other things, finding ways of improving working conditions of health personnel in the health sector. Rapid inflation meant that medical staff were no longer able to survive on their salaries. This forced many to take on other jobs or leave the health sector entirely. Existing health facilities are in poor shape. Today when a woman delivers in most government hospitals, her family has to find money to buy all the drugs, dressings and things she may need. Due to the shortage of virtually all-essential drugs and materials from hospitals, these must be purchased from private pharmacies.

One of the most visible outcomes of the on-going sector health reforms has been the growth of the private sector. The 1990s have been characterized by the emergence of private hospitals, dispensaries and pharmacies. There is little doubt that private health care has helped relieve the government of the burden of provision of health services. An increasing number of people who are able to pay are now receiving medical care from the private sector and it appears certain that in future the private sector will provide the bulk of essential health services in the country. While the growth of the private sector continues unabated the government is rapidly shedding its responsibility as the principal provider of health services in the country. The growth of the private sector has been accompanied by a number of serious problems that further hinder the provision of basic health services to the general public. There is increasing evidence to suggest that the growth of the private sector has contributed to the decline of government health services. An increasing number of doctors, nurses and other medical personnel are moving from the public sector in favour of the private sector. Government hospitals are also becoming empty of drugs and other essential health facilities, which usually appear to find their way to the private hospitals and dispensaries. These private practitioners are even more urban-biased than government medical services. In addition,

doubts have been expressed about the quality of service available in circumstances where the urban and rural poor have few alternatives. Government health workers who remain in government employment put in short hours at government facilities in order to make ends meet by working outside in the private sector. Rising prices being charged by the private health facilities tend to exclude more and more people. Many hospitals, dispensaries and pharmacies are being established and run without regard to laid down regulations and guidelines. Health facilities are being built at random in any location and without any regard to standards. Some are without basic equipment while some don't even have toilets or running water. The qualifications of some of the medical personnel employed in these private health facilities are at best questionable. But perhaps most important problem of the private sector is linked to treatment of patients. There is a tendency prescribe drugs and services that are not necessary but is profitable and Misdiagnosis and overdoses are very frequent. Some of the drugs in some of the private health facilities are out of date or in poor storage conditions. The situation in the private sector is clearly one of great concern as there appears to be lack of coherent policies or guidelines to oversee the private sector. Poor implementation of even existing policies and lack of direction has resulted in an out of control private sector that appears to take advantage of the plight of an increasing number of people in need of health care. The overall state of the health sector is thus in urgent need of reforms to improve the quality of health services.

6. The Road Ahead.

We have noted that Man-Centered approach to development was the cornerstone of Nyerere's legacy. This is evidenced by his consistent commitment to improving the health and welfare of all Tanzanians even after he had retired from public office. At his 75th birthday party Mwalimu once again showed his concern for the continued poor health of the majority of Tanzanians, particularly children. He questioned why young children under the age of five should continue to die for lack of essential health services. This concern for improving the health of the general public must continue even in the face of increasing economic hardship and the dominance of the free market economy. Health care services must be aimed at improving the development of society and development must lead to better health for all. This is an important lesson that we must learn and carry forward from the Nyerere legacy. This requires firm

commitment and dedication from those who have taken over from where Mwalimu Nyerere left of to ensure that health remains a basic right.

In order to improve health services in Tanzania the economy must grow to meet the needs of a rapidly increasing population. Mwalimu Nyerere's achievements in the health sector were hindered as a result of a persistent economic crisis and inability to manage the economy. An important lesson that we can learn from this is the necessity of linking development of the health sector to overall economic and social development. There can be no sustained health improvement without economic and social development. Similarly, there can be no sustainable economic development without significant improvement of the health of the general public. If for instance, we are to improve maternal and child health care, we must ensure that wider concerns of women and children are addressed. These include domestic violence, rape and gender inequalities, which exclude women from becoming equal partners in the development process.

We need to critically examine the proposals for the financing of the health sector and look at what the implications of this may be on the public. While the current thrust is towards the public contributing more and more to towards health care and health facilities becoming self sustaining, necessary safeguards must be put in place to protect the poor and other disadvantaged groups. This will help keep alive Mwalimu Nyerere's ideal of a fair and just society with health as a basic right for all members of society. The era of structural adjustment has led to a severe decrease in public financing of health care in Tanzania. Efforts must be made to diversify sources of funding for the health sector. For instance, some of the taxes being collected can be re-invested in the health sector.

The government has to ensure that health facilities continue to go to rural areas. Mwalimu Nyerere was able to identify rural areas as a dynamic source for development. We can build on this by investing in the rural sector and to promote health. The existing situation where most of the funds tend to be spent on urban-based clinical services for a small elite must be addressed. Despite the rhetoric in favor of primary health care, expenditures on rural and preventive services continue to lag. This is now the time to learn important lessons from the Nyerere era in regard to provision of essential health care.

In view of the above, Nyerere's philosophy of equality for all needs to be revisited. The implementation of cost-sharing schemes has not attained the proposed goals of protection of equity and

basic needs. The fee-for-service system is increasingly denying service to the poorest citizens. The poor and disadvantaged are slowly being excluded from health care and this can only spell disaster, as the majority of Tanzania's population are poor.

Tanzania has a long and proud history in the provision of essential health care to its public. The on-going health sector reforms are in danger of reversing past achievements. The major lesson that we must learn and emphasize at every juncture is that health is a basic right for all. From this arises the necessity of the government to continue to be the main health provider and spear head the struggle towards improved health services, which will in turn help in addressing outstanding challenges and problems. These include:

(a) The emergence and rapid spread of AIDS poses a special health problem. Even the modest gains made over the past there decades are likely to be reversed in the next few years if the epidemic continues to spread at current rates.

(b) The recent introduction of cost sharing has created accessibility problems for some sections of the population, especially the poor who are estimated to make up about 50percent of the population .

(c) Lack of awareness of the causes of some health problems is a major challenge. Most problems could be eliminated if the people were adequately informed about their causes.

The above problems and challenges have to be addressed under difficult conditions. The quality and availability of health services in the country are severely constrained by shortages of medical supplies and equipment. This is another sensitive area. Whoever dominates this sub-sector dominates the entire sector. For many years, this has been the domain of DANIDA. In this area, the government should take measures to phase out dependence and regain control. The government should allocate enough funds for drugs but it should also encourage private importation for private buying. In addition, the government should regulate health care so that the public can be assured that private providers will high quality, affordable and accessible health care.

We have noted that health facilities are in poor physical condition. Buildings are decaying, water and electrical supplies are out of order, and sanitation measures are often non-functional. This makes for

unpleasant and unhealthy working conditions for staff and adversely affects the quality of services received by patients. Necessary steps to tackle these problems include increased investment in health, better management of resources and motivation for staff. Besides the government, local participation is also very important to rectify the situation.

Priority should be given to Primary Health Care facilities that provide greater access to the population. As the majority of the population live in rural areas these facilities must be situated in rural areas. The fact that primary health care will continue to be the main strategy means that the major source of financing will be the public sector.

As a short and long-term measure, the health sector should have people at district and regional levels who appreciate data collection, and are able to analyze it and to make it usable at these levels. General health ducation, which is currently underplayed, must be effectively promoted.

Community participation is very important. Households and communities determine behaviours and make key decisions about the use of health services. Any sustainable initiative in health services must therefore respond to their needs. This includes setting priorities, planning and managing health services.

An important component of any strategy to improve the quality and impact of health care must reach beyond the health authorities: a multi-sectoral approach is needed. It is therefore important for the health sector to augment communications with those in other sectors, taking advantage of the commonality of their goals by sharing ideas and possibly resources. This is particularly important during the planning, monitoring and evaluation stages.

7. The Need to Revisit the Concept of Self-reliance.

The Party under the leadership of the late J.K. Nyerere put great emphasis on self-reliance, an important feature of "Another Development in Health". Mwalimu clarified the concept.

"Self-reliance is not some vague political slogan… Self-reliance is a positive affirmation that we shall depend upon ourselves for the development of Tanzania, and that we shall use the resources we have for the purpose, not just sit back and complain because there are other things we do not have… We are saying: "This is the amount of knowledge, skill and experience we have; and this is the amount of money we have for supplementing our skill and knowledge or for buying more advanced machines. Now let us get

on with it. And we are saying to other people: "This is what we are doing; if you want to help us, do this and this, for that is what we need most at this stage.

The on-going health sector reforms have to be carried out in the spirit of trying to be self reliant and able to define our needs in the field of health.

The emphasis that Nyerere put on smaller health units, medical auxiliaries, self-help, control of health expenditure, community involvement and mass mobilization through campaigns such as Mtu ni Afya ("Man should be healthy") 'are in line with' the stated policy of self-reliance. They can be built upon particularly in this era of structural adjustment and the dominance of the free market economy. However, we are a long way from achieving self-reliance in the health sector. We must do much more. In particular, we must find appropriate technology that enables us to fully utilize all the health resources in the country.

Nyerere's philosophy on human development leads us to conclude that in order to serve mankind there must be a social organization of economic activities which is conductive to the greater production of things useful for the material and spiritual welfare of man. Sadly Mwalimu Nyerere was not able to put in operation such a social organization. It is our responsibility, particularly those in power to do so that Nyerere's cherished dream of health for all will become a reality in the twenty-first century and beyond.

8. Concluding Remarks: Beyond Health Care.

The government including its political and administrative leaders must increasingly see that health promotion does indeed go beyond the health care system. The government must re-affirm their commitment to put health on the agenda of policy-makers by direct actions that demonstrate are aimed at providing health for all. The late Mwalimu Nyerere realized that equity between population groups is much more likely to be fostered through coordinated health, social and income polices. The present government must do the same so that the impact of liberalization and the free market economy do not prevail in the provision of health services in Tanzania.

While the world is rapidly losing sight of its priority to reduce poverty through better health and foster development by fighting disease, Nyerere's legacy on health remains a burning candle of hope for Tanzania and the world. The late Mwalimu Nyerere recognized health problems as a common threat to mankind and that the way forward for sustainable development lay in provision of better health services to all.

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