

ECONOMIC AND SOCIAL RESEARCH FOUNDATION (ESRF)

**THE STATE OF TANZANIA'S SOCIAL SECTOR IN
THE DEVELOPMENT CONTEXT**

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1.0 Introduction

The Government has a long enduring history of progress in the social sector, and a recognition that the country's development depends on the welfare of the citizenry. From independence, delivery of a wide range of social services has been considered as the government's responsibility and policy makers have sought to extend health, education, water and other social services to the largely rural population of the country. Given the low-income levels of most Tanzanians, the government has provided services at no direct charge.

Bilateral and multilateral donors have played an important role in the development of Tanzania's social service infrastructure. A significant part of the capital for construction of service delivery points (dispensaries, health centres, primary schools and water systems) has come from external sources. In addition, some basic inputs such as essential drugs for rural health units and primary school textbooks have been provided by donor agencies. Both short and long-term technical assistance has been offered as managerial and technical support for social services. Non-governmental organizations particularly churches, have also contributed to the development of social services in Tanzania. For example, religious missions have supplemented government services with hospitals, dispensaries and schools in many parts of the country. Through the efforts of the government, donors and non-governmental organizations, significant strides were made in the social sectors in the 1960s and 1970s. However, systems of social service delivery that worked well in those early years were eroded in the 1980s and 1990s.

This paper assesses the state of Tanzania's social sector in the context of development. It summarizes background information on conditions in the social sector within a historical context, reviews trends during the last decade, identifies key policy issues and their implications on key sectors, projects the future of the Tanzania social sector and finally outlines areas that need intervention by development actors including churches.

2.0 Evolution of the Social Sectors in Tanzania.

This section describes the two earlier phases that characterized the supply of social services in Tanzania after independence.

2.1 Independence to the Early 1980s

At independence in 1961, Tanzania inherited a colonial economic and public sector structure. The country declared war on the nation's three archenemies; poverty, ignorance and diseases. At that time, the health system consisted of a few hospitals and private doctors in urban areas, and religious mission services and traditional healers in rural areas. The education system was stratified by racial categories (African, Asian and White), and the quality and accessibility of African schools were relatively poor. In the water sector, most households (particularly rural) obtained water from natural sources.

Recognizing fundamental inadequacies in the colonial system, and the vast needs of the population and the economy, the government sought to increase access to basic health, education and other social services. Much of this was done with the help of bilateral donors willing to assist the newly independent country. The government's approach was to provide both basic and complex social services to the full population, financing the services using tax revenues and donor support. Hence, the services were provided at no charges to the users. This general approach was interpreted within each sector.

Education

The government was the primary provider of education services from primary through secondary, tertiary and vocational. Private and missionary schools were nationalized. Primary education was to be universally available, compulsory and affordable to the poorest households. The curriculum and structure was oriented to rural life. The government tried to increase the equity of admission into the limited secondary schools through a quota system that gave preferential treatment to certain disadvantaged groups (e.g. children from disadvantaged districts, girls e.t.c).

Expansion of the education system was very rapid. Both the enrollees in primary schools and the number of education sector workers increased by nearly four-fold during the 1970s. The majority of the primary schools now in operation were constructed during the 1970s, allowing each village to have its own primary school (URT, 1994). Most of the teacher training colleges now in operation were also opened during that period. Secondary school enrolments expanded at a much lower pace. This was due to deliberate rationing of secondary schooling as part of the governments effort to attain universal literacy and co-ordinate outputs from the educational system with the nation's manpower requirements.

Health

The government took the responsibility for meeting the population's health service needs. Much of the private medical sector was outlawed or nationalized. Services were made available at no charges to patients and were mainly directed towards the rural areas and towards basic health needs, as defined under Primary Health Care. This included family planning services integrated with maternal and child health. At the base of the pyramid and close to the village were rural dispensaries and health centres, while at the apex were consultant hospitals in large cities. The country tried to invest to attain self-sufficiency in all types of medical and paramedical personnel.

The number of government operated rural health centres more than tripled between 1969 and 1978, and the number of dispensaries doubled. Most of the institutions currently training health personnel were opened during that period, and large numbers of rural medical aides, medical assistants, medical officers and nurses were trained and deployed to the rural areas. As a result, the number of doctors increased more than three-folds and the number of medical assistants, rural medical aides, and health assistants increased by a factor of 10. This

expansion allowed about 90 percent of the population to be within 10 kilometres of a health facility, and nearly three-quarter to be within 5 kilometres of public health services (URT, 1994).

Water

The government instituted a policy of free water supply in the rural areas, in which users were not required to pay for services provided. The aim was to provide the rural population with clean, potable, dependable water supplies within 400 meters of the households. All water supply investments were financed by the government with substantial material and technical assistance from donor agencies. Construction of water systems was based on “Regional Water Master Plans” which typically projected water system construction and the “optimal” domestic and agricultural use of all water resources over a 20-year time horizon.

Water systems expanded greatly during the 1970s. Under the “Regional Water Master Plans” donor-financed blueprints for improved water schemes were created in nearly all regions, and large-scale construction was initiated. The proportion of the population with access to improved water sources increased from 12 to 47 percent. As the water sector picked up momentum, similar centrally planned activities were initiated to expand access to sanitary facilities, and in 1973 the government introduced the “latrinization” campaign, which required households to have and use a latrine.

2.2 The Crises Era (1980s)

The impressive investments and accomplishments of the 1970s could not be sustained through the 1980s. The government encountered difficulties in financing and managing the social services that had been put in place and at the same time the expectations of the population increased. By the end of the decade (1980s), the system that had promised rapid improvement in human welfare, failed to meet its ambitious coverage targets, and progress towards improved outcomes was lagging. Problems that emerged in the delivery of social services can be grouped into two categories; supply-side conditions and demand side conditions.

Supply-Side Conditions

First, the recurrent cost burden following large capital investments in health, education and water services, and training of large numbers of personnel was enormous. While donors had been willing and able to finance much of the capital costs of developing the infrastructure, financing of the recurrent costs was largely left to the Tanzanian government, which in turn depended on too small a tax base. Overextension of the health, education and water systems was compounded with rapid increases in the costs of imported materials, financial demands of other sectors, unfavourable international trading conditions and an overall decline in growth of the economy. Numerous resources also went into the war with Uganda and to offset the impact of the oil crises and the collapse of the East African Community (EAC).

Secondly, the capacity to manage the vast networks of water systems, health facilities, schools and associated staff and cope with supply requirements was limited. Things were made more difficult by the poor transportation and communication network in rural areas. There was also lack of co-ordination and changing lines of responsibility and authority between central and local governments, which were re-instituted in 1983 after having been abolished a decade earlier. Standard plans and norms established on a national basis by ministries in Dar es Salaam were to be implemented by local governments, though the local administrations had few financing alternatives and their management capacity was limited.

Thirdly, inadequate co-ordination of donor efforts sometimes led to a situation in which some donor funded vertical programmes, were not in line with core supervisory and service delivery functions in the health sector. External technical assistance in some sectors (especially water) was poorly integrated into the government's existing structure, and little indigenous capacity was built to maintain the systems after the termination of consultant contracts. Donor resources also dwindled in the early to mid-1980s pending government agreement with International Financial Institutions on the reforms to be instituted.

Demand Side Conditions

The Tanzanian population grew by 2.8 percent annually during the 1980s (Economic Surveys). Population growth alone placed increasing pressure on the government's ability to deliver social services. Graduates from the first Universal Primary Education cohort, placed severe pressure on the tightly constrained number of places in secondary schools. In part, the government deliberately raised the expectations of the people for social services delivery through "villagization programme". Also, with successes in the social sectors, incomes rose and so did expectations about what the government would provide. The remarkable rise in living standards in the first 15 years of independence (with a population that had begun to dress better, improved eating standards, higher consumer spending, better public transport, universal primary education and improved supply of water) came with new expectations and demands for greater state expenditure to satisfy appetites.

As a result of the severe financial pressure and inherent inflexibility in the structure of social service delivery, the quality of services declined drastically. The government was not able to do much to improve the situation in the 1980s, in face of the economic crises that prevailed. Without altering the fundamental definition of the government's role and near monopoly position in social service delivery, policy makers attempted to stretch shrinking resources over expanding needs but failed.

3.0 Trends in Social Sectors in the 1990s

The stresses placed on the system of social service delivery, and the inability of the system to adapt to those stresses during the 1980s can be seen in the health, education and other outcomes during the 1990s. While enrolments in primary schools declined, basic health

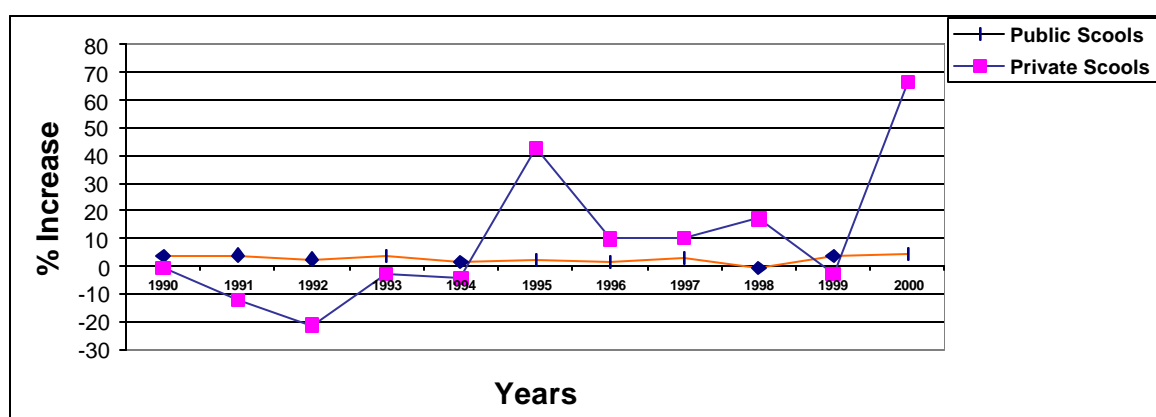
conditions including those related to water supplies and nutrition leaves much to be desired. The AIDS pandemic brought new critical problems. Population growth and high levels of fertility persisted. This section describes trends in key social sectors in the 1990s.

2.2 Education¹

The State of Primary Education

During the 1990s, the decline in the gross and net school enrolment ratios, the extremely low pass rates at primary school leaving level, the exceptionally low intake at secondary and university levels, the large number of unqualified teachers in classrooms, the appalling physical state of many schools and weaknesses in management and leadership in the sector have combined to create a genuine crises in Tanzania's educational system. Figures 1, 2, 3 and 4 show some of the basic statistics underlying the state of primary education.

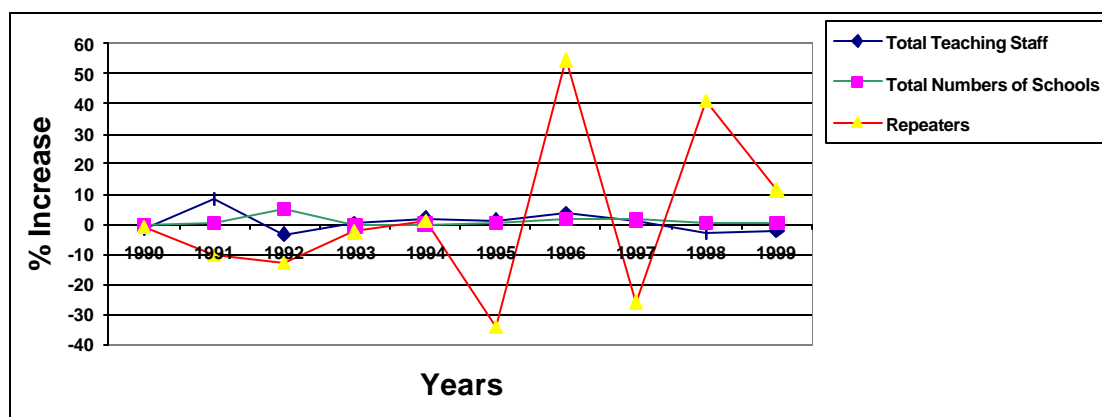
Figure 1: Enrolment Rate (% Increase) in Primary Schools, 1990 – 2000



Source: MOEC, Various Years

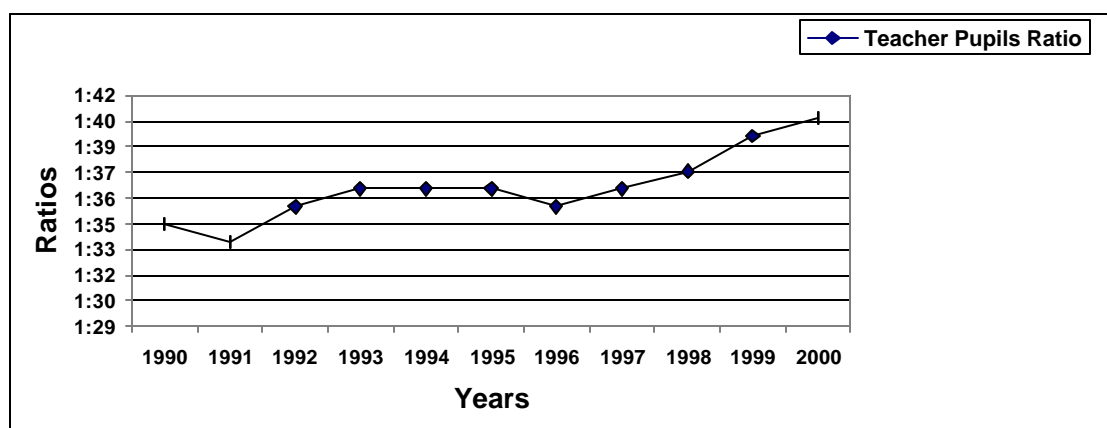
¹ Unless otherwise noted statistics in this section are from MOEC, *Basic Statistics in Education 1990-2000*.

Figure 2: Primary Education – Teaching Staff, Number of Schools and Repeaters (% Increase)



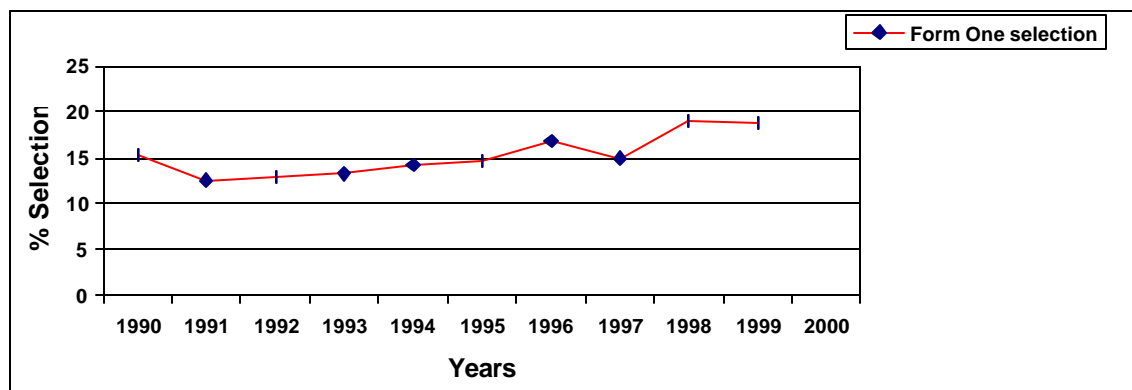
Source: MOEC, Various Years

Figure 3: Primary School Teacher/Pupil Ratios



Source: MOEC, Various Years

Figure 4: Form One Selection (% Increase)



Source: MOEC, Various Years

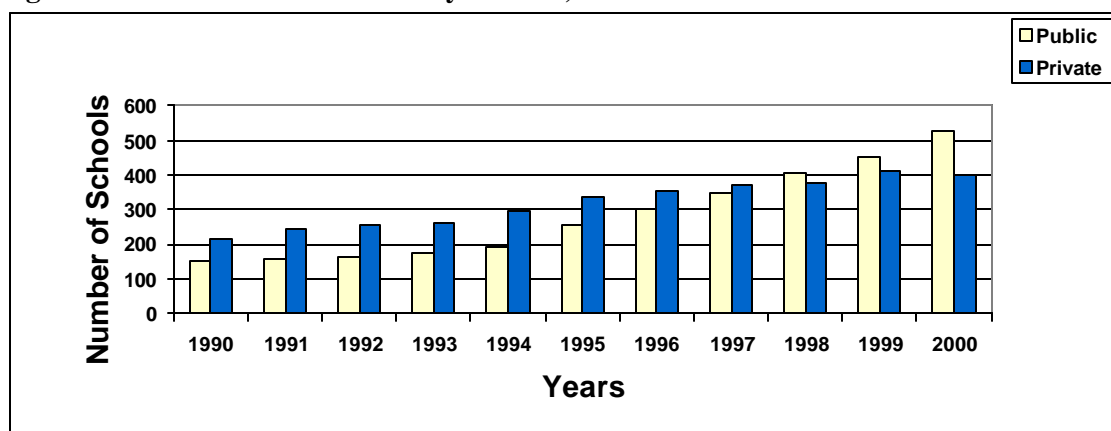
Unfortunately, enrolment rates say very little about the quality of learning and impact of schooling on Tanzania's children. These statistics only convey an impersonal aggregate impression of primary education and not the despair of parents, children and educators over the collective inability of the country to provide a reasonable standard of basic education to the youth.

In co-operation with UNICEF, In 1998, the Ministry of Education and Culture (MOEC) carried out school mapping surveys to better understand the state of primary education and to assist in school location planning, initially in ten of Tanzania's 123 districts. These provide a grass root view of the extent and depth of the primary education problem in Tanzania. The surveys of Kyela, Morogoro and Serengeti districts revealed that schools do not have clean water, and hygiene was not taught. Parental participation was limited to disciplinary problems. Most of the schools had not switched to new curriculum adopted in 1992 as of July 1998. Absenteeism was high and 12 percent of the children walk more than 6 km a day to and from school. Textbooks were only available to a very small proportion of the children.

The State of Secondary Education²

Secondary education suffers from problems of quantity, quality, access and participation. Figure 5, and 6 show some of the basic trends underlying the state of secondary education in Tanzania since 1990.

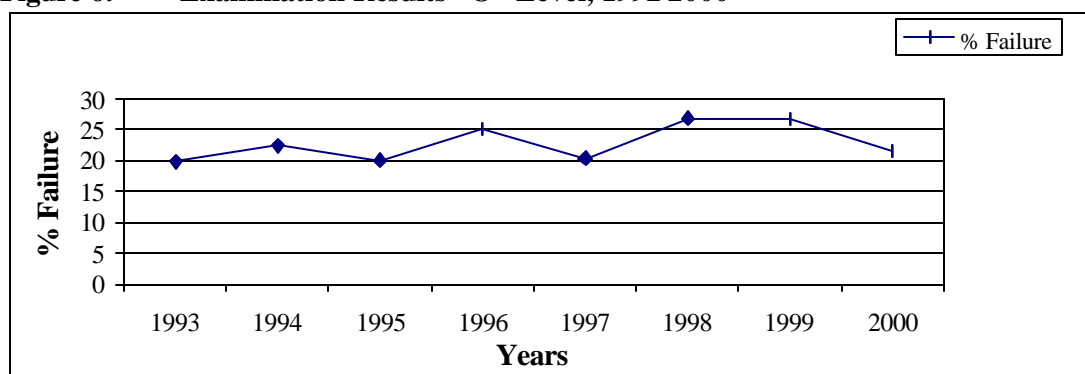
Figure 5: Number of Secondary Schools, 1990-2000



Source: MOEC, Various Years

² While most of the statistics were obtained from MOEC, other information has been drawn from Secondary Education Master Plan 1999-2000, the Education Sector Development Programme (ESDP) appraisal of March 1999, the Medium Term Expenditure Framework for 1999-2000 and the MOEC/UNICEF school-mapping project.

Figure 6: Examination Results “O” Level, 1992-2000



Source: MOEC, Various Years

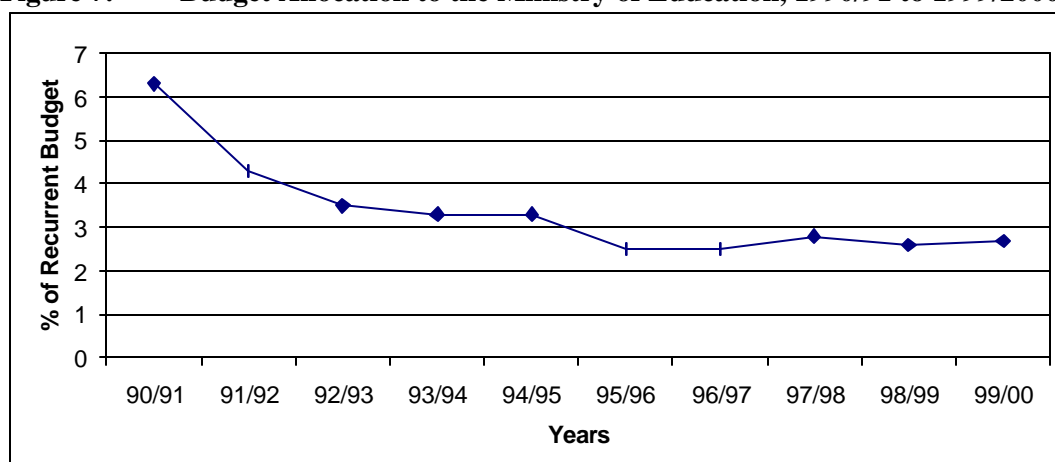
Although secondary enrolment doubled from 1988 to 1998 (from 118,810 to 226,903 in forms I-IV), the gross enrolment rate is just 5% compared to Kenya, which is 26%, Zambia 28% and Zimbabwe 44%. The transition rate from primary to secondary levels is 18% compared to 53% for Kenya and 29% for Uganda. This suggests that Tanzania is unable to enrol the great majority of primary school leavers. The transition from Form IV to Form VI is also very competitive, with about 21-25% of students entering Form V and about 20% of this group entering University.

Poor language instruction at primary level results in a much-reduced learning capacity among secondary school pupils, whose language of instruction switches from Swahili to English in Form I. The use of unqualified teachers also has a major impact on quality. Of 6,292 public secondary school teachers in 1998, only 13% were graduates while 23% of private secondary school teachers were graduates. In addition, school libraries lack even basic textbooks. Only 25% of public secondary schools have received any maintenance in the past 15 years. Also instructional materials are in short supply and the curriculum needs a thorough review. Not surprising, the results of secondary education are disappointing and the majority of students who do not continue to tertiary level are ill equipped for the world of work.

Girls represent 45% of lower secondary and 44% of teacher training college students. However, the enrolment declines rapidly in Form V to 32%. The secondary Education Master Plan (SEMP) does not mention disabled students or the growing number of students infected with HIV/AIDS. While there are specialized institutions for some disabled students, no mention has been found of their relationship to mainstream schools or what efforts are being made to co-ordinate their activities and move some disabled students into regular schools.

There has been a decline in the government budget to the education sector (Figure 7). During the entire second half of the decade, recurrent budget allocation to the sector has been less than 3% of the total recurrent budget.

Figure 7: Budget Allocation to the Ministry of Education, 1990/91 to 1999/2000



Source: MOEC, Various Years

3.2 Health

The health situation through the 1990s leaves much to be desired. Access to health services was low due to limited facilities (infrastructure and equipment), low availability of essential drugs, and limited number of personnel. This situation affected all levels of delivery (i.e. primary health care, preventive and curative services, MCH services as well as at the referral level). The most significant change that occurred in health provision was the growth in non-government health care facilities, particularly at the initiative of the health entrepreneurs during the 1990s. For example, the total of 3,577 health facilities in 1995 had increased to 4,961 by 1999 (MoH, 1998).³ Out of the 4,961 health facilities, only 3,035 are government-owned. While Tanzania has a good network of health facilities, these facilities are often poorly maintained, poorly equipped and poorly staffed.

Table 1: Number of Health Facilities (1999)

Facility Type	Managing Agency					
	Government	Parastatal	Vol/Rel	Private	Other	Total
Consultant/specialized	4	0	2	0	0	6
Regional Hospital	17	0	0	0	0	17
District Hospital	55	2	13	0	0	70
Other Hospitals	2	6	56	20	2	86
Health Centers	409	6	48	16	0	479
Dispensaries	2,450	202	612	663	28	3,955
Specialized Clinics	75	0	4	22	0	101
Nursing Homes	0	0	0	6	0	6
Private laboratories	18	3	9	184	0	214
Private X-ray Units	5	3	2	16	1	27
Total	3,035	222	746	927	31	4,961

Source: MoH, Health Statistical Abstract, 1999

³ URT – MoH, 1999, Health Statistics: Abstract, Vol. II. Inventory Data, Dar es Salaam.

Community based studies indicate that virtually all major health problems of infants, young children and other vulnerable groups in Tanzania are preventable. Major diseases affecting the population include malaria, HIV/AIDS, respiratory infections, waterborne and water washed diseases such as typhoid, cholera and dysentery.

Malnutrition amongst children is most severe in rural areas and urban areas other than Dar es Salaam. The major child nutrition problem appears to be stunting from longer-term chronic under nutrition rather than short-term acute food deficiencies. Malnourishment for a significant proportion (about 17 – 19 percent) of children begins in the first year of life. Reasons for this may be low birth weight (under 2,500 grams) compounded by inadequate breast-feeding and complementary feeding practices.

Table 2: Infant and Under Five Mortality Rates, 1985 - 2000

Year	U5MR ^a	IMR ^b
1985	160	100
1990	163	102
1995	164	103
2000	165	104

Key: ^a Under-five Mortality Rate (U5MR): probability of dying between birth and exactly five years of age, per 1 000 live births.

^b Infant Mortality Rate (IMR): Probability of dying between birth and exactly one year of age, per 1000 births.

Source: UNICEF – data derived from population censuses and national demographic and health surveys

With regard to the under-five mortality rate (Table 2), it has actually increased from 163 deaths per 1000 live births in 1990 to 165 deaths in 2000, contrasting improvements of earlier decades when the mortality rate was decreasing. Maternal mortality rate has been falling from 44% in 1991-1992 to 36% in 1999. Access to reproductive health services is improving.

3.4 Water and Sanitation

The water supply situation through the 1990s also leaves much to be desired. Water supply coverage is only 46% in rural areas and about 68% in urban centres. Furthermore, out of the 46% rural water supply coverage, 30 % is erratic or inoperative. Safe water supply is a crucial factor in disease prevention. Considering that water-borne and water related diseases account for over half of the diseases affecting most of the population, and bearing in mind that more than 80% of Tanzania's population lives in rural areas, it is only logical that the government's endeavors are geared towards improving the health and socio-economic well-being of the people through improved sustainable rural water supply services in the rural areas. Available data for the period 1995-1998 shows that in 1995, 50.5% and 68.3% of the rural and urban population respectively had access to safe and clean water within a 400-500 meter distance. By 1998, rural coverage had declined slightly to 49% while urban coverage increased to 81% (MoH, 1999). There has been some improvement in sanitation, rural access increasing from 79% in 1995 to 84% in 1998 and urban access from 85% of households in 1995 to 97% in

1998. Generally, the poor, most of who live in rural areas, have limited access to clean water for domestic and inadequate sanitation. Economic benefits are achievable indirectly through improved health and time saved from the drudgery of carrying water over long distances.

Improving rural water supplies faces a number of significant challenges including sector reforms. With the reform process underway the Ministry of Water and Livestock will need to re-define its role as coordinator and facilitator rather than the provider of water infrastructure. At the same time local government must develop the capacity to coordinate access to safe water. At all levels the ministry and local government will need to pursue a wide range of partnerships with both NGOs and the private sector. There is also increasing emphasis on community management of water supplies. However, the burdens of cost sharing may prove difficult especially for the poorest communities and users. Furthermore, extensive training and support will be needed to ensure communities are capable of planning, managing and maintaining village water infrastructure.

3.5 HIV/AIDS Situation in Tanzania

Through out the 1990s, the pandemic has posed serious threat to the very foundation of Tanzania's socio-economic development and people's survival, as it cuts across all age groups, including the very young and the youth, and across all socio-economic groups. According to the National Aids Control Programme (NACP), 60 percent of new HIV infections occur in the 19 to 24 years age group, while about 70,000 to 80,000 babies are estimated to be contracting HIV each year. This has contributed to the reversal in the trends of IMR, U5MR and life expectancy. 1998 UN estimates put the population of Tanzania by the year 2015 at 9.5 percent less than would have been the case in the absence of HIV/AIDS.

The social and economic impact of HIV/AIDS on households, productive and service sectors and at the macro level could severely affect economic growth and development in general if spread of the pandemic is not controlled. A total of 8,850 cases were reported to the National Aids Control Programme (NACP) from 20 regions of Tanzania Mainland in 1999. It is estimated that only 1 out of 5 AIDS cases are reported. NACP estimates that 44,250 cases occurred in 1999 and 600,000 cumulative cases have occurred from 1983 to 1999. According to NACP, HIV/AIDS/STD's surveillance report of 1999, both males and females were equally affected in 1999, but the peak number of AIDS cases in women was at the age of 25–29 years compared with 30–34 years in men. However the sex-specific case rate indicated that males had a higher case rate (28.2 per 100,000 population) compared to females (26.5 per 100,000 people).

Children are also increasingly affected by this endemic. More than 1 million Tanzanian children have lost one or both parents due to HIV/AIDS. The ability of families, communities and local organisations to cope with the care of orphans no longer meets existing and growing demands. Widespread infection among women means that children are increasingly infected. Some 70,000 children are born with the infection every year, most of which are likely to die before they reach two years of age.

The rates of HIV/AIDS infection for the last decade, has had a severe impact on economic and social prospects of the country. The concentration of deaths in the early to mid-adult years has taken many trained workers, depleted workforces and necessitated increased investment of scarce resources in combating the disease. HIV/AIDS has imposed substantial additional costs on health systems. Currently, infected persons occupy more than half of the available hospital beds. It is estimated that each adult AIDS case treated in the healthcare system absorbs about \$290 in nursing and drug costs. There is also the problem of AIDS orphans who go without education, health care or nutrition. Many are hard pressed to support themselves, their siblings and their overburdened adoptive families.

Table 3: Comparison of Basic Human Development Indicators

Indicator	Tanzania	China	United Kingdom
Life expectancy at birth (years) 1999	55.1	70.2	77.5
Combined primary, secondary and tertiary gross enrolment ratio (%) 1999	32	73	106
Population not using improved water sources (%) 1999	46	25	0
Underweight children under age five (%) 1999	27	10	0
Population using adequate sanitation facilities (%) 1999	90	38	100
Physicians (per 100,000 people) 1990-99	4	162	164
Adult people living with HIV/AIDS (% age 15-49) 1999	0.11	0.07	8.09
Infant mortality rate (per 1,000 live births) 1999	90	33	6
Under five mortality rate (per 1,000 live births) 1999	141	41	6

Note: While Tanzania represents a low human development country, China and the United Kingdom represent medium and high human development countries respectively.

Source: UNDP, 2001

Regional Welfare Ranking

Social service delivery is closely linked to welfare. An attempt was made in 1999 to compare regional welfare by calculating a composite deprivation index for regions in Tanzania. This index took into account social service indicators of education, health and nutrition, together with food security, income and production. The results suggest that Dodoma, Kagera, Lindi, Kigoma and Coast are the most deprived regions. The least deprived regions are Dar es Salaam, Ruvuma, Kilimanjaro, Singida and Tabora (Table 4). It can correctly be derived that the most deprived regions are likely to have problems in accessing social services.

Table 4: Tanzania Regional Welfare Variation, 1999

Indicator	Least deprived region	Most deprived region	Most deprived regions
Per capita GDP in 1997 (Tanzanian shillings)	371,811 (US\$608)	95,623 (US\$156)	Kilimanjaro, Dodoma, Kigoma, Kagera.
Literacy rate (per cent) ^{1/}	96.4	68.1	Shinyanga, Arusha, Singida, Kigoma.
Gross primary school enrollment rate (per cent)	100	63.0	Kagera, Kigoma, Rukwa, Tabora, Dodoma
Boys	99	65.0	Tabora, Dodoma, Kagera, Kigoma, Rukwa
Girls	100	60.0	Tabora, Dodoma, Kagera, Kigoma, Rukwa
Life expectancy (years)	59	45	Dodoma, Morogoro, Mtwara, Kagera, Rukwa, Iringa.
Men	57	44	Dodoma, Morogoro, Mtwara, Kagera, Rukwa, Iringa
Women	62	45	Dodoma, Morogoro, Mtwara, Kagera, Rukwa, Iringa
Infant Mortality (per 1000)	52	130	Dodoma, Lindi, Kagera, Mtwara
Under-five mortality (per 1000)	78	220	Dodoma, Lindi, Kagera, Mtwara
Low birth weight (per cent)	4.7	15.6	Mara, Ruvuma, Mwanza, Morogoro.
Severe malnutrition (per cent)	2.7	14.7	Iringa, Lindi, Kagera, Singida
Food security (cereal equivalent) ^{2/}	590	177	Coast, Dodoma, Morogoro, Tanga

1/ For women the most deprived regions were Shinyanga, Tabora, Coast and Kigoma

2/ Availability of cereal equivalent levels (in kilograms) during 1992-96

Source: PRSP (2000)

4.0 Key Policy Issues

During the decade (1990 – 2000), the Government of Tanzania in collaboration with other stakeholders has produced and chartered out different poverty reduction initiatives under Vision 2025. Vision 2025 spells out and provides guidance on economic and social development efforts towards combating mass poverty in the country up to year 2025. Based on the Vision 2025, other policy documents (PRSP, NPES and TAS), which address poverty eradication, have been produced. In addition, relevant sectors have also determined their respective sector targets and strategies in such documents like Medium Term Expenditure Framework (MTEF) prepared under the Public Expenditure Review (PER) exercise and the different sector policy documents. These policy documents clearly indicate the government's awareness that a large proportion of existing social service delivery facilities are in poor condition and that the services being provided are of poor quality. They also state that primary emphasis will be placed on rehabilitating existing structures and raising the quality of the services being offered.

A host of reform measures were adopted during the period. The wave of reforms in the 1990s has been both intensive and extensive covering all aspects of the economy. In the social sectors, reforms focussed on concentrating public funds on core activities of government,

decentralizing authority to the local levels, relaxing constraints on private sector participation in provision of social services, promoting improved standards and shifting control over resource allocation closer to the household and promoting household investment in human capital.

Education

Education in Tanzania is guided by sector policy components and initiatives. These are; The Education and Training Policy (1995), National Higher Education Policy (1999), Technical Education and Training Policy (1996), National Science Technology Policy (1996), Vocational Education Policy (1995), Education Sector Development Programme, Comprehensive Pre-Education Programme, Comprehensive Secondary Education Programme and establishment of Community Education Funds. Most of these policies and initiatives reflect a shift from the emphases of the 1960s to the early 1980s, which placed strong reliance on government control of the economy. It is this shift of emphasis that has influenced the form and direction of most of the education and training provided in the country. However, most of the policy statements lack intentional focus to the poor. They also do not address how quality improvement and total education coverage are going to be achieved, given the scarce resources at the country's disposal. Secondary and post secondary level education is essentially elitist in that it is only the minority of the poor that has access to it. Community initiated schools are poorly resourced in terms of both human and financial inputs. As for higher education, focus is on cost sharing, implying that households have to meet part of the cost of this education. Also policies related to provision of vocational education demand huge investments for implementation for which poor countries like Tanzania cannot easily afford.

Health

The National Health Policy formulated in 1990 guides health care policy in Tanzania. Although not formally revised, the Policy is being implemented within the context of Health Sector Reform (HSR) as outlined in the 1995 proposals for health sector reform, whose strategy for implementation have been presented in subsequent programmes of work. The National Health Policy focuses on Primary Health Care (PHC) with objectives that include those under the mandate of other sectors such as water, agriculture and education. Effective implementation of the health objectives remains constrained by several problems including: gaps in implementation strategies, inadequate funding as manifested through, among other things, shortage of drugs and essential medical supplies, inadequate quality of care, exclusion from access to health care of those with no ability to pay, and inadequate HIV/AIDS awareness programmes

Water

The revised National Water Policy of 1991 and the Rural Water Policy of 1999 currently guide the water sector. Under the ongoing reforms, the role of the ministry has changed from that of an implementer and manager to that of a facilitator and regulator. The government has

significantly encouraged community participation in most water supply schemes and other projects, especially in rural areas. Based on the policy objectives, the government has been implementing few programs/plans leaving room for the participation of other stakeholders. Communities benefiting from the schemes now manage many of the water schemes through various management options of water user entities like water user groups, water committees, water user associations and so on. The government has adopted different strategies for facilitating safe water provision in urban and rural areas. In urban areas, the strategy focuses on private sector participation while in rural areas the focus is on cost-sharing and community participation. The success of the strategies will depend on the capacity of communities to plan and manage the village water infrastructure. Communities must also be capable of making decisions about water usage, in order to strike a workable balance between domestic and agricultural needs. The government reform programme has tasked local government with responsibility for managing and coordinating access to safe water. As such, improvements in rural access to water will strongly depend on the capacities of local government to carry out this new mandate.

Effective implementation of the policy objectives remains constrained by several problems including; dominance of donor resources in financing of projects and inadequate capacity of local communities to plan and manage village water infrastructure.

5.0 Vision and Mission for the Next Ten Years

The Tanzania Vision 2025, basically a determination to disentangle Tanzania from the scourge of poverty, states that Tanzania of 2025 should be a nation with five main attributes: high quality livelihoods by all Tanzanians; peace, stability and unity; good governance; a well educated and learning society; and a competitive economy capable of producing sustainable growth and shared benefits. The general targets to be achieved by the year 2010 (according to the Programme of Action for Tanzania), are as follows:

Economic Indicators:

- Real growth rate of the economy at between 8 percent and 10 percent.
- Increased income per capita to between US\$ 300 and US\$ 500.
- Increasing the share of the manufacturing sector from the current 8.4 percent to 10 percent.

Poverty Reduction:

- Proportion of the population below the food poverty line at 16 percent.
- Proportion of the population below the basic needs poverty line at 29 percent.
- Reduction of absolute poverty by 50 percent by year 2010.

Social Indicators:

- Achieve a literacy rate of 90 percent.
- Access to clean and safe water by 90 percent of the population within 400 metres distance.
- Maternal mortality rate of 100 – 200 per 100,000 live births (currently 529).
- Reduced severe malnutrition to 2 percent (currently 6 percent).
- Reduced infant mortality rate by 50 percent.
- Reduced under-five mortality by 50 percent.
- Achieve an unemployment rate of less than 10 percent.

Tanzania has set itself ambitious targets both in the medium and long terms as evidenced in the Action Program for Development of the United Republic of Tanzania. Achieving these targets is undoubtedly a daunting task basing on past records. Tanzania has in the past decade shown seriousness about economic reforms. While growth has increased, it is still too low to have much impact on poverty in an economy where population growth is thought to be between 2.8 and 3 percent per annum. The pace at which Tanzania is currently travelling (about 4 - 5 percent per annum in real terms) is too slow to make a sizeable impact in the short and medium term. Economic growth is very important and targets to be achieved by the year 2010 will only be possible with a real growth rate of between 8 percent and 10 percent.

The challenge of meeting the requirements for providing adequate quantity (stated targets) and quality of social services in Tanzania is immense. Trends in social services delivery suggest that there is little in recent history to motivate achieving projected trends. Private sector participation and contributions by users to financing the costs of providing the requirements are necessary. The interest of the private sector in supplying education services at the post-primary level has been demonstrated. For example, this sector runs nearly half of the secondary schools in the country. Much less involvement has been recorded in primary education, which remains the dominant purview of the public sector. Similarly, private dispensaries and hospitals have recently mushroomed in urban centres, while public services still dominate in rural districts and villages. A natural divide is therefore emerging that can be exploited to concentrate and rationalize the involvement of the public and private sector in the provision of social services. There is also increasing evidence of the willingness of users to contribute towards financing the costs of these services, provided they are of acceptable quality.

6.0 Conclusion and Recommendations

Tanzania's development depends on a well-educated and healthy population. The engine of growth will be the skills and productivity of the population. The slow progress in the social sectors requires new thinking about the role of the government and other development actors and the opportunities for investing more into social services.

Based on the preceding analysis, education sector is characterized by falling enrolments, declining quality at all levels, a growing number of poorly educated youth and an increased divide between the wealthy and the poor. The analysis suggests that the country has a large and expansive physical and human resource infrastructure in the basic education sector. The demand for secondary and tertiary education is huge and there is potential for the private sector to meet the demand. A summary of areas for intervention in the sector that non-government development actors (including the churches) could assist is presented below:

- Increasing sector infrastructure and provision of equipment.
- Expanding of post-primary educational institutions.
- Sensitising the population on the importance of taking children to school.
- Providing special educational services for the disabled.
- Providing adult education.

The health sector is characterized by declining quality at all levels of the health care system. There is also a persistent differential between the services available to the better off and to the poor. The analysis suggests that the country has a large and expansive physical and human resource infrastructure in the basic health sector. Households would invest more in health services if facilities had a ready supply of drugs and higher quality environment. The demand for private sector involvement in the health sector is great and could alleviate the burden on the government. A summary of areas for intervention in the sector is presented below:

- Increasing sector infrastructure and provision of equipment
- Provision of nutritional education especially to mothers.
- Delivery of adequate rural primary health services in order to enhance equity.
- Providing special health services for the disabled.
- Creating population awareness on preventive measures against disease contraction and causes of mortality.

As for water and sanitation, the official targets to provide water and sanitation for all is not consistent with the severe financial and other resource constraints facing the sector. At current government and donor funding levels, it is likely that the proportion of Tanzanian households with improved water and sanitation coverage will continue to decline as population increases. A summary of areas for intervention in the sector is presented below:

- Creating awareness on protection, conservation and optimal utilization of water resources with full consideration of the impact on the environment.
- Rehabilitation/upgrading and expansion of water schemes.

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