Chapter 1  The Social and Political Environment in Tanzania: Background to the Project

This case study will take up and illustrate a general overview of the Morogoro Health Project (MHP). Before proceeding with this, however, it will begin with a synopsis of what sort of social and economic situation Tanzania was in as the historical backdrop to when the project was requested and formulated. It will also outline the manner in which the HSR, decentralization, and other national development strategies were worked out.

1-1 Social and Economic Situation

In May 1992 Tanzania transitioned from single-party rule under the Revolutionary Party to a multi-party system, and in October 1995 elections for the president and members of parliament were conducted for the first time under this multi-party system. Tanzania is said to be one of the most politically stable countries among the countries of Africa. Since the introduction of the multi-party system, the political and social situation has remained stable under the leadership of the governing CCM (Chama Cha Mapinduzi, Revolutionary Party). In 2000, President Benjamin William Mkapa was reelected, and in 2005 the former Minister of Foreign Affairs and International Cooperation Jakaya Mrisho Kikwete was inaugurated as the new president, with both of them representing CCM.

Diplomatically, since 2001 Tanzania along with Kenya and Uganda have comprised the East African Community (EAC). In striving to strengthen regional cooperation, it has entered an EAC customs union that came into effect beginning in January 2005. Furthermore, it served as the chair country for the Southern African Development Community (SADC) for one year starting in August 2003. As an important member, Tanzania has played the important role of a mediator in Eastern and Southern Africa. Moreover, it also displays diplomatic leadership aimed at achieving peace in Burundi and the Democratic Republic of the Congo in order to stabilize the Great Lakes region as a whole.

In addition, since 1995 Tanzania’s economic situation has been showing favorable growth as a result of the implementation of the development strategies described above. Over the five year period from 2000 to 2004 the country has displayed a real economic growth rate that is at the high level of 5.8%. This growth has largely come about as a result of the development of the mining industry, which is centered around gold (over this period the mining industry had an average yearly growth rate of 15.2%). The average yearly growth rate over this same period for the agricultural sector, which constitutes 80% of Tanzania’s labor population, remained at 4.8%. For this reason, the stable development of rural areas, which comprise roughly 80% of the total population and some 80 to 90% of those living in poverty, will be a challenge for the immediate future. It is important that poverty reduction be achieved in a visible manner that does not unevenly distribute the benefits of growth solely to urban areas.

1-2 Poverty Reduction Strategies

In 1997 the Tanzanian Government formulated the National Poverty Eradication Strategy (NPES) as a national development strategy. Then, in 1999 it announced Vision 2025, which stipulated the course for long-term development in Tanzania (improving the quality of life, ensuring good governance and the rule of law, and a competitive economy). Taking these as its basic policies, in 2000 it was the first among other
countries to formulate a Poverty Reduction and Strategy Paper (PRSP), initiating Poverty Reduction Budget Support (PRBS) the next year in 2001. Following this, it created the Tanzania Assistance Strategy (TAS) in 2002, and the National Strategy for Growth and the Reduction of Poverty (NSGRP; or MKUKUTA in Swahili) in 2005 to serve as its second poverty reduction strategy. In parallel with the setting in place of such policy foundations, it also established financial foundations such as the Public Expenditure Review and the Medium-Term Expenditure Framework (MTEF), and developed laws one after another. This was done for the implementation of the national development plans PRSP/NSGRP.

The First PRSP (2000) aimed to directly benefit specified impoverished groups via priority sectors such as health and medicine, education, and others. While holding to a policy of reducing poverty, the second poverty reduction strategy from April 2005 narrowed its focus down to “poverty reduction through growth and income,” “improving the quality of life and social welfare,” and “good governance and accountability.” The health sector was integrated into the social welfare service cluster along with education, water, and the environment. Enhancing the policy foundation posed a challenge for the sake of enabling cross-sectoral activities and financial cooperation.

1-3 Sector-Wide Approach (SWAp)

The 1995 Helleiner Report criticized the proliferation of individual projects as imposing a significant burden on the part of the partner country, and pointed out that aid should be provided in a manner that is consistent with the policies of the partner country. In particular, the report clearly indicated that donor-led development aid acts as a hindrance to fostering ownership by the partner country. This is exemplified by the inefficiency of project implementation by individual aid agencies, as well as government employees in the partner countries losing out on opportunities to carry out their basic duties as a result of their having to deal with differing aid modalities. As a result, aid coordination designed to foster Tanzania’s self-reliance was examined, and in 1998 a health SWAp was introduced ahead of the other sectors. Because of this, use of the HSBF was begun in 1999 as an independent revenue source for decentralized health systems.

Figure 1-1 illustrates by what sort of stages aid coordination was carried out in the project accounting and government general accounting systems. The “ownership of the partner country and the establishment of sustainability” are emphasized in the SWAp. It defines the objective as being to carry out budget drafting, execution, and evaluation and monitoring under the unified control of the partner country. Sugishita (2006) lists the following items as outcomes of the introduction of a health SWAp in Tanzania.

- A foundation was established by which the government and development partner were able to work together to implement development strategies in line with the nation’s priority issues.
- The strategic aspects were clarified by means of sharing the monitoring system for the achievement of national objectives.
- Set the foundation for the sustainable and autonomous development of district health provision founded on a long-term outlook by means of stably ensuring revenue sources for health in local areas.
- Allowed comprehensive sector-spanning regional development to be conducted by means of strengthening collaboration between government functions and local government authorities.
- Can be expected to increase the efficiency and transparency of aid, as well as utilize resources

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1 Japan has contributed an amount of 500 million yen to PRBS through grant aid for debt relief on two occasions, once in March 2002 and again in March 2003. In 2004 Japan approved the input of substantial funding of non-project grant aid.
2 MKUKUTA is the abbreviation for Mkakati wa Kukuza Uchumi na Kupunguza Umaskini Tanzania.
efficiently via the centralized management of revenue sources by the state.

- By promoting health activities under the leadership of the local areas, it will raise the incentives to and motivation of the actual site, and allow for the implementation of more vigorous health activities.

**Figure 1-1 Steps towards SWAp/GBS**

In development assistance for Tanzania, an important factor is that two major reforms, HSR and LGRP, are being actively pursued (refer to 1-5 regarding LGRP). This section will describe the transformation of health policy and important foundations for the HSR.

**1-4 Health Sector Reform (HSR)**

In development assistance for Tanzania, an important factor is that two major reforms, HSR and LGRP, are being actively pursued (refer to 1-5 regarding LGRP). This section will describe the transformation of health policy and important foundations for the HSR.

**1-4-1 Transformation of Health Policy**

Against the trend of new public management in the early 1990s, the Tanzanian Government introduced the restructuring of central government ministries and agencies in order to respond to the needs of the people. In 1994 the MOHSW released the Health Sector Reform Policy and Guidelines. HSR was initiated ahead of reforms in other sectors, and was designed to delegate authority for health services to local government authorities (Table 1-1). The goal was to have local government authorities that were closer to the residents provide prompt health services to the community by means of the decentralization of the health sector. The same guidelines list the following challenges.

i) Regarding residents as “customers” when it comes to providing health services, it is necessary to convert to a viewpoint of “customer-oriented” services through health management teams.

ii) Processes for planning, budgeting, and reporting that would ensure the quality of health services must
be introduced.

iii) It is essential that the Regional Health Management Team (RHMT) provides the Council Health Management Teams (CHMTs) with technical and managerial support on a case by case basis according to needs.\(^3\)

iv) Motivated and eager human resources should be allocated.

v) Pertinent and well-managed health infrastructure is required.

vi) A sufficient budget should be guaranteed.

vii) CHMTs must encourage the participation of residents and the medical care providers at health facilities, as well as act with accountability.

viii) Tools to evaluate the quality of health services and standard operating procedures should be adopted.

\begin{table}
\centering
\caption{Health Sector Reform and its Surrounding Policies}
\begin{tabular}{|c|c|}
\hline
Year & Development Policy \hline
1991 & Public Sector Reform Programs \hline
1993 & Civil Service Reform \hline
1994 & Health Sector Reform Policy and Guidelines \hline
1995 & Vision 2025 \hline
1997 & National Poverty Eradication Strategy \hline
1998 & Proposal for a Sector-wide Improvement Program (SIP) \hline
1999 & Agreement on Health SWAp \hline
2000 & Tanzania Assistance Strategy (medium-term development plan) \hline
2001 & Poverty Reduction Budget Support MTEF 2002-2004 \hline
2002 & Tanzania Assistance Strategy \hline
2003 & Poverty Reduction Strategy Paper II (medium-term development plan) \hline
2006 & Joint Assistance Strategy (draft) \hline
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\end{tabular}
\end{table}

Source: Compiled from Cowi et al. (2007)

\(3\) CHMTs and RHMT are comprised of regional and district physicians and health officers, as well as staff members from regional and district hospitals and others. In districts they effectively serve as the health divisions for the government authorities, and at the regional level they play a role of technically supporting the region as branch agencies of the MOHSW.

\(4\) Public Expenditure Review by the Tanzanian Government through donor participation.
In order to set in place the independent financial foundations to promote the HSR, the Ministry of Health and Social Welfare (MOHSW) of Tanzania abolished budget management for health projects led by development partners that lacked accounting statements to aid agencies. It also sought fiscal management in line with the mid-term health expenditures plan based on health policy. As a result, in 1999 the HSBF through the SWAp was examined and introduced as an independent source of revenue for local health services. This established the financial foundation for the local government authorities to independently plan and implement health activities.

Traditionally, health service delivery was primarily provided by the government. However, as a result of the health sector reform, health and medical services came to be provided by the private sector, religious groups, and Non-Governmental Organizations (NGOs). Furthermore, by increasing the burden for medical costs borne by the public, the Tanzanian Government is aiming to strengthen revenue sources for health with an eye toward financial autonomous development. This will be accomplished through the phased introduction of cost sharing by starting to charge fees for medical treatment, community health funds, drug revolving funds, and national health insurance schemes.

1-4-2 The Three Foundations of HSR

Through such means the policy and financial foundations were set in place. As a consequence of this, the vulnerable capacity regarding the problem-solving ability of local health administrations was thrown into relief. In particular, this highlighted the lack of the managerial capabilities of local health administrators and their inexperience in the organizational aspects of regional and district health administration (Figure 1-2).

Figure 1-2 The Three Foundations of HSR

Source: Created by Sugishita (2006b)
1-5 Local Government Reform Programme (LGRP)

1-5-1 Transformation of Local Administrative Policies

In 1972 the Tanzanian Government did away with the local government authorities that had persisted until that time. The reasons for this included a shortage of capable administrators, improper disbursements from budgets, a lack of operation and maintenance capacity for the social infrastructure developed by the central government, a lack of managerial capacity on the part of administrators, and others. After that, from 1972 to 1984 the system shifted to one of centralized administrative authority, thereby turning into a bureaucratic, inefficient, and ineffectual system. The declining living standards of the people and soaring costs of operation and maintenance led to a deterioration in social and economic services. It was acknowledged that the morbidity and disease prevalence rates were increasing as a result of the drop in the number of people receiving health services, while literacy rates were declining along with the decrease in the number of children enrolled in primary education. In 1984 the central government set out to rebuild the local government authorities in the wake of legal reforms, and the provision of administrative services by local government authorities was resumed. However, the number of public servants had decreased substantially on account of the structural adjustment programs implemented from the 1980s to the 1990s. As such, there was a shortage of human resources, and all of a sudden improving the quality of regional public services was no longer feasible.

Decentralization by devolution (D by D) was articulated in the 1998 Policy Paper on Local Government Reform. The objectives for this were given as devolving authority related to personnel, finances, and other matters to the local government authorities, as well as rebuilding the administrative system (Table 1-1). Following this, the LGRP was officially announced in 2000. This ranked the health, education, water, agriculture, and roads sectors together as strategic pillars for restructuring of regional administration and poverty reduction. The following objectives are established within the LGRP.

- A system of local government authorities with autonomous authority5
- A system of local government authorities with resources (particularly financial and human resources)
- Local authorities comprised of democratically elected leaders
- Local authorities that allow for public participation in development planning and implementation
- A system which reflects regional needs
- An autonomous system which ensures transparency and accountability

Furthermore, the following matters were requested of the various local government authorities with regard to the devolution of authority to the local areas.6

- Establish comprehensive strategies and objectives aimed at improving public services
- Establish indicators to measure performance
- Identify causes for discrepancies in performance
- Invest strategic resources (financial, human resources) so that services benefit the local residents
- Promote democracy in the determination process

The following action policies are indicated in the Mid-term Plan and Budget 2005-2008 (MTP05-08), which serves as a specific action plan for the achievement of the items above.

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5 Additionally, at the regional level in Tanzania regional governments which act as branch agencies of the central government have been established instead of local government authorities.

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- Mainstreaming of D by D
- Fiscal Empowerment
- Human Resource Empowerment
- Legal Framework
- Restructuring LGAs
- Governance
- PMO-RALG & Regional State Capacity Building

Based on the aforementioned items, the provision of various public services was transferred from the central government to the local government authorities. There were problems involved with this, such as missteps between government ministries and agencies, as well as the fact that smooth progress was not seen with the legal framework or the transfer of personnel authority. Yet regardless, the financial foundations were established within the ministries for local authorities in a manner consistent with the national development plans (PRSP, TAS, MKUKUTA, etc.). The basket fund designed to promote the LGRP serves as an example of this.

1-5-2 Decentralization of Health Services through the LGRP

The introduction of the LGRP in 2000 defined the roles of the central and local governments: the former formulates policies and the latter provides administrative services, including the planning, implementation, and monitoring of various projects and programs. Within the health sector, the carrying out of health and medical services was transferred to the initiative of the local government authorities. Due to the devolution of authority with regard to personnel, health sector human resources were shifted from the MOHSW to the local government authorities. Furthermore, in the wake of the decentralization the division of labor among central government ministries and agencies changed as well. Local governments were required to manage local revenue sources and provide services, while the MOHSW was called upon to strengthen its capacity for technical backstopping and human resources development.

Figure 1-3 offers a comparison of the relationship diagrams from 2001 and 2005 for actors who had their roles altered as a consequence of the decentralization. Prior to decentralization, MOHSW maintained consistent responsibility for everything from policy formulation to the implementation of services, and CHMTs provided services as branch agencies of the MOHSW. After decentralization, the fact has not changed that MOHSW still formulates the policy. However, services in the local areas are provided solely by the districts, and the President’s Office-Regional Administration and Local Government (PO-RALG, currently the Prime Minister’s Office-Regional Administration and Local Government (PMO-RALG)) came to bear responsibility for the supervision and backstopping of administrative management as a whole. The function of the MOHSW has changed to focus on the formulation of the policies as well as technical backstopping and support to the local authorities.

Budgetary allocations from the HSBF to the RHMT, which are part of the central government, were not planned in the institutional design from the time of the HSBF’s establishment. But gradually, however, autonomous activities like the backstopping and supervisory functions of regional governments targeting district governments came to be called for. Based on this background, in 2005 it became possible for the HSBF to make contributions to the RHMT.7

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7 During the implementation of MHP, expenses were not actually allocated to the RHMTs for their routine visits and guidance to the various districts.
In this manner, the MHP was created in order to promote the HSR. Accompanying the advance of local administrative reforms the role of regional governments was reconsidered. Furthermore, since the MHP’s activities and mid-term evaluation onwards there have come to be calls for activities to strengthen management related to the organizational enhancement of the region as a means of converting it from a manager of the districts to a joint implementer alongside them.

Against the background of the two important reforms mentioned above, MOHSW had to accept the fact that, despite the setting in place of policy and financial foundations, this had largely not led to the provision of the health services sought by the local residents. It therefore worked out a policy of giving priority to promoting the enhancement of management capacity for regional and district health administrations. The expectation was for JICA to create a model of region-district partnerships in the Morogoro Region. Yet even though authority was transferred to the region during the project period, creating this model took time on account of the fact that the budgetary measures for regional governments were not carried out smoothly relative to those for district governments.
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Box 1-1 “There’s no budget...” What would you do? (Part 1)

One day I received the message, “There’s no budget, so we can’t attend the next working group” on my cell phone. The message was sent by a member of the Monitoring and Evaluation (M&E) Working Group (WG) which I was in charge of.

This was in the last year of the project. In consideration of autonomous development after its completion, the project requested that each district bear part of the daily subsistence allowance (cost sharing) related to the project. This came right in the middle of the M&E WG’s compilation of the “District Health Management Handbooks,” which served as a final tangible outcome of the project, and in which all of the group members played their part for the writing.

The WGs gathered representatives from each district and were held over a two to three day schedule on the basis of at least one each month. Therefore, we only had a few chances left to come together in order to complete the handbooks as planned by the end of the project. With each opportunity precious, the situation was such that the participation of each member sharing the work of writing for the sake of completing the tangible outcomes was indispensable.

“When considering the completion of these tangible outcomes, even though the project was covering the daily subsistence allowances, I still preferred that every member took part. This was my true feeling as the manager. At the same time, “if there was a problem with the bearing of cost between the district and CHMTs I would like them to consult with me openly as the manager.” This was my true feeling, too.

When managing a project, these sorts of problems concerning daily subsistence allowances and lodging expenses occur on a daily basis. As such, I realized that the accumulation of these sorts of daily-occurring matters serves as a collection of live “lessons” on the ground in CD support projects that aim to “improve management capacity.”

So, if you were asked for your judgment as an expert placed in such a situation how would you respond?

Furthermore, by what means would you expect the counterpart to deal with this?

(Written by: Erika Fukushi, former MHP expert)

(Continued in Part 2)