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SHARING IN COMMUNITY-BASED SOCIAL SERVICES IN RURAL TANZANIA: A CASE STUDY OF MTWARA AND LINDI REGIONS

Marja-Liisa Swantz

October 1996

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Development Economics Research
(UNU/WIDER)

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ISSN 1455-3090

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ABSTRACT

The first part of the paper describes steps which Tanzania took in order to provide key social services to her people. Tanzania made great efforts within the *ujamaa* socialist system to provide free social services for rural as well as urban people, regardless of their income level. Even after the decline of Tanzanian economy the party-led government tried to maintain and improve social services but could nonetheless not prevent the deterioration of the education and health services nor the water and sanitation systems, built with the assistance of foreign development agents. I analyse the effects on the services of export liberalisation measures, different phases of Economic Recovery Programmes, the Structural Adjustment Programme with its Priority Social Action Programmes, and the recent World Bank Human Development Programme.

The second part presents a case study of social services provision in two south-eastern regions of Tanzania, Mtwara and Lindi, which on the basis of statistics are among the poorest in the country. The study is based on first hand field experience as is also the analysis of the effects of the new emphasis on decentralisation and local government which follows in the third part of the paper. After the new participatory bottom-up experiments, in which the World Bank and several foreign development agents are partners have been described, the fourth section of the paper brings out the basic contradictions between 'traditional' and 'modern' in social services provision and the difficulty that any development efforts face in trying to integrate people's own understanding and practice of sharing in service provision with the externally introduced models. I bring out different ways in which rural people do share in giving services and show that credit must be given to these sharing practices when new systems of cost sharing are developed.

Tentative conclusions bring out the need to make detailed studies (based on participatory action research) of division of weath in rural communities so that those already heavily involved in self-help work, or who provide many kinds of payments, would be identified, and work registers for their contributions made. The citizens who belong to the wealthy quintile but manage to escape regular cost sharing practices need to be approached and encouraged to contribute more, in addition to paying attention to the tax revenue collection.

1. TANZANIAN SOCIAL POLICY AND PRACTICE

1.1 Introduction

Tanzania has considered the basic social services to be public goods which citizens were entitled to enjoy. Great efforts were made to satisfy people's basic needs. After the two first decades of independence, it became evident that the fragile economy of a newly independent country cannot carry the costs that provision of free education, health, water and sanitation would warrant, not even with people's self-help efforts. With the structural adjustment programmes the tension between benevolently oriented political leadership and the economic realists caused considerable tension.

This paper describes and analyses the national and local strategies and struggle of the state, local communities, and external development agents and service organisations which have been involved in trying to solve the problem of provision for key social services in Tanzania. After a general review of the strategies and programme implementation on the national level, the attention is focused on specific rural communities of Mtwara and Lindi regions in southern Tanzania. The illustrative case studies of social services are given in concrete situations in regions which Tanzanian public opinion - rightly or wrongly - considers to be the most backward. In the World Bank estimation, based on GNP per capita, the Lindi region is at the moment the poorest region in the second poorest country of Africa, the poorest being the neighbouring Mozambique.

On the basis of concrete case studies, the paper probes new and old experiments, including some traditional ways, in which the central government, the regional and district authorities, the elected district councils, and local village communities have carried their responsibility in providing social services to the citizens. The paper describes and analyses local situations in which new education policy and resultant institutions are being implemented, health services are administered, and new categories of health workers are being trained. It also looks at solutions sought for creating and maintaining water and sanitation services as part of the larger public health and preventive health programmes. The case studies concern areas which in inter-regional perspective have been disadvantaged for historical, environmental or cultural reasons. The responsibility of the international community and the ways in which external bi-lateral and multi-lateral development agencies have intervened are also analysed. The question is asked how the responsibility can be shared with the local community without putting inordinate burdens on deprived sections of population nor creating a dependency syndrome which at present seems to be excessively evident.

'Local community' signifies here primarily a village but the term is extended to cover a cluster of villages which administratively form a Ward. The term 'local government' signifies the elected district council, but depending on the context, it can also refer to local government in a more general sense and include the village government and the Ward Development Committee. Of key social services, health, education, water, and sanitation are considered and, to some extent, food security.

Tanzania as a nation offers an appropriate case study because of her initial policy to provide social services to all her citizens although subsequently she ran into difficulty in trying to fulfil the political promise. The countrywide national systems of health, education, water and sanitation were developed which makes it possible for us to examine the weakness and strength of a planned welfare system in a developing country. Tanzania also made an effort to include elements from the traditional system in the new system of health which enables us to explore how the traditional relates to the new system. Is there any way of synthesising the old and the new in carrying out the required services? If so what does it demand from the different parties concerned?

The substance of this paper derives from recently done research in the south-eastern parts of Tanzania. The encounters with administrators, civil servants, business people, and villagers of all categories including men, women, youth, and children provide the background and sounding board to the description and analysis in which also the writer's earlier research experience in other parts of Tanzania is reflected.

The first part of the paper looks at the evolution of the social services in the Tanzanian context to the present day. It gives brief background information about the relative priority that the social sector had within the Tanzanian political programmes before and after the gradual acceptance of the economic restructuring programme (ERP) starting with the first Annual Plan 1982/3 which was prepared within the framework of the structural adjustment programme (SAP).[1]

The efforts that the Tanzanian government has made to include the traditional healers and birth attendants in the health system serve as the transitional step to the description of the communities of southern Tanzania and their concepts of health and their healing practices in general. As the background to the situation I give a few glimpses of history of the two regions, especially pointing out the factors that have influenced the relative poverty and the shape of social services in these regions.

The paper then goes on to describe the present changes and the intensive planning that has gone on in the last years by the GOT, the WB and the major donors. Instead of giving a detailed description of the plans,[2] I narrow the focus to the south-eastern regions and exemplify the planning procedures in specific contexts. I take up some of the weaknesses of the present delivery system and reflect on the possibilities to improve the educational and health services. I assess the attempts which are being made to reform the service delivery systems toward sharing in cost recovery at the instigation of the World Bank and the new experimentation made in cooperation with the local governments and the external development agencies, more specifically with UNICEF and the Department of Development Cooperation, formerly FINNIDA, in the Ministry of Foreign Affairs of Finland.

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[1] Speech by the Minister of State for Planning and economic Affairs in the office of the Vice-President, Prof. Kighoma A. Malima, M.P., when Presenting the Economic Survey for 1982/83 and the Annual Plan for 1983/84, the National Assembly on 16th June, 1983. Government Printer, Dar es Salaam 1983.

[2] See the List of Planning Documents in the Bibliography

Finally, I wish to take up some theoretical notions about the different ways that anthropologists and economists have looked at the economics of the poor, from an angle which I call anthropological economics. I ponder whether the substance of the paper gives any new angles to the theoretical discussion and how it helps us in providing public goods at the grassroots level.

The main concern for development of education or the social sector in general often boils down to the question of funding. It is obvious that the financing of services is a central issue which also affects the quality and motivational factors among the staff. There are, however, many immediate ways in which the health and education can be improved and promoted. I explore how the economics of the poor work, emphasising especially women's ways of sustaining life and giving service, and go on to ruminate what guidance such social economics give to decision makers in solving the problems of delivery of the 'public goods'.

Overemphasis on monetary issues for improvement of the level of services may deviate from the central issues of quality in service, personal motivation, individual and group effort, social concern, initiative, and creative learning. An issue surfaces whether an end product of a long process in Western society has been a fitting model for shaping the social service structures in totally different kinds of social situations and cultures in developing countries. The question needs to be probed whether other educational and health modes of service could also be entertained and rewarded and what signs there are that such forms are emerging.

1.2 Evolution of Tanzanian social policy and practice

An extensive programme of social services formed the core of the ujamaa socialism which Tanzania adopted as its political programme at an early stage of her development. The ruling Party TANU [3] directed the government in 1971 to place greater emphasis on rural development in order that the majority of people living in rural areas would get the basic needs, namely water, education and health.[4] This coincided with the acceleration of the villagisation programme which had started after the Arusha Declaration in 1967[5] in southern parts of Tanzania. One of the main motivations of the villagisation was to

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[3] TANU is the acronym for Tanganyika African National Union which was later united with the Afro-Shirazi Party of Zanzibar and was called the Revolutionary Party, Chama Cha Mapinduzi, referred to as CCM.

[4] As the source is used Report from the Joint Swedish/Tanzanian Health Sector Review in Tanzania April 1982, but much of the general information is based on the writer's own observations as a resident in Tanzania through those decades.

[5] The Arusha Declaration which was given by the Party Conference in Arusha 26th of January 1967 in Swahili formed the basis for the new socialist political and economic direction that Tanzania oriented towards. It included The Arusha Resolution which contained the Leadership Code. In the declaration itself there is little said about the social services as such, but the equal distribution of benefits in *ujamaa* villages and the policy of self-reliance aim at community initiative in providing social services for all. (Nyerere, Julius, *Freedom and Socialism*, Oxford University Press/Dar es Salaam, Nairobi, London, New York 1968)

resettle people in compact villages within a communicable distance from services which the government intended to provide eventually for all citizens.

President Nyerere's visions for rural development, in which social service programmes came to have a high profile, aroused wide international interest. Aid agencies and foreign personnel were incorporated into operationalising lofty ideals. Tanzania became in many ways an experimental ground for enthusiastic social reformers who were given an opportunity to work out new approaches and methods in the fields of health and education. The Tanzanian social reforms were quoted in international research and media circles as models for other developing countries. A long term health sector development plan 1971/72 up to the year 1980/81 was formulated in a direction which later was integrated into the global programme 'Health for All by the Year 2000' at the WHO conference in Alma Ata in 1978.

Tanzania experienced an economic decline for various reasons to which there is no need to go here in any detail. The causes were both external and internal. The development programme which was supposed to have been built on self-reliance and only secondarily on external assistance became excessively donor dependent, top-to-bottom instead of the intended bottom-up development. Eventually outside support began to dry up and the WB and IMF put pressure to reform the economic and social system before granting new loans.

Tanzania resisted subjection to the conditions set by the IMF for further loans. In 1979 the Tanzanian government agreed to a programme outline of low-conditionality But negotiations for a major programme broke down over the IMF demands for devaluation, a reduction of real government expenditure, a wage freeze, abolition of price controls and higher interest rates. The main dispute was over devaluation, food subsidies and producer prices. The Tanzanian side wanted to spread the reforms over a longer period of time to prevent the shock effect of sudden changes. A new Extended Fund Facility which was signed in August 1980 was withdrawn by the Fund soon after and the programme was suspended. The IMF conditions were rigid and even in the government economic adviser's view, had they been implemented, they would have led to even greater disaster, the collapse of education and health services[6]. The 'take-it or leave it' attitude of the IMF exacerbated the situation and the negotiations broke down in 1980 and 1983. Thus an important reason for Tanzania's resistance to the externally set conditions was to 'maintain equity in income distribution as well as the provision of social services and other basic needs to the majority of population'. The conditions set by the IMF threatened these objectives (United Republic of Tanzania 1986).

The country made her own stabilisation and adjustment programmes which met many of the IMF conditions. A National Economic Survival Plan was approved in 1981 and a Stabilisation and Adjustment Programme for the period 1982/83-1984/85. The decline of the national economy continued, not only as the Fund would maintain, because of the poor management of the economy, but also with the aftermath of Uganda war 1978-79, recurring droughts resulting in declining agricultural production, the decline of external

[6] Green, R. H. 'Sparring with the IMF'. *Africa Report*, September-October 1984:74.

terms of trade and increase in oil prices, which meant that 55-60 per cent of exchange earnings had to be spent in oil imports. The overextended state control of almost all sectors of economy proved inadequate and inappropriate.

In 1984 started a liberalisation process whereby private importation of goods for sale was allowed, rights were granted to retain 50 percent of the foreign exchange earned from non-traditional exports in order to import consumer goods, crop authority parastatals were downgraded to marketing boards, primary and regional cooperatives were reactivated, political structures in the country side were gradually decentralised and the country was opening up to foreign ventures. Not only had the WB loan money been drying up but the other donors had followed the suit. The decline in productive sectors had affected also the social sector. After the government had come to a formal agreement with the IMF the economic recovery programme (ERP I) along the same lines as SAP was finally adopted in 1986 for the following three years.

In the ERP I nothing was said about the social sectors. Efforts were concentrated on attempts to revive the productive sectors, not least agriculture, and economic infrastructure. The cuts made in government expenditure and the squeeze of funds from the social sector caused wide criticism of the whole SAP. The rapidly declining health conditions and reduced inputs in education had an influence in preparation of the second ERP II for 1989-92 during which priority social action programme (PSAP) was 'appended' to the main programme (Mabele 1994:64).[7]

PSAP acknowledged that the commitment of the Tanzanian government to the social sector since the independence was a correct one and still valid. The document acknowledged also the need to try new managerial strategies and to pay attention to sustainability. To quote: 'The objective of priority interventions in the educational sector is to ensure *a smooth transition from a centrally funded school system to one that will be mainly funded by the local community*'. Decentralisation has been the theme since, although its implementation has taken time.

According to PSAP financing increasing resources to the social sectors would be possible through budgetary shifts, user charges (cost-sharing), community contributions and participation in support of health services. Dependence on foreign aid would continue. 57 per cent of the costs were projected to be covered from external donor sources. No estimates were made of the country's own contribution, but potential sources were listed: budgetary reallocations, money obtained from food aid, debt swamps, user charges, contribution in kind through self-help, fees from hiring PSAP constructed facilities, and interest obtained from credit advances. (Ibid. 1994:65-66; 120-121. See Annex Table 2; The United Republic of Tanzania 1989)[8].

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[7] Mabelle, Robert B. 'The Health Sector Structural Adjustment and the Environment', *in The Economic Trends. A BI-annual Review of the Economy*. Vol. 7, No. 1 June, and No. 2 December 1994

[8] The United Republic of Tanzania *Priority Social Action Programme. A Summary. Report*, prepared by the Government of Tanzania for the Meeting of the Consultative Group for Tanzania, Paris, December 1989. Dar es Salaam 30 November 1989 (see Annex Table 1).

A Social Dimension of Adjustment Unit (SDA) under the Macro-Economic Directorate of the Planning Commission was to oversee the implementation of PSAP and to liaise with the Line Ministries. UNDP was the executing foreign donor agency. The donor contributions were slow in coming and lacked sustainability. We return to this problem in the context of the case study from the southern Tanzania.

In the beginning of the 1980s the Tanzanian government allocated one quarter of its budget for Social Services (25.5 per cent), more than the country's defence budget.[9] The peak year was 1984/85 (26.7 per cent). The figures differ depending which services are included in the Social Services. Other items variably included in the social sector budget besides health and education were social welfare, housing and community development, water and electricity and miscellaneous social services. Annex Table 3 puts the social sector to 30.5 per cent. After accepting the IMF induced economic recovery programme the Social Services sector was reduced to 17.5 per cent in the 1986/87 budget. In the Ministry of Finance statistics (Annex Table 3) the figure is 15.3 per cent. It still was more than the defence budget (which was 11 per cent) but severe cuts had to be made in the health and education programmes.[10] The allocations declined to 4.6 per cent 1989/90 and then came up again to 18.2 per cent 1991/92.

Tanzania which counts as the second poorest state in the *World Bank Development Report 1995* rises 30 countries higher when social indicators are taken into consideration, as shown by the Human Development Report 1996 (144th country of the 174 included). The Capability Poverty Measure, based on three variables: underweight children, unattended births and female adult literacy, ranks Tanzania 40 points higher than the Real GDP per capita rank and puts it in the 58th place of the 101 countries included in the table (Human Development Report 1996:109-112).

The social sector has still today a priority, although the structural adjustment programmes that the country has been obliged to undertake have greatly reduced the expenditure for the sector. The social sector strategy of 1994 provides a general guide for future development in the social sector. Even after almost two decades of economic decline, the Tanzanian health programme is still in principle oriented toward serving the total population, but the financial allocations have been reduced and increase of user fees together with privatisation has advanced steadily.

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[9] The defence budget was 24.5 per cent. The speech by Malima gives the budgeted figures from the total development budget estimate for 1983/84 as follows: directly productive sector 42.1 per cent, economic infrastructure 35.6 per cent and social infrastructure and administration 22.3 per cent. The speaker emphasized the bias towards directly productive sectors as being a shift from the earlier emphasis (cf. Fn.1).

[10] Meena, Ruth, 'The Impact of Structural Adjustment Programs on Rural Women in Tanzania', in *Structural Adjustment and African Women Farmers*, University of Florida Press, Centre for African Studies, Gamesville 1991:169-191 (cf Table 2).

1.3 Developing educational programme

The child has a basic human right to primary education. Tanzania had recognised that the state has the duty to provide basic education long before signing the Convention on the Rights of the Child which in the Article 28 obliges the state 'to make primary education compulsory and available to all' (UNICEF 1996:163).

Education was a priority area of development when the *ujamaa* programme was introduced. In 1967 the first president Julius Nyerere formulated an education policy, Education for Self-Reliance, which aimed at making the schools an integrate part of self-reliant communities embodying the precepts of equality, human dignity and the value of work (Lugalla 1993).[11] With people's self-help and support from donor agencies the Tanzanian government also embarked on a massive adult education programme which brought adult literacy to 85 per cent by 1987.

The government declared education to be obligatory for all by 1977. Through the Universal Primary Education (UPE) all the school age children were to be given a chance to attend primary school. School children enrolled for Standard I doubled from one year to another in 1975. A countrywide crash programme for training teachers had to be organised. Ward level Education Coordinators were mobilised to give training courses and in-service training to selected Std. 7 leavers. Schools were built by village communities with support of the government and teachers with shaky competence filled the open posts.[12] In 1983 90 per cent of all children (with some exceptions) were living within 4 km of a school in the rural communities and the enrolment figures rose to 74 per cent in 1994 (UNICEF 1996:163).

The way in which education was implemented was in some ways in counter purposes with the declared policy of 'education for self-reliance'. After independence the practical subjects were removed from the syllabus and the teachers trained in agriculture and carpentry were transferred to regular teaching duties. The educated Tanzanians conceived the practical subjects to be 'Bantu education' which did not belong to a more sophisticated school system. There still are remnants of this thinking in the Ministry of Education. It divorces education from practice, concentrates on academic learning and takes theory as a model. It has resulted in a generation of young people who are not prepared or able to do practical work. In the words of the parents their youth 'do not know anything', because they have not learned any useful skills for village life in school. Agriculture which is part of the school activity deteriorates often to bare work duty in the absence of teachers or to toiling on teachers' fields. The issue of teaching programme will be discussed in the second part of the paper.

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[11] Nyerere, Julius, 'Education for Self-Reliance' in *Freedom and Socialism*, Oxford University Press, Dar es Salaam, Nairobi, London, New York 1968:267-290. Lugalla, Joel L. P., 'Structural Adjustment Programme and Education in Tanzania' in Gibbon, Peter (ed.), *Social Change and Economic Reform in Africa*, the Scandinavian Institute of African Studies, Uppsala 1993.

[12] According to some estimates more than 70 per cent of primary teachers are still underqualified (Draft Proposal for Strategies...SIDA, 1996:7). Supplementary teacher training courses have been conducted later for the so called UPE teachers but the basic education continues to suffer from the weak educational base that a large number of teachers had.

The government is still the main funder of education but a substantial part is contributed by families. Since the UPE, families have paid a fee for children's education. Until today it is officially 200 shs but, in fact, there are additional hidden costs which the families provide in the form of uniforms, desks, school supplies, sports equipment, food, etc. Because of the extra costs the poorer parents feel they cannot afford sending their children to school.

In 1996, a total of 6.1 per cent of GNP was spent on education. Of total expenditures for education, 60 per cent is provided by the government, 30 per cent by households and only 10 per cent by external donors (Ibid.).

The Annex Table 2 shows that in the 1980s education had been given twice or three times the amounts allocated for health. More than a half of the total budget for social services was earmarked for education throughout the 1980s. While in 1981/82 the government allocated 18 per cent of the total budget to education, in 1984/85 the figure was 8 per cent (Meena 1991:180), and in 1996 6.1 per cent, yet the numbers of children had grown rapidly, the average annual change in population being 3.36 (rural 2.44) per cent (The World's Women 1995:62).[13]

In constant 1980 prices the total capital expenditure for primary education declined from 40.4 million shs in 1981 to 17.1 million in 1985 (15.2 per cent to 11.0 per cent of total for education) while corresponding figures for public secondary education grew from 22 million in 1982 to 58.6 million in 1986 (Meena 1991:183). In 1982/83, 58 per cent of total educational expenditures were allocated to primary education against 16 per cent to higher education. The trend to transfer from primary to higher education is evident. In 1990/91 only 46 per cent was allocated to primary education against 30 per cent to higher education. According to official estimates a yearly cost for a primary school pupil is USD 20 against USD 4,400 per university student.

Even if the allocations percentage wise have shown the priority status of education, the funds received by schools have been crudely insufficient. The schools have suffered from shortage of funds for basic supplies, buildings, teaching aids of all kinds, even food to feed the students in boarding schools. The decline of educational services is obvious. The number of children attending school has dropped dramatically and the number of drop-outs has also increased steadily. 30 per cent is estimated to drop out of school before completing the primary cycle. From the one time high net enrolment rate of 70 per cent (gross enrolment 74 per cent) there has been a drastic drop to roughly 55 per cent net enrolment by 1996 (UNICEF 1996:164).

In the south-eastern regions the school enrolment is even lower than the national average. In Mtwara region it is estimated that at present only 40 per cent of the primary school age children attend school and only one half of those who begin school finish Std 7. Part of the reason is inadequate facilities, but motivation for learning has also sunk because the returns and rewards are minimal. The schools do not equip the youth to

[13] *The World's Women 1995*. Trends and Statistics. United Nations, New York 1995.

enter into work life and only 4 per cent have passed the entrance examination to secondary education. Many schools pass only one or two students annually to secondary education and there are schools which never yet have had any passes.

The numbers in secondary schools have always been low in Tanzania - the lowest in the world, possibly with the exception of present Rwanda - since the policy was to offer some education to all children rather than educate a small class of elite. The percentage of students entering secondary schools, however, doubled in five years, from 3 per cent in 1983 to 6.3 per cent in 1987/88 according to the Ministry of Education figures (Meena 1991:183-4). Entrances have increased rapidly in recent years since private schools have been started by local development corporations, religious bodies and parents. Many of these schools have taken in students whose marks did not come up to the passing mark in the national Std. 7 examinations.

The low salaries in both education and health sectors, and the long intervals before the salaries at times have reached the employees, have forced the workers to earn money with sideline projects. Professional employees cultivate, keep livestock, sell products, have small shops or kiosks, etc. Teachers tutor outside of school hours and health workers give injections and distribute medicines, usually from public stores. In 1983, primary school teachers were receiving salaries at the rate of USD 662 while teachers in Kenya took home USD 1,233, and the average salaries of teachers in sub-Saharan countries were USD 2,255 (Meena 1991:180).

Now, after ten years of steady cutting the health and education sectors are again receiving priority treatment. UNICEF is investing heavily in primary education in the coming five year period and the World Bank with its new emphasis on social sector is providing new extensive loans with a controlled funding programme, partly administered through non-governmental agencies and private agents. The system is based on considerably larger user contributions than the case has been so far.[14] It contradicts with the basic principle that every child has a right to education since it discriminates against the poorest part of population. The issue at hand is how this right can be realised.

1.4 Evolving health sector policy

The ten year health sector development plan 1971/72 - 1980/81 aimed at reaching the maximum number of people in the rural areas with basic health services. The service infrastructure was to be expanded drastically to provide curative and preventive services to the majority of population. 'The Health for All' (HFA) programme was implemented with an early adoption of Primary Health Care as the core of the health services.

In 1972 the Ministry prepared a health plan which provided the blueprint for implementing the National Health Policy. The aim was to provide a health facility within the reach of everyone (See Annex Figure 1 for structure of health facilities).

[14] The parents of a primary school pupil is expected to contribute ten times the fee they have been contributing so far, a rise from 200 to 2000 Tsh. More of the WB programme later.

There was to be a village health post for each village, a dispensary for every 10 000 people, a health centre for every 50 000 people and a hospital in each district and region. By 1980 about 72 per cent of the people lived within 5 km of a health facility and another 20 per cent were 5 to 10 km away. Four to five contacts per person per year were made with health services. All services were free of charge (Planning and Management...1991:3; Report from the Joint...1982:7).[15].

The rural health facilities were to be served by trained auxiliaries, medical assistants, rural medical aids (RMA), nurses, health assistants (HA) and mother child health aids (MCHA). In 1978/79 56 per cent of the health workers worked at hospitals, 14 per cent at health centres and 30 per cent at dispensaries. Only 2 per cent were university trained doctors, 17 per cent nurses, 5 per cent RMAs and MCHAs and MAs 2.5 per cent of each. 61 per cent were 'other categories'. In 'other categories' were included village health workers (VHW) and traditional birth attendants (TBA), both trained in short courses starting from 1983, and dispensary assistants, who often were upgraded from being cleaners and learning through practice. 'Other workers' covered also such categories as (environmental) health assistants or dental assistants. With an increasing emphasis on primary health care (PHC), an accelerated training programme of most categories of health workers was put in place to which several development agencies contributed substantially[16]. Moving of resources from highly costing hospitals and curative services to prevention and wide distribution of primary level care was not as easy in practice as in theory. Three large referral hospitals drained a large chunk of the health budget. A special mother and child health services programme had been initiated already in 1974. An expanded programme of immunisation (EPI) which aimed at immunising all children by 1988. Another preventive programme in place already in the 1970s was tuberculosis and leprosy control programme to which later was added essential drugs programme (EDP) (Planning and Management...1991:3,7)[17].

When the cost of providing health facilities for all the 8 300 villages proved to be an insurmountable task the training of village health workers (VHW) and traditional birth attendants (TBA) in short courses was started, with the emphasis on preventive and MCH care to supplement the other paramedic services. The training of these workers was seen to be beneficial not only for financial reasons but for promotion of the PHC at the grassroots level. By 1988 about 2000 VHWs had been trained.

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[15] Report from the Joint Swedish/Tanzanian Health Sector Review in Tanzania, April 1982. SIDA Health Division, Stockholm 1982. *Planning and Management of Primary Health Care in Tanzania. A Manual for District Health Teams*, eds. Magari, F., E.G. Malangalila, S. M. Mukoyogo, S. S. Ndeki and C. J. Nyoni. Ministry of Health, GOT, Dar es Salaam 1991.

[16] Finland's contribution was the building of 11 rural medical aid training schools 1973-79 which were in full operation by 1983. One of them, the centre in Arusha, was converted to a centre for educational development for health (CEDHA), the task of which was the educational development and retraining of teachers in the country's 97 health workers' training institutes (*Effects of Finnish Development Cooperation on Tanzanian Women*: Swantz, Marja Liisa, *Concluding Report*, Report1/1985B Kokkonen, Päivi, *Finnish Aid to the Tanzanian Health Sector. A Study of the Training of Rural Medical Aids and the Health of Women.* Report 2/1985B. University of Helsinki, Institute of Development Studies, Yliopisto paino, Helsinki 1985.)

[17] EPI and EDP have been supported substantially by the Danish International Development Agency.

At the instigation of the Swedish International Development Authority (SIDA) an extensive evaluation of the health sector was carried out in cooperation with the Ministry of Health of Tanzania (MOH) from 1978 till 1981. At a conference organised by the MOH and SIDA, leading members of the medical profession and all major donors attended to summarise and evaluate the findings, and to plan further the health sector activities.[18] The inventory 1978/79 had covered all health institutions in all twenty regions and was followed by a regional health sector analysis. The data thus compiled provided good comparative base in assessing the later development in the health sector.

The guidelines for 1980 - 2000, proposed by the MOH to realise the goal HFA, had following objectives among others:

i) To raise average life expectancy at birth from 50 (1978) to 60 years by reducing infant mortality rate from 137 per 1000 births during the first living year to 50 per 1000.[19]

ii) To provide health for all by using PHC approach.

iii) To increase self-sufficiency in *man*power.

iv) To improve the management of health care delivery system at all levels through training and retraining, including the development of a viable health information system.

v) To involve the people in implementation and management of health projects and programmes; 6. To improve the drug supply system and to strive for self-reliance.

The peak level of 9 per cent from the total government budget was spent on health in 1973/74, the very years in which Tanzania experienced her first financial setback because of a severe drought (Meena 1991). In 1981, 2.8 per cent of the GDP was spent on recurrent health services (52 shs per inhabitant) while in 1980 per capita income was 1,978 shs in 1980 prices. In addition, the country was served by voluntary agencies' health institutions, which customarily charged a moderate fee. In 1980/81 the Voluntary

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[18] As a continuation to this evaluation the writer was asked by the MOH to assess the impact of the health services on the ordinary village women. Having worked in a participatory mode I proposed a plan to be financed by FINNIDA to develop an ongoing evaluation system which would be built into the training of health workers. It resulted in a series of training workshops for healthworkers trainers from all the levels in all the zones and the inclusion of the village participation component in the curriculum as part of the community medicine course. From Finland the Physicians for Social Responsibility were involved. A guide for use by the healthworkers' training institutes was developed in a participatory manner and later published in three editions: *Mbinu za Ushirikishwaji wa Jamii katika Kuboresha Afya. Mwongozo kwa Wafanyakazi wa Afya*, CEDHA, Arusha 1993. 3rd version (earlier versions: 1985, 1988; Translation: Methods for People's Participation in Improving Health. Guide for Health Workers.) The book is still in use in healthworkers training institutes, but practical training has dwindled to minimum because of lack of funds.

[19] The Human Development report shows infant mortality rate 85 per 1000 and life expectancy at birth 52.1 years (1993). The WB corresponding figures are 90 and 47 years (Cf. WB Report 14982-TA:73).

Agencies contributed 18 per cent of the total health expenditure. (Report from Joint ...1982:6; App. XII:iv).

In spite of the economic decline the government supported rural health centres increased from 22 at Independence to 161 in 1976 and 260 in 1986. The number of dispensaries increased from 1,847 in 1976 to 2,831 in 1986. In 1986 there was one rural health centre per 84,231 people and one dispensary per 6,846 people. By the end of 1980 there were 20 000 inhabitants per doctor compared to 28 000 by 1972. In 1992 the reported figure is 21 496 per doctor (WB Report 1996). Of the total health care expenditure 65 per cent was spent in rural areas which had 90 per cent of population. Donor support to the cold chain system including procurement and distribution of sufficient and regular supplies of vaccines to over 3500 health delivery points each year has made it possible to sustain the MCH programme so that immunisation coverage has been maintained.[20] By 1985/86 it was estimated that about 80 per cent of children had been immunised against tuberculosis and 67 per cent against measles and 80 per cent coverage has been maintained till the present time.[21]

1.5 Budgetary concerns in health sector

In the planning and evaluation of the health sector policy or practice during the decade 1970-80 there was no discussion about the cost coverage, apart from reporting how much and in which parts of the health service each development agency had provided and were going to continue to assist. The reports reveal that 63 per cent from the health development budget 1981/82 was to be covered by foreign assistance, SIDA providing 15 per cent of it. SIDA had been the biggest donor in the health sector since 1972/73 and continued to be so, equalling with UK for 1981/82 (The Joint Swedish...1982:14).

It was assumed from the start that the implementation of the rural health service programme required a substantial self-help component. Community participation and the responsibility of people to care for their own health were recognised aspects of health care throughout the planning but there were difficulties in implementation. The non-specified 'people' contributed at times up to 50 per cent of the construction costs giving free labour and local building materials. It was taken for granted that 'people' would continue to contribute but the reports do not contain any discussion as to how the recurrent costs would be covered in future. There was no questioning whether 'the people' would continue to construct buildings to cover the expanding needs, or to maintain them, or whether 'the people's' contribution could come for recurrent expenses from the 'people' in another form than labour and building materials. The estimates in cash of 'people's' labour and material contribution were not included in the budgeting. To my knowledge this is the case until today. Even the new UNICEF plan for 1997-

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[20] The role of UNICEF, WHO and DANIDA needs special mention, but the government and MOH are determined to maintain the basic services.

[21] Johnsson, Urban, 'The Health Sector in Tanzania 1980-87'. Paper presented at the 5th Economic policy Workshop, Dar es Salaam, May 1988 (quoted in Meena 1991:177). Country Programme Recommendation 1996.

2001 is devoid of discussion of the costs apart from what the UNICEF's own continued support will be.[22]

The cost sharing programme for health services in the form of user charges was introduced with the Health Sector Reform Plan in 1993. It was to be implemented in four phases. The first phase covered grade one and grade two patients and the second phase also grade three patients in the referral and regional hospitals. The third phase concerned grade three in and out-patients in district hospitals. The implementation of the fourth phase, which concerned village dispensaries and rural health centres, was delayed and had not yet been implemented in June 1995. Even the hospitals which were permitted to charge were directed to exempt Maternal and Child Health services with an affirming directive by the Minister of Health in June 1996. Thus exempted groups were pregnant mothers until delivery, children under five years, and in addition, patients with epidemic diseases such as AIDS, meningitis, cholera, and dysentery as well as patients with diabetes.[23]

Not all health care requires funds for implementation. The maternal mortality has been very high and has not always received the attention it needs. UNICEF reports most recent figures based on hospital data at 342 maternal deaths per 100,000. A community based safe motherhood initiative, emphasising low cost affordable interventions with full household participation, has shown significant 45 per cent reduction of maternal morbidity in the districts in which its has been applied with participation of several agencies (UNICEF Country Programme of Cooperation 1997-2001. Master Plan 1996).[24]

The factors which make women vulnerable, such as poor nutrition, heavy work, powerlessness to make decisions, incorrect information and inadequate service delivery, are mostly avoidable without large monetary inputs or even without trained health personnel. This points to the importance of intersectoral approach to Primary Health Care. Intersectoral approach is put into practice in implementation of the health programme in the regional and district primary health care committees which combine development and medical officers, agricultural, education, water, information and administrative officers and non-governmental organisations (Planning and Management...1991:14-15). Participation in such committee meetings gives evidence that intersectoral work is not easy to accomplish on the committee level if it is not implemented in practice. The medical personnel tend to lead the discussion to their professional needs unless concrete local problems such as environmental measures for malaria prevention frame the discussion.[25]

The issues involved in user charges and community support for their health services will be covered in a later section.

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[22] I place the 'people' in quotations marks to indicate that in debate about the cost sharing the category has to be broken down to different components.

[23] Sunday News June 4, 1995.

[24] Evaluation was done in one district. The programme will be intensified (UNICEF Plan 1996)

[25] Notes from a PHC regional meeting in Mwanga, Kilimanjaro Region March 1993.

1.6 Water and sanitation

The third sector to be considered in this paper is water and sanitation. Since the beginning of the 1970s the basic need of providing communities with potable drinking water was given priority treatment, not only in Tanzania, but universally. 'Water for all by the year 2000' was the slogan. For Tanzania the programme became one of political credibility of the ruling Party. I refer here to my earlier study and other case studies on water development, particularly in Mtwara and Lindi regions (Swantz 1989; von Troil 1986; Sitari 1984 and 1987; Therkildsen 1988).[26]

Tanzania launched her Rural Water Supply Development programme with a planned cost of USD 700 million at 1971 constant prices (Mutahaba 1987).[27] Mutahaba points out how the acceleration of development speed distorted the water supply programmes and transferred the total responsibility of building the water system from the hands of the Ministry of Water and regional water engineers into donor hands. In place of programme support, project support became the dominant form of assistance. The programme prepared by the Ministry of Water was discarded. It would have taken longer time to carry out, but the responsibility would have remained in the hands of the local people. All the regions were divided between various donors. At the same time the WB declared its shallow well programme which forced the implementers of projects to reject the drawn plans and carry out a crash programme with little previous planning (Swantz 1989:141). Almost all assisting countries have had their water projects and have experimented in ways of making the local population feel ownership of the wells and water supply systems. These problems relate to difficulties faced in development assistance in general.

The 1970s was also the decade when the donors' initially more altruistic and recipient-oriented programmes were changed to policies which were accentuated with the spirit of 'enlightened self-interest'. In practical terms, it meant that the technical projects were expected to have a high return flow back to the donor countries in terms of commodity and import support, cash disbursements and use of foreign personnel for technical assistance. This meant that the capital goods were supplied from the respective donor countries. The water pumps were developed and supplied by each donor separately and cooperation was difficult to bring about. The WB organised a study of most viable pumps but the 'self-interest' deterred the use of the results. Interestingly enough, one of the main findings was that technology was not the main constraint; participation of people in the whole process was a central issue. It took two decades before the donor

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[26] Water Supply Project was one of the case studies of the Transfer of Technology research project the results of which the writer as the director of the project gathered together (Swantz, Marja Liisa, *Transfer of Technology as an Intercultural Process*, TAFAS 24, The Finnish Anthropological Society, Helsinki 1989; von Troil, Margaretha, *Exchange of Knowledge in Technology Transfer from Finland to Tanzania*, University of Helsinki, Institute of Development Studies, TECO Publications No. 12; Report B series 11/1986; Sitari, Taimi, *Technology Transfer to Developing Countries: From Place to Place or from Space to Space*, ibid. Report B series 15/1988; Therkildsen, Ole, *Watering White Elephants? Lessons from Donor Funded Planning and Implementation of Rural Water Supplies in Tanzania*, Centre for Development Research Publications 7, Scandinavian Institute of African Studies, Uppsala 1988)

[27] Mutahaba, Gelase, 'Foreign Assistance and local Capacity-Building in Tanzania', Working Paper at the EADI General Conference 1-5. Sept. 1987.

agencies or even the government conceded to the fact that participation of all parties concerned in development was central to any development effort (Ibid.).

At the present time it is difficult to estimate the coverage of clean drinking water for the population since the working condition of the shallow wells or the operational level of piped water systems varies from season to season and location to location.[28] The weakness of the programme is shown in the weak post-project performance. When user cost was not indicated for political reasons at the time of building the systems, introduction of payments *post factum* for wells to which people do not feel ownership is an overwhelming task. In the two southern regions with which we are specially concerned here it would not be an exaggeration to say that one third of the population is within the reach of reasonably safe water. We shall return to the discussion of problems in the water sector in the concluding sections. (See Annex Table 3 for country statistics. Annex Table 4 gives the 1988 statistics of distribution of source of water in rural areas.)

Sanitation is an even more complicated issue than water. Tradition affects people's behaviour in this area of life much more than what is obvious even to people themselves. Some customs originate in long-forgotten traditions, the significance of which has no relation to the present mode of living, yet they linger and prevent an improved practice. These are areas of life in which PHC with no or little additional cost is possible to implement. The aggregate figures of a survey which was completed 1994 show that 11.9 per cent of population have no facility for latrine, 86.9 per cent have a traditional pit latrine in rural areas. In urban areas only 2.2 per cent are with no facility and 91.1 per cent have a traditional pit latrine (Annex Table 5).

With all the three service sectors the prevailing sentiment of dependence on outside assistance does not only pertain to village people but also to the administrative personnel. Within the RIPS [29] programme we have two dominating metaphors for this dependence. To the question why a school building has not been constructed, a well does not work or why an agricultural programme has come to halt the most common answer is, *hatujaletewa* (tools, seeds, spare parts) have not been brought to us. 'Waiting for nails' is another signum. When nails were provided for building an adequate goat house, even a wealthy man did not build a shelter for his goats before he got his nails. This kind of dependence on external provision of social services makes the problem similar to the corresponding problem in the North where dependence on social service coverage is pervasive. The difference is only of scale.

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[28] The Ministry of Water regional statistics are inadequate, and the channels of information about breakages and local needs for repair of the water system do not operate well.

[29] RIPS is a Regional Integrated Project Support programme supported by the Ministry for Foreign Affairs of Finland in which the writer has been serving as a senior sociologist.

2. CASE STUDY

2.1 Social services in Mtwara and Lindi regions

What has been said about the provision of social services in Tanzania in general pertains by and large also to the Mtwara and Lindi regions. There are, however, some differences in the structure and culture of the south-eastern societies which have affected the recent development. Whereas in the northern part of the country citizens, especially parents, have taken the responsibility of starting schools this development has been slower in the south-eastern regions. There are historical and cultural reasons for this, the regions have until now suffered from greater isolation than the northern parts of the country.[30]

Outside the government system but substantially supported by both the colonial and independent governments, the Catholic and Anglican churches have been active in the south-eastern Tanzania for over a century and their influence in the area of social services is not negligible. The Mtwara and Lindi regions were among the first in Tanganyika (the mainland Tanzania) for the work of the Universities Missions to Central Africa, UMCA. Before the turn of the century the German Benedictines entered and established themselves in both regions. The missions initiated western type of education and started primary schools in villages. Later secondary schools, teacher training schools, medical workers' training, and technical training were started by the churches.[31] UMCA emphasised women's education from the beginning. Three of the women who have led the national women's movement have come from the Mtwara region as also the present President of the United Republic of Tanzania, Benjamin Mkapa. UMCA and Catholic missions, which in the 1960s became national churches, also started hospitals, dispensaries and clinics as well as nurses' and medical assistants' training. After independence the church schools and other educational facilities were nationalised whereas many of the medical institutions continued to be run by the churches. The UMCA health facilities were nationalised in the 1970s, but in the recent privatisation process the main hospital Mkomaindo in Masasi has been offered to be returned to the Anglican Church. The Catholic Church retained their support to their main large hospitals and have continued to give high level medical service charging moderate graded payments. The Catholic Church has also made an impressive contribution with their technical training institutions in Ndanda and Lukuledi.

Islam spread in the south-eastern regions before Christianity, but the Islamic learning which was limited to religious texts and made use of Arabic script was not made part of

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[30] I refer to the longer version of this paper which deals with the historical and cultural development in the two regions. For early history see e.g. 'Mikindani Bay before 1887', *Tanganyika Notes and Records* (TNR) No. 28 (January 1950): 29-37. UMCA was initiated in the universities of U.K by the inspiration of David Livingstone who visited Mikindani 1866. Anderson-Morshead, A. E. M., The History of the Universities' Mission to Central Africa, vol. I, 1859-1909. London, 1955. Blood, A. G., The History of the University Missions to Central Africa. vol. II (1909-1932), London 1957; vol. III (1937-57), London 1962. Liebenow, Gus J. *Colonial Rule and Political Development in Tanzania: The Case of the Makonde.* Northwestern University Press, Evanston 1971.

[31] I specify the number of VA institutions in the later version of this paper.

the official educational system.[32] Muslims experienced the Christian presence as a threat to their converts' religious identity. This meant that government supported school education did not penetrate the Muslim communities. Islam became a kind of an umbrella under which people could protect their traditional ways of life and were slower to enter their children to schools.

The colonial government initiated a Makonde Water Development Corporation in the 1950s and built a water supply scheme which provided water for a large part of the dry Makonde Plateau. The water was bought at water kiosks, ten cents for two calabashes, reminisces a man who was a young boy at a time (von Troil 1986:71-72).[33] The scheme went out of operation after independence in 1970s when the Tanzanian Government promised free water. We shall return to discuss this problem below.

After the country gained independence in 1961 the south-eastern regions were affected by the independence struggle of Mozambique which Tanzania supported and for this purpose isolated the southern parts of the country as an emergency area. It remained a restricted area until the independence of Mozambique in 1974, after which the refugee settlements gradually became ordinary villages. The emergency state gave the government opportunity to carry out the country's first villagisation operation in the Mtwara region in the late 1960s and early 1970s[34] which had long lasting effects on the development in the regions. The regional director of development in Lindi region reported in 1981 that the entire rural population of the Lindi region lived by 1978 in registered villages.[35] The process had been completed. As elsewhere, under the Villages and Ujamaa Villages Act 1975, each village had an elected Village Chairman and Committee responsible for controlling its affairs.[36] The villages also had the legal status of a primary cooperative society and they acted as marketing agents for villagers' crops. Starting from the fiscal year 1977/1978, the villages had also appointed village

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[32] The British Government supported a fact-finding mission to study Muslim education in East Africa in 1957. It was followed by a conference on Muslim education held in Dar es Salaam, which was attended by 40 professional educationalists and Muslim delegates from Tanganyika, Kenya, Uganda, Zanzibar, British Somaliland, the Sudan, Somalia and Northern Nigeria. The Mission's report recommended the preparation of a series of text books in Arabic for non-Arabic speaking children, an improvement in the teaching of the Arabic language, an increase of Muslim teachers in primary schools, and an enlargement of the Muslim Academy in Zanzibar so that it might become a centre for teaching Islam and train teachers in Islam for the whole East Africa. The Mission also proposed more educational broadcasting, an adviser on Muslim education, and the provision of administrative help for Muslim education associations. *Report by the Fact-Finding Mission to Study Muslim education in East Africa*, V. L. Griffiths and R. B. Serjeant. East Africa High Commission, The Government Printer, Nairobi 1958. Reported in Tanganyika Standard 29 September 1958.

[33] Von Troil, Margaretha, Exchange of knowledge in technology transfer from Finland to Tanzania, Report 11, series B; TECO Publications No. 12, Institute of Development Studies, University of Helsinki 1986.

[34] The Party had a chance to start the first villagisation operations because of emergencies. In the Rufiji basin the resettlement took place about the same time because of unusually big floods in the valley.

[35] Lindi Regional Integrated Development Plan 1981-86, Regional Commissioner's Office, Lindi, 1981.

[36] The names of candidates for village chairmen had to be approved by the Party which could reject the names if they for some reason did not satisfy the Party requirements.

managers to advise the village committees. The refugee agencies[37] assisted the creation of social services for the Mozambican refugees in the settlements which after the departure of most of the refugees were turned to regular cooperative villages.

Since the early 1970s external development schemes have been carried out by agencies of development assistance. The Finnish International Development Administration, FINNIDA,[38] has been active in the regions since 1972, first making regional master plans, then a Water Master Plan and implemented the plan in 1980-1990. British Overseas Development Administration, ODA, also made a Mtwara Regional Integrated Development Plan 1981-1986 with the regional staff and implemented parts of it until Thatcher cut off the aid to Tanzania. The Finns returned to give support to the regions in carrying out the Regional Integrated Project Support, RIPS, which has been implemented in two phases, the Phase I from 1988 till March 1993. The RIPS Phase II (1994-1999) is at present being implemented as a participatory programme in which the service functions play an important role.

UNICEF started its programme in Mtwara region in 1980 and has been active in the Child Survival, Protection Development, CSPD, which includes the service sectors this paper deals with. UNICEF is starting a new five year Country Programme of Cooperation 1997-2001 in the Mtwara region. The Danish International Development Assistance, DANIDA, has implemented a rehabilitation programme of tertiary level schools and training institutes and has assisted in the EPI programme. The World Bank has been supporting the agricultural sector, especially cashew production, and has assisted the rehabilitation of health facilities in the Lindi region. WB has also carried a pre-test in ten schools in Mtwara rural district in cooperation with an external consultant, but in future cooperates with RIPS and UNICEF in carrying out the pilot programme in education, covering in three years time all the 38 schools in the Mtwara rural district.[39]

2.2 Social service statistics in Mtwara and Lindi regions

From the 1988 census figure 889,494 population of the Mtwara region is estimated in 1996 to have grown to approximately. one million, with the growth per cent 1.4. For the Lindi region the corresponding figures are 646,550 and 744,788 (Mtwara Rolling Plan 1996/97-1998/99; Lindi Plan 1996/97).[40] The deterioration of social services in the two

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[37] UNHCR and the Lutheran World Service

[38] FINNIDA is no longer in use for the Finnish International Development Administration, but it is referred to now and then for the sake of brevity and also because that is the popular term in use.

[39] Rural Integrated Project Support (RIPS) Programme, Lindi and Mtwara regions, Tanzania. Programme Document, Phase II 1994-1999. URT and GOF. Revised Document May, 1996. Report of: MOE&C and WB Joint Visit to CEF Pretest Schools and RIPS Schools in Mtwara Rural District, 18-20 June, 1996. Dar es Salaam 22 June 1996.

[40] Mkoa wa Mtwara, Fungu 80. *Rolling Plan and Forward Budget 1996/97 - 1998/99 na Bajeti ya Mwaka 1996/97* (Kama ilivyokubaliwa na Tume ya Mipango na Hazina), Jamhuri ya Mwuungano wa Tanzania, Ofisi ya Waziri mkuu. Ofisi ya Mkuu wa Mkoa, Mtwara. Mkoa wa Lindi, Fungu 76. *Mpango wa Maendeleo wa Mkoa 1996/97* Jamhuri ya Muungano wa Tanzania, Ofisi ya Waziri Mkuu. Ofisi ya Mkuu wa Mkoa, Lindi.

regions in the 15 past years has been in many ways alarming, even if the records tell also of some positive developments.

The education sector

According to the 1978 census, of the total the population over 5 years of age, 72-75 per cent had not had any formal education in either Mtwara or Lindi regions. Ten years later in 1988, the percentage of those who never had attended school was reported to be 53.5 per cent in Newala district and 45.4 per cent in Masasi district.[41] In the beginning of the 1980s, after the universal primary education had been enforced, the enrolment of the age group 7-13 years in primary schools in Mtwara region was reported to be 90 per cent, as a consequence of the accelerated primary education programme.[42] By 1996 the numbers attending school had started to dwindle and truancy was rampant. While the enrolment in primary schools in Mtwara region was 139 803 pupils in 1981, it was only 127,584 (in 482 schools) in 1995, but increased slightly by 1996 to 130 398, according to the regional estimate.[43] The more detailed data from several schools below indicate the general trend. The 1996 regional plan gives 1,731 (1.2 per cent) as truants who left the school during the year, of whom 731 were girls. In 1994 the corresponding figures were 997 (0.8 per cent) and 394 girls. This would indicate that the trend is no longer steadily rising. The reason given for the girls' leaving school is early marriage. However, an analysis made in ten Mtwara rural district schools revealed that the female gap was small, out of 2 530 pupils girls were only 14 less than boys.

The situation of declining enrolment of children is similar in Lindi region. In 1974 Lindi region had 194 primary schools and in 1996 339 schools with the enrolment of 86,711 pupils. This would mean only 36 pupils per one class, assuming that each school had only one stream in each standard, which seldom is the case. The region reported the difference of 130 between girls and boys in 1991 (35 990:36 120) and 611 in 1996 (42,161:44,550) (Lindi ---Plan 1996/97:17). According to the most recent 1996 figures in the Ministry of Education the number of 7-year old children in Lindi primary schools is 4011, with a difference of 21 between girls and boys, whereas 11-year olds are 12 734 (6 456 boys, 6 278 girls) with the difference of 178 (1.4 per cent). For the 13 year olds the difference is 470 (out of the total 10 044, 4,68 per cent). The Bureau of Statistics figures show the total difference to be 2 389 (2.75 per cent).[44]

In general, the gender gap hardly can be considered to be very large in regions in which universal education is a relatively new concept. One likely reason for the growing gender gap in the upper classes is the older age at which the children enter school

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[41] *1978 Population Census, Vol. VII. Basic Demographic and Socio-Economic Characteristics.* Bureau of Statistics, Ministry of Planning and Economic Affairs, Dar es Salaam 1982. 'Feasibility Study on the Soil and Water Conservation Project in Makonde Plateau, Mtwara', proposed by the Regional Commissioner's office, Mtwara, 1994.

[42] *Mtwara Regional Integrated Development Plan 1981-1986.* URT Mtwara 1981:31.

[43] The 1981 figure is an estimate updated from the 1978 census figures (Fn. 12).

[44] Oddly enough, the difference for 14-year olds was reported to be only 3, but out of the rest 9 558 students up to 17 years there were 1 036 less girls than boys (10,8%). The inadequacy of the data is obvious.

because of the crowding and lack of space for all the registered children to get in. Every year more and more children stay outside which means that only relatively few 7 year olds start school. The girls mature and get pregnant or are married off before they finish the school. If the statistics can be trusted, Lindi has more teenage pregnancies than any other region in Tanzania.[45]

Both south-eastern regions have a staff recruitment problem which has its roots in their reputation as the 'Cinderella' regions of Tanzania. This affects social sectors as well as other civil service posts. Mtwara region reports that it had 838 open teaching jobs in primary education in 1995/96. Other factors which discourage teachers are indicated by the reported need of 2,423 new classrooms and 4,254 teachers' houses (Mtwara -- Plan 1996/97:79). The school buildings are run down and supplies leave much to be desired. The parents buy exercise books and books - if available - are shared by many students. All and all, it is no wonder that the students do not feel happy with the schooling they get nor that teachers are not motivated to do their work properly.

Statistics of education in selected villages

A more detailed study of the school attendance in *ten villages in the Mtwara rural district in April 1996 indicated the net enrolment* to be even smaller than the general statistics would indicate. A house-to-house survey showed that out of 4013 school age children only 1644 had been enrolled, an average of 40.97 per cent enrolment. The lowest percentage in those ten schools was 30.47 and the highest 68.94 per cent.[46]

The last educational census of primary school enrolment and of school age children not attending school was done in 1990. The annual records in the district education office show the numbers enrolled and average attendance in each class. In 1990 in Masasi district 5451 children entered the school, of these 161 children, 96 boys and 65 girls, started school in Mnavira Ward. Further statistics which were noted down in the *Mnavira Ward* in Masasi district, Mtwara region, evidence a downward trend especially in higher classes. Of those 161 children there were 127 left in the 7th standard in the beginning of 1996. Out of 707, who were registered as being of school entry in Mnavira villages in 1995, 320 actually started, 387 stayed outside and only 299 continued to attend in 1996. There were the total of 1797 children in different classes in Mnavira schools in the beginning of 1996.

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[45] Shuma, Mary, 'The Case of the matrilineal Mwera of Lindi', in *Chelewa, Chelewa. The Dilemma of Teenage Girls.* Eds. Tumbo-Msabo, Zubeida and Rita Liljeström. The Scandinavial Institute of African Studies, Uppsala 1994:120.132.

[46] Basic data for Primary School Children Enrolment Kibaha, Kilosa and Mtwara CEF Pre-Test Schools, Vol.1, April 1996. URT, Ministry of education, Dar es Salaam.

TABLE 1
ENROLMENT OF CHILDREN IN MNAVIRA SCHOOLS IN 1996

Class	Girls	Boys	Total	
I	140	159	299	
II	170	153	323	
III	174	174	348	
IV	117	143	260	
V	116	152	268	
VI	78	94	172	
VII	54	73	27	(42% of the first year students)
Totals	849	948	1797	

THE AGE SCALE IN DIFFERENT CLASSES IN 1990:

Class	Age (in the brackets number of pupils of the highest age)
I	7-12 (5)
II	8-14 (4)
III	9-14 (5)
IV	10-16 (2)
V	11-16 (11)
VI	12-17 (4)
VII	13-17 (5) Over 17 years of age were not recorded.

The village of Mtangalanga in Newala district, Mtwara region, had 269 registered households with a population of 1198 (666 women, 532 men, a difference of 134), under fives 144 (of whom 125, 86 per cent had been vaccinated). During the two days which a team of us spent in the village we saw only one female Std. 7 leaver and two young mothers in public places. If there were other girls in the village they were not visible. We were told that girls are taken by town people, often relatives, as house girls or barmaids. In comparison with the large number of adult women, the absence of girls was striking.

The performance of the school was miserable in spite of the fact that it had had an adequate number of teachers until very recently. Even now the number of teachers per student was adequate, 148 students and five teachers. The village had built only one teacher's house, others had to rent living quarters, which was at least partly the reason why two teachers lived in Newala town and came daily (5 km). The school had passed only one student, a son of a teacher, to secondary school since it started 1975.

TABLE 2
SCHOOL STATISTICS OF MTANGALANGA FOR TWO YEARS 1995 AND 1996

	1995			1996		
	boys	girls	total	boys	girls	total
Std. 1	20	13	33	12	13	25
2	19	8	27	16	9	25
3	13	14	27	16	8	24
4	9	11	20	13	13	26
5	12	6	18	9	8	17
6	5	8	13	12	6	18
7	10	11	21	5	8	13
Total	88	71	159	83	65	148

Naipanga in Nachingwea district, Lindi region, had registered 2525 households with population of 13,452 people, 4212 working men and 5364 working women, 856 old people, 784 with limited physical capacity (*vilema*) and 2236 children (0-13 yrs) of whom 887 boys and 1349 girls. The discrepancy of having such an excess of women (1152) and girls (462) indicates that the accuracy of records can be called to question.[47]

The Naipanga school has 12 streams and 12 teachers, the five lower standards have two streams each and the upper standards, 6th and 7th, have one stream each. One lower stream comes in the morning, another in the afternoon, taught by the same teacher. There are 530 registered students of whom about 460 attend, which means only 38 children in a class. The rest are truant, *watoro*, or have become pregnant, *wenye mimba*. 90 children had been taken in this year out of the eligible 382 of the school age (i.e. children up to 13 years). 120 were invited but only 91 came in the end, which is only 27 per cent of the eligible ones. It means that 292 stayed outside which would have meant six more streams if there were 50 in a class. That is the number the schools aim at but none of the classes actually have it. In some of the urban schools e.g. in Mtwara there are 100 in a class, which obviously is not the ideal. Even then the Mtwara town schools pass 25-37 to go to secondary school.

Both the statistical record and the observations made of school life give ample evidence that the deterioration of the school system is not due only to lack of physical structures or even the number of teachers. The quality of education, of the teaching, teaching equipment used, the competence of the teachers, willingness of the parents to send their children to school or of the children to go to school, all need to be more closely studied and overhauled. This work has been started and the results of it are recorded later in this paper.

[47] The villages statistics are frequently inaccurate, but the village leadership does not often question such discrepancies. The RIPS PSO is creating a computerised village data base for which village statistics will be scrutinised more carefully.

The health sector

In Mtwara region the health facilities, counting also voluntary agency (VA) hospitals and dispensaries, could offer an average of one hospital bed for every 800 persons in 1981. The distribution of the hospitals is not equal for all the districts. In Newala district there were 1300 people per bed, but in Masasi district, where two large hospitals are situated, there was one bed for every 500 people. Average of 78 000 persons in rural areas shared one Rural Health Centre (in Newala district 98 000) and there were 8 400 persons per dispensary (Mtwara --- Plan 1981:33).

The work of UNICEF has concentrated almost totally on Public Health programmes of preventive care, including all the sectors under scrutiny here. Because of the work of UNICEF the immunisation has been accomplished in the 15 divisions in which the CSPD has operated, covering nearly one half of the under fives of the total of 21 divisions in Mtwara region. By September 1995 over 90 per cent of children had attended the village health day when the immunisation and weighing and checking children's general state of health was done. The number of vaccinated children has increased from 61.8 per cent to 91.2 per cent in 1995 in the divisions which UNICEF covered, since the programme started in 1987.

Malnutrition has also decreased during the same period from 8.1 to 1.5 per cent which is below the government 2 per cent target for the nation by the year 2000. Village Health Workers often volunteer their labour if the village fails to pay its share. They keep the village health records, following the health management information system (HMIS), which UNICEF has developed together with DANIDA, writing down numbers of children examined, nutritional status, vaccinations, deaths, etc. Many villages also provide gruel to the under fives who are brought to the clinic on a 'village health day'.[48] The Mtwara regional medical officer (RMO) complained that the records do not show any maternal deaths, which he considered a falsified picture deriving from certain taboo beliefs, still pending study.

Masasi district in Mtwara region has had a problem of hunger from time to time, especially during the cultivation season when the food stores have already been emptied. On government order every able bodied person is supposed to grow an acre of cassava as a measure of food security in an event of low rainfall and to carry over the cultivation season until new crops are harvested. Excess use in feasting of harvested grain in communal and family celebrations has been curbed by government by reducing the annual initiation celebrations to a triennial event. To extend the cultivated crops, people use products from the bush land and have been encouraged to continue to do so. Digging and preparing wild roots, *ming'oko,* for food is a laboursome process and even dangerous for women whose work it is. They spend even nights in bush and encounter wild animals and snakes. Women sell the roots under priced in comparison to cultivated

[48] A group of women who started bee keeping as their productive activity in Mnima, Newala, donated a share of their produce to be given to the small children on a Village Health Day.

roots, but they sell well. Bush land still supplements people's diet with roots, fruits, nuts, leaves and trapped or hunted birds, rodents, even rats.[49]

There is a number of villages which have no health posts, not even a first aid station nor trained village health workers. Naipanga in Nachingwea district Lindi region, is one such village. Although in many ways a very active village Naipanga has lacked the initiative to build its own health facility, when government has considered it to be relatively close to town and dispensaries. The nearest dispensary is in Ndomondo, a distance of 8 km, and a further one in Lukuledi, twice the distance, is also frequented by Naipanga villagers. No villagers own a car. People depend on a few passing vehicles with no regular schedules.

The Lindi region is still far from offering access to curative health service to all its citizens. The World Bank loan money has rehabilitated dispensaries and health centres, but shortage of medicines is acute. Particularly the scarcely populated Liwale district, which has one hospital and 14 dispensaries in its 39 villages, has the disadvantage of long distances and few vehicles. Few villages have regular through traffic, people rely increasingly on bicycles. Seeing a group of villagers transporting on the back of a bicycle a woman in birth pains in an epileptic fit convinced me that even a stretcher carried on foot would have been a better solution. Yet village-made stretchers are not in general use.

Villages near or within the municipal areas usually have to depend on the town facilities which makes their position more disadvantaged than many distant villages with health centres or dispensaries. Mtangalanga 5-6 km from Newala was one such village. The village had two registered traditional healers. In acute cases patients were taken to Newala hospital. There were two traditional birth attendants (TBAs) who had been trained in a health and nutrition training unit located in the village itself. At the time of the study the place had not been in use for lack of funds for training courses.

All the 19 divisions in which UNICEF is active there are trained VHWs and regular village health days are organised. UNICEF had funded the building of training units with simple facilities in one village in each district for training VHWs and villagers in maternal and child health and nutrition. The districts are short of funds for recurrent expenses, not of buildings.

The RMO has noted that the VHWs or TBAs do not as a routine report many maternal deaths. In the 1995 Quarterly Report gave statistics from the villages in which VHWs and TBAs had been active. They had examined 906 pregnant mothers and delivered 614 infants, 42 infant deaths at birth were reported but no maternal deaths in the columns provided for them. There are cultural reasons which prevent people from reporting maternal deaths. While the UNICEF counts show hardly any maternal deaths the

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[49] A man in Mbonde, Masasi, went on foot 45 km on up to five days hunting trips to distant maize and ground nut fields to catch rats with home made traps. He roasted all 700 rats in front of an open fire and sold them for 20 sh a piece upon return. He had no problem of market. He estimated about 15 villagers did the same. Other Tanzanians look down on the Makonde 'who eat rats and snakes'.

hospital records show 775 average of maternal deaths in 1991-94 (Cf. Table). A study is being undertaken to find out the reasons for the underlying taboos.[50]

Water and sanitation

The Makonde Plateau has been a problematic area in Mtwara region. It has been inhabited for centuries, yet it has no ground water which could be utilised for shallow wells. The colonial Makonde Water Corporation was built to provide the plateau with piped water. The installations needed rehabilitation which the Finnwater Consulting Engineers were to do. Finnwater built a pumping station in the Kitangari valley and villagers, largely women, dug the trenches for the pipes within their own village areas. At the time of writing this, 120 villages get piped water which is led to water tanks in villages from Kitangari pumping station.[51] Initially diesel was used for the generators but it was found to be too costly. The pumping station now gets its electricity from Masasi power plant.

When Finnwater handed over the responsibility of the water projects in Mtwara and Lindi regions to the Tanzanian government in 1987, of the two regions' 1.5 million people (1988) 27 per cent had potable water, 34 per cent obtained some improved water, and 19 per cent relied on former water sources. Taking into consideration the vast territory, 83 720 sq. km, large population (at present close to two million) to be served, and the relatively few years of implementation the result can be considered reasonable (Swantz 1989:150). The weakness of the programme is shown in the weak post-project performance. When user cost was not indicated for political reasons at the time of building the system, introduction of payments *post factum* for wells to which people do not feel ownership is an overwhelming task. In the two south-eastern regions it would not be an exaggeration to say that one third of the population is within the reach of reasonably safe water.

The availability of safe water which was reported to have reached 75.5 per cent of population by 1992 (national average 45.0) in Mtwara and Lindi regions[52] has deteriorated greatly, for lack of maintenance and lack of local funds for acquiring spare parts. Above all, there is lack of technical skills in the villages to repair the broken pumps or care for the pumping machines. According to the regional water engineers' reports, 47.2 per cent of the pumps in rural shallow wells were in operation in Mtwara region and 57 per cent of rural population had safe water near them in Lindi region 1996. [53] Statistics of water sources in operation might be somewhat optimistic because the functioning of wells and machines is erratic. In fact, 80 per cent of people live close

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[50] 'Maternal Health Project, Mtwara region 1995-1996'. URT, PMO and ROF, MOFA, DDC. 'CSPD Programme 4th Quarter Evaluation Report 1995' in Mtwara region.

[51] Information from the water technician in charge of the Kitangari pumping station Hassan Lihoka 07.05.96.

[52] The figure most likely represents the number of wells and water facilities constructed and the potential use of them by the population who live within reasonable reach from them.

[53] The Finnwater Consulting Company built 1285 shallow wells in 221 villages in Lindi region. 1048 were reported in 1996 still to be in operation (Lindi Plan 1996/97:25). If this was the case, more than 57 per cent of population would be using potable water.

to safe water sources but not all are able to appropriate the water. The availability of skills and funds for spares and maintenance is at the heart of the problem (Mtwara Plan - 1996/97:17).

UNICEF has a special concern for safe water and has technical staff for building wells and instructing villagers in water harvesting methods. Schools have also been provided with clean water tanks.

Building of latrines is one of the major concerns for medical teams which fight recurring meningitis in Masasi district and waterborne diseases in all the districts. The Environmental Health Officers have cooperated with teams from EHO training institutes to keep the impetus in latrine construction going (statistics in the Annex Table 6). The regional environmental health officer has activated all the levels of health staff to approach PHC problem through a PRA approach with encouraging results. This approach develops an integrated approach from below; workers from different sectors learn to work together with issues and real problems. School health programmes can be carried out with little or no extra cost.

3. DECENTRALISATION OF SERVICE DELIVERY

In the Part 1, I gave a brief overview of the ways in which Tanzania took care of the social service sector after Independence. There were political reasons at the root of the determination of the ruling Party CCM to provide free social services, while at the same time, emphasis was also laid on voluntary self-help in construction of the physical infrastructure. In Part II I described how the cuts in funding have affected the social services in the south-eastern regions as evidenced in the deterioration of primary education and health services. In this part I take up the issue what possibilities there are to manage the education, health and water sectors in the present economic conditions, paying special attention to the political remedy offered for the social ills: decentralisation, democratisation, and privatisation.

3.1 Transfer of responsibility for social services to the local governments

Tanzania pledged to provide her people social services, but from the start the policy also exhorted people to work hard: *Uhuru na kazi* was the slogan. People were urged to initiate self-help projects and the government would share in the costs. Villagers were told to build physical structures for dispensaries and schools and the government would give the roofing or staff them. This worked for some years, but the most common complaint later was that the government did not keep its part of the contract. This pattern of people's active role in their own development is now returned to. The communities respond if the supply side keeps its promise. Initial experiences indicate that the rarity of kept promise in the form of matching funds, which the village people themselves are actually allowed to handle is a new incentive which will go a long way, at least at the initial stage of the user contribution of the social service

provision.[54]ppGood governance has been the challenge to developing countries for the past decade. Bringing the responsibility closer to the level of implementation has been part of that demand. In the early 1970s Tanzania took steps to decentralise the administration with the result that the regional level of administration was established while the local district councils were abolished. The regions were given rather independent administrative powers and the regional commissioners had the status equal to that of the secretaries of state in central government. The regional development committee was to authorise plans which were proposed from the lower level district and ward development committees. The committees were also the arm of the ruling Party. The procedure was cumbersome and often non-operational. In Mtwara region the committee meetings could be endlessly postponed and even then the decisions were nominal and there was little guarantee that the proposals coming from the local communities actually reached the highest decision level. When the process of democratisation started the local governments in the form of elected local councils were reintroduced in 1984. Transfer of powers can, however, be only nominal if the decision-making and the financial means for implementation are not firmly in the hands of the local governing institutions. The process of transferring these powers from the regional level to the district level has been accelerated in Tanzania in recent months.

The structure of administration is at present going through major changes (Annex Figure 2). The Prime Minister declared the abolishment of the regional administration in his speech to the Parliament on the 28th of June 1996. This is a major step in the fresh process toward decentralisation. It follows the continuing pressure by the IMF and WB to reduce the administrative costs and will result in further retrenchment of staff. It is too early to say at this time what consequences the move will have in practice, but it aims at shifting the power closer to the scene of implementation of development programmes. It will have a major effect on the decision making procedures, but it will also bring the responsibility for the provision of social services closer to the rural and urban communities themselves.

The district officers under the District Executive Director rather than the regional officers have even in the existing system been the implementers and they have acted in cooperation with the wards and villages, but a great part of funds coming from the central government has ended up in the regions which have eaten up resources and yet have had hardly any implementation powers. The regional and district development committees will in the new system be abolished. the decisions will be made by the elected district councils in which the villages and municipalities are represented. The change will require a major programme in civic education for the councillors to be fully aware of their responsibilities in utilisation of funds. In the present situation the district leadership complain that the councillors' foremost interest is in the share that they themselves can 'eat' from the district funds in the form of 'sitting allowances', travel

[54] The WB and RIPS experiments which depend on shared costs have been encouraging. The villagers surprise is visible when they receive a cheque of the size which matches their own contribution.

compensation, etc.[55] When cash is short voting for causes which fatten one's own purse is not only an African phenomenon.

Rather than beginning civic education from some abstract concepts, the handling of funds for social services is a concrete matter the benefits of which the councillors as well as ordinary citizens can quickly grasp. For this reason, the process of decentralisation and democratisation can start with concrete processes of education, health, water and sanitation.

The international organisations and donor governments have placed much importance on the activities of NGOs. The number of registered NGOs has grown exponentially, but their capacity for action is not as great as their number. In the two south-eastern regions which are under scrutiny in this paper only a relatively small number of local NGOs are registered and those which are there are still learning the rules of operation and trying out their powers. For this reason, the preferred model is coordination of inputs of various agencies. When the 'donors' are few and in development traffic there is little crowding, the opportunity to develop a coordinated model is opportune.

In the case of RIPS work in Mtwara and Lindi regions project support office model could be developed further as a common support office from which services could be purchased. This would follow the pattern already established in vehicle pools in districts where the projects can order a vehicle for a project use and pay according to set rates. In the PSO in Mtwara the media centre provides services for any agents or the GOT in video, radio, and TV production as well as other information services with links to press. In the same way the village data base is being developed together with remote sensing and general information system based on maps. The village data base is used for monitoring programmes as well as for giving the villages feedback and providing the village data back to them in a printed form which has been produced in cooperation with them. The WB programme will also be using the village data base office.

RIPS has also introduced mutual learning as the basic mode of communication. It means that the village analyses are made in gatherings in which villagers, village leaders, government officers from various levels who are concerned with the affairs of those villages, political leaders, and facilitators work together and each bring their contribution from their own expertise. The contacts are initiated by using modified participatory rural appraisal methods first introduced by Robert Chambers with his Indian colleagues. The meaning of 'participation' is worked out in everyday practice. 'Mutual learning' as a concept corresponds better with what takes place; it emphasises the fact that all parties are learning from one another.

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[55] 'Eating' is a verb used for rent seeking or appropriation of public funds or property with some means the legitimacy of which the outsider is not certain. The councillors and government officials can legitimately claim allowances for all the days they spend outside their duty station. They can also have lunch allowances when in the home area. There are many ways of making days longer and having extra duties to perform to lengthen the stay away from home.

3.2 Basis for decentralisation is people's participation

Participation has become a buzz word in recent development parlance. It is offered as the key to local development programmes, as a kind of *talitha cum* which opens blocked channels and accelerates local development programmes. It is not an accident that participation has accompanied the privatisation and free market boom. People's participation in their own development transfers the responsibility of funding and work to the people themselves and lightens the burden of the State. In fact, the first versions of the present WB supported education programme depended on selected consultants or NGOs to carry out the management of the education programme itself, probably for lack of trust in the bureaucratic system. In the present version, the district education office carries the main responsibility for the programme, but much of the local management has been transferred to the local communities and the village through the Community Education Fund handles directly the finances.

The earlier socialist policies consciously avoided the kind of voluntarism on which the new policies are based because voluntarism was conceived to be in line with privatisation ideology. In the final analysis, it leaves the way open to exclude large segments of population and creates doubt whether educational and health services will remain public goods, entitlements accrued to whole population. Yet the socialist programmes also depended on voluntary labour and numerous collections of 'voluntary' payments toward the Party, for building its offices, meetings halls, stadiums, etc. Both cash and work contributions were part of the system. Every time when the Uhuru Torch was carried around the whole country, from district to district, before the Saba Saba celebrations, money collections were made for some cause within or outside the country's borders.[56]

Goran Hyden has provided an interesting analysis of the voluntarist base of the US society and the reasons why the US climate tends to be so antagonistic toward state provision of social services or any idea of a welfare state. Hyden's point that Nyerere's socialism in fact was a kind of populism which depended on voluntary contributions offers an explanation why the Nordic people and aid agents so readily approved of it. Voluntarism preceded the welfare state also in the Nordic countries.[57]

Participation is thus not an unproblematic concept and requires contextual definition and analysis whenever it is applied. Much of participation in fact ends up as an effort to incorporate people in a project the parameters of which the external designers of the project define. On the other hand, education or health programmes cannot be planned entirely as 'people's own' projects. The state has to have its general health and education policies in order to carry its share of the responsibility for them. The state will have to

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[56] The torch to commemorate the first torch taken to the summit of Mount Kilimanjaro on the first day of Independence is carried every year around the whole country and brought to the main national festival grounds on the 7th of 7th which was the day the Tangasnyika National Union was inaugurated.

[57] Hyden, Goran, 'Bringing Voluntarism Back In, Eastern Africa in Comparative Perspective'. In: *Service Provision under Stress in East Africa,* eds. Semboja, Joseph and Ole Therkildsen. Centre for Development Research, Copenhagen, in association with E.A.P.H. Nairobi, Mkuki wa Nyota, Dar es Salaam; Fountain Publishers, Kampala, Heinemann, Portsmouth, James Currey, London, 1995.

carry also the greatest share in funding of the wage bill. Thus 'participation' on this level means compromising in finding solutions to social service programmes and drawing contracts between the communities and appropriate levels of government, or agreeing in negotiations between different levels of planning and implementation. Yet, without people's concrete participation in local planning and in carrying out the plans, they hardly will take on a sufficiently large share in implementation.

3.3 Educational goals and motivation for greater self-support

The need to improve the quality and facilities of education as offered at present on primary and post primary level is obvious. The facilities are inadequate, there is lack of supplies, the buildings leave much to be desired, and the level of teaching offered is often poor. Even worse, the present facilities can accommodate an ever diminishing part of the school age children. The school statistics leave no doubt but that the numbers of those who receive no formal education increases year by year.

The question of education reform is first of all one of quality and contents and only after that of finance. Without an assurance that the education children receive truly equip them for future life and work the parents do not have the desire to continue to support their children's education. In the south-eastern regions this is evident, not least because the tradition of education is only thinly spread and value of education for its own sake is not appreciated. Yet, without equipping new generations at least with basic skills of reading and writing regional and individual inequalities become intolerable.

The educational experiments build on what people consider realistic to implement at present. The plans seek to reorient the institutional set-up toward more viable practical goals which parents, teachers, and students are motivated to reach.

The present primary schools orientation is toward the secondary school entrance examination. Parents' and students' hope that the primary education would open the way to higher institutions has been waning. Parents' common remark about the school leavers is, 'they know nothing', meaning that not only do they fail to get into secondary schools but they have not learned any marketable skills either. Currently, all the children who do not pass on to secondary schools, i.e. 94-96 per cent, are said to 'have failed'. From many schools not a single student passes the exam, or at most only one or two go for secondary education. This means that the primary schools are oriented toward an impossible goal. Even when the secondary school facilities fast increase, they are out of reach for the majority of children. Thus the problem of education is not first and foremost one of costs. The quality and objectives of education are closely tied with the problem of finance. The question needs to be asked how the primary education should change so that it would better correspond with the needs of the students and the community and thereby motivate the parents to find the means to finance a greater share of education and children to go to school.

A growing number of parents would want their children to pass the primary exams and continue in secondary school. These parents are usually prepared to look for funds for

this education. The problem is with students who would deserve to continue and whose parents are not willing to pay for their children's schooling. This is often the case with girls for whom special arrangements are made in the new educational plans. Such students need to be identified already during their primary education and be given scholarships which enable them to continue. Parents, development corporations, religious bodies, or local communities have started an increasing number of private secondary schools to which even students with somewhat lower passes are accepted. There has been a tendency for the educated part of the population, often coming for the meetings from Dar es Salaam, to take over the decision making so that for example the levy extracted from the cashew crop has been used by the district education or development funds for establishing new secondary schools with no other choices given for the use of the money to those who pay the levy.[58] Many of these schools frequently suffer from lack of resources and the quality of teaching is poor.

With improved communication between the school and the parents the communities will be in a position to have more influence on the education their children receive. As it is, the great majority of primary students have neither the motivation nor the inclination to go on with academic studies. For them, the important question is how to improve the learning of basic literacy skills at an early stage of their schooling and how to combine primary and post-primary education with learning useful practical skills which equip the youth to become self-supporting productive members of their societies after they leave school.

The present primary education does not take into consideration the different kinds of demands that either the parents or the students have toward their education. A primary school in a fishing village which does not increase knowledge about marine life or teach improved methods of fishing, fish processing and fish marketing, or a school in a pastoralist area which does not have books available or give useful information and science-based knowledge about cattle and cattle keeping cannot motivate parents to send their children to school or children in these communities to go to school. Fishing and earning cash daily, or herding cattle and having prospects of owning goats, are much more attractive alternatives than sitting in classroom if after seven years the students have not acquired knowledge or skills for making living.[59] The new educational policy of the Ministry of Education and Culture incorporates 'work studies' from the first grade on. These can include learning productive, management and organisational skills while

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[58] The goal is to have a secondary school in each division. In itself the goal is not unreasonable, but the present funds do not permit even the running of the existing schools for full school terms.

[59] In the mid-seventies I did participatory youth studies in the coast region with the university students from Dar es Salaam. In the new Rufiji villages the youth learned their income earning skills during school holidays. Immediately after the last school day the youth were on move and only an odd one remained in the village. They headed for Dar es Salaam and the bigger towns and villages (Swantz, Marja Liisa, 'Youth and Development in the Coast Region of Tanzania'. Bureau of Resource Assessment and Land Use Planning, University of Dar es Salaam, Research report No. 6, Jan. 1974). The opportunities are not available for the young people in the same way. When the youth leave they do not as readily return if they manage to start some income earning activities. If they are satisfied that the school gives them better skills the school has b better attraction to them.

also expanding the students' general knowledge base. There is no reason why the two branches of learning cannot be combined.

Thus a plan for relevant primary education, which starts from the contents and methods of education, is as important as a plan for financing education. It leads to giving a great preference to the retraining of teachers and introducing fresh approaches into the teaching institutions. The south-eastern regions are in the fortunate position that they have several teacher training institutions in which students can be learning practical participatory approaches to education already while they are in training.

3.4 School reform

In the following, I first give a brief description of the educational situation as it is being developed in some villages in Lindi and Mtwara regions. The description is illustrative of the present situation in over 200 villages in which participatory analysis with the participatory rural assessment (PRA) approach has been made with groups of people and village leaders. The primary schools operate under school committees the members of which are elected by the village government. At times villages have been able to request changes in staffing of the schools and they have also put forth wishes as to the agricultural and other work oriented inputs that the schools and students could make, but the school committees have not had the authority to monitor the quality of teaching, dismiss teachers or to determine the use of school fees.

Nandagala in Mnacho Ward in the Lindi region serves here as a case study. I describe the experiments in cooperation with the government and other agencies, their differences and similarities, and then discuss how they relate to the decentralisation and democratisation process which is going on in the Tanzanian society today.

The demand in Nandagala was for more classroom space to accommodate literally hundreds of children who were left outside. In 1994 the school had registered 400 children for starting the first grade, but only 120 were taken in. Even they could not start their school properly for the lack of space and the numbers dwindled to less than a hundred in attendance. Some parents had already had uniforms sewn for their children but had to withdraw them from school for lack of space. The children were directed to go to the pre-school which had already been started and from which many of the children came. For other households, children who had no room to go to school were welcome extra labour which the family now could utilise without feeling guilty.

In 1995 only two students passed on to secondary school from Nandagala school. The post-primary classes, which, in theory, could have accommodated 40 students to learn carpentry, masonry, metalwork or domestic science, had only seven students. There was little motivation for the primary school leavers to continue because of the almost total lack of equipment, materials and tools, and lack of imagination on the part of teachers to improvise.[60]

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[60] On the other hand, the carpentry teacher used his own house for storing both the tools and the items students made, and the classes were held under a large tree.

The school served both Nandagala and Ng'au villages and the school committee consisted of members from both villages. In Nandagala, there was also a special building committee which had been charged with the task of planning the construction of a new building for primary classes.[61] The building committee had been elected to make arrangements for the construction of the new school. The foundation had been dug two months before the school was to begin, a good number of bricks had been made by villagers, and the village had set aside 180 000 to start the construction. The rest of the money was to come from the earnings of the village truck. The building was delayed and the problems which incurred illustrate how village politics can obstruct local governance.

The school and building committees had several meetings with village and ward leaders trying to disentangle the mess into which the school issue had drifted. The money from the truck did not come forth because the truck was most of the time grounded and the two men in charge of the transport on behalf of the village economic committee claimed that the money earned was spent for repairing the truck. Suspicion of the misuse of money from the truck paralysed the building plans. It turned out that underneath there lurked a long standing conflict. The men who dominated the scene belonged to two ruling clans whose power was resented in village politics.

Through PRA analyses and seminars held with the youth[62] they were challenged to organise themselves. This they did and started working in some twenty small production groups. The youth requested and received small loans after demonstrating considerable effort in cultivating fields and planting cash crops. The income from agriculture would help them to build up their other small enterprises. They engaged in substantial projects of farming cash and food crops (onions, maize, cashew), some groups run a milling machine, started teahouses, small shops, and carpenter workshops.

The youth started what they called a 'trouble-shooting committee' with the intention to monitor the village government activities and to make sure that the school was built. The youth were determined to make a change in the village management. They pressed for answers to their questions in meetings and managed to make significant changes in the leadership of the various committees. The Ward Executive Secretary became very sympathetic to the cause of the young people but, as it too often happens, he was moved to another ward, and a new man with little background to the community affairs came in his place. This did not stop the progress that was now being made in village affairs.

The village decided to sell the truck to be able to go ahead with the building plans. After negotiations, the village obtained matching funds and an additional loan from RIPS and it contracted local professional builders to construct the school on a condition that they

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[61] The existing school was common with the neighbouring village Ng'au. The location was in between the villages and the space was not enough to accommodate the children from both villages. The new school was planned for Nandagala children in their own village where the Ward office was. The Divisional office was in Ng'au.

[62] Youth are of the age bracket 18-35 years; in the text I use interchangably the term 'young adults'.

employ a group of skilled youth to do part of the building. The youth in turn could thereby procure better tools for their carpentry workshop.[63] The funds obtained were put directly on a bank account which the village opened for the purpose under trustees which the committee elected. In the school committee and the building committee the head teacher, some teachers, village leaders and ordinary villagers, men and women, and also a couple of Std. 7 students were represented. The committee elected the ward community development officer, resident and native of the village, as the treasurer with the main responsibility to oversee the operation.

After thus clearing the internal problems within the village the construction went smoothly and the building is now a pride of the village and the region. However, there is a long way to go. Two classrooms is only a beginning to fulfilling the requirements. Yet the encouragement which the village and especially the young adults received from their success has multiplied the fruits also in other ways. The older youth integrated teenagers into their groups which was a condition for getting their group loans. Together they levelled a football field next to the school and the village football teams got a new lift. Another group started practising a theatre show on the school steps. Nandagala in Mnacho Ward was an excellent example of the readiness of the youth to respond when they were taken seriously and had a chance to analyse their own situation through a participatory process. In the seminar of five days which was organised for this purpose the participants also started an emergency fund for some specially needy youth to which they contributed from their own pockets.

While making a PRA analysis and drawing in the ground grids showing the available and needed skills in Nandagala village, the village participants discovered that column for the young people remained almost empty when they listed the categories of people who were skilled in village technologies. The idling non-schooled youth who flocked around the market place worried the parents. The villagers came upon the suggestion that *technical and agricultural primary classes* could be started for the non-schooled children beyond the school starting age of 13 years. While learning marketable skills the youth would also discover the necessity to know to read, write and do basic arithmetic. These classes could use the school building after hours and they could build a shed for the practical work.

The agricultural and technical primary classes are waiting for an approval of the authorities as a legitimate form of learning. The beginning has been made in a fishing village where the youth adjust their school time to their fishing schedule. The fishing brings sufficient income to pay to young girls who have finished Std. 7 and can be trained to act as teachers. This means repeating the UPE exercise, this time for a different kind of a school. Training of these teachers will start presently. In place of adult education another category of education, *youth education*, is now needed.

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[63] The youth team of carpenters had learned their skills in an earlier phase of the post-primary training when the school was still equipped with tools. They claimed that the tools were stolen subsequently from the school and they suspected some teachers as the culprits. This they gave as the reason why students did not go to porst-primary classes.

3.5 Experimentation in cooperation with external agencies

With the development focus on poverty alleviation, the reputably poorest regions of Tanzania are at the moment receiving increasing attention. UNICEF started its Child Survival, Protection and Development (CSPD) in 1980 and is at present preparing to launch another five year continuation of its work in the Mtwara region, with special emphasis on primary education. The RIPS Phase II, with support from the Ministry of Foreign Affairs of Finland, started its new three year programme midyear 1996. The World Bank has taken Mtwara rural district as one of its three pilot areas to test the user fee and matching funds strategy in primary education. Several NGOs are offering services in the field of health, also concentrating in Mtwara rural district.[64]

UNICEF has worked through the regional and district administration and has handed the funds to them. RIPS has its own project support office (PSO) with an external financial controller whose office hands out the money to the local implementing personnel or office. The responsible implementing agents can be individuals, managers of working groups, district administrators, or funds can be handed directly to the village implementing groups or committees which choose their trustees. The PSO includes also other services, such as a media centre and a computerised village data base and geographic information system (GIS) for map drawing and remote sensing office. The plan is to concentrate all regional or district resource services with trained local personnel in such external offices totally at the disposal of whoever need them and can pay the actual costs regardless from which agency or government office they come from.

In reorganising the primary education and health programmes the assumption is that the communities will carry a greater share of financial responsibility if they can influence the planning and management of these services. After initial studies, several pilots, and many donor agency and government conferences, the World Bank has formulated its plans and is trying them out. In the meanwhile, the Government of Tanzania has prepared a new *Education and Training Policy 1995* which gradually comes into operation. The RIPS and UNICEF are cooperating with the district governments in Mtwara region working out some parts of the new policy and also trying out the pilots in agreement with the WB. RIPS applies the same principles also in the Lindi region.

As proposed in the WB plan there is a need to reform schools so that they are more demand-driven. The schools have to fulfil the needs of the parents, pupils, communities and the nation. If people are expected to share the costs of education for their children they have to have the sense that the education they pay for satisfies their expectations. In order that primary and post-primary education could do that the parents and the community as well as the pupils themselves must have a say how they would like the schools to be shaped and in what way they would be willing to participate in the costing of them.

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[64] The Irish NGO Concern has been investigating potential areas of cooperation, The Doctors Over Boarders from Spain and medical personnel from Germany have also started processing their plans. A Finnish Midwives Association worked for three years in the Mtwara Rural supporting the local health personnel in training TBAs.

Decentralisation of responsibilities and benefits require establishments of local funds. The WB programme is based on establishment of community education fund in the villages which now take part in the experimentation. The school committee, which carries the responsibility, is made up of the head teacher, and his/her deputy, village leadership representatives, parents' representatives and the students' representatives. The school committee discusses the school plans and carries out the implementation of them being supported by the district education office.

The central idea of the new plan is that the villagers, the parents of the students in particular, agree to carry a larger part of the financial responsibility than has been the case so far. The UPE payment has been 200 sh per child, with some reductions if the family has several children. The new WB suggestion is that each household would pay 2 000 sh in cash into the community education fund, CEF. The district government which gets the money from the funders, whether it is WB, RIPS or UNICEF, would then match the same amount as the village puts forth.[65] This would double the total amount at the disposal of the school committee or the village community.

The WB scheme trains the school committees to take up the responsibility over the primary school if they agree about the financial conditions of the suggested plan. The committee is instructed to start a Community Education Fund to which the cheque is sent semi-annually to match whatever the village contribution has been at certain agreed dates. The village decides what their first priorities are and commit to give a certain sum in cash. The WB money through the government channels matches the sum which the village contributes, not more than total of 6 000 sh per student in one year.

The RIPS programme also calls for negotiations and community participation in planning so that the plan is not dictated to them, but is made by them. RIPS supported local staff engage usually first in a participatory rural assessment with the community before narrowing the discussions on the school plans. This puts the school programme into a wider context and adds to the motivational force through communication between the different parties concerned, i.e. the bureaucrats, facilitators, villagers of mixed categories, and students. A working group is formed which acts as a liaison with the local community, the district government and RIPS PSO.

Another difference between the WB and RIPS is in the manner of assessing the village contribution. The WB promotes cash contributions, leaving it to the villages to collect the fees. When challenged, a considerable number of villagers pride themselves in being able to pay cash. They might even compete who shows the highest level of wealth. The community can then decide in what form those households contribute who cannot pay cash. The WB representative suggested that they might be able to work for the wealthier villagers in order to earn the money they need to pay. For the WB this programme serves as an instrument of introducing people to the logic and management of cash economy.

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[65] It has to be remembered that WB gives a long time low interest loan to the GOT for covering the social service expenses. This is a matter that needs separate discussion in another context.

The RIPS and UNICEF had already been implementing similar programmes which the WB pilots are adopting. The difference is that WB demands cash as the village contribution while the other two agents accept also villagers' work and material contributions as the village input. The work and materials which individuals provide for improving educational facilities are registered as their household share in payment toward the project. This requires a different kind of record keeping than what has been done so far. In the earlier self help schemes the work each household outs in has not been recorded and thus certain fatigue has occurred when households contribute very selectively. When the work contribution is recorded and cash value is given to it according to the minimum salary scale the work contribution does not carry any stigma. Both the wealthy and the poorer members of community can decide to work instead of paying in cash, if they so wish, or they can do both. Materials such as bricks which the village contributes are counted according to current local prices.

In WB, RIPS, and UNICEF supported cases the school committees decide how they wish to use the money and what the priorities for the community are. Some committees decide to start from construction, other committees think of supplies or school meals, some request money for sports equipment or garden tools with their first instalments. As they continue to pay, they then continue also to receive more money and can think of further improvements of their school programme.

The education plans of which the district education office carries the administrative responsibility present a way to greater self-sustainability than previously in the education sector in Mtwara and Lindi regions. It makes use of substantial components from the present World Bank plan which is based on demand driven approach to primary education and is supported from a Community Education Fund. After both cash and work contributions have been tried the plan can be modified using participatory, bottom-up approach which is being implemented with RIPS and UNICEF support. The question which remains is whether the government sources, wherever they in future will come, will continue to be provided in equal sums with the community contribution and whether one half is a fair division of responsibility.

The WB supported programme is now after pre-testing at the pilot stage and is carried through only in three districts in Tanzania. The WB contribution as a loan to Tanzania raises the question how the programme can be sustained. The villages were given no indication how long the subsidy would continue, but the excitement was great when the cheques were delivered matching the exact sums which the villages had collected. The WB model and its variations by other agencies create a precedence which, if successful over the three years of testing, can be replicated by GOT in other parts of Tanzania. Even the experimentation is in principle administered by MOE&C via the district education office. The model can also be supported by other external funders. It is anticipated that people's own cost sharing will grow when the school reform brings results and education children receive is substantially improved.

3.6 Cost sharing in health sector

Cost sharing has to go together with great improvement in the health service delivery system. The GOT together with WB and UNICEF and with the support from major donors have been preparing and piloting Tanzania's health sector reform which was approved by the Parliament in March 1996. In April all partners in health reform reviewed and approved a health sector reform plan of action for 1996-1999.[66] 'With strong leadership provided by the Ministry, the reform will assure consistency and coherence of policy, investments and interventions of the different stake holders and partners in health in Tanzania.' (UNICEF Country Programme Recommendation, Summary draft, 8/6/1996) UNICEF is active in 50 districts in 11 regions in Tanzania.

The WB has actively involved itself in the evolving Human Resource Development Programme and has called together the other donors for the implementation of the health sector reform project, in close cooperation with the GOT via MOH. Similar pilot projects to those which were proposed by WB have been in operation in Iringa and Mbeya regions in which DANIDA is supporting education, water and health sector programmes. In a donor conference on the HRDP which WB called together in May 1995, the EU representative provided critical comments to the WB plans and DANIDA similarly claimed to be a critical partner of the WB. Some basic alterations were made in the plans before the education and health pilots were started but the experimentation is going ahead.

The WB intention in initiating donor cooperation with the MOH in health sector reform was to improve health services in rural and peri-urban areas through client participation in cost sharing and thereby lifting the level of services. The government representatives held meetings in October 1995 and April 1996 with the major donors which have been supporting the health sector since the Health Reform Plan 1993. They recommended that a district focus be developed within a Strategic Health Plan and donor contributions be better coordinated in provision of the essential health packages. The three year plan needed still to be detailed as to the costs and sources of financing (UNICEF Master Plan 1996:79).

The WB interest has been in privatisation of social services to make them more effective. The reform project was to include the following components:

i) Provide support for effective and sustainable public health programmes;

ii) Increase the role of households in meeting their health needs and promote sustainable health financing mechanisms;

iii) Assist the government in implementing its health reform programmes, especially within the Strategic Health Plan: 1995-1998.

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[66] The agencies co-operating with the MOH with a major stake in health sector are: DANIDA, USAID, ODA, JICA, WHO, UNICEF and Rotary International and WB with loan funds. Cf. the list of Documents.

The initial proposal to work the social sector reforms via NGOs and private agents has been altered to conform more with the wishes of the government and the recommendations by the Tanzanian staff who have acted as consultants and done research for the programme. The donor agencies as representatives of their governments work in cooperation with the Tanzanian government, yet they take the role of the outside agent. However, the work itself is carried out by professional district staff and the communities themselves.

Since Tanzania has implemented the economic recovery programmes later than most other developing countries it appears that she has to a degree benefited from the bad experiences that WB has had in pushing for user charge plans through too quickly.[67] In Tanzania, the first pilot is only now implemented and only in one district in Igunga district, Tabora region where the dispensaries and health centres have been rehabilitated and are considered to be well-functioning.

The basic idea in the health reform is to transfer part of the costs to the users and to develop eventually health insurance schemes which help the households to pre-pay for medical services in advance of sickness.[68] At the core is the establishment of community based community health funds (from here on referred to as CHF) in villages, controlled by the community themselves and the district health board. Households which resolve to join the fund make voluntarily yearly contributions to the fund and matching funds will then be paid by the government/donors/WB via IDA. Each CHF member household will have a membership card which gives any member of the household the right to health services at the health facility of its choice. Non-members can also receive health services at the (now well functioning) units but will have to pay user charges. Very poor community members can be exempted by the CHF committees. The elected CHF committee determines the amount to be contributed by the members but they can also use other means for raising funds for the CHF. Once the CHF system shows signs of working well the dispensaries and health centres will receive a 'capitation grant' to accommodate health entitlement of households which have chosen the particular facility for its health care. We shall discuss the implications of this programme in a later section of this paper.

Some of the remaining problems to be considered in the following sections are outlined here:

We pose basic questions which we try to answer after presenting some concrete examples of social services and on the basis of them sort out the ingredients of which problem itself of provision of social services consist of:

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[67] Cf. the study of Germano Mwabu 'Health Effects of Market-Friendly Reforms in Developing Countries', UNU/WIDER Working Paper No. 120.

[68] See Annex Figure 3 for the organisational chart of the pilot. Community Health Fund Guidelines Annex to Support to Health Sector Reform Community Health Fund, World Bank draft document, April 26/96.

⇒ How deep is the underlying conflict between the development modes in which the social services are provided and the ways in which the majority of the village people in Mtwara and Lindi would more readily be willing to cooperate?
⇒ What kind of education would attract a) the youth?, b) the parents?
⇒ What triggers the sense of 'ownership' of the innovations?
⇒ What makes a specific development rural people's own sincere political process?

Where does the problem lie?

- in education?
  Is the problem one of funds? of poor quality of teaching? poor teaching facilities, including equipment and teaching aids? inadequate nutrition? inadequacy of the educational principles on which education is based? lack of an adequate social context? lack of understanding of the real needs? basic inherent conflict of interests? do people have more burning problems to take care of first, e.g. immediate needs, sustaining themselves and their families?

- in health?
  Is the basic problem one of funds? in what other ways people look for solutions to their health problems? do they find better answers? does the difference in concepts of health play a real role in managing the health services? why do the health workers not take their work more seriously? is the answer in a poor reward system?

4. COST SHARING IN COMMUNITY-BASED PROVISION OF KEY SOCIAL SERVICES IN SOUTH-EASTERN TANZANIA

4.1 Development as the bridge between the 'tradition' and the 'modern'

We need to further examine what is meant by 'community-based social services'. This in turn leads us to defining the boundaries between 'traditional' and 'modern' services. Conceptually this distinction can be made in terms of people's own inherited social care system and social practice which claims as its basis scientific theory. Cost sharing is in no way a new concept now introduced by the SAP. Sharing is a central part of everyday life and it is possible to distinguish areas in which there is continuity from 'traditional' cost sharing to covering costs in organised health service. In people's everyday lives the boundaries between two systems get blurred and people move from one side to another in one integrated world of their own making. There is a sense, however, in which the distinction between what is 'modern' and what belongs to 'tradition' is very clear in villagers' minds and prevents them from associating their own sharing tradition with the new requirements.[69]

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[69] I use the terms 'modern' and 'traditional' metaphorically to denote the conceptual difference which villagers as well as people from outside tend to make between what has been imported to the village and is identified as a representative of another system, and what now is an integrate part of village life, whatever

The contradiction which the 'modern' creates in relation to the 'traditional' is evident in pursuit for development which in people's minds translates to mean the same as 'modernisation'. The border between what is traditional and what is modern is in fact the demarcation line over which 'development' as a 'project' is trying to build a bridge. The core problem in development work is to bridge the conceptual abyss between 'traditional' and 'modern'. It can also be expressed in relation to knowledge systems, bridging the chasm between popular knowledge and dominating knowledge which claims its base in science and ever higher technology.[70]

People are willing to pay for services of traditional healers because they belong to their own conceptual world and they take care of aspects of health which the formally organized services do not cover. They go beyond the mere symptoms of health disorders in penetrating to the causes of them. They do not treat a human being in fragmented parts but rather deal with people as whole human beings with social relations which profoundly affect their health. The borderline between systems becomes problematic when people are no longer willing to pay for the service of a TBA or a VHW who have been trained in courses organised by the formal - 'modern' - health system, even when those courses last only one or two weeks and the service the women do after the course is for all practical purposes the same as they did before training.[71] People pay thousands of shillings for rituals which pass the youth to adulthood, but claim to have no cash to pay 200 shillings school fee per year. They consider the marginal social benefit from one school year to be smaller than from a ritual which keeps them integrated in their society. A person might pay ten thousand shillings for inviting his kin to eat the meal for 'sweeping the graves' or to finalise the death rites by killing a goat in honour of the deceased but s/he wants the 'donor' to finance the nails for the improved goat house s/he builds to follow the instructions given to her/him. Sharing the meal with close kin in honour of the past generations is one of the many preventive rites with which the family health is upheld. What to a development worker seems to be a contradiction is within the framework of 'traditional' a reasonable way of sharing costs for sustaining health and cementing social bonds as a precondition for social and organic health. Because this way of cost sharing is totally apart from the 'modern' it brings the difficulty of bridging the gap into a sharp focus.

One way to learn which institutions villagers do not perceive to be an integral part of their life world is to look how they use the Venn diagram in analysing the village institutions. One often finds such 'modern' institutions as dispensary, agricultural extension, and even school away from the centre or even totally outside the circle which

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its roots or origin. This distinction does not denote African over against 'European' (or 'Western', 'Asian', or 'Arab'). One can give innumerable examples of mixed origins of a custom, song, rite, language, etc. The distinction here is what *subjective connotations* people give to institutions or ideas and how they are socially shared.

[70] Cf. Marglin, Stephen, framework in *Dominating Knowledge, Development, Culture, and Resistance*, eds. Apffel-Marglin, Frederique and Stephen Marglin. Clarendon Press, Oxford 1990; *Decolonizing Knowledge, From Development to Dialogue*, eds. Apffel-Marglin, Frederique and Stephen Marglin. Clarendon Press, Oxford 1996.

[71] Cf. Swantz, Marja Liisa, 'Women/Body/Knowledge: From Production to Regeneration' in *Feminist Perspectives on Sustainable Development*, ed. Harcourt, Wendy, SID, Zed Books Ltd. London and New Jersey 1994:98-108.

depicts the conceptual village space.[72] Survey results also commonly show that teachers or health personnel are left out of the samples because they are not conceived to be part of the village.

The demarcation line between traditional and modern existed also in the minds of Tanzanian planners who started to reshape the Tanzanian society after Independence. In planning what kind of social services people would need and should have, the independent Tanzanian government gave little thought to existing social organisations and traditional systems of service even if the main architect of Tanzanian socialism himself wanted to keep the link to essentials in the old culture. The concept 'traditional', in Swahili *kienyeji*, freely translated 'as the natives do it', was readily rejected by the educated. Nyerere elevated the well recognised *ujamaa* concept, which could be translated as a 'sense of caring for extended family members', as a value worth preserving, but it was poorly worked out in practical terms. The failure of the *ujamaa* village experiments is an illustration of the difficulty of transferring concepts from one context to another.

When Nyerere elaborated his ujamaa policy he started from what was valuable in tradition.[73] There were three points: First was 'love' or 'respect' which really meant 'recognition of mutual involvement in one another', i.e. 'each member of the family recognised the place and the rights of the other members'. The second traditional principle related to property, 'all the basic goods were held in common'. The third principle was that everyone had to work towards the common good (Nyerere 1968:338-9).[74] However, apart from recognising the general principles, neither Nyerere nor other leaders returned to the issue of tradition and modern.

It does not seem that the value of what I call 'sociality' inherent in African culture was discussed in terms of its real significance for the political process or development. Finding a sounding board in 'tradition' which could act as an inducement for development would have required mutual search to people's cultural roots which would have gone beyond culture as a *ngoma*.[75] Those who saw no relevance in referring to

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[72] The Venn diagram measures both the potential importance of the institutions and people's assessment of the real significance of them. This reflects the degree of 'foreigness' of the institutions, but also their effectiveness. Often more hopes are set on them than what is realised, which is also a common attitude toward development. 'Development' is acceptable in principle, but it works out differently in practice.

[73] These were aspects which were strongly opposed by the ideologies of socialism who saw no point in going back to tradition and saw little relevance in relating to old sentiments of "familiarity" and sharing when creating new socialism. E.g. Giovanni Arrighi and John Saul in their introduction to *An Interdiscplinary Reader to Socialism in Tanzania* call Nyerere's approach ' "*simpliste*" African Socialist themes of presumptive solidarity and an automatically socialist "attitude of mind" '(1972:3)

[74] Nyerere also recognized negative traditions among which he listed that women had to work too hard.

[75] *Ngoma* refers to a dance accompanied with drums which is the basic musical expression of most African cultures. The Jipemoyo research project which was carried out under the Ministry of Culture and Youth aimed at finding the inspirational aspects of tradition and the negative cultural features which were a hindrance to development. The discussion which went on within the research team and the Ministry staff never reached the level of official politics. Modernisation took place in ways which had little respect to people's feelings. (*Jipemoyo* series of eight publications: *Jipemoyo: Development and Culture research*, 1977-1995. University of Helsinki, Institute of development Studies.)

tradition perhaps realised that continuity is not automatic (Ref. 5). It is interesting to note that Nyerere himself has also realised the disconnectedness between 'tradition' and 'modern'. In a recent interview he 'acknowledges that socialism never mixed well with the traditional ways of African villages'. 'You can socialise what is not traditional.' 'The *shamba* (field) can't be socialised' (Herald Tribune 2 Sept. 1996). This is not true only about socialisation, it is true also in relation to modernisation in general. The external and internal domains have to find ways of being integrated as if from within. *Shamba* could not be socialised because working it was people's inalienable right of which they not only made their living but it also linked them to their forebears. The more intimate the strings which the modern demands touch the more acute is the question of integration from within. The issue of cost sharing is intimately related with the issue of integration.

Village women and men readily respond to the beat of a drum, and a gossip goes around like a wind - in fact the same word is used in Swahili for a blowing wind *kuvuma*, to blow, and *uvumi*, gossip. It is much harder to have a similar response when ideas from another context are introduced. There is a definite divide between what is conceived to be 'traditional' and 'modern'. It is this divide which makes it imperative that ideas are born and developed by the grassroots people themselves and that they thus become their own.

Traditional can be dealt with as modern. I thereby mean that tradition can serve society in a modern context in a way that it forms an important building block within the modern context. It is transformed to something new but at the same time anchors the present to the historical past and helps people's own self-integration within themselves and the societies of which they are part. The question remains: How can it happen? How can the abyss be crossed over? What is the secret of 'development' which would not be one linked only to the 'modern'? What makes true integration take place?

Has the traditional not been made a building block in the modern context when traditional birth attendants (TBA) have been retrained to act as village midwives or when healers, *waganga*, have been registered as part of the health system and instructed in basics of contagious diseases or hygiene? Why is there a difference between villagers' treatment of the retrained *waganga* and the TBAs? The latter tell us that they are no longer given any reward, in kind or cash, after their retraining. In a course of one week or two they have been transferred to the sphere of modern! The same woman can get paid if she acts as a young girl's instructor in traditional initiation rites but a family categorised differently a child delivery, which she assisted as a retrained TBA. It is possible that the difference between the TBAs and *waganga* is in their different social standing, but it might also be that at this point we have less information about the latter. Registering the *waganga* most likely enhances their professional position within the modern structure and thereby integration in fact does take place. Registering does not remove the *waganga* from their own traditional practice since they depend on it, but it makes 'modern' use of 'traditional'. In the south-eastern context I am not aware that specific courses would have been organised for the *waganga,* although it has been done elsewhere. On the other hand, the TBAs or VHWs do not have their own organisation comparable to BAWAKITA, *Baraza la Waganga wa Kienyeji wa Tanzania*, Tanzanian

traditional healers' association. The rural medical assistant (RMA) is referred to as *mganga wa kisasa*, 'modern doctor', whereas a traditional healer is called *mganga wa jadi*, or *mganga wa kienyeji*, 'traditional doctor'. As a consequence from their mediating role, more extensive cooperation and mutual learning process could be developed between the *waganga* and health personnel.[76]

The TBAs are referred to as 'traditional midwives', *wakunga wa jadi*, but in fact, some are traditional, some are selected by village leaders from among their relatives, some are chosen because they have a sprinkling of education and can benefit from additional learning. This means that the position of TBA is in between the new and the old in an ambiguous way. Now and then the retrained traditional midwives are compensated after the delivery, as was the case in a Catholic community in which the people knew the fellow Catholic woman well from her earlier practice as a traditional midwife and they trusted she now had increased her knowledge. I interpreted this to mean that both the educational background of women, and the fact that the pregnant women were also accustomed to go to a pre-natal clinic helped to bridge the gap between the old and the new.

The difficulty that all well meaning development agencies have found in trying to build the bridge of development confirms the necessity for integration to take place from within and leave it for people themselves to find the ways in which it can happen. I have argued elsewhere that if tradition becomes transformed as if from within it generates genuine change which becomes creative. In this way, a break in tradition contains at the same time creative continuity.[77] I quote from an excellent collection of essays which touches the issue at hand here, 'Often, what gets ignored are the means by which Africans have learned to compensate the impossibility of their everyday lives.'[78] Perhaps what outsiders call development is at best 'compensation' for what gets lost.

The unforeseeable nature of what in anthropology has been called culture contact, and the difficulty to predict consequences even of best external efforts, makes it that much

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[76] I refer her to some of my writings on the subject: Swantz, Marja Liisa, 'Manipulation of Multiple Health Systems in the Coastal Region of Tanzania', in *Culture, Experience, and Pluralism*, eds. Jacobson-Widding, Anita and David Westerlund, Uppsala 1989. Swantz, Marja Liisa, 'Community and Healing among the Zaramo in Tanzania'. *Social Science and Medicine*. Vol.13D, Nr.3 1979:15-19. Swantz, Marja Liisa, 'Community participation in health care' in *Health and Disease in Developing Countries*, eds. Lankinen, K. S., Bergström, S., Mäkelä P.. and Peltomaa., M., MacMillan, London and Basingstoke 1994:433-442. Swantz, Lloyd, *The Medicine Man in Dar es Salaam*, Scandinavian Institute of African Studies and Dar es Salaam University Press 1990.

[77] I have dealt with this issue of creative change in Swantz, Marja Liisa, *Ritual and Symbol in Transitional Zaramo Society with special reference to women.* Scandinavian Institute for African Studies, Uppsala (1972)1986:359-368. Also in Swantz, Marja Liisa, *Blood. Milk, and Death. Body Symbols and the Power of Regeneration Among the Zaramo of Tanzania.* Bergin and Garvey, Westport, Connecticut, London 1995:136-7.

[78] This is not the place to expand the topic. I refer to literature which describes the rich creativity of African social life and the wealth of ingredients it absorbs from other cultures. The secret is the spontaneity of it, creative change taking place on people's own conditions. Cf. *Invisible Governance. The Art of African Micro-Politics*, eds Hecht, D. and A.M. Simone, Autonomedia New York, 1994. The book hopes 'not to locate the 'real' Africa, it is to locate complex and fundamentally ambivalent African social conditions' (Preface).

more necessary for communication between the systems of knowledge to be of mutual learning. The development buzzword 'participation' must for this reason be people's participation in development of their own making. Participation then means a process of *mutual learning* in which all participants discover new things and can build together on their new discoveries. This necessitates genuine self-willed, if not always self-initiated, participatory and mutual learning approaches which open space for *creative change*.[79]

4.2 How do rural people share social service costs at present?

The rural people have from time immemorial shared in provision of the social services which they have consumed. This is commonly overlooked when the question of cost sharing is discussed. How it is realised today in a village society requires closer scrutiny. In the previous section we could see that the transition from the old to new is not self-evident nor without complications.

In traditional village society there prevailed a system of exchange for social services which were mutually provided within the village.[80] In social exchange based on reciprocity participants keep mental records of what has been given and what return services are expected. This system is in anthropological economics referred to as gift economy. The main difference between gift and commodity economy is in gift being an inalienable exchange on personal level, keeping balance in giving and receiving, approximation in values but never returning exactly the same as what has been received. In a gift economy loans can be forwarded with an agreement of returns and new loans are given and received on a personal trust. In the commodity economy the exchange takes place in impersonal terms and the commodity is alienable. Neither side needs to feel any further obligation to each other. In present day Africa, the borderline between the two is not at all clear which leaves much room for manipulation and ambiguity especially in intercultural margins.

Today people pay either in cash, kind or mutual service. Payments in the form of service are seldom counted in cash value. When women help each others in serving at funerals, religious and ritual occasions, wedding celebrations or other family or communal events they are at times compensated in kind or in small cash payments which are collected from the participants or are given by the celebrant. Such payments are voluntary and the amount depends on person's ability to contribute. Poor families' celebrations are small in size, fewer neighbours and relatives contribute. A family or an individual who totally lacks the means to share in celebrations can become isolated and withdrawn and social groupings based on wealth, pedigree, educational level, ethnicity and religion do divide local societies, but by and large, social exchange in some form or other is part of life.

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[79] In the longer treatment of the subject I discuss the mutual learning concept and practice more fully. I also elaborate the difference between the ITK=Indigenous Technical Knowledge approach to the problematic at hand showing the one-sided direction which often limits the ITK to developing 'ethno' sciences as distinct from mutual learning processes. A mutual learning process is also a research methodology as will be shown later.

[80] I shall give a theoretical account of how an exchange and service economies work in a later fuller treatise of the subject.

The analyses made of women's working groups in Masasi, Newala and Rwangwa districts showed that those sharing in groups belonged mostly to the middle income category. The poorest quintile could be left without help because they could not reciprocate (Annex Figures 4 and 5). The failing support indicates separation from kin and children. The breaking of traditional social systems, especially because the alienated school youth no longer feel obligation to their parents, have weakened social bonds, there is a growing number of villagers who are not in any exchange circuit. When care systems are reshaped the potential of social exchange systems and the marginalisation of some categories of people have to be considered.

The customary work parties with which people cultivated their fields and built their houses together tend to turn to paid work assignments, although the communal work system is still known and they can be popular because they give people opportunity for sharing a drink together after work has been completed.

The custom of sharing in social celebrations or in each other's grief has been transferred also to urban situations. At workplaces lists are frequently circulated for contributions in support of a colleague whose relative has died or who might be celebrating his or her wedding. The personal and social interferes with the official and formal in ways which give clues how the bridging of traditional and modern can take place also in the 'modern' context.[81]

This leads to another aspect of cost sharing which has not been taken into consideration when sharing systems have been developed. There is to my knowledge no estimates of remittances from relatives working outside their home areas, not at least in the south-eastern regions. They are considerable and they have an impact in sustaining life in rural areas in all parts of Tanzania. Funeral rites and home visits because of deaths and illnesses at home as well as other family events and special celebrations as indicated above use a large share of migrant family members' savings.[82] On the other hand, returning visitors also replenish their food stores and get other socially significant services from their rural family members and neighbours. The monetary value of care given to a dependent family member can be based on what an absent family member pays for a servant or for daily necessities as their contribution to the care of a parent, infant or other dependent.[83]

A form of cost sharing which has been given little attention but is probably the largest area of sharing with no compensation is the care given to minors. At no time when women were asked to describe their working schedule and list the main daily chores did

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[81] An interesting analysis of the mixing of traditional beliefs with the responsibility that colleagues take at a death of one amidst them is given by Trish Nicholson in Susan Wright's (ed.) book *Anthropology of Organizations*, Routledge, London and New York 1994.

[82] At this time I do not have statistically significant information about this aspect. A household survey including this kind of data is being undertaken in Lindi Region and the results will hopefully be available before April 1997. I shall compensate the statistical information by giving descriptive case studies in an Appendix.

[83] Not seldom a single mother sends her child to her mother or grandmother to be cared for and might or might not compensate for the care. When the child grows s/he contributes to the household by doing small chores, but when the child is of school age the liabilities on account of the child increase.

they specify childcare or attending the sick or handicapped as a specific area of work. They did list bathing, food preparation, taking a member of family to hospital, as a work task, but childcare did not appear as a category nor other caring tasks they had. If we analyse forms of service which in a western welfare society would be taken care of through the state services, but which in Tanzania have been left for families to care for, the cost sharing estimates would rise sky high.

The largest contribution which people give in kind and cash is the care of infants and under fives, but also care of the disabled: the blind, crippled, deaf, mentally handicapped; chronically ill, bedridden patients and old people with no ability to contribute to work. The value of these services can be estimated from village demography documented annually with lists of the working population, children, school age children, old people and disabled categorising them somewhat differently depending on the recorder's style. Apart from the external family members' remittances, the monetary value of special time and money-consuming care can be estimated on the basis of opportunity cost for lost working time or reduced production capacity for those on whom the care duties fall. This time use and physical and mental effort usually devolves upon women.

The state and even more so religious bodies have provided institutional care for the deaf and blind, but some family costs do also incur in travel expenses, clothing and incidentals.[84] The state has developed programmes of integrating handicapped children to regular schools especially in urban schools. Those remaining at home demand attention which they often do not receive since the funds which the Social Welfare district staff have at their disposal are minimal.

Another aspect which needs to be given attention is women's workload in carrying water often from distant places. The availability of water and the effort it takes to acquire it must be in some proportion to the payments required from water users.

Women share in work by joining together in small groups. These groups are at times casual but most of the time they have some permanency; women know whom they can call on for help or with whom to rally together for specific tasks. The past experience taught the government that people were not readily volunteering to share work in large groups. Cooperation in which work inputs were unequal, and after the work was over there was little to share, did not encourage greater sharing. Yet women do like to work with fellow women, usually in groups of two or three. The Ministry of Community Development has now encouraged women to join in small groups of five. For larger projects women themselves decide on the size of the group they need to take on fishfarming, milling, cultivating specific cash crops, or running teahouses. Women are now learning that if they are organised they can more easily apply for loans. If one woman is ill others work on her behalf, also on her personal field, and care of children can also be shared. Much of women's work is of such nature that one person can do it only with great difficulty. This is the case with pounding corn, lifting heavy loads on

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[84] The state has built a good standard blind school for older boys in Masasi with support from SIDA. The school was closed early last year for lack of funds to feed the students. Students were left to care for themselves if they did not have the travel money to go home.

each other's head, assisting in thrashing, going together to distant fields, carrying firewood, digging wild roots in forest, just to mention some.

On the basis of this brief glimpse into village care systems and sharing I conclude that 'cost sharing' is widely practised and is by no means a new concept in rural communities. In discussing with communities the issue of cost sharing the starting point will have to be recognition of the forms of cost sharing that prevail in communities. At least a rough assessment of the monetary value of the services rendered needs to be made. The PRA analyses which are being done in the south-eastern regions can more purposefully include these aspects in the meetings which are held with groups of people and in various committee meetings.

As a point of comparison, a mother of one child in Finland is paid 1,200 Fmk per month for taking care of her own child at home. If she has two children she gets 800 Fmk more per month.[85] If the Western social system is taken as a model for what public goods are and what people should be entitled to, village women in Africa, as a category, should be freed from all cost sharing in cash. The value of their health and social care they give covers all that the state can expect from them until the time comes when the state or some form of insurance can start covering some part of their work.

This is likely to be an unrealistic conclusion at this time. After having assessed women's share in social care I shall make a rough assessment of the capacity of a village community to cover educational and health expenses and to end up with suggestions how the cost sharing can be implemented at this time.

5. TENTATIVE CONCLUSIONS

I am not in the position to draw firm conclusions until I have made an analysis of the level of wealth in an average south-eastern village and assessed how much can be expected from village population in terms of social services. I can, however, at this stage present some factors of a general nature which have to be considered when the capacity of a community to pay user fees is estimated and demands put on rural people.

The points which I consider to be important when cost sharing is proposed are both of principle and practice:

- One basic question is who in Tanzania carries, relatively speaking, the heaviest economic and social burden. The statistics show that the conditions are much better in urban centres than they are in rural areas. Poverty is concentrated in villages. A problem which cannot be explored here is how correct the measures are which make Tanzania such a poor country and Lindi the poorest of all regions. If we assume that they give a fairly good picture of

[85] What the actual sums should be is being debated, but the approximation is all we need here.

the economic state of the people in these parts then it must have some consequence in allocations and demands which are put on people.

- I have shown above that rural people, women in particular, take care of the sick, disabled, young and old with no compensation given to them for it. There are ways in which this kind of care can be calculated. In Tanzania, every village keeps records of its people house by house. The cell leaders know the people who live in their cell and can vouch whether the weak members are cared for. Even better would be to elect a health attendant, usually a woman, to share this responsibility in each cell and to report annually, and more often, if there are changes in the houses of the cell. If a health card system is adopted then such households in which the care of the sick is already overwhelming can be given a free card for the services they need over and above the daily care of their patients.
- Village work-register can be established. When there are public works to be done, especially in the field of health, education, water and sanitation and food security, the hours spent and the work accomplished can be recorded. This work can be estimated following the current price level and minimum wage level in the village (except when specialised skills are used like masonry or carpentry in which case the value of the work must be estimated higher). This becomes a form of village employment, but instead of getting paid in money one gets paid in services: lower school fees and reduction in health card payments.
- Special attention needs to be paid to employed workers who often skip payments or work duties since they are not counted as real members of the rural communities. This happens also with the returnees who have come back to retire in the rural areas. Wage labourers do pay taxes which has to be taken into consideration but wealthier households which do not consider that they can do manual work do not contribute their fair share in relation to their wealth. If the school fees as suggested go up substantially and the wealthy members pay those fees they thus compensate their lack of work. Often one time big payment might give a wealthy person the reputation of being generous, yet in terms of regular payments s/he is negligent.
- What happens to the poll tax money, school fees, licences paid for stalls at the market, duties paid for selling even smallest wares, entertainment tax paid for rituals and *ngomas*, is a central question when decentralisation and community funds are proposed. If CEFs or CHFs or water fees are started then it is essential that the community has some say in the use of that money. There must be a radical change in the financial management which must become transparent if people are burdened with additional payments.
- Systems must be established for monitoring funds in the way which gives the local people possibility to share in this task. Forms of participatory monitoring need to be worked out and people trained in it.
- Civic education which goes together with councillors' responsibilities (school committees, health funds, water systems) needs to be conducted on ward level

in a very practical way in relation to the councillors' concrete tasks in managing funds, book keeping monitoring, learning to reason in making choices, conducting easy surveys, discussing with fellow villagers about decisions, etc.

Another set of questions comes from the quality of services and their relevance to people. These questions relate to people's value systems but also to adequacy and relevance of the educational and health systems or even the water system. They relate also to village technologies and reasons why schools do not teach the most urgently needed practical skills and technologies.

- In all the years when water systems have been developed the school classes have not been introduced to the technology that village water supply system uses so that students could at least repair a pump when it breaks or would know how to fix a water tap - or even to close a tap when they find it running and so learn to save water!! Science teaching should relate to village technology. Teaching maintenance as the basic practical subject starting from standard one in the *stadi za kazi* (work studies which are in the new syllabus in Tanzania, at least in theory) is the most useful way of making the students understand how corners are kept clean and how decay is prevented and small repairs done immediately when something breaks.[86]
- Bridging the border between traditional and modern must take concrete forms. Fixed ideas about theoretical knowledge being more valuable than practical knowledge need to be challenged. It seems that the ideas what real knowledge is are stuck in the minds of westerners as they are also dominating the minds in Africa, and the awe northerners and Africans alike feel when they face the world of telecommunications, electronics and money market. It paralyses people from using their own hands and feet and their own strength in relation to their concrete world.
- Health inspections have not been done in schools although they could be done with no extra expense at all if the teachers would carry them out with local health staff as daily or monthly routine, or even once in a term.
- The mutual learning process can be institutionalised in such a way that different partners (facilitators, government officials, village men, women, and youth learn through shared narration and analysis. Without it there is no way in which one side can teach the other?

No satisfying recommendations can yet be given at this point. The system of user fees can be started moderately, but it will have to have exemptions which make it possible for the lowest income quintile also to receive services. There is wealth in villages which can be used for payments,[87] but the needs are huge and the funds which need to be

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[86] This is being done in the Mtwara and Lindi school programmes now.

[87] In a later version of this paper I shall show the division of wealth in a village which makes it easier to see that there is unevenly distributed wealth in villages.

established are many. Life can be improved with a multiplicity of small inputs, even though they do not solve the basic questions of poverty they improve life conditions significantly. Emphasis should be on things that can be done, given the existing resources, rather than on those which are beyond reach at this time.

ANNEX TABLE 1
PRIORITY SOCIAL ACTION PROGRAMME (1989/90-1991/92) SUMMARY OF FINANCIAL REQUIREMENTS)

	1989/90	1990/91	1991/92	TOTAL
Total Requirements				
Education	22.84	21.95	11.55	60.34
Health	45.50	50.00	57.50	153.00
Water Supply	24.00	24.60	29.60	78.20
Food Security	5.54	5.54	5.73	16.81
Programme Total	99.91	104.22	110.22	314.65
External Support Already Identified				
Education	10.50	10.59	10.59	31.79
Health	26.00	36.60	36.60	96.30
Water Supply	17.20	17.20	17.20	51.60
Employment	0.00	0.00	0.00	0.00
Food Security	0.00	0.00	0.00	0.00
Programs Total	53.79	61.49	64.39	179.69
Unfunded Gap - PSAP Request				
Education	12.24	11.35	4.96	28.55
Health	19.50	16.30	20.90	56.70
Water Supply	8.78	7.36	12.06	26.60
Food Security	5.54	5.54	5.73	16.81
Employment	2.03	2.13	2.14	6.30
Programs Total	46.09	42.68	46.09	134.96

Source: The United Republic of Tanzania, Planning Commission Priority Social Action Programme, University Press, 1992, Table 5, p. 101.

ANNEX TABLE 2
TOTAL GOVERNMENT RECURRENT AND DEVELOPMENT EXPENDITURE BY SECTOR

	1980/81	81/82	82/83	83/84	84/85	85/86	86/87
Social Services							
Education	1473	1613	1738	2440	2524	2890	2009
Health	688	721	789	981	1020	1131	977
Social welfare	37	52	44	51	54	67	59
Housing and community development	108	45	190	187	209	217	119
Other social services	240	277	176	332	374	448	590
Water and electricity	773	639	597	1027	880	1003	564
Subtotal	3319	3447	3534	5018	5061	5756	4318
Defense	3194	1110	1612	2308	1555	2660	2377
Other sectors	6497	9857	9748	11670	12383	14199	17985
Total	13036	14413	14895	18998	18993	22615	24680
Social Services as % Total	25.5%	23.9%	23.7%	26.4%	26.7%	25.5%	17.5%

Source: United Republic of Tanzania 1980–89.

ANNEX TABLE 3
CENTRAL GOVERNMENT OPERATIONS 1983/84-1993/94

	83/84	84/85	85/86	86/87	87/88	88/89	89/90	90/91	91/92	92/93*
Total Revenue	15,465	18,000	22,321	31,096	46,829	71,790	94,655	135,920	173,566	164,238
Total Expenditure	23,918	26,066	32,864	50,607	77,780	110,494	132,156	185,025	207,000	352,153
Recurrent Expenditure	18,182	20,675	27,403	38,774	61,705	93,457	115,893	160,304	194,347	251,568
Development Expenditure	5,736	5,391	5,461	11,833	16,076	17,036	16,263	24,721	32,663	64,710
Deficit	-8,453	-8,066	-10,543	-19,511	-30,951	-38,704	-37,501	-49,105	-33,434	-187,915
GDP at Market Prices	70,375	93,113	124,474	170,621	242,765	310,600	373,495	495,831	634,377	835,633
PE on Social Sector	4,398 (18.4)	7,862 (30.5)	7,216 (22.0)	7,734 (15.3)	10,041 (12.9)	14,775 (13.4)	19.351 (4.6)	30,401 (16.4)	37,628 (18.2)	48,178 (13.7)
PE on Economic Services	5,573	6.367	6,567	9,283	11,915	18,723	21,460	45,837	35,327	51,279

Source: Ministry of Finance.

Notes: * Likely outturn
** Estimates
Figures in brackets are percentages.

ANNEX TABLE 4
PER CENT DISTRIBUTION OF POPULATION SOURCE OF WATER
RURAL AREAS

	1	2	3	4	5	6	7	TOTAL %
ARUSHA	7.91	24.52	16.42	19.42	12.05	19.41	.28	100.0
COAST	2.75	10.50	19.17	59.41	0.16	6.99	0.02	100.0
DSM	9.07	24.92	20.18	44.53	0.76	0.40	0.14	100.0
DODOMA	14.20	10.51	39.44	22.13	7.34	6.11	0.27	100.0
IRINGA	14.65	10.04	30.44	25.15	12.84	6.86	0.03	100.0
KAGERA	1.33	2.32	23.22	23.48	17.60	31.98	0.07	100.0
KIGOMA	9.01	14.59	16.00	17.09	16.82	26.48	0.01	100.0
K'NJARO	16.55	34.07	6.29	8.45	6.76	27.84	0.04	100.0
LINDI	4.61	8.44	24.75	51.41	1.97	8.83	0.00	100.0
MARA	1.45	3.73	19.37	58.80	4.09	12.56	0.01	100.0
MBEYA	6.10	8.25	29.83	35.73	7.26	12.79	0.04	100.0
MOROGORO	2.56	18.87	18.38	32.58	4.97	21.84	0.81	100.0
MTWARA	10.65	29.85	18.08	39.75	0.65	1.01	0.01	100.0
MWANZA	0.56	3.65	24.74	56.75	4.54	9.70	0.05	100.0
RUKWA	0.23	19.29	7.88	44.95	1.73	25.92	0.00	100.0
RUVUMA	1.05	13.93	16.12	58.82	0.74	9.30	0.04	100.0
SHINYANGA	1.38	3.58	31.09	46.29	6.19	11.40	0.07	100.0
SINGIDA	1.20	5.40	19.02	56.86	3.24	14.27	0.01	100.0
TABORA	0.76	2.21	29.45	63.18	0.73	3.67	0.00	100.0
TANGA	4.71	18.38	10.25	43.61	5.92	16.98	0.15	100.0
MAINLAND	5.41	12.07	22.17	39.00	6.76	14.98	0.11	100.0

Key:
1: Piped water inside the house or village
2: Flush toilet outside the house or village
3: Well water in plot or village
4: Well water outside the plot or village
5: Other water in plot or village
6: Other water outside the plot or village
7: Not stated.

Source: Population Census 1988.

ANNEX TABLE 5
HOUSING CHATRACTERTISTICS

Table 5 Housing characteristics

Percent distribution of households by housing characteristics, according to urban-rural residence, Tanzania 1994

Characteristic	Residence		
	Urban	Rural	Total
Electricity			
Yes	32.3	2.2	9.4
No	66.9	97.2	89.9
Missing	0.8	0.7	0.7
Source of drinking water			
Piped into residence	37.1	1.3	10.0
Public tap	45.4	18.7	25.2
Well in residence	0.7	0.9	0.9
Public well	12.8	33.1	28.2
Spring	0.7	16.5	12.7
River/stream	0.8	23.3	17.9
Lake/pond	1.3	3.2	2.7
Dam	0.1	2.2	1.7
Rainwater	0.0	0.1	0.1
Missing/Don't know	1.1	0.6	0.7
Sanitation facility			
Own flush toilet	2.5	0.2	0.8
Shared flush toilet	1.7	0.0	0.4
Traditional pit latrine	91.1	86.9	87.9
Improved pit latrine	1.8	0.3	0.7
No facility/bush	2.2	11.9	9.6
Missing/Don't know	0.7	0.6	0.6
Floor material			
Earth/sand	39.4	90.2	77.9
Wood planks	0.2	0.3	0.3
Ceramic tiles	0.2	0.0	0.0
Cement	59.3	8.8	21.0
Missing/Don't know	0.9	0.7	0.7
Persons per sleeping room			
1-2	63.3	56.3	58.0
3-4	25.5	28.5	27.8
5-6	8.1	8.8	8.6
7 +	1.0	4.4	3.6
Missing/Don't know	2.1	2.0	2.1
Total	100.0	100.0	100.0
Mean persons per room	2.5	2.9	2.8
Number of households	972	3051	4023

Source: World Bank Report No. 14 982 Ta (cf Documents)

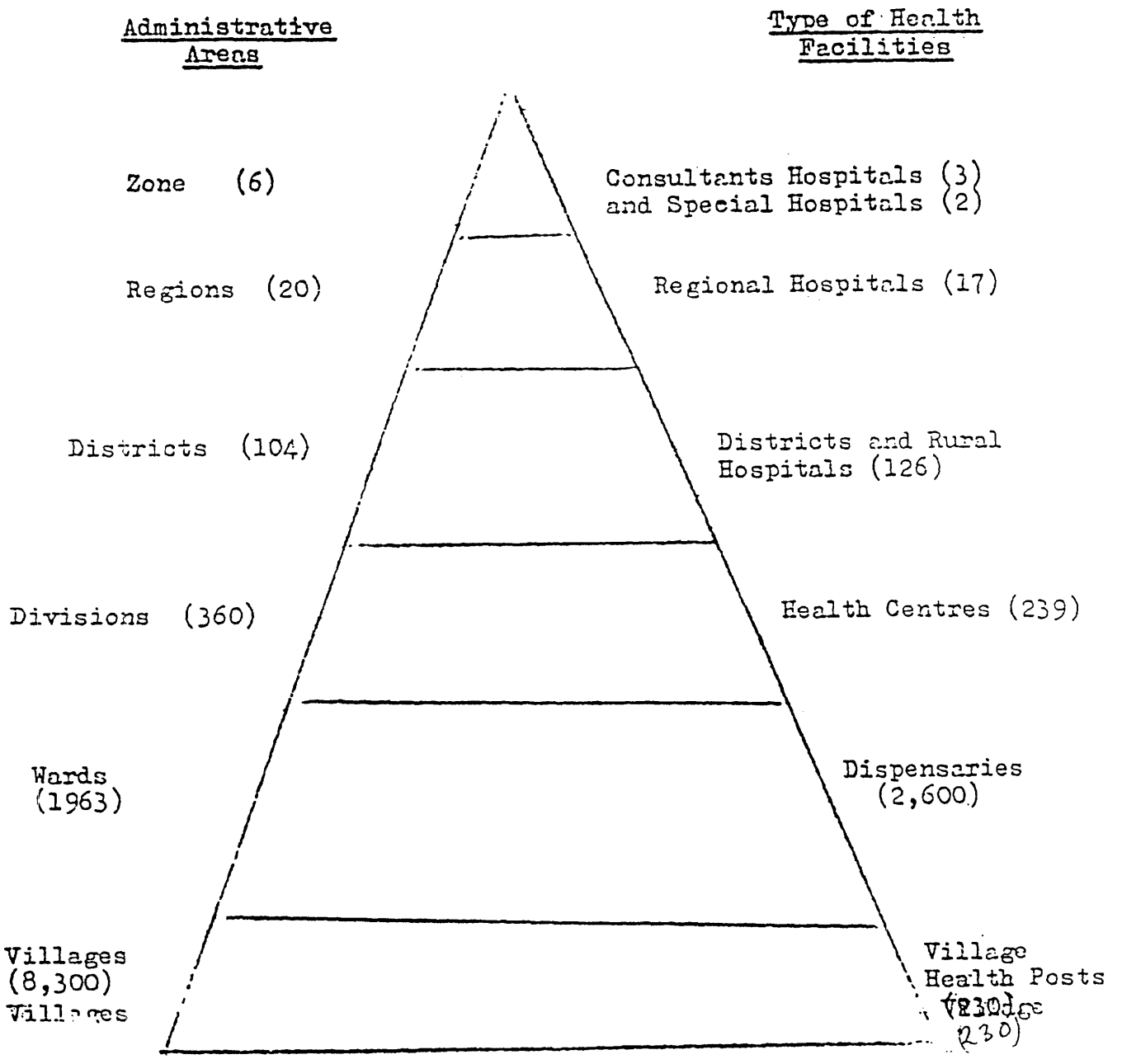
ANNEX TABLE 6
REGIONAL SUMMARY OF MALFUNCTIONING SHALLOW WELLS, 1996
MTWARA REGION

S/No.	DIVISION	TOTAL SHALLOW WELL	FUNCTIONING (NUMBER)	NOT FUNCTIONING (NUMBER)
MASASI DISTRICT				
1.	Nakopi	38	15	23
2.	Namyumbu	59	20	39
3.	Lisekese	261	87	174
4.	Lulindi	19	3	16
5.	Mchauru	2	2	-
6.	Chikundi	49	6	43
7.	Chiungutwa	19	-	19
MTWARA DISTRICT				
1.	Dihimba	45	18	27
2.	Ziwani	116	45	71
3.	Namyamba	49	38	11
4.	Mpapura	59	30	29
5.	Mayanga	20	9	11
6.	Kitaya	39	25	14
MTWARA URBAN				
1.	MTWARA URBAN	163	39	24
2.	Mikindani	48	28	20

Source: Regional Water Engineers' Report 19/4/1996.

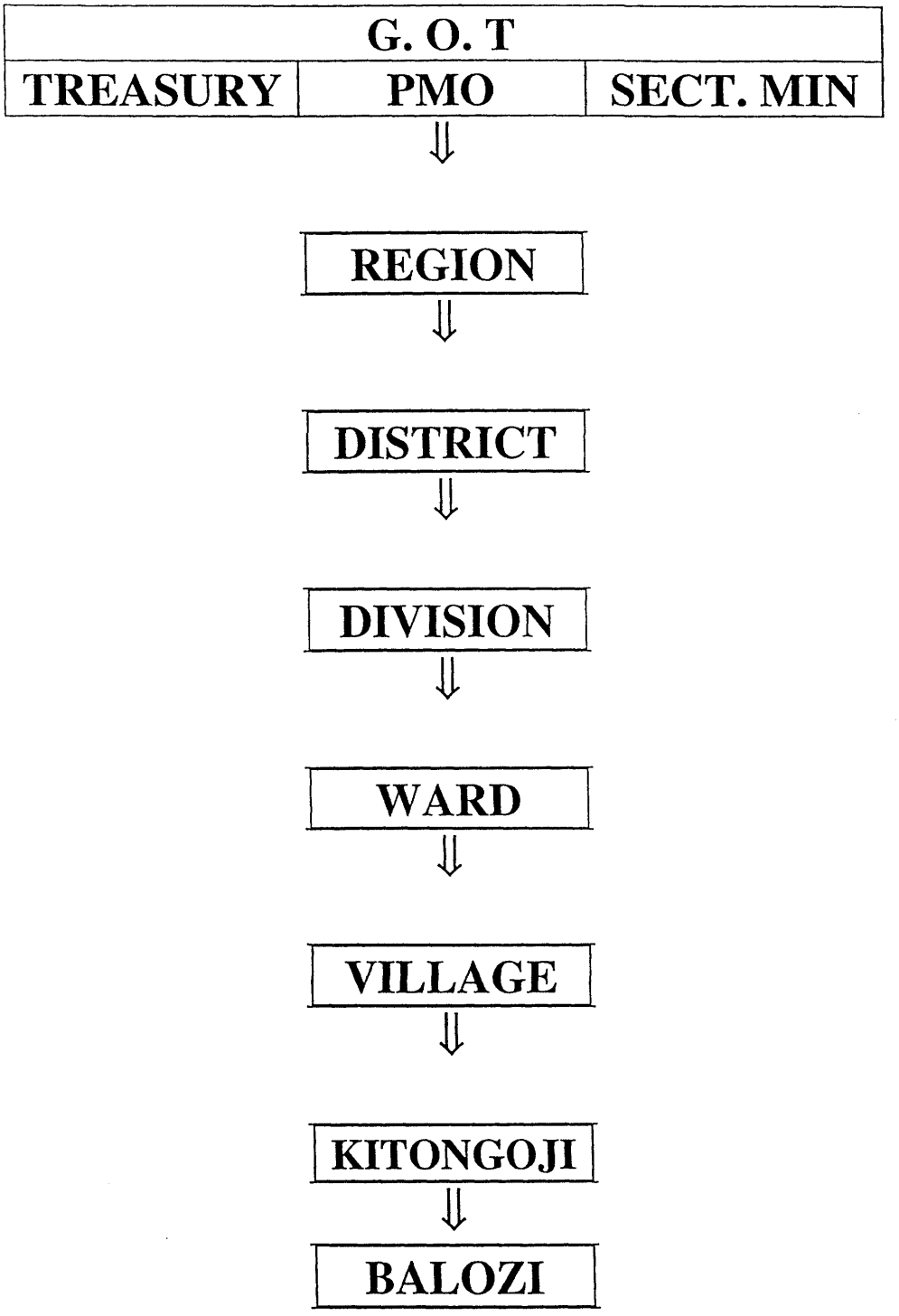
ANNEX FIGURE 1

Structure of Health Facilities



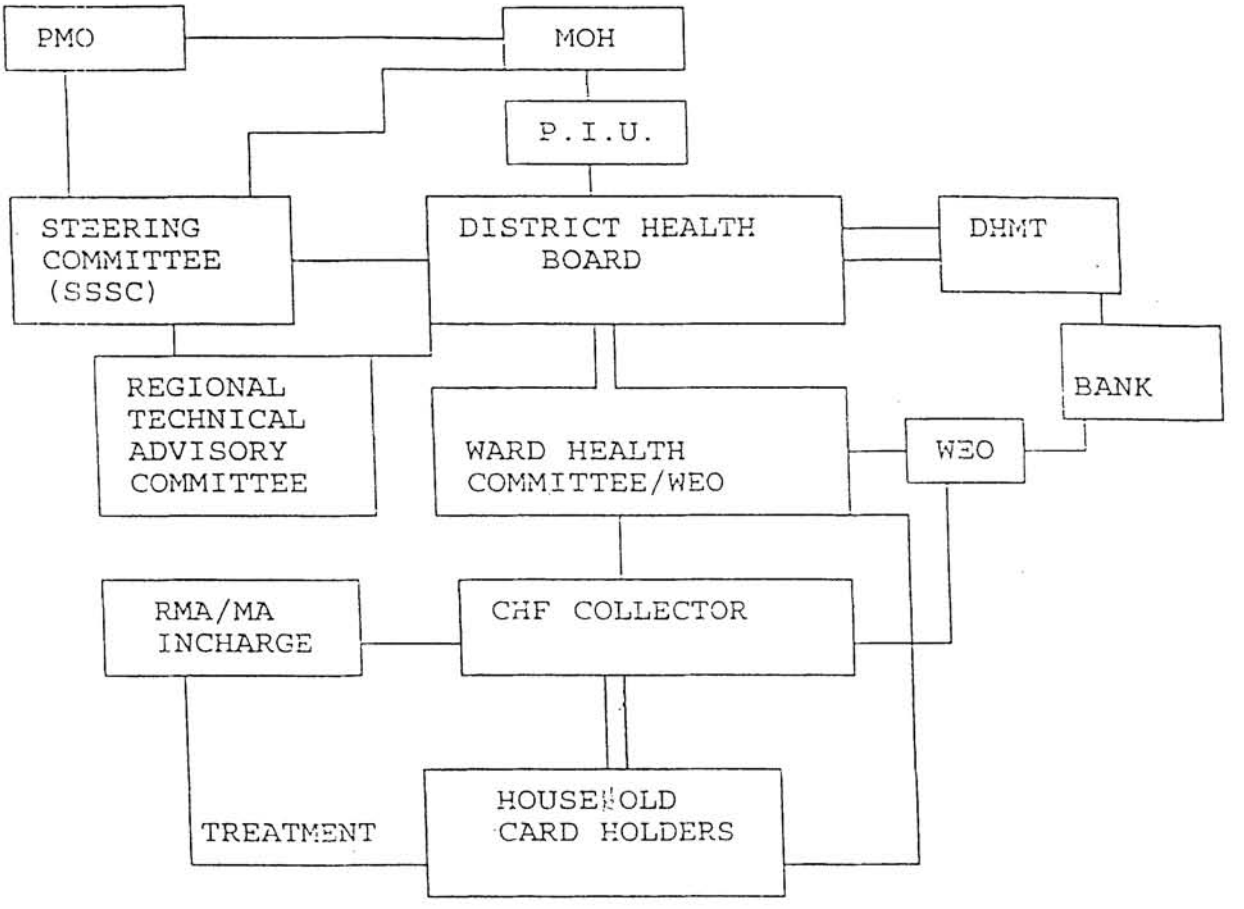
Source: Inventory of Health Facilities 1979

Tanzanian Administrative System



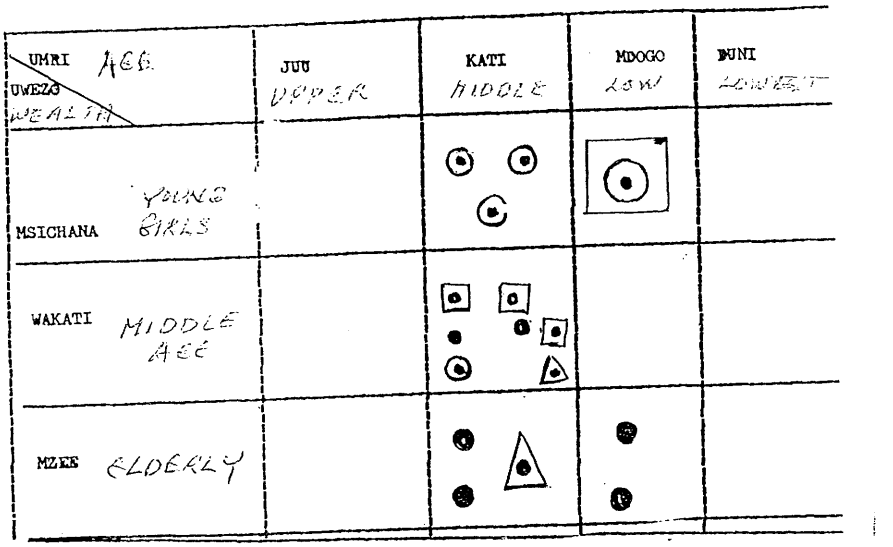
ANNEX FIGURE 3

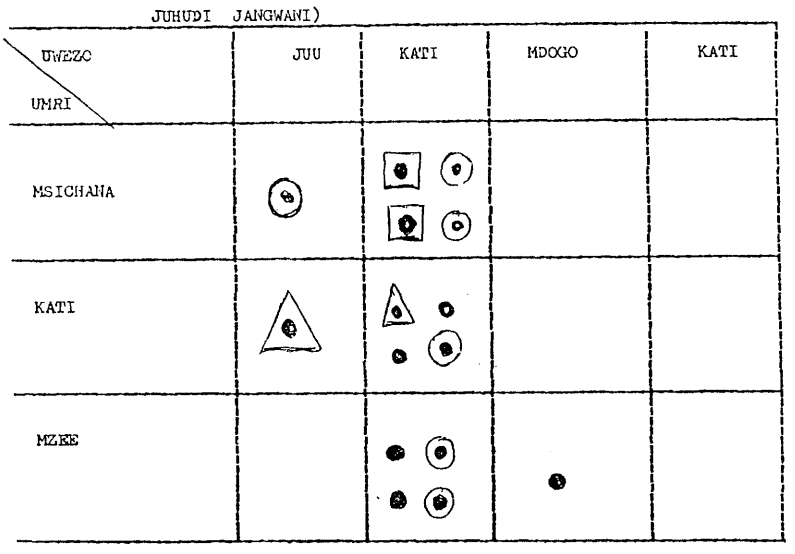
THE ORGANIZATION STRUCTURE OF CHF SHALL BE AS OUTLINED ON THE LINE DIAGRAM BELLOW

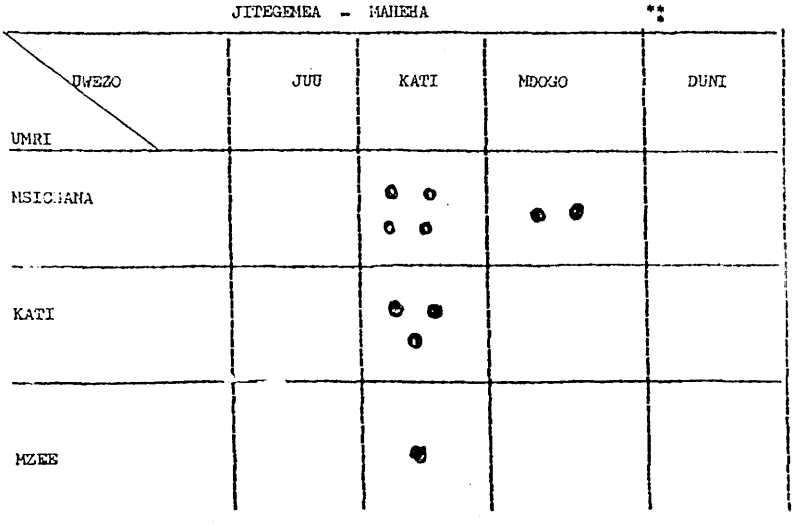


ANNEX FIGURE 4
WOMEN HAVING SUPPORT GROUPS

The symbols in the columns indicate the types of supportive relations that women who work in groups have. Middle income women in all age groups both need and get support from other women. The wealthy do not need support nor do they join the groups. The same is true for the poorest income group, only they would need the support but do not get it since they are unable to reciprocate.

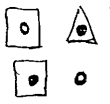






ANNEX FIGURE 4 (CONTINUED)

AZIMIO - MAHEHA ○○○ ○○○ : : :

UWEZO / UMRI	JUU	KATI	MDOGO	DUNI
MSICHANA				
KATI				
MZEE				

JUHUDI - MAHEHA ○○○○ ○○○○

UWEZO / UMRI	JUU	KATI	MDOGO	DUNI
MSICHANA				
KATI				
MZEE				

DOCUMENTATION AVAILABLE FOR THE ANALYSIS OF THE PRESENT SITUATION IN THE SOCIAL SECTOR

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