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**The Political and Social Economy of Care:
Tanzania Research Report 1**

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Political and Social Economy of Care:

Research Report 1 on Tanzania

Introduction

The Political and Social Economy of Care project of UNRISD encompasses comparative research on the provision of care by households and families, government, markets and the voluntary/‘community’ sector across two countries in each of four continents. The emphasis in the study is on the multiplicity of sites where care takes place, and the mix of institutions involved. Of special interest is analysis of how unpaid care is articulated with the commodity economy from a gender perspective – the ‘labour/care regime’, and how responsibility for unpaid care shapes the carer’s paid work profile, access to income and poverty (and vice versa).

Tanzania was selected to be included in this comparative research, alongside South Africa as the other African case. One of the non-negotiable criteria for selecting countries for inclusion in the project was that they must have had a time use survey, and that data from this survey had to be available for further analysis. There are very few African countries which have, to date, conducted national time use surveys. Tanzania joined this small group in 2006 when it included a time use module in the Integrated Labour Force Survey of that year. Within each region, UNRISD aimed to select one country that had a more developed welfare/care infrastructure and a second with a less developed one. For Africa, South Africa and Tanzania were felt to present good contrasts. Both countries also are experiencing serious HIV&AIDS pandemics. This will allow for interesting comparisons as to how the political and social economies of care cater for the particular needs arising from this crisis in the two countries.

The following section provides a brief socio-economic and political context analysis within which the care economy is going to be further analysed.

Political Transformations

Tanzania’s current political system results from a series of socio-economic and political processes over the past four decades. The major political shifts have influenced the economic processes at the same time as the economic process has influenced the political shifts.

From opposition party to a ruling party

During the struggle for independence, the Tanganyika National Union (TANU), the political party which eventually led the country to independence, succeeded in mobilizing support from diverse interests. These included the cooperative movement, labour, women’s organizations, youth and various cultural and ethnic groups. Support was won through TANU’s demand of the colonial state that it improves educational facilities together with health services, ensure better prices for crops, improve living conditions and create an environment for participatory political processes.

With independence, the immediate challenge to the Party was to redefine its role from that of opposition to a ruling party. TANU inherited the very centralized bureaucratic structures of the colonial state, which generally restricted civil society involvement and were based on a politics of social exclusion, particularly of women. In the process of transforming itself to a political party in power, TANU slowly eroded some of the basic principles it had been fighting for.

Asserting party supremacy

In asserting its role as a ruling party, TANU exploited its historical role of leading the independence struggle. Firstly, it had an open membership, which created a popular image. Secondly, it had established branches throughout the country, giving it a national character. Thirdly, its organizational structure provided room for organizations at grassroots level to express the views of ordinary members to higher levels of organization, giving the Party a democratic appearance.

Finally, the Party chairperson Julius Kambarage Nyerere resigned as a Prime Minister in 1962 so as to devote more time to strengthening the Party and its popular support, and thus the role of ordinary people in the fight against poverty, ill-health and ignorance.

Between 1961 and 1967 the Party pursued measures which asserted its power over other organs of the state. In 1965, Tanzania officially became a one-party state.

In search of an alternative ideology: The Arusha Declaration

In 1967, the National Executive Committee of TANU endorsed the Arusha Declaration which spelt out socialism and self-reliance as principle tenets guiding the country's development philosophy. The approach was based on the African traditional philosophy of family-hood, popularly known as Ujamaa.¹ The Arusha Declaration was seen as ushering in a new era. Nationalization of the key sectors of the economy, the creation of public enterprises and the collectivization of people in villages were intended to create a political, social and economic environment which supported the state in implementing social equity and redistributive policies implied in the Declaration

In 1972, the Party endorsed a decentralization exercise which replaced the district councils with centrally controlled administrative apparatus. The transfer of certain administrative powers from the central ministries to the regional and district levels was undertaken in the name of democratizing decision-making processes even though the exercise involved abolishing popularly established institutions such as town and city councils. One of the effects of decentralization was the state's incapacity to mobilize local resources for development in the same way as local governing institutions had done (Therkildsen: 1987).

By the end of 1970s, the Party had established institutions and structures which enabled it to assert itself as the supreme organ of the state. However the economic crisis and the Economy Recovery Program (ERP), Tanzania's structural adjustment programme, eroded some of the Party's powers.

The crisis, structural adjustment programmes and the impact on Party supremacy

The signing of the structural adjustment agreement between the International Monetary Fund (IMF) and Tanzania in 1986 was a major landmark in the country's political history. The conditions of the Agreement included liberalization of the economy, the devaluation of the local currency, fiscal control measures, as well as downsizing the public sector, including the civil service.

The launching of the ERP in 1986 symbolically inaugurated the defeat of Ujamaa philosophy. Liberalization supported by re-direction of both internal and external resources from the social services to the "productive" sector symbolized the public denunciation of Ujamaa philosophy and the associated social equity principles and practices. This was a big blow to the Party and a challenge to its supremacy.

Economic liberalism and its politics

The processes that led to the subsequent opening up of political space resulted from two contradictory forces. First, there were internal forces which were demanding the opening up of political space. These demands were in part a response to the economic crisis of the 1970s and 1980s. Between 1974 and 1988, for instance, the real wages of workers fell by 83% at a time when the government's ability to support the social sectors had greatly deteriorated (IFPRI: 2001). In response to this situation, various associations emerged, some of which attempted to fill in the service delivery gap, while others started to engage the state on human rights issues, and a good number challenged the state on politics of exclusion and marginalization of women from mainstream processes.

¹ The Term Ujamaa is a Swahili word which stands for "family hood" or communal type of living based on African traditional values of sharing, supportive systems, respect for each other and the extended family.

From 1980s, therefore, when the forces for political reform emerged, Tanzania's civil society began to grow, as expressed in the density and diversity of organizations, and the growing role of the free media. Indeed, in 1993, there were only 224 registered NGOs in Tanzania. But by 2000 there were approximately 8,499 NGOs registered with the Registrar of Societies in the Ministry of Home Affairs (Lage et al. 2002).

The second set of forces was coming from external sources, particularly from the international financial institutions (IFIs) for "liberalizing" politics, in line with the market-driven economy. Thus IMF/World Bank conditions included, among other things, liberalization of the political system to reflect the redefined role of the state in creating a regulatory and legal environment supportive of a market-driven economy. Pluralist politics were favoured as they were considered to be supportive of the doctrine of a "free" market economy. In response to this pressure, in 1990 President Ali Hassan Mwinyi appointed a Commission (popularly known as the Nyalali Commission) to seek peoples' views on a multi-party system. Although the majority of those whose views were sought preferred a one-party state, the commission recommended establishment of a multi-party system. The recommendations were unanimously endorsed by the National Executive Council of the ruling party, the Chama Cha Mapinduzi (CCM). In May 1992, the Eighth Constitutional Amendment Act (Act 4 of 1992) provided for multi-party elections for the Union Government. Further amendments of Local Government Election laws were subsequently affected to provide for multi-party elections for local government. Additionally, affirmative action in favour of women which had been introduced in 1985 was expanded to include 25% of members of parliament and 33% women representatives in the District Councils (URT: 1992). In July 1992 several political parties were registered and in October 1995 Tanzania held its first multi-party elections for the Union President and Parliament.

The process which led to the multi-party system of government in Tanzania was engineered and largely controlled by the state. Typical of state-engineered transitions, the process has been slow, as the state has not been willing to rewrite the political rules to make it possible for other actors to participate freely and fairly. There is reluctance to guarantee many rights, a strong interest to control media persists, and there is unwillingness to open up the system for fair and free competition. There is a tendency in the local government reform process towards imposing an authoritarian model rather than a participatory and democratic system. Nevertheless, there are some areas of progress.

Successful multi-party elections were held in 1995, 2000 and 2005, but the Parliament is still essentially controlled by the ruling party. Although the opposition members play a critical role in debates, they are unable to influence the bills because they are numerically too few to have an impact on the major decisions that demand voting. Further, politically conscious interests groups such as labour and farmers associations have not been very successful in articulating and organizing group interests and hence have largely been unable to influence major political decisions. Overall, multi-party politics is elite-dominated and characterized by elite power struggles. Nevertheless, other civil society actors, including youth, women's movement, religious organisations, and media have found entry points to influence the process. The women's movement and gender activists have been demanding more democratic space, have challenged the state to direct more resources to the "people", and have critiqued neo-liberal reforms which have put more emphasis on a market-driven economy than on a welfare state economy.² The media could be a potential instrument to challenge elite-controlled transition. However, it remains very vulnerable to repressive forces within the current political environment (Shivji 1991).

² Reference is made to various campaigns such as those organized by TGNP and Feminist Activist Coalition members in various areas including NGO Bill, The Gender Budget Campaign, the Land Bill, to mention but a few.

The government has established “democratic institutions” but they remain weak and vulnerable. The parliament, for instance, is yet to assert itself as effective in playing its oversight role in areas such as control of corruption and redirection of resources to pro-poor ends. Individual members of the judiciary have been struggling for independence and impartiality, but a strong executive remains a challenge to the judiciary’s autonomy. An electoral commission has been established to monitor free and fair elections but the members are vulnerable to manipulation by the incumbent party. Anti-corruption organs have been established but they are largely toothless in holding public office bearers accountable for corrupt practices.

The politics of social exclusion continues to characterise political liberalism. Women continue to be under-represented in key decision-making organs of the state and the private sector, despite the constitutional provision which provides that every citizen shall have the right to participate directly and through elected representatives in the governance of Tanzania. It has taken the country more than 40 years, and two decades since the inception of multi-party politics, to reach a level of 30% of representation of women in parliament. Women’s representation in the National Assembly increased from 15% in 1985 to 20% in the year 2000, to 30.4% in the year 2005 (TGNP/SIDA: 2007). Top-level decision making in the public service of Tanzania remain male-dominated. As of March 2006, for instance, women constituted only 30% of permanent secretaries and 28% of directors of ministries (ibid.).

Economic Policies and Growth Rates

This section identifies four major phases of economic policies which have impacted patterns of economic growth and defined labour force characteristics. The first phase is from 1960 to 1967, when the country implemented a pro-growth market-driven economic policy which was based on the colonial economic model. This model did not address the problems of poverty, disease and ignorance which had been declared as national enemies. The second phase is the implementation of the Arusha Declaration from 1967 to 1986, which pursued a socialist model emphasizing policies for social equity and self reliance with involvement of the state in managing key sectors of the economy. The implementation of the socialist model was, however, short-lived as it was impacted by a socio-economic crisis and paradigm shift of major sponsors of the socialist experiment, which included the Soviet Union and the Peoples Republic of China. In responding to the crisis, Structural Adjustment Programmes (SAPs) were implemented from 1986 to 2000, which were to lay the foundation for the liberalization of the economy. The emphasis here was growth, efficiency, and a lead role for the private sector in the management of the economy. The final phase is the current phase from 2000 onwards, in which the economy has been fully liberalised, with some attempt to balance concerns of social equity, good governance, and poverty reduction strategies. The main challenge has been how to implement social equity policies in the context of neo-liberal ideologies which are based on policies of exclusion and profit maximization.

Transformation and improvement: The growth model

Tanzania inherited from the colonial state an agrarian economy with more than 90% of the population living in rural areas. At independence, disease, poverty and ignorance were declared by Nyerere, the then President of Tanganyika, as the immediate enemies of the newly independent state. Development strategies were then expected to lead to improved wellbeing of the people in terms of material welfare, health status as well as literacy levels. A modernization approach was adopted which was recommended by a World Bank Mission which had been commissioned by the British colonial state. The World Bank mission had been instructed to assess the country’s resources so as to recommend the best way to utilize them in order to reach a balance between social and economic development (IBRD 1967: vii).

It is ironic that the ex-colonial power which was partly responsible for the impoverishment and underdevelopment of the country and its people was to be interested in searching for a “balanced program of social and economic development” for its ex-colonial state. The mission acknowledged the fact that Tanganyika was going to continue relying on agriculture as the mainstay of the economy. It thus recommended improvement of the methods of peasant agriculture and cattle keeping as well as a gradual transformation of methods and organizations of farming into systems which made greater use of new production techniques and better land use patterns (ibid.).

Resulting from the mission, two approaches were adopted for rural development. These were the transformation and the improvement approaches. Through the improvement approach, it was hoped to achieve a progressive improvement in the present methods of crops and animal husbandry by working on the peasant farmer on both psychological and technical planes, to induce an increase in his/her productivity without any radical changes in traditional social and legal systems (URT 1964: p.14). This strategy did not basically differ from the colonial policy which had been pursued in an effort to increase peasant cash crop production.

The transformation approach, in contrast, was supposed to concentrate resources in a few selected areas which would enable peasants (mainly men) to improve production of specified crops. Like the improvement approach, the transformation approach had its origin in the colonial economy as well. A few producers were to be isolated, located in settlement schemes and provided with modern farming techniques and ideas as a strategy to improve their production capacities. In Tanzania’s First Five Year Development Plan (FFYDP) 1964-69, the government envisaged the establishment of 74 such schemes which were expected to cost approximately three million shillings for the basic infrastructure (ibid.). The second approach did not target the majority of the poor peasants who had been ‘missed out’ of the colonial state economy. The trained farmers who were equipped with modern tools were basically male farmers leaving out the majority of women who constituted the majority of the rural producers (URT 1964).

By the end of 1960s neither the transformation approach nor the improvement approach had yielded the expected results. Although the economic indicator of gross domestic product (GDP) suggested growth of 6% per annum, this growth did not have significant impact on the people’s livelihoods as real per capita income increased by only 1% per annum. The economy experienced what then President Nyerere called “Growth without Development” (Nyerere 1968). The Ministry of Economic Affairs and Development further noted that while the transformation approach led to increased production in general terms, it had nevertheless led to colossal waste of capital equipment, caused heavy debts to cooperatives which were unable to pay, and further demonstrated how the country was ill-equipped with human resources for rapid technological advances of the nature adopted. This is the context within which an alternative economic model was to be proposed through the Arusha Declaration discussed in the previous section.

Arusha Declaration: Socialism and rural development

As discussed in the previous section, the Arusha Declaration marked a significant policy shift away from a market driven economy with its emphasis on commercial peasant production, into a state-controlled economy emphasizing social equity, and an increased role for the state in managing the economy and distributing the benefits from the production systems. The implementation of the Declaration entailed two strategies, namely nationalization of the major means of production and the creation of Ujamaa villages. The latter targeted improvements in the livelihoods of the majority of men and women, while the former aimed at building the capacity of the state to regulate the economy and hence distribute the benefits accruing from it.

Socialism and development

A socialist policy was declared in 1968 through the Arusha Declaration which provided the ideological basis guiding subsequent economic policies. The socialist principles were based on the notion of Ujamaa, itself anchored in traditional African philosophy of love, mutual respect, and shared responsibilities. In the rural sector, the policy entailed re-settling people into Ujamaa villages. Unlike the previous village settlement schemes which were adopted immediately after independence, the Ujamaa villages programme covered a wider spectrum of the rural population. The village was not only considered as a basic unit of production, but also as a social entity which provided social space for people's participation in their own development processes. Through the Ujamaa villages the government was going to channel resources particularly those targeting the wellbeing of its people. Purposeful measures were undertaken to invest public resources in human development, particularly in health, education and provision of water.

In the area of health, a national health policy was formulated in the early 1970s with the overall objective of providing comprehensive basic health services to all citizens equitably and as close to the people as possible. The primary health care policy adopted in 1972 and the Third Year Development Plan 1976-81 focused on major aspects of the National Health Policy whose main aim was: rural health development, promotion of preventive care rather than curative care; and building small and simpler health units rather than hospitals and free health services (Kjell.Havnevik, Kjaerby et al. 1988). The implementation of the health policy was supported by many western donors including SIDA, DANIDA, UNICEF, NORAD, FINNIDA, and USAID. By 1974/75, almost 9% of government total expenditure was channeled to the health sector (UTR: 1974/05). The result was the rapid expansion of the physical facilities for health services. By 1976 for instance, 161 rural health centers had been established compared with 22 at independence. By 1981, the number had increased to 239 and by 1987 to 260 (ibid.). The number of dispensaries grew from 1,847 in 1976 to 2,644 in 1981 and further to 2,831 in 1986 (URT 1988). This development resulted in a marked improvement in the population/facility ratio so that by 1982 there were one rural health centre per 75,732 people and one dispensary per 6,846 people. The corresponding figures for 1986 were 84,231 and 7736 (ibid). By 1980, approximately 72% of the population was within 5 km. of a health facility and 93% within a 10 km. range (ibid.).

Furthermore, a mother and child health strategy was adopted in 1974 based on the recommendations of a Young Child Study supported by UNICEF. This strategy aimed at providing mothers and young children with immunization, nutrition education, antenatal and postnatal care, treatment of minor health problems and monitoring of maternal health clinics. The goal of this strategy was to achieve universal coverage by 1988. By 1985/86, approximately 80% of all children had been immunized against tuberculosis and 67% against measles (ibid). Additionally, in 1985, a Village Health Worker programme was launched to support further the initiative of equitable distribution of health services. The goal was to establish a dispensary for every 10,000 people, a health centre for every 50,000 people and a hospital for every district and region, together with a consultancy hospital for each zone.

Alongside the government health sector, health services were provided by voluntary agencies, Parastatal organizations and traditional healers including traditional birth attendants. Available data indicate that traditional services were used as frequently as government services (SIDA 1987). Public investment in the health sector laid a foundation upon which equitable health services could have reached the majority of the citizens in both rural and urban areas if all other factors remained the same.

In the field of education, Tanzania inherited a colonial system with a pyramid structure. In 1960, only one quarter of the total school age population had been enrolled in primary schools, and of the total adult population, only about 10% were literate. By 1984 however, universal primary education

had been more or less achieved, with gender parity, while adult literacy had increased from 10% in 1961 to 60% in 1981 and by 1987, had reached 85% (URT 1987).

Secondary education did not record similar growth: in 1986 only 11,721 primary school leavers were enrolled out of the 380,096 who had completed primary school. Although the numbers had increased in absolute terms, the proportion had decreased from 29.2% in 1963 to 6.4% in 1985 which includes both public and private schools (ibid). The government pursued deliberate policies to bridge the gender gap at this level as well. Whereas, in 1961 only 1,229 girls were admitted to Form 1 (the first year of secondary schooling) compared to 2,967 boys, in 1988 4,017 girls were enrolled in Form 1 constituting 38.4% of the secondary school population (ibid). At university level, the situation was worse. In 1960, only six female students were enrolled compared to 70 male students, and by 1986 the corresponding figures were 190 and 1113 respectively. By 1987, female students at university level amounted to 25.6% of the total student body (ibid.).

The implementation of the Arusha Declaration was supported by many Western donor agencies including the World Bank as it coincided with a global paradigm shift which advocated pro-poor approaches in the development agenda. In the 1970s the total volume of foreign aid increased dramatically from US \$51.2 million in 1970 to a peak of US \$ 701.9 million in 1981. Total aid as a share of GDP rose from an average of 7.2% in the period 1970-73 to 10.9% between 1974 and 1976 and 13.2% between 1980 and 1982. In 1983-85 there was a decline to 10.3 but another increase to 16.9% in 1986. This is illustrated in the table below.

Table 1: Foreign Aid as a share of total GDP, of imports and of the foreign aid trade deficit (1970-1986) (annual averages, %)

Period	As a share of GDP (%)	As a share of total imports (%)	As a share of the trade deficit (%)
1970-73	7.2.	9.6.	39.8
1974-76	10.9	25.4	61.3
1980-82	12.4	34.6	71.1
1983-85	10.2	43.3	72.9
1986	16.9	40.1	60.1

Source: Jkell, Havenvik-Finn jaerby at.al (1988) (p.125 cited from different sources including budget speeches for financial year 1987/88.

Crisis and Structural Adjustment Programmes

The 1970s pro-poor approach and the Ujamaa philosophy were, however, short-lived due to several reasons. First, there was a global economic crisis which impacted the Tanzania economy severely. In 1974, the country had experienced drought which caused a decline in agricultural production. The situation was worsened by increases in the price of oil which led, in turn, to severe balance of (trade) payment problems and poor terms of trade. Second, there was a shift in donor interest which was influenced by the end of the Cold War as well as a critique from Western economists of poverty-oriented activities by the Bank and other donors. Third, in 1978 the war with Uganda had forced the country to increase imports of military equipment and fuel. The share of defense spending in total government expenditure, for instance, increased from 12.3% in 1976/77 to 24.4% in 1978 (KJell.Havnevik_Finn Kjaerby at.al (1988). As if these were not enough, in 1978-79 the cost of oil imports increased to US \$150 million per year, which was almost three times more than the 1974-75 import bill. Furthermore, the break-up of the East African Community in 1977 forced Tanzania to establish new structures such as harbor administration, railways, a telecommunication

system and central services for post and telegraphs. These investments added to the import bill which caused severe balance of payment problems.

These negative trends were further worsened by declining volumes of exports, and a decrease in export earnings. The cumulative effect was an increase in Tanzania's import bill from US \$748 in 1977 million to US \$1,219 million in 1980 while export earnings declined from US \$543 to US \$506 in the same period. The overall result was an accumulated balance of payment deficit of about US \$530 in 1978-81. This eroded the foreign exchange reserves which had been built up in 1976-77. Meanwhile Tanzania started to accumulate payment arrears. The situation was further worsened by gross mismanagement of the state-controlled enterprises, which were meant to play an important role in the Ujamaa economy.

The cumulative factors negatively affected the performance of the economy and negatively influenced the rate of growth as illustrated in the following table.

Table 2: GDP Growth Rates from 1967/70-1981/85 averages.

	1967-70	1976-1980	1981-85	1967-1986 (averages)
GDP Growth	3.9%	3.8%	2.8%	2.8%
Agriculture Growth	2.1%	2.5%	1.8%	2.3%

Source: URT (1967-1985) Various Economic Surveys for respective years.

The table indicates that while agriculture was the mainstay of the economy and provided employment for the overwhelming majority of the population, its growth did not keep pace with GDP growth. This might explain why this sector is still hosting the majority of the absolute poor. The declining trends of GDP as illustrated in the table affected the capacity of the government to sustain its support of the social services. The share of education in total government expenditure, for instance, declined from 14% during the period 1975/76-1977/78 to 9.4% during the period 1982/83-1985/86. The most affected areas in the expenditure cut in education were primary education, which had been the only sector with redistributive effect. Similarly health sector expenditure dropped from 7.2% of total government expenditure to 4.9% over the same period (UTR/Ministry of health and education respective years) This created a crisis in the social sector.

All in all, the Tanzanian economy experienced deep crisis from the mid 1970s to 1980s, as expressed in high inflation rates, budget deficits, balance of payment problems, shortage of basic goods, and capacity under-utilization of public enterprises. This in turn affected the capacity of the state to manage and sustain the social services, particularly health and education. As a response to the economic crisis, the government embarked upon initiatives to adjust and stabilize the economy.

Home-grown Structural Adjustment: 1981-82 and 1982-85

From 1982 to 1986, the Tanzanian government attempted to design its own home-grown structural adjustment programme when negotiation with the World Bank on a Standby Agreement failed in 1979. The home-grown initiative was intended to resist the World Bank-imposed approach, which included minimization of the role of state in the economy, removal of protection for domestic producers and promotion of privatization, devaluation of the local currency, and elimination of subsidies such as those provided on fertilizers and food.

As part of the home-grown reform, the government reviewed the health sector which had been seriously affected by the resource constraints. In the review of the Public Health Programme in 1984, it was suggested that the Ministry of Health had to be more aggressive in increasing its share of the government budget. The Review recommended further that local communities should start contributing to their own health services through cooperative schemes developed by village councils. It suggested that much of the public health cost could be transferred to the community, particularly by payments in kind for facility maintenance, and through use of community-based health workers. In addition, health should get a share of local government resources (URT 1984).

The implementation of the home-grown structural adjustment program was, however, constrained by lack of support by major donors. As illustrated in table 1, the share of foreign aid as a percentage of GDP declined from 12.4% from 1980-82 to 10.2% during the period 1983-85 and rose to 16.9% when the government bowed down to the IMF/World Bank conditions by signing an agreement in 1986.

Economic Recovery Program: 1987/88-1989/90

In 1986 the Government signed a standby agreement with the International Monetary Fund and an agreement in respect of a structural adjustment programme with the World Bank. The subsequent Economic Recovery Programme (ERP) aimed to move the country from the partial liberalization which characterized the home-grown reform programmes into fully-fledged liberalization and stabilization. In the light of this, ERP focused on elimination of price controls, market reforms, liberalization of exchange rates, fiscal reforms, and the downsizing the public sector through laying off large numbers of workers from the government sector and the state-owned enterprises.

In 1989, the reform entered a second phase known as ERP II (1989-1991). The new reforms continued to focus on trade liberalization, and exchange rates, liberalization and macroeconomic stabilization. The reforms were also extended to include the banking system, agricultural marketing, government administration, and the civil service as well as social service sectors.

The main critique of ERP is that it did not address the social dimensions of the economic crisis. Hence even though the measures taken did lead to stabilization of the economy, and prevented downward trends in the economy, gains from these measures did not result in poverty alleviation. Further, ERP assumed that women and men were impacted by the crisis in the same manner and thus measures to address gender-specific constraints were not considered in the ERP processes.

The ERP was intended, among others, to restore the confidence of the donor community in the government. In 1992, donor support reached an all-time peak. By 1993-94, however, the relationship between the government and donors became strained. Donors complained that the government was too lax about corruption, and that internal revenue collection had not reached a benchmark defined by the Bank. They complained in particular about excessive tax exemptions which contributed to low domestic revenue generation (Daima Associates Ltd and Overseas Development Institute (Odi): 2005)

From their side, the government of Tanzania felt that the donor community was intruding too much in its domestic affairs, and hence threatening its autonomy in respect of domestic policies. Because of these tensions, the government was unable to conclude a new Enhanced Structural Adjustment Facility with the IMF, a factor which contributed to the worsening of government-donor relations and impacted the implementation of the reform agenda. This is the context within which the Helleiner Commission was established. The Commission's terms of reference were to study donor-government relations and recommend new modalities which would restore the relationship between the two. The Commission reported in 1995. The report called upon donors and the government to develop a new aid agenda based on partnership. It highlighted the importance of dialogue in order

to enhance “ownership” by government of the second generation of the reform processes. In 1996, the government of Tanzania entered into a three-year Enhanced Structural Adjustment Facility (ESAF) with the World Bank.

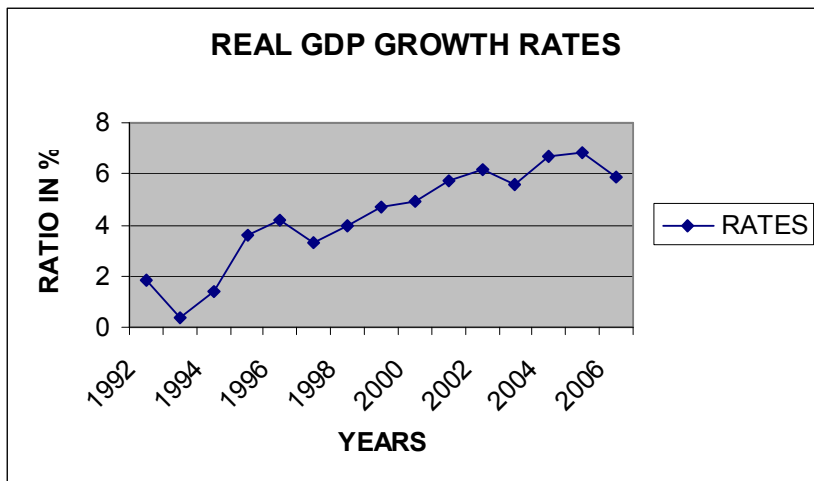
The first poverty reduction strategy paper (1997-2004)

In 1997, the Tanzanian government produced its first National Poverty Eradication Strategy. The strategy was seen as an instrument for implementing the new government-donor partnership. The strategy had a target of eradicating absolute poverty and achieving a poverty-free society with improved social conditions and general welfare by the year 2025.

The implementation of the National Poverty Eradication Strategy more or less coincided with some policy shifts of the international financial institutions (IFIs) on issues of poverty and growth. In 1999, responding to voices from civil society on the negative impacts of structural adjustment programmes, initiated by the 1987 UNICEF-supported critique of the IMF/World Bank-led macroeconomic reforms which had ignored the social dimensions of economic reform calling for “adjusting with a human face”, the World Bank introduced Poverty Reduction Strategy Papers (PRSPs) as a conditionality for debt relief to highly-indebted poor countries (HIPC). The Tanzania government, which was in dire need of debt relief, responded immediately and in 2000 produced its first PRSP. Ironically, the PRSP which was supposed to have been “country driven, participatory, result oriented, and comprehensive” had also to be endorsed by the Board of Directors of World Bank and IMF before the country was eligible for debt relief. The approval was duly obtained allowing the country to obtain debt relief under the HIPC debt relief programme.

The impact of macroeconomic policies

A report commissioned by the Swiss Development Agency (Burki 2001) noted that by the end of 2000 the Tanzanian economy had largely stabilized and had become market-oriented. The tight monetary and fiscal policies had succeeded in bringing down the inflation rate to single digits, and price controls had been lifted as imports and exports were liberalized. Exchange rates were market-determined, and official reserves had reached sustainable targets. The report further commended the Government of Tanzania for the privatization process initiatives. All in all, it noted that the foundation for private sector growth was in place. Whereas, the real GDP growth rates in the 1990s were very low, they subsequently accelerated to peak at 6.8% in 2005 as illustrated in the following figure. As will be seen below, the latter years saw an accompanying increase in the employment rate. Figure 1: Real GDP Growth Rates from 1992-2006.



Source: URT (2000-07) Economic Surveys. Ministry of Planning, Economy and Privatization President's office (2000-2006), Economic Surveys : Ministry of Planning, Economy and Empowerment.

Ironically, the growth rate and other positive indicators seem to have had little or no direct impact in reducing poverty, at least up to 2000/01, the latest date for which poverty data are available. Mbelle (2007) argues that macroeconomic success (growth) did not lead to corresponding microeconomic success and wonders: “Where did all the growth go?” The author asserts that growth was not translated into poverty reduction; the growth process was not pro poor! This paradox will be discussed further in the section below which discusses poverty and inequality.

MKUKUTA

In the year 2005 a National Strategy for Growth and Reduction of Poverty (NSGRP) popularly known as “Mkukuta³” emerged as the next version of the PRSP (URT 2005a).

The introduction to the NSGRP notes positive growth over recent years, which it attributes to “enduring structural reforms in a stable social-political environment” (URT 2005a :2) against which background there was an attempt to focus on the “priority” sectors of education, health, water, agriculture, rural roads, the judiciary and land. The document acknowledges, however, that the goals and targets were not reached, which it attributes to inadequate resources.

The NSGRP is based around three clusters: Economic Growth and Reduction of Income Poverty; Improved Quality of Life; and Good Governance and Accountability. It attempts to combine growth and equity issues, including social justice and people’s welfare. Hence, while the government continues to emphasize efficiency and effectiveness, there is also a provision which is meant to ensure that “benefits are shared”.

MKUKUTA identifies five forces which push people into poverty. These include: (i) environmental issues which would include aspects such as flood, drought, gradual environmental degradation of forests, fishing, pastures and so on; (ii) macroeconomic conditions, which include national economic decisions such as privatization, trade liberalization, elimination of subsidies, cost-sharing in health, reduced spending on agricultural services, employment, rural livelihoods, costs of and access to social services; (iii) governance, which includes coercion, extortion, all forms of corruption, unsatisfactory taxation, as well as political exclusion; (iv) lifecycle-linked conditions, which include ill health, risk and social marginalization because of age, childhood, youth, and old age; and (v) cultural beliefs and practices including cultural habits and traditional beliefs that limit people’s freedoms of choice and action. Additionally, MKUKUTA spells out guiding principles which include equity and mainstreaming of cross-cutting issues. The identified cross-cutting issues are gender, HIV&AIDS and environment.

The pro-poor focus spelt out in the poverty reduction policy papers, as well as the inclusion of social equity issues, have the potential for mitigating the negative impacts of HIV&AIDS on the poor. But this potential is highly challenged by the liberal and pro-market policies which emphasize a limited role for the state in redistributing the benefits of wealth created in pursuing macroeconomic policies. It becomes more difficult to implement the social equity policies because the direction of the market forces is almost in the opposite direction to that of social policies. Thus a market-driven economy requires that the government removes subsidies, reduces the size of the public sector, limits its core function to that of regulation, and requires increased contributions from the poor to meet the costs of social services through cost-sharing. In short, market forces are not morally or otherwise obliged to take into consideration the marginalised situation of low-income groups. “ Unless qualifying measures are introduced which help redress the inbuilt discrimination and vulnerability to which liberalized markets expose them, women in the workplace and in their livelihood and caring roles will tend to lose out. The thrust of contemporary neoliberal economic policy, however, has been against the use of regulatory measures to compensate for social risks and redress inequalities, in the name of efficiency, growth and freedom (UNRISD: 2005: 65)

³ MKUKUTA is a Swahili term which stands for *Mpango wa Taifa wa Kukuza Uchumi na Kufuta Umaskini* or National Strategy for Growth and Poverty Reduction.

Employment, Poverty, Inequality and Social Policies

The government of the United Republic of Tanzania defines poverty as “a state of deprivation, prohibitive of a decent human life” (URT 1999). Poverty in Tanzania is measured in two ways. The first is the food poverty line, which is the price of a minimum food basket to provide minimum calories necessary for an adult per day. The second is a basic needs poverty line which allows for non-food consumption as well. For Mainland Tanzania as a whole, the basic needs poverty line was set at Tshs. 7,253 per adult equivalent, while the food poverty line stood at Tshs. 5,295 per adult equivalent in 2000/01 (National Bureau of Statistics 2002: 78).

The poor however, do not define poverty in terms of income alone. Instead they emphasize the importance of access to and control over productive resources such as land, inputs, and production oriented services, as well as entitlements to social security. In other words the poor would tend to focus on conditions which have led to their inability to earn a decent income, the amelioration of which will enable them to improve their living conditions (Research and Analysis Working Group 2003b).

Even using the standard income poverty measures described above, the Household Budget Surveys of 1991/2 and 2000/01 revealed that levels of poverty have not changed much during the 1990s, despite the impressive growth in macroeconomic performance discussed in the previous section. Approximately 36% of Tanzanians were living below the basic needs poverty line in 2000/01, only 3 percentage points less than the 39% estimated for 1992. The comparative figures for the food poverty line were 19% and 22% respectively. Over the same period, the incidence of basic needs poverty in rural areas decreased from 41% to 39%, while in Dar es Salaam the decrease was from 28% to 18% and in other urban areas from 29% to 26% (National Bureau of Statistics 2002: xxiii-xxiv). Poverty remains an overwhelmingly rural phenomenon with about 87% of the poor located in rural areas, a similar proportion as in 1991/92. In absolute terms it is estimated that some 11.4 million Tanzanians were living below the basic needs poverty line in 2000/01 compared to the 9.5 million in 1991/92.

Poverty is unevenly spread nationally. Regions with the highest levels of poverty include Mwanza, Shinyanga, Singida, and Manyara. The regions with the lowest levels of poverty include Dar es Salaam, Arusha and Mbeya (URT 2005b). Coincidentally, Dar es Salaam and Mbeya have higher HIV&AIDS prevalence rates. These relatively high rates of poverty do not result from lack of engagement in economic activity. Indeed, in 2006 89.6% of the population aged 15 years and above was recorded as economically active, with rates of 90.5% for males and 88.8% for females (National Bureau of Statistic 2007; this source is used for information in this sub-section).

Further, among the economically active population, the overwhelming majority are under-employed rather than unemployed. Tanzania uses two different definitions of employment. The international definition of employment is referred to as the “standard definition” and refers to a person who worked for at least one hour in any of a wide range of economic activities or was temporarily absent from such activity during the previous calendar week. The “national definition” excludes all persons who were temporarily absent from work during the reference period because they were unable to find work, or suitable land for cultivation or because it was the off-season. In addition, persons who were working but whose work was not reliable with regard to its availability and adequacy in terms of hours were considered unemployed as well. For this report, we use the national definition.

In 2006, 88.3% of the currently economic active population was employed, with the proportion employed somewhat higher for males (89.3%) than for females (87.4%). Dar es Salaam has the

lowest employment ratio (i.e. employed as a proportion of the total population), at 58.6%, while for other urban areas the rate stands at 72.7% and for rural areas at 84.0%. The lower employment ratio in Dar es Salaam is due to both higher unemployment rates and more females being economically inactive. The overall employment ratio for females is 77.6% compared to 80.8% for males.

The overall employment ratio increased from 69.3% to 89.0% between 2001 and 2006 for the population aged 10 years and above. While the female rate remains lower than the male, the gap is narrowing. Thus the male ratio increased from 71.4% to 90.0% and the female ratio increased from 67.4% to 88.1%. The female employment ratio thus increased by 20.7 percentage points compared to 18.6 points for males.

The employment situation appears to have improved over recent years. Thus the absolute number of unemployed persons aged ten years and above decreased by 4.3% to 2.2 million in 2006, from 2.3 million in 2001. This occurred despite the increase in population over this period. All localities of Mainland Tanzania experienced a decline in the unemployment rate, with the rural unemployment rate declining by 1.3 percentage points and urban unemployment rates declining by more than 10 percentage points. This turn-around in the unemployment trend can be attributed to economic growth, in that the real GDP growth rate increased from the previous five-year average of 4.2% to 6.1%.

Females register a higher rate of unemployment than males in all areas of Mainland Tanzania, except rural. In Dar es Salaam, the female rate stood at 40.3% in 2006, while the male rate was 19.2%. The national aggregate figure was 11.7%. Unemployment rates tend to increase with increasing levels of education. However, for Dar es Salaam, the situation is reversed as the unemployment rate decreases as education level rises. There is an exceptionally large margin between the unemployment rates of males and females with secondary education and above. Every year, approximately 700,000 young people enter the labour market. This exacerbates the under-employment and unemployment challenges.

Why, despite the relatively high rates of employment, are there such high rates of poverty? One reason is that two thirds (67.2%) of employed persons work on their own farm or shamba with females being more likely to have this status (71.7%) than males (62.4%). Many of these individuals are, in effect, subsistence farmers. Many live in poverty. Further, as noted above, it is in Dar es Salaam, where employment is most likely to be paid rather than subsistence, that unemployment rates are highest. And the rate is higher for women than for men. More generally, 74% of employed people were employed in the primary sector in 2006, compared to only 14% in the secondary sector and 12% in tertiary.

A further reason for large-scale poverty despite high levels of employment is that much of the paid work occurs in the informal sector. In 2006, 40% of all households in Mainland Tanzania engaged in informal sector activities – 55% in urban areas and 33% in rural. For both the main and secondary activity, the overriding reasons for male and female engagement in the informal sector are the inability to find other work and the need for families to get additional income. These two reasons are more likely to be offered by females than males. The fact that these women and men are employed is thus a reflection of poverty rather than a contradiction of the high poverty rates.

A third reason for poverty despite high rates of employment is the low levels of pay for those who do paid work. The government minimum wage, which had been set at Tsh. 17,500 per month since 1995, was only increased to Tsh. 60,000 per month during the budget year 2005/06 (URT 2006). While this increase might look impressive, when adjusted to the US Dollar the increase is not as impressive. Whereas in 1995/96 one US Dollar was worth Tshs. 575-580, in 2004 the equivalent

was Tshs. 1,060. This means that the increase was from US \$30 per month to US \$54 in 2004. When one takes into account the increased prices of all consumer goods, this minimum wage is barely sufficient to support a worker to sustain and reproduce himself or herself and his/her family.

Further problems arise. Firstly, this minimum wage theoretically applies to all employees in the private sector. It is, however, not well enforced. Secondly, there is a clear gender gap in earnings. The Integrated Labour Force Survey (ILFS) of 2006 indicates that in that year the median monthly income of male paid employees aged 15 years and above stood at Tshs. 50,000, compared to Tshs. 32,000 for females. Similarly, the median monthly income of self-employed males stood at Tshs. 40,000, compared to Tshs. 20,000 for females. In terms of educational achievements, paid employees with secondary education or above had a mean monthly income of Tshs. 207,433, compared to Tshs 40,134 for those who had never attended school. For the self-employed, mean monthly earnings stood at Tshs. 129,494 and Tshs. 48,920 for the more and less educated respectively.

While poverty is widespread, there has also been a slight increase in the degree of inequality. Thus the Household Budget Surveys record an increase in the Gini coefficient from 0.34 in 1991/92 to 0.35 in 2000/01 (NBS 2002: xxvii). (The database of the World Institute for Development Economics Research database records much higher levels for the 1960s as well as for 1991, but we prefer to rely on the national source.) Stated differently, inequality in rural areas is minimal because almost everyone is poor. Inequality is also reflected in the distribution of national consumption. In 2000/01, the richest 20% of the population accounted for 44% of national consumption whereas the poorest 20% accounted for only 7% (NBS 2002: 83).

The relatively low value of the index in part reflects the widespread nature of poverty across the nation. The Gini index for the rural sector is low and remained unchanged between 1991/02 and 2000/01. In Dar es Salaam, however, the coefficient rose from 0.30 in 1990/91 to 0.36 in 2000/01 (NBS 2002: 83). This confirms the suggestion that the relatively low value of the index is about widespread poverty more than anything else.

Other indicators of well-being that go beyond income-based poverty show a rather mixed picture. The Human Development Index (2006) goes beyond measuring income-based poverty in that it brings together, in one composite measure, measures of per capita gross domestic product with measures of educational and health achievements. The HDI calculated for the 2006 report ranks Tanzania at 162nd out of 177 countries for which the index was calculated. It is thus situated about halfway in the list of low human development countries. Its ranking has, if anything deteriorated over the years. In 1995, for example, it was ranked 147 out of 174 countries (UNDP 1995: 157) while in 1999 it was ranked 156 out of 174 (UNDP 1999: 137). Part of the explanation for the worsening performance compared to others is almost certainly HIV&AIDS, as many of the countries that have risen “above” Tanzania are located outside the regions worst affected by the epidemic. HIV&AIDS affects, in particular, the health component of the HDI in that it results in lowered life expectancy. The rankings are also calculated on data from a few years prior to the date of publication. The apparent upturn in economic growth and employment of recent years might thus not be fully reflected.

Beyond income, primary school enrollment rates have increased but retention rates and transition rates to higher levels are still very low. Literacy rates have improved but a good number of Tanzanians are still illiterate. Infant mortality rates and under-five mortality rates have decreased but maternal deaths have either stagnated or increased. Access to safe water is still a challenge to some Tanzanians particularly those dwelling in rural sector. The HIV&AIDS pandemic has emerged as a major force of impoverishment which is posing a big challenge to the social fabric of the Tanzanian society generally and tends to overburden the care economy. The non-income

poverty indicators show unevenness across geographical location, gender, and class. The following section will highlight this in a more detailed manner.

Access to education

Levels, amount and quality of education determine the quality of life individuals lead as well as their social status. Studies have consistently demonstrated that, educational attainment has an impact on level of income, reproductive behaviour, fertility, child mortality as well as awareness and knowledge of various life skills.

Tanzania made commendable progress in providing primary education to most of its children when it embarked on a universal compulsory primary education programme during the 1970s to 1980s. Public commitment to expand and invest in universal primary education was made through the Education Act No. 25 of 1978 which made primary enrolment and attendance universal and compulsory. By 1984, universal primary education had more or less been achieved, with gender parity, while adult literacy had increased to 60% in 1981 and by 1987 had reached 85% (URT/Ministry of Education 1987). During the 1990s, however, the introduction of user fees in a context in which people's livelihoods were deteriorating led to declines and stagnation of enrollment and attendance which undermined the achievements of the early 1980s.

Access to primary education has expanded since 2000 as a result of the implementation of the Primary Education Development Plan (PEDP) (URT 2005e). According to government official figures, in 1999 the net enrolment rate for primary education was 57% (URT: 2005c),⁴ but by the year 2004, net enrollment in primary school had reached 96.1% (ibid.). By 2005 Tanzania had almost reached gender equity in primary education with a gender parity ratio for net enrollment of 0.98 (UNESCO 2006: 84).

Despite high enrollment in primary education, actual attendance at school and completion of seven years of primary school is low. Census data also suggest lower rates than administrative data, perhaps partly because the census is conducted later in the school year by which time some children may no longer be attending school. In 2002, net attendance was 68% as against an official net enrollment figure of 81 (URT: 2005e). In 2004, the completion rate for primary education was 76% (UNESCO: 2006). This implies that the expansion of enrolment has not paid sufficient attention to the quality of the content and the delivery of the service. Interventions are needed to support the children who enroll to remain in school and to complete the basic level.

Although primary survival rates are similar for boys and girls, throughout the period 1998 to 2004, boys' performance in the primary school leaving examination exceeded that of girls by about 15 percentage points (URT 2005e). This disadvantages girls in accessing secondary and other post-primary vocational training institutions, and in turn reinforces gender inequality in accessing the labour market after the schooling cycle.

Significant progress has been made in improving the literacy levels of women and men in Tanzania and yet a third of the adult population aged 15 and above is illiterate. The female adult literacy rate is 62.3 compared to 77.5 for males (UNDP 2006: 366). The literacy rates for younger women and men are, however, higher than for the older cohort. Official data from the Ministry of Education indicate that the literacy rate for youth aged 15-24 years is 78%, and that the gender difference is small, at 76% for young women compared to 81% for young men (UNESCO 2006: 174). The higher literacy rates among the young population can be attributed to the expansion of primary school and adult literacy programmes. Improved access to primary education complemented with high literacy levels provides a base for communicating information and knowledge on various life skills including HIV& AIDS knowledge.

⁴ UNESCO figure states that in 1999 Primary NER in Tanzania was 48 (UNESCO: 2006).

In contrast to the high levels of participation in primary education, access to secondary education is extremely limited in Tanzania. While there are 7 million children in primary schools, there are only just over half a million children in secondary schools (UNESCO 2006). The percentage of primary school leavers transiting to secondary education declined from 36% in 1961 to 19% in 1967 and to only 7% in 1980. The decline is attributed to the expansion of primary schooling without a corresponding expansion of the secondary level. The proportion then rose to about 15% by early in the 1990s (ibid.). The forthcoming 2007 Poverty and Human Development Report suggests that roughly 67% of children completing the seven years of primary education made the transition to Form 1 in 2007; but that the gender balance is starting to deteriorate (REPOA forthcoming). The expansion is attributed to government initiatives of increasing classrooms, recruiting teachers on a short-term basis and encouraging private sector investment at this level of education. Although enrollment of girls at entry level for secondary school is similar to that of boys, retention drops off significantly for girls (URT 2006). As a result a clear gender gap in enrollment emerges during the last years of secondary education. By form IV, the final year of lower secondary education, the ratio of boys to girls is 2 to 1 (GPI is 0.5) (ibid.). One of the contributory factors for drop-out among girls is teenage pregnancy.

Access to education is also unevenly spread in Tanzania. The Tanzania Demographic and Health Survey (DHS) 2004-05 found that the median number of years of schooling was 6.1 among urban males and females, compared to 2.5 and 1.5 years of schooling for rural males and females respectively. Wealth is another determinant of access to school in Tanzania. The 2003/04 Demographic and Health Survey found that among males just 9% of those from wealthiest households had never been to school compared to 42% of those from poorest households. A similar pattern was observed among females. More than half (53%) from the poorest households had never been to school compared with just 13% from wealthiest families.

Health and people's livelihoods

Low household incomes, inadequate and unequal access to health facilities, lack of qualified health personnel, increasing costs of health care, and introduction of user fees have cumulatively contributed to the poor health status of the majority of Tanzanian women and men. Due to biologically determined and socially constructed roles, women shoulder a greater burden as a result of illness and poor health of household members including those who are living with the HI virus.

Data from the Demographic Health Surveys 2003/04 quoted in the Poverty and Human Development Report (PHDR) (2005), show that the maternal mortality rate (MMR) has not improved for the past two decades. The MMR rose from 529 women dying among 100,000 live births in 1996 to 578 in 2004/05. There has not been significant change from the 1987 to 1996 ratio of 529 per 100,000 live births (URT 2004/05d).

These statistics mean that an average of 24 women die every day in the process of child bearing. The high maternal death rate is partly attributable to the cost of health care, which includes user fees, distance to health facility, transport cost as well as lack of trained skilled personnel. Furthermore, the Ministry of Health is not sufficiently resourced through budgetary allocations to be able to cope with the increased demand for its health care services including maternal and child care, opportunistic diseases, and HIV&AIDS related illness.

The proportion of births attended by a skilled health worker provides a measure of the delivery services important to reduce both maternal and infant mortality rates. Similarly the proportion of institutional deliveries provides a second measure of maternal care. The assumption is that deliveries taking place in a health facility under skilled personal are safer and more hygienic.

The Poverty and Human Development Report 2005 (URT: 2005d) singled out lack of human resources as being the most pressing problem facing the health system in Tanzania. The report observed that there was a serious shortage of human resources at the primary health facility level which in turn impacts negatively on the quality of care delivered at this level. Using 2001/02 estimates, the report revealed that active health workers were estimated at 54,200, with unskilled workers forming the largest group (31%) followed by the professional group of nurses and midwives (24%). Between 1994/95 and 2001/02, the number of health workers per 100,000 population decreased from 249.4 to an estimated 162.1 per 100,000 population. This is attributed to government policy of “freezing” employment as per World Bank recommendations during the implementation of the Structural Adjustment Programmes.

In Tanzania, only 46% of births are attended by skilled personnel (UNDP 2006). There are variations based on urban/rural and social status. Data compiled by UNDP (2006) revealed that whereas just 29% of women from the 20% poorest households are attended by skilled personnel, the reverse is true for the 20% richest households among whom 83% of women get attended by skilled personnel when giving birth (UNDP 2006: Table 8). In rural areas, only 4 out of 10 pregnant women have a skilled health worker to provide assistance at birth, compared to 8 out of 10 in urban areas (TGNP 2005/06). This forces the majority of women in rural and poor households to give up on formal health facility during delivery. Most deliveries taking place at homes are at a high risk of death or infection.

The same Budget Review paper by TGNP for 2005/06 further revealed a serious gap in skilled personnel. Only 30-40% of key health cadre staffing requirements are presently met and the situation is worse in health centres and dispensaries which serve the majority of the poor. The review further noted that some 20,000 additional health workers were needed in the next five years to fill the skill gaps. The gap between rural and urban areas is large. For instance, Dar es Salaam has 30 times more medical officers and specialists than rural districts despite a much smaller population (ibid.).

In addition to lack of skilled personnel, the 2005 PHDR further observed lack of participation by communities in planning and financial management of health services as a problem. As a result of this, communities do not have access to relevant information about budgets, incomes, expenditures, use of medical supplies, and so on (URT 2005d). This implies that information such as the waiver of fees introduced by the government for certain categories of population and for certain services including maternal health care are not known even among some service providers, let alone among potential users, and the amounts of user fees collected and its expenditure are unknown and can be subject to abuse by public office bearers in this sector.

Shifts in infant and child mortality rates follow a pattern that suggest that the lower investment in child health care programmes that accompanied the neo-liberal reforms impacted negatively on infant and child health. The IMR increased from 92 to 99 out of 1,000 live births between 1987 and 1999. The IMR then dropped to 68 out of 1,000 live births in 2004. Similarly, the under-five mortality rate rose from 141 to 147 out of 1,000 live births over the period 1987-1999 and then dropped to 112 out of 1,000 births (URT 2003; URT 2005d). The decline is attributed to public re-investment in various campaigns, including Integrated Management of Childhood Illness, immunization and bednets to prevent malaria.

Access to child health care is unevenly spread. The poor are more disadvantaged in terms of access. UNDP data (2006: 310) suggest that only 53% of the one year olds from the 20% poorest household were fully immunized as compared to 78% of the 20% wealthiest households. Similarly, the IMR for the 20% poorest households was 115 per 1000 live births as compared to 92 for the richest 20% of households. The high rate even among the “wealthiest” is an indication of how

poverty is widespread nationally. It also indicates the lack of resources in most health facilities including those which can be afforded by the “richest” people in the country. Under-five mortality rates show a more or less similar pattern, with a rate of 160 out of 1000 live births for the poorest 20% as compared to 130 for the 20% richest. There is also an urban/rural inequality. Infants born in urban areas have a 30% higher probability of surviving than those born in rural area (URT 2003).

The sickness and ultimate death of children is an additional care burden to women who assume most of the caring roles for the children as well as responsibilities emerging from the burial ceremonies. There is investment of time in the care, as well as emotional stress which cannot be quantified resulting from the loss of a child. When such households are also caring for an adult living with the HI virus, the burden of care becomes unbearable.

Anemia rates remain very high; in 2004 for instance, some 41% of children aged 6 to 59 months suffered from anemia, with higher rates for rural children (42.7%) than urban (34.2%). Some 13.1% of women of reproductive age (15-49 years) also suffered from anemia. In this case, anemia was more common for urban women (15.0%) than rural women (12.2%), which can be attributed to the differences in access to iron-rich foodstuff. Most rural households including very poor households either keep a small garden of vegetables, some of which are rich in iron, or keep a few cattle from which they get milk even though in small amounts. The urban poor generally do not have access to such resources (URT 2004).

The mean distance to reach a health facility is another factor constraining individuals from using health facilities. Nationally, the mean distance to a dispensary or health centre is 3.9 km and about 75% of households live within 6 km of such a facility. If these facilities were to be adequately resourced, it would reduce the care burden of the resource-poor households, and also reduce the time it takes to take a sick person to a medical facility with resources. However reports from the annual Poverty Week of October 2003⁵ indicated that a growing number of citizens, and particularly poor women, have given up on the formal health system and in the case of women they are forced to deliver their babies at home without access to modern safer facilities. This is despite the introduction by the government of waivers of user fees for particular categories of illness and people. Those who participated in the dialogues claimed that the waiver system was too complicated and had left loopholes which could be abused by corrupt individuals (TGNP 2005).

In addition to the mentioned indicators of poverty, the HIV& Aids pandemic has been considered as yet another impoverishing force which is undermining the few gains in reducing levels and intensity of poverty.

The HIV & AIDS pandemic in Tanzania

HIV&AIDS is one of the most impoverishing forces facing Tanzanians today as it affects individuals in their prime reproductive and child-bearing years. Its impact on the economy, demography and social relations has not been fully explored. The few existing studies point out the dangers of its impact on the development process generally and particularly on the initiatives to address poverty and underdevelopment. The household dynamics of care and its impact on the individual members and the household institution are yet to be fully analyzed. The growing numbers of widows, orphans, and the burden of care for those impoverished households who have people living with HIV&AIDS (PLHA) is a pointer to a larger crisis of the pandemic in the economy.

In Tanzania the first HIV case was reported in 1983 in Kagera region, and by the year 2003 it was estimated that about 1,820,000 people in Mainland Tanzania were living with HIV (UTR: 2004).

⁵ In 2002 an annual public forum was established which provided space for the general public to debate, reflect and discuss progress made in poverty reduction efforts as provided in the country's Human Development Report.

The Tanzania HIV&AIDS Indicator Survey (THIS) 2003/04 showed that 7% of Tanzanian adults aged between 15 and 49 years are infected with HIV, with the prevalence rate among women being higher, at 8%, than it is for men at 6% (Tanzania Commission for AIDS et al. 2005). Urban residents (10.9%) have considerably higher rates of infection than rural residents (5.3%). Younger people are more vulnerable to infection; some 60% of new HIV infections are among 15-24 year olds. Young women are six times more likely than young men to be infected (ibid.).

THIS survey 2003/04, further shows that the predominant mode of transmission is through heterosexual contact, accounting for 80% of all new infection, while mother-to-child transmission accounts for 18%. The survey revealed that the number of people living with HIV&AIDS is 1.3 million which includes adults and children.

Ironically, for both men and women, prevalence increases with level of education. Adults with secondary education and above are more likely to be infected than those with no education. Among those with no education, levels are 4.2% for males and 5.8% for females. With secondary education the rates are 7.3% for males and 9.3% for females. Prevalence rates among separated and divorced/widowed is significantly higher (men 15% and women 19.8%) than among those currently in unions/married (men 7.8% and women 6.9%), and never in unions (men 3% and women 3.8%). Interestingly, HIV prevalence seems to also increase with wealth in that prevalence rates among the poorest are 4.1% for men and 2.8% for women while among the richest men the rate is 9.4% and for women 11.4%.

There are also regional disparities in prevalence rates which go alongside urban/rural disparities. HIV prevalence rates for Iringa, Mbeya and Dar Es Salaam for instance are well above the national average. Within regions there are also variations. In Mbeya for instance, there are districts like Kyela with prevalence rates of 19.8% while Ilemba has a prevalence rate of 5.1%. These variations in prevalence rates have to inform interventions to mitigate impact, prevent new infection and supporting and caring for the people living with the HI virus. (ibid.)

The immediate national response to the pandemic was narrow as it focused on the medical aspects of the pandemic. This focus is what informed the creation of the HIV and AIDS Control Programme (NACP) under the Ministry of Health. The national response consisted of developing strategies to prevent, control and mitigate the impact of the HIV&AIDS pandemic through health education. This narrow focus was later reviewed in the National Policy on HIV&AIDS of 2001 which was developed with the aim of providing guidelines and a framework for the coordination of a multi-sectoral response. The Policy clearly stated that "People living with HIV&AIDS have the right to comprehensive health care and other social services". However, the policy cautioned that, "The PLHAs may be required to meet some of the cost for anti-retroviral therapy". It was not until 2003 that the government introduced free anti-retroviral therapy (ART) as part of its treatment plan. In the light of this, a National Care and Treatment Plan (NCTP) was launched by the government in 2004. When ART was introduced in October 2004 only about 2,000 patients were receiving it. As of 2006, around 70,000 patients were receiving the treatment (TGNP 2005). It is difficult to know what percentage this is of those who need treatment as it is not clear how many people are AIDS sick.

Internationally, HIV plans sometimes conceive care primarily as the care provided for ill people in health facilities, and pay less attention to the care provided in the home. This is a serious bias given that the increased pressure placed on health facilities by the pandemic has generally resulted in policies which try to shift the burden elsewhere. Budlender (2007), in a scan of policies across five African countries, finds that Tanzania pays more attention than most to home-based care. In particular, the documents have a greater degree of acknowledgement of the role played by family carers. In 2005, the National AIDS Control Programme issued National Guidelines for Home Based

Care services for People Living with HIV at three levels, namely at facility, community and home levels. The purpose of the guidelines is to ensure improvement in the quality of life of the people with chronic illness including HIV&AIDS-related diseases within the health facilities and at their homes. These national guidelines define home-based care as “any form of care given to chronically ill people in their homes.” Such care includes psychological, social and spiritual services. Families are expected to be the central focus of care and form the basis of home-based care. It is assumed that patients receiving such care will benefit through “receiving care and treatment in a familiar, supportive environment that allows them to participate in family matters, maintains the sense of belonging, maximizes their emotional health, makes it easier for them to accept their condition, reduces medical and other related costs, death occurs at home amongst loved ones.” (URT 2005f). Tanzania’s recognition of the importance of care provided by home carers does not, unfortunately, mean that the necessary resources necessarily follow. These issues will be examined in greater depth in research reports 3 and 4.

The Tanzania HIV Indicator Survey (THIS) 2003/04 report indicated that care and support services are not widespread in Tanzania. For example, only about 4 to 6% of orphans and vulnerable children live in households that reported receiving various types of external support. This estimate is based on a definition of orphans as any child under age 18 years who has lost one or both parents, while a vulnerable child is a child with one or both parents having been very ill for at least three months in the twelve months preceding the interview. Support services were more prevalent in urban areas, but there was no clear pattern across wealth quintiles. Similarly only 16% of adult women and men aged 18-59 who were chronically ill reported to be living in households that received medical support from outside the household, 14% in households that received emotional support, and only 12% in households that received external material or practical support. The survey data indicated that the support was more common for adults living in urban areas than in rural areas (Tanzania Commission for AIDS (TACAID), USAID et al. 2005: 16).

The National Multi-sectoral Strategic Framework on HIV & AIDS (2008-2012) which is currently under review also provides for home-based care as a strategy for support and treatment. It spells out a goal of creating a political, social and cultural environment for the national response to HIV based on the human rights approach, accountability at all levels and broad public participation. This implies that the inequalities discussed in the previous sections have to be addressed in order to ensure that all people affected by the HIV virus have equal access to the necessary resources, including those who are being taken care of at home. It further implies that home care should be left to the choice of the individuals and that all public facilities should be resourced to enable individuals to make such choices. The existing health infrastructure does make this possible if resources are directed to these facilities at community levels. But resource allocation to these facilities is not clearly spelt out in budget guidelines or budget proposals. The national expenditure on health for the past 10 years has fluctuated from 3.6% of GDP in 1996 to 4.2% in 2005/06 (Health Equity Group 2006).

Further analysis of 2006/07 budget indicates that health’s share of total allocations excluding those for State House and public debt declined from 12.6% to 11.0%. This implies that the health sector has not gained as much as other sectors from the resources freed up from the big drop in debt servicing (Health Equity Group 2007). The Ministry of Health’s development expenditure increased from Tshs. 5 billion in 2005/6 to Tshs. 7.1 billion in 2006/07 (Health Equity Group 2006/07). The largest portion of this, however, was for strengthening referral hospitals. The priority accorded to referral hospital is not in line with the observations made in the Poverty and Human Development Report of 2005 which revealed that primary health care is under-resourced and needs urgent measures to arrest further deterioration of these services (URT: 2005d).

Approximately 40 billion (or 45%) of the Tanzania's national development budget is for HIV&AIDS. This is in addition to the 20 billion (13%) allocated for HIV& AIDS under recurrent expenditure. These amounts and percentages look impressive, but one needs a more detailed analysis of who is going to benefit from these resources. For instance it is estimated that only 400,000 PLHA will be able to access the ART drugs, and that the support for this is from external sources. The criteria to select those who are going to access and those who are not are not clear. One fears that urban-based individuals might take advantage of their positions in decision-making to access the drugs, hence disadvantaging the poor and particularly poor women who are less represented in decision-making organs (Bank of Tanzania (BOT); 2007) In addition to drugs, people living with the virus will also need nutritious food, proper sanitation, emotional support and safe clean water.

Access to safe drinking water

The distance to a water source, the time it takes to fetch water and the quality of water available and its affordability are still a big problem for the majority of rural households. Women in Tanzania are essentially responsible for domestic water supply due to the existing gender division of labour. This affects their health and diverts their time away from other productive activities which could have increased their income.

Poverty monitoring progress reports indicate that there has been some improvement in access to improved water supply. As of June 2003, for instance, 53% of households had access to safe water compared to 42% in 2000. There are however, inequalities in accessing safe water. Approximately 42% of rural households have access compared to 88% in Dar es Salaam and 84% in other urban areas (URT 2003). The Poverty Monitoring Progress Report of 2004 further indicated that 50% of rural households have no toilet facilities. There is a close link between water supply, sanitation and hygiene practices and the unpaid workload particularly for those households with people living with HIV&AIDS. Diarrhea, skin disease and vomiting are some of the more common symptoms which affect people living with the virus and which require access to safe, clean water and easily accessible toilet facilities. Lack of access to safe drinking water not only endangers the health status of the people, but also increases the workload of women and girls who are primarily expected to be the providers of household water supply. This also increases the burden of care for people living with the virus due to increased demands for water use for the patients.

Social demographic factors

The HIV&AIDS pandemic discussed above impacts many of the demographic indicators discussed in this section. The World Bank's current estimate of Tanzania's population is 37.6 million with an estimated growth rate of 2.6% per annum. This is similar to the ILFS 2006 survey report, which shows 37.5 million out of which 51.2% are females. The majority (73.6%) of the population lives in rural areas (ILFS 2006 unofficial data calculated by Debbie Budlender).

The current total fertility rate (TFR) is 5.7 births per woman for Tanzania as a whole. This is among the highest rates for Africa south of the Sahara (National Bureau of Statistics (NBS): 2004/05). Fertility in Tanzania has not changed in the last ten years (URT 2004/05). The TFR is more or less the same as the TFR reported in the 1999 Tanzania Demographic and Health Survey (5.6 children per woman) (NBS: 1999). The crude birth rate in Tanzania is 42.4 births per 1,000 women with regional variations. Fertility reaches its peak among women in their 20s. Age-specific fertility rises from 132 births per 1,000 women aged 15-19, to 274 births among women ages 20-24 and falls gradually to 18 births among women 45-49 (ibid.).

There are differences in fertility rates by geographical location, with a TFR of 6.5 in rural areas compared to 3.2 in urban areas. The differences are even more pronounced by poverty quintiles, the

poorest having a TFR of 7.8 and the richest 3.4. Changes between 1991 and 1999 have a strong bias towards the richer women, the poorest 51% women showed a less than 0.2 decrease in the TFR compared to a decrease of 1.5 children per woman in the richest 49% (ibid.)

Teenage pregnancy is a problem which forces significant numbers of girls to terminate their schooling. The maximum fertility, however, occurs at the age of 25-29, the prime years for productive work as well. The HIV&AIDS prevalence for this age group is 8.2% for females (slightly higher than the overall national average of 7%) and 6.9 % for males. It is believed that the maternal deaths are inflated by teenage pregnancy (NBS: 2004-2005).

The Tanzania Demographic and Health Survey (NBS 2004-2005) indicates that Tanzania has a larger proportion of its population in the younger age groups than in the older groups. Approximately 47% of the population is under age 15, with most of the other half (49%) aged 15-64; the remaining 4% is aged 65 and above. With only about half of the population in the economically productive age (15-64), a substantial burden is placed on persons aged 15-64 to support the older and younger population as well as the sick household members. The dependency ratio, an indicator of the dependency responsibility of adults in their productive years, is 104 in Tanzania, indicating that there are 104 dependents for every 100 persons in the productive age group (National Bureau of Statistics 2005). A young and fast-growing population not only places high demands on social services; it also increases the care burden on women who shoulder the bulk of the reproductive chores at the household level. The average number of people per household remains high with a slight decrease from 5.7 in 1991/92 to 4.9 in 2000/01 (NBS : 2006).

Urban-based households have a smaller percentage of children under five, indicating a lower preference for larger families, as well as access to various contraceptive methods. However, urban-based households tend to have larger numbers of members aged 15-34 years than rural-based households. This might indicate migration patterns of this young age group which tend to run away from rural poverty in search of “green pastures” and better employment prospects. At older ages, the urban/rural differences disappear, essentially because of the low life span of the majority of Tanzanians but also because those who survive might migrate to the rural areas because of the social networks which bind rural and urban.

Why Isn't Growth Trickling Down to Poor People?

There are two explanations for this. One is associated with the paradigm shift in economic policy combined with inherent structural elements in the Tanzanian economy. The shift from the pro-poor economic policies of the 1970s and 1980s to the market-driven economy which started towards the end of the 1980s and continued through the 1990s had a significant negative impact on efforts to reduce poverty. There was an assumption that the pro-growth model anchored in a market-driven doctrine with minimal state intervention would lead to the reduction and finally the elimination of poverty. This did not happen in the Tanzanian context in the 1990s as illustrated in the declines of both income and non-income indicators discussed in the previous sections of this report.

In addition to the neo-liberal policy context, there are structural elements of the Tanzanian economy which act as a barrier to eliminating or reducing poverty. Liberalization of the economy has not changed the basic structure of the Tanzanian economy. Agriculture is still the lynchpin of Tanzania's economy, as it accounts for 45% of the GDP (URT 2005d). It is also a source of livelihood for the majority of its people. Thus according to the ILFS (2006), 75.3% of employed people aged 15 years and above are in agriculture, with a further 1.2% in fishing. Most of the agricultural activities by smallholders are seasonal and dependent on weather conditions. Periodic droughts subject agricultural producers to food insecurity which threaten their livelihoods. The

performance of the agricultural sector has been poor for most food and cash crops, particularly among smallholder producers. The quality of exports has remained poor too (URT 2005d).

Annual growth rates for the agricultural sector have been very low. From 1998-2000 the sector registered annual growths of 3.1% on average (URT 2006). Rates have slightly improved since with a recorded growth rate of 4.8% for 2006 (ibid.). However, since the 1990s growth has been lower in this sector than in other sectors and its shares of employment has also been falling. Thus, in 2000/1 agriculture accounted for 84.2% of total employment, while by 2006 the share had dropped to 76.5% (National Bureau of Statistics 2007). The contribution of agriculture to the GDP compared to other sectors is illustrated in Table 3 below.

A reduction in the relative contribution of the agriculture sector to GDP and to employment has been a concomitant of economic development in all “developed” economies. But the problem in Tanzania, as in many other developing countries, is the slow growth and lack of dynamism of the industrial/manufacturing sector. In the historical development path of today’s “developed” countries, including the more recently developed countries of East Asia, the labour that left agriculture (due to the increasing labour productivity in agriculture thanks to technological improvements) was absorbed into the manufacturing/industrial sector with the latter acting as the engine of growth and the source of employment for an increasing proportion of the labour force released from agriculture. Such changes in growth and employment patterns are not yet visible in Tanzania. The agenda of economic reform and liberalization which has been implemented in Tanzania for more than two decades has not yet created the conditions for dismantling the structural barriers to the transformation of the economy.

Table 3: Contribution of Agriculture to Economic Growth Compared to Other Sectors: 1990-04

Economic activity	Average ann. Growth rates			Average Contribution to Growth		
	1990-94	1995-99	2000-04	1990-94	1995-99	2000-04
Agriculture	3.1	3.6	4.8	1.5	1.8	2.3
Industry	2.0	5.4	8.7	0.3	0.9	1.5
Services	1.9	3.8	5.9	0.7	1.3	2.0
Total GDP (factor cost)	2.5	4.0	5.8	2.5	4.0	5.8

Source: URT: 2005d: 4.

Poor technology, difficult topography, climatic changes as well as patriarchal land tenure systems cumulatively contribute to under-utilization of the country’s arable land. At least 78% of the land is held under customary laws which discriminate against women. The most affected category of women is widows including those whose spouses have died of HIV-related diseases. This discrimination continues despite the new Village and Land Acts which purportedly nullified all discriminatory practices in land tenure systems.

Related to the production patterns, is the structural links between the rural and urban sector. As discussed in the previous section, the urban sector which has less population than the rural sector, seems to extract most of the growth benefits experienced from the macroeconomic reforms. The pattern of growth discussed in the previous sections points to the asymmetrical relations emerging between the rural and urban in terms of education, income, health, and relatively “decent” livelihoods.

Finally and not least, poor governance further pushes citizens, men and women, into impoverishment particularly where scarce national resources are mismanaged by public office bearers. Where this happens, what limited resources there are do not assist those who are most needy of assistance. Thus Tanzania's 2005/06 Controller and Auditor General's assessment report, revealed that Tshs. 273 billion could not be accounted for. The money which the Ministry of Education failed to account for (Tshs. 11.5 billion) was enough to pay annual salaries for 10,000 primary school teachers. Local governments, which are responsible in building health infrastructures and other facilities, could not account for Tshs. 31 billion.

When public resources are not properly managed and used for the targeted purposes, the people who suffer are the existing and potential service users. It will lead to an inability to purchase and deliver required resources such as medicine, school material, equipment, and additional staff to bridge gaps in human resources such as those identified for the health sector system (Hakielimu 2006).

Conclusions

This paper has provided context analysis of socio economic and political situation within which the care economy is going to be further explored. While there are indications of a growing economy with impressive improvement of macroeconomic policies, benefits of growth have not impacted poverty reduction processes. As the government grapples with efforts of balancing growth and poverty reduction, the larger political and context of liberalized economy proves to be a challenge yet to be addressed. Pro poor and social equity policies have been implemented concurrently with political shifts that have moved the state from welfare and socialist model to a pro market model. The challenge is whether a pro market oriented model can lead to the elimination or reduction of poverty.

The paper further pointed out the pervasive nature of poverty, and how it is widespread with an uneven impact on rural/urban, women/men as well as geographical differences. This is a challenge to any initiative of supporting the care economy. Finally, the paper highlights some of the demographic indicators, particular the population pyramid with a high dependency ratio, which demands private and public resources to support the dependent population. This is again a challenge to the care economy.

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