WOMEN HEALTH PROBLEMS AND THE HEALTH BUDGET IN TANZANIA

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Abstract: The national budget is expected to be an instrument for the judicious allocation of public resources. It is true however that priorities are not always followed as influential groups are able to get access to more of these scarce resources than others. While the consequences of misallocation of public resources in some sectors are missed opportunities in the health sector the consequence are often citizens dying of avoidable causes. The most vulnerable groups in this case are women and children.

Our paper raises gender issues as they manifest themselves in Tanzania's national budget and the health sector. Issues of contention which have been raised concerning the budget have usually covered the weight of allocations between recurrent and development budgets as well as the disparity between the amounts allocated and the actual performance of the budget. Issues of gender hardly come to the picture. It is often taken for granted that the budget is gender neutral. Recently however there have been calls to look at the budget as it affects different groups in society. One such area which needs attention is the health budget as it affects men and women who often face different health problems.

INTRODUCTION

Women's health issues arise from their productive and reproductive work which creates health problems and needs for health care (Turshen, 1995: 239). Often women's productive work is undervalued, a fact which limits the claims they can make on national and household resources. Investment on women's health at these two levels is often construed as benevolence while in fact it is only a fraction of women's productive contribution.

Environmental issues also affect health both in the form of ecological degration which reduce food production but also pollution and contamination which contribute to many communicable diseases which are often chronic. Low education and lack of information for women also effect women's health as preventive measures do not reach many women.

THE NATURE OF WOMEN'S HEALTH PROBLEMS IN TANZANIA

Women's health problems are many and complex. A life cycle approach can however provide a clear picture of the nature of these problems and the required interventions. This approach would also take into account both specific and cumulative effects of poor health and nutrition (World Bank, 1994). The stages include infancy and childhood; adolescence; reproductive years; and post reproductive years.

Infancy and Childhood

It has been observed in many parts of the third world that boys often receive more preventive care and more timely attention than girls when they fall ill. At the same time girls often receive less food leading to malnutrition and impaired physical growth. Often more girls than boys die before their fifth birthday (WHO 1995). The situation in Tanzania would appear to be a bit different.

Table 1: *Age Specific Mortality Rates in Tanzania Mainland*

Age Group	1978		1988	
	Male	Female	Male	Female
0-1	147	126	129	116
1-4	110	103	80	76
5-9	46	42	33	31
10-14	18	17	17	16
15-19	31	28	20	20
20-24	41	38	26	25
25-29	43	38	28	27
30-34	45	40	30	30
35-39	50	45	34	34
40-44	59	52	39	39
45-49	73	65	45	45
50-54	97	84	57	57
55-59	127	111	74	75
60-64	180	156	105	107
65-69	245	212	155	157
70-74	376	304	232	237
75-79	480	425	338	248
80	1000	1000	1000	1000

Source: MOH Health Statistics Abstract 1997 p. 67.

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From Table 1 we see that from birth to the 10-14 age group girls have slightly lower death rates than boys. It should be pointed however that girls are born with certain biological advantages which usually are only negated by discrimination. Secondly, it has been pointed out that because women live longer than men it does not mean that they are healthier, infact they are more likely to experience poor health (World Bank, 1994: 14-15).

Nutritional problems facing children in Tanzania are complex as they concern both the availability and utilization of food at the family level. Ante natal statistics by Mother and Child Health (MCH) and Family Planning reports show that children with undernutrition levels of below 60% make up 9% of those who visited the health facilities. There are regions which have figures which are significantly different from that national average. These include Mtwara, (22%) Iringa (20%), Coast (15%), Mbeya 14%, Rukwa (13%) and Ruvuma with 12% (Health Statistics Abstracts, 1997: 86).

One however can assume that the very poor and uneducated parents would most likely not be making regular visits to the clinics. The malnutrition statistics would therefore most likely be an underestimation. Indeed, the problem of malnutrition and over-work for girls is a serious one which leads to stunting among girls with consequences on their reproductive and post reproductive health throughout their lives. (Kasale and Mbuya, TEHIP July, 1998).

Adolescence

Gender problems of adolescence include emerging sexuality and abuse of substances (drugs, alcohol, cigarettes). They affect both boys and girls. Emerging sexuality expose girls more than boys to a variety of risks, which jeorpadize their survival and wellbeing. Health policies and programmes are least effective in addressing the needs of this age group.

The problems of adolescence include early childbearing, unsafe abortions and sexually transmitted diseases (STDs) including AIDS. Adolescent girls are by far more at risk from these problems than women in their twenties. Adolescents face at least 20% greater likelihood of maternal or infant death than women in their 20s and the risks increase several fold for women under sixteen (World Bank, 1994: 18).

The major problems facing adolescent girls and boys in Tanzania need further research, on problems of emerging sexuality and on substance abuse which when looked casually would seem to be an urban and largely a boys' problem. Yet, there is need for research to look for example at the magnitude of alcohol abuse the county over as beer brewing and selling (including illicit liquor) is considered a source of income by many women and drawing into it many adolescent girls.

When we look at the mortality figures for Tanzania we find that unlike earlier years when mortality rates for girls were slightly lower than boys, the adolescence years, 15-19 reveal an equal rate for boys and girls. Yet with the increase of STDs and with more young girls being lured to promiscuous sexual behaviour by well off older males, this balance would most likely be tilted towards girls in the near future.

The vulnerability of adolescent women in terms of STDs, especially HIV infections, is becoming evident as data on laboratory tests indicate.

Reproductive Years

During the reproductive years, women's risks of premature death is greatest. Problems here include unplanned pregnancy and abortions and pregnancy related complications. In Tanzania these are mainly treated in a curative manner which means that essentially the root causes of such problems remain untouched. The reproductive years usually cover the years 20-44.

When we look at women as child bearers it is important to look at the performance of maternal and child health clinics, which are the most common means for delivering pre and post natal care as well as preventive and curative

health care for mothers. Another area of attention is family planning because women are affected by early child bearing, frequent child bearing as well as late child bearing. It is important however to reiterate two points. In the first place it is important to go beyond the times when women are child bearers. After all there are many reproductive health complications which affect women well beyond menopause. Secondly, family planning should not be reduced only to fertility control as a means to slow population growth.

Indeed for long, women were getting attention because of the children they were bearing; in other words programmes really targeted children, only they had to deal with their mothers to get to them. Indeed delivery clinics are not popular even with the donors who support PHC. It is only recently that safe motherhood is starting to be considered a significant issue on its own merit and UNICEF is supporting such programmes.

Table 2: *Laboratory Blood Tests for HIV*

Ages 15-19	1994	%	1995	%
Male				
Positive	68	8.9%	75	8.20%
Total Tests	764		912	
Female				
Positive	91	16.6%	96	14.9%
Total Tests	547		644	
Age 20-24				
Male				
Positive	139	8.4%	186	8.40%
Total Tests	1660		2224	
Female				
Positive	121	15.8%	147	16.4%
Total Tests	765		897	
Ages 25 & older				
Male				
Positive	737	15.1%	893	13.4%
Total Tests	4879		6646	
Female				
Positive	364	24.6%	454	24.8%
Total Tests	1478		1830	

Source: MOH - Health Statistics Abstract 1997: 88

Maternal Morbidity and Mortality

Maternal health problems during the reproductive years include unplanned pregnancies, STDs, abortions, pregnancy complications and malnutrition, especially iron deficiency. By Mid 1980s an estimated a million women in the world died each year from pregnancy related causes, 99% of them in developing countries (WHO 1995).

Perinatal/material deaths tops the causes of mortality in Tanzania and East Africa in the 1990's.

Table3: *Eastern Africa Regional Comparison of Burden of Disease, 1993*

	Percent of life Years Lost	
Causes of Death	Tanzania	Eastern Africa
Perinatal/Maternal	22.9	23.3
Malaria	18.2	9.80
Diarrhea	7.50	12.7
AIDS	6.00	4.70
Injury	5.90	3.30
Pneumonia	5.70	11.7
TB	4.80	4.20
Cardio Vascular	3.50	2.40
Measles	1.00	2.30
Protein Cal. Malnutrition	0.90	3.30
Total causes	76.5	76.9
All other causes	23.5	23.1
Total	100.0	100.0
Dieses of children < 5	38.0	53.4

Source: World Bank, Social Sector Review (SSR), 1996: 21

Perinatal and maternal deaths at 22.9% are ahead of Malaria, Diarrhea, AIDS and injury. It certainly requires more attention. It shows that despite a slight advantage over other Eastern African countries, Tanzania needs more attention to reduce these deaths. What is alarming is that the maternal mortality rate (MMR) is increasing. In 1992 it was 199 per 100,000, while in 1995 it was 208 (World Bank, SSR 1996: 114).

The problem of maternal deaths concern both preventive and curative health services. An estimated 80% of maternal deaths are a result of 5 major complications; hemorrhage, infections, hypertensive disorders of pregnancy,

obstructed labour and unsafe abortions. Many of these causes could be averted by early detection. The remaining 20% of deaths are caused by existing diseases which are aggravated by pregnancy, for example malaria, tuberculosis and heart diseases (World Health Organisation, 1995).

Table 4: *Maternal Mortality Rate by Regions for Four Consecutive Years (1992-1995)*

Region	*MMR*			
	1992	1993	1994	1995
Arusha	102	158	114	159
Coast	209	111	70	187
Dar es Salaam	220	298	237	328
Dodoma	197	214	208	266
Iringa	311	321	276	281
Kagera	204	343	190	242
Kigoma	144	155	105	87
Kilimanjaro	126	46	107	63
Lindi	262	289	193	264
Mara	67	59	106	124
Mbeya	67	361	436	264
Morogoro	289	172	190	153
Mtwara	264	212	161	252
Mwanza	221	186	266	207
Rukwa	172	294	243	267
Ruvuma	225	189	186	177
Shinyanga	143	188	199	184
Singida	242	171	238	207
Tabora	151	185	130	216
Tanga	255	172	220	195
Total	199	211	197	208

Source: Health Statistics abstract 1997: 66

In the case of prevention, ensuring access to family planning, prenatal and deliver care is one of the most cost effective health sector interventions, costing less than US$ 5 per capita in low income settings (WHO, 1995).

Post Reproductive Health

Post reproductive health problems are the effects of a lifetime of nutritional deprivation, hazardous and heavy work, continuous child bearing and low esteem which leaves women both physically and mentally frail. At the same time abandonment and widowhood often leaves women destitute. Most of the problems affecting women after the age of 45 are chronic and most of these health problems of post menopausal women continue to be ignored (World Bank, 1994: 23).

In many developed countries women live longer than men, when they reach old age, the statistics for Tanzania (Table 1) shows that mortality rate for women is higher between 55 and 75 years of age and dwindles only after 75. In Tanzania the problems facing post reproductive years do not get any special attention. Infact, non reproductive ailments do not receive much attention either. In the case of cancer for example, with fairly standard procedures at early stages, (pap smear) cervical cancers could be identified and treated. The same could be done for breast cancer. Palpitions of breasts to discover lumps by skilled health workers and some equipment at district and health centre level could facilitate widespread early screening (Kasale and Mbuya, TEHIP 1998). In short there is no systematic health strategy to reach post reproductive health problems of women nor those of men.

HEALTH POLICY AND HEALTH SECTOR REFORMS

To understand the health services context *vis a vis* gender issues it is imperative that we understand the legacy of the sector and the direction of the current reforms.

The Health System and Policy in Tanzania

The current health system can be traced to the establishment of the first missionary hospital in 1888 (Clyde David, 1962). The Germans laid the basis of the system with the establishment of the Medical Department, zonal offices and research centres.

The British took over from the Germans in 1918 and reconstructed the civil medical practise upon which the current health services are based. At the centre was the Chief Medical Officer, regional hospitals and then a string of dispensaries run by local governments. No major policy or structural changes were made to the British system in the first years of

independence until the time of the Arusha Declaration.

It should be noted that the prime target of colonial health services was to reach Africans involved in the colonial economy, hence health services were essentially for government workers, plantation and Africans in the export crop sector. This criteria worked also for missionary hospitals. They were not evenly distributed in the country. Women, most of them working in the "informal" sector were marginalized by the health system. Those in the missionary areas could receive health services if their husbands could pay the modest rates required.

From Independence until 1990 the health sector was run without a written health public policy. What was done in the sector was influenced by the development plans. In the First Five Year Plan (FFYP) and the Second Five Year Plan (SFYP) of 1968 which sought to implement the Arusha Declaration, the emphasis was the expansion of health facilities and services to areas hitherto unreached by the government and other agencies, such as the missionaries. There was community participation in this endeaveur because such communities placed high premium on health sevices. The actors in the first decade of independence were the government, voluntary agencies (VAs), mainly Christian mission hospitals, local governments (dispensaries and health centre) and some private practitioners especially in the urban areas.

Table 5: *Health Facilities in 1996*

	Gvt	VAs	Paras	Private	Total
Hospitals	81	81	17	45	224
Health Centres	284	43	6	11	344
Dispensaries	2512	724	260	780	4276
Total	2877	848	283	836	4844

Source: MOH. Health Statistics Abstracts, 1997

Of the 224 hospitals, 19 were non government hospitals which became designated district hospitals qualifying in the process for government funds and personnel. Four are consultant hospitals and two are specific disease hospitals. Muhimbili is the apex of the referral system which starts at the dispensary level.

The Arusha Declaration directed attention of health services to the rural areas. While in the long run it unleashed economic weakness which would contribute to the dis-functioning of the system, it was the precursor to the Primary Health Care (PHC) strategy which is the basis of the Public Health Policy. This marks the time when women came into the picture. Previously, general attention to the rural areas took the form of vaccination campaigns for children, most of them reached through the primary schools. The expansion of health facilities permitted mother and child programmes.

The PHC strategy was enshrined in the Alma Ata World Declaration of 1978 which called for health for all by the year 2000 which could only be attained through implementation of PHC. The MOH issued guidelines on the implementation of PHC in the country and started its implementation in 1983. It was adopted in the official health policy of 1990. The PHC is "essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally acceptable to individuals and families in the community through their full participation at a cost" (MOH Health Policy, 1990).

The 1990 policy was followed by an appraisal of the health sector in 1993 resulting in the Health Sector Reform Document of 1994.

The Health Sector Reforms (HSR) should therefore be regarded as the current health policy. Subsequent plans of action can be considered as elaborations of the policy and preparations for implementation. Other documents which are part of the Health Sector Reforms is the Strategic Health Plan (1995-1998), the Health Sector Reform Plan of Action (1996/1999) and the Health Sector Programme of Work (1998-2001).

The vision of the government of Tanzania after the reforms is a health sector which is efficiently managed, well organized and restructured. It is expected that the required drugs and medical supplies will be available at all health facilities for a reasonable price. It is also expected that a sustainable health financing system would have evolved and that the health workforce would be motivated and productive (HSR Plan of Action, 1996: 1).

The vision is sound but the problem is whether the reforms would adequately confront the entrenched weaknesses in the health sector without marginalising from health services large sections of Tanzania's population.

The problems facing the health sector are both economic and managerial. The governments' expenditure on health services is estimated at US$ 3.46 per capita which is below the US$ 12 per capita suggested by the World Development Report of 1993 (HSR 1996: 5).

On the managerial side, there are more than 5,433 health facilities, 106 training institutions and around 68,000 health workers. The recurrent cost to maintain the facilities and staff is considered too high and not cost effective.

By 1996 the direction of MoH became that favouring cost sharing and increased role of the private sector. The Plan of Action (1996-99) of May 1996 states that the national budget will be increased to at least 14% and reformulated to support cost-effective health packages. It also states that cost sharing will be extended to the health center and dispensary levels, and communities would be expected to take full responsibility for financing their health services through formal and informal risk pooling mechanisms eg. community health funds (MoH Health Sector Reform Plan of Action, 1996-1999: v).

Two observations can be made on the health policy. In the first place although apparently the overall objective of improving health status for all Tanzanians remains the same, there is a move towards more privatization and the public health system is more and more deprived of funds. It is evident that some Tanzanians are being left out of the health system.

Yet as tax payers Tanzanians of both gender are entitled to an effective public health system, cost sharing and community financing notwithstanding. While the private health sector has a very important role to play and the government needs to encourage and regulate it to ensure quality services, it is however not a direct extension of the public health system and accessible to all Tanzanians as the current health policy seem to suggest. More specific managerial reforms are needed, especially at unit level (hospital, etc.) to ensure efficiency and effective public health service to the people through elimination of wastage and fraud.

In the second place, the Health Reforms Plans still do not show what the government can concretely do for the health sector. The HSR Plan of Action (1996-1999), for example, gives what looks like a shopping list for donors to finance, even the estimates are in US dollars. The health plan seems to have the intention to define areas of priority and financing in which donors would be requested to fill the gap. It does not, in our opinion, even deal with the main problem of donor funds, which is lack of transparency on the funds used; which means that most of the funds declared as aid are used by the donor agencies and consultants. The onus of funding the public health system still remains with the government.

When it comes to gender issues, current health policies and strategies purport to give top priority to the child and mother. The draft guidelines for the health sector of October 1997 gives as the first objective of the health policy, "to reduce infant and maternal morbidity and mortality and increase life expectancy through the provision of adequate and equitable maternal and child health services." The challenge however, remains that of implementing the health priorities. MCH services receive limited funds both from the government and from lonors. The government is not keeping its priority commitment. In the health policy for

example, pregnant women and children under five are not supposed to pay for health services in public hospitals.

Yet the most recent cost sharing manual shows that expecting mothers have to pay admission charges while stating in the same vein that delivery services are free of charges (MOH-Cost Sharing Manual Dec. 1997: 9). One wonders whether a woman can deliver without being admitted into a hospital. Theoretically cost sharing is acceptable to many if it is followed by improved health services. In reality however, expecting mothers are still being expected to pay informally for the services in the maternity wards as they have always done. They have to come with important delivery items which are often unavailable in hospitals.

It would seem to us that no health reform will lead to efficient and effective services unless it confronts the questions of accountability and transparency and integrity. At present a system of privillage undermines services to priority areas. The system is not limited to the MoH nor is it based on professional privillege; it is the privillege of leaders which encourages wastage, mis-allocation and outright corruption. There is no scarcity of funds, for a minister or a permanent secretary who wants to travel, nor is there scarcity of funds to entertain a visiting government leader in a region or a district. These funds are diverted from other budgeted areas. It explains why even in the times of "belt tightening" there are many cases of extravagances.

The Budget in the Ministry of Health and Organizations

The major health services provided by the MoH include: curative services, preventive and environmental services, nursing, training, medical stores and the office of the chief government chemist. The Hospital Services Department manages and/or supervises referral/consultant hospitals, regional, district and other hospitals, local government health facilities and it also regulates NGOs, private and voluntary hospitals and pharmaceutical services. The preventive service department focuses on disease control, maternal and child health, environmental health and sanitation. The chief government chemist oversees drugs quality while the medical stores procures and distributes drugs, medical supplies and equipment.

The budget in terms of subsidies to local governments for the running of health centres and dispensaries passes through the Prime Ministers Office (PMO). The MoH is collaborating with donors and some NGOs in implementing the following programmes: Malaria Control, Maternal and Child Health, Essential Drugs Programme, National Aids Control Programme, Expanded Programme on Immunization, National TB and Leprosy Programme, Control of Diarrhoea Diseases, Family Planning, Health Education, Oral Health, School Health, Control of Blindness, Mental Health, Village Health Workers and Control of Plague.

Table 5: *Total Government Expenditure and Health Sector Expenditure as % of Government Expenditure, 1977/78-1996/97*

Year	*Govt. Exp.* (Tshs. mil)	*Health Exp.* (Tsh mil)	*Health* (%)
1977/78	8894.10	669.20	7.50
1978/79	13035.4	688.00	5.30
1979/80	13969.9	720.60	5.10
1980/81	15320.0	791.70	5.20
1981/82	18399.1	992.10	5.40
1982/83	20017.0	1037.8	5.20
1983/84	21460.9	1170.8	5.40
1984/85	26720.0	1328.7	4.90
1985/86	33219.3	2446.3	7.70
1986/87	51142.1	2122.6	4.30
1987/88	76911.5	3908.9	3.90
1988/89	78911.5	3908.9	4.90
1989/90	112284.8	6998.4	5.90
1990/91	143812.3	8561.6	5.90
1991/92	173107.1	8561.6	4.90
1992/93	220706.6	9763.7	4.40
1993/94	349738.0	39803.0	11.4
1994/95	361239.0	42024.0	11.6
1995/96	371183.0	44923.0	12.1
1996/97	387064.0	47589.0	12.3

Source: MOH 1998

Table 6: *Distribution of Recurrent and Development Expenditure Among Health Sector Programs 1994/95*

Category	*Recurrent*	*%*	*Development. govt*	*%*	*Donor*	*%*	*Total Govt/ donor*	*%*
Total	56968	100	1610	100	8382	100	66960	100
Curative	51027	90	1127	70	2539	30	54693	82
Ref. Hosp/	15324	27	140	9	0	0	15464	23
Reg/distr. Hosp.	17978	32	642	40	408	5	19028	28
Disp/HC	17725	31	345	21	2132	25	20202	30
Preventive	3840	7	376	23	5843	70	10059	15
HOH/Admin.	284	1	15	1	0	0	300	1
Training	1787	2	83	5	0	0	1870	3
Other	28	1	9	1	0	0	37	0

Source: Fullmer and Kessy, SSR(1996)

When we look at the total government expenditure on the health sector in the past 20 years we find a largely declining trend in the first ten years from 7.5% in 1977/78 to 3.9% in 1987/88. The trend was reversed after 1993/94 with a sharp increase (*see* Table 5).

The picture which emerges on contribution to the public health sector is that government budget goes mostly to curative services while donors usually prefer to support preventive services.

Table 7 show that the curative takes 90% of recurrent expenditure and 70% of government development expenditure on health, although as we can see, the government expenditure on development is only 2.7% of total government health budget. Donors for their part use only 30% of their funds for curative services which explains why most of their expenditure is at dispensary/health centre level. They spend very little at higher levels, that is 5% for district and regional hospitals and virtually 0% for referral hospitals. The government for its part spends much on hospitals allocating only 30% of its budget to preventive health services, 7% as recurrent expenditure and 23% as development funds.

When we look at lower levels, the breakdown of expenditure is not clear because of poor accounting of lumpsum grants. The picture which emerges still puts personal emoluments at the top.

Table 7: *Input Use in Health Sector Programs, 1994/95 (shares of total program expenditures)*

Input	Total excl. admin & Misc.	Referral Hosp.	Ref/ Distr.	HC/ Disp.
Total	100	100	100	100
Personal Emol.	41	23	31	67
Travel/ Visits	0.1	0	2	0
Facility oper./ Maint.	0.4	6	4	1
Treat. Abroad	3	11	0	0
Total School Costs.	0	0	0	0
Hosp. Supl	0	1	4	1
Food	3	2	4	1
Laboratory Services	0	0	0	0
Drugs	14	7	13	26
Non-Pers. Preventive Inputs	1	0	0	0
Internal Subventions	25	46	36	0
Others	5	4	6	3

Source: Fullmer and Kessy, 1996 in SSR p. 97

Expenditure by inputs in hospitals involves some unreliability in the figures because of poor accounting of lump sum grants. However in general 41% goes to personnel costs, drugs takes 14%. In referral hospitals 23% goes to personnel costs, 11% goes to treatment abroad which is

high compared to the 6% allocated to facility operation/maintenance and by far more than the 7% allocated to drugs and 2% spent on food. Since it is only highly placed officials and members of their families who go for treatment abroad, it shows that they take more than their fair share of health services which are mostly very strained with many people losing their lives from diseases which need simple interventions.

Treatment of patients abroad is infact subject to querries by the Controller and Auditor General who states "... No proper records were kept to control expenditures during the year under review, similar payments totalling shs. 205,365,381. were made without adequate accountability" (Controller and Auditor General, Report - MoH, 1997). Apparently this was a trend which had continued over the years and earlier querries were not answered.

THE HEALTH BUDGET AND SPECIFIC WOMEN HEALTH PROBLEMS

To get a clear picture as to how women are faring in the health budget it is important to look at women in their life cycle as shown in the first part and see how their health problems are addressed.

Infancy and Childhood

The MoH has recognized that infant and child health indicators are lagging behind. Infant mortality rate (IMR) decreased by 12.8% compared to 27.7% for the rest of Sub Sahara-Africa.

There is no comprehensive data available on service outputs in terms of patients treated by different types of facilities (MoH - PER 1996: 4). It is even worse for service outputs along gender lines. We can however get some picture on budgetary allocation in terms of MCH services, family planning as well as immunization. These are part of PHC which is the priority issue of the government policy.

The sub-sector breakdown of government budget for 1997/98 shows the dominance of allocation to hospital services which stood at 50% and especially for PE, which stood at 52%.

Table 8 shows a relatively high share of total government health spending allowed to hospitals despite government claims to give priority to PHC. This is justified on the grounds that the government has to fund salaries to its existing staff as well as to run existing infrastructure. The paradox is that most health personnel are lowly paid which implies that funds which go under PE are allowances and compensation which are drawn by a small group of people.

Table 8: Sub-sector Breakdown of Government 1997/98 Recurrent Budgets for Health (billion shillings)

	PE Amount	%	OC Amount	%	Total Amount	%
MoH HQ	0.7	2%	1.0	6%	1/7	4%
Hospitals	15.6	52%	5.5	44%	21.1	50%
Muhimbili	3.5	12%	0.3	2%	3.8	9%
5 Cent Hosp.	2.5	9%	2.4	19%	5.0	12%
Distr./Reg. Hosp.	9.5	32%	2.8	23%	12.3	29%
PHC	13.4	45%	6.1	49%	19.5	46%
MoH prev	1.1	4%	0.9	7%	2.0	5%
Reg prevent.	0.2	1%	0.0	0%	0.2	0%
HC/Distr.	12.1	41	5.1	41%	17.3	41%
Total	29.7	100	12.5	100%	42.3	100%

Source: MoH - PER, 1997

Significant funds for PHC and MCH services come from donors who are willing to fund supplies for preventive and PHC services. In 1996/97, 82% of donor support for health was for preventive services, mainly such supplies as vaccines and contraceptives (HSR - Budget Guidelines for Health Sector, Oct 1997).

The PHC programme has been supported by DANIDA from 1989-1996 to the tune of US$9.3 million. The Expanded Program on Immunization (EPI) which largely concerns children is being funded by DANIDA (US$20.5m), USAID ($ 1.2m), JICA ($4.8), WHO ($0.005m). Rotary International ($0.135m) and UNICEF ($0.985). The MCH gets a paltry 0.016 from the government as project money. UNICEF and JICA are helping MCH directly at the district level (PHC Plan of Action p. 47-48, 1996).

The situation in Tanzania shows that despite the total high spending, especially to limit mortality due to childhood diseases, the health system has not produced adequate results. The health system is seen as very inefficient in terms of results. Thus, for example with a lower overall level of spending and about the same pattern of government allocation, Kenya is able to achieve 8 years longer life expectancy, over a third lower child mortality rate and a total fertility rate that is one child lower (World Bank, Social Sector Review 1995).

In a bid to increase outputs and improve efficiency, the MoH is planning to increase the outputs of basic services including preventive services through improving the functioning of existing dispensaries and health centres, expanding preventive activities and encouraging private and NGO providers to fill the gap. Yet inefficiency has also to be explained in terms of fraud, not only as regards drugs but also of other medical equipment. At present there are plans to supply health facilities with different medical equipment. But without proper management these would either disappear through theft or will break down, which would discourage future donors and affect services to women, infants and children.

Adolescence

As seen above gender problems of adolescence include emerging sexuality and abuse of substances which affect both boys and girls. Girls more than boys are however more exposed to risks of emerging sexuality which jeorpadize their survival and well-being. Health policies and programmes are not effective in addressing the needs of this age group.

The non recognition of the problems of adolescence means that specific budgetary allocation is not made. Intervention is only a small part of the family planning project which deals not only with assisting women to avoid too early childbearing which in turn affects adolescents but also too frequent child bearing as well as too late child bearing which effects older women with serious health consequences (Simbakalia, C. May 1998). The project supported by USAID was asking for Tshs. 1,312,381,517 or us $1,988,457 for 1998/99. The breakdown being Tshs. 587,804,889 for training, Tshs. 53,775,675 for community based delivery (CBD), Tshs. 79,773,478 for dissemination of reproductive health strategy in the regions, Tshs. 180,777,852 for logistics, Tshs. 29,767,600 for research Tshs. 194,857,125 for information, education and communication and Tshs. 185,824, 898 for administration. Government funding of family planning is limited and is mostly in terms of paying salaries to its personnel. Intervention targeted to this adolescent group is in the form of educative and information by the Reproductive Health Unit on STDs and early pregnancies which is generally inadequate.

Reproductive Years

As seen above, these reproductive years cover the ages 20-44 and the health problems include unplanned pregnancies, STDs, abortions, pregnancy related complications, iron deficiency and general malnutrition.

Budgetary intervention here therefore involve financing of MCH services and family planning as well as nutrition programmes because poor nutrition affects reproductive health. The general MCH service which is concerned with prenatal and delivery care services receives limited funding from both government and donors. Yet it is one of the most cost effective health sector interventions. At the same time the infrastructure for nation wide intervention already exists; it only needs the maintenance of basic health equipment and supplies such as the standard delivery tray, blood pressure (BP) machines, stethoscopes, thermometers, microscopes, screens, weighing scales for infants and metric scales, antiseptic materials, gloves etc.

Table 9 shows that the percentages are low in Dar es Salaam with 32% for MCH services and 25% for family planning and Coast Region

with 48% and 47% for MCH and Family Planning respectively. These however are Region of easy communication accessibility and so increasing the percentage of facilities providing those services can be done relatively easily.

The infrastructure of MCH was built with USAID assistance, it included a national network and 18 MCH schools. USAID assistance was however withdrawn and the services have run down. The Family Planning Project supported by the same USAID is working to supply the facilities again. The hospital/dispensary management aspect however needs to be looked into, otherwise every few years total resupply might be needed. The Government however would be providing critical services to women if it provided the basic facilities and the budget to run these services in the whole country reaching women all over the country.

Table 9: *Share of Health Facilities Providing MCH and/or Family Planning Services, 1993*

Region		*MMR*	
	Total Number of Facilities	Providing MCH Services % of Total	Providing Family Planning % of Total
Arusha	230	83	68
D SM	315	32	25
Dodoma	201	68	76
Iringa	217	95	56
Kagera	167	99	86
Kigoma	142	89	71
Kilimanjaro	227	91	86
Lindi	128	83	76
Mara	163	88	87
Mbeya	251	86	65
Morogoro	258	74	53
Mtwara	142	95	95
Mwanza	244	95	86
Pwani	233	48	47
Rukwa	116	91	61
Shinyanga	147	95	95
Singida	204	94	76
Tabora	132	90	68
Tanga	158	89	87
	250	77	70
Total	3925	80	69

Source: SSR, 1996: 114

We can say however that maternity services are inadequate. Attention is supposed to start during pregnancy when an expecting mother is expected to see a Doctor or an experienced Nurse at least six times and have blood tests as well as high blood pressure tests among others. This is not usually done. After normal delivery mothers are expected to rest in hospital for at least 24 hours. At present most leave after 6 hours. During the delivery time itself women have to come with all important items needed for delivery. This does not happen with male conditions eg. hernia. Women are usually told to come with 2 pairs of gloves (sterilised) 2 pairs of gloves (standard), sanitary pads 92 boxes), disinfectant solution, 2 syringes, ergotemine (incase of bleeding), 4 pairs bed sheets, 1 pair bedsheets for the child and stitching catgut. This is not only costly to women but brings up the problem of sanitary standards. It is risky to bring items from outside the hospital because of possible contamination which can bring diseases to the hospital (*per. com.*Dr. S. Masawe Muhimbili May1998). A group of obstetricians at Muhimbili has formed an NGO which provides safe delivery for a lump sum of Tshs 50,000 including costs for a doctor and nurses.

At present women are involved in multiple cost sharing not only for delivery services but in taking care of other patients. In the absence of adequate food in hospitals women take the burden of providing food to sick members of their families. At Muhimbili for example, food is only provided for patients in the first grade wards and patients referred to the hospital from the regions.

The official cost sharing is being expanded as shown above. It means that patients would start paying from Health Centre level. The rationale is that with cost sharing and improvement in the provision of services, especially drugs, more people could use the public health system. Yet presently the official cost sharing income has not been used effectively. In a system which is used to receiving grants from the government and donors, collection of revenue is not only lax but the

amount collected is easily misappropriated by collectors and officials.

In the 1994/95 financial year for example Muhimbili collected 109,258,618/= as cost sharing user fees, which was 27% of the amount collected in all Regional and Consultant hospitals. In 1995/96 it was 89,648,794/= which was 36% of the amount collected nationally. (MoH. *Statistical Abstracts* 1997: 90). It is interesting to note that instead of the amounts collected increasing they were decreasing, not only at Muhimbili but the country over. Even the limited funds could have some significance if they had been directed to specific activities. Yet the funds can not be traced specifically because they are lost in a rigid budgetary system which is not performance oriented. There is also weakness in the process of accounting for cost sharing, not only for the health system but also for other areas such as education. Consequently fraud can come in easily. The new cost sharing system has set a responsibility system for it, placing responsibility on the Heads of Departments, yet the financial control aspects are not spelt out clearly.

The added danger to maternal health would be the reduction of public spending and reliance on the private sector. Those who are capable of using the private sector should be allowed to do so but those who count on the public sector should not be treated in a run down system. Few people will find it acceptable to get poor services from a Health Ministry facility which has shown many examples of mis-allocation, misuse and misappropriation of public funds. It should be understood that what is at stake is the life of patients. The Tshs. 205,365,281 mentioned in the Controller and Auditor General's report as unaccounted funds for treatment abroad as mentioned above is double the Tshs. 100,000,000 allocated as other charges for Muhimbili, in the 1997/98 budget. Surely this raises serious doubts on the sense of priority in the MOH.

The Post Reproductive Years

The major health problem facing women at this stage include cardiovascular diseases, gynecological cancers, osteoroprosis, osteoarthritis and diabetics (Word Bank, 1994). Attention to women above 45 is limited, the same applies to problems facing men after that age. Intervention is most based on curative measures and not preventive measures. More pointed intervention could be facilitated by research, yet Medical research in Tanzania is not given importance. Institutions dealing with medical research in Tanzania include the umbrella organization, The National Institute for Medical Research, (NMRI), with branches in Dar es Salaam, Mwanza, Tanga, Mbeya and Tabora.

In the 1995/96 and 1996/97 budget year the government did not allocate a single cent for research except to pay salaries, the other charges (OC) readings were zero. Even when sums are allocated by the budget, in actual expenditure research would most likely get nothing during disbursement because it has the least priority.

Household Expenditure on Health Care

In a country like Tanzania where communication is difficult, household surveys are expensive and can not be done every other day. Yet those few which were done show important trends. The most recently available is the Tanzania Human Resources Development Survey (HRDS) 1993/94 used by the Social Sector Review of the World Bank (1996).

The survey shows that 58% of all those who were sick sought first services from a government provider; about 70% of the poorest 20% of the households went to a government facility - mostly dispensary or health centers. The more well-off individuals sought care in the private sector. Yet when it comes to regional and referral hospitals, 46% of those from the richest went to a government facility. In the final analysis this group took more advantage of government facilities than the poorest 20 per cent.

The survey shows that women slightly more than men reported that they were ill and women

just as men sought care outside home. Women however, were exposed to more health problems which impact more generally on family welfare.

In 1994/95, the typical Tanzanian household spent around Tshs. 15,139 per year on health services, representing about 1.8 percent of their income.

Table 10: *Share of Total Household Expenditures to Health by Residence*

	Poorest 20%	Richest 20%	All
Dar es Salaam	2.0	2.0	2.2
Other Urban	1.3	2.2	2.1
Rural	1.3	2.0	1.6
All	1.2	2.2	1.8

Source: SSR 1996 p.83

The survey showed that there was no difference between male and female headed households. It is not however indicated how many of the sample were women. The survey also showed that most respondents were dissatisfied. Above all consumer were highly dissatisfied with the non availability of drugs.

Table 11: *Ratings of Government Health Facility Quality %*

Characteristics	*Good*	*Adequate*	*Poor*	*Total*
Drug Availability	9.8	26.6	63.6	100
Personnel Qualification	34.9	39.8	25.3	100
Distance	28.0	27.3	44.7	100
Preventive Services	36.9	37.8	25.4	100
Clean toilet/water	25.6	44.1	28.8	100

Source: SSR, 1996: 85

It is reported that there were no differences between male and female respondents. Both gender were alienated by poor services, especially shortage of drugs caused partly by mismanagement as health workers attempted to supplement their wages through drug sales. Most respondents were ready to pay for improved services. The current cost sharing plan is based on the assumption that with the improved supply of drugs services will improve and the public system will win back patients. However without management reforms patients will still get poor services.

The household survey show that when services are quite good most Tanzanians prefer the public health system to the private sector. The government therefore need to improve such system instead of expecting to heave a considerable number of patients into the private sector.

CONCLUSION: The Health Budget and Cost Effective Packages

The frequent story about Tanzanian government budget is serious shortfalls. The overall budgetary constraints can not be ignored, yet it is true that there are many examples of misuse of funds and fraud which indicate that a lot more could be done to ensure that public funds are used more effectively. At present, with the health budget one can not say with precision as to how efficiently resources have been used. The introduction of performance-based budget is therefore imperative.

In the health sector, a number of cost effective packages for health problems can be implemented within the capability of the government's budget. Women and men as revenue generators and tax payers have a right to an effective public health system. The cost effective packages for essential services for women include:

1. Prevention and management of unwanted pregnancies and sexually transmitted diseases.
2. Safe pregnancy and delivery services.
3. Enhanced maternity care.
4. Nutrition assistance for vulnerable groups.
5. Cervical and breast cancer screening and treatment.

One of the most cost effective services to women is the MCH services. The government would be reaching most women in Tanzania if these were funded adequately. Donors could be asked to fund the initial equipment and supplies, but the government should be able to maintain the network through correct management and replacements. It is difficult to understand how

a government which has funds to send leaders abroad for casual medical checkups can fail to get the Tshs. 600 million donor money allocated for X'rays in 1996 because it could not pay its contribution of Tshs. 25 million (MoH appropriation account for the year ending 30 June 1996: 13).

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