Participation for local development
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Health and education services

Introduction

In the Tanzanian system the primary responsibility for social services such as primary education and primary health care has been devolved to the local governments. This devolution follows the decentralisation policy, intended to bring the government closer to the people that it serves. The idea is that these local governments can respond more effectively and efficiently to the local needs and preferences (Research on Poverty Alleviation 2006). Furthermore, this decentralisation lays more emphasis on the improvement of the quality and distribution of these services (The United Republic of Tanzania 1998, the Policy Paper on Local Government Reform).

This chapter provides an overview of the organisation of the social services in Tanzania. It focuses on primary education and primary health care. The chapter is comprised of three sections. The first section gives a general overview of the government initiatives on quality provision of public services. The following two sections describe the organisational systems for both primary education and primary health care respectively.

A brief history of the provision of social services

The effort to improve the quality of public services has been one of the most challenging tasks in the history of Tanzania. Since independence in 1961 the government undertook several initiatives to ensure ‘quality social services for all’, but most of these initiatives have ended with no or little success. For instance, just after the independence, the government set out an ambitious plan in the Arusha Declaration (5 February 1967), aiming for the eradication of poverty, ignorance and disease. This plan was based on the
so-called ‘Ujamaa’ policy, which was guided by the principle of socialism. However, an economic crisis in the late 70s ended all plans and programmes with little or no success. According to Tibaijuka & Cormack (1998), the government failed to mobilise and maintain resource allocations at a satisfactory level for both health and education sectors. As a result, the sectors deteriorated seriously, both in quality (standards) and quantity (coverage).

Consequently, at the beginning of 1985, Tanzania initiated and implemented massive Structural Adjustment Programmes (SAPs) which were an attempt to correct economic imbalances and improve efficiency of developing transitional economies. Education and health care were among the sectors which were adversely affected by these programmes.

‘Many schools under the LGAs became desolate in terms of run-down buildings, lack of teaching facilities, such as books, copybooks, chalk, desks, pit latrines, teachers houses and offices, and suffered a serious shortage of classrooms. The government owned primary schools became the least conducive places for learning. The health sector was also in the same pathetic state. Hospital, health centres and dispensaries faced: shortages of medicines; poor or inadequate health facilities; inadequate and unqualified staff and; inadequate and dilapidated infrastructures including building for provision of clinical services, offices, staff houses, and waste collection and drainage facilities. Similarly, the government owned health facilities became the last resort for people seeking primary health services.’ (Mukandala & Peter 2004: 13).

However, it was widely reported that the SAPs could neither generate sustainable, equitable growth nor increase productive investment (Campbell & Stein 1991). Instead, these programmes increased external debt and caused considerable social, economic and environmental decline. So to speak, the social sector continued to perform poorly and deteriorated (Global Coalition 1993; Economic Commission for Africa 1989). According to Tibaijuka & Cormack (1998: 7):

‘The 1980s have been branded a lost decade for development. The widening gap between the rich and the poor, accelerated by adjustment policies represents one of the greatest sources of instability in sub-Saharan Africa.’

In response to this situation the Tanzanian government launched reform programmes, the purpose of which was improving quality, quantity, and sustainability of public services at the local level. These programmes were later integrated into the Local Government Reform Programme (LGRP).

Education system

Investment in human capital and provision is recognised as essential for improving the quality of life (URT 1989). In fact, after the Jomtien Declaration of 1990, universal primary education and education for all became two important goals of the national government. However, how to achieve and sustain these ambitions appeared more difficult to determine and to realise (Galabawa 2001). Serious doubts were raised about the quality of the schools and the relevance of the education provided (Galabawa, Senkoro & Lwaitama 2000; Tibaijuka 1998). In general the Jomtien Declaration, stating the objective of achieving a basic education for all in 2000, has equally remained
elusive (Galabawa 2001; Tibaijuka 1998). The forces preventing the achievement of quality primary education are many and complex.

However, despite these limitations and complexities in attaining the objectives of the Jomtien Declaration, the government of Tanzania could not give up. Together with donors, the Government launched the Primary Education Development Programme (PEDP) in 2001. Its aim is to ensure that all children have equitable access to good quality primary education. The option of decentralising primary education to the local government authorities is seen as a step further toward ensuring access and quality of primary education for all the citizens, wherever they are. Ensuring the availability of adequate and quality classrooms, and equipment as well as adequate qualified teaching staff is expected to be among the major focuses in attaining quality primary education.

The Tanzanian education system consists of three major levels, namely: basic, secondary and tertiary. The basic education consists of two years of pre-primary and seven years of primary education. Secondary education consists of four years of junior secondary education (ordinary level) and two years of senior secondary education (advanced level). The tertiary level consists of three or more years in school.

Primary education in particular is recognised as being key to universal basic literacy (Tibaijuka & Cormack 1998). It is thus important that resources towards the level of education with the highest rates of social returns be improved as a way of improving efficiency and effectiveness of resources allocation. This role has now been left to the LGAs as the main provider of primary education services at the local level. According to the World Bank (1986) and Diambomba (1992), decentralisation is regarded as the key to both increasing the efficiency and effectiveness of education systems, and to redressing inequalities in access to education. Likewise, a decentralised system is expected to enhance the quality and development of education and enable local communities and parents to participate in the decision-making process (Tibaijuka & Cormack 1998). Therefore decentralisation was the vehicle for implementing the policy, coupled with a strong political commitment from the central government.

The policy enabled each village to have at least one primary school. Villages are the lowest government unit with an estimated population of about 3,000 to 3,500. However, the massive quantitative expansion does not necessarily match the qualitative improvements and the education provided was of a generally low standard. It is therefore interesting to study how the community participation contributes to the improvement of primary schools infrastructure.

Health system

The Tanzanian national health system is organised in a referral pyramid, made up of six levels, namely national, regional, district, divisional, ward, and village. The structure is characterized by an increasing degree of specialization in staff (clinical and administrative), drugs, and equipment coinciding with the area that is depending on the facility. It is important to note that all facilities are designed to ensure access and equitable health services to all the people, wherever they are.
The villages are the lowest level in the health care system. On this level there is a ‘village health post’ staffed by two village health workers. These village health posts serve the entire village population of about 3,000 to 3,500. This facility is supposed to be managed by the village government. The mandate of choosing their own health workers is left to the discretion of village government. The role of health workers is to link the community with the nearest health facility, to provide health education, and to assist with relevant public health intervention. This lowest level of health care is considered informal and has always received less attention (Haroub & Athumani 2002).

The dispensary is the first real entry point in formal health care provision. The dispensary caters at the ward level for 6,000 to 10,000 people and oversees all the village health services in its ward. Its main function is to provide comprehensive outpatient services. According to the national standards the dispensaries are supposed to provide facilities for an outpatient department, mother and child health care, a maternity room with at least two beds, water closets and a room for the dispensary staff. A medical assistant supported by a maternal health assistant and two health assistants staff the dispensary.

The health centre is the second level of formal health services. Health centres cater for approximately 50,000 people. The health centre is a primary health facility and offers outpatient and in-patient services, maternity care, a laboratory, dispensing medicines and mortuary services. According to the national standards the health centre is supposed to be staffed by an assistant medical officer, a rural medical aide, a senior nurse, a midwife/nurse, a mother and child health aide or a public health nurse, a health officer, an assistant health officer, an assistant laboratory technician and a pharmaceutical assistant.

District hospitals provide hospital services for the people in a district and are the referral point for all primary health facilities (health centres and dispensaries) in the district. The district hospital is expected to serve a population of about 450,000 to 2,000,000. Every district is supposed to have at least one district hospital. In districts where the government does not own a hospital the government has agreements with the religious organisations that have a designated voluntary hospital. Under these arrangements, the designated hospital receives subvention from the government. The services provided by the district hospital include: outpatient, inpatient, and general surgical and obstetric operations.

The regional hospital is located in every region. The regional hospitals offer similar services to those provided by district hospitals, however, these regional hospitals employ specialists in various fields and therefore offer some additional services and a higher level of health care. And finally, at the national level there are four national hospitals.

The main problem with the standard of the health care at the local level is one of a human resource crisis. There are simply too few nurses and doctors available to provide the care needed. Other problems are of course the condition of the buildings and the shortage of equipment. Poor maintenance of health facilities and deterioration in health equipment were major factors, which were reported as undermining the delivery of
quality of health services in Tanzania (Tabaijuka 1998). Tabaijuka (1998) refers to the health evaluation survey, conducted by the Ministry of Health, which indicated that, out of the 7,700 building that were assessed, only 19 percent were in good shape. By 1984 the situation was completely unacceptable and resulted in unnecessary referrals and patients not receiving the required services.

The bulk of health care is provided by the so-called primary health facilities. These are the dispensaries and the health centres. These facilities are seen as most cost-effective method of providing basic and preventive health services (Vogel 1993). This is why the national health policy in 1990 stated that the primary health care was the cornerstone of Tanzanian health care. In an attempt to improve the primary health care, community involvement and ownership through active participation in identification of problem areas, planning, implementation, monitoring and evaluation of health care services were seen as important instruments (The United Republic of Tanzania 1990, the National Health Policy).

Decentralisation of primary health services to the respective local government is one of the efforts being made by the government to ensure quality health care for all. It is an attempt to improve the quality through involvement of citizens who know their problems better and to decide on better options and strategies for health in their regions. This is a policy that suits ideas of international organisations, such as the World Health Organisation (WHO 1993: 51):

‘Decentralisation is a method for promoting greater responsiveness to consumer preferences and sustainable development.’