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Brief 2: Progress Towards Improved Quality of Life and Social Well-being for All Tanzanians

Produced by the Research and Analysis Working Group of the MKUKUTA Monitoring System, Ministry of Finance and Economic Affairs

The broad outcomes of MKUKUTA's Cluster II are to improve the quality of life and social well-being of Tanzanians, and to reduce inequalities across geographic areas and between income, age, gender and other groups. Expanded access to, and delivery of, quality social services and the establishment of social protection mechanisms are vital to attaining these outcomes. This brief, the second in the series of briefs on PHDR 2009, assesses MKUKUTA's achievements in education, healthcare, water, sanitation and social protection, and draws policy implications.

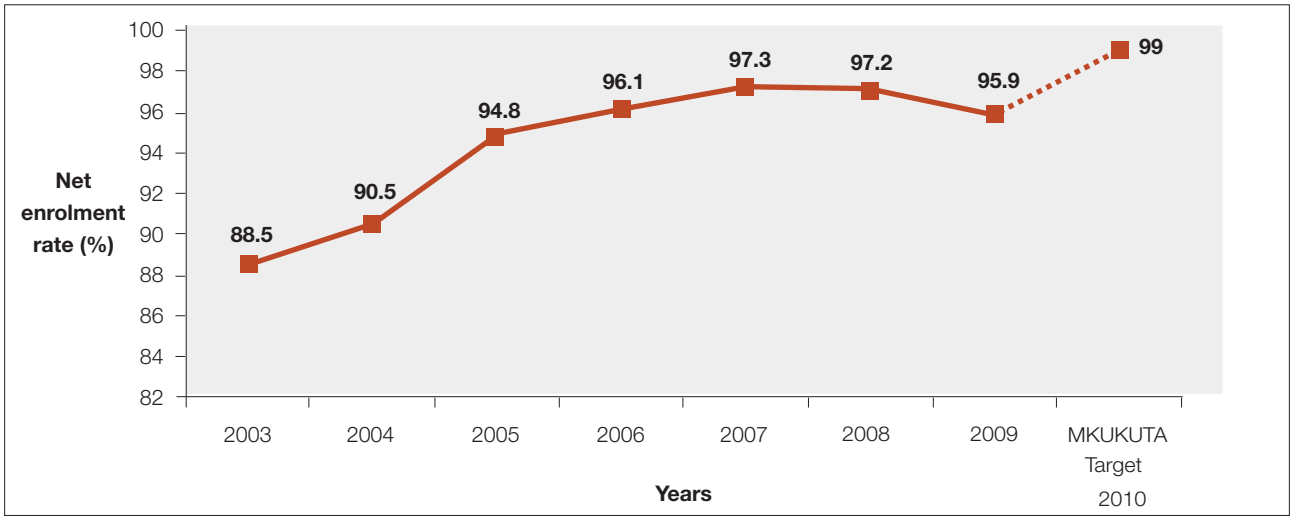
Literacy

The Household Budget Survey (HBS) 2007 reports a literacy rate of 72.5% among Tanzanians over 15 years of age. Data by gender show that literacy among women has slightly increased from 64% to 66.1% since the HBS 2000/01, while the literacy rate among men was unchanged at 80%. Improvement in literacy rates will largely be driven by increased and sustained access to education for new generations of Tanzanian children.

Education

Enrolment in primary education remains high, but has declined from 97.3% in 2007 to 95.9% in 2009 (Figure 1). The MKUKUTA target of 99% by 2010 is still attainable, however, reaching the children not yet enrolled will be a significant challenge, since it implies enrolling the children who are the hardest to reach at the requisite age, including the disabled.

Figure 1: Net Enrolment Rate in Primary Education, 2003 – 2008 (with MKUKUTA Target for 2010)



Sources: PHDR 2007 and Ministry of Education and Vocational Training (MoEVT), Basic Education Statistics in Tanzania (BEST) 2009

There has also been sustained progress in access to pre-primary, secondary and tertiary education. However, pass rates of the Primary School Leaving Examination (PSLE) and the transition rates from primary to secondary school have deteriorated recently, highlighting the ongoing challenges of achieving quality in educational outcomes at all levels.

Children from all wealth quintiles have benefited from the expansion of primary and secondary education since 2000 as shown in the higher net attendance rates reported by HBS 2007 (Table 1). However, data indicate that the least poor continue to benefit disproportionately from government spending in education, particularly in access to tertiary education. The proportion of young people from the poorest two quintiles of households who are attending tertiary institutions is only 4%, compared with 56% from the least poor quintile. Gender parity has been achieved in primary enrolment but only limited improvements are recorded at higher levels.

Table 1: Primary and Secondary School Net Attendance Rates, by Wealth Quintile, 2000/01 and 2007

	Primary Education		Secondary School (Forms 1 to 4)	
	2000/01	2007	2000/01	2007
Poorest Quintile	0.47	0.78	0.01	0.10
2nd	0.58	0.79	0.05	0.12
3rd	0.57	0.84	0.03	0.13
4th	0.65	0.89	0.05	0.21
Least Poor Quintile	0.72	0.91	0.15	0.25
Tanzania	**0.59**	**0.84**	**0.05**	**0.15**

Source: Hoogeveen, J. & Ruhinduka, R. (2009). Poverty reduction in Tanzania since 2001: Good intentions, few results.
Note: Calculations interpret attendance data in the HBS as equivalent to enrolment, and report them as enrolment rates.

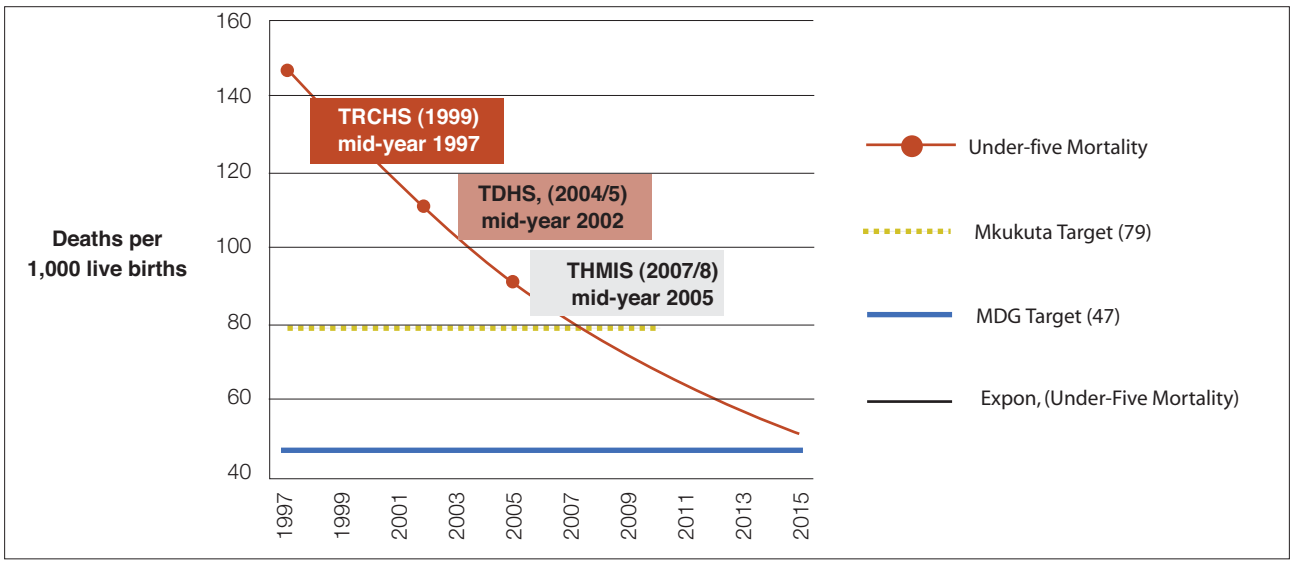
The wide variations in educational outcomes reflect persistent disparities in budget allocations to local government authorities (LGAs) for education. In 2008/09, the ten LGAs with the lowest budgets received on average TShs 21,000 for staffing per child, compared with TShs 161,000 per child for the ten LGAs with the highest budgets. In the 20% of districts with the highest budgets, the average pupil:teacher ratio is 44:1; in the 20% with the smallest budgets, it is 70:1. In the 20% of districts with the highest budgets the PSLE pass rate is 57.6%, whereas in the bottom 20% of districts it is 43.6% (URT, 2008). Formula-based grants to LGAs were intended to improve equity in education funding, but are not yet fully implemented. Brief 3 in this series provides more analysis of this issue.

Health

Under-Five and Maternal Mortality

The continued decline in under-five mortality means that Tanzania is on track to meet the MKUKUTA goal in 2010 and the MDG for under-five mortality in 2015 (MDG 4) is also within reach (Figure 2).

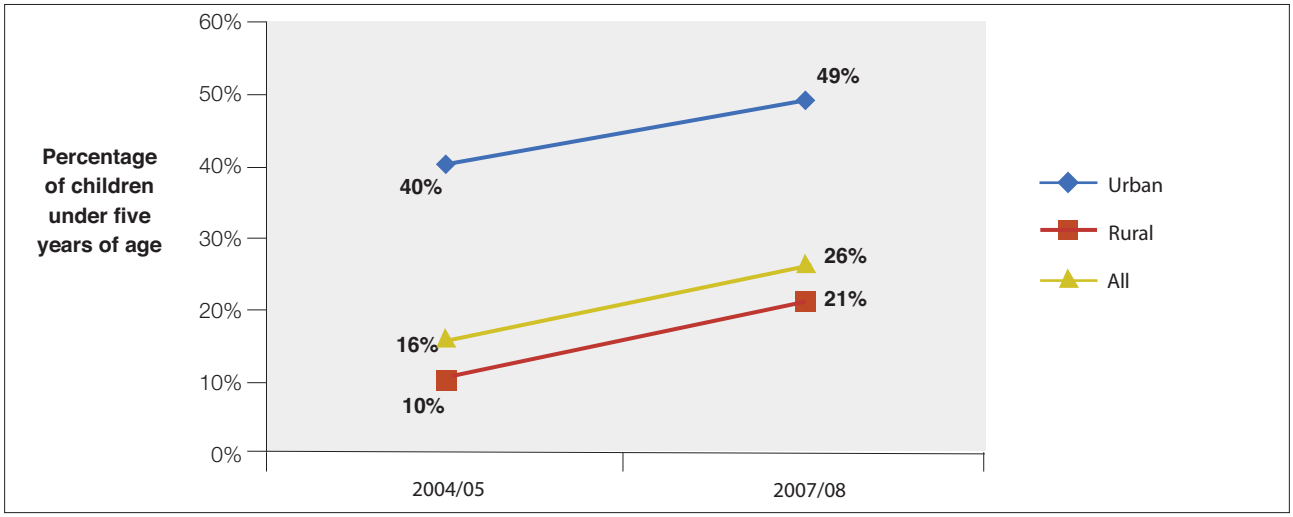
Figure 2: Estimated and Projected Under-Five Mortality 1997 - 2015



Sources: Tanzania Reproductive and Child Health Survey (TRCHS) 1999; Tanzania and Demographic Health Survey (TDHS) 2004/05; Tanzania HIV/AIDS and Malaria Indicator Survey (THMIS) 2007/08.
Notes: Each survey measures mortality in the five years preceding the survey. For the purpose of trend estimation, survey estimates are assigned to nearest "middle year" with exponential trend line.

The extraordinary improvement in child survival since 1999 is most likely explained largely by gains in malaria control, particularly coverage of mosquito nets, especially insecticide-treated nets (ITNs) (Figure 3) and more effective treatment.

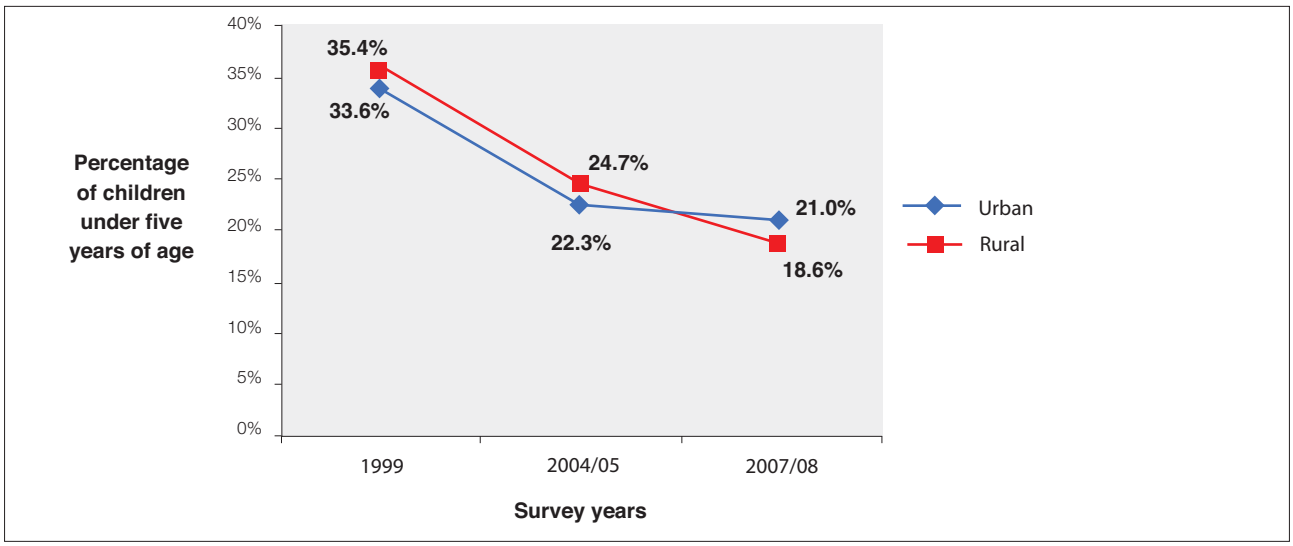
Figure 3: Percentage of Under-Fives who Slept Under an ITN the Night Before the Survey, Rural and Urban, 2004/05 and 2007/08



Sources: THMIS 2007/08 and TDHS 2004/05

Recent gains in under-five nutrition, anaemia and fever incidence (Figure 4) are probably also attributable to the decline in malaria.

Figure 4: Percentage of Children Under Five Years with Fever in the Two Weeks prior to a Survey, by Residence, 1999, 2004/05 and 2007/08



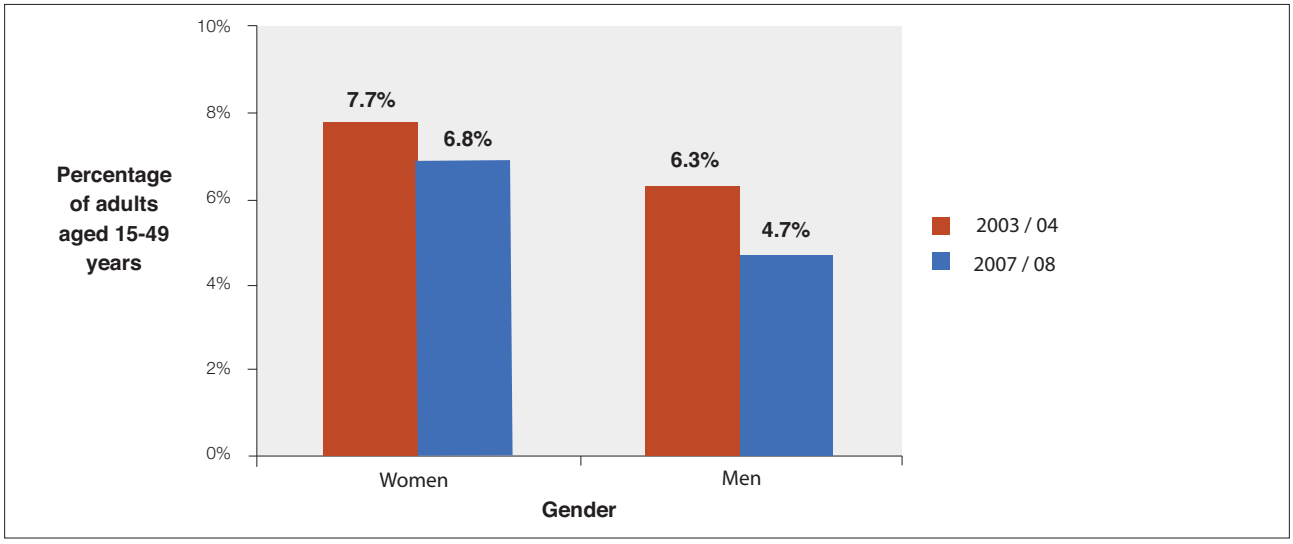
Sources: TRCHS 1999, TDHS 2004/05, THMIS 2007/08

However, there have been negligible improvements in rates of skilled birth attendance or facility-based deliveries, which are key indicators of lower risk of maternal mortality, and little change in neonatal mortality, which accounts for an increasingly large proportion of all under-five deaths.

HIV/AIDS

Encouragingly, HIV prevalence rates have declined for both men and women (Figure 5), and across all age groups, including among youth (15-24 years) which is a key indicator of new infections. However, youth HIV prevalence (15-24 years) declined largely because of a significant fall in prevalence among young men from 3.0% to 1.1%; the decline in prevalence among young women was small from 4.0% to 3.6% and not statistically significant. Survey results also show huge disparities in prevalence rates across the country from less than 3% in five regions, to 9% in Dar es Salaam and 15% in Iringa.

Figure 5: HIV Prevalence in Adults Aged 15-49 Years, 2007/08



Source: THMIS 2007/08

Since 2005, there has been a three-fold increase in the number of sites offering voluntary counselling and testing and a four-fold increase in the number of clinics offering anti-retroviral treatment (ART) (NACP, 2008). However, only 50,000 – 60,000 new patients have been enrolled for ART in each of the past three years (2006 to 2008), compared with the estimated 100,000 people who become clinically eligible for ART annually. Coverage under the programme to prevent mother-to-child transmission of HIV has increased since 2005 but remains fairly low despite a rapid increase in the number of programme sites. The percentage of HIV-positive pregnant women who receive nevirapine prophylaxis or start on ARV is estimated to have risen from about 10% in 2005 to around 40% in 2008.

Tuberculosis Control

The performance of the National Tuberculosis and Leprosy Control Programme continues to exhibit solid performance – with recent year-on-year improvements in treatment success. This is accompanied by very low (<<1%) rates of treatment failure. The treatment success results for 2006 and 2007 exceed the WHO target of 85% of all TB cases.

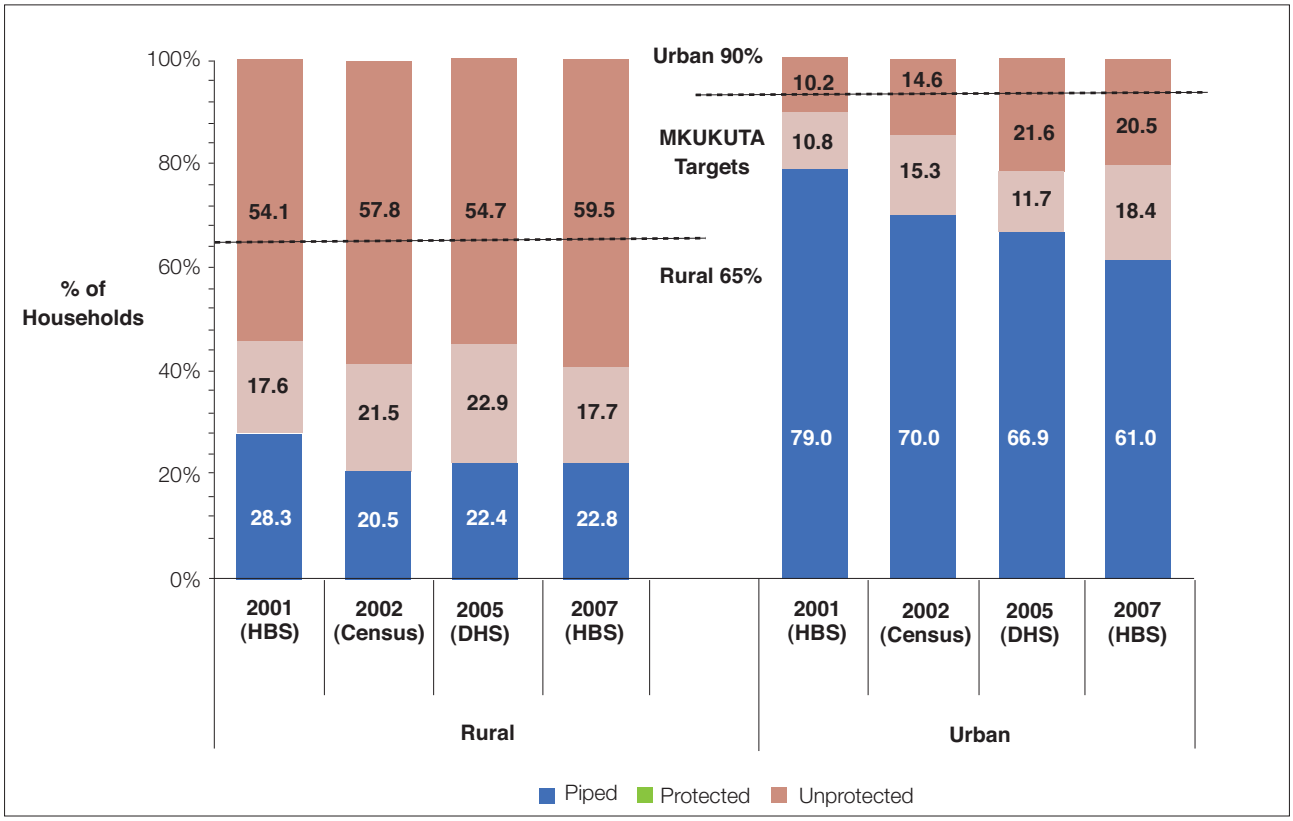
Access to Healthcare Services

Data from the HBS 2007 indicate that overall use of health services remained more or less unchanged since 2000/01, but reveals a remarkable shift away from private health providers to public providers. In 2007, the use of private health services dropped by 30% relative to 2000/01, while the use of government health facilities increased by 19%. This shift occurred across all wealth quintiles and all areas of residence.

Water and Sanitation

The latest survey data show a downward trend in access to clean and safe water in both urban and rural areas. In HBS 2007, only 40.5% of rural households and 79.4% of urban households reported access to a piped or protected water source (Figure 6). These data were collected prior to implementation of the Water Sector Development Programme but the trend is nevertheless very worrying.

Figure 6: Survey Data on Water Supply

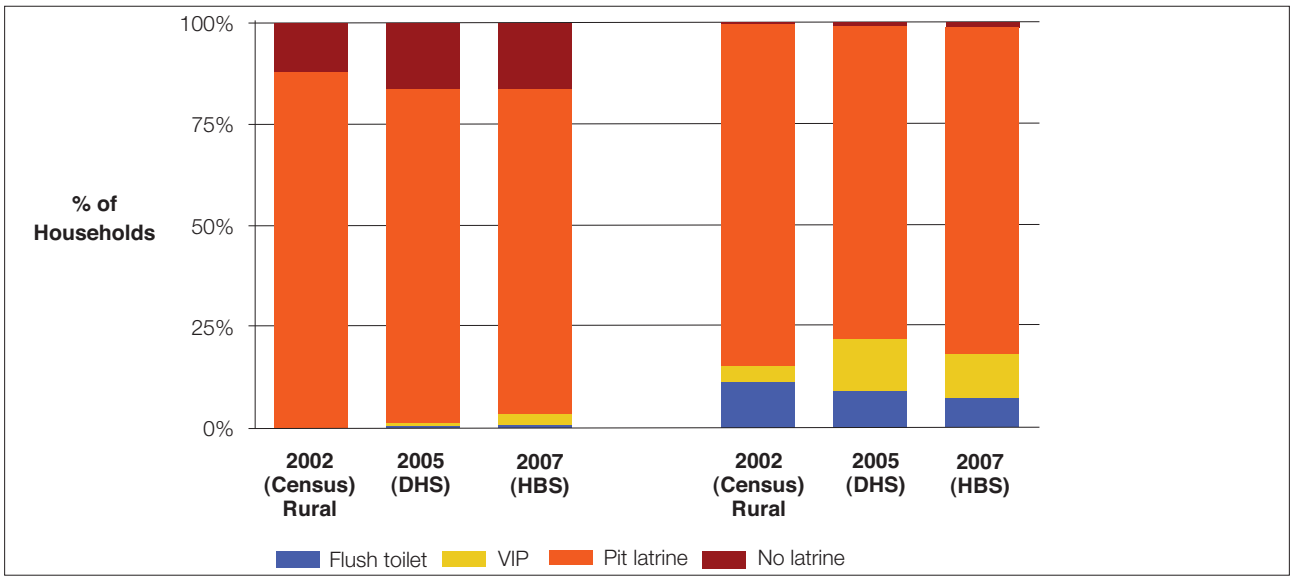


Sources: HBS 2000/01 and 2007; Census 2002; TDHS 2004/05

At the current rate of progress MKUKUTA targets for water supply (rural 65%; urban 90%) are out of reach. Further analysis reveals that water access is substantially higher for wealthier households, yet poorer households are paying more for water as a proportion of total household expenditure.

Data also indicate almost no improvement in household sanitation. The HBS 2007 show that access to basic sanitation facilities is close to the MKUKUTA target of 95% (Figure 7), but the vast majority of traditional pit latrines (the most common type of household facility) are 'unimproved' and of poor hygiene.

Figure 7: Trends in Household Sanitation, by Residence



Sources: Census 2002, TDHS 2004/05, HBS 2007
Note: A ventilated improved pit (VIP) latrine is a specific high standard pit latrine design

Data for school sanitation show a generally positive trend until 2006 with the number of pupils per latrine, declining from 74 in 2003 to 60 in 2006. However, figures indicate no change between 2006 and 2007, and a slight deterioration in the number of pupils per latrine in 2008. Without a significant increase in investment, the MKUKUTA targets for school sanitation of one latrine for every 20 girls and one latrine for every 25 boys will not be met by 2010. Adequate and private hygiene facilities are critically important for girls as the lack of proper facilities can reduce school attendance and some girls drop out of school altogether (Sommer, 2009).

Social Protection

MKUKUTA pays particular attention to groups of people who might be considered most vulnerable and who may not be accessing essential services: children engaged in child labour; children with disabilities, orphaned children and the elderly.

Child Labour

Over one-fifth (21.2%) of children aged 5-17 years are working in conditions deemed to be child labour (Table 2). Most child labour is time-excessive – children are performing domestic chores and helping out on the farm for long hours, potentially jeopardising their health and development, including school attendance or performance. Rural children are much more likely to be involved in child labour – 25.2% compared with 7.7% of urban children.

Table 2: Percentage of Children in Child Labour, by Type of Child Labour, and by Sex and Age Group, Mainland Tanzania, 2006

Type of Child Labour	Boys				Girls				All
	5-6 Years	7-13 Years	14-17 Years	Total	5-6 Years	7-13 Years	14-17 Years	Total	
Time-related excessive work	6.5	20.2	29.8	20.6	5.1	16.9	25.1	17.0	18.8
Occupation-related hazardous work	1.7	3.3	1.8	2.7	0.6	2.2	2.0	1.9	2.3
Total	**8.2**	**23.5**	**31.6**	**23.2**	**5.7**	**19.1**	**27.0**	**18.9**	**21.1**

Source: Integrated Labour Force Survey (ILFS) 2006

Children with Disabilities

Data from the Tanzania Disability Survey (TDS) 2008, the first rigorous national survey of disability in Tanzania, show that only 40% of children with disabilities are attending primary school, an attendance rate which is less than half the rate for Tanzanian children overall.

Orphaned and Vulnerable Children (OVC) and the Elderly

The THMIS 2007/08 found that 18% of children under 18 years of age in Tanzania are orphans and/or vulnerable children (OVC).[1] The percentage of OVC increases rapidly with age, from 10% of children under 5 years to 29% of children aged 15-17 years. However, rates of school attendance among OVC and non-OVC are very similar (87% and 89% respectively).

Data from the HBS 2007 indicate that households with only children and the elderly – i.e. those households with no adults of working age (20-59 years) – are more likely than the average household to be poor, but households with only elderly members are much less likely to be poor. However, the HBS also revealed that less than one-fifth of elderly people who consulted government health services did not pay for health services. The National Aging Policy 2003 provides for exemptions for elderly people who are unable to share the costs.

Key Policy Implications

To date, funding for education has focused more upon expanding access than improving quality. Going forward, greater attention needs to be given to the set of skills acquired by students rather than years of schooling, and increasing numbers of skilled teachers are required to bring down class sizes and ensure students receive higher standards of education. Expansion of apprenticeship schemes and mentoring systems are urgently needed, including innovative partnerships with the private sector, so that young people are equipped with the knowledge and skills in demand in the labour market.

In health, major progress has been made on some key health indicators – largely as a result of successful implementation of new technologies – but provision of maternal healthcare services (particularly skilled attendance at birth and availability of emergency obstetric care) lags far behind. Investment in quality antenatal, delivery and post-natal services is urgently required to bring down the high rates of maternal and newborn deaths in Tanzania. Promotion of exclusive breastfeeding, particularly in the first six months, is also critical to reduce neonatal mortality (Edmond et al., 2006) and improve childhood nutrition and development, and routine immunisation programmes need to be strengthened given declines in coverage between 2004 and 2007. Initiatives to scale-up of ITN distribution to all households need to be sustained. HIV data by age group and gender also reveal that prevalence among young women increases sharply after 15-19 years, which highlights the crucial importance of early prevention interventions.

Since 2004/05, water sector allocations have increased substantially after a long period of low funding, however, the reversal in the funding trend in 2008/09 is of much concern. Increased national commitment to water and sanitation will be essential to sustainably improve water supply and expand access to sanitation in households, schools and health facilities.

Well-targeted and coordinated schemes of social protection will continue to be needed to protect the most vulnerable from extreme poverty and deprivation, and enable adequate access to essential services.

Recommendations for Improved Monitoring

In education, the absence of data for Technical and Vocational Education and Training (TVET) is a glaring omission. A wider range of indicators to assess the quality of education is also required – current indicators for completion

[1] The THMIS 2007/08 defined a 'vulnerable' child as one who 'has a very sick parent, or lives in a household where an adult has been very sick or died in the past 12 months.

rates, examination pass rates and teacher qualifications can all increase without necessarily improving the uptake of skills and competencies of school leavers.

The national set of health indicators needs to be harmonised with the new Health Sector Strategic Plan (III), and planned improvements to the Health Management Information System (HMIS) need to emphasise tracking and analysis of indicators at sub-national level to enable planning and performance monitoring at local and health facility level. The (multiple) commissioned health surveys need to be rationalised and coordinated to avoid duplication of data collection.

Given current data constraints and weaknesses in data systems for water, it is recommended that routine data only be used to monitor and report on progress in sector infrastructure, not on access to water supply. Access should be monitored through the use of survey data. To monitor access to improved sanitation, in line with international best practice, household surveys should divide the previous broad category of "pit latrine" into "pit latrine with slab" and "pit latrine without slab". The forthcoming TDHS 2009/10 is expected to do this.

Disabled children are especially disadvantaged in access to schooling, and further analysis of the Tanzania Disability Survey may provide indications of specific types of disability which are particularly problematic and areas of the country where children are disproportionately affected, so that corrective measures may be taken. A programme of follow-up surveys of disability needs to be scheduled within the MKUKUTA monitoring system.

Panel surveys of households conducted by the NBS will provide more regular and up-to-date information about households' income and other circumstances which lead to vulnerability. The experience of several initiatives to provide support in kind or in cash for the most vulnerable children and the poorest households must be shared and carefully assessed so that lessons may be learned for the development of social protection programmes. Routine HMIS systems need to be expanded to capture data on elderly Tanzanians accessing health services so as to assess the application of exemptions policy by health facilities.

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