

**ASSESSMENT OF ACCESS TO HEALTH CARE SYSTEMS IN TANZANIA WITH
EMPHASIS ON SOCIAL HEALTH INSURANCE AND MICRO -INSURANCE SCHEMES**

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Research dissertation presented for the approval of Senate in fulfillment of part of the requirements for the Master of Law Degree in Labour Law in approved courses and a minor dissertation. The other part of the requirement for this qualification was the completion of a programme of courses.

I hereby declare that I have read and understood the regulation governing the submission of Master of Laws dissertations, including those relating to length and plagiarism, as contained in the rules of this University, and that this dissertation conforms to those regulations.

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LIST OF ABBREVIATIONS

- AAR - Against All Risks
- ADDO- Accredited Drugs Dispensing Outlet
- AIDS -Acquired Immune Deficiency Syndrome
- ARV- Anti Retroviral Drugs
- BMAF- Benjamin Mkapa Aids Foundation
- CBHF- Community Based Health Financing
- CED- Council's Executive Director
- CHF- Community Health Fund
- CHMT- Council Health Management Team
- DASICO- Dar es Salaam Small Industries Cooperative Society
- DED- District Executive Director
- DMO- District Medical Officer
- HIV- Human Immune Virus
- ILO- International Labour Organisation
- LAPF- Local Authorities Pensions Fund (LAPF)
- MCH- Maternal and Child Health
- MDGs- Millennium Development Goals
- MED-EX -Medical Express
- MKUKUTA- Mkakati wa Kukuza Uchumi na Kupunguza Umaskini Tanzania (in English:
NSGRP)
- MOHSW- Ministry of Health and Social Welfare
- MRALG- Ministry of Regional Administration and Local Government
- MSD- Medical Stores Department
- NFP- Not-for-Profit
- NGO- Non Governmental Organisation
- NHIF- National Health Insurance Fund
- NSGRP- National Strategy for Growth and Reduction of Poverty
- NSSF- National Social Security Fund

OAU- Organisation of African Unity
PHC- Primary Health Care (PHC)
PHCSDP- Primary Health Care Service Development Programme
PPF- Parastatal Pensions Fund
RDT- Rapid Diagnostic Test
RMO- Regional Medical Officer
RVF- Rift Valley Fever
SADC -Southern African Development Community
SPHC- Selective Primary Health Care
STDs- Sexually Transmitted Diseases
TACAIDS- Tanzania Commission of AIDS
TAWG -Tanga AIDS Working Group
TB- Tuberculosis
TBAs -Traditional Birth Attendants
TFDA -Tanzanian Food and Drugs Authority
TMPs- Traditional Medicine Practices
TNCHF- Tanzania Network of Community Health Funds
TZS- Tanzanian Shillings
UMASIDA- *Umoja wa Matibabu sekta Isiyo Rasmi Dar es Salaam* (mutual health insurance scheme in the informal sector).
UNICEF- United Nations Children's Fund
UPE- Universal Primary Education
URT- United Republic of Tanzania
VIBINDO- *Vikundi vya Biashara Ndogondogo* (associations of petty traders with health schemes)
WHO- World Health Organisation

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ABSTRACT

Health care services in Tanzania vary according to geographical location and the provisioning of health services is relatively poor. This is true when one considers the fact that about 25 % of Tanzanians live below the poverty line. Other factors include the lack of human resources personnel and the problems in drugs supply. This study examines the efforts of the government on health care provision and administration since 1961. The study critically discusses the current health care services financing system by way of insurance both statutory and the micro insurance schemes. The study reveals that the government allowed private health care services which have a good partnership with public sector in the provision of health care services. Besides, in 2002 the government allowed traditional and alternative health practices. Also, the study describes the effectiveness of health sector reforms which led to the decentralisation of the provision of health services to the local government and the adoption of primary health care services which focused on the improvement of health care services in the village and ward level. The government introduces alternative means of financing health care services after it became impossible to provide free health care services. On this footing the study examines the challenges and effectiveness of the National Health Insurance Fund (NHIF) which provides health care insurance to public service employees. In addition, the Social Health Insurance Benefits offered by the National Social Security Fund (NSSF), Community Health Fund (CHF), Community Based Health Financing (CBHF) and private insurance are examined on the basis of their achievement and challenges in financing health care services. Initiatives of providing health care assistance for the identified groups of people as per the National Health Policy 2007 attract attention of the researcher. The study makes a number of recommendations including the need to amend the Constitution to provide for right to health. Also the study recommends on the need to increase the public budget on health services which would solve the problem of inequalities of health care facilities in some districts and sponsor education to medical personnel. The study further recommends on the improvement on drugs supply and legal control of private health providers. The fact that the provisioning of health care services has taken the dimension of health care financing by way of either statutory insurance or micro insurance schemes the study recommends on the need to increase the coverage of health insurance schemes and further that the government need to address the issue of regulation of private health insurance schemes. On the part of micro insurance schemes there is need to adopt the means of collaboration as between the informal health insurance schemes and formal health insurance schemes so as to attain solidarity.

CHAPTER ONE

1.0 INTRODUCTION

This study examines the access to health care systems in Tanzania.¹ The provision of Healthcare constitutes an essential component of a minimum package of goods and services for the development and advancement of people.² The provision of this package involves several challenges for any scheme. Tanzania faces severe development challenges especially on the aspect of social health protection as the country is overburdened by the epidemic diseases such as HIV/AIDS and malaria.³ The majority of the poorest population do not have access to health care for the prevention or treatment of any illness due to various barriers related to access and quality.⁴ Tanzania is classified by the UN as one of the least developed countries and about 25 % of Tanzanians were living below the poverty line in 2007.⁵ In a 2005 report,⁶ it was noted that there was high level of poverty in the country in which 18.7 per cent population were below the national food poverty line whereas 35.7 per cent were below the national basic needs poverty line.

The study acknowledges that before independence, health services in Tanzania were established in urban areas and were mainly curative.⁷ The colonial government did not make any efforts to develop health services in rural areas.⁸ After independence the government of the United Republic of Tanzania recognized the importance of health and has given it high priority by adopting free health care provision and abolished user charges in government hospitals and

¹ In this research, unless otherwise stated, the term Tanzania excludes Zanzibar. "Tanzania" is intended here to be restricted to Tanzania Mainland (the former Tanganyika), because in both parts of the union that is to say Mainland Tanzania and Tanzania Island (Zanzibar) there are two ministries responsible for health affairs and this research is restricted to Mainland Tanzania.

² Committee of inquiry into a comprehensive system of social security for South Africa, *Transforming the present-protecting the future*, Consolidated Report, March 2002 at 85.

³ Beth Rogers-Witte, et al, 'Improving Access to Health Care for Vulnerable Children in Tanzania: An Evaluation of Pact's Community Health Fund Insurance Card Implementation', *CHF Card Evaluation 2009*, GWU / Pact Tanzania at 10.

⁴ Ibid.

⁵ The United Republic of Tanzania: Ministry of Health and Social Welfare, Health Sector Strategic Plan III; 'Partnerships for Delivering the MDGs' July 2009 – June 2015 at 6.

⁶ The United Republic of Tanzania, National Strategy for Growth and Reduction of Poverty (NSGRP) Vice President's Office June 2005 p 4 found in www.tanzania.go.tz/pdf/nsgrptext.pdf (Accessed 27 August 2009).

⁷ The National Health Policy 1990 at 1.

⁸ Ibid.

health centres. Within the social sector, the government introduced the policy of “Mtu ni Afya” (Man is Health), aimed at increasing mass awareness of the importance of health care and at galvanising community efforts towards the provision of health-care services.⁹ Although the post-colonial leadership declared poverty, diseases and ignorance enemies of the post-colonial state, from 1961-1967 the country did not formulate policies to fight the three declared ‘enemies’.¹⁰ The immediate focus in the social sector was to abolish racial segregation in education and health services by banning racially segregated services.¹¹ This however created problems in the provision of health care services in the country as there were no defined objectives by the government in the provision and administration of health care services.

The study starts from the premise that provisioning of health care services in Tanzania features many problems. The Arusha Declaration of 1967 which committed itself to a policy of providing essential health care services free at a point of use¹² failed to achieve its goals. Similarly, the government adopted a primary health care in the 1980s as a result of Alma-Ata Conference of 1978.¹³ Primary health programme, universal compulsory primary school education, mass literacy campaigns as well as Maternal and Child Health (MCH) programmes were launched.¹⁴ As a result of these efforts, rural health centres and district and regional hospitals were constructed, and training institutions for health workers were established.¹⁵ Nevertheless, government has failed to provide primary health care to its people to date.

The government took the decision of restricting the administration and provision of health services to the public sector. This is legally enforced by the Private Hospitals (Regulation) Act, 1977 which restricts the management of private hospitals to approved organisation.¹⁶ Despite the enactment of the law in the early 1990s, the provision of free health care for all

⁹ Angwara Denis Kiwara, ‘Health Insurance for the Informal Sector in the United Republic of Tanzania’ in Wouter van Ginneken (Editor) *Social Security for the Excluded Majority: Case Studies of Developing Countries*, International Labour Office Geneva, 1999, at 117-118.

¹⁰ Ruth Meena, ‘Social policy regime, care policies and programmes in the context of HIV/AIDS Tanzania’, United Nations Research Institute for Social Development, July 2008 at 3 available in <http://www.unrisd.org> (Accessed 28 September 2009).

¹¹ Ibid.

¹² Lilani Kumaranayake, et al, ‘How countries regulate the health sector? Evidence from Tanzania and Zimbabwe’, *Health Policy and Planning*; 15(4): 357-367 Oxford University Press 2000 at 359.

¹³ The National Health Policy 1990 at 3.

¹⁴ Meena, (note 10) at 4.

¹⁵ Kiwara, (note 9) at 118.

¹⁶ Section 6 of Act No 6 of 1977.

became apparently difficult in the face of rising health care costs and a struggling economy.¹⁷ In 1985 to 1986, Tanzania embarked on a policy of economic liberalisation and by the end of 1980s, resources for health sector had been substantially reduced, with real per capita expenditure falling by 46% in the decade to 1988/89.¹⁸ As a result, Parliament passed the Private Hospitals (Regulation) (Amendment) Act 1991 which allowed provision and management of private hospitals by approved persons.¹⁹ This was another problem which hindered the provision of health care services in the country.

In 1993, the central Government started the health sector reform process in an effort to improve the utilization of health resources, primary care, increase user access, and cut rising costs.²⁰ The provision and administration of health care services changed as the government introduced the decentralization of health care services provisioning at the district level, free public health care services were replaced by cost sharing and private health care services were seen as the major partner of the state in the provision of health services. However, the decentralisation process has delayed to be realised as there is still tight control from the central government.

Furthermore, the cost sharing of health services in the public health sector was complemented by the adoption of financing health care in rural areas by way of Community Health Fund (CHF) which was introduced in 1996 in Igunga district and later was given legal force by the enactment of the Community Health Fund Act, 2001.²¹ In 1999, the government enacted the National Health Insurance Fund Act.²² This Act came into force in 2001 covering health care insurance to central government employees to start with. Despite the introduction of health insurance schemes both statutory and micro insurance, they have failed to cover a considerable population.

¹⁷ Gemini Mtei et al 'An Assessment of the Health Financing System in Tanzania', Report on shield work package Ifakara Health Research and Development Centre; Ministry of Health and Social Welfare, Tanzania and London School of Hygiene and Tropical Medicine May 2007 at 15.

¹⁸ Kumaranayake et al, (note 12) at 360.

¹⁹ Under section 3 of the Private Hospitals (Regulation) (Amendment) Act 1991 approved person include qualified medical practitioners or dentist approved by the minister to manage hospitals according to the provisions of this Act.

²⁰ Mtei, et al, (note 17) at 15.

²¹ Act No 1 of 2001.

²² Act No 8 of 1999

This chapter introduces the study generally. It also provides the statement of the problem and definition of health. It also sets objectives of the study, describes methodology employed in conducting the research and provides an overview of other chapters.

1.1 Statement of the problem

The right to health is recognized by Article 12 of the International Covenant on Economic, Social and Cultural Rights, 1966. It is also contained in the African Charter on Human and Peoples' Rights, 1981²³ and the African Charter on the Rights and Welfare of the Child, 1990.²⁴ However, the right to health is not recognized in the domestic law of Tanzania. The Constitution of the United Republic of Tanzania 1998 as amended from time to time considers right to health care as one of directive principles of state policy.²⁵ This situation necessitates the conduct of this study.

The National Health Policy aims to 'improve the health and well-being of all Tanzanians, with a focus on those most at risk' and to ensure that "health services are available and accessible to all urban and rural areas. Since the advent of the first poverty reduction strategy, the 'universalist' approach has been modified to pay particular attention to the poor.²⁶ The MKUKUTA²⁷ speaks of improved quality of life and social well-being, with particular focus on the poorest and most vulnerable groups. It also makes an explicit commitment to reduced inequalities across geographic location, income, age, gender and other groups.²⁸ In spite of the clear policy commitments described above, there is surprisingly little documentation on health inequalities and equity in Tanzania.²⁹

The World Health Organisation (WHO) released a report in 2000 which has developed three primary roles of what a good health should be; that is, good health 'making the health status of the entire population as good as possible' across the whole life cycle, responsiveness

²³ Article 16 of the African Charter on Human and Peoples' Rights, 1981.

²⁴ Article 14 of the African Charter on the Rights and Welfare of the Child, 1990 (adopted July 1990, entered into force 29 November 1999, ratified by Tanzania 16 March 2003) OAU Doc. CAB/LEG/24.9/49 (1990).

²⁵ Article 11 (1) of Constitution of the United Republic of Tanzania 1998 as amended from time to time.

²⁶ Paul Smithson, 'Fair's fair: Health Inequality and Equity in Tanzania', Ifakara Centre for Health Research and Development and Women's Dignity Project, November 2006 p 1 available on <http://womensdignity.org> (Accessed 24 September 2009).

²⁷ MKUKUTA- is the Swahili acronym for National Strategy for Growth and Reduction of Poverty (NSGRP)

²⁸ Smithson (note 26) at 1.

²⁹ Ibid.

'responding to peoples expectation of respectful treatment and client orientation by health care providers, and fairness in financing by ensuring financial protection for everyone, with costs distributed according to one's ability to pay.³⁰ This study examines the question as to whether health care system in Tanzania follows the tenets of good health as per the World Health Organisation.

In addition, access to health care is examined in the light of access to essential medicines. The treatment of a patient is compromised when he or she is not able to obtain the medications needed.³¹ Another contributing factor may be the funding mechanism for public sector facilities (all funds for drugs are deposited with MSD), which can be a barrier for public sector purchase of supplies from alternative wholesalers/suppliers that are available to the NGO/private sector.³² The study analyses the Medical Stores Department Act, 1993³³ and the Food, Drugs and Cosmetics Act, 2003.³⁴ The former establishes Medical Stores Department (MSD) and the latter establishes the Tanzanian Food and Drugs Authority (TFDA).³⁵ The question that needs to be answered is whether the two authorities respond to the expectation of people in as far as good health is concerned.

Furthermore, access to health care in Tanzania can be achieved by the access to social security by the population. Social security is contained in the ILO Social Security (Minimum Standards) Convention 102 of 1952. The Convention enumerated nine risks which the society has to protect to its members. Health is one of the nine classical risks enumerated in the ILO Convention on Social Security (Minimum Standards), Convention 102 of 1952.³⁶ In Tanzania, majority of population can not afford to contribute to statutory social security schemes due to high level of poverty and illiteracy. The average of working force who contributes to statutory social insurance was 5.4 percent by the year 2003.³⁷ This situation of low coverage reflect a

³⁰ WHO, *the World Health Report-Health System Improving Performance*, Geneva WHO 2000 at 27-35 available in www.who.int/whr/2000/en/ (Accessed 28 August 2009).

³¹ Centre for Pharmaceutical Management, *Access to Essential Medicines: Tanzania, 2001*. Prepared for the Strategies for Enhancing Access to Medicines Program. Arlington, VA: Management Sciences for Health at 50 Available on www.msh.org/seam (Accessed 28 August 2009)

³² Ibid.

³³ Act No 13 of 1993

³⁴ Act No 1 of 2003

³⁵ Section 4 of Act No 1 of 2003.

³⁶ LG Mpendi, 'et al' in Olivier et al *Intoduction to social security*, LexisNexis Butterworths, Durban 2004 at 233.

³⁷ The National Social Security Policy 2003.

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³² Ibid.

³³ Act No 13 of 1993

³⁴ Act No 1 of 2003

³⁵ Section 4 of Act No 1 of 2003.

³⁶ LG Mpendi, 'et al' in Olivier et al *Intoduction to social security*, LexisNexis Butterworths, Durban 2004 at 233.

³⁷ The National Social Security Policy 2003.

failure by countries and international community to meet the obligations under article 9 of International Covenant on Economic Social and Cultural Rights which recognizes the right of everyone social security including social insurance.³⁸ Tanzania has subscribed to the SADC Social Charter of Fundamental Social Rights 2003. The Charter provides for the social protection and social security.³⁹ Also Tanzania as the member of East Africa Community undertakes to follow the principles of human rights and social protection as well as social security.⁴⁰ The study examines efforts of the government by focusing on the introduction of both statutory and community health insurance schemes as the means of achieving social security by focusing on the following issues.

The first issue is whether the National Health Insurance Fund Act, 1999 is effective and to what extent the Act has resolved the problem of financing health services in Tanzania. The study deals with the question of the adequacy of benefits provided by the NHIF to its members. Another question is on the position of the members after retirement. This is examined in light with the provision of the Act. The study further examines the issue of accreditation of service providers by looking at the guidelines and procedure.

The second issue is whether Community Health Fund (CHF), Community Based Health Financing (CBHF) and private insurance schemes have achieved their intended objectives. This is addressed by establishing if the government has managed to sensitise society on the importance of the CHF and CBHF and if the schemes provides sufficient benefits. On the same footing, the study explores private health insurance by looking on their coverage and regulatory authority. Social health assistance is analysed in the light of National Social Security Policy 2003 and the National Health Policy 2007.

Lastly the study investigates the question as to whether there is solidarity among the existing health insurance schemes. Solidarity is one of the important factors in achieving the proper provision and administration of health care services in the society. The principle of solidarity entails the sharing of risks, for instance, in situation of the health care services between

³⁸ Wouter van Ginneken, 'Overcoming Social Exclusion' in *Social Security for the Excluded Majority: Case studies of developing Countries*, International Labour Office, Geneva 1999 at 2.

³⁹ Article 1 (e) read together with article 2 of the Charter.

⁴⁰ Article 3 (3) (b) read together with articles 7 (2) and 120 of The Treaty of East Africa Community 1999.

the healthy and the sick, and from the rich to the poor. The question in this research is whether the government has achieved social solidarity in the presence of different health insurance schemes covering different classes of people from those who are unemployed to those employed in the formal sector.

1.2 Definition of health

In Tanzania the Ministry of Health and Social Welfare (MOHSW) revised the 1990 National Health Policy in the year 2007. The 2007 National Health Policy defines health as a state of complete physical, mental and social well-being and the absence of the diseases.⁴¹ The policy states that proper health enhances reduction of poverty and improves development of the society.⁴² MOHSW definition of health is in accordance with the WHO definition. The WHO defines health as ‘a state of complete, mental and social well-being and not merely the absence of disease’.⁴³ Many scholars in the field of health agree that there is a broader definition of health that can be used.⁴⁴ In line with the broader definition as pointed by Schaller;⁴⁵

[E]ncompasses the overall physical, psychological and social well-being of each individual human being. Such a definition includes a multiple factors that influence physical, mental and social health: public health, nutrition, water and sanitation, social economic rights, problems of conditions of poverty, and attention to the well-being of specific groups such as women children and elderly. These factors are interrelated; it is neither possible nor realistic to separate physical health from the other conditions that influenced it greatly. Promotion and maintenance of good health are the realm of preventive medicine, primary health care and public health; treatment of ill health lies within the realm of so-called curative medicine. Although there has traditionally being some tension between these realms, both preventive and curative programmes are important to the health of the society.

In the Republic South Africa the court defined health in the landmark ‘kidney case’ judgment of *Soobramoney v Minister of Health, KwaZulu-Natal* by Justice Albie Sachs, who said:

⁴¹ The National Health Policy 2007 at 1.

⁴² Ibid.

⁴³ www.who.int/endefinition.html cited from Mpendi, ‘et al’ (note 36) at 234.

⁴⁴ E Kalula and E Levy, ‘Access of Care and systems of Health in South Africa’, 2008 at 4.

⁴⁵ Mpendi, ‘et al’ (note 36) at 235.

A healthy life depends upon social interdependence: the quality of air, water, and sanitation which the State maintains for the public good; the quality of one's caring relationships which are highly correlated to health; as well as the quality of health care and support, furnished officially by medical institutions and provided informally by families friends and the community.⁴⁶

1.3 Objectives of the study

The study critically examines the position of the Constitution of the United Republic of Tanzania on the provision of the right to health care and to see as to whether the same is provided and enforceable before the courts.

In addition, the study examines the position of the health policies and other strategies on the access of health care in Tanzania and determine as to whether the same have achieved the intended objectives.

The study further seeks to critically examine on the financing of health services in Tanzania focusing on the means of financing especially of insurance schemes and see as to whether the same have facilitated access to health care of the citizens of Tanzania.

Lastly, this study examines the existing insurance schemes and establishes the existence of social solidarity in health care system in the country and further suggests proper ways of achieving social health solidarity in the different health care insurance schemes.

1.4 Research Methodology

This study is informed by extensive deskwork. It is of a critical character and largely non-empirical. The primary sources used are treaties, policy, and legislation. The secondary sources are books, academic articles, journals and all related literature. In doing both, the author has used the internet and the library.

⁴⁶ 1997 12 BCLR 1696 (CC) 1712E-F.

1.5 Overview of Chapters

The study is divided into five chapters. Chapter one introduces the study by focusing on the health care system in Tanzania. It further defines health and states the problem to be researched by indicating that the problem lies on access to health care services and its financing system.

Chapter two examines the health care system in Tanzania. It is mainly critical, pointing out the inadequacies of the system in its extreme form, with a few strengths especially on the efforts taken by the government to restructure the health system to deal with the challenges faced by the state in the course of striving to provide health care services to all citizens and if at all the changes and the revision of the National Health Policy 1990 made by the MOHSW in a way have made health services accessible by Tanzanians.

Chapter three explores the issue of health sector reform programmes especially on the adoption of the local government reform and decentralization by devolution; the national poverty eradication strategy and the primary health care service development programme and at this point the study will determine the question as to whether all these strategies adopted by the government have succeeded in their goals.

Chapter four shows how health insurance by statutory health insurance and micro insurance have been strong alternatives in the financing of health care services in the country after the government failure to provide free health care services to all citizens due to economic decline which affected the country from the mid 1980s and early 1990s. This chapter analyses the coverage of health insurance in the country by focusing on the health insurance schemes. In so doing this chapter analyses health insurance under the National Health Insurance Fund and National Social Security Fund as part of the health insurance to employees of the formal sector. This chapter further focuses on the effectiveness of the CHF and CBHF schemes as part of social health protection to the people under informal employment and unemployed. It also covers social health assistance. It however concludes by offering a model on which the existing health insurance schemes and social assistance measures to be improved to cover a reasonable number of population.

Chapter five offers a general conclusion of the whole study. It starts by giving the high light of the problems found in the preceding chapters. It further gives some recommendations which will assist in the improvement of the provisioning of health care in Tanzania.

CHAPTER TWO

HEALTH CARE SYSTEM IN TANZANIA

2.1 Introduction

This chapter examines health care system in Tanzania. World Health report defines a health system to include all the activities whose primary purpose is to promote, restore or maintain health.⁴⁷ Thus, health system activities include health promotion, health prevention, treatment, rehabilitation and nursing/care (including community and home based care).⁴⁸ Formal health services, including the professional delivery of personal medical attention, are clearly within these boundaries.⁴⁹ So are actions by traditional healers, and all use of medication, whether prescribed by a provider or not.⁵⁰ Health system performs functions of stewardship (oversight), health financing, creating resources/inputs (including human resources for health) for producing health, delivering (providing) personal and non personal services with a view to improving responsiveness to people's non medical expectation, ensuring fair financial contribution to health systems and ultimately improving health status.⁵¹

Recent political, social and economic changes in countries at all levels of development have generated a growing awareness of the pluralistic nature of both health care financing and provision.⁵² The issue of the role of the government and public sector capacity to regulate and coordinate diverse health agencies has become major concern.⁵³ The Health system is no longer characterised by state interference but has features of private sector involvement in the administration and provisioning of health services. Health system in the country varies from the most basic primary health care, which was formally offered free by the state, to highly specialised secondary health services available in regional and referral hospitals as well as in

⁴⁷ WHO (note 30) at 5.

⁴⁸ J. M Kirigia et al, 'An overview of health financing patterns and the way forward in the WHO African Region', *East African Medical Journal* Vol 83 No 9 September 2006, at S3.

⁴⁹ WHO (note 30) at 5.

⁵⁰ Ibid.

⁵¹ Kirigia et al, (note 48) at S3.

⁵² Sara Bennett and Elia Nyalande-Banda, 'Public and private roles in health: a review and analysis of experience in sub-Saharan Africa', *Division of Analysis, Research and Assessment*, WHO, Geneva 1994 at 1.

⁵³ Ibid.

private sector. Hence, health system generally includes public health which is offered by the state. It is also featured by private health offered by private companies, individuals and non governmental organisations. Lastly, the system features traditional and alternative health practices.

2.2 Public health sector

Health care policy in most developing countries has emphasized the development of government-owned health services, largely financed by government tax revenues.⁵⁴ Over most of the period since the Second World War, attention has focused on how to plan and develop these public investments.⁵⁵ Following the recommendations of international agencies, such as the World Health Organization, many countries have established similar systems of peripheral clinics and health workers, integrated community health centres, and a tiered system of public hospitals.⁵⁶ As such systems became established, there was increasing attention given to how to obtain greater health impact from this service capacity.⁵⁷ In Tanzania, government remains the main provider of health services and owns about 64 % of all total health facilities; about 87 % of all facilities are dispensaries; health centres and hospitals account for about 9 and 4 %, respectively.⁵⁸

According to the National Health Policy 2007, the provision of health services is divided into seven levels: national, zonal, regional, district, ward, village and family.⁵⁹ The referral system assumes a pyramid pattern starting from the village level, where there are village health posts; ward level, where there are community dispensaries; divisional level, where there are rural health centres; district level, where there are district or district designated hospitals; regional

⁵⁴ Kara Hanson and Peter Berman, 'Private health care provision in developing countries: A preliminary analysis of levels and composition', Data for Decision Making Project Department of Population and International Health, Harvard School of Public Health Boston, at 1 available in www.hsph.harvard.edu/ihsg/publications/pdf/No-76.PDF (Accessed 17 December 2009).

⁵⁵ Ibid.

⁵⁶ Ibid.

⁵⁷ Ibid.

⁵⁸ Ministry of Health and Social Welfare 2006.

⁵⁹ The National Health Policy 2007 at 67

level, where there are regional hospitals; zonal level, where there are referral hospitals and national level, where there are national and specialised hospitals.⁶⁰

The public health system - funded by the Government, with general taxation as its largest source of funding - is mainly used by those who are unable to afford the private system.⁶¹ This is not necessarily due to a lack of income or poverty but because there are no appropriate health and social security products available that they can access with the funds that they have. Because of limited funding, public health services are generally of an unacceptable standard.⁶² Despite all these, the public health sector in Tanzania has been improved to address the following;

- a) Geographical distribution of health facilities
- b) Availability of human resources
- c) Access to essential medicines
- d) Strategies for fighting HIV/AIDS

2.2.1 Geographical distribution of health care facilities

In Tanzania, the geographical distribution of health care facilities, the quality of services provided by health personnel and budgetary constraints impinge on the right to health.⁶³ In terms of geographical distribution of health care facilities, the national average indicates that most households live within 5 kilometres of a primary health care facility.⁶⁴ However, there are large variations in physical access between rural and urban households, between poor and poorer households, and between the accessibility of primary health care facilities and hospitals.⁶⁵ The access to hospitals as between those in rural areas and urban areas differs, while rural residents have to travel for a distance of 27 kilometres in seek of health services the urban citizens have to travel for 3 kilometres.⁶⁶ These barriers to access disproportionately affect poorer households

⁶⁰ Mtei, et al (note 17) at 17.

⁶¹ Kalula and E levy, (note 44) at 11.

⁶² Ibid.

⁶³ Legal and Human Rights Centre, *Tanzania Human Rights Report 2008: Progress through Human Rights*, Legal and Human Rights Centre, April 2009 available on http://alpha.web2.netshine-hosting.co.uk/~lhrc/index.php?option=com_docman&task=cat_view&gid=28&Itemid=56 (Accessed 28 August 2009).

⁶⁴ Smithson (note 26) at 25.

⁶⁵ Ibid. It is necessary to attend hospitals for more complex procedures, such as caesarean sections.

⁶⁶ Mtei et al (note 17) at 49.

and women.⁶⁷ Inaccessibility of health care services can negatively affect a person's life expectancy.⁶⁸ Inequality in geographical distributions affects provision of public health care since more than 60 per cent of health care facilities are owned by the government. However, in his New Year 2010 address of the Nation President Jakaya Kikwete stated that the government is working hard to improve public health facilities in the country as evidenced in the increase of the number of hospitals, health centres and dispensaries from 5,800 in the year 2008 to 6,240 in 2009.

2.2.2 Availability of human resources

The country has acute shortage of medical staff in public hospitals.⁶⁹ Only 35% of the required personnel are in place to provide health services and this is aggravated by the failure to reduce Maternal Mortality and Neonatal Mortality which has remained persistently high.⁷⁰ However, the health system is gradually expanding, but not enough to cover the unmet needs of the population.⁷¹ The study conducted by the legal and human rights centre revealed that, in 2008, it was estimated that there were two Tanzanian doctors per 100,000 people.⁷² Tanzania has four nurses per 10,000 patients, which translates into a ratio of 1:40 while international standard is 1:6.⁷³ The government is said to have contributed the problem as there is meagre financial allocation in the health department which is expected to meet procurement of materials for the wards, equipment, uniforms, as well as payment of night and risk allowances for medical personnel.⁷⁴ In the meantime some nurses have not been given uniform allowances for more than two years.⁷⁵

The shortage of trained personnel is compounded in certain areas by the fact that trained personnel do not want to be posted to districts with poor communication, poor schooling and

⁶⁷ Smithson (note 26) at 25.

⁶⁸ Legal and Human Rights Centre, (note 63) at 65

⁶⁹ The United Republic of Tanzania (note 5) at 6

⁷⁰ Ibid.

⁷¹ Ibid.

⁷² Unnamed reporter 'Tanzanian doctors overworked –study' *This Day* (Tanzania) 22 July 2008. See also Legal and Human Rights Centre (note 62) at 66

⁷³ Jaffar Mjasiri, 'Nurses are overworked, underpaid' *Daily News* (Tanzania) 2nd January 2010.

⁷⁴ Ibid.

⁷⁵ Ibid.

inadequate infrastructure.⁷⁶ As a result, people who are already disadvantaged due to their economic status or the area in which they reside receive poorer health care services, as there is a lack of facilities and personnel present in these areas.⁷⁷ This also affects the efforts of the introduction of health insurance schemes which their success depends on the presence of hospitals, doctors and nurses in areas where their members are working.

In 2008, the Minister of Health and Social Welfare announced the government's intention to train more nurses and doctors to address the problem of personnel shortages.⁷⁸ In the least developed districts the government in collaboration with Mkapa Fellows Programme have employed 99 medical personnel in 33 district councils. Employment of these medical personnel is funded by government of Norway and Clinton HIV/AIDS Foundation.⁷⁹ In addition the government in collaboration with Benjamin Mkapa Aids Foundation (BMAF) has employed 176 medical employees in other 19 least developed districts councils under Emergence Hiring Project.⁸⁰ The employment under this programme which is funded by Global Fund will last for three years and it will end in the year 2010.⁸¹ The measures adopted by the government aimed to reduce the problem of access to health care services to people in poor districts and regions; however they need to be sustainable.

Furthermore, the government in the period between 2005 and March 2009 has employed 11, 709 medical personnel including doctors, nurses and pharmacists.⁸² The government further has increased the number of employees employed in the medical sector; this is witnessed from the data that in the year 2006/07 the number of medical personnel employed was 3,669, this figure has increased to 4,812 in 2007/08 and until March 2009 the government had employed 2245 people and the exercise was still in progress.⁸³

⁷⁶ Smithson, (note 26) at 29.

⁷⁷ Ibid at 32.

⁷⁸ Unnamed reporter 'Tanzanian doctors overworked –study' *This Day* (Tanzania) 22 July 2008. See also Legal and Human Rights Centre (note 62) at 66.

⁷⁹ The United Republic of Tanzania, *Report on the Implementation of Ministry goals from 2005 to March 2009*, Ministry of Health and Social welfare, April 2009 at 6.

⁸⁰ Ibid.

⁸¹ Ibid at 7.

⁸² Ibid at 3.

⁸³ Ibid.

2.2.3 Access to essential medicines

Access to health care will not be effective if there is no access to essential medicines. The regulation of pharmaceuticals is covered by the Food, Drugs and Cosmetics Act, 2003 which have established the Tanzanian Food and Drugs Authority (TFDA).⁸⁴ The authority regulates all matters relating to quality, and safety of food, drugs, herbal drugs, medical devices, poisons and cosmetics.⁸⁵ Act No 1 of 2003 also gives direction, and controls all clinical trials of drugs, medical devices or herbal drugs in Tanzania. However the supply of medicines to public health facilities is regulated under the Medical Stores Department (MSD) which is established by Medical Stores Department Act, 1993.⁸⁶ Act No 13 of 1993 is responsible for developing, maintaining and managing procurement, storage and distribution of approved drugs and other medical supplies required for use by public facilities.⁸⁷ According to the establishing law, MSD is an autonomous department of health. MSD has a large degree of monopoly power and because of this it faces warehouse and storage management problems, especially in the zonal stores and further that its fleet for distribution of medicines to districts is aging.⁸⁸ Moreover, there have been substandard and counterfeit pharmaceuticals, cosmetics, medical supplies, traditional and alternative medicines circulating in the market which have brought health threats to the population.⁸⁹ In rural areas, for instance, there were few or no private sources of pharmaceuticals and medical supplies, which meet quality standards.⁹⁰

In dealing with the problems of access to essential medicines, the MOHSW intends to ensure constant and adequate availability of pharmaceuticals, medical supplies and equipment of acceptable quality in the supply chain system for public health facilities and accredited private facilities.⁹¹ More pharmaceutical personnel will be trained and recruited.⁹² In hospitals Drugs and Therapeutic Committees will be introduced as part of quality improvement and essential drugs list will be regularly reviewed and adapted to new treatment insights as well as distributed to

⁸⁴ Section 4 of Act No 1 of 2003.

⁸⁵ Section 5 (1) (a) of Act no 1 of 2003, the whole of section 5 of Act No 1 of 2003 provides the functions of the authority and how it functions in the making sure that there is access to drugs in Tanzania.

⁸⁶ Section 3 (1) of Act No 13 of 1993.

⁸⁷ Section 4 (2) of Act N0 13 of 1993.

⁸⁸ The United Republic of Tanzania (note 5) at 37.

⁸⁹ *Ibid.*

⁹⁰ *Ibid.*

⁹¹ *Ibid.*

⁹² *Ibid.*

health workers on time.⁹³ MSD will decentralise part of its functions to the zonal stores, which will be able to respond quicker to client needs.⁹⁴ Also, MSD has introduced Medium Term Strategic Plan 2007-2013 which aimed at improving the whole system of medicines and medical facilities supply in the country.⁹⁵ Recently MSD is reported to have launched a pilot project to distribute essential drugs down to the district level.⁹⁶ Once the new move, now in the pilot phase in Kilindi district, Tanga region, proved effective, MSD would be distributing drugs and other medical supplies directly to districts.⁹⁷

On the question of quality of drugs supplied by MSD, the TFDA is making a close follow up by invoking the provisions of section 59 and 79 of the Act which prohibit the sale of drugs, medical devices, or herbal drugs which do not comply with prescribed requirements and sale any counterfeit drug, herbal drug or medical device respectively. In so doing in March 2009 TFDA suspended the importation, distribution, sale and use of Metakelfin an anti-malarial medicine manufactured by Pharmacia & Upjohn, Italia S.p.A. Ascoli Piceno due to presence of counterfeit tablets in Tanzania market.⁹⁸ The problem was discovered through an investigative inspection done by TFDA in collaboration with Police Officers in 40 pharmacies in Mwanza, Arusha, Mbeya and Kilimanjaro regions which ultimately found that the supply was in contravention of sections 59 and 76 of the Act.⁹⁹

2.2.4 Strategies for fighting HIV/AIDS

Public health care was shaken after the outbreak of HIV/AIDS. In the year 2003 The Tanzania Commission for HIV/AIDS (TACAIDS) summarized the situation stating that HIV/AIDS presented a disastrous threat to the nation.¹⁰⁰ Since the first three cases of AIDS were reported in 1983, HIV infection has spread throughout the country and hundred of thousands of people in all

⁹³ Ibid.

⁹⁴ Ibid.

⁹⁵ The United Republic of Tanzania, (note 79) at 43.

⁹⁶ Njonanje Samwel 'MSD mulls distributing supplies to district level' the Guardian (Tanzania) 14 January 2010.

⁹⁷ Ibid.

⁹⁸ See the home page of TFDA at www.tfda.or.tz (Accessed 28 December 2009).

⁹⁹ Ibid.

¹⁰⁰ TACAIDS. 2003. *National multi-sectoral strategic framework on HIV/AIDS 2003-2007*. Dar es Salaam, Prime Minister's Office — Tanzania Commission for HIV/AIDS. See also, Tulia Ackson, 'Disability benefits and workers with HIV/AIDS: Coverage issues and challenges in the United Republic of Tanzania', *International Social Security Review*, Vol. 61, 4/2008 75-96 at 76.

walks of life have lost their lives.¹⁰¹ The outbreak of HIV/AIDS has affected the extension of health care services to the majority of citizens. In response of this epidemic the government in the year 2001 passed the HIV/AIDS Policy which has declared the disease as a national crisis which has spread relentlessly affecting people in all walks of life and decimating the most productive segments of the population particularly women and men between the ages of 20 and 49 years.¹⁰² With the outbreak of the epidemic it has become difficult for the society to access health care especially those who are infected with HIV/AIDS because the disease requires the allocation of more funds to fight the problem. Although HIV/AIDS is one of the diseases for which the Tanzanian Government has devised specialised programmes for medical care, the Government provides no financial assistance to sufferers.¹⁰³ In fighting the scourge the government enacted the Tanzania Commission of AIDS Act, 2001¹⁰⁴ which has established TACAIDS with the functions of formulating policy guidelines for the response to HIV/AIDS and management of its consequences in Mainland Tanzania. Furthermore, the Commission fosters national and international linkages among all stake holders through proper co-ordination of all HIV/AIDS prevention and control programmes and activities within the overall national multisectoral strategy.¹⁰⁵

The government has enacted the HIV and AIDS (Prevention and Control) Act, 2008¹⁰⁶ which requires the MOHSW to develop and conduct programmes to train on the precautionary measures and the prevention of HIV/AIDS. The provisions of Act No 28 of 2008 provide for the role of the government to provide basic health services for every person and vulnerable children and orphans living with HIV/AIDS by using available resources.¹⁰⁷ According to National Strategy for Growth and Reduction of Poverty (NSGRP) HIV/AIDS has undermined the foundations for development and attainment of the Millennium Development Goals and national targets.¹⁰⁸ This is the government report which acknowledges that the epidemic has led to failure of the attainment of millennium goals. One may hope that the enactment of the laws on the

¹⁰¹ Ibid.

¹⁰² The National Policy on HIV/AIDS 2001 at 2.

¹⁰³ Ackson, (note 100) at 76.

¹⁰⁴ Section 4 of Act No 22 of 2001, section 4 (2) provides that the Commission is established as the independent department under the office of the Prime Minister.

¹⁰⁵ Section 5 (1) (a) – (p) of Act No 22 of 2001 provides for the functions of TACAIDS.

¹⁰⁶ Act No 28 of 2008.

¹⁰⁷ Section 19 (1) of Act No 28 of 2008.

¹⁰⁸ The United Republic of Tanzania, (note 6) at 13.

prevention and control of the disease will make it possible for the attainment of primary health services but the critical thing is that even the CBHFs are not prepared to finance the treatment of the diseases as they have been formed to cater for the primary health services. This affects citizens in the rural areas who are not covered by the insurance funds and they are far from the reach of the free health care services.

Recent initiatives are that, the government under the Clinton Foundation¹⁰⁹ has started the initiative of providing Anti Retroviral Drugs (ARVs) to indigent citizens. These initiatives are recent and in the huge country like Tanzania with poor infrastructure the achievement of the programme cannot be seen in the recent years. This is due to the position of the Act No 28 of 2008 which states that the MOHSW shall, where resources are available, take necessary steps to ensure the availability of ARVs and other medicines and health services to persons living with HIV/AIDS and those exposed to risks of HIV infection.¹¹⁰ There are government initiatives to solve the problem of HIV/AIDS in the society however; the benefit packages provided for by the insurance companies does not cover for HIV/AIDS. This is despite the fact that the government makes it mandatory under the law for the insurance institutions to provide health services to persons infected with HIV/AIDS without discrimination on the basis of their status.¹¹¹

However in 2009 the country reported the drop in infections which is attributed to, among other factors, increased efforts in public education and general sensitization.¹¹² Sensitisation programmes are yielding positive results, with the number of people volunteering to be tested for HIV having increased significantly since President Jakaya Kikwete launched the national testing campaign in 2007.¹¹³ The national infection rate has dropped to about 5 per cent from a high of 14 per cent five years ago.¹¹⁴

¹⁰⁹ The Clinton Foundation HIV/AIDS Initiative (CHAI) was established in 2002 in order to assist governments in developing countries to develop and execute integrated care, treatment and prevention programs for people living with HIV/AIDS.

¹¹⁰ Section 24 (2) of Act no 28 of 2008.

¹¹¹ Section 24 (1) of Act No 28 of 2008.

¹¹² Unnamed reporter 'More needs to be done in Aids fight *The Citizen* (Tanzania) 31 November 2009.

¹¹³ Ibid.

¹¹⁴ Ibid

2.3 The private health sector

The term private sector is used to signify all those organisations and individuals working outside the direct control of the state, that is both for profit private companies and individuals and not-for-profit (NFP) private organisations.¹¹⁵ For example, private ownership would include health care facilities owned by individuals who seek to earn profits, clinics and hospitals owned by private employers, and those operated by religious missions and other Non-Governmental Organizations (NGO's).¹¹⁶ Not-for-profit providers include international non-governmental organisations (NGOs), national voluntary associations, religious missions and community self-help groups.¹¹⁷ Different levels of health services- primary, secondary tertiary and different categories of private providers exist from traditional healers to super specialists.¹¹⁸

Health care services in Tanzania include those which are provisioned by the central government under the Ministry of Health and Social Welfare and those decentralized under the Local government, faith based organisation and private health services.¹¹⁹ In general, Faith based organisations fall under the private sector. Interestingly, private health care is often significant for rural as well as urban populations and for lower income groups as well.¹²⁰

The amendment of the Private Hospitals (Regulation) Act, 1977 by the Private Hospitals (Regulation) (Amendment) Act, 1991 lifted the ban on private practice, by individuals not necessarily approved organisations.¹²¹ This has become the single most significant change relating to the provisioning and administration of health care services by the private sector in Tanzania. Applications for the establishment of private hospitals must be lodged to the board established under section 6A of Act No 26 of 1991 and the board is empowered to consider such an application and advise the Minister to register an individual as private hospital or not.¹²²

¹¹⁵ Bennett and Nyalande-Banda (note 52) at 3.

¹¹⁶ Hanson and Peter Berman (note 54) at 3.

¹¹⁷ Bennett and Nyalande-Banda, (note 52) at 3

¹¹⁸ Mukund W Uplekar, 'Private health care' *Social Science and medicine* 51 2000 897-904 at 898.

¹¹⁹ The National Health Policy 2007 at 67.

¹²⁰ Hanson and Peter Berman, (note 54) at 1.

¹²¹ Under section 6 of Act No 6 of 1977 the organisation which operated as the private hospital should be approved by the Minister.

¹²² Section 6B of Act No 26 of 1991.

Importantly, the Act contains some provision to regulate prices as well as entry and exit of providers. The Minister of Health and Social Welfare is able to determine and review the price structures of medical treatment provided by private hospitals.¹²³ Ministerial power further extends to the control of salary scales payable to medical practitioners employed at private hospitals, as well as allowances and other benefits.¹²⁴ The minister may require the private hospital to submit among other things the particulars relating to salary scales, particulars of the expected income of the hospital in financial terms and the particulars of the estimated expenditure of the private hospital in a typical financial year.¹²⁵ In practice, this mandate has not been applied, and private hospitals are more or less free to fix their own health care prices.¹²⁶

With respect to the quality of services, The Registrar of Private 'Hospitals, an Assistant Registrar of Private Hospitals, a medical officer or any other public officer authorized by the Minister in writing for that purpose, has the remit to conduct inspections in private facilities to ascertain whether the medical treatment is provided in accordance with specified conditions.¹²⁷ Again, there is very little evidence as to the extent to which this has actually been implemented.¹²⁸

Following the importance of private health provisioning in Tanzania, it is estimated that between 1991 and 1996 there was a 36-fold increase in the number of private-for-profit dispensaries and that the number of for profit hospitals increased five-fold.¹²⁹ The private sector is now seen as a crucial partner in providing health services, complementing government.¹³⁰ Non-government organizations and private-for-profit providers now own about 18 and 15 % of total health facilities respectively.¹³¹ The private health sector though said to be a reliable partner with the government in the provisioning of health services the question remain as to whether the ordinary citizen can afford the costs for health services.

¹²³ Section 13 of Act No 6 of 1977 as amended by Act No 26 of 1991.

¹²⁴ Section 19 (1), (2), (3) of Act No 6 of 1977.

¹²⁵ Section 19 (5) (a), (b) and (c) of Act No 6 of 1977 as amended by Act No 26 of 1991.

¹²⁶ Mtei et al (note 17) at 39-40.

¹²⁷ Section 23 of Act no 6 of 1977.

¹²⁸ Mtei et al (note 17) at 40.

¹²⁹ Kumaranayake, (note 12) at 360.

¹³⁰ Mtei et al (note 17) at 18.

¹³¹ Ibid.

The government has undertaken measures to enhance partnership with private health care providers; however, the increase of private health care providers' centres has necessitated the need of the number of medical practitioners. The government admits that most of medical practitioners employed in the public sector use their working time to work in the private hospital and this in turn has led to poor health services in public hospitals.¹³² These problems call for the MOHSW to effect the existing public service regulations, such as the Public Service Regulations, 2003 (Government Notice No 168 of 20th June 2003) and the Public Service Scheme (Government Notice No 169 of 20th June 2003) which provide for the disciplinary provisions of all public servants including public sector medical practitioners. If these regulations will be used the ministry will be able to control the absenteeism on the part of public medical practitioners who works for private hospitals during their working time.

2.4 Traditional health services and alternative medicines

In 1977 the World Health Assembly urged member states to utilize their traditional systems of medicine (resolution WHA30.49).¹³³ In 1978 the International Conference on Primary Health Care, held in Alma-Ata, recommended that governments give high priority to the utilization of Traditional medicine practices and Traditional Birth Attendants (TBAs), and incorporate proven traditional remedies into national drug policies and regulations.¹³⁴

Traditional medicine is the diagnosis and treatment of psychological and medical illnesses based on local knowledge and socio-cultural and religious beliefs, developed over time by local people within their belief systems and specific environmental (particular biodiversity) conditions of a particular area.¹³⁵ It is a well-established system of medicine, parallel to the western or orthodox medicinal system, still in active use by rural communities in developing countries.¹³⁶

¹³² The National Health Policy 2007 at 31.

¹³³ Torunn Stangeland et al, 'Recognition and development of traditional medicine in Tanzania', *Journal of Ethnopharmacology* 117 (2008) 290–299 at p 291.

¹³⁴ Declaration of Alma-Ata. International Conference on Primary Health Care, Alma-Ata, USSR, 6–12 September 1978 Declaration VII (7) Available at <http://www.who.int/hpr/archive/docs/almaata.html> (Accessed 17 November 2009).

¹³⁵ Stangeland et al, (note 133) at 290.

¹³⁶ *Ibid.*

In Africa, during the nineties several conferences and meetings on the use of traditional and alternative medicines were held in Tanzania and other African countries, starting with the International Conference of Experts from Developing Countries on Traditional Medicinal Plants, Arusha, February 1991.¹³⁷ Since 2003 Africa has been observing 31 August as African Traditional Medicine Day.¹³⁸ This day was a result of the Inter-African Experts Committee on African Traditional Medicine and Medicinal Plants in the Organization of African Unity (OAU) meeting which proclaimed 2001 to 2010 as the Decade of African Medicine.¹³⁹ Tanzania celebrated the day for the first time in 2003.¹⁴⁰

In Tanzania traditional and alternative medicines during colonization was not officially accepted. The Medical Practitioners and Dentists Ordinance, 1929 which was constituted before independence held exemplary status for traditional practitioners. Traditional Medicine Practices (TMPs) were allowed under the Ordinance but cooperation between TMPs and conventional doctors was forbidden.¹⁴¹ The ordinance stated that;

Nothing contained in this ordinance shall be construed to prohibit or prevent the practice of systems of therapeutics according to native methods by persons recognized by the community to which they belong to be duly trained in such practice. Provided that nothing in this section shall be construed to authorize any person to practise native systems of therapeutics except amongst the community to which he belongs, or the performance of an act on the part of any persons practising any such system which is dangerous to life.¹⁴²

The National Health Policy 2007 recognized the role of traditional and alternative medicines as one of the ways of provisioning health care services in the country. The policy acknowledges that about 60 percent of Tanzanians currently use traditional medicine as their first contact for advice and/or treatment of health concerns and recently the good number of people uses alternative medicines.¹⁴³ The Policy further states that the ministry will ensure that the

¹³⁷ *Ibid* at 291.

¹³⁸ Christopher Magola 'Integrating traditional and alternative medicine in healthcare' *the Guardian (Tanzania)* 9 September 2008.

¹³⁹ Stangeland et al, (note 133) at 291.

¹⁴⁰ *Ibid*.

¹⁴¹ World Health Organization 2001, *Legal status of traditional medicine and complementary/alternative medicine: A worldwide review*, Geneva 2001 at 37.

¹⁴² Section 53 of the Ordinance.

¹⁴³ The National Health Policy 2007 at 32.

traditional and alternative health practitioners will be accountable to their own prescriptions, remedies and therapies.¹⁴⁴

In 2002 Parliament passed the Traditional and Alternative Medicine Act, 2002,¹⁴⁵ which repealed and replaced the old laws. The Act establishes the Council to be known as the Traditional and Alternative Health Practice Council.¹⁴⁶ The functions of the council include among others, supervising and controlling the practice of traditional and alternative health practitioners and publishing newly registered practitioners and other necessary issues.¹⁴⁷

The Council, when performing its duties under this Act, particularly when issuing instructions or directions in connections to the matters pertaining to the quality, efficacy and safety in herbal medicine and herbal drug, shall consult first with other institutions or bodies and whose functions are related or similar to those specified under this Act.¹⁴⁸

The law empowers the council under section 7 (1) of the Act to censure, suspend from practice or remove from the roll an aide or de-register a traditional health practitioner or alternative health Practitioner who is found guilty of a profession misconduct or convicted of a criminal offence or has done anything that has lowered the estimation of the traditional or alternative medicine integrity. In addition the council has powers to inspect and scrutinize practising premises of practitioners; grant or refuse to grant recognition of practitioners; remove any member of the Committee and Secretariat; terminate or suspend operation, permit or professional certificate to practice as aide or traditional or alternative health practitioner and revoke permits to premises performing illegal practices.

Moreover, a person can not act as a traditional or alternative practitioner unless has been registered pursuant to the provisions of section 14 of the Act. The law is to the effect that before person is registered as traditional practitioner is required to present to the Registrar any relevant identification documents and a written statement from the local government authority within

¹⁴⁴ The National Health Policy 2007 at 67 recognised the need of alternative treatment.

¹⁴⁵ Act No 23 of 2002.

¹⁴⁶ Section 4 (1) of Act No 23 of 2002.

¹⁴⁷ Section 6 (1) of Act No 23 of 2003 provides for the functions of the Council.

¹⁴⁸ Section 6(4) of Act No 23 of 2002.

which he is practicing.¹⁴⁹ The duty of registration is imposed in the office of the registrar appointed as per section 10 of the Act who among other functions is the secretary of the Council. The qualifications for one to be registered are provided for under sections 15 and 16 of the Act. The Act further prohibits a person registered to practice witchcraft and any other practice likely to be dangerous to health or life of another person.¹⁵⁰

The Act imposes duties on the part of the traditional and alternative health practitioners to attend and treat their patients with clear knowledge, skills and right attitude. In so doing every traditional and alternative health practitioner is duty bound to ensure to be compatible with the traditional and alternative health profession; does not conduct professional misconduct; adheres the traditional and alternative health ethics and professional etiquettes as well as confidentiality aspects of his patients; transfers difficult cases to hospitals or other practitioners; of keeping records to all cases attended by him and observes cleanness of himself, appliances used and premises under which the service is rendered.¹⁵¹

Under the Act it is an offence for a person to practice as traditional health practitioner or aide, or practice as alternative health Practitioner or aide without being registered or enrolled, and such a person may be convicted to a fine or imprisonment as per section 45 (1), (2) and further that section 45 (3) empowers the trial court to order any traditional medicine remedies or diagnostic instruments or appliances used by or belonging to or found in Possession of a person convicted, be forfeited, destroyed or otherwise disposed of. In January 2009, the government officially banned traditional healers in an attempt to stop the killing of albinos for medicine.¹⁵² The ban came after the report that at least 40 albinos have been murdered in Tanzania since mid-2007, many of them hacked to death in front of their families, and their legs, breasts, genitals and other parts carried off.¹⁵³

Generally, the Act is substantially comprehensive in as far as practicing as traditional practitioner and alternative practitioner as it requires before registering as traditional health

¹⁴⁹ Section 14 (1) of Act No 23 of 2002.

¹⁵⁰ Section 30 of Act No 23 of 2002.

¹⁵¹ Section 35 of Act No 23 of 2002.

¹⁵² Donald G. Mcneil Jr. 'Tanzania: Government Bans Traditional Healers to Try to Save the Lives of Albinos' New York Times, January 27 2009.

¹⁵³ Ibid.

practitioner one to be approved by a letter from the local government. The government is committed to formulate guidelines for traditional and alternative practices and TBAs in collaboration with the stakeholders.¹⁵⁴ The World Health report 2000 acknowledges that such traditional public health activities as health promotion and disease prevention, and other health enhancing interventions like road and environmental safety improvement, are also part of the health care system.¹⁵⁵

Notwithstanding, despite the usefulness of traditional healers some of the western trained people and especially physicians seems to down play traditional health practices. This is one of the obstacles likely to occur during collaboration between traditional healers and formal physicians.¹⁵⁶ This has been caused by the fact that during colonialism cooperation between TMPs and the health sector did not exist in Tanzania as in most other African countries.¹⁵⁷ However the study has revealed the existence of cooperation between traditional healers and formal physicians such as the cooperation between Tanga AIDS Working Group (TAWG) and the regional as well as district hospitals in Tanga region.¹⁵⁸ TAWG is an interdisciplinary group, which includes conventional physicians, service providers, traditional healers, patients, social scientists and botanists and the organisation collects plant medicines from traditional healers and distributes the medicines to their patients.¹⁵⁹ The objective of TAWG is to reduce transmission of HIV and assist people with AIDS.¹⁶⁰

2.5 Conclusion

Access to health care services varies geographically, but on average, the rural population in Tanzania tends to be closer to health facilities than the rural population in neighbouring countries.¹⁶¹ There is a need to strengthen the relationship between public and private health care in Tanzania. The existing health system has certain problems which need to be solved by

¹⁵⁴ The National Health Policy 2007 at 32.

¹⁵⁵ WHO (note 30) at 5.

¹⁵⁶ Edmund J Kayombo et al, 'Experience of initiating collaboration of traditional healers in managing HIV and AIDS in Tanzania', *Journal of Ethnobiology and Ethnomedicine* 2007 at 8.

¹⁵⁷ Stangeland et al, '(note 133) at 296.

¹⁵⁸ Ibid.

¹⁵⁹ Ibid.

¹⁶⁰ Ibid.

¹⁶¹ Mahmud Khan et al, 'Geographical aspect of poverty and health in Tanzania: does living in poor area matter?' *The London school of Hygiene and Tropical Medicine and the Oxford University Press*, 12 December 2005 at p 111.

comprehensive policy and laws. Public health sector is features by inequalities in geographical distribution of health facilities in the country. In addition, lack of human resources, problems in access to essential medicines and HIV/AIDS affect access to health care system in the country. Private health sector though is taken as the partner to the public sector in the provision of health services has failed to stand on its own as it depends on the human resources from public sector. Despite of an increased use of traditional and alternative health services in the country, still there is no cooperation between traditional health practitioners and western trained physicians. Also, local governments have failed to facilitate the registration of traditional practitioners which ultimately caused presence of traditional healers who are involved in witchcraft in the society. Despite of an increased population and disease burden, the public health sector system faces a constant or declining real budget allocation. Sustainable health care systems are built on reliable access to human, capital and consumable resources. Securing these inputs requires financial resources to pay for investment in buildings and equipment, to compensate health service staff for their time and to pay for drugs and other consumables.¹⁶²

¹⁶² Elias Mossialos and Anna Dixon, 'Funding health care: an introduction' in Elias Mossialos et al (eds) *Funding health care: options for Europe*, European Observatory on Health Care Systems series World Health Organization 2002 at 1.

CHAPTER THREE

HEALTH SECTOR REFORM

3.1 Introduction

Health sector reform has been defined as sustained, purposeful change to improve the efficiency, equity and effectiveness of the health sector.¹⁶³ The Health Sector Reforms are in the following dimensions: decentralisation of health services; financial reforms, such as enhancement of user-charges in government hospitals, introduction of health insurance and community health funds and public/private partnership reforms such as encouragement of private sector to complement public health services.¹⁶⁴ Primary health care was adopted as the most cost-effective strategy to improve health of the people.¹⁶⁵

Prior to the year 1994, the government did not have health care reform strategy. Health service reform was formally considered as an integral part of development plans.¹⁶⁶ The government approved the first five year development plan (1964-1969) with section of health.¹⁶⁷ One of the goals of this plan was to establish a regional hospital, to provide specialist and surgical medical care in all regions.¹⁶⁸ The second five year plan was developed after Arusha declaration (1969-1974) which emphasized the policy of self reliance.¹⁶⁹ The plan focused on preventive services to curb the spread of communicable diseases.¹⁷⁰ The third five year development plan (1976-1981) aimed at the provision of clean water, health services in urban and rural areas and to provide Universal Primary Education (UPE).¹⁷¹ The objectives were vital in the implementation of the Primary Health Care approach which were declared internationally at Alma-Ata USSR in 1978.¹⁷²

¹⁶³ Jane A Thomason, 'Health sector reform in developing countries: a reality check' (undated) at 2.

¹⁶⁴ The United Republic of Tanzania (note 5) at 16.

¹⁶⁵ *Ibid.*

¹⁶⁶ National Health Policy 1990 at 1.

¹⁶⁷ *Ibid.*

¹⁶⁸ *Ibid.*

¹⁶⁹ *Ibid* at 2.

¹⁷⁰ *Ibid.*

¹⁷¹ *Ibid* at 3.

¹⁷² The priorities of the Primary Health Care are set at page 3 of the National Health Policy 1990.

In the process of decentralising public health functions the government concentrated on the rapid growth of the public health sector between 1972 and 1980, with its emphasis on rural development and expanded services in education, health, water and other social services in the rural areas.¹⁷³ However, in the 1980s, the country found itself in an economic slump, the demands of an expanded health sector could not be met, and shortages, dilapidated structures and inadequate services became the norm.¹⁷⁴ In response, the Government decided that the focus should be to strengthen district health services, which required devolution of power from the centre to the district. Such shifts of power, of course had to be accompanied by the strengthening of management capacity at each level.¹⁷⁵ The health sector reform went hand in hand with the Public Service Reform Programme which were initiated in 1992, with a view of addressing the roles and functions of public services in the context of a liberalised and market-oriented economy. Health Sector Reforms (HSR) started in 1994 aimed at improvement of access, quality and efficiency health service delivery.¹⁷⁶ This chapter attempts to address reforms adopted by the government to improve health care system focusing on the introduction of primary health care system, the decentralisation of health care activities and the poverty eradication strategies.

3.2 Primary Health Care (PHC)

In the 1960s and 1970s, China, Tanzania, Sudan and Venezuela initiated successful programs to deliver a basic but comprehensive program of primary care health services covering poor rural populations.¹⁷⁷ From these programs came the name “primary health care”. In 1978, the Alma-Ata conference formulated the Primary Health Care (PHC) strategy to achieve ‘Health for-All by the year 2000’ on a global basis. The conference which was organized by WHO and UNICEF, greatly influenced national policies in improving and expanding health services. The Alma-Ata Declaration defined PHC as:

[E]ssential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost the

¹⁷³ Mtei et al, (note 17) at 18.

¹⁷⁴ Ibid.

¹⁷⁵ Ibid.

¹⁷⁶ The United Republic of Tanzania (note 5) at 16.

¹⁷⁷ John J Hall and Richard Taylor, ‘Health for all beyond 2000: the demise of Alma-Ata Declaration and primary health care in developing countries’, *MJA* Vol 178 6 January 2003 at 17.

community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process — Alma Ata Declaration, 1978.¹⁷⁸

In the primary health care definition one important notion arises that is, “essential health care”. What this essential health care entails differs from country to country, but includes, according to the Alma-Ata Declaration; universal coverage of basic services such as education on methods of preventing and controlling prevailing health problems; promotion of food security and proper nutrition; adequate safe water supply and basic sanitation; maternal and child health, including family planning; vaccination; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs.¹⁷⁹ Three prerequisites for successful Primary Health Care were identified as: A multisectoral approach, community involvement and participation and appropriate technology.

A multisectoral approach is a principle linking health provision to other aspects of socio economic development that are closely related to health.¹⁸⁰ Health is often determined by other sectors; such as, sectors dealing with water, sanitation and housing. While health affects development and the HIV/AIDS epidemic continues to have a disastrous effect on the economically active section of the population hence threatening development, in achieving PHC goals the need to link health sector with other sectors is of paramount importance.

Community involvement is vital in PHC where the emphasis changed from the larger hospital to that of community- based delivery of services with a balance of cost effective preventive and curative programs. The community, through its leaders, should be involved in the planning and implementation of its own healthcare services through Community Primary Health

¹⁷⁸ Declaration of Alma-Ata. (note 134)

¹⁷⁹ Hall and Richard Taylor, (note 177) at 9-18.

¹⁸⁰ Rufaro Chatora and Prosper Tumusiime, ‘Health sector reform and district health systems: District health management team training modules’, Module 1, World Health Organization, Regional Office for Africa, Brazzaville 2004 at 6.

Committees.¹⁸¹ The village leadership was required to make regular check on the health facilities to ensure security of drugs and supplies.¹⁸² In addition, the community was motivated to participate in the construction and maintenance of health facilities.¹⁸³

With regard to appropriate technology, PHC depends on practical, scientifically sound and socially acceptable methods and technology; a kind of technology that best fits the local situation in all respects.¹⁸⁴ Studies have further shown that traditional health practices including services rendered by Traditional Birth Attendants may be much more acceptable in some communities than modern health services. To achieve the provisioning of PHC, the integration of these traditional practices to the district health services and/or providing them with required technology to perform their practices is very important for the achievement of the PHC goals.

3.2.1 Challenges of PHC

After Alma Ata conference, PHC was put under attack, politicians and aid experts from developed countries could not accept the core PHC principle that communities in developing countries would have the responsibility of planning and implementing their own healthcare services.¹⁸⁵ A new concept of “Selective Primary Health Care” (SPHC)¹⁸⁶ was later advocated providing only PHC interventions that contributed most to reducing child below five years mortality in developing countries.¹⁸⁷ SPHC reintroduced vertical programs at the cost of comprehensive PHC.¹⁸⁸

Currently in Tanzania the achievement of the PHC has not yet been realized as many ordinary people felt PHC was a cheap form of healthcare and, if they were able to, they bypassed this level to attend secondary and tertiary centres because of a lack of staff and essential medicines at the PHC level.¹⁸⁹ Natural disasters and, especially, HIV and AIDS affected the

¹⁸¹ National Health Policy 1990 at 8.

¹⁸² Ibid.

¹⁸³ Ibid.

¹⁸⁴ Chatora and Prosper Tumusiime, (note 180) at 7.

¹⁸⁵ Hall and Richard Taylor, (note 177) at 18.

¹⁸⁶ K. Warren, ‘The evolution of selective primary health care’. *Soc Sci Med* 1988; 26: 891-898.

¹⁸⁷ Hall and Richard Taylor, (note 177) at 18.

¹⁸⁸ Unger J Killingsworth J, ‘Selective primary health care: a critical review of methods and results’ *Soc Sci Med* 1986; 22: 1001-1013. See also Werner D. Health hazard: user fees. *New Internationalist* 2001; 31(Jan): 22-23.

¹⁸⁹ Hall and Richard Taylor, (note 177) at 18.

ability of PHC to maintain comprehensive services.¹⁹⁰ Since the outbreak of the epidemic in 1980s the government shifted its efforts by embarking on the researches and formulation of the policies as well as strategies to combatting the outbreak which led to the failure of PHC.

Since it has been the requirement that states have to adopt the PHC for the provisioning of health care, the 1990 National Health Policy substantially covers PHC but until recently the government has been quoted admitting the failure to reduce infant mortality. Politicians saw PHC as a way of reducing expenditure in health and lacked the political will to ensure that services were equitably shared and distributed.¹⁹¹ Most healthcare resources continue to be directed to the large urban-based hospitals.

3.2.2 Future prospects

In 2007 the MOHSW developed the Primary Health Care Service Development Programme (PHCSDP) (2007-2017) addressing the revised Health Policy and the health related Millennium Development Goals in the areas of maternal health, child health and priority diseases.¹⁹² PHCSDP aims at accelerating the provision of primary health care services for all by 2012, while the remaining five years of the programme will focus on consolidation of achievements.¹⁹³ The main areas will be strengthening the health systems, rehabilitation, human resource development, the referral system, increase health sector financing and improve the provision of medicines, equipment and supplies.¹⁹⁴

However, with the existing policies, strategies and legal framework, the government has failed to protect infant and maternal mortality. In the period 1999 to 2005, infant mortality dropped from 99 to 68 per 1,000 live births, and under-five mortality dropped from 147 to 112 per 1,000 live births.¹⁹⁵ It is MKUKUTA's target that by 2010 the under-five mortality rate will

¹⁹⁰ Hall and Richard Taylor, (note 177) at 18.

¹⁹¹ Ibid.

¹⁹² United Nations: United Nations Millennium Declaration: New York: United Nations, 2000; three amongst eight millennium goals were related to health thus from 24-27 April 2001 the members of OAU met in Abuja Nigeria for a special summit addressing challenges of HIV/AIDS, tuberculosis and other related infectious diseases hence the passing of Abuja Declaration.

¹⁹³ The United Republic of Tanzania (note 5) at 18.

¹⁹⁴ Ibid.

¹⁹⁵ Poverty and Human Development Report of 2007, at 32.

be 79 out of 1,000 live births.¹⁹⁶ If Tanzania can achieve the goal set in MKUKUTA, it is possible that it will meet the 2015 MDGs of 48 deaths per 1,000 live births. In Tanzania, the lifetime risk of maternal mortality is one in ten.¹⁹⁷ The government also announced that services in government hospitals to expectant mothers and infants or children below five years of age would be provided free of charge.¹⁹⁸ However, in the recent MDGs report titled, "Tanzania Mid-way Assessment at Glance," reported the country to be off-the track in achieving most of the MDGs.¹⁹⁹ Goals and sub-goals that are unlikely to be achieved by 2015 deadline include halving proportion of population below basic needs poverty line, under five children who are underweight and under-five stunted children.²⁰⁰ Others include halving maternal mortality rate, births attended by skilled health personnel and access to portable water as percentage of rural population.²⁰¹

The government efforts' to provide the PHC will be achieved if the proposed PHCSDP (2007-2017) will achieve its objectives by addressing the increase of the workforce in health by increasing the throughput in the existing training institutions by 100%, upgrading 4 schools for enrolled nurses, production of health tutors and upgrading the skills of existing staff by providing information and technology skills and acquiring new medical technology.²⁰² The rehabilitation of existing health facilities and construction of new ones which is planned as well as improving the outreach services by maintenance of 8,107 primary health facilities, 62 district hospitals, 128 training institutions by year 2012 as provided by the programme is likely to achieve the expectation of the people.²⁰³ This programme which caters for the fulfillment of 2025 MDGs is estimated to cost around 11.8 trillion TSH, which is beyond the current available budget range.²⁰⁴ Therefore if no innovative modalities of financing the proposed programme then the government is likely to witness the failure of this programme which is the second effort to see PHC is attained by Tanzanians after the failure of PHC programmes which were introduced after the Alma-Ata Conference.

¹⁹⁶ Ibid.

¹⁹⁷ Save the Children, 'State of the World's Mothers 2007' (May 2007). <<http://www.savethechildren.org>>

¹⁹⁸ C. John 'Probe mothers' deaths at hospital, NGO urges' *The Citizen* (Tanzania) 5 June 2008.

¹⁹⁹ Faraja Mgwabati, 'MDGs: Tanzania is off the track' *Daily News* (Tanzania) 18 January 2010.

²⁰⁰ Ibid.

²⁰¹ Ibid.

²⁰² The United Republic of Tanzania (note 6) at 18.

²⁰³ Ibid.

²⁰⁴ Ibid.

One of the diseases posing a great challenge in the attainment of PHC is malaria. In fighting the disease the government has introduced the Rapid Diagnostic Test (RDT) kit for malaria as part of efforts aimed at reducing deaths related to the killer disease by 80 per cent by 2013.²⁰⁵ The RDTs are reliable and easy to use, particularly for health workers in situations where services are deficient or poor.²⁰⁶ They can serve as an epidemiological tool for the rapid screening of the disease, giving prompt results.²⁰⁷ The introduction of the new test is one of the government initiatives to ascertain that a patient has malaria parasites before starting treatment.²⁰⁸ The use of RDT has been introduced in Dar es Salaam region. Iringa, Kagera and Coast regions have been identified as pilot sites for the initiative but the kits will be distributed to the rest of the regions by the end of this year.²⁰⁹

3.3 Local Government Reform and Decentralization by Devolution

In October 1994, the Social Sector Strategy sought to increase resource allocation to the social sectors, decentralise authority to local level, promote high quality standards and higher private sector participation, and move resources closer to the households.²¹⁰ In December 1994, the government further articulated its vision for the reform of the health sector in the Proposals for Health Sector Reform where the government redefined its role in the health care system from one of dominant provider, to the facilitator.²¹¹ The goal was to have local government authorities that were closer to the residents provide prompt health services to the community by means of decentralization of the health sector. The Cabinet approved the Proposals for Health Sector Reform of December 1994 in March 1996.²¹² The process of decentralization of health care services in the country took place in the following dimensions;

Political decentralization involved devolution of powers from the central government to the district councils by enabling districts to have powers and authority to plan, prioritise and

²⁰⁵ Edwin Agola, 'Plan to reduce malaria deaths by 80% ready', the Guardian (Tanzania) 15th January 2010

²⁰⁶ Ibid.

²⁰⁷ Ibid.

²⁰⁸ Ibid.

²⁰⁹ Ibid.

²¹⁰ Olivier Burki, Sector-Wide Approach in Tanzania: The Health Sector Example: Observations From A Bi-Lateral, February 2001 at www.sdc-health.ch/.../health/.../sector-wide_approaches.../sector-wide_approach_in_tanzania visited on 17/12/2009

²¹¹ Ibid at 12.

²¹² Ibid at 13.

allocate resources.²¹³ In so doing the central government remained with the role of policy making and facilitation.²¹⁴ This went hand in hand with the introduction of the Ministry of Regional Administration and Local Government (MRALG) under the Prime Minister's Office, power was devolved to local government authorities.

Administrative decentralization took the form of de-linking local government staff from their ministries.²¹⁵ The District council was the only authority to hire, remunerate, discipline and fire the staff.²¹⁶ The District, Town and Municipal Health Councils were established, led by council chairpersons elected among, and by, ward councillors.²¹⁷ The District Medical Officer (DMO) who was prior to the changes in charge of health sector was now made to report to the Council's Executive Director (CED) [sometimes known as District Executive Director—DED], who, is a Presidential appointee, and the Secretary of the Council Meetings.²¹⁸

Similarly, the Regional Medical Officer (RMO) who was in charge of the administration of health services at the regional level was made to report to the Regional Administrative Secretary (RAS) on administrative matters concerning health.²¹⁹ The DMO and RMO however remained in charge of medical services at the council and the regional levels respectively, by continuing to report to the (MOHSW) headquarters only on technical issues.²²⁰ In general the change which was formed after the adoption of decentralisation by devolution has brought technical and complex system of administration of health services in the local level. The complexity of health care administration at the district and regional level is caused by the factor that while the DMO and RMO posts are assigned at the MOHSW headquarters, survival of the

²¹³ Innocent A. J. Semali, "Understanding Stakeholders' Roles in Health Sector Reform Process in Tanzania: The Case of Decentralizing the Immunization Program" Genehmigt von der Philosophisch-Naturwissenschaftlichen Fakultät der Universität Basel auf Antrag von, Basel, 2003 at 10.

²¹⁴ *Ibid.*

²¹⁵ *Ibid.*

²¹⁶ *Ibid.*

²¹⁷ Godfrey Mubyazi, et al, 'Implications of decentralization for the control of tropical diseases in Tanzania: a case study of four districts; *International Journal of health planning and management* 2004; 19: S167–S185 at 167-168.

²¹⁸ *Ibid.*

²¹⁹ *Ibid.*

²²⁰ *Ibid.*

²²⁰ *Ibid.*

posts is a political issue as it is subject to meeting the interests and expectations of the CEDs, ward councillors and regional and local government administrative authorities.²²¹

The management and administration of health services has been devolved to districts through their respective standing committees. The Local Government (District Authorities) Act, 1982²²² establishes the District Council standing Committee and the Township authority Standing Committee on health, education and water.²²³ Meanwhile the Local Government (Urban Authorities) Act, 1982²²⁴ gives the council the power to establish standing committee on economic affairs, health, and education.²²⁵ The Council Health Management Team (CHMT), in cooperation with stakeholders from other key sectors such as water, agriculture, environment and education, were given task to develop comprehensive health plans in conformity with guidelines provided by the government in 2001. According to the guidelines CHMT is formed as per section 86A of Act No 7 of 1982, section 155 of Act No 7 of 1982 and section 52 A of Act No 8 of 1982 as amended in the year 1999. It stipulates that a district, town and municipal council may, for the purposes of discharging its functions establish by instrument published in the gazette, a service board for provisions of services within its areas of jurisdiction.²²⁶

From these changes the government through the MOHSW and MRALG has remained the overseer, the administration of provisioning of the health services after decentralisation has been put in the hands of the CHMT which comprises of eleven members who are divided into two groups; members with right to vote and those without right to vote.²²⁷

Further that decentralization of provisioning of health services took the form of financial decentralization which enabled district councils to levy local taxes to meet the obligations to

²²¹ Ibid.

²²² Act No 7 of 1982.

²²³ Section 74 and 96 of Act No 7 of 1982 as amended by the Local Government (Miscellaneous Amendments) Act No 9 of 1999.

²²⁴ Act No 8 of 1982

²²⁵ Section 42 (1) (b) of the Local Government (Miscellaneous amendments) Act no 6 of 1999.

²²⁶ Section 86A (1) of Act No 7 of 1982 as amended, the same powers are exercised by the Town councils under section 155 of Act No 7 of 1982. Further that section 52 A of Act No 8 of 1982 as amended in 1999 provides for the exercise of the power of urban authorities.

²²⁷ The Government of the United republic of Tanzania, Guidelines for the Council Health Management Team, The Ministry of Health and the Ministry of Regional Administration and Local Government, 2001 at 2 available in www.government.go.tz/ministries/documents.

render social services to the people in the district.²²⁸ At the Council level a separate health sector account is maintained (account number 6), where earmarked funding for health is kept.²²⁹ Central government grants were to top up funds from local rates and alternative sources to finance the health services i.e. cost sharing, and establishing health insurance schemes. The financing of district health services improved, with increase in government funding and Health Basket funding.²³⁰

The MOHSW and the MRALG in their guidelines have directed the councils to form District Hospital Committee with the role of ensuring residents get suitable health services and the availability of resources in administration of hospital.²³¹ Other committees include Health Centre Committee, the Ward Health Committee and the Health Committee of the Dispensary.²³² It should be noted the Ward Health Committee members include the Councillor, the Ward Executive Officer, one head teacher from the schools of that ward, two community members one of whom should be female, the head of Health centre and a member from the community appointed by the Ward Development committee.²³³

The health sector reform has decentralised the provision and administration of the health services, however, the current government's terms of reference defining the powers of the CHMT/DMO's office and CED's office seem to be vague, contributing to existing overlaps or by-passes between the two offices in arriving at particular decisions.²³⁴ Delegation of planning and managerial powers should be made real, and one way towards achieving this is to have adequate training of all the key players from the CHMT level through to health facility and village levels on realistic planning for and their participation in the control of diseases.²³⁵ This is important because there is a situation whereby the local authority has to report to the Council at the same time it reports to the MOHSW.

²²⁸ Semali (note 213)

²²⁹ The United Republic of Tanzania (note 5) at 22.

²³⁰ The Health Basket Fund (HBF) is a joint funding mechanism which was created in June 1999 as part of the SWAP approach. It consists of the central basket and the district basket and the sources of the funds are from the central government, local government and basket donors.

²³¹ The Government of the United Republic of Tanzania (note 227) at 20.

²³² *Ibid.*

²³³ *Ibid* at 30.

²³⁴ Mubyazi, et al, (note 217) at 182.

²³⁵ *Ibid.*

There is also a possibility of limitation in the actual degree of decentralization. The central level maintained tight control through, for example, the budget ceilings, the guidelines' requests for national packages of health care and the impact of the vertical programmes.²³⁶ Where the funds are not from the Council instead from the MOHSW, the community allegiance was naturally placed where the financial resources came from and a routine has been that the report to the financing authority is prepared by way of cut and paste operation aiming at 'feeding the beast', that is, providing the MOHSW/Basket Committee with what is wanted in order to ensure a continued flow of funds and then proceed with business as usual.²³⁷ Thus with this system, though decentralisation aimed at facilitating the provision of health services in the district level by empowering the local governments the trend has become a means of getting funds, rather than making a difference in health in the district.²³⁸

Despite the fact that there is decentralisation and the CHMT are supposed to administer, plan, and respond to the local needs the national priority diseases with global programme backing, i.e. malaria and TB came out as high priority in almost all districts, which is more or less in accordance with the perceptions of the need, both in the community and in the CHMT.²³⁹ After decentralisation one would expect that the CHMT should focus on the community diseases rather than national and global programme. It is not possible for all districts in Tanzania to advocate for the fighting and prevention of say, malaria and TB. There are some districts where eye related diseases and AIDS are the major problems. With these differences after decentralisation CHMT could focus on the local needs rather than basing on the national and global programmes.

3.4 National Poverty Eradication Strategy

The National Strategy for Growth and Reduction of Poverty (NSGRP) was launched in 2005 and is the guiding national strategy on reducing the growth of poverty in Tanzania. It emphasises the improvement of survival, health and well being of all, in particular women and children and other vulnerable groups.²⁴⁰ In tackling existing health system problems, the NSGRP addresses

²³⁶ Ibid.

²³⁷ Ibid.

²³⁸ Ibid.

²³⁹ Ibid at 181.

²⁴⁰ The United Republic of Tanzania (note 6).

issues of finances and infrastructure together with human and logistic weaknesses. An essential component of the strategy is to reduce the income poverty of both men and women in rural areas and increase sustainable off-farm income generating activities. The target is to reduce the proportion of the population who are below the basic needs poverty line from 39 % in 2001 to 24 % by 2010; and those below the food poverty line from 27 % in 2001 to 14 % in 2010.²⁴¹

Despite the fact that NSGRP emphasises improvement of survival, health and well being for all, the Minister for Finance in the National Budget speech said that research has revealed the failure of the government in fulfilling the goals of NSGRP to reduce infant and maternal mortality.²⁴² From the statement of the minister for finance it is clear that though the government is always coming with reforms and policies in addressing the primary health care from the 1970s, there have been failures in achieving this strategy. The Financial year 2008/2009 has recorded failures in achieving primary health care in the country. This failure was recorded while the country was in the process of implementing NSGRP, Health Sector Strategic Plan II²⁴³ and the National Health Policy 2007.

3.5 Conclusion

The primary health care and decentralization of health care provisioning to the local government level are the central issues in the reform of health care services in Tanzania. Another aspect is the financing of health care services by way of statutory and micro insurance schemes.²⁴⁴ In as far as PHC the Health Sector Strategic Plan III has come up with a programme which if well managed the country will achieve for the first time to have the provisioning of PHC services to all districts in the country. However, the decentralization process requires more attention from both the government and stakeholders from the local government level because; first of all there are no unified laws binding the local government authorities in case they fail to fulfill the goals of health care decentralisation. Also the government is required to conduct sensitising seminars to the local government members who are part of Regional Hospital Health Committee, CHMT,

²⁴¹ Ibid.

²⁴² The United Republic of Tanzania, the speech by the Minister of Finance and Economic Affairs Honourable Mustafa Haidi Mkulo on the government budget estimates for the financial year 2009/ 2010 at 26.

²⁴³ See The United Republic of Tanzania, Ministry of Health, second health sector strategic plan (HSSP) (July 2003- June 2008) 'Reforms towards delivering quality health services and clients satisfaction' Ministry of Health, April 2003

²⁴⁴ This will be covered under chapter four of this study.

Ward Health Committee, and Health Centre Health Committee on their roles in the improvement of health care deliveries in their areas. Although the guidelines released by the MOHSW and MRALG mentions the composition of the teams there is also the need to educate the members on their powers and duties in the improvement of health care delivery because instead of being creative in fighting the diseases in their areas they are still relying on the national and global programmes.

CHAPTER FOUR

HEALTH CARE INSURANCE AND SOCIAL ASSISTANCE IN TANZANIA

4.1 Introduction

This chapter examines the financing of health care services by health insurance which is one of the efforts of health care reform that required the adoption of an alternative means of health care financing due to the failure of the government to provide free health care services. The study will analyse the effectiveness of the National Health Insurance Fund (NHIF) and other schemes which provide for health insurance such as the National Social Security Fund (NSSF) established by the National Social Security Fund Act, 1997²⁴⁵ and the CHF.

This chapter also examines the role played by micro insurance schemes organised by the groups in the society. One of their main objectives is to provide security during the whole year regardless of the season, and to lower the individual burden by risk-sharing within a group of people.²⁴⁶ The micro insurance schemes have been introduced in the rural and informal sector since the income of the people in the informal sector is irregular and even the contingencies like sickness are irregular and unforeseeable. All these will be examined taking into account the problems and achievements faced by these schemes. The chapter will also focus on the social assistance.

4.2 Origin of Health Insurance

Health insurance is one of the components of social security. Social security is suggested to be defined on the basis of an alternative or additional nomenclature that would sufficiently capture the broad range of social security measures as well as chronic forms of deprivation alongside the temporary adversity to which people living in developing countries are exposed rather than making reference to an enumerated list of risks, or focusing on the involvement of the state or in

²⁴⁵ Act No 28 of 1997.

²⁴⁶ Luise Steinwachs, 'Extending health protection in Tanzania, Networking between health financing mechanisms', *ESS Extension of Social Security ESS Paper No 7*, Social Security Policy and Development Branch, International Labour Office, Geneva 2002 at 18.

terms of the aims served by social security generally and/or particular schemes specifically.²⁴⁷ Funding access to health care through social health insurance has its origins from Germany in the nineteenth century.²⁴⁸

Sickness funds organized by the workers for mutual support often attracted support from employers, who saw benefits in their workers having access to better health care.²⁴⁹ Thus, a model arose in which health insurance was provided for some or all the workers in a firm, with much of the control remaining with the workers but with some management and financial input from employers.²⁵⁰ The early sickness funds varied in their structures and governance but were mainly based on mutual support (in which contributions were based on income) and provided access to care based on need. In Germany, under Chancellor Bismarck, the sickness funds were formalized into a broader and more consistent system of health insurance.²⁵¹ This marked the origin of the Bismarckian approach on social security which favours social insurance by advocating mandatory health insurance scheme in terms of which employers and workers were obliged to contribute towards the cost of low paid workers' health insurance.²⁵²

Health financing systems through general taxation or development of social health insurance are generally recognized to be powerful methods to achieve universal coverage with adequate financial protection for all against healthcare costs.²⁵³ The WHO estimates that every year about 100 million people are vulnerable to falling into destitution as a result of unaffordable health care.²⁵⁴ The failure by the government to provide adequate health care at a low or no cost, has led to the use of social (including community-based) health insurance as a good alternative. In tax-funded systems, the population contributes indirectly through taxes, whereas in social

²⁴⁷ Olivier 'the Concept of social security' in Olivier et al *Social security: A legal analysis*, 2003 LexisNexis Butterworths, Durban at 25.

²⁴⁸ Charles Normand and Reinhard Busse, 'Social health insurance financing' in Elias Mossialos et al (eds) *Funding health care: options for Europe*, European Observatory on Health Care Systems series World Health Organization 2002 at 59.

²⁴⁹ *Ibid.*

²⁵⁰ *Ibid.*

²⁵¹ *Ibid.*

²⁵² WHO (note 26) at 4.

²⁵³ Guy Carrin et al, 'Community-based health insurance in developing countries: A study of its contribution to the performance of health financing systems', *Tropical Medicine and International Health* volume 10 no 8 August 2005 pp 799–811 at 799.

²⁵⁴ Wouter van Ginneken 'Extending social security coverage: Concepts, approaches and knowledge gaps', Technical Seminar on the Extension of Social Security Coverage Geneva, 16 October 2008 at 11.

health insurance systems, households and enterprises generally pay through contributions based on salaries or income.²⁵⁵ Under these schemes, members pay a premium to a social security or another (often non-profit) agency in exchange for an agreed entitlement to a defined package.²⁵⁶

Social health insurance has no uniformly valid definition, but two characteristics are crucial. Insured people pay a regular, usually wage-based contribution. Independent quasi-public bodies (usually called sickness funds) act as the major managing bodies of the system and as payers for health care.²⁵⁷ Health insurance allows payments for services to be spread across time and between those insured, and implies cross-subsidization between the healthy and the sick.²⁵⁸

Social health insurance can ensure that people are treated on time and with quality services.²⁵⁹ It also provides a secure and cost-effective protection against the financial consequences of medical treatment and it greatly increases the predictability of household expenditure.²⁶⁰ All these advantages have a direct and positive impact on the income-earning capacity of the household.

4.3 Health insurance in Tanzania

Historically there are various factors which led to the adoption of statutory health insurance in developing countries like Tanzania. Dissatisfaction with the quality and quantity of curative services provided by public systems, along with a growing inability of a substantial proportion of the population to pay for private medical services, often stimulated the debate on whether basic health care should be provided as a right of every citizen.²⁶¹ One option that countries had was to set up a national health service which provides health care as a right of all (or groups of) citizens, and is financed and organized by the government.²⁶² However, with this option, the government of Tanzania has not provided health care as a right since the Bill of rights was enshrined in the Constitution in the year 1984. Health care has remained as the policy directive so if not provided

²⁵⁵ Carrin et al, (note 253).

²⁵⁶ van Ginneken (note 254).

²⁵⁷ Normand and Reinhard Busse, (note 248) at 60.

²⁵⁸ van Ginneken (note 254).

²⁵⁹ Ibid.

²⁶⁰ Ibid

²⁶¹ Wouter van Ginneken, 'Extending social security: Policies for developing countries', *ESS Paper No. 13*, International Labour Office, 2003 at 15-16.

²⁶² Ibid.

by the state cannot be justiciable before the court. The other option is statutory social health insurance, mainly financed by (employers' and employees') contributions, supervised – and often co-financed - by the government, and managed by semi-public or private institutions.²⁶³

The economic crisis which faced most developing countries in the 1980s, made it difficult for the government to maintain its commitment to provide free medical care. As a result the country witnessed deterioration in its economic performance resulting in declining terms of trade.²⁶⁴ There was the increase in oil prices which led to the economic crisis in the country. The result of this economic crisis was the tightening of government budgets, and the government found it difficult to meet the costs of large social sectors, including health.²⁶⁵ The government budget on the health sector was grossly under funded as Donor assistance in the social sector had declined. From this epoch the government started to compromise on the need for universal access to cost-sharing health provision.

In early 1990s, the government adopted new social and economic development policies characterized by the structural adjustment programme, and internal changes in the health sector itself.²⁶⁶ The government redefined its role to be more focused on policy formulation and to increase support to the role of private sector development.²⁶⁷ Along with these changes, the government started to explore alternative sources of health financing such as cost-sharing in public facilities, pre-payment systems and insurance arrangements.²⁶⁸

4.4 The National Health Insurance Fund

The National Health Insurance Fund is established under the National Health Insurance Fund Act, 1999.²⁶⁹ Its membership size as of 2001/2002 was 164,708 and by 2008/2009 the number of members has increased by 99.5 percent making the position of membership as of present to be 328,633 members.²⁷⁰ The NHIF beneficiary position as of 2001/2002 was 691,774, this number

²⁶³ Ibid at 16.

²⁶⁴ Emmanuel Humba, 'Social health insurance implementing social security health care: The experience of the National Health Insurance Fund', ISSA Regional Conference for Africa Lusaka, Zambia, 9-12 August 2005 at 3.

²⁶⁵ Ibid.

²⁶⁶ Ibid at 4.

²⁶⁷ Ibid.

²⁶⁸ Ibid.

²⁶⁹ Section 4 (1) of Act No 8 of 1999.

²⁷⁰ See www.nhif.or.tz/Fact sheet.

has increased to 1,809,671 in the year 2008/2009 thus beneficiaries have increased from 2% to 5.3% of the total population.²⁷¹

Under section 5 of the Act the management and administration of the fund is vested in the board. The scheme is compulsory; it covers all public sector employees. The membership includes principal members their spouses and up to four children and/or legal dependants.²⁷² In the event of both spouses being civil servants, the Board may set criteria for enrolment of more than four children or dependants as beneficiaries under this Act.²⁷³ The scheme has no option for opting out.

The Minister of Health and Social Welfare has been empowered under the existing legislation after consultation with the Board and by notice published in the Gazette, any other category of public servant to be a member of the Fund and the type, of benefit package which may be granted to the beneficiary of the Fund.²⁷⁴ The contribution rate provided in the Act establishing the Fund is three per cent of employee's salary and three per cent contribution from the employer to the Fund.²⁷⁵ The Board may, under an order published in the Gazette, vary the rate of the contributions as it may deem proper.²⁷⁶ The Act provides for a penalty of 5% to the Employer who delays in remitting contribution to the Fund.²⁷⁷

Under section 15 of Act No 8 of 1999, the Fund is obliged to issue an identity card to any beneficiary for identification, verification and utilization recording purposes. The law requires the issuance of the identity card to be accompanied by an explanation to the enrolled of his rights, privileges and obligations and a list of health care providers accredited by the Board shall be likewise attached thereto. Likewise the Fund is required to produce identity cards and distribute them to employers so that they can be handed over to members.²⁷⁸ The Fund devised a special NHIF "sick sheet" to be used with the employers' identity cards whenever members

²⁷¹ Ibid.

²⁷² Section 11 (1) of Act No 8 of 1999.

²⁷³ Section 11 (2) of Act No 8 of 1999.

²⁷⁴ Section 2(2) of Act No 8 of 1999 as amended by Act No 25 of 2002.

²⁷⁵ Section 9 (1) and (2) of Act No 8 of 1999.

²⁷⁶ Section 10 of Act No 8 of 1999.

²⁷⁷ Section 45(1) of Act no 8 of 1999.

²⁷⁸ AD Kiwara et al, Review of claims status for the National Health Insurance Fund Phase One May 2006 at 15 available on www.districthealthservice.com/cms/upload/policycat_151_4124.doc (Accessed 27 November 2009).

require accessing services from the accredited health facilities.²⁷⁹ As of 2001/2002 the Fund had produced and distributed 183,764 identity cards, the number of identity cards distributed to the beneficiaries increased to 1,263,380 in the year 2008/2009 which indicates that, 70 per cent of the total beneficiaries have been issued with Identity Cards.²⁸⁰

To avoid the abuse of the use of the NHIF identity cards, section 15 of Act No 8 of 1999 was amended in the year 2002 by adding sub sections (3), (4) and (5) which impose duties on the member to collect identity cards from his children, who have attained the age of eighteen years, or dependants who cease from being lawful beneficiaries of the Fund and surrender them to the employer. The employer is required under the amended section to collect all the identity cards from the employees who ceased from being members of the Fund together with those of the children and dependants submitted to him by a member, and submit them to the Director General. The fund is entitled to recover the expenses incurred by failure to fulfil the requirements of section 15 (3) and (4).

The fund issues identity card to the beneficiaries so as to access health care services from the accredited providers. It follows therefore that no beneficiary can have access to health care services without the NHIF identity card. There are plans in place to revamp all the existing ID cards.²⁸¹ NHIF coordinators working in or with the CHMT should facilitate that all eligible NHIF members have membership cards to avoid failure to access health services by NHIF members.

The Act makes it clear that any member who has become a public servant²⁸² and whose contributions have been paid for three months after the coming into operation of the Fund shall be entitled to the benefit package under the Fund.²⁸³ According to section 14A (1) of Act No 8 of 1999 as amended in 2002, death of a member, termination from employment, retirement from employment; dismissal from employment; or any other act that may terminate the employment of a member are circumstances which lead to the end of membership of the fund.

²⁷⁹ Ibid.

²⁸⁰ www.nhif.or.tz//fact sheet.

²⁸¹ Kiwara 'et al'(note 278) at 15.

²⁸² Section 3 of Act No 8 of 1999 as amended by Act No 25 of 2002 defines 'public servant', to extend to and includes every person holding a public office invested with or performing duties of public nature, whether control of a local government authority but does not include a person holding such office only on part time basis.

²⁸³ Section 12 (1) and (2) of Act No 8 of 1999.

The NHIF provides a wide range of portable medical care benefits within mainland Tanzania.²⁸⁴ However according to the law, personal health service benefits granted to a beneficiary shall be the inpatients hospital care fee consisting of a fixed sum determined by the Board and the outpatient care consisting of drugs and medicine in generic prescription in accordance with the Essential Drug List unless an explicit exception is granted by the Fund.²⁸⁵ Further that, if the actual fees for inpatient hospital care exceed the fixed sum determined by the Board the difference of that amount shall be paid by the beneficiary. All costs not included in associated costs other than the costs referred to in paragraph (b) of subsection (1) shall be paid by the beneficiary.²⁸⁶

To avoid problems on the health care services covered by the NHIF, especially on the excluded services the parliament revisited section 17 of the Act which listed excluded services by the fund and repealed the whole section. The position of the law as amended by the Written Laws (Miscellaneous Amendments) (No 2) Act of 2005 is to the effect that the minister may, upon recommendation by the Board, prepare a list of health care services that may not be granted under this Act. This amendment is very important as it instead of waiting for a long time for the complained list to be amended by the parliament the power is vested to the minister thus easier for the board of the fund to take care of the members' complaints.

4.4.1 Accreditations

Accreditation is a process of assessing health institutions against a commonly accepted set of standards and in case of Tanzania, there are; standard treatment guidelines and standard facility guidelines.²⁸⁷ The very purpose of accreditation is to ensure that members access services from providers who have proved to offer quality services.²⁸⁸ The NHIF in principle requires that all health care providers who wish to register with the fund for providing services to its members be accredited. The authority to grant accreditation to a health care provider is vested into the

²⁸⁴ Humba (note 264) at 8.

²⁸⁵ Section 16 (1) (a) and (b) of Act No 8 of 1999.

²⁸⁶ Section 16 (2) and (3) of Act No 8 of 1999.

²⁸⁷ Emmanuel Humba 'Assuring Quality Health Care through Social Health Protection: The Role of Purchasing and Quality Management: Meeting set standards and Quality Management as Contractual Obligation,' Kigali, 31 October- 2 November 2007.

²⁸⁸ *Ibid*, the same is defined under section 3 of Act No 8 of 1999.

Board.²⁸⁹ The accreditation process is done by using pre-determined criteria prepared by the NHIF using the MOHSW standard guidelines and the criteria stated under the Act.²⁹⁰

The accredited facilities are categorized according to the MOHSW levels of service provision regardless of their ownership i.e. whether the facility is privately or government owned.²⁹¹ Accreditation of private providers is intended to ensure free choice of provider for the NHIF members.²⁹² A beneficiary requiring treatment or confinement shall be free to choose the accredited health care provider subject to the area of jurisdiction and in the case of confinement, the ceiling of such health care provider.²⁹³ The NHIF also accredit pharmacies in order to respond to the problem of drug shortages which is experienced in many facilities.²⁹⁴

According to the NHIF,²⁹⁵ the number of accredited facilities such as dispensaries increased from has increased from 2,618 in 2001/2002 to 3,578 in the year 2008/2009. the government dispensaries accredited within this period constituted 89.9 per cent. In as far as health centres in the year 2001/2002 the fund had accredited 450. The increase in this category is slow as in 2008/2009 the health centres accredited is 477, government health centres constituting 77.9 percent. As for the hospitals in the year 2001/2002 the fund had accredited 128 hospitals. The report in 2008/2009 shows that the accredited hospitals are 201, government hospitals constituting 50.2 percent. Furthermore by 2001/2002, the fund had accredited one pharmacy. However, the position changed in the year 2008/2009 in which the number of pharmacies accredited were 176. To ensure continuous supply of drugs and medicines to the members NHIF has accredited 108 ADDO (Accredited Drugs Dispensing Outlet) shops in Morogoro, Ruvuma, Mtwara and Rukwa regions.

However, the NHIF admits that it is not feasible to accredit only providers with high quality standards of care as they are extremely few and mostly in urban areas.²⁹⁶ The problem is

²⁸⁹ Section 19 of Act No 8 of 1999.

²⁹⁰ Section 20 of Act No 8 of 1999 provides for the requirement for accreditation of the health provider by NHIF.

²⁹¹ Section 21 of Act No 8 of 1999.

²⁹² Kiwara (note 278) at 9.

²⁹³ Section 23 of Act No 8 of 1999.

²⁹⁴ Section 24 of Act No 8 of 1999.

²⁹⁵ See www.nhif.or.tz/Fact sheet.

²⁹⁶ National Health Insurance Fund, 'Tanzania, Building confidence to stakeholders through transparency to members: Client days: A case of the National Health Insurance Fund international Social security association' at 4 available at www.issa.int. (Accessed 27 November 2009).

reported basically on the part of the government providers and the fund has put in place a process of monitoring and improving quality of care especially among Government Facilities despite reporting that the problem and the process of change is slow.²⁹⁷

4.4.2 Problems facing NHIF

According to the level of reimbursement, the rates reimbursed by NHIF are currently unilaterally determined by NHIF, although with some consideration to market prices.²⁹⁸ If rates are set too low, some providers may not find it worthwhile to provide services under the NHIF scheme.²⁹⁹ Generally, faith based health care providers are willing to be accredited with NHIF, and find the rates of reimbursement offered by NHIF more or less acceptable, especially immediately after revisions of prices.³⁰⁰ NHIF reimbursements now finance up to 25 per cent of the administrative costs of faith based organizations expenditures.³⁰¹

Regarding awareness, the NHIF is required to raise awareness to health care service providers and to the public at large. When the fund started to operate in 2001 the public thought that the fund focused on the central government employees but later in the year 2002 when the local government employees became aware of the fund took proactive measures and pressurized to become the members of the fund. On the same premise it is reported that some private for profit providers have inadequate knowledge of the details of the NHIF.³⁰² However, in response for the lack of awareness the NHIF has introduced client day. Client Day is as well a training platform on NHIF standards and regulations whereby providers are informed on various best practices such as proper filling of NHIF claim forms which has resulted to the reduction of the time used to pay service providers from 60 days to 14 days in 2008.³⁰³

General perception of government operations; NHIF being a public agency has been difficult for the fund to win public trust. There is a problem on the side of the private for profit sector and the general public on the status of the fund due to the perceived inefficiencies

²⁹⁷ Ibid.

²⁹⁸ Kiwara (note 278) at 10.

²⁹⁹ Ibid.

³⁰⁰ Ibid.

³⁰¹ National Health Insurance Fund (note 296) at 4.

³⁰² Kiwara (note 278) at 10.

³⁰³ National Health Insurance Fund, (note 296) at 4.

(bureaucracy, delayed flow of funds) on the part of government related agencies, bad experience and misperceiving NHIF as a government structure.³⁰⁴ Such perceptions are barriers to even seek more information on NHIF.³⁰⁵

The National Health Insurance Fund which covers public servant members, of which over half of them are teachers have a range of complaints about the fund. The scheme covers up to four children or dependents and members complain that those with more than four dependants therefore have to pay user fees for each additional dependent.³⁰⁶ Members also report delays in issuing of membership cards thus delaying access to care and inequities in the type of facilities that can be accessed due to lack of specialised services in rural areas.³⁰⁷ However, the NHIF members are privileged compared to their counterparts in the private, formal and informal sectors as well as those in subsistence agriculture as government, their employer, is in effect subsidising the health care of government officials through their part of the contribution.³⁰⁸

4.4.3 Observations of NHIF

The fund in its efforts to cover many members has introduced changes by covering the retired employees who were formally the members of the fund. However, the changes which are part of the Bill proposal by the government in the year 2009 puts it clear that after retirement the fund will only insure the retired member and the spouse; the beneficiaries of the retired employee have been excluded.³⁰⁹ In as far as a spouse, the law is to the effect that even after the death of the retired member such a spouse will benefit from the fund until his or her death.³¹⁰

Another observation concerning the extension of the scope of coverage by NHIF is the extension of the scope of coverage of the fund to councilors. The proposed Bill covers both elected and appointed councilors and they are required to contribute three percent of their

³⁰⁴ Kiwara (note 278) at 11.

³⁰⁵ Ibid.

³⁰⁶ Meena, (note 10) at 18.

³⁰⁷ Ibid.

³⁰⁸ Ibid.

³⁰⁹ [www.nhif.or.tz/huduma ya matibabu kwa wanachama wastaafu kuanza julai 2009](http://www.nhif.or.tz/huduma%20ya%20matibabu%20kwa%20wanachama%20wastaafu%20kuanza%20julai%202009) (Health insurance for the retired employees to start in July 2009).

³¹⁰ Ibid.

monthly remuneration to the fund.³¹¹ It has to be noted that councilors are local government leaders in the ward level in Tanzania and they are the members of the District/Town/Municipal/City Council. Their role is to oversee the operation of the councils and they have powers to hold Council leaders responsible if they find that they are not fulfilling their duties. With the decentralisation of provisioning and administration of health care services in the country it is very clear that the administration of health care services at the ward level and the questioning of the failure in the councils are scrutinized by the councilors. In the same premise it follows that with the introduction of the CHF which operates from the level of the district down to the ward and village level the same is under the scrutiny and control of the councilors. The commitment of these officials in sensitizing the community to join CHF will be low as they will be covered under NHIF which provides better health benefits hence the failure of CHF will not affect them.

Moreover, the research found that NHIF contracts health care providers to provide health care services to its members and beneficiaries. The law is very clear and has set the criteria on the qualifications to be met before a service provider is accredited by the fund. In that regard the fund has further set accreditation guidelines, the study by a group of experts revealed that accreditation guidelines do not appear to be widely known by the health care providers.³¹² Something which has to be taken care by the fund is the fact that up to 2006 those applicants who applied to be accredited by the fund were accepted.³¹³ In this situation taking into consideration on the nature of health care providers in Tanzania one would expect in the report of the fund to see some applicants not accepted. The accreditation of all applicants could raise some concern about the quality or effectiveness of such a screening procedure.

There limited coverage by NHIF as the fund only covers about 1.8 million of the population of Tanzania as of 2008/2009.

³¹¹ www.nhif.or.tz/ Utaratibu wa huduma za matibabu kwa waheshimiwa madiwani (Guidelines for health insurance for Councilors).

³¹² Kiwara (note 278) at 11.

³¹³ Ibid.

4.5 Social health insurance benefit under NSSF

NSSF provides for health insurance by way of preventive and curative medical care, essential drugs, simple pathology and X 'rays, laboratory tests hospitalization where need and minor surgery to a member, the spouse and four children if the insured person has contributed to the fund for the minimum of three months of which three months of contribution were paid to the Fund in the three months immediately.³¹⁴ Benefits under this section shall be limited to the medical services to be provided by doctors, nurses and other medical providers in the accredited hospitals.³¹⁵ Diseases under special preventive programs and Public Health Care Services such as TB and Leprosy, Cancers, HIV/AIDS, Epidemics, MCH, Mental Illness, Sexually Transmitted Diseases (STDs), and any other disease that will be categorized in this domain are not covered under NSSF health insurance.³¹⁶ The fund further excludes from their medical cover self-inflicted diseases or injuries like, drug abuse, tobacco, alcohol, attempted suicide, and criminal abortion and luxurious like Cosmetic treatments with no medical indications e.g. plastic surgery.³¹⁷

The fund makes it clear that for emergency cases – for principal beneficiaries traveling away the fund limits its coverage to outpatient - not more than 4 times in a year and inpatient (48 hours) - not more than 2 times in year; in as far as hospitalization the funds service is limited to a maximum of 42 days of inpatient care per beneficiary per year.³¹⁸ Although there has been a positive response from the majority of members about this newly introduced benefit, a number of members and beneficiaries have their reservation. The main complaint as Tulia puts it is about the paper work involved.³¹⁹ It was learnt that most of the members of the fund would prefer to contribute to the Community Health Fund which requires less paperwork and fewer documents before registration.³²⁰

³¹⁴ Sections 41 and 42 of Act No 28 of 1997.

³¹⁵ Section 42 (3) of the Act No 28 of 1997.

³¹⁶ www.nssf.or.tz/exclusions.mht.

³¹⁷ *Ibid.*

³¹⁸ www.nssf.or.tz/health_limitations.mht.

³¹⁹ Tulia Ackson, *Social security law and policy reform in Tanzania with reflections to South Africa experience*, Thesis submitted for the degree of Doctor of Philosophy, Faculty of Law of the University of Cape Town 2007 at 120.

³²⁰ See Part III of Act No 1 of 2001.

4.6 Social Health insurance under other schemes

The Parastatal Pensions Fund (PPF) which offers social security coverage to employees of the both private and parastatal organizations, and the Local Authorities Pensions Fund (LAPF) offering social security coverage to employees of the Local Government have not introduced social health insurance to their members and their beneficiaries. However it has to be noted that under Act No 25 of 2002 which amends the National Health Insurance Fund Act of 1999, 'public servant' extends to and includes every person holding a public office invested with or performing duties of public nature, whether control of a local government authority but does not include a person holding such Office only on Part time basis. It follows from this definition that all employees under parastatal organisation working under the auspices of public service are now covered by the NHIF, likewise the law as amended is clear that local government employee who benefits their retirement and other benefits from the LAPF are members of NHIF for the purposes of health insurance. For the Political Service Retirement Benefits Act, 1999, the president, the vice president and the prime minister upon retirement are entitled to health insurance policy for treatment within the country.³²¹

4.7 Private Health Insurance

There are also private insurance institutions which provide health insurance in Tanzania; there are private health insurance providers which cater for the select minority who are employed in the formal sector and for the affluent.³²² Private health providers deal with employers who want to insure their employees as the corporate customers and employees in most cases do not contribute anything to this undertaking.³²³ These provide health insurance to their members for specific health problems and social risks.³²⁴ Examples of the private social insurance in Tanzania include AAR, which excludes diabetics, hypertension, asthma and HIV AIDS in its policy but gives the possibility of covering these diseases through a special fund which is paid up by corporate customers,³²⁵ MED-EX which excludes HIV AIDS in their insurance policies.³²⁶

³²¹ Sections 9 (2) (b), 12 (2) (b) and 14 (2) (b) of Act No 3 of 1999.

³²² Ackson (note 319) at 124.

³²³ Ibid.

³²⁴ Ibid.

³²⁵ Ibid.

³²⁶ MED-EX Tanzania, an overview of genesis health, undated p 3 cited from Ackson (note 311) at 124.

There is, as yet, no specific regulatory framework for private health insurance, thus in practice, the Insurance Act of 1996³²⁷ which regulates all kinds of insurance firms in Tanzania is used.

The introduction of private health insurance in Tanzania can be advantageous to the public in general as the literature shows that private health insurance enables the demands of relatively affluent people to be self-financed, leaving the government to target (limited) public resources on delivering health care to the poor and disadvantaged people without access to private health insurance.³²⁸ Furthermore the scheme mobilizes additional resources for infrastructure that may benefit poor and rich people alike, encourages innovation and efficiency, which may catalyse the reform of the public sector, because of its flexibility and the profit motive and increasing choice for the consumer.³²⁹ However, private health insurance if not well managed by the state can lead to problems relating to benefit package and setting premiums.

In as far as benefit packages, there should be regulations which are seeking to reduce this uncertainty by pressing for the definition of a basic benefits package – the size and content of what is available to consumers.³³⁰ Insurers are supposed to be regulated by setting benchmark or core term product. Such a basic package would facilitate comparison of differing products by consumers.³³¹ Until a core or basic package is defined, consumers will be very uncertain about what their insurance purchase will provide for them as compared with what they would get from other insurers.³³² The good example is the two examples of private insurance companies in Tanzania which were revealed by insuring some diseases and exclude others. If the government set up the core term services the consumers would be in a better position in deciding which private insurance company they should join.

Another problem is associated with premiums which can be risk rated (based on an individual assessment of the future risk of ill health), community rated (based on the average risk in a defined group or population) or group rated (based on the average risk of employees in a

³²⁷ Act No 18 of 1996.

³²⁸ Alan Maynard and Anna Dixon, 'Private health insurance and medical savings accounts: theory and experience' in Elias Mossialos et al (eds) *Funding health care: options for Europe*, European Observatory on Health Care Systems series World Health Organization 2002 at 111.

³²⁹ Ibid.

³³⁰ Ibid.

³³¹ Ibid.

³³² Ibid.

firm).³³³ Competing health insurers usually adopt risk rating and charge higher premiums to individuals likely to be at greater risk of using care.³³⁴ As a result, private health insurance tends to discriminate in favour of healthy, young adults who use little health care. Because of the potential for spreading financial risk across several people, many private insurers only market their plans to groups (usually of employees). Purchasing individual insurance, therefore, tends to be very expensive, and poorer people (with a risk of ill health that is higher than average) have great difficulty purchasing health insurance. Because older people need relatively more health care, private insurance coverage tends to be available only at a very high premium after retirement.³³⁵

4.8 Community Health Fund

The CHF is a general term for voluntary health insurance schemes organized at community level, that are alternatively known as mutual health organizations, medical aid societies, medical aid schemes or micro-insurance schemes.³³⁶ The CHF is a form of voluntary health insurance, a pre-payment arrangement for health services in the event of illness.³³⁷ Some of the common characteristics are, they are run on a non-profit basis and apply the basic principle of risk-sharing. These systems intend to respond to the goal of fairness in health care financing, whereby beneficiaries are asked to pay according to their means while guaranteeing them the right to health services according to need.³³⁸

The adoption of the CHF in Africa is based on the recognition that for African households, financial accessibility to quality health care is a strongly felt need and the success of the Western European experience social health insurance, initiated through small CHF schemes at the end of the 19th and beginning of the 20th century suggesting that the financing of health care based on pooling of resources and risk sharing may constitute a relevant policy option for

³³³ Ibid.

³³⁴ Ibid.

³³⁵ Ibid.

³³⁶ Bart Criel et al 'Community health insurance (CHI) in sub-Saharan Africa: researching the context' *Tropical Medicine and International Health* volume 9 no 10 October 2004 pp 1041–1043 at p 1041.

³³⁷ GK Munishi, 'Intervening to address constraints through health sector reforms in Tanzania: Some gains and the unfinished business', *Journal of International Development* J 15, 115–131 (2003) at 119.

³³⁸ Carrin, et al, (note 253) at 799.

African health care systems.³³⁹ It aims to be flexible in that contributors are encouraged to pay at the time of harvest, with an option of paying in instalments for those with more regular incomes.³⁴⁰

In Tanzania the CHF which is a quasi-health insurance system was introduced in Igunga District in December 1995 covering only 26 wards. From August 1996 the whole of Igunga District adopted CHF model.³⁴¹ The scheme was identified as a possible mechanism granting access to basic health care services to populations in the rural areas and the informal sector in the country.³⁴² CHF members were required to pay a flat rate of Tshs. 5000 per annum per household for all services.³⁴³ In the year 2001 the government enacted the Community Health Fund Act, 2001 in which section 4 established the CHF with its objectives provided for under section 5 (a) –(c) of Act.

Membership contributions are decided at the council after consultation with members of that community on the level of annual contributions to be paid by each household depending on whether the contribution is for outpatient or, inpatient health care services.³⁴⁴ The level of annual contributions may be varied from time to time by the Council after consultations with the members of that community.³⁴⁵ The Government may through the respective Council, contribute to the Fund any specified amount of money.³⁴⁶ The law is to the effect that every members' household of the community health fund shall be entitled to medical services of its choice which have been prepaid for at a pre selected health care facility within the respective district.³⁴⁷

There is no limit on the number of children who can be insured, and in this way families in rural areas with more than four children are catered for.³⁴⁸ Another distinct feature of CHF is

³³⁹ Criel, et al, (note 336) at p 1041.

³⁴⁰ Munishi (note 337) at 119.

³⁴¹ G. Munishi, 'Constraints to Scaling up Health Interventions: Tanzania', *Commission on Macroeconomics and Health, Paper No. WG5: 16*, June 2001 at 17 Available on www.emro.who.int/cbi/pdf/HealthInterventionsTanzania.pdf (Accessed 27 August 2009).

³⁴² Mtei et al (note 17) at 32-33.

³⁴³ Munishi, (note 341) at 17.

³⁴⁴ Section 8 (1) of Act No 1 of 2001.

³⁴⁵ Section 8(2) of Act No 1 of 2001.

³⁴⁶ Section 8(3) of Act No 1 of 2001.

³⁴⁷ Section 9 of Act no 1 of 2001.

³⁴⁸ Ackson (note 319) at 123.

that it is voluntary as compared to all other schemes which are compulsory.³⁴⁹ Although CHF is yet to emerge in many parts of Tanzania because the law was enacted in 2001, the scheme is especially designed for the excluded sectors in both rural and urban areas.³⁵⁰ The contribution of the members is determined by the local government thus makes it easy for the local government to decide the amount to be paid by the households depending on their economic power.

4.8.1 Challenges of the CHF in Tanzania

In Tanzania one of the most pressing issues for the CHF is the low enrolment rate and early drop outs in membership.³⁵¹ One of the factors which lead to the low enrolment of the households in the CHF is that user fees in some councils are set at 1000 Tanzania shillings per visit at health centre level and many community members are more willing to pay the user fee rather than pay the higher CHF premium.³⁵²

The inability to pay membership contributions is another factor which contributes to poor enrolment. Some council have set high CHF membership fees which have also contributed to poor enrolment.³⁵³ When Act No 1 of 2001 was enacted, the issue of inability to contribute by members due to their poverty was taken in account and Ward Health Committee is vested with the powers to issue exemptions for payment of the Community Health Fund annual contribution to any person after receiving recommendations from the Village Council.³⁵⁴ It is further stated that when the exemption order has been issued by the council, the exempting authority shall seek alternative means of compensating the Fund.³⁵⁵ Despite the fact that exemption policy has been issued by the government as well as the provision of the law to the effect that poor people can be

³⁴⁹ Section 4 of Act No 1 of 2001.

³⁵⁰ It has to be understood that as per the law as it was in the year 2001 the CHF were supposed to be established only in 10 councils listed in the first schedule to the Act No 1 of 2001. However the MOHSW in its budget estimates speech of the financial year 2008/09 reported that until the end of January 2008 the councils which had already joined the CHF were 92 and had formulated regulations on the operation of CHF in their councils. (See the United Republic of Tanzania, MOHSW, the summary of the speech by the Minister of Health and Social Welfare Honorable David Homeli Mwakyusa on the estimate of the budget for the MOHSW in the financial year 2008/09 at 4.

³⁵¹ Mtei et al (note 17) at 33

³⁵² Ibid.

³⁵³ Ibid.

³⁵⁴ Section 10 (1) of Act No 1 of 2001.

³⁵⁵ Section 10 (2) OF Act No 1 of 2001.

exempted from the annual contribution of the membership of the CHF, the study revealed that District and ward managers indicated a negative attitude towards exemption.³⁵⁶

Low quality of health care; four main problems with the quality of services were identified: shortage of drugs and essential medical supplies; inappropriate diagnosis due to lack of diagnostic equipment, particularly laboratory equipment; staff-related problems; limited range of services provided and lack of possibility to use health facilities of members' choice, coupled with referral problems.³⁵⁷ Thus, those who register initially into the scheme may drop out quickly if the quality of care does not reach expectations.³⁵⁸

In solving this problem the CHF need to adopt strategic purchasing which involves an active search for the best health services to purchase, the best providers to purchase from and the best payment methods and contracting arrangements.³⁵⁹ Strategic purchasing requires that the mandate that the CHF scheme receives from their members is sufficiently strong and that the scheme management has the ability to carry out this mandate.³⁶⁰

Under normal circumstances and taking into account on the infrastructures and health facilities available in developing countries like Tanzania the issue of strategic purchasing cannot be achieved in the provision of health services by way of CHF. Strategic purchasing involves the mandate comprising of the right of the CHFs to purchase a set of health services at the best price from pre selected providers. It is stated that;³⁶¹ The CHF may receive the authority, among others, to determine the list of healthcare providers from which CHF members can then freely choose; to establish the set of insured health services or benefit package; to set quality standards of care; to propose the provider payment mechanisms.³⁶² Thus, strategic purchasing is opposed to simple funding or reimbursement of non-specified health services by various providers with whom the CHF has no special contractual relationship.³⁶³ While this seems to be the best way to

³⁵⁶ Peter Kamuzora and Lucy Gilson, 'Factors influencing implementation of the Community Health Fund in Tanzania', *Health Policy and Planning* 2007;22:95–102 Oxford University Press in association with The London School of Hygiene and Tropical Medicine at 98.

³⁵⁷ *Ibid.*

³⁵⁸ Mtei et al (note 17) at 35.

³⁵⁹ Carrin, et al, (note 253) at 801.

³⁶⁰ *Ibid* at 801-2.

³⁶¹ *Ibid* at 802.

³⁶² *Ibid.*

³⁶³ *Ibid.*

organise CHF under normal circumstances its achievement will take a long time to be achieved in the low income countries like Tanzania in which the CHF is made up of poor people who contributes low amount of money to at least receive primary health care in their locality.

Lack of trust in CHF managers is one of the factors which led to ineffectiveness of the CHF.³⁶⁴ It has been observed that ward leadership are accused of corruption, lack of transparency and sensitisation of the public by giving information about the general operations of the CHF in the district in general.³⁶⁵ On the same footing the CHF leaders at the district level are accused to have failed to supervise the ward-level CHF managers and health facility staff.³⁶⁶ There is insufficient sensitisation/education on the community on the important of community insurance funds.

The average and wealthy groups generally argued that many people in the community did not see the reason why they should pay before they fell sick often linking this to little knowledge about the benefits of the CHF.³⁶⁷ To take care of this problem the government is supposed to give public education on the need of the society to join the CHF rather that leaving it to the people to choose themselves.

Lack of capacity and experience in community mobilisation and financial management are among the factors that are cited as hindering the implementation of CHF in councils.³⁶⁸ Districts are not conversant with CHF management rules and procedures and they reported that there was mismanagement of CHF funds and in some other instances it was found that CHF funds were not utilised at the district level.³⁶⁹

According to Act No 1 of 2001 the Board is duty bound to keep proper accounts and other records in relation thereto and shall prepare in respect of each financial year of the Council statement of accounts as the Council may direct.³⁷⁰ The accounts of the Fund shall be audited by competent and qualified auditors in accordance with regulations governing auditing of Council's

³⁶⁴ Kamuzora and Lucy Gilson, (note 356) at 99.

³⁶⁵ Ibid.

³⁶⁶ Ibid.

³⁶⁷ Ibid at 100.

³⁶⁸ Mtei et al (note 17) at 35.

³⁶⁹ Ibid at 36.

³⁷⁰ Section 25 (1) of Act No 1 of 2001.

accounts.³⁷¹ The Board shall as soon as practicable after the end of each financial year of the Council prepare a full report on the performance of its functions during that financial year, and one copy of such report together with a copy of the audited accounts shall be submitted to the Council and the Ministry responsible for health.³⁷² Despite these requirements of the law in the year 2003 an assessment by the MOHSW showed that not all councils conducted regular audits or reported to community members.³⁷³

4.9 Community Based Health Financing (CBHF)

Governments in most low-income countries do not provide free or subsidized access to basic health care, and this has contributed to the emergence of the community- and area-based health insurance schemes.³⁷⁴ The main advantage of these schemes is that they improve health expenditure efficiency or the relation between quality and costs of health services.³⁷⁵ The CBHF is a mechanism whereby community members (households) finance or co-finance costs associated with health services, offering them greater involvement in the management of community financing scheme and organization of health services.³⁷⁶ CBHF schemes can be seen as a step towards universal coverage following the widely acknowledged difficulties which exist in tax financing and social health insurance, especially in less developed countries (LDCs).³⁷⁷

Governments have decided to adopt CBHF due to the reason that; a tax-funded health system may not be easy to develop, due to the lack of a robust tax base and a low institutional capacity to effectively collect taxes.³⁷⁸ Other problems of tax financing include: a typically small tax base and large informal sector; dependence on donors; weak income and asset taxes; and high dependence on international trade.³⁷⁹ A move towards social health insurance also poses challenges, namely: difficulties in arriving at a national consensus for a scheme's structure;

³⁷¹ Section 25 (2) of Act No 1 of 2001.

³⁷² Section 25 (3) of Act No 1 of 2001.

³⁷³ Mtei et al (note 17) at 36.

³⁷⁴ van Ginneken (note 261) at 32.

³⁷⁵ Ibid.

³⁷⁶ Gemini Mtei and Jo-Ann Mulligan, 'Community Health Funds in Tanzania: A literature review', Ifakara Health Institute, Dar es Salaam, January 2007 at 2.

³⁷⁷ Ibid.

³⁷⁸ Carrin, et al, (note 253) at 799.

³⁷⁹ Mtei and Jo-Ann Mulligan (note 376) at 2.

income inequalities; and, weak government managerial capacity and poor infrastructure which limits the facilitation of collections, re-imbursments and monitoring.³⁸⁰

Following the above stated problems of tax financed schemes and the statutory health insurance, CBHF schemes are seen as an option for extending insurance coverage in low-income countries, particularly among rural and informal sectors of society. However, it must be stressed that most existing micro-insurance systems are fairly small, thus they need to form partnerships by way of for instance a federation, so as to strengthen their negotiating power with the State and health care providers, to pool their knowledge and improve their financial situation by enlarging the group in which the risks are pooled.³⁸¹

In Tanzania there are about 12 schemes that have registered themselves under the Tanzania Network of Community Health Funds (TNCHF), although many others choose not to register.³⁸² Examples of such schemes include UMASIDA and VIBINDO, both based in Dar es Salaam.³⁸³ Services that are covered by these schemes include primary health care, outpatient services, reproductive health, and minor surgery.³⁸⁴ Some community based health financing schemes are owned by faith-based organisations; others are operated by various NGOs or receive assistance from various donors and international organisations.³⁸⁵

In general, state has the means to create a favourable environment for the development of micro-insurance. For instance UMASIDA³⁸⁶ is the project established in 1995 with a mission of devising a method that will enable participants in the informal sector to obtain health care services at affordable costs.³⁸⁷ It was established as a micro-health insurance project under the technical assistance of the ILO.³⁸⁸ The project is administered through a board, with a small

³⁸⁰ Ibid.

³⁸¹ Reynaud, E 'The extension of social security coverage: the approach of International Labour Office' ILO Geneva, 2002 at 10.

³⁸² Mtei et al (note 17) at 35.

³⁸³ Ibid.

³⁸⁴ Ibid.

³⁸⁵ Ibid.

³⁸⁶ Ramadhani Dau *Extending Social security coverage through micro-insurance schemes in Tanzania*, International Social Security Association Meeting of Directors of Social Security Organizations in English-speaking Africa Banjul, the Gambia 7-9 October 2003 at 6.

³⁸⁷ Ibid.

³⁸⁸ Ibid.

workforce in its office and health services are provided by contracted private hospitals and government hospitals on a fee-for-service basis.³⁸⁹

The problems encountered by this project have been reported to be irregular payment of contributions by members and pressure from members for more benefit packages.³⁹⁰ Also abuse of the system by the group leaders who are the custodial of sick-sheets by giving sick sheets to non group members, there is also the problem in the side of the service providers contracted by the schemes who prescribe drugs which are not approved by WHO essential drug list.³⁹¹ According to Kiwara these problems have been noted by the members and corrected but it has to be noted that these are just the problems of accountability which cannot be cited as the failure of micro insurance schemes. In spite of these problems the government and the society is supposed to work on the formation of micro insurance schemes while taking note of the identified problems.

Apart from the problems said to be faced by the scheme the members of UMASIDA have benefited as there have been accessibility to quality health care.³⁹² The good example is DASICO³⁹³ members who have managed to build a dispensary which provides full primary health care with a medical assistant and a nurse. Hernia operation for the DASICO members has been paid by the by UMASIDA.³⁹⁴ Reduction of health care costs, the risk pooling aspect of the scheme has eliminated the burden of the individual family in meeting their own health care costs. Health care services are available throughout the year, and that the premium paid is much lower than the actual cost.³⁹⁵ Another advantage is the improvement of services provided for by private health care providers. UMASIDA has set up criteria to be met by all private health care providers at all levels before they are accredited to provide health care services to UMASIDA members.³⁹⁶ This has made private health care providers to improve their services so as they can be accredited to provide services to UMASIDA members.

³⁸⁹ Ibid.

³⁹⁰ Ibid.

³⁹¹ Kiwara (note 9) at 137.

³⁹² Ibid at 135.

³⁹³ DASICO is one of the groups which form UMASIDA.

³⁹⁴ Kiwara (note 9) at 135.

³⁹⁵ Ibid at 136.

³⁹⁶ Ibid.

4.10 Social assistance

Historically, social assistance is the first provision being introduced to tackle the problem of income interruption when private-sector provisions fail to support.³⁹⁷ The National Social Security Policy 2003³⁹⁸ covers social assistance programmes that constitute services such as primary health; primary education, water, food security and social welfare services to vulnerable groups such as people with disabilities, the elderly and children in difficult circumstances on a means tested basis.³⁹⁹ The most considered group of people for the provision of social assistance benefits by means testing include elderly, sick, invalids (disabled), survivors, unemployed. Normally these groups of people fall out of contributory schemes.

Beveridge advocated social assistance which was a national scheme to meet the special needs of the minority of people and those who were unable to qualify for insurance benefits.⁴⁰⁰ Social assistance schemes are better able to extend social protection to the poor than are social insurance schemes, mutual societies or micro-insurance.⁴⁰¹ Since they are not contribution-based and/or are not dependent on long employment records, they can reach the poorest – including the rural sector. Nevertheless the inadequacy of funds which is derived from government revenue marginalizes prospective and current beneficiaries into destitution.⁴⁰² For the Tanzania health care to avoid unintended exclusion more resources should be channelled to health services in poor societies. Another way of providing social health assistance is by the government advocating factors influencing health care such as nutrition, food clean and adequate water and transportation. Social assistance schemes are not widespread because the poor and the rural population have little political clout in most countries and they are a group that rulers can afford to overlook.⁴⁰³ Providing social assistance is difficult, since such schemes are riddled with various administrative and incentive problems.⁴⁰⁴

³⁹⁷ Tom Yee-Huei Chin, 'The Beveridge Report and the development of British social security', *Journal of Social Science and Philosophy*, 81/11 at 324.

³⁹⁸ The National Social Security Policy 2003 at 13.

³⁹⁹ *Ibid.*

⁴⁰⁰ Yee Huei (note 397) at 337.

⁴⁰¹ Einar Overbye, 'Extending Social Security in developing countries: a review of three main strategies', *International Journal of Social Welfare* 2005:14: 305–314 at 310.

⁴⁰² Mpendi, et al, (note 36) at 247.

⁴⁰³ Overbye, (note 401) at 310.

⁴⁰⁴ *Ibid.*

Administering discretionary social assistance which is means tested requires administrators who have a strong professional work ethic and an administrative culture where there is a sharp distinction between public and private money.⁴⁰⁵ If this administrative apparatus and culture are lacking, social assistance can degenerate into patronage and vote-buying.⁴⁰⁶

In as far as social health assistance in Tanzania the MOHSW has put in place mechanisms of assisting special groups of people who can not afford the costs of health care services. The MOHSW acknowledges that poor people above the age of 60 years, children in vulnerable environment, children below the age of 5 years, pregnant women, people with chronic diseases such as cancer, asthma, sickle cell, tuberculosis, leprosy and mental diseases should be exempted from paying health care costs.⁴⁰⁷

Social health assistance can be achieved where there is collaboration between department of social welfare and health department. MOHSW admits that social welfare is fragmented and mostly institution-based and at the Local Government level which is close to the people social welfare is weak; only 56 among 133 councils provide social welfare services.⁴⁰⁸ There is a shortage of skilled human resources and funds; department has only 210 welfare officers, compared to the 3,892 needed.⁴⁰⁹ In Councils and village governments the concepts of social welfare and social protection are often not fully understood.⁴¹⁰ Vulnerable groups are not sufficiently recognised and risks not identified. In rural areas where most people are active in the informal sector, support to vulnerable groups is left to traditional systems, which are not always functioning well in catastrophic situations.⁴¹¹

Social health assistance is also required in case of natural calamities; in these cases the government has formed the National Rapid Response Team with 40 experts.⁴¹² The team is divided into two groups; the first group is involved in surgical emergency cases while the second

⁴⁰⁵ Ibid at 311.

⁴⁰⁶ Ibid at 311.

⁴⁰⁷ The National Health Policy 2007 at 29.

⁴⁰⁸ The United Republic of Tanzania (note 5) at 33.

⁴⁰⁹ Ibid.

⁴¹⁰ Ibid.

⁴¹¹ Ibid.

⁴¹² The United Republic of Tanzania, (note 79) at 13.

one is involved in medical emergency cases.⁴¹³ These teams are further involved in times of outbreak of diseases and they were involved during the time of the outbreak of Rift Valley Fever (RVF) in the year 2006 and further that the team was involved in medical examination to the people affected by the volcanic eruption of Oldonyo Lengai Mountain in Arusha region.⁴¹⁴

4.11 Conclusion

Access to health care through health insurance in Tanzania is recent and the efforts by the government to achieve it are yet to be realised due to former system of free health care services. NHIF and NSSF insurance schemes which cover insurance services to employees in formal sector has been welcomed by both employees and employers as a form of backing up government efforts in financing health care services, however, the contribution by the employees of 3 percent of salary has been seen as the burden to employees with low income. In avoiding complains on the contribution on health insurance the government is supposed to reduce the amount of the employees' contributions on taxes since one of the reasons for the paying taxes is to cater for health services.

Nonetheless, research reveals the deterioration of the CHF. Since introduced in 1996 has failed to spread in all districts of the country and where the fund was introduced the same is having many problems ranging from lack of information by members, failure to pay membership fees by members and despite the fact that the law gives the council the power to give exemption to indigent families the district and ward managers are not in favour of the exemption. Also it has been observed that, CHF membership does not cover referral level where costs are higher and it is needed most and lastly poor quality of services at lower levels discourages community members who can afford to contribute to the fund from joining the scheme because they have possibility of accessing better-resourced facilities owned by voluntary agencies or private for profit organisations.⁴¹⁵ Therefore the research found that the government has a lot to do before concluding that it has achieved in financing of health care services by CHF.

⁴¹³ Ibid.

⁴¹⁴ Ibid.

⁴¹⁵ Meena, (note 10) at 21.

Also, this work witnessed lack of solidarity in the health care insurance schemes; before explaining in profound how there is the lack of solidarity it is the high time to understand that the comprehensive social security entails the presence of solidarity in the society. Solidarity describes the presence of systems of mutual dependencies, responsibilities and entitlements within a defined group of people or a community.⁴¹⁶ Solidarity is one of the important aspects of social security, and even more for the adequacy of social security benefits.⁴¹⁷ The practice of solidarity can take place following different principles like reciprocity, mutual aid, and redistribution.⁴¹⁸ Solidarity can be defined as a complex system for the transfer of goods and services that serves people's lives and tries to improve their general situation and standard of life.⁴¹⁹ Lack of solidarity has been witnessed as between the operation of statutory health insurance and micro insurance schemes.

The study has shown that the benefit packages are limited by the ability of the members to contribute.⁴²⁰ This is for those under the CHF and micro insurances established in the society either by group of people who voluntarily decides to form their schemes or those under the supervision of the religious organisation. The capacity of the population who are engaged in informal and agricultural income activities and contribute to health schemes is more limited than that of the formally employed population.⁴²¹ Thus the benefit package of schemes in rural areas with members who have irregular and low income is smaller than the package provided by the NHIF for public servants. The benefits that can be provided by health funds are restricted by the limited financial resources of its members; and further that the size and quality of the benefit package depend on the pre-paid amounts of contribution and there is no form of redistribution yet among these schemes.⁴²²

Furthermore, low contribution capability by the members in the informal sector to the insurance schemes introduced in their locality has been witnessed as one of the bar in achieving the financing of health care services. Levels of income for most of the informal sector

⁴¹⁶ Steinwachs, (note 246) at 5.

⁴¹⁷ Ackson (note 319) at 177.

⁴¹⁸ Steinwachs, (note 246) at 5.

⁴¹⁹ *Ibid.*

⁴²⁰ *Ibid* at 20.

⁴²¹ *Ibid.*

⁴²² *Ibid.*

employees are quite low. Their income is just enough to provide for subsistence, making it difficult to meet their immediate needs as well as paying contributions to social insurance schemes for their future protection.

Financing of health services by way of CHF and CBHF though have achieved to provide for the support on health financing the same need to be revisited so as the beneficiaries of the schemes may get health services above primary health care which seem to be the focus of CHF and CBHF. As for health assistance the MOHSW need to establish department of social welfare in all councils which will have the role of identifying those who are in need of health assistance in collaboration with the village and/or street government.

CHAPTER FIVE

RECOMMENDATIONS AND CONCLUSION

5.1 Introduction

This chapter concludes the study. It provides the high light of the problems found in the preceding chapters. Recommendations to the government and stakeholders on how to improve access to health care services in Tanzania are made.

5.2 Problems identified

The study has found that in the provision of health care services in Tanzania, there are problems related to geographical distribution of health care facilities, the number of health care personnel and access to essential medicines. Another problem found is on the effects of the outbreak of HIV/AIDS which has affected the achievement of national health programmes such as the attainment of primary health care. On the supply of pharmaceuticals there is the problem of substandard of counterfeit of drugs since MSD is the only supply of the drugs in the country; however this problem has been attended by TFDA by banning the supply of substandard drugs. Also the study found the problems related on the degree of decentralisation which indicated that despite the decentralisation of the management of health care services to the district level there is still tight control from the central government.

In addition, the study found that in financing of health care services there have been efforts to adopt social health insurance. However, it is demonstrated that there is the low coverage of health care insurance schemes as NHIF covers only 5 percent of the population. The introduction of private health care schemes, CHF and CBHF aimed at complementing the efforts of the government in financing health care services but the study revealed the existence of many problems. For instance there is no a particular law enacted to regulate the operation of private health insurance and CBHF. On the part of CHF the study revealed that lack of skills to administer community schemes by local government officials, high enrolment fees for members and lack of public education on the importance and advantage of CHF which has led to the deterioration of the activities of CHF in the districts.

The study found that there is another problem on the ability of micro insurance schemes as they only provide for primary health care. There is no referral system to the tertiary health facilities to the members. This has also hindered the community members to join the funds as they prefer user fee services which cover both primary health services and referral charges.

Besides, the study found the lack of solidarity on the health insurance schemes. The members of CHF and CBHF depend on their contributions as there is no pooling of risks between the poor and the rich. This is because the schemes are formed by the people of the same level with the same amount of contribution. On the part of private insurance there is the problem of regulatory authority setting the minimum health care packages insured by private insurance schemes. Non existence of such regulation may make private insurance schemes to have the tendency of avoiding some of the people in their services. Despite the fact that social assistance is recognized under the National Social Security Policy of 2007 and the National Health Policy of 2007 the same is not recognised as a constitutional right. In addition the department of social welfare is not established to more than 50 percent of Councils in the country. This affects the ability of the government to identify people eligible for social health assistance.

5.3 Recommendations

To start with the constitution has to provide for the right of social security and the right to health care. In other jurisdictions such as the Republic of South Africa the Constitution provides for health care, food, water and social security as a right and the same was made justiciable in the courts of law in the case of *Soobramoney v Minister of Health, KwaZulu Natal*⁴²³ where the Constitutional Court held in terms of s 27(1) that the obligation on the State to provide access to health care is qualified by s 27(2) and the tasks of deciding how scarce resources should best be allocated is that of the responsible authority.⁴²⁴

That, the public sector budget system needs to be revised to ensure that the regional allocation of health services is equitable. This will reduce the problem of both physical and financial access to health care services. There is a the need for a targeted approach to the

⁴²³ 1998 (1) SA 765 (CC).

⁴²⁴ Section 27 of the Constitution of the Republic of South Africa of 1996.

development of new health infrastructure, prioritizing the most under-served districts and ensuring that rural people receive better access to services normally only provided at hospitals.

That, it is recommended that the government to work on the problem of the acute shortage of higher level medical officers particularly doctors and nurses in some rural areas. Since there is a significant variation in the distribution of medical personnel in our regions depending on the geographical location, the government should make radical changes in hiring and deployment practices. There is the need to, for instance, attract doctors and nurses to go and work in regions where there is less than 1 medical doctor per 100,000 people.⁴²⁵ This variation is worst especially when assessed on the basis of districts, as the vast majority of skilled staff is found in the district hospital.⁴²⁶ Strategies may need to be introduced to bond employees, re-centralize some hiring, and/or offer financial and non-financial incentives to make remote districts attractive. This will make less popular districts to reduce chronic problems of health personnel by attracting health workers.

That, the decentralization of health care sector in the district level needs to be well defined. After the adoption of decentralisation of health care services the government has delegated the administration of health services in the teams such as village health management team, CHMT Regional hospital and Referral hospital teams. There is the need of enacting a unified law reflecting the introduced changes.

That, the MSD is supposed to establish offices in all 21 regions of Mainland Tanzania and in some districts which are less developed. This is because the department is only established in eight zones; taking into account the role played by the department as the sole supplier of drugs to all public health facilities having only eight branches in the country is not enough.

That, the government is supposed to create measures to contain private sector cost by having direct controls on the supply of services, various market-related measures and improved regulation of competition. This will help people to have access to health care services to private health service provider by regulating costs of health services.

⁴²⁵ Policy brief, 'Health inequality and equity in Tanzania', (undated) at 8.

⁴²⁶ Ibid.

Access to health care services in Tanzania has witnessed the efforts by the government to introduce insurance schemes, however it is recommended that since the NHIF, NSSF, CHF and CBHF are striving to increase the number of their members there is the likelihood that in the future if efforts will not be taken to build hospitals, health centres and dispensaries members in these schemes will be getting health services with different quality. For instance the members of NHIF in the urban areas will have better health care services as compared by those members in rural areas where health care facilities are relatively poor. The local government employees are now covered by NHIF but some local authorities do not have even district hospital, from this fact it means that despite the fact that these members will be contributing the same like those in areas with quality hospitals their health benefit packages will be of low quality. Due to this it is recommended that while the government is encouraging the introduction of health insurance schemes efforts to improve health care facilities and increasing of human resources have to go hand in hand with the widening of the scope of the insurance schemes.

From the 1991 government accepted the introduction of private health care services for profit; these are cited as the good partners to the public health sector, however, if not well regulated they will not be serving the society surrounding them. The research has revealed that NHIF, NSSF, private health insurance schemes and CBHF contracts not only public health providers but also private health providers. It follows therefore that some private health providers since they are for profit after getting assurance of clients from the insurance schemes may raise fees of their services to other community members who are not insured under the mentioned schemes. Therefore the government is supposed to put the regulatory mechanism binding them to provide health care services to the surrounding society.

Health financing schemes by way of statutory insurance such as the NHIF, NSSF and CHF as well as micro insurance schemes is not supposed to be discourages but the mechanism of achieving social solidarity has to be worked upon. It is clear from the existing schemes that there is no social solidarity as there is the failure of redistributing benefits and funds across the schemes. Social health insurances redistribute from the healthy to the sick (risk solidarity) and from the rich to the poor (income solidarity). This is not working under the current health care financing schemes which operate under the rule that the member of the fund benefits from what he has contributed. Despite the fact that the government has decided to contribute for indigent

citizen under CHF, still the fact remains the same that the health facilities for those under CHF and Micro insurance are far back behind when compared by those under NHIF and NSSF. It is necessary to introduce vertical redistribution so that the risk-sharing takes place not only horizontally within the respective health schemes, but also beyond. The redistribution of resources includes cross-subsidies between the different schemes (subsidies for the CHF could be taken in part from the NHIF contributions), and forms of social assistance for those who cannot afford to pay fully for their health care.⁴²⁷

On the question of lack of solidarity therefore the extension of health financing can be achieved by relying on the national budget allocated for health provisioning in a financial year, further that the extension of the formal schemes to cater for those in rural areas and employees of informal sector is far from being achieved. This being the case though the introduction of CHF and micro insurance has put the principle of solidarity at stake the national solidarity may be sought through the tax system and the coordination between different schemes covering different groups of people.⁴²⁸

That, there should be regulations or guidelines to setting the minimum health care packages provided for by the private insurance schemes. To date there is no law or regulatory authorities for the administration or regulation of private health insurance companies. It was observed by this study that these companies are registered by the general law of insurance but if there will not be the common requirement before an institution is registered as a private insurance scheme there is the likelihood of having private insurance schemes focusing some groups of people abandoning others. Therefore state is supposed to be involved to set minimum health packages and minimum premium otherwise the country may find some insurance companies excluding some diseases such as AIDS and cancer in their policies.

It is recommended that for the access of health care services, the public and the health care providers to be held responsible where it is established that they have failed to purchase medicines after being accredited by the NHIF to provide health care services to its members. In the course of accreditation of health care providers NHIF accredited all public health care

⁴²⁷ Steinwachs, (note 246) at 20.

⁴²⁸ Ackson (note 319) at 145.

services in the country. The fund is said to have used 10.2bn/- in the year 2008/2009 as the payment to its accredited health providers but this huge amount of money did not have any impact on the ground.⁴²⁹ Local councils in the country have the tendency of overstaying with the fund's cheques until they expire. When closing its accounts at the end of the 2007/2008 fiscal year the fund found that 237 cheques worth 2.45bn/- had not been presented for cashing.⁴³⁰ In the year 2008/2009 the Eastern zone was still holding on cheques worth 127.4m/-.⁴³¹ Likewise the councils are blamed for poor monitoring of medical supplies, leading to pilferage of medicines.⁴³² With these problems on the side of the public health care providers it is recommended that since more than 60 percent of the accredited health care providers are public institutions more stringent measures should be put in place on the local government officials who are the custodian of funds from the NHIF otherwise the country will be experiencing poor health care services to its people despite the fact that, they are insured and contribute their basic salary for health care financing.

It is recommended that, since NSSF has introduced health insurance schemes to its members; the fund is at a better position to improve the coverage of health insurance in Tanzania as it was reported to have 363,000 members in the year 2003.⁴³³ Accordingly, the NSSF Social Health Insurance Benefits can cover many members as compared to NHIF because if all members of the fund join health insurance then the beneficiaries will be above 2 million which is a reasonable number. The fund is supposed to sensitize all of its members to join its health insurance benefit.

The study recommends that for the NSSF health insurance benefits to extend coverage to the retired beyond three months after the date of retirement. The position as it stands now makes an individual to take care of her/his own health cost and those of dependent members of the households after retirement, thus might likely fall under vulnerability in the cases of those who occupy low status in the government service. If the fund reviews its law and policy they may

⁴²⁹ Patrick Kisebo, NHIF to extend its services to villages in the next fiscal year, the Guardian (Tanzania) 17 April 2009.

⁴³⁰ Ibid.

⁴³¹ Ibid.

⁴³² Ibid.

⁴³³ This is in accordance to the National Social Security Policy 2003.

adopt the same system as NHIF which nowadays covers retired employees by considering the member and the spouse.

Although the government of Tanzania is encouraging on the adoption of the micro insurance schemes there is a need of the establishment of the clear control and regulatory mechanisms for micro-insurance, for example, in the framework of legislation on the efficient and transparent management of the systems.⁴³⁴ If the micro insurance schemes will be left to organise without legal framework the likelihood of their survival is very low. The study have revealed that it has been within the powers of the leaders of the micro insurance organisations to either register them under the Non Governmental Organisation Act, 2002 and others may just operate without any legal control or registration. While the study has unveiled that there is lack of solidarity in the health care financing because of the lack of the redistribution and subsidies among the government owned health insurance schemes and micro insurance schemes, the same cannot be achieved if there is no proper way of controlling them.

That, official registration of the existing health insurance schemes is of paramount importance. There can be a mechanism of registering them under the “collective health financing mechanism”, “health scheme”, or “health fund”.⁴³⁵ Through registration or the provision of a licence, various alternative social security arrangements could claim a status similar to the formal security schemes that would include the entitlement to subsidies.⁴³⁶

The government is supposed to view micro-insurance not simply a mechanism of financing or pooling risks, for they are also capable of playing an important role in various fields but their role are supposed to be focused in the light of being able to contribute to the following functions such as the identification, at the community level, of problems, constraints and priorities; prevention, education and promotion in relation to health care; identification of the families and groups facing serious difficulties or which are most vulnerable; defining a realistic basic benefit package that is adapted to the local context; the establishment and (co)management of the supply of local services, including basic health care and access to generic medicines; improving the transparency and quality of service and reducing costs; ... effectively and

⁴³⁴ Reynaud (note 381) at 11.

⁴³⁵ Steinwachs, (note 246) at 27.

⁴³⁶ Ibid.

transparently channeling aid and subsidies for the most vulnerable members of society; enhancing the visibility, negotiating power and capacity to participate of excluded categories, especially women, who are very active within such systems.⁴³⁷

Moreover, there is the need of extending the coverage of the existing social security schemes to informal sector workers. However as noted by ILO, most of existing social security schemes cannot easily be extended to the self-employed and the informal sector, because the threshold of entry in terms of social contribution and benefit structure is too high for most of those excluded and because the benefits provided are not consistent with the priorities of people living in poor circumstances whose social protection need are essentially short-term.⁴³⁸ Also it needs to be determined whether the administrative capacity of the existing public social security schemes is inadequate to take the task of extending coverage.⁴³⁹ As for NSSF registration of workers in the informal sector is growing as it sponsored a Trade Fair for the informal sector and some 200 members were registered at the end of the Fair.⁴⁴⁰ The employees in the informal sectors who will join NSSF will be the one to benefit with the fund as it is the one which have social health insurance to its members.

In Tanzania since social assistance is not a constitutional right, there is a need to amend the constitution or enact legislation as is in South Africa where there has been a scheme for means-tested old age grant which is regulated by the Social Assistance Act No 13 2004.⁴⁴¹

5.4 Conclusion

Health care services are not accessible by all Tanzanians and this is caused by unequal geographical distribution of health care facilities in the country. However the efforts' of the government have been to achieve access to health care to a large number of people by improving the health care services to the population. In responding to people's expectations on health care delivery the government has reformed health sector by decentralizing health care administration

⁴³⁷ Reynaud (note 381) at 11.

⁴³⁸ M P Olivier and E R Kalula, the *Future of Social Security in SADC: Some critical element*, Paper presented and IRASA Conference on Regional social Security (SADC) Protection. Minimum Standards and Coordination, Spier, Stellenbosch, 4-6 October 2005 at 10.

⁴³⁹ Ibid.

⁴⁴⁰ Dau (note 386) at 5.

⁴⁴¹ Section 4 and 5 of the Act provide for the grants given by the government and the eligibility respectively.

and delivery to the district level. The provisioning and administration of health care services has been devolved to the district level but the study found that there is still tight control from the central government which to some extent has delayed the achievement of process of decentralisation. The CHMT, Ward Health Committee and Health Centre Health Committee, instead of concentrating on the local diseases are still operating from the top giving priorities on the national and global campaigns.

Further effort has seen the introduction of health insurance schemes such as NHIF NSSF and CHF to supplement financing of health care services. Different groups in the society have formed micro insurance schemes which have organised health care financing in their communities. However, the introduction of health insurance schemes both formal and community based have not absolutely solved the problem of financing of health care services in the country as they cover small proportion of the population and have problems related to administration especially on the part of CHF and health benefits coverage and others as has been discussed above. All these efforts reveal that the government in cooperation with the community is striving to improve health care system by providing financial protection against the costs of ill-health to all citizens. These changes have brought some improvements in solving of the problem of access to health care in Tanzania, but more need to be done in order to achieve the goals of health reforms by having the proper control of the strategies, policies and the schemes which are intending to improve health care delivery in the country.

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