2005 budget speech
Notes on priorities for health

The health sector has seen important achievements in recent years, including improvements in immunization coverage, drug supplies, capacity for decentralization, funding allocations to district level, and recent optimism in HIV rates. Preliminary results from the just completed Demographic and Health Survey (DHS) point to real progress on reducing infant mortality and improved use of insecticide treated bednets, potentially impacting the tremendous toll taken by malaria in Tanzania. NGOs recognize the efforts of Ministry of Health and other partners in achieving these gains.

At the same time, data indicate that budgetary investments and concerted action are required to address intractable health problems such as childhood nutrition and maternal health and to the *rural – urban* and *poor – non poor* disparities in access to care and health outcomes. We face challenges in reducing maternal mortality and childhood malnutrition to targets set in the MKUKUTA. Current trends also suggest that the MDG targets are not likely to be met in these areas. The basic indicators of equity are in question: whether the poorest women and children achieve positive health outcomes.

Priorities

1. **Urgently resolve the human resource crisis by improving salaries and benefits for healthworkers including incentive packages for hardship posts**. The continuing human resource crisis has a devastating effect on provision of quality care, particularly for the poor and those living in remote areas. The number of Nurse B/MCH Aides is down 33 percent since the mid-1990s; clinical officers down 30 percent. Doctors are virtually unavailable in rural areas. Funded posts must be urgently filled, and additional health workers trained in key cadres. Monetary and non-monetary incentives should be implemented to motivate health workers to live in 'hardship' posts and to encourage doctors to work in rural areas.

2. **Dramatically improve provision of accessible and affordable care during childbirth and delivery, including emergency obstetric care.** The rate of skilled attendance at delivery is unique among the DHS indicators for having declined between 1992 and 1996, and between 1996 and 1999. There was no improvement according to preliminary findings of the 2005 DHS. A substantial increased investment in provision of caesarean section down to the health centre level, and a major improvement in referral systems (including roads and transport) is required so women can reach a hospital in event of an emergency. While ANC services are widely available and used, their quality needs to be significantly improved.

3. **Improve provision of drugs and supplies to peripheral facilities.** Health facilities in remote areas continue to face continual "stock-outs" of essential supplies and drugs, despite improvements in drug availability. A strong and reliable supply-line is needed to ensure essential drugs and supplies are regularly available from MSD at all facilities, and that drugs that arrive at health facilities are provided to people through official and formal channels.

4. **Ensure a minimum package of life saving health interventions are available for all regardless of their ability to pay.** Payment at point of use poses a barrier to poor

people to access care, and the exemption and waiver system has not been effective. Honest discussion is needed to assess the barriers that poor people face in accessing health care and how goals of equity -- particularly improved health outcomes for the poorest – can be achieved. User fees for basic health and life saving services should be suspended as a critical step towards improving health access for the poor.

5. **Ensure that the basic interventions that promote childhood nutrition and health are accessible for all, particularly in rural areas**. Under-nutrition is an underlying cause of 53% of deaths of children under five years of age. The average Tanzanian child becomes malnourished by the age of 16 months and nearly half are moderately or severely malnourished by that age. Higher levels of funding are needed for expansion of IMCI (e.g., breastfeeding, deworming, immunization, and reinforcement of multiple micronutrient supplementation), improvement of water and sanitation, and improved nutritional education by health and community development officers regarding proper nutrition of pregnant women and children.

6. **Significantly strengthen efforts in HIV/AIDS prevention, care and support highlighting the needs of young people and women who are particularly vulnerable to HIV/AIDS infection and are the key care-givers of people living with AIDS.** We must increase PMTCT efforts in both ante- and post-natal interventions, promote safer sex, and ensure care and support for people living with and affected by AIDS. Government and non-governmental resources must support community and family-based support structures so the burden of care and treatment is not resting on the shoulders of the poor and vulnerable. We need to revisit home-based care strategies and develop more gender-sensitive and community-based approaches with full government support. Concrete mechanisms are needed to ensure that ARVs are regularly available to the poor as well as the non-poor, women, and to people living in rural areas. .

7. **Establish, as called for in the MKUKUTA, inter-sectoral linkages to improve food and income security within the household and family.** People in rural areas (who experience regular food insecurity every year) require specific measures and support to produce enough food to provide for domestic consumption as well as sale for cash needs. Similarly, inter-sectoral linkages must strengthen the capacity of families and communities to care for children from the earliest stages of life, and with a particular emphasis on most vulnerable children and families.

8. **Develop inter-sectoral strategies for secure employment and livelihoods in rural as well as urban areas**. Improve food production, food security and nutrition of the poorest. Key sectors include farming, livestock keeping, fishing and other basic livelihoods that typically reach those living in poverty and for whom the basic right to employment and livelihood is often denied. Special attention is required to the (self) employment and livelihood needs of women, youth and the disabled.

9. **Implement Health Committees and Boards, and ensure broad representation on these bodies.** Health Committees and Boards are not functioning to the extent planned and wished for particularly beyond the District level. While they have the potential to improve health consumers' role in service delivery, this will require that the boards are truly representative of their constituencies and accountable to them. This should include effective mechanisms of providing feedback across all levels on issues of health worker performance, flow of drugs, allocation and use of money, and other priorities as defined by health users and providers. Leaders should demonstrate that feedback is used and responded to, so that the public is assured that participation makes a difference.

10. **Require that financial allocations and information on the use of money at any level is publicly posted and available.** Simple and easily understood systems for public scrutiny of budgets, disbursements and uses of health funds need to be instituted in every village, ward and district. While some villages and districts have begun to establish this, it is extremely rare. In addition, the information posted is often difficult for health consumers to understand and there is no feedback mechanism for raising questions and recommendations on use of finances for improved health service delivery.

This statement has been prepared by the following NGOs participating in the 2005 Joint Health Sector Review: African Youth Development Foundation, CARE, Marie Stopes, Save the Children, Shinyanga Foundation Fund, Tanzania Gender Networking Programme, Youth Action Volunteers, Women's Dignity Project.