MKUKUTA CLUSTER II:
Improvement of Quality of Life and Social Well-being

Assessment of Broad Outcomes

The two broad outcomes for the second cluster of MKUKUTA are:

- Improved quality of life and social well being, with particular focus on the poorest and most vulnerable groups
- Reduced inequalities (e.g. education, survival, health) across geographic, income, age, gender, and other groups

The central role of social service sectors – notably education, health, water and sanitation – is clearly recognised for achieving these outcomes, as is the key role of local government authorities as the primary providers of services at the local level.

This cluster includes sectors that were considered "priority sectors" in Tanzania's first Poverty Reduction Strategy (PRS), and it should be noted that strategies to ensure a well educated and healthy population are critical for promoting growth and for ensuring sound governance, and vice versa. The three clusters of MKUKUTA are thus mutually reinforcing, and despite the wider scope of MKUKUTA, the objectives of Cluster II, are no less important than they were in the PRS.

Assessment of Cluster Goals

MKUKUTA's Cluster II has five supporting goals:

1. Ensuring equitable access to quality primary and secondary education for boys and girls, universal literacy among men and women, and expansion of higher, technical and vocational education
2. Improved survival, health, and well-being of all children and women and especially vulnerable groups
3. Increased access to clean, affordable and safe water, sanitation, decent shelter, and a safe and sustainable environment
4. Adequate social protection and provision of basic needs and services for the vulnerable and needy
5. Effective systems to ensure universal access to quality and affordable public services

The most recent data from national surveys are analysed below for each of Cluster II's goals. However, for some indicators no new data are available since the PHDR 2005, though significant changes would not be expected over this short period of time. For several critical indicators, population based estimates offer a more comprehensive view of service-users' perspectives. Service site information, routinely collected by ministries and local government authorities, supplies useful information about the services provided.

Goal 1: Ensuring equitable access to quality primary and secondary education for boys and girls, universal literacy among men and women, and expansion of higher, technical and vocational education

A well educated population is indispensable for Tanzania's development, and rights to education are legally recognised in the Constitution and in ratified international conventions.

GOAL 1

Educational indicators for Goal 1 are:

- Literacy rate of population aged 15+
- Net enrolment at pre-primary level
- Net primary school enrolment rate
- Percentage of cohort completing Standard VII
- Percentage of students passing the primary school leavers' exam
- Pupil/teacher ratio in primary schools
- Percentage of teachers with relevant qualifications
- Pupil/text book ratio
- Transition rate from Standard VII to Form 1
- Net secondary enrolment
- Percentage of students passing the Form 4 examination
- Enrolment in higher education institutions

Several indicators rely on reported age and population projections for particular age groups. The population projections are provided by the National Bureau of Statistics, based on the Population and Housing Census 2002 (NBS, 2003), and incorporate assumptions about fertility and mortality rates, and the likely impact of HIV/AIDS. Errors in age reporting and uncertainties about projections can lead to estimates of net enrolment that are problematic. This situation is most noticeable in sub-national data, where net enrolment rates of over 100 per cent are reported for some areas.

Overall, the available data sourced from the basic data series of the Ministry of Education and Vocational Training (MoEVT) show positive trends. Net enrolment rates are higher in pre-primary, primary and secondary schools; the pupil:teacher ratio in primary schools is falling; the

percentage of pupils passing the Primary School Leavers' Examination is increasing; and the percentage of Standard VII pupils going on to secondary schools is also rising. However, strong regional differences are apparent from a more detailed examination of the data, similar to those reported in the PHDR 2005. Table 3 summarises the indicators and data for education.

Table 3: MKUKUTA Indicators for Education

Indicator	Baseline		Trends						Targets
	Estimate	Year	2001	2002	2003	2004	2005	2006	MKUKUTA 2010
Literacy rate of population aged 15+ %									
- Total	71%	2000/1	-	69	-	-	-	n/a	80%
- Male	64%		-	62	-	-	-		80%
- Female	80%		-	78	-	-	-		80%
Net enrolment at pre-primary level %	24.6	2004	-	-	-	24.6	25.7	28.5	-
Net primary school enrolment rate %	59%	2000	66.5	80.7	88.5	90.5	94.8	96.1	99%
% of cohort completing Standard VII	70%	2000	62.5	68.1	67.4	72.2	68.7	n/a	90%
% of students passing Primary School Leavers' Exam	22%	2000	28.6	27.1	40.1	48.7	61.8	n/a	60%
Primary pupil/teacher ratio	46:1	2000	-	53:1	57:1	58:1	56:1	52:1	45:1
% of teachers with relevant qualifications	-	-	50	-	-	58[4]	-	69.2	-
Transition rate from Standard VII to Form 1	21%	2002	22.4	21.7	30.0	36.1	48.7	n/a	50%
Net secondary enrolment %	6%	2002	-	5.9	6.3	8.4	10.3	13.4	50%
% of students passing the Form 4 Examination	25.8	2000	28.3	36.2	38.1	37.8	33.6	n/a	70%
Gross enrolment in higher education institutions		2000/1	2001/2	2002/3	2003/4	2004/5			
	22,065		24,302	30,083	39,318	48,236	n/a	n/a	

4 From PHDR 2005; figure includes diploma and graduate teachers

The 2002 census provides the most recent data for adult literacy. Rates are not expected to achieve MKUKUTA's target of 80 per cent by 2010. Adult literacy programmes face resource constraints, squeezed by priorities accorded programmes for younger learners. However, adult programmes need not consume large resources, and the benefits are well demonstrated. For example, higher rates of female adult education are strongly associated with lower rates of infant and child mortality.

The data for pre-primary enrolment specifically refer to 5 and 6 year-olds enrolled in pre-primary classes associated with primary schools. As a result, the data for pre-primary enrolment do not capture the full range of provision for young children. The proportion of younger children enrolled in early childhood development centres is thought to be much lower than the percentages reported for the pre-primary cohort. Interim arrangements also require parental and community contributions to help resource pre-primary schooling, which may have equity implications.

For primary and secondary education, there are serious shortages of teachers, especially of qualified teachers, and while the primary pupil:teacher ratio is falling, it remains high, compared to MKUKUTA's target of 45:1.

There has been a substantial increase in the proportion of pupils passing the Primary School Leavers' Examination over the past few years. There may be several reasons for this improvement. The Primary Education Development Programme (PEDP) has clearly led to improvements in inputs for teaching and learning. The weighting of subjects has also changed to give Kiswahili greater weight in the examinations, and most pupils get higher grades in this subject than in English and mathematics. Ongoing quality control and monitoring is required to ensure that the demands of the Primary School Leavers' Examination remain constant and that questions in the examination are not getting easier.

Data on the availability of textbooks in primary schools to pupils is being strengthened and its importance as an indicator of quality of education is well recognised. Districts' reports of aggregate numbers of text books may require further study to ensure that pupils actually have access to the books.

The pass rate of secondary students in the Form 4 Examination faltered in 2005. The percentage of students who achieved a pass with division 1 to 3 was 33.6 per cent compared with 38 per cent for the two previous years.

Enrolment in higher education institutions has increased, and the percentage of women enrolled has also increased over the past five years from 23.9 to 32.7 per cent. However, data need further disaggregation. For example, the number of graduates each year disaggregated by subject may provide information about whether skills shortages are being addressed, such as those in the health sector. Efforts to strengthen higher education data have begun.

Additional public funding is required to resource education, including expansion of quality secondary education and provision of greater opportunities for vocational and technical training and higher levels of education. Funds may need to be identified through a re-prioritisation of items in the government budget, not only in the education sector. In addition, alternative financing options, such as the more extensive use of soundly managed loans schemes, need to be examined for those aspects of education and training with high private benefits.

GOAL 2: Improved survival, health and well-being of all children and women and especially vulnerable groups

A healthy population is more likely to be a productive and civically active population. MKUKUTA's goal for health focuses on those groups who bear a disproportionate burden of disease and have greater need for health care – girls/women of reproductive age and young children. This specific goal is a key component of the broader strategic goal to ensure universal access to quality health services, which is articulated in Goal 5 of this cluster.

GOAL 2

Indicators for health for Goal 2 are:

- Infant mortality rate
- Under-five mortality rate
- Diphtheria, Pertusis, Tetanus and Hepatitis B (DPTHb3) immunisation coverage
- Percentage change in mortality attributable to malaria among children under-five
- Proportion of under-fives moderately or severely stunted (height for age)
- Maternal mortality ratio
- Proportion of births attended by a skilled health worker
- Percentage of persons with advanced HIV infection receiving anti-retroviral (ARV) combination therapy
- HIV prevalence among 15-24 year olds
- Tuberculosis (TB) treatment completion rate

The majority of these indicators are reported periodically; the most recent data are available in the PHDR 2005. New surveys are in progress which will provide further data in the near future. In the interim, reviews of the health sector examine a comprehensive set of indicators for health care delivery. However, the health management information system needs further strengthening to ensure timely data is available to inform planning and budgeting.

The 2002 Census and the Tanzania Demographic and Health Survey (TDHS) 2004/05 (NBS and Macro International, 2005) are the most recent sources of data for estimates of infant and under-five mortality rates. Both surveys showed declining mortality rates, with data from the TDHS suggesting that the decline may be largely attributable to the more effective

prevention and management of malaria. **Estimates for the change in mortality attributable to malaria in young children are not available**, but an alternative indicator – the percentage of young children and pregnant women sleeping under treated mosquito nets – could be valuable as a proxy indicator. The TDHS can report this data periodically, which would provide useful information to monitor the effect of important preventive measures. These measures, in turn, can reduce costs of treatment.

Table 4: MKUKUTA Indicators for Health

Indicator	Baseline		Trends						Targets
	Estimate	Year	2001	2002	2003	2004	2005	2006	MKUKUTA 2010
Infant mortality per 1,000 live births									
- TDHS	99	1999				68		n/a	50
- Census				95					
Under-five mortality per 1,000 live births									
- TDHS	147	1999[5]				112		n/a	79
- Census				162					
% DPTHb3 coverage									
- MoH&SW	78%					80[6]	85	n/a	85%
- TDHS	81%	1999				86			
Proportion of under-fives moderately or severely stunted (height for age)	44%	1999				38		n/a	20%
Proportion of births attended by a skilled health worker	36%	1999				46		n/a	80%
% of persons with advanced HIV infection receiving ARV combination therapy						Start of progr-amme		By August 48% of target	100,000 by Dec 2006
% HIV prevalence among 15-24 year olds									
- THIS					3.5			n/a	5
- Blood donors			9.1	7.4	6.7	7.4			
% TB treatment cure rate	81%	2001			80.9			n/a	

The footnotes for this table are overleaf

There are wide variations in estimates of infant and under-five mortality rates across regions and districts, which were also reported in the PHDR 2005. The high rates of under-five mortality per 1,000 live births in Rwangwa (250), Dodoma Rural (239), and Mtwara Rural (231) imply that 1 child in 4 dies before reaching the age of five years in these districts. In fifteen districts, the majority of which are located in the south-east of the country, under-five mortality rates are 200 or higher. By contrast, several districts in the north-east have under-five mortality rates of around 50, or four times lower than rates in the worst affected areas.

Malnutrition in children under-five years continues at a high rate. The rate of malnutrition has declined in the past few years, but not at the same rate as the reduction in under-five mortality. Nearly 4 children in 10 are stunted for their ages, a reflection of under-nutrition over a long period of time. In Tanzania, stunting typically begins as early as 3 months, continuing to 2-3 years of age, after which children do not continue to lose stature compared to the norm, at these ages low height stabilises. However, it is difficult for children to recover from early stunting and its implications for cognitive development. Of note, the age at which malnutrition sets in coincides with the period that young children and their caregivers have frequent contact with health services. Consequently, the health sector review urged that health services pay closer attention to monitoring and preventing child malnutrition.

Immunisation coverage should be near universal, and coverage has been maintained at a high level. Data on immunisation coverage comes from the TDHS and from routine reporting of the programme of immunisation.[7]

The proportion of births attended by a skilled health worker is an indicator of access to reproductive health care and a proxy indicator for maternal mortality, which is extremely difficult to monitor because of the very large samples needed to generate reliable estimates. The proportion of births attended by a skilled health worker recorded in the TDHS 2004/05 increased to 46 per cent, but is still very low compared to MKUKUTA's target of 80 per cent. Urban women and the least poor are much more likely to give birth with a skilled health worker in attendance. The provision of skilled obstetric care, especially for rural women, requires much greater priority.

The government has set a target of 100,000 people with advanced HIV infection to be provided ARV combination therapy by the end of 2006. As of August 2006, 48 per cent of the targeted number of people was reported to be receiving treatment. Recognising the critical importance of preventing the spread of HIV, the MKUKUTA monitoring system also reports on the HIV prevalence among 15-24 year olds, an indicator used to estimate the rate of newly

5 Estimates are recorded against the year of data collection, but under-five mortality rates refer to deaths during five year period prior to survey and three year period prior to census, maternal mortality to ten year period prior to survey.

6 Does not include Hb

7 The Health Abstract, covers only DPT3, and shows coverage of 91.3% for 2004. TDHS and the Expanded Programme of Immunisation (EPI) results cannot be compared directly, as TDHS results are population-based and EPI are facility-based. Hepatitis B antigen was introduced recently. Therefore, previous surveys collected DPT3 information only. Late in 2006 a new antigen will be introduced and results in the following year may show a decline until all children are immunized. The new antigen will also cost three times the old one, which will require additional budgetary support to maintain the same level of coverage.

infected people. The initial Tanzania HIV/AIDS Indicator Survey (THIS) 2003/04 (TACAIDS, NBS and ORC Macro, 2005) reported a rate of 3.5 per cent. A second survey is planned for 2007/08, which will provide national trend data.

HIV rates are also assessed through tests of blood from donors. The infection rate derived from this source of data is higher – 6.7 per cent in 2003. This is likely due to the higher urban weighting of this sample. Infection rates are higher in urban locations compared with rural areas, and among girls/women than among boys/men. The blood donor data, which showed a downward trend in new infections from 2001 to 2003, rose slightly to 7.4 per cent in 2004.

The control of HIV/AIDS has attracted high external funding, especially for treatment, and there are concerns about the sustainability of this funding beyond the short term for which it is currently pledged.

GOAL 3: Increased access to clean, affordable and safe water, sanitation, decent shelter and a safe and sustainable environment

Increased access to safe water is one of the most pressing priorities for many communities, especially in rural areas.

GOAL 3

Indicators identified for this goal are:

- Proportion of population with access to piped or protected water as their main drinking water source (with a 30 minute timeframe spent on going, collecting and returning to be taken into consideration)
- Number of reported cholera cases
- Percentage of households with basic sanitation facilities
- Percentage of schools having adequate sanitation facilities (as per Ministry of Education and Vocational Training policy)
- Total area under community based natural resources management

For access to water and basic sanitation, data from the 2002 census and the TDHS 2004/05 shows that less than half of the rural population has access to safe water. This is a priority deserving more resources. Significant differences are also noted between estimates from population-based surveys and routine administrative data from ministries responsible for water and sanitation. The latter do not report on the time taken to reach the water source, collect water, and return home. Instead, they report on the numbers of households connected to, or within a short distance of, water schemes. In addition, the percentage of households with basic sanitation facilities includes all households who reported having any type of toilet or latrine, and does not consider whether such facilities are actually used by all members of the household.

The MoEVT policy for schools' sanitation facilities stipulates ratios of facilities to pupils of 1:20 for girls and 1:25 for boys. The figures reported below relate to sanitation facilities in primary schools that meet the required standards. Schools with 'temporary' facilities are not counted. In terms of infrastructure, the PEDP has focused on building classrooms, although there is increasing recognition that school sanitation must be improved.

Table 5: MKUKUTA Indicators for Water and Sanitation

Indicator	Baseline		Trends						Targets
	Estimate	Year	2001	2002	2003	2004	2005	2006	MKUKUTA 2010
Proportion of population with access to piped or protected water as their main drinking water source (with a 30 minute time to go, collect and return considered)	Urban 73%	2000/1		Urban 85%	Urban 73%				Urban 90%
	Rural 53%			Rural 42%	Rural 53%			n/a	Rural 65%
	Within 200m of water source			from Census	from admin data				
% of households with basic sanitation facilities	91%	2002		91				n/a	95%
% of schools having adequate sanitation facilities (as per MoEVT policy)			35.7	36.2	32.8	36.7		n/a	100% Ratio of 1:20 girls 1:25 boys
Number of reported cholera cases (attack rate per 100,000 people)			6.9	28.5	35	20.9		n/a	Reduce outbreaks by half by 2010

Data show cholera peaked in March, June and December in 2005. Forty per cent of cases were in Tanga, 26 per cent in Kigoma, and 17 per cent in Rukwa. Despite more extensive press coverage, Dar es Salaam accounted for only 5 per cent of cases.

The PHDR 2005 noted progress in developing an indicator for the MKUKUTA operational target of reducing cholera outbreaks by half by 2010, which would recognise the wide

fluctuations from year-to-year and the localised epidemiology of cholera. The report recommended counting 'attack rates' of more than 10 cases per 100,000 people, and to make the operational target a reduction by half in the number of regions experiencing annual attack rates over this level. This new indicator would represent an improvement on the descriptive 'snapshot' data currently provided. Adopting this indicator is recommended.

The indicator for community based natural resource management usefully links issues of environmental protection with economic development, especially given recent studies showing large untapped reserves of natural resources in Tanzania (World Bank, 2005). Acknowledging this link, the indicator might be better placed with goals in MKUKUTA's first cluster, rather than among indicators specifically related to access to water and sanitation. Nonetheless, the essential role of protecting water sources through sound environmental practice is recognised. Broad issues are included for this indicator, including forestry and wildlife as well as marine fisheries and tourism development. Data are scanty. The most detailed information is available for the forestry sub-sector. The estimated area of Tanzania's forests and woodlands is 38.8 million hectares, of which, 15 million hectares are reserves that could directly benefit from better and sustainable management as provided under the Forestry Act 2002. However, only approximately 600,000 hectares were owned and managed by local governments in 2001, and only 1% of the total forest reserve area is currently under community based or joint management arrangements (Tanzania Development Partners' Group, 2006). Procedures and regulations to implement the Act are currently being prepared, but the need exists to improve the monitoring, information and records systems at central government level within the Ministry of Natural Resources and Tourism (MNRT). This would improve oversight of land management and wildlife stocks, as well as promote transparency and accountability in setting and collecting fees and licenses.

GOAL 4: Adequate social protection and provision of basic needs and services for the vulnerable and needy

GOAL 5: Effective systems to ensure universal access to quality and affordable public services

The goals for social protection and access to public services were developed in recognition that vulnerability is widespread in Tanzania, and that principles of equity require that everyone should be able to access public services.

The goal for social protection is new in Tanzania, and MKUKUTA recognises that a comprehensive policy on vulnerability and social protection should be developed and enforced. Until such time, particularly vulnerable groups of people – notably the long-term ill, children and the elderly – are the focus of government action.

GOALS 4 & 5

Indicators for these two goals are:

- Proportion of children in child labour
- Proportion of children with disability attending primary school
- Proportion of orphaned children attending primary school
- Proportion of eligible elderly accessing medical exemptions at public health facilities
- Proportion of population reporting to be satisfied with health services

These are new indicators, and for most of them the data are not yet available.

Child labour is defined as work performed by children under 18 years of age which is exploitative, hazardous or inappropriate for their age, and which is detrimental to their schooling, or social, mental, spiritual and moral development. While data is available on the proportion of children who are working, no national survey assesses and reports whether the work performed is exploitative or hazardous. Rapid assessments carried out by the International Labour Organization (ILO) in 2002/3 identified commercial agriculture, mining, domestic service, commercial sexual exploitation, and the urban informal sector as the sectors most associated with hazardous and exploitative child labour.

Data from the MoEVT show 18,291 disabled children attending primary schools, which represents 0.25 per cent of the mainstream school population. Clearly, this percentage is much lower than the proportion of disabled children in the population. The variance may be accounted for in part by the significant differences in levels and kinds of disability which determine whether a child enrols and actually attends school. Moreover, the 2002 Census reported that only 2 per cent of the population were disabled, well below the general yardstick of the World Health Organisation of 10 per cent. Recent analysis of census data shows that children with disabilities are less educated than their peers without disabilities. The absolute difference in potential years of primary education missed is 1.9 years for 14-year-old children with a disability, increasing to 2.3 years for 17-year-olds (Lindeboom, et.al., 2006).

The most recent estimate of children under 15 years who have been orphaned (i.e., who have lost one or more parents) is 8.5 per cent of the total population for this age bracket (TDHS 2004/05). **The MoEVT reported in 2006 that 9.4 per cent of children attending primary school were orphans.** The risk of becoming orphaned rises with age, and so these two statistics suggest that orphanhood per se may not be a great barrier to school attendance, especially with community support for school attendance. Analysis of census data similarly indicated little difference in aggregate school attendance between children who had been orphaned and those with both parents. However, this relationship is confounded by the fact that large proportions of children who are orphans have lost their parents due to HIV/AIDS, and that the prevalence of HIV is higher among urban and less poor households. Further disaggregation of data is needed to isolate a more precise indicator of vulnerability. Research shows that maternal

orphans (i.e., children who have lost their mothers) are more vulnerable than others, and orphanhood at an early age leads to greater disadvantage.

Data on the proportion of eligible elderly accessing medical exemptions at public health facilities will be collected for the first time in 2007 via the HBS. The elderly that are eligible for exemption are those deemed by the community as being unable to pay. A clear and comprehensive policy on waivers and exemptions, backed by systematic information dissemination to all stakeholders about entitlements, and financial provisions to ensure that costs incurred by individual health facilities in treating patients with exemptions will be reimbursed by government are required in order to reach the 100 per cent compliance target set in MKUKUTA.

The HBS 2000/01 (NBS, 2002) examined levels of satisfaction with public health services by the following types of facility or practitioner visited: public dispensary/hospital, regional hospital, community health centre, private dispensary/hospital, private doctor/dentist, missionary hospital/dispensary, traditional healer, and pharmacy/chemist. The highest satisfaction overall was with pharmacy/chemist followed by private doctor/dentist; the lowest with regional hospitals and community health centres. The biggest causes for complaint were the cost of regional hospitals and the lack of drugs at community health centres. In total, the proportion expressing satisfaction was 62 per cent. However, this data fails to capture community perspectives on reasons for not seeking health care. The next section of the report on goals for governance and accountability includes further discussion on satisfaction with public services.

MKUKUTA Cluster II: Indicators, available data and targets[8]

Indicator	Baseline		Trends						Targets
	Estimate	Year	2001	2002	2003	2004	2005	2006	MKUKUTA 2010
GOAL 1: Ensure equitable access to quality primary and secondary education for boys and girls, universal literacy and expansion of higher technical and vocational education									
Literacy rate of population aged 15+ %	71%	2000/1		69					80%
- male	64%			62					80%
- female	80%			78					80%
Net enrolment at pre-primary level	24.6%	2004				24.6	25.7	28.5	Increase
Net primary school enrolment rate	59%	2000	66.5	80.7	88.5	90.5	94.8	96.1	99%
% of cohort completing Standard VII	70%	2000	62.5	68.1	67.4	72.2	68.7		90%
% of students passing the Primary School Leavers' Exam	22%	2000	28.6	27.1	40.1	48.7	61.8		60%
Primary pupil/teacher ratio	46:1	2000		53:1	57:1	58:1	56:1	52:1	45:1

8 Sources as noted in the Ministry of Planning, Economy and Empowerment, MKUKUTA Monitoring Secretariat, Indicators to Monitor National Strategy for Growth and Reduction of Poverty (MKUKUTA), draft 1 July 2006

Indicator	Baseline		Trends						Targets
	Estimate	Year	2001	2002	2003	2004	2005	2006	MKUKUTA 2010
% of teachers with relevant qualifications			50			58[9]		69.2	
Pupil/text book ratio	4:1	2000							1:1
% Transition rate from Standard VII to Form 1	21%	2002	22.4	21.7	30.0	36.1	48.7		50%
% Net secondary enrolment	6%	2002		5.9	6.3	8.4	10.3	13.4	50%
% of students passing the Form 4 examination (division 1-3)	25.8%	2000	28.3	36.2	38.1	37.8	33.6		70%
Gross enrolment in higher education institutions	22,065	2000/1	2001/2 24,302	2002/3 30,083	2003/4 39,318	2004/5 48,236			
GOAL 2: Improved survival, health and well-being of all children and women and especially vulnerable groups									
Life expectancy at birth	51	2002		51					
Infant mortality rate[10]									
- Census				95					50
- TDHS	99	1999				68			
Under - 5 mortality rate[11]									
- Census				162					79
- TDHS	147	1999				112			
DPTHb3 coverage									
- TDHS	81	1999				86			85
- EPI	78					80[12]	85		
Proportion of under-fives moderately or severely stunted (height for age)	44	1999				38			20
Maternal mortality ratio[13]	529	1996				578			265
Proportion of births attended by a skilled health worker %	36%	1999				46			80%
Number of persons with advanced HIV infection receiving ARV combination therapy		2004				Start of programme		By Aug 48% of target	100,000 by Dec 2006
HIV prevalence amongst 15-24 year olds %									
- THIS					3.5				5%
- Blood donors	9.1%	2001	9.1	7.4	6.7	7.4			
TB treatment completion rate	81%	2001			80.9				To be determined

9 From PHDR 2005, which covers diploma and graduate teachers.
10 Estimates are recorded against the year of data collection, but infant and under-five mortality rates refer to deaths during five-year period prior to survey and three-year period prior to census, maternal mortality to ten-year period prior to the survey. Infant mortality per 1,000 live births.
11 As per footnote 9 above
12 Does not include Hb
13 As per footnote 9 above. Maternal mortality number of deaths per 100,000 live births.

Indicator	Baseline		Trends						Targets
	Estimate	Year	2001	2002	2003	2004	2005	2006	MKUKUTA 2010
GOAL 3: Increased access to clean, affordable and safe water, sanitation, decent shelter and a safe and sustainable environment									
Proportion of population with access to piped or protected water as their main drinking water source (with 30 minutes - go, collect, return to be taken into consideration)	Urban: 73% Rural: 53% within 200m of a water source	2000/1		Urban: 85 Rural: 42 from Census	Urban: 73 Rural: 53 from MoW				Urban: 90 Rural: 65 (within 30 minutes to go, collect & return)
% of households with basic sanitation facilities	91%	2002		91					95
% of schools having adequate sanitation facilities (as per policy ratio of toilets to pupils)			35.7	36.2	32.8	36.7			100% with ratios 1:20 for girls 1:25 for boys
Number of reported cholera cases (attack rate per 100,000 people)			6.9	28.5	35.0	20.9			Reduce cholera outbreaks by half by 2010
Total area managed by mandated local institutions for the purposes of community based natural resources management									To be determined
Goal 4: Adequate social protection and rights of the vulnerable and needy groups with basic needs and services									
Goal 5: Systems are in place to ensure universal access to quality public services that are affordable and available									
Proportion of children in child labour			Children working 2000/1 HBS 28.2% 2000/1 ILFS 19% 2001 Census 16%						Below 10%
Proportion of children with disability attending primary school									20%
Proportion of orphaned children attending school									
Proportion of eligible elderly accessing medical exemptions at public health facilities									100%
Proportion of population reporting to be satisfied with health services				62%					To be determined