

DECENTRALIZATION IN TANZANIA IN THE 1990S

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In 1978, the Alma Ata declaration made the push for primary healthcare and health services for all a global priority. While countries around the world chose to pursue this goal in different ways, Tanzania chose to intensify its pursuit of decentralization to reach rural populations who had previously been neglected by colonial healthcare systems as well as centralized system in place from the 1960s. In the 1990s, following a shift from socialist policy, Tanzania began to implement decentralization-by-devolution as a continuation of a world-wide push to reform healthcare. While local governments were granted more responsibility for local health care, responsibility did not necessarily translate to progress as health care reforms were continually impeded by a lack of funds, a lack of qualified workers, and incomplete decentralization reforms.

The British colonial government maintained control of Tanzania until 1961. Their focus was primarily on the urban curative medicine, as was typical of the time period, and few resources were dedicated to rural or preventative care. Medicine resources were also primarily directed towards white residents, such as civil servants, as opposed to the Africans. The new Tanzanian government as established in the early 1960s inherited the colonial healthcare system and began altering it (Gilson 45).

Tanzania became an independent nation in 1961 with Julius Nyerere as its first president. Nyerere would go on to be known as the “father of the nation” and his ideas would continue to influence Tanzanian governance and politics for decades (Havnevik 19). Before independence, Nyerere served as the chairman of the Tanganyika African National Union (TANU), which was the only party present in Tanzanian politics at the time. Nyerere and TANU utilized the general post-independence optimism of the public to implement their ideas of what form an independent Tanzanian state should take. In February 1967, Nyerere and the Tanzanian government

published the Arusha Declaration, a figurative “blueprint” for policy Nyerere intended to pursue for the development and modernization of Tanzania (Hyden 1). The Arusha Declaration was primarily based on the idea that Tanzania was a “country for all.” It looked to build a socialist society and provide basic services, such as health care, to all Tanzanian citizens and workers. The Arusha Declaration asserted the necessity of state intervention in the economy in order to prevent excess wealth accumulation and similar unfair conditions present in capitalist society (Havnevik 36).

A strong political party and centralized government was necessary to guide Tanzania in this direction (Hyden 1). The ideas stated in the Arusha Declaration garnered substantial domestic support from citizens with the “strong emphasis on basic needs satisfaction” (Havnevik 42). Ultimately, the power granted to the party and government in Tanzania was meant to allow for investment in education and health infrastructure (Havnevik 74). Tanzanians trusted that the government would use this power to provide the healthcare services promised in the Arusha Declaration throughout the country (Munga 3). The Ministry of Health was responsible for the administration of the entire healthcare system in Tanzania. Communication and planning followed a strict hierarchy with individuals in charge of health facilities reporting to the District Medical Officer. The District Medical Officer then reported to the Regional Medical Officer, who then finally reported to the Chief Medical Officer at the Ministry of Health (Mubyazi S168).

Unfortunately, the development scheme as proposed by Nyerere and the fledgling Tanzanian government was too ambitious for the time. Tanzania’s public sector revenue was not able to match the public expenditure and the economy was suffering as a result. In order to maintain the development program, Tanzania began accepting foreign aid in 1970. By 1980, the amount of aid coming into the country eclipsed Tanzania’s export revenue (Hyden 3). Foreign

aid to Tanzania initially came without contingencies. However, the worldwide sentiment and the donors supporting Tanzania became increasingly critical of the inefficiency and incompetency of the socialist based society. The subsidies provided by the Tanzanian government to poor farmers were holding these farmers back from becoming efficient and successful and was thus the source of Tanzania's economic woes. As oil shocks rocked the world in 1973 and 1979, Tanzania's trade and economic situation continued to suffer. Ultimately, the economic situation became dire and world-wide sentiment prompted Tanzanian government began discussing the possibility of implementing a structural adjustment program with the World Bank and International Monetary Fund in 1978 (Havnevik 75-76).

The Tanzanian government acquiesced to popular global sentiment and a three-year Economic Recovery Program (ERP) was implemented in 1986, one year after Nyerere left office as the president (Hyden 1401). Tanzania also came to an agreement with the IMF and after the end of the ERP, implemented a longer-term Structural Adjustment Program. Both programs focused on the privatization of economic and banking services and in general, cut government support to many ancillary support programs, such as those subsidizing rural farmers. The SAP as implemented in Tanzania sought to stabilize agriculture exports via foreign aid and allowed foreign ownership of Tanzanian enterprises (Hyden 1400).

Ultimately, Nyerere's ambitions for a socialist Tanzania as stated in the 1967 Arusha Declaration fell short of reality. Tanzania was unable to successfully build on the bare bones of the British health care system and provide all Tanzanian citizens with their basic health-care needs, despite widespread popular support. The failure of Nyerere's government to keep the economy afloat and a rise in worldwide neoliberal sentiment pushed Tanzania to enter into an agreement with the World Bank to liberalize their economy. The increase in support for

neoliberal policy in the 1980s was followed by a series of decentralization reforms intended to take power and responsibility for basic services, such as health care, away from the central government (Munga 4).

The push for decentralization came from a change in healthcare policy as well as a shift in politics and economic ideas. Decentralization itself is defined as “the transfer of responsibility for planning, management, and the raising ... of resources from the central government... to ... regional authorities” (Gilson 452). In the early 1970s, decentralization gained traction worldwide as an effective approach to providing healthcare and was accompanied by a global push towards preventative and primary care medicine. The Alma Ata declaration in 1978 advocated for these ideas and numerous countries, donors, etc. (including Tanzania) incorporated these ideas in their plans for development. Rural healthcare access and broader rural development was an important component of these policies (Gilson 455).

Tanzania lay the groundwork for decentralization throughout the 1980s by passing several important laws that re-established district-based governments that had been abolished and granted them the power to generate financial revenue (Munga 4). As a tool to promote development, decentralization also fit in with larger shifts in Tanzanian economic policy at the time by allowing central governments to cut costs and shift the financial burden of services like healthcare to local governments and citizens. Initially, the reforms from the 1980s yielded marked improvements in healthcare; funding to rural healthcare doubled and there were four times more medical auxiliaries working in rural areas. The number of people living within ten to five kilometers of a health unit also reached 90% (Gilson 456).

While there are several different ways to achieve decentralization, Tanzania chose to implement healthcare reform through decentralization-by-devolution (D-by-D). Devolution

specifically entails the complete transfer of power from a central government authority to a local one (Inkoom 105) Devolution was intended to enable rural and healthcare development by promoting self-empowerment and cutting out the bureaucracy of the centralized system. In theory, devolution allows for greater community involvement and allow local authorities to serve individual community needs more effectively (Gilson 455). Both the community and the local authority engage in exchange of trust and services. In order to generate revenue from the community, the local authority must show that they will provide the services promised (in this case healthcare) and the community must become involved with the financing and planning of the intended healthcare system to ensure its success (Lufunyo 31)

In 1990, the Ministry of Health and Social Work released an official “National Health Policy,” indicating an expansion of the national push for decentralization to healthcare. The official policy document delineated the goals for the upcoming decade and how they would be accomplished. The document gives “self-reliance” as an important driving factor for Tanzanian development, echoing popular neoliberal ideas. The document also highlights decentralization as a primary way of pursuing the broader goal of primary health care, by way of strengthening district health services while the Ministry of Health continued to provide broader health policy guidelines. Tanzania also intended to address the broader factors that played an important role in primary health care, such as healthcare education, nutrition, water sanitation, etc. The official policy documents also elaborate on how important community involvement was to ensure decentralization and health care reform measures were effective (Ministry of Health 18).

The official policy document released by the Ministry of Health outlines how healthcare systems should be restructured as healthcare reform was implemented. The new system was a drastic departure from previous systems and established a new hierarchy for patient care. The

lowest level of patient interaction was the village system which was to be staffed by at least two workers, one dedicated to maternal/infant care and another dedicated to environmental sanitation. The next level of health services are dispensaries, which are intended to serve multiple villages, and provide health education and vaccinations, treat diseases, etc. to six to ten-thousand people. Health centers were intended to serve as a smaller-scale hospital for up to 50,000 people, allowing for short-term patient hospitalization as well as supervision of the local dispensaries. The district hospital was the next step up and was to provide all standard medical services (x-rays, standard illness treatment, etc.) that did not require a specialist. These hospitals were required in each district by the Ministry of Health and required to have access to transport facilities such as ambulances, etc. The next level of care was the regional hospital, of which there were four throughout Tanzania. They offered similar services to those offered at district hospitals but had specialists, such as surgeons or gynecologists, onsite to provide additional services. The highest level of care was the referral hospital, of which there were six at the time. These hospitals were to be fully modernized and offer preventative care, teaching, and research opportunities in addition to normal medical services (Ministry of Health 21-30).

While the national Ministry of Health and Social Welfare provides regulations and guidance, the figurative “unit” of the restructured Tanzanian healthcare system was the district (Inkoom 105). Power and responsibility were mainly transferred from the central government to local government authorities (LGA) operating on the district level. Districts were intended to serve fifty to five hundred thousand people which was, in theory, “compact” enough to allow for comprehensive treatment and medical care for the population, as well as careful management of village-level healthcare. The consideration of the district as a unit also allowed for a space to integrate both bottom-up planning, allowing for what communities need, as well as vertical

programs, such as those corresponding to broader national healthcare goals (Gilson 452-453). The local governments, as outlined in the official 1990 Health Policy document, was responsible for raising funds to effectively run the dispensaries and health centers in their purview, supplemented to some extent by the central government (Ministry of Health 37).

While the Ministry of Health developed guidelines for planning and required centers, as previously discussed, the district council and the District Health Management Team (DHMT) were primarily responsible for the execution of these plans. The district council approves health plans and budgets, raises funds to finance district activities by levying taxes, and supervises other government functions (such as providing clean water) (Inkoom 106). The district council meetings are also intended to function as a forum for community members to become involved in local healthcare planning and to make their concerns known. The council is composed of elected councilors and the District Executive Director (DED) (Mubyazi S168). The DHMT was responsible for preparing the plans as well as the logistics of running the local medical facilities. The DHMT may also work with local lower-level facilities to provide health services. Similar management teams and councils also operate at the regional level and fulfill many of the same functions (Inkoom 105-106).

While rebuilding the healthcare system, the government left vestiges of the old regional administration in place while strengthening the district system, creating a hybrid two-tier system of administration (Gilson 457). The old system was not completely separated from the new system, resulting in less strict boundaries between the responsibilities and authority of different units within the healthcare system. The new, less strict hierarchy also required excellent communication between all members to ensure that operations proceeded smoothly, but this was difficult to ensure (458).



While the general intended structure of the healthcare system is same for each district, each district has chosen to implement these reforms in unique ways. However, similar problems exist between districts, reflecting greater flaws in the system. For instance, LGA were given the authority to generate revenue to direct towards local healthcare by levying taxes but they were ultimately unsuccessful in generating revenue this way from the local community. Most funding for district healthcare initiatives come from the central government and international/national organizations (Kigume 1055-1056). The difficulty in generating local revenue may stem from the fact that farmers in rural districts faced a substantial decrease in income due to the devaluation of the Tanzanian currency during economic reforms in the 1980s, making it difficult for them to shoulder the additional financial burden of a new tax (Booth 52). LGAs are also responsible for funding a several other public services, including primary education, water supply, etc. Overall, locally generated revenue accounts for less than ten percent of expenditure (Frumence 2-3). Therefore, in practice, the decentralization of financial power to districts has not effectively increased district's financial capacities.

The lack of local revenue has left districts primarily dependent on the funding provided by the central government. However, funding from the central government is tied to several conditions that must be fulfilled; for example, the health plans drafted by the DHMT must adhere to priorities set by the Ministry of Health and Social Welfare in order to receive funding. In addition, there is a long approval process for the health plans to be processed and approved by the central government (3). The central government has limited resources to allocate to struggling districts after decentralization reforms. Concurrent with national adoption of the structural adjustment program, the Tanzanian government spent thirty-eight percent less on healthcare from 1980 to 1990 (Gilson 458).

The funds from the central government are also often disbursed late, as the funds come from the government's annual revenue collection (Frumence 6). Members of district health management teams often complain that funds are not disbursed on times, causing delays in the implementation of health initiatives (5). In cases that the government does not generate enough funds from revenue collection, districts are left to deal with insufficient allocation funds (6). The lack of funds and delayed funds leads to alterations in the health plans drafted by the DHMT and the prioritization of cheaper, less time-intensive projects over others (6). The lack of funds also impedes health workers from carrying out their duties; for example, there may be insufficient funds for fuel to allow a worker to conduct an onsite visit (Kigume 1960).

The lack of qualified staff working in the Tanzanian healthcare system is also a significant barrier. In general, health care facilities in Tanzania are extremely shorthanded, with some districts facing shortages of up to fifty percent of skilled workers (10). It is difficult to recruit highly skilled workers to rural areas as there is little funding (resulting in low salaries for civil workers) and much higher demand in urban areas as well as the private sector (Munga 8). In addition, the workers staffing the district level facilities were unfortunately not trained and underprepared for their positions. Limited funds also make it difficult for the districts to pay for financial or administrative training for its employees (Kigume 1058). Health managers have varying backgrounds; most health managers possess bachelor's degrees, and some have obtained advanced degrees in addition. However, few members received any training on planning district health plans and budgets (Kigume 1062). The lack of personnel trained in budgeting and administration makes it even more difficult for districts to adjust to sudden changes in budget or a lack of funds (1063). Ultimately, in the wake of healthcare reforms throughout the 1990s, rural

districts in Tanzania found it so difficult to recruit workers that responsibility for hiring rural workers was re-centralized to the Civil Service Department in 2006 (Munga 3).

Community engagement is a central aim of healthcare decentralization. By involving the community in local healthcare reforms, the needs of the individual community could theoretically be identified and addressed (Kigume 1054). It was found that community members were given more opportunities to participate in the identification of local healthcare needs and comment on local policy through forums (such as district council meetings); despite this, actual community participation is generally low. In a survey of district healthcare managers, it was found that the lack of community input was due in part to the haphazard nature of local healthcare administration; it is difficult for managers to incorporate community ideas when the managers do not know what their budget will be (1062). When setting priorities, managers must also consider that the funds from the central government must be utilized on activities the government has prioritized; if the community's priorities do not align with national priorities, the community initiatives are often omitted (1056). On the other hand, in districts where the community is more involved in healthcare initiative planning and execution, the local government is unable to follow through with what is planned. For instance, in the Iramba District, healthcare workers had successfully mobilized the community to help construct a health center. However, the government did not take any action to finish the project after it was handed over by the community (1059).

The authority of local government authorities was further undermined by the continued presence of vertical programs in Tanzania. These vertical programs were designed to facilitate implementation of global initiatives, such as TB eradication, immunization, etc. For instance, each district received drug kits from the Ministry of Health (funded by the district's allocated

funds) as a part of the Extended Drug Program (EDP). However, these kits were packed in Europe, with decisions about its contents made on the national level; local officials were not allowed to make any requests or alterations to the kit itself or their supply. The kits “ultimately reduced the role of the [district medical office] to that of a supply depot” (Gilson 463). The existence of vertical programs like the EDP undermined local authorities’ ability to manage their resources.

Fundamentally, decentralization was meant to give greater autonomy and decision-making space to local authorities. While there are numerous complications with local healthcare institutions utilizing their power, members of DMHT teams were inclined to agree that they had more authority and opportunity to make decisions for their communities (1051). Practically, their authority is dramatically narrowed by the constraints placed upon them by the capabilities of the workers and the organization. Local authority is further eroded by the substantial involvement of central government authorities, such as the Civil Service Department’s oversight over employee recruitment or the presence of vertical programs like the EDP (Munga 4).

The roots for decentralization were, ironically, sown with Julius Nyerere’s push towards a socialist government with a centralized healthcare system. Julius Nyerere saw Tanzania’s independence in 1961 as an opportunity to push the country towards an egalitarian society that would provide for the basic needs of all its citizens, as stated in the Arusha Declaration. For healthcare, his goals entailed building on the bones of colonial health practices that were primarily urban and curative to build a centralized health system to serve all. The Tanzanian government and foreign donors initially invested a significant capital to improve access to healthcare in Tanzania. However, Tanzania’s dire economic situation in the 1980s pushed the country sign an agreement with the World Bank for a structural adjustment program, reducing

the power and budget of the central government, Concurrently, global health as a field recognized the importance of primary health care with the Alma Ata Declaration in 1978 and sought to enable initiatives that would work towards this goal. Decentralization of healthcare aligned with the economic policies had Tanzania adopted and was viewed as an effective tool for improving a country's primary health system. Decentralization was intended to bring healthcare services to all and give local government authorities more authority and flexibility to address their community's needs. However, the DHMT and district councils enabled under the new decentralized system face several barriers. Local authorities were unable to generate enough to finance their activities and are dependent on unreliable, insufficient government funding. There is also a dearth of qualified workers at the district level, especially in rural areas, and the workers that are there do not have the necessary administrative or financial training. All these factors, and the existence of vertical programs in which local workers have no say, lead to local government authorities and healthcare workers underutilizing the decision-making authority they have. All of these factors combined have reduced the efficacy of a well-intentioned series of reforms that continues to this day.

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