Social Sector Review

Investment in Human Capital in Tanzania

Issues Paper

January 14, 1994

Overview and Summary

1. Purpose of the Study. The World Bank is preparing for a renewed effort in the social sectors in Tanzania that will be consistent with the government's stated policies of concentrating on its core functions, improving the environment for private sector development, improving the efficiency of public expenditures, and investing in infrastructure and human development.[1] For the Eastern Africa Department, the proposed economic and sector work will provide an analytically based review of policies to support both our policy dialogue with the government and sector operations. In our policy dialogue, we will assist the government to improve the efficiency and equity of investments in human capital, with particular attention to gender, public/private roles, and financing issues. For operations, the review will lay the analytical groundwork for a potentially large lending program in the social sectors (education, health, nutrition, family planning, and water and sanitation) over the next five years. Specific operations to be supported are the Human Resource Development Project, identification and appraisal of which will begin immediately upon completion of the review, and the next education project. The Government of Tanzania is simultaneously developing new strategies in health and education, which creates a unique opportunity for the analytical work completed as part of this review to support the Government's preparation of its strategies.

2. Conceptual Framework. The orientation of the review will be from the household up. The household (especially the mother) is the principal agent determining who gets how much human capital through investments in education, health, and other related services. Household behavior in demanding social services is thus the primary determinant of the effectiveness of public sector policies, yet policies in most African countries (this is certainly the case in Tanzania) have been dictated by beliefs about what should be done, with little or no attention to actual household behavior. Households and governments play key roles in financing social services, but services may be produced by a variety of providers, including individuals, businesses, communities, religious groups, and government. Public policies are often determined with little or no reference to non-government provision and financing of services; again, this has certainly been the case historically in Tanzania. We expect this "household-up" framework to provide many new insights about, and options for, public policy in the social sectors.

3. What Will Be Done. A thorough review of the social sectors will be completed. The review will critically evaluate the effectiveness of current policies in Tanzania within constraints imposed by limited resources at the household and national levels. The distinctive elements of the sector work will be (a) an economic review of social sector policies and outcomes from the household perspective, (b) a review that is solidly grounded in budgetary constraints and a need for priority-setting, and (c) quantitative estimates of impacts of alternative public expenditure options in the social sectors.

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[1] This summary of policies is based on the "Guidelines for the Preparation of the Rolling Plan and Forward Budget for 1993/94-1995/96," December 1992, pages 30-31.

4. How the Work Will Be Completed. We are currently completing a nationally representative household survey focused on household behavior in utilizing social services, paying for these services, and distributing the benefits of social services within the household. This survey, plus related participant-observer activities, will form the basis for the "household-up" approach underpinning the review. A team of four long-term consultants at headquarters has been assembled to allow us to incorporate these primary data collection activities into the review while maintaining a tight schedule. Secondary data collection, background papers, donor coordination, and government involvement in the work is being managed in Tanzania through the Resident Mission and three long-term Tanzanian consultants. A Steering Committee has been formed by the Planning Commission to coordinate government participation, with a subcommittee of that body meeting on a monthly basis to manage the local team. The formal involvement of the government is evidence of the high priority it places on this review and on its own strategy work in these sectors. Discussion notes covering each topic in the report will be circulated before the main mission in April. This discussion notes will (a) allow the mission to be a consultative experience based on a written document that can be discussed, critiqued, and changed in the field; (b) allow substantial Tanzanian input into the final product; and (c) efficiently use the talents of the international experts on the mission to improve an existing document.[2] We want to facilitate a serious and open discussion, which will be encouraged by making it clear that the Bank does not have a preconceived outcome in mind, although the discussion notes will outline options and preliminary recommendations. Bank participants on the main mission will undoubtedly disagree publicly with each other during the workshops, which we view as a positive aspect of the process. The mission will produce a revised set of papers that will be reviewed again at a closing workshop.

5. Schedule of Events. Table 1 summarizes the schedule for completing the *Social Sector Review*.

Table 1
Planned Time Schedule for Completion of the Tanzania Social Sector Review

Activity/Product	*Completion Date*
Overview Papers in Education and Local Government	January 1, 1994
Overview Papers in Health, Nutrition, Family Planning, and Water/Sanitation	January 15, 1994
Special Analyses	February 15, 1994
Focused Area Studies	February 28, 1994
Draft Discussion Papers Distributed	March 15-25, 1994
Main Mission	April 15 - May 7, 1994
Yellow Cover Report Distributed	May 15, 1994
Green Cover Distributed	June 15, 1994
Final Workshop to Discuss Green Cover Report	July 15, 1994

[2] A tentative list of the mission members appears in Table 8, page 18. The intention is to do as much of the data collection and background work as possible before the main mission to take best advantage of the specialized human resources available to the mission.

6. Lead Adviser. William McGreevey and Jeffrey Hammer.

7. Reader's Guide to the Issues Paper. The Issues Paper is 19 pages long and provides a cursory review of issues in the social sectors in Tanzania. The discussion has benefited from the recently completed *Public Expenditure Review*, which provided an in-depth analysis of public spending in the social sectors. The *Social Sector Review* is outlined, with a synopsis of each chapter. Management and a proposed list of mission members are outlined. Detailed Terms of Reference for the various activities have been prepared as attachments. While not distributed, these attachments are available on request.

Social Sector Review

Investment in Human Capital in Tanzania

Goals, Analytic Approach, Process, and Audience

1. The social sectors in Tanzania have been a traditional area of focus of the government, with mixed results. Much analytic and project work has been completed in education, health, family planning, nutrition, water, and sanitation in Tanzania, yet we are witnessing dis-investment taking place in all of them. Dis-investment takes the form of collapsing physical infrastructure, but most importantly, collapsing investment in people as evidenced by falling primary enrollment rates, worsening health conditions, and backwards movement from earlier successes in the complementary sectors, such as water and sanitation. Most observers consider the problems to be of crisis proportions, not only for the welfare of Tanzanians but also for prospects for long-term economic recovery and future competitiveness of the economy.

2. Goals: The goals of this study are (1) to examine the state of human capital investment policies in Tanzania, and (2) to evaluate priority actions to increase equity and efficiency within the social sectors, taking into account constraints that households, government, and donors face.

3. The study will identify inputs required for increasing and improving human capital investments in Tanzania during the next five to ten years. In particular, we are seeking information about how to increase household capacity to invest in children through systematic interventions that require partial or full public financing. Methods to increase household capacity might include targeted income supplements for the purchase of effective schooling and health services for children; an ability to exercise choice over the quality of education, health, and family planning services; greater responsibility for financing investments (and thus a greater interest in outcomes); a more healthful environment; and greater opportunities for advancement (hence higher payoffs to investments).

4. Households are not perfect by any means. There is typically discrimination within households against human capital investments in girls. Poorer households may not be able to fulfill desired investment plans for their children. Poorly educated farm households may be so constrained by low incomes or lack of knowledge that they trade off high potential future payoffs to investing in their children for immediate income from child labor. Government may be the only source of incentives to offset intra-household discrimination or impaired ability of households to invest at all. It has an interest in doing so to achieve goals for economic growth, improved health and education for the whole population (including future generations), and greater fairness in the distribution of all types of assets and income. But the government cannot and should not attempt to do everything; it merely works at the margin of what a household can do for itself.

5. Analytic Approach: Three features characterize the study's analytic approach. First, we take a long-term perspective, consistent with an interest in understanding opportunities for costly capital investments. This long-term perspective implies, for example, that we will focus on primary and secondary school enrollment among girls because of the long-term payoff to such investments for improved social outcomes and productivity. In the health, nutrition and water/sanitation sectors, it suggests that we should look carefully at ways to increase the effectiveness of public spending to

address the most prevalent *preventable* problems that require public intervention.[3] We will use projections and public expenditure simulations to arrive at an understanding of long-term payoffs from current investment choices.

6. Second, we take the household as the starting point, examining the determinants of the demand for goods and services in the social sectors and how government interventions can increase the demand for effective human capital investments. Among the questions to be addressed are: What investments do households make in human capital, as seen in their use of education (and its substitutes), health, family planning and other social services? What are the determinants of those choices? What are the costs of those choices? What are the demand- and supply-side constraints faced by households? How do social sector institutions interact with households, and what expenditure patterns, management behaviors, and incentives account for these types of interactions? Which households benefit from public spending, and which do not? How are behavioral patterns in the household and subsidy patterns by the government either encouraging or discouraging achievement of desired outcomes for human capital investment?

7. The third aspect of the analytic approach is an application of appropriate quantitative analyses to estimate cost-effectiveness of investments (or, the costs associated with a unit of output, such as a secondary school graduate). While it is useful to describe the qualitative dimensions of existing problems in education, health, and other social sectors, project development and public resource allocation decisions will benefit from quantification of how investments can be transformed into highly productive, equitably distributed outcomes. Quantification requires knowledge of outputs, costs of production, prices and quantities of inputs, and incidence of benefits.

8. Process: This study will be carried out in a consultative manner, in which the Government of Tanzania is a key participant. Leading academics in Tanzania will assist in carrying out background analyses; a local Steering Committee of government representatives will review and guide the studies; and a team composed of local and expatriate experts will prepare the report. The main mission will be highly consultative. This approach is expected to create a policy dialogue on priorities in the social sectors through which all parties can learn from each other, with a strong implicit voice from the ultimate beneficiaries through the household survey and participant-observer field work. We do not expect agreement on all aspects of the work, but we do expect to spark a lively, fact-based debate on priorities and strategies.

9. We will frequently consult with representatives of multilateral and bilateral donor organizations in Tanzania. Donors will be invited to participate in the main mission and/or workshops that will take place during the mission. These consultations will bring to bear the widest range of perspectives and project experience, particularly in health, education, and water, where donor activity has been strong.

10. Audience: The audience for the study will be government and community leaders in Tanzania, World Bank staff, and the donor community. The study will inform future discussions at the 1994 Consultative Group meeting and provide input into the Tanzanian government's concurrent strategic planning for the social sectors.

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[3] All preventable problems in the social sectors do not fall by definition into the domain of government. However, problems that do fall within the government's domain tend to require preventive-type interventions.

Social Sector Indicators and Issues

11. This section provides a brief overview of conditions and public policies in each of the social sectors.

Education

12. Conditions: While Sub-Saharan Africa has low enrollment rates by global standards, Tanzania's performance is poor relative even to that standard, particularly in secondary schools. After relatively good performance in the 1970s, when the government declared that it could achieve almost universal primary school enrollment by 1980, Tanzania is now outperformed by its neighbors and falls below the average for Africa for both primary and secondary enrollment rates (see Table 2). Gross primary school enrollment rates fell from about 93 percent in 1980 to 63 percent in 1990, while the gross secondary rate has stagnated at about 4 percent.[4] Secondary enrollment has been rationed, so this low rate has been achieved by design. However, the result is that Tanzania is matched only by Malawi in having the lowest secondary enrollment rate *in the world*.

Table 2
School Enrollment in Sub-Saharan Africa

Country	Gross Enrollment Rate (1990)	
	Primary School	Secondary School
Ethiopia	38	15
Kenya	94	23
Tanzania	63	4
Uganda	76	13
Zambia	93	20
Sub-Saharan Africa	68	17

Source: *World Development Report 1993*
Note: Gross Enrollment Rate is defined in footnote 4.

13. Recent national household-level information on educational attainment, from the Demographic and Health Survey, indicates that the following low percentages of children were in school in 1991/92: 26 percent of children aged 6 to 10, 71 percent of those aged 11 to 15, and 18 percent of those aged 16 to 20. Up through age 15, girls and boys are approximately equally likely to be in school; however, in the 16 to 20 age group, 25 percent of young men but only 12 percent of young women are in school.

14. The combination of a late start and early exit from school translates into low completion rates and an extraordinarily low level of human capital investment. In the Demographic and Health Survey, only 6.3 percent of females between 15 and 19 years of age had completed primary school. 7.6 percent of females aged 20 to 24 had finished, although 76 percent had attended primary school. For boys, the numbers are only slightly higher. For the 20 to 24 age group, 81 percent had attended primary school, but only 9.4 percent had finished.

15. Financing and Policy Issues: Tanzanian government goals in the education sector continue to be ambitious. The Government's stated aims are to offer education at every level, including pre-primary, primary, secondary, teacher training, higher education, technical training, and non-formal

[4] Gross enrollment rates are calculated as the number of children in school divided by the number of children in the age groups who should be in school. They can be greater than 100 percent because of repeaters or late starters. These rates are from *The World Development Report 1993*; the government estimates the gross primary enrollment rate in 1991 to be 81.3 percent and the net rate to be 58.8 percent. The net rate is the percent of the relevant age group attending primary school.

education and training. Within this broad framework, it proposes Universal Primary Education, expansion of public and private secondary education, elimination of diversified secondary schools and their replacement with polytechnical schools, and increasing enrollments in higher education. These are truly ambitious goals, and they are not feasible within current fiscal and administrative realities. School infrastructure is deteriorating, and the capacity of the public secondary system is so limited that advancement is simply not an option for most primary school leavers.

16. The national budget constraint is severely limiting. The *Public Expenditure Review* estimated that the average share of the total budget devoted to education for FY90-93 was 17.5 percent. This figure compares to 19.9 percent of a much larger total budget for Kenya in 1991. Tanzania's low public spending is not counterbalanced by higher private (household) spending on education, which is estimated to account for only 3 percent of household consumption,[5] compared to 10 percent in Kenya. In purchasing power parity terms, the public sector in Kenya at least doubles Tanzania's per capita spending, and households spend almost seven times more than in Tanzania.

17. Inadequate spending is compounded by inefficient allocation to low-return activities. Only about US$15 is spent by the government per primary school student, $167 per secondary student, $244 on teacher training students, $1,480 on technical college students, and $3,500 per university student. At the primary level, only 5 percent of spending ($0.75 per student) goes for school materials; there is no spending on operations and maintenance. At the secondary level, 49 percent of expenditures are for boarding costs, and only 5 percent is spent for school materials. At the university level, 34 percent of spending is for student boarding and welfare. The result is that at every level, but especially at the primary level, the system is starved for nonsalary instructional inputs and maintenance of infrastructure.

18. Yet there are probably too many teachers, and the cadres at the primary level may be unnecessarily under-educated. There are 34 students/teacher at the primary level (compared to 45/1 in Sub-Saharan Africa). There are only 16 students/teacher at the secondary level (compared to 23/1 in Sub-Saharan Africa). At the university level, the ratio is on the order of only 3.5 students per faculty member.

19. A 1992 analysis, updated using 1993/94 prices, indicates that the current level of spending on primary education (Tsh 27 billion) would have to be more than tripled (Tsh 89 billion) to provide adequate quality primary education just for existing low enrollments. About 84 percent of the additional resources would have to be earmarked for non-personnel expenditures. For Tanzania to move beyond low current enrollment rates and actually achieve Universal Primary Education while maintaining this higher standard of quality would require approximately Tsh 143 billion, over 5 times current primary school spending by government, and 1.8 times total education spending. Without even considering expansion of secondary and tertiary enrollments and all of the other desirable goals the government has outlined in its recent education policy paper, the government will have to make tremendous reallocations just to achieve Universal Primary Education in any meaningful way. It will need to take drastic action to reform education finance to make Universal Primary Education possible.

20. In addition to the financing issues, problems associated with school management have had

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[5] The *Tanzania Poverty Profile* estimates that less than 1 percent of total household expenditure was for education in 1991. The figure in the text is from the mid 1980s, as reported in *The World Development Report 1993*.

serious consequences in Tanzania. Teacher morale is reputed to be low, as evidenced by the December 1993 teacher strike. Parents are apparently disillusioned with educational opportunities and withhold their children from school, which shows up in the low age-specific enrollment rates cited in paragraph 13.

21. Many donors have played a role in the Tanzanian educational system. The World Bank is currently implementing its eighth project in the sector. Despite these efforts, we are witnessing significant backsliding in both quality and quantity of educational services. Success stories are, unfortunately, few and far between. Before the Bank considers additional lending for education, a thorough review of options is merited.

Health

22. Conditions: With more than 10 percent of children dying before age 1, persistent high mortality rates from infectious and parasitic diseases, a malaria problem of epidemic proportions, and an HIV seroprevalence rate among the highest in the world, Tanzania faces both familiar and new challenges in the health sector.

23. Declines in infant mortality, a sensitive indicator of both access to health services and environmental influences on health, have been difficult to achieve in Tanzania. Between 1970 and 1991, Tanzania's Infant Mortality Rate fell from 132 to 115 per 1,000 live births, while the region-wide decline in infant mortality was from 144 to 104 (see Table 3 for current rates).

Table 3
Infant Mortality in Sub-Saharan Africa

Country	Infant Mortality Rate Per 1,000 Live Births (1991)
Ethiopia	130
Kenya	67
Tanzania	115
Uganda	118
Zambia	106
Sub-Saharan Africa	104

Source: *World Development Report 1993*

24. Malaria is the most severe of health problem. It is a persistent and growing threat to adult and child health, as it is in all of Sub-Saharan Africa, which has an estimated 80 percent of the world's malaria cases. It is endemic even in Dar es Salaam where, in 1992, malaria accounted for 30 percent of all new public sector outpatient visits. Upper respiratory infections or pneumonia accounted for about 15 percent. These two problems thus accounted for nearly half of new visits in the country's wealthiest and best educated population.[6] A study of a single district hospital in rural northwest Tanzania in 1990-91 found that malaria was the leading cause of both morbidity and mortality at the hospital. 33 percent of the 1,494 admitted malaria patients were under 1 year of age, and 75 percent were under 5. About 5 percent of the admitted patients died, with 94 percent of the deaths among the under-5s. 14 percent of the available bed-days in this hospital were consumed by these malaria-stricken patients, a huge drain on public resources.[7] Malaria impedes other efforts to

[6] The Dar es Salaam Urban Health Project (1993) "Basic Information on Dar es Salaam."

[7] D.G.C Emerton (1992) "An Audit of the Management of Malaria in a Tanzanian District Hospital," *Transactions of the Royal Society of Tropical Medicine and Hygiene*, 86:476-478.

improve child health. Increases in deaths from malaria were found to have reversed the gains in combating under-five mortality in a community-based nutrition program in Iringa region, and with a measles vaccination program in another region.

25. The current and future impact of the AIDS epidemic darkens an already bleak picture. Tanzania is ranked sixth in the total estimated number of HIV-infected persons, after Uganda, Zaire, Zambia, Côte d'Iyoire and Malawi. About 7 percent of blood donors were found to be HIV-positive in a 1990 study, and a 1989 study found that 10 to 16 percent of pregnant women in urban areas were HIV-positive. This lethal disease, which kills infants, plus men and women (equally) in their most productive years, is concentrated in cities and along major transportation routes.

26. The high HIV prevalence has serious long-term consequences and is already taking a heavy toll on households, the health system, and human capital investment. According to the World Bank's *AIDS Assessment*, "in the late 1980s...the costs of treating existing AIDS cases [in Tanzania were] estimated to be the equivalent of approximately 40 percent of the public health budget and almost one-quarter of combined public and private spending." The non-health social costs of AIDS, because it hits people in the prime of their lives, are thought to be very high. These include loss to the nation of highly educated professionals, children whose schooling may be interrupted or stopped because of the loss of one or both parents, and increased poverty of widowed spouses and their children.

27. Financing and Policy Issues: The public health system in Tanzania, which has been committed to providing universal access, expanded rapidly following the Arusha Declaration of 1967. Emphasis has been placed on primary health care through development of basic, rural health service units (dispensaries, health centers, etc.). Hundreds of health centers and thousands of dispensaries were built and equipped, the number of doctors multiplied by more than three-fold and the number of medical assistants, rural medical aides and health assistants increased by an order of 10. This expansion allowed about 90 percent of the population to be within 10 km of a health facility, and 72 percent to be within 5 km of public health services.

28. This system has made substantial progress in delivering specific services. Use of important types of care for pregnant mothers, including prenatal services and tetanus toxoid injections, is high

Table 4
Percent of Mothers Using Birth- and Child-Related Health Services in Tanzania, 1991-92

Mother's Education	Modern Prenatal Care	Two Tetanus Inoculations for the Mother	Modern Delivery Assistance	Measles Vaccination for Children 12-23 Months	Use of Oral Rehydration Solution or Increase Fluids for Diarrhea
None	86	66	38	71	66
Some Primary	93	72	53	82	77
Complete Primary	95	76	64	88	74
Secondary/Higher	99	72	84	94	84

Source: Tanzania Demographic and Health Survey 1991/92

and fairly even across education groups (Table 4).[8] Similarly, except for mothers with no education, coverage levels for immunizations and appropriate treatment of diarrhea is very good (Table 4) by any standard. However, this system has not really had a large impact on measured health outcomes, while it has created a huge recurrent cost burden and is financially unsustainable as currently financed. The resources that are available are probably spread too thinly to be used to best advantage. Despite the orientation to basic services, resources even at the dispensary level are heavily devoted to acute curative care.

29. Inadequate resources are left to address the fundamental public and environmental health problems, such as vector-borne diseases like malaria; water-borne diseases like schistosomiasis or cholera; sexually transmitted diseases; and other infectious diseases like tuberculosis. These types of diseases, which cannot be controlled in the absence of vigorous action by the public sector, generate most of the current use of the curative system in Tanzania. They are the major health problems facing Tanzania, and virtually all are preventable, although not always at low cost. Failure of government-led preventive action results in a tremendous amount of public and private spending on curative services that could be avoided.

30. The *Public Expenditure Review* estimated annual public health spending at $3.50 per capita in 1992. A relatively large share, about $2.17 (62 percent) of that goes toward "essential health spending," mostly for basic clinical services; the remainder is devoted to non-essential services, administration, and training. Compared to the estimated $12 per capita that would be required in most African countries for the *World Development Report 1993* package of basic services, it is clear that funding in the health system is inadequate. The success of the health system in providing inputs , but not in seeing the expected effect on outcomes, creates a complex set of issues for the *Social Sector Review*. The basic conundrum seems to be that the extensive dispensary-based system is not affordable as a fully publicly-financed system and has had limited impact on the core causes of the considerable disease burden.

Nutrition

31. Tanzania experiences high levels of malnutrition. Protein-calorie malnutrition, nutritional anemia, and iodine deficiency disorders all have been identified as serious problems in the country, as throughout the region. The Demographic and Health Survey 1991/92 found that about six percent of children under five were wasted, or severely underweight for their height — two standard deviations below the average for a healthy population. These children are the acutely malnourished, and they are unfortunately broadly distributed throughout the country, so they cannot be targeted with geographically focused programs. Indicators of less acute problems include children under five who are short relative to healthy international populations (about 43 percent), and those who are relatively underweight for their age (about 29 percent).[9] Among adults, about 80 percent of pregnant women suffered from anemia and 52 percent from iodine deficiency in one study by the Tanzanian Food and Nutrition Center.

32. These nutrition problems are inextricably bound to health problems, and causality goes in both

[8] Assistance during pregnancy, however, is quite variable.

[9] The latter measure is, of course, not independent of height.

directions. Malaria and parasites reduce nutritional status, especially among the very young, but poor nutritional status increases susceptibility to disease. Women are particularly susceptible to nutritional deficiencies during pregnancy. Thus a successful health strategy is a building block of a successful nutrition strategy, and vice versa. Tanzania has been a leader in nutrition — the Tanzania Food and Nutrition Centre was established in 1972, and the UNICEF-sponsored Iringa Nutrition Project has received world wide attention. However, there is little integration of nutrition interventions with health interventions or with primary school policy except on an experimental basis.

Population/Family Planning

33. Tanzania suffers from a serious population growth problem. The Demographic and Health Survey of 1991/92 confirms a very high average total fertility rate[10] of 6.3 children per woman, which is almost the same as the rate of 6.4 in 1970 and is similar to Tanzania's high-fertility neighbors (see Table 5). At this level of fertility, population will grow from 25 million in 1991 to 33 million in 2000, an increase of about a third in less than a decade. In the following 25 years, population is expected to nearly double.

Table 5
Total Fertility Rate in Sub-Saharan Africa

Country	Total Fertility Rate (per woman) 1991
Ethiopia	7.5
Kenya	6.5
Tanzania	6.3
Uganda	7.3
Zambia	6.5
Zimbabwe	4.7
Sub-Saharan Africa	6.4

Source: *World Development Report 1993*

34. Population growth at this rate has serious negative implications for human capital formation. It contributes to high morbidity and mortality among women and children, reduces educational investments in children, contributes to increased malnutrition, and compounds the negative impacts of poverty on human development.[11]

35. Tanzania has long recognized its population growth problem. The first family planning services were provided by the Family Planning Association of Tanzania in 1959, and in 1974, MOH health facilities began providing these services throughout the country as part of maternal and child health programs. In January 1992, the government adopted an explicit National Population Policy, which emphasizes regulating population growth, enhancing population quality, and improving the health and welfare of women and children.

36. Family planning activities in Tanzania are primarily supported by donors. The MOH contributes its facilities and personnel. The family planning program has a supply-side and public sector focus. It supplies services and commodities to women free of charge through public clinics. On the demand side, the program promotes knowledge of family planning through public information

[10] Total Fertility Rate is the total number of children a woman would be expected to have during her lifetime if she experienced current age-specific fertility rates and if there were no maternal mortality.

[11] This is a roundabout way of describing the tradeoff between the quantity of children and their quality that is a key feature of the household economics literature.

campaigns (information, education, and communication programs) and a limited family life education program in schools.

37. The two major findings emerging from preliminary analysis of the Demographic and Health Survey data are (a) success in these supply-side efforts (although with little impact on fertility), and (b) at the margin, the greatest payoff in terms of impact, given success on the supply side, may be to more fundamental efforts to increase demand for child spacing. On successes, 78 percent of currently married women and 84 percent of men know of at least one modern method of contraception. About a quarter of the women live within one kilometer of a facility that provides family planning, and two-thirds live within five kilometers. About a fifth are served by health workers providing outreach services. Despite these statistics, only 7 percent of women and 10 percent of men use a modern method of contraception (despite the related problem of HIV transmission).

38. The main explanation for low contraceptive prevalence is that the average desired number of children among currently married women is 6.4, and only 8 percent want fewer than 4 children. Women with no education want the largest families (7.3), but this is only about 14 percent or 1 child more than the average for all women. If all unwanted births were eliminated, the Total Fertility Rate would fall only to 5.6. Thus, unless demand for child spacing or limiting is increased, the cost effectiveness of supply side interventions is likely to remain low. How to approach the demand problem will be a difficult task for the *Social Sector Review* and for future project work.

Water and Sanitation

39. In 1971 the government declared that all rural people should have easy access to safe water before 1991. The government's 1991 water policy paper states that 44 percent of rural households are within 400 meters of an improved water system, but that 40 percent of these systems are not operational, making actual access to improved water in rural areas more on the order of 25 percent. The Demographic and Health Survey found the situation to be somewhat better: about 98 percent of Dar es Salaam residents, 89 percent of other urban residents, and 52 percent of rural residents use an improved water source for drinking water.[12] The *Tanzania Poverty Profile*, based on a much smaller national sample, shows almost the same picture of water use patterns: 97 percent of Dar es Salaam residents, 91 percent of other urban residents, and 52 percent of rural residents used a well or tap as the main source of water in 1991. Even among the hard-core poor with incomes inadequate to provide for their basic needs, 54 percent used a well or tap. 42 percent of rural residents took less than 15 minutes to reach their main source of water, and 74 percent took less than 30 minutes.[13] The population-based information shows a better situation than the service-based statistics would imply.

40. The apparent inconsistency may be related to the poor operational characteristics of rural schemes and the low volume of water people are able to secure from them over the course of the

[12] The following list defines *improved source* and shows the national percentage using each type: piped into residence (11), public tap (22), well in residence (1), and public well (28), for a national total of 62 percent getting drinking water from an improved source. Note that people using an improved source may have to walk more than 400 meters to get there and thus would not be counted in national statistics as having access to the source they use.

[13] These times are to whatever the main source of water is, be it an improved source or a stream, so the apparently good access may be overstated.

year. A 1988 study of the Kitangari Water Scheme (in Mtwara), serving 106 villages and 162,000 people, found that this system operated at about half its intended capacity due to fuel shortages and other problems. At full capacity with no leakages, it could provide 30 liters per capita per day to the service population; in fact, during the dry season when the system worked, consumption was about 17 liters per capita per day. When the system did not work, average consumption fell to 8 liters per day, with huge amounts of time required, particularly of women and children, to search for and carry water. Thus the main source of water for these 162,000 people may be improved and readily accessible, but they also collect rain water, buy water, search for water, and ration water when the improved water scheme fails. The issue of water supply is a complex one, and the policy questions depend heavily on geographic conditions, settlement patterns, and seasonal variations in water availability.[14]

41. Many donors are heavily involved in the water sector in Tanzania, and an estimated quarter of a billion dollars has been invested in the sector during the last decade alone. However, the effectiveness of these investments seems to have been low, with systems built to engineering specifications that took little or no account of needs of the intended beneficiaries. Many systems have been literally abandoned by the intended beneficiaries either because the systems were inappropriate to their needs, they could not be maintained with available resources, or the incentives for free-riding behavior created by the financing of the system led to collapse. How to move forward in this sector requires careful analysis and debate of the issues and options, especially appropriate and sustainable financing of water interventions, which has been neglected in the past.[15]

42. Poor sanitation and inadequate solid waste disposal are among the most serious environmental problems facing Tanzania today. Water pollution control institutions are poorly funded, laboratory testing equipment is scarce, and enforcement is ignored with the result that industrial waste water is discharged mostly untreated to waterways across the nation. Even in Dar es Salaam, with some 2 million people, only 20 percent of the city has a sewage collection system and 81 percent of this sewage is discharged to coastal waters without treatment. In contrast to the fairly positive findings in the Demographic and Health Survey about water use, sanitation is probably a serious problem and becoming more of one with increased population density and urban growth. About 84 percent of households nationally used a traditional pit latrine and another 12 percent had no facility at all ("No facility, bush"). In Dar es Salaam, 92 percent used a traditional pit latrine.

43. Epidemics of cholera occur — during the 1980s, cholera cases were averaging about 5,000 per year with 450 deaths — and childhood mortality from water-borne diseases is high. Not only do such crises kill people, they are preventable and are a drain on the public health budget. Given the apparent low effectiveness against morbidity and mortality of the widely distributed system of health clinics, plus the apparent improvement (however problematic) in water supplies, a natural question is to what extent improved sanitation, knowledge of sanitary practices, and environmental health may be an important missing link in the health system.

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[14] Whittington, Dale, Mark Mujwahuzi, Gerard McMahon, and Kyeongae Choe (1989) "Willingness to pay for Water in Newala District, Tanzania: Strategies for Cost Recovery," Water and Sanitation for Health Project Report No. 246.

[15] Therkildsen, Ole (1988). *Watering White Elephants? Lessons from Donor-Funded Planning and Implementation of Rural Water Supplies in Tanzania.* Uppsala: Scandinavian Institute of African Studies.

Interactions among Social Sector Interventions and their Relationship to Poverty Alleviation

44. The primary advantage of examining the social sectors together is to evaluate interactions among them and develop priorities across them. Two types of interactions exist across the social sectors, (a) when public investments in one sector increase the productivity of public investments in other social sectors (complementary activities) and (b) when public investments in one sector

Table 6
Complementary Interactions of Public Investments in the Social Sectors

PUBLIC INVESTMENTS IN THESE SECTORS...	*...HAVE A POSITIVE IMPACT ON OUTCOMES IN:*				
	Education	*Family Planning*	*Health*	*Nutrition*	*Water & Sanitation*
Education					
Family Planning				+	
Health	+	+			+
Nutrition	+				
Water & Sanitation				+	

Note: The strongest cross-sector effects are shaded. These effects are hypothesized by the authors, based on their knowledge of the literature.

substitute for possible public investments in other sectors.[16] The major complementary impacts are displayed in Table 6, where the + sign indicates that an investment in the sector listed down the left side has a positive impact on outcomes for the sectors listed across the top. The strongest impacts are shaded. It is easy to see from this table that education and health probably have the widest impacts, but the health impacts are relatively weak. It also shows that education is the strongest *producer* of cross-sector benefits; health is the strongest *consumer* of cross-sector benefits. These are the types of interactions we expect to quantify for Tanzania to develop an effective investment package for the Bank in the social sectors. Although efficient investments in the social sectors are likely to improve equity, this is not guaranteed. Therefore, we will also pay close attention to the incidence of benefits and evaluate the potential for improved targeting of social sector investments.

45. The subsections below provide a cursory discussion of some of the issues related to these interactions, on both efficiency and equity grounds.

46. *Education, Health, and Family Planning*

a. Population Growth and Public Financing. It is well established that at the household level, family size and closely spaced births reduce parental investment in the education of their children and contribute to poorer health outcomes for the family. At the

[16] The two interactions are not independent. For example, public investments resulting in more schooling for mothers increase the productivity of public investments for well-baby services. Yet more schooling for mothers also reduces the need for public investments in well-baby services because a more educated mother will have a healthier child even without well-baby care and she will be more willing and able to purchase the service from the private sector.

national level, failure to reduce the population growth rate also strains the ability of the public sector to invest adequately in schooling and health services, as historical per capita spending levels become difficult to maintain. At current growth rates, the population of Tanzania will double in 22 years, and per capita Gross Domestic Product will double in 24 years — the latter is not expected to keep up with the former. This spells disaster for the social sectors, as the education system in particular faces both the need to catch up in per capita spending and to maintain higher levels of per capita spending in the face of shrinking per capita resources.

b. Education and Population Growth. Female education is strongly correlated with lowered demand for children and higher rates of child survival. According to the Demographic and Health Survey 1991/92, Tanzanian women with no education have an average of 6.5 children during their lifetimes, while women who have at least some secondary education have 4.2 children. The same survey estimated infant mortality in the past 10 years to be 103 per 1,000 live births for mothers with no education but 72 per 1,000 live births for mothers with secondary or higher education. These same relationships are well documented in industrialized and developing countries alike. A World Bank study of 13 African countries between 1975 and 1985 found that a 10 percent increase in female literacy rates reduced child mortality by 10 percent, while changes in male literacy had little influence.

c. A disturbing issue in this regard for Tanzania is that female education does not have a large negative impact on fertility until girls get through secondary school. In Tanzania, total fertility and the mean number of children ever born for women falls only slightly with more education, at least until secondary school (Table 7). Much of the impact is direct in the sense that it comes from delayed first births while girls are still attending school (last column of Table 7).[17] One problem for Tanzania is that girls are starting primary school so late that they may complete only a few years before child-bearing begins. Very few are advancing at all to secondary school, as discussed in the education section.

Table 7
Fertility and Education in Tanzania, 1991-92

Education	Total Fertility Rate for Women Age 15-49	Mean Number of Children Ever Born to Women Age 40-49	Percent of Teenagers 15-19 Who Have Begun Child-Bearing
No Education	6.5	6.9	35.5
Primary Incomplete	6.4	7.1	20.4
Completed Primary	6.0	6.5	33.5
Secondary/Higher	4.2	4.8	4.6

Source: *Tanzania Demographic and Health Survey 1993*, page 23

[17] Although Table 7 contains simple correlations, the pattern is supported by multivariate work and is robust across many developing countries.

47. *Nutrition, Health, Water/Sanitation/Environmental Health*

a. Nutrition and Health. Poor nutrition compromises both short- and long-term health outcomes, as noted earlier. According to one World Bank study, a third of infant and childhood mortality is attributable, at least indirectly, to malnutrition.

b. Health, Nutrition, and Schooling. Poor health and marginal nutrition handicap a child's ability to attend and benefit from school.

c. Water, Sanitation, and Health. Most of the major causes of infant and child mortality are related to poor access to safe water and exposure to vector-borne diseases. In a review of 144 studies, for example, improved water supply and sanitation was found to reduce mortality from child diarrhea by 50 to 80 percent.

48. *Human Capital Investment and Poverty*

a. Education and Poverty. According to the *Tanzania Poverty Profile*, secondary education is one of the strongest correlates of both relative and absolute poverty. Among the population over 14 years of age, nearly 35 percent of the very poor had no education, and only about 1 percent had any secondary schooling. At the same time, only about 19 percent of the better off individuals had no primary or secondary schooling, and 11 percent had secondary education. Indeed, the substantial difference in secondary education between rich and poor households in rural areas was the most distinguishing feature of the two groups.

b. Poverty and Poor Health. Poor households are at much greater risk than better-off households for exposure to infectious disease, inadequate nutrition and poor sanitation.

c. Public Health Investments and the Poor. Government human capital investments that have broad community benefits (such as primary education, preventive health services, and environmental health) generally are highly beneficial to disadvantaged populations. They are excellent instruments for a poverty alleviation strategy.

Products, Activities, and Relationship to Other Work

49. Product: The *Social Sector Review* will contain the following chapters (see Attachment 4 for a detailed table of contents). The chapters listed below will be preceded by a ten-page summary.

a. *Chapter 1. Introduction*. This chapter will explain the conceptual approach taken, highlighting differences in short-term ("curative") and long-term ("preventive") approaches, the role of the household, and the emphasis on quantitative analyses. In addition, it will provide an overview of Tanzania's performance in the social sectors, in comparison with countries in the region and other low-income nations.

b. *Chapters 2, 3, and 4. Demographic, Economic and Institutional Contexts*. Each chapter will discuss the "givens," or constraints in the macro environment within which human capital investment opportunities must be viewed. For example, in the chapter on the economic context, we will examine macroeconomic parameters and

estimate the social sector expenditure envelope. In the chapter on the institutional context, we will describe the capabilities and comparative advantages of various institutions in the public and private sectors.

c. *Chapter 5. The Household.* This chapter will describe the characteristics of Tanzanian households, available resources, overall expenditure patterns, and regional variations in household features and behavior.

d. *Chapters 6-10. Sector Analyses.* These chapters will analyze current conditions, opportunities, and constraints in each of five sectors — education, health, nutrition, family planning, and water/sanitation. The analysis will be built up from household behavior. The chapters will provide a critical evaluation of sectoral policies and identification of capabilities, constraints, and priorities.

e. *Chapter 11. Interactions.* This chapter will discuss interactions among current conditions and investment patterns in the social sectors. It will point the way toward a set of human capital investments that have the greatest potential for producing desired outcomes. The analysis will be as quantitative as available data permit.

f. *Chapter 12. Local Government and Implementation.* This chapter will analyze the resources, constraints and incentives operating at the local government level, where implementation of basic social sector actions occurs in Tanzania. The analysis will identify obstacles to reform and include recommendations for ways in which those obstacles can be overcome.

g. *Chapter 13. Human Capital Investment Priorities.* In this final chapter, a concrete assessment of human capital investment priorities will be presented, in light of the results of the preceding chapters. Expected impacts of different scenarios on demographic, economic, and poverty-related outcomes in Tanzania will be presented.

50. Activities: Discussion papers for each section will be prepared in advance of the main mission to Tanzania. These papers will be based on all available evidence, including existing documents, analysis of secondary data, population and economic projections, data from the household survey, and the work of the local team led by three Tanzanian consultants. The Tanzanian team will prepare overview papers, oversee intensive local area studies, and commission special analyses (see Attachment 1 for a summary of inputs, and Attachment 3 for terms of reference for the overview papers).

51. All background work will be completed and shared widely at least two weeks before the main mission. The main mission will be preceded and closed with workshops in which experts from the Tanzanian government and academic communities, donor organizations, and the World Bank will participate. Our goal is to complete as much of the basic work before the mission so those participating in the initial workshop can see where the work is headed, debate disagreements, bring new information to the table, and share the information that we will be pulling together for the first time. Our hope is that by assembling comprehensive information on the social sectors, workshop discussions will be disciplined by facts, budget constraints, and an orientation to outcomes. Between the opening and closing workshops, the discussion papers will be revised not only to reflect criticisms and suggestions, but also to take advantage of the worldwide experience of experts who will join us

on the mission. The revised versions will be distributed in advance of the closing workshop. A thoroughly discussed and debated yellow-cover version of the study will be distributed within several weeks of the main mission.

52. Government and Donor Participation: The main reason for choosing this unconventional approach of preparing discussion papers before the main mission is to make preparation of the *Social Sector Review* a joint effort of Tanzania and The World Bank, with inputs welcomed from other interested donors. Government participation will be channeled primarily through a 10-person Social Sector Review Steering Committee, which has been established by the Government's Planning Commission. The Steering Committee, which is made up of Government representatives from each of the social sectors, will meet approximately three times before July 1994 to review progress and to provide guidance.[18]

53. A six-person sub-committee[19] of the Steering Committee has been responsible for screening, interviewing, selecting, and supervising the three local consultants.[20] The sub-committee has participated in development of all activities being undertaken in Tanzania for the Social Sector Strategy, including the household survey, and will periodically review the work of the long-term consultants to be sure that it is on schedule, conceptually sound, and useful for the *Social Sector Review*. They will meet approximately once every two weeks to receive brief oral reports on progress. These reports will include information about which tasks have been accomplished and which are pending. In addition, the sub-committee will provide technical guidance to the consultants.

54. Donor participation will be fostered through frequent consultation prior to and during the workshops connected to the main mission. Donors will be represented on the Steering Committee. Donors will also have the option of co-financing activities leading up to the writing of the Review. For example, the British Development Division in Eastern Africa, part of ODA, has funded about half the costs of the household survey. The United States Agency for International Development has committed an economist from its Nairobi regional office for the main mission. The local consultants will communicate regularly with donors in Dar es Salaam and will circulate background studies for donor review and comment as they become available.

55. Relationship to Other World Bank Work: The *Social Sector Review* is closely linked to several recent studies of the social sectors in Tanzania and Sub-Saharan Africa. The *Tanzania Human Resources Development Survey*, currently in the field, will provide information on household characteristics, their investments in human capital, the incidence of benefits from social expenditures, and demand behavior for social services. The *Social Sector Review* will use the information presented in the recent *Poverty Profile* (December 1993) and the *Public Expenditure Review* (December 1993).

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[18] The final composition of the Steering Committee has not yet been completely determined.

[19] From the government's side, the subcommittee is composed of Mr. Zayumba of the Planning Commission (Chairman), Mr. Mwenisongole and Mr. Msaki of the Ministry of Education and Culture, Professor Hiza of the Ministry of Health Working Group on Health Sector Reform, and Mr. Ndaba of the Prime Minister's Office (Local Government). Dr. Malangalila of The World Bank Resident Mission participates fully in the work of the subcommittee.

[20] The local consultants, who will work with us from December 1993 through November 1994, are listed in paragraph 59. They will first participate in preparation of the Social Sector Review, then they will shift to preparation of the Human Resources Development Project.

The latter, on which AF2PH and AF2CO collaborated, provides the first detailed review of government expenditures in the social sectors. Information from somewhat older studies, including *Teachers and the Financing of Education* (1991), the most recent *PHN Sector Review* (1988), and the *Tanzania AIDS Assessment and Planning Study* (1992) will be reviewed and built upon. Recent Bank-wide publications in the health sector, including *Better Health in Africa* (October 1993) and the *World Development Report 1993* (July) will assist us in analyzing priorities in the health sector.

56. As noted previously, this sector work will become the basis for appraisal of the Human Resource Development Project, which will begin immediately following preparation of the yellow-cover draft of the *Social Sector Review*, using the same team of people. The same is true of the next education sector project, the appraisal for which will begin a bit later.

57. Relationship to Related Work by the Government of Tanzania. The 1993 Paris Consultative Group meeting recommended that Tanzania prepare strategies in education and health prior to the next meeting in 1994. The Ministry of Education and Culture prepared a statement of policy in 1993, and the Ministry of Health is in the process of doing the same. The data gathering and analysis underpinning the *Social Sector Review* will be available to assist these ministries in their preparations for the 1994 Consultative Group meeting. As an example of the joint nature of the work being carried out, in November and December, a World Bank Mission[21] participated in a Joint MOH-Donor Health Strategy Mission, with the World Bank Team producing research and analysis on households and health, health sector financing options, and the legal/regulatory environment for the private sector. The product of the World Bank Team was shared with the Ministry of Health and donors as an input for the strategy work. It will also become the basis for part of the *Social Sector Review*. We will offer to undertake (in February and March) joint missions with Health and Education on personnel and training issues.

Management, Timetable, and Resources

58. Management. Charles Griffin is task manager of the *Social Sector Review* and the subsequent Human Resources Development project. Young Kimaro, task manager of the current education project, will be closely involved in the work. Dr. Emmanuel Malangalila of the Resident Mission will be responsible for day-to-day management in Tanzania and will participate in the technical work. William McGreevey and Jeffrey Hammer will be lead advisers.

59. Preparatory and Background Research. Long-term consultants at Headquarters, Luisa Ferreira (survey and poverty specialist), Ruth Levine (health and family planning specialist), Tamara Fox (public health and personnel specialist), and Lynn Tsoflias (research assistant, survey specialist, and programmer) will devote most or all of their time to the *Social Sector Review* through the yellow-cover stage. Ruth Levine will work closely with Griffin and Malangalila to manage this complex operation. Three long-term, high-level Tanzanian consultants have been hired to prepare overview papers, recruit and supervise other Tanzanian analysts for short-term assignments, and assist with the organization of meetings, the main mission, and workshops. These individuals are Faustin Mukyanuzi, a social sector specialist with extensive experience in the Government's Planning Commission; Issa Omari, an expert on the Tanzanian education system; and Liberatus Shirima, a specialist in local government. Their terms of reference are presented in Attachment 5. The entire

[21] Ruth Levine, Emmanuel Malangalila, Albert Mallya, and Benson Obonyo.

team will stay together for what is hoped will be a relatively quick appraisal of the Human Resources Development Project.

60. Additional Experts for the Main Mission. The main mission is designed to follow the completion of the background work and the preparation of the discussion papers so that top experts in the social sectors, both within Tanzania and outside the country, can be called upon to discuss and refine the draft papers. Experts from the Bank's side will also take responsibility for redrafting the discussion papers during the mission for a yellow cover report that can be issued soon after the end of the mission. We will have working groups in each area. Tentatively, we expect members of the Bank team to include the people listed in Table 8. The composition of the team is subject to change due to budgetary limits or scheduling conflicts, but the table indicates the exhaustive coverage for which we are aiming.

61. Timetable. The timetable is shown in Table 9. Figure 1 shows the time line for the work.

62. Budget. The cost to the department for this project is expected to be the equivalent of 70 staff weeks plus travel. An additional $700,000 to $800,000 will be financed through co-financing arrangements for the following categories of expenditure:

a. Salary ($300,000) and travel costs ($200,000) for the long-term consultants in Washington and Dar es Salaam.

b. The household survey ($170,000 in direct costs not otherwise accounted for above).

c. The focused area studies and related activities ($60,000 in direct costs).

While these costs are being attributed to the *Social Sector Review*, they should actually be spread over the review, plus the two follow-up projects (Human Resource Development and Education).

63. Attachments. The various attachments that have been referred to in this document are listed on the next page. These attachments are not being distributed but are available from Bee Peng Pang, AF2PH, 34142).

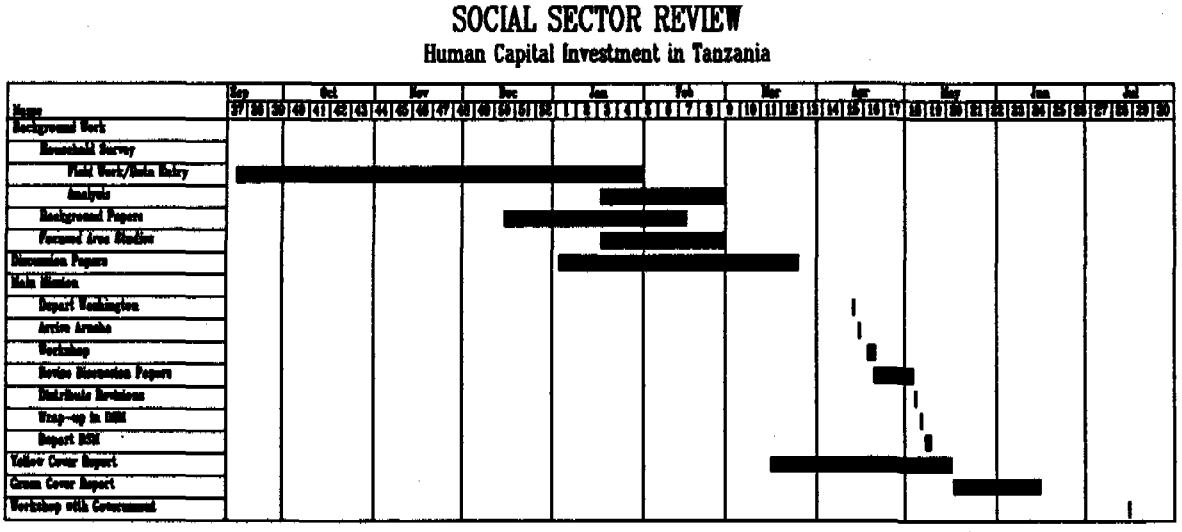
Table 8
Tentative Personnel for Main Mission

Education	Health, Water, Sanitation	Family Planning	Nutrition	Poverty, Incidence, Targeting	Implementation
Issa Omari	Emmanuel Malangalila	Martha Ainsworth (PRDPH)	James Greene (ASTPH)	Margaret Grosh (PRDPH)	Sverrir Sigurdsson (ESP)
Tanzania Education Policy	*Health Policy*	*Economics of Family Planning and AIDS*	*Nutrition Policy*	*Targeting*	*Social Sector Implementation*
Faustin Mukyanuzi	Jose-Luis Bobadilla (PHN)	Susan Cochrane (PHN)	Jayshree Balachander (AFTPH)	Larry Forgy (USAID)	Liberatus Shirima
Social Sectors in Tanzania	*Cost-Effectiveness in Health*	*Family Planning Policy*	*Nutrition Programs*	*Incidence*	*Local Government in Tanzania*
Peter Moock or Indermit Gill (ESP)	Paul Shaw (AFTHR)	Paul Shaw (AFTHR)	Anil Deolalikar (Consultant)	Nisha Agrawal (AF2CO)	Marisol Ravicz (Consultant)
Education Policy	*Health Financing*	*Economic Demography*	*Household Economics of Nutrition*	*Incidence and GOT Finance*	*Strategic Planning*
Ward Heneveld (AFTHR)	Ruth Levine	Ed Bos (PHN)		Luisa Ferreira (AF2PH)	Don Winkler (LATAD)
Primary and Secondary Education	*Non-Government Provision and Financing*	*Demographic Projections (at Headquarters)*		*Poverty*	*Decentralization*
William Saint (AFTHR)	Tamara Fox			Lynn Tsoflias	
Higher Education	*Health Personnel and Training*			*Data and Programming*	
Jee-Peng Tan (ESP)	Dale Whittington (Consultant)				
Cost Effectiveness	*Water and Sanitation*				
Estelle James (PRDPH)					
Non-Government Provision					
Young Kimaro (AF2PH)					
Education Policy					

Table 9
Planned Time Schedule for Completion of the Tanzania Social Sector Review

Activity/Product	*Completion Date*
Overview Papers in Education and Local Government	January 1, 1994
Overview Papers in Health, Nutrition, Family Planning, and Water/Sanitation	January 15, 1994
Special Analyses	February 15, 1994
Focused Area Studies	February 28, 1994
Draft Discussion Papers Distributed	March 15-25, 1994
Main Mission	April 15 - May 7, 1994
Yellow Cover Report Distributed	May 15, 1994
Green Cover Distributed	June 15, 1994
Final Workshop to Discuss Green Cover Report	July 15, 1994

Figure 1
Gantt Chart of Major Steps to Completion of the Tanzania Social Sector Review



LIST OF ATTACHMENTS

The World Bank
INTERNATIONAL BANK FOR RECONSTRUCTION AND DEVELOPMENT
INTERNATIONAL DEVELOPMENT ASSOCIATION

1818 H Street, N.W.
Washington, D.C. 20433
U.S.A.

(202) 477-1234
Cable Address: INTBAFRAD
Cable Address: INDEVAS

March 2, 1994

Recipients of SSR Issues Paper

Dear Recipient:

Attached for your information is the issues paper for the Tanzania Social Sector Review. It describes the planned analytical work. It was reviewed in the Bank on January 10, 1994, and this revised version was issued on January 14.

Because of the importance of this work for our lending program in the social sectors, we are seeking the input of Tanzanians (both government and nongovernment) and donors who have an interest in the social sectors. The issues paper explains the participatory process we intend to pursue, which in fact began six months ago with the initial planning for this exercise.

Listed below are three possible options for participation by you or your organization.

1. Information: We keep you informed and send materials resulting from the work. Following the mission, we will have a debriefing in Dar es Salaam on May 6, 1994, to which you would be invited.

2. Workshop participation: You participate, at your expense and space permitting, in a two-and-a-half day workshop, April 18-20, 1994, at the start of the Bank's main mission. Participants in the workshop will need to read a considerable volume of background materials that will be distributed in early April. The location is to be determined.

3. Funding consultants for the main mission. You finance consultants for the main mission, April 20 to May 3, 1994. The mission will write the first draft of the report, working in teams. Mission members may optionally leave after May 3 or stay for the May 6 wrap-up. Table 8 on page 18 of the issues paper shows the areas of expertise we expect to need for this mission. Although it appears from this table that we have fully staffed the mission, everything is in flux. You may find that we have neglected important areas; you may be familiar with an excellent consultant whom you would like to fund; or both. We are open to suggestions. My only word of caution is that this is a Bank mission, and we will make the final staffing decisions.

Please respond to me directly or to Dr. Emmanuel Malangalila (or Ruth Levine during February) at the Resident Mission in Dar es Salaam. My address and telephone numbers are as follows:

Charles C. Griffin
The World Bank
AF2PH, Room J10-003
1818 H Street NW
Washington DC 20433

202-473-8500 (telephone)
202-473-8299 (fax)

We look forward to your participation in this exciting and important work.

Sincerely yours,

Charles C. Griffin

Charles C. Griffin
Senior Human Resource Economist
Population and Human Resources
Eastern Africa Department

THE UNITED REPUBLIC OF TANZANIA
PRESIDENT'S OFFICE
PLANNING COMMISSION

72/02

Telegraphic Address: "DEVPLAN".
Telephone Number: 29411/3.
Telex: 41451 DEPLAN TZ
In reply please quote:
Ref. No. PCC/B.10/1/18

P.O. Box 9242,
Dar es Salaam.

14th February, 1994

To.....

.....

The Planning Commission, in collaboration with the World Bank, has initiated a review of the social sectors, including health, education, family planning, water and sanitation, and nutrition. Through careful analytic work and a collaborative process, we are seeking to identify the highest priority issues within the social sectors, and to develop a means to address pressing problems within tight resource constraints. Ultimately, we are hopeful that the Social Sector Review will lead to improvements in the ability of the Government, non-governmental organizations, and households to invest in Tanzania's human resources.

Attached for your information is a description of the planned analytical work that was prepared by the World Bank in January, 1994. Because of the importance of this work, we are seeking the contributions and cooperation of individuals throughout the government, the private sector, and the donor community. The issues paper explains the participatory process that is being pursued, which will include a workshop to be held in April, 1994.

You are invited to a briefing on the Social Sector Review, to be held at 10.00 a.m. on February 18 at the British Council COnference Room. At the briefing, we will describe the analytic and other work being undertaken for the Social Sector Review, the April workshop, and possible roles that donor organizations can play. In addition, Tanzanian specialists in the social sectors and local government who

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are preparing the Review will be available to address any specific questions you might have.

Looking forward to your full cooperation.

Yours,

John Zayumba

DIRECTOR OF SOCIAL SERVICES
For: PRINCIPAL SECRETARY

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DONOR AGENCY BRIEFING

ON THE SOCIAL SECTOR REVIEW

AGENDA

Friday, February 18, 1994
10:00 a.m.

Objective of the Meeting: To inform the donor agencies that have an interest in the social sectors in Tanzania of the progress of the Social Sector Review, currently being undertaken by the Planning Commission in collaboration with the World Bank.

I. **Welcome**

II. **Objectives of the Social Sector Review**
- -- To identify highest priority problems across the social sectors, building on past studies and policy documents
- -- To identify constraints to private and public investment in health, education, and other social sectors
- -- To identify ways of increasing public and private investment in human resources

III. **Organization and Management of the Social Sector Review (see chart)**

IV. **Activities for the Social Sector Review (see chart)**

V. **Donor Role in the Social Sector Review**
- -- role of the World Bank
- -- role of the donor community
  - -- participation in workshop (April 15-20)

ACTIVITIES AND PRODUCTS FOR THE SOCIAL SECTOR REVIEW

Overview Papers
(health, education, nutrition, family planning, water/sanitation, and local government)

Human Resources Development Survey
(5,000 households)

Focused Area Studies
(8 communities)

Special Studies to Fill "Knowledge Gaps"
(6-8 small-scale literature reviews and special analyses)

Workshop (April 15-20, 1994)
(defining social sector priorities)

Report and Dissemination

ORGANIZATION AND MANAGEMENT OF THE SOCIAL SECTOR REVIEW

STEERING COMMITTEE

Dr. J. Kipokola, Deputy Principal Secretary, Planning Commission (Chair)

Mr. L.K. Msaki, Commissioner for Education, Ministry of Education and Culture

Mr. H.K. Mwenisongole, Director of Planning, Ministry of Education and Culture

Professor Mmari, Vice Chancellor, Open University

Dr. F. Mrisho, Assistant Chief Medical Officer, Director of Preventive Services

Dr. M. Mvungi, Director, Training Fund, Ministry of Community Development, Women Affairs, and Children

Dr. A. Chiduo, Chairman, Parliamentary Social Sector Committee

Mr. B. Mchomvu, Deputy Principal Secretary, Prime Minister and First Vice President's Office

Mr. Motoo Konishi, Resident Representative, World Bank

STEERING SUB-COMMITTEE

Mr. J. Zayumba, Director for Social Sectors, Planning Commission

Mr. F. Ndaba, Former Commissioner for Local Government, Prime Minister and First Vice President's Office

Mr. L.K. Msaki, Commissioner for Education, Ministry of Education and Culture

Mr. H.K. Mwenisongole, Director of Planning, Ministry of Education and Culture

Dr. P. Hiza, Director, Christian Social Services Council; Chair, Health Sector Reform Working Group, Ministry of Health

Dr. G. Upunda, Vice Chair, Health Sector Reform Working Group, Ministry of Health

Mrs. R. Mang'enya, Commissioner for Budget, Ministry of Finance

Dr. E. Malangalila, Programme Officer, Social Sectors, World Bank (DSM)

TECHNICAL CONSULTANTS

Mr. L. Shirima, Local Government Consultant

Dr. F. Mukyanuzi, Social Sectors Consultant

Prof. I.M. Omari, Education Sector Consultant