United Republic of Tanzania
Ministry of Health and Social Welfare

Mid Term Review of the Health Sector Strategic Plan III 2009-2015

Social Welfare and Social Protection

October 2013

Recommended Citation:. MOHSW, 2013, Mid Term Review of the Health Sector Strategic Plan III 2009 – 2015, Social Welfare and Social Protection, Technical Report, Ministry of Health and Social Welfare, United Republic of Tanzania

Mid Term Review of the Health Sector Strategic Plan III 2009-2015

Social Welfare and Social Protection

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Acronyms

ADD	(NGO working with PLWD)
AIDS	Auto-Immune Deficiency Syndrome
CBM	Community Based Monitoring
CBO	Community Based Organisation
CCHP	Comprehensive Council Health Plan
CD	Community Development
CDO	Community Development Officer
CHF	Community Health Fund
CHMT	Council Health Management Team
CHSB	Council Health Service Board
CP Study	Community Perspectives Study
CSO	Civil Society Organisation
DPO	Disabled People's Organisation
ECM	Early Child Marriage
EH	Environmental Health
EPI	Extended Programme of Immunisation
FBO	Faith Based Organisation
FGM/C	Female Genital Mutilation/Cutting
FP	Family Planning
GBV	Gender Based Violence
HAI	HelpAge International
HF	Health Facility
HFGC	Health Facility Governing Committee
HIV	Human Immuno-deficiency Virus
HSSP	Health Sector Strategic Plan
ITN	Insecticide-Treated Net
KfW	Kreditanstalf fur Wiederaufbau (development banking group)
LGA	Local Government Authority
M&E	Monitoring and Evaluation

MMAM	Mpango wa Maendeleo wa Afya ya Msingi (The Primary Health Services Dev. Programme)
MOHSW	Ministry of Health and Social Welfare
MSD	Medical Stores Department
MTR	Mid-Term Review
MVC	Most Vulnerable Children
NCPA	National Costed Plan of Action (for MVC)
NGO	Non-Governmental Organisation
OOP	Out-of-Pocket
PICT	Provider Initiated Counselling and Testing
PLWD	People Living With Disability
PLWHIV	People Living With HIV (or AIDS)
PMO-RAG	Prime Minister's Office, Regional Administration and Local Government
PMTCT	Prevention of Mother to Child Transmission
PPP	Public Private Partnership
RHF	Regional Health Forum
RHMT	Regional Health Medical Team
RSWO	Regional Social Welfare Officer
SA	Service Agreement
SC-Tanzania	Save the Children Tanzania
SDC	Swiss Development Cooperation
SDH	Social Determinants of Health
SP	Social Protection
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
SW	Social Welfare
SWA	Social Welfare Assistant
SWAP	Sector-Wide Approach
SWD	Social Welfare Department
SWO	Social Welfare Officer
TASAF	Tanzania Social Action Fund
TBA	Traditional Birth Attendant
TIKA	(Tanzania employees health insurance)
TWG	Technical Working Group

UN	United Nations
UNICEF	United Nations Children's Fund

1. Introduction

1.1 The Status of the Social Welfare Department

This report looks at the **Social Welfare and Social Protection** aspects of HSSP III 2009 – 2015, which provides overall strategic direction for the health sector. This report, one element of a broader Mid-Term Review of the HSSP III, examines the objectives of Social Welfare (SW) and Social Protection (SP) in relation to the overall goals of HSSP and reviews the extent to which the Social Welfare Department (SWD) has so far been successful in taking a Human Rights approach to **protection, equity and the reduction of vulnerability** in Tanzania. This means that much of this report focuses on the **cross-cutting issues** which HSSP III sets out to address: **quality, equity, gender sensitivity, community ownership and coherence**. These are the core issues to be addressed in provision of a modern SW system with focus on the fulfilment of human rights to health and well-being, for individuals, families and communities.

The Joint External Evaluation of the Health Sector in Tanzania 1999-2006 noted that "The sector has not responded effectively to address some causes of unequal access" and recommended that "improving equity of access should be a crosscutting theme of HSSP III"[1]. The Social Welfare Department was effectively joined to the Ministry of Health under HSSP III and, in 2010, the new Ministry of Health and Social Welfare (MOHSW) was officially recognised[2]. Nevertheless, and despite a number of successes during the HSSP III period up to the Mid-Term Review (MTR), Social Welfare remains marginalised from the main approaches, strategies and interventions under HSSP III. Social Welfare receives only 1% of the total HSSP III budget, though the budget trend from 2009 – 2014 shows that actual amount dedicated to Social Welfare is increasing:

Table 1: Social Welfare Department, Budget Increase

2009/10 Tshs	2,701,035,000.00
2010/11 Tshs	3,064,148,000.00
2011/12 Tshs	3,228,565,000.00
2012/13 Tshs	3,881,825,000.00
2013/14 Tshs	4,893,688,042.00

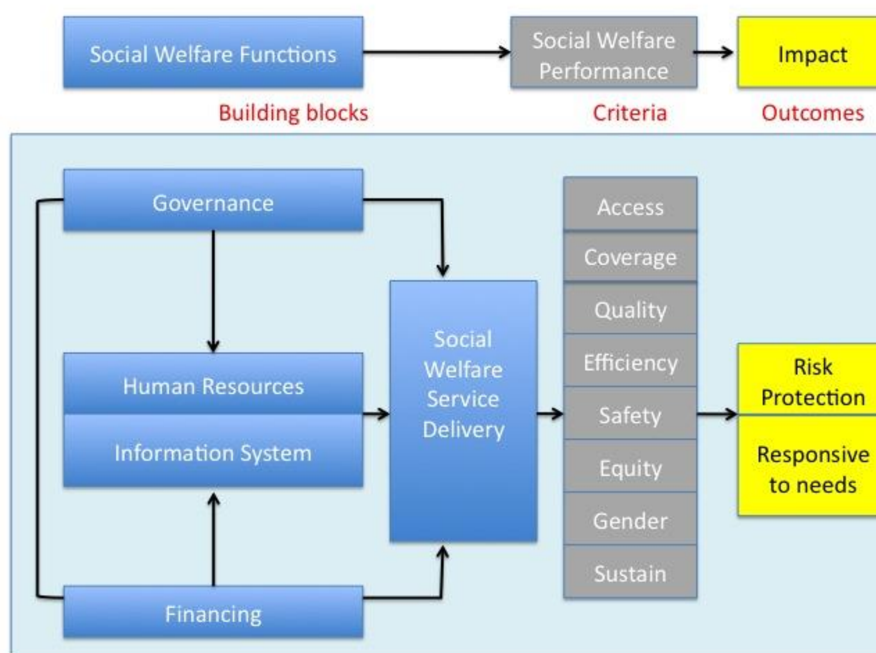
Nevertheless, as this report will show, the budget available is still inadequate for the needs of the Department. With so few resources, the SWD cannot fulfil the contribution it could be making to achieve the policy vision: "… to improve the health and well-being of all Tanzanians with a focus on those *most* at risk, and to encourage the health system to be more responsive to the needs of the people"[3].

[1] Ministry of Foreign Affairs, Denmark (2007)
[2] Government Notice No, 494, 17th December 2010
[3] Republic of Tanzania (October 2003)

1.2 Analytical Framework

The overall analytical framework for this report has been adapted from the WHO Health Systems framework[4], which was used for the Mid-Term Review (MTR) as a whole.

Figure 1: Adjusted Framework for Social Welfare Analysis



The MTR was carried out during July and August 2013 and involved: document review; consultations with key stakeholders at national level and consultations with stakeholders and visits to health facilities and communities in three regions (Geita, Lindi and Mbeya)[5]. The report on Social Welfare has also gained from a Community Perspectives Study (CP Study)[6], which was carried out as part of the overall MTR effort. The CP Study, which included research in a ward in each of the three MTR regions and a ward in Dar es Salaam, provided insight on demand-side issues and concerns in relation to health services. In both the MTR and the CP Study, the approach taken was participatory. Initial findings on the MTR and the CP Study were presented to the MOHSW during August, with initial feedback taken into consideration in this report.

[4] World Health Organisation(2006), Everybody's Business, WHO, Geneva
[5] See main report for list of persons met. Brief field visit reports are also available.
[6] Crawford, S. (2013 c)

1.3 Approach to Vulnerability: Groups, Complex Vulnerabilities and the Social Determinants of Health

1.3.1 Understanding vulnerability

This report is based on the understanding that **vulnerability is complex and dynamic**. Poverty is not the only driver of vulnerability and exclusion. Drivers of vulnerability stem, ultimately, from power inequities and inequalities. Key drivers are: inadequate government will, policies and/or resources to protect vulnerable people; inattention to gender issues; lack of focus on equity of access to services; social-economic structures; differing cultures and livelihood strategies of different social groups; social norms and behaviours which discriminate against, and disadvantage, certain people and reduce their ability to participate fully in society; Harmful Traditional Practices (HTPs), such as Female Genital Mutilation/Cutting (FGM/C) and Early Child Marriage (ECM); the pressures of a modernising society; and a combination of some, or all, of these factors[7]. These drivers are key aspects of the Social Determinants of Health (SDH).

Box 1: Vulnerability and the Social Determinants of Health

There is a great heterogeneity amongst people who are poor and vulnerable. In order to remove barriers to gender-sensitive and equitable access to health and well-being, the range of **Social Determinants of Health** needs to be understood. The full social context (geography, socio-economy, politics, culture etc.) affects possibilities for equity, and affects different people in different ways.

Vulnerability can be understood from two different, but interconnected, perspectives:

1. The effect of **particular events, traumas or "shocks"** in a person's life: such as the death of a parent or carer, loss of shelter and/or sustenance, FGM/C, early marriage, dropping out of school etc.,
2. The effect of a **series of life decisions and choices** made by families, or people as individuals; a chain of causes and effects, each dependent on the one before it, which work to make people more resilient or more vulnerable.

With these two perspectives **Vulnerable Life Pathways** can be understood. These pathways are events and choices in life, which combine in different ways to make some people more vulnerable, more susceptible to risk, than others – even though their life circumstances may look similar. Understanding this **complex vulnerability**, and working to build resilience, can lead to better predictions in terms of health service and social welfare needs in the population, support preventative measures, increase value for money and reduce future financial burdens on the health and social welfare sector.

For example, whilst some events – such as early marriage – are universally negative, they will still have worse effects on some girls than on others, and some will suffer greater health effects than others. Vulnerability will, for example, be compounded where ECM is linked to FGM/C. Both FGM/C and ECM have deeply traumatic effects on girls'/women's emotional and sexual relations. They also perpetuate gender inequities and reinforce lack of communication between men and women and an institutionalised accepted violence against women and girls, within marital and family relations, so vulnerability is further increased. FGM/C affects 15% of all women in Tanzania (incidence rates appear to be falling, though more research is needed).

It is easier to look at vulnerability in terms of Vulnerable Groups than it is to look at the, more complex, Life Pathways, but by identifying only groups, definite markers of high vulnerability will be missed, as will opportunities to lessen future burdens on health services by strengthening proactive, rather than reactive responses to need (prevention rather than cure).

Source: Crawford, S. 2013; Crawford, S. 2013b.

[7] Crawford, S., (2013 a)

1.3.2 Vulnerability in HSSP III

The approach to vulnerability, taken in HSSP III, is to develop interventions aimed at meeting the needs of specific **vulnerable groups** (for example, Most Vulnerable Children, People Living with HIV (PLHIV), People Living With Disabilities (PLWD), the elderly, families in conflict etc.). There are advantages and disadvantages to this approach, for example:

Advantages: working only with targeted groups may make identification and targeting easier and may make it easier to secure dedicated, external funding – as agencies and organisations often specialise by group (e.g. HelpAge International, ADD).

Disadvantages: People are invariably members of more than one group or, only occasional group members. For example, people may engage in sex work continually, or only at times of extreme financial need. Working only with groups, misses the connections between different types of vulnerability and reduces opportunities to prevent **complex vulnerabilities,** which lead to high resource and financial burden on health and social welfare services.

1.4 The Need for Social Welfare and Protection

The exact number of people in Tanzania, in need of social welfare and protection, is not known. The DSW, and other arms of government have identified groups of people whom they consider to be vulnerable (see below, and HSSP III) but, as is stated in HSSP III, ""the actual needs in the country are not yet fully mapped" (HSSP III, p.39). There are, however, numerous indicators of high vulnerability (see Box 1).

Box 2: Indicators of vulnerability Tanzania

- 36% of the population live below the poverty line
- 24% of the rural population is in the lowest wealth quintile (3.2% of the urban population is)
- 46.2% of the population over 6 years old, and in the lowest wealth quintile, have no education
- 25% of all households are headed by women
- The maternal mortality rate is 460/1000 live births
- At least 2 million children can be categorised as Most Vulnerable, 40% of these are children orphaned through AIDS
- 26% of all households contain orphans and/or foster children.
- Approximately 9% of the population are living with disabilities
- The growth of 32% of children is stunted
- Approximately 5% of the population is over 60, and the number of older people is growing
- 46% of the mainland rural population do not have access to improved drinking water sources
- 47.8% of the rural population eat 2 or fewer meals per day
- Only 13% of households have improved toilet facilities that are not shared with other households
- Only 16% of children are registered and only 8% of children have a birth certificate
- 39% of women report that they have ever suffered physical violence (since age 15)
- 1 in 3 girls, and 1 in 7 boys, are subject to sexual abuse

- Approximately 3.3 million women have undergone Female Genital Mutilation/Cutting (15%)
- 2 out of 5 girls are married by the time they are 18 (legal age of marriage = 14)
- Countrywide, average HIV prevalence is 5.1% (rising to 15.7% in Iringa) and women are twice as likely to be infected as men
- Approximately 70% of the population demonstrate discrimination against people living with HIV

Sources: Republic of Tanzania, 2010; UNICEF 2011; www.indexmundi.com; Mboghoina and Osberg, 2010

As Box 1 shows, there are many, varied, indicators of vulnerability in Tanzania. These indicators often overlap, cross sectors and depend on a complex web of life opportunities and challenges. For example, a girl who has been abused is more likely to engage in behaviour, which leads to HIV infection[8]. But, whether she becomes infected or not depends on the various different choices she makes, the support available to her and the opportunities, which are open to her.

This means that, whilst the "vulnerable group" approach can, initially, help MOHSW in its transition towards modern and developmental approaches to Social Welfare (SW), it will not be enough, on its own, to ensure that the health and well-being rights of vulnerable people in Tanzania can be fulfilled, because the "group" approach is never holistic enough to capture and address the complexities of vulnerable life pathways[9].

[8] UNICEF (2011)
[9] Crawford, S., 2013a

2. HSSP III Health Strategic Objectives and Expected Results

The HSSP III SW strategic objectives, expected results and indicators are given in Table 1, below.

Table 2: HSSP Social Welfare Strategic Objective, Expected Results and Indicators

Strategic Objectives	Expected Results	Indicator
To operationalise Social Welfare strategy (2008)	Regulatory framework and guidelines based on the new SW strategy in place, involving partners from other sectors and private providers	Regulations and guidelines produced
To integrate social welfare and health offices at Regional and Council level	Social welfare officers incorporated into CHMTs and RHMTs Joint planning, implementation and monitoring of health and social welfare activities is in place in order to create synergies in programmes for vulnerable groups and poorest in the society	Percentage of RHMTs and CHMTs with social welfare officers CCHP expanded with social welfare chapter
To ensure gender sensitive socio-economic wellbeing and to establish an efficient system for deliverer of social welfare services	Partnership agreements are in place at all levels Accreditation system for all service providers is in place Client liaison and referral system is functional for effective social welfare services delivery and protection at Council level	Number of partnership contracts in districts Number accredited institutions and organisations Number of referred cases in SW
To improve social protection in the community	Collaboration between social welfare officers, CHF and health facilities is in place to improve equitable health service delivery, using prepayment, exemption and waiver systems The traditional and modern systems structure of social protection is strengthened. Social insurance schemes in formal and informal organisations are established. Social assistance programmes are implemented	Number of identified poor and vulnerable enrolled in prepayment schemes Prevalence of traditional system in social protection. Number of social insurance schemes in the country. Number of social assistance programmes. Number of effective micro and area-based schemes.

The objectives show an intention to move from traditional institution-based social welfare, to modern systems that embed social welfare systems at regional, district ward and community levels. Under HSSP

III, regulations and guidelines are to be established to promote standardisation/good practice in all areas. Inclusion is to be encouraged through waivers and exemptions and through insurance and prepayment schemes, intended to benefit poorer citizens as well as those in higher income brackets. Direct social assistance will be provided through partner programmes (including socio-economic programmes), and through council- and community-level involvement.

3. Findings and Issues by Strategic Objective

Assessment of progress is based on the HSSP III expected results and indicators for social welfare, in relation to achieving the strategic objectives. The assessment also considers the extent to which fulfilment of the strategic objectives will contribute to the visions and goals of HSSP III as a whole. The support to MKUKUTA[10] aims is also considered; specifically the ways in which social welfare contributes to:

- Deepen ownership and inclusion in policy-making processes by recognising the need to institutionalise participation rather than a one-off event. Public debate on growth, equity and governance issues will continue throughout the five years of the strategy, along with arrangements for monitoring and evaluation;
- Pay greater attention to mainstreaming cross-cutting issues - HIV and AIDS, gender, environment, employment, governance, children, youth, elderly, disabled and settlements; and
- Address discriminatory laws, customs and practices that retard socio-economic development or negatively affect vulnerable social groups (MKUKUTA, 2005, pp 2-3)

A summary of progress is given in Table 2, below. This is followed by detailed findings and highlighted concerns.

Table 3: Summary of Progress to Date (August 2013)

Achievements	Challenges
Strategy 1: Operationalise SW Strategy	
Policy and strategy development covering different Vulnerable groups	Over-arching policy/strategy not yet ratified
Involvement of wide range of partners (UN, CSOs etc.) covering specific vulnerable groups	Very low budget allocated from HSSP III. Dependence on external funding
	No signs yet of coherent and comprehensive move, within the DSW, to modern SW approaches
Strategy 2: Integrate SW and Health Offices	
Significant increase in SWO numbers at regional and lower levels	Only half of districts in country have SWOs; appointments new and staff do not fully understand remit
SW is beginning to be mainstreamed at local government level	Range of different offices and agencies hire staff operating as SWOs: no standardisation as yet
	M&E weak; communications weak; DSW oversight and close partnership only with few external agencies (e.g. HelpAge)
Strategy 3: Gender-sensitive socio-econ well-being and efficient SW delivery system	
Model programmes, implemented by external partners, seem to be successful	No mechanisms to up-scale successful programmes
	No standardisation/accreditation of external

[10] United Republic of Tanzania (2005)

Achievements	Challenges
	partner programmes; only parts of policy/practice put into operation
	Client liaison and referral system does not function
	Weak understanding of vulnerability; incomplete identification and mapping
	No over-arching system for modern SW and SP
Strategy 4: Improve Social Protection in communities	
SWOs embedded in some health facilities	Promotion of SW and SP issues in HFs is often weal
Social insurance; exemptions; voucher schemes exist. Works well for pregnant women and <5s	Strong dissatisfaction and de-motivation re CHF and exemptions amongst citizens and health staff
SWOs appear to be committed to their work	SWOs frustrated and de-motivated because of lack of operational budgets; from highest level in DSW through to HFs, SW staff are giving hand-outs because there are no available funds to help the worst-off people.

3.1 To Operationalise Social Welfare Strategy

HSSP III Strategic Objective 1 focuses on the enabling environment: using the SW strategy to ensure that policy and strategy is in place to cover the range of vulnerable groups in Tanzania.

3.1.1 Acceptance of the Strategic Plan

There has not yet been top-level acceptance and ratification of the DSW strategic plan (2007 – 2011). This is a major concern, as the document will support the department in its move towards modern social welfare systems and practices. To date, whilst the department supports rights- and community-based programmes implemented by external agencies (see below), the department is still organised and run on a more traditional basis (see section 4), which is at odds with what it is aiming to achieve. The traditional basis is reflected throughout the department – with different floors allocated to offices dealing with different vulnerable groups. The central DSW offices remain a magnet for poor and vulnerable citizens petitioning for individual, charitable support. The current layout, resources and equipment in the DSW offer little opportunity to operate in the dynamic way needed for modern, developmental approaches to SW.

3.1.2 Policy and Planning

Policy and Plans for Particular Vulnerable Groups

Policy and planning is the mandate of the DSW, but DSW does not always have the power, influence or resources to drive policy development in the way it should do, and would like to do. To date, the DSW's focus has been on MVCs (40% of whom are children orphaned by AIDS); Older people; People Living With Disabilities; and mainstreaming MVC committees into multi-sectoral AIDS committees.

For certain vulnerable groups, particularly children, a new law is being translated into policy and guidelines, which contribute to transitioning towards a modern social welfare system. For example:

Box 3:

Building on the landmark legislation for children in Tanzania, the Law of the Child Act (2009), the Department of Social Welfare developed 7 sets of rules and regulations, which are essential for the law's operationalisation. These regulations have now been gazetted and thus provide legally binding procedures on children's care and protection in Tanzania. The government is working with UNICEF and other partners to build and strengthen a national child protection system – which includes the set of laws, policies, regulations and services needed across all social sectors – especially social welfare, education, health and justice which provide protection services. In Phase II of this programme, the Department is developing regulations on child protection which will formally set out how a child protection system will work at the local level and set out the minimum package of child protection services to be provided by the local government authorities (LGAs).

Source: UNICEF-Tanzania; http://dewjiblog.com/2012/10/25/unicef-insists-on-child-protection-in-tanzania/

There is now a second National Costed Plan of Action (see Box 4), which is a strong example of good quality policies, strategies and plans, that have been developed at central level. But, it is also indicative of the gap which can exist between central level and district/ward levels, between policy and possibilities for mainstream practice. During the MTR field visits, and the Community Perspectives Study, none of the SWOs met at district level said that they knew of the Plan or the process of its development. Many of the SWOs, now in districts, are newly in post; yet this should indicate greater likelihood that they would know of the Plan, as they have recently been in training.

Box 4: The National Costed Plan of Action for Most Vulnerable Children

The National Costed Plan of Action (NCPA) for MVC, 2013-2017 builds on the first NCPA for MVC (2006 – 10) and the 2009 National Guidelines for Improving Quality of Care, Support, and Protection for Most Vulnerable Children in Tanzania. The Plan has been produced by the DSW and is an output of the National Task Force. The task Force comprises multi-sectoral representation from the key Government Ministries, Departments and Agencies, UN agencies, donors, CSOs etc. USAID, UNICEF, UN Women and World Vision *(inter alia)* provided technical and financial support. The Plan identifies 14 categories of highly vulnerable children (those affected by Harmful Traditional Practices are not specifically mentioned) and sets out strategic and specific objectives to meet the rights and needs of these children, and the outcomes expected.

Source: Crawford, S. and United Republic of Tanzania, MOHSW (2012)

3.1.3 Partnership

The DSW is dependent on partners for the implementation of SW programmes (see 3.3. below). There is a wide range of partner organisations involved in the TWG and, for example, in the MVC Task Force. Implementation of the NCPA for MVC depends almost entirely on donor agendas and the action plans of implementing agencies, specifically UNICEF, UN Women, and a number of international NGOs (especially those involved with HIV-prevention). Similarly, for an integrated and rights-based approach to implementing plans for older people, the Ministry is largely dependent on HelpAge international (see 3.3 below).

It is a positive advantage that the DSW has been able to forge strong partnerships. This has allowed it to promote modern approaches advocated in new policy for specific vulnerable groups. However, the dependence on partnership means that much social welfare and protection work in the country is out of full DSW control in the sense that the department is involved, but is not a driver. External partners often operate with their own systems and staff protocols, training community-based workers to do what is, essentially, SWO work, but giving different job titles. Presently, there is an evident gap between how partner organisations are working and the work of SWOs at regional and district levels.

3.1.4 Coherent, Comprehensive, Modern Approaches

There is not yet a unified, comprehensive and coherent approach to social welfare and protection, though this is gradually being built up in relation to children (see 3.3, below). This is in part because the DSW does not have the resources to drive such an approach across the whole of its target population[11]. It is also because the DSW both feels itself to be marginalised from, and by, the rest of the Ministry, and because – in terms of location at least – it actually is.

Institutional Care

The operational budget available to the DSW, from government, is almost entirely dedicated to funding traditional SW components: individual requests from vulnerable citizens seeking assistance, and the provision of institutional care.

Table 4: Institutional Care Facilities

Type of MOHSW Institution	Number
Homes for elderly people and People Living With Disabilities	17
Children's home	1
Approved school	1
Vocational training centres for PLWDs	5 (but only 2 function)
Retention homes	5 (but one not open)

Shortfalls in budgets to run these institutions are common according to the Commissioner for Social Welfare. It was reported that budgets are often late, and may not arrive in full. Box 5 gives one example of the difficulties caused by this.

Box 5: Borrowing food

The Department for Social Welfare reported that, in 2012, 500+ million Tz shillings of the agreed budget never arrived. It was needed to pay for food in the institutions. To overcome this difficulty, the DSW was forced to ask suppliers to lend food to the department and wait for payment until the next year's budget arrived. This situation – borrowing goods or services – is not uncommon within the MOHSW. At district level, for example, building contractors often wait for payment. But the DSW feels it is particularly iniquitous for them as it contributes to increasing people's vulnerability rather than alleviating it.

Source: pers. comm. DSW, MTR consultations.

3.1.5 Conclusions on Strategy 1

The intentions of the 2007-11 Department of Social Welfare Plan, to be rights-based, community-based and developmental are progressing slowly within the ministry. They are mostly evident in work supported by partner agencies and organisations. SW carried out by the ministry itself remains largely focused on traditional case-work and institutional care. With only 1% of the HSSP III, and even less in some districts, the Ministry is very highly dependent on external funding and agencies to put modern SW approaches into operation. The 2007 – 2010 strategic plan shows that there is good understanding of the benefits of rights- and community-based approaches. But, if the ways in which a developmental and preventative approach to Social Welfare can reduce burden on health services are recognised in theory, this is not supported by internal budgets or other resources.

[11] This is in contrast, for example with the Environmental Health section in the Ministry, which, despite limited internal influence and resources, is able to unite and drive a range of partnership activity, around sanitation and hygiene at least.

3.2 To Integrate Social Welfare and Health Offices at Regional and Council Levels

Strategic objective 2 focuses on development and deployment of Social Welfare cadres and on building up integrated planning, monitoring and evaluation processes/systems to embed SW within CCHPs.

3.2.1 Increase in the Number of Social Welfare Officers (SWOs) and Deployment

Over the HSSP III period, there has been a significant increase in the number of SWOs deployed at Regional and District levels (from approximately 200 in 2008 to nearly 400 in 2013). Around half of the districts in the country now have an SWO. Some of the new SWOs were previously Community Development Officers. They have been given further training and re-deployed to the MOHSW.

Although there are currently close to 400 SWOs spread across half the districts in Tanzania, this remains far short of the nearly 3800 officers which the HSSP III document states are needed. Currently, in per capita terms, there is only 1 SWO to every 112,000 people (using a population estimate of 44.8 million, Census 2012). Even taking the most conservative estimate of the number of vulnerable people in the country (based on 26% of the population living in the bottom wealth quintile, DHS 2010), assuming equal levels of vulnerability throughout the country (which is not the case in reality), and working on the districts that currently have an SWO, each officer is in theory responsible for roughly 14,560 vulnerable people. Currently, there are no SW cadres below district level.

In the past, there was a cadre of SW Assistants (SWAs) at ward level. The DSW has the intention to recreate this layer of staffing. A workforce strategy has been completed by the MOHSW, with the aim of speeding up employment, but has yet to be put into operation.

A major concern, voiced by staff within the DSW, is that, unlike students in the medical profession, SWOs have to pay for their own training. Following pressure from the department, the government has given 45 million TZ shillings for training SWOs in 2013 (yet, this sum is only sufficient to train 4 – 5 officers).

The Institute of Social Work now offers training at certificate, diploma and degree level, and is soon to offer a Master's programme. The Institute has links with the Jane Addams College of Social Work, University of Illinois at Chicago, and have established para-social work training with the college's support.

3.2.2 Additional SW Staff

Another major concern for the DSW is the fact that there are unknown numbers of people carrying out different social welfare and social protection tasks, but unregulated by the DSW. There is heavy reliance on para-professionals – such as community volunteers, community justice facilitators, community development officers etc. In addition to work carried out by Community Development Officers (CDOs from the Ministry of Community Development), external agencies (UN and CSOs/FBOs etc.) hire, train and deploy a range of community-based workers, under a variety of job titles. This means that it is not possible to assure the quality standards which exist (even if the DSW had the resources to do so).

3.2.3 Integration into Local Government

There has been an initial advance in the process of integrating SW into local government services. At central level, quarterly meetings are now scheduled between DSW, other MOHSW departments, PMO-

RALG and Civil Service, to promote cooperation and coherence at all levels. In the regions, the Regional Social Welfare Officer (RSWO) is part of the Regional Health Management Team (RHMT). However, despite successes in deploying greater numbers of SWOs at district level, the DSW is not happy with their placement and they sit under the Community Development Cluster at district level. This reduces their influence and makes it hard for them to bring social welfare issues into top-level discussions.

The DSW states that placement of SWOs within the CD cluster is the main reason why SW issues and concerns are not taken up in CCHP planning and budgeting. The DSW believes that, to get SW higher on the agenda, SW needs to be independent within local government (i.e. not part of the CD cluster). It also believes that a directive is needed to ensure that councils set aside funds for social welfare issues, and an operational budget for materials, equipment, transport and programme development.

Consultations during the Community Perspectives Study showed that there is little effective representation of women, youth or PLWDs at ward and lower levels. Many people, especially women, feel that their concerns are not addressed in local level planning or budgeting and that, in the current situation, there is little point in raising their voices, as they are not listened to by the "higher-ups"[12].

3.2.4 Monitoring and Evaluation, Communications

Monitoring and evaluation of social welfare interventions are weak throughout the DSW and, particularly, in relation to social welfare work in the districts and communities. This is, in part, because so much work is dependent on external organisations and they have their own frameworks and systems for M&E. Results are not always properly shared with MOHSW. There is, as yet, little or no evidence of synergies created through joint planning and monitoring (an expected result of Strategy 2). In programmes designed and implemented with or by external agencies, there is possibility for good monitoring and evaluation (c.f. MVC Guidelines and NCPA, HelpAge International etc.), and systems are being developed, but there is little solid evidence base as yet against which to monitor progress

Unless the extent of vulnerability is mapped, in a way that allows for addition to, and refinement of, data bases over time, it will be hard to establish a basis against which to monitor positive change. To date, mapping has only been conducted adequately where external organisations are working. Guidelines on identification of vulnerable people exist for some vulnerable groups, but not for others. Guidelines which have been developed and approved through the ministry, appear not to be well known or used at local levels (cf Mbeya region). Weak M&E, and lesson learning leads to a number of significant problems:

a) It is harder to gain control of the sector and to regulate the work of partners

b) There is no solid basis on which to leverage more funding (internal and external)

c) Success stories are not publicised: successes cannot be celebrated or used to gain popular support for DSW work (through, for example, local and national media).

3.2.5 Communicating Success

The ability to communicate successes is a vital component in strengthening trust between citizens and services. People do not notice positive health and well-being status change in the way that statistics may demonstrate it. For that reason, it is vitally important that there are good programmes of communication which not only draw attention to issues and problems around health and well-being, but

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[12] Crawford, S. et al, (2013 forthcoming) "No Money, No Service": Community Perspectives on the Health Services in Tanzania

also celebrate successes. The MTR noted that the Public Relations section of MOHSW is not strongly involved in ensuring that successes (throughout the work of MOHSW) are communicated to the Tanzanian people. The links between Public Relations and DSW are not strong.

3.2.6 Conclusions on Strategy 2

Despite the increase in SWOs, there is heavy reliance on para-professionals – such as community volunteers, community justice facilitators, community development officers etc. It is unrealistic to expect proper quality control in these circumstances. At local levels, SWOs may have low influence and be unable to ensure that SW issues are properly integrated into CCHPs. Local budgets for SW are very low. M&E in under-developed in the sector and development of the evidence base is piecemeal. Throughout MOHSW, little effort is made to communicate successes to the general public. This means that opportunities to get the public "on-side" are not being optimised.

3.3 To Ensure Gender Sensitive Socio-Economic well-being and to Establish an Efficient System for Delivery of Social Welfare Services

Strategy 3 focuses on development of programmes (through partners) in order to establish a modern welfare system and improve well-being for all vulnerable people. The expected results are related to the number of partnerships established, accreditation and standards set and observed within these partnerships, and establishment of an effective client referral system at council level.

3.3.1 Setting Guidelines and Standards; Accreditation

The Ministry has established guidelines and protocols, some of which pre-date HSSP III, for a number of social welfare related services and/or efforts. These include:

- Standards Rules on Equalization of opportunity for people with disability
- National guidelines for community-based care, support and protection of orphans and vulnerable children
- The community based identification of the Most Vulnerable Children guides
- Community Facilitation guidelines
- Guidelines for care and psychosocial support of orphans and vulnerable children, and guardians
- Guidelines for the establishment and management of Children's Homes
- Guidelines for Foster Care and Adoption Services
- Facilitation guides for training on early childhood stimulation for cognitive and psychosocial development
- Guidelines for probation services

DSW is in the process of developing standards for quality care and social welfare service delivery[13].

[13] United Republic of Tanzania, MOHSW (2010)

As is the case with policy and strategy (see section 3.1) there appears to be a gap between the standards, guidelines and protocols developed at central level and what is actually understood and used at local levels. This is because a) it is not yet possible for the DSW to have full oversight and control over the work of external agencies (international and national), b) some agencies may have different levels of knowledge and understanding of the guidelines, c) SWOs do not all yet have the experience or expertise, and none has the operational resources, to supervise all work which may be undertaken by external agencies in their areas. At present, a functioning accreditation system cannot be put into operation because there are no resources, at any level, to do so.

3.3.2 Model Programmes

There are several excellent, model approaches (also see section 3.4) that are helping to map vulnerable groups in parts of Tanzania and apparently improving the well-being of vulnerable people. These programmes are mostly implemented by external partners. Model programmes which are likely to be successful are characterised by:

- Fit with national policy and strategy (created with multi-stakeholder involvement)
- Adherence to new national guidelines and protocols
- Development and implementation of programmes in a participatory way, and with involvement of vulnerable people
- Working for fulfilment of rights (not just needs) and in a rights-based way

Two examples of such programmes are given in the following boxes.

Box 6: Children's access to justice

UNICEF is supporting the DSW in practical application of a child protection system in four districts, engaging all relevant sectors of local government and civil society. In these districts, the social welfare, police, justice, health and education sectors and informal community structures are working together to ensure cases of child abuse are dealt with swiftly and appropriately. Establishment and functioning of the MVC Committees at local levels has been supported, and a solid baseline of understanding on vulnerable children in the area is being built up. Amongst other activities, strong liaison is being established between district SWOs and a dedicated police focal person/room where and with whom children can discuss issues of abuse in a safe environment. A strong communications campaign has been developed and is supported by the long-running "Fakati" programme on the dangers of cross-generational sex.

Source; www.unicef.org; file:///G:/Tanzania%2013/ABT%20MTR/Tanzania%20%20Fataki

Box 7: HelpAge International

HelpAge International (HAI) is helping the DSW to implement its policy on older people. It is now working intensively, with a rights-based approach, in 54 districts, and carrying out outreach in another 27. Baseline information is built-up; older people and their needs are identified through ward level mechanism. Forty-eight district councils, out of a total of 132, now include older people's needs and concerns in their plans and budgets. In villages where HAI works, the number of murders related to accusations of witchcraft has been cut by 90%, and there has been a large drop in malaria cases where insecticide-treated nets have been provided. Older people have been support in providing community and home-based care for MVCs. HAI has assisted health facilities in opening older people's windows and treatment rooms. Nationally, HAI is a strong advocate for older people and continues to push for a universal non-contributory old age pension. They will also work more intensively on widows'

inheritance rights and killings of older women. HAI also promotes the sexual rights of older people and aims to ensure that they are part of all HIV and AIDS prevention, treatment programmes and services.

Source: pers. comm. MTR review; HAI, (undated) Building Bridges: Home-Based Care Model for supporting older carers of people living with HIV and AIDS in Tanzania; URT, Ministry of Labour and HAI (2010) Achieving income security in old age for all Tanzanians.

The examples given are both of programmes that are reaching quite widely. However, there are currently limited expectations that these initiatives can be mainstreamed throughout Tanzania without on-going external funding and technical support.

3.3.3 Female Genital Mutilation/Cutting and ECM

Despite the resources devoted to addressing the rights and needs of MVC – through programmes such as that implemented though UNICEF – some aspects of girls' vulnerability are hardly addressed. Key amongst these is the relatively low level of attention given to harmful traditional practices, such as FGM/C and ECM. Although the incidence of FGM/C is thought to be decreasing, it is still high in the central area and amongst certain populations, such as the Maasai. It is noticeable that, although the UNICEF (2011) report on Violence Against Children makes mention of FGM/C, UNICEF has no current plans to address the issue.

"Working for the ending of FGM/C is fundamental to achieving gender equity in countries where FGM/C occurs. This is because FGM/C is driven by:

a) The belief that FGM/C "controls" female sexuality and that, without it, women's sexual desire is un-checkable

b) That it is a necessary component of what makes a woman a woman and of what makes her a social being;

c) A desire to ensure that girls are marriageable; uncircumcised girls are not believed to be acceptable

d) To ensure a girl's purity as a human being (for example, amongst the Maasai, uncircumcised women are thought to be likely to be cursed by ancestral spirits and, being thought to have impure blood, will not be helped by traditional birth attendants during childbirth).

e) Asset poverty and lack of education are also thought to be drivers. The link is not always direct, but education has been shown to offer some protection against FGC "[14].

FGM/C also has strong links, in many cultures, to ECM. Both these HTPs have been shown to have heavy impact on girls' and women's health and well-being. Although value-for-money research is far from complete on the subject, the cost impacts on the health and social welfare services are known to be high[15].

3.3.4 Client Liaison and Referral Systems

The client liaison and referral system is gradually improving. In specific instances good systems, involving coordination and cooperation between different ministries, are being established. However, SWOs are generally unable to offer adequate client care as they have no operational budgets. This means that they

[14] Crawford, S. (2013 b)
[15] Ibid.

are unable to offer support and guidance and unable to refer properly to other agencies or services. Box 8, below, gives an example of this.

Box 8: Lack of case follow-up

The SWO in a health clinic in Mbeya told the MTR team about a woman who had come to the office seeking help. The woman said that her husband had been drinking heavily and had been violent towards her and then deserted her and their three children. He had recently returned to the family home but was causing trouble. The SWO gave the woman a letter, addressed to the husband and requesting that he would come, with his wife, for an interview and counselling. We asked what had happened. The SWO said that neither the woman, nor her husband, showed up again at the office. When asked about follow-up in the community, the SWO explained that that was not possible in this, or the many similar cases she sees, because she has no transport and no resources to go into the communities. She has no idea what became of the woman, whether her husband remained violent, or what happened to the children. She agreed whole-heartedly that this made her job very frustrating and she feels de-motivated. She also pointed out that, when she can, she gives hand-outs to people in need and sometimes pays for her own transport so as to be able to visit a client at home.

Source: MTR visit to Mbeya

SWOs do liaise with other health personnel and committees (particularly around HIV issues and PICT) and with local governance mechanisms such as the ward councils. However, particularly in local government structures, members do not often have the skills or resources to take up social welfare issues – such as GBV or child neglect. The DSW is aware that, currently, it cannot deal adequately with problems in the communities and this is a major reason why it is pushing to (re)create the cadres of SWAs at ward level.

3.3.5 Identification of Vulnerable People and Understanding Vulnerability

Nationwide, there is incomplete knowledge and understanding on who is vulnerable within communities, where they are and the full causes (Social Determinants) of their vulnerability. Ward councils and local level committees are responsible for identification of vulnerable people, using guidelines developed by the DSW. However, much of the country remains unmapped. Where mapping is done, it may be inaccurate and there are known to be times when the system is abused if people feel they can get extra benefits (see 3.4, below). Organisations, such as PACT, are working with ward councils to identify vulnerable children and their families, and developing gender-sensitive income generation activities to support these families.

Box 9: Income for vulnerable families

PACT is just beginning its work in the Mbeya region and is already forging strong links with the RSWO and the Mbeya City SWO. At present, and as PACT has done in other parts of the country, it is involved in a process of strengthening the capacity of district and ward level local government committees to identify vulnerable children and their families. Committee members are being taught how to use national guidelines and formats to make identifications which will enable them to put children and families forward for special social welfare assistance. In Ibaba (Ileje district) the MTR team talked with ward level executives who have been involved in this work. They said how useful it is, and stressed how it will help them to work for the well-being of their communities.

PACT began its work for vulnerable children in Tanzania in 1998. After identifying vulnerable families, PACT uses the WORTH model to help women set up small savings and credit groups for income-generating activities. In addition, meetings are held at which women can discuss their problems and learn more about parenting skills, health etc..T states that "by 2011, 1,061 groups representing 20,166 caregivers caring for 52,262 vulnerable children were operating, with notable household improvements

in food security, shelter and care. Pact also carries out substantial work in better governance, empowering citizens at local levels, and civil society organisations, to work with political representatives toward transparency and accountability at the local and national levels".

Source: PACT, Mbeya and http://pactworld.org/tanzania

These, and other programmes (such as that implemented by Save the Children in Tanzania) are contributing to the socio-economic well-being of an increasing number of vulnerable people in Tanzania.

3.3.6 Other Support for Vulnerable Groups

Outwith support offered by organisations which partner the DSW, the major source of social and economic support for vulnerable groups in Tanzania is implemented through the Tanzanian Social Action Fund (TASAF). TASAF is run by the Government of Tanzania with support from the World Bank and the World Food Programme. TASAF works in cooperation with the Ministry for Community Development, Women and Children, and through local government authorities.

Box 10 TASAF

The Tanzania Social Action Fund is a Government of Tanzania funding facility organisation. The fund works through local government. TASAF Two has been running since 2008. Building on its first phase, the organisation has been funding demand-driven socio-economic and income generating projects with poor and vulnerable village communities. It has also provided capacity strengthening for organisations working with poor communities and for individual sub-project administrators. The criteria for funding to sub-projects were: communities lacking access to basic services; able-bodies, but food-insecure families, and households containing vulnerable individuals. By end 2011, c. 200 billion TZ shillings had been disbursed, with 50% going to vulnerable groups (MVC, older people, PLWDs etc.). The fund now, under TASAF III, plans to reach 1.2 million households (c. 7.5 million people) through Community-based Conditional Cash Transfers, focusing MVC and older people.

Source; www.tasaf.org; Brathen, E.(2006); TASAF 4th Quarterly Report 2011); www.dailynews.co.tz. Sept. 5th 2013

The MTR did not find that cooperation between TASAF and the DSW was strong. One reason for this may be that, at present, there is insufficient cooperation and collaboration between Community Development and Social Welfare at district levels.

3.3.7 Conclusions on Strategy 3

There are some excellent model programmes being undertaken. However, there are four major issues:

1) There are many small- and medium-scale interventions, by NGOs, FBOs and other civil society organisations, which appear to show promise for positive change and reduction of vulnerability. There is no guarantee, as yet, that successes will be properly evaluated, or sustainable. Mechanisms to bring successful models to scale have not been developed.

2) The DSW does not have the finances or other resources to "take over" approaches modelled by external organisations. Therefore, the MOHSW is almost entirely dependent on external funding to progress towards greater equity, gender equity, and high quality services to improve the socio-economic well-being of vulnerable people in Tanzania.

3) Presently, district, ward and village levels do not give strong enough focus to social welfare and equity issues. Vulnerability and social welfare are not well understood by people on the various representative decision-making committees; women are poorly represented, young people and people living with disabilities have hardly any representation at all.

4) Some aspects of vulnerability – such as FGM/C and ECM – which affect significant numbers of girls and women, are ignored or inadequately addressed.

3.4 To Improve Social Protection in the Community

Strategic objective 4 focuses on increasing equity by encouraging poorer people into health services through the Community Health Fund insurance scheme, exemptions and waivers. It also addresses the way that traditional social protection measures can be strengthened. (The expected results on this are unclear in HSSP III).

3.4.1 The Community Health Fund (CHF)

"The CHF in Tanzania is a voluntary pre-payment scheme which offers a client (household) the opportunity to acquire a "health card" after paying a contribution. A household can be an individual or a family. A card is renewed after every 12 months. The CHF in Tanzania started as a pilot in 1996 in Igunga district and, after evaluation in 1998, was rolled out to 9 more districts. In 2001, the policy decision was reached to cover all districts, through an Act of Parliament. … The scheme operates at district level and is a cooperation between communities and government. The government provides a matching grant to CHF at district level. Communities can pay contributions during harvest time [when funds are available] and enjoy services throughout the year. CHSBs and Community Health Committees manage the Fund. CHF is not intended to replace government funding". (MOHSW, 2007)

Much has been written on the CHF in Tanzania both by organisations and offices working to support the scheme, and by independent researchers[16]. These documents present a varied, and sometimes confusing, picture of the functioning of the CHF. What is clear that there are many challenges to be addressed in order for the scheme to work properly.

There are issues over how CHF bank accounts are managed:

"In 2011, the PMO-RALG, … instructed LGAs to consolidate their bank accounts to a maximum of six. This direction created mass confusion regarding what to do with CHF accounts. After some time, guidance was provided to deposit complementary funds into the DED Miscellaneous Account. Although that guidance is now clear, it has continuing negative effects. First, having the CHF funds in a co-mingled account make it more difficult for Councils to provide the necessary documentation to access government matching funds for CHF membership fees. Secondly, facility staff and the DMO are reportedly less motivated to encourage CHF membership because they no longer can directly access the funds. Thirdly, there is no longer a clear role for community members in approving use of the funds, as control of the funds now rests with the DED and DMO" (Chee, G. and Chitama, D. 2013).

This means that there is little transparency on where CFH funds are, how they can be used, or have been used, or when and how matching funds will be made available.

Staff at health facility level have not been fully trained and motivated to promote CHF and to ensure that membership is properly recorded, and may be de-motivated. The MTR team found this to be particularly the case in Mbeya, where the bank account problems have yet to be solved. In addition, and as the CP study confirmed, some people do not feel that the CHF scheme is worthwhile because they believe that services on offer are of poor quality (especially that there are often drug shortages and stock-outs).

[16] See, for example Ifakara (2012a and b), GIZ (2013) Chee, G. and Chitama, D. (2013)

Currently, the national enrolment rate in CHF is low (7.5%[17]). In areas where it is higher, this has been achieved through intensive promotion and support – both by health directors and local staff, and by external agencies (such as, the SDC funded Dodoma Project). Enrolment has also been boosted where it is linked into other projects (e.g. the KfW-supported scheme for pregnant women and families, e.g. in Mbeya region). However, the MTR consultations found that this scheme is not always well-understood by staff and incorrect information may be given to clients[18]. To date, there has been little attention on linking CHF to other initiatives – such as school enrolment. New opportunities are emerging: such as linking CHF to the new birth registration campaigns.

In terms of increasing equity in access to services, where CHF has worked well (e.g. Dodoma and Tanga) it appears that poorer citizens' access to health services is increased. However, increased access for the poorest and most vulnerable people is only possible when they are correctly identified and able to get CHF cards for free (through local governance mechanisms). The most destitute and most highly vulnerable people are unlikely to gain greater access as they are unlikely to get into the system (see below).

The CP Study found that in the study areas, whist most men know about the existence of CFH, most women are unaware of it. The general feeling, among community members was that CHF is not worth it because the services available are not of high enough quality, drugs are not available in the facilities so have to be paid for in pharmacies, and other out-of-pocket costs are high[19].

3.4.2 Vouchers and Exemptions

The CP Study found that the one area of social protection with which women are generally satisfied is the Hati Punguzo programme. Started under the malaria programme, this provides vouchers for Insecticide Treated Nets to pregnant women[20]. Women did, however, state that the nets are not of good quality.

The main, national exemption schemes are for:

- Pregnant women and children under five
- Highly vulnerable/poor people
- Older people: over 60
- PLWDs
- People living with particular critical illnesses

According the citizens, and to staff, these systems do not operate optimally. Citizens make many complaints about being unable to get exemptions when they are entitled to do so (vulnerability and over 60 identification is at the ward level and requires the council to provide a letter of justification). They also state that health services are, in any case, never free – because of the many out of pocket costs. Where special exemptions and facilities are available for older people, these may lead to resentments amongst some members of the community who feel that they, too, deserve special treatment. Health

[17] MOHSW et al. (2013)
[18] Field visit, Mbeya, MTR 2013
[19] Crawford, S. et al., (2013 forthcoming) "No Money, No Service": Community Perspectives on the Health Services in Tanzania
[20] http://www.meda.org/connect/

facility staff have stated that they cannot be expected to run good services with so many exemptions in operation[21].

3.4.3 Conclusions on Strategic Objective 4

Visits carried out under the MTR, and the Community Perspectives Study, showed that many citizens (men, women, girls, boys, highly vulnerable people etc.) are dissatisfied with exemption systems: because of out-of-pocket costs (payment for nursing care, drugs, equipment, gate costs, transport etc.); many citizens say "no money, no service". Whenever citizens have to pay to get services they believe should be free, or covered by their health insurance, citizens see this as corruption within the services. Citizens consulted in the CP Study did not draw a strong line between payments which they see as illegal (e.g. paying to jump queues or to get adequate service) and those which may be legal (such as transport and food costs), but which severely limit their access to services. For example, some citizens were unclear as to whether health services are allowed to charge for patients to be collected by ambulance, but they consider this to be a corrupt costs anyway – especially if the patient is poor or pregnant22. Out-of-pocket costs are major barriers to equity within the health services.

The poorest and most vulnerable people currently "slip through the net": they may not be identified as vulnerable, or they may feel socially unable to access services (see below).

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[21] Crawford, S. et al., (2013 forthcoming) "No Money, No Service": Community Perspectives on the Health Services in Tanzania and MTR fieldwork.

[22] Ibid.

3.5 Cross-Cutting issues

Cross-cutting issues are summarised in a SWOC analysis in section 5, below. Major issues on equity, gender and community ownership are noted here.

3.5.1 Equity

The MTR Analytical Review report 2013 suggests that there has been considerable progress in achieving greater equity in access to health services. For example, gives a main finding that child mortality has continued to decline rapidly, and that "the gaps between urban and rural children and between the poorest and best-off have reduced considerably and are generally small" (MTR-AR 2013, p. 15[23]).

Despite achievements, in other ways, vulnerability gaps remain, or are growing. Whilst more people are accessing services, they are also suffering from the out-of-pocket costs of doing so, and from the fact that the waiver and exemption schemes are not yet functioning optimally. The equality which is demonstrated in statistical analysis does not match with people's perceptions and lived experiences of access to health and well-being.

During consultation in Mbeya, one health care worker told the MTR team:

"It is a challenge for the poor &vulnerable to get access to health services. The policy is clear but the question is where to get the resources to support these groups. Unfortunately these groups consume most of the resources. They are often sick and need health care. Identification of the poor and vulnerable is done at community level but experience shows it is not often realistic some are not very poor. We rely on a letter from the executive officer and there is no other means of verification". (*pers. comm.,* health worker, Mbeya region).

There are people in vulnerable groups who remain largely untouched by services. Key amongst these are people suffering with mental health issues. Although there are moves for policy and supportive systems to protect people with mental health problems, there are practically no services to assist them[24]. For example, the Director of Mental Health in Mbeya told the MTR that they have few resources to help people with alcohol or drug abuse and that, in districts, anyone presenting with serious mental health issues is referred on as "psychotic". In the referral hospital, there is a locked ward for violent cases[25].

3.5.2 Discrimination and stigma

The Community Perspectives Study[26] and other recent reports[27] show that instances of **discrimination, mistreatment and violence towards poor and vulnerable people, especially women, are common within the services**, and that this is a key reason for people's mistrust of, and dissatisfaction with, services. No HSSP III goals can be met successfully whilst this is the case.

A number of Harmful Traditional Practices, notably FGM/C and ECM, affect large number of girls and women in Tanzania. These place burdens on the health services and have highly serious, negative

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[23] Based on GoT DHS 2005 and 2010
[24] Mbatia, J. and Jenkins, R. (2010)
[25] MTR fieldwork, RHMT
[26] Ibid.
[27] See, for example, Human Rights Watch International (2013) "Treat us like Human Beings"

impacts on girls' and women' health and well-being. They are major rights abuses, yet not enough is being done to address them.

3.5.3 Community Ownership and the need for better communication

Extending accurate information to citizens is particularly needed in relation to participatory planning processes. Systems for community participation in planning have long been in place in Tanzania. However, the evidence suggests that these are not working well, and that citizens have little or no confidence that participatory planning processes will lead to services which reflect citizen's priorities and concerns.

Consultations during the Community Perspectives Study showed that citizens think that whilst their participation in decision-making processes is important, they also think that it is currently without meaning: their priorities are not given weight in budgets and they have no real part in improving service governance. The Community Perspectives Study showed that, despite protocols to encourage women's, younger people's and PLWDs participation in local level committees and decision-making fora, this is still weak. Women, younger people and PLWDs do not think they are welcome or will be chosen as representatives. They think they are not listened to and that their concerns are not taken seriously.

It appears that a major reason why people are mistrustful of services is that they feel that their voices are not heard by people in services who have decision-making power[28]. Equally, health services do little to promote themselves to the general public. For example, both services and the general population agree that there has been great progress in provision of EPI and HIV prevention, treatment and care. However, MOHSW does little to **celebrate these successes** and to share them, with the population. Using active and accessible communications methods, right through to local levels, would allow services and citizens to recognise where they are working together in efforts to secure and protect the health and well-being of citizens. Currently, whilst government may be able to demonstrate improvements in numerous aspects of health status, citizens are often unaware of these achievements and can focus only on areas where they feel dissatisfied.

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[28] Crawford S. et al, 2013a

4. Governance

4.1 Lack of budget, agreed policy/strategy and influence

4.1.1 Budget and financing

The DSW stated that the fact that it receives only 1% is indicative of the fact that it is marginalised within the Ministry and its work is not taken seriously. The MTR team was told that the DSW had submitted a budget request of 9 billion shillings, but had received only 2 billion.

The DSW is severely under-funded, and this leads to a **lack of influence and power to change the situation and leverage more government funding**. The DSW in Tanzania is currently over-dependent on external funding to operationalise modern social welfare and protection interventions. This means that it is unable to drive agendas and it is forced to continue planning around the interests of implementing agencies and donors. Inevitably, social welfare remains siloed. There is, for example, funding for issues related to HIV-AIDS and to Most Vulnerable Children, particularly children orphaned by AIDS and children who have been abused. Yet, there is for instance, limited funding for community-based casework to support women reporting violence or desertion or to conduct outreach work and follow-up around children truanting from school, committing offences, neglected children, adolescent well-being, mental health, families in crisis and so on.

4.1.2 Policy/strategy

As outlined above, the DSW has, with the support of external implementing agencies, been able to produce and ratify a number of policies and guidelines on various aspects of social welfare (ageing, MVC, PLWD etc.). However, it has yet to have its over-arching policy and strategy ratified. This further weakens the position of the DSW within the Ministry, and within government as a whole.

4.1.3 Influence

The DSW Strategic Action Plan 2007 – 2011 states that:

"With the dire need for systematic approach to social welfare service delivery … the department found it necessary to realign itself … the DSW had no vision of its own but was always aligned to the vision of the ministry to which it was affiliated. Consequently the thrust of operations had always been in a way influenced by the position of the parent ministry". [29]

As in many other countries, the DSW suffers a dilution of its power and influence because social welfare and social protection issues are split between a number of different ministries and offices (MOHSW; Community Development, Women and Children; Ministry of Labour, Youth and Sports; PMO-RALG etc.). This means that, without highly effective cooperation and coordination between all these offices, developing a systematic approach is not possible.

As yet, there is little evidence to suggest that the approach to partnership with other government offices or, indeed, with other parts of the MOHSW, is strategic or effective.

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[29] United Republic of Tanzania, MOHSW, DSW. Strategic Action Plan 2007 - 2011

4.2 The Technical Working Group (TWG)

Under the Technical Committee Sector-Wide Approach (SWAp) , the TWGs are multi-stakeholder forums, which support government in the implementation of HSSP III. The TWGs are open to government departments and to external actors, such as UN agencies, NGOs, FBOs etc. They do not have standardised Terms of Reference. Meeting with the different TWGs under the HSSP III, was a major focus of the mid-term review. However, because of the busy schedules of TWG members, it was not possible to meet with the TWG for Social Welfare. Meetings were held with staff at different levels, and with the Commissioner, but no TWG meeting could be called during the time of the mission.

It is, therefore, difficult to judge the effectiveness of the Social Welfare and Social Protection TWG.

4.3 Structure and Organisation

The DSW structure requires offices and officers at regional and district levels. However, owing to staffing shortages, Social Welfare Officers (SWOs) have only been deployed to around half of the districts.

At all village and ward levels, social welfare committees are supposed to link in to wider local government decision-making fora, to assist in the identification of vulnerable people and advocate for district and ward level budgets. This does not appear to be working well. There are numerous committees at local levels. Those that work well, do so when they are support by external agencies. But since mechanisms to ensure sustainability are not in-built, without external support there is high likelihood that they collapse. The CP Study showed that women, young people and PLWDs are not well-represented at local government level and that welfare issues which concern these people are not likely to be addressed properly. Whether village level social welfare, and related, committees work, may depend on a) external support, b) provision of incentives (transport/sitting allowances), c) existence of local "champions", d) level of local interest.

4.3.1 Staffing

The DSW is not able to fulfil its role of ensuring standards and quality of staff performance as some staff operating as SWOs are hired by different ministries (Community Development) or by external agencies (NGOs, missions etc.). Currently, DSW has neither the funds nor the influence to ensure that standards are agreed and kept. During HSSP, there has been a marked increase in the number of SWOs, and increased cooperation with the Ministry of Community Development – with some Community Development Officers (CDOs) gaining further training as SWOs and being moved to MOHSW.

4.4 The need to reposition

The recent status of Tanzania's vulnerability indicators (see Section 1.4 above) show that there is great need for an integrated and effective approach to vulnerability. To a certain extent, this was envisioned under HSSP III, and explored in the (draft) DSW Strategic Action Plan. However, the ability to put these visions into practice has been almost entirely dependent on the work of external actors: UN agencies (for example, UNICEF, UNFPA), NGOs (for example, Save the Children, Plan International ,Sight Savers, CBM, ADD, HelpAge, PACT, Intra Health), FBOs and other Civil Society Organisations (see Section 3, for more details). This has advantages and disadvantages. The advantages include the fact that these external organisations can mobilise dedicated budgets with which to model rights-focused social welfare interventions for and with particular groups of people (for example, Persons with

Disabilities, Older people, MVCs, PLWHIV,etc.). The disadvantages are that; the Department of Social Welfare itself, remains marginalised and relatively ineffective. It cannot offer a coherent and resourced approach to integrated social welfare and protection. In preparation for HSSP IV, the Ministry will need to work now to reposition DSW in relation to the rest of the Ministry Departments by increasing its budget (by rationing) in order to reduce the gap between the 99% for the rest of HSSP III and the 1% that goes to the DSW. The increase in budget would not only strengthen the department's profile among the ministry's departments but would also influence other sources of funding so as to be in a position to command a larger slice of the budget.

5. SWOC Analysis on Cross-cutting issues in relation to Social Welfare, Protection and Vulnerability

The following table summarises key observations on cross-cutting issues.

Table 5: SWOC Analysis on Cross-cutting Issues in Relation to Social Welfare, Protection and Vulnerability

Strengths	Weaknesses
Quality ▲ Increased focus given to SW and equity in HSSP III compared with previous plans ▲ Commitment and dedication shown by SW staff Equity ▲ Policy and plans on MVCs well-developed ▲ Some excellent model programmes Gender ▲ Gender equity is addressed in all policy and planning Community Ownership ▲ Pockets of success: eg. Village HIV/Aids Committees, where there has been heavy external investment (eg. Save the Children)	Quality ▲ Identification of vulnerable people not adequate. Focus on groups is helpful for targeting but misses many aspects of vulnerability and exclusion Equity ▲ Poorest, most marginalised and vulnerable people are disproportionately affected Gender ▲ Little disaggregation of difference between women living in different circumstances – particular needs, socio-cultural differences etc. ▲ Little/no attention to Harmful Traditional Practices e.g. FGM/C (affects c. 2.9 – 3 million girls/women) Community Ownership ▲ Communities do not have faith in Voice and participation mechanisms and feel they do not work
Opportunities	**Challenges**
Quality ▲ Work more closely with PMO-RALG, e.g. in strengthening community representation and participation ▲ Clarify and strengthen role of health promotion: central level standard-setting, guidance and oversight. Equity ▲ Develop mechanisms, structures and systems to integrate, up-scale and institutionalise successful NGO models (etc. PACT, Save the Children, HelpAge) ▲ Expand the range of community-based services: up-skill existing workers to provide better prevention and treatment services at local level (cannot wait for MMAM roll-out) Gender ▲ Focus on multiple linked vulnerabilities can reduce later burden on health services, and is of particular benefit to poor, most marginalised and vulnerable women Community Ownership ▲ Focus on community participation, especially women, youth, PLWDs	Quality ▲ SW still conceptualised by staff as charity rather than human rights ▲ Inadequate resources (human, finance etc.) SW receives 1% of total HSSP III budget ▲ Total dependence on external/NGO budgets and strategies to operationalise Equity ▲ Social protection measures do not work well yet ▲ There is widespread and deep-rooted institutionalised discrimination against sex workers, sexual and gender minorities and people who use drugs Gender ▲ Lack of focus on adolescent SRH and well-being means prevention opportunities are lost (and costs to services ultimately higher) Community Ownership ▲ Citizens do not trust the health services or health service providers. ▲ Citizens, especially poor and vulnerable people, feel there is corruption throughout the services "no money, no service".

6. Recommendations

Recommendations are drawn from the analysis of findings (coverage and access: availability, accessibility, acceptability of quality and adaptability) and the SWOC analysis on cross-cutting issues. The recommendations are made in light of the Department of Social Welfare (DSW) Strategic Action Plan 2007-2011, which stressed the need and intention to move from traditional casework and institutional care approaches to "… adopt and integrate community based welfare approaches that involve wider community participation, Faith based Organisations, Civil Society organisations, and the private sector"[30]. They also take into account the need to operationalise the rights-based approaches advocated in HSSP III.

Recommendations are divided into actions, which could be started in the short to medium term and those, which would require new approaches under HSSP IV.

Short / Medium Term:

1. **Begin now to address the issue of discrimination against, and mistreatment of poor and vulnerable people within health services.**

It is not easy to change entrenched social attitudes about poor and vulnerable people, especially PLWDs (particularly those with mental health issues), those engaged in sex work or substance use, and those people from sexual or gender minorities. It is, however, relatively easy to monitor the attitudes and behaviour of health service personnel. There is no excuse for improper behaviour towards service users, nor for discrimination against any person needing to use services. Efforts to improve attitudes and behaviour could lead to **quick wins at relatively low cost**.

a) **Performance monitoring is key**. Performance monitoring, (involving citizens – both service users and those not currently willing to use services) can be used to reduce unacceptable out-of-pocket payments (for treatment, drugs etc.) and to reduce the burden of unavoidable costs, such as transport. In other places (see, for example, the work of Transparency International Bangladesh, where Concerned Citizen, and Young People's, Committees monitor costs, attendance, attitudes etc. in health services) performance monitoring activities are highly beneficial in improving standards and strengthening the relationship between citizens and services. **Sikika might be interested in piloting performance monitoring schemes**.

b) **Explore possibilities of pay for performance initiatives** related to non-discrimination and improvement in client treatment and care.

c) **Include modules on equity, discrimination, staff behaviour etc. within all staff training.** This component is crucial (development of modules to be overseen by the Health Promotion department).

2. **Within the remaining HSSP III period, strengthen capacity to implement exemption systems with equity.**

a) **Ensure that all staff are fully aware of, and committed to application of existing waiver and exemption schemes** (pregnant women, under-fives, over 60s, critical illness, destitute etc.)

[30] (United Republic of Tanzania, MOHSW (2008?) DSW Strategic Action Plan

b) **Use all possible means to reduce out-of-pocket costs for service users**. This means following-up samples of people identified for exemptions throughout their health services experience, checking on whether/where/how OOP costs occur etc..

c) **Explore now how greater safety net protection can be provided under HSSP IV.** This will link with work to identify more fully the Social Determinants of Health (see below). RHMTs and local health teams need to work with regional and local government to develop more rigorous health and well-being profiles for districts, and to identify links/separations between poverty and vulnerability.

These approaches **can be started as pilots now**, **with inputs from civil society partners**, and intensified and institutionalised under HSSP IV.

3. Standardise training and employment of SWOs and SWAs and formalise the working relationship with PMO-RALG at region, district and ward levels.

During the remaining period of HSSP III:

a) **Conduct skills gaps** amongst all staff working on social welfare issues (government and civil society)

b) **Identify communications blocks** between all actors working for social welfare in communities, and

c) **Agree, and implement, standards** which must be met, whatever ministry or organisation these staff are working for.

This is a role for the Social Welfare Department supported by the Institute for Social Welfare. d) d) **Ensure that social welfare and equity issues are included within ward level agendas and budgets:** PMO-RALG Community Development Officers will play a vital role in this. A closer working relationship with social welfare needs to be established.

These moves need to start now, in order to facilitate a stronger relationship between health and social welfare in the design of HSSP IV.

4. Gain cabinet approval for the over-arching Social Welfare Strategic Action Plan

The DSW Strategic Action Plan is based on the move from traditional to more developmental approaches.

a) **Intensify efforts for cabinet approval now, so that the developmental and rights-based SW approach can be mainstreamed in HSSP IV** – rather than use the approach only piecemeal, in partnership with NGOs as is currently the case – full approval needs to be achieved during the remaining time of HSSP III, so that all DSW work can be developmental.

5. With NGO assistance, but with strong government oversight, intensify design and implementation of model approaches using existing policy for increased equity (e.g. parts of the MVC plan).

a) **Strengthen ties with staff in other departments/ministries/sectors:** through the TWG and at all levels.

b) **Continue working closely with interested and experienced NGOs and other organisations.** For example, through the Save the Children working on MVC in 5 districts in the North-West and UNICEF working on child abuse, social welfare and protection approaches can be modelled.

c) **Develop replication and scale-up mechanisms and systems**, so that successful models can be brought to scale quickly. The processes of bringing these successful models to scale can help in development of nationally ratified mechanisms, structures and systems for scale-up of successful approaches.

6. **Clarify and strengthen the role of the central level Health Education and Promotion section and include in its responsibilities the promotion of trust between citizens and services, at local levels.**

   a) **Strengthen the role of the Health Education and Promotion (HE&PS) section in setting standards**, and ensuring that these are kept by all agencies and organisations involved in health promotion.

   b) **Strengthen the role of HE&PS as a hub, ensuring that more and more of the population are able to access information and understanding** on all aspects of health and well-being, rather than the section aiming to produce that information itself.

   c) **The HE&PS can become the driver for all research and health promotion interventions**, for and with different communities The section can coordinate and catalyse all health promotion work. Ideally, health promotion extends to all forms of communications and drives research, policy development, practice, monitoring and evaluation

   d) **Use Health Promotion to strengthen citizens understanding of the connections between their concerns and priorities, health promotion activities, and people's ability to take control of their own health**. Promote and celebrate successes: such as reduction in child mortality and overall increased equity between urban and rural areas. Openly communicate on areas where inequity still persists. With clear and accurate information, people are also more likely to trust the services that are on offer, and to be willing to participate, as clients and in management.

7. **In selected areas, build and model an integrated approach (with PMO-RALG) to improving community participation in planning (and monitoring and evaluation, see below): based on evidence and information shared by government (on priorities, needs, available resources etc.)**

There are 2 immediate ways in which greater willingness to engage fully in planning might be encouraged:

a) **Ensure that Government health and social welfare priorities and agendas are shared with district and ward level health committees**. Information can be transmitted through mass media, modern communication methods and social networking, as well as through local government and staff in health facilities. Clear process and information guidelines are needed, as is training for local staff, to ensure that guidelines are followed. Since this may be resource heavy, the recommendation is for pilot interventions in selected areas. When the benefits have been demonstrated these can be scaled up under HSSP IV.

b) **Join with PMO-RALG in supporting planning processes and giving feedback to communities**. Currently, communities do not feel part of a feed-back loop. They feel their priorities are not represented in budgets, and they feel little enthusiasm for joining in the planning process[31].

[3131] See Crawford, S. et. Al. (2013c)

8. **In selected districts and wards, build capacities to promote greater resource allocation for social welfare and equity issues, monitor progress and assess results.**

Capacity strengthening at ward and district level can increase awareness of the need to allocate resources for social welfare and increased equity.

a) **Strengthen representative decision-making committees at local levels** (on-the-job training, exchange visits, symposia etc. ;

b) **Strengthen capacity amongst existing committee members so that they understand how to budget and work proactively for greater equity** (as above, plus radio shows, phone-ins etc.) and

c) **Support women's, young people's and PLWD's representation on effective committees.** This is not something that can be achieved in the short term, but further efforts need to be made now, through scale-able pilots, to minimise the long-term burdens of social inequity on the health and social welfare services.

9. **Working with PMO-RALG and experienced NGOs, develop model programmes of Citizen-Service Engagement and Participatory Planning, Monitoring and Evaluation on specific issues. (e.g. drug monitoring; HF staff attendance monitoring; staff attitudes and behaviour; legitimate and non-legitimate out-of-pocket costs).**

a) **Involve school students and adults in monitoring services – such as the availability of drugs in health facilities**. This was suggested by students and adults during the CP study fieldwork. In other countries[32], citizens have been involved in monitoring staff attendance, attitudes and behaviour; ensuring that service agreements are posted in health facilities, operating complaints desks etc.. This is an extension of performance monitoring in recommendation 1.

b) **Introduce these, and other PM&E approaches, with strong and experienced facilitation and considerable time-resources investment up-front**. These interventions have been shown to be sustainable and effective in stimulating public interest in participation, building transparency in services, improving performance and increasing the trust that citizens have in services.

Medium / Long Term

10. **To facilitate and mainstream a rights-based and developmental approach to Social Welfare, give focus to understanding the Social Determinants of Health, vulnerable life pathways and multiple vulnerabilities; implement standards on identification of vulnerable people and strengthen identification processes in the districts.**

a) **Ensure that full understanding on the Social Determinants of Health is built-up amongst all staff**. The possibilities for reducing vulnerability, and increasing equity, gender equality and sustainability, will be greatly enhanced if a stronger Social Determinants of Health approach is taken in development of HSSP IV.

b) **Develop a deeper understanding of the causes and effects of life choices, which increase (or potentially increase) vulnerability, and communicate this amongst all relevant actors**. This can strengthen coordination between social welfare and health services, at all levels and across all sectors. The identification of vulnerable people – in terms of health,

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[32] See, for instance, Bangladesh and Malawi

well-being and social welfare – needs to be a priority in HSSP IV, so that rights goals can be met.

c) **Institutionalise, and adopt nationally, model processes of identification of vulnerable people (e.g. PACT)**. This will necessitate resource allocation to ensure that staff and community representatives are skilled and able to make realistic and reliable identification.

11. Ensure that the value of social welfare in reducing future burden on the health service is fully reflected in budget allocations in HSSP IV

a) Continue to strengthen developmental and rights-based Social Welfare approaches, throughout the DSW, not just by external organisations. These approaches are crucial in securing goals of equity, community ownership, gender equity, effectiveness and sustainability, and need to be embedded within the ministry. Recent UNICEF modelling in health services[33] has indicated that an approach, which focuses on inclusion of the poorest and most vulnerable people (bottom quintile) leads to greater value for money than a more traditional approach.

b) Increase Social Welfare budgets significantly in HSSP IV – at central and at all other levels.

12. Give greater focus to community-based health and social welfare interventions, particularly in remote and under-served areas (rural and urban).

a) **Increase work at community levels: both preventative and curative services**. Greater elaboration of the Social Determinants of Health will support the Department of Social Welfare in working closely with other departments for expanded and improved community-based and outreach services. In order to decrease vulnerability and increase equity (thereby increasing social and health well-being and reducing the burden on social welfare services), there is real need to give more focus to community-level services from a range of actors.

b) **Capacitate selected community representatives (e.g. village health workers, teachers, CDOs etc.) in basic curative as well as preventative care**. The ideal is for all births to be with skilled attendance, however, where no SBAs are available, intensified training of TBAs (in "first aid and referral") may save lives and reduce burdens on the health service.

c) **Increase trust between citizens and services** by fully communicating results of intensified and effective community-level services, which improve customer satisfaction and reduce out-of-pocket costs.

13. Develop and implement mechanisms, structures and systems to facilitate scale-up and institutionalisation of successful model interventions for greater equity and reduction of vulnerability.

The kind of interventions necessary to facilitate scale-up of successful models include:

a) **Develop MoUs and agreements with government, from the outset, on a scale-up pathway** (future planning);

b) **Record and widely disseminate lessons-learned** from model interventions and partnership

c) **Refine government policy (and implementation of it) on how NGO models can be shared between organisations and between NGOs and government**,

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[33] UNICEF 2012

d) **Allocate adequate government budgets and staff resources to scale-up** (which means operational budgets must be made available).

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