EVIDENCE OF THE IMPACT OF IMF FISCAL AND MONETARY POLICIES ON THE RESPONSE TO HIV/AIDS AND TB IN TANZANIA

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Submitted by Ifakara Health Institute (IHI)
Dar es Salaam, Tanzania to

Centre for Economic Governance and AIDS in Africa and RESULTS Educational Fund (REF)

This study was supported by the Open Society Institute
Through REF, USA

June 2009

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AIDS	Acquired Immune Deficiency Syndrome
AMMP	Adult Morbidity and Mortality Project
ANC	Antenatal Clinics
BCC	Behaviour Change Communication
BoT	Bank of Tanzania
CFS	Consolidated Fund Services
CSOs	Civil Society Organizations
CSS	Care and Support Services
CT	Counseling and Testing
DDH	Designated District Hospitals
DPs	Development Partners
ESAF	Enhanced Structural Adjustment Facility
FBOs	Faith Based Organizations
GDP	Gross Domestic Product
GoT	Government
HIPC	Highly Indebted poor Countries
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HRH	Human Resources for Health
HSSP	Health Sector Strategic Plan
IEO	Independent Evaluation Office
IFIs	International Financial Institutions
IMCI	Integrated Management of Childhood Illnesses Program
IMF	International Monetary Fund
MDAs	Ministries, Departments and Agencies
MDRI	Multilateral Debt Relief Initiatives
MGG	Millennium Development Goals
MKUKUTA	*Mkakati wa Kukuza Uchumi na Kupunguza Umaskini Tanzania*
MoEVT	Ministry of Education and Vocation Training
MoFEA	Ministry of Finance and Economic Affairs
MoHSW	Ministry of Health and Social Welfare
MTEF	Medium Term Expenditure Framework
NACP	National AIDS Control Program
NHA	National Health Account
NPES	National Poverty Eradication Strategy
NSGRP	National Strategy for Growth and Reduction of Poverty
OED	Operation Evaluation Department
PE	Personal Emoluments
PEMR	Public Expenditure Management Review

PEP	Post Exposure Prophylaxis
PER	Public Expenditure Review
PPP	Public Private Partnership
PoW	Program of Work
PRGF	Poverty Reduction and Growth Facility
PRSP	Poverty Reduction Strategy Paper
PS	Principal Secretaries
PSI	Policy Support Instrument
SAP	Structural Adjustment Programs
SMP	Staff Monitored Program
SWAp	Sector Wide Approach
TACAIDS	Tanzania Commission for AIDS
TAS	Tanzania Assistance Strategy
TB	Tuberculosis
TSPA	Tanzania Service Provision Assessment Survey
THE	Total Health Expenditure
THIS	Tanzania HIV and AIDS Indicator Survey
TRA	Tanzania Revenue Authority
URT	United Republic of Tanzania
VAT	Value-Added Tax
WHO	World Health Organization

ACKNOWLEDGEMENT

The Tanzania research team would like to extend appreciation to CEGAA for the opportunity to work on this important research project, including Dr. Urbanus Kioko and Teresa Guthrie. The research team would also like to extend sincere gratitude to various Government Ministries and Departments, Development Partners, and Civil Society Organizations for their invaluable cooperation and input in accomplishing this assignment and by accepting to give information either through face-to-face interviews, or by filling the questionnaires electronically. In this regard, the research team is highly indebted to the following individuals, organizations and officers: The Deputy Permanent Secretary at the Ministry of Finance and Economic Affairs (Mr Msongole); Mr. Maxmilian Mapunda (Health Economist at WHO Tanzania Country Office); Prof. Majorie Mbilinyi (Tanzania Gender Networking Programme); Mr. Irenei Kiria (Youth Action Volunteers); The Resident Representative of IMF in Dar es Salaam; Mr. Godlove Mbise (Ministry of Finance and Economic Affairs); Mr. Goodluck Mosha (Dutch Embassy, Dar es Salaam Office; and Mr. Emmanuel Mungunasi (World Bank, Tanzania Country Office).

EXECUTIVE SUMMARY

HIV/AIDS and TB are among the major causes of morbidity in Tanzania. HIV & AIDS rank among the top impediments to a country's social and economic development as they affect all sectors of the economy. The Tanzania HIV & AIDS Indicator Survey (THIS) 2003-04 indicates that 7% of Tanzania Mainland adults are infected with HIV, with the prevalence higher among women (8%) than among men (6%). HIV & AIDS poses significant risks for human resource development, as the prevalence rate is much higher among the economically active population. In addition, the incidence of TB in Tanzania has increased dramatically since 1984 corresponding to the spread of HIV infection. In 2005 alone over 65,500 new TB cases were notified compared to only 11,000 in 1984. Data from National Sentinel Surveillance system of the Adult Morbidity and Mortality Project (AMMP-2001) indicates that TB/HIV conditions contribute to 17.5% of the total disease burden in Tanzania for population above 5 years of age, behind AIDS (49.8%), and prenatal conditions (32%).

While confronted with the huge task of responding to the HIV & AIDS and TB crises, Tanzania has simultaneously undertaken IMF- and World Bank-backed economic reforms over the past two decades. The IMF macroeconomic stabilization policies with a strict focus on reduction of fiscal deficits, inflation, and other macroeconomic indicators, have in a way translated into budget and wage bill ceilings. Restricted fiscal space indirectly ultimately constrains health spending and the number of, and remuneration for, public sector health workers in HIV & AIDS, TB and other programs. This study set out to provide evidence of the impact of IMF policies on the government of Tanzania's ability to increase budget allocation for health in general, TB and HIV & AIDS.

In line with this objective, this study has reviewed the IMF's involvement in Tanzania – the Enhanced Structural Adjustment Facility (ESAF), the Poverty Reduction and Growth Facility (PRGF), and Policy Support Instrument (PSI). The analysis was carried out using qualitative data from both the literature (including IMF publications and various government documents) and interviews with key respondents. Interviews were held with major stakeholders from the Government, civil society, the IMF, World Bank and other international agencies.

The impact of IMF policies on the government's ability to respond to the HIV/AIDS crises is indirect, yet significant. This is due to the fact that IMF policies for achieving its formula of macroeconomic stability sets overly restrictive targets for growth, inflation, exchange rate, interest rate, balance of payments, and fiscal deficit.

FINDINGS

The key issues that have emerged from this research and other relevant, recent evidence include:

- The IMF's prescriptions for limiting domestic spending, channeling significant amount of aid to the foreign exchange reserves, and "absorbing" instead of "spending" aid in the name of macroeconomic stabilization have manifested in budget ceilings which limit spending even on priority sectors under the country's development framework, MKUKUTA.

- By putting too much emphasis on very low inflation targets (5%), IMF policies have almost closed doors for accommodating monetary policy, which could have allowed for a more expansionary fiscal policy.

- Even after the IMF removed formal wage bill ceilings from its programs, the excessively tight fiscal (deficit-reduction) and monetary (inflation-reduction) policies still keep overall national budget constrained at unnecessarily low levels, with consequential impacts on sector budgets and wages for personnel.

- Limited capacity due to weak health systems has so far been the major constraint in the efforts to respond to the HIV & AIDS and TB crises. In particular, poor health infrastructure, and inadequate human resources for health have resulted in low absorption capacity of available HIV & AIDS and TB resources. As much as the inadequacies of human resources in Tanzania can be associated with the employment freezing under structural adjustment programs, there is emerging evidence that even after the employment freezing was lifted, few graduates were employed and in most cases even those employed have high rates of absconding. The challenges resulting from the low absorptive human and financial capacity of funds have to be addressed if the current policy of having a health centre at every ward and a dispensary at every village is to work.

- Money for HIV & AIDS programs is mainly from donors. This has implications on the future response and sustainability of the programs without increased funding from the government.

- Too few services are available for some components of HIV/AIDS. Only one- fourth (26%) of all health facilities in Tanzania have an HIV testing system. Other HIV-related services, however, are offered by very few facilities nationwide. Less than 5% of facilities offer post-exposure prophylaxis or antiretroviral therapy. Only 13% of facilities provide any services to prevent Mother-to-Child Transmission (PMTCT) of HIV.

- Tanzania's national TB program is designed to help ensure that patients take their drugs regularly and complete their treatment. This process not only cures patients but

also helps prevent drug resistance. However, a substantial percent of facilities do not have all of the elements needed for proper TB diagnosis and treatment.

RECOMMENDATIONS

Based on these findings and opportunities for both the government and the IMF to reevaluate these policies and their impact, the following are the key recommendations from this study:

- Each of the major assumptions of the IMF and Finance Ministry's macroeconomic framework must be publicly revisited and reexamined, and alternative perspectives be discussed and considered by a much broader group of public stakeholders including CSOs, independent academics, parliamentarians, line ministries, domestic media, and donor agencies. It should be asked if such a framework allows for a "scaling up" of spending and investment in order to achieve the MDGs and, if it is not, to make adjustments.

- The IMF, World Bank, and other donors must eliminate harmful quantitative, structural and policy conditionalities in lending so that Tanzania can be clearly given the policy space to consider more expansionary fiscal policies in order to increase public spending and investment in line with MKUKUTA. The IMF should allow for more flexibility in fiscal and monetary policies by refraining from the conventional emphasis on deficit reduction and inflation-reduction targets, which too conservatively restrict the size of the overall national budget. Expanded health and education spending must be exempt from policies that unduly constrain overall government spending.

- The IFIs, other donors, banks and other financial institutions should work together to set up arrangements to provide loan guarantees, subsidized credit and other assistance to Tanzania so that it can: 1) renegotiate its current domestic debt burden so that it can create more fiscal space to engage in increased spending and investment—and 2) so that Tanzania could engage in future deficit spending at much lower rates and/or for over longer time frames so that such higher levels of deficit spending are both affordable and sustainable.

- Stakeholders should more carefully examine the consequences of the loss of public control and democratic responsiveness of monetary policy to changing economic circumstances associated with the kind of central bank independence (CBI) reforms the IMF advocates. A proper response to shocks requires a flexibility and agility of finance ministries that is not possible under detached CBI formats. The costs and benefits of such policies should be discussed and considered by a much broader group

of public stakeholders including CSOs, independent academics, parliamentarians, line ministries, domestic media, and donor agencies.

- IMF should explore and allow for more productive and non-inflationary domestic spending of aid, and reasonable levels of domestic financing where necessary, which would channel more aid to the domestic goods and services and human resources. This would give the government more space to spend aid to upgrade the health system, both in terms of infrastructure and human resource development.

- IMF should explore the possible ways to engage a much wider spectrum of stakeholders in macroeconomic policy issues – particularly the other Government Ministries and Departments (apart from Finance and Planning) and the CSOs. This would broaden the consultative process and make the policy process more transparent than it is at the moment.

- Civil society and parliamentarians should push the government to negotiate for removal of all conditionalities that prevent the government from increasing investment in health and particularly on HIV/AIDS and TB.

- There is need for CSOs, labor unions, MPs, domestic media and independent academics to be sensitized on important IMF policies and loan agreements. In particular, these stakeholders must build their understanding of the content of the policies, the context in which they are introduced, the potential impact of the policies, and the costs and benefits of alternative approaches.

- There is need for improved transparency in the formulation of policies, access to key IMF policy documents and agreements, information on conditionalities tied to loans and their potential impact. Restrictions on access to information should be lifted and a mechanism should be put in place to facilitate access to key documents that will enhance informed decisions and active contribution by the CSOs, MPs and other stakeholders in the policy dialogue. This will enable the CSOs and MPs to hold the governments accountable for its decisions.

- The need to look on the ART policy and guidelines and establish mechanism to scale up ART provision is imperative.

1 INTRODUCTION

1.1 Background to the Study

Like other countries in Africa, Tanzania has been seriously hit by HIV & AIDS. HIV is a serious health and socio-economic challenge in Tanzania. It ranks among the top impediments to the country's social and economic development as it affects all sectors of the economy. The Tanzania HIV & AIDS Indicator Survey (THIS)[1] 2003-04 indicates that 7% of Tanzania Mainland adults (aged between 15 and 49) are infected with HIV, with the prevalence higher among women (8%) than among men (6%) (URT, 2005a). This is a decline from 13% which was observed in the early years of this decade. Further, THIS shows that HIV & AIDS prevalence is higher in urban areas (12 % for women and 9.6% for men) compared to rural areas (5.8% for women and 4.8% for men). As the most affected group is the economically active population, the negative impacts of the scourge cannot be overstated. Increases in the prevalence of the disease undermine the foundations of development and the attainment of the Millennium Development Goals and national targets. According to Arndt and Wobst (2002), HIV & AIDS lower skill accumulation, and the authors provide a static analysis on the impact of HIV & AIDS in the Tanzanian economy and argue that in the absence of HIV & AIDS the labour force would have been more skilled.

By 2007, the National Care and Treatment Program had enrolled 103,036 people living with HIV & AIDS for free medical treatment and 49,315 had started to use ARV drugs. Also, HIV & AIDS has been mainstreamed into curriculum of the primary and secondary schools. Booklets were printed and teachers were trained on HIV & AIDS prevention and teaching methods. The Government has issued a circular on how to assist HIV & AIDS infected public servants. A total of 1201 Civil Society Organizations were financed to carry out HIV & AIDS activities. However, according to the recent budge guidelines, there are several challenges still existing, including:

- Low priority given to implementation of HIV & AIDS activities;
- Inadequate mainstreaming of HIV & AIDS activities in the Ministries, Departments and Agencies (MDAs) Medium Term Expenditure Frameworks (MTEFs); and
- Inadequate human resources especially in the health sector

According to the Guidelines for the Preparation of Medium Term Plan and Budget Framework for 2008/09 – 2009/2010, the Priorities for the 2007/08 are:

- Scaling up of community response by involving more NGOs, FBOs, CBOs and Private sector;
- Strengthen public /private partnership in the implementation of HIV & AIDS activities;
- Scaling up care and treatment program by reaching a target of 200,000 People Living with HIV and AIDS (PLHAs) enrolled;

[1] THIS is a population based survey showing indicators of HIV & AIDS in Tanzania.

- Scaling up education sector response by reaching more schools and workplace programs for teachers;
- Strengthening Monitoring and Evaluation for HIV & AIDS in the country; and
- Strengthening workplace programmes for public and private sectors.

In addition to HIV & AIDS, Tuberculosis (TB) is one of the major causes of morbidity and mortality in Tanzania. The incidence of tuberculosis has increased dramatically since 1984, corresponding to the spread of HIV infection. In 2005 alone over 65,500 new TB cases were reported compared to only 11,000 in 1984. Data from National Sentinel Surveillance system of the Adult Morbidity and Mortality Project (AMMP-2001) indicates that HIV/TB conditions contribute to 17.5% of the total disease burden in Tanzania for population above 5 years of age, behind AIDS (49.8%) and prenatal conditions—32% (URT, 2008b).

The consequences of both disease conditions include overstretched health systems and reduced economic productivity since most of those affected are in the productive age group, which adversely affects the growth of the national economy due to absenteeism and reduced productivity. Tanzania's ability to respond to the HIV & AIDS and TB crises has been constrained by the state of the health system, which took a slight downturn during the first wave of reforms as the country attempted to restore macroeconomic stability. During the 1990s, the health sector in Tanzania faced a period of comparative stagnation and even decline. Up to the late 1990s, local health services were characterized by severe shortages of essential drugs, equipment and supplies and deteriorating infrastructure, as well as poor management, lack of supervision and lack of staff motivation. The sector also faced stagnating or deteriorating hospital care. There was little cooperation or coordination in health service delivery between the public sector, Faith Based Organizations (FBOs), and private service providers. The health sector was severely under-funded, with public health sector spending at USD 3.46 per capita. There was also little coordination of support to the health sector by Development Partners (DP). Since late 1990's, the Government and Development Partners have taken several measures to reverse the situation, and there have been some improvements. However, many improvements are still needed for the health system in Tanzania to not only function efficiently, but also properly respond to the HIV & AIDS and TB crises.

1.2 Statement of the Problem

With the aim of restricting fiscal deficits, inflation, and other macroeconomic indicators, the IMF promotes conditionalities within countries receiving IMF financing. These conditionalities translate into budget and wage bill ceilings, which can ultimately restrict health spending and the number of, and remuneration for, public sector health workers in HIV/AIDS, TB, and other programs. There is accumulating evidence to suggest that IMF policies have negatively impacted the capacity of Tanzania to invest adequately in health. Restrictions on the hiring of health workers have created a situation where thousands of trained nurses and other health workers remain unemployed, despite health worker shortages across all health programs. This study examines the impact of IMF policies on the government's response to health, HIV/AIDS and TB crisis.

1.3 Objectives of the Study

The study's objectives are to:

- Review the content, process and transparency of the IMF PRGF and PSI policies,
- Identify the key stakeholders in the process of accepting policies and conditionalities, their influence and power,
- Identify trends in the total public (domestic) health expenditure,
- Identify trends in the public (domestic) expenditure for TB and HIV & AIDS,
- Identify trends in the public (domestic) expenditure for personnel for health, TB and HIV & AIDS,
- Identify trends the numbers of health professionals working in the health sector, in TB and HIV & AIDS,
- Consider trends in accessing TB and HIV & AIDS treatment services, and
- Identify other effects of IMF policies on country ability to respond to TB and HIV & AIDS

1.4 Organization of the Report

This report is organized as follows: The first chapter presents the background to the study, the objectives of the study, methodology, a brief description of the Tanzania's health sector, and the limitations of the study. Chapter two presents an overview of the budget process in Tanzania, highlighting the roles of various stakeholders in the process. Chapter three discusses Tanzania's socioeconomic environment, highlighting the status of HIV/AIDS and TB, Macroeconomic framework, and poverty situation in the country. Chapter four presents the major findings of the study, outlining the review of IMF policies, and the issues relating to HIV & AIDS and TB financing. Chapter five presents the conclusions of the study and recommendations (which are main areas for advocacy).

2 METHODOLOGY

2.1 Scope and Design of the Study

In line with the above objectives, this study has reviewed the IMF's involvement in Tanzania, highlighting the key policy areas under the Enhanced Structural Adjustment Facility (ESAF), the Poverty Reduction and Growth Facility (PRGF), and Policy Support Instrument (PSI). The analysis was carried out using qualitative data from both the literature and interviews with key respondents. Major stakeholders from the government, civil society, IMF, and other international agencies were covered. On this particular aspect of the study, the focus has been on the content and process of policy formulation – including the transparency of policy process, involvement of various stakeholders, and role of various players in the process. This is then linked up with a brief analysis of the budget process, and trends of budget allocations for HIV/AIDS and TB based on the available data from the literature. Also, in line with the outlined objectives, this study has analyzed information and data on the civil servants in the health sector, and working in HIV/AIDS and TB programs from the current Health Management Information System (HMIS)[2], and Data on trends in accessing HIV/AIDS and TB treatment from the HMIS.

2.2 Data Collection Methods

The assignment used data collected from both primary and secondary sources. As much as possible data were gathered from various documents ranging from policy and expenditure analysis related reports from IMF publications.

2.2.1 Secondary Data/Desk Review

A desk review of all accessible and relevant documents was done. The desk review was used to get data and information on IMF policy content and the expenditures on the two health conditions (HIV/AIDS and TB). Furthermore, information on health sector manpower was also sought from the literature. In particular, five categories of documents were reviewed:

- IMF policy and related documents: These were reviewed in order to gauge the content of the IMF policies. The documents reviewed include; Various Evaluation Reports for Poverty Reduction and Growth Facility (PRGF); Poverty Reduction Strategy Paper Progress Reports; Public Support Instrument (PSI) documents, and Public Expenditure Management Review (PEMR).
- National Policy Frameworks: These include the Poverty Reduction Strategy Paper (PRSP) and the National Strategy for Growth and Reduction of Poverty (NSGRP) known in Kiswahili acronym as MKUKUTA. MKUKUTA annual implementation reports were also reviewed.

[2] Disaggregated data on the personnel working on the area of TB and HIV and AIDS are not available. This report presents the total health personnel as reported in the HMIS report.

- National Planning Tools: The major tool reviewed was the planning and budget guidelines.
- Expenditure related documents: Public Expenditure Reviews (PER) were used to extract data on expenditures in general health and expenditures for HIV and AIDS whereas the National Health Account (NHA) provided data on HIV & AIDS and TB expenditures.
- Health Statistical Abstract: This document was mainly used to establish the number of personnel in the health sector.
- Others: These include publications and research report as indicated in the reference list.

2.2.2 Primary Data Collection

Primary data was collected from sampled institutions that were important in the policy formulation process. The main instrument used to collect data was quasi-structured and open-ended questionnaire guide containing guiding questions.[3] A total of 23 questionnaires were distributed but only 11 responses were received (see Annex A for the list of respondents and Annex B for institutions where questionnaires were sent but no response was received). The questionnaire was administered to the key respondents from the institutions purposively sampled. The essence of the interviews was to get views of stakeholders on the content, process and transparency of the IMF policies, to understand the key stakeholders involved in the process of accepting policies and conditionalities, their influence and power, and getting perceptions on the impact of the IMF policies on government spending on health, HIV/AIDS and TB.

2.3 Data Analysis and Synthesis Report Writing

A synthesis of desk reviews, and field notes was done and presented in this report. Desk reviews have provided very important information. Since the information collected from the interviews was purely qualitative, the synthesis involves the presentation of summary of responses as expressed by the different respondents, and no particular statistics are presented in this regard. Data analysis methods used include triangulation and policy analysis approaches and stakeholders' analysis using qualitative data from both the literature and interviews with key respondents. For the quantitative data on health, HIV/AIDS and TB spending, budget and expenditure analysis was done.

2.4 Limitations of the Study

The study faced several challenges but the major ones include:

- Too loaded questionnaire: In many cases, it was difficult to find someone who could fill it without reading several documents in advance. This is because it was difficult to find someone who is conversant on the issues in the three areas—"macroeconomic policy issues," "health financing issues," and "HIV & AIDS and TB issues". This challenge highlights the need for more informed and engaged participants that can understand and influence the relationship between macroeconomic polices and public health spending.

[3] See the standard questionnaire adopted for the three countries.

- Majority of the respondents in particular from the CSOs are not very conversant with the specific IMF fiscal and monetary policies, and were found to be more knowledgeable about the implications of the policies and their impact on the welfare of the people. Thus, it was difficult for the interviewed CSOs to participate in IMF discussions without having the specific knowledge of particular polices.
- Some respondents were of the opinion that substantial literature is available on the subject matter and thus primary data collection was not necessary. This was particularly the case because the respondents could not fill the questionnaire freely without referring to various documents, which effectively translated the interview into an exercise of "literature review" by the respondent.
- The collected data did not allow the analysis of trends in the public (domestic) expenditure for personnel for health, HIV/AIDS and TB.

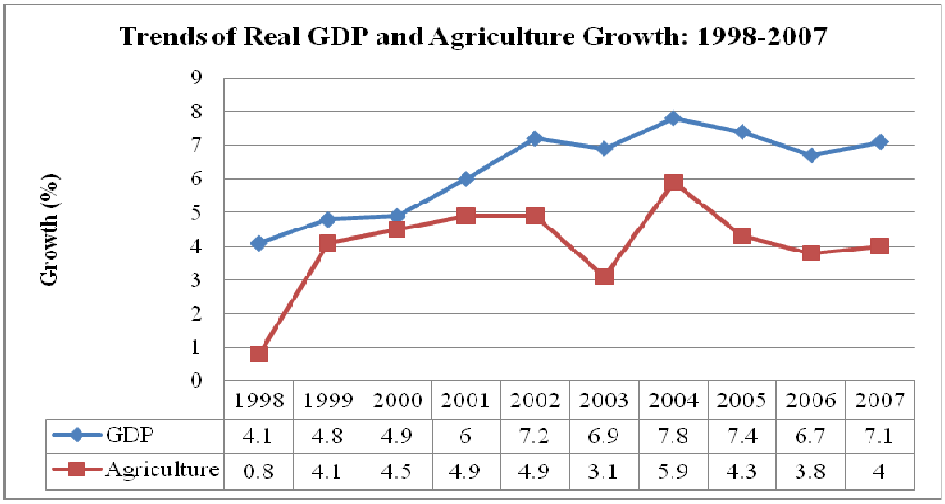
3 SOCIO-ECONOMIC ENVIRONMENT

3.1 Key Economic Indicators

3.1.1 Trends in GDP growth

Tanzania has continued to record good overall macroeconomic performance, benefiting from sustained economic reforms over the last ten years. The real Gross Domestic Product (GDP) grew at an average rate of 6.3% between 1998 and 2007. The country has experienced consistent positive growth despite the continued worsening in terms of trade and a slowdown in tourism related to the current adverse global security situation. The continued good performance has to a large extent been a result of relatively good weather, sustained macro-economic and structural reforms pursued by the government, enhanced investment, and improved efficiency in marketing and financial services and trade. Agriculture has continued to be the main contributor to economic performance, with the sector itself depending heavily on weather (so far, agriculture sector has grown at an average rate of about 4% between 1998 and 2007). Other sectors that contributed to the economic performance over the past decade include construction; mining and quarrying; manufacturing; trade, hotels and restaurant (including tourism); and transport and communication. In 2007, the GDP grew by 7.1% compared to 6.7% in 2006. The increase in the growth rate was mainly attributed to an increase in economic activities in communication (20.1%), mining (10.7%), financial intermediation (10.2%) trade (9.8%), construction (9.7%), health (8.8%), and agriculture (4.0%). Figure 1 below shows the trend in GDP growth and growth in agriculture, which is the mainstay of the economy, from late 1990s to 2007.

Figure 1: Trends Real GDP and Agriculture Growth: 1998-2007



	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
GDP	4.1	4.8	4.9	6	7.2	6.9	7.8	7.4	6.7	7.1
Agriculture	0.8	4.1	4.5	4.9	4.9	3.1	5.9	4.3	3.8	4

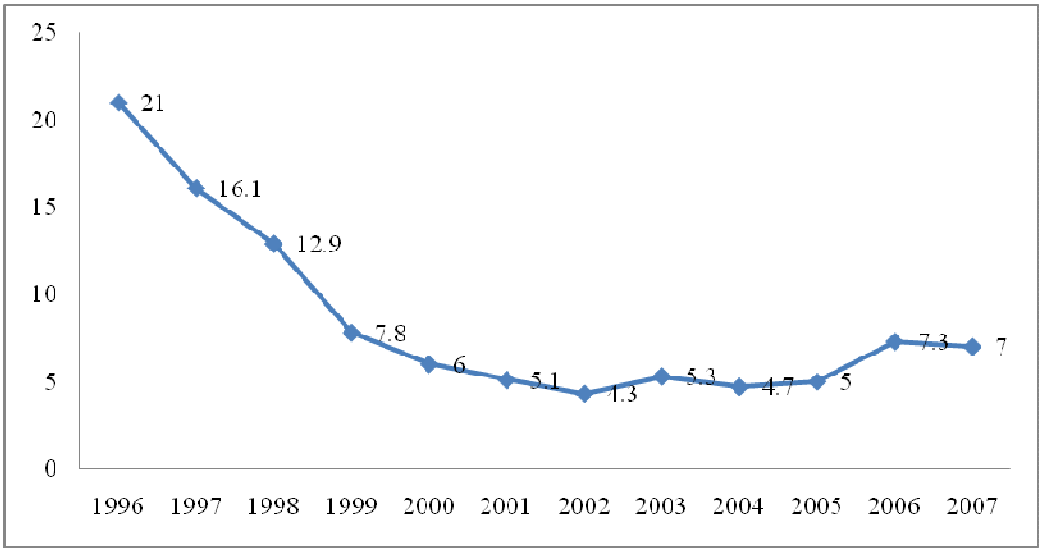
Source: URT, (2008a).[4]

[4] Note that the official statistics have been revised from the 1992 constant prices to 2001 constant prices. Therefore, following this change of base year, there would be slight differences between the current figures and the previous official statistics.

3.1.2 Inflation Developments

In line with economic growth, Tanzania has also reduced inflation to single digit levels. In 2007, the economy of Tanzania continued to experience inflationary pressure emanating primarily from the rise in oil prices in the world market and the rising food prices. Despite this, overall inflation declined to an annual average of 7.0% in 2007. Figure 2 shows inflation trend from 1996 to 2007.

Figure 2: Inflation Trend 1996 – 2007



Source: URT, (2008a).

3.1.3 Public Debt Developments

Tanzania's external debt has been brought to sustainable levels following various debt relief initiatives and strict adherence to National Debt Strategy. By the end of December 2007, the national debt declined slightly from US$ 7,188.4 million in December 2006 to US$ 7,041.2 million. Out of that amount, domestic debt amounted to US$ 1,673.5 million, equivalent to 23.8% of the total national debt, and external debt was US$ 5,367.7 million. Domestic debt consisted largely of government securities. The decrease in total debt was on account of sound debt management practices following debt relief under the HIPC and Multilateral Debt Relief Initiatives (MDRI) arrangements. US$ 57.6 million was spent on debt service in 2006 compared to US$ 91.1 million that was put on actual debt service in 2005 – a decrease of about 36.8%. Out of the actual debt service, principal payment was US$ 30.4 million, while interest payment amounted to US$ 27.2million. Table 1 shows the key external debt indicators for Tanzania.

Table 1: External Debt Indicators

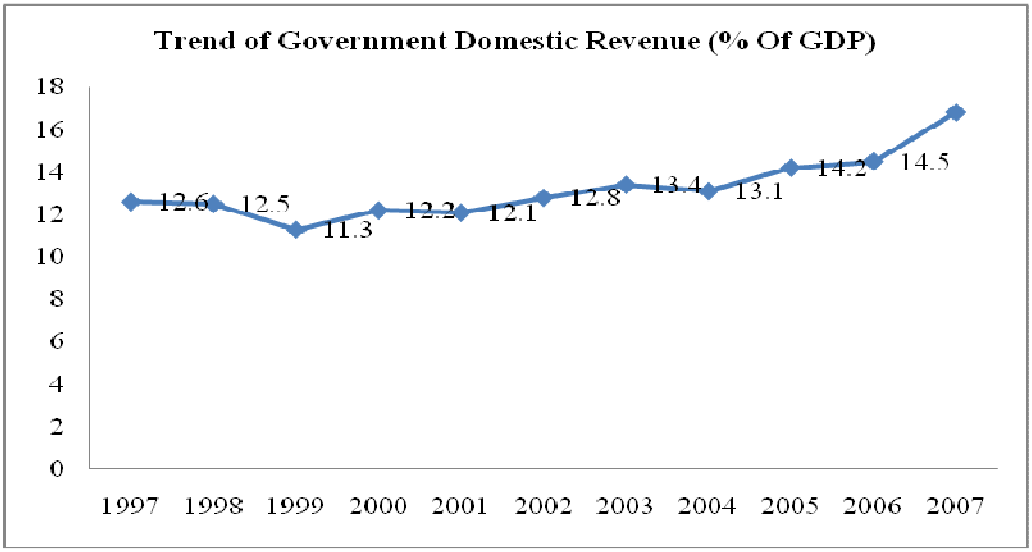
	Debt Service as a % of Exports	Debt Service as a % of GDP	Debt outstanding and disbursed as a % of GDP
1995	18	4.1	145
1996	18.5	4.1	116

1997	13.1	2.1	95
1998	21.3	2.9	93
1999	18.1	2.4	95
2000	13.1	1.8	80
2001	9.8	1.6	72
2002	5.9	1.1	75
2003	4.1	0.9	73
2004	4.2	1.1	94
2005	8.3	2.3	95

3.1.4 Domestic Revenues

Following various fiscal reform measures, which included the establishment of Tanzania Revenue Authority (TRA), Tanzania's domestic revenue collections have improved dramatically. In fact, over the past few years, collections have been consistently surpassing the targets. However, Tanzania's budget to a large extent remains dependent on foreign financing despite rising domestic revenue. The daunting budget challenge that remains is to strengthen the collection of domestic revenue and contain the growth of unmatched recurrent Government expenditures. Figure 3 shows the trend of domestic revenues as a percentage of GDP.

Figure 3: Domestic Revenue as Percent of GDP



Source: URT, (2008a).

On average, domestic revenues averaged about 12.9% of GDP from 1997/98 to 2006/07. This has been partly attributed to the narrow tax base in the country, where many activities in agriculture which accounts for a lion share of GDP are not taxable.

3.2 Macroeconomic Policy Framework

After strong pursuit of rigorous economic reforms, the overarching focus of policies is towards consolidating and maintaining macroeconomic stability and strengthening domestic resource

mobilization and the external sector, whilst implementing key sectoral strategies, as outlined in MKUKUTA. In the absence of exogenous shocks, the real GDP was earlier projected to grow by 7.4% by the year 2006, but as indicated earlier, the growth in that year turned out to be 6.2%. The trends of Tanzania's key macroeconomic indicators over the past ten years (1997 – 2007) are summarized in Table 2.

A number of constraints could hinder the realization of economic growth prospects based on the projections of the Macroeconomic Policy Framework: First, there has been drought in some parts of the country in recent, which significantly affected agricultural output and thus lowered growth prospects. Second, the continuous increase of the price of oil globally will also have adverse effect on the growth prospects. Monetary policy is geared towards maintaining price stability, and in this respect the inflation rate is projected to decline to below 4%, consistent with the average inflation rate in Tanzania's major trading partners (though this ambitious target has met a stumbling block after higher fuel prices and food prices which pushed the average inflation rate to above 6% in 2007). The exchange rate is freely floating, with the Bank of Tanzania (BoT) intervening only to smoothen wide fluctuations and for the purpose of liquidity management.

The Tanzania's macroeconomic projections and policy targets for the period 2007/08 – 2009/10 are:

- Attaining a real GDP growth of 7.3% in 2007, 7.8% in 2008 rising to 7.9% by 2010;
- Controlling Inflation at below 4.5% by end June, 2008;
- Increasing domestic revenue collection to the equivalent of 15.6% of GDP in 2007/08, and 16.4% of GDP in 2008/09 and 17.4% in 2009/10;
- Containing the growth rate of M2 within limits of 23.1% in 2007/08, 23.0% in 2008/09 and 22.6% in 2009/10, consistent with GDP growth and inflation targets;
- Maintaining adequate official foreign reserves of not less than a value equivalent to five months worth in imports of goods and non-factor services;
- Maintaining a market determined realistic exchange rate, with the Bank of Tanzania's interventions exclusively limited to smoothing wide fluctuations and/or liquidity management purposes; and;
- Accelerating requisite reforms in the legal and regulatory framework for enhancing access to credit by the private sector.

Table 2: Tanzania's Macroeconomic Indicators

	Real GDP Growth (%)	Inflation - annual average (%)	Current account balance (Million USD)	Foreign Reserves (Months of imports)	Government Domestic Revenue (% Of GDP)	Total Government Expenditure (% of GDP)	Fiscal balance (before grants) - % of GDP	Fiscal balance (after grants) - % of GDP	Total Debt Stock (Million USD)
1997	3.3	16.1	-403	3.8	12.6	17.4	-2.3	-0.2	7384.6
1998	4.1	12.9	-905.4	3	12.5	17.6	-2.3	-0.8	7669.7
1999	4.8	7.8	-829.6	4.1	11.3	18.3	-5.8	-1.6	7624.8
2000	4.9	6	-498.6	5.6	12.2	20.6	-4.6	-1.2	7482.1
2001	6	5.2	-200	6.3	12.1	29.1	-5.6	-1.1	7464
2002	7.2	4.5	-83.6	8.6	12.8	23.4	-8.2	-1.7	7268.17
2003	6.9	4.4	-87.5	9.2	13.4	24.9	-11.2	-4	7890.7
2004	7.8	4.2	-383.3	8	13.1	24.4	-11.8	-4.5	9219.3
2005	7.4	4.3	-881.7	5.8	14.2	27.7	-13.5	-6.6	9383.9
2006	6.7	7.3	-1379	5.3	14.5	28.3	-13.8	-5.4	7188.4
2007	7.1	7	-2056	5	16.8	28.8	-12	-3.9	7041.3

Source: URT (Economic Survey, Various issues); URT (2008f)

3.3 Poverty Situation

Tanzania's effort towards reducing poverty and meeting the MDGs is guided by MKUKUTA formulated through very broad consultations, and linked to the National Development Vision 2025. MKUKUTA is a broad medium term framework, with focus on growth and on governance. The strategy is built on the premise that growth and governance merit much greater attention to ensure a more rapid reduction of poverty and improvement of the social well being of the population. It therefore puts emphasis on the need to generate broad-based growth, and to deliver more equitable access to services and opportunities. The MKUKUTA Annual Implementation Report which was released in November, 2007 showed progress in most areas, even as the measurement of poverty status is hampered by the infrequency of household budget surveys. MKUKUTA areas recording good performance include real GDP growth, domestic revenue collection and related revenue services, improved food self sufficiency, and public expenditure management.

Table 3 summarizes the poverty trend in Tanzania up to 2010, and it clearly portrays the fact that poverty is predominantly a rural phenomenon.

Table 3: Poverty Trends (Actual and Projected), up to 2010

	HBS		Actual					Projections			**2010 Target**
	1991	2001	2002	2003	2004	2005	2006	2007	2008	2009	
Rural	40.8	38.6	36.8	36.1	34.5	32.9	31.1	30.3	28.8	26	**20**
Urban	28.4	23.1	20.8	18.6	17.1	15.3	14.1	12.7	11.5	8.1	**14**
National	38.6	35.6	33.7	32.7	31.1	29.5	28	26.8	25.4	23.1	**19**

Source (URT, 2006c)

Poverty trends summarized in Table 3 show that the target for urban poverty by 2010 (14% of urban population) will be met. But the trend for rural poverty indicates very slow decline, and the 31.1% figure for 2006 sends a signal that the 20% target for 2010 could be difficult to achieve.

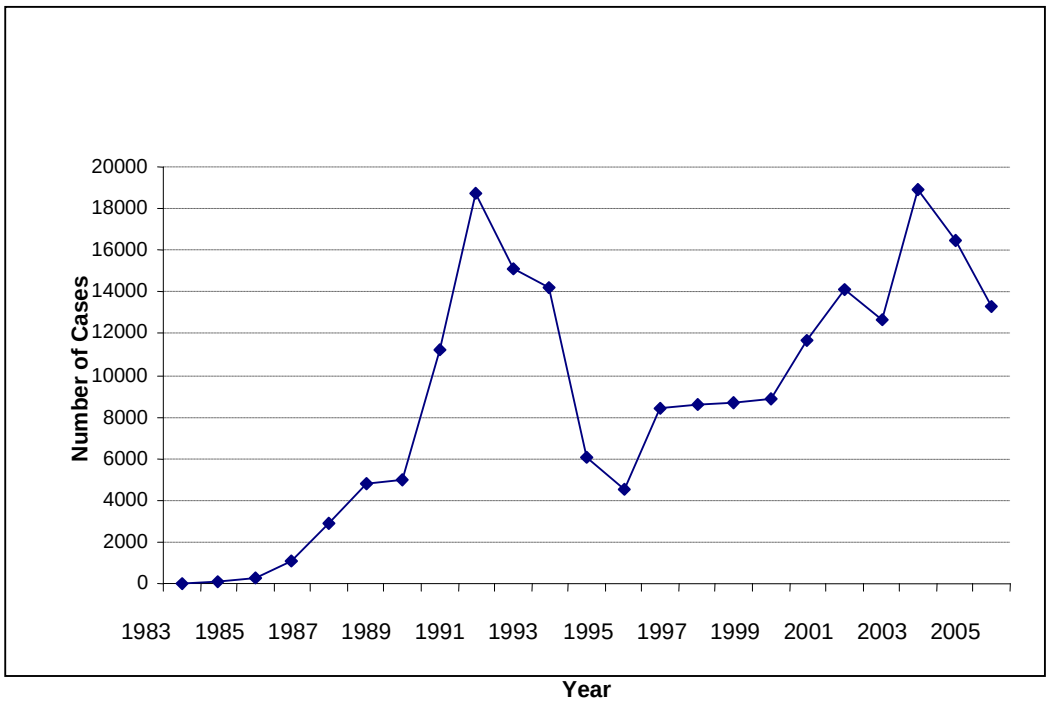
3.4 Status of HIV and AIDS in Tanzania

3.4.1 AIDS Cases and HIV Prevalence

As mentioned earlier, HIV is a serious health and socio-economic problem in Tanzania and it ranks among the top impediments to the country's social and economic development, as it affects all sectors of the economy. The disease prevalence varies strongly across residence and regions in Tanzania. Analyzed by region, Tanzania HIV/AIDS Indicator Survey (THIS) reveals that Mbeya has the highest HIV prevalence rate (14%) followed by Iringa (13%) and Dar es Salaam (11%). Regions with lowest HIV prevalence levels are Manyara and Kigoma, with 2% each. Overall, seven regions showed HIV prevalence levels below 5% (URT, 2005a). Again, in many regions, women have higher degree of prevalence of HIV infection than men.

A total of 13,285 AIDS cases were reported to the National AIDS Control Program (NACP) from the 21 regions during the year 2005. This resulted into a cumulative total of 205,773 reported cases since 1983 when the first 3 cases were identified in the country. About 5.6% (439) of the AIDS cases reported in 2005 were below 15 years of age and most of these are likely to have acquired infection through mother to child transmission. The age group 20-49 years remained the most affected for both sexes, an observation that has remained consistent for several years since the beginning of the epidemic in the country. The observed clustering of cases in the age group 20-49 indicates that the majority of infections occur during the age of maximum sexual activity. Figure 4 shows the trend of reported AIDS cases in the country.

Figure 4: Trend of Reported AIDS Cases: 1983 – 2005



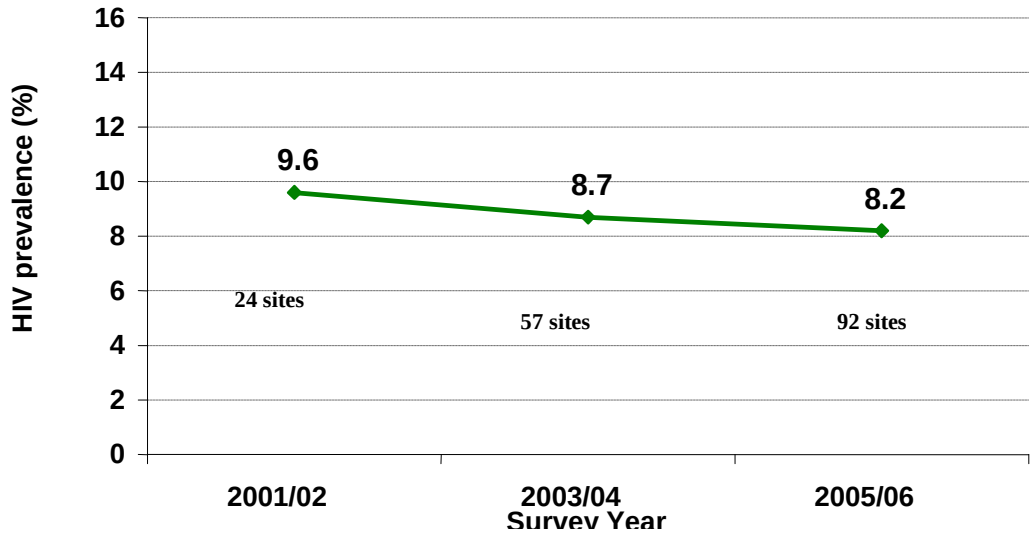
Source: URT, (2006a).

NACP has also been recording HIV prevalence trends among women of all ages who attended Antenatal Clinics (ANC) in specific sentinel sites. Prevalence estimates have been made for every round of survey and included all women who were recruited into the survey for the respective years. Overall these estimates suggested that there is a decline in HIV prevalence, from 9.6% in 2001/02 to 8.7% in 2003/04 and further to 8.2% in 2005/06 (

Figure 5).

When the point estimates were calculated from the three rounds of surveys using only the 24 sites that had three data points, a similar trend was observed where the prevalence declined from 9.7% in 2001/02, to 8.8% in 2003/02 and 8.9% in 2005/06.

Figure 5: Trends of HIV Prevalence among Women who Attended ANC, 2001-2006

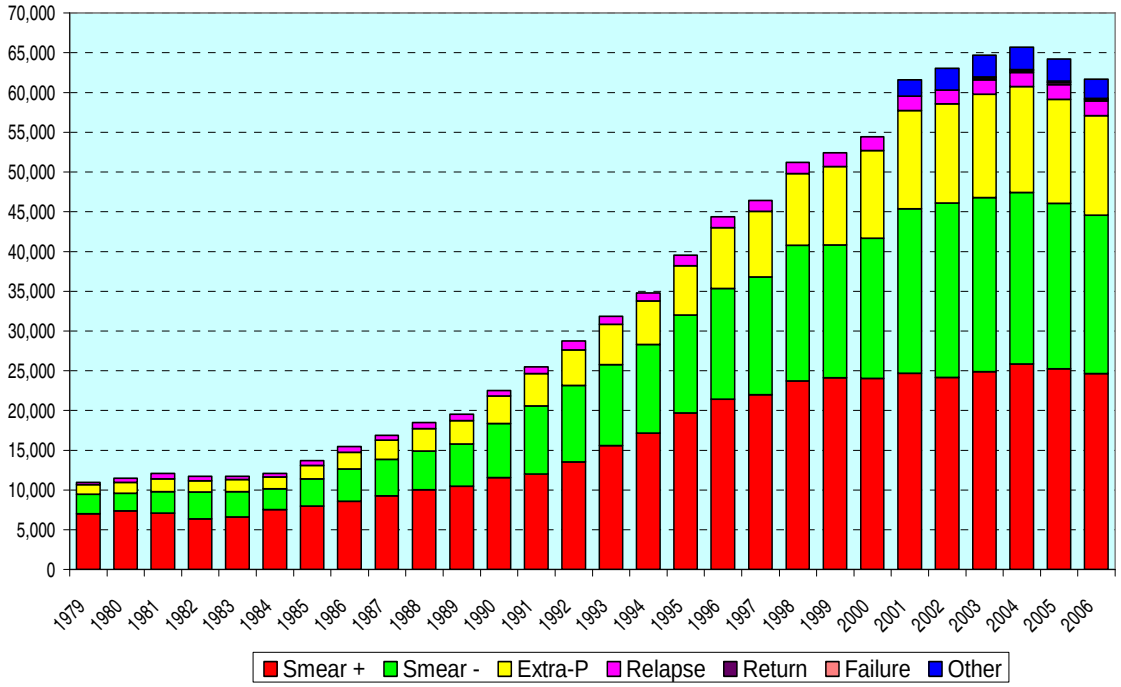


Source: URT, (2006a).

3.4.2 Status of TB in Tanzania

The incidence of tuberculosis has increased dramatically since 1984 corresponding to the spread of HIV infection. In 2005 alone over 65,500 new TB cases were notified compared to only 11,000 in 1984. Data from National Sentinel Surveillance system of the Adult Morbidity and Mortality Project (AMMP-2001) indicates that TB/HIV conditions contribute to 17.5% of the total disease burden in Tanzania for population above 5 years of age, behind AIDS (49.8%) and prenatal conditions (32.0%). Figure 6 shows the trends of TB case notification.

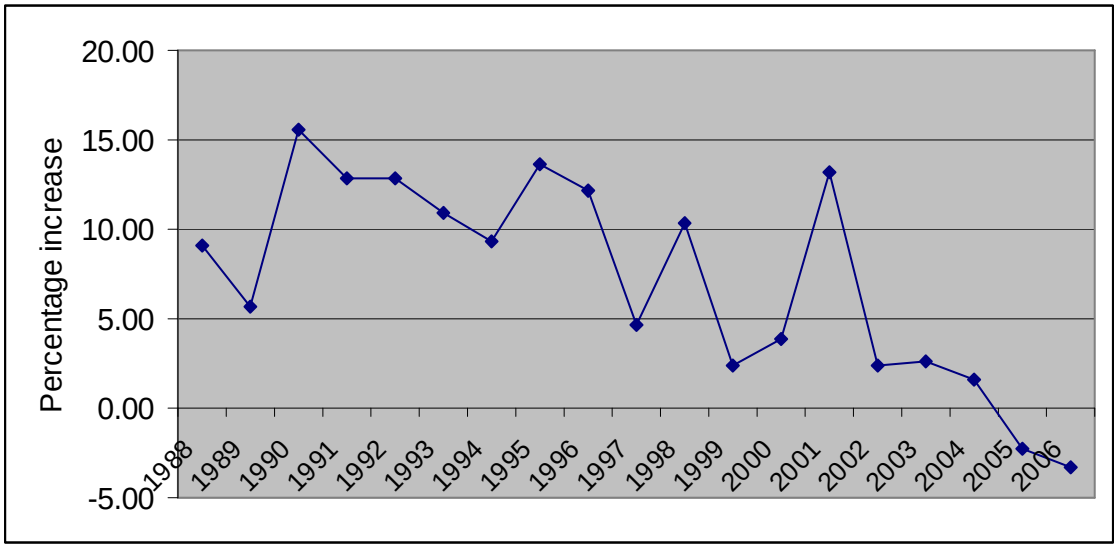
Figure 6: Trends of TB Case Notification (all forms) between 1979 and 2006



Source: URT, (2008b).

Although the TB case notification has been increasing over time, there is an increase at a decreasing rate notably from 1990 (Figure 7).

Figure 7: Percentage Change in the TB Cases Notified in Tanzania, 1988 - 2006



Source: URT, (2008b).

4 KEY FINDINGS

4.1 Content and Process of IMF Policies

The background to the engagement of the IMF in the Tanzania's economic policy could be traced back to the economic crisis of the late 1970s. Tanzania's economy was highly state-controlled, characterized by an inflexible economic system comprised of monopolistic and heavily regulated production structures. The rigid economic system, the war with Uganda, and external shocks during the late 1970s, resulted in major macroeconomic imbalances, economic stagnation, and a decline in per capita income that lasted over 15 years. Following a shift in the mid-1980s away from administrative control of economic activity, progress was made in liberalizing external trade and payments, domestic prices, and agricultural marketing. In the early 1990s, Tanzania began pursuing market-oriented reforms, initiating a liberalization of the financial sector and of the civil service and, to a limited degree, privatization. Large segments of the economy, however, continued to be dominated by public sector monopolies and, more importantly, macroeconomic stability proved elusive.

Following macroeconomic imbalances, the key challenge at the onset of the IMF's engagement in Tanzania was to restore macroeconomic stability. Once this objective was met, the overarching challenge was to accelerate growth and alleviate poverty—including greater emphasis on private sector development and improving the economy's supply response, a reorientation of public expenditure toward social spending, as well as laying the foundation for a gradual reduction in the dependence on aid. Macroeconomic stabilization has remained the overriding goal, despite shifts in emphasis on the priority of certain reforms. *The IMF's Structural Adjustment Programs (SAP) in Tanzania have evolved significantly since 1996.* First under the Enhanced Structural Adjustment Facility (ESAF, 1996–1999) then under the Poverty Reduction and Growth Facility (PRGF1, 2000–2002 and PRGF2 2003–2006), and subsequently under Policy Support Instrument (PSI) (since 2007).

Monetary policy options in Tanzania have been strictly limited by macroeconomic stabilization agreements made with the IMF and World Bank in conjunction with IMF loans, the HIPC (Heavily Indebted Poor Country) initiative and the PRSP (Poverty Reduction Strategy Paper) process. In addition to the typical IMF requirements to limit credit to the government and increase foreign reserves, the Bank of Tanzania (BoT) has also been encouraged to focus on reducing inflation into the mid single digits. This focus on inflation fighting and the other limitations imposed by IMF conditionality has reduced the prospects broad-based employment generation, increased public investment and poverty reduction in Tanzania. Monetary policy has been strongly influenced by the IMF's PRGF and PSI arrangements and commitments undertaken by Tanzania as well as commitments made in conjunction with the development of the NSGRP, ands part of the HIPC debt-relief initiative.

The most important finding is that Tanzania's macroeconomic framework prioritizes the maintenance of a very restrictive degree of macroeconomic stability—as the IMF defines it—and thus the framework does not enable sufficient "scaling up" of ODA inflows or increases in domestic spending of the kind projected to be needed to achieve the MDGs or fight HIV/AIDS effectively. The framework cannot enable such increases in spending because it requires and prioritizes a very restrictive definition of macroeconomic stability (inflation at 5 percent per year and deficits below3 percent of GDP), which prevents sizeable increases in public spending whether from foreign or domestic sources.

The report identified several fundamental assumptions that underpin the IMF approach to monetary policy in Tanzania which deserve greater public scrutiny by a broader group of public stakeholders:

1. The IMF makes an assumption that IMF-defined macroeconomic stabilization must come first and be constantly maintained; this stabilization will create the conditions necessary for higher growth and poverty reduction over the long term. Therefore, it is assumed that in the short-term and medium term, the goals of maintaining low deficits and low inflation must take precedence over achieving the MDGs and fighting AIDS effectively. It is assumed that these social and health goals will only be achieved eventually, some day, after a sustained long-term commitment to maintaining low deficits and low inflation. According to the assumptions of this orthodox approach, the main monetary policy goal should be an inflation-focused monetary policy, and that other important goals, such as rapid economic growth and employment creation are seen as inappropriate direct targets of central bank policy. Therefore, this orthodox approach to monetary policy focuses on stabilization rather than growth or development, with an implicit assumption that once stabilization is achieved, higher rates of economic growth, employment creation, and poverty reduction will follow. This orthodox view not only specifies the appropriate target of monetary policy, but also the appropriate tools or instruments. The orthodox approach has emphasized the use of "indirect", market-based instruments of policy, such as short-term interest rates, as the primary and often exclusive tool of monetary policy. This is in contrast to the "direct", quantitative tools often used by central banks which have involved credit allocation methods, interest rate ceilings, and other ways to direct credit to priority economic sectors and goals. In short, the IMF-sponsored orthodox approach has narrowed both the goals, options and the tools of monetary policy in Tanzania.

The IMF approach of targeting for very low inflation (often 5 percent or lower) informs the type of conditionality that the IMF imposes. As the IMF states: "Conditionality in Fund supported programs is intended primarily to ensure that Fund resources are used to support adjustment toward sustained external viability, and thereby to safeguard the capacity to repay the Fund. Traditionally, monetary conditionality consists of limits on monetary aggregates - specifically, a floor is set for the level of net international reserves (NIR) and a ceiling is

established on the net domestic assets (NDA) or on base money" (IMF 2006). Under the standard IMF financial programming methods, target ceilings are set for central bank monetary and credit expansion and floors are established on net foreign reserves. The original motivation for these restrictions was to ensure the ability of countries to reduce their foreign debt and remain solvent, including protecting the ability of the IMF to get repaid. Recently, other goals, such as reducing inflation, increasing foreign exchange reserves and "creating room for private investment," have been emphasized.

According to Epstein (2006), the IMF is concerned that this NDA-NIR approach could allow for higher inflation than they might like, if, for example, larger than necessary increases in net international reserves result from inflows of capital (including foreign aid). As a result, some IMF programs require a further tightening of monetary conditions in order to maintain inflation rates in the low single digits.

Financial programming has been used since the 1970's as part of the IMF's lending program to least developed countries. This programming has now been folded into the PRSP and HIPC processes without much alteration. The programming uses a set of "identities" and extremely simple models (at best, a set of assumptions about the structure of the economy) to establish a set of targets that the IMF will monitor and the government will have to meet in order to receive the next installments of IMF loans, or qualify for HIPC relief and other donor support (Easterly 2002).

The typical program connects balance of payments constraints, the government fiscal deficit, and central bank policy in order to attempt to reduce indebtedness to a sustainable level, primarily by keeping economic growth in line with likely available foreign resources from export receipts, aid and capital inflows. Increasingly, reducing inflation into the mid single-digits has become a central focus. Therefore, a central assumptions of these program are (1) that inflation rates between 10 and 20 per cent are bad for economic growth and reducing inflation below that level will not reduce economic growth; and (2) that reducing government spending is good for the economy, because more government spending crowds out private investment.

Regarding the first assumption on inflation, the IMF has very little empirical evidence in the economics literature to justify pushing inflation down to the 5-7 percent level, with the consequences of lower growth, lower taxes and lower spending that result. This is often considered surprising, given the widespread belief that the IMF is the expert on such matters.

While high inflation is universally accepted as unsustainable and must be checked, a more relevant question is how low inflation should be brought down and at what level must it be maintained. On this point, the IMF's position that inflation must be brought down to and maintained at the 5-7 percent range is not backed up by the empirical literature or historical

record. At least 9 major studies have examined this question and have tried to find the "kink" in the inflation-growth relationship, or at what level inflation begins to hurt a country's long-term GDP growth rates: 1) Fischer (1993) found the point to be between 15-30 percent; 2) Bruno (1995) cites a major unpublished World Bank study of the link between inflation and economic growth in 127 countries from 1960 to 1992 that found that inflation rates below 20 percent had no obvious negative impacts for long-term economic growth rates; 3) Barro (1996) found that an increase by 10 percentage points in the annual inflation rate is associated on impact with a decline by only 0.24 percentage points in the annual growth rate of GDP but says nothing about the disinflation policy targets; 4) Sarel (1996) found the danger point at 8 percent; 5) Bruno and Easterly (1998) found the danger point to be as high as 40 percent; 6) Ghosh and Phillips (1998), found inflation-growth relationship is convex, so that the decline in growth associated with an increase from 10 percent to 20 percent inflation is much larger than that associated with moving from 40 percent to 50 percent inflation, but this says nothing about disinflation policy targets; 7) Khan and Senhadji (2001) found the danger point for inflation at between 11 percent-12 percent for developing countries and 1-3 percent for industrialized countries); 8) Gylfason and Herbertsson (2001) found the danger point for inflation at between 10-20 percent; and 9) Pollin and Zhu (2005) found the danger point to be between 14-16 percent (for middle and low-income countries).

What these 9 major studies show is that not only are the estimates varied and that further research is still needed, but as Pollin and Zhu note, "There is no justification for inflation-targeting policies as they are currently being practiced throughout the middle- and low-income countries" (Pollin and Zhu 2005). The same literature was reviewed by a 2007 study from the Washington-based Center for Global Development which found, "Empirical evidence does not justify pushing inflation to these levels in low-income countries" (CGD 2007) and by the House Financial Services Committee of the US Congress, which wrote to the IMF in 2007, "We are concerned by the IMF's adherence to overly-rigid macroeconomic targets" and, "It is particularly troubling to us that the IMF's policy positions do not reflect any consensus view among economists on appropriate inflation targets" (Financial Services Committee 2007).

Maintaining such low levels of inflation in developing countries has been the policy for 25 years; it has been effective at stabilization, but has done very poorly at generating higher economic growth that translates into poverty reduction, job creation and increased public investment as a percent of GDP. While it might seem obvious that stabilization-focused central bank policy represents the only proper role for central banks, in fact, looking at history casts serious doubt on this claim. Far from being the historical norm, Epstein (2007) notes this focus by central banks on stabilization to the exclusion of development represents a sharp break from historical practice, not just in the developing world but also in the now developed countries as well. In many of the successful currently developed countries, as well as in many developing countries in the post-Second World War period, development was

seen as a crucial part of the central bank's tasks. Now, by contrast, development has dropped off the "to-do list" of central banks in most developing countries (Epstein 2006). This approach underscores why the IMF should not be in the "development business" and is not a "development organization" and should not be involved in an ongoing way with LICs. As the 2007 IEO report explained, there were differences of views among the members of the IMF Executive Board about the IMF's role and policies in poor countries. After more than 7 years after adopting PRSPs and re-branding the Enhanced Structural Adjustment Facility (ESAF) into the Poverty Reduction and Growth Facility (PRGF) and ostensibly backing the MDGs, IMF leadership never gave any indication on how to change any of the macroeconomic policies to create a scaling-up environment. "[L]acking clarity on what they should do" the IMF staff "tended to focus on macroeconomic stability, in line with the institution's core mandate and their deeply ingrained professional culture" (IEO 2007).

Another key finding was related to the IMF's assumption that reducing government spending is good for the economy, based on the thinking that increased deficit spending by the government "crowds out" the limited available credit in the country, and limits the ability for further private sector investment, and therefore that deficit financing leads to inflation. However, there is little empirical evidence that deficits lead to higher inflation; and there is mounting evidence for the reverse of "crowding out" effect, as even noted by IMF's Sanjeev Gupta, et al (2006), that, depending on the nature of the public investments, public spending can actually have a "crowding-in" effect that creates new opportunities for private investment (IMF 2006; Roy, et al, 2006). However, the IMF's zero-sum approach (crowding out) has led to an overly restrictive stance on the government drawing from the limited supply of credit in the economy and continues to restrain government financing for increased public spending and investment.

A third major assumption made by the IMF in the macroeconomic framework's design is that inflation can be effectively controlled by having the central bank try to carefully restrict and modulate the growth rate of the money supply in the economy. However, the empirical evidence shows that in most developing countries:

- Central banks have influence over a small portion of the money supply—only the currency and reserves of the banking system;
- Monetary policy is not always effective. Central banks may have limited influence over all of the multiple factors that contribute to the growth of the money supply (broadly defined);
- The link between the money supply and inflation is often weak;
- Uncontrollable growth of the money supply will lead to hyper-inflation, but such targets often cannot "fine tune" low rates of inflation;
- Richer countries (like the US & Europe, Brazil, South Africa) target interest rates, not the money supply;

- Inflationary pressures in most low-income countries tend to come from price shocks (food, energy price increases, etc) and therefore monetary policy is not effective in managing this type of inflation (non-monetary shocks).
- Adopting a tight monetary policy in response to a negative price shock can make the situation worse, but this is what Tanzania is doing in the face of a global economic downturn;
- Many African countries have a history of fairly stable inflation, so the preoccupation with restricting inflation over other indicators is misplaced;
- Other IMF reforms (like devaluing the currency) can actually contribute to inflation

In addition, the IMF was found to assert that within the macroeconomic framework, monetary policy should be dominant and that fiscal policy goals should follow and be constrained accordingly in order to help the monetary goal be achieved (monetary policy dominance). This is what the Policy Support Instrument (PSI) means by calling for "greater coordination between fiscal and monetary policy." Unfortunately, such a policy approach works to restrict a scaling-up developmental fiscal policy frameworks form being adopted, prioritized or realized, and makes the fiscal policy fall in line with monetary policy goals. Under this approach, as long as the monetary policies are geared for tight stabilization goals, any "scaling up" of public spending or investment to meet the MDGs or fight HIV/AIDS will be constrained.

The IMF also states that inflation-reduction or "price stability" should be the only monetary policy target. This is an ideological preference of the monetarist school of thought within neoclassical economics, and neglects other possibilities from consideration. However, other goals could be made part of the central bank's agenda and mandate. For example, the US and European Central Bank is tasked with achieving targets for employment as well as inflation, and must balance the two objectives; other possible targets include a target for achieving certain growth rates or employment rates. This is also connected to the IMF policy regarding the private-sector and job creation. The IMF does not address unemployment, or what steps could be taken to increase employment. This is despite widespread agreement among economists that creating jobs is necessary for poverty reduction. The neoclassical school of thought assumes jobs shall be mostly created by the dynamism of the private sector.

4.1.1 ESAF (1996 – 1999)

The medium-term strategy underlying the ESAF programs was primarily aimed at achieving macroeconomic stability. The program was based on strengthening fiscal performance, and central to this effort was improving the cash management system, established under the IMF's Staff Monitored Program (SMP), and civil-service reform. Fiscal discipline and subsequent improvements in the fiscal balance were expected to play crucial role in bringing down the inflation. Structural reforms, including privatization and financial sector

liberalization, were aimed at enhancing efficiency and improving competitiveness, with a view to enabling the private sector to play a greater role in economic activity.

4.1.2 First Poverty Reduction and Growth Facility – PRGF1 (2000-2002)

With macroeconomic stability largely achieved under the ESAF arrangement, the objective of the first PRGF program (PRGF1) was to sustain the stability and create the conditions favorable for higher growth, with particular focus on poverty reduction. Growth was to be led by the private sector, predicated on further structural reforms. Policies to reduce poverty included a greater reorientation of expenditures toward social spending, consistent with the objectives and priorities laid out in the PRSP.

4.1.3 Second Poverty Reduction and Growth Facility – PRGF2 (2003-2006)

The 2003–06 program (PRGF2) aimed to accelerate investment-led growth and further reduce poverty. Program objectives were to be met through a three-pronged strategy comprising of greater focus, relative to the previous programs, on increasing domestic government revenues, with a view to reducing gradually aid dependence; further liberalization of the trade regime; and enhancing the economy's supply response by removing key impediments to growth and improving the investment environment, with a view to boosting private sector development.

Under the PRGF, macroeconomic policies need to be better integrated with social and sectoral objectives, to ensure that plans are mutually supportive and consistent with a common set of objectives to spur growth and reduce poverty. Tanzania's policy matrix, which was the basis of PRGF support focused on policies in the following broad areas;[5]

1. External sector policies
2. Fiscal Policies
3. Monetary and Financial Sector Reforms
4. Public Sector Reforms
5. Social Sector Policies, Poverty Reduction, and Environmental Protection

The highlights of objectives, strategies and measures, and timing for achieving policy targets in these areas, are summarized in Table 4.

[5] The major focus of IMF's involvement so far has been on macroeconomic stability issues. The other aspects including the Civil Service Reforms, Trade Reforms, Tax Reforms are all meant to get the macroeconomic fundamentals right.

Table 4: Tanzania's Policy Matrix

Sector	Objectives and Targets	Strategies and Measures	Timing
1. External sector policies			
Overall	Achieve benefits of international integration and reduce aid dependency	Continue financial and economic reforms and liberalization	Continuous
		Maintain flexible exchange rate	Continuous
Foreign reserves	Promote external stability	Increase gross reserves to the level of four months of imports of goods and non-factor services	June 2000
2. Fiscal policies			
Overall	Achieve and maintain fiscal stability and increase domestic savings	Maintain recurrent budget savings above 1% of GDP	Continuous
Revenue	Broaden revenue base and improve efficiency	Introduce Value-Added Tax (VAT) and make complementary changes to the tax system	July 1998
		Introduce VAT in Zanzibar with the same rate and coverage as on the mainland	January 1999
		Limit exemptions on capital goods under the investment act using the harmonized tariff system	July 1998
		Strengthen customs administration and continue implementation of the customs reform program	Continuous
		Introduce pre-shipment inspection for private sector imports to Zanzibar	January 1999
		Establish a harmonized tax appeals mechanism	1998/99
		Reduce customs exemptions in conjunction with revision of tariff structure	July 1999
		Further simplify and rationalize the tax system	July 1999
Expenditure control	Limit expenditures to maintain fiscal stability	Strengthen sub-treasury system	1998/99
		Institute comprehensive personnel database	December 1998
		Install new payroll system	July 1999
		Complete reviews of transfers to public institutions	December 1998
		Protect expenditure on social services in administering the cash management system	Continuous
		Introduce an expenditure commitment monitoring system in ten key ministries to run in parallel with	July 1998

		the cash management system	
		Extend the expenditure commitment monitoring system to all ministries	July 1999
		Strengthen the system for monitoring overall public debt	1998/99
		Conduct Public Expenditure Reviews	Annually
Development of expenditure management	Reallocate resources to reflect changing roles of government in economic management and improve accounting and efficiency of public expenditures	Prioritize development expenditures among and within sectors and ensure their consistency with the medium-term expenditure framework (MTEF)	Continuous
		Achieve full budgeting and accounting coverage of donor-financed government expenditures in collaboration with donors in the context of the public expenditure review	1999/2000
		Integrate fully the recurrent and development budgets to take into account sector priorities and recurrent cost implications	2000/01
3. Monetary policy and financial reform			
Overall	Reduce inflation, increase domestic resource mobilization, and improve allocation of financial resources	Maintain market-oriented policies of monetary restraint	Continuous
		Promote and sustain positive real interest rates	Continuous
Inflation	Reduce inflation rate to 4% by 2000/01	Maintain low rates of monetary expansion	Annual targets
		Limit bank financing of the budget	Continuous
4. Public sector reform			
Civil service reform	Establish efficient and motivated civil service and improve quality and effectiveness of delivery of public services	Prepare recommendations on the affordable size of the civil service, consistent with the MTEF pay targets and efficiency	Annually from December 1998
5. Social sector policies, poverty reduction, and environmental protection			
Poverty	Reduce poverty	Finalize and initiate implementation of National Poverty Eradication Strategy (NPES)	December 1998
		Institutionalize poverty monitoring system to assess impact of policies on poverty	December 1998
		Establish a poverty data bank	March 1999
		Finalize implementation guidelines for the NPES	June 1999
Health	Improve health outcomes by increasing level	Complete compilation of the national health	July 1999

	and improving allocation of resources for basic health care	accounts and develop a public sector resource envelope for the health sector, including all donor resources, within the MTEF	
		Set targets for intra-sectoral allocations of resources, with priority to basic health services and non-salary items	December 1999
		Introduce revolving drug funds at pilot hospitals to ensure sustainable financing of pharmaceuticals	January 1999
		Review and improve efficiency of revenue collection for hospital services	Continuous
		Extend cost-sharing to dispensaries and health centers	Continuous
		Develop legislation and regulations for health insurance for public servants	July 1999
		Implement action plan for malaria control	1998/99
		Raise public awareness of HIV and AIDS epidemic as a national development issue and strengthen political commitment to fighting it	December 1998 onward

4.1.4 Policy Support Instrument – PSI (Since 2007)

By 2006, the IMF was satisfied that in the course of the PRGF Tanzania had achieved strong economic performance and solidified its position as a mature stabilizer. With market-oriented macroeconomic and structural policies backed by development partner support, Tanzania had secured high growth, low inflation, adequate reserves, and a sustainable external debt position. The authorities had met all quantitative and structural performance criteria for the final (sixth) review under the PRGF. However, an ex-post assessment of longer term program engagement highlighted several outstanding medium-term challenges, including the need to make significant inroads into alleviating poverty and to reduce gradually the dependence on aid, the need to sustain rapid growth for long periods, improve domestic revenue mobilization, and alleviate structural deficiencies. The assessment emphasized that with large aid inflows expected over the medium term, greater coordination between fiscal and monetary policies would be critical to promote the spending and absorption of such flows. At the same time, to improve external competitiveness, the assessment hinted that it would be important to enhance the supply response and absorptive capacity of the economy.

In that regard, the IMF was satisfied that Tanzania has no need for IMF resources going forward, but it could benefit from continued IMF engagement that goes beyond a pure surveillance relationship. In particular, rather than providing financial support, the most critical role for the IMF would be to provide signals to the donor community about the appropriateness of the government's policies. Against this background, a PSI would be an appropriate form of IMF engagement with Tanzania over the medium term. It is envisioned that a PSI would provide a clear framework for core macroeconomic and structural policies, guided by Tanzania's second generation PRSP (MKUKUTA), and the Millennium Development Goals. It would also signal to development partners the soundness of government policies. The PSI focuses on high and sustainable broad-based growth and more rapid poverty reduction centered on three core themes:

(1) Enhancing public resource mobilization and efficiency of spending to help achieve government objectives;

(2) Increasing the financial sector's contribution to growth and the effectiveness of monetary policy; and

(3) Improving the business environment and enhancing investment.

While the PSI does not come with financial support, the conditionalities are essentially a continuation of PRGF features. And in some cases, the targets are even tighter under the PSI. For instance, the inflation target under PSI is 5%, while under PRGF it was 6%. Likewise, the PSI demands a slightly higher level of foreign reserves (US$ 1.683bn) compared to the conditionality under PRGF (US$ 1.656bn). Table 5 below summarizes the most important quantitative and structural criteria under PRGF and PSI.

Table 5: Significant Quantitative and Structural Criteria under the PRGF and PSI

PRGF	PSI
Key Quantitative Macroeconomic Targets	
• Inflation target: 6% • No budgetary arrears • Ceiling - domestic financing • Floor on international reserves: $1.656b • No external payment arrears • No non-concessional external debt	• Inflation target: 5% • Ceiling on net domestic financing • No budgetary arrears • Targets for average reserve money • Floor, international reserves: $1.683b • No external payment arrears • No new non-concessional debt
Other important Structural Criteria	
• Limit government guarantees under three medium-term credit facilities • Submit legislation on banking • Customs reform • Increase audit department staff • Develop framework for financial sector reform • Audits of credit facilities • New anti-corruption law • List tax exemptions • Financial recovery plan for TANESCO (power utility)	• Adopt recovery plan for TANESCO • Raise electricity tariff, full cost-recovery • Establish cash management unit • Report on financial sector reform • Submit anti-corruption bill to legislature • List tax exemptions • Risk management plan for customs

Tanzania completed the first PSI review in 2007. Table 6 shows PSI assessment criterion and structural benchmarks for 2008/09.

Table 6: PSI Assessment Criterion and Structural Benchmarks for 2008/09

Measure	Target Date of Implementation
Monetary Policy	
Establish a Memorandum of Understanding between the Ministry of Finance and Economic Affairs (MoFEA) and the BoT setting out respective responsibilities, including cost sharing of monetary policy operations	End-September 2008
Fiscal Policy	
Cash Management Unit (CMU) in the Accountant General's Department to produce Government's three month rolling cash-flow forecast	Continuous
Introduce a functional classification of expenditures consistent with the IMF's *Government Financial Statistics Manual 2001* in the budget for 2009/10	End-June 2009
Complete the integration of the Customs and Excise Department and TISCAN's import clearance processes	End-December 2008
Financial Sector	
Prepare a review of the regulatory framework governing capital and financial account transactions	End-September 2008
Prepare quarterly financial stability reports for the BoT Board, including assessments of risk-based prudential supervision	End-September 2008
Establish an operational credit reference databank	End-June 2009

4.1.5 Comments on January 2009 4th IMF Review of Tanzania PSI

On Monetary Policy: The overall goal is macro stability, not an increase in spending and investment to achieve the MDGs. The theory behind the IMF's conditionalities is that stability must be achieved and maintained, with sustained growth to follow over time, which will lead to the achievement of the MDGs and other important development objectives. As the January 2009 4th Review of the PSI explained:

"Key objectives for 2008/09 are to strengthen macroeconomic stability while raising productivity through continued structural reform and improved public infrastructure. Discussions focused on three main issues:

- Maintaining sound fiscal policy to anchor macroeconomic stability;
- Restoring low inflation by improving liquidity management; and
- Increasing public accountability and restoring confidence in Tanzania's institutions.

In addition, discussions covered policies to raise Tanzania's long-term growth potential, including infrastructure financing, second generation financial sector reforms, and gradual capital account liberalization" (IMF 2009).

According to the PSI review: "Monetary policy should seize the opportunity to return inflation to its 5 percent medium-term target. Falling world food and fuel prices will help, but the Bank of Tanzania also needs to strengthen liquidity management. Better coordination with the fiscal authorities and decisive steps to mop up liquidity, including through rising interest rates when necessary, are key steps in that direction" (IMF 2009). However, as has been documented, there is no empirical justification in economics literature for pushing

inflation so low, yet there are substantial costs to foregone growth and spending because of the use of a high interest rate to bring or keep down inflation.

On Fiscal Policy: The PSI review says the goal of fiscal policy is: "To reduce deficit from 3.7 percent of GDP in 2008/09 down to 3.1 percent by 2010/11" (IMF 2009). The PSI review explained: "Fiscal policy should be supportive of disinflation. The zero net domestic financing target remains a useful and transparent fiscal anchor, and any signs that revenue may fall short should be accompanied by expenditure restraint" (IMF 2009).

The PSI review acknowledges infrastructure spending is crucial to future growth, but is willing to forego it anyways in order to keep public debt "sustainable": "Improving public infrastructure is critical to raising Tanzania's long-term growth potential. However, in considering financing options any recourse to non-concessional financing sources will require a careful evaluation of economic returns to avoid a re-accumulation of unsustainable public debt" (IMF 2009).

The IMF wants Tanzania to continue its "cash only" budgeting system designed to prevent deficit financing and, as mentioned above in IMF Finance Ministry Assumption #5, is implemented due to the belief that public spending will "crowd out" private spending: "The zero NDF ceiling, as targeted in the 2008/09 budget, remains a useful and transparent fiscal anchor, which will help reduce inflation and minimize crowding out of the private sector." (IMF 2009). But as mentioned above, the IMF's "crowding-out" theory does not always hold true. In November 2008 Tanzanian President Kikwete told experts drawn from banks and other financial institutions that the Government had over the past 10 years substantially reduced its share of the total domestic credit and was therefore much less of a problem in terms of "crowding out" the private sector. But, he said, "Unfortunately, most of the credit released tends to sit in the banks as excess liquidity instead of being lent out. As a result, the cost of credit made available to the private sector has to be borne by the small part that is lent" (The Citizen 2008a).

In terms of the 12 standards & codes that the IMF is responsible for monitoring, the IMF reported in its 2002 Report on the Observance of Standards and Codes (ROSC) that Tanzania's reform efforts had yielded some enhancements to fiscal transparency. Chief among these were the newly introduced Integrated Financial Management System (IFMS) and the Public Expenditure Review, as well as several legal reforms. However, the 2002 ROSC found that more legislative reforms were needed to accompany the ongoing decentralization of political, administrative, and financial responsibilities. The government's 2005 Letter of Intent to the IMF acknowledged the need to improve its internal and external audits of public spending, and called for greater parliamentary oversight and a further strengthening of the National Audit Office. The 2007 IMF Article IV Consultations report notes that Tanzania has expanded participation in the IFMS to 87 out of the 122 local

government agencies and has staff training programs on the use of the system in place. Tanzania does not subscribe to the IMF's Special Data Dissemination Standard but participates in the less rigorous General Data Dissemination System.

This will prevent Tanzania from being able to adopt more expansionary fiscal policies and constrain public spending and public investment as a percent of GDP. This logic prevents Tanzania from being able to make big, up-front public investments in health or education now that will more than pay for themselves over time (known as "the multiplier effect") (Roy, et al 2006). Fan, et al., (2005) provide striking examples of the "sacrifices" made by such a tight monetary policy. They studied public investment in Tanzania and found that despite recent improvements in Tanzania's economic performance, poverty remains widespread and shows few signs of diminishing. This is in part because the country's investment in human capital and rural infrastructure and technology has been allowed to stagnate (public investment as a percent of GDP). They show that there is both a major need and massive opportunities to use public investment funds more efficiently to achieve national economic growth and poverty reduction goals. They found that additional investments in rural education can have very favorable impacts on poverty, raising about 43 poor people above the poverty line per million shillings spent. Education investments also lead to sizeable increases in per capita income per shilling spent, with an average benefit/cost ratio of 9. These impacts are strong and statistically significant in all regions of the country. The authors conclude that investments in education should be a priority in all regions of the country (Fan, et al 2005).

Additionally, they found that rural road investments also have a large impact on per capita incomes with an average benefit/cost ratio of 9.13. Their impact on poverty per shilling spent is about half that of investments in education; each shilling spent raises about 27 poor people out of poverty. Unlike education investments, roads have much more diverse impacts across regions. Their poverty and growth impacts are most favorable in the South Highlands and Central and Western zones and least favorable in the Northern parts of the country. This implies that regional targeting is appropriate. Investments in agricultural research also have a large impact on rural poverty, raising about 40 persons out of poverty per million shillings spent, and have the largest impact on incomes with an average benefit/cost ratio of about 12. Again, regional targeting is important because while the impacts are very favorable in the Central and Southern part of the country, they are much less attractive elsewhere. Basically, however, the studies show what could be possibly attained with increased up-front public investments—but which are restricted by macro policies that prioritize low deficits, low inflation and market-based interest rates over higher public spending.

The Need to Restructure Domestic Debt: Because of high interest rates on domestic borrowing and the already high buildup of domestic debt, Tanzania is seeking to float its first international bond for global investors as a way to raise $500 million for infrastructure

investment; but because of market turmoil, the IMF is cautioning against this. (This follows in the steps of Ghana and Gabon, which have already tapped into the international markets through successful Sovereign bond issues floated in 2007.) As The East African reported, "The Tanzanian government appears convinced that borrowing money from international markets through a sovereign bond is a better way of raising money than having to resort to heavy domestic borrowing" (East African 2008). But the IMF warned that the cost of interest payments Tanzania would have to pay to be attractive to foreign investors would be too costly (The Citizen 2008b). In November 2008, an IMF Staff Paper explicitly suggested Tanzania not float an international bond issue and instead to encourage greater private participation in their sector either through direct investment or public-private partnership arrangements (IMF 2008).

However, Tanzania would have to further reduce and eliminate what is left of its capital controls in order to float the bond: "The issuance of a sovereign bond would however necessitate wide ranging economic reforms to open up sectors of the economy that are still under Government control. Such reforms include lifting Government current account control which limits foreign exchange transactions and restricts sale of Government securities to foreigners" (Monitor 2008). "The issuance of a sovereign bond would, however, necessitate wide ranging economic reforms to open up sectors of the economy that are still under government control. Such reforms include lifting government current account control, which limits foreign exchange transactions and restricts sale of government securities to foreigners" (East African 2008).

Advancing Toward Central Bank Independence (CBI) and an IT Regime: Some requirements for inflation targeting are already in place: the new Central Bank Act of 2006, which granted the BoT greater independence and put the emphasis on price stability; clarity in conducting monetary policy; and the significant improvement in BoT communication with the market and the public, which is already having a positive impact on its credibility. The main challenges to Tanzania's formal adoption of inflation targeting are the lack of an analytical framework for forecasting inflation—underpinned by a strong statistical framework—the lack of understanding of monetary policy transmission mechanisms, and shallow domestic financial markets. Risks include the potential that CBI will increasingly subordinate fiscal policy to monetary policy (leading to monetary policy dominance), and constrain government expenditure in order to maintain low inflation. Maintaining low inflation in this case is seen as necessary to establish "monetary policy credibility" of the central bank in the eyes of potential domestic and international bond investors. Adopting an IT regime could more firmly establish tight monetary policies to which fiscal policy would become subordinate.

4.1.6 Participation of Stakeholders in the IMF Policy Process

In this sub-section we analyze the stakeholders' involvement in the process of accepting policies and conditionalities and their influence and power. The major focus is on participation in the formulation of PRSP. In Tanzania, the initial formulation of the PRSP took place within an extremely compressed timetable, under pressure to reach the HIPC completion point. Inputs from non-state actors such as civil society were limited and hence had little influence on the initial policy content of the PRSP. Participation of local non-state actors in policy process in the country was limited to information sharing. The socio-political landscape preceding the introduction of participatory conditionality attached to the PRSP thus significantly shaped the trajectory of participation in formulation of the PRS. Though civil society organizations had started to actively voice their concerns in various forms in the second half of 1990s, the closed technocratic nature of policy formulation dominated the process of formulation of the Interim PRS for Tanzania such that participation was limited to consultations among a small group that Booth (2005) and Gould and O'Janen (2003) have termed an 'iron triangle' of donors, internationally-linked NGOs and government technocrats. Outside this sphere, consultations were utterly absent.

The picture was somewhat different in the preparation of the full PRS in that representatives of civil society—most notably at the national level—were consulted in the process. But even at this stage the process was still assessed to be compressed as the consultations were not only rushed, but there was also deliberate move to block participation of some CSOs, thus leading to exclusion of some sections of the local non state actors (Evans and Ngalewa, 2003). For instance, during the PRS consultation phase, the government refused to acknowledge the report from the Tanzania Coalition on Debt and Development (TCDD) on the macroeconomic framework of the strategy, and it even refused to acknowledge the existence of the TCDD/PRSP-Committee, blocking the leading role of the coalition in zonal workshops. At regional level smaller NGOs (such as local women and youth networks) and representatives from some community based organization (CBO) were invited to participate in consultation workshops, but due to limited knowledge many spent more time trying to understand the PRSP rather than to contribute constructively towards policy formulation. In the end due to the hurried nature of consultations it became difficult to know to what extent the views and concerns of the people consulted outside the "iron triangle" were included in the final PRSP document.

Also, the evaluation by IMF's Independent Evaluation Office (IEO) and World Bank's Operation Evaluation Department (OED) noted that the Ministry of Finance officials were frustrated over the lack of clarity of what was expected from a PRSP. A country-led and comprehensive poverty reduction strategy, set in the context of the long-term Vision 2025, already existed in the form of the National Poverty Eradication Strategy (NPES). With respect to partnerships, the Helleiner report had initiated a fruitful dialogue with the country's

external partners and the Tanzania Assistance Strategy (TAS) aimed at coordinating donor assistance.

A key contribution of the process has been the opening up of a dialogue between the government and civil society. Civil society is now more actively engaged in national policymaking through channels such as participation in the public expenditure review (PER). The PER has broadened to become the main avenue for public policy debate and strategy formulation in Tanzania. The institutionalization of the policy dialogue, through the PER process, where the World Bank played a critical supporting role, has been crucial—although it is not possible to attribute this development to the PRSP approach *per se*. The PER process provided a forum for follow up of the policy debate which was very important given initial gaps in the poverty reduction strategy. It is broadly participatory, government-led and encourages domestic and external partnership. It also facilitates a multi-sectoral results orientation of the PRSP via links to the budget and assessments of the poverty focus of expenditure.

One area where stakeholder involvement has been limited is on macro policy issues—involving mainly the four layers of stakeholders: the Government (largely the Ministry of Finance and Economic Affairs and the Planning Commission, Bilateral Donors, the World Bank and the IMF). While this is partly due to the weak technical capacity among civil society groups, it also reflects limited success by the IMF in framing key macro policy issues in a manner digestible to a wider audience and in ensuring that all major macro issues were included in that debate. The evaluation by Fund's IEO and Bank's OED signaled that IMF staffs were not clear as to what their role should be if some key policy issues were not emerging and were reluctant to intervene too actively in what was meant to be a government-led domestic debate.

Also, the evaluation found that the ownership of the PRSP was strongest at the level of top leadership and the Ministry of Finance, followed by priority sector ministries, but was lower in non-priority central ministries. Among civil society and local government, ownership has been mixed, being a function of their involvement in the process, with Dar es Salaam-based groups more favorable to the process than those outside. Parliament has been largely outside the process, and its ownership is low.

The second generation of PRSP in Tanzania has witnessed a significant improvement with regard to stakeholders' participation. There was substantial improvement in participation during the formulation of the National Strategy for Growth and Reduction of Poverty – NSGRP (MKUKUTA). Formulation of MKUKUTA was a broadly consultative process, involving a wide range of stakeholders at all stages, including the Government, Civil Society Organizations, and the Development Partners. Many different methods were used to create

awareness, stimulate discussion and gather feedback, resources were made available from a wide range of sources, and enough time was made available.

However, to-date, it is widely acknowledged that the policy process under the IMF's program in Tanzania has evolved significantly, but the critical challenges pointed out in the earlier evaluations still remain. Outstanding issues raised here are:

1. Limited number of stakeholders – still, very few participate in the preparation process.

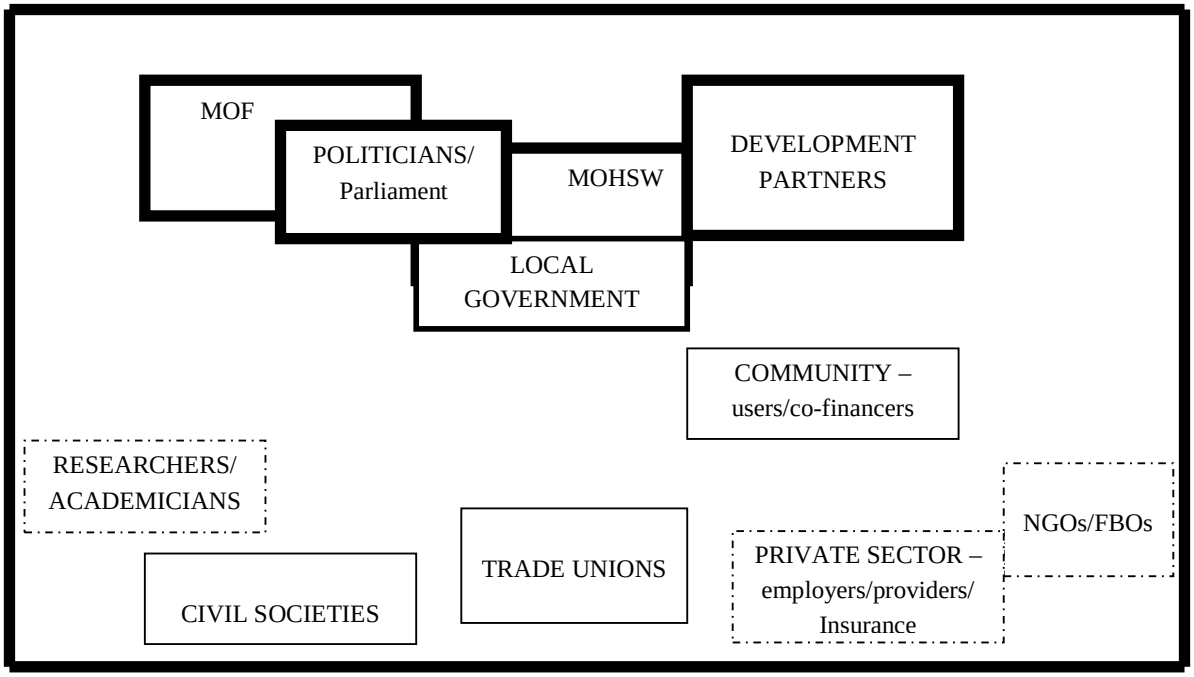
2. Quality of participation in the "process" by local CSOs is sometimes poor largely because of inadequate capacities. This is especially the case with the Public Expenditure Review (PER), which is most praised as the participatory element of the PRSP.

3. Limited information about "Macroeconomic Policies" among the large section of stakeholders in the policy process. In many cases, only four categories of stakeholders – the World Bank, IMF, Donors, and the Government (Ministry of Finance) are well informed about the macroeconomic policies, and they dictate the "pace of the game."

4. Some observers have aired their concerns about the expected degree and nature of participation in the formulation of "Monetary and Fiscal Policies." The question here is: to what extent should the formulation of fiscal and monetary policies be participatory? In most cases, since this stands out to be a technical issue, many people would be aware of the consequences of the policies, and the very basic issues involved, not the details.

Low involvement of stakeholders in policy processes is not only notable with IMF policies. A study by Mtei et al., (2007) revealed the same pattern whereby development partners and Ministry of Finance are key actors in formulation of health financing policies (Figure 8). Other stakeholders such as NGOs and CSOs are least in the list.

Figure 8: Stakeholders Influential Positions in Health Financing Policies



Source: Mtei et al., 2007.
Note: The top and bottom levels depict most and least influential respectively.

4.2 IMF Policies and Tanzania's Budget Process

Having summarized the IMF's engagement in Tanzania – Structural Adjustment Programme (SAP), Enhanced Structural Adjustment Facility (ESAF), Poverty Reduction and Growth Facility (PRGF), and Policy Support Instrument (PSI); it is now important to highlight the mechanisms through which these policies have limited Tanzania's fiscal space. In particular, it is important to point out the key avenues through which the IMF's strict macroeconomic stabilization rules (current account and fiscal balance consistent with low and declining debt levels, low inflation levels, and market-based interest rates) find their way to the budget process. This section gives a brief outline of the budget process in Tanzania, highlighting the key players at each stage of the process and their roles.

4.2.1 Overview of the Budget Process in Tanzania[6]

Government budgeting is a process of determining resources and their use for the attainment of government objectives. The process starts with the identification of goals and objectives which the government wants to attain in the coming fiscal year, guided by the medium and long term development plans. The current main development objective of the government of

[6] This chapter draws heavily from Kessy et al., (2008).

Tanzania is to implement the second generation of Poverty Reduction Strategy (PRS) renamed the National Strategy for Growth and Reduction of Poverty (NSGRP), popularly known in Swahili acronym as "MKUKUTA"[7] in the perspective of the Millennium Development Goals.

The process of budget priority determination starts by determination of resource availability and utilization, which is presented in the budget guidelines. On the basis of that, the Government prepares the budget by estimating revenue and expenditure needs and allocating the available resources to different sectors. Each year the Planning Commission[8] of Tanzania provides budget guidelines to all the Government Ministries, Departments and Agencies (MDAs), or regions on projected revenues and expenditure for the following fiscal year. Financial allocations (budget ceiling) to the MDAs are based on the expected or forecasted government revenue and government development priority. Currently, the government development priority is poverty reduction. Accordingly, MDAs have been categorized in accordance to their functional-role in achieving this goal.

Once the budget guidelines have been issued, each ministry, department, agency or region prepares its budget and plans in line with the allocated budget ceiling and in accordance to the respective MDAs' priority towards achieving the national development objectives, including on HIV/AIDS and TB. The budget and plans of all the MDAS are then scrutinized by the inter-ministerial technical committee composed of all permanent secretaries (accounting officers of ministries). Thereafter, these plans are forwarded to the inter-ministerial technical committee for further discussion and recommendation. The cabinet then receives and discusses the recommendations of the Inter-ministerial Technical Committee (IMTC) and finalizes the estimates which are then presented to Parliament. In Parliament, the Finance and Economic committee holds meetings with government officials, studies the estimates and makes a report to the whole Parliament which is debated.

Only after the budget has been approved by Parliament does execution of programs start. Budget execution generally covers the collection of revenue and disbursement of funds for expenditure. It also covers monitoring and control of government operations to ensure that the budget operations are on track. Another component of the budget process is the evaluation of budget performance to identify successes and failures with respect to the prescribed goals and objectives. This activity is done through the Medium Term Expenditure Frameworks (MTEFs) and the Public Expenditure Review (PERs). This is a vital stage in the process of setting up new budget goals, objectives, and policies. In this way, the budget

[7] *Mkakati wa Kukuza Uchumi na Kuondoa Umaskini Tanzania.*

[8] The Planning Commission was changed to President's Office Planning and Privatization (PoPP) and fully fledged Ministry (Ministry of Planning, Economy and Empowerment) in 2006. Further, in the same year, the Ministry of Regional Administration and Local Government was removed from the President's Office to Prime Minister's Office. In 2008, the Ministry of Planning, Economy and Empowerment was dissolved and Planning Commission was reinstated.

process never ends since the outcome of one budget process forms the beginning of the next one.

The budget process in Tanzania can be described as using both the top down and bottom up approach. The budget process is bottom up in the sense that, at the Ministry, Departments and Agencies (MDAs) level, Strategic Action Plans for each of the MDAs are prepared. The strategic action plans provide a framework for resource allocation to the various priority activities at the MDAs level aimed at achieving the MDA's targets with respect to the MKUKUTA. At the MDA's lower level, technicians prepare the first budget estimates for each priority activity, based on the budget guidelines provided by the Planning Commission. These estimates are then forwarded to the Head of Section for scrutiny, making adjustments if any, and forwarding upwards within the Institution. Finally, the estimates are sent to the Accounting Officer who makes final decision on the estimates for the whole institution or MDA.

The budget process can also be said to be "Top-Down" in the sense that the Budget Guidelines are issued to all MDAs by the Planning Commission. The Medium Term Plan and Budget Guideline provide a guiding framework for the preparation of the Medium Term Expenditures for the Ministries, Independent Departments, and Executive Agencies as well as Regions and Local Government Authorities. The MDAs plans address the Tanzania Development Vision 2025, MKUKUTA and Ruling Party (currently *Chama cha Mapinduzi* [CCM]) Election Manifesto priorities. The MDAs therefore have to align their resource allocation to their priority activities in accordance to provided budget ceiling in the Budget Guidelines. Tanzania's budget cycle is summarized in Table 7, which shows the key activities at each stage of the budget process and the institutions involved.

Table 7: The Budget Cycle and Institutions Involved

Budget Activity /Process	Dates	Responsible Institutions	Main Activity Output
Budget Guidelines Preparation and Distribution to the MDAs (projection of resources and development of the budget frame)	November to December	**(National Budget Committee):** Planning Commission, Ministry of Finance and Economic Affairs, and Prime Minister's Office, Regional Administration and Local Governments	Macroeconomic and Sectoral Performance Review, Budget Frame, Sectoral and Vote Expenditure ceilings
Estimating Revenue and Expenditures: Past and Current **budget** performance review Preparation of detailed plans and targets; Identify activities and costing of inputs; Prepare a three year performance based **budget** – Medium Term Expenditure Framework Submission of Draft **budget** estimates to Ministry of Finance and Economic Affairs for scrutiny	January to March	Ministries, Departments and Agencies; Development Partners	Revenue Estimates, Expenditure Priorities of the Ministries, independent Departments and Government Agencies
Finalization of Budget Preparation: Scrutiny of MDAs estimates by the: Ministry of Finance and Economic Affairs, Donor/Government Consultation and the PER Consultative Meeting	April to May	Ministry of Finance and Economic Affairs; Other Ministries, Independent Departments and Agencies; Development Partners.	
Submission of estimates to Cabinet Secretariat (IMTC) and then Cabinet	April to May	The Inter-ministerial Technical Committee, and the Cabinet Secretariat	Budget Frame and Expenditure Approval Cabinet Approve Budget Proposal
Budget Authorization by the Parliament	June to July	Parliamentary Committee and Ministries	Submission of the Budget Proposal to the Parliament by the Minster of Finance and Economic Affairs, Parliamentary debates/discussions on Ministerial estimates submitted by each Sector Ministry Parliamentary approval of estimates by passing the Appropriation Bill. Parliamentary approval and passing the Finance Bill that empowers the Minister for Finance and Economic Affairs to raise the money required to finance the **Budget**
Budget Execution	July to June	Ministry of Finance and Economic Affairs, Development Partners, the various Ministries, Departments and Agencies.	Release of funds by the Ministry of Finance and Economic Affairs and the Development Partners, Collection and Accounting for revenue collections by Tanzania Revenue Authority (TRA) and other MDAs. Delivery of Services and Project Implementation by the MDAs. Maintenance of proper accounts for control and accountability reporting on budget performance (both financial and physical and evaluation)

4.2.2 Budget Ceilings

4.2.2.1 Rationale for Budget Ceilings

The responses from the officials at the Ministry of Finance and Economic Affairs indicate that fiscal policy in Tanzania has focused mainly on fiscal stability, with specific conditions of this policy aimed at reducing fiscal deficits. The Ministry of Finance and Economic Affairs officials maintain that excessive fiscal deficits in the past (which led to frequent domestic financing) were major sources of inflationary pressures, and resulted in the 'crowding out of private investments' by diverting away credit from the private sector. The government insists that the ceilings are set based on the available resources. With domestic revenues averaging 18% of GDP and total resources estimates (domestic resources and grants) of around 27% of GDP, the total expenditure ceiling for 2007/2008 was 31.9% of GDP, and is projected to decline to 27% of GDP by 2009/2010. Accordingly, the wage bill is set to be contained around 5.9% of GDP until 2009/2010.[9]

4.2.2.2 Process for setting the Budget Ceilings

Budget ceilings in Tanzania are set in two stages. The first stage of the process is the determination of resource availability and utilization, by the Budget Guidelines Committee. The key players at this level include: "National Budget Committee" (comprised of the Ministry of Finance and Economic Affairs, President's Office – Planning Commission, Public Service Management, and Prime Minister's Office, Regional Administration and Local Government); Sectors, Public Expenditure Review Forum, and Donors. At this the budget guidelines are issued, which specify the budget ceilings based on the resource availability. At the second stage, each ministry, department, agency, region, or LGA prepares its budget and plans in line with the allocated budget ceiling and in accordance to the respective MDAs' priority towards achieving the national development objectives, including on HIV& AIDS and TB (the explanation of the entire process and players are given in section 4.2 above).

4.2.2.3 Budget Ceiling for the Health Sector

Budget ceilings for the Health Sector (and subsequently for HIV/AIDS and TB) are set like ceilings for other MDAs as detailed in section 4.2 above. According to the responses from the interviews, the stakeholders involved in setting the budget ceilings for the health sector (including HIV/AIDS) are: The Ministry of Health and Social Welfare, Tanzania Commission against AIDS (TACAIDS), The Ministry of Finance and Economic Affairs and Development Partners. The Ministry of Health sets priorities, and carries out costing for the health sector, while TACAIDS does the same for HIV/AIDS interventions. The Ministry of finance and Economic Affairs together with Donors play an important role in the analysis of resource envelope and allocation.

[9] Note that , the 5.9% figure is for "salaries" alone, when all allowances (both remunerative and duty related) are taken into account, wage bill is much higher, reaching about 9% of GDP.

4.2.3 Role of IMF and other Development Partners

While in principle the budget process is owned by the Government of Tanzania, the IMF's influence from the preparation stage is evident, particularly with respect to the observance of strict macroeconomic stability conditions. These strict rules then find their way to the budget guidelines, where the involvement of IMF and other donors is not as direct. In practice, the influence of IMF policies in Tanzania's budget process begins at a very early stage of the formulation of Budget Policy and Resource Projections. This is usually done based on the macroeconomic review, to inform the preparation of the budget guidelines. At this stage, the following important parameters are considered:

- Assessment of performance of previous budget assumptions and targets
- Economic growth
- Inflation
- Government finance
- Sectoral performance especially those under MKUKUTA.

As mentioned earlier, budget guidelines are prepared by the Planning Commission in collaboration with Ministry of Finance and Economic Affairs with close involvement of the ministry responsible for regional administration and local government (currently, the Prime Minister's Officer, Regional Administration and Local Government – PMO-RALG). These guidelines provide a review of the performance during the just ended financial year and serve to inform Ministries, Independent Departments, Executive Agencies, Regions and Local Government Authorities about the priorities of the Government as spelt out in the sector policies. The guidelines also include information to councils about levels of funding by way of grants for the ensuing year, providing a brief recap of sector policies, and pointing to the areas which should be accorded priority in the allocation of resources in the coming year. For the time being, the priority areas in resource allocation include the pro-poor sectors of education, health, water, roads, agriculture and lands.

Therefore, the IMF policies affect the allocation to HIV & AIDS and TB indirectly through the deficit-reduction and inflation-reduction targets and their impacts on the size of overall national budget. For instance, with GDP growth target of 7.2% in 2007, overly ambitious inflation target of 4%; foreign exchange reserves target of about 7 months of imports, and very limited domestic financing – (less than 0.2% of GDP), the budget ceiling for 2005/06 put the total government expenditure at only about 28.9% of GDP, and the expenditures were projected to decline further to 27.5% of GDP and 25.9% of GDP for 2006/07 and 2007/08 respectively. Since the government is given limited or no room for domestic financing under the IMF rules, it cannot engage in expansive fiscal policy to finance the much needed HIV/AIDS and TB projects, particularly those relating to the upgrading of the health system in terms of infrastructure and human resources.

4.2.4 The budget and MDGs

Tanzania is currently implementing the second generation of Poverty Reduction Strategy, which is home grown, known as National Strategy for Growth and Reduction of Poverty – NSGRP (popularly abreviated as MKUKUTA in Kiswahili). MKUKUTA is an MDG+ strategy, with targets well ambitious beyond the MDG targets themselves. MKUKUTA focuses on outcome based interventions, and has three clusters namely: growth and reduction of income poverty; quality of life and social well being; and governance and accountability Implementation of the NSGRP or MKUKUTA started in the financial year 2005/06, and since then, the strategy has been claiming a significant portion of budget resources – in many cases more than 60% of budget resources. It is important to note at this juncture that, because of the difficulties involved in classifying transfers to the Local Government Authorities, it is difficult to estimate the proportion of budget channeled to MKUKUTA implementation.

4.3 Government budget Allocations for Health and HIV & AIDS (2004/05-2006/07)

4.3.1 General Trends in Government Health Budget Allocations, (2004/05-2006/07)

Health sector spending in Tanzania remains low compared to other countries in Sub Saharan Africa. It is estimated that Tanzania is spending a meager US $ 10 per capita for health, while other countries in sub Saharan Africa are said to be spending about US$ 12 per capita or above. However, there have been some improvements over the past decade, especially following the PRSP-1 prioritization which put health sector as one of the sectors where spending was not allowed to fall. And, while per capita health spending still remains low, the sector has shown modest growth in recent years. Health services grew at 8.8% in 2007, compared to 8.5% in 2006. The growth specifically emanated from the implementation of vaccination, malaria, tuberculosis and HIV/AIDS programs. In fiscal year 2008/09, the Government is committed to implement various plans and strategies of public and primary health programs, including the Integrated Management of Childhood Illnesses Program (IMCI) and strengthening medical research. The Government also is committed to implement the medium term strategy in acquiring medical equipment so as to treat all diseases in the country which will reduce number of patients treated abroad.

The following sub-sections attempt to present the performance of the health sector budget and expenditure over a four year period, and according to three different measures:

- The sectoral share of total government budget/expenditure;
- Absolute levels of spending, both nominal and real;
- Nominal and real spending in per capita US dollar terms.

4.3.1.1 Health as a Share of Overall Government Spending

Table 8 shows the trend in health spending as a share of total government budget/expenditure, both including and excluding Consolidated Fund Services (CFS), i.e. largely public debt.

Table 8: Health Sector Spending as a Share of GoT Budget/Expenditure, FY1999/00 – FY2007/08

Financial Year	Actual Expenditure as share % of GoT Spending including CFS	Actual Expenditure as share % of GoT Spending excluding CFS
1999/00	6.8	8.8
2000/01	8.0	10.6
2001/02	8.7	11.0
2002/03	8.9	10.4
2003/04	8.5	9.7
2004/05	9.7	10.9
2005/06	9.6	10.9
2006/07	10.8	11.4
2007/08	9.8	10.8

Source: URT (2005d); URT (2008c).

Table 8 shows an increasing trend of the share of health spending as percent of the total government expenditure. However, the FY08 budget for the sector has fallen as a share of the total government budget from its nine year high in FY2006/07. This fall is sharper as a share of the total including CFS, dropping a full percentage point. The fact that it falls at all is of concern given the well-publicized constraints in the sector. However, this is likely to be due to the stated priority in the FY2007/08 budget to productive rather than social sectors. The actual effective share for FY2006/07 is not known due to the absence of figures for total GOT expenditures for that period.

4.3.1.2 Absolute Levels of Health Spending, Nominal and Real

Table 9 shows the absolute actual levels of health sector spending in nominal terms since FY2001/2. While clearly showing an increase in the nominal value of the budget each year, it also shows the shortfall of expenditure against budget. In contrast to FY2005/06 when the increase in the nominal allocation to the sector was driven by a large increase in the recurrent budget, largely the Personal Emoluments (PE) component, in FY2007/08 the increase was almost completely due to a 77% increase in the Development budget (URT, 2005). Table 10 shows the trends in absolute spending, both in nominal and real terms, the latter in FY2004/05 prices. Both nominal and real spending have been on a steady upward trend over the four year period. Also, in real terms, the FY2007/08 budget represents a 28% increase over actual spending in the previous year, and a 78% increase over the period.

Table 9: Nominal on-budget Health Spending, Recurrent and Development, FY2001/02 – FY2006/07 (Million US$)[10]

Financial Year	Recurrent (Actual)	Recurrent (budget)	Development (Actual)	Development (Budget)
2001/02	125.3	132.8	25.7	38.5
2002/03	130.0	140.0	30.0	37.3
2003/04	160.5	159.6	43.6	44.5
2004/05	213.9	214.8	53.7	70.4
2005/06	240.2	274.1	103.6	105.4
2006/07	325.4	351.9	90.8	107.6
2007/08		377.3		188.6

Source: United Republic Tanzania (2005d); URT (2008c).

Table 10: Nominal and Real on-budget Health Spending, FY2001/02 – FY2006/07

Financial Year	Total (Nominal) (Million US$)	Total (Real) (Million US$)	Per capital spending (US$)
2001/02	150.96	144.54	4.1
2002/03	160.00	155.45	4.9
2003/04	204.08	178.11	5.4
2004/05	267.59	267.59	7.3
2005/06	343.75	325.00	9.1
2006/07	416.23	349.21	10.7
2007/08	653.28	449.78	14.1

Note: Real figure from 2004/05 are calculated based on the FY 2004/05 prices).
Source: United Republic Tanzania (2005d); URT (2008c).

4.3.1.3 Per capita Health Spending

Table 11 presents nominal value of health spending in per capita US dollars. The Table gives both the annual estimates, and the data used to produce them[11]. Again, the trend in per capita US dollar terms has been steadily upwards since fiscal FY05 to FY 08, virtually doubling from $7.32 to US$14.08.

[10] Exchange rates used in conversion are: TShs 934 in 2001/02; TShs 1,100 in 2002/03; TShs 1,078 in 2003/04; TShs 1080 in 2004/05; TShs 1,120 in 2005/06; TShs 1,134 in 2006/07; TShs 1,145 in 2007/08.

[11] The difference in the figure for FY05 actual and that given in the PER FY06 update is due to both a change in the exchange rate used, and a different measurement of the National Health Insurance Fund (NHIF) contribution.

Table 11: Trend of Per capita health Spending, FY2004/05 – FY2007/08

	FY05 Actual	FY06 Actual	FY07 Actual	FY08 Budget
In per capita US$	7.32	9.11	10.71	14.08
Nominal Spending	288,989,428,769	384,636,244,512	472,149,951,325	648,169,039,500
Population projections	36,576,738	37,704,872	38,867,802	40,066,599
Exchange rate	1,080	1,120	1,134	1,149

Source: URT (2008c).

4.3.2 Trends in the Health Allocations for HIV & AIDS

This section provides data and information on the public allocations for HIV & AIDS. Two major sources of information have been used: The draft National Health Accounts (NHA) report (URT, 2008d) and the 2007 HIV & AIDS PER update (URT, 2008e).

Table 12 shows spending on HIV & AIDS based on the resources from the government and Development partners for the period 2005/06 – 2007/08. As the table reveals, total Government plus donor spending on HIV & AIDS increased by 76% in 2006/7, a real increase of 66% after adjusting for inflation. The most remarkable feature is the continued rapid growth in donor HIV & AIDS spending, now expected to reach US$ 496 Million in 2007/8 but this increase has been from off-budget sources of finance, and only 23% of expected aid in 2007/8 is included in the budget. As a result of the sustained increases in aid, total Government plus donor spending on HIV & AIDS in 2007-08 is expected to equal over 10% of public expenditure, over 3% of GDP, and a staggering one third of all aid to Tanzania.[12]

[12] Aggregate public expenditure, GDP and aid data are from IMF (July 2007). These percentages include off-budget donor aid.

Table 12: HIV/AIDS Expenditure and Financing, 2005/06 - 2007/08 (Million US$)

	Actual 2005/06	Budget 2006/07	Actual 2006/07	Budget 2007/08
1.Ministires, Departments and Agencies (MDAs) Recurrent	19.5	21.2	18.9	18.9
2.MDA Development	86.5	32.5	25.8	93.4
-Of which, GOT funded		0.3		5.2
3.Transfers to regions and Districts	1.1	9.6	10.0	25.0
4.Total Budget expenditure on HIV & AIDS (=1+2+3)	107.1	63.2	54.7	137.3
5.Of which, ODA financed (captured in the government exchequer system)	87.6	41.8	35.8	113.3
6. Off-budget ODA for HIV & AIDS	94.7	249.7	297.4	383.0
7.Total ODA for HIV/AIDS(=5+6)	182.3	291.5	333.2	496.2
8.Estimated Total Public & Donor Expenditure on HIV/AIDS (=4+6)	201.8	313.0	352.0	520.3
Total HIV spending as a % of:				
Total Govt Spending	5.8	7.4	8.3	10.9
GDP	1.6	2.2	2.5	3.3
HIV and AIDS as % of total aid	15.1	21.8	24.9	32.9
ODA as % of HIV and AIDS expenditure	90.4	93.2	94.6	95.4
% of HIV & AIDS aid included in Govt budget	48	14.3	10.8	22.8

Source: URT (2008e).

Table 13 shows total HIV/AIDS expenditure and financing from financial year 2001/02 to 2004/05. The table shows the total amount of resources recorded by Accountant General, which went up to more than US$ 50 billion in 2004/05 budget. The data also captures aid to NGOs, which went up from US$ 4.9 bn in 2001/02 to the estimates of about US$ 24.2 bn in 2003/04.

Table 13: HIV/AIDS Expenditure and Financing, 2001/02 to 2004/05 (bn US$)

	2001/2	2002/3	2003/4	2004/5
	Actual	Actual	Estimate	Budget
Government Recurrent	2.5	6.4	13.5	13.5
Government Development	0.0	0.0	0.0	0.0
Aid via Government systems	N/A	4.1	8.0	37.4
Total recorded by Accountant General	0.0	10.5	21.4	50.9
Other aid to Government	N/A	14.7	17.2	12.2
Total Aid to public sector	10.7	18.7	25.1	49.6
Total public sector expenditure	13.1	25.1	38.6	63.1
Aid to NGOs	4.9	17.6	24.2	11.6
Total expenditure	18.0	42.7	62.8	74.7
Aid total	15.5	36.3	49.4	61.2
Government Total	2.5	6.4	13.5	13.5

Source: URT, (2005e).

Recurrent expenditure on HIV & AIDS is falling in real terms (some of this may reflect recurrent costs being shifted onto donor programs). However, some of the reduction is a real one, including the proposed reduction in the recurrent budget for Tanzania Commission for AIDS (TACAIDS) over the coming Medium Term Expenditure Framework (MTEF). This merits reconsideration, given the need to expand the TACAIDS role in a number of areas. These include identifying priorities and persuading donors to fund them, further strengthening of monitoring and evaluation, and identifying, producing, and disseminating best practice guidance on Behaviour Change Communication (BCC) and economic and social support. It is worth noting that the reduction in budgeted development spending in 2006/7 was not the result of any actual decline in Government spending. It is entirely due to MoHSW not including any of the HIV/AIDS funding they receive from donors in their budget in that year, although several major donor programs were included in 2005/6 and in 2007/8.

Table 14 shows total Government expenditure on HIV & AIDS by vote. Expenditure continues to be dominated by MoHSW and TACAIDS. Community development was the only other MDA spending more than TShs 1bn on HIV & AIDS in 2006/7. The 2007/8 budget features significantly increased budget spending by the uniformed services, the Ministry of Education and Vocation Training (MoEVT), and labor and youth development.

Table 14: Government Expenditure on HIV & AIDS (Million US$)

	Actual	Actual	Budget	2006/07	%Shares
	2005/06	2006/07	2007/08	% Spent	2007/08
Public Safety & Security	0.2	0.4	3.4	87	3.01
Home Affairs - Prisons Services	1.3	0.4	1.9	19	1.65
Defence	0.0	0.0	0.3		0.31
The National Service	0.0	0.0	0.7		0.65
Education and Vocational Training	1.9	0.0	1.8	3	1.58
Ministry of Health & Social Welfare	69.1	11.1	49.0	99	43.32
Community Development etc	0.0	2.5	0.5	96	0.45
PMORALG	2.4	5.5	1.1	95	0.98
Labour and Youth Development	4.9	0.1	0.9	15	0.78
TACAIDS	24.8	24.7	46.5	97	41.12
Other	0.0	0.0	0.0		
TOTAL MDAs	105.9	51.3	113.1	87	100
Regions	0.0	3.4	10.3		
LGAs	1.1	-	13.9		
Transfers TACAIDS to LGAs	0.0	0.0	0.0		
Grand Total	107.0	54.7	137.3		

Source: URT (2008e).

4.3.3 Trends in the Public Health Allocations for TB

This section presents expenditures on TB as reported in the draft NHA report (URT, 2008d). Generally all indicators in Table 15 show that TB expenditures have decreased significantly in all dimensions and directions. Analyzing absolute decrease, TB expenditure decreased by 37% from FY 2002/03 to 2005/06. This is actually contradicting with the general trend of the Total Health Expenditure (THE) which had an increase of 129% within the same period. Observing TB expenditure ratio per total health expenditure, the ratio has decreased from 2% to 0.55%. Similarly, per capita TB expenditure also decreased from TShs 64 for FY 2002/03 to TShs 185 for FY 2005/06.

Table 15: Summary of General Indicators of TB Expenditure and Financing

Indicator Description	2002/03	2005/06	% Change
TB Total Expenditure (In US$)	9,095,322	5,598,109	-37
TB expenditure as % of total health spending	2	0.55	-73
Per capita TB expenditure (US$)	0.28	0.14	-50

Source: URT (2008d).

The decrease in spending on TB is a concern given the correlation between HIV & TB health conditions (Table 16). However, as noted in earlier section, HIV prevalence rate has been declining to the current level of 7%. Further, the notification of TB cases has also been increasing at a

slackening rate. Another explanation could be on the un-captured funds due to different format for TB interventions supported by donors. It is worth noting however that the TB budget allocation for 2006/07 was about US$ 10.6 million and this money is mainly from the Global Fund to Fight AIDS, TB, and Malaria. The major constraint is absorption of that money. For instance, while the TB Programme has been allowed to hire 100 personnel using the GFATM money, it has not been able to hire even 50% of this total and the hired ones, particularly in the rural areas, do not last.. The major problem is unavailability of requisite capabilities in the labor market that calls for resurgence of the zonal health institutions.

Table 16: TB/HIV Notification in Tanzania for the Year 2006

Indicators	Cases notified
Number of all registered TB patients	3,239
Number tested for HIV	1,613 (49.8%)
Number tested HIV positive	841(52.1%)
Number registered for HIV care	568 (67.6%)
Number started ARVs	188 (22.3%)
Number started Contrimoxazole Preventive Therapy (CPT)	418 (49.7%)

Source: URT (2008a).

In FY 2002/03, the sources of financing for TB expenditures were government, private funds and donors (Table 17). It is worth noting that although supposedly TB services are not paid for, there was a substantial private expenditure in 2002/03. However, these private funds are not from households rather from other private sources. In the FY 2005/06 donors substantially contributed around 57% and money from GFATM was only 3% (Table 17). The government provided 40% of the total expenditure. The noted significant decrease of TB expenditures over the years was substantial—about 37%. The Government funding increased marginally just by 4.7%.

Table 17: Distribution of National TB Expenditure by Financing Source, FY 2002/03 and FY 2005/06 (US $)

	2005/06		2002/03	
Source of Fund	**Total (US$)**	**%**	**Total (US$)**	**%**
Government Funds	2,227,419	40.00%	2,273,831	25%
Global Fund	168,071	3%	-	-
Private Funds	-	-	4,183,848	46%
All other donor funds	3,202,618	57%	2,637,643	29%
National Total TB Expenditure by Source	**5,598,109**	**100.00%**	**9,095,322**	**100.00%**

Source: URT (2008d).

4.3.4 Comparison of allocations to Estimated Resources required for HIV & AIDS and TB

HIV & AIDS and TB interventions have been receiving much more than what the projections are shown. Table 18 shows the summary of MKUKUTA costing with projections for HIV & AIDS estimated at US$ 51 million in 2006/07. This is only 1/8 of the actual HIV & AIDS expenditure in 2006/07.

Table 18: Summary of Costs for Health Sector Interventions (in US$)

Year	HIV & AIDS	TB	Total (HIV/AIDS and TB)	Health Sector (Total)
2006/07	50,896,030	996,000	51,892,030	445,325,403
2007/08	51,045,150	1,095,600	52,140,750	476,427,895
2008/09	51,198,084	1,205,160	52,403,244	529,308,299
2009/10	51,354,930	1,325,676	52,680,606	588,099,211
2010/11	51,515,789	1,458,244	52,974,033	511,001,808
2011/12	51,691,093	1,604,068	53,295,161	751,709,246
2012/13	51,871,135	1,764,475	53,635,610	834,955,930
2013/14	52,056,046	1,940,922	53,996,968	928,581,207
2014/15	52,245,957	2,135,014	54,380,971	1,034,372,516
TOTAL	463,874,214	13,525,159	477,399,373	6,099,781,517

Source: URT (2006a)

4.4 Trends in Human Resource Allocations and Positions for HIV/AIDS and TB

Disaggregated data on the total number of health personnel for HIV and AIDS and TB are not available. However, the extent of deficiency can be gauged from the data on general Human Resource for Health (HRH) data and from the data on availability of health facilities offering HIV and AIDS and TB related services.

4.4.1 Human Resource Profile and Distribution

The Health Sector in Tanzania is facing a serious Human Resource crisis that is negatively affecting the ability of the sector to deliver quality health services. There is a severe shortage of human resource at all levels, especially in rural districts. Disparities in the distribution of human resource exist at various regions including urban to rural and facilities level. The shortage is exacerbated by the expanded population, HIV & AIDS epidemic, malaria, tuberculosis and others. Table 19 and Table 20 indicate the human resource status by levels in 2006 (both public and private health facilities).

Table 19: Human Resource Status by Facility Levels in Public Health Facilities 2006

Facility Level	No.	Health Professionals			Shortage %
		Required	Available	Shortage	
Referrals/Specialized Hospitals	8	8,546	4,477	4,069	48
Regional Hospital	19	7,266	2,481	4,785	66
District Hospitals including Designated District Hospitals (DDH)	95	22,458	7,364	15,094	67
Health Centers	331	11,916	4,908	7,008	59
Dispensaries	3,038	30,380	9,384	20,996	69
Training Institutions	72	1,711	449	1,262	74
TOTAL	**3,565**	**82,277**	**29,063**	**53,214**	**65**

Source: URT (2008b).

Table 20: Human Resource Status in Private Health Facilities, 2006

Facility Level	No.	Health Professionals			Shortage %
		Required	Available	Shortage	
Hospitals	132	26,004	3,251	22,753	87.5%
Health Centers	150	5,400	758	4,642	86.0%
Dispensaries	1,641	11,487	1,842	9,645	84.0%
Training Institutions	36	756	288	468	61.9%
TOTAL	1,959	43,647	6,139	37,508	85.9%

Source: URT (2008b).

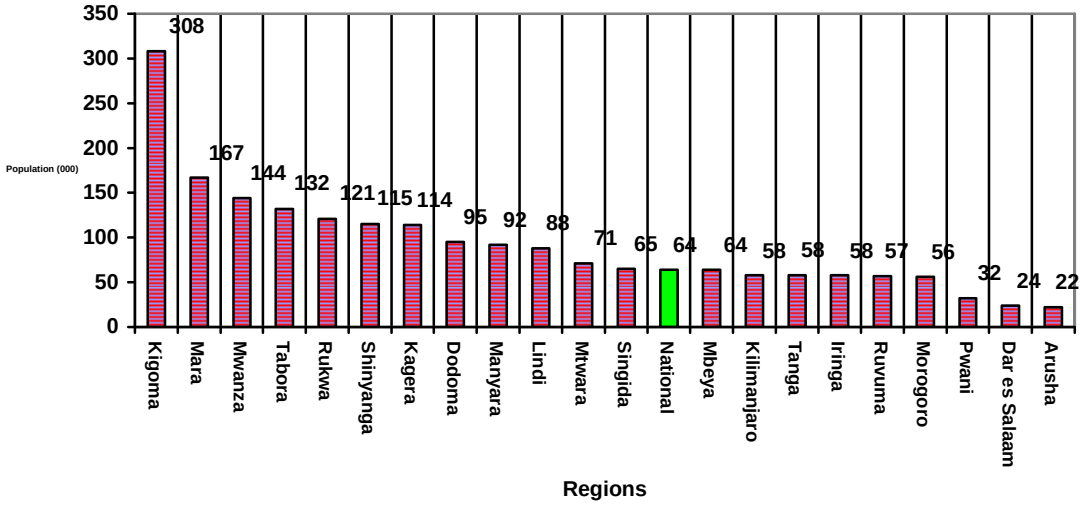
According to proposed staffing level (2005), the existing health facilities require 125,924 health workers while the actual professional staffs available are 35,202 (24%) indicating a deficit of 90,722 (76%) for both public and private health and social welfare services. There is a need to review and improve current staffing norms to match the increase in the burden of diseases, workload, and expanding populations. In addition, the workforce continued to experience the loss of skilled health workers through attrition. While the government is undertaking efforts to hire staff to replace the lost workforce, the net effect

of this move is marginal compared to existing shortage caused by freezing of employment between 1993 up to 2005 across the regions in the country due to low absorption rate. Within ten years between 1995 up to 2005, out of 23,474 graduates produced, the Government hired only 3,836 (16%).

Information per population per selected health professions cadre and per region in 2006 is provided in URT (2008b).[13] Here we present data on population per medical officer and specialized medical doctors as an example of the extent of deficiency. Source: URT, (2008b).

shows the population per one medical doctor in each region. The number of people served by one medical doctor was found to be very high in three regions namely Kigoma (308,000), Mara (167,000) and Tabora (132,000). The regions reported to have lowest populations per medical doctor were Arusha (22,000), Dar es Salaam (24,000) and Pwani (32,000). The national average was 64,000 persons per doctor, while the WHO recommendation is for one doctor to serve a population of 10,000.

Figure 9: Population per Medical Officer and Specialized Medical Doctor 2006

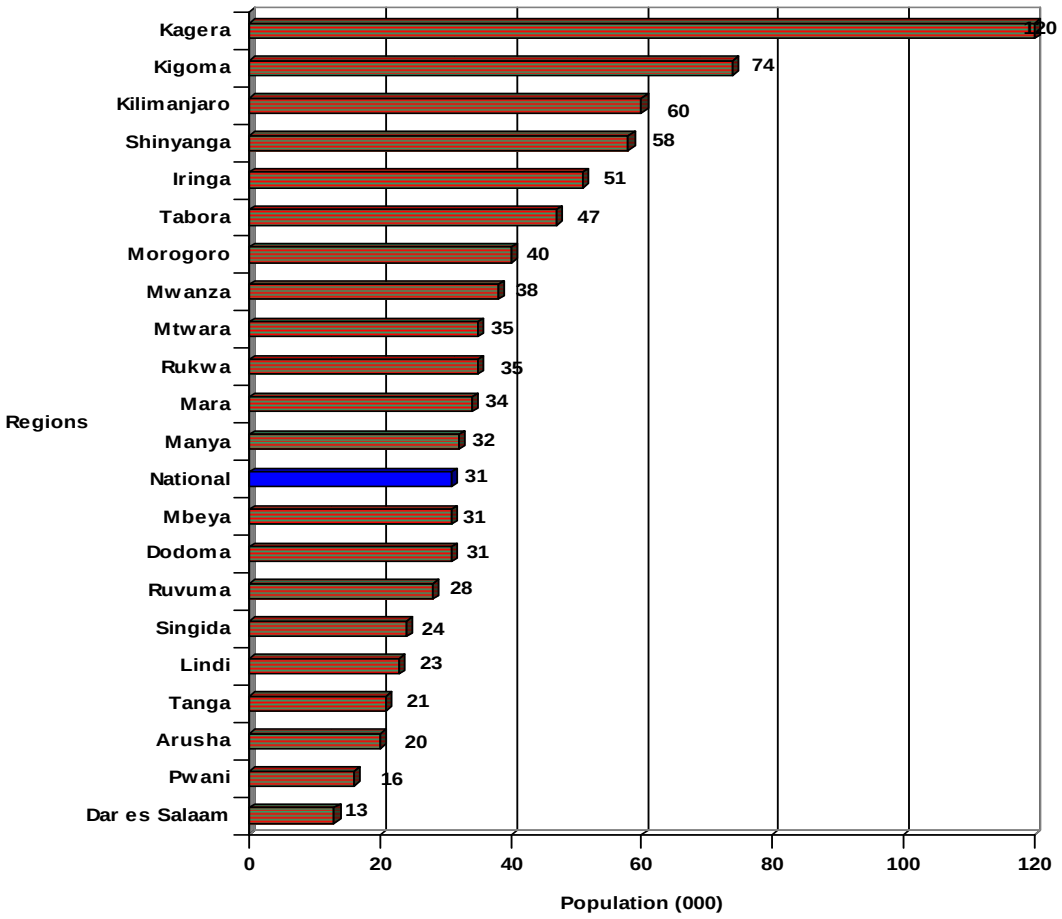


Source: URT, (2008b).

[13] Note that information is available on population per medical officer and specialized medical doctors, assistant medical officer, clinical officers, trained nurse, nursing officer and nurse midwife, and dental officer and assistant dental officer (URT, 2008b).

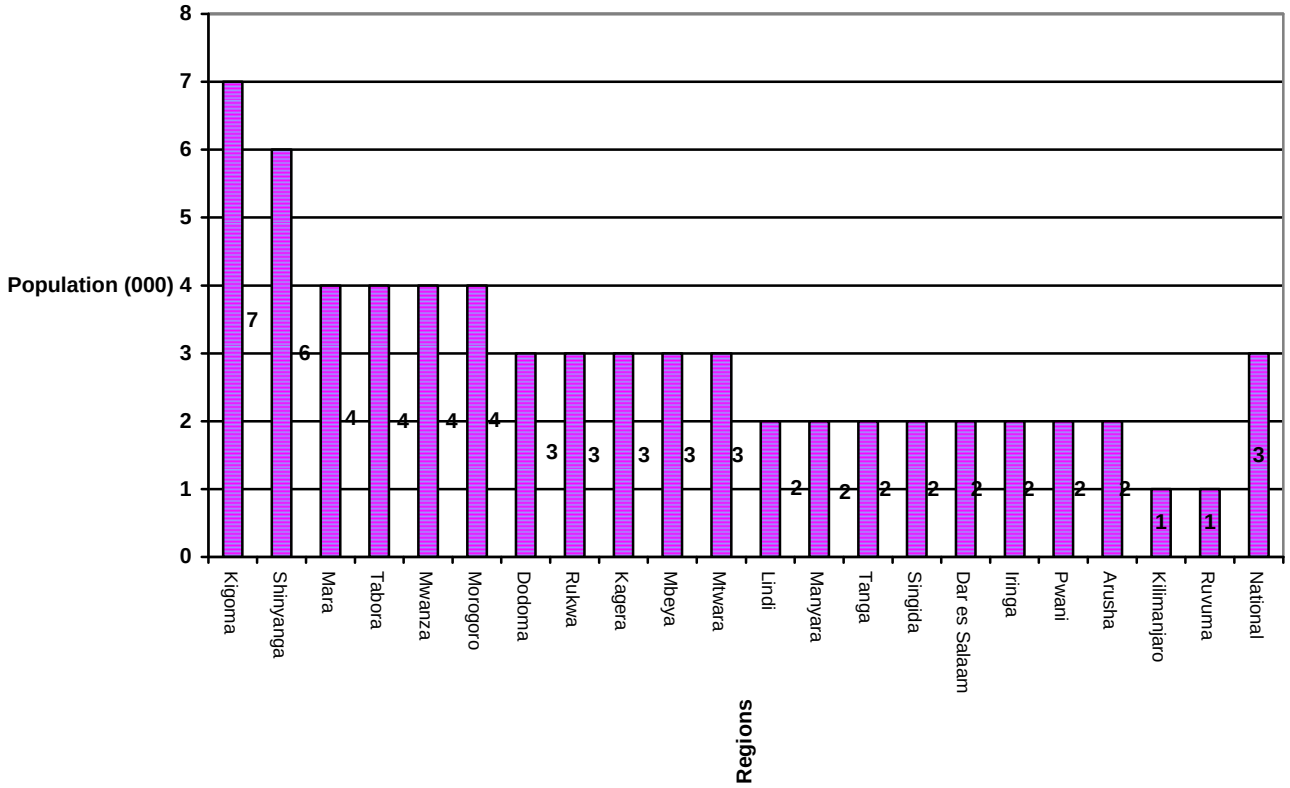
Error! Reference source not found. shows population (in thousands) per Assistant Medical Officer, while **Error! Reference source not found.** shows population (in thousands) per trained nurse, nursing officer and nurse midwife for year 2006.

Figure 10: Population (in thousands) per Assistant Medical Officer: 2006



Source: URT, (2008b).

Figure 11: Population per Trained Nurse, Nursing Officer and Nurse Midwife 2006



Source: URT, (2008b).

The health human resource, particularly in the rural areas, is significantly under-motivated to function effectively due to several reasons: the limited ability of the health sector to meet the basic personal needs such as favorable salary, extra work pay, health insurance, workplace hazard allowance and opportunities for self development. Other hardships include lack of basic requirement such as passable roads, communication network, electricity, recreation, water, and schools for children. There is need therefore to explore available opportunities such as complementary financing options and involvement of stakeholders as partners to improve human resource situation.

The weak health services situation is also a result of human resource crisis facing the country. The Retrenchment Policy coupled by an employment freeze implemented from 1993 until 1999 led to a sharp decline in the health workforce even as the disease burden increased, and consequently, present human resource crisis in the health sector. The second setback was the decision made which had a negative impact, for example in the 1990s civil service reform undertaken resulted in position of budget ceiling and

downsizing of the workforce. Thirdly, the sector faced the problem of weak planning and forecasting of human resource requirements. There were also problems of inadequate involvement of the private sector in human resource planning. Another major contributor to the crisis is the brain drain. However, the magnitude of the problem is not well understood and there is therefore an urgent need to put in place a mechanism to monitor health professionals' movement within and outside the country.

4.4.2 Availability of HIV and AIDS and TB Services

The National Bureau of Statistics in collaboration with the Ministry of Health and Social Welfare conducted the Tanzania Service Provision Assessment Survey (TSPA) in 2006 and some findings on the availability of HIV and AIDS and TB services have been presented (URT, 2006b).

4.4.2.1 Availability of HIV and AIDS Services

The availability of HIV & AIDS services varies widely throughout Tanzania without following any clear pattern. Almost 85% of health care facilities in Tanzania provide some Care and Support Services (CSS) for HIV. Far fewer facilities, however, provide HIV testing and prevention services. Only one fourth (26%) of all health facilities in Tanzania have an HIV testing system. Basic CSS are widely available in 84% of all facilities in Tanzania. Other HIV-related services, however, are offered by very few facilities nationwide. Less than 5% of facilities offer post-exposure prophylaxis or antiretroviral therapy. Only 13% of facilities provide any services to prevent Mother-to-Child Transmission (PMTCT) of HIV. Overall, HIV and AIDS services are more likely to be available in hospitals than in other facility type. Table 21 presents an overview of HIV-related health care services in Tanzania.

Table 21: Overview of HIV Related Health Care Services in Tanzania, % of Facilities Offering Services (N = 611)

	Counseling and Testing (CT)	**Care and Support Services (CSS)**	**Anti-Retroviral Therapy (ART)**	**Preventing mother-to-child- Trans-mission (PMTCT)**	**Post Exposure Prophylaxis (PEP)**	**Youth-Friendly CT Services (YFC)**
Northern	41	80	5	21	10	14
Central	7	93	2	5	1	1
S. Highlands	24	100	2	5	3	5
Western	30	90	3	16	2	2
Lake	18	85	3	6	2	2
Southern	14	70	7	8	1	0
Eastern	33	82	6	24	6	5
Zanzibar	28	42	1	1	4	5
TOTAL	**26**	**84**	**4**	**13**	**4**	**5**

Source: URT, 2006b.

Antiretroviral drugs can significantly prolong and improve the quality of life for people living with HIV. Not all HIV & AIDS clients, however, are eligible for these medicines. According to national guidelines, Antiretroviral Therapy (ART) should be prescribed only to a person with clinical AIDS and/or a CD4+ cell count below 200. The government of Tanzania started providing free ART services in October 2004. Quality ART services includes the following:

- Trained staff
- Protocols and guidelines for care and support services
- Consistent supply of antiretroviral (ARV) medicines
- Good storage practices for ARVs
- A system for client appointments and follow-up services
- Individual client records for continuity of care, and
- Record-keeping systems to ensure ARV compliance.

Nationwide, only 4% of all health facilities prescribe ART. In Southern Highlands, where HIV infection is most prevalent, only 2% of facilities offer ART. ART services are mostly available at hospitals. About 70% of hospitals prescribed ART compared to only 9% of health centers.

The quality of ART services varies among health care facilities offering ART. Only 76% of facilities offering ART had the first-line regiment available on the day of the survey. ARV stock-outs are common. A third of hospitals and three-quarters of health centers that prescribe ART had stock-outs of ARVs within six months of the survey. Irregular use of ARV can compromise patient treatment and also lead to the development of drugs-resistant strains of HIV. National guidelines for managing ART are available in 91% of hospitals and more than half of the health centers offering ART.

4.4.2.2 Availability of Tuberculosis Services

Tuberculosis (TB) is a leading cause of death among people infected with HIV. Overall, 64% of facilities offering any CSS provide TB diagnosis or treatment and/or follow up services or both. The World Health Organization (WHO) recommends Directly Observed Treatment Short-course (DOTS) to treat TB. Among facilities offering any CSS, only 39% report that they are part of the National DOTS Program. However, 54% of facilities say they follow the DOTS strategy.

DOTS ensures that patients take their drugs regularly and complete their treatment. This process not only cures patients but also helps prevent drug resistance. However, a substantial percent of facilities do not have all of the elements needed for proper TB treatment. All first-line TB medicines (any combination of isoniazid, rifampicin, ethumbutol, and Pyrazinamide) are available in 60% of facilities offering CSS and following the DOTS treatment strategy. Of these facilities, only 52% have observed client registers for DOTS and only 55% have treatment protocols. The availability of TB treatment and/or follow-up using DOTS varies by zones, ranging from a low of 45% in Central to high of 68% in Southern Zone.

4.5 Evidence of the Impact of IMF Policies[14]

Perhaps, it could be argued immediately that there is no direct link between "spending in HIV/AIDS and TB" and IMF policy prescriptions. As HIV & AIDS is prioritized under "Social Sector Policies, Poverty Reduction and Environmental Protection," and it is well understood that under PRSP, spending in these sectors was "ring-fenced" – i.e. not allowed to fall, supporters would immediately argue that the policies had "positive

[14] For a more elaborate analysis see a presentation by Prof. Brook K. Baker in Mexico on "How (and why) the IMF Blocks the Response to HIV & AIDS."

impact" on HIV spending. However, it is understood that the macroeconomic policies related to "budget ceilings," inflation targets, and foreign exchange reserves can influence spending in HIV/AIDS and TB. Therefore, the ultimate challenge is to identify the indirect link which exists between some of the "policy prescriptions," for instance, foreign reserves, or cash budgeting, or public sector reforms, etc., with the country's ability to respond to HIV/ AIDS and TB crises.

4.5.1 Fiscal and Monetary Policies

It is argued that IMF fiscal programs have often been too conservative or risk-averse. Some observers have noted that the IMF has not done enough to explore more expansionary, but still feasible, options for higher public spending (Center for Global Development, 2006). As pointed out earlier, many of the resources channeled to HIV & AIDS programs are from Official Development Assistance (ODA) and resources in this area have been increased dramatically over the past few years. McKinley and Hailu (2006) noted that, between 2002 and 2004, ODA resources going to HIV & AIDS in Tanzania increased by 394%. And, if we assume that ODA inflows associated with HIV & AIDS are not significantly different from other ODA inflows, then, the standard argument that such huge increases could precipitate macroeconomic instability as a result of "Financial Dutch Disease" would be the basis of IMF's macroeconomic policy concern.[15] In this case, the thrust of IMF policies would be the macroeconomic effects of these ODA inflows and what would be the correct monetary policy to deal with them.

In order to understand the potential macroeconomic impact of ODA for HIV & AIDS, we need to know what it will finance. In the absence of a curative therapy, some authors have recommended increases in funding for prevention services and treatment and care services, rather than just increased spending for antiretroviral therapy, which is the best way to prevent the premature death of the millions of people being infected with HIV each year (Vernengo, 2007). The most important effect of prevention versus treatment spending is that the former implies spending on domestic services (non-tradables), while the later requires large imports of foreign medication (tradables). The monetary impact of both is significantly different. From the UNGASS Report (2008) data are available on HIV & AIDS expenditure (including health and non-health HIV & AIDS related

[15] Rajan and Subramanian (2005) suggest that aid inflows could lead to overvaluation of the domestic currencies, and reduce external competitiveness, a phenomenon usually referred to as the "Financial Dutch Disease". But, some authors have also suggested that the link between aid inflows and overvaluation is weak or non-existent (see Gupta, Powell, and Yang, 2006; and Mckinley and Hailu, 2006).

expenditures) by broader functions (URT, 2008b). Prevention programs have the highest expenditure followed by care and treatment component. About 41.8% of all expenditure in HIV & AIDS is channeled to prevention, while 32.2% is channeled to treatment and care. Program management and administration strengthening account for 24.5% of the HIV & AIDS expenditure. Since treatment involves substantial importing of antiretroviral medicines, this component should have little monetary impact. Imports of related medical supplies and equipment (also 'tradables') should have similar negligible impacts.

Given the massive increase in ODA for HIV & AIDS, the expectation is that a significant proportion of financing could go to public investment to expand the capacity of the health system (create more institutional capacity, more trained personnel and more health infrastructure). Otherwise, large quantities of imported medicines, such as anti-retrovirals, cannot be delivered to the people who need them. However, since under IMF policies, Tanzania has been strictly adhering to the cash budgeting, (with limited or zero domestic financing)[16], it has not been possible to carry out such broadly-targeted government programs to respond to the HIV & AIDS crisis. Though not very direct, this has been difficult because of IMF's policies that limit increasingly higher ODA financing of larger government deficits to expand domestic expenditures.[17] Recently, Tanzania has failed to utilize significant amount of HIV & AIDS resources[18], due to low absorption capacity, partly attributable to the weak health system.

4.5.2 Inflation Targets

Closely linked to the above is the concern by the Bank of Tanzania about expansionary fiscal policy, which could spur inflationary pressures in the economy. As part of IMF

[16] IMF program provides a very limited room for domestic financing in case of a temporary shortfall in foreign assistance. This 'limited or zero domestic financing, is aimed at making the fiscal policy 'easy inflationary pressures' and provide room for rapid expansion of credit to the private sector.

[17] Capital inflows can be used to import foreign goods or be exchanged for domestic currency and spent on domestic non-tradable goods and services. And conventionally, (1) aid is absorbed when the current account deficit increases either because more is imported ore increased domestic demand caused producers to export less and (2) aid is spent when the fiscal deficit increases, either as a result of higher government expenditure or lowered domestic revenue (see Vernongo 2007 for a detailed discussion).

[18] For a country like Tanzania, in the case of HIV & AIDS epidemic, aid inflows are likely to be partially spent on non-tradable goods and services (e.g. doctors and nurses) and partially absorbed (e.g. spent on imported anti-retroviral medication). Hence, it is to some extent unavoidable to associate aid inflows with budgetary transfers that would lead to higher government spending in the short run.

policy prescription, the Government of Tanzania has always resorted to setting exclusively low inflation targets – usually below 5%, in order to "preserve" economic stability. Containing inflation has always been done through "fiscal tightening", which means the government has little or no room to embark on expansionary fiscal policy to address emergencies such as HIV/AIDS and TB. And in practice the monetary policy does not accommodate an expansion of government expenditures, but effectively undermines it. This belief that extremely low inflation will always be good for the economy, has indirectly limited the government opportunities to embark on expansionary fiscal policy to respond to the HIV & AIDS and TB crisis.[19]

4.5.3 Foreign Exchange Policy

Foreign Exchange Policy, which favours accumulation of foreign exchange reserves, has also indirectly affected the capacity of the Government to embark on financing of targeted programs to respond to the HIV and AIDS and TB crises. A major roadblock to implementing expansionary fiscal policies and accommodating monetary policies is the current penchant of Central Bank to use ODA to build up large stockpiles of foreign-exchange reserves. McKinley and Hailu (2006) found that 100% of net aid inflows in Tanzania went into an increase in reserves.

4.5.4 Civil Service Reform

While the IMF did not impose Wage Bill conditionally on Tanzania, the first wave of public sector reforms witnessed significant retrenchment of public servants, and freezing of employment. The health sector was not excluded from this exercise, and what followed was an exacerbation of shortages in Human Resource for Health and a critical problem facing the health sector in the entire nation. For example, between 1995 up to 2005, out of 23,474 graduates produced, the Government hired only 3,836 (16%). This has significantly limited the ability of the government to respond to the HIV & AIDS and TB crises.

The overall objective of the Civil Service Reform Program (CSRP) was "to achieve a smaller, affordable, well compensated, efficient and effectively performing civil service." During the IMF and World Bank Structural Adjustment Programs, the CSRP was

[19] Low inflation targets have always been at the heart of Tanzania's Macroeconomic Policy Framework. While this seems to be the rule of the day, some IMF researchers have concluded that inflation rates of 5-10% are not likely to harm growth, at least in sub-Saharan Africa (Gupta et al. 2006)

implemented in two phases: (1) restoration of the structural preconditions to support fiscal stabilization measures, including: the removal of ghost workers, staff retrenchment, rationalization of the pay and grading system, and reinstatement of establishment and payroll controls expected to bring employment and the wage bill under control; and (2) institutional improvements, including: a redefinition of the role of government, restructuring for organizational effectiveness and efficiency, outsourcing of certain services, decentralization of service delivery, and managerial capacity building.

In the context of the Civil Service Reform Program, from 1993 to 1999 the civil service was rationalized, with view toward establishing the integrity of the payroll by removing "ghost workers" and consolidating salary and non-salary benefits to achieve transparency of pay. As a consequence, a total of about 90,000 civil servants were retrenched, reducing the size of the civil service to 264,000 employees, and the civil service wage bill as a proportion of GDP declined from 4.8% in 1994/95 to 4.4% in 1998/99.

While many public servants were declared redundant and retrenched, recruitment into the public service froze even for those graduating from public service institutions (including technicians and professionals in teaching, health services, agriculture development, and others) and the public service wage bill was effectively controlled while pay structures were rationalized. This resulted in reduced real pay for many senior public service officers, and many senior staff lost their positions as a result of ministerial restructuring of the regional administrations.

5 CONCLUSIONS AND RECOMMENDATIONS:

5.1 Conclusions

This study sought to identify the impact of IMF related policies on Tanzania's ability to respond to the HIV/AIDS and TB crises. The study has highlighted the major socioeconomic developments in Tanzania under the IMF policies. It has also detailed the HIV/AIDS and TB situations in Tanzania, highlighting the magnitude of the crises, the response by the Government and donors thus far, and the challenges involved. After a review of the IMF policies in Tanzania, the study has found that the IMF policies indirectly impact Tanzania's ability to respond to HIV/AIDS and TB crises. The key issues that have emerged include:

- Limited capacity due to weak health systems is a major constraint in efforts to respond to the HIV/AIDS and TB crises. In particular, poor health infrastructure, and inadequate human resources for health have resulted in low absorption capacity as far as HIV/AIDS and TB resources are concerned. As much as the inadequacies of human resource can be associated with the employment freeze under the SAPs, there is emerging evidence that even after the employment freeze was been lifted, only few graduates were employed and in most cases even those employed had high rates of absconding in the rural areas particularly. Furthermore, there are not enough personnel in the market in particular for TB programs which call for reviving of the health training institutes in order to produce the cadres of the required capacity.

- By limiting domestic financing, and channeling significant amount of aid to the foreign exchange reserves in the name of macroeconomic stabilization, the IMF policies have indirectly affected the ability of the Government of Tanzania to respond to HIV/AIDS and TB crises. This is manifested in the budget ceilings which limited spending even on priority sectors under PRSP, health sector been one of them.

- Because IMF favors aid absorption (increase in imports) rather than "spending" (increase in expenditures on domestic goods and services and human resources), this has limited the government's use of aid to upgrade the health system, which is essential in responding to the HIV/AIDS and TB crises.

- By putting too much emphasis on very low inflation targets (5%), IMF policies have almost closed doors for accommodating monetary policy, which could have allowed for a more expansionary fiscal policy.

- Even without formalized wage bill ceilings, the excessively tight fiscal (deficit-reduction) and monetary (inflation-reduction) policies still keep overall national budget constrained at unnecessarily low levels, with the consequential impacts on sector budgets and wages for personnel. These have locked the doors for the government to engage in expansive fiscal policies to finance targeted projects and programs aimed at strengthening the health system, which would be instrumental in the efforts to respond to HIV/AIDS and TB crises.

- Too few services are available for some components of HIV. Only one fourth (26%) of all health facilities in Tanzania have an HIV testing system. Other HIV-related services, however, are offered by very few facilities nationwide. Less than 5% of facilities offer post-exposure prophylaxis or antiretroviral therapy. Only 13% of facilities provide any services to prevent Mother-to-Child Transmission (PMTCT) of HIV.

- DOTS ensure that TB patients take their drugs regularly and complete their treatment. This process not only cures patients but also helps prevent drug resistance. However, a substantial percent of facilities do not have all of the elements needed for proper TB treatment.

5.2 Recommendations

- Each of the major assumptions of the IMF and Finance Ministry's macroeconomic framework must be publicly revisited and reexamined, and alternative perspectives be discussed and considered by a much broader group of public stakeholders including CSOs, independent academics, parliamentarians, line ministries, domestic media, and donor agencies. It should be asked if such a framework allows for a "scaling up" of spending and investment in order to achieve the MDGs and, if it is not, to make adjustments.

- The IMF, World Bank, and other donors must eliminate harmful quantitative, structural and policy conditionalities in lending so that Tanzania can be clearly given the policy space to consider more expansionary fiscal policies in order to

increase public spending and investment in line with MKUKUTA. The IMF should allow for more flexibility in fiscal and monetary policies by refraining from the conventional emphasis on deficit reduction and inflation-reduction targets, which too conservatively restrict the size of the overall national budget. Expanded health and education spending must be exempt from policies that unduly constrain overall government spending.

- The IFIs, other donors, banks and other financial institutions should work together to set up arrangements to provide loan guarantees, subsidized credit and other assistance to Tanzania so that it can: 1) renegotiate its current domestic debt burden so that it can create more fiscal space to engage in increased spending and investment—and 2) so that Tanzania could engage in future deficit spending at much lower rates and/or for over longer time frames so that such higher levels of deficit spending are both affordable and sustainable.

- Stakeholders should more carefully examine the consequences of the loss of public control and democratic responsiveness of monetary policy to changing economic circumstances associated with the kind of central bank independence (CBI) reforms the IMF advocates. A proper response to shocks requires a flexibility and agility of finance ministries that is not possible under detached CBI formats. The costs and benefits of such policies should be discussed and considered by a much broader group of public stakeholders including CSOs, independent academics, parliamentarians, line ministries, domestic media, and donor agencies.

- IMF should explore and allow for more productive and non-inflationary domestic spending of aid, and reasonable levels of domestic financing where necessary, which would channel more aid to the domestic goods and services and human resources. This would give the government more space to spend aid to upgrade the health system, both in terms of infrastructure and human resource development.

- IMF should explore the possible ways to engage a much wider spectrum of stakeholders in macroeconomic policy issues – particularly the other Government Ministries and Departments (apart from Finance and Planning) and the CSOs. This would broaden the consultative process and make the policy process more transparent than it is at the moment.

- Civil society and parliamentarians should push the government to negotiate for removal of all conditionalities that prevent the government from increasing investment in health and particularly on HIV/AIDS and TB.

- There is need for CSOs, labor unions, MPs, domestic media and independent academics to be sensitized on important IMF policies and loan agreements. In particular, these stakeholders must build their understanding of the content of the policies, the context in which they are introduced, the potential impact of the policies, and the costs and benefits of alternative approaches.

- There is need for improved transparency in the formulation of policies, access to key IMF policy documents and agreements, information on conditionalities tied to loans and their potential impact. Restrictions on access to information should be lifted and a mechanism should be put in place to facilitate access to key documents that will enhance informed decisions and active contribution by the CSOs, MPs and other stakeholders in the policy dialogue. This will enable the CSOs and MPs to hold the governments accountable for its decisions.

- The need to look on the ART policy and guidelines and establish mechanism to scale up ART provision is imperative.

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ANNEXES

Annex 1: List of Organizations Interviewed

1. Ministry of Health and Social Welfare—Head of the Budget Section (Mr. Richard Mkumbo—general discussion on IMF policies)
2. Swiss Development Cooperation (Ms Rose Aiko)
3. Swiss Development Cooperation (Ms Jacqueline Matoro)
4. World Bank (Mr. Emmanuel Mungunasi)
5. World Health Organization (Mr. Maxmilian Mapunda)
6. Dutch Embassy (Mr. Goodluck Mosha)
7. Tanzania Gender Networking Program (Prof Marjorie Mbilinyi)
8. Youth Action Volunteers (Mr. Irenei Kiria)
9. Ministry of Finance and Economic Affairs (Mr Laston Msongole—Deputy Permanent Secretary—general discussion on IMF policies).
10. Muhimbili University College of Health Sciences (Dr Phares Mujinja).
11. Ministry of Finance and Economic Affairs (Mr. Godlove Mbise)

Annex 2: No Response

1. Ministry of Health and Social Welfare (three questionnaires)
2. IMF (one questionnaire)
3. Ministry of Finance and Economic Affairs (two questionnaires)
4. World Bank (two questionnaire)
5. CSOs Policy Forum (one questionnaire)
6. University of Dar es Salaam (two questionnaires)