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Economic Reforms and Health Conditions of the Urban Poor in Tanzania

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"Since the human being is the centre of all development, the human condition is the only final measure of development. Improving that condition is essential for the poor and vulnerable human beings who comprise the majority of our peoples in Africa. Africa's men and women are the main factors and the ends for whom and by whom any programme and implementation of development must be justified" (The 1988 Khartoum Declaration).

1. Introduction

This paper examines the impact of economic reforms, namely Structural Adjustment Policies (SAPs), on the health conditions of the Tanzanian urban poor. My conclusion is that these policies have had detrimental effects on the living conditions of the urban poor. Thus, SAPs are contributing to the deterioration of health conditions among these people rather than improving them. SAPs are affecting these people in a variety of ways. First, by affecting negatively the development of the urban environment, SAPs are destroying the environmental conditions on which the poor depend for their existence and survival. Secondly, by impacting the provision of urban health services, SAPs are affecting facilities which serve the health needs of the urban population. Thirdly, by fueling inflation, SAPs have raised the general cost of living which has exacerbated poverty rather than eradicated it.

2. The Historical Background of SAPs in Africa

SAPs, aimed at stabilizing developing countries' external and internal balance of payments and promoting their export growth through devaluation, producer price changes, trade liberalization, privatization and legal reforms, have become a fact of life in most African countries in the last decade. Their adoption usually (but not always) occurs in times of economic crisis and in response to promises and threats from donors led by the two foremost international financial institutions, the IMF and the World Bank (Gibbon 1993: 11). In most cases these financial institutions are largely responsible for designing the SAPs. The history of SAPs in Sub-Saharan Africa begins with the World Bank's 1981 Berg Report on social and economic crisis in Africa. In response to this report the World Bank recommended the adoption of structural reforms or SAPs.

Structural reforms involve adjusting the economy in order to properly manage the balance of payments, reducing fiscal deficits, increasing economic efficiency and encouraging private sector investments and export-oriented production. As indicated elsewhere (Lugalla 1995a: 44),

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the major principles of SAPs include the control of money supply, devaluation of the local currency, reduction of public borrowing and government expenditure, (particularly in unproductive sectors of the economy) and the introduction of user charges (cost-sharing) in education and health. Other measures include trade liberalization, reduction of tariffs, creation of a conducive environment for foreign investments, abolition of price controls, privatization of parastatals, withdrawal of subsidies, retrenchment of workers and, above all, democratization, which is generally understood to mean multiparty politics. Since the early 1980s, most countries in sub-Saharan Africa have been forced to implement these measures as a pre-condition to aid and loans from the IMF, the World Bank, and other donor agencies.

In order to solve the persistent severe economic crisis which has been confronting Tanzania since the late 1970s, Tanzania signed an agreement with the World Bank and the IMF in 1986 to adopt SAPs. The various programs include the Economic Recovery Programme One (ERP I) in 1986, ERP II, Economic and Social Action Plan (ESAP) and the Priority Social Action Plan (PSAP) in 1989.

Now, more than a decade later, the living conditions of most Tanzanians have worsened. Real incomes of most households have declined sharply, malnutrition is rampant, food production has fallen relative to population, and social services have deteriorated both in quantity and quality. Furthermore, Tanzania's population is exploding amidst severe socio-economic and environmental crisis. All these problems have been occurring at the same time that Tanzania has been implementing social and economic reforms prescribed by major donors and financial institutions like the World Bank and International Monetary Fund (IMF) as a necessary pill for curing socio-economic crisis.

3. Impact of SAPs on Urban Environment

The quality of life in urban areas depends to a great extent on the availability of social services including health, education, recreation and such urban infrastructure as water, electricity, communication, transportation, sanitation and drainage systems. Due to economic crisis and the accompanying reform policies, urban areas in Tanzania have not experienced positive development. Despite reforms, most of the towns and cities are in a state of chaos and decay; their social as well as economic problems have multiplied rather than decreased. The majority of the urban population has difficulties in accessing clean water, adequate shelter, good health care, employment, and other basic services. In Dar-es-Salaam there are frequent water cuts which sometimes leave areas dry for more than a week. There are electricity blackouts, telephones which maintain an eerie silence, inadequate parking spaces, overflowing sewage, congestion of vehicles which do not observe traffic regulations, hospitals without medicine, roads with pot holes, pick-pockets and gangs of armed robbers, and streets without lights but with the pungent smell of uncollected garbage. There are more beggars, disabled, street-children, hawkers, cows and goats, all of which contribute simultaneously to traffic jams.

Spontaneous slum settlements have increased tremendously during the last few years. These settlements accommodate the majority of the urban poor who are continuously being marginalized by various processes engendered by both economic crisis and economic reform

policies. We also see a rapid increase of competing official and unofficial "illegal" income-generating activities like prostitution, black-marketing of drugs and hawking.

In contrast, some parts of Tanzanian cities show evidence of developmental efforts, planning or management initiatives. Multi-story buildings are changing the urban geography of Tanzania. The winds of modernization and dependency have increased their speed to the extent that even the Sheraton Hotel chain has found a home in Tanzania. Luxurious buildings have mushroomed in beach zones like Msasani, Mikocheni, Kawe, Mbezi, and Tegeta in Dar-es-Salaam. Airports have been rebuilt and expanded in order to suit the Western model. The number of luxurious air-conditioned four-wheel vehicles fitted with telephones, video and television sets has increased These processes reveal that SAPs have not meant the same thing to everyone; wealth and poverty are not isolated trends but rather two sides of the same coin.

Emphasis on reducing government expenditure on unproductive sectors like social development in urban areas is one way SAPs have negatively impacted urban development in Tanzania. Lack of sufficient budget has made it difficult to finance a variety of urban development projects including the provision of adequate housing. As a result, 70% of the urban population live in squatter settlements without such necessities as sanitation facilities (drainage and sewage systems) and adequate refuse and garbage collection. Most of the houses are built of low quality materials. In 1988, at least 90% of the urban population were living in areas or homes which did not merit required official and legal standards (ILO 1982: 122). The 1991/92 Household Budget Survey (HBS) shows that 40% of the total urban population live in overcrowded houses. Only 41% of the population of Dar-es-Salaam City have access to piped water; about 4% of the total urban population have no toilets facilities, with 80% using pit latrines and only 7% with flush toilets. Nearly 66% have garbage pits outside the compound, 18.5% throw their garbage out of their compound and only 6% have rubbish bins. Out of the 20 regional headquarters (towns), only eight have central sewage systems. These serve less than 10% of the population of each town. In 1990, Dar-es-Salaam, a city of more than 2 million people, had only 15 public toilets, none of which were functioning (Lugalla 1990: 356). In 1985/86 the city generated 1,200 tons of solid waste daily. The city needed 120 vehicles to remove all this garbage but had only 12. In order to be able to remove all the waste water the city needed 150 emptiers, but due to financial constraints, it had only 20 cesspool emptiers in March 1988 (Kulaba 1985: 45).

Social sector expenditures between 1978-88 dropped from 8 percentage of GDP in 1978 to 4.5 percent in 1988. For health and housing alone, the percentages declined from 2.4 percent to 1.9 percent and from 0.1 percent to 0.03 percent, respectively (Lugalla 1993: 196). As far as urban areas are concerned, these declining trends meant that the government became less and less able to finance new development let alone maintain the same quality of urban social services. Considering that by 1988 the population of Tanzania had increased from 17 million in 1978 to 22.5 million in 1988, one can see the relationship between reform policies, poor living environment (housing conditions), and health. For example, improved water supplies were built in the early and mid-seventies to serve some 50 to 70 percent of the urban population, and about 45 percent in the rural areas. In both cases, inadequate maintenance due to lack of funds have reduced the number of people served to about 25 percent (Kulaba 1989). While the urban population has been expanding over the past decade at an annual growth rate of almost 12

percent, the capacity of urban authorities to collect and dispose of an increasing amount of refuse and solid waste has been declining.

Although this data assists us in understanding how SAPs have affected the ability of the government to provide public services in urban areas, it does not show concretely how the living environment of the urban poor has been affected and how this contributes to their poor health. In order to see the relationship between poverty, living environment and health, I carried out an in-depth study in 1995 in two squatter settlements in Dar-es-Salaam, namely Kinondoni-Hananasif and Vingunguti. The major findings of this study are presented in brief in the section below.

4. Urban Poverty, Urban Environment and Health

Vingunguti and Hananasif settlements are located along the Msimbazi River which cuts across Dar-es-Salaam city from East to West dividing the city into two parts (North and South). The river's basin is mainly vegetated by mangrove swamps. The area is popular in Dar-es-Salaam because of the role it plays in the urban economy. Most of the fresh vegetables, i.e., mchicha (spinach), sold by street vendors in Dar-es-Salaam is grown here. Msimbazi River is also a source of domestic water for families which do not have access to piped water. Several industries located along Pugu Road industrial area discharge their waste materials into this basin. The biggest city dump for solid waste disposal is located in Vingunguti area which is situated further west along this basin.

The basin also is home to many urban dwellers of Dar-es-Salaam. All areas bordering the river basin contain residential houses which reflect the conditions of urban poverty and squalor. Most of the housing units are built of simple and impermanent materials like mud, sticks, poles, mangrove trees, thatched grass and recycled metals. Seventy-seven percent of the head of households in our sample admitted that their houses were made of temporary building materials and 54.5 percent were not satisfied with their houses. There are a few attractive houses in the area, indicating the co-existence of both poverty and wealth.

The area is densely populated with a high degree of overcrowding in and between houses. Houses have been built with little space between them; small corridors or paths separate one residential unit from the other. According to our findings, health problems associated with overcrowding are common including malaria, respiratory diseases, scabies, diarrhea, tuberculosis, influenza and meningitis. The houses have small windows and therefore ventilation is poor.

In addition, different families live in one house in which they rent separate rooms. In most cases poor families rent a single room and share the kitchen and sanitary facilities. Our findings show that more than four people may live, cook, eat and sleep in one room. This overcrowding is a health hazard. There is no doubt that communicable diseases can be easily transmitted from one person to another. Studies elsewhere have shown that overcrowding, inadequate ventilation, and the use of open fires (charcoal or wood) contribute to respiratory health problems (Environment and Urbanization 1990: 3-4).

Most of the inhabitants lack security of tenure (lease holds), and those who rent do not have a contract or a written agreement with their landlords. Few houses have electricity.

Seventy-one percent of the households surveyed have no electricity; 95.7 percent have no telephones. Since obtaining electricity connections is an expensive and cumbersome exercise, illegal power connections are common, contributing to life-threatening accidents.

Most of the residents of Kinondoni-Hananasif and Vingunguti settlements do not have piped water in their houses. The majority use pit latrines to dispose of human excreta. Only 9.4 percent have flush toilets and 5.2 percent have no system for disposing of human waste. Drainage systems, storm and surface water drains and sewers do not exist. Facilities for disposing of garbage are lacking. Only 15.2 percent of those surveyed have waste pits. Nearly 60 percent throw their garbage outside their houses and 23.4 percent throw it on their streets. In-depth interviews show that garbage is left uncollected and untreated for a longtime. The Daily News Paper recently carried a story entitled, "Garbage Dumps Mushroom in Dar Streets":

Dar-es-Salaam City is gradually turning into a stinking city following the mushrooming of sew dumps and heaps of uncollected garbage scattered all over the city. A survey has shown that garbage collection has deteriorated prompting health hazards to city residents. In 1993 the Dar-es-Salaam City Council contracted a private company to collect garbage on commercial basis (Daily News Paper, September 5, 1995).

Pit latrines have multiple purposes. Many houses use them as bathrooms as well as garbage pits. This was confirmed by 58.6 percent of the households surveyed. When asked whether they were satisfied with conditions of their latrines, 71.4 percent indicated they were not happy with the situation. They said the main problem is the overflowing of latrines due to the absence of emptying trucks, not to mention the high costs involved in hiring one. Most of the pit latrines tend to be located outside the house and are relatively shallow because the water table in Dar-es-Salaam is high. In most cases the pit latrine holes are not covered by lids. This allows the easy movement of flies from latrines to the kitchen to food stalls and elsewhere.

Some of the latrines exist side by side with open pit wells where people draw water for washing and cooking. Given the high water table in Dar-es-Salaam, it is likely that water from open wells can be contaminated with human waste. Overflowing of pit-latrines tends to contaminate shallow sources of water supply in low income settlements. This happens because the city council is unable to provide trucks for emptying them. Even if they could provide trucks, the cost of such services are unaffordable to most of the people. Some people, who do not have their own pit latrines, defecate in the river. One can argue that Msimbazi River has turned into an open sewer, a situation which endangers the lives of those who depend on its waters. It is no wonder that during floods, houses in this area tend to float in their own sewage. This is confirmed by one resident who said the following:

The river is filthy. It accommodates everything -- human remains, industrial waste and all waste from Vingunguti abattoir flow into this river. People bathe and some defecate and children play and swim throughout the day. The whole river basin stinks. But a lot of us get our domestic water from here. I have no doubt that the several diseases we suffer are manufactured here. We are poor! We have no alternative. We have complained to the city fathers, some of them have even visited these areas and promised to do something but nothing has happened so far. Instead of solving our problems, they keep on sending to us researchers like you. We have seen several people of your kind but our situation has not changed. Go and tell your bosses that

we want good water, electricity and dispensaries and not research! We know that you people are using our situation of poverty in order to enrich yourselves. We are tired now.

"Go and buy us some beer over there," echoed his friend sitting nearby. "We know you are paid for this."

Typical of the unplanned settlements of urban Tanzania, these squatter settlements demonstrate in concrete terms how the state's policies marginalize the urban poor as far as social services and other civic facilities are concerned. We have seen that very few have access to piped water, and my findings show that most people travel long distances to collect water for domestic use, especially for drinking and cooking, because public taps and taps from neighbors are in most cases dry. People buy water at very high prices. Some get their water from dug wells, ponds, streams, and the polluted Msimbazi River. How is this urban environment affecting health conditions of the urban poor?

When asked to list the kind of diseases from which the residents of these two settlements suffer, the majority of the household heads named diseases which are water-borne, infectious and communicable. There is a lack of readily available water, sewage connections, or other systems which dispose of human waste. These, combined with a failure to collect garbage and an absence of basic measures to prevent disease and provide primary health care, have resulted in many debilitating and easily prevented diseases becoming endemic among poorer households. These include dysentery, diarrhea, scabies, skin diseases, eye problems, typhoid, and intestinal parasites. Cholera remains a threat to those who live in these areas. Information derived from respondents shows that the incidence of diarrhea and malaria among children is very high as is the rate of infant mortality (IMR) and death in children below five years of age. The 1988 National Population Census shows that this rate was 104 per thousand and a study by the World Bank itself argues that the infant mortality rate has not improved over the last decade (World Bank 1995: XVII). The decline of IMR from higher levels in late fifties of about 137 deaths per thousand to about 115, in the 1988 population census, should be attributed to pre-SAP policies which put more emphasis on child immunization, primary health and other preventive strategies. Another study revealed that inadequate food consumption, together with malaria, diarrhea and respiratory diseases, caused 75-80 percent of deaths among young children (UNICEF 1990: 20).

There is a very close relationship between income and health. A study on health and infant-feeding practices in Dar-es-Salaam conducted in 1979/80 found that there was an association between income and the mortality rates of children under five years. The lowest income group, which included those households earning up to Tsh. 799 per month, had a mortality rate of 110 per thousand, while those earning Tsh. 2,000-3,199 and those earning Tsh. 3,200 and more per month had mortality rates of 64 and 13 per thousand, respectively (Kahama et al. 1986). The 1991/92 Demographic and Health Survey shows that the trend has not reversed. Given that the Tanzania Poverty Profile (using data from 1991) shows that 51 percent of the population had incomes of less than an absolute poverty line of $1 per day per person in 1991 (World Bank 1995: XV), there is no reason to believe that the health situation has improved.

Birth weight is another health and development indicator that is significant in assessing overall health because it has a major impact on infant mortality and is closely linked to mothers' general health. The occurrence of low weight reflects physical and psychological stress on the

mother that may be caused by a variety of social, economic, and health factors, especially malnutrition and unregulated fertility. The Dar-es-Salaam study cited above showed that the birth weight did indeed increase with income: 3,06 kg. was the average weight for the poorest group and 3,26 kg. was the average for the wealthiest (Kahama 1986).

Recent data show that perinatal/maternal malaria and diarrhea continue to rank at the top as causes of death. The three contribute 22.9, 18.2, and 7.5 percentage respectively in terms of percent of life years lost (World Bank 1995: XXXII). At the same time, conventional wisdom regarding urban planning and hygiene teach us that improved drainage systems can help to control water-borne diseases or disease vectors and that stagnant water can be a breeding place for schistosomiasis, snails, malarial mosquitoes, and mosquitoes which serve as vectors for dengue and yellow fever.

Another characteristic observed in these areas is that a higher proportion of children and young adolescents live in settlements with little or no provision for public space and the facilities they need for sports and other social activities. Roads, garbage heaps, and other hazardous places become their playgrounds in absence of any better alternatives. Children are particularly at risk from vehicles, pathogens and toxic substances. The problems range from contracting diarrhea (through ingesting pathogens from fecal matter which contaminates the land on which they play) to coming into contact with toxic chemicals.

Due to a shortage of land in the area, some residential units are located in unsafe areas. Many houses stand in areas where floods can easily sweep them away. The floods which have been occurring in Dar-es-Salaam since 1989 have been responsible for destroying houses in this basin and leaving people homeless. We noted several demolished houses in Hananasif and in Vingunguti, where part of the basin had been reclaimed and turned into a cemetery. We were told that heavy rains have been disastrous. Many people remember the floods of 1992 which eroded part of the cemetery, unearthed the human remains and swept them into the river basin. Nevertheless, these problems have not deterred people from building in the area. In Hananasif, people continue to build housing units in areas which are unfit for human habitation. We noted during our visits to the area that there were a lot of activities to reclaim land submerged in marshy and dirty water. This means that the dire need for shelter is indeed overriding the fear of floods. It is no wonder that the floods which happen periodically in Dar-es-Salaam claim lives of many people.

5. The Urban Poor and Provision of Health Services

The Structural Adjustment policy of reducing government expenditures on social service sectors like health and education has created a lot of problems with these services. Statistics show that aggregate central government expenditures on health fell by 9 percent in real terms between 1980 and 1987. The development budget for urban areas, as a percentage of the total development budget, began to decline in 1978-79 when it was only 1.62 percent; the situation worsened in 1986-87, the year SAPs were adopted, when it was just 0.31 percent (Kulaba 1989: 234).

Per capita spending on health declined by more than a third between 1980 and 1986 (Afro-Aid 1991; World Bank 1995). According to the total financial requirements of the Priority Social

Action Programme of 1989/90 to 1991/92, the percentage of the unfunded gap in health was 42.9, 67.4 and 63.5 for 1989/90, 1990/91 and 1991/92, respectively. The government's ability to maintain, expand or improve the health care system has declined tremendously, leading to serious deterioration of health services. As has been shown, the main health problems in urban areas result from diseases associated with infection, most of which are water-borne. However, the health care system still emphasizes curative hospital services rather than preventive measures.

Besides the poor environment, the critical problems associated with health care include shortage of health and medical staff, medical equipment and medicine. In 1978, there were only 275 dispensaries in all urban areas of Tanzania. Of these, 81 were owned by government, 21 by voluntary agencies, 89 by public parastatal organizations, and 84 were owned privately (Lugalla 1995b: 97). During this period, the service ratio was 21,000 people per dispensary which was much below the official required national standard of one dispensary for every 8,000 people (Lugalla 1995b: 97). In 1982, there were only 24 health centers in urban areas. Given the total urban population of approximately 2,957,674 at that time, the service ratio was 123,236 people for one health center which was far below the national standard of one health center for every 50,000 people (Lugalla 1995b: 97).

During the same period there were 67 hospitals with 11,366 hospital beds (Lugalla 1995b: 97). The number of these facilities has remained constant despite urban population growth. Examining the figures for the number of hospitals in the entire country, it is clear that although the number has been increasing, the population served by one facility as well as population per doctor also has been increasing. For example, in 1978 there were 148 hospitals in the whole country. With a population of 17 million people at that time, each hospital was supposed to be serving 114,864 people, and 815 people were supposed to use one bed. In 1988 when the population increased to 22.5 million, the number of hospitals increased by only four. The population per facility went up to 148,026 people, and the population per bed rose to 987 people. By 1990 there were 173 hospitals for a population of about 23,670,400. This meant a total of 136,823 people per facility, and 1012 people were now supposed to use one bed (computed from various tables from Statistical Abstracts of Tanzania of 1993).

With regard to medical personnel, one notes that the number of doctors has not increased with population growth. In 1984 there were only 1115 medical doctors; the population per doctor was 17,937 people. In 1989 (three years after adopting SAPs) the number of doctors dropped to 978 and as a result the ratio went up to 23,006 people per doctor. By 1993 the number of doctors increased slightly to 1134 but due to increase in population, the ratio per doctor rose to 23,920 people (ibid.). Although the number of health facilities has increased, overcrowding and inadequate and demoralized personnel portends that the services offered must have become worse. It is true, as the World Bank argues in its report on "Socio-Economic Growth and Poverty Alleviation in Tanzania" (1995), that the percentage of the population which have a health facility less than 5 km away has increased from 57 percent in 1976 to 87 percent in 1993. This does not mean however that the services offered are of good quality. It is also important to note that most of these health institutions were established in the late seventies and early eighties when Tanzania was implementing redistributive economic policies.

Information from the Ministry of Health as well as the Planning Commission shows that there has been very little development in health infrastructure during the period of SAPs. In other words, pre-SAP policies are the ones which have been responsible for improving the accessibility (distance-wise) of health services. For example, between 1967 to 1985 the number of hospitals increased from 116 to 152 (an increase of about 31 percent). Health centers increased from 46 to 260 (an increase of 465 percent) and dispensaries increased from 1237 to 2852 (an increase of 131 percent) during the same period. But from 1986 to 1993, a post-SAP period of seven years, the increase was only 14, 6.2, 0.7 percentages for hospitals, health centers and dispensaries, respectively (United Republic of Tanzania: Selected Statistical Series. Bureau of Statistics, 1995: 85). Taking into consideration the rising population, this increase is indeed very insignificant and is a clear indication of the fact that pre-SAP policies paid more attention to the welfare of the people. The World Bank itself admits in its recent various reports on the social services sector in Tanzania that the huge health infrastructure which was created in the seventies has been crumbling due to lack of essential equipment, medicine and personnel. What we have now in Tanzania are "empty institutions" which lack the basic necessary resources to be able to function well. One can argue therefore that it is not the number of institutions that matters, but the nature of these institutions and the quality of the services they provide. A variety of people's narratives presented in this paper reveal that things are not getting better as far as health services are concerned. They also confirm that there was a time when things used to be good, particularly from mid-sixties to early eighties.

Urban health facilities do not provide their services to every urban dweller; they are segregated. Those owned by the Agha-Khan organization are private and essentially provide services to Asians, Europeans, and to a very few affluent Africans. Those owned by public parastatal organizations provide free services but serve only their employees and their families. The unemployed have to depend solely on public-owned health facilities. While these provide free medical services, but they offer extremely poor services and often lack medicine.

In the case of Dar-es-Salaam, the urban poor have to depend on the services provided by the Muhimbili Medical Centre, Mwananyamala, Ilala, Temeke and Magomeni health centers. Given the present population of Dar-es-Salaam, these health centers are very inadequate and complaints about their poor services are common. Beginning in the past two years, public health institutions charge fees for their services. The bulk of the available evidence appears to confirm that while user charges in health care generate income, they also deter those patients at greatest risk who cannot afford the charges. This is confirmed by one of our informants in the following narrative:

"There are countless diseases in this area. I have just recovered from dysentery three days ago," said one household head in Vingunguti squatter settlement in Dar-es-Salaam.

This morning I attended a funeral of my `Ten Cell' leader's son who died two days ago. They say it was cholera that killed him. My elder brother died last year from this disease. In fact, several people have perished because of this. Look! My granddaughter who is lying there has been sick now for the last three weeks. Her mother spends more time in hospitals than at home. The doctors are telling us that she is anemic and malnourished.

"The Ilala hospital do not have medicine and the doctors directed us to a private chemist where we got some but she has not recovered," responded his wife sitting nearby. "So far we have spent more than 10,000 Tanzanian Shillings."

"The doctors have advised us to feed her a special kind of food but we are poor, we cannot afford it," said the husband. I am a minimum wage earner. My salary does not last us for a week. I have six people in my family. The months of April and May were bad for us, malaria attacked the whole family. It started with my two sons, then came the daughter and her daughter and then me. Finally it ended up with my wife. This time we decided to go to a private hospital. The blood test alone cost 1,100 Tanzanian Shillings for one person. At first, the doctors gave us chloroquine tablets. They didn't work. Then they put us on a full dose of quinine injections. We ended up paying 2,000 Tanzanian Shillings for each person. Although the others have recovered, I am still not feeling well. They are now saying I should take Fansidar. But this drug is very expensive, I cannot afford it! I have so many debts now and I do not know how I am going to pay them back. Hayo ndiyo maisha ya kila siku ya sisi `Walala-Hoi. This is the daily life of we people who are poor, those who toil but get nothing in return."

Although using public hospitals is the only alternative available to the urban poor, there are government directives and circulars which allow some employees, especially senior ones, to get treatment from the expensive privately-owned hospitals. The poor and the unemployed, who are the majority, experience critical health problems in urban areas because they live in a poor environment. They are the ones who have access to poor facilities or no medical and health care at all. The affluent, who experience fewer health problems, have access to all types of medical and health care facilities at the government's expense, or are sometimes sent abroad for treatment. It is a zero-sum game.

In addition to the appalling conditions in most of the government owned hospitals, corruption is also rampant. Good treatment depends on "technical know-who" instead of technical know-how. The moral code of conduct of most of the doctors has been eroded by inflation and the high cost of living. As a result, corruption has become deeply entrenched. A majority of the medical personnel is investing more time in private practice and other sideline income generating activities than in public services. This is a new trend of behavior which was not evident during the pre-SAPs period.

SAPs have reduced the health budget significantly. The state allocation for health is now estimated at less than 5 percent of the government's recurrent budget. Information from the Ministry of Finance shows that every Tanzanian is at present spending 5$ a year to service foreign debts but spends only 2$ for his/her own health. Low wages and the poor conditions of work have demoralized health workers and led many to leave the public sector. The monthly wages offered to health personnel do not correspond to the monthly household cost of living. As in education, salaries of medical and health personnel in 1990 were the same as in 1980. This has bred corruption in the medical sector. As I have argued elsewhere, drugs are sold illegally while prescriptions and medical attention are available to those who can pay or have influence. Kickbacks have become the medium of exchange for medical attention (see Lugalla 1995a: 45).

The Ministry of Health estimates that since SAPs began, about 500 doctors and medical assistants have left the public hospitals for private ones. "I used to earn 15,000 Tanzanian Shillings (22 U.S. Dollars) a month, but now I get three times this amount," says nurse Mariam

Semtawa, who now works in a private hospital (IPS 1995). Some doctors have left public services for greener pastures outside the country. In the last ten years, Tanzania and Kenya seem to be the leading countries in Africa, exporting health personnel to Southern Africa in general, particularly to Lesotho, Swaziland, Zimbabwe and Botswana (IPS 1996). Due to trade liberalization, private hospital fees are no longer subject to government control. Quality control of both services and drugs is proving to be difficult. A lot of private clinics have been opened during the last few years. Most of them are housed in undesirable environments and some are operated by quacks and therefore pose more health problems. Cases of drugs being sold after faking labels are countless. One informant in Knondoni-Hananasif described the conditions of public hospitals in Dar-es-Salaam:

Angalia ile Hospitali ya Muhimbili. Ukubwa wa bure! Majengo tu! Lakini hakuna kitu pale. Vifaa hakuna! Dawa hazipo! Madaktari hawapo! Opereshenihazifanyiki kwa vile dawa za usingizi hakuna. Kila siku wanakufa watu pale! Nenda ukaone chumba cha maiti. Kimejaa! Ukitaka kufa nenda Muhimbili. Ile siyo hospitali bali ni machinjoni.

Look at that Muhimbili Hospital. It is big for nothing! It is only buildings! There is nothing there. There are no equipments! No medicine! No doctors. Operations are not taking place because there is no anesthesia medicine. People die there every day! Go and see the mortuary, it is full. If you want to die, go there! That is not a hospital but a slaughter house. (Translated by the author. This interview was carried out on July 24, 1995).

Tanzanian public hospitals have become danger zones for nurses, who have fallen victim to drastically reduced government spending on health. Doctors at Muhimbili Medical Center (MMC), the country's biggest referral hospital, say six nurses died there in September alone, including three who contracted cholera after attending to patients without protective gear. An average of five nurses die every month after being infected by patients. It is not only at MMC that such deaths have been reported. Sources from the Tanzania Nurses Association told IPS that they had received similar complaints from Bugando Medical Center and Kilimanjaro Christian Medical Center (KCMC). According to the association, an average of two nurses die every month at Bugando and one at KCMC. A senior official at MMC identified tuberculosis, cholera, the plague and meningitis as the main causes of deaths among nurses. He admitted that hospitals do not have enough funds for protective gear such as gloves, boots, aprons and masks. "It is very dangerous to work under the current conditions where protective gear is seen as a luxury," said Rashid Mussa, a nursing officer at MMC (IPS 1995).

This section argued that the provision of health services in urban areas is skewed and favors the rich. The poor not only suffer by living in very poor environmental conditions, but when they get sick, access to health institutions and good treatment is not easy. Why is this so? How can this situation be explained? The section below looks at the kind of social processes which have brought Tanzania into this situation.

6. Dependent Urbanization

It is important to know the historical factors which have contributed to the evolution of contemporary urban forms, their associated socio-economic structures, their urban-rural context, and how they contribute to rampant poverty in urban areas. This analysis requires a

brief discussion of how colonialism transformed the traditional political economy of Tanzania by replacing it with structures of dependency and underdevelopment.

To suggest that economic reforms undertaken by Tanzania have caused the economic crisis and urban poverty is ahistorical. Poverty existed in urban Tanzania before SAPs began. Therefore the decay of the urban environment as well as the predominance of urban poverty in Tanzania must be placed in historical context. Colonial policies laid down the roots of urban poverty and, unfortunately, post-colonial policies fed these roots rather than uprooted them. This argument has important implications as far as policy formulation is concerned. It suggests that abolishment of SAPs will not necessarily eliminate poverty or improve the living conditions of people in urban Tanzania. The latter requires a radical transformation of the socio-economic relations of dependency which enhance underdevelopment of the one hand, and generate poverty on the other.

Since Tanzania became independent, post-colonial policies have not succeeded in altering the pattern of urbanization inherited from the colonial economy. The only major change which occurred was the substitution of white colonial administrators with black African elites as key people in urban politics. The dependent nature of the economy has continued to be the same and SAP policies of free market systems and liberalization of trade are in fact compounding the situation of dependency and therefore exacerbating exploitation and intensifying conditions which generate poverty rather than eradicating it. Dependent development has influenced the formulation of health policies. The distribution of government health spending has continued to be heavily biased towards curative services rather than community based health care approaches or preventive strategies. Until 1995, the curative approach was 77.9 percent of the total government expenditure, while community based care and preventive approaches received only 6.7 percent and 15.4 percent, respectively (World Bank 1995: XXXII).

Urban development in Tanzania has been characterized by the adoption of a socio-economic system with significant inequalities. This has taken place without proper planning and has led to the creation of unstructured urban areas which have substandard infrastructure. Colonial urban planning policies favored the interests of those who commanded social and political power. They introduced a system of social organization of urban space which favored social relations of inequality. The zoning system segregated residential areas in terms of high, medium and low density residential zones which in practice meant poor, middle and high income earners. This marked the beginning of residential segregation by class in urban Tanzania. Unfortunately, the situation has been made worse by post-independent policies of urban planning which have not only adopted the colonial policies wholesale, but have added to the list another type of residential area which is considered as "overcrowded." This kind of segregation influences the way in which the state provides the basic urban services and infrastructure. These policies have therefore continued to generate segregation and poorly organized and financed urban space, excluding the majority of the urban people from enjoying social services necessary for good health.

Dar-es-Salaam is divided into four main types of residential areas, the environmental conditions of which reflect the class nature of their residents. The first residential area is that of the affluent population. It includes all the Indian Ocean beaches like Oyster Bay, Msasani, Masaki, Mbezi and Tegeta. Other areas are Mikocheni, Regent and Ada estates and some few

parts of East Kinondoni. These areas, inhabited by higher income social groups, who have access to social and political power, also have easy access to basic social and civic service facilities and satisfactory levels of health care. Government ministers, diplomats, permanent secretaries, managers or director generals of local and foreign companies, and very successful private business people live in these places.

The second residential area characterized as medium density, accommodates most of the middle-income earners. This includes areas like Sinza, Kijitonyama, Kurasini, Mlalakua, some parts of Makongo and Upanga. These follow the above affluent areas in terms of the infrastructure and social services. Although some of them originally started as squatters, (i.e., Makongo) they have now improved considerably. Some of these areas have been surveyed and their occupants have official land title deeds.

The third type is the high density area which includes Ilala, Magomeni, Manzese, Mwananyamala and Temeke. These are basically low working-class residential areas. Some are up-graded squatter settlements but are still characterized by housing of low standard, built of impermanent materials and lacking facilities like water, drainage and centrally connected sewage systems.

The fourth type of residential area is the one considered as overcrowded. This type includes all the squatter settlements which are occupied by the urban poor. These include Vingunguti, Hananasif, Ubungo Kisiwani, Mabibo, Buguruni, Kiwalani, Shimo la Udongo, Kipawa and several others. The majority of the people who live in these areas are poor and desperate. They do not have access to a variety of urban benefits like paid formal employment. Most of them survive on incomes generated from marginal jobs. They experience worse living conditions than the people living in the other residential areas. Seventy percent of the urban population in Tanzania live in these areas.

Clearly, then, the social organization of urban space mirrors the correlation between income and access to health services, hygiene, sanitation facilities, transport, good housing and good education. The nature of these facilities reflects the class inequality that exists in Dar-es-Salaam and the close correlation between low income levels, lack of services and health. In a situation where the government is experiencing severe financial constraints, the limited budget available tends to be used to improve the environmental situation of the high standard areas because these areas accommodate those who wield economic and political power.

This kind of social organization of space in urban areas has not happened accidentally, but is planned, and reflects the colonial legacy in urban planning. It also confirms the relationship existing between ideology, politics and urban planning. For example, the post-master plan for Dar-es-Salaam, published in 1968, and the Master Plan for the Capital City of Dodoma, which came out in 1976, recognize social and class differentiation, and perpetuate it by emphasizing the quality of urban residential areas along the lines of class income and social status. The master plan for Dar-es-Salaam uses terms including "high standard," "medium standard" and "low standard" residential areas. These areas are supposed to differ from each other in terms of the following: the "high standard" area must contain high-priced, private homes, paved roads, street lighting, adequate water, power supply and should be linked to a central sewage; the "medium standard" area should have medium-priced National Housing Corporation homes and private houses, paved roads, power, water connections, and public septic service; the "low

standard" areas are supposed to be self-built houses capable of accommodating multi-families. Roads should be unpaved and houses should have pit latrines or septic tanks. Power should be provided in the collector streets only.

The master plan for Dodoma adopted the same system but used different terms, namely "low density" (high standard), "medium density" (medium standard) and "high density" (low standard) areas. It is clear from these master plans that the urban poor are not a priority in these urban development policies. Since the organization of urban space reflects the socio-economic inequalities existing in urban Tanzania, it has highly influenced the provision of health services precisely because the latter is also influenced by this situation. Severe financial constraints mean that the poor are now completely forgotten in the development processes.

At present, the situation is made worse because Tanzania has identified development with modernization, which is a social process equated with Westernization. This path of development runs against national ability, values and traditions. The emphasis on Westernization is leading to resource constraints; it is now proving difficult for Tanzania to provide the basic necessities of life to everybody. Hence, modernization can be identified as benefiting only the privileged. It has led to two distinct lifestyles, namely "traditional" and "modern" or "affluent." This is evident in housing, employment, and more particularly in terms of facilities available to different social classes. The existence of squatter settlements co-existing with luxurious housing structures in urban areas and the increasing number of tourist hotels in urban areas amidst few inadequate public owned health and medical care facilities are concrete examples of how dependency has been internalized in Tanzania and how it is leading to urban inequality and urban poverty. It is now indisputable that urban poverty and environmental problems as well as those associated with urban health in Tanzania are products of the broader politics in Tanzania. The decay of the urban system is a reflection of how these politics manifest themselves at a micro level.

Ever since colonialism, policies adopted have emphasized the exploitation of the countryside by insisting on production of cash crops instead of food crops. As a result, Tanzania's economy has always been externally oriented and is not able to satisfy internal demands. Policies which emphasize the improvement of rural conditions of life have been very rare. If any, (i.e., Ujamaa socialist policies) their implementation has had its own limitations. One may want to know whether the situation in Tanzania would have been better without the introduction of SAPs and donor support. This is a difficult question. Many recent studies confirm that the majority of the population are now having difficulties in making ends meet (World Bank 1995; Bagachwa 1994; Gibbon 1993; Lugalla 1995; Schmied 1996). This is a clear indication that things are worsening rather than improving.

If one looks at the history of development in Tanzania, one notes that during the period characterized by Ujamaa policies, which can roughly be considered as the period between 1967 to the late 1970s, Tanzania attained a variety of successes in social development initiatives. Private schools and hospitals were nationalized, the government began providing free education and health care services. Through the primary health care development strategy, the government built many rural health centers and many secondary and primary schools. The budget for social services was enormous. As a result, literacy rates rose, access to education and

health care increased for the majority of the people, and the standard of living improved. This is also confirmed by the following narratives from urban and rural informants.

Things have changed nowadays in urban areas. The roads are bad, the cost of living is high, houses for rent are not available, schools have no desks and hospitals are lacking everything from personnel to equipment. A resident of Kinondoni, Dar-es-Salaam, showed dissatisfaction with the present situation in the following statement:

Nchi imeharibika. Enzi za Ujamaa mambo hayakuwa hivi. Maisha siku hivi ni magumu sana.

The country is now torn asunder. Things were not like this during the era of Ujamaa. Life is now very difficult (Translated by the author. Urban informant, Dar-es-Salaam, August 1995).

A rural resident from Sumve Mwanza seems to support the above opinions in the following way:

Watu wangi wamakimbilia mijini kwa sababu vijijini hukukaliki. Maisha ni magumu mno. Bei za karibu kila kitu ziko juu sana. Shule hazina walimu. Kwenye vituo vya afya huwezi kupewa dawa mpaka uhonge. Rushwa imekuwa ndiyo mtindo wa maisha vijijini na mijini kwa sababu mishahara ya wafanyakari haitoshi. Mambo hayakuwa hivi miaka ya sitini na sabini.

Many people are running for towns because village life is unbearable. Prices of almost everything are so high. The schools do not have enough teachers. You cannot get medicine in rural health centres unless you bribe. Bribing is now a way of life in both rural and urban areas because the salaries workers get are not enough. This was not like this in the sixties and seventies (Translated by author. Rural informant, Sumve Mwanza, Tanzania, July 1995).

Many people acknowledge that in the period before the crisis and SAPs things were relatively better. This is not to say that policies were perfect, but now under SAPs, the government has abandoned those redistribution policies which focused on improving the quality of life for the majority of the people. Expenditure in social services has been reduced drastically and my previous studies on the impact of SAPs on education and health show that the majority of the people are having difficulties in accessing good education and health care (Lugalla 1993: 184-214; Lugalla 1995a: 43-53). In a recent study on "Social Sectors in Tanzania", the World Bank itself has admitted that the gross primary school enrollments which reached nearly 100 percent in 1979 to the early 1980s has now dropped to less than 70 percent (World Bank 1995: XVII). The Bank also admits that growth has been accompanied by greater inequality and that the really poor at the bottom appear to have fallen far behind (ibid.).

7. Recommendations

One aspect which requires emphasis and understanding is that the urban people, poor and rich alike, understand how social services in cities are provided. The people interviewed in two settlements know that they are living in an environment which puts their health at risk, but they cite their poverty as the main limiting factor. The government officials also know that parts of urban areas are filthy and therefore vulnerable to epidemics. It is unclear, however, whether they understand that it is the government's development policies which are responsible for these conditions. A statement made by a Dar-es-Salaam City Council Land officer, summarized below, reveals concretely the official view concerning squatters:

Squatter problems may take so many years to get solved. We have done our best to restrict these people in building in these risky areas but they do not listen. The floods are also assisting us in sweeping away these settlements but still these funny houses continue to mushroom. People are leaving their good rural areas in order to come and live in this hopeless situation. What do you do with such people? The government has always been repatriating the jobless to their rural areas but the next day they are back again. I think the government must use force. This may also solve the problem of increasing rate of crimes.

Certainly official policies which are influenced by this kind of view are bound to criminalize the poor as if they are responsible for their poverty. These officials need to be educated. Looking at political practices in Tanzania, it is clear that there is a serious discrepancy between theory and practice in the question of how urban poverty can be eliminated. Despite the extreme poverty, basic health education could alleviate some of the factors that put the poor at risk. There is a need for people to be well informed about methods of prevention. For example, they need to know that unhygienic practices are likely to be the cause of their health problems. These practices may include handling water in unclean vessels, leaving food uncovered from flies, and not washing hands before handling food. Lack of government support in solving these environmental problems has led to the creation of a variety of grass-roots level organizations that are interested in protecting the environment in most urban areas, but particularly in Dar-es-Salaam. If the government is serious about these issues, it will have to cooperate with such organizations in order to improve the urban environment.

Poverty is at the center of environmental and health problems in urban Tanzania. The urban poor are the most needy people but the least assisted by government policies. They are the most vulnerable population in the urban system and government policies must aim at assisting them. Once food and good shelter are offered to these people through easy access to well paying employment opportunities and credit schemes, more efforts must be directed at solving their environmental related health problems. Basic sanitary services and refuse collection must be provided. Prevention programs focusing on immunization and ante-natal care could prevent communicable diseases.

Since poverty is the main problem, any long-term solution must focus at tackling this social problem. In doing this, one must be cognizant of the fact that poverty is not only a function of disposable income but is also a state of relative lack of access to other resources such as information, social networks, adequate time and space, and above all, the decision-making process that affects the lives of the poor. Poverty-oriented strategies must target the poor. Indirect approaches that rely on the proper functioning of the micro-economy may not benefit the poor, even by following the New International Economic Order, or the World Bank and International Monetary Fund models. Although the active role of the government in the fight against poverty is necessary, it often hurts the poorest of the poor by formalizing their informal processes (Sanyal 1988: 79).

Tanzania's urban poverty is a reflection of rural poverty. Therefore, efforts to tackle urban poverty must also focus on improving the conditions of life in the countryside. In Tanzania, there is extensive rural-urban migration. Seventy percent of the urban population are migrants from the rural areas. Policies must seek to address the question: Why do people run away from the countryside? People migrate to towns and cities because of the difficulties of rural life.

Access to productive land is difficult. The methods of production as well as the instruments used in agriculture are still traditional and therefore income derived from agriculture is not sufficient for living a good life. Social services, communication infrastructure, and other basic necessities of life are underdeveloped and the chances for establishing small scale income-generating projects are rare. In fact, the very poor urban migrants are relatively better off than their rural poor counterparts. This means that new policies must make sure that rural Tanzania is an attractive place to live. This can be done by promoting social and economic development in the countryside. This may limit rural-urban migration, which can then limit the urban population pressure and possibly reduce the scale of urban environmental problems. Only policies which are part of an overall socio-economic development plan can bring positive results.

These recommendations assume that Tanzania has a government which is capable of implementing these policies. Although committed leadership, good governance and accountability are the preconditions for success, the participation of Tanzania in the global socio-economic system suggests that strategies adopted by Tanzania in order to solve poverty can only succeed if there is an enabling international environment. It is very unlikely that Tanzania can manage to accomplish this alone. In order to change the design of SAPs, Tanzania needs to question the role of the World Bank and the IMF. Things can change only if these institutions are subject to democratic control and accountability, and if the structures of dependency are radically altered. It is in this area that international collaboration is required in order to make radical changes in the global economic system.

8. Conclusion

In conclusion, it is important to strongly affirm that the position of this paper has not been to argue that SAPs policies are the initial cause of poverty in Tanzania. In fact, our analysis of the process of dependent urbanization has been presented here in order to address the historical roots of poverty and social inequality existing in Tanzania. The focus of this paper has been to show concretely that the arguments propagated by contemporary neoliberals and institutions like the World Bank and IMF that SAPs are capable of solving the social-economic crisis confronting countries in sub-Saharan Africa do not hold true for Tanzania. Examples from Tanzania show that SAPs have exacerbated hardships and are therefore enhancing poverty rather than alleviating it. Their emphasis on reducing government expenditure in unproductive sectors of the economy is leading to negative trends in social development in urban areas, including physical and civic infrastructure. The urban environment is now decaying progressively rather than improving with deleterious consequences on people's health. The adoption of SAPs seems to be hurting the poor instead of assisting them. The urban poor live in an environment which is conducive to ill-health, and have severe difficulties in accessing both private and public health institutions because of the introduction of user charges. Although poverty lies at the center of these problems, SAP programs are failing to address this problem adequately. It is important for Tanzania to implement development strategies that focus on human beings. They must strive to improve the welfare of the majority people. Without this, Tanzania will be, "draining the pond in order to catch the fish."

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