Social Protection in Tanzania:
Establishing a national system through consolidation, coordination and reform of existing measures
The National Youth Development Policy and the National Disaster Management Policy foresee numerous interventions to enhance prevention, preparedness, recovery and rehabilitation in the event of natural or man-made disasters. Related institutional responsibility lies with the Disaster Management Department in the Office of the Prime Minister and the National Food Security Department of the Ministry of Agriculture and Food Security.

The Ministry of Health and Social Welfare (MoHSW) delivers a wide range of health and social welfare services under its Health Sector Strategic Plan III putting emphasis on the extension of healthcare to the poor and vulnerable, including supporting those with HIV/AIDS. Health services are largely publicly financed (a cost-sharing model with a system of exemptions – e.g. applying to children under five years and diseases such as tuberculosis, AIDS, epidemics and leprosy,) although since 1993 the Government has opened the health sector to private providers.

The National Education and Training Policy (1995) guarantees access to education and adult literacy for all citizens as a basic right. The Ministry of Education and Vocational Training assumes the responsibility of facilitating access to education for the disadvantaged, such as people with disabilities and orphans. In this light, the Government abolished fees for public primary schools, while fees for secondary schools were reduced.

The Government has adopted several international conventions and the Social Policy Framework of the African Union. Further, the Government is engaged in the Social Protection Floor agenda.

In 2003, the National Social Security Policy was enacted to expand the coverage of social security under the Ministry of Labour and Employment, to harmonise the existing funds and to reduce fragmentation. The policy indicated three major areas in the development of a social security system, namely mandatory schemes, social assistance to the vulnerable, and voluntary market-based schemes. The policy also established the Social Security Regulatory Authority (SSRA), which sets the agenda and implements the Social Security Reform Programme with a focus on extension of coverage, including informal workers.

The Ministry of Labor and Employment oversees national employment policies and programs. The National Employment Policy (2007) aims to provide productive employment with equal access to decent employment opportunities with a focus on vulnerable groups. The Youth Employment Action Plan was developed to execute the objectives of the National Youth Development Policy.
unit of the Ministry of Empowerment, Social Welfare, Youth, Women and Children is the leading entity that coordinates and supervises all non-contributory social protection intervention in Zanzibar.

Social protection schemes

**Contributory schemes (social insurance):**

Contributory schemes are based on the social insurance model and provide protection against loss of income resulting from old age, invalidity, maternity, death of a breadwinner, work injury and illness. Almost the entire informal sector accounting for over 93% (incl. peasants, agricultural employees, and persons employed in small businesses, small-scale industries, fishing, etc.) is not covered by any form of social security scheme (other than limited access to certain public health services.) No pension benefit arrangements exist in the informal sector, with some private arrangement made at best. Therefore, these workers tend to depend on the extended family and clan for support.

The key contributory instruments are: National Social Security Fund (for private sector workers), Parastatal Pension Fund (for parastatal and private), Public Service Pension Fund (for central government employees), Local Authorities Pension Fund (for local government employees only), Government Employees Provident Fund (for non-pensionable government employees), and Public Service Retirement Benefit Scheme (for politicians). Coverage remains limited. Tanzania has seven social security institutions, of which six operate in Tanzania Mainland; the Zanzibar Social Security Fund (ZSSF) operates in Zanzibar.

**Health insurance**

There are two compulsory social insurance funds offering health and medical coverage:

The Community Health Fund (CHF) was established as an alternative for the fee-for-service scheme and targets poor households (HHs) in rural areas. However, in 2011 about 560,000 HHs were enrolled, accounting for only 7.4% of the total population. Overall only 14% of the total population were covered by NHIF and CHF in 2011, implying that the majority of the population, who is not entitled to exemptions, must pay at the point of service.

Non-contributory program (social assistance):

Non-contributory programs entail transfers in cash or in kind without linking provision to any required contribution. In Tanzania the following are the key social safety net programs:

- **Most Vulnerable Children** (MVC) Program: managed by the DSW, this instrument provides social assistance to vulnerable children including orphans. The MVC Program ensures community-based care, support and protection for about 570,000 orphans and MVCs. DSW also implements small scale support programs for other vulnerable groups such as the elderly, persons with disability and drug users.

- **Subsidized Food Distribution**: the National Food Reserve Agency is used by the GoT to distribute free food or at a highly subsidized price in food insecure districts. It reaches about 1.2 million annually.

- **School feeding**: covers about 600,000 primary school students (8% of the total). The program is largely funded by WFP and targets food insecure districts.

- **Community-based cash transfers (TASAF)**: see separate box

- **Public Works Program**: TASAF (see separate box) and WFP Programme “Food for Assets”, which pays in food.

In terms of economic empowerment, Savings and Credit Cooperative Societies (SACCOS) constitute the most common micro-finance institutions, especially in rural areas. TASAF (see box) is developing a strategy and roll-out plan for livelihood enhancement, which will entail advice and support concerning savings and investments through community driven interventions.

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**Tanzania Social Action Fund (TASAF)**

In the early 2000s, realizing that rapid economic growth may not be sufficient to substantially and sustainably reduce extreme poverty and inequality, the Government of Tanzania (GoT) established the Tanzania Social Action Fund (TASAF) as one of the National Strategy for Growth and Reduction of Poverty (NSGRP) implementation initiatives to ensure more inclusive growth. The implementation of the first two phases of TASAF achieved impressive results in facilitating community access to social services through infrastructure projects such as schools, health facilities and water points reaching 7.3 million people in TASAF I and 16.1 million in TASAF II.

Based on this success, in 2013 GoT decided to design and implement the Tanzania Productive Social Safety Net program (TASAF III – PSSN.) The objective of TASAF III is to increase household (HH) consumption while improving human development indicators and helping beneficiaries save and invest for income generation, HH asset accumulation, and therefore be on the path out of extreme poverty. The objectives of the scaling-up of the PSSN are to be achieved through the following components:

i. Establishment of a National Safety Net incorporating transfers linked to participation in public works and adherence to co-responsibilities;

ii. Support to community driven interventions which enhance livelihoods and increase incomes (through community savings and investments as well as specific livelihood enhancing grants);

iii. Targeted infrastructure development (education, health and water) to enable poor communities to realize the objectives of the safety net;

iv. Capacity building to ensure adequate program implementation by communities, Project Area Authorities/Districts and at the national level.

The program has recently been scaled up, with plans to reach about 920 000 HHs living below the food poverty line by the end of 2015. The PSSN has already targeted about 275,000 beneficiary HHs (and more than 12 mil have been delivered to beneficiary HHs.) Payment transfers have been made to about 138,000 beneficiary HHs.

Targeting: TASAF III uses a combination of four elements to successfully identify program beneficiaries, i.e. a geographical mechanism to identify and select districts, wards and villages and allocate an appropriate level of resource; community targeting to identify extremely poor and vulnerable households in selected villages; a Proxy Means Test to verify and minimize inclusion errors; and a Community Validation test to confirm the results of the community targeting and Proxy Means Test.

Targeting for all sub components of the PSSN uses a common
targeting system. The resulting list of beneficiaries will become available on a database as a Unified Registry of Beneficiaries.

Conditionality: cash transfers are conditioned on family’s participation in education and health related services, as well as community sessions on health, nutrition & sanitation every two months.

A Supply side capacity assessment in the target area is carried out to determine the actual coverage and quality of available services. On the basis of the assessment, the program determines which of the co-responsibilities outlined above apply.

### Size of benefit (per month):

<table>
<thead>
<tr>
<th>Transfer type</th>
<th>Transfer name</th>
<th>Amount (US$)</th>
<th>Conditionalities</th>
<th>Caps (US$)</th>
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<td>Fixed</td>
<td>Basic transfer</td>
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<td>Extreme poverty</td>
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<tr>
<td>Fixed</td>
<td>Household child benefit</td>
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<td>Children in HH less than 18</td>
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<tr>
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<td>Infants benefit</td>
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<td>Infants 0-5 health compliance</td>
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<tr>
<td>Variable</td>
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<td>Max total benefit</td>
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</tr>
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### Tanzania Mainland: key indicators and spending trends

#### Demographic indicators
- Population (2012): 44.9 million
- Population under 18 (2012): 22.5 million
- Annual population growth rate (2012): 2.7%
- Average Household Size (Number) (2012): 4.7
- Life expectancy at birth (2012): 61 years
- Female Headed Households (2012): 33.4%
- Average Household Size (Number) (2012): 4.7
- Literacy rate (population above 5 years) (2012): 72%

#### Education indicators
- Pre-Primary School enrolment (2013): NER: 35.5% and GER: 37.3%
- Primary School enrolment (2013): NER 89.7% and GER 96.2%
- Transition rate (primary to secondary) (2013): 59.5%

#### Mortality and health indicators
- Infant mortality rate (per 1,000 live births) (2012): 45
- Under-5 mortality rate (per 1,000 live births) (2010): 81
- Maternal mortality rate (per 100,000 live births) (2012): 432
- Children under five moderately malnourished - stunting (height for age) (2010): 42%
- HIV infection prevalence (15 – 49 yrs) (2012): 5.1%

#### More social indicators:
- Population with Birth Certificate (2012): 15.0%
- Use of safe drinking water (2012): 54.8%
- Use of improved sanitation facilities (2012): 24.5%
- HDI: currently ranked 152 out of 182 countries

#### Economic indicators
- Growth Rates for the Second Quarter 2014:
  - GDP: 6.9%
  - Poverty Headcount (2012): 28.2% (basic needs), 9.7% (food - extreme poverty)
- Annual Inflation (July 2014): 6.9%
- Gini coefficient (of consumption per capita): 0.34 (2012)
- Total public social protection expenditure and health expenditure (% of GDP): 6.8% (2.3% excl. health care)
Increase in public social protection expenditure, selected low-income countries, 2000 to latest year (percentage of GDP)


Public social protection expenditure on child and family benefits (excluding health), 2010/11 (percentage of GDP)

Source: Ibid
The agenda ahead:

Tanzania is developing a framework for national coordination and investments in social protection. Examining and drawing up a plan for reforming the existing social protection/safety net measures including various subsidies is one of the top priorities before the NSPF taskforce. Addressing health, age, adolescence/youth, disability and migration related vulnerabilities is central to this reform and consolidation vision, supported by a series of ongoing analyses. Finally, it is increasingly clear that achieving the social protection objectives as espoused in the NSGPR would require the integration of social protection within the national and sectoral planning and budgeting exercises.


iii. i.e. living below the basic needs poverty line (36,482 Tanzanian Shillings - US$21 - per adult equivalent per month.

iv. i.e. living below the food poverty line (26,085 Tanzanian Shillings – US$15.7 – per adult equivalent per month).


vi. Poverty Reduction Strategies for Tanzania mainland and Zanzibar respectively.

vii. The Reform Program has four key results area: sustainability of the social security schemes, harmonization, coverage, and programme governance and management.


x. Ibid

xi. The urban equivalent is known as TKA.

xii. Health Sector Public Expenditure Review 2010-11.

xii. It is estimated that less than 3% of the population is covered by private health insurance (ibid)

xiv. Out-of-pocket payments constitute a considerable share of total health care spending in Tanzania. According to the National Health Accounts 2010, the share of HH contribution to total health spending increased from 25% in 2005-06 to 32% in 2009-10, thus raising serious equity concerns. Recent studies show that the exemption and waiver system is widely ineffective in ensuring access to health care for the poor.


xvi. Ibid

xvii. Ibid


xix. Key analytical pieces like ‘Analysis of Fiscal Space for Social Protection’ (commissioned by MoF and conducted by EPRI with support of UNICEF and ILO), ‘Disability and Social Protection’ (just concluded by REPOA and London School of Hygiene and Tropical Medicine) the most recently concluded GIZ supported study on health social sector financing are important injects in this analysis and thinking.