THE GENDERED IMPACT OF THE GLOBAL ECONOMIC CRISIS ON FINANCING AND ACCESS OF HEALTH CARE IN TANZANIA

By Dr Paula Tibandebage & Dr Tausi Kida

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LIST OF ACRONYMS

AIDS	Acquired Immuno Deficiency Syndrome
CCHP	Comprehensive Council Health Plan
D by D	Decentralization by Devolution
EmOC	Emergency Obstetric Care
FGM	Female Genital Mutilation
GBS	General Budget Support
GDP	Gross Domestic Product
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
HBS	Household Budget Survey
HIV	Human Immuno-deficiency Virus
HSBF	Health Sector Basket Fund
LGAs	Local Government Authorities
LGRP	Local Government Reform Program
HSSP	Health Sector Strategic Plan
MDGs	Millennium Development Goals
MoHSW	Ministry of Health and Social Welfare
MMR	Maternal Mortality Ratio
MTEF	Medium Term Expenditure Framework
NBS	National Bureau of Statistics
NSGRP	National Strategy for Growth and Reduction of Poverty
PEFFAR	President's Emergency Fund For AIDS Relief
PRS	Poverty Reduction Strategy
PRSP	Poverty Reduction Strategy Paper
TB	Tuberculosis
TDHS	Tanzania Demographic and Health Survey
TMAP	Tanzania Multi-sectoral AIDS Program
URT	United Republic of Tanzania
USAID	United States Agency for International Development
WB	World Bank
WDR	World Development Report
WHO	World Health Organization

1.0 INTRODUCTION

Health care in Tanzania is recognised as a basic social service and remains one of the government's priorities (URT 2005). In recent years, Tanzania has been struggling to improve the health care system and improve health indicators towards achieving the targets set in the National Strategy for Growth and Reduction of Poverty (NSGRP) and those set for the Millennium Development Goals (MDGs). The global economic crisis has come at the time when Tanzania was showing signs of improvements in financing health care that was made possible by, among others improvements in economic growth averaging over 6 percent per year over the last six years (ESRF, 2009). Indeed, adequate financial resources are pivotal for effective delivery of health services. Nonetheless the level of public spending on health remains inadequate and the health sector is still heavily reliant on out of pocket payments in financing health care (Kida 2009, HBS 2007, Mackintosh and Tibandebage 2004, USAID 2010). Moreover, the development budget for the health sector in Tanzania remains highly dependent on external funding.

Shocks in the economy have in the past adversely affected on the supply side, the capacity of the Government to provide adequate health services and on the demand side, the ability of the population to access health care. A case in point is the economic crisis of the late 1970s and early 1980s that among others led to fiscal pressure associated with cuts in social spending including the health sector. Although before these crisis Tanzania was making steady progress in meeting the basic needs of the population, the economic crisis severely strained the capacity of the government to provide basic services and even eroded some of the earlier gains. The global economic crisis poses similar threats to the health sector. It is therefore essential to explore the potential impact of the current global economic downturn, with a view to determining in advance essential steps to mitigate its adverse effects on provision of, and access to health services.

This paper therefore examines the potential gendered impact of the current global economic crisis on health care financing and access to health services. The paper argues that the effects of the current global economic crisis on the economy in general and health care financing in particular are likely to further weaken the capacity of the health system to provide adequate and equitable health services to the population, and at the same time affect people's ability to access health services. The paper then explores the implications of this on gender equity in access to health services, arguing that women who have more health needs because of their reproductive role and at the same time are disadvantaged due to lack of control and/or decision making powers over resources will be disproportionately affected.

This paper has been developed based on a review of secondary data and information from government reports and independent research reports; reviews on issues of health care financing and access to health services in Tanzania; and available assessments and reviews of the impact of the global economic crisis. The paper is divided into six main sections. Section one provides the introduction which sets out the rationale for the paper. Section two provides an overview of the Structure of Health care financing in Tanzania, while section three assesses the already experienced and potential impact of global economic crisis on the economy of Tanzania. An assessment of the likely effects of the global economic crisis on the health care supply side in terms of capacity to

finance health services, and demand side in terms of the ability to access health care is provided in section four while section five discusses the gendered implications of the impact of the global economic crisis on both sides. Section six provides a conclusion and suggests ways to mitigate the gendered impacts of the global economic crisis on health care financing and access to health services.

2.0 THE STRUCTURE OF FINANCING HEALTH CARE IN TANZANIA

The health sector has been one of the priority sectors in the ongoing socio economic reforms in Tanzania and in particular in the poverty reduction initiatives as reflected in the Poverty Reduction Strategy (PRS) (URT-PRSP 2000) and also the National Strategy for Growth and Reduction of Poverty (NSGRP) (URT-VPO 2005). In relation to health care, the NSGRP identified two broad outcomes: (i) improved quality of life and social well-being, with particular focus on the poorest and most vulnerable groups; and (ii) reduced inequalities in provision and access to health care services across geographic, income, age, gender and other groups. In this regard, the health sector has benefited from the increase in absolute levels of government funding and from development partners; the latter being mainly through a Sector Wide Approach (SWAP). Other sources including the National Health Insurance Fund, Community Health Fund and fees from cost sharing have also contributed to the financing of health care. This section provides a summary of the recent status of the key aspect of health care financing in Tanzania. This includes: financing sources and shares; trends in health sector spending; trends in per capital health expenditure; and level and share of government spending at the local government level.

Financing Sources and Shares: The main sources of financing the Tanzania health sector is from two main types of budget resources - on budget and off budget, each comprises of domestic and foreign sources (See Table 2.1). On budget sources include revenue of the government as well as grants and loans from development partners, mainly the Health Sector Basket Fund (HSBF) and General Budget Support (GBS). Off –budget financial resources include revenue raised through cost sharing mechanisms and councils' own resources in addition to a large portfolio of direct foreign funded projects and programmes (COWI et al, 2007)

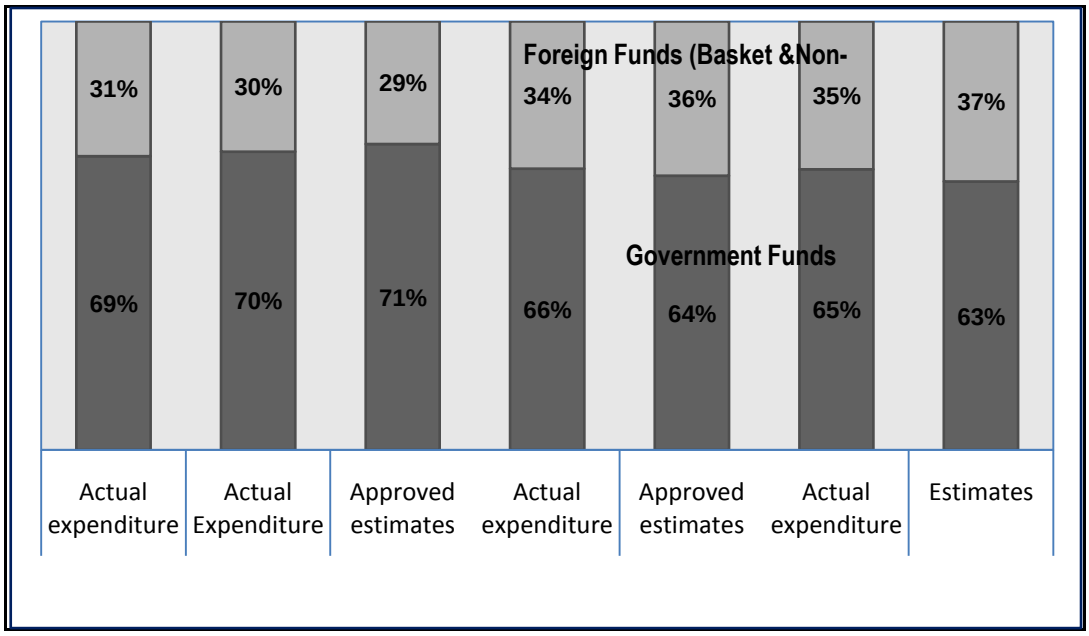
Table 2.1: Overview of Main Sources of Financing Health Care in Tanzania

Source	On – Budget	Off- Budget
Domestic	Central Government Funds (Including National Health Insurance Fund – NHIF)	Health Services Fund (User Fees), Community Health Fund (CHF), Drug Revolving Fund, Council Own Sources
Foreign	General Budget Support (GBS), Health Sector Basket Fund (HSBF), Foreign Funded Projects and Programmes	Foreign Funded Projects and Programmes

Source; COWI et al. 2007

The recent review of the health sector financing indicates that there is still high dependency of external sources to fund the health sector activities (MOHSW/PER, 2008). Figure 2.1 shows the percentage shares of government and foreign contributions to health financing for the period 2004/05 to 2008/09. It indicated that while the government funds remain higher, foreign funds have accounted for an average of 33% of resources between the two time periods

Figure 2.1: Shares of Government and Foreign Funds in Health Sector Financing

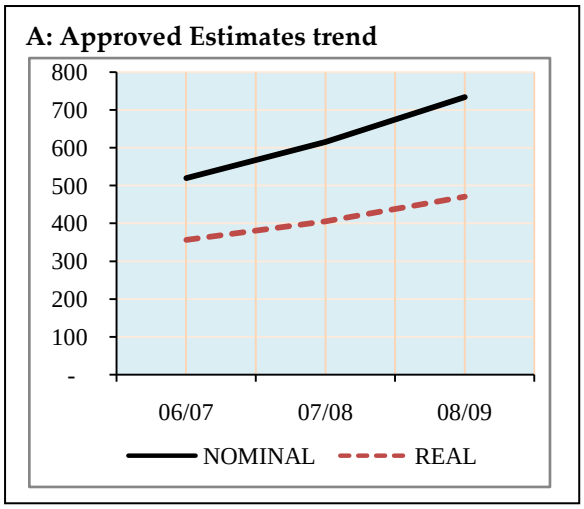


Source: MoHSW/PER 2008

Although the share of foreign funds has consistently remained lower than the local component, the development budget of the health sector (which funds most of the intervention programmes) is heavily reliant on funds from external sources.

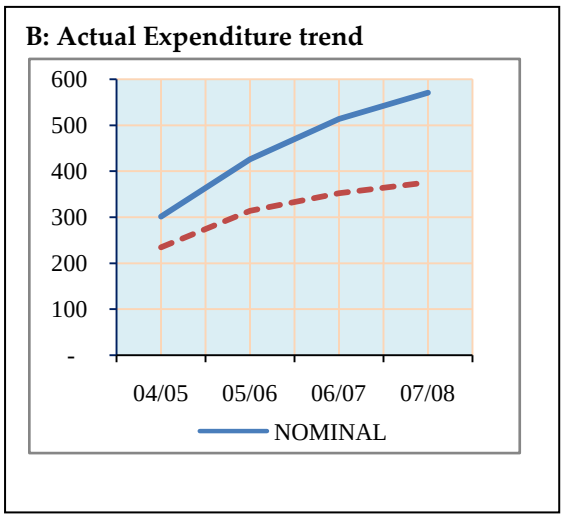
***Trends in Health Sector Spending*:** The Health sector reforms through the SWAP initiative, introduced the Health Sector Basket Fund (HSBF) in 1999 in collaboration with development partners to finance the MoHSW's annual plan of action. The HSBF entails pooling of funds into one basket with the aim of providing budgetary support allocated according to Government priorities, within the approved budget framework. Following the establishment of HSBF, the level of nominal and real spending in the health care sector has been rising rapidly since the early 2000's (Kida 2009). However the trend in health sector spending as outlined in Figure 2.2 indicates that actual health expenditure between 2005/2006 and 2008/09 has been increasing at decreasing rate. The health sector spending grew by 41% in 2005/06, then by 20% in 2006/07 and by 12% in 2007/08 (MoHSW, 2009/PER 2008).

Figure 2.2: Trend of Nominal Expenditure in Health 2004/05 – 2008/09



Source: MoHSW/PER 2008

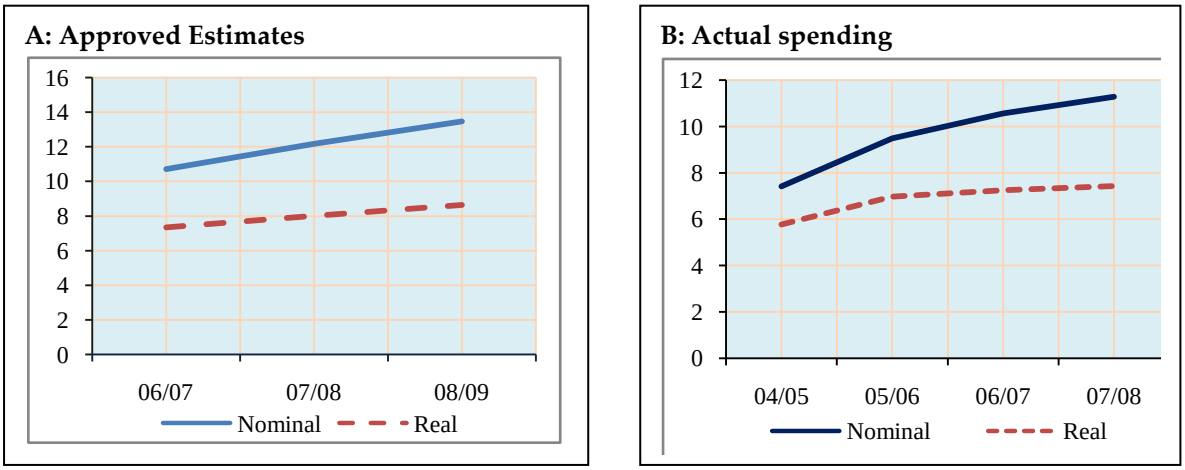
Figure 2.3: Trend of Real Expenditure in Health 2004/05 – 2008/09



Source: MoHSW/PER 2008

Per Capital Health Expenditure: Per capita expenditures in health, is one of the key benchmarks used to assess the scope of health spending in a country. Available data indicates that there has been a gradual increase of per capita spending between 2006/2007 and 2007/2008. Per capita health spending increased modestly from about 7.25 USD (real) in 2006/07 to 7.74 USD (real) in 2007/08. Figure 2.4 below shows the trend of both nominal and real per capita health spending between these two periods, based on official exchange rates and population projection figures from the National Bureau of Statistics (URT/Moshe 2009). However, this data indicate a worrisome trend as the per capita health spending remains well below the government target of US$ 12 per capita expenditure by year 2005 (Kida 2009). Also, the figure even in nominal terms, is still very far from the target set by WHO Commission on Macroeconomics and Health of US$ 34 per capita during this period. With costs in the health sector escalating and health care expenditure below targets, there is a need for the government and development partners to increase funding to the health sector (URT –MoH 2006; COWI et al 2007)

Figure 2.4: Trend of Per Capita Health Spending in USD

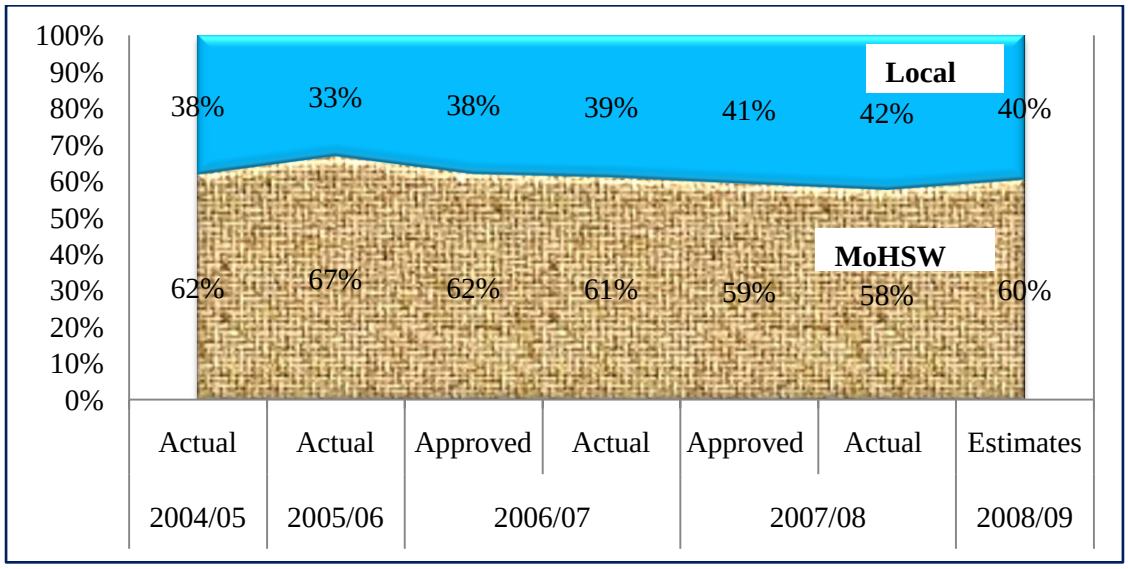


Source: MoHSW/PER 2008

Level and Share to the Local Government Level: The decentralisation programme is in place in Tanzania and the Health Sector Reform's (HSR's) are being implemented within the boundaries of a decentralised local government structure. Following implementation of the Local Government Reform Programme (LGRP) in early 2000, decisions regarding personnel planning and financing of health care service delivery were decentralised to the district levels. The vision behind it was that it would enhance transparency and accountability of resources allocated to health care and improves access to care by the poor.

Research findings and evaluations done in Tanzania suggest that to some extent decentralization of health services as part of the broader Decentralization by Devolution (D by D) process has had a positive impact on health care service delivery. For example, an evaluation working paper on LGRP in 2007 concludes that D by D was having a positive impact on service delivery. It however acknowledged that there were other factors that could affect service delivery including: the level of autonomy and discretion that LGAs have the resources they have, and the compliance with policy and legal framework both locally and centrally (Tibandebage, 2009).

Figure 2.5: Trend of Distribution of Resources between Central and Local Govt



Source: MoHSW/PER 2008

In line with the decentralisation programme, the MoHSW was to increase funds allocated to the local government level. This was to enhance health care service delivery at the most accessible level for the majority of health care service beneficiaries. However, the recent trend indicates an almost stagnant share of the resources to the local government level and this is contrary to increased decentralisation of resources as intended by the policy (see Figure 2.5). For example, figure 2.5 clearly indicates that there was a modest improvement in the share of resources to the local level from about 33% of actual expenditure in 2005/06 to about 42% of actual expenditure in 2007/08, but it slid back to about 40% of the actual expenditure in 2008/09. Although this change might seem small, it indicates a worrying reversal of policy intentions. This move implies that fewer resources will flow to primary levels of health care where the majority of the poor people are supposed to have access to adequate and quality public health care service, including poor women and children.

3.0 OVERVIEW OF THE IMPACT OF GLOBAL ECONOMIC CRISIS ON THE ECONOMY OF TANZANIA.

The current instability in the global economy which has mainly occurred in the richer nations has also made the poor countries like Tanzania to become victims. The experiences from past economic downturns indicate that there were substantial drops in foreign aid to developing countries and also substantial decline in government revenue due to decrease in export earnings,(USAID, 2009).

> ***"As richer countries buy less from low- income countries, revenue decrease, which lowers worker incomes and raises unemployment. Health and Social programs targeting the poor are often the first victims of budget cuts" USAID,2009***

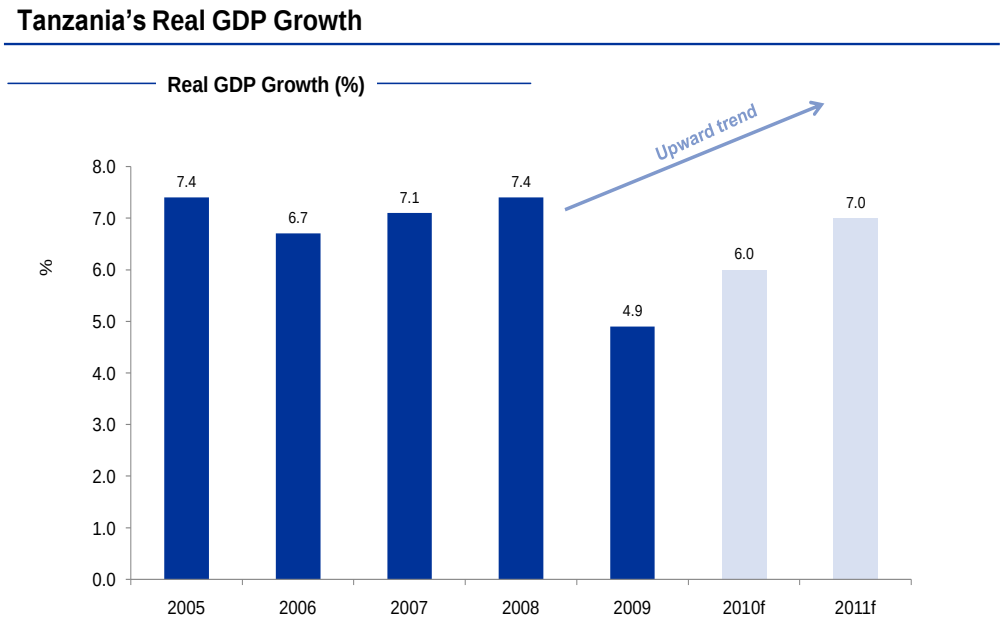
The effects of economic crisis in Tanzania have started to be felt especially from the mid 2008. This section specifically provides an overview of the impact of global economic crisis in the Tanzanian economy by analysing its effect on the broad macroeconomic indicators and also it's on the selected three key sectors i.e. Mining, Tourism and Agricultural exports.

3.1 Broad Macroeconomic Indicators

Overall Tanzania has recorded good macroeconomic performance in recent years, which has resulted from sustained economic reforms over the last decade. This has been reflected in enhanced investment, improved fiscal stability (via revenue mobilisation and prudent expenditure management), stable economic growth, improved balance of payment, as well as support to private sector led development (URT, 2008, URT/PHDR 2009). However the impact of global economic crisis has started to shake the so far achieved macroeconomic stability in the country. This section outlines the status of the selected three key macroeconomic indicators (real GDP growth, domestic revenues, and exchange rate and inflation trends) to show this impact

Real GDP growth: Figure 3.1 below shows that the real Gross Domestic Product (GDP) progressively grew at an average rate of 7.2% between 2005 and 2008. However, the main challenge now is that the global economic crisis might have started to reverse this favourable pattern by reducing growth and ultimately endangering the so far achieve economic stability in the country (Kessy 2009). As indicated in Figure 3.1 real GDP growth for 2009 took a steep downturn, declining from 7.4% in 2008 to 4.9% in 2009. This entails further impact on decline in income, employment generation activities and other poverty reduction initiative including provision and access to health care services.

Figure 3.1: Tanzania Real GDP Growth 2005-2009



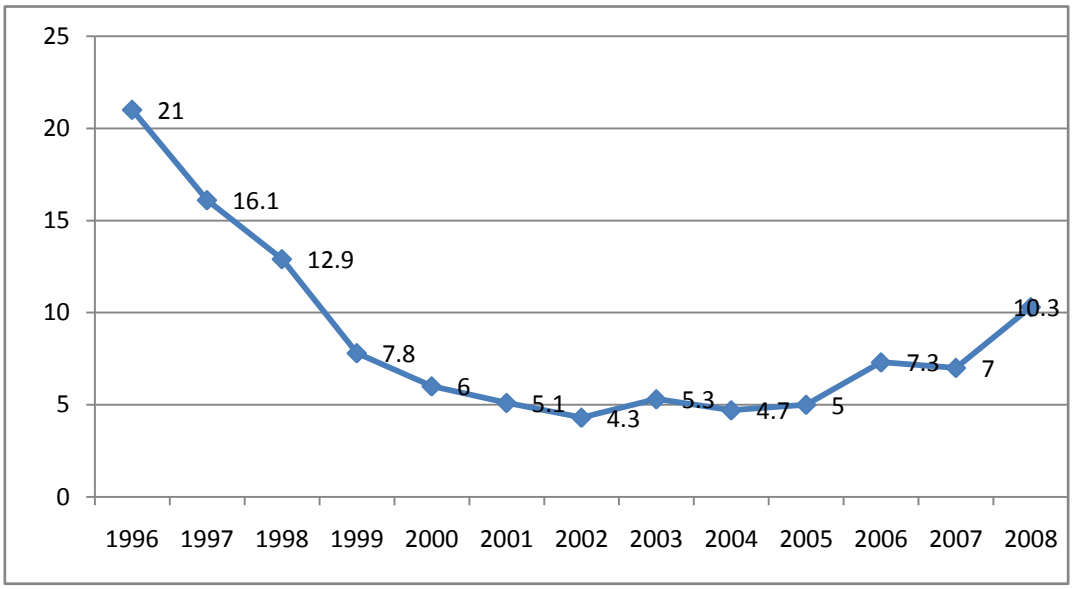
Sources: Bank of Tanzania, Economic Bulletin for the Quarter Ending March 2009 (Vol. XLI No.1); EIU Country Report for Tanzania (January 2010)

Deloitte.

- 1 -

Exchange Rate and Inflation Trends The Tanzanian Shilling has depreciated significantly starting from the end of 2008 to mid 2009. During this period the Tanzanian shilling has depreciated for about 15%, and this has caused further impact in the economy including rising food prices as well as affecting investor's confidence in the local currency (Kessy 2009). The depreciation of Tanzanian currency has also been accompanied by increasing inflationary pressures in the economy. Starting from the year 2008 the Tanzanian economy began to experience inflationary pressure that have been mainly linked to increase of import prices including oil prices. The inflation rate in 2008 was recorded to be 10.3%, which was the highest annual average in almost a decade (see Figure 3.2).

Figure 3.2 Inflation Trends 1996 – 2008



Source: United Republic of Tanzania (2008), the Economic Survey.

Domestic Revenues: Tanzania's domestic revenue collection also fell short of projections by about 9% during the years 2008 and 2009. This was mainly attributed to economic slowdown, and also reduced importance of trade taxes arising from regional trade integration efforts (UNAIDS, 2009). Furthermore, the financing of general budget to a large extent still depends on the foreign financing (this also includes the health sector as indicated in section 2). For example in the past three years foreign funding accounted for slightly over 30% of the Tanzania government budget (Kessy, 2009). This is a major concern especially at this time where the rich nations are experiencing the economic downturn. This is because, slower growth and recession in rich countries is likely to decrease and/or postpone overseas aid for development. This fear that the global financial crisis might lead to reduction in the external financial support has also been expressed by the Minister for Finance and Economic Affairs in February 2009.

"The Crisis has disturbed all that we expected when I read the budget last June" The Citizen Newspaper, 6Th February 2009

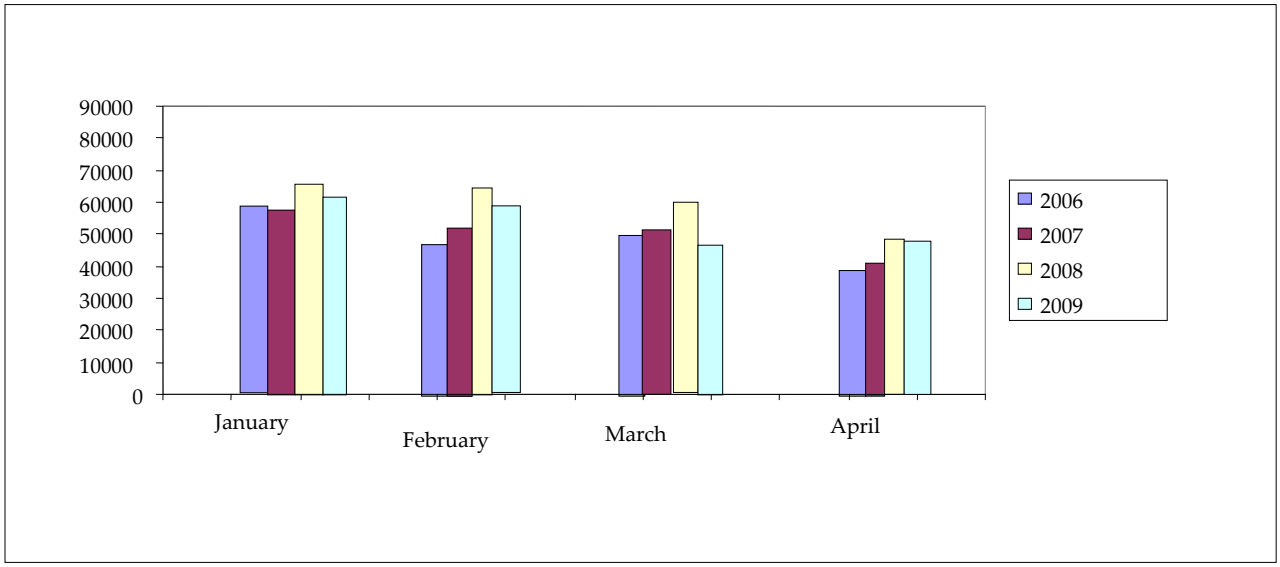
3.2 Impact on Selected Sectors: Mining, Tourism and Agricultural Exports

Tourism: Tourism is one of the key sectors that contribute about 16% to the country's GDP and about 25% of foreign exchange earnings (Lunogelo et al 2009). However from 2008 this sector has been affected by the global economic downturns mainly because it largely depends on external/foreign tourism. Between July and December 2008, this sector expected to receive about 500,881 tourists, but ended up receiving only 425,137 tourists. This is about 15% shortfall during this period (July – December 2008), a shortfall that was mainly attributed by decline of foreign tourists in the country.

In addition, the data also indicates a further 10% decline in the number of tourists to the Tanzania mainland from January to April 2009 as compared to same period (January - April) in 2008 (Figure

3.3). Between January – April 2009, 214,733 tourists were received as compared to 238,139 tourists within same period in 2008. This situation is also confirmed by the fact that the revenue obtained from the international tourism went down to $302.1 million between January to April 2009 compared to $388.2 million during the same period in 2008 (Lunogelo et al 2009).

Figure 3.3: International tourism arrivals in Tanzania, 2006-2009



Source: Ministry of Tourism and Natural Resources data.

Mining: The Mining sector has also been affected by the global economic crisis mainly due to a decrease in world market prices for the key minerals i.e. diamond, tanzanite, nickel and aluminium[1]. The impact of the crisis was more severe to the Tanzanite mining companies and small scale miners as there was a 50% decline in the price of tanzanite in the world market indicates in 2009. Furthermore, Investment in the mining sector was also expected to decrease by more than 50% in year 2009 as compared to the investment level achieved in year 2008. That is from $90 million in 2008 to $40 million in 2009, as projected through a decline in request for mining licences (Lunogelo et al 2009). Table 3.1 indicates that by April 2009, only 15 licences were granted compared to 224 licences in 2008.

Table 3.1: Mining licenses granted for mining activities in Tanzania, 2007-2009

	2007	2008	2009 (Jan-Apr)
Prospecting licenses with reconnaissance	155	224	15
Prospecting licenses	607	1169	72
Special mining licenses	1	0	0
Mining licenses	28	69	9
Primary mining licenses	1863	3573	678

Source: Lunogelo et al 2009

Agricultural Exports: The agricultural exports, both traditional and non traditional crops, have recorded a negative growth between year 2007/08 and 2008/09. Table 3.2 clearly indicates the

[1] Gold was not affected as it also used as nations alternative currency for value stabilization (e.g. euro, sterling pound, US dollar etc)

vulnerable situation of the agricultural exports by June 2009 that was mainly caused by the global economic downturn (Lunogelo et al 2009). It is important to note that poor performance in agricultural earnings has a tremendous impact to the livelihoods of the majority of the Tanzanians since about 70% of the labour force is employed in the agriculture sector.

Table 3.2: Agricultural export growth, 2007/08-2008/09 (%)

	2007/08	2008/09	Change
Traditional crops	15.8	15.6	-0.2
Non-traditional Crops	27.0	22.8	-4.2

Source: BOT data.

4.0 POTENTIAL IMPACT OF THE GLOBAL ECONOMIC CRISIS ON HEALTH CARE FINANCING AND ACCESS (SUPPLY AND DEMAND SIDES)

Although significant improvements in health services have been in the provision of health care services in Tanzania, the health sector still faces major challenges including inadequacy of financial resources, which adversely affect the quality and quantity of health services in Tanzania. Shortage of skilled health workers remains a crisis and shortage of drugs and medical supplies and equipment a major problem. For example, while Maternal Mortality Ratio (MMR) in Tanzania is still at an unacceptably high level of 578 deaths per 100,000 live births, currently only 15 percent of the dispensaries are able to provide 24 hours maternity services by qualified personnel. In antenatal care, basic procedures such as checking blood pressure, analyzing HB and giving pregnant women folic acid are not done (Koor and Kirian, 2009). It has also been found that there is often a lack of basic equipment such as delivery kits, and in many hospitals even standard treatment protocols are not followed. These problems often cause maternal deaths or stillborns. Such has been the situation before the onset of the global economic crisis. It is a situation where massive improvement of infrastructure for obstetric care is needed, implying allocation of more financial resources. Indeed these problems characterize the Tanzania health care system as a whole. It is thus important to assess the extent to which the current global economic crisis is likely to affect health care provisioning. We explore potential impact from both the demand and supply side.

4.1 Likely impact of the global economic crisis on financing health services (Supply side)

We have shown in section two, how the development budget of the health sector remains heavily dependent on external funding. As the economies of the countries providing these financial resources are hit by the economic crisis, it is likely that financial support to the health sector will be cut, adversely affecting the health system as a whole. Indeed HIV and AIDS prevention and treatment programmes which are heavily dependent on external support were in 2009 expected to be affected by a cut in foreign funds. It has been reported that Tanzania was the first country in Sub Saharan Africa (SSA) to announce a 25 percent cut of its annual HIV/AIDS budget (Palitza, 2009). In 2006/07, foreign funding accounted for 90 percent of the total HIV and AIDS budget, and in 2007/08 the proportion was expected to increase to reach 95 percent (URT, 2008b).

It has also been reported that the Global Fund to fight AIDS, TB and malaria announced that it is at least $ 4 billion short of the money it will need to continue supporting essential AIDS, TB and malaria services in 2010 (UNAIDS, 2009). Data from Public Expenditure Reviews (PER) on HIV/AIDS expenditure show that the most significant funding Sources for HIV/AIDS activities are the Global Fund for AIDS Tuberculosis and Malaria (GFATM), the President's Emergency Programme for Aids Relief (PEPFAR) and the World Bank financed Tanzania Multi-sector AIDS Programme (TMAP). In addition, it has been argued that because of the depreciation of the Tanzanian shilling over the last two years, prices of imported drugs (including ARVs) are likely to increase, making them even harder to afford.

We have also shown in section three the current and potential impact of the crisis on government revenues. It is thus also likely that the local component of the health sector budget will also decrease as revenue collections dwindle due to the reasons highlighted in section three. Although in nominal terms there was a slight increase in the health sector budget from 2008/09 to 2009/10, the increase was rather small and with the continued depreciation of the Tanzanian shilling over the same period, there was probably no increase in real terms. It is thus likely that the crisis will worsen the availability of both foreign and domestic resources that are allocated to the health sector.

4.2 Likely impact of the global economic crisis on the ability to afford health services (Demand side)

In Tanzania more than 50 percent of spending on health care is out of pocket and the poor have been excluded due to inability to pay. With the introduction of user fees in all public health facilities in the early 1990s, starting with hospitals and later extended to lower level facilities, people have been paying for health care services. A number of studies that have assessed the impact of user fees on the poor in various countries show that user fees accompanied by an ineffective exemption system have increased exclusion of those unable to pay (Gertler and Van der Gaag 1990; Karanja et al. 1995; Booth et al. 1995; Gilson 1997; Newbrander and Sacca, 1996).

Exemption of those unable to pay user fees is provided for in user fees guidelines. However, evidence suggests that this has largely been ineffective. For example the exemption policy in Tanzania has not worked for the poor, who often are not even aware that such provision is in place. At times the exemption policy has been found to benefit those not eligible such as hospital staff and relatives of health facility workers (Tibandebage and Mackintosh, 2002). The tendency for exemption policy to benefit wealthier groups has also been observed in other African countries (WB, 2000 – WDR). In a specific example, the 2000 World Development Report (WDR) points out that in Volta region, Ghana only about 1 percent of the patients got exemptions, with 77 percent of the exemptions going to health service staff.

With the anticipated increases in unemployment and the general increase in the cost of living, it is clear that people's income levels will be affected. This will not only affect their ability to pay for quality health care but also their food security and nutrition. The latter might in turn have an adverse effect on their health implying that they now, at a time when they are even more vulnerable to poor health, have to dig even deeper in their pockets to cover the cost of increased demand for health services. This in turn is likely to increase inequality and exclusion. Such outcome is especially attributed to the fact that Tanzania, as many other low income countries lacks adequate mechanisms (e.g. unemployment benefits and other social security arrangements) to cushion the effects of the crisis.

5.0 THE GENDERED IMPACT OF THE GLOBAL ECONOMIC CRISIS IN ACCESS TO HEALTH SERVICES

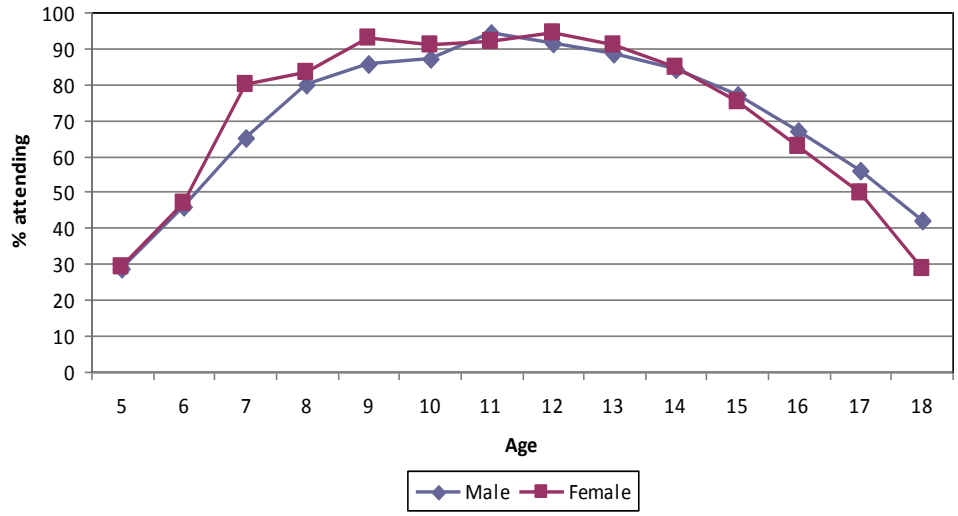
Since social provisioning is gendered, shocks in the economy that have impact on the level of service provisioning also have gendered implications, i.e. they impact women and men differently. In this section we utilise both the gender equity and women's health needs approaches to explore potential gendered impact of the global economic crisis in access to health care services. The gender equity approach recognizes existence of inequalities between sexes in different socio-economic processes, and the women's health needs approach recognizes that over and above the general health needs common to both sexes, women have health needs related to their reproductive role. In this regard the issue of women's health is taken as not only defined by their biological reproductive role, but also by their general health as affected by the gendered social, cultural and economic context in which they are placed. We utilize the two approaches to illustrate why the global economic crisis is likely to have a disproportionate adverse impact on women in access to health care.

5.1 Gender Equity

We have illustrated in the previous chapters how the global economic crisis is likely to lead to cuts in the health sector budget. This would in turn affect the quality and quantity of public health service thus increasing reliance on more expensive private provision or lack of services or exclusion.

Women in Tanzania remain a disadvantaged sex in all spheres of life despite the fact that they constitute slightly over 50 percent of the total population. For example, women are disadvantaged in terms of control and decision making over resources, opportunities for employment and access to education. In employment, women are disproportionately represented in formal employment. According to the 2007 Household Budget Survey (HBS), only 3.8 percent of women are government employees or employees elsewhere compared to 9.1 percent of men, which is close to three times as much. While economic hardships have increasingly forced more women to engage in income generating activities in the informal sector, to a large extent this has been more of a survival strategy to supplement family income, primarily for consumption purposes. In education, data in figure 5.1 below shows for example, that while the proportion of boys and girls who are in school at age 11 is almost at par (about 90%), by age 18 the proportion of girls in school drops to 30 percent while that of boys drops to just over 40 percent.

Table 5.1 Percentage of Children Studying by Single Years of Age and Sex



Source: HBS 2007

These inequalities in access to key opportunities that enhance human capabilities result into economic and social inequalities between the two sexes. There is thus an apparent interaction between gender equality and women's health. Women being the more disadvantaged sex are therefore likely to be more constrained than men in accessing health care. As employment opportunities dwindle and income levels fall because of the economic crisis, the inequalities in access to health services are likely to be even more glaring.

Socio-cultural factors have also been found to adversely affect women's health. These include, for example, acts of discrimination for instance in eating certain types of food which deny women adequate nutrition and might contribute to the development of complications during pregnancy. There are also other harmful traditional practices such as Female Genital Mutilation (FGM), which has both short and long term health consequences (WHO, 1996). In 1996, about 18 percent of girls and women in Tanzania were found to have been subjected to FGM (TDHS, 1996).

5.2 Women's Health Needs

Because of their reproductive role, women have specific health needs over and above those of men. Women vulnerability to health problems is compounded during their childbearing years, as they suffer from health problems related to pregnancy and childbirth. Also, because of their biological features, women are more likely to be disproportionately affected by HIV and AIDS. Indeed HIV prevalence data show that women are actually more disproportionately affected by the epidemic than men. About 5.7 percent of adults in Tanzania mainland are infected, with prevalence being higher among women (6.6%) than among men (4.6%) (URT, 2008). Of course in Tanzania as in other countries in SSA where heterosexual activity is the main form of HIV infection, this is compounded by women's powerlessness in sexual relationships including marriage and their inability to negotiate for safe sex (SIDA, 1999).

Complications during pregnancy and childbirth often lead to maternal mortality, which remains a major health issue in Tanzania. With less than five years away from 2015, the year by which MDGs are to be achieved, in Tanzania there is very little hope if any for achieving MDG5 - reducing Maternal Mortality Ratio (MMR) by three quarters between 1990 and 2015. In Tanzania MMR remains alarmingly high, having increased from 529 per 100,000 live births in 1996 to 578 in 2004/05 (TDHS 1996, TDHS, 2005). Indeed, other estimates of adjusted MMR indicate MMR in Tanzania to be even higher and in terms of ranking put Tanzania among the 13 countries which by 2000 accounted for 67 percent of all maternal deaths globally (WHO et al, 2005).

It is important therefore that all planned interventions to reduce MMR be implemented if significant improvement in MMR is to be achieved. However, the health sector remains ill-equipped to effectively cater for pregnant women before, during and after childbirth. As already pointed out, many health facilities face severe shortages of qualified staff and essential medical supplies and equipment. Qualified staff is required especially during delivery and in Emergency Obstetric Care (EmOC). It is apparent therefore that the likely cuts in the budget because of the crisis will exacerbate this situation. As such, reducing MMR to acceptable levels, let alone meeting the MDG 5 target might be difficult to realise in the near future.

6.0 SUMMARY AND CONCLUSION

This paper has attempted to explore the potential impact of the global economic crisis on health care financing and access to health services in Tanzania, and illustrate how the impact is gendered. We have shown on one hand, how the global economic crisis is likely to adversely affect the health sector budget which in turn will affect quantity and quality of health services; and on the other hand, how it will adversely affect people's incomes and overall well-being, compromising further their ability to afford health services. We have further shown how, because of their disadvantaged position in all spheres of life and because of more health needs related to their reproductive role, women are likely to be disproportionately affected by the crisis. It is important therefore, that measures not only be taken to mitigate the impact of the crisis, but also to address its gendered implications. It is worth noting that some of the studies done to assess the impact of some of the interventions to address earlier shocks show that even these interventions have a differentiated impact on women and men (Mackintosh and Tibandebage (2006). Below are some suggestions as to how the gendered effects of the global economic crisis might be mitigated:

- Effort should be made to fulfill commitments already made in the health sector Medium Term Expenditure Framework (MTEF) to ensure that planned programmes are fully implemented.

- Prioritize spending on health while paying close attention to the gender differentiated needs by designing and implementing interventions that are responsive to the needs of women and men.

- In the medium and long term social; protection mechanisms should be designed and implemented, especially those that are likely to have a great influence on health outcomes, e.g. different types of health insurance and cash transfer programmes.

- Prioritize spending on other areas such as education and employment promotion programmes for more vulnerable groups of the population. These complement health care provisioning in enhancing the capacity of the people to cope with various shocks.

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