Child Poverty and Disparities in Tanzania

Tanzania has made significant progress towards the achievement of global and national targets in some of the key areas of child well-being, particularly health and education. However, these achievements risk being undermined by persistent poverty. Children are particularly affected by poverty. Child advocates contend that children's rights and needs are often seen as marginal to development efforts and the central role of childhood in shaping individual capacities and human development opportunities is left overlooked.

This brief provides an overview of child well-being in Tanzania, and highlights some of the main opportunities and constraints related to reducing child poverty and disparities, going beyond national averages to capture clear inequities in progress. The analysis identifies key challenges and opportunities for capitalising on achievements to ensure that all children have equal opportunity to benefit from enhancing capabilities. It is hoped to help influence economic and social policies that affect resource allocations for children and reduce inequalities. This brief is written by UNICEF. It is a summary of a much larger and detailed national study on the same subject, a global effort spearheaded by UNICEF to shed light on the situation of children whose rights are being violated and well-being undermined by poverty and deprivation.*

Child survival

Infant and under five mortality in Tanzania has improved substantially in the past few years, approaching the right trajectory to meet the Millennium Development Goal (MDG) target. But disparities persist, between districts and regions, urban versus rural, and also by wealth status. Children living in rural areas and those in poverty remain disadvantaged both in terms of service uptake and outcomes. They are much more likely to die than their better-off urban peers.

Demographic and Health Survey (DHS) estimates from 2004/05 and 1999 suggest that Tanzania has made great strides in improving child health:

- a decline in infant mortality by 31% from 99 per 1,000 live births to 68, within reach of the MDG target of 48 by the year 2015, if the pace of recent progress can be sustained
- a drop in under-five mortality by 24%, from 147 to 112 per 1,000 live births – that is 39,200 fewer child deaths per year in Tanzania. Mortality was 139 for rural children, compared to 108 for their urban peers and a 3 to 4 times higher probability of an underfive dying in Mtwara or Lindi than in Kilimanjaro or Arusha.

Most of the improvement has occurred in post-neonatal mortality, largely due to the success of preventive measures such as measles vaccination, vitamin A supplementation and promoting the use of insecticide treated bed nets (ITNs).

Neonatal mortality – deaths in the first month of life, accounting for nearly half of all infant deaths and almost a third of under-five deaths – has not changed much since 1999. Neonatal mortality is intrinsically linked with maternal health.

The maternal mortality rate remains very high and shows no improvement since the previous survey in 1996, with 578 women dying from conditions related to pregnancy, delivery, and related complications for every 100,000 births.

Source: URT, NBS, et al., 2005

*REPOA, NBS and UNICEF. *Child Poverty and Disparities in Tanzania.* 2008

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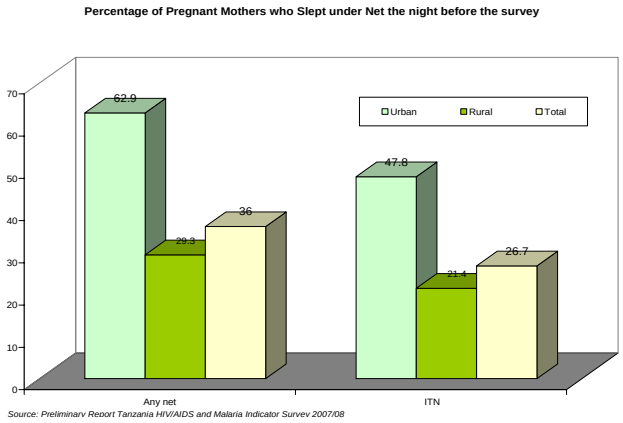
This implies that roughly one woman can be expected to die every hour from maternal causes in Tanzania. Regardless of high antenatal care attendance, with 94% of pregnant women attending at least once, only 47% of births occur at health facilities, and only 43.3% of these births are attended by skilled birth attendants. There is a major gap in skilled attendance at delivery between urban areas (79%), and rural areas (34.5 %).

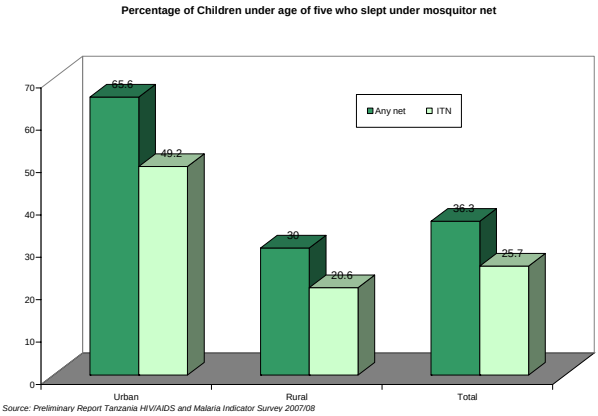
The poorest women are more than **7 times** more likely to give birth at home AND receive no post-natal care for their infants. The biggest gap here is between the richest quintile and the rest.

Women with at least some secondary education are **2.6 times** more likely to deliver at a health facility than those with no education.

Babies born in rural areas are nearly **4 times** more likely <u>not</u> to have been weighed at birth, or to receive post-natal care.

Smithson (2006), based on 2004/05 TDHS data





Weakness in the health system has direct impact on the delivery of maternal and newborn services. Despite remarkable improvements over the years since the advent of health sector reforms in the early 1990s, the health system is generally weak and is unable to handle effectively the disease burden in the context of the HIV and AIDS epidemic which is exerting more demand on an already over stretched system. Accessibility to health care is still inadequate, and the quality of care delivered is sub-standard for various reasons, including an enormous shortages of skilled workforce across all main cadres at all levels of the system, insufficient medical equipment and supplies, and a shortage of medicines. The referral system is compromised by lack of emergency transport and communication systems.

- *From 2004/05 to 2007/08 the percent of under fives sleeping under ITNs increased from 40% to 49% in urban and from 10% to 21% in rural households.*
- *For pregnant women, from 39% to 48% in urban areas, and from 10% to 21% for those living in rural areas.*

There are ***three main challenges***: to sustain the gains which have been achieved in child health; to address disparities – geographic, socio-economic and urban/rural; and to give priority to the implementation of interventions towards improving neonatal and maternal health care.

Government spending on health has increased in recent years. In FY08 per capita spending was US$ 13.80 – double the FY06 level. But the increase in terms of GDP level was less impressive, from 9.7% to 10.5% in the same period. These figures do not take into account significant 'off budget' funding, especially US assistance for HIV/AIDS and malaria.

Nutrition

Undernutrition is most prevalent in young children from rural households and in the poorest households - stunting increased by 8% amongst the poorest households but fell by 20% amongst the least poor households between 1991/92 and 1999. This gap remains but has narrowed between 1999 and 2004. There are strong regional differences, ranging from 17% of children who are stunted in Dar es Salaam to 54% of children in Lindi.

Malnutrition is a major cause of childhood morbidity and mortality. The 2004/05 survey estimates suggest significant improvements in all measures of undernutrition among under-fives compared to 1999 and 1996, though levels still stood high with 38% of children moderately or severely stunted (under-height for age) and 22% underweight (weight for age). Undernutrition in Tanzania was indirectly responsible for more than a quarter of under-five deaths – even at its much reduced rate in 2004/05.

> *Recent improvements at the national level are largely due to declining stunting rates in rural children, while rates among urban children have increased slightly.*

The geographic pattern of undernutrition in Tanzania suggests that **areas of the country which are the source of cereal surpluses, mainly in the south and west, are also areas of the country with relatively high rates of undernutrition**. Food security, therefore, in the limited sense of cereal crop production, **is not the most critical determinant of the high prevalence of undernutrition in children under the age of two years,** but rather breastfeeding practices, the number of times a child is given anything to drink or eat during the day, and the energy and nutrient density of their diets.

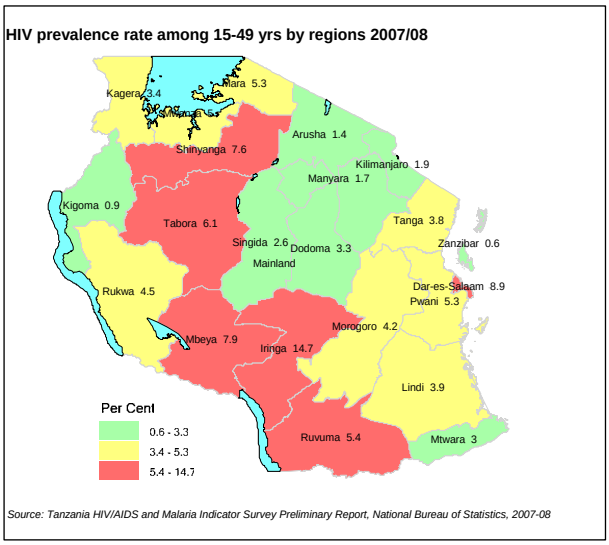
In the past, nutrition has not explicitly figured into key overall policies, however more recently there is a National Nutrition Strategic Plan for 2007-2011 – an ambitious plan that encompasses many key areas for improving nutrition. This notwithstanding, current nutrition funding remains constrained – on average less than USD1 per person is spent on those most vulnerable to malnutrition.

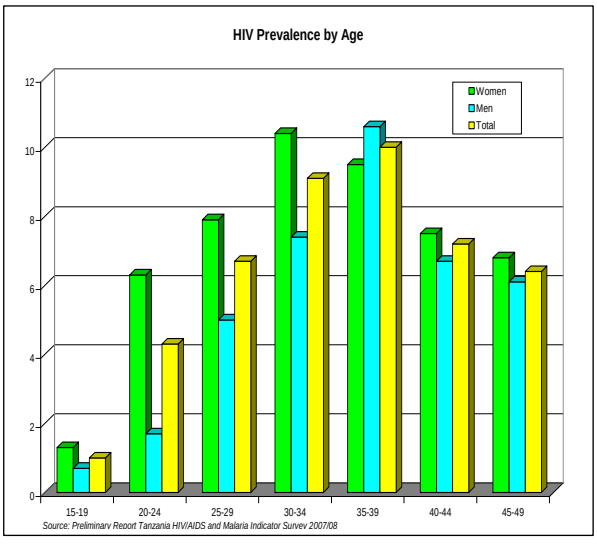
Fundamental to all of the processes which influence nutritional outcomes is the **importance society places on nutrition and on those who are most likely to suffer from poor nutrition – young children and pregnant women**. **The case for investing in nutrition is clear, but not widely understood**.

HIV

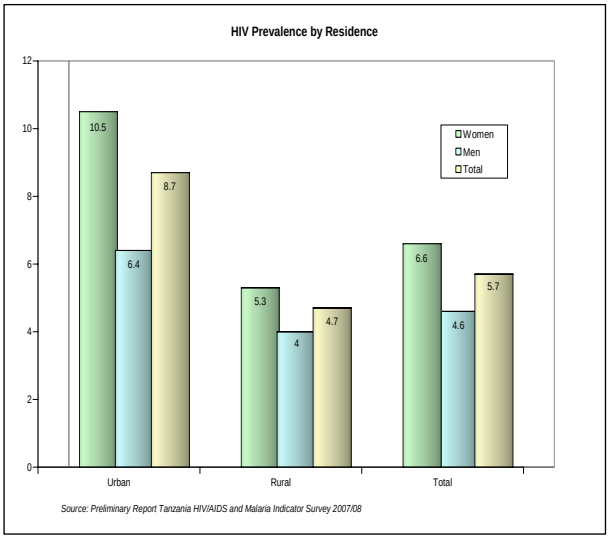
The second 2007/08 population-based HIV survey estimates an overall prevalence in the Mainland at 6% among adults aged 15-49 years, with women (7%) being more infected than men (5%) –a slight reduction from an overall prevalence of 7% in 2003/04. The survey also suggests that:

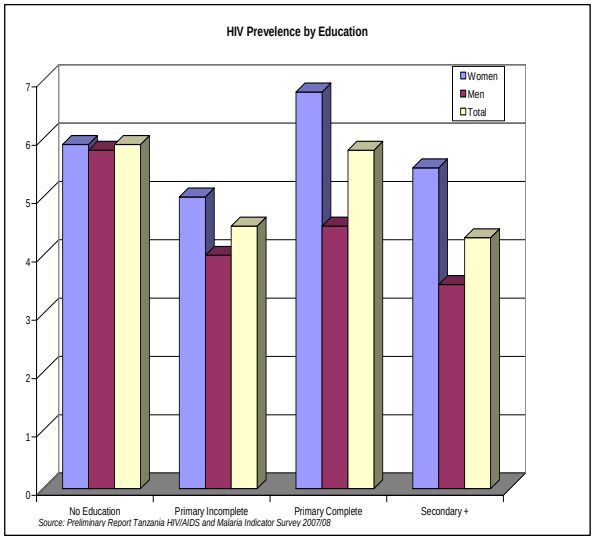
- HIV prevalence is almost double in urban than in rural areas (8.7% vs. 4.7%). Among urban women, HIV prevalence is 11% compared with 5% in rural areas. For men, the corresponding prevalence is 6% and 4%, respectively.
- More wealthy persons are more likely to be HIV positive - infection rates are almost three times higher among adults in the least poor quintile than among adults in the poorest quintile.
- Women get infected earlier than men.
- There are strong regional variations. HIV rate in Iringa (14.7%) is more than twice the national average. Dar es Salaam (8.9%), Shinyanga (7.6%) Mbeya (7.9%) and Tabora (6.1%) – all have a much higher prevalence than the national average.





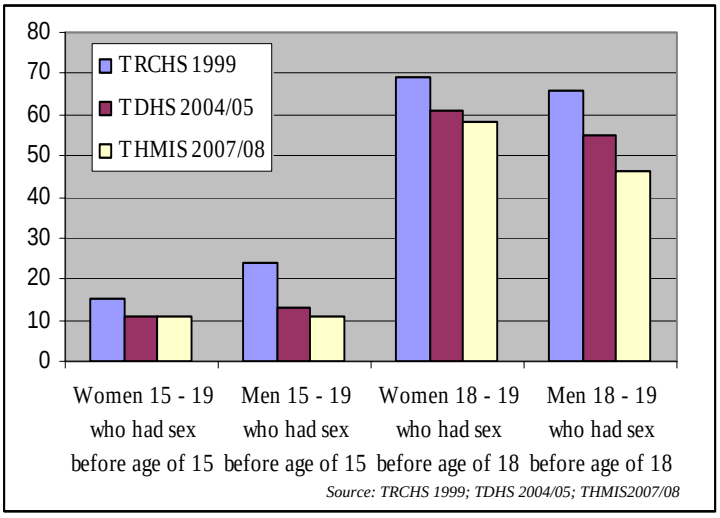
- The least well educated have a higher HIV prevalence than the better educated – suggesting the opposite from the earlier 2003/04 results where prevalence rose with levels of education.
- The age of sexual debut has increased.
- More reported use of condoms, more people having been tested, especially well educated urban adults in 2007/08 compared with 2003/04.





Prevention is not working. *Evidence points to the importance of structural rather than solely behavioural interventions, especially when addressing the vulnerability of young girls. Structural prevention measures demand that a range of fundamentally different issues – gender inequity, social mores, poverty and vulnerability – be tackled.*

Trends in Sexual Debut



The most recent public expenditure review of HIV/AIDS budgets and spending in Tanzania casts an alarming picture on the extent to which HIV/AIDS programming is aid-financed and off-budget.

"Aid increased by three quarters, and now finances 95 per cent of Government plus donor spending. The increase has been from off-budget sources of finance, and only 19 per cent of expected aid in 2007/8 is included in the budget. HIV/AIDS is now taking a staggering one third of all aid to Tanzania! (IMF ODA)

Emerging challenges:

- Access to free condoms, especially in rural areas, needs to be improved through channels and outlets beyond the public sector health service outlets. Access to female condoms is a challenge, primarily because of their high costs
- Rural women are four times less likely to be offered HIV testing and counselling in antenatal care than urban women. The majority of rural population has limited access to antiretroviral treatment. Constraints are related to weaknesses in the health system and poor access to care.
- Quality services for sexually transmitted infections are still lacking in many remote rural areas.
- Stigma and domestic violence – a major impediment in uptake of prevention-of-mother-to-child-transmission.

- Ensuring a balance between prevention, care and treatment.
- The growing burden of unpaid care - social costs - borne by women at the household level as treatment is scaled up.
- Make effective use of available HIV/AIDS resources towards health system strengthening.

Child Development – Education

National educational indicators reveal largely positive trends at all levels – an overall increase in pre-primary, primary and secondary school enrolment – although the quality of education remains a major concern. In addition, ongoing challenges exist in achieving geographic equity in educational outcomes and in meeting the needs of poor vulnerable children – their enrolment rates.

Net primary enrolment among Mainland children continues to show a steady improvement and is reported to be 97.3% in 2007. Enrolment ratios for girls and boys are nearly the same. Below the national aggregations there are **significant regional and district disparities in enrolment**, which range from 86.2% in Tabora to over 99% in Kilimanjaro, Arusha, Mara, Iringa and Mwanza*. Only 0.3% of children enrolled in primary school are disabled, a much lower percentage than the expected population of school-age **children with disabilities**.

The TDHS reported that in 2004/05 the ***net attendance ratios*** differed between urban (just over 85%) and rural children (just under 70%), and in each case girls' attendance was better than boys. Net attendance among children in the poorest quintile was 58.3% and for the least poor (mostly urban) it was 88.3%.

In 2006, 70.5% students passed the ***Primary School Leavers' Exam (PSLE)*** in the Mainland, with large gender and regional variations - from a low of just under 50% of students passing in Tabora, to just over 80% in Kilimanjaro, and the pass rates for boys exceeded girls in every region except Kilimanjaro.

Net secondary enrolment has also expanded quickly from 6% in 2002 to 13.4% in 2006 and 20.6% in 2007. But there are growing disparities. By Form V, girls are only 40% of the total pupils. Whilst children from the highest income quintile had a 22.7% net attendance rate, the chance of a poor child from the lowest income quintile of going to secondary school was close to zero. The 2004/05 TDHS demonstrated clearly that enrolment and attendance in secondary schools was largely a matter of income and locality. **It is unlikely that the majority of Tanzania's children will access secondary education, and those benefiting are most likely from better-off households living in parts of the country where there is a tradition of prioritising education.**

The policy objective for education is education for all, and the emphasis is on comprehensive provision for the vast majority of children. ***On-going challenges*** are meeting the needs of those 'disadvantaged groups' for whom the one-size-fits-all model does not work, education of a sufficient quality to retain children in school, and ensuring that disadvantages from children's home background, particularly poverty, does not interfere with their education.

The children who do not access ***pre-primary*** are often from poorer families – missed potential opportunities to even up the inequalities faced by children at birth through comprehensive multi-sectoral approaches are lost.

The idea behind ***Complementary Basic Education (COBET) or MEMKWA*** was to offer education flexibly to children out of school, at times and in locations identified as appropriate by communities, with more flexible teaching and learning methodologies, but also with the potential to transfer into mainstream education following success in standard 4 and PSLE examinations. **If implemented according to its original vision, MEMKWA would be a major step towards addressing issues of child poverty and education. The main challenges are funding and lack of priority both at central level, district level, and in some schools which are MEMKWA centres.**

*BEST (2007), table 2.7.

Progress in providing quality education services for children is integrally connected with reforms which focus on strengthening the effectiveness of government systems in general, in particular at the local government level. The **major programmes of PEDP (Primary Education Development Programme) and SEDP (Secondary Education Development Programme) are hampered in implementation by a lack of funds**, at the same time officials in central government and development partners express concerns about management and capacity in local authorities. There are problems of linking plans to budgets and in transparency of disbursements and subsequent reporting. There is a major financing gap between the PEDP costed plans and actual budget allocations. Thus **despite major successes, the plan is not living up to its potential to address child poverty**.

The Views of the Children survey noted that financial contributions were expected in all the schools surveyed and that children were being excluded for non-payment of expected contributions. Over three-quarters of the 22% of children who failed to complete primary education in 2006 were reported to have done so as a result of truancy, and the next largest group were reported because of 'lack of school needs' – meaning shoes or writing equipment that parents are usually expected to provide.

Reasons behind lack of attainment by girls compared with boys *include lack of female teachers as role models, especially in remote rural areas, poor classroom dynamics, poor hygiene facilities for girls, and in some parts of the country less interest in schooling the girl child than the boy.*

Child protection

Tanzania ratified the Convention on the Rights of the Child (CRC) in 1991 and acceded to the Optional Protocol to the Convention on the involvement of children in armed conflict in November 2004 and the Optional Protocol on the sale of children, child prostitution and child pornography in April 2003. Tanzania has also ratified the African Charter on the Rights and Welfare of the Child (ACRWC) (1990).However, its commitment and capacity for realising protection rights is still inadequate. Current provisions lack precise definitions, are outdated and do not adequately protect children from violence, abuse, neglect and exploitation. Contributing factors include official sensitivity to social norms and customs, some of which may not be in a child's best interests, and inadequate budgetary provision.

In spite of many years' deliberation, there is, to date, no unified children's statute which could supersede the fragmented and inconsistent laws now affecting children. The legislative response to ensure children's rights is, at best, weak, and at worst, punitive and in direct violation of child rights. A new children's act would domesticate the obligations of the State party of Tanzania incurred through ratification of the CRC, its optional protocols, and the African Charter on the Rights and Welfare of the Child, and set legal standards for the realisation of children's rights. Its public presentation would provide an opportunity to raise the profile of children on the national agenda, to advocate with legislators that all future legislation, policies and budgets be assessed from the perspective of children's well-being, and more specifically, highlight the likely impact on poor, deprived children.

In addition a consolidated act would substantially increase the ability of the State Party to monitor and report on the impact of policy developments and the realisation of children's rights and provide the necessary data for programme and policy amendments, where necessary.

The true, full extent of violence, abuse, neglect and exploitation of children in Tanzania is not known, but some factors can be identified.

Child labour is prevalent - just over 20% of all Mainland children aged 5-17 years are engaged in work which is excessive or exposes them to dangers. The most common form of work is on the farm and in domestic chores, and is considered by adults in their communities to be part of normal socialisation, as well as contributing to the household economy. These children also attend school for the most part. There is no significant difference in the proportion of girls and boys who work, but there are geographic differences – a greater percentage of rural children work (25%), especially at an early age, than their urban peers (8%). In a poor rural household, child labour is likely to be a necessity rather than a choice, a reflection of rural poverty and economic deprivation.

Early marriage, sexual abuse and child bearing is common, especially in rural communities. Nearly a third of girls have already conceived by the age of 18 years. Among all 15-19 year-old female adolescents, 26% had either had a baby already or were pregnant; more rural (29%) than urban (20%); more poor (around 30%) than the least poor (16%); more in the Mainland (26.6%) than in Zanzibar (9.3%).

Female genital mutilation (FGM) still affects many girls. The prevalence has dropped slightly from 18% reported in the 1996 DHS and the 2003/04 THIS to 15% in the 2004/05 TDHS. About one-fourth (23%) of the most recently circumcised daughters were reported to have been circumcised before their first birthday, and 17% between one and four years of age. The most vulnerable are those in the rural areas and the urban poor

Internal ***child trafficking*** for exploitation of children in domestic servitude and prostitution, is prevalent - most of the victims are young children from rural areas.

Registration of rural births is low, 10.1%, while 48.8% of births in urban area were registered. Possession of birth certificates is lower still - only 5.7% of children whose births had taken place in the five years preceding the TDHS 2004/05 had birth certificates: 2.7% of rural children; 24.8% of children born in Dar es Salaam, and 15.4% of children born in other urban areas.

Social Protection

Tanzania has a population of about 40 million people, more than half of whom are children – under the age of 18 years. **The Mainland population is predominantly rural** – 75% of the population live in rural areas – and depends on underdeveloped smallholder primary agriculture production.

Poverty is pervasive**,** especially in rural areas – 36% of households were living below the basic needs poverty line of TShs 262* per adult equivalent per day in 2000/01, well below US$1 per day. Nearly 20% – around 4 million children - lived below the food poverty line. Their income could not provide enough food to satisfy their basic minimum nutritional requirements. Income disparities have grown over the last two decades both between rural and urban households and among urban households. Most recent poverty estimates from 2007 suggest that the proportion of people living in poverty has decreased by 2.4 percentage points, from 35.7 % of the population in 2001 to 33.3 % in 2007. This reduction however, has not been able to compensate for the growth rate of the population of about 2.6% per year.

The Most Vulnerable Children – *those who may be considered to be particularly vulnerable and in special need of social protection measures - children with disabilities, orphans, child labourers, street children and other most vulnerable children. According to the 2002 population census:*

- *Nearly 11% of all children in Tanzania had been orphaned – close to 2 million children.*
- *About 1.2% of the households were headed by a child, on average between 14 and 15 years of age. There are higher proportions of child-headed households in the least poor districts.*
- *Close to 3% of all households are occupied by children and the elderly (age 60 years and above) only – they are households without any adult between 18 and 60 years of age.*
- *Children with disabilities are particularly vulnerable - they are more likely to be denied the opportunities of their able-bodies peers.*

Current programmes for most vulnerable children have low coverage *compared to the large numbers of children and households who are very poor and vulnerable. There is little evidence of their impact. They are uncoordinated and financed largely from external sources, frequently providing support to few in ways which are socially disruptive and sometimes stigmatising.* ***A strategy which is likely to generate strongest public support is one which aims at inclusiveness*** *– ensuring that all children go to school, get health care when sick. Ensuring that they also are adequately fed, clothed and sheltered is a more complex mix of the private, domestic arena and civic, state responsibilities. A* ***transformative national scheme of social protection must be based on the practical recognition of state responsibilities****, formally acknowledged in the Constitution.*

*2006 rate: US$1=Tshs1200

Economic growth has been strong, over 6% annually in four of the last five years, and well in excess of population growth. Agriculture, the mainstay of the rural economy, has not benefited from the economic growth. It is expected to grow at only 4 percentage points annually over the next few years. About 42 per cent of agricultural production is farmers producing for their own consumption. It is in agricultural, rural households where poverty is most prevalent and disparities with urban households strongest. **Therefore, despite encouraging trends in GDP growth,** the overpowering public perception is that only a small minority of Tanzanians are benefiting from reform and economic growth.

A comprehensive ***social protection*** system would necessarily include all of the elements which have been summarised here, addressing the prevention of malnutrition, rights to education and health, children and HIV/AIDS, child protection. Other aspects of social protection aim to improve capabilities for generating income and to provide income/consumption support.

The prognosis for rural children is not an optimistic one in the near-term. The major challenge is how to ensure that national policies and strategies are focused on addressing rural poverty, given multiple and competing priorities and also provide for those children in need who might not, because of their particular circumstances, benefit from general economic strategies.

There are several policies and programmes which might be part of a national scheme of social protection, but they are implemented by different institutions – governmental and non-governmental. Strategic plans and budgets for their implementation are lacking. Implementation of progressive policies falters because of weak systems, resource constraints, overstretched human resources, and the level of ambition in plans to provide quality services universally. The bewildering multiplicity of initiatives and parallel financing mechanisms often undermine local capacity and cause as much harm as good. A national framework for Social Policy is in the making with the objective of a more coordinated response.

Improved education, health and water services are public concerns, and mobilisation around these issues in general is not problematic. ***Other important aspects of children's well-being, such as nutrition, child protection and social protection, have not been accorded priority***. The positive lessons which have been learned in improving outcomes for children in education and health offer strong building blocks for a strategy for children and development.

Policy is essentially a political process. While sound data analysis and timely, effective communication are helpful, familiarity with the policy making process and the key actors involved is indispensable. Policy making, strategic programming, planning and budgeting for children, and especially for poor children, is particularly complex. Especially where the capacity to legislate and refine outdated policies is more limited than the often externally driven processes of programmatic financing and delivery. Some expenditures for public goods, such as water, health and education— all of which benefit children—are not amenable to a child-adult categorisation.

Why do policy makers give so little attention to children, especially to some aspects of children's well-being?

- Because they believe that economic growth and development will benefit children, and that there is no need to have specific goals for children in these policies and strategies? And this is true as long as growth is pro-poor and addresses rural poverty. This however, does not address distribution of resources and possible existing inequities within households.
- Because they are unaware of the likely effects on children, and especially on poor and vulnerable children, of public policies and strategies?

Focus on Zanzibar

Overall, children in Zanzibar, compared with their peers on the Mainland, are less likely to die in infancy and early childhood, less likely to be malnourished. They are more urbanised, and while there are geographic disparities between urban and rural children, between children in Pemba and the most rural parts of Unguja compared to those in other parts of Unguja, these disparities are not as pronounced as those among children in the Mainland.

Economic growth has been robust with an average growth rate of 6.8 % over the period 2000 – 2004. Growth is **driven mainly by the service sectors**, which now represent over 50 % of GDP, and which grew at an average of 8 % over the period 2000 – 2004, due mainly to tourism related activities. The share of agriculture in GDP, at 2001 prices, has been about or slightly below 25 % from 2002 to 2004.

Income poverty - nearly half (49%) of the almost one million people living in Zanzibar live below the basic needs poverty* line i.e. have difficulties in meeting their basic needs - food, shelter, and clothing. Close to 14% live below the food poverty line.

Disparities in poverty are evident: rural/ urban, and between and within Unguja and Pemba:

- Compared to roughly 55% and 16% of the rural population, 41% and 9% of those located in the urban areas live below the basic needs and food poverty line, respectively.
- More than 60% of people in Pemba live below the basic needs poverty and 22% below the food poverty line, while corresponding figures for Unguja are 42% and 10%. Within Pemba, the prevalence of poverty ranges from 74% in Micheweni district to 36% in Urban district.
- Poverty is related to household size and the educational attainment of the household head. The majority of poor households have a larger number of dependents while the head of the household has very low or no education at all.
- The level of income inequality is low. The Gini coefficient for the whole of Zanzibar is 0.28, for Pemba it is 0.26 and for Unguja it is 0.28. In addition, there is no marked difference in the measure of inequality between rural (0.26) and urban (0.30) households.
- Compared with less than 10 % of the least poor households, 31 % of the poorest households reported that they frequently face food insecurity. Relatively high levels of frequent food insecurity were experienced by households in the districts of North A, Micheweni and Chakechake: 28, 25, and 22 % respectively.

Child Survival

Improvements in ***infant and under-five mortality*** have been lower than the Mainland, not been constant over time, nor equal across all segments of the population. The respective rates have fallen from 75.3 and 107.5 per 1,000 live births in 1996, to 61 and 101 in 2004/5, partially attributed to an improved ***immunisation coverage*** - in 2004 the coverage was 89 % for DTP3, and 82 % for measles

Geographic disparities:

- ***Underfive mortality*** stands at 139 for rural children versus 108 for urban children. Regionally, the difference between the lowest rate, in Town West, and the highest, in North Unguja and Pemba North, was a factor of 1.5.
- ***Immunization coverage*** is better in Unguja (94 % DTP3 and 93 % measles), than in Pemba (81 % DTP3 and 70 % measles) Almost all the children from the least poor households (close to 100 %) have been vaccinated, compared to 77 % from the poorest households.
- ***Maternal mortality*** is high, at 377 per 100,000 births in 1998. The proportion of births attended by skilled personnel increased from 37 % in 1996 to 51 % in 2004/2005 and the proportion of births taking place in a health facility has increased from 33 % in 1991/92 to 49 % in 2004/05, with the largest increase (37 %) taking place between 1999 and 2004/05.

*set at TShs 21,383 per capita/per 28 days

Geographic and Wealth-Poverty Disparities:

- Fewer women are assisted by health professional in Unguja North (25 %) and in Pemba (35 %), compared to Unguja (62 %), specifically Unguja South (62 %) and Town West (76 %),
- Compared to 88 % of the least poor, only 26 % of the poorest and were assisted during a delivery by a doctor, clinical officer or nurse/midwife.
- More than half the deliveries in Unguja South and Town West are facility-based; the corresponding figures for Pemba and Unguja North are between a quarter and a third of the deliveries.
- Children from poorest households are 5 times more likely to be delivered at home than those from the least poor households - 75 % versus 15 % of children.

Malnutrition: 23% of Zanzibari children are stunted and 19% under-weight. As in under-five mortality, there are strong regional differences, which range from 15% of children stunted in Town West to 37% in Pemba North. Overall, rural and the poorest children are significantly more likely to be malnourished than urban and less poor children.

Child Development

Net primary school enrolment rates have increased over time - from 51% in 1990 to 79% in 2002 then went down to 76 % in 2006 - *with near gender parity and improving completion rates*. Because of the different system of compulsory basic education in Zanzibar, which includes the first years of secondary schooling, ***enrolment in secondary education*** is higher there than on the Mainland. In 2005 gross and net secondary school enrolment in Zanzibar was reported to be 42 % and 33 %, respectively. Secondary transition rates have increased from 10 % in 1990 to 44 % in 2004.

Disparities between districts, by gender and by wealth status:

- Since 2000 the proportion of females moving from primary to secondary education has been higher than that of males; by 2004, 80 % of primary school females entered secondary education compared to 72 % of males.
- 2006 net primary enrolment rates have ranged from 66 in the poorest 20 % of household to 88 in the least poor 20 % of households.
- Gross and net secondary enrolment ratios are comparatively lower in Pemba and in the North district of Unguja, than in most of the remaining districts of Unguja.

The tip of the iceberg: 8.4% of children were engaged in ***child labour***, mostly the older ones between the ages of 14 and 17 years, and this practice is twice as common in the rural (10%) than in the urban (5.8%) areas.

Emerging Challenges to Human Development and Equity in Tanzania

- ***Important gains in child survival, in nutrition, in education have been achieved in Tanzania in the past few year, but disparities persist.*** Where access is more problematic, because of distance, costs, staffing, disparities remain, with rural and the poorest children significantly worse off compared with their urban and least poor peers. There are **large disparities by district and region, above and beyond those explained by poverty and urban-rural divides**.

- ***Poor quality shelter and lack of access to clean water are major concerns, especially for rural children.*** A new programme to address water supplies is underway, with substantial external financing, and this will go some way to addressing these disparities. Deprivations in shelter, however, are unlikely to be redressed until the incomes of rural households increase.

- ***There are critical issues of governance and accountability in delivery of services of importance for children. These issues include difficulties in accessing schools and health services with exemptions from charges, according to policy, and the extensive use of corporal punishment in schools.*** Access by citizens to information about local authorities' budgets and staffing is improving, but still not easy to interpret.

- Tanzania is dependent on aid – about 40% of the national budget in the past few years. Realistic projections of the amount to be provided in aid are critical for the plans. **Several aid programmes, however, are not able to provide commitments for future years, and others, while committed, are not in a position to provide the level of detail which is demanded of the statutory budget process.** There are significant contributions, including for children, which are "off-budget," not reflected in the budget submissions to the National Assembly. Thus, ***while elaborate systems of review, planning and budgeting are in place, the allocation of funds is complex, not always captured in the budget process, and it is extremely difficult to establish and analyse a clear link between strategic plans, approved budgets and actual expenditures against goals and targets***. National leadership is compromised.

Beyond the specific challenges and related recommendations in the brief, overarching recommendations include:

- Promote effective participation of children's "champions" in key policy, planning and budgeting processes, so that children's concerns are mainstreamed, recognised as state responsibilities, especially for some aspects of children's well-being, such as nutrition, child and social protection.
- Promote universal access to quality social services - health, education, water- , in particular meeting the needs of the most disadvantaged and address the large geographic and rural-urban disparities by:
  - Increasing overall funding for all sectors that impact child well-being - education, health, child protection, access to clean water and sanitation;
  - Increasing financial and technical support to local government authorities to achieve effective management, in increasingly transparent processes;
  - Continued support to the new formula funding allocations to local authorities; and,
  - Ensuring a larger share of the budget for local authorities and incentives for staff to work in underserved areas.
- Strengthen national leadership in designing and financing social protection programmes by mainstreaming existing systems towards a more coordinated response.
- Enact effective and efficient strategies to ensure equitable service provision.
- Prioritize resource allocations for growth and development at the local level towards addressing rural poverty.
- To enact one unified Children's Act and improve capacity to address children's rights.

Bibliography

Assad. M. and Kibaja A, Resource Allocation and Challenges of Education Reform in Tanzania: A paper presented to the Education Review Workshop. 2007

Dahoma M, Salim A.A, Abdool R, Othman A.A., Abdullah A, and A.S. Prevalence of HIV, Hepatitis B and C and Syphilis Infection in Substance Users in Zanzibar, Tanzania. 2005

HakiElimu. Secondary Education Progressing? Key Findings from Government Reviews of SEDP Implementation. Dar es Salaam, Tanzania. 2007

HakiElimu. Redefining Quality Education in Tanzania: From Inputs to Capabilities. Dar es Salaam ,Tanzania. 2007

Leach, V. Children and Vulnerability in Tanzania: A Brief Synthesis. REPOA Special Paper. Dar es Salaam, Tanzania. 2008.

Lindeboom, W. and Kilama, B. Trends in Malnutrition in Tanzania: Draft Report submitted to the World Bank. REPOA. 2004.

National Bureau of Statistics and Macro International Inc. Tanzania Service Provision Assessment Survey 2006. Dar es Salaam, Tanzania. 2007

National Bureau of Statistics and Measure DHS+. Tanzania Demographic and Health Survey 2004/05: Preliminary Report. Dar es Salaam, Tanzania. 2005

National Bureau of Statistics and Measure DHS+. Tanzania Reproductive and Child Health Survey 1999. Dar es Salaam, Tanzania. 2002

PEFAR/MKUKTA Annual Consultative Meeting. Review of Fiscal Performance and Public Expenditure Management Issues 2005/06 and first half 2006/07. 2007

Revolutionary Government of Zanzibar. Office of Chief Statistician. Household Budget Survey 2004/05. 2006

Revolutionary Government of Zanzibar. Ministry of Finance and Economic Affairs. Zanzibar Strategy for Growth and Reduction of Poverty. 2007

Smithson, P. Fair's Fair: Health Inequalities and Equity in Tanzania. Ifakara Centre for Health Research and Development (ICHR) and Women's Dignity Project. Dar es Salaam, Tanzania. 2006

Tanzania Commission for AIDS (TACAIDS), National Bureau of Statistics (NBS), and ORC Macro. Tanzania HIV/AIDS Indicator Survey 2003/04. Claverton, Maryland, USA. 2005

United Republic of Tanzania. Integrated Labour Force Survey 2008. Preliminary Report. Dar es Salaam. 2008

United Republic of Tanzania. Ministry of Education. Basic Education Statistics Tanzania. Dar es Salaam, Tanzania. 2007.

United Republic of Tanzania. Ministry of Education. A Tracer Study for CBET Graduates in the Six Selected Councils, conducted in October 2007, in Mainland Tanzania. Dar es Salaam. 2007

United Republic of Tanzania. Ministry of Health. 2008, Health Sector Public Expenditure Review Update FY07, Draft Report. Dar es Salaam, Tanzania. April 2008.

United Republic of Tanzania. National Bureau of Statistics (NBS). Household Budget Survey 2007. Preliminary Findings. Dar es Salaam, Tanzania. 2008

United Republic of Tanzania. National Bureau of Statistics. Household Budget Survey 2000/01. Dar es Salaam, Tanzania. 2002

United Republic of Tanzania. National Bureau of Statistics. National Population and Housing Census 2002. Dar es Salaam, Tanzania. 2002

United Republic of Tanzania. National Bureau of Statistics. Revised National Accounts for Tanzania Mainland, Base Year 2001, Dar es Salaam. July 2007.

United Republic of Tanzania. National Bureau of Statistics. Tanzania HIV/AIDS Malaria Indicator Survey, Preliminary Report 2007/08.

United Republic of Tanzania. National Bureau of Statistics (NBS) and USAID, ORC MACRO. Tanzania Demographic and Health Survey. 2005

United Republic of Tanzania. Research and Analysis Working Group. Views of the Children in Tanzania 2007: Children's Perceptions of Education and their Role in Society. Dar es Salaam Tanzania. 2008

United Republic of Tanzania. Research and Analysis Working Group. Poverty and Human Development Report 2005. Dar es Salaam. 2005

United Republic of Tanzania. Research and Analysis Working Group. Poverty and Human Development Report 2007. Dar es Salaam. 2007

United Republic of Tanzania. Tanzania Commission for AIDS (TACAIDS). Public Expenditure Review, Multi-sectoral Review: HIV/AIDS. Dar es Salaam, Tanzania. 2007

World Bank, Tanzania Food and Nutrition Centre and UNICEF. Advancing Nutrition for Long-term, Equitable Growth: Report for Economic Sector of the World Bank. 2007.