Childhood Poverty in Tanzania: Deprivations and Disparities in Child Well-Being

The cover design of this report was inspired by the Global Study on Child Poverty and Disparities, a multi-country initiative to leverage evidence, analysis, policy and partnerships in support of child rights. The overlapping, multi-coloured frames symbolize the national, regional and global contributions to the Global Study, which form the basis for exchanging experiences and sharing knowledge on child poverty.

The design encapsulates three central tenets of the Global Study: ownership, multidimensionality and interconnectedness.

Ownership: Although children's rights are universal, every country participating in the study has its own history, culture and sense of responsibility for its citizens. The analyses aim to stimulate discussion and provide evidence on how best to realize child rights in each country.

Multidimensionality: No single measure can fully reflect the poverty that children experience. A multidimensional approach is therefore imperative to effectively understand and measure children's wellbeing and the various forms of poverty that they experience.

Interconnectedness: Today's world is increasingly interconnected through economic, social, technological, environmental, epidemiological, cultural and knowledge exchanges. These exchanges have important implications for child poverty – and can also help provide avenues for its reduction.

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Foreword

Tanzania has made significant progress towards achieving global and national targets in key areas of child well-being, particularly health and education. However, these achievements risk being undermined by persistent poverty. Children account for half of the country's population, yet their 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 easily overlooked.

Drawing on national statistics, this report presents a large body of evidence concerning child well-being. Importantly, the report introduces an internationally recognised definition and operational measure of child poverty based upon severe deprivation of basic human needs, which suggests that many more Tanzanian children live in poverty than indicated by household-based measures of income or consumption shortfalls. Despite substantial gains in recent years, findings show that many Tanzanian children are still deprived of the opportunity to develop into healthy, informed and productive citizens.

The report then provides a comprehensive analysis of national policies, programmes and budgets in sectors of critical importance for children in both Mainland Tanzania and Zanzibar. To shed light on how policies, programmes and budgets impact children, the analysis goes beyond national averages in order to capture inequities in outcomes. Key challenges and opportunities for capitalising on achievements and removing existing obstacles are discussed. The clear message is that, for all children to have an equal opportunity to benefit from national development and lead productive, fulfilling lives, more needs to be done to address the situation of the disadvantaged, the poor and the vulnerable, who are often excluded from progress.

Production of the report has been a joint effort by national institutions and UNICEF, as part of a global initiative spearheaded by UNICEF to shed light on the situation of children whose rights and well-being are jeopardised by poverty and deprivation. Nearly forty countries around the world are taking part in the global initiative, including ten from Africa. Because of its long-standing commitment to poverty reduction and strong tradition of poverty monitoring and data analysis, Tanzania was identified as one of the countries to be included in this exercise.

The main purpose of the report is to raise the profile of children in public policy debates, identify opportunities and constraints to stepping up efforts to reduce child poverty and disparities, and generate knowledge that can help shape the design of policies, programmes and budget decisions that will effectively protect and promote the rights of all children.

It is our hope that the evidence and analysis presented here will encourage a national debate about what constitutes child poverty in Tanzania, and what meaningful actions can be implemented to ensure that their rights are fully realised.

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The report on child poverty and disparities in Tanzania is a joint effort between the National Bureau of Statistics, Research on Poverty Alleviation (REPOA) and UNICEF Tanzania.

The UNICEF Office in Dar es Salaam commissioned the National Bureau of Statistics to undertake data processing and analysis of national statistics, together with researchers from the Graduate Program in International Affairs at the New School University, New York. REPOA was commissioned to engage local researchers to carry out the policy analysis contained in the report and consolidate it into a single publication based on a set of thematic background papers.

Compilation of the report was done by Valerie Leach from REPOA. Background papers were contributed by Flora Kessy, Ifakara Health Research and Development Centre (all aspects of child well-being in Zanzibar) and, for Mainland Tanzania, by Kate Dyer, Maarifa ni Ufunguo (education), Valerie Leach, REPOA (nutrition and social protection), Masuma Mamdani, REPOA (health and HIV/AIDS) and Robert Mhamba, University of Dar es Salaam (child protection). Alberto Minujin and Enrique Delamonica, from the New School University, and Ahmed Makbel, Aldegunda Komba and Francis Sichona from the National Bureau of Statistics were responsible for the statistical analysis of deprivation. Analytical and substantive support was also received from Edith Mbatia, Louisa Lippi, Mikala Lauridsen and Carol Watson of the UNICEF Tanzania office.

The background papers were written in early 2008, based on the data then available to the researchers. However, every attempt has been made to update data following the release of national surveys and include important policy developments since the background papers were prepared. Valerie Leach from REPOA, and Masuma Mamdani and Alejandro Grinspun from UNICEF reviewed the final draft and prepared it for publication. The revised version was edited by Chris Daly.

The report would not have been possible without the support and collaboration of a wide range of individuals and institutions, from the Government of Tanzania as well as from research institutions, national and international non-governmental organizations, and the UNICEF Office in Dar-es-Salaam and UNICEF Headquarters in New York.

We are most grateful to all those who participated in writing and reviewing the report and offering their reflections on the issues raised.

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EXECUTIVE SUMMARY

In 1999, to usher in the new century with optimism for growing security and prosperity, the Government of Tanzania set forth its vision for the nation. Vision 2025 began by imagining the kind of society that would be created by children born on that day who, 25 years later, would have grown up, joined the workforce and become parents to a new generation. For the Millennium generation, the Government envisioned a country free of abject poverty, where all Tanzanians enjoyed a high quality livelihood, and where development was people-centred and based on sustainable and shared growth. In adopting the Zanzibar Development Vision 2020, the Revolutionary Government of Zanzibar similarly dedicated itself to eradicate absolute poverty.

Tanzania reinforced this vision by adopting the Millennium Declaration in 2000. Consistent with Tanzania's aspirations, the eight Millennium Development Goals seek to eliminate poverty and overcome the inequalities that deprive so many of their most fundamental human rights to be free from hunger, to have access to life-saving healthcare, and be educated. As in Vision 2025 for the Mainland and the Zanzibar Development Vision 2020, the Millennium Development Goals recognise that poverty reduction begins with today's children. Key MDG targets relate directly to reducing childhood poverty and deprivation and improving outcomes for children – reducing malnutrition in under-fives (MDG 1), achieving universal primary education (MDG 2), and reducing child mortality (MDG 4). Achieving the MDGs by 2015 is, therefore, a critical stepping stone towards realizing Vision 2025 and 2020. By meeting and exceeding the goals, the well-being of hundreds of thousands of children will be safeguarded so that they have the chance to fulfil their potential as empowered members of Tanzanian society.

A second generation of poverty reduction strategies have been adopted by the Mainland and Zanzibar to achieve their respective Visions and the Millennium Development Goals.

Purpose of the Study

To accelerate progress towards the MDGs, UNICEF launched the Global Study on Child Poverty and Disparities in September 2007 in over 40 countries. The study aims to put children's rights and needs at the centre of national development strategies and budgets. Its objectives in Tanzania were three-fold:

- to assess the status of child poverty and disparities nationally
- to analyse existing policies and programmes that significantly impact child outcomes
- to identify gaps and opportunities in national poverty reduction strategies to rapidly improve outcomes for the least advantaged children.

Conceptual Framework

Significantly, this study aims to measure how Tanzanian children experience poverty in their lives by applying an internationally recognised definition and operational measure of childhood poverty based on deprivation of seven basic human needs: nutrition, health, shelter, water, sanitation, education and information. This conceptual framework, therefore, goes beyond the commonly reported measures of income poverty based on households' consumption expenditure under which childhood poverty is indistinguishable from overall poverty.

Whether a child lives in poverty depends not only on family income, but also on access to essential public goods and services, such as water and sanitation, healthcare and education. By including the childhood deprivations approach, the report's analysis of child

well-being overcomes some limitations of relying solely upon monetary measures of poverty. In particular, the deprivations approach assesses child poverty based upon the basic rights of the child, and measures outcomes directly relevant to children – for example, child survival, nutrition and schooling – instead of indirectly through reference to household means alone. By expanding the analysis of child poverty to outcomes rather than just means, a more direct link is established between child well-being and national policies and programmes that provide essential services.

A policy analysis was then conducted on six areas or 'pillars' of public policy which are fundamental to safeguarding and promoting child well-being: health, nutrition, HIV/AIDS, education, child protection and social protection. For each pillar, national laws, policies and programmes relevant to children were examined to identify building blocks for a comprehensive strategy to rapidly improve outcomes for all Tanzanian children. As legislation, policies and programmes affecting children in Zanzibar are governed by the Revolutionary Government of Zanzibar, separate policy analyses were performed for the Mainland and Zanzibar.

Children and Pro-poor Growth

Though historically high compared with the 1980s and 1990s, current levels of economic growth remain low relative to the rates required to achieve the income poverty targets of Vision 2025 and 2020, and the MDGs. Evidence to date also indicates that recent growth has not been pro-poor. Over one-third of all households live below the basic needs poverty line, well below $1 per day, and nearly 20% live below the food poverty line. Poverty has remained overwhelmingly rural, both in Mainland Tanzania and Zanzibar, with many children affected by it. Estimates from 2007 suggest that roughly six million children aged 0-14 years are living below the basic needs poverty line, and around three million children fall below the food poverty line.

Official priorities are to maintain and accelerate the country's growth rate. Foreign direct investment is encouraged, and the structure of the economy is changing. Sectors of the economy which have grown most rapidly in the past few years and are expected to do so for the next few years are mining and construction and services, including tourism, transportation services and communication. However, these sectors have had limited linkages with local economies. Over three-fourths of the population lives in rural areas, and agriculture, the mainstay of the rural economy, has grown more slowly. It is in rural households reliant on agriculture where poverty is most prevalent and disparities with urban households most pronounced. Pervasive poverty, low levels of education and poor health limit the extent to which individuals, households and communities are able to provide a decent standard of living for themselves. Attention is now turning to the need for a strategically focused growth strategy to enable the economy to expand at higher and sustained rates of growth with benefits for the rural majority.

Child Poverty and Deprivation

Around half of Tanzania's population of 40 million are children under the age of 18 years. The analysis of childhood deprivation indicates that the incidence and impact of poverty on children is far greater than indicated by conventional income-consumption measures, especially in rural areas. Based on data from the Tanzania Demographic and Health Survey 2004/05, almost half of all children in rural Tanzania (48%) suffered three or more severe deprivations of basic need compared with 10% of children in urban areas. The incidence of severe deprivations among children was far higher on the Mainland than Zanzibar; approximately 41% of Mainland children suffered three or more severe deprivations compared with 19% of Zanzibari children.

Deprivation was also associated with the wealth of the child's household, underlining the need to measure and address child poverty more effectively. The vast majority (86%) of children in the lowest wealth quintile suffered three or more severe deprivations compared with less than 1% of children in the highest wealth quintile. In addition, the depth of poverty – the average number of severe deprivations experienced by children – varied inversely with the level of education attained by children's mothers, underscoring the critical importance of investing in

girls' education to break the cycle of poverty over time and across generations.

A promising, though slight, decline was recorded in the incidence of severe deprivation between 1999 and 2004/05, in large part due to the achievements of the Primary Education Development Programme. Circumstances for children in Zanzibar showed greater improvement than in Mainland Tanzania. However, even after adjusting the thresholds of severe deprivation to more closely reflect the national context, the analysis found that a majority of Tanzanian children were living in unacceptable and damaging conditions.

Child Survival – Health, Nutrition, HIV

Major gains in child survival have been achieved over the last decade and, if the pace of recent progress is sustained, the targets for reductions in infant and under-five mortality in MKUKUTA and MKUZA (2010) as well as the MDGs (2015) are within reach. Preventive measures such as measles vaccination and vitamin A supplementation campaigns have contributed, but there is little doubt that the significant fall in child mortality in the past five years is largely due to improved malaria control. However, there is no indication of any improvement in neonatal mortality, which accounts for nearly half of all infant deaths. Maternal mortality – which is intrinsically linked to neonatal mortality – has also remained exceptionally high, with no improvement in the 1990s.

Despite progress in child survival, children are extremely vulnerable to shocks and stresses occasioned by poor living conditions, malnutrition and ill-health, and thousands of Tanzanian children succumb to preventable deaths every day. Child malnutrition, which indirectly accounts for between a third and a half of under-five deaths, is still widespread. Dehydration caused by severe diarrhoea also remains a major cause of morbidity and mortality among young children in Tanzania, with sound hygiene practices in households severely hampered by lack of access to clean and safe water. Mother-to-child transmission remains the leading cause of HIV infection in children.

Health problems faced by adolescents, girls in particular – such as HIV, sexually transmitted infections and early pregnancy – deserve greater visibility and attention from policy makers. The uptake of any AIDS-specific service, especially by poor and vulnerable groups in rural areas, is constrained by the extent of general health service provision. Continuing issues are posed by the existence of numerous interventions that are poorly coordinated and that do not achieve the required scale. The key question is how available resources for HIV/AIDS can best be used to overcome existing health system challenges and improve the overall delivery of healthcare services. In turn, prevention of HIV demands that issues such as gender inequity, social mores, poverty and vulnerability be tackled as matters of priority.

Altogether, despite the achievements of vertical programmes, health conditions vary widely. The incidence of severe deprivation among Tanzanian children is exceedingly high, and large disparities in key indicators of child outcomes persist on the Mainland and, to a lesser degree, in Zanzibar. Children from rural areas and the poorest households are commonly worse off than their urban and least poor peers. They are more likely to be malnourished, have less access to healthcare, and more likely to die.

Further gains in child survival and health call for a more coordinated, systemic approach to strengthen healthcare delivery, a renewed focus on the importance of nutrition among young children and pregnant women, and improved access to clean and safe water in households, health facilities and schools, especially in rural and under-served areas. The development of a comprehensive health framework that transcends the emphasis on single, disease- or sector-specific interventions will ensure that vulnerable children are neither neglected nor allowed to slip through cracks between individual programmes. By positing key programmes that influence child outcomes within an integrated approach, gaps in provision can be more clearly identified and inter-sectoral cooperation and synergies can be harnessed for the benefit of all children. If strengthened, linkages and efficiencies could significantly reduce costs for implementing agencies and reduce the burden of time and cost on families.

Education

National educational indicators reveal largely positive trends at primary and secondary levels. Primary school enrolment rates are within reach of the MKUKUTA target of 99% by 2010. Little disparity exists between regions, and enrolment ratios for girls and boys are nearly the same. Net secondary enrolment has also expanded quickly from 6% in 2002 to 21% in 2007, but geographic disparities are more pronounced and a disproportionately high number of poorer and vulnerable children are left out of secondary schools. Parity in enrolment rates between girls and boys falters at higher levels of secondary school and girls comprise only 40% of all pupils by Form V. The TDHS 2004/05 also showed that a substantial percentage of children in the poorest quintile and in rural areas were still not attending primary school, while 2007 HBS data show that children from poor families have benefited from the recent expansion of secondary schools, but remain under-represented. Children with disabilities are unlikely to be enrolled in school

Despite its substantial successes, the PEDP has failed to live up to its full promise and potential of bringing about expected quality improvements. In 2008, the percentage of school entrants who had completed seven years of schooling had declined to approximately 65%, from 78% in 2007. In addition, both the pass rate in the Primary School Leavers' Exam and the transition rate from Standard VII to Form I decreased in 2007. Statistics also show large gender and regional variations in pass rates with boys exceeding girls in every region but Kilimanjaro in 2006. Classroom sizes on average still exceed 50 students.

Primary and secondary education programmes, therefore, face ongoing challenges – securing adequate resources, financial and human; achieving greater geographic and gender equity; improving the quality of educational inputs and outcomes; improving attendance rates; and meeting the needs of vulnerable children. More attention needs to be given to the quality and scope of education to ensure that today's graduates are equipped with the skills in demand in the labour market.

Child Protection

Both within and outside family environments, a high number of Tanzanian children suffer abuse and exploitation, including abandonment, physical abuse, corporal punishment, sexual and gender-based violence. The true, full extent is not known. Child labour is common, particularly in rural areas and among older children, who work on family farms and perform domestic chores, working more hours each week than may be considered compatible with their age and demands of their schooling. Many children are also victims of everyday abuse and violence by adults, including parents and teachers, and by older children at school or when travelling to or from there. Gender-based violence still affects many girls. Adolescent child-bearing remains common, especially in rural communities, and more so amongst girls without secondary schooling. Registration of rural births is low and possession of birth certificates even lower.

The timely passage of a unified Children's Act, now being considered by the Parliament in the Mainland and the Cabinet in Zanzibar, will lay a solid foundation for the realisation of children's rights. Indeed, such legal reform will represent the linchpin for a *transformative* strategy of social protection, by establishing the rights and obligations to protect Tanzania's youngest citizens from discretionary acts, neglect or abuse by relatives or government officials. Public consideration of the Children's Act will also facilitate open discussion of sensitive social mores and attitudes towards children. Its enactment and dissemination will provide an invaluable opportunity to raise the profile of children on the national agenda. However, implementation of the statute is likely to be haphazard unless there is strong and consistent public pressure.

Social Protection

As detailed above, poverty among children in Tanzania is pervasive and substantial numbers of children are living in desperate conditions. However, public programmes for the most vulnerable children have low coverage compared to the numbers of children and households in extreme need, and there is little evidence of their impact. Existing interventions are uncoordinated and financed largely

from external sources. Moreover, programmes tend to provide support to limited numbers of children and in ways which are socially disruptive and sometimes stigmatizing.

All children, whether they are most vulnerable or slightly less so, need to have access to social protection when necessary. The development of universal mechanisms for delivering essential social services to poor families is a basic foundation of a comprehensive strategy for improving child outcomes. Broad-based programmes that acknowledge overlapping interests between poor and non-poor, and rely on common institutions for delivery, have demonstrated the capacity to sustain political support and promote social cohesion. Whichever mix of strategies is pursued to ensure that all children are adequately fed, clothed and sheltered, a transformative national scheme of social protection must be based on the practical recognition of state responsibilities, formally acknowledged in the Constitution.

Such a system of social protection is consistent with the aspirations and goals of Vision 2025 and MKUKUTA on the Mainland, and Vision 2020 and MKUZA in Zanzibar, and can play a critical developmental role in support of economic growth and productivity – by enabling universal access to essential social services, removing barriers to risk-taking behaviour, and enhancing capacities for self-reliance.

A Vision for Child Well-Being in Tanzania

Tanzania has made great strides in protecting and enhancing the lives of its children. Commitments of Government and of official aid assistance have ensured that basic education and health programmes (and more recently water) receive a substantial share of the public budget – and these efforts are paying off in the form of enhanced child well-being. However, despite significant achievements – which show that progress is *possible* even in severely resource-constrained environments – numerous challenges remain. Both health and education suffer from poor quality and entrenched inequities by district, urban-rural residence and by wealth status.

HIV/AIDS and malaria – both critical areas of child well-being – have received increased funding. However, much of this funding is highly dependent on donor pledges, hence, beset by questions of predictability and sustainability, and much of this aid is also provided off-budget which increases the complexity of national planning and budgeting. External financing continues to provide a large proportion – over a third of the total budget – but several aid programmes 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. Therefore, it is extremely difficult to establish and analyse links between strategic plans, approved budgets and actual expenditures against national goals and targets for poverty reduction. In reality, planning and implementation is frequently ad hoc and major gaps between costed plans and actual budget allocations are common. From a plethora of uncoordinated projects, the government is therefore keen to move towards general budget support, sector-wide approaches, and pooled funding.

Progress in providing quality services for children is integrally connected with reforms to strengthen government systems. Under the strategy of Decentralisation by Devolution, local government authorities are responsible for implementing quality public services, including health, education, water supply and agricultural development. All of these services can address child poverty, but authorities are constrained by insufficient funding, personnel and information, while also being overwhelmed by the multiple demands placed upon them. The full implementation of formula-based allocations to local authorities (which are designed to correct for geographic disparities), increased on-budget financing, and an increased share of budgetary resources flowing to local authorities will be essential for strengthening local capacity and services. While changes are being made to streamline flows of funding to local governments, there is a persistent capacity challenge ahead. Adequate technical and financial support to LGAs – with stronger accountability mechanisms for effective use of resources – will be a prerequisite in improving child outcomes

The positive lessons learned in education and health offer strong building blocks for a comprehensive strategy for children's development, one which deliberately focuses on closing the gaps and disparities that leave some children behind. Three core elements have been identified as essential for an effective strategy: national leadership; effective management by decentralised government authorities; and collaboration with national, non-state organisations. The first two elements are especially important in raising the profile of children on the national agenda, and progress will require persistent and patient effort.

The robust and sustained economic growth since 2000 provides a unique opportunity to reflect on Tanzania's aspirations for its Millennium generation. Despite perceptions to the contrary, economic growth does not benefit children automatically. Whether children benefit from national development will ultimately depend on how national policies and strategies are focused on addressing rural poverty; how the benefits of growth are distributed; and how resources are allocated and disbursed to provide for children most in need who, because of their particular circumstances, may not benefit from general economic strategies.

INTRODUCTION

2015...the deadline for the Millennium Development Goals is rapidly approaching.

Adopted by 189 nations, the Millennium Declaration represents unprecedented consensus and commitment to international development. For each country, 2015 will be a time to assess national progress towards meeting the development and socio-economic challenges embodied in the eight Millennium Development Goals (MDGs) – ending extreme poverty and hunger, achieving universal education, implementing life-saving healthcare, promoting gender equity, promoting environmental sustainability, and improving governance. For each country, achievements in 2015 will depend on a conducive international environment, and on the plans made and actions taken today and each day over the next six years.

Child Poverty and Disparities: Delivering Results for Children

To accelerate progress towards the MDGs, UNICEF launched the *Global Study on Child Poverty and Disparities* in September 2007 in over 40 countries, including Tanzania. The study aims to mobilise international resolve to combat child poverty, and put children's rights and well-being at the centre of national strategies and budgets. Its objectives are three-fold: i. to comprehensively assess the status of child poverty and disparities; ii. to analyse existing policies and programmes that significantly impact child outcomes; and iii. to identify gaps and opportunities in national poverty reduction strategies to rapidly improve outcomes for children left behind. In short, the study seeks to translate new context-specific, country-level evidence into better lives for Tanzanian children.

Poverty Reduction Begins with Children

Children are often hardest hit by poverty due to their age and dependency. A child's start in life – before birth and in the first few years – is critical to physical, intellectual and emotional development. Impaired development in early childhood often cannot be regained later in life, and may consign a child to an adulthood of gruelling poverty. Children living in poverty are also frequently denied their rights: to survival, health and nutrition, education, and protection from harm, abuse and exploitation. Failure to achieve the key targets related to child poverty and disparities in the MDGs – for example, reducing malnutrition in under-fives (MDG 1), achieving universal primary education (MDG 2), and reducing child mortality (MDG 4) – will have tragic consequences. Alternatively, by meeting and exceeding the MDGs, hundreds of thousands of Tanzanian children will have a chance at realising their full potential; to survive and thrive as individuals, and as empowered members of society. Prioritising the rights and special needs of children and championing child development will have a profound impact on the social and economic progress of Tanzania. A renewed focus on child poverty within national policy is a necessary foundation for the improvement of child outcomes to meet the MDGs, and to break the cycle of poverty from its earliest and most devastating manifestations in childhood mortality and arrested child development.

Structure of the Report

The report is divided into four chapters. Chapter 1 introduces the overall national context for pro-poor growth and poverty reduction in Tanzania, including current progress towards key indicators for MDGs relevant to children. The chapter also presents the conceptual framework for the analysis of child poverty. Chapter 2 assesses the status of child poverty and deprivation on Mainland Tanzania and Zanzibar. A three-part analysis is performed to arrive at a comprehensive picture of child poverty nationally: i. Incidence of income poverty based on

households' consumption expenditure; ii. Extent and depth of child poverty based on indicators of severe deprivation for seven basic childhood needs; and iii. Key indicators of child survival and their links to poverty. Chapter 3 then analyses six areas or 'pillars' of public policy that are fundamental to safeguarding and promoting child well-being: i. health; ii. nutrition; iii. HIV/AIDS; iv. education; v. child protection; and vi social protection. Chapter 4 presents the study's key findings and recommendations for a comprehensive strategy to address child poverty and disparities. Since legislation, policies and programmes affecting children in Zanzibar are governed by the Revolutionary Government of Zanzibar (RGoZ), Chapters 1 through 3 include separate sections for Mainland Tanzania and Zanzibar.

CHAPTER 1

CHILDREN AND DEVELOPMENT

This chapter establishes the foundation for the analysis of child poverty in Tanzania and the policies and programmes relevant to child well-being. Section 1.1 outlines recent trends in population and economic growth. Section 1.2 then provides an overview of national macroeconomic strategies and resource allocations for growth and poverty reduction – MKUKUTA for Mainland Tanzania and MKUZA for Zanzibar – and assesses whether these strategies are responsive and inclusive of children's development. Section 1.3 presents the conceptual framework for the current study.

1.1 POPULATION AND ECONOMIC GROWTH

The latest population census, in 2002, reported a population of 34 million, of whom almost one million people were in Zanzibar. The projected population in 2006 was 38.7 million, of whom 1.1 million lived in Zanzibar (National Bureau of Statistics (NBS)[1], 2007a). Life expectancy at birth was estimated to be 51 years[2] of age in the 2002 census compared with 49 years of age in the 1988 census. The small increase is attributed largely to the impact of adult mortality from HIV/AIDS, even as under-five mortality has decreased significantly in recent years.

Data from demographic and health surveys conducted every five years show fertility rates falling slightly since the 1990s, from a total fertility rate of 6.3 in 1991/92 to 5.7 in 2004/05. In Zanzibar, the total fertility rate was 5.3 in 2004/05. Fertility rates are much higher among rural women (6.5) compared with urban residents (3.6), and much lower among those with some secondary education (3.3) and in the least poor quintile (3.3) (NBS et al., 2005), revealing that the number of children borne by women is closely associated with educational attainment and income. Even though urbanisation has increased over the last three decades, the population remains predominantly rural – three-quarters of Tanzanians reside in rural areas, earning their living from small-scale, rain-fed farming. The Zanzibari population is more urbanised, with 40% living in urban areas (RGoZ, 2003). Poverty is pervasive, especially in rural areas. In fact, rural-urban disparity in child outcomes is a common thread throughout this report.

The most recent Integrated Labour Force Survey (ILFS), conducted in 2006, shows that almost all of the rural labour force – 77% down from 84% in 2000/01 – is employed in agriculture. Overall, informal employment has increased from 6% to 9% over the same period. Workers in the informal sector are overwhelmingly self-employed (NBS, 2008a).

Within the agricultural sector, irrigation schemes are being promoted, but still have low coverage (8%). Fewer than 20% of all smallholders use any form of inputs, other than farmyard manure which is used by 26%. Only 3% of all agricultural households access credit; among female-headed farming households, the proportion is less than 1% (NBS, 2005).

Economic growth over the past five years has been strong – 7.4% in 2005, 6.7% in 2006 and 7.1% in 2007 – and well in excess of population growth. Industry and construction (particularly mining) and the services sector have performed strongly. However, growth in agriculture has been much slower than average GDP growth, at around 4%. Figure 1.1 shows the pattern

[1]Projections based on an estimated intercensal (1988 to 2002) growth rate of 2.8% of the "national" population of Mainland Tanzania (i.e. minus those in refugee camps in Kagera and Kigoma), and of 3.1% for Zanzibar.
[2]This compares closely with life expectancy in 2007 in neighbouring countries (Uganda 51 years; Kenya 54 years) and across sub-Saharan Africa (51 years), but is much lower than in North Africa and the Middle East (70 years) or in Latin America and the Caribbean (73 years) (World Bank, 2009).

of growth in the Mainland economy by sector from 2000 to 2006. Gross Domestic Product (GDP) per capita (current prices) increased from an estimated US $301 in 2001 to US $521 in 2008 (IMF, 2009). In purchasing power parity, gross national income per capita (current prices) in 2006 was estimated to be $980, which ranked Tanzania as 190 out of 208 countries (World Bank, 2008).

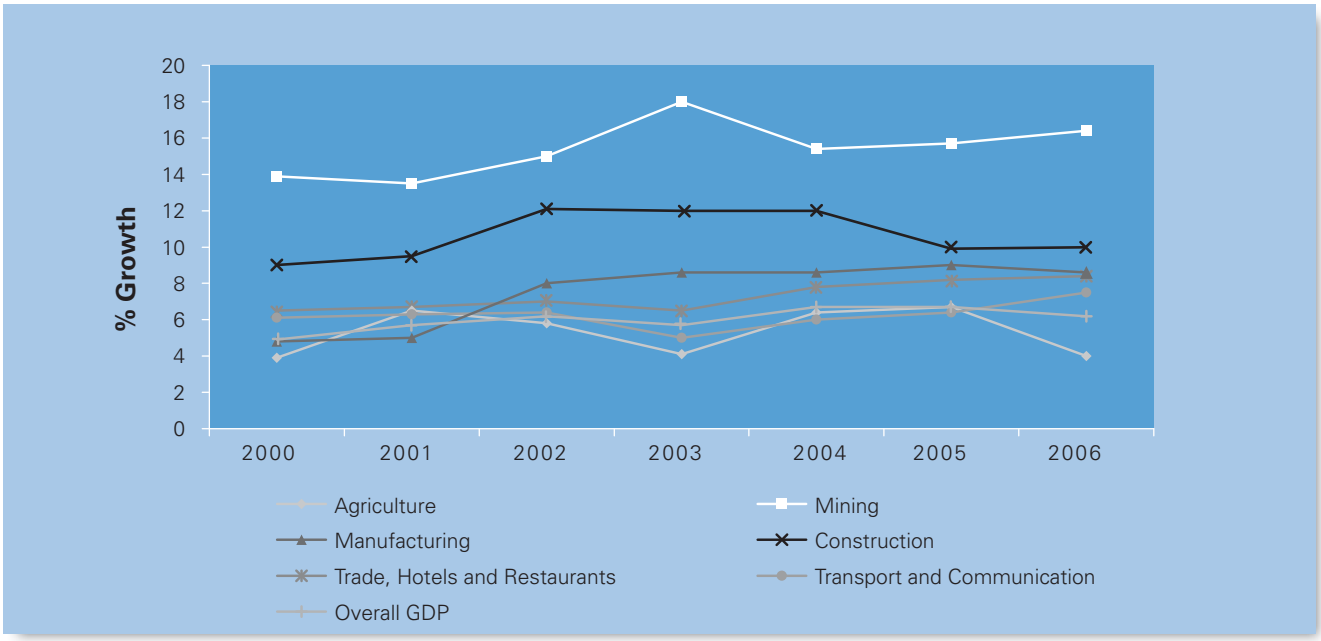
Previous estimates of the national accounts for Mainland, based on 1992 prices, have been rebased to 2001 prices to incorporate relative price movements and changes in the structure of the economy. Critically, the revised GDP estimates show that the agricultural sector's share of GDP is about one-quarter (25.8% in 2007) of the total, compared with over 40% in earlier years and in the older series. Just over 40% of total agricultural production is accounted for by non-monetary production (NBS, 2007b). Structural changes in the economy have largely bypassed agriculture. Appendix 1 provides a more detailed breakdown of the revised GDP estimates by sector for 2001 through 2007.

Zanzibar's GDP in 2007 was TShs 588.5 billion, a significant increase from the average of TShs 189.5 billion in the 1990s (RGoZ – OCGS, 2008). This translates to an annual per capita income of US $415 in 2007. Since 2000, Zanzibar's economic growth has been robust. The average growth rate over the period 2000-2004 was 6.8%. In 2005, 2006 and 2007, the economy grew by 4.9%, 6.0% and 6.3% respectively. Growth has been driven mainly by the service sectors, which now represent over 40% 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, was about 27.5% in 2007.

1.2 PRO-POOR GROWTH AND CHILDREN: MACROECONOMIC STRATEGIES AND RESOURCE ALLOCATION

Tanzania's low-income, informalised economy generates what has been characterised as 'generalised insecurity' (Wuyts, 2006), which exacerbates vulnerability. Economic growth has been led by two sectors, services and mining, with low levels of linkage with local economies. Investment strategies have aimed especially at attracting foreign investment.

Figure 1.1: GDP Growth in Mainland Tanzania by Sector 2000 – 2006



Source: URT Economic Surveys, various years.

Evidence to date indicates that the recent strong growth has not been pro-poor. Attention is now turning to the need for a strategically focused growth strategy entailing the identification of growth drivers based on Tanzania's comparative and competitive advantages, and their potential for reducing poverty and creating jobs (RAWG, 2007).

Under the national government, the country is divided into 26 administrative regions (21 on Mainland and five in Zanzibar), and 143 districts (133 and ten, respectively). In 1997, the Government of Tanzania initiated the Local Government Reform Programme. Under the strategy of Decentralisation by Devolution, the duties and financial resources for delivering public services are transferred from the central government to local government authorities (LGAs). The long-term goal is to reduce the proportion of Tanzanians living in poverty, by improving citizens' access to quality public services provided through autonomous local authorities. LGAs are considered to be better placed to identify and respond to local priorities, and to supply the appropriate form and level of public services to meet citizens' needs. Commencing in 2000, block grants from the central government are transferred to district councils to expand and improve the services provided at the local level, including education, healthcare, local roads, water and sanitation, and agricultural extension services.

1.2.1 Mainland Tanzania

A. Macroeconomic Strategies for Pro-Poor Growth

Vision 2025, adopted in 1999, sets the country's long-term development agenda. In this Vision, the Tanzania of 2025 will be a nation imbued with high quality livelihood; peace, stability and unity; good governance; a well educated and learning society; and a competitive economy capable of producing sustainable growth and shared benefits. A high quality livelihood for all Tanzanians is expected to be attained through realisation of national goals encompassing food self sufficiency, universal access to essential services (including education, healthcare, water), gender equality and the empowerment of women, the elimination of abject poverty, and the reduction of infant and maternal mortality rates by three-quarters (President's Office, Planning Commission, 1999).

Tanzania qualified for Highly Indebted Poor Countries debt relief in 2000 with the first Poverty Reduction Strategy Paper (PRSP). The PRSP operationalised the National Poverty Eradication Strategy which had been developed in the second half of the 1990s. It focused on ensuring resources for "priority sectors" of basic education and primary health care, as well as provision of agricultural extension and research, HIV/AIDS, rural roads and water supplies. The bulk of the resources made available from HIPC relief was allocated to education and health.

A review of the PRS led to the second phase National Strategy for Growth and Reduction of Poverty (NSGRP) commonly known as MKUKUTA (Vice President's Office (VPO), 2005). MKUKUTA is the national framework to achieve Vision 2025 and the Millennium Development Goals (MDGs). Started in 2005, MKUKUTA has three major clusters:

- Cluster 1 - Economic growth and reduction of income poverty
- Cluster 2 - Quality of life and social well-being
- Cluster 3 - Governance and accountability

The strategy recognises the multidimensional nature of poverty, and adopts an outcomes approach which requires all sectors to contribute to the poverty reduction agenda. The goals of MKUKUTA are incorporated in government plans and budgets. Implementation is reported annually in a MKUKUTA Annual Implementation Report. Progress towards outcomes and targets is reviewed and reported annually by the MKUKUTA monitoring system, either through an analytic volume, the Poverty and Human Development Report (PHDR), or through a Status Report. These reports are publicly available and are discussed at open public meetings.

As a result of deliberate efforts to stabilise the economy and attract external capital, foreign direct investment has increased consistently over the last several years, especially in mining enterprises.

Relations with official financiers, strained in the early 1990s, were strengthened such that levels of official development assistance (ODA) have risen. External financing and investment have both influenced changes in the economy. Increased ODA has also facilitated increased public allocations for education and health, and more recently, water. In particular, substantial increases have been made in school enrolments. With close to universal primary education across Tanzania, poorer, rural children have benefited from the expansion of enrolment.

However, most economic growth has not been pro-poor. The poor in Tanzania are predominantly small-scale farmers practicing rain-fed crop production with elementary tools and low productivity, and public inputs to improve and transform rural livelihoods are limited. Extension services, fertilisers and financial services are not reaching most farmers. Contract farming and out-grower schemes are being promoted as a way of increasing agricultural productivity and farming incomes. Schemes are well developed in sugar, tea and sisal – commercial crops, but not yet for maize.

Though historically high compared with the 1980s and 1990s, current levels of growth remain low relative to the rates of 8-10% needed to achieve the income poverty targets of Vision 2025 and the MDGs. Recently, the development of a focused, national growth strategy has received increasing attention by national policy makers and analysts, including a special chapter in the PHDR 2007. A Framework for Designing a Strategic Direction for Growth and Development in Tanzania emphasises the need to sustain and accelerate growth by building on Tanzania's comparative and competitive advantages of location and natural resources. It argues for an investment strategy in infrastructural development which would serve neighbouring landlocked countries, expand tourism opportunities and reduce the costs of doing business for local farmers, mining and other larger commercial enterprises (RAWG, 2007). Public investment in infrastructure is being given priority, and this should help rural households gain easier access to markets, as well as essential economic and social services.

B. Resource Allocation: Budgets and Outcomes for Children

Changes in the structure of the economy and public sector management reforms, including tax administration, have helped raise domestic tax revenues as a percentage of GDP from 12.2% in 2000/01 to an estimated 16.4% in 2007/08. Tax revenues can now cover recurrent costs of the national budget, excluding debt service. External financing, nonetheless, continues to provide a large proportion of the total budget, especially for development programmes. In addition, a considerable amount of ODA is not reflected in budget documents, but is subject to analysis in the public expenditure review process. Data from the Development Partners' Group indicate that 90% of donor contributions in 2005 was recorded in the official budget (DPG, 2007). Table 1.1 summarises the composition of budget revenue for financial years 2005/06 to 2007/08. In some sectors, notably health and HIV/AIDS, high proportions of off-budget aid complicate national planning processes (see Chapter 3).

The budget process involves the issuing of guidelines from the Ministry of Finance and Economic Affairs (MoFEA) and Ministry of Planning, Economy and Empowerment (MPEE). The guidelines summarise recent economic developments, outline the priorities for the coming budget period, and provide estimates of expected revenues and budget ceilings for all Ministries, Departments and Agencies (MDAs) of the central government, and for each region and local government authority (LGA).[3] Recent guidelines have emphasised the need to focus funding on priority projects and to limit the number of projects.

The guidelines for 2006/07 stated that the main objective of the Medium Term Plan and Budget Framework was to incorporate and support

[3] Under the Government's decentralisation programme, formula-based allocations of funding from central to local government are to be used for non-staff costs, with formulae to incorporate estimates of under-five mortality, school-age population, as well as measures of household poverty and weighting towards rural populations. For rural councils with limited potential for revenue generation, central funding accounts for over 90% of their funding (PEFAR, 2007). In health, for example, 36% of on-budget funding went to LGAs, up from 28% in 2004/05 and 2005/06 (PER Health updates, 2007 and 2008). However, the lower relative funding of local authorities compared with central ministries continues to reflect an imbalance of power and lack of capacity at the local level. Moreover, the continued central control over staffing and associated funding, which is tied to existing facilities, serves to perpetuate historical disparities in access to services and to outcomes.

Table 1.1: Government Revenue and Expenditures, 2005/06 – 2007/08 (% of GDP)

	Budget 2005/06 [a]	Budget Guidelines 2006/07 [a]	Budget 2007/08 [b]
Domestic revenue	14.3	14.4	16.4
External financing	11.9	12.9	12.0
programme funding	4.3	4.2	4.1
basket funding	2.9	4.1[d]	2.3 [d]
project funding	4.7	4.6	5.6
Recurrent expenditure	19.3	18.4	17.7
debt service	2.2	1.2	1.6
salaries, wages	4.7	6.1	5.5
other charges	10.6	10.3	9.3
Development expenditure	9.6	10.0	10.7
locally financed	1.8	3.7	3.9
externally financed	7.0	6.3	6.8

Notes: [a] from MPEE and MoFEA, 2006; [b] from MoFEA, 2008;
[c] basket funding includes contributions to the education and health baskets as well as general budget support - in 2005/06 32% and 12% of all basket funding was allocated to education and health baskets, respectively; and in 2006/07, 20% to the health basket (there was no special basket for education from 2006/07 onwards; it was fully incorporated into General Budget Support) [d] includes 2.0 in 2006/07 and 1.0 in 2007/08 from IMF's MDRI.

MKUKUTA cluster interventions, to encourage broad-based growth and significantly reduce poverty (MPEE and MoFEA, 2006). Similarly, in 2008 the guidelines reinforced the focus on growth and emphasised the need for fiscal discipline (MoFEA, 2008). However, both sets of guidelines make no specific mention of children, nor reference to sectoral priorities, for example in the education and health development programmes – though issues of equity and quality of social services are flagged, as they have been in sector-specific reviews.

Since MKUKUTA was approved, there has been a consistent shift towards an increased budget share for Cluster I interventions, reflecting a national priority to accelerate economic growth (see Table 1.2).[4] Overall public spending has increased, and the nominal budgets for education and health under Cluster 2 have also increased. Special provision for recruitment of teachers and health staff has been made, especially for rural and more isolated local government authorities. Health and education are therefore "protected" sectors, a reflection of the priority for these public services accorded by citizens, the government and external financiers. Cluster 3, governance and accountability, is accorded a smaller share of the budget. However, improving sectoral management systems also contributes to goals of improved governance and accountability, and may be difficult to budget and monitor separately.

Nonetheless, critical issues of governance and accountability remain in the delivery of services of importance for children, as expressed in two citizen perception surveys: Views of the People (RAWG, 2008a) and Tanzanian Children's Perceptions of Education and Their Role in Society: Views of the Children 2007 (RAWG, 2008b). These issues include difficulties in accessing health services due to problems in implementing the policy of exemptions from charges, poor distribution of learning materials, lack of motivation among

[4] Budget submissions by MDAs are made against their strategic plans so as to match planned expenditures with specific MKUKUTA goals and targets. In the 2008/09 guidelines, plans for MDAs' spending against MKUKUTA account for 67% of the total ceilings for development spending and recurrent non-salary costs ("other charges").

Table 1.2: Percentage Share of Government Budget, by MKUKUTA Cluster

MKUKUTA Cluster	Budget Guidelines (2006/07) [a]	Budget Guidelines (2008/09) [b]
Cluster 1 – Growth and Reduction of Income Poverty	43.4	48.3
Cluster 2 – Improvement of Quality of Life and Social Well-Being	34.9	34.1
Cluster 3 – Governance and Accountability	21.7	17.6
Total	100.0	100.0

Notes: [a] MPEE and MoF, 2006; [b] MoFEA, 2008.

teachers, and extensive use of corporal punishment in schools.

As noted earlier, Tanzania is heavily dependent on aid. About 40% of the national budget has been externally financed, though the past two years have seen a reduction to about 34%. Tanzania has been in the forefront of efforts to improve systems for international aid and, in October 2006, the Cabinet approved the Joint Assistance Strategy for Tanzania (JAST). The JAST is a medium-term framework for managing development cooperation and achieving national development and poverty reduction goals. JAST specifically commits external financiers to support MKUKUTA and MKUZA, and includes commitments on alignment of development cooperation programmes, increased use of government systems, increased aid predictability, open dialogue between government and domestic stakeholders, improved division of labour, and a move towards the government's preferred aid modalities, including basket funding for sector-wide approaches and general budget support.

Commitment to 'increased use of government systems' implies reporting plans and budgets through the official budget documents. A total of 14 agencies provide support through general budget support (GBS). Nonetheless, significant contributions, including those for children, remain "off-budget," not reflected in the budget submissions to the National Assembly. Funding from the U.S. President's Emergency Plan Fund for AIDS Relief (PEPFAR), which constitutes a large proportion of financing for HIV/AIDS programmes – including support for most vulnerable children – is off-budget, as is much of the UN's contribution. A 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 [for HIV/AIDS] increased by three-quarters, and now finances 95% of Government plus donor spending. The increase has been from off-budget sources of finance, and only 19% of expected aid in 2007/08 is included in the budget. HIV/AIDS is now taking a staggering one-third of all aid to Tanzania!" (IMF ODA data) (Tanzania Commission for AIDS (TACAIDS), 2008[a]).

Planning and budgeting processes that aim to achieve national goals and targets are intended to match expected resources. With a large percentage of development programming in Tanzania dependent on external assistance, realistic projections of the amount of aid to be provided by donors are critical. 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. As a consequence, the Medium-Term Expenditure Framework (MTEF) process is compromised – future years appear to be funded at lower levels than is likely. Without more consistent incorporation of plans and budgets in national systems, national leadership in addressing poverty reduction is, in turn, undermined.

In addition, some priority programmes in MKUKUTA, such as education and health, have histories of ministerial collaboration with particular aid organisations or groups, which continue to

provide support outside the resource constraints of the government budget. A report of the Public Expenditure and Financial Accountability Review (PEFAR) in 2007 concluded that this practice also undermined the budget process (Appendix 3).

Reporting on actual expenditures according to strategic priorities is also complicated by the overlay of different information systems. PEFAR 2007 reported that:

"The preliminary stages of budget cycle have established good linkages with national programmes and MKUKUTA-related planning. The budget reporting systems, however, have not caught up with the developments in the early stages of the budget cycle. Aggregate budget execution reports are disconnected from strategic plans, making it difficult to associate expenditure patterns and trends with the MKUKUTA. They are presented at an administrative level, rather than presenting a functional budget showing strategic allocations."

Therefore, significant improvements in financial reporting systems are required to strengthen the government's capacity to finance, implement and report on MKUKUTA priority sector interventions. In turn, these improvements will help strengthen the planning process and channel resources more effectively to reduce poverty and improve the quality of life of all Tanzanians, particularly children.

1.2.2 Zanzibar

A. Macroeconomic Strategies for Pro-Poor Growth

The Zanzibar Development Vision 2020 underpins development and poverty reduction policies and strategies in the Isles (RGoZ – MoFEA, 1998). Vision 2020's objective is to eradicate absolute poverty. The document acknowledges that sustainable development and poverty reduction not only require improvements in household income but also increased access to basic services, expanded social security, stronger democratic institutions and citizen participation. Vision 2020 emphasises development of a social security system to meet the basic needs of vulnerable groups in society, including the elderly, widows and orphans.

As for the Mainland, the government has launched MKUZA, a second-generation poverty reduction strategy that has three clusters of goals. Cluster 1 focuses on ensuring that growth is inclusive and benefits poor and marginalised groups, and Cluster 2 addresses social services and social well-being. The broad outcome of Cluster 3 is a society governed by the rule of law and a government that is predictable, transparent and accountable (RGoZ, 2007a). The overall focus of MKUZA is on attaining sustainable growth to reduce both income and non-income poverty. The strategy is in line with international goals, commitments and targets, including the Millennium Development Goals.

Economic growth in Zanzibar has been driven mainly by the increasing contribution and growth of the service sectors which, in 2007, represented up to 44% of GDP, followed by agriculture (27.5%) and industry (15.1%) (RGoZ – OCGS, 2008). Children can benefit from the growth of the services sector if increased employment in the sector benefits the poor. The agricultural sector is important for both income generation and household food security.

To provide a conducive environment for implementation of MKUZA, Zanzibar has undertaken core reforms in financial and economic management, governance, and institutional and human resources similar to those introduced in Mainland Tanzania, including Public Expenditure Review (PER), Public Financial Management Reform, and Legal Sector Reform. These reforms aim to improve domestic revenue collection, and to streamline and improve the Government's financial accounting and reporting.

As in Mainland Tanzania, the involvement of Zanzibar stakeholders and communities in articulating priorities for development has also gained momentum. The MKUZA Poverty Monitoring Master Plan and PER have been put in place to promote and encourage effective participation. The PER process forms the basis for consultation to relate budgets with priority interventions of MKUZA. A special progress report on goals and

targets for children is also tabled annually for discussion in the House of Representatives around the Day of the African Child, representing a critical advance in advocacy and action for children's development in the Isles.

B. Resource Allocation: Budgets and Outcomes for Children

Close to half of the resources to fund the Zanzibar growth and poverty reduction strategy derive from domestic revenue; but, as like the Mainland, the Zanzibari Government is heavily reliant on external assistance for its development spending. Foreign expenditure on development accounted for 94% of total development expenditure in 2005/06 (RGoZ – MoFEA, 2007b). Much of this is transferred by the Union Government according to the agreement whereby 4.5% of annual donor contributions through general budget support is allocated to Zanzibar. In addition, specific programmes and projects are externally financed. In health, external funding accounted for almost two-thirds of all public health spending in 2005/06 (RGoZ – MoFEA, 2007[c]).

Table 1.3 shows the distribution of development spending in 2006/07 according to the three clusters of MKUZA. Overall, 30% of the development budget has been directed to interventions for improvement of social services and well-being (Cluster 2). Twice that amount (61%) has been directed to Cluster 1 interventions for economic growth and reduction of income poverty (RGoZ – MoFEA, 2007[b]). Of the total budget, spending on education and health accounted for 13.2% and 11.1% respectively in 2006/07, compared with 11.1% and 8.6% in 2005/06. The health budget, while rising, still falls short of the Abuja Declaration target of 15%.

Ongoing financial reforms in the Isles will enhance the predictability and flow of funds as well as domestic revenue collection. Financial matters with Union Government continue to be harmonised, and the Zanzibar Revenue Board (ZRB) is being strengthened. The formation of the Joint Finance Commission is intended to clear most impediments in financial relations between Zanzibar and the Union Government. A Tax Administration Programme has been rolled out to Zanzibar from Tanzania Mainland, which will enhance efficiency in tax administration and the capacity of the ZRB.

1.2.3 Conclusions - Pro-poor Growth and Children in Tanzania

Elaborate systems of review, planning and budgeting are in place, but the allocation of funds is complex, and not always captured in the budget process. As a result, it is extremely difficult to establish and analyse links between strategic plans, approved budgets and actual expenditures against national goals and targets for poverty reduction.

Table 1.3: Development Funding per MKUZA Cluster, 2006/07 (TShs Million)

MKUZA Cluster	Number of Projects	Government Contribution	Grants	Loans	Total	% of Total Development Budget
Cluster 1 – Growth and Reduction of Income Poverty	11	5,414	9,415	50,687	65,516	61%
Cluster 2 – Social Services and Well-being	21	2,651	25,781	7,413	35,845	30%
Cluster 3 – Good Governance and National Unity	8	793	2,290	-	3,084	9%
Total	40	8,858	37,487	58,100	104,445	100%

Source: RGoZ – MoFEA, 2007[b]

National planning and budget processes also do not directly prioritise children's development in spite of their large share in the total population as well as among Tanzania's poor. Allocations for mainstream public education and health services – which clearly benefit children – have increased, but other critical aspects of children's well-being – nutrition, child protection and social protection – have not been accorded priority, nor were they recognised as priorities in the PRSP. Consequently, these aspects have been neglected in recent PERs and in sector reviews.

Children are not a sector, nor recognised as a "cross-sectoral issue" as in earlier budget guidelines. More recently, there has been renewed efforts to commission a PER for children and young people, but available budget data do not allow for a systematic PER analysis.[5] Advocacy for children's rights is required in all relevant policy, planning and budgeting processes, so that children's development is clearly recognised among state responsibilities and adequately financed. The current study has been conducted to ensure that children's well-being is at the forefront of the national poverty reduction

Box 1.1: Progress Towards the Millennium Development Goals (MDGs)

Tanzania has made solid progress towards several key targets relevant to children, but concerted and strategic efforts will be required to sustain and accelerate improvements if the MDGs are to be met by 2015. The following targets are for Mainland Tanzania.

MDG 1: Eradicate Extreme Poverty and Hunger
Key Indicators and Targets for Children
- Proportion of under-weight children under five years of age has declined from 29% in 1991 to 22% in 2004, which is on track to achieve the target of 14.4% by 2015.
- Proportion of under-height children under five years of age (stunting) has fallen from 43% in 1999 to 38% in 2004. Urgent attention is needed to reach the target of 23.3% by 2015.

MDG 2: Achieve Universal Primary Education
Key Indicators and Targets for Children
- Primary net enrolment ratio has increased from 59% in 2000 to 97.2% in 2008 which is on track to the target of 100% by 2015

MDG 3: Promote Gender Equality and Empower Women
Key Indicators and Targets for Children
- Net enrolment ratio of girls (97.0%) to boys (97.5%) in primary school is almost the same. Gender Parity Index of 0.99 in 2008, which is on track to achieve ratio of 1.0.

MDG 4: Reduce Child Mortality
Key Indicators and Targets for Children
- Under-five mortality rate (per 1,000 live births) has declined from 141 in 1992 to 91 in 2007/08, which is on track to meet the target of 48 by 2015.
- Infant mortality rate (per 1,000 live births) has declined from 92 in 1992 to 58 in 2007/08, which is on track to meet the target of 38 by 2015.

MDG 5: Improve Maternal Health
Key Indicators and Targets for Children
- Maternal mortality is extremely high (578/100,000 live births in 2004/05) and levels have changed little in the last 20 years. Urgent attention is needed to reach the target of 133 by 2015.
- Proportion of births attended by skilled attendants has increased from 36% in 1999 to 46% in 2004/05. Urgent attention is needed to reach the target of 90% by 2015.

Sources: MPEE, 2006a; NBS et al., 2005; Ministry of Education and Vocational Training (MoEVT), 2008; TACAIDS, Zanzibar AIDS Commission (ZAC), NBS, Office of the Chief Government Statistician [Zanzibar] (OCGS) & Macro International Inc. (2008).

[5]A study was commissioned by the Ministry of Community Development, Gender and Children (MoCDGC) in 2008, which was financed by UNICEF.

agenda and that rapid progress might be made towards achieving the Millennium Development Goals by 2015.

1.3 CONCEPTUAL FRAMEWORK FOR THE ANALYSIS OF CHILD POVERTY

Acknowledging the urgent need to mainstream children's development into national policy and planning, UNICEF commissioned a global study in 2007 to strengthen the knowledge base to address child poverty and to intensify policy advocacy for child rights and well-being.

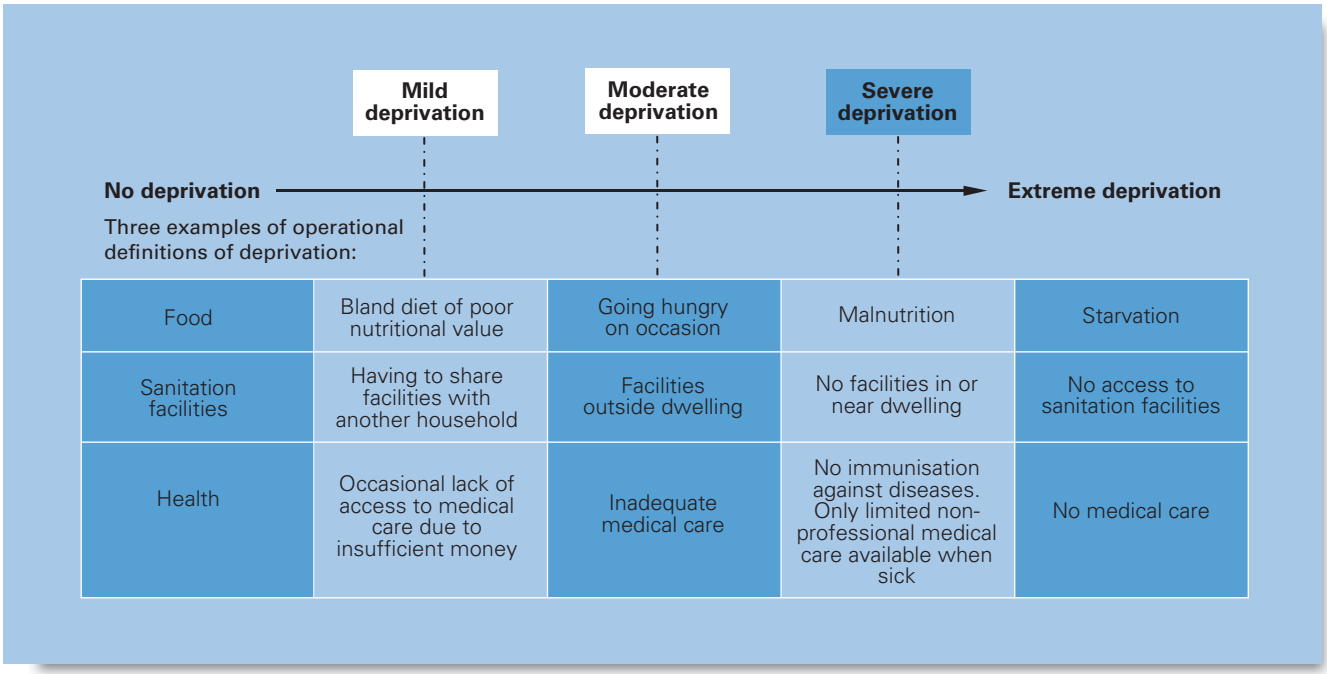
The study seeks to measure how children experience poverty in their lives by applying a concept of poverty which builds on existing international definitions – specifically, the one adopted by the Heads of Government of 117 countries at the 1995 U.N. World Summit for Social Development. According to this definition, *absolute poverty* is 'a condition characterised by severe deprivation of basic human needs, including food, safe drinking water, sanitation facilities, health, shelter, education and information [which] depends not only on income but also on access to social services.'

To operationalise this internationally agreed notion, the extent and depth of child poverty is assessed through the lens of deprivation of basic human needs. Threshold levels were identified for each of seven basic human needs, and a severe deprivation was deemed to occur when it denotes "circumstances that are highly likely to have serious adverse consequences for the health, well-being and development of children." (Gordon et al., 2003)[6]

Figure 1.2 illustrates, with three examples, where severe deprivation lies on a continuum from mild to extreme deprivation.

Given the restrictions of available survey data and to

Figure 1.2: Continuum of Deprivation



Food	Bland diet of poor nutritional value	Going hungry on occasion	Malnutrition	Starvation
Sanitation facilities	Having to share facilities with another household	Facilities outside dwelling	No facilities in or near dwelling	No access to sanitation facilities
Health	Occasional lack of access to medical care due to insufficient money	Inadequate medical care	No immunisation against diseases. Only limited non-professional medical care available when sick	No medical care

Source: Gordon et al., 2003

[6]This approach was subsequently reinforced by the January 2007 UN General Assembly statement on child poverty:
"Children living in poverty are deprived of nutrition, water and sanitation facilities, access to basic health-care services, shelter, education, participation and protection, and that while a severe lack of goods and services hurts every human being, it is most threatening and harmful to children, leaving them unable to enjoy their rights, to reach their full potential and to participate as full members of the society."

Box 1.2: The Childhood Deprivation Approach

Key dimensions and indicators

Severe nutrition deprivation
Children whose heights and weights for their age are more than –3 standard deviations below the median of the international reference population – severe anthropometric failure.

Severe water deprivation
Children who only have access to surface water (e.g. rivers) for drinking or who live in households where the nearest source of water is more than 15 minutes away – these are indicators of severe deprivation of water quality or quantity).

Severe health deprivation
Children who either have not been immunised against any diseases or young children who have a recent illness involving diarrhoea and have not received any medical advice or treatment.

Severe deprivation of sanitation facilities
Children who have no access to a toilet of any kind in the vicinity of their dwelling – no private or communal toilets or latrines.

Severe shelter deprivation
Children in dwellings with more than five people per room (severe overcrowding) or with no flooring material (for example, a mud floor).

Severe education deprivation
Children aged between seven and 18 who have never been to school and are not currently attending school (e.g. no professional education of any kind).

Severe information deprivation
Children aged between three and 18 who live in a household with no access to, radio, television, telephone or newspapers at home.

enable comparison of data across countries, seven indicators of severe deprivation for children were developed (see Box 1.2).

The seven measures of severe deprivation are purposefully designed to be so strict as to unequivocally indicate that a child suffering any single severe deprivation is living in unacceptable and damaging conditions. Indeed, all of the indicators selected represent more severe deprivations of basic needs than measures frequently used by UN agencies and other international institutions. For example:

- Severe food deprivation is set at –3 standard deviations from the reference population median, not –2 standard deviations as is commonly used.
- Severe health deprivation uses no immunisations of any kind instead of incomplete immunisation against common diseases.
- Severe education deprivation applies the criteria no schooling for children aged seven to 18 years, instead of non-completion of primary school.
- Severe sanitation deprivation is defined as no toilet of any kind in the vicinity of a child's dwelling instead of unimproved sanitation facilities.

Under this approach, a child is considered to be living in absolute poverty only if he or she suffers from multiple deprivations – two or more severe deprivations of basic human need.

The childhood deprivation approach, therefore, goes beyond the conventional indicators of household-based income-consumption poverty analysis, to more comprehensively measure child poverty. Most importantly, this approach:

- establishes measures of child poverty that are grounded on the human rights of the child, and relate directly to children's rights established in the Convention on the Rights of the Child (CRC), for example, Articles 6, 13, 24, 27 and 28.
- measures outcomes relevant to children directly – for example, nutrition, immunisation and schooling – instead of indirectly through reference to household means alone.

The child deprivation concept overcomes some of the limitations of relying solely upon monetary measures of poverty. Under the income-consumption approach, the extent of childhood poverty is indistinguishable from overall household poverty as expenditure analyses typically assume equal sharing/consumption of resources within a household. However, this approach fails to recognise that girls and boys often have widely varying access to household income and may experience poverty far differently from adults due to their age, gender and social status.

Moreover, whether a child lives in poverty depends not only on family income but, particularly in developing countries, also on access to public goods and services such as water supply, healthcare and education. Since access to these services typically depends on public provisioning, individual families may not be able to provide them for their children even if they have sufficient income. Yet, the income-consumption approach does not adequately capture the impact of public infrastructure and services that are especially critical for children.
By expanding the analysis of child poverty to outcomes rather than just means, the childhood deprivation approach aims to establish a direct link between child well-being and national policies and programmes that provide essential services to fulfil their rights. It likewise seeks to assess the impact of existing poverty reduction strategies on outcomes for children.[7]

Given the global and cross-country comparative nature of the study commissioned by UNICEF, a question arises as to how relevant the thresholds established for measuring severe deprivation are in the Tanzanian context. Thus, the report includes a first attempt at adapting those thresholds so as to better reflect the conditions faced by children in Tanzania (See Box 2.1, page 22 and Appendix 2).

After presenting the various dimensions and levels of child deprivation in the country, the report goes on to review the status, disparities, policies and programmes seeking to address them along the six main pillars of child well-being: health, nutrition, HIV/AIDS, education, child protection, and social protection.

While a first of its kind, the analysis of child well-being through the lens of deprivation of basic human needs certainly sheds new light on the situation of children in Tanzania.

[7]Even more troubling is the fact that using the income/consumption approach to poverty measurement, increases in household income that would reduce poverty could actually be detrimental to child well-being. Child labour is a case in point. Sending children to work may increase family income and thus reduce poverty, but at the cost of violating their rights and compromising their well-being.

CHAPTER 2

CHILD POVERTY AND DEPRIVATION

This chapter assesses the status of child poverty and deprivation on Mainland Tanzania and Zanzibar using both income and non-income indicators. A three-part analysis is provided to arrive at a comprehensive national picture of child poverty. Section 2.1 details the incidence of income poverty based on households' consumption expenditure from recent Household Budget Surveys. Section 2.2 assesses the extent and depth of child poverty in Tanzania based on indicators of severe deprivation for seven basic childhood needs: nutrition, safe drinking water, sanitation facilities, health, shelter, education and information. Section 2.3 then presents data on neonatal, infant and under-five mortality along with analysis of trends and disparities in child survival. Section 2.4 summarises key findings.

2.1 INCOME-CONSUMPTION POVERTY

2.1.1 Mainland Tanzania

Findings from the 2007 Household Budget Survey (HBS) indicate that 34% of Tanzanians live below the basic needs poverty line, which represents the percentage of the population that has difficulty in attaining basic needs for food, shelter, health and clothing. In turn, 17% of Tanzanians live below the food poverty line, which reflects the cost of a basket of food covering the minimum required human calorie intake per day (2,200 calories per adult per day).[8] Both of these figures indicate only slight declines in national poverty levels since 2000/01 despite robust and sustained economic growth during the intervening years (Figures 2.1 and 2.2) (NBS, 2009).

MKUKUTA Goals and Targets

Basic Needs Poverty Line

- Reduced proportion of rural population below the basic needs poverty line from 38.6% (2000/01) to 24% in 2010.
- Reduced proportion of urban population below the basic needs poverty line from 25.8% (2000/01) to 12.9% in 2010.

Food Poverty Line

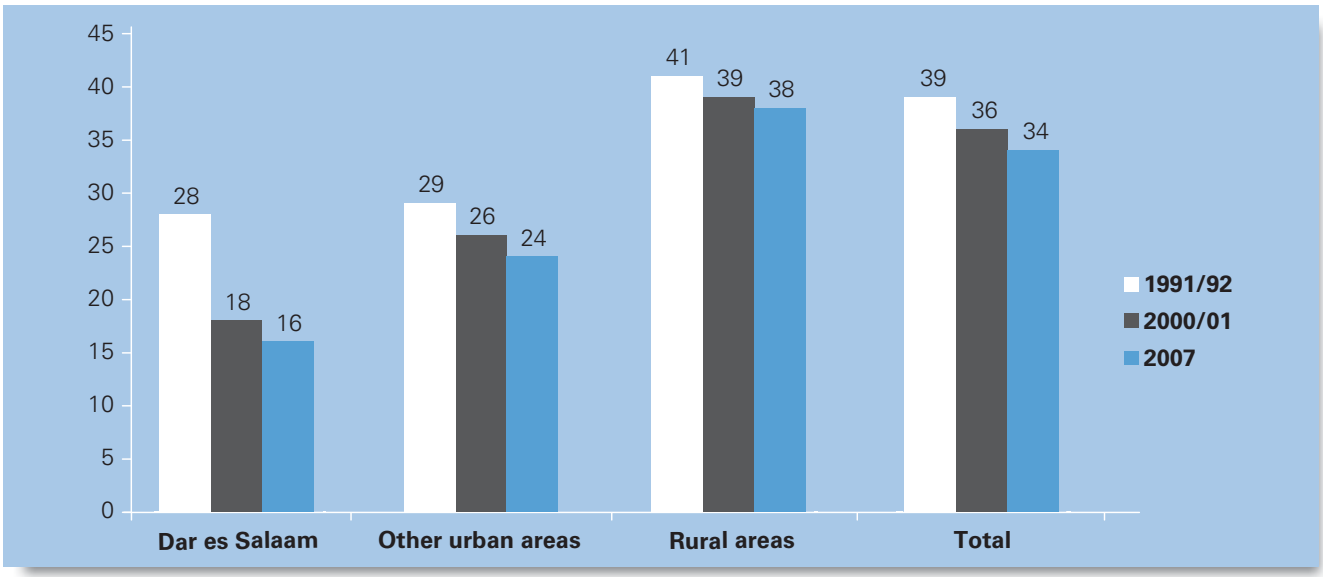
- Reduced proportion of rural food poor from 27% (2000/01) to 14% by 2010.
- Reduced proportion of urban food poor from 13.2% (2000/01) to 6.6% by 2010.

Source: VPO, 2005.

[8] For Mainland Tanzania, the basic needs poverty line was set at TShs 7,253 using the HBS 2000/01 data. As prices increased by 93% between 2000/01 and 2007, it was set at TShs 13,998 per person per 28 days in 2007 (equivalent to roughly TShs 500 or US$ 0.40 per person per day at current rates). The food poverty line was calculated to be 10,219 TShs per month per adult (equivalent to US$ 0.29 per day at current rates) in 2007, up from 5,295 TShs in 2000/01.

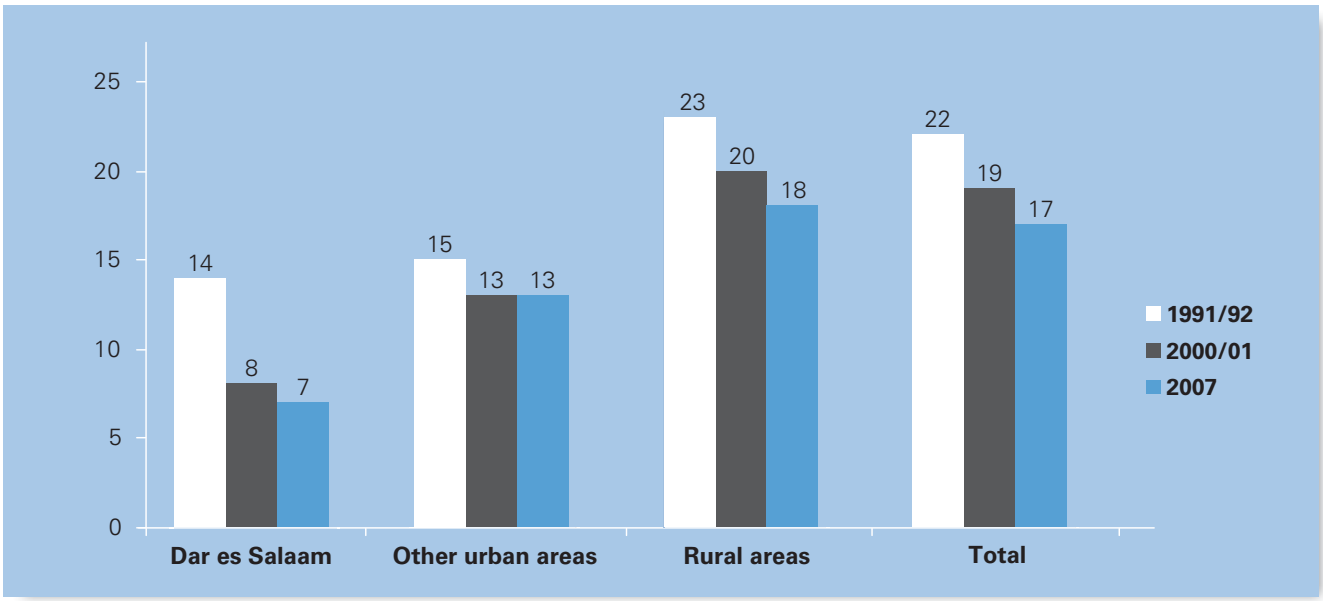
However, based on projected population growth, the total number of individuals experiencing *basic needs* poverty in Mainland Tanzania has increased from 11.4 million to 12.9 million. Poverty remains overwhelmingly rural – 10.8 million or 84% of the poor live in rural areas. Based upon population and poverty estimates for 2007, approximately 5.7 million children aged 0-14 years are living below the basic needs poverty line, and approximately 2.8 million children fall below the food poverty line.[9]

Figure 2.1: Percentage of Population Below the Basic Needs Poverty Line, by Residence, Mainland Tanzania, 1991/92, 2000/01 and 2007



Source: NBS, 2009.

Figure 2.2: Percentage of Population Below the Food Poverty Line by Residence, Mainland Tanzania, 1991/92, 2000/01 and 2007



Source: NBS, 2009.

[9] HBS 2007 estimates: total population estimate, 38.291 million; total number below basic needs poverty line, 12.870 million; total number below food poverty line, 6.353 million; population aged 0-14 years, 44%. Note that these are crude estimates of numbers of children in poverty and do not allow for household composition or other factors. Estimates from the HBS also do not disaggregate 15-18 year age bracket.

Half of all rural residents eat only two meals per day compared with 10% in Dar es Salaam and 21% in other urban areas. Income inequality has changed little since 2000-01. However, the share of total consumption expenditure of the richest quintile of Tanzanians was 42% in 2007, or six times greater than the 7% share of expenditure recorded for the lowest quintile.

Similar results were recorded in the Tanzania HIV/AIDS and Malaria Indicator Survey (THMIS 2007/08), with rural households disproportionately affected by food insecurity. Overall, 42% of all households (23% urban; 49% rural) reported usually eating two meals per day. Meat consumption is not common; half of all households (52%) reported not consuming meat in the week prior to the survey (59% rural; 30% urban). One-third of households (33%) said that they 'sometimes', 'often' or 'always' had problems meeting the food needs of the family over the last year. The disparity by residence was again pronounced; 37% of rural households had trouble meeting their food needs compared with 22% of urban households (TACAIDS, et al., 2008).

2.1.2 Zanzibar

Nearly half of all Zanzibaris (48%) live below the basic needs poverty line , while 14% live below the food poverty line[10]. Rural-urban disparities in poverty are also evident in Zanzibar. About 55% of people in rural areas live below the basic needs poverty line, compared with about 41% in urban areas. Similarly, 16% of rural residents live below the food poverty line, compared with 9% of urban residents.

Table 2.1: Percentage of Population below Basic Needs and Food Poverty Lines, by Residence, Zanzibar, 2004/05

	Basic Needs Poverty	Food Poverty
Urban	40.5	8.9
Rural	54.6	16.0
Total	**49.1**	**13.2**

Source: (RGoZ – OCGS, 2006)

MKUZA Goals and Targets

- Reduced population below basic needs poverty line from 49% (2005) to 25% in 2010.
- Reduced population below food poverty line from 13% (2005) to 10% in 2010.

Source: RGoZ, 2007

Poverty is also related to household size and the educational attainment of the household head. The majority of poor households are characterised by larger numbers of dependents, while the heads of these households typically have limited or no education. In addition, less than 10% of households in the least poor quintile frequently face food insecurity, compared with 31% of households in the poorest quintile. Relatively high levels of frequent food insecurity were experienced in the districts of North A (Unguja), and Micheweni and Chakechake (Pemba): 28%, 25% and 22%, respectively (REPOA and UNICEF, 2006).

2.2 CHILD DEPRIVATION

2.2.1 Incidence of Severe Deprivation Among Children

Table 2.2 shows the percentages of children who are severely deprived based on the seven indicators of childhood deprivation (see Box 1.2, page 13). The most frequent severe deprivations relate to shelter and water. According to the thresholds defined in the global study commissioned by UNICEF, almost four out of five Tanzanian children (78%) suffered from severe shelter deprivation, and over three out of five children (63%) suffered severe water deprivation in 2004/05. The least common severe deprivations were in nutrition (13%) and health (9%). However, it must be remembered that severe deprivations represent conditions which are highly likely to have serious adverse consequences for the health, well-being and development of children.

[10]The basic needs poverty line in Zanzibar was set at TShs 21,383 per capita/per 28 days using the HBS 2004/05 figures.

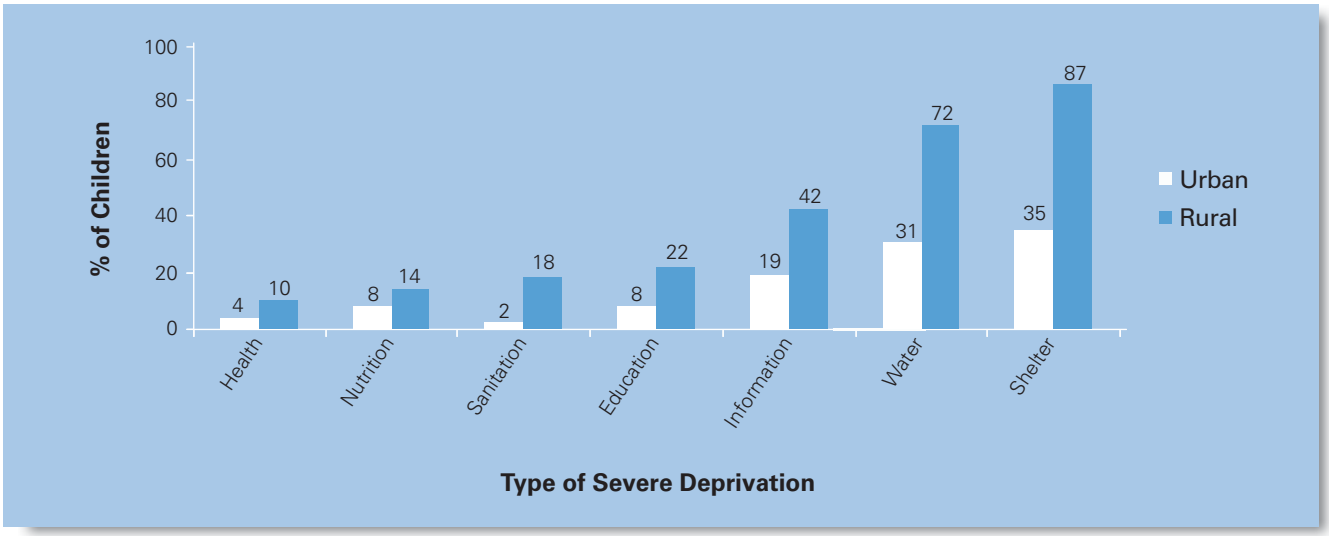
Table 2.2: Incidence and Trends in Deprivation Among Children in Tanzania, by Residence, 1999 and 2004/05 (% of Children)

Indicator	1999					2004/05				
	Mainland		Zanzibar		Total Tanzania	Mainland		Zanzibar		Total Tanzania
	Urban	Rural	Urban	Rural		Urban	Rural	Urban	Rural	
Nutrition	8.9	20.2	6.9	15.0	18.0	7.7	14.8	5.7	8.3	13.2
Health	2.7	5.9	3.4	5.0	5.3	4.2	9.8	9.0	11.7	8.8
Shelter	39.8	94.4	24.6	75.7	83.2	36.2	90.3	15.8	55.8	77.9
Water	44.4	76.0	8.7	34.7	68.7	32.2	73.4	6.4	16.4	63.3
Sanitation	1.3	14.9	3.6	59.2	13.2	2.8	17.7	5.1	42.4	15.0
Information	27.4	61.0	17.9	32.2	35.7	20.1	44.1	9.7	20.6	38.3
Education	19.8	39.8	13.6	27.1	35.5	7.3	2.1	8.2	22.6	18.8
1 or more deprivations	77.6	98.9	67.5	94.1	94.6	58.4	96.6	34.8	74.0	87.-8
2 or more deprivations	52.2	93.6	27.9	78.6	85.0	29.2	83.1	10.1	49.1	70.8
Average number of deprivations	1.6	2.7	1.0	2.3	2.4	1.0	2.5	0.5	1.6	2.1

Source: The New School, 2008, based on data from TDHS 2004/05

Overall findings indicate a slight decline in the incidence of severe deprivation – in at least one of the seven dimensions of child well-being – among Tanzanian children between 1999 and 2004/05 from 95% to 88%. For individual indicators, the most significant declines were recorded in education, where severe deprivation almost halved from 36% to 19% – in large part due to the achievements of the Primary Education Development Programme (PEDP) and severe malnutrition, which dropped by one-quarter from 18% to 13%. Circumstances for children in Zanzibar showed much greater improvement than in Mainland Tanzania.

Figure 2.3: Incidence of Severe Deprivations Among Children in Tanzania Urban/Rural, 2004/05



Source: The New School, 2008, based on data from TDHS 2004/05

The data show that rural children are far more likely to be severely deprived than urban children (see Figure 2.3). For six of the seven indicators, the proportion of rural children suffering severe deprivation is 1.75 to three times higher than the percentage of urban children. For sanitation, children in rural areas are nine times more likely to be without access to a toilet of any kind in or near their dwelling.

Table 2.3 shows that large disparities in severe deprivation exist between different zones of the country.[11] For example, children in the Southern and Central zones are almost twice as likely to be severely malnourished than children in the Eastern zone. Children in the Lakes region are more than three times as likely to be severely deprived with regard to sanitation as children from the South, and over five times as likely as their Eastern counterparts. The picture that emerges from the analysis is one where, overall, children in the Eastern and Northern zones are the least deprived, while children in the Southern, Central and Lake zones are the most severely deprived.

2.2.2 Severity of Deprivation Among Children

Table 2.4 presents findings on the severity of deprivation – the number of severe deprivations – suffered by children in Tanzania, while Figure 2.4 illustrates the severity of deprivation among children by urban-rural residence. The data show that the overwhelming majority (88%) of children are severely deprived – they suffer one or more severe deprivations. The severity of deprivation is significantly worse among rural children. Children in Mainland rural areas are almost five times more likely to suffer three or more severe deprivations than their urban peers (48% compared with 10%), and eight times more likely to suffer four or more severe deprivations (16% compared with 2%).

The incidence of absolute poverty among Tanzanian children – the proportion of children who suffered multiple (two or more) severe deprivations of basic needs – is extremely high at 71%, which is over twice the percentage of the population assessed as below the basic needs poverty line (34%) in the 2007 HBS.

Table 2.3: Incidence of Severe Deprivations Among Children, by Geographic Zone, 2004/05 (% of Children)

Indicator	Mainland Tanzania						Zanzibar	Total Tanzania
	East	South	Southern Highlands	Lake	North	Central		
Nutrition	9.2	18.1	14.8	12.1	10.9	17.7	7.5	13.2
Health	4.1	5.3	9.4	9.8	9.2	10.7	11.0	8.8
Shelter	57.4	91.7	78.0	85.5	70.4	89.3	44.3	77.9
Water	48.8	73.2	66.1	72.1	59.3	67.7	13.5	63.3
Sanitation	3.9	5.9	10.0	22.1	16.3	17.5	31.7	15.0
Information	29.2	45.5	44.4	35.7	37.2	46.9	17.5	38.3
Education	10.8	20.9	21.5	18.7	12.7	26.9	18.4	18.8

Source: The New School, 2008, based on data from TDHS 2004/05

[11] The Mainland zones used in the deprivation analysis vary slightly from the TDHS 2004/05. They are as follows: East (Dar es Salaam, Pwani, and Morogoro regions); South (Lindi and Mtwara regions); Southern Highlands (Rukwa, Mbeya, Iringa and Ruvuma regions); Lake (Kagera, Mwanza, Mara and Shinyanga regions); North (Arusha, Manyara, Tanga and Kilimanjaro regions); and Central (Kigoma, Tabora, Singida and Dodoma regions).

This finding strongly indicates that poverty impacts children much more frequently than is revealed by conventional income-consumption measures for the general population, and underlines the need to measure and address child poverty more effectively.

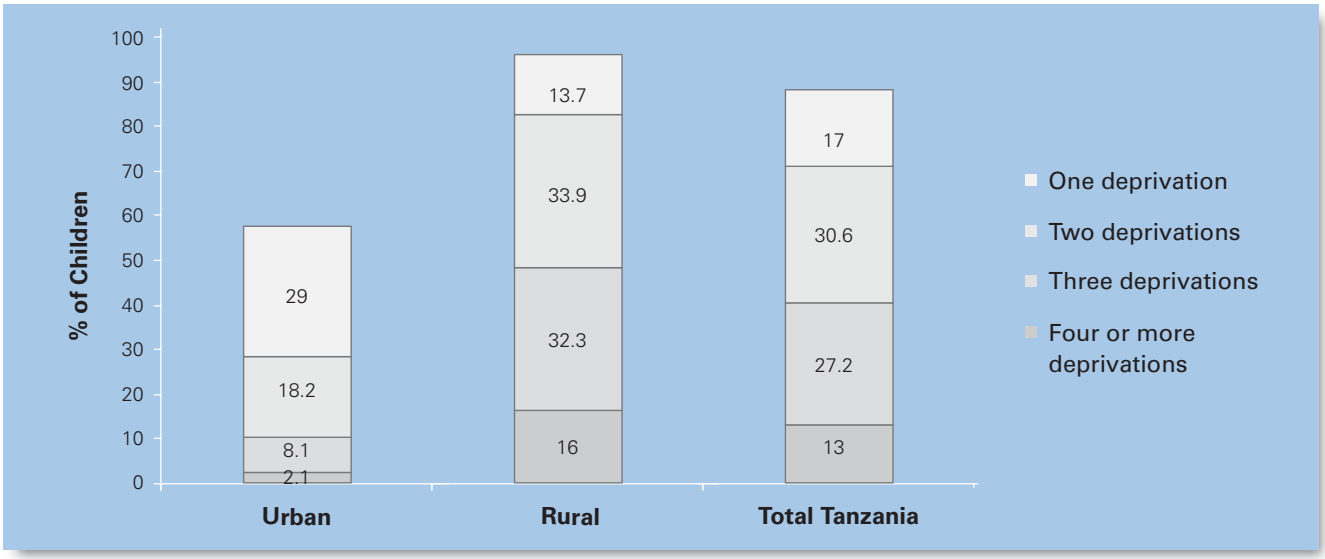
Again, large rural-urban disparities prevail. On the Mainland, almost three times as many children in rural areas (83%) suffered absolute poverty as their urban counterparts (29%). The rural-urban divide was even more pronounced in Zanzibar, with 49% of rural children living in absolute poverty compared to 10% of urban children. However, the overall incidence of absolute poverty among children was much lower in Zanzibar (38%) compared with the Mainland (72%).

Table 2.4: Severity of Deprivation Among Children, by Residence 2004/05 (% of Children)

Number of Severe Deprivations	Mainland Tanzania			Zanzibar			Total Tanzania
	Urban	Rural	Total Mainland	Urban	Rural	Total Zanzibar	
None	41.6	3.4	11.5	65.2	26.0	37.2	12.2
One	29.2	13.4	16.7	24.7	24.9	24.8	17.0
Two	18.7	34.2	31.0	6.8	23.6	18.8	30.6
Three	8.4	32.7	27.6	2.5	17.6	13.3	27.2
Four or more	2.1	16.2	13.2	0.8	7.9	5.9	13.0
TOTAL	100%	100%	100%	100%	100%	100%	100%
One or more severe deprivations	58.4%	96.6%	87.8%	34.8%	74.0%	62.8%	87.8%
Average number of severe deprivations (Depth of Poverty)	1.0	2.5	2.1	0.5	1.6	1.2	2.1
Average number of deprivations	1.6	2.7	2.4	1.0	2.5	0.5	2.1

Source: The New School, 2008, based on data from TDHS 2004/05.

Figure 2.4: Severity of Deprivation Among Children in Tanzania by Residence, 2004/05



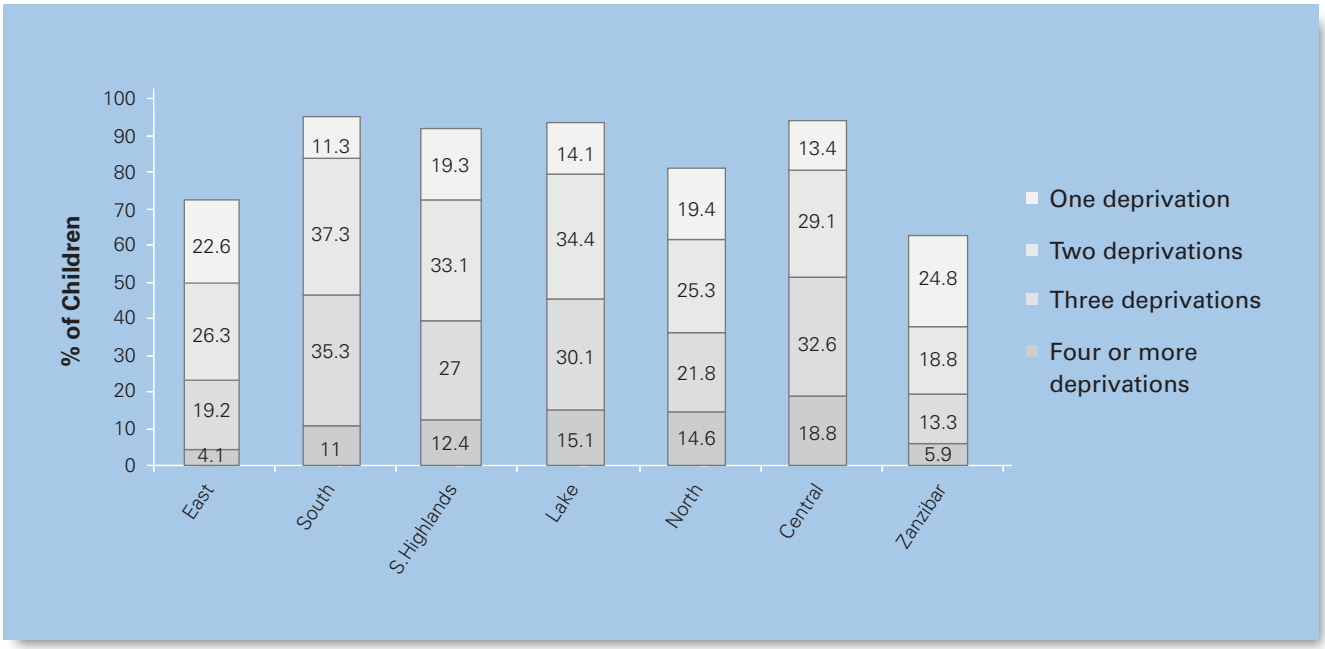
Source: The New School, 2008, based on data from TDHS 2004/05
Note: Incidence of absolute poverty = percentage of children experiencing two or more severe deprivations.

Figure 2.5 presents the data on severity of deprivation among children by geographic zone. Results show large disparities in the severity of deprivation by zone. The incidence of absolute poverty – two or more severe deprivations – among children is highest in the Southern (84%), Central (81%) and Lake zones (79%), and lowest in Zanzibar (38%) and the Eastern zone of the Mainland (50%).

Not surprisingly, the severity of deprivation is closely related to the wealth of the child's household, meaning that, despite large differences in magnitude, income and non-income aspects poverty are strongly correlated (see Table 2.5). The depth of poverty – the average number of severe deprivations – is over six times higher for children in the poorest quintile (3.2 severe deprivations) compared with the richest quintile (0.5 severe deprivations). Children in the poorest households were the most severely deprived for all seven indicators.

Further analysis revealed that the depth of poverty varied by the mother's level of education. The average number of deprivations among children whose mothers had no formal education was 2.7 compared with 1.9 for children whose mothers had completed some education. This underscores the critical importance of investing in girls' education, and female literacy, to break the cycle of poverty over time and across generations. The depth of poverty, on the other hand, did not vary according to the child's gender or family size.

Figure 2.5: Severity of Deprivation Among Children in Tanzania by Geographic Zone, 2004/05



Source: The New School, 2008, based on data from TDHS 2004/05
Note: Incidence of absolute poverty = percentage of children experiencing two or more severe deprivations.

Table 2.5: Incidence and Severity of Deprivation Among Children, by Household Wealth, 2004/05 (% of Children)

Indicator	Wealth Quintile				
	Lowest	2nd	Middle	4th	Highest
Nutrition	18.1	16.0	14.4	11.1	4.0
Health	13.1	8.7	10.3	6.4	3.7
Shelter	100.0	100.0	99.4	72.7	7.1
Water	80.0	75.8	72.4	58.5	23.8
Sanitation	40.5	13.1	12.5	5.4	0.7
Information	82.2	34.7	39.8	22.3	8.2
Education	35.3	26.6	17.7	9.3	4.8
2 or more severe deprivations (Incidence of Absolute Poverty)	99.3%	91.4%	87.2%	60.1%	6.6%
3 or more severe deprivations	85.8%	47.0%	45.0%	15.6%	0.6%
Average number of severe deprivations (Depth of poverty)	3.2	2.5	2.4	1.7	0.5

Source: The New School, 2008, based on data from TDHS 2004/05.

Box 2.1: Thresholds for Severe Deprivation in Tanzania

Despite the fact that the thresholds of severe deprivation defined in the global study commissioned by UNICEF are more stringent that the conventional measures used in similar studies, they may still not be fully appropriate to the Tanzanian context. For instance, sleeping on a mud floor can surely be an indication of deprivation in countries with colder climates, but not in others. Besides, while certain conditions can clearly be deemed unacceptable regardless of context, any measure of deprivation must be meaningful both for analysis and for setting policy priorities. If, for cross-country comparative purposes, a threshold is set at a level such that almost all households in a country are deemed to be deprived, then threshold adjustments may be warranted so that analysis can more adequately inform policy.

An exercise was, therefore, completed to adapt the indicators to more closely reflect the Tanzanian context (see Appendix 2). Four of the seven thresholds – health, nutrition, education and information – were assessed as appropriate to the Tanzanian context and no changes were recommended. However, based on consultations held with national stakeholders, alternative measures for three indicators – shelter, water and sanitation – were identified to better reflect the conditions in which Tanzania children live day to day. Preliminary analysis was performed on the alternative thresholds as described below: less stringent criteria were applied for shelter and water deprivation, and more stringent criteria were used for sanitation.

Severe shelter deprivation
The original threshold – *'children in dwellings with more than five people per room (severe overcrowding) or with no floor material (e.g., a mud floor)'* – was assessed as too stringent as mud flooring is prevalent in rural homes. Therefore, in addition to the above indicators, the quality of the walls and the roof of the dwelling were factored into the measurement of shelter deprivation. Households were assessed as deprived if, in addition to being overcrowded, the dwelling had no floor material, its walls were made of poles, mud or grass, and its roof was made of grass, leaves or mud. Applying this new threshold, the incidence of shelter deprivation among children dropped dramatically from 78% to 29%, the overall incidence of severe deprivation (children suffering from one or more deprivations) declined from 88% to 81%, and absolute poverty (two or more deprivations) from 71% to 51%.

Severe water deprivation
The original threshold was *'children who only had access to surface water (e.g. rivers) for drinking or who lived in households where the nearest source of water was more than 15 minutes away'*. Given that access to water within 15 minutes is not the norm in rural areas, most children would be labelled as severely deprived according to that criterion. Therefore, the threshold for distance to nearest water source – to go, collect the water and return home – was raised to 30 minutes. With the new threshold, the incidence of severe water deprivation fell from 63% of children to 57%, and the overall incidence of deprivation from 88% to 87%. This would indicate that the most important factor was the quality of the nearest water source. Most households still lacked access to piped or protected water sources within 30 minutes of home.

Box 2.1 cont'd
Severe sanitation deprivation

'Children who had no access to a toilet of any kind in the vicinity of their dwelling, i.e., no private or communal toilets or latrines' was the original threshold in the global study commissioned by UNICEF. However, traditional pit latrines, which are the most common type of toilet in Tanzania, are often of very poor quality and unsanitary. Therefore, this threshold was tightened so children were considered to be severely deprived if they only had access to an unimproved pit latrine. As a result, the incidence of severe sanitation deprivation dramatically increased from 15% to over 90%. This is consistent with findings from the THMIS 2007/08, which found that 96% of Tanzanian households did not have access to an improved sanitation facility. In turn, the incidence of severe deprivation among children increased from 88% to 96%, and the incidence of absolute poverty from 71% to 86%.

These results point to the need for further fine-tuning of the thresholds of severe deprivation in future rounds of analysis so as to more closely reflect the living conditions faced by children in the Tanzanian context.[12]

2.3 CHILD SURVIVAL

This section presents data on key indicators of child survival – neonatal, infant and under-five mortality – for Mainland Tanzania and Zanzibar, followed by analysis of links between child mortality rates and poverty.

2.3.1 Mainland Tanzania

A. Neonatal, Infant and Under-Five Mortality

Infant and under-five mortality rates in Tanzania have improved substantially over the last decade. The THMIS 2007/08 indicates that under-five mortality rate (U5MR) has declined from 112 deaths per 1,000 live births in 2004/05 to 91, a fall of approximately 19%. Over the same period, the infant mortality rate (IMR) – deaths before a child's first birthday – declined from 68 to 58 per 1,000 live births, a fall of approximately 15% (TACAIDS et al., 2008). If the pace of recent progress is sustained, both the MKUKUTA target (2010) and the MDG target (2015) for reductions in infant and under-five mortality are within reach (Figure 2.6).

However, most of the improvement in early childhood mortality has occurred in post-neonatal mortality. As depicted in Figure 2.6, neonatal mortality – deaths in the first 28 days of life – has not shown the same rate of decline. Between 2004/05 and 2007/08, neonatal mortality fell from 32 deaths per 1,000 live births to 29, a decline of under 10%. Neonatal deaths now account for half of all infant deaths and almost a third of under-five deaths.

Neonatal mortality is intrinsically linked with maternal health. Maternal mortality (the ratio of women who die during pregnancy, delivery and the postpartum period) remains exceptionally high at 578 per 100,000 live births and has shown no improvement over the last ten years (NBS, et al., 2005). This implies that over 8,000 women die from maternal causes in Tanzania each year. TDHS 2004/05 data also show that the vast majority (83%) of women whose last live birth occurred outside a health facility did not receive a postnatal check-up. Only one in ten women (13%) was examined within two days of delivering, as recommended.

The THMIS 2007/08 shows large spatial and socio-economic disparities in childhood mortality rates – across geographic zones, between wealth quintiles, by mother's education and based on fertility behaviours (birth intervals, mother's age). However, given the small sample sizes for the disaggregated analysis (and the resultant large confidence intervals), caution should be drawn in interpreting these findings until further analysis.

MKUKUTA Goals and Targets

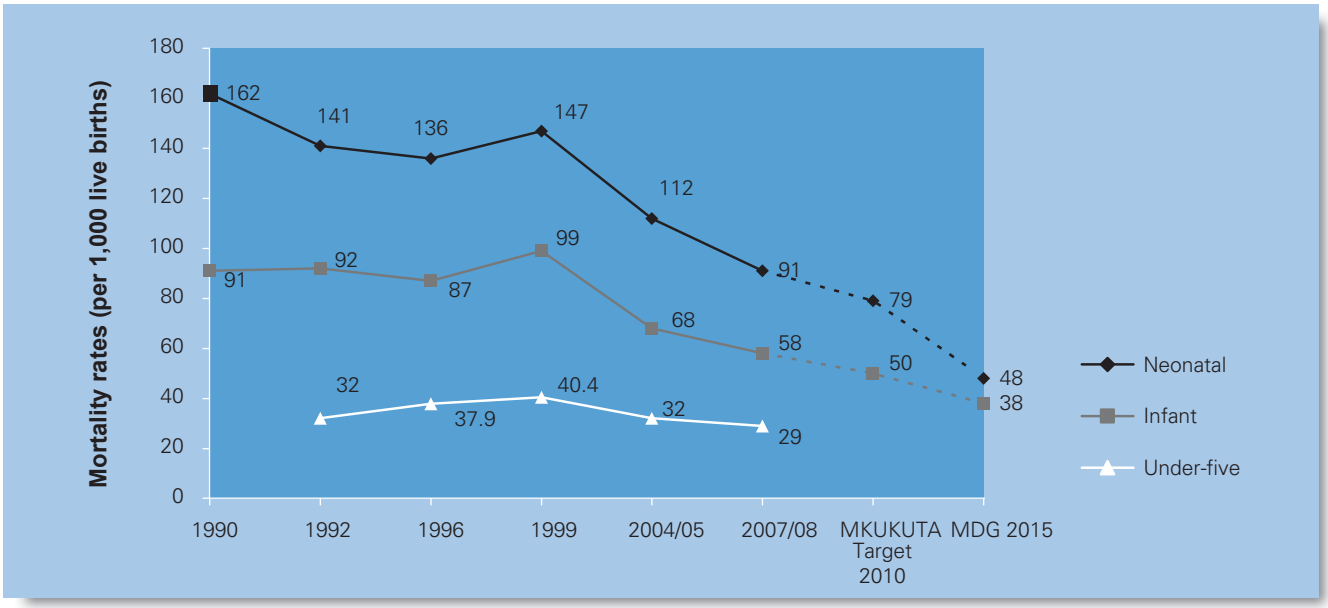
Child Survival
- Reduce infant mortality rate from 95 per 1,000 live births (2002) to 50 in 2010.
- Reduce child (under-five) mortality from 154 per 1000 live births (2002) to 79 in 2010.

Maternal Health
- Increase coverage of births attended by trained personnel from 50% to 80% in 2010.
- Halve maternal mortality from 529 to 265 per 100,000 live births in 2010.

Source: VPO, 2005

[12] It is worth reiterating, nonetheless, that the thresholds of severe deprivation as originally set in the UNICEF study were such that they would indicate a child was living in ***unacceptable and damaging conditions.*** Indeed, all of the thresholds represent more severe deprivations of basic needs than the indicators commonly used internationally. The findings, therefore, will more likely err on the side of caution and under-estimate the extent of severe deprivation and absolute poverty among children, even before the adjustments made to better reflect the realities faced by Tanzanian children.

Figure 2.6: Trends in Neonatal, Infant and Under-Five Mortality in Tanzania, 1990 to 2007/08



Source: John (2005) and THMIS 2007/08. The 2007/08 figures are mortality rates for the five-year period preceding the THMIS.

TDHS 2004/05 data also show that improvements in under-five mortality have neither been constant over time, nor equal across all segments of the population. For example, in 2004/05, under-five mortality for rural children was 139; for urban children it was 108. Indeed, the urban-rural disparity in U5MR in 2004/05 was wider than 1992, largely due to the fall in mortality of urban children. The change in mortality among rural children over this period was not statistically significant, resulting in the widening disparity between urban and rural areas (The New School, 2008).

Disparities between the richest and the other wealth quintiles increased from 1992 to 1996 and narrowed thereafter, though they continue to exist, as illustrated in Figure 2.7. Under-five mortality for children in the least poor households was 93; among the poorest 60% of households, it was about 145 (NBS et al, 2005).

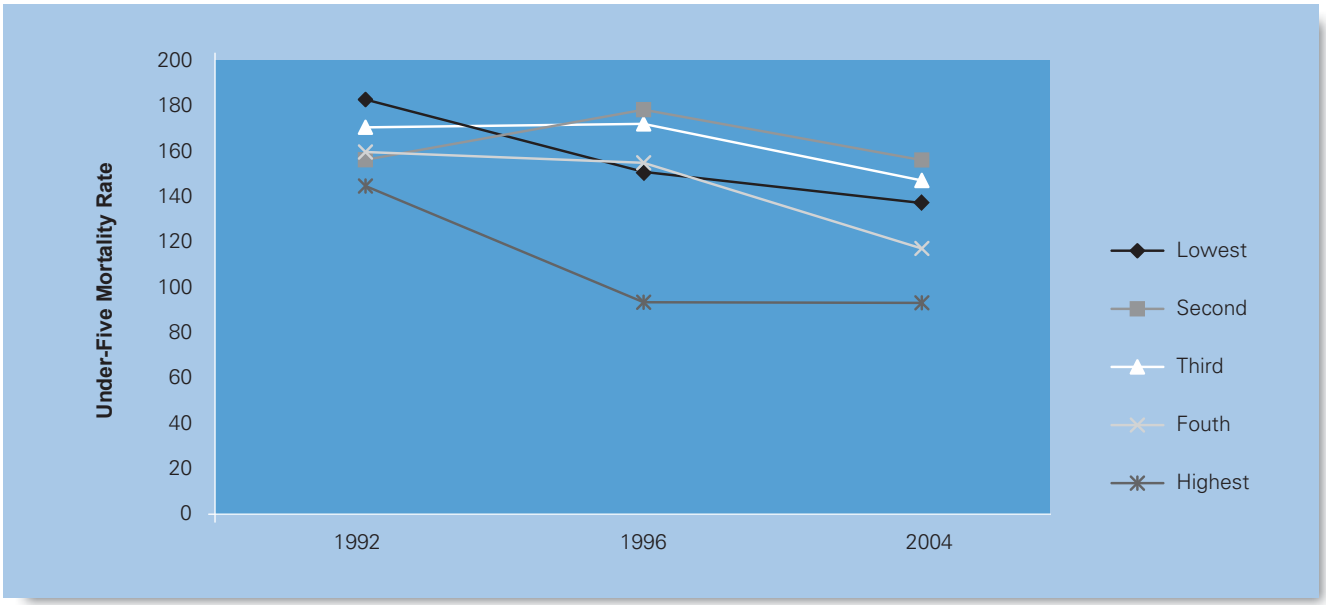
B. Child Mortality: Links to Poverty

Analysing data from the TDHS 2004/05, Smithson (2006) found that children from poorer families, children living in rural areas, and those with less educated mothers are more likely to die. Results also indicated that the marked disparities in under-five mortality across different parts of the country were associated with three key variables: average (adult) educational attainment, childhood stunting rates, and childhood anaemia rates. Insufficient data was available to independently assess if income poverty alone was a key driver of child outcomes. Rather, the analysis tentatively concludes that mortality disparities in Tanzania are likely explained by a combination of variables rather than a single dominant factor.

The same study also found that despite suffering a greater burden of disease, the children of disadvantaged groups (the poor, the less well-educated and rural residents) tend to consume less healthcare. For example:

- The poorest women are more than seven times more likely to give birth at home and receive no post-natal check-up for their infants.
- Compared to their poorer counterparts, the children of richer women are 40% more likely to receive measles vaccination, 40% more likely to receive treatment for fever at a health facility, and 20% more likely to receive ORS for diarrhoea
- Under-fives in the richest households are 14 times more likely than the poorest to have slept under an insecticide-treated mosquito net (ITN) the previous night.

Figure 2.7: Under-Five Mortality Rates by Wealth Quintile, 1992 to 2004/05



Source The New School, 2008, based on data from demographic and health surveys

- Babies born in rural areas are nearly four times more likely not to have been weighed at birth, or to receive post-natal care.
- Women with at least some secondary education are 2.6 times more likely to deliver at a health facility than those with no education.

People living in rural areas and those in poverty remain disadvantaged both in terms of service uptake and outcomes. The scale of differences in outcomes is such that infant mortality rates for the two poorest quintiles are around 50% higher than those of the least poor.

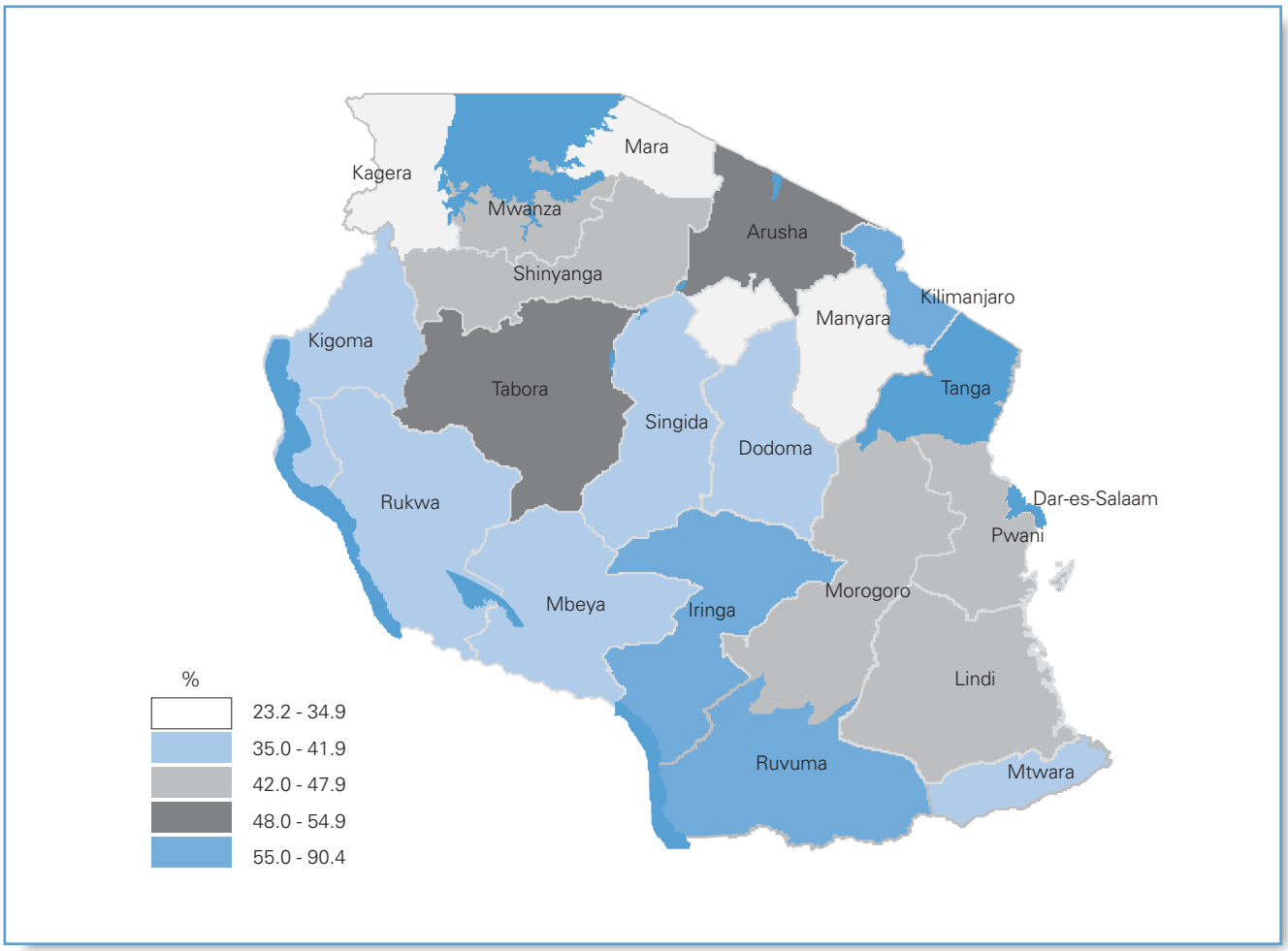
It would seem that in-depth analyses of child mortality are warranted to examine a broad range of socio-economic, ecological and proximate variables. Important variables must include income, education, access and utilisation of healthcare (facilities and MCH services), disease risk (malaria and mother-to-child HIV transmission), nutritional status and diet (in turn, related to soil types, rainfall and farming systems), access to safe water and sanitation, infant feeding and child rearing practices, and fertility characteristics (such as birth interval).

Data from the THMIS 2007/08, HBS 2007 and the upcoming TDHS 2009, present a critical opportunity to strengthen the evidence base to inform short and long-term interventions for children. Preventive measures such as measles vaccination and vitamin A supplementation campaigns have contributed, but there is little doubt that the significant fall in child mortality in the past five years is largely due to improved malaria control – greater ownership and use of insecticide treated nets (ITNs) and more effective treatment, in particular preventive treatment in pregnancy (see Section 3.2.1). Further improvements in child survival are expected with wider distribution of free, permanently-treated ITNs.[13] Given the apparent link between child mortality and mothers' educational attainment, a key long-term solution to improve child outcomes is to support universal education, to the highest level possible, especially for girls.

Moreover, neonatal (and maternal) risk can be immediately and drastically reduced if reproductive health policies expand cost-effective access to skilled attendance at delivery and provision of emergency obstetric care. Currently, only 47% of births in Tanzania occur in health facilities (46% with a skilled

[13] In 2008/9 Tanzania began to distribute free, permanently-treated ITNs to all under-fives in the country. With financial support from Global Fund for AIDS, TB and Malaria, this initiative is expected to be scaled up further to all households in the country – a move towards universal distribution of ITNs.

Figure 2.8: Births Taking Place in Health Facilities, Mainland Tanzania, by Region, 2004/05



Source: UNICEF, Tanzania Socio-economic Database, using data from TDHS 2004/05.

attendant) (NBS et al., 2005), with stark regional disparities, ranging from one-third of births in Mara (32%), Kagera (33%), and Manyara (34%) to 90% in Dar es Salaam (Figure 2.8). Availability of emergency obstetric care is also extremely low; only 5.5% of health centers can provide basic care, and only 64% of hospitals can provide comprehensive one (Ministry of Health and Social Welfare (MoHSW), 2008). A systematic approach towards addressing health system factors, such as functioning health facilities with equipment, medical supplies and trained human resources with the requisite skills, is essential for reducing maternal and newborn mortality.

Antenatal care (ANC) represents a significant untapped opportunity to provide essential healthcare to improve maternal and newborn outcomes, including iron supplementation and intermittent preventive treatment (IPT) of malaria, as well as counselling to encourage facility-based delivery, use of postnatal care and sound child-feeding practices. The THMIS 2007/08 indicates that 97% of pregnant women in Tanzania received ANC from skilled personnel with no significant differences by urban-rural residence, women's level of education or household wealth status. However, the TDHS 2004/05 indicates that the quality of ANC services varied substantially by background characteristics. Rural women, those from poorer households, and women with lower educational attainment were less likely to receive iron supplementation or anti-malarial medication.

Regional disparities were also pronounced. For example, only 15% of women in Rukwa and 17% in Pemba North (Zanzibar) were informed of signs of

pregnancy complications compared with 68% in Dar es Salaam. The THMIS 2007/08 also showed that only 30% of women received intermittent preventive treatment (IPT) of malaria (2+ doses of SP/Fansidar, at least one during an ANC visit) during their last pregnancy, again with substantial disparities. For example, women with secondary education and those in the highest wealth quintile were twice as likely to receive IPT as women with no education and those in the lowest wealth quintile.

2.3.2 Zanzibar

A. Neonatal, Infant and Under-Five Mortality

Under-five and infant mortality rates in Zanzibar have also fallen since 2004/05 (Figure 2.9). The U5MR declined from 101 to 79 (22% fall) and the IMR fell from 61 to 54 (11% decline). However, neonatal mortality remains stubbornly high at 31 (a 7% increase) over the same period. U5MR is higher on Pemba (89) compared with Unjuga (72), but Unguja recorded higher levels of both neonatal and infant mortality.

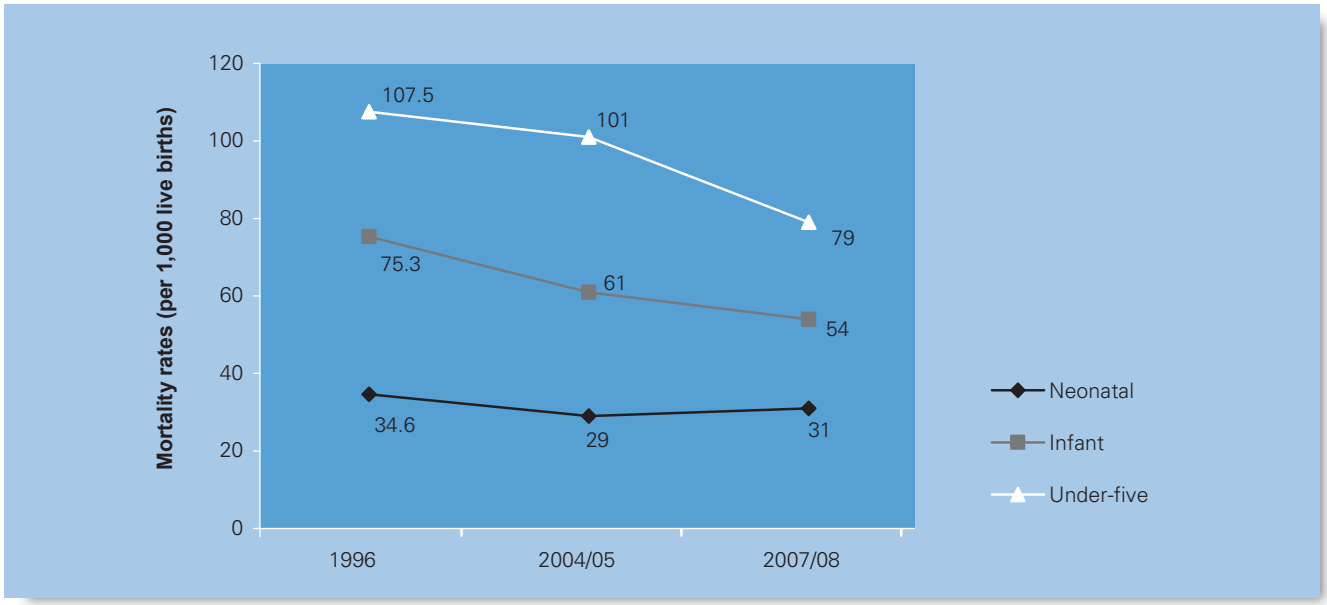
B. Child Mortality: Links to Poverty

The fall in mortality rates has been partially attributed to increases in immunisation coverage. Analysis of vaccination rates by wealth/poverty distribution shows that almost all the children from the least poor households had been vaccinated, compared with 77% from the poorest households (The New School, 2008). However, as suggested by THMIS data on anaemia and malaria, much of the recent decline can be attributed to improved malaria control, including free distribution of ITNs to under-fives, achieving almost 75% coverage (TACAIDS et al., 2008).

Maternal mortality in Zanzibar is high. The most recent data (1998) show that maternal mortality was 377 per 100,000 births. However, two proxy indicators are used to assess reproductive health risks encountered by pregnant women: skilled assistance at birth and facility-based deliveries. 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 increased from 33% in 1991/92 to 49% in 2004/05, with the largest increase (37%) taking place between 1999 and 2004/05 (NBS et al., 2005). Given these improvements in key indicators of maternal health, maternal mortality is expected to have declined since 1998.

The highest rates of skilled assistance were noted in Unguja (62%), specifically Unguja South (62%) and Town West (76%). In contrast, fewer women

Figure 2.9: Trends in Neonatal, Infant and Under-Five Mortality in Zanzibar, 1996 to 2007/08



Sources: TDHS 1996 and 2004/05; THMIS 2007/08

MKUZA Goals and Targets

Child Survival
- Reduce infant mortality rate from 61 per 1,000 live births (2005) to 57 in 2010.
- Reduce child (under-five) mortality rate from 101 per 1,000 live births (2005) to 71 in 2010.

Maternal Health
- Increase coverage of births attended by trained personnel from 50% to 80% in 2010.
- Halve maternal mortality from 529 to 265 per 100,000 live births in 2010.

Source: VPO, 2005

are assisted by a health professional in Unguja North (25%) or in Pemba (35%). There is also a clear difference in the rates at which the least poor and the poorest women are assisted in birth; 26% of the poorest and 88% of the least poor were assisted during a delivery by a doctor, clinical officer or nurse/midwife (NBS et al., 2005).

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 deliveries. Among the poorest households, 75% of children were delivered at home, five times more than the 15% of children from the least poor households.

2.4 KEY FINDINGS

The analysis of child poverty and deprivation in this chapter highlights critical issues for the development of a comprehensive strategy to improve child outcomes in Tanzania. Key findings include:

Economic Growth and Income Poverty

Despite historically high levels of economic growth in the last five years, the prevalence of both basic needs and food poverty remains high, with only slight declines since 2000/01. Indeed, the number of Tanzanians experiencing poverty in Mainland Tanzania has increased by 1.5 million to 12.9 million. An estimated 5.7 million children aged 0-14 years live below the basic needs poverty line. Poverty has remained overwhelmingly rural, both in Mainland Tanzania and Zanzibar.

Childhood Deprivation

The current analysis of childhood deprivation based upon the Bristol indicators – the first of its type in Tanzania – indicates that the incidence and impact of poverty on children is far greater than indicated by conventional income-consumption measures. Based on TDHS 2004/05 data, 71% of Tanzanian children were assessed as living in absolute poverty – they were suffering multiple (two or more) severe deprivations of basic needs.

Again, childhood deprivation is overwhelmingly rural. The incidence of absolute poverty was much lower in Zanzibar (38%) than on the Mainland (72%). Overall findings indicated a promising decline in absolute poverty among children since 1999, largely due to a marked decline in severe education deprivation.

Findings underscore the need to measure and address child poverty directly. Even after adjusting the thresholds of severe deprivation to better reflect the national context, preliminary analysis found that the majority of Tanzanian children were living in unacceptable and damaging conditions. Further refinement of thresholds in future rounds of analysis will be needed. Nonetheless, both the original and revised thresholds represent more severe deprivations of basic needs than indicators commonly used internationally. Findings, therefore, likely err on the side of caution and under-estimate the current extent of deprivation among children in Tanzania.

Child Survival

There have been major gains in child survival over the last decade, and if the pace of recent progress is sustained, the targets for reductions in infant and under-five mortality in MKUKUTA and MKUZA (2010) as well as the MDGs (2015) are within reach. However, neonatal mortality has not improved as rapidly and now accounts for almost a third of under-five deaths. Further gains in child survival will only be achieved with improved coverage of basic maternal and neonatal interventions. Maternal mortality has remained exceptionally high with no improvement over the last ten years. Data clearly highlight the need to strengthen the health system, address the human

resource crisis, and expand cost-effective access to skilled attendance at delivery and provision of emergency obstetric and postnatal care, with a focus on reaching mothers and children in disadvantaged groups.

Children from poorer families, children living in rural areas, and those with less educated mothers are more likely to die, and marked disparities in childhood mortality exist across different parts of the country. In the short term, preventive and curative health and nutritional interventions need to be targeted to vulnerable children in under-served areas. However, long-term solutions to improving child outcomes will involve broader social and economic change, for example, in expanding access to secondary, technical and higher levels of education, especially for girls, and developing the agricultural sector and rural economy.

CHAPTER 3

THE PILLARS OF CHILD WELL-BEING

This chapter analyses six areas or 'pillars' of public policy that are fundamental to safeguarding and promoting child well-being: i. health; ii. nutrition; iii. HIV/AIDS; iv. education; v. child protection; and vi. social protection. The chapter is divided into two main sections, one focused on Mainland Tanzania, the other on Zanzibar.

For each pillar:

- Key goals and targets for children's development under MKUKUTA or MKUZA are identified;
- The status, trends and disparities in key indicators of child outcomes are analysed;
- Relevant national laws and policies are briefly described; and
- Building blocks for a comprehensive strategy to address child poverty and disparities are presented, first with a description of the programmes considered to have the most significant influence on child outcomes, followed by discussion of sector financing and partners.

3.1 MAINLAND TANZANIA

3.1.1 Health

MKUKUTA Goals and Targets

Immunisation

- Increased percentage of children under two years immunised against measles and DPT-HB from 80% in 2002 to 85% in 2010.

Water

- Increased proportion of rural population with access to clean and safe water (within 30 minutes of time spent on collection of water) from 53% (2003) to 65% in 2009/10.
- Increased urban population with access to clean and safe water from 73% (2003) to 90% by 2009/10.

Sanitation

- 100% of schools to have adequate sanitary facilities by 2010.
- 95% of people with access to basic sanitation by 2010.

A. Status, Trends and Disparities in Child Outcomes

Malaria

The THMIS 2007/08 found that the prevalence of malaria in under-five children was 18% in Mainland Tanzania compared with 1% in Zanzibar, with marked regional differentials on the Mainland. Prevalence ranged from less than 1% in Arusha, Kilimanjaro and Manyara to 36% in Lindi and 41% in Kagera (Figure 3.1). Socio-economic disparities were also stark:

- Children in the lowest wealth quintile were almost six times more likely to have malaria (23%) than children in the highest quintile (4%).
- Children of mothers with no education were over four times more likely to have malaria (21%) than children of mothers with secondary education or higher (5%).
- Children from rural areas were almost three times more likely to have malaria (20%) than their urban counterparts (7%).

Malaria is the leading cause of death among under-five children in Tanzania (see Table 3.1). If untreated, children may die within 48 hours of the onset of illness. Therefore, prompt recognition and treatment is essential.

The THMIS 2007/08 measured prevalence and prompt treatment of fever in children. On the Mainland, 19% of children under five had a fever in the two weeks preceding the survey, with the

Table 3.1: Top Six Causes of Mortality in Children Under Five Years of Age, 2006 (% of children)

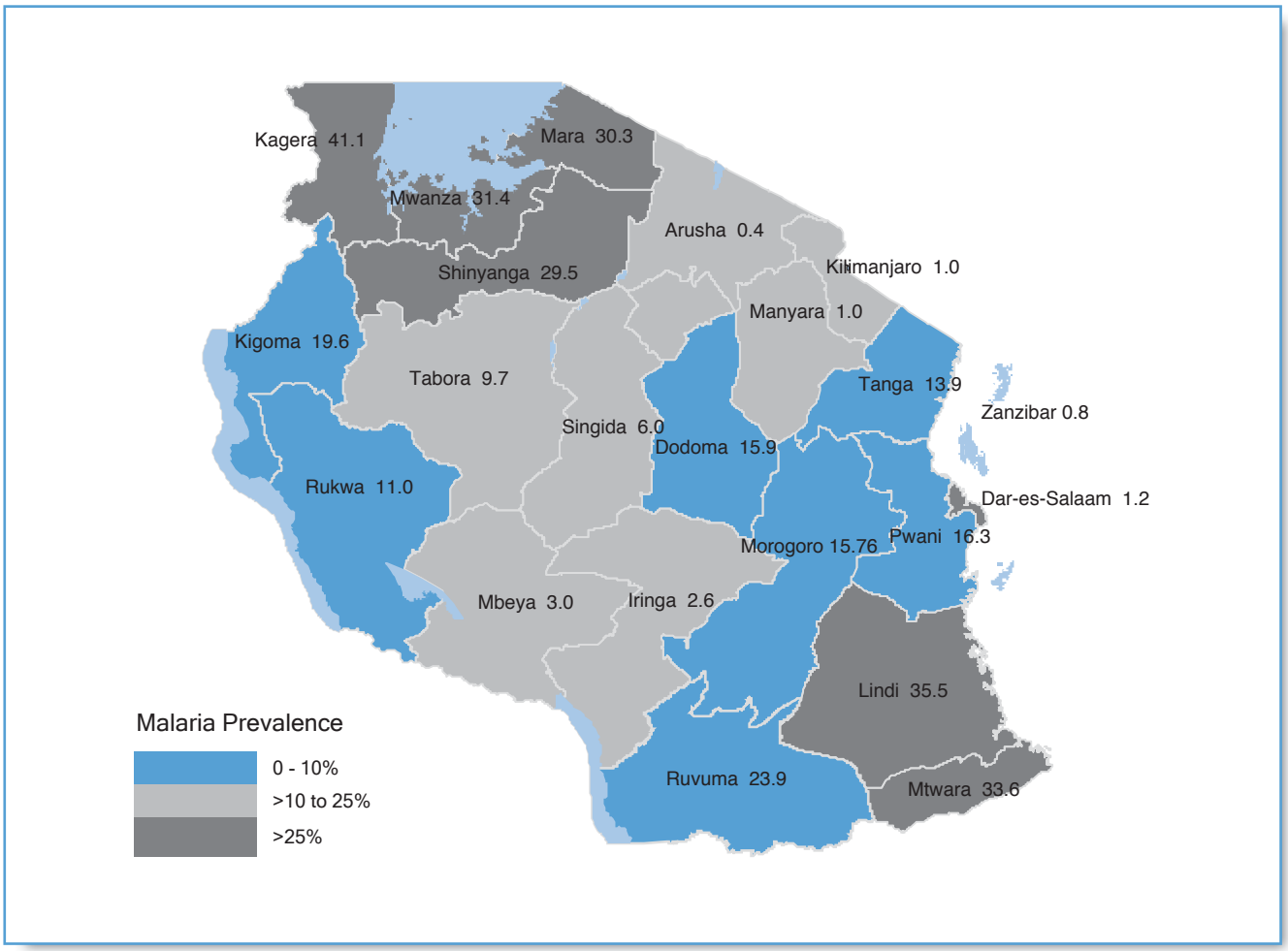
Causes of deaths	%
Malaria severe, complicated	32.5
Pneumonia	12.5
Anaemia	12.0
Malaria-uncomplicated	7.5
Diarrhoeal diseases	3.8
Poisoning	3.0

Source: MoHSW, Data from out-patient departments, February 2008, pp.16 and 17.
Note: 2006 data were obtained from 85.7% of all Mainland districts.

lowest regional prevalence recorded in Singida (6.5%) and Mbeya (9.3%) and the highest in Pwani and Mtwara (both 27%), Morogoro (29%) and Mara (30%). Overall, 57% of children with fever took anti-malarials, but only 34% took them on the same or next day following onset of fever. Children in urban areas are more likely to receive anti-malarials than children in rural areas (69% versus 54%) and to receive prompt treatment (50% versus 31%). Striking differences in the prompt treatment of fever were recorded across regions, ranging from only 5% of children in Arusha to 61% in Morogoro.

Use of insecticide-treated nets (ITNs) by children under-five and pregnant women in Mainland Tanzania is increasing, and will continue to increase as the free distribution of ITNs is expanded. The THMIS 2007/08 recorded that 25%

Figure 3.1: Malaria Prevalence among Children Under Five Years of Age, by Region, 2007/08



Source: THMIS 2007/08.

of under-fives (up from 16% in TDHS 2004/05) and 26% of pregnant women (up from 15% in TDHS 2004/05) slept under an ITN the night before the survey. Disparities by rural-urban residence, region and household wealth are again marked. Children in the highest wealth quintile are over four times more likely to sleep under an ITN than the poorest children (55% to 13%). A similar differential was recorded for pregnant women (49% to 14%).

Immunisation

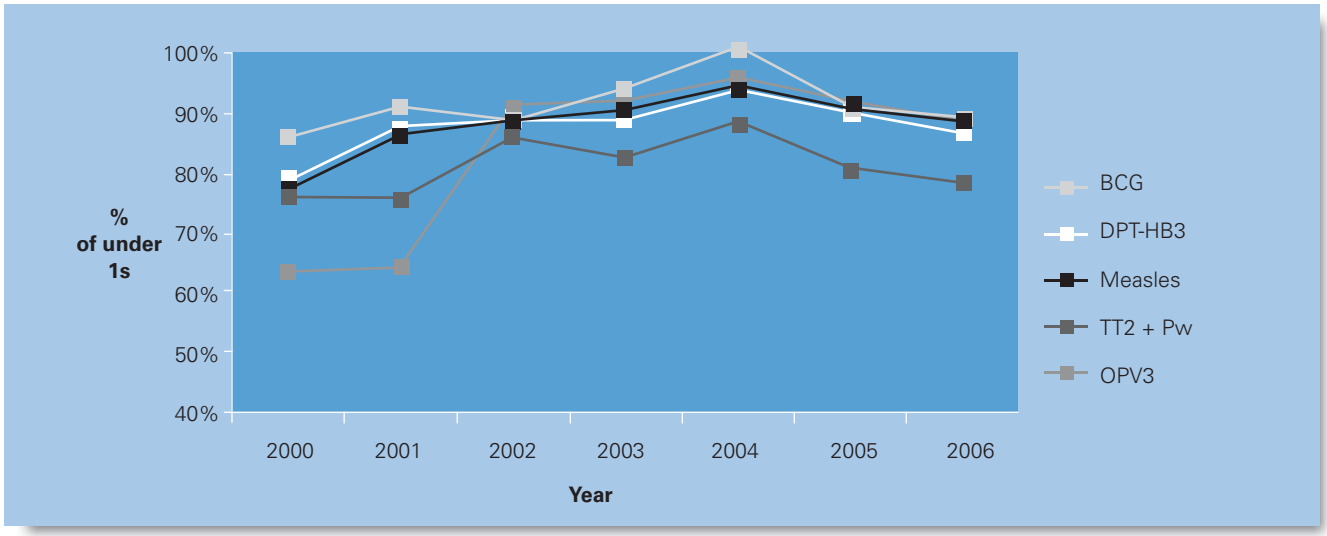
According to statistics for the Expanded Programme of Immunisation (EPI) from MoHSW, 2006 coverage of vaccination for DPT-HB3[14] – commonly taken as a proxy for overall performance in immunisation – stood at 87%, exceeding the MKUKUTA target of 85% (Figure 3.2). Indeed the rate for each of the last five years (2002-2006) has been at or above the MKUKUTA target (RAWG, 2007, 2005).[15]

However, there are disparities in immunisation uptake between urban and rural areas, between different regions and districts, and by poverty status (RAWG, 2005). Surprisingly, some relatively well-resourced regions are among the poorest performers – Kilimanjaro (71%), Kigoma (73%), Coast (75%) and Dar es Salaam (75%) in immunisation uptake (RAWG, 2007).

Water and sanitation

Dehydration caused by severe diarrhoea is a major cause of morbidity and mortality among young children in Tanzania. Hygiene practices are hampered by shortages of water and soap, unsanitary latrines and poor waste disposal. As a result, waterborne diseases including diarrhoea and dysentery are prevalent in Tanzania. The TDHS 2004/05 recorded that 13% of children under five years of age suffered diarrhoea in the two-week period prior to the survey. Access to safe and clean water and hygienic sanitation facilities are therefore critical to child well-being. However, the survey found that only 54% of Tanzanian households (urban 79%, rural 45%) had

Figure 3.2: Trends in Vaccination Coverage for Children Aged 0-11 months, 2000–2006



Source: RAWG, 2007, p.34; EPI data from MoHSW.
Notes: TT2 = Two doses of tetanus toxoid vaccine + Pw = Whole cell pertussis vaccine
BCG = Baccillus Calmette-Guerin, the vaccine for tuberculosis
OPV3 = Three doses of oral poliovirus vaccine
DPT-HB3 = Diptheria, Pertussis (whooping cough) and Tetanus + HB = Hepatitis B

[14] The third of a series of vaccinations against diphtheria, pertussis (whooping cough), tetanus and hepatitis B, introduced to the routine infant immunisation programme in January 2002.
[15] Though the EPI routine statistics are facility based and cannot be compared directly with survey data that are population-based, the two estimates accord well. The latter measures coverage in children aged 12-23 months, most of whom received their immunisation the year before. The EPI measures vaccines administered per year against the expected number of infants (0-11 months) in that year. The survey result (end 2004, DPTHB3: 86%, +/- 3%) corresponds closely with the 2003 EPI statistic (89%). Note also that the TDHS annual analysis also found a steady increase in DPT3 coverage, from 77.5% five years before the survey to 84% in the most recent cohort, confirming the rise found by EPI statistics.

access to clean water sources. Despite high coverage of some form of latrine – 90% of rural and 98% of urban households – a much smaller proportion have access to an improved latrine.[16] Further analysis of TDHS 2004/05 data shows that 32% of the poorest households had no access to basic latrines (i.e. considering both improved and unimproved latrines together) compared to just 1% of the wealthiest households (TAWASANET, 2008). HBS 2007 data, also show that poorer households pay more for water as a proportion of their household expenditure than richer households (Taylor, 2009).

HBS data from 2000/01 and 2007 show a declining trend in household access to clean and safe water sources, in both urban and rural areas: urban from 90% to 79% and rural from 46% to 40%. Two possible reasons for this worrying trend – investment in water supply infrastructure has not been keeping pace with population growth; and existing water points have not been sustained. Significant geographical disparities exist in both access and in the availability of infrastructure – the north-central regions and south-eastern regions face major challenges in accessing clean and safe water, while regions in the north-west and in south-central Tanzania are relatively well-served. This is partly due to the hydrological conditions across different areas of Tanzania. However, in recent years, funding allocated to water sector has increased significantly with the establishment of a sector-wide approach and the Water Sector Development Programme. It will however take some time before the increase in spending translates into increased water coverage in national surveys.

The rapid increase in primary enrolment has posed significant challenges for water and sanitation in schools. Few schools meet the draft national minimum standards contained in the Minimum Educational Standards for

National laws and policies

The **National Health Policy (2007)** and the **Primary Health Sector Development Programme (PHSDP) 2007-2012** aim to ensure delivery of equitable and quality health services. The new policy directs the establishment of a dispensary in every village, a health centre in every ward and a district hospital in each district (May 2007). The PHSDP seeks to address some of the dominant constraints facing the health system: infrastructure at the primary level, shortages of skilled human resources for health; short supply of essential equipment, pharmaceuticals and medical supplies; poorly functioning referral systems including lack of emergency transport and communication systems; and inadequate financing.

The **Health Sector Strategic Plan (HSSP) 2007-2010** continues implementation of the **Health Sector Reform (HSR) Programme** begun in the 1990s. Core reforms include decentralisation and devolution of management to districts, hospital reforms, human resource development and financial reforms. Three key changes in health financing were associated with the reforms: i. the pooling of government and donor resources under the SWAP (sector wide plan of action) into a common "basket fund" (created in 1999); ii. direct funding of districts, and iii. the introduction of cost sharing – user fees and Community Health Funds (CHF). Districts were encouraged to focus on cost-effective interventions that address the largest shares of the burden of disease. An Essential Package of Health Interventions was also developed to assist districts in planning for priority health programmes.

Water sector reforms[17] have been implemented with the objectives of re-orienting the sector towards a more commercial approach to water supply, particularly in urban areas; aligning the sector to the decentralisation by devolution process; providing a stronger role for community management of rural water supplies; and strengthening the weak institutional framework for water resource management. The launch of the **Water Sector Development Programme (WSDP)** in March 2007 represents a sector-wide approach to planning by the Ministry of Water and Irrigation (MOWI) and its major development partners, including a switch from project to sector-wide basket-funding (Taylor, 2009). The shift to basket funding, and the increased flow of resources to LGAs with limited capacity to absorb new funds and weak accountability structures, present huge challenges to the sector. So does the provision of water supply for the most vulnerable, which has not yet been a specific priority. The focus has been on improving coverage for all.

[16] According to Taylor (2009), data from household surveys do not accurately reflect the availability of adequate and hygienic sanitation facilities as the data do not differentiate between 'improved' or 'unimproved' pit latrines – an issue highlighted by the deprivation analysis in this report. Very few households have no access to any latrine, but facilities are frequently of very poor quality and unsanitary. Pastoralist communities and poorer households, however, are both more likely to lack access to even a basic latrine.

[17] Includes a new National Water Policy launched in 2002, a National Water Sector Development Strategy in 2006 and water legislation passed in 2009 (Taylor, 2009).

Primary Schools for toilet facilities of one latrine for every 20 female students and one for every 25 male students (Taylor, 2009). The construction of toilet facilities to provide hygienic conditions and privacy for girls following menarche is also critical. Inadequate sanitation facilities can result in decreased attendance at times of menstruation, or dropping out of school altogether.

The universal provision of clean, safe water in healthcare facilities is essential to enable best-practice infection control. However, the 2006 Tanzania Service Provision Assessment Survey (TSPA) showed that only 33% of healthcare facilities in Tanzania, including half of all hospitals, had running water. One-third of the facilities also did not have soap (NBS & Macro International, 2007).

B. Building Blocks for a Strategy

Key Programmes

Four key health programmes or strategies have been developed to address the major causes of child mortality:

- Integrated Management of Childhood Illness Strategy (IMCI)
- National Malaria Strategic Medium-Term Strategic Plan (NMMP), and in particular, the National Strategic Plan for Insecticide-Treated Nets in Tanzania (NATNETS) under the National Malaria Control Programme
- Expanded Programme on Immunisation (EPI)
- National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania.

Integrated Management of Childhood Illnesses

IMCI develops the capacity of child caregivers in first-level health facilities and communities to improve quality of care and address the major causes of under-five mortality and morbidity. IMCI commenced in 1997 in two pilot districts (Morogoro Rural and Rufiji) with support from the Canadian-funded Tanzania Essential Health Interventions Project (TEHIP). By the end of 2005, the strategy had been rolled out to 107 districts (94% coverage of districts).

Evidence from IMCI and TEHIP suggests that with training and health systems support, productivity of health workers is improved and the greater burden of disease in under-fives can be addressed cost-effectively. Findings from IMCI evaluations[18] demonstrated that:

- After two years, mortality levels were 13% lower in the two TEHIP/IMCI districts compared with control districts, and there was also a significant reduction in stunting.
- IMCI costs less than conventional care. The cost of under-five care per child was estimated at US$11.19 in IMCI districts compared with US$16.09 in non-IMCI districts.
- Children in IMCI districts received more thorough assessments, and were more likely to be correctly diagnosed and to receive appropriate treatment.
- Supportive supervision of health workers was much more common in IMCI districts. Case management of sick children is improved by IMCI training – those caring for sick children were routinely informed of how to look after the children and how to administer medicines.
- Improved quality of care provided to children in health facilities with IMCI-trained health workers resulted in greater utilisation of health facilities; in Morogoro Rural and Rufiji districts, the utilisation increased from 30% in 1997 to 70% in 2001.
- Introduction of a series of practical management, priority-setting tools for[19] District Health Management Teams significantly improved budget allocation, and evidence-based health planning and practice (de Savigny, et al., 2004; Armstrong Schellenberg et al., 2003; Tanzania IMCI MCE Health Facility Group, 2004).

National Malaria Medium-Term Strategic Plan (NMMP) 2002-07

The NMMP advocates four main strategies to fight malaria mortality and morbidity: i. improved malaria case management; ii. selective vector control, in particular expansion of use of ITNs; iii. IPT for pregnant women; and iv. prevention and control of malaria epidemics.

[18] In many ways, it is not possible to separate the impact of IMCI from other interventions in the TEHIP districts that resulted in improved planning and managerial capacity at the district level.

[19] The tools used to plan health evidence-based interventions included: *district burden of disease profile* to repackage population health information from the DSS in a way that the district officials can easily understand; *district health accounts* to analyse budgets in a standard way to generate easy-to-use graphics that show how plans for spending coalesce as a complete plan; *district health service mapping* to allow health administrators to access a quick visual representation of the availability of specific health services or the attendance at health facilities for various interventions across the district; *community voice* tools to promote community participation and ownership, and inform health planning.

With respect to treatment, the 2006Tanzania Service Provision Assessment survey found that almost all health facilities treat malaria and have anti-malarial medicines available, though treatment guidelines are not available at the majority of the services sites, and laboratory testing capacity for the disease is low (NBS & Macro, 2007). The survey also found that few facilities offered ITNs, but vouchers for ITNs were more widely available. However, this is likely to have improved with the expansion of free distribution of nets to under-fives and pregnant women (and potentially to all households in the future).

NATNETS, a long-term multi-donor, multi-partner initiative endorsed in 2000, aims to expand the use of ITNs by under-fives and pregnant women through social marketing and public-private partnerships in the commercial sale and distribution of nets. As part of NATNETS, the Tanzania National Voucher Scheme (TNVS), a five-year programme supported by the Global Fund to Fight AIDS, Malaria and TB, was launched in October 2004. The scheme seeks to rapidly increase ITN coverage in poorer households and hard-to-reach rural areas. Vouchers for ITNs are given to all pregnant women at their first antenatal care visit, and to all infants attending Maternal and Child Health (MCH) clinics for their measles vaccination at nine months of age. These vouchers can be used as part payment for purchase of an ITN at shops participating in the scheme. In addition, in six pilot districts, equity vouchers are being provided to pregnant women and mothers of infants who cannot afford the top-up required to redeem the voucher.

Evidence from the TNVS household, facility and facility users' survey in 2007 showed that ownership and use of bed nets had increased in the period 2006-2007 (Marchant, et al., 2007). Nearly two-thirds of households owned at least one bed net, and 36% had at least one effectively treated net. However, results indicated that coverage and year-on-year gains in usage were lowest in the poorest households. Earlier data on ITN use in Tanzania also found that affordability was a significant obstacle to net use, especially for the poorest households (Nathan et al., 2004; Armstrong Schellenberg, et al., 2001, 2003). In order to improve ITN coverage in the poorest households, there has been increasing support for free net distribution – for example, by UNICEF in Lindi and Mtwara, and by USAID/PEPFAR in other regions with high prevalence.

Expanded Programme of Immunisation (EPI)

Immunisation services in Tanzania are very strong, effective and efficient. Polio eradication and the introduction of a universal measles campaign have been significant events for Tanzanian children. The EPI was established in 1975/76 with the primary aim to protect children from vaccine preventable diseases. The overall goal is to contribute to the reduction of infant and childhood mortality rates. Universal immunisation campaigns from 1985-89 raised immunisation coverage of children under one year of age from less than 50% to more than 80%. High rates of immunisation have been maintained as indicated by DPT-HB3 coverage (see Figure 3.2). Over 90% of health facilities now provide routine immunisation services. However, there are some worrying signs of a slight drop in performance since 2004 – a consequence of the devolution of EPI logistics to local authorities. The problem is not with the level of funding, but with the timing of release of funds to avoid stock-outs. Key issues identified include vaccine forecasting and ordering, cold-chain supplies and maintenance, and poor supervision in some councils (MoHSW, 2007d). In addition, adequate technical support and oversight to districts must be provided to sustain the levels of coverage.

National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania

The National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania (also known as the 'One Plan') was launched by Tanzanian President, Jakaya Kikwete, in April 2008. The objectives of the 'One Plan' include reducing maternal mortality from 578 (per 100,000 live births) to 193 by 2015, neonatal mortality from 32 (per 1,000 live births) to 19 by 2015 and under-five mortality from 112

(per 1,000 live births) to 54 by 2015 (MoHSW, 2008a).

Key operational targets for maternal health services under the strategy include increased antenatal care attendance for at least 4 visits from 64% to 90% by 2015, and expanding coverage of skilled attendance at births from 46% to 80% by 2010. The One Plan has been incorporated in the new Health Sector Strategic Plan that is to be officially launched by the President on 30 June 2009. The policy focus is clear – maternal and newborn care is getting the attention it deserves. The challenge now is a systematic implementation of the Plan – ensure that facilities are well-equipped and functional, staffed by trained health workers, equipped to provide basic and comprehensive emergency obstetric care (including caesarean section), and be able to provide rapid referrals for women with obstetric complications.

Financing and Partners

Tanzania uses a mix of financing sources to support the health system. National Health Accounts data from 2000 and 2006 indicate that 60% and 42% of total expenditure on health was private, and out-of-pocket expenditure on health was 80% and 54% of private (WHO, 2009). The Government finances a basic package of public preventive health services for the entire population and a minimum level of financial protection against catastrophic illness for some vulnerable segments of the population. The Community Health Fund, a government-supported initiative, has met with limited success. Government funding is channelled through several sources – Ministry of Health and Social Welfare, local government authorities (LGAs), Regional authorities, and the Prime Minister's Office-Regional Administration and Local Government (PMO-RALG).

According to MoHSW Public Expenditure Review and Medium-Term Expenditure Framework figures:

- Total health sector budget increased by around 37% in nominal terms from 2006/07 (TShs 499.6 bn) to 2007/08 (TShs 682.6bn) (MoHSW 2007g, 2007h);
- Estimated annual per capita spending (nominal) on health for FY06, FY07 and FY08 was USD 6.8, 10.3 and 13.8 respectively.
- Health expenditures in FY06, FY07, and that budgeted for FY08 amount to 9.7%, 10.3% and 10.5% respectively, of total anticipated government expenditure – a slight increase but still falling short of the Abuja[20] target of 15%. While these figures do not take into account significant 'off budget' funding, it is clear that increased funding is required to achieve the health targets set in MKUKUTA.

Health basket funds and block grants have provided stable and predictable funding for health at LGA level, made local planning and budgeting possible and contributed to service quality improvements at health facility level (JEE, 2007). The Health Basket Fund – jointly funded by ten donors - has played a particularly important role in strengthening district health services. From 2000/01to 2004/05, districts received US$0.50 per capita from the basket fund. In 2005, the allocation increased to US$0.75 per capita.

Global health initiatives and large multi-country programmes – including U.S. assistance for HIV/AIDS and Malaria (PEPFAR and U.S. President's Malaria Initiative) – have injected substantial aid to the health sector, but much of this funding remains off-budget and largely outside health planning and management systems. This makes it impossible to predict total sector resources, thereby impeding national strategic planning. Additionally, unless financial support to HIV/AIDS is applied to reducing current health system constraints, such support may distort and impact negatively on the delivery of the Essential Package of Health Interventions at the local level.

According to the LGA Budget Guidelines, priority areas for health resource allocation for the period 2007/08-2009/10 include an increasing emphasis on implementation of reproductive and child health services, integration of IMCI and immunisation services, prevention and treatment of malaria, and scaling-up of provision of immunisation services (PMO-RALG, 2007).

[20]Total expenditures include Consolidated Fund Services, comprising debt service payments and State House (Votes 20 and 22).

Despite advances in funding mechanisms, local government resources are insufficient to deliver quality health services and meet expected targets. Geographic disparities should narrow with the use of formula-based allocations from central to local government that incorporate estimates of under-five mortality, as well as a weighting towards rural populations. However, the implementation of the formulae has not incorporated allocations for personal emoluments – a substantial share of the total budget – and since staff are not equitably distributed, geographic disparities in funding for LGAs persists. In addition, greater disbursements are needed to underpin improvements in health system infrastructure and service delivery, particularly an expansion in skilled attendance at birth and access to emergency obstetric care to reduce neonatal and maternal mortality. To make further progress towards equity in healthcare outcomes across the country, financial and other incentives are required to attract skilled personnel to under-served areas. Performance-based incentives are also needed to improve productivity. The success of TEHIP further indicates the importance of building capacity of local government authorities, health administrators and facility personnel to enable better management and utilisation of scarce health system resources.

Government capacity must also be strengthened to regulate an increasingly pluralistic health sector. Tanzania's health system faces many challenges. Currently, 40% of facilities are operated outside the public system, mainly by faith-based organisations. The government is aiming to improve coordination and complementarity between health services and health insurance systems, and to strengthen decentralised healthcare systems. The development of private health insurance schemes presents both opportunities and threats to the healthcare system. Appropriate policy guidelines for private healthcare, including modalities for funding and contracting out services, have not yet been developed. Without an appropriate regulatory framework, strong public sector involvement and citizens' participation, private schemes could undermine the objective of universal coverage and lead to rising inequalities in access to health care (Mamdani, 2007). Managing the public/private mix in health care is inevitably a difficult task, and always the responsibility of government.

3.1.2 Nutrition

MKUKUTA Goals and Targets

- Reduced prevalence of stunting in under-fives from 43.8 % to 20.0% in 2010.
- Reduced prevalence of wasting in under-fives from 5.4% to 2.0 % in 2010.

A. Status, Trends and Disparities in Child Outcomes

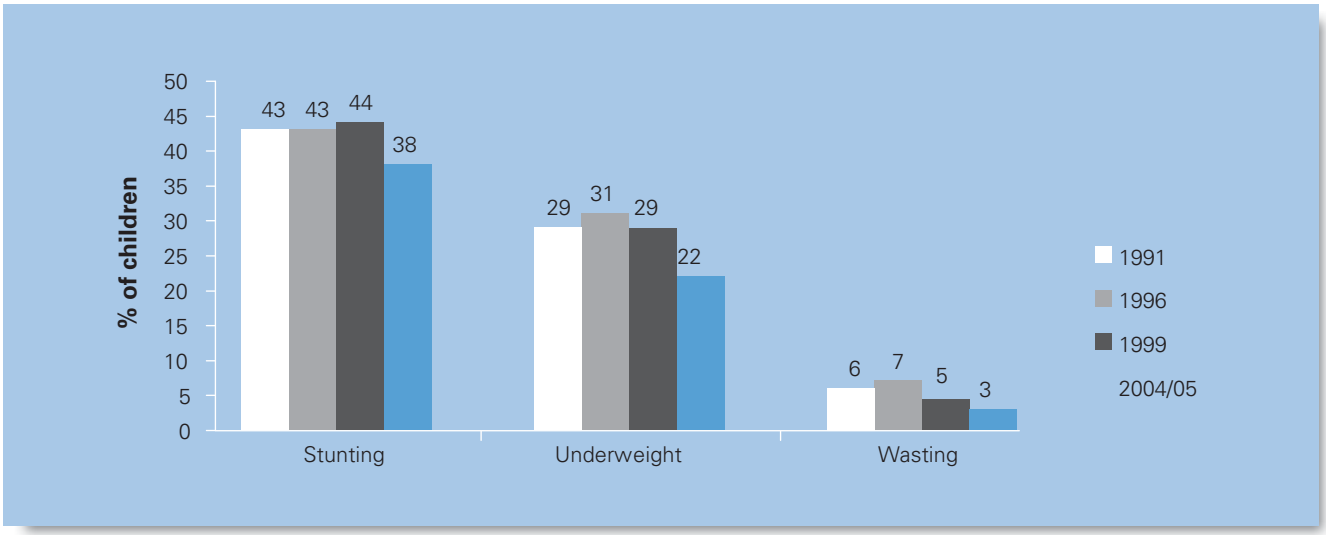
Malnutrition

Indicators for malnutrition among under-fives improved between 1996 and 2004/05. The proportions of under-fives who were stunted (under-height for age) or under-weight (weight for age) both dropped by 6-7 percentage points, with most improvements occurring between 1999 and 2004/05. Nonetheless, the percentages of children who were stunted (38%) and under-weight (22%) both remain unacceptably high (see Figure 3.3). Almost 4 out of every 10 children aged 0 to 59 months are chronically undernourished and about 1 out of every 5 children weighs too little (NBS et al., 2005).

Rural children are significantly more likely to be malnourished than urban children. Overall in Tanzania, stunting varies little between the lowest wealth quintile (45%) and fourth wealth quintile (38%). Only the fifth (highest) wealth quintile is less affected (16%). Among rural children, there is little difference in prevalence of stunting by poverty quintile, except for the least poor. Rural residence is the most important determinant of malnutrition in children. Among urban children, however, changes by poverty quintile are marked – rates of malnutrition steadily decline as poverty is reduced. However, there are no significant gender differences overall (NBS et al., 2005).

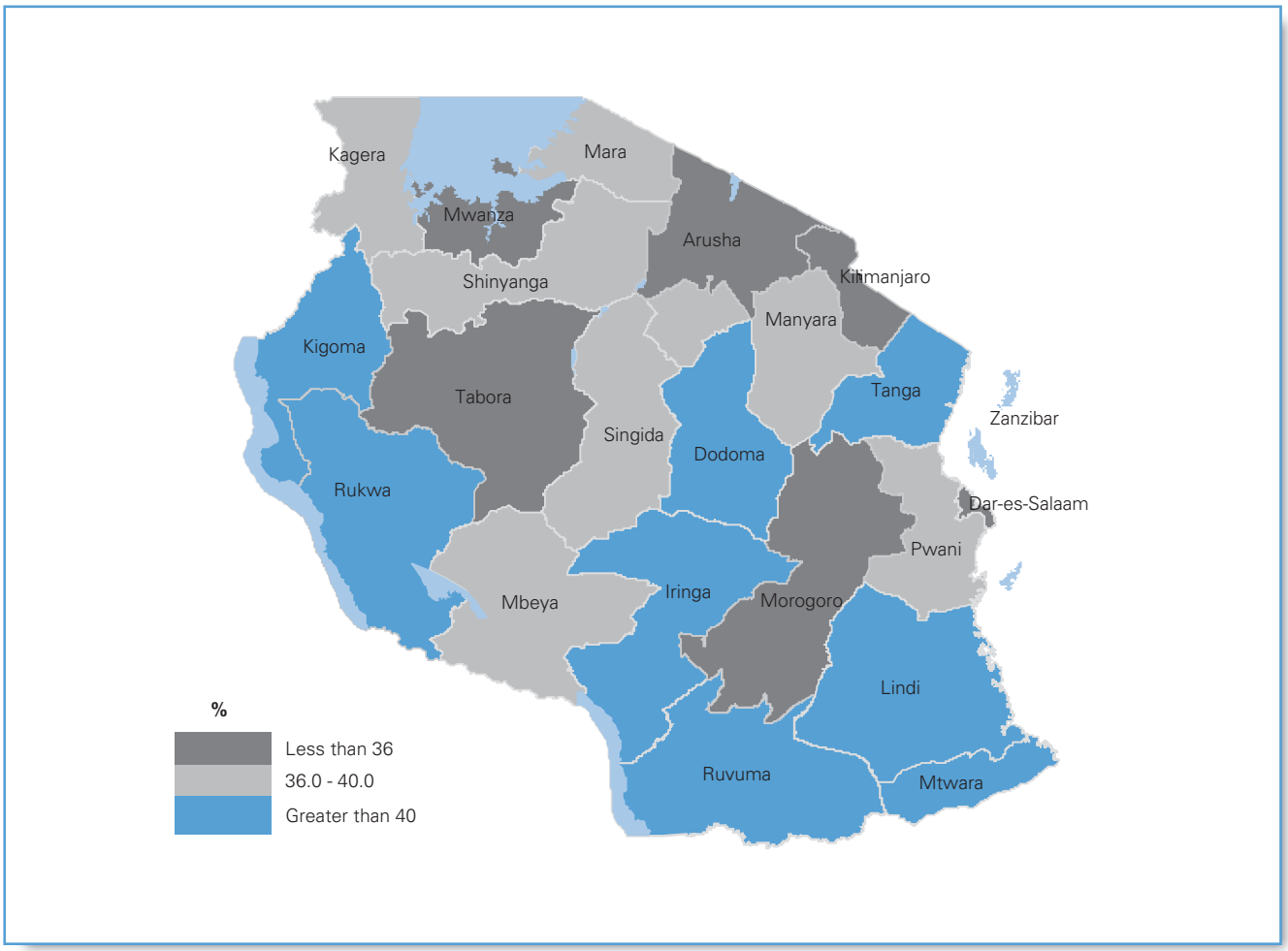
Again, as in under-five mortality, there are strong regional differences in the prevalence of malnutrition, ranging from 17% in Dar es Salaam to 54% in Lindi (Figure 3.4) and in the types of nutritional problems that affects regions. Dar es Salaam, for example, does well on stunting and underweight but has a prevalence of wasting

Figure 3.3: Malnutrition Among Children Under Five Years, 1991 to 2004/05 (% of children below -2SD)



Source: DHS surveys for 1991, 1996, 1999 and 2004/05.

Figure 3.4: Prevalence of Stunting in Children Under Five Years, by Region, 2004/05



Source: TDHS 2004/05

that is 30% above the national average. Mwanza has a high prevalence of anaemia, but has one of the lowest prevalence of underweight and stunting. Parents' education also appears to be a critical factor: children of mothers with secondary education are much less likely to be stunted (Lindeboom and Kilama, 2004).

Data show a consistent pattern that growth faltering sets in at a very early age, and then stabilises when children are 18-24 months of age. Low birth weight (below 2.5 kg) rates have changed little in the past few years, though definitive trends are difficult to ascertain because a large proportion of births, especially in rural areas, take place at home where weights are not recorded. In 1999, 9% of the babies who had been weighed at birth were under 2.5 kg, compared to 7% in 2004/05 (NBS et al., 2005). Low birth weight is a reflection of poor maternal health and nutritional status.

Micronutrient disorders

Micronutrient disorders, including anaemia, and vitamin A and iodine deficiencies, are important factors in childhood morbidity and mortality.

Anaemia is caused predominantly by inadequate dietary iron intake, malaria and parasitic infestations. Data from THMIS 2007/08 found that 7.7% of all under-fives were severely anaemic (<8g/dl), with the prevalence peaking in children aged 12-23 months (12.4%) and progressively declining in older age groups. Re-tabulation of TDHS 2004/05 data using the same cut off point reveals a marked reduction among rural children (from 11.8% to 7.5%), and a slight increase among urban children (from 7.4% to 8.5%). However, further investigation of the data is required to ensure the comparability of results given adjustments in the urban/rural definitions used by the THMIS.[21] The observed improvement in the prevalence of severe anaemia in rural areas is most probably related to gains in malaria control. The TDHS 2004/05 data also showed that 1% of women were severely anaemic. Pregnant women were more likely to be anaemic (58%) than women who were breastfeeding (48%) or who were not pregnant (47%).

A national survey in 1997 found that 24% of children aged 6-71 months and 69% of lactating women were vitamin A deficient (Tanzania Food and Nutrition Centre (TFNC), 1997). It is likely that the prevalence of vitamin A deficiency in children has reduced considerably during the last decade due to the high coverage of twice-yearly vitamin A supplementation, however no recent data are available.

The TDHS 2004/05 found that iodised salt reaches almost three-quarters (74%) of households, and has reduced the prevalence of goiter from 25% (van de Haar, et al., 1988) in the 1980s to 7% in 2004 (TFNC, 2004). Nevertheless, the quality of iodised salt remains a concern, particularly in rural areas where only 34% of household salt contains adequate iodine (NBS et al., 2005).

Food Security

The predominant diet in Tanzania is cereal-based with low energy and nutrient density. During critical food shortages, children suffer with others in affected households. However, food shortages per se are not the most important determinant of under-nutrition in young children. The geographic pattern of malnutrition in Tanzania suggests that even areas of the country with cereal surpluses, mainly in the South and West, also demonstrate relatively high rates of malnutrition. Food security, therefore, in the limited sense of cereal crop production, is not strongly associated with nutrition security. Several analysts have pointed out that increasing income accounts for only part of the decrease in malnutrition rates. Similar results are found in analyses of the relation between higher national income (GDP) and rates of child malnutrition (Mkenda 2004, Alderman et al., 2005). As indicated earlier, household wealth is also not a good predictor for malnutrition in Tanzania.

Caring and feeding practices

Nutritional outcomes are strongly impacted by health and caring practices. Children should be breastfed immediately after delivery and exclusively breast-fed for six months. Complementary foods should be introduced from six months of age,

[21] THMIS 2007/8 and TDHS 2004/5, retabulated by Ifakara Health Unit with <8g/dl cut-off.

while breastfeeding continues up to two years, and beyond. According to the TDHS 2004/05, almost all children (96%) are breastfed at some time, and 91% of children are still being breastfed at 12-15 months, but this falls to 55% by 20-23 months of age. Only 60% infants are put to the breast within one hour of birth. The percentage of infants aged less than six months who were exclusively breastfed increased from 29% in 1996 to 41% in 2004/05. However, breastfeeding tapers off quickly with age and by 4-5 months of age only 13.5% of infants are still exclusively breastfed. Over 90% of infants aged 6-9 months are given complementary foods in addition to milk, but the quality of foods is often poor (NBS et al., 2005).

B. Building Blocks for a Strategy

Key Programmes

Micronutrient Supplementation and De-worming Programmes

External support is provided for biannual community child health and nutrition days to coincide with the Day of the African Child (June 16) and World AIDS Day (December 1). From 2001, most vitamin A supplementation services to children aged 6-59 months were provided during these two events. Since 2004, de-worming for children aged 12-59 months was also integrated with the supplementation campaigns to improve their cost-effectiveness. A nationally representative survey of 21 regions of the Mainland carried out in July 2004

National laws and policies

Food and Nutrition Policy for Tanzania

The national nutrition policy was approved in 1992, and is currently under revision. A draft of the revised policy was prepared in December 2004, and the Tanzania Food and Nutrition Centre (TFNC), a parastatal of the Ministry of Health and Social Welfare, advocated for the mainstreaming of nutrition into national socio-economic development:

> *"Realisation of the Vision 2025 among others requires development of a healthy, educated and productive workforce over the next 25 years. In view of the above therefore, deliberate efforts must be made to reduce malnutrition focusing on the most vulnerable members of society that is infants, children and women of reproductive age (MoH, 2004a)."*

The TFNC is charged with responsibility for nutrition research and for advocating, advising, monitoring, evaluating, harmonising and facilitating nutrition activities.

National Nutrition Strategy (NNS) 2009-2015

To operationalise the policy, TFNC and its partners developed the NNS, which was endorsed by all stakeholders in April 2009. Women of reproductive age and young children under five years of age are priority groups under the plan, particularly children in the first two years of life when the greatest developmental damage from malnutrition occurs. The NNS is focused on the prevention of malnutrition among under-fives, women of reproductive age and vulnerable groups (MoHSW, 2009).

Priority actions for the plan of direct relevance to children include:

- Improving infant and young child nutrition and growth through community and facility-based nutrition and health services, with a focus on nutrition education, exclusive breastfeeding, adequate complementary feeding, growth monitoring and promotion, early stimulation and management of severe malnutrition;
- Developing technical competency of community- and facility-based service providers to implement integrated minimum health and nutrition care packages;
- Improving nutritional and micronutrient status among women aged 15-49 years and preventing low birth weight through iron/folate or multi-micronutrient supplementation, intermittent presumptive treatment of malaria, de-worming and nutrition education among pregnant women;
- Alleviating mineral and vitamin deficiencies among infants and young children through micronutrient supplementation; food fortification of staple and complementary foods; and sustained salt iodation.
- Addressing nutritional needs of people living with HIV/AIDS (PLHA), most vulnerable children (MVC) and those in emergencies.
- Addressing the new emerging problem of over-nutrition through community-based programmes and networks to promote and support appropriate behaviours and a healthy life style.

The NSS is ambitious and illustrates a high level of understanding of what needs to be done, but is yet to be costed and resourced. Generating the necessary high level of attention to implement the plan will require concerted action.

indicated that 85% of children aged 6-59 months had received vitamin A supplementation (HKI & TFNC, 2005).

Financing and Partners

TFNC receives financing from the central government through the MoHSW. For FY2005/06, this subvention was around $2.5 million, about one-third of which covered staff costs. Several external partners have provided project funding. The official budget books of the Government planned for a development project budget for FY2005/06 of about US$0.5 million, though the centre also received external financing not reflected in the budget books. The recurrent budget for 2007/08 for TFNC was reduced, with about three-quarters allocated for staff costs and office upkeep. Development financing for 2007/08 was TShs 850 million (approximately US$0.7 million), the bulk of which was for rehabilitation of TFNC's office buildings. This was sourced from basket funding for the health sector development programme. None of the funds from major contributors to nutrition programmes are reflected in the budget. Strategic and coordinated national programming under these conditions is difficult.

The overall budgetary provision for nutrition is explicitly provided within the Ministry of Health's Preventive Services, and the Ministry's Plan and Budget Guidelines for 2006/07 included policy commitments for improving nutrition (MPEE and MoFEA, 2006).[22] However, nutrition was not explicitly mentioned as a priority area for resource allocation. A recent study by TFNC, the World Bank and UNICEF on the role of nutrition in long-term, equitable growth estimated the cost of implementing nutrition interventions as: "approximately $0.03 per capita for salt iodisation, $0.71 for vitamin A supplementation, $3.40 per for iron supplementation per pregnancy, and up to $14 - $60 for intensive targeted growth promotion per infant" (World Bank et al., 2007).

Yet based on past experience and current plans the total amount of funding available for nutrition is unlikely to exceed US$5 million annually, of which about US$3 million might be provided for children and pregnant women. On average, this would represent less than US$1 per person for these population groups considered most in need of nutrition interventions. This level of funding is clearly insufficient to cover even the highest priority elements of a cost-effective nutrition programme.

Four possible sources of greater nutrition funding include: i. increased aid from development partners (DPs); ii. MoHSW budget allocation; iii. efficiencies in delivering nutrition interventions; and iv. inter-sectoral collaboration. Given the fiscal restraints on the health budget in the short run – currently only US$12 per capita – the scope for increased MoHSW allocations is limited. In addition, if DPs did commit to provide additional funding, this would likely be channelled through MoHSW as part of budget support or the health basket (World Bank et al., 2007).

Thus, greater operational efficiencies and stronger inter-sectoral collaboration in nutritional programming are required, especially with MoHSW and local authorities. The 2006 Health Sector Review concluded that the health sector is best placed to spearhead actions to prevent malnutrition in young children. The IMCI/TEHIP experience shows that child malnutrition can be reduced through more effective case management by health staff. The 2007 Health Sector Review renewed its plea for greater emphasis on nutrition. However, the only milestone for nutrition that was proposed was the establishment of a technical working group on nutrition under the Technical Committee of the Health SWAP.

Much of what is needed to dramatically improve childhood nutritional outcomes is known. Recent improvements in nutrition are attributed to widespread coverage of micronutrient supplementation and more effective prevention and control of malaria. Both of these programmes are assured of funding for the next few years. However, improving infant and child feeding will depend on stronger social support for child caring practices and more effective public dissemination and advocacy about the critical role of nutrition in personal and socio-economic development. Much greater focus

[22]Among the commitments mentioned in the Guidelines were improving neo-natal and infant care, screening of under-fives for developmental disabilities, targeting nutrition education and supplementation for undernourished children, rolling out IMCI throughout the country and improving access to and quality of maternal health services.

and support will be needed from MoHSW and local health staff, especially in rural areas.

3.1.3 HIV/AIDS

MKUKUTA Goals and Targets

- Reduced HIV prevalence among pregnant women aged 15-24 years from 11% in 2004 to 5% in 2010
- Reduced HIV prevalence among young people aged 15-24 years from 11% in 2004 to 10% in 2010.

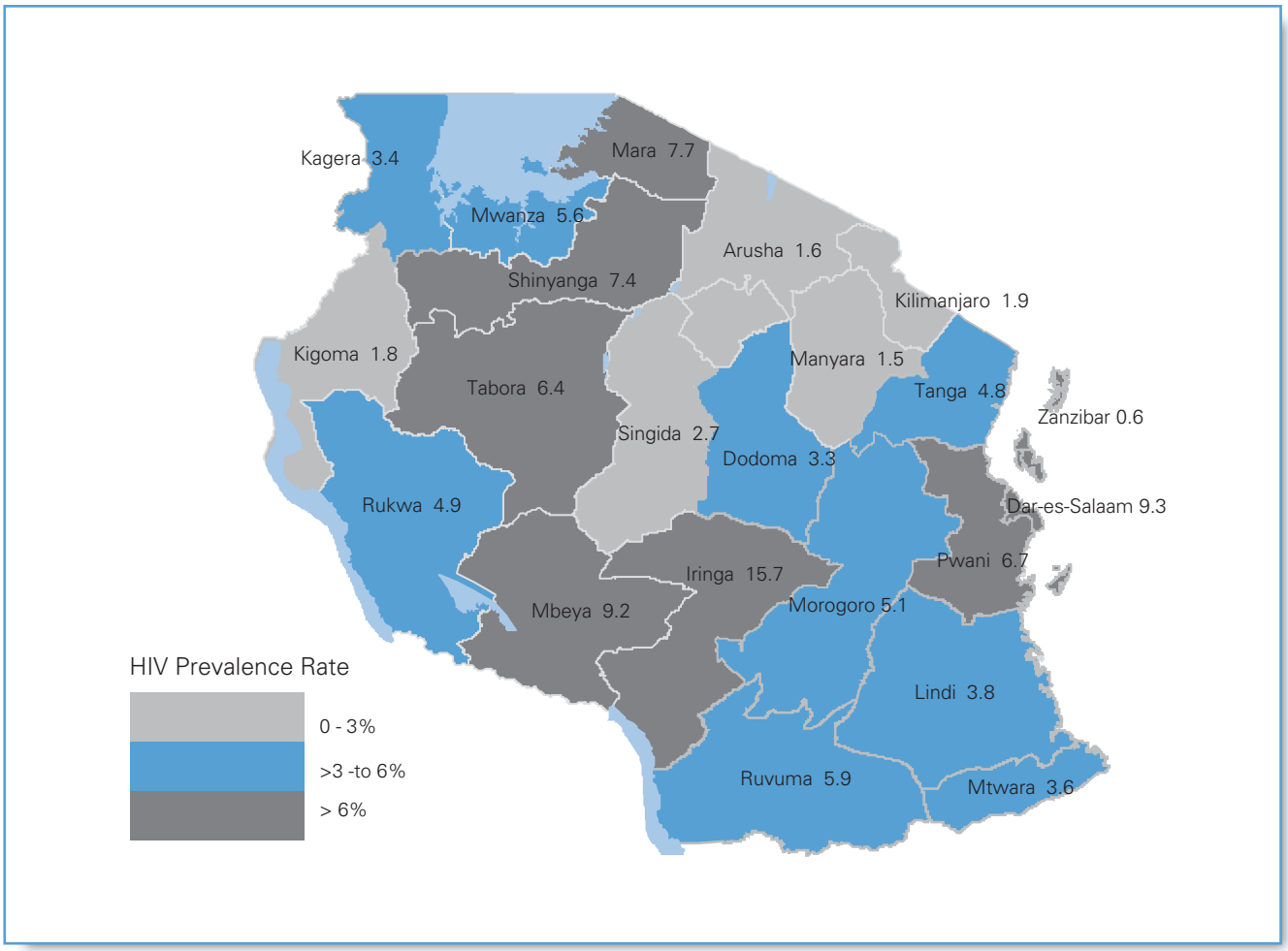
A. Status, Trends and Disparities in Child Outcomes

HIV Prevalence

The THMIS 2007/08 indicates that national HIV prevalence among Tanzanian adults aged 15-49 years has declined to 5.7% from 7.0% in 2003/04. HIV prevalence is higher among women (6.6%) than men (5.7%). The survey also found large variations in prevalence rates by:

- Region – Infection rates range from 15.7% in Iringa region to 1.5% in Manyara region of the Mainland and 0.6% in Zanzibar. This indicates that there is no single HIV epidemic in the country but probably several dozen localised HIV epidemics.
- Residence – levels of infection are significantly higher among urban (8.7%) than rural residents

Figure 3.5: HIV Prevalence among Population Aged 15-49 Years, by Region, 2007/08



Source: THMIS 2007/08

(4.7%). In particular, prevalence among urban women (10.6%) is twice that of rural women (5.3%).

- Household wealth status – HIV prevalence is highest among adults in the top wealth quintile (8.1%) and lowest in the bottom quintile (4.6%).
- Age – infection rates increase with age for both sexes, from 1.3% among women aged 15-19 years to a peak of 10.4% among those aged 30-34 years, and from 1.0% of men aged 15-19 years to a peak of 10.0% among men aged 35-39 years.

The predominant mode of HIV transmission in Tanzania is through heterosexual contact, accounting for over 90% of new AIDS cases.

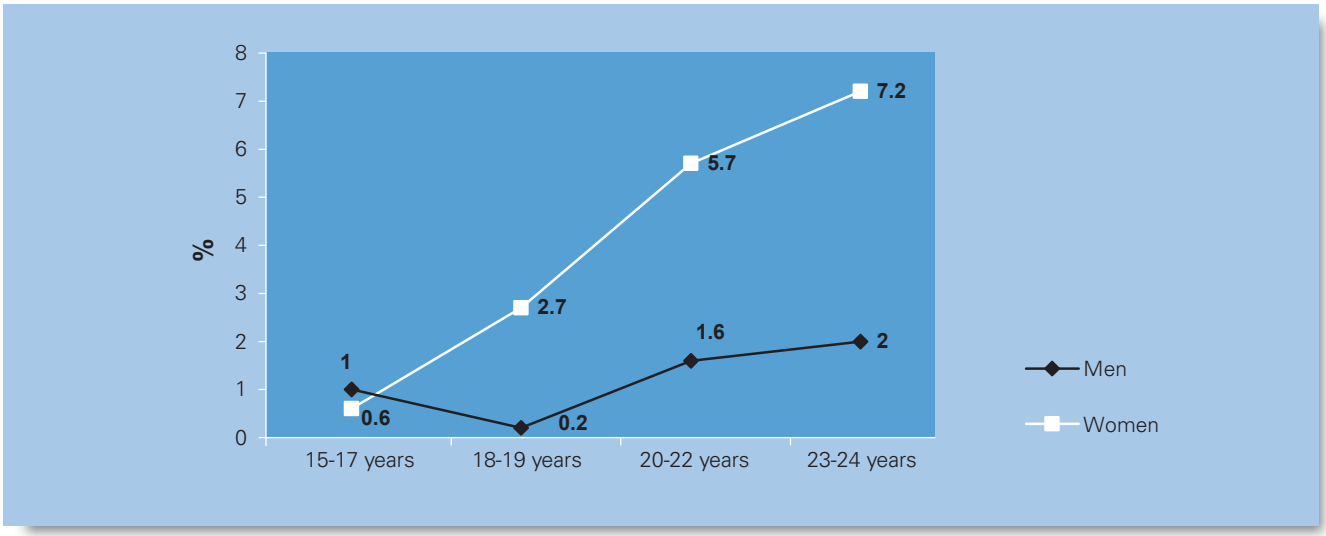
Mother-to-Child Transmission of HIV

After heterosexual transmission, the next most common mode is mother-to-child transmission (MTCT)[23], whereby the mother passes the HIV virus to the child during pregnancy, at the time of birth, or through breastfeeding (NBS, et al., 2008). Mother-to-child transmission remains the leading cause of HIV infection in children. The 2006 IATT Joint Technical Mission (JTM) estimated that 110,000 pregnant women in Mainland Tanzania were living with HIV/AIDS in 2004 and, without any preventive interventions, perinatal transmission could account for 44,000 new paediatric HIV infections every year (JTM, 2006).[24] Recent WHO figures suggest that the under-five mortality attributable to HIV is 9% (data quoted in NACP, n.d.)

Youth and HIV/AIDS

Overall, HIV prevalence among youth aged 15-19 years is 1.0%. However, prevalence among young women rises much faster with age than among young men (Figure 3.6). Given that heterosexual contact is the predominant mode of transmission, age at first sexual intercourse marks the time at which most individuals risk exposure to HIV. The THMIS 2007/08 found that 11% of young women and 10% of young men aged 15-19 years had sex before the age of 15 years – the same proportions as recorded in the Tanzania HIV/AIDS Indicator Survey (THIS) 2003/04 (TACAIDS, NBS, NACP and ORC Macro, 2005). A strong inverse relationship exists between educational attainment and age at first sex, especially for women. Women aged 15-24

Figure 3.6: Youth HIV Prevalence, by Sex and Age, 2007/08



Source: DHS surveys for 1991, 1996, 1999 and 2004/05.

[23]Little information is available on homosexual transmission, and transmission through blood and injection materials.
[24]Monitoring and reporting on Health Sector Response to HIV/AIDS (MoHSW, Universal Access Report, 2008) show that there were 127,920 estimated number of HIV positive pregnant women in 2008.

with no education were over five times more likely to have had sex before age 15 (21.5%) than those with secondary education or higher (4.0%).

Overall, 39% of young women and 42% of young men aged 15-24 years had comprehensive knowledge of HIV/AIDS in 2007/08, down from 44% and 49% in 2003/04. Comprehensive knowledge of HIV/AIDS increases both with educational attainment and household wealth. For both sexes, individuals with secondary education or higher are three times more likely to have this knowledge compared with those with no education, and women in the highest wealth quintile are twice as likely to have comprehensive knowledge as those in the lowest quintile. Overall, 41% of young women and 23% of young men did not know where to get a condom, a slight improvement since 2003/04 figures of 48% and 28% respectively. Knowledge of a condom source is lowest among the poorest youth (TACAIDS et al., 2005, 2008).

Care, Treatment and Support for People Living with HIV/AIDS

Estimates from end of 2008 suggest that 154,468 adults and children with advanced HIV infection were receiving ART at that point in time (i.e. current users). Of these, 8% were children under 15 years of age.[25] Two-thirds of people accessing care and treatment clinic services are women (TACAIDS, 2008b). By the end of 2006, about 50,000 PLHAs were receiving home-based care services, out of the 320,000 who are reportedly in need (MoHSW, 2007a).

B. Building Blocks for a Strategy

Key Programmes[26]

National Scale-up Plan for Prevention of Mother to Child Transmission (PMTCT)

The first five pilots of PMTCT services were launched in 2000 with support from UNICEF. By September 2007, PMTCT services had scaled-up to 1,347 health facilities or 25% of facilities providing ANC services. The proportion of pregnant women tested and counselled increased from 6.6% in 2004 to 31.7% by September 2007. Uptake of HIV testing in health facilities offering PMTCT services is high, with 85% of pregnant women attending antenatal care tested in the period January-September 2007. However,

National laws and policies

The **National Policy on HIV/AIDS 2001** upholds rights for people living with HIV (PLHAs), including non-discrimination, equal protection, and equality before the law; the highest attainable standard of physical and mental health; equal access to education; and social security (PMO, 2001). Key national bodies include the National AIDS Control Programme (NACP) within the MoHSW, set up in 1987, and the Tanzania Commission on HIV and AIDS (TACAIDS) established in 2001 to provide strategic leadership and to coordinate the national response. TACAIDS is positioned under the Office of the Prime Minister. **The HIV and AIDS (Prevention and Control) Act 2007** was enacted in February 2008, though its implementation is doubtful.

The **National Multi-Sectoral Strategic Framework on HIV/AIDS (NMSF)** operationalises the national policy. The second NMSF on HIV/AIDS (2008-2012) enumerates four goals to reach by 2012:

1. Create a political, social, economic and cultural environment for the national response to HIV based on a human rights and gender-sensitive approach with transparency and accountability at all levels, broad public participation, and empowerment of PLHIV, women and youth;
2. Reduce HIV transmission in the country;
3. Reduce morbidity and mortality due to HIV and AIDS;
4. Improve the quality of life of PLHIV and those affected by HIV and AIDS, including orphans and other vulnerable children.

The NMSF stresses the need to increase HIV prevention efforts, in particular in the younger generation (10-24 years of age) (PMO, 2007).

A draft National HIV Prevention Strategy is now in place (Mujinja et al., n.d.).

[25] Monitoring and reporting on Health Sector Response to HIV/AIDS (MoHSW, Universal Access Report, 2008)
[26] Information about the MVC programme, which is coordinated by the Department of Social Welfare and addresses aspects of impact mitigation for children affected by HIV and AIDS, is included later in the report, in the section on social protection.

Nevirapine (NVP) prophylaxis coverage of PMTCT has been quite low – only 55% of women found to be HIV-positive received anti-retroviral (ARV) prophylaxis. Extrapolating these data nationally, roughly 28% of the estimated HIV-infected pregnant women received ARV prophylaxis (NACP, MoHSW, 2007). It is noteworthy that rural women are four times less likely to be offered HIV testing and counselling during antenatal care than urban women.

In response to an IATT JointTechnical Mission in 2006, a National Scale-up Plan[27] was established in 2008 to: increase facility coverage through integration of PMTCT services into routine reproductive and child health services in hospitals, health centres and dispensaries; routinely refer HIV-positive mothers to care and treatment centres; provide ARV prophylaxis to 75% of all HIV-positive pregnant women who are not eligible for anti-retroviral therapy (ART); and to follow up babies of infected mothers, including providing access to paediatric AIDS care. The programme is being led by NACP with UNICEF, WHO and the Clinton Foundation. The NACP seeks to reach 1.4 million pregnant women and 96% of HIV-positive pregnant women by 2012. The Ministry is looking to mainstream community IMCI with a potential to integrate PMTCT, and an integrated phased decentralisation of PMTCT and ART services (MoHSW, 2007a).

Education Sector Strategic Plan for HIV and AIDS (2003-2007)[28]

The plan and guidelines were developed by the Ministry of Education and Vocational Training (MoEVT) to implement comprehensive HIV and life skills training in schools and teachers' colleges (PMO, 2007). Recent MoEVT data indicate that 75% of schools are providing life skills-based HIV education (TACAIDS, 2008b). In many of these schools, 'carrier subject' teachers have been trained, but manuals and teaching materials are insufficient and the quality of teaching varies considerably. Although peer education is conducted in some schools, it appears to be limited to those schools with external NGO support.

Prevention Interventions and Youth-Friendly Health Services

A significant number of civil society organisations have implemented HIV prevention interventions aimed at young people – through a mix of peer education and educational entertainment programmes, skills building, contraceptive promotion and distribution, and capacity building of health facilities to provide quality, gender-sensitive, youth-friendly services (JSI, 2007; PMO, 2007). The programmes aim to empower young people with knowledge and practical skills about sexuality, to encourage adoption of attitudes and practices (for example, delay in sexual debut, reduction in the number of sexual partners, and contraceptive use) to protect against HIV-infection, and to utilise reproductive health services. Altogether, around 10% of 15-24 year olds in 19 districts have been reached (PMO, 2007).

However, information, education and communication (IEC) and behaviour change communication (BCC) interventions targeting young people are inadequate. Coordination between partners is weak at all levels, and the majority of IEC interventions use ineffective communication channels. Major constraints include limited skills in developing balanced and culturally-sensitive messages and poor availability of providers with relevant skills. Prevailing cultural and societal pressures, gender roles and religion beliefs, severely impact the success of communication activities.

Especially in rural areas, access to free condoms must be improved through channels and outlets beyond public sector health facilities. Access to female condoms is a challenge primarily due to their high cost, while youth access to condoms through health facilities seems to be restricted. Additionally, myths and misconceptions surrounding HIV/AIDS and condoms persist, especially among some religious

[27]A five-year scale-up plan for PMTCT/Paediatric AIDS (2009-2013) was launched in April 2009; roughly USD 240 million will be required for the scaling-up the specific activities (MoHSW, n.d).
[28]A new draft Education Sector Strategic Plan for HIV/AIDS (2008-2012) has been developed and will be disseminated soon. The Plan is based on NMSFs four thematic areas to strengthen the sector's response to HIV/AIDS.

groups. Condom use also needs to be promoted for couples both outside of marriage and within marriage, especially if HIV status is unknown.

Sexually Transmitted Infection (STI) Control and Case Management

Significant progress has been made in expanding services for STIs. By the end of 2006, services for STI syndromic management were available in all public hospitals, all health centres and about 60% of dispensaries. Some FBOs and NGOs, including private health facilities, also provided services. From 2003 to 2006, the reported number of patients with STI cases diagnosed and treated in health facilities had doubled – more than 400,000 patients in 2006 compared to 223,000 in 2003 (MoHSW, 2007a). Compared to men over 25, young men have a much higher self-reported rate of STI (or symptoms of an STI) (Family Health International (FHI), 2006). Despite progress, quality STI services are still lacking in many remote rural areas. The most recent 2006/07 HIV/AIDS Public Expenditure Review reports "worrying shortages" of drugs for STIs (TACAIDS, 2008a).

Voluntary Counselling and Testing (VCT)

Voluntary counseling and testing (VCT) is a mainstay of HIV/AIDS prevention and treatment. Integrated VCT can contribute effectively to detection of HIV cases because patients attending health facilities have a higher chance of being HIV-infected. In addition, the linkage to care and treatment is strengthened. Recent reports suggest phenomenal progress in HIV testing following a national HIV testing campaign inaugurated by President Kikwete in mid-July 2007, with 1,981 VCT sites operating by November 2007, and 3.2 million people tested by end of December 2007 – 78% of the targeted number of 4.2 million by end of 2007 (TACAIDS, 2008b).

However, the 2006 Tanzania Service Provision Assessment found that among facilities with an HIV testing system, only one in six offered youth-friendly testing services (NBS & Macro, 2007).[29] Expansion of youth-friendly VCT is critical as data show that youth are particularly vulnerable to poor sexual and reproductive health outcomes – youth account for almost two-thirds of all new HIV infections, and nearly half of all maternal deaths in Tanzania occur in young women (15-24 years) (FHI, 2006).

National Care and Treatment Plan (2003-2008)[30]

Phased initiation of ART was implemented beginning with referral hospitals and followed by regional and district hospitals and private hospitals throughout the country. As of September 2007, 230 care and treatment clinics had been established. However, the majority of the rural population has limited access to ART. The plan is to scale-up access to primary health facilities and make ART accessible to all in need by 2012. The plan also includes building the capacity of health facilities and community members to provide home-based care services to PHLAs in all districts. Around 70 districts (out of 133) have trained HBC facility focal persons (MoHSW, 2007a).

Financing and Partners

The Multi-Sectoral HIV and AIDS Public Expenditure Review 2006/07 shows that resources committed to HIV/AIDS have grown at an extraordinary rate in the last five years. From 2001/2002 to 2006/2007, the annual budget increased from TShs 17 bn to over 399 bn (US$ 333 million) (PMO, 2007; TACAIDS, 2008a). Estimates for 2007/2008 show HIV/AIDS funding at TShs 596bn (US$ 496m)[31], and the level of support is likely to be sustained around this level for the next few years.

Spending on HIV/AIDS represented less than 3% of all foreign grants and loans in 2002/03, 15% of external assistance in 2005/06, and a staggering one-third of all aid to Tanzania in 2007/08.[32] ODA support for HIV/AIDS represents over 95% of total HIV/AIDS expenditure. The increase in funding comes from off-budget sources. Compared to 47% in 2005/6,

[29]The survey defines a facility as having a testing system if the facility either conducts the test (on site or in an affiliated laboratory), or the test is conducted elsewhere and there exists a system such that test results get back to the facility for follow-up with the client.
[30]A revised Health Sector HIV/AIDS Strategy II (HSHSP II, 2008-2012) is in place with a new target – 60% of all eligible persons put on ART and 20% of patients on treatment are children (MoHSW, 2007a).
[31]The total expenditure is an under-estimate as it does not capture significant spending on HIV/AIDS financed from the health basket and from Local Government's own revenues. It also excludes the 40% share of staff costs estimated to be accounted for by HIV/AIDS, as well as any share in the capital costs of hospital beds and other families.
[32]IMF ODA data (quoted in TACAIDS, 2008a), using an exchange rate of $1= TShs 1,200.

Table 3.2: HIV/AIDS Expenditure and Financing, 2004/5-2007/8, TShs Billion

	Actual 2005/6	Budget 2006/7	Actual 2006/7	Budget 2007/8
Estimated Total Public + Donor Expenditure on HIV/AIDS	226.0	354.9	399.2	595.7
Total ODA for HIV/AIDS	204.2	330.6	377.8	568.2
Expenditure on HIV/AIDS on Budget MDA Recurrent MDA Development -of which, GoT funded Transfers to regions and districts	119.9 21.8 96.9 0.0 1.2	71.7 24.0 36.8 0.3 10.9	62.0 21.4 29.3 0.0 11.3	157.2 21.6 107.0 5.9 28.6
ODA as percentage of HIV/AIDS expenditure	90.4	93.2	94.6	95.4
Percentage of HIV/AIDS ODA included in Government budget	48.0	14.3	10.8	22.8
ODA for HIV/AIDS as a percentage of Total ODA	15	22	25	33
Total HIV spending as a percentage of: Total Govt Spending GDP	 5.8 1.6	 7.4 2.2	 8.3 2.5	 10.9 3.3

Source: TACAIDS, 2008a

only 23% of expected aid for HIV/AIDS in 2007/08 is included in the government budget. This high degree of dependence on external support is worrying and poses a significant challenge for the financial sustainability of the NMSF and scaling-up initiatives. In addition, the magnitude of off-budget financing increases the complexity of national planning.

PEPFAR and the Global Fund to Fight AIDS, TB and Malaria provide the largest share of the financing, accounting for 86% of donor support expected in 2007/08, and may reach more than 90% of the total in 2008/09.

MoHSW and TACAIDS accounted for over 95% of budget and 97% of actual spending on HIV/AIDS in 2005/06. According to the 2006-2007 HIV/AIDS Public Expenditure Review, resources are increasingly being directed towards care and support interventions, accounting for 60-70% of all spending on HIV/AIDS in Tanzania (TACAIDS, 2008a). Care and treatment represented 64% of combined US and Global Fund spending in 2006/07. Prevention was just 15% of total expenditure, and economic and social support about 8%. The high expenditure on care and treatment is attributed to the roll-out of ARVs, including training of health care workers. This is cause for concern, bearing in mind the equally important role of prevention interventions to keep the 94% of Tanzanians who are not infected free from HIV.

These budget allocations are inconsistent with the health sector strategic plan for HIV/AIDS, which proposes that half of the spending will be for care and treatment, 20% for health-related aspects of prevention, and 30% for health systems and facilities improvements. According to the PER, in order to turn the health sector plan into an implementation strategy, a more credible and detailed costing and prioritisation exercise is needed such that stakeholders agree on who will finance what, when, and where.

Although TACAIDS has overall responsibility for coordination, in practice coordination of the health sector is parallel to and separate from the coordination of the multi-sector response. In principle, the overarching framework should be the health sector-wide approach and the annual reviews carried out within the health sector. As it turns out, the specific fora established by the main HIV/AIDS donors are the most important institutions for coordination of health sector HIV/AIDS interventions. This limits the

extent to which HIV/AIDS expenditures are reviewed in the context of overall health sector priorities.

There are continual delays and difficulties in providing timely funding to districts and communities, partly because of complex flows of funding with different reporting obligations. The various multi-sectoral bodies of local authorities remain ill-prepared, insufficiently staffed and ill-equipped to meet their obligations. While the Council HIV and AIDS Coordinator as well as the District AIDS Coordinator of the health sector are in place, experiences from the district response initiatives show lack of integrated planning and execution of district, ward and village level responses to HIV. Non-health and health planning officers appear to be working in isolation both in analysing and monitoring the impact of the epidemic and its implications for development.[33]

The pace of new funding for HIV/AIDS is staggering, far larger than all other public health spending combined, taxing Tanzania's capacity to absorb the dramatic increase in HIV resources. Continuing challenges are posed by the proliferation of coordinating structures and funding mechanisms; lack of convergence of efforts, and the need to strengthen district responses and scaled up prevention efforts.

Overall, progress on health interventions has been better than other aspects of a multi-sectoral response. However, despite numerous efforts and initiatives, the health care infrastructure is currently overstretched in coping with the additional demand for treatment of opportunistic infections and the provision of ART services. The number of patients with HIV/AIDS-related diseases continues to increase steadily, placing a significant burden on health professionals caring for the terminally ill, and on the already overburdened public health care facilities.

Currently, the majority of people in need of services cannot access them, especially the poor and vulnerable groups in rural areas. The NMSF has prioritised prevention efforts towards keeping young people free from HIV/AIDS. But the NMSF is not an operational plan, and a major challenge remains in the implementation of strategies. The uptake of any AIDS-specific service is constrained by the extent of general health service provision and some of the challenges are specific to health systems. A key question is how available HIV/AIDS resources can be used to address existing health system challenges and improve the overall delivery of health care. Given the pervasive presence of poverty, vulnerability and social exclusion, prevention demands that a range of other fundamental issues – gender inequity, social mores, poverty and vulnerability – be tackled as well.

3.1.4 Education

MKUKUTA Goals and Targets

Early Childhood

- Increase in the number of young children prepared for school and life.

Primary and Secondary Education

- Increased gross and net enrolment of boys and girls, including children with disabilities, in primary schools from 90.5% in 2004 to 99% in 2010.
- At least 90% of cohort completes standard VII.
- At least 60% of girls and boys pass Standard VII examinations by 2010.
- At least 50% of boys and girls aged 14-17 years are enrolled in ordinary level secondary schools by 2010.
- 90% of primary and secondary schools have adequate, competent and skilled teachers by 2010.

Complementary Basic Education

- Reduced numbers of young people involved in COBET from 234,000 in 2004/5 to 70,566 in 2007/08.

A. Status, Trends and Disparities in Child Outcomes

Primary school enrolment rates are within reach of the MKUKUTA target. Net primary enrolment among Mainland children is 97.2% in 2008, a very slight decline from 97.3% in 2007 (MoEVT, BEST 2008). Figure 3.7 clearly indicates the significant upswing in primary enrolment rates nationally between 2004 (90.5%) and 2008 (97.2%). According to BEST 2008, there is little disparity between regions – all reporting

[33]According to the NMSF 2008-2012, the application of the "Three Ones Principle" – one agreed HIV/AIDS action framework that provides the basis for coordinating the work of all partners; one national AIDS coordinating authority with a broad-based multi-sectoral mandate; and one agreed country-level monitoring and evaluation system – at district level has proved to be "quite challenging to all actors due to lack of experience in participatory planning and coordination and sharing of responsibilities across sectors" (PMO, 2007).

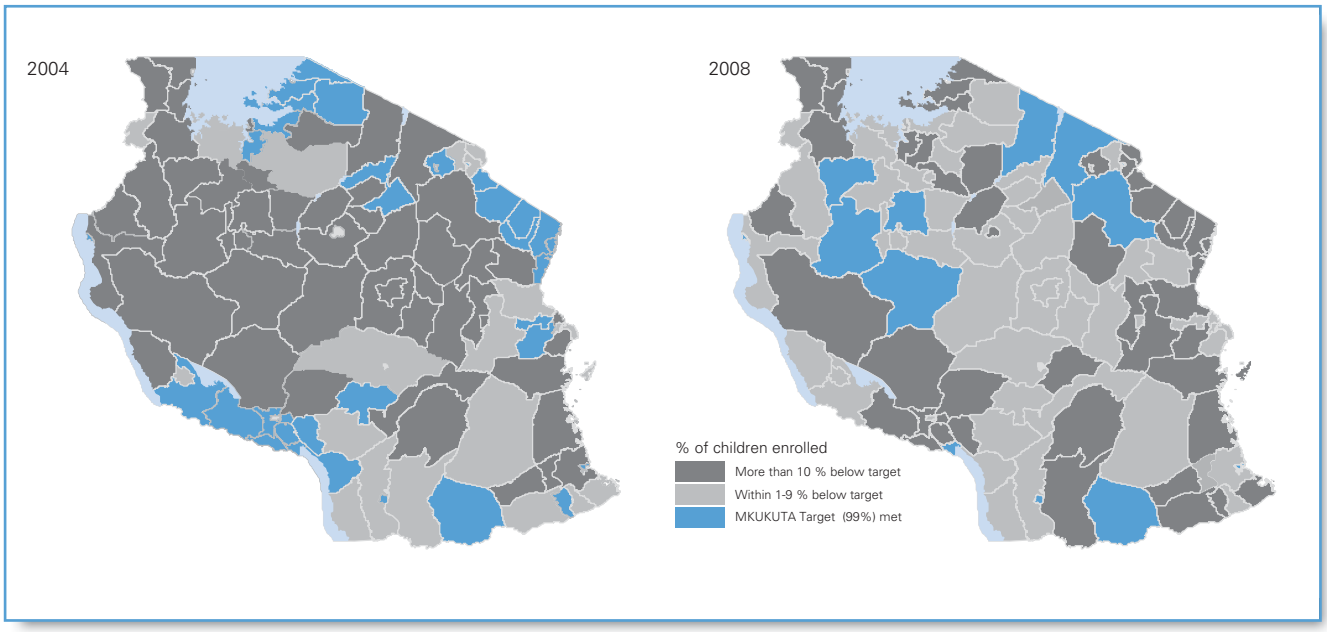
net enrolment rates of over 90% (but disparities may exist between districts). Enrolment ratios for girls and boys are nearly the same, and the gap in educational attainment between girls and boys is narrowing. The difference in median years of education (male to female) declined from 1.8 years in 1992 to 0.8 years in 2004/05 (The New School, 2008). HBS 2007 data also reveal strong improvement in total attendance – from 58.7% in 2000/1 to 83.8% in 2007. In 2007, truancy was noted to be the most common reason (66%), followed by 'other' (15.6%) and pregnancy (5.5%) for dropping out of primary school (MoEVT, 2008).

Of concern is the decline in the quality of primary education – a possible consequence of the rapid expansion of secondary schools and the resultant strains in the system. In 2008, nearly 65% of school entrants had completed seven years of schooling (a decline from 78% in 2007). Compared to 70.5% in 2006, only 54.2% students passed the Primary School Leavers' Exam in 2007. Though the transition rate from Standard VII to Form I has exceeded the MKUKUTA target, the rate is down from 67.5% in 2006 to 56.7% in 2007 (62.5% boys and 45.4% girls) (MoEVT, 2008). Further, 2006 statistics show large gender and regional variations in pass rates – from a low of just under 50% of students in Tabora, to just over 80% in Kilimanjaro; and the pass rates for boys exceeded girls in every region except Kilimanjaro (RAWG, 2007). In Kigoma, Mara, Mwanza and Shinyanga, pass rates for boys exceeded those for girls by more than 20 percentage points. The pupil-teacher ratio has declined slightly, from 53:1 to 54:1; given existing constraints, reaching the MKUKUTA target of 45:1 looks increasingly unlikely.

Through expansion in the number of places at government schools, net secondary enrolment has also expanded quickly from 6% in 2002 to 21% in 2007, though the number of students selected to Form I in secondary schools ranges from 40.7% in Dodoma region to 73.1% in Kagera region. At entry into secondary school, the parity in enrolment rates between girls and boys starts to falter, and by Form V, girls comprise only 40% of all pupils. The challenge is how to improve access to secondary education, meet the MKUKUTA target of 50% net enrolment rate without straining the system further, and without compromising on the quality of primary and secondary education.

Reasons for lack of attainment by girls compared with boys include lack of female teachers as role models, poor classroom dynamics, poor hygiene facilities for girls and, in some parts of the country, less interest in

Figure 3.7: Net Enrolment Ratios in Primary School, by District, 2004 and 2008 (% of children enrolled)



Source: MoEVT, 2008 – BEST Regional Report

schooling the girl child than the boy. Notably, there is no specific education policy in education to address gender issues.

The TDHS 2004/05 showed that a substantial percentage of children in the poorest quintile and in rural areas were still not attending primary school, and that a poor child had a close to zero chance of attending secondary school. Net attendance among children in the poorest quintile was 58%; while net attendance for the least poor (mostly urban) quintile was 88%. Rural net attendance was just under 70% and urban just over 85%. Enrolment and attendance in secondary schools was largely a matter of income and locality. Whilst children from the highest income quintile had a 23% net attendance rate, (25% for boys and 21% for girls), for the lowest income quintile it was 0.4% (0.5% for boys and 0.3% for girls). HBS 2007 data show that children from poor families have benefited from the recent expansion of secondary schools, but remain under-represented, possibly because they are unable to pay school fees and few scholarships are available.

Children with disabilities are also unlikely to be enrolled in school.[34] Current data for Mainland Tanzania reveal that pupils with disabilities enrolled in primary schools increased from 24,003 in 2007 to 34,661 in 2008 (MoEVT, 2008).

There has been steady progress in pre-primary net enrolment rates in government pre-primary facilities from 25% of 5-6 year olds in 2004 to 36% in 2008, ranging from 16% in Dar es Salaam to 63% in Manyara (MoEVT, 2008). However, many more children (68,574) accessed non-government schools. Gender differences in the NER are relatively small, at less than 1%.

B. Building Blocks for a Strategy

Key Programmes

Besides the two 'comprehensive' mainstream education programmes, PEDP and the Secondary Education Development Programme (SEDP), this section focuses on two approaches with particular potential to address child poverty: early childhood care and development/ pre-primary schooling, and the Complementary Basic Education and Training (COBET), known usually by its Kiswahili acronym, MEMKWA.

National laws and policies

Education and Training Policy (ETP) (1995)

The overarching policy objective is education for all, with emphasis on provision for the vast majority of children. Given the focus on the 'greatest good for the greatest number', there is minimal consideration for the 'hard to reach', whether due to poverty or other forms of marginalisation and vulnerability. It is noteworthy that one single paragraph in the entire ETP is devoted to the educational needs of disadvantaged social and cultural groups.[35]

Since 2000, the ETP has been operationalised through development programmes, and implemented through the collaboration of relevant ministries. The lead role is vested in the Ministry of Education and Vocational Training (MoEVT), which sets policy, regulation, standards, and ensures quality control and assurance (though inspection).

Education was identified as a priority sector under Tanzania's first Poverty Reduction Strategy (PRS) and the lion's share of debt relief funding in education went into the Primary Education Development Programme (PEDP 2002-06). The responsibility for delivery of basic education lies with local government authorities.

[34]The 2002 population census reported 2% population with disabilities (NBS, 2006) compared with the WHO estimate of the rate of disability in the general population of 10%.

[35]'Disadvantaged Groups: Despite all efforts to make education accessible, certain groups of individuals and communities in society have not had equitable access to education. . . . Some have not had access to this right due to their style of living, for example, hunters, gatherers, fishermen and pastoralists; others on account of marginalisation e.g. orphans and street children, still others on account of their physical and mental disabilities, such as the blind, the deaf, the crippled and the mentally retarded. . . . Therefore, 3.2.3 Government shall promote and facilitate access to education to disadvantaged social and cultural groups' (ETP, p. 18).

Pre-Primary Schooling and Early Childcare and Development (ECD)

Currently the needs of the youngest children are divided among different ministries: the Department of Social Welfare in MoHSW has jurisdiction for day care centres for two-six year olds; the MoEVT runs pre-primary education for five and six year olds attached to primary schools; and the Ministry of Community Development, Gender and Children is the coordinating body for early childcare and development, responsible for setting guidelines and standards and for leading the development of a national policy on ECD. Net enrolment rates in pre-primary is an official MKUKUTA indicator, but there is no specified goal to be attained by 2010.

Despite the laudable effort undertaken by the government, the ECD programme faces many challenges, among them lack of trained and skilled teachers, unequipped classrooms, and lack of developmentally appropriate curriculum. Early childhood provision tends to be implemented as starting the Standard one curriculum earlier – readying children for Standard one, rather than meeting the developmental needs of children at a younger age. Hence potential opportunities to address inequalities faced by children at birth are lost. Children who do not access pre-primary are often from poorer families, who anticipate their children to be in school from age seven, but who do not understand the value of an earlier start. School fees of any kind, including for meals, can prohibit poor parents from sending children to school. However, these kinds of services would contribute to more holistic development of the young child and, in the medium term, better educational and other outcomes for poor children.

Primary Education Development Programme (PEDP)

The PEDP is implemented largely through a 'one size fits all' service delivery model. The programme abolished school fees and other mandatory contributions tied to enrolment and attendance. As a result, primary school enrolment almost doubled from five to eight million children between 2002 and 2008, demonstrating that poverty impacts children's right to education. Quality improvement is supported through capitation grants to support the purchase of textbooks and other teaching and learning materials, as well as to fund school repairs, administration materials and examinations. In addition, development grants have been provided for the construction of school buildings and the purchase of furniture. Between 2002 and 2006, 41,000 new classrooms were built, and the number of teachers increased by 50% from 100,000 to 150,000. However, a major financing gap exists between PEDP costed plans and actual budget allocations. Given such under-financing, the plan is not realising its full potential to address child poverty.

Achieving the last few percentage points in net enrolment will be a bigger challenge than achieving the initial surge at the start of PEDP, since it implies enrolling the hardest to reach children at the appropriate age. On-going challenges are meeting the needs of those 'disadvantaged groups' (such as the disabled, and children from pastoralist and hunter-gatherer communities) for whom the 'one-size-fits-all' model does not work, providing education of a sufficient quality to retain children in school, and ensuring that disadvantage from children's home background, particularly poverty, does not interfere with their education. All schools are meant to enrol children with disabilities, but it is unclear how many have adequate facilities such as ramps and special toilets.

Cost remains a significant issue underlying disparities. The *Views of the Children survey*, carried out in 2007, noted that financial contributions were expected in all the schools surveyed, and that children were being excluded for non-payment of expected contributions (RAWG, 2008b). 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 reported 'lack of school needs' (MoEVT, 2006, 2008) – meaning shoes or writing equipment that parents are usually expected to provide.

In theory, procedures are in place at community level for obtaining exemptions from costs. However, some poor households are denied support on the basis that both parents are alive and able-bodied. Currently no government funding is available to support school meals. Rather, the initiative is left to village governments and school committees to raise contributions in cash and kind, generating further

problems for poor households. Where meals are provided in school, attendance goes up, as does performance of pupils (Maarifa ni Ufunguo, 2008). Many children, especially from poorer households, go to school without breakfast, or with only tea with no milk, and are so hungry that they fall asleep in class, or are not meaningfully engaged in learning.

More children are completing the primary cycle at an earlier age (around age 13) than ever before, and for a majority this will be the end of their formal education. Parents express concern about their children having nothing to do (too old for school, too young for work), spending their time loitering or drifting to towns, and eventually getting into trouble. Many children express an interest in skills training, for example to become *fundi* (craftsmen), but the rate of expansion in vocational training is much smaller than the expansion in the number of school leavers. Informal apprenticeships to local *fundi* rely on parental contacts, as well as ability to pay. At the end of the training, parents also need to have funds to set the child up with 'tools of the trade'.

Secondary Education Development Programme (SEDP)

Following on from PEDP's success in increasing the numbers of children enrolled and retained in school to the end of their primary course and passing the PSLE, there was increased demand for provision of secondary education. The SEDP is aiming to increase by about five-fold the number of children joining secondary school. However, there are difficulties in determining progress towards SEDP goals because of the lack of a consistent comprehensive set of targets (HakiElimu, 2007a). Even if the plan succeeds in full, only half of Tanzania's children will be able to access secondary education, and those most likely to benefit are from better-off households living in parts of the country where there is a tradition of prioritising education.

SEDP has recognised the disparities in income and locality, and specific measures, in particular bursary provision and the construction of secondary schools in each ward (as opposed to urban centres), have been taken to try to improve access to secondary schooling. Still, post-primary education faces many challenges. Will the rapid expansion of secondary schools provide quality education delivering the kind of skills and capacities to help lift individuals and their families out of poverty? Recent research suggests problems in the costs charged to students, late arrival of bursary money resulting in children being sent home from school, and contributions to pay for secondary school construction being expected from all community members regardless of ability to pay – amounting to a kind of regressive taxation not unlike the Universal Primary Education fee of the 1990s (Maarifa ni Ufunguo, 2008).[36]

Complementary Basic Education (COBET)

The original vision for COBET 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 IV and PSLEs. The programme was initially supported by UNICEF in five pilot districts targeting children aged 8-18 years, but was adopted by government as part of the first phase of PEDP. COBET sought to catch a 'missing generation' of potential students who under the former 'cost sharing regime' had been excluded from schooling due to inability to pay fees, disability, distance to schools or other reasons.

A tracer study of COBET graduates in six districts found that achievements were limited and varied markedly. For example, no COBET learners in Bagamoyo or Hai districts were registered for Standard IV and PSLE examinations, whereas in Temeke district, 354 students sat the Standard IV exams, with 39 being mainstreamed into Standard IV and 315 mainstreamed into Standard V (MoEVT, 2007c). However, the study records no children mainstreamed into vocational provision (Maarifa na Ufunguo, 2008).

The principal challenges are funding, a lack of skilled facilitators and educational materials to meet the needs of 'hard to reach' or reluctant learners, and a lack of priority accorded the programme at central, district and school levels. Currently, districts are expected to meet their programme costs as the PEDP capitation grant does

[36]Charges beyond fees include excessive cost for uniform which can only be purchased from the school, including compulsory purchase of two school ties for Tshs 4,000, and an identity card which is not laminated, and for which the student has to provide the photograph. Poorer community members draw the conclusion that secondary schooling is still not for them, and that despite having contributed in cash and kind for the construction of the school, their children will not attend (Maarifa ni Ufunguo, 2008).

not apply to COBET learners. Despite the fact that many children were not in school due to poverty, they were expected to make financial contributions all the same (MoEVT, 2007c). Even where COBET is implemented with commitment and in the best interests of children, the focus remains on the flagship programmes of PEDP and SEDP, where the largest gains are to be made in reaching MKUKUTA goals.

Financing and Partners

A substantial increase in funding for education has occurred since 2003/04, both in nominal terms and as a percentage of the total budget. There was a surge in the share of the budget for primary education from 2001/02, associated with the launch of PEDP – though allocations for primary education had already been high since the mid-1990s. The overall decline in the share of the budget going to primary education since 2004/05 (49% in 2007/08 down from 63% in 2004/05) coincides with the launch of SEDP. Despite the importance of sufficient teachers of adequate quality, which underpins both programmes, teacher education is receiving a reduced share of the budget (1.7% in 2007/08).

However, according to the 2007 PEFAR study, public expenditure on education is subject to an intricate circuit of disbursement involving several MDAs (PMO-RALG, MoFEA and MoEVT) and the regions (PEFAR, 2007). Figure 3.8 clearly illustrates the acute lack of clarity and transparency in financial flows between central government, districts and schools. Existing documents do not allow reconciliations to be carried out between approved budget allocations and actual disbursements to districts, and disbursements to final beneficiaries. The complexity is amplified by the lack of harmonisation in the conditions for disbursement. For example, the formula for education block grants differs from PEDP capitation grant policy.

Not unexpectedly, therefore, planning and budgeting at the local level is highly problematic. Districts and schools are not well informed about what funds will be forthcoming from national level, and tend just to be grateful for, and re-plan with, whatever they receive, whenever it is received. Programme design is too often unrealistic, based on improbable budget allocations, so implementation does not take place as planned.

Table 3.3: Trends in Government Budget Funding for Education, by Level, 2003/04-2007/08 (million TShs)

	2003/04	2004/05	2005/06	2006/07	2007/08
Primary Education	146,145	385,542	390,974	491,243	544,220
Secondary Education	32,184	91,481	104,483	119,987	174,227
Vocational Training	3,650	4,672	8,926	10,654	18,978
Teacher Education (MoEVT)	12,371	5,653	8,540	10,438	19,257
Administration	20,379	21,926	27,597	45,769	30,405
Folk Development	1,833	1,506	2,360	2,568	3,132
University Education	69,254	73,175	118,359	181,784	264,343
Technical Education	6,342	6,618	11,131	14,493	14,289
Other Tertiary	15,554	15,576	20,186	21,497	29,343
UNESCO Commission–MoHEST	260	280	383	322	381
Science and Technology-MoHEST	2,215	1,990	3,254	5,535	5,134
Administration – MoHEST	8,070	2,252	4,932	7,726	3,729
Total Education	318,256	610,671	701,124	912,015	1,107,437
Percentage of total Govt Budget	**12.6%**	**18.7%**	**17.4%**	**18.8%**	**18.3%**
Total Government budget	2,516,900	3,257,600	4,035,100	4,850,600	6,066,800

Source: Assad and Kibaja, 2007.
Note: Published Government figures do not disaggregate between pre-primary and primary, and between lower and upper secondary.

The absence of a holistic financing picture for the education sector reflects the weaknesses of inter-ministerial coordination, and has been a major obstacle to efforts to strategically allocate resources between sub-sectors.

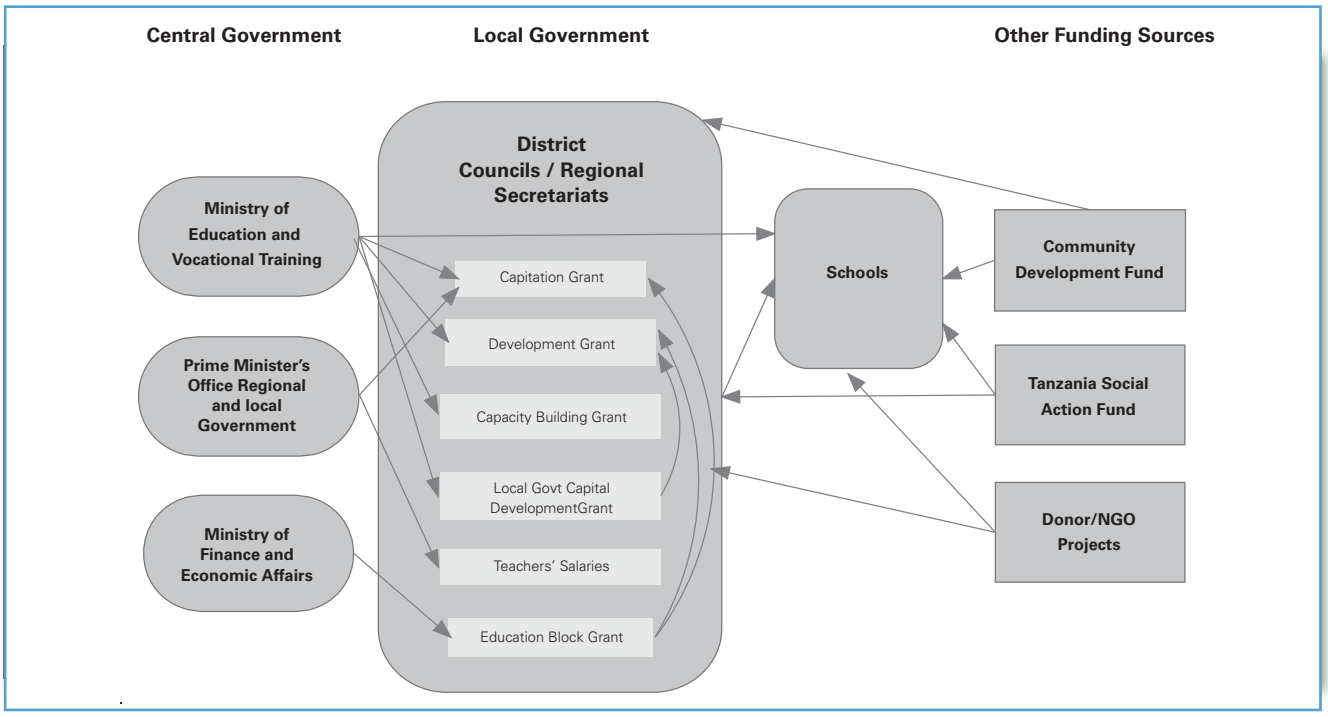
A recurring theme is the need to balance comprehensive provision to meet the needs and rights of the majority with access to quality education for the poorest, most vulnerable and marginalised. The fully-costed plans of PEDP and SEDP would make meaningful in-roads into child poverty if implemented in full, but requisite financing is not made available. Arguments about resourcing tend to be couched in terms of re-allocation between different sub-sectors of education, rather than making the case for more education funding at the cost of unproductive expenditure.[37]

Outside the mainstream, there is inadequate policy and use of monitoring indicators to support analysis and provision of programmes for children in need of special support. Indicators in the key performance assessment frameworks, which trigger funding especially from General Budget Support, do not look beyond overall national figures to disaggregate by gender, geographic location, or parental income. There are no specific policies to support gender equity or the needs of nomadic and semi-nomadic learners.

Approaches that are key to a child's survival in school and acquisition of useful skills are delegated to a level 'below the radar' – not visible from national level and often not adequately followed up at local level. Examples include: i. school meals which are left to communities to provide for, ii. support for slow learners or children with difficulty fitting into mainstream schooling, where much depends on the goodwill of individual teachers, and iii. leaving councils to fund COBET out of their own resources.

Finally, progress in providing quality education services for all children is integrally connected with local government reform: strengthening the capacity of education personnel and coordination of government systems to plan, budget and deliver

Figure 3.8: Flows of Primary and Secondary Education Funds



Source: Carlitz, 2007

[37]Examples here could include income forgone through provision of tax and other incentives to direct foreign investment, and other education expenditure which is subject to 'elite capture' such as higher education loans, or secondary education exemptions.

sufficient and equitable funding within the sector, monitor and report on status and achievements, and ensure community and stakeholder confidence in these systems. Proposals for budget allocations are beyond the likely budget ceilings. Annual review reporting strengthens year on year, but does not yet specifically address equity issues. Local government lack financial capacity, and their ability to design and deliver approaches to meet the needs of a diverse population is underdeveloped.

3.1.5 Child Protection

MKUKUTA Goals and Targets

- Reduced proportion of children in labour country-wide from 25% to less than 10% by 2010, and avail to them alternatives including enrolment in primary education, COBET and employable vocational education skills training.

A. Status, Trends and Disparities in Child Outcomes

Child protection generally refers to interventions and services aimed at ensuring the safety and welfare of children against violence, abuse, neglect and exploitation. At root are the prevention, response, rehabilitation and recovery of the child who suffers or is likely to suffer significant harm. For the purposes of this report, a child is considered as suffering or at risk of suffering significant harm when the actions or omissions of others (individual or institutional) result in a detrimental impact on the child's physical, psychological and emotional development. Many of these issues are not easily captured quantitatively, and data are lacking in Tanzania to assess the extent to which children are nurtured and protected.

Six issues relevant to child protection are explored here: living arrangements, birth registration, child labour, child abuse, early childbearing, and juvenile justice.

Living Arrangements

Much of the care and protection of children, especially of young children, takes place in the family. Families form the first line of defence for children; the further away children are from their families, the greater their vulnerability.

However, a substantial proportion of children in Tanzania live apart from their parents, and this proportion increases as children reach primary school leaving age (see Table 3.4). By the age of 10-14 years, just over half of all children are living with both parents (51%), and by 15-17 years, this proportion has fallen to 45%. Similarly, the percentage of children who do not live with either parent increases with age: 22% by 10-14 years of age, and 31% by 15-17 years of age.

Table 3.4: Children's Living Arrangements, by Age, 2007/08

Age	Children living with both parents	Children not living with a biological parent
0-4 yrs	72.3	7.1
5-9 yrs	59.8	17.0
10-14 yrs	51.2	22.3
15-17 yrs	45.3	30.7
Total <18 yrs	60.0	16.6

Source: THMIS 2007/08

Birth Registration

The THMIS 2007/08 estimated that only 20.1% of births in Mainland Tanzania are registered, a marginal increase from 17.6% in 2004/05. Registration of urban births (48%) is almost three times higher than rural births (16%). This is partly a reflection of the much higher proportion of urban births that take place in health facilities. Possession of birth certificates is lower still. Only 6% of children under five years had a birth certificate (rural 5%; urban 23%). Marked disparities persist in birth registration by region and household wealth status. Registration rates range from under 5% in Tabora and Manyara to 75% in Dar es Salaam. Children in the highest wealth quintile are six times more likely to be registered (60%) than children in the lowest quintile (10%).

Child Labour

The Integrated Labour Force Survey 2006 found that over one-fifth (21%) of all Tanzanian children aged 5-17 years are engaged in child labour – work which is either time-excessive (assessed on time spent in work by age) or in hazardous occupations (for example, miners, chemical or metal processing,

house girls/boys, construction labourers, etc.). Data revealed that:

- Child labour in rural areas (25%) is over three times higher than urban areas (8%).
- Older children are more likely to be involved in child labour: 32% of boys and 27% of girls aged 14-17 years.
- For all age groups, boys are more likely than girls to be working as child labourers: 23% of boys compared with 19% of girls aged 5-17 years are engaged in child labour (NBS, 2008a).

The common pattern of child labour, especially for rural children, is work on the farm and in domestic chores, which is considered by many adults to be part of normal socialisation, as well as contributing to the household economy. Nonetheless, farming and domestic work can be hazardous: 38% of working girls and 36% of working boys frequently or sometimes carry heavy loads; 38% of girls and 34% of boys are exposed to dusts, fumes and gases in their work environment; and 19% of both girls and boys work in an environment with extreme temperatures. Injuries at work are slightly more common among boys (18%) than girls (16%). Overall, more than 60% of all working children are exposed to at least one of these specified hazardous situations.

Table 3.5: Child Labour, Mainland Tanzania, by Sex and Residence, 2006 (% of children)

Residence	Boys	Girls	All
Rural	27.7	22.5	25.2
Urban	7.9	7.5	7.7
Total	23.2	18.9	21.1

Source: THMIS 2007/08

A gender profile in 2006 found that girls are particularly vulnerable to becoming commercial sex workers and domestic workers (TNGP and SIDA, 2006). Girls in domestic work are exploited through working long hours, for little pay or payment in kind, and can be subjected to physical, psychological and sexual abuse by both women and men in the family.

Early Child-bearing

Early child-bearing is associated with increased health risks for both mother and child. Levels of adolescent child-bearing in Tanzania have shown no decline over the last 15 years. Adolescent child-bearing remains common, especially among rural, poorer and less educated women:

- Among all 15-19 year-old female adolescents, 26% (rural 29%; urban 20%) had begun child-bearing, i.e. either had a baby already or were pregnant.
- Nearly one-third (32%) of women aged 15-19 years in the lowest wealth quintile had begun child-bearing, twice the proportion as women in the least poor quintile (16%).
- Only 4% of female adolescents with some secondary schooling had begun child-bearing compared with 43% of female adolescents with no education (NBS, et al., 2005).

Child Abuse and Gender Violence

Unfortunately, many children in Tanzania suffer child abuse, which can take many forms including abandonment, physical abuse, corporal punishment, sexual and gender-based violence, and/or child trafficking.

- Abandonment is the leading type of child abuse in the country (URT, 2006b). The major reasons for abandonment are economic hardship, marital problems, parental death and poor education of parents.
- Many children report physical abuse by adults, including parents and teachers. Discipline at home is frequently meted out with physical chastisement. This practice is socialised – children report being bullied by older children at school or when travelling to or from school (Sokoni and Hambati, 2006). Corporal punishment is still practiced or threatened in schools. A recent study revealed that corporal punishment creates truancy among children because of the fear of being severely punished (Songora and Nsemwa, 2006). In the Views of the Children 2007 survey, children reported that teachers bearing sticks to threaten punishment engendered such fear as to prevent them from learning (RAWG, 2008b).

- Gender-based violence. The TDHS 2004/05 revealed that 42% of men and 60% of women considered it acceptable for a husband to beat his wife in some circumstances, which indicates the extent to which gender-based violence is socially accepted. Alarmingly, the percentages are highest among both young men and women aged 15-24 years (NBS, et al., 2005).
- Forced marriages and female genital mutilation (FGM) still affect many girls. The prevalence of FGM 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 of the most recently circumcised daughters (23%) were reported to have been circumcised before their first birthday, and 17% between one and four years of age.
- The most prevalent type of child trafficking in Tanzania is internal, for exploitation of children in domestic servitude and prostitution (IOM, 2008). Most victims are from rural areas. Dar es Salaam and Zanzibar are the main destination areas for trafficking. Children are usually recruited in rural villages with promises of education and jobs in domestic work by relatives or people respected by their parents/guardians. Trafficking victims are more likely to have been orphaned or fostered, to be a school drop-out, or never have attended school.

Juvenile Justice

The number of criminal cases against young people remanded in the five juvenile homes in the country was 798 in 2003, 913 in 2004 and 847 in 2006. There are substantially more boys than girls in remand. The number of girls in remand has remained more or less stable, ranging from 87 in 2003 to 81 in 2005. Children in conflict with the law suffer violence and abuse in the hands of law enforcers. The Report by the Commission for Human Rights and Good Governance shows that:

- cases involving children are commonly conducted in an open court, and children handcuffed when sent to court or prison
- social welfare officers are not involved
- children under 18 years of age are placed in cells with adults in police stations, remand facilities and prisons (URT, 2006b).

Research for the same report found 22 infants in prisons in 2002/2003.

B. Building Blocks for a Strategy

Key Programmes

The government of Tanzania is implementing two specific programmes which aim to improve child protection: The Time Bound Programme on the Worst Forms of Child Labour and The Vital Registration Programme.

Time Bound Programme on the Worst Forms of Child Labour

In 2001, Tanzania was selected to implement the ILO Time Bound Pilot Project to eliminate the worst forms of child labour, with technical assistance from the International Programme on the Elimination of Child Labour (IPEC) and funding from the U.S. government (US$ 5.4 million for a period of 42 months, ending August 2006). During this initial phase, Tanzania focused on eliminating child labour in the commercial sex sector, mining, abusive forms of domestic work and commercial agriculture in the 11 worst-affected districts. The ILO reports that a total of 20,798 children (12,510 girls and 8,288 boys) were withdrawn from the worst forms of child labour between January 2002 and March 2005 (ILO, 2006). The goal was to have 30,000 children withdrawn by the year 2010. The average cost of withdrawal per child is reported to have been just over $59 (MoHSW, 2008c). Implementation of the second phase of the programme is underway. However, a lower target to reach 22,000 children has been set, due to reduced resources.

The Vital Registration Programme

The Vital Registration Programme seeks to transform birth registration system in Tanzania into a one-stop process where all registration services are provided under one roof. The programme aims to improve access to birth registration and certification – and children's access to basic services by increasing protection mechanisms in line with the CRC. Among its objectives, free certification is to be provided for the most vulnerable children (MVC).

The Vital Registration Transformation Project is being implemented in 13 districts.[38] As part of its phasing

[38]The districts are Temeke, Makete, Magu, Bagamoyo, Hai, Mtwara, Siha, Kasulu, Kiobondo, Ngara, Kigoma, Bukoba Municipal and Mwanza City.

National and international laws and policies

International Conventions

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 2004 and the Optional Protocol on the sale of children, child prostitution and child pornography in 2003. However, provisions of the CRC and Optional Protocols have not yet been incorporated into domestic legislation. Tanzania has also ratified the African Charter on the Rights and Welfare of the Child (ACRWC) (1990), the ILO Convention No. 138 on the Minimum Age for Employment in 1998, and Convention No. 182 on the Elimination of the Worst Forms of Child Labour in 2001. The conventions stipulate that the minimum age for employment shall not be less than the age for completion of compulsory schooling, and call for access to free basic education and vocational training where possible for those removed from worst forms of child labour.

Statutes relevant to Child Protection

Many statutes in Tanzania have provisions for child protection. A review of policies and laws affecting children in Tanzania noted serious inconsistencies, and characterised existing legislation as haphazard and fragmented. In many Tanzanian communities, customary law prevails which may not be in children's best interests (Rwebangira and Mramba, 2007). Current provisions lack precise definitions, are outdated, and do not adequately protect children from violence, abuse, neglect and exploitation. Different definitions of a child are used, ranging from the age of 12 to 18 years: the Penal Code states that a child has criminal capacity at the age of 12 years; the Criminal Procedure Act defines a child as a person who has not attained the age of 16 years; while the labour laws define a child as a person less than 15 years. The Marriage Act of 1971 sets a different minimum marriage age for girls (15) and boys (18). This is in contradiction with the Sexual Offences Special Provisions Act 1998, which considers any act of sex with a female person below the age of 18 years as a criminal offence. Accordingly, under this Act parents can be prosecuted for marrying off their girls at the age of 15 years, while under the Marriage Act they are committing no crime by doing so (TGNP et al., 2006).

A review of legislation affecting children was started by the Law Reform Commission as early as 1986. Despite a protracted delay in domesticating international commitments into national law – a delay of great concern to children's rights activists in Tanzania and one noted by the United Nations Committee on the Convention on the Rights of the Child (Tumbo-Masabo and Leach, 2008) – a decision has finally been made to draft and table a single piece of legislation before the National Assembly that will codify all the rights pertaining to Tanzanian children as well as the roles and responsibilities of various duty-holders in a comprehensive Children's Act.

Customary and religious laws

The Customary Law (Declaration) Order applies to Tanzanians of African descent who are not Muslims in matters relating to marriage, inheritance and succession. Other Tanzanian communities which are not of African origin, such as Hindus, are regulated by their own personal laws, with the exception of those that have been modified by statute such as the Law of Marriage Act Islamic Law remains the personal law applicable to Islamic children for issues that are not covered by the Law of Marriage Act, including succession and inheritance. Islamic Law (as customary law) provides that children born to unmarried couples have no right of inheritance (Rwebangira et al., 2007).

The coexistence of customary laws, religious laws and government legislation complicates administration in the judicial system. Without a unified law to provide a harmonised interpretation, different institutions administer these legal frameworks according to their own standards, which are at times contradictory. Primary Courts give precedence to customary laws based on patriarchal interpretation of gender rights, which favour men (TGNP et al., 2006).

Child Development Policy (2008)

The policy places special emphasis on a child's right to nutrition, health, shelter, education, safety and the right not to be discriminated against. This is in line with MKUKUTA's focus on securing basic welfare rights, equity, non-discrimination, and participation in democratic institutions. The policy has since been updated and a Kiswahili version was publicly released in March 2008.[39] This revised policy stipulates the roles and responsibilities of key stakeholders for childcare and aims to provide an enabling environment for effective implementation of the various programmes for protecting child rights and improving their well-being.

[39] An official English translation is to be released soon (supported by UNICEF).

in, the Registration, Insolvency and Trustee Agency (RITA), with support from UNICEF, is implementing a pilot birth registration project in these districts.

Partners

MoCDGC has responsibility for policy formulation and implementation for child protection and development in collaboration with other stakeholders, as well as design and enforcement of legislation in the best interests of children. The government is currently examining a proposal submitted by MoCDGC to establish a national body to coordinate all matters related to child rights.

The Department of Social Welfare within MoHSW is mandated to facilitate the development of social welfare policies, guidelines and laws, and supervise their implementation; and to monitor, supervise and evaluate social welfare activities nationally, including implementation of the National Disability Policy, the Plan of Action for Most Vulnerable Children, national guidelines for foster care and adoption services, and for children's homes, including institutions for physical or mental disability, psychiatric or other severe illness.

Tanzania has a critical shortage of social workers and probation officers at both central and local government levels. As part of decentralisation to local authorities, social welfare staff are being recruited and trained. At the ward level, para-professionals – retired people, such as teachers, nurses, army officers – are being trained on social welfare, child protection and probation skills, with the aim of having at least one para-professional social worker in each ward. Training has started in the three regions with the highest HIV/AIDS prevalence rates: Dar es Salaam, Mbeya and Iringa. The para-professionals will have responsibility for overseeing MVC Committees in communities, and providing a link between the committees and social welfare officers at the district level.

The Office of the Registrar General in RITA, located under the Ministry of Justice and Constitutional Affairs is the executive agency of the Government responsible for registration of births and deaths. Each district has one registrar. Government reports show that birth registration suffers from lack of resources – staffing, equipment and supplies – and uncoordinated and fragmented organisational responsibilities. A major constraint for rural citizens is the distance and cost of ensuring a birth is registered and a birth certificate issued.

The responsibility for enforcing laws against child labour is primarily that of the Ministry of Labour, Employment and Youth Development (MoLEYD). A Child Labour Unit serves as a liaison between the various government ministries and stakeholders. Labour inspectors from MoLEYD inspect, report and take actions against child labour.

Child protection in Tanzania requires much greater awareness of the rights of children. Though the Government has ratified key international conventions, its commitment and capacity to protect children from exploitation, abuse, violence and neglect is limited. Existing legislation is inadequate and outdated, and enforcement is weak. Contributing factors include official sensitivity to social norms and customs which may not be in a child's best interests, and lack of budgetary provision. A unified statute for children would set the standard for the realisation of children's rights and lay the basis of claims on the state for social protection. In turn, a clearly defined operational infrastructure with adequate financial and human resources is needed to ensure prevention, response and enforcement of child protection.

3.1.6 Social Protection

MKUKUTA Goals and Targets

- Increased number of orphans and most vulnerable children reached with effective social protection measures by 2010.
- 20% of children and adults with disabilities reached with effective social protection measures by 2010.

A. Status, Trends and Disparities in Child Outcomes

Social protection can be considered a set of publicly mandated actions that address risk, vulnerability and chronic poverty (Slater et al., 2008). A comprehensive social protection system for children would, therefore, include all elements of child well-being: adequate nutrition, quality education, appropriate healthcare and child protection.

In the previous section, the analysis focused on measures to prevent or minimise the risk of significant harm to children. In this section, measures to improve capabilities for generating income and to provide income support are examined, with a focus on children who may be deemed to be most in need of assistance. The section also addresses the systemic measures needed to provide a coherent and coordinated set of actions for social protection.

Most Vulnerable Children (MVC)

Poverty, social breakdown and the impact of HIV/AIDS have resulted in an increase of orphans and vulnerable children (OVCs). The 2002 population census showed that nearly 10% of all children in Tanzania had been orphaned – close to two million children. Data from the THMIS 2007/08 estimate that orphanhood has increased to 11%, and that 17.6% of children are OVC (see Table 3.6). Orphans and vulnerable children are more common in areas with high current or past prevalence of HIV/AIDS such as Iringa. Whereas the survey could not assess if orphanhood was due to HIV/AIDS or other causes of death, indirect demographic analysis estimated that 44% of orphanhood in Tanzania was the result of HIV/AIDS totalling about one million children (UNAIDS and UNICEF, 2006).

Analysis of individual data, which applies poverty mapping techniques to the census data, indicates that orphaned children are poorer than children who are not orphaned. No differences were found in household living conditions, however, and orphaned children, overall, tend to be in school at the same rate as children who are not orphaned (Lindeboom et al., 2006). A study of orphanhood in Kagera found that maternal orphans were more likely to be stunted and lose years of education. Paternal orphans were less affected. Older children and those already in school were less likely to suffer from these adverse nutritional and educational outcomes than children who had been orphaned at a younger age and who had not yet started school (Beegle, et al., 2005).

Estimates of the numbers of children who are poor and considered most vulnerable were generated for the costing of the national programme for Most Vulnerable Children. The population census is the most recent data set that provides detailed demographic data as well as information on orphanhood and disability. Poverty and vulnerability were assessed on the household characteristics in which children were living. MVC living in poor conditions were defined as:

- children living in child-headed households, or elderly-headed households with no adult of age 20 to 59 years present
- children with both parents deceased
- children with one surviving parent living in a house with very poor quality roofing (grass and/or mud) – or, in urban areas only, with very poor wall materials or without toilet facility – and children with a disability living in similar poor conditions.

Based on these criteria, the number of MVC in Mainland Tanzania was estimated at 930,000 in 2006, or 5% of the child population (Lindeboom et al., 2007). Of note, the criteria recognise that not all orphaned children are most vulnerable, and that children living with a parent can also be among the most vulnerable.

Table 3.6: Percent of Children Orphaned and OVC in Tanzania, by Age, 2007/08

Age	Orphans	Vulnerable Children	OVC
0-4 yrs	3.2	7.4	9.8
5-9 yrs	9.3	8.5	16.6
10-14 yrs	17.5	9.0	23.9
15-17 yrs	21.7	9.6	28.5
Total <18 yrs	10.8	8.4	17.6

Source: THMIS 2007/08

One group of children who are particularly vulnerable are those with disabilities. Overall, national data sets under-report the population with disabilities – including the 2002 census, which reported that 2% of the population had some form of disability, the most common being physical loss of use of limbs. Preliminary findings from a recently conducted *Disability Survey*[40] reveal that around 2.4 million people (8% of the Tanzanian population) experience some type of activity limitation. The prevalence is lower in Zanzibar (6%) than the Mainland (8%), higher in rural (8%) than in urban areas (6%), and ranging from around 3% in Manyara to 13% in Mara region. There are no gender differences. Detailed findings will provide critical data for development of policies for disabled children.

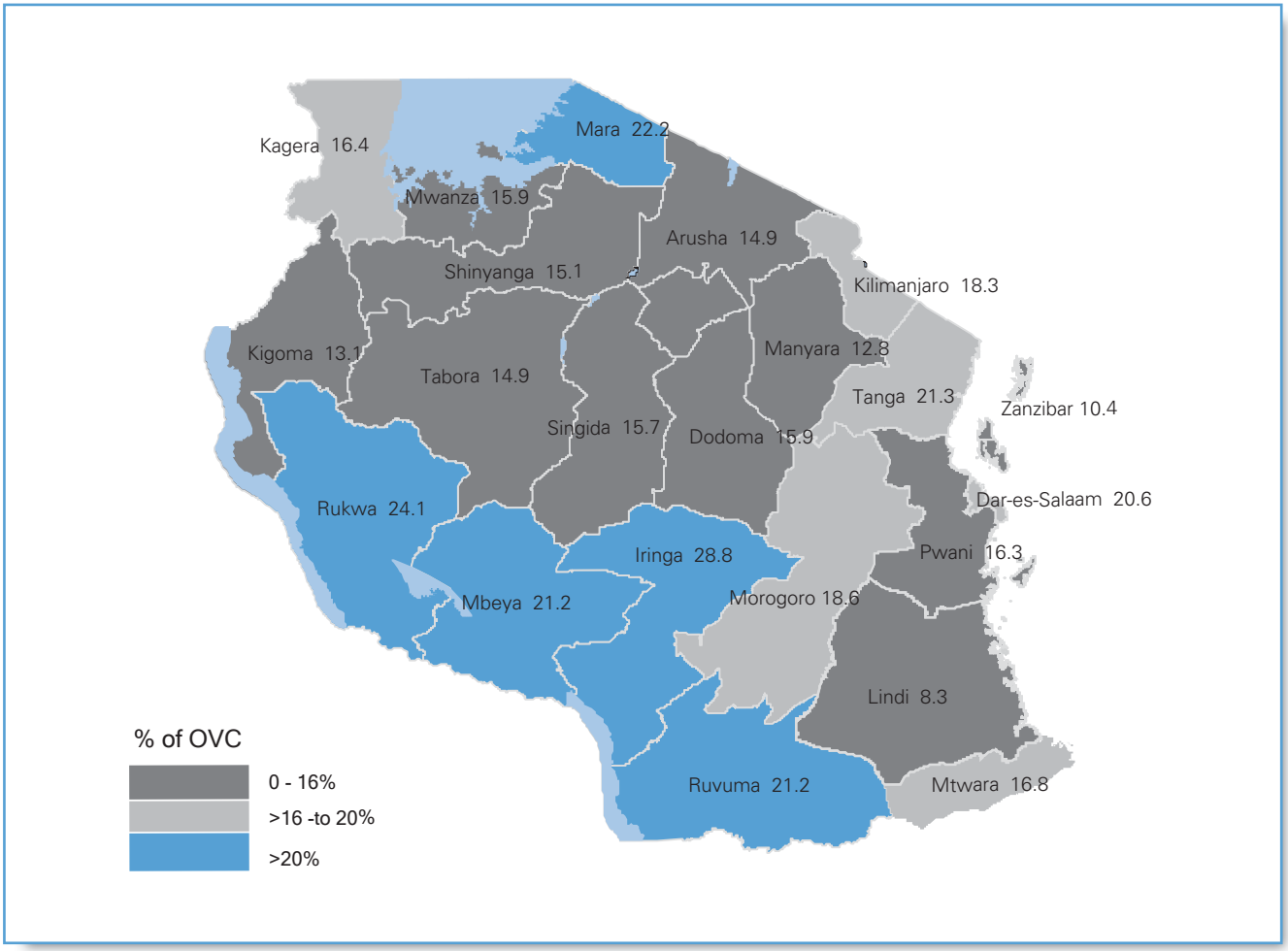
B. Building Blocks for a Strategy

Key Programmes

Tanzania Social Action Fund (TASAF)

TASAF was established by the government in 2000 through a World Bank credit. The first phase of the project (TASAF I) was implemented for four years, covering 40 Mainland districts as well as Unguja and Pemba Islands in Zanzibar. Like other social funds, TASAF is a multi-sectoral programme that provides financing for small-scale public investments that meet the needs of poor and vulnerable communities, with the aim of improving social capital and economic infrastructure, enhancing capacity and skills among rural and peri-urban communities, and creating a safety net for the poorest section of the

Figure 3.9: Percent of Children Orphaned and Vulnerable Children (OVC), by Region, 2007/08



Source: THMIS 2007/08

[40]The survey covered a total of 7,025 households selected from Mainland and Zanzibar – a total of 7,000 households were successfully interviewed (99.6% response rate). Field work was carried out in July 2008; data cleaning and analysis is ongoing (Press release by Minister of Health and Social Welfare on 10 June 2009 in Dodoma).

community through cash transfers in exchange for participation in local public works projects. The public works element of TASAF reported around 110,000 participants by June 2004 (REPOA, 2005). Phase II of TASAF (2005-2009) is funded by the World Bank and the government. By November 2008, USD 120 million (around Tshs 121 billion) had been disbursed[41] from the National Village Fund to respective LGAs in the Mainland, and Unguja and Pemba for implementation of sub-projects at the community level (TASAF, 2008). TASAF II is also piloting a community-based cotshnditional cash

National laws and policies

Social Security Policy 2003
Cluster 2 of MKUKUTA calls for studies on vulnerability and safety nets, as well as pilots leading to the implementation and resourcing of a comprehensive policy on vulnerability and social protection. It also specifically calls for the operationalisation of the Social Security Policy 2003 by developing and implementing a national strategy for social security and protection for vulnerable groups (VPO, 2005).

The policy aims to extend social security to the majority of Tanzanians. It recognised that *"the existing social security system has many shortcomings that include low coverage, fragmentation of legislation, lack of regulatory framework, lack of a mechanism for portability of benefits and inadequacy of benefits provided".*

At that time, only 5.4% of total labour force or 2.7% of the total population was estimated to be covered by the mandatory formal social security. No coverage was available for the estimated 93% workforce in the informal sector, of which 80% were engaged in agriculture (MoLYDS, 2003b).

The policy envisages different strategies – mandatory schemes for all employees in the formal sector and for workers in the informal sector wherever possible, supplementary schemes (such as pensions and health insurance) run by employers and private companies, and means-tested social assistance programmes for vulnerable groups, such as people with disabilities, the elderly and children in difficult circumstances

National Social Protection Framework (SPF)
A national framework was expected to have been approved by June 2008. Developed under the leadership of MoFEA with support from UNICEF, WB, ILO and other stakeholders, it has been awaiting approval by the Cabinet since late 2008. Consistent with MKUKUTA's objective to address vulnerability, the framework envisages a comprehensive set of mechanisms to reduce the risk of all vulnerable members of Tanzanian society – both poor and non-poor. The document conceptualises social protection broadly as *"measures designed to strengthen the response of poor and vulnerable households / individuals, social groups and communities to risks with a view to making them capable of sustaining their livelihoods." Such a system seeks to "address both insecurity of the generally poor people and extreme poverty of the most vulnerable groups. While its primary aim is to reach the most vulnerable and ensure their protection, it is also a means of building the capability of the poor to engage in production"* (MPEE, 2007b). The national focus of social protection has, therefore, shifted beyond responses to single-cause crises to address the structural, multi-causal vulnerabilities that can and do lead to persistent poverty and generalised insecurity.

Other key national policies, systems and strategies relevant to a comprehensive social protection framework
- National Policy for People with Disabilities 2004 aims to promote social and economic opportunities, equity, and services for people with disabilities
- National Employment Policy 2007, National Employment Creation Programme and Youth Employment Action Plan aim to promote full employment
- For agricultural development, the Agricultural Sector Policy (1983) is complemented by the Rural Development Policy (2001), the Sector Development Strategy (2001) and national interventions, such as the Participatory Agriculture Development Project (PADEP), and the Agriculture Sector Development Programme (ASDP)
- The Strategic Grain Reserve (SGR), through which the Government purchases grains for distribution at times of shortage, which are then sold to beneficiaries at a subsidised price. Food aid complements the SGR.[42]

[41] Resources were allocated on basis of a formula that includes population size (40%), poverty counts (40%) and geographical size (20%); 25% of the National Village Fund was first deducted and distributed equally to all councils.
[42] The main modalities for distributing food aid are "food for farming" and small seed inputs. A key donor is the World Food Programme (WFP). WFP, in conjunction with IFAD, run a supplementary school meals programme mainly targeting vulnerable children in drought-prone areas; and provide support to HIV/AIDS patients with supplementary food.

transfer (CB-CCT) programme in Bagamoyo District to test the feasibility of implementing cash transfers through a social fund employing a community-driven development approach (Dunn and Mhamba, 2009). The CB-CCT is intended to provide cash transfers to poor and vulnerable families conditional upon increased family access to education and health services.

A beneficiary assessment from TASAF II showed that the vast majority of projects were benefiting service-poor communities, with very few targeting either food insecure or vulnerable households. In terms of sustainability of community assets, an evaluation of TASAF Phase I underscored the importance of integrating capital investments through TASAF with sectoral spending in district development plans. For example, of the 328 health facilities built, nearly half were not fully staffed. The beneficiary assessment also found shortages of teachers and books for schools and the lack of relevant permissions, staff, facilities, and medical supplies for dispensaries (Wylde and Rutasitara, 2008).

National Costed Plan of Action for Most Vulnerable Children (NCPA)

While TASAF largely focuses on developing community assets, MKUKUTA also commits to supporting children who are especially vulnerable to poor outcomes. Interventions for most vulnerable children (MVC) were initiated in light of concern about the growing number of children orphaned as a result of HIV/AIDS. Programmes now provide support for all children who are considered to be most vulnerable, no matter what the cause in order to avoid stigma associated with the identification of MVC with HIV/AIDS, and because a large proportion of MVC are not orphans but rather children in destitute conditions.

A pilot programme, supported by UNICEF, has now been expanded nationally, with funding from the Global Fund, PEPFAR and UNICEF. The NCPA aims to ensure that MVCs in Tanzania are identified, protected from harm, and given access to essential services. The plan focuses on strengthening community-based care and assistance mechanisms. Under the plan, MVC Committees are established at ward and village level. District and ward facilitators are trained, and communities are engaged in defining vulnerability criteria within their community and in planning and coordinating the response. In particular, community members take some responsibility for each child identified, if only an oversight role, and CSOs – international and national non-governmental, faith-based and community-based organisations – support provision of essential services to both children and their caregivers. Programmes for MVC are coordinated by the Department of Social Welfare within MoHSW.

According to the MVC database, the NCPA has now extended to at least one ward in 62 districts of the Mainland, 410,000 MVC have been identified through the standard identification process, and, of these children, 160,000 are receiving some form of support (Mamdani and Omondi, 2008). Nonetheless, these numbers represent a small proportion of the estimated one million MVC in Mainland Tanzania.

Amounts and types of allowable costs also vary considerably among participating organisations; some provide assistance only to students, and many do not provide food. Where foodstuffs are provided, they tend to be provided directly, incurring high transport costs. In addition, financial support to individual children for non-food items often far exceeds the norm for other children in the community.

Financing and Partners

In addition to the two most prominent programmes, TASAF and the NCPA for MVC, there is a myriad of charitable programmes supported by local NGOs and CBOs (RAWG, 2003). Social assistance also continues to be provided in response to specific crises – floods, droughts, and the impact of HIV/AIDS. An assessment of social protection programmes undertaken in 2005 reported that the bulk of public expenditures for social protection and reflected in the budget were for food relief, even in years with good harvests (REPOA, 2005). The operation of the strategic grain reserve was budgeted at TShs 25,776 million in 2005/06, a year of drought, and at TShs 6,983 million in 2006/07, representing 0.7% and 0.2% of the total budget respectively.

Current interventions to address the needs of vulnerable members of society depend on collaboration of different levels of government and

several agencies, public and non-governmental. They are implemented by different institutions, and reviews have concluded that they suffer from lack of a coherent systemic approach. Strategic plans and budgets are lacking, and implementation largely derives from institutional sources of funding and their interpretations of social protection.

Current public MVC programmes have low coverage, and there is little evidence of their impact. To date, they have been uncoordinated and largely financed from external sources. Frequently, assistance is provided to a minority of children and households in ways which are socially disruptive and sometimes stigmatising. Targeted programmes of social assistance to MVC, such as the NCPA, must be carefully designed, monitored and evaluated, especially if means-testing is applied to identify beneficiaries, as indicated in the social security policy.[43] Instead, the majority of MVC programmes uses a community-based approach to identify and support those most in need. Pilot cash transfer programmes in neighbouring countries similarly use community-based targeting of poor households, some in combination with categorical targeting of households with children and/or the elderly with no able bodied adult present.

The financing of a national programme for MVC could follow the pattern of other programmes through local government authorities: grants made to local authorities according to a formula built around sound national data, for example the estimated number of vulnerable children in poor living conditions.[44] Access to the grants would depend on application from village authorities with established identification and support mechanisms for vulnerable children. Civil society organisations would continue to play an important part in supporting the establishment of these institutions and in programme implementation, ensuring that the necessary support goes to those who most need it, reporting any discrepancies to village and neighbourhood meetings, to district councils or other fora as needed. A critical element will be to ensure that all children, including the most vulnerable, are able to access the services to which they are entitled.

The amount of funding now in the budget for social protection, excluding health and education, is negligible, covering small amounts for the Department of Social Welfare beyond its running costs (ILO-Geneva, 2008). The amount of resources that would be needed to raise the income of the poorest households – those living at 30% below the poverty line – up to the poverty line was estimated and applied to the 930,000 children considered to be most vulnerable. In 2006, the cost of bridging the expenditure gap amounted to US $31.5 million. By far the largest amount (four-fifths of the total) would be needed to cover the expenditure gap for food, with the remaining fifth for non-food items. If administrative and overhead costs are estimated at 15% to generate total costs, the annual costs of such income support would rise to US $ 36.2 million.

By comparison, the initial estimate of the annual cost of the NPA in 2006 in the Costed MVC Action Plan was about US $150 million (MoHSW, 2007c). Revised estimates issued in 2008 proposed much more modest levels of support, according to the norms of children living at about the national poverty line and assuming some contributions of food by communities in support of MVCs. The revised costing was US$ 39 million in 2007 and US$ 33 million annually thereafter (MoHSW, 2008c).

Funding currently available from external sources through PEPFAR and Global Fund Round 4 amounts to around US $15 million annually. Claims on other likely sources of funding, such as TASAF's Village Funds[45], can be made on behalf of most vulnerable children. Together with funds already in the national budget, for example for disaster relief through the Strategic Grain Reserve, the amount of financing for national coverage of support for MVCs at the very modest level estimated above is clearly within reach.

[43]Possible support mechanisms include cash transfers to individual households, paid employment through public works and programmes providing care for children or the sick. Public works programmes and the direct provision of clothing and food have been favoured forms of support, but they can be expensive to administer and distort local production and markets. Subsidies may also be provided to increase access by poor farmers to fertilisers, credit and other inputs to boost productivity and income.
[44]An equalisation element in grants to local authorities is still under consideration. This would provide additional funding for public services for those local authorities which are not able to raise their own revenues to the same extent as others. Poor rural districts are especially disadvantaged compared with councils in urban areas which have greater potential revenues from property taxes.
[45]The National Village Fund finances projects aimed at improving service access to health, roads, education, water and sanitation, banking and markets. It also provides cash transfers through labour-intensive public works programmes and supporting income-generating projects for vulnerable households.

3.2 ZANZIBAR

The long-term national framework for development policies and strategies in the Isles is the Zanzibar Development Vision 2020 (RGoZ, 1998), while the four-year Zanzibar Strategy for Growth and Reduction of Poverty (ZSGRP), commonly known as MKUZA, is the overarching national strategy to implement Vision 2020. The main objective of MKUZA is to increase economic growth and reduce poverty by promoting the productive sectors; expanding access to social services; containing extreme vulnerability; and promoting community participation and democratic governance. Like MKUKUTA for the Mainland, MKUZA represents the key national platform for assessing progress towards improved child outcomes in the Isles.

In addition to MKUZA, the Zanzibar Child Survival, Protection and Development Policy (2001) paves the way for the enactment of laws relating to children's affairs. It promotes children's health to reduce infant and child mortality and malnutrition with emphasis on combating malaria and anaemia and improving access to clean and safe water. Reduction of child poverty and child labour, and provision of education for neglected children, disabled children and orphans are also covered, as is increased support to improve outcomes for girls and children with HIV/AIDS.

This section analyses the status of children's development in the Isles under the six pillars of child well-being: health, nutrition, HIV/AIDS, education, child protection and social protection. The institutional framework and budget allocations for children are presented at the end of the section.

3.2.1 Health

MKUZA Goals and Targets

Immunisation
- Increased percentage of fully immunised children from 85% (2005) to 95% (2010).
- Reduced incidence of malaria from 45% (2004) to 35% (2010).

Water
- Increased access to clean, safe and sustainable water supply in urban areas from 75% in 2004/5 to 90% in 2010.
- Increased access to clean, safe and sustainable water supply in rural areas from 59% in 2004/5 to 65% in 2010.

A. Status, Trends and Disparities in Child Outcomes

Malaria

The THMIS 2007/08 found that the prevalence of malaria in under-five children in Zanzibar was less than 1%. However, a very high percentage of children under-five (24%) had fever in the two weeks preceding the survey. Of these, one-third received anti-malarials on the same or next day following onset of the fever. Use of insecticide treated nets (ITNs) by children under-five and pregnant women in Zanzibar has increased substantially since 2004/05. The THMIS 2007/08 recorded that 59% of under-fives (up from 22% in TDHS 2004/05) and 51% of pregnant women (up from 20% in TDHS 2004/05) slept under an ITN the night before the survey. Current ITN coverage for under-fives is more than double that of the Mainland (25%).

HMIS data further indicate improvements in malaria prevention. Malaria prevalence in hospital attendees has dropped from 41% in 2004 to 34% in 2006. Similarly, the number of children suffering from malaria decreased from 431,767 in 2004 to 206,300 in 2006 (RGoZ – MoFEA, 2007d).

Immunisation

Compared to 2006, immunization coverage declined in 2007 for most of the antigens – BCG, polio, measles, DPT-HB3 – but started to increase by mid 2008. Shortage of vaccines was given as the main reason for the decline in

2007 when coverage was 78% for DPT-HB3 and 88% for measles. There are, however, considerable differences between Unguja (92% DPT-HB3 and 100% measles) and Pemba (64% DTP-HB3 and 73% measles) (RGoZ, 2008).

Water

Households in Zanzibar are more likely to have access to clean water than in the rest of the country. The TDHS 2004/05 estimated that 83% of households use piped or protected water sources compared with 54% on the Mainland. Recent policy has solely focused on supporting piped schemes. However, despite the widespread coverage of piped schemes, water is not always available due to power outages. Pemba currently does not have mains power supply so all power is from generators

B. Building Blocks for a Strategy

Key Programmes

Six key programmes relevant to improving child health outcomes were identified.

Reproductive and Child Health Programme

This programme aims to improve coverage and quality of MCH services – under-five care, and antenatal and post-natal care, including delivery services. Technical and financial support is provided by UNICEF, WHO and the Government. Implementation challenges include inadequate human resources – in terms of staff numbers and skills, and high staff turnover.

Health care services in Zanzibar are offered through 142 government health facilities, 62 of them located in Pemba and 80 in Unguja. The facilities providing RCH services include 135 Government (95%) and seven privately owned healthcare facilities (5%).

Road Map to Accelerate the Reduction of Maternal, Newborn and Child Mortality in Zanzibar (2008-2015)

The Road Map signals a renewed commitment to improve maternal, newborn and child health. It stipulates various strategies to aid different stakeholders – the government, Development Partners, NGOs, CSOs and others – in the implementation of interventions. Launched by the President and the UNFPA Executive Director in March 2009, the Road Map is expected to guide decision making in terms of budget allocation, influence policy change, and foster partnerships towards scaling up of evidence-based, low cost and effective interventions (RGoZ – MoHSW, 2008).

Expanded Programme on Immunisation

The EPI aims to reduce morbidity and mortality due to vaccine-preventable diseases. The programme's broad areas of activity are routine immunization service delivery, disease surveillance and supplementary immunization activities, including capacity building for health staff. Beneficiaries include adolescent girls, pregnant mothers and children under five years of age. Every district is covered. Coverage for under-fives is high (86% in 2006, 78% in 2007) (RGoZ, 2008). Technical and financial support is provided by the Government, UNICEF and the Global Alliance for Vaccines and Immunisation (GAVI).

Integrated Management of Childhood Illnesses (IMCI)

This programme has two main components – community IMCI and facility IMCI. In collaboration with MoHSW, UNICEF supports community IMCI, whereas WHO supports facility IMCI, capacity building to manage childhood illnesses, and monitoring and evaluation. The programme has good coverage for facility IMCI. Community IMCI suffers from lengthy and cumbersome processes to reach communities; heavy workload of staff at the healthcare units, which limits their capacity to offer community extension services; and unmotivated Community Owned Resource Persons (CORPs). The main role of CORPS is community sensitisation, mobilisation and advocacy. Crucially, CORPS are not recognised in the government structure despite their important role in implementing community-based health programmes.

Zanzibar Malaria Control Programme (ZMCP)

This programme is supported by the Government, the Global Fund and the World Bank and is aimed at controlling malaria generally, but with emphasis on pregnant women and under-fives. The use of effective anti-malaria drugs (the current first line treatment being artemisinin compounds) and ITNs are promoted, as well as the use of biological means to disrupt the breeding cycle of mosquitoes. Recent

National laws and policies

The **Zanzibar Health Policy (2000)** aims to safeguard the health status of all Zanzibaris. Policy statements stress the need to put greater emphasis on safe motherhood and child survival with the objective of reducing maternal, infant and under-five morbidity and mortality through supporting the national programme of action for women and children, ensuring provision of quality reproductive health services at all levels according to stated policy guidelines, and collaboration and coordination of sectors in promoting Maternal and Child Health (MCH) services for the well being of mother and children.

The **Zanzibar Water Policy (2004)** recognises the right to adequate and clean and safe water as a prerequisite for sound health conditions. The introduction of fees for water has recently commenced, so the impact on the poorest members of the community, including children is yet to be known. At present, a standard fee will be charged across Zanzibar of Tshs 4,000 for a house connection per month (although Parliament is currently discussing to reduce this charge) and Tshs 2,000 for a water kiosk per month. Water kiosks are provided for consumers unable to afford a house connection. Discussions are ongoing about how to ensure that the most vulnerable will be able to get water.

data indicates that the free distribution of ITNs has had a major impact on malaria. The ZMCP has had tremendous impact on reduction of malaria cases and Zanzibar is now talking of eradicating malaria.[46]

Rural Water Supply Project

Since 2003, the Zanzibar Water Authority (ZAWA) and MoHSW, with support from UNICEF, has been implementing an integrated water, sanitation and health programme in Pemba. The project has targeted areas not covered by piped water projects. Given the difficulties of expanding water access to under-served areas via piped schemes, a total of 78 ring wells have been dug with hand pumps supplied, and training provided to community members for the operation and maintenance of the facilities. Each well serves 300-500 people, and each household in the project areas has water within 400m. Ensuring sustainable water access is the key priority. Out of the 78 wells dug since the programme's inception, only 5 are no longer operational – one well is not used due to problems with iron in the water and a piped scheme has now been installed, and a second well was affected by saline intrusion (v/c ZAWA, Pemba). The programme also supported the training of artisans in the construction of sanitation facilities. One artisan was trained in each shehia (133 in total) in Pemba. In addition, CORPs have also been trained in all 694 villages in Pemba on Participation Hygiene and Sanitation Transformation (PHAST).

All three components of the programme are monitored on a regular basis with solid progress in the construction of improved facilities. In addition, the cost of an improved latrine has decreased from an average of over 500,000 TShs per latrine before the training to about 300-350,000 TShs. However, this is still very expensive for the poorest in the community. Some have constructed their own traditional latrines but others remain without facilities. In addition, the trained masons have, in turn, trained other artisans, resulting in increasing the number of tradespeople who can build the improved latrines. MoHSW and ZAWA staff have noted a marked reduction in diarrhoea cases since the programme began, but updated health facility data are not yet available to assess impact.

3.2.2 Nutrition

MKUKUTA Goals and Targets

- Reduced prevalence of stunting in under-fives from 23% (2005) to 10% (2010).
- Reduced prevalence of anaemia in under-fives from 75% (2005) to 50% (2010).

[46] There is a debate on whether Zanzibar is really achieving malaria eradication. In 1968 the same low malaria infections rates were observed as today. This was due to intensive programmes for malaria control that were in place. The argument is that the current intensity of interventions is also high and should be maintained if these low levels are to be sustained. Other development partners contributing to malaria control programmes include UNICEF, USAID (PMI program), GVT, Italian Cooperation, and Zamruki (under Karolinska Institute).

Strategies to address child nutrition are presented in Cluster II of MKUZA, in particular Goal 6 – improved food security and nutrition among the poorest, pregnant women and children and most vulnerable groups. Specific indicators for nutrition include the reduction of stunting in children under the age of five years from 23% (2005) to 10% (2010), and reduction of the prevalence of anaemia among under-fives from 75% (2005) to 50% (2010).

A. Status, Trends and Disparities in Child Outcomes

Malnutrition

As with infant and under-five mortality, Zanzibari children are less likely to be malnourished than their Mainland peers. Data from the TDHS 2004/05 indicate that 23% of Zanzibari children are stunted, 7% are severely stunted and 19% are under-weight (NBS, et al., 2005). Again, as in under-five mortality, there are strong regional differences in malnutrition from 15% of children stunted in Town West to 37% in Pemba North. Anaemia affects 75% of children aged 6-59 months and 63% of women, higher than their Mainland peers (NBS et al., 2005).

Regional figures for Vitamin A deficiency are available for Unjuga, with VAD prevalence rates ranging from 33% of children in Zanzibar North to 50% in Town West (RGoZ – MoHSW & UNICEF, 2005). Iodised salt to combat iodine deficiency is used by 48% of households in Zanzibar, considerably lower than the level observed in Mainland Tanzania (74%), and only

Table 3.7: Malnutrition in Children under the Age of Five, Zanzibar, by Region, 2004/05

Regions	Height for age (stunting)	Weight for height (wasting)	Weight for age (underweight)
Zanzibar	**23.1**	**6.1**	**19.0**
Unguja	18.0	6.7	17.0
Pemba	32.1	4.9	22.5
Regions			
Zanzibar North	27.5	6.7	22.7
Zanzibar South	16.6	10.3	20.8
Town West	14.5	5.9	13.9
Pemba North	36.6	5.3	24.8
Pemba South	27.4	4.5	20.2

Source: REPOA and UNICEF, 2006 using data from TDHS 2004/05

National laws and policies

Two policies are considered most relevant for improved nutritional outcomes in children.

The **Zanzibar Health Policy (2000)** includes provisions to improve and sustain the nutritional status of Zanzibari people, particularly women and children. Specific strategies include increasing consumption of nutritious food, ensuring the availability, safety storage and distribution of food throughout the country, and initiating nutritional education.

The Zanzibar Food Security and Nutrition Policy [ZFSNP] is currently being drafted. The ZFSNP aims to ensure equitable access at all times to safe, nutritious and culturally acceptable food in sufficient quantities for an active and healthy life, and to provide special protection of vulnerable population groups from the effects of emergency situations on their food security and nutrition. Strategic areas of intervention include: domestic food production and productivity; food marketing and trade; diversification of rural and urban livelihoods; public health and nutrition education interventions.

18% of households use salt that contains adequate levels of iodine (NBS et al., 2005).

B. Building Blocks for a Strategy
Key Programmes
Child Survival, Protection, and Development (CSPD) Programme

Funded by UNICEF and the G Government, this programme implements campaigns for vitamin A supplementation, de-worming, and provision of micronutrients. The main beneficiaries are children under five years of age. A significant proportion of children are covered during campaigns. Iodine deficiency diseases are addressed through support to the production of iodised salt. The main challenges facing the programme include inadequate human resources in numbers and capacity. Funding by UNICEF for the Vitamin A campaigns and de-worming in Zanzibar is approximately US$60,000 per annum.

3.2.3 HIV/AIDS

MKUKUTA Goals and Targets

- Reduced HIV prevalence among pregnant women aged 15-24 years from 1% in 2005 to 0.5% in 2010.

A. Status, Trends and Disparities in Child Outcomes

The THMIS 2007/08 estimated HIV prevalence in Zanzibar at 0.6%, compared with 5.8% on the Mainland. Research indicates that the HIV epidemic in Zanzibar is concentrated in three high-risk groups: substance users, in particular injecting drug users; sex workers (both male and female) and their clients; and men who have sex with men. Studies carried out in 2005 showed that the HIV prevalence was 13% among substance users, and 26% among those injecting drugs (Dahoma, et al., 2005).

Data from the PMTCT services progress report for ZACP show that HIV prevalence among pregnant women has not changed much in the last three years – 1.0% during 2005/06, 0.9% in 2007 and during the period January to June 2008 the rate was 0.8%.[48]

B. Building Blocks for a Strategy
Key Programmes

Prevention of the spread of the virus has received the biggest share of national and external funding under the Zanzibar HIV/AIDS Strategic Plan. A larger number of civil society organisations are supporting HIV/AIDS activities in Unguja and

National laws and policies

MKUZA
To strengthen the multi-sectoral response, HIV/AIDS has been presented as a cross-cutting issue in MKUZA, and strategies to combat the epidemic are included in all three clusters of the strategy.

HIV and AIDS Policy (2007)
The policy focuses upon: i. HIV prevention (including PMTCT); ii. treating, caring and supporting those who are infected; iii. mitigating the impact of HIV and AIDS on the social and economic status of individuals, families, and communities; and iv. capacity building to develop and implement interventions within gender-sensitive and human rights approaches. There is great concern about the alarming HIV prevalence among substance abusers, who are mostly young people, and other most-at-risk-populations (MARP) since these groups can be "bridging populations" for HIV to cross over into the general population.

Zanzibar National HIV and AIDS Strategic Plan (ZNSP) (2004/05 – 2008/09)[47]
In line with the policy, the plan focuses on HIV prevention and mitigation of the impacts of the disease. With respect to children, the strategy focuses on preventing mother to child transmission which is the main route for HIV infection among children. However, if not addressed, child sexual abuse, mistreatment of children and other forms of harassment are risk factors that can fuel the epidemic in children, both girls and boys. Most children who are sexually abused are mistreated at an early age.

[47] ZNSP III (2009-2013) has been drafted and is expected to be finalised in June 2009. There is a major strategic shift; the focus of the new ZNSP will be on most-at-risk populations, including youth.
[48] Report Presented to the House of Representatives during the African Child Day on Progress on Child Rights', 16 June 2007, Ministry of Labour, Youth, Women and Children Development.

Pemba. The magnitude of funds channelled to these CSOs is substantial but is not reflected in the national budget (RGoZ – Zanzibar Aids Commission (ZAC), 2007).

3.2.4 Education

A. Status, Trends and Disparities in Child Outcomes

Primary school enrolment rates in Zanzibar have increased over time with near gender parity and improving completion rates. The net enrolment rate (NER) for primary education increased from 51% in 1990 to 79% in 2002, but slipped slightly to 76% in 2006 (RGoZ, 2007a; RGoZ – ZEDCO, 2007). Primary transition rates have been consistently high at an average rate of 80% since 1990. Substantial differences, however, exist between districts, with NERs ranging from 51% in Micheweni district (Pemba) and 65% in North A district (Unguja) to 88% and 90% in Urban and South districts (both Unguja) (RGoZ – OGCS, 2006). HBS 2004/05 data permit an analysis of enrolment ratios by household wealth status. All gross and net enrolment ratios show a steady increase with increasing household wealth status. Net primary enrolment ranges from 66% in the poorest wealth quintile to 88% in the least poor quintile (REPOA and UNICEF 2006).

Due to compulsory basic education in Zanzibar including the first years of secondary schooling[49], enrolment in secondary education is higher than on the Mainland. In 2005, net secondary school enrolment in Zanzibar was 33% (RGoZ – MoFEA, 2006a). Secondary transition rates have increased from 10% in 1990 to 44% in 2004. Since 2000, the proportion of females moving from primary to secondary education has been higher than that of males; by 2004, 80% of girls and 72% of boys entered secondary education (RGoZ, 2007a). Again, substantial differences by district were recorded, with comparatively higher net secondary enrolment ratios in Urban and South districts of Unguja, and lower ratios in Pemba and in North A and B districts of Unguja.

B. Building Blocks for a Strategy

Key Programmes

Programme to Strengthen Primary Education

The programme, funded by the Government, SIDA, African Development Bank (ADB), UNESCO and USAID, aims to achieve universal access to primary education. It covers all primary schools and focuses mainly on school infrastructure and supply of reading materials. No special focus is given to the most vulnerable children, but they are included if they attend primary school. Ongoing challenges include inadequate human resources; problems attracting teachers to remote and marginalised areas; depleted

MKUZA Goals and Targets

Early Childhood

- Increased gross enrolment rate in pre-school from 15.9 % in 2005 to 35 % in 2010.

Primary and Secondary Education

- Increased net enrolment rate in primary education from 77% in 2005 to 90% in 2010.
- Increased proportion of children with disabilities, enrolled, attending and completing school by 5% annually.
- Increased net enrolment rate in secondary education from 36.1% in 2006 to 75% in 2010
- Increased proportion of girls who join lower and higher secondary education from 46% in 2005 to 50% by 2010.
- Increased proportion of orphans and vulnerable children who join higher secondary education.

Vocational Education and Training

- Enhanced entrepreneurial skills among young people.

[49] Zanzibar has implemented a ten-year basic education cycle, comprising seven years of primary and three years of lower secondary education. One of the essential elements of the education reforms proposed in the 2006 Education Policy is the extension of basic education from ten years to 12 years.

National laws and policies

Statutes relevant to Education
The Education Act No 4, 1982 (as amended) stipulates that basic primary and secondary education is the right of every child in Zanzibar and the Revolutionary Government of Zanzibar is bound to provide that education to every child. The Spinsters and Single Parent Children Protection Act No 4, 2005 allows a girl who has been suspended from school as a result of pregnancy to be reinstated to the school in the next academic year following her delivery, or at any time deemed appropriate, but in any case suspension shall not exceed two academic years.

Education Policy (2006)
Education reforms in the new policy include the extension of education from ten to 12 years, improving the quality of education, strengthening teachers' training, provision of alternative learning opportunities for out-of-school youths, and general skills development. The policy is innovative in that it mainstreams HIV/AIDS in the school curriculum. It also provides opportunities for girls to go back to school after delivery of a baby, and bans corporal punishment.

Zanzibar Education Development Programme (ZEDP) 2008-2015
MKUZA's education goals and the Education Policy 2006 are operationalised through ZEDP.
The overall objectives for ZEDP are:
- Increased and more equitable access to education through ensuring that the necessary infrastructure is in place; and
- Improved relevance and quality of education throughout the sector by implementing curriculum reform and ensuring that qualified teachers are evenly distributed across Zanzibar.

The ZVETP is a framework for learning opportunities for youth with the aim of creating employment opportunities and fostering entrepreneurship values and skills.

school infrastructure due to poor maintenance; and un-empowered school committees.

Alternative Learning and School Development

This programme, funded by the Government and ADB, addresses the educational needs of children who missed out on formal education. The programme operates mainly in urban areas, with limited coverage due to inadequate staffing and infrastructure.

The programme began in 2000 and was initially aimed at mainstreaming out-of-school children (12-14 year olds) into primary school. Between 2000 and 2006, there has been a steady increase in number of centres (from three to 20) and enrolment (growing from 77 students to 475). In 2006, 70% of the students passed the one-year intensive course and were mainstreamed into primary schools. An alternative learning centre was established in 2006 providing primary education – a three-year intensive curriculum to out-of-school children aged 15-19 years. At the centre's inception (in 2007) a total of 344 students were enrolled.

However, there is no information to date regarding completion (RGoZ – MoEVT, 2007b).

Teaching and Learning Materials Project

The project supports primary schools by supplying learning materials, especially books. It has comprehensive coverage (even in marginalised areas) but no special focus is given to most vulnerable groups as they are assumed to be included if attending primary school. The project is financed by the Government and UNICEF.

Early Child Development (ECD) programme

Pre-primary schooling was previously not a separate category in the education system in the Isles, but its development is recognised as a priority in MKUZA. Funds are allocated through the ECD programme. Many Zanzibari children go to 'madrasa' – a form of early education. 'Formal' ECD programme (pre-primary education) is included in the 2006 Education Policy, which extends basic education from pre-primary to lower secondary education. The ECD component is still being developed – curriculum

preparation, teacher training, learning/teaching materials and infrastructure construction.

3.2.5 Child Protection

MKUZA Goals and Targets

- Reduced proportion of children in labour country-wide from 25% to less than 10% by 2010, and provide alternatives including enrolment in primary education, COBET and vocational education skills training.

A. Status, Trends and Disparities in Child Outcomes

Living Arrangements

A larger proportion of Zanzibari children are living at home with parents, compared with children in Mainland Tanzania (Table 3.8). Because of sample size restrictions, no breakdown by age is available. For Mainland Tanzania, 60% of children were living with both parents and 17% were not living with either parent. In Zanzibar, the respective figures are 67% and 16%. Proportionately, more children in Pemba than in Unguja were living with both parents.

Table 3.8 Children's Living Arrangements, Zanzibar, by Island, 2007/08 (% of children)

Region	Children living with both parents	Children not living with a biological parent
Unguja	63.4	18.1
Pemba	71.8	13.5
Zanzibar	66.7	16.3

Source: THMIS 2007/08

Child Labour

The incidence of child labour in Zanzibar (8.4%) is much lower than on the Mainland (21%) (Table 3.9). Boys are slightly more likely than girls to be involved. By far the most common form of child labour involved excessive hours of work, rather than involvement in hazardous occupations. Rural children are almost twice as likely to be involved in child labour than urban children. Child labour exists in several sectors including fishery, transport, construction and tourism (RGoZ – MoLYWCD, 2004).

Table 3.9: Child Labour in Zanzibar, by Sex and Residence, 2006 (% of children)

Residence	Boys	Girls	All
Rural	10.5	9.6	10.0
Urban	5.5	6.0	5.8
Total	8.6	8.1	8.4

Source: ILFS 2006

Birth Registration

Unlike the Mainland, birth registration is almost universal in the Isles. In Zanzibar, 90% of children under five years of age are registered and 67% have a birth certificate. Registration and certificate figures are slightly lower for Pemba compared with Unguja.

B. Building Blocks for a Strategy

Key Programmes

International Programme on the Elimination of Child Labour (IPEC)

This ILO-supported programme has been implemented in North A District of Unguja and Micheweni District in Pemba. The Catalyst Organisation for Women Progress in Zanzibar (COPWZ) and Pemba Island Relief Organisation (PIRO) are the implementing organisations. Its objective is to withdraw, prevent and rehabilitate 2,510 children from fishing and seaweed farming in the two districts. The programme provides institutional support and community mobilisation. Opportunities are provided for alternative education and skills, vocational and entrepreneurship skills and training, and strengthening income capacity of members for 110 of the most vulnerable households in the districts.

Other Initiatives

Little progress has been made in addressing specific complaints of child abuse, abandonment or neglect because of lack of evidence and medical support, and the long process of court proceedings. In addressing these problems, the Ministry of Labour, Youth, Women and Children Development has initiated periodic meetings with the Police Force, Ministry of Health and Social Welfare, Courts, and Director of Public Prosecution. The main goal of these meetings is to follow up on all reported complaints from

National laws and policies

International Conventions
Under the Constitution, the Revolutionary Government of Zanzibar is bound legally to international agreements ratified by the United Republic of Tanzania, including the Convention on the Rights of the Child (CRC), the African Charter on the Rights and Welfare of the Child and relevant ILO Conventions No. 138 and 182 on child labour.

Statutes relevant to Child Protection
Several laws safeguard the rights of children (RGoZ – MoLYWCD, 2007). These include Part XV (Offences against morality) of the **Penal Act No. 6, 2004** which allows for punishment of a woman who attempts or conducts abortion, and also provides for punishment for sexual exploitation of children; and Part XVI (Offences relating to marriage and domestic obligations) which includes charges related to cruelty of children such as ill-treatment, abandonment, female circumcision, neglect and desertion, child trafficking, and child stealing. However, the age of a child is defined differently in different sections of the Act. For example, Section 168 of Part XVI refers to a child as any person under 18 years of age, while Section 169 addresses desertion of children and refers to any person under the age of 14 years. **The Employment Act No 11**, 2005 also alludes to restrictions on employment of children and prohibits child labour; and under the **Spinsters and Single Parent Children Protection Act No.4, 2005**, any person who is found to be responsible for the pregnancy of a spinster shall be guilty of an offence and shall be liable to serve in an Education Centre for not more than five years. In addition to this punishment, the person will be ordered to provide maintenance to the child.

Zanzibar Education Development Programme (ZEDP) 2008-2015
In addition, the **Zanzibar National Guidelines on Child Labour** broadly describes measures to protect children against the worst forms of child labour. Implementation of the **Gender Based Violence Action Plan 2008-2011** prepared by the Ministry of Labour, Youth, Women and Children will also improve child protection outcomes.

women and children in order to make sure that cases are pursued on time and that justice prevails.

Further strategies to address sexual abuse of children include the following:

- reinforcing the laws that protect the rights, interests and well being of children;
- creating awareness of child sexual abuse in families, communities and schools;
- enhancing effective implementation of the Child Survival, Protection and Development Policy, the Convention on the Right of the Child (CRC), and the African Charter on the Rights and Welfare of the Child;
- eliminating the worst forms of child labour from Shehia[50] to national level;
- educating parents and religious leaders on the adverse consequences of early marriages;
- encouraging parents, pre-school teachers, madrasa, non-governmental organisations, and faith-based organisations to provide necessary information to children about sexual abuse and help them avoid being abused;
- reviving community responsibility of protecting children in their respective areas and reintroduce communal upbringing of children;
- creating a conducive environment including parent's support for girls to complete their basic education and pursue higher learning and professional skills to support themselves;
- educating children on the negative consequences of engaging in early sexual activity; and
- strengthening collaboration with institutions dealing with children's well-being and interests.

3.2.6 Social Protection

MKUZA Goals and Targets

- Increased number of orphans and most vulnerable children reached with effective social protection measures by 2010.
- 20% of children and adults with disabilities reached with effective social protection measures by 2010.

[50] A Shehia is the lowest government administrative structure covering around 15 villages. Currently there are about 230 shehias in Zanzibar.

A. Status, Trends and Disparities in Child Outcomes

Most Vulnerable Children (MVC)

The number of orphans and vulnerable children is lower in Zanzibar than the Mainland. The THMIS 2007/08 indicates that 6.7% of children in Zanzibar are orphaned (Pemba 6.0%; Unguja 7.2%) and the proportion of orphans and vulnerable children (OVC) is 10.4% compared with 17.8% in Mainland Tanzania.

According to 2002 Population and Housing Census data, just over 5,000 children under the age of 18 years were classified as disabled which is likely to be a significant underestimate (REPOA et al., 2006). Due to stigma, certain disabilities may not be registered, mild ones may go unnoticed, and others may be undetected in young children. Further analysis suggests that children with disabilities have poor access to education, with enrolments of disabled children lagging far behind those of non-disabled children. At all ages, school attendance was lower among children with disabilities, compared to their non-disabled peers.

B. Building Blocks for a Strategy

Key Programmes

Participatory Agricultural Development and Empowerment Programme (PADEP)

Supported by the Government and the World Bank, this programme has a significant budget allocation. It aims to increase the income and assets of households and farmers' groups. The project targets an estimated 376 farmer groups, with the aim of benefiting more than 7,500 households in about 94 Shehias in five districts. Two modalities are used: farmers' group investment and community investment, both of which supply grants matched by contributions in cash from beneficiaries. This programme addresses

National laws and policies

MKUZA's Goal 7 of Cluster 2 envisages strengthened and expanded social security and safety nets for the disadvantaged and the most vulnerable population groups. However, as on the Mainland, no social protection framework has yet been developed that provides a consolidated direction for designing and implementing social protection strategies.

Existing social security and pension schemes have very limited coverage and low benefits. They are largely confined to formal sector employees and are therefore unlikely to directly benefit poor children. All in all, few and weak safety nets are available for vulnerable groups in Zanzibar.

More general strategies to improve household income poverty are included in Cluster I of MKUZA, including promoting growth of the agricultural sector, improving the availability and accessibility of gender-responsive microfinance services, and increasing gender-sensitive youth training and employment.

Given the importance of agriculture in Zanzibar's economy, the following policies are keenly relevant to addressing child poverty and vulnerability in the Isles:

The **Agricultural Sector Policy (2002)** promotes sustainable development in agriculture with the main objectives of attaining household and national food security, and improving the nutritional status of the population, in particular children and lactating mothers.

The **Small and Medium Enterprise (SME) Policy (2006)** aims to create an enabling environment for small- and medium-scale enterprises in order to expand employment and opportunities for income-generation. As such, the policy has a direct link to child well-being by encouraging self-employment, creation of stable enterprises, and increased diversification of household livelihoods.

Employment Policy (2007) was adopted towards the end of 2008, with an overall objective to promote employment and increase national productivity.

Finally, the **Policy on Protection and Development of Women (2001)** is also relevant as it seeks to implement the principles enshrined in the **Convention on Elimination of All Forms of Discrimination against Women (CEDAW),** including equal participation for women in development processes and in access to resources such as land, education and employment opportunities.

disparities in income and food poverty by targeting areas with large numbers of households below the food and basic needs poverty lines.

3.2.7 Financing and Partners

The establishment of the Ministry of Labour, Youth, Women and Children Development was a major step towards ensuring that children and gender issues are not sector-specific, but integrated in development plans and budgets.

However, inter-sectoral collaboration and synergies must be strengthened through formalised institutional arrangements. To further this objective, the Ministry has established an Inter-Sectoral Committee drawing members from other Ministries implementing child-related interventions:

- Labour, Youth, Women and Children Development (gender and child protection)
- Health and Social Welfare (health and social welfare)
- Education and Vocational Training (education)
- Agriculture, Livestock and Environment (nutrition and household income)
- Water, Construction, Energy and Land (water and public works programmes for income generation)
- State (President's Office) – Constitution Affairs and Good Governance (law and child registration)
- Internal Affairs of the Union Government (child protection)
- State (President's Office) – Regional Administration and Special Departments (vulnerable children)
- Information, Culture and Sports (leisure and entertainment).

The role of this committee is to assess progress in implementing policies and interventions for child development. To do this, it drafts a report that is read and discussed in the House of Representatives and during the Day of the African Child every year. The committee also advocates for inclusion of child-related budget lines in the MTEFs of key Ministries, and has initiated discussion with their Directors of Planning.

A further development is the establishment of District Committees to oversee implementation of child policy. These Committees work closely with Gender Coordinators at the Shehia level to report on violence against women and children. A Gender-based Violence Action Plan has already been drafted to guide the process of protecting women and children against violence.

While policies aimed at addressing key child rights issues are in place, major gaps in implementation remain, including:

- weak institutional capacity at all levels caused by a lack of adequately skilled staff, high turnover and difficulty attracting staff to remote and marginalised areas
- low awareness of existing policies among implementers and the community at large
- under-funding of programmes related to child development
- lack of inter-sectoral collaboration and synergies
- lack of coherence and alignment between overall sectors' objectives and donor funding
- weak capacity of communities to organise, plan and implement interventions
- failure to integrate poverty reduction activities at grassroots level
- little focus on most vulnerable groups
- depleted infrastructure due to poor maintenance.

In general, child-related programmes in Zanzibar suffer from under-funding, which in large part results from broader macro-economic deficiencies. Crucially, major challenges exist in collection of government revenue. An inefficient fiscal environment, the lack of tax policy, and weak tax administration seriously impede revenue collection, thereby limiting domestic financing of core economic and social services such as health, education and infrastructure.

Of serious concern to child health outcomes, a joint review of the HIV response in Zanzibar found that overall health sector financing had almost halved from 11.0% in 1998/99 to just 5.8% in 2003/04 of the total government budget. Moreover, actual disbursement to the sector over the same timeframe has been less than 60% of the allocated amount due to limited revenue inflows. The Health Sector Strategic Plan (HSSP) is critically under-funded. HSSP costing indicates that Tshs 97.625 billion is required for health

sector expenditure for the five years commencing 2007. However, the 2007 PER indicates that actual expenditure in the health sector was only Tshs 7.142 billion (RGoZ, 2007b).

Funding for HIV/AIDS has not been mainstreamed in the national budget framework and the government's commitment of resources to the national response is small. For example, in 2006/07, government expenditure was Tshs 494.35 billion, while donor public sector support (which is off-budget) Tshs 4171.46 billion, and donor funds channelled to civil society organisations was Tshs 1,716.86 billion. Overall, 89% of the budget for HIV/AIDS is currently donor funded. Not surprisingly, a high degree of uncertainty exists on future funding for the Zanzibar National HIV and AIDS Strategic Plan.

In education, the Government has developed a three-year plan (2009-2011) to implement the Zanzibar Education Development Programme, with an estimated budget of Tshs 129.816 billion over the three years (MoEVT, 2007a). In the current fiscal year (2009/10) UNICEF is also providing support totalling US$185,000 for the Early Child Development Programme.

For child protection interventions in Zanzibar, UNICEF has also budgeted US$ 350,000 in 2009/10.

Available data for budget allocations for child-related programmes for financial years 2005/06 and 2006/07 are summarised in Table 3.10 However, the figures do not usually include overseas development assistance which is largely off-budget.

Table 3.10: Key Budget Allocations for Child Outcomes, Zanzibar, FY 2005/06 and 2006/07

Sector and Programme	Total spending 2005/06 ('000 TShs)	Total spending 2006/07 ('000 TShs)	% of total Govt spending 2005/06	% of total Govt spending 2006/07
Health[51] Primary health care facilities**	931,190	992,779	0.66	0.56
Immunisation programmes**	249,418	238,241	0.18	0.13
Antenatal care programmes[52]*	NA	35,631	NA	0.02
Reproductive health and maternal care[53]	261,462	321,810	0.18	0.18
Other 1– Zanzibar Malaria Control Programme*	3,112,083	975,353	2.20	0.55
Other 2 – IMCI*	5,530	72,646	0.004	0.04
Nutrition Community based nutrition and health services (growth promotion, supplementary feeding)[54]*	NA	172,706	NA	0.1
Micronutrient supplementation*	NA	63,000	NA	0.04
Other – Mother child survival protection and development*	35,646	32,376	0.03	0.02
HIV/AIDS Care and treatment services	215,000	NA	0.15	NA
Prevention	1,343,000	NA	0.76	NA
Social and economic impact mitigation	NA	NA	NA	NA
Total Zanzibar AIDS Control Programme (ZACP) budget	744,000	1,147,083	0.53	0.65
Total Zanzibar AIDS Commission (ZAC) budget	956,322	2,037,614	0.68	1.15
Expenditure for HIV/AIDS at sub-national level[55]	5,140	59,900	Negligible	0.03
Child friendly school and life skills	NA	32,367	NA	Negligible
Donor funds channelled to CSOs	628	1,717	Negligible	Negligible
Education Primary education **	9,055,942	10,667,584	6.4	6.0
Other – Vocational training[56]**	32,814	79,243	0.02	0.04
Other – Youth development	37,839	62,700	0.03	0.04
Child Protection Birth registration[57]**	172,262	266,292	0.12	0.15
Alternative care – foster care, adoption services, residential care[58]*	13,094	26,630	Negligible	Negligible
Child protective services[59]**	NA	289,557	NA	0.16
Other 1– Women and children development**	73,753	89,950	0.05	0.05

[51] Expenditures on primary healthcare facilities include development budget for primary health facilities, plus the recurrent budget for preventive care since that is where activities related to health centres and cottage hospitals (rural hospitals) are stipulated. Budgets for immunisation programmes include mother and child health support and the Expanded Programme on Immunisation. No budget information available for water projects.
[52] Family planning only.
[53] Represent funds allocated to the Zanzibar Child and Reproductive Health Program
[54] Represents funds allocated to nutrition component under the Child Survival, Protection and Development Program (CSPD).
[55] Shehias use these funds for peer education, capacity building, developing by-laws related to HIV/AIDS, community sensitisation and the support of orphans and most vulnerable children.
[56] Total funds recorded in sub vote 15 of Vote 23 (RGoZ – MoEVT) and sub vote 9 of Vote 28 (MoLYWCD). The sub-vote was moved to MoEVT from 2006/07.
[57] This is overestimated as it includes all the funds allocated to the Office of the Government Registrar General.
[58] This is the money under budget line item named General Subsidy for Children
[59] These are the funds allocated to the MoLYWCD for activities aimed at combating worst forms of child labour.

Sector and Programme	Total spending 2005/06 ('000 TShs)	Total spending 2006/07 ('000 TShs)	% of total Govt spending 2005/06	% of total Govt spending 2006/07
Other 2– Labour improvement of women and children**	NA	152,291	NA	0.09
Other 3—Anti-drug budget**	15,491	48,463	0.01	0.03
Other 4—Gender and advocacy*	194,076	86,658	0.14	0.05
Social Protection Cash for human development programmes[60]*	1,252,737	2,739,939	0.89	1.54
Cash for work programmes[61]	NA	75,000	NA	Negligible
Price subsidies, tax allowances[62]	321,900	348,000	0.22	0.19
Social pensions (old age and disability)[63]**	1,889,429	2,305,620	1.33	1.30
Other – General social welfare fund	103,739	101,105	0.07	0.06

Notes: *=Actual Expenditures; **=Estimated allocations; NA=Not Available.
Sources: RGoZ – MoFEA, 2006a, 2006b, 2007a, 2007b and 2007c; RGoZ – ZAC, 2007).

[60] The funds included here are those channelled through Ministry of Agriculture, Livestock and Environment and which are aimed at boosting household income through increased agricultural and livestock production. The programs captured include: Participatory Agricultural Development and Empowerment Programme (PADEP), Agricultural Services Support Programme (ASSP), Agricultural Sector Development Program-Livestock (ASDP-L), and Irrigation Development and Food Security Program.
[61] This is the fund spent by TASAF for food-insecure households. It is implemented in two Shehias only with 40% paid to participants in the form of cash for work and 60% goes to interventions.
[63] This figure represents an estimate of tax allowance but captured for employees under the government payroll only. Note that there are a significant number of employees paid by the government but their number has not been captured, for example, employees in the army. Tax allowance was estimated as 15% for employees receiving a salary ranging from TShs 0-80,000; total number of employees estimated at 29,000 for the 2006/07 budget cycle. For the 2005/06 budget cycle, the salary range was TShs 0-60,000 and the tax allowance was 18.5%. The same number of employees has been used for both years.
[64] Funds captured here are the contributions from the government to pension and welfare scheme in particular contributions to Zanzibar Social Security Fund (ZSSF).

CHAPTER 4

A COMPREHENSIVE STRATEGY TO IMPROVE CHILD OUTCOMES

In his seminal work on development, the 1998 Nobel Economics Prize winner Amartya Sen argues that development cannot be gauged solely, or primarily, by the growth of gross national product, the rise in personal incomes, or the level of industrialization or technological progress of a country. Development, rather, must be assessed by the extent to which it allows people to lead the kinds of lives they have reason to value. Development, therefore, is understood "as a process of expanding the real freedoms that people enjoy", most importantly, the freedoms to satisfy hunger, to be educated, and to avoid preventable morbidity and premature mortality (Sen, 1999).

Judged against this yardstick, it is clear that, despite severe resource constraints, Tanzania has made great strides in enhancing the lives, freedoms and capabilities of its people in recent years, who are now better able "to survive rather than succumb to premature mortality" and to "escape widespread illiteracy" (Sen, 1999). For its children, solid progress has been achieved in health and education, as evidenced by the steep decline in infant and under-five mortality rates and the steady rise in primary and secondary school enrolments. Programmes and interventions such as the Integrated Management of Childhood Illnesses, immunisation and vitamin A supplementation campaigns, the Primary Education Development Programme and, more recently, the Secondary Education Development Programme and the national scale-up plans for the Prevention of Mother To Child Transmission of HIV/AIDS and of Insecticide Treated Nets for the control of malaria have been core components in achieving improved health and schooling outcomes for children.

These programmes offer positive lessons for the design of a comprehensive strategy for children's development. The most successful ones are characterised by the following qualities:

- Strong political commitment under national leadership and collaborative relationships between the Government, donors, implementing institutions and communities.
- Shared goals of attaining universal access to core public services, including an effort – still unfulfilled – to extend services and facilities to under-served areas and populations.
- Management and budgets devolved to local authorities, based on nationally defined standards that incorporate equity criteria in the allocation of resources.
- An effort to use and strengthen national systems of planning, budgeting, implementation, monitoring and reporting on development outcomes in line with national priorities.
- The presence of a lead Ministry responsible for setting policy and galvanising support from development partners.

As these programmes scale up to national level within capacity constraints, challenges remain in achieving comprehensive service provision for all children. These include strengthening delivery systems; maintaining and improving the quality of schools and health facilities; enhancing the skills, productivity and motivation of staff; deploying resources more evenly across regions; and expanding coverage to 'hard to reach' children – whether due to poverty, distance or other forms of marginalisation or vulnerability.

Tanzania's recent achievements show that progress is possible within resource-poor environments, but striking disparities in children's outcomes persist – by place of residence, location, household wealth, and educational attainment of a child's mother. The analysis of child poverty and deprivation in this report has clearly highlighted the scope

and depth of these disparities. To enable further advances in coming years, a comprehensive strategy for children will need to address the following concerns:

- Children are still regarded as belonging to the private domain, mainly governed by customary law. As a consequence, key aspects of child well-being are not regarded as being within the purview of public policy.
- Inter-sector and intra-sector linkages between programmes and interventions remain limited, which undermines the provision of an integrated continuum of care and protection for children.
- Existing systems are inadequately resourced and coordinated. While financing has increased for certain areas and interventions (in particular, HIV/AIDS, malaria, immunisation and water), much of this funding is off-budget and highly dependent on donor pledges, hence, beset by questions of predictability and sustainability.
- Key areas with significant impact on child well-being are much less visible on the national agenda. These include nutrition interventions, hygiene, early child development, child protection and social protection.

A VISION FOR CHILD WELL-BEING IN TANZANIA

People's freedom to lead the lives they value is severely curtailed if they experience crippling deprivations early in life. At their most extreme, children may "succumb to premature mortality". If children manage to survive, denying them the opportunity to attend school or "to achieve sufficient nutrition, or to obtain remedies for treatable illnesses, or... to be adequately clothed or sheltered, or to enjoy clean water and sanitary facilities" will lead to impaired lives (Sen, 1999). In these circumstances, children are unnecessarily deprived of the chance to realise their full potential.

A comprehensive strategy for children's development must, therefore, deliberately strive to close the gaps and disparities that leave some children behind. Based on the evidence in this report, the following priority areas for action have been identified.

Child Survival

Infant and under-five mortality rates have improved substantially in Tanzania over the last decade. MKUKUTA, MKUZA and MDG targets for under-five mortality are all within reach if the pace of recent progress is sustained. However, neonatal mortality has not shown the same rate of decline, and now accounts for half of all infant deaths and almost a third of under-five deaths. Neonatal mortality is intrinsically linked with maternal mortality which has also remained exceptionally high.

There is an urgent need to expand cost-effective access to skilled attendance and emergency obstetric care at delivery, as well as neonatal and postnatal care for newborns, with a focus on reaching disadvantaged mothers and children. The *National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania*, launched by President Kikwete in April 2008, represents a critical opportunity to reduce maternal mortality and improve child well-being through safeguarding the health of mother and child through pregnancy, delivery and the post-natal period when so many young lives are lost.

An integrated framework for early childhood needs to be developed that transcends the emphasis on single, disease- or sector-specific interventions to ensure that vulnerable children are neither neglected nor allowed to slip through cracks between individual programmes. While it is widely accepted that progress in one sector will have flow-on benefits to other sectors, truly multi-sectoral strategies are in short supply. Administrative and implementing responsibilities for programmes that impact child outcomes are commonly divided between different ministries, agencies and development actors, with few opportunities for interaction. By positing key programmes for children within an integrated approach, gaps in provision can be more clearly identified and inter-sectoral cooperation and synergies can be harnessed for the benefit of all children.

For example, a framework for early childhood will include antenatal care, skilled assistance at delivery, basic and comprehensive emergency obstetric care, neonatal and post-natal care, immunisation and IMCI. But it will also highlight entry points for inter-programme and inter-sectoral collaboration – nutrition, child protection, education and social protection – to ensure comprehensive provision of child services. If strengthened, linkages and efficiencies could significantly reduce costs for implementing agencies and reduce the burden of time and cost on families.

Water and Sanitation

Progress in the water sector has been slow, undermined by a history of under-investment in water infrastructure, and recent data indicates that access to clean and safe water sources is declining. A more coordinated approach through the Water Sector Development Programme will lead to better outcomes, but achieving adequate support to local government authorities and implementing appropriate accountability mechanisms for the effective use of water resources will be ongoing challenges. Improving coverage, especially in rural areas, and addressing geographical disparities must be top priorities.

Most households have access to a basic latrine, but without improvements such as a washable slab, these latrines are often unsanitary and vectors for disease. There is also a need to step up public health campaigns promoting improved household hygiene practices, without which, any gains in water and sanitation, however costly, will be compromised.

Additionally, priority must be given to meeting national standards for water and sanitation facilities in schools. Currently, most schools fail to meet basic sanitation needs, and children with disabilities and adolescent girls following menarche are particularly affected. Lack of clean water in a majority of healthcare facilities severely compromises the quality of care offered, with poor infection control practices endangering both staff and patients.

Education

Despite major successes, the primary and secondary education programmes face ongoing challenges – securing adequate resources, financial and human; achieving greater geographic and gender equity; improving the quality of educational inputs and outcomes; and meeting the needs of vulnerable children. More attention needs to be given to the quality and scope of tuition to ensure that today's graduates are equipped with the skills in demand in the labour market.

Periodic assessment of support to, and better coordination between, the various sub-sectors will facilitate planning and strategic resource allocation. Areas deserving of greater attention include early childhood development (to promote the holistic development of young children), technical and vocational education, adult literacy and non-formal education to meet the needs of 'hard to reach' children and youth.

A number of critical governance and accountability issues also exist in education delivery, including ensuring the appropriate exemptions from school charges, and combating the extensive use of corporal punishment in schools. In addition, access by citizens to information about local authorities' budgets and staffing is improving, but there is room for further improvements.

Adolescent Health and Development

Problems faced by adolescents deserve greater visibility and attention from policy makers. Tanzanian youths face a number of threats to their health, including HIV infections. Millions more suffer from sexually transmitted diseases, which can leave young women infertile and stigmatized by their families and communities. Teenage mothers are at a much higher risk of dying of pregnancy-related causes.

Increasing young people's knowledge of sexual and reproductive health (SRH) is critically important in its own right. Given the burden of morbidity and mortality among youth and the greater likelihood of risky behaviours in this population, every effort should me made to facilitate their access to SRH services. At the same time, knowledge

alone does not reduce exposure to infection. Evidence points to the importance of structural as well as behavioural interventions. Gender and social mores, poverty and vulnerability that disproportionately impact young women must also be addressed.

The youth population in Tanzania is reaching unprecedented levels, and formal educational systems are unable to accommodate the growing demand. As a result, many young people fail to complete primary education, and access to secondary and higher education is even more limited. Young people, therefore, face an uphill battle to gain the skills and experience they need to compete in the job market or make a living through self-employment. The majority of youth end up working in the informal sector with limited opportunities to earn sufficient income to break out of the poverty cycle. Further investment in education, vocational training and life skills, and in creating meaningful employment opportunities for young people is essential to enable them to thrive as tomorrow's healthy, informed, and active citizens.

Budgets and Implementation

Progress in providing quality services for children is integrally connected with reforms to strengthen government systems. Policy makers are frequently torn between multiple demands on the national budget, and mismatches between budget allocations, medium term expenditure frameworks and sectoral development plans. In turn, implementation of policies often falters due to severe constraints at the local level.

Substantial off-budget financing is being made available for some programmes for children, which has relieved pressure on government plans and budgets. However, local authorities still have insufficient funding to discharge their responsibilities and meet service delivery targets. Major gaps between costed plans and actual budget allocations are common, and existing systems of disbursements are still complex and non-transparent. In reality, the system of planning is often ad hoc – based on whatever is received, whenever it is received.

The absence of clear and predictable flows of funds undermines local planning and budgeting, unnecessarily hampering the effective utilisation of limited resources. From a plethora of uncoordinated projects, the government is therefore keen to move towards general budget support, sector-wide approaches, and pooled funding. Full implementation of formula-based allocations to local authorities, increased on-budget financing and an increased share of budgetary resources flowing to local authorities will be essential for strengthening local capacity and services that impact child outcomes.

Staffing, too, is a critical constraint in providing quality services for children. Increased incentives for staff to work in remote, rural communities are being implemented, but many areas still suffer acute shortages of trained personnel. More teachers, health staff, child protection officers and social workers are urgently required to meet needs. While changes are being made to streamline flows of funding to local governments, there is a persistent capacity challenge ahead.

Ultimately, children will only benefit when programmes in their best interest are accorded greater priority in budget discussions. Advocacy is required so that children's concerns are mainstreamed into regular planning and budgeting. To improve accountability for results, public and parliamentary oversight of government will need strengthening too.

Transformative Social Protection

Despite the achievements of vertical programmes, the incidence of severe deprivation among Tanzanian children is exceedingly high, and large disparities in key indicators of child outcomes persist on the Mainland and, to a lesser degree, in Zanzibar. Children from rural areas and the poorest households are commonly worse off than their urban and least poor peers.

The development of universal mechanisms for delivering essential social services to poor families is a basic foundation of a comprehensive strategy for improving child outcomes. Broad-based programmes that acknowledge overlapping interests between poor and non-poor, and that rely on common institutions for delivery have demonstrated the capacity to sustain political support and promote

social cohesion. When programmes fall short, a framework of social protection must be available to safeguard children's rights and well-being.

Such a framework goes well beyond the implementation of narrow, time-bound safety nets of a temporary or emergency nature, but will require a combination of strategies and instruments that include:

- Protective programs that offer relief from economic and social deprivation, including alleviation of chronic and extreme poverty.
- Preventive programs, such as health and unemployment insurance, and non-contributory pension schemes, that are put in place before a shock to mitigate the impact of the event and avert deprivation.
- Promotive programs that enhance assets, human capital and income earning capacity among the poor and marginalised, such as skills training and active labour market programs.
- Transformative interventions that aim to address persistent disadvantages due to stigma, discrimination or power imbalances, which create or sustain marginalization and social exclusion (Devereux and Sabates-Wheeler, 2004).

A system of social protection that combines all four strategies to respond to diverse needs is not merely compensatory. It can play a critical developmental role in support of economic growth and productivity – by enabling universal access to essential social services, removing barriers to risk-taking behaviour, and enhancing their capacities for self-reliance. A system of this kind is not a luxury as the experiences of developed economies convincingly attest – the expansion of social protection in those countries was an integral part of socio-economic development and rising prosperity. A comprehensive social protection framework is also consistent with Tanzania's overall development vision, as reflected in the aspirations and goals of Vision 2025 and MKUKUTA on the Mainland, and Vision 2020 and MKUZA in Zanzibar.

The larger transformation of Tanzania through the development of the rural economy and broad-based economic opportunities, through skills accumulation, encouragement of investment and expansion of social security, health insurance and pension schemes will take time. So will reducing women's workloads and promoting change in social customs that perpetuate discriminatory practices and limit care for children. In the meantime, destitute and vulnerable families and children deserve better organised and supportive protection, administered through responsive national systems.

The choice of delivery mechanisms will depend on the particular circumstances of each household and community. Whatever the mix of strategies adopted, increasing the budgetary provision for social protection will signify greater recognition of national responsibility for the care and protection of children. This, in turn, can be expected to engender greater commitment and coordination among development partners. Local authorities must also be fully equipped to fulfil their responsibility for implementation of social protection programmes, and to coordinate the efforts of community-based, faith-based and other non-governmental organisations. Programmes that aim at inclusiveness are likely to generate strongest public support. All children, whether they are most vulnerable or slightly less so, need to have access to social protection when necessary. This will enable them to seek health care when sick, to stay in school, and to avail themselves of every opportunity to develop their full potential.

A Children's Statute

The timely passage of a unified Children's Act, now being considered by Parliament on Mainland Tanzania, will underpin progress in the key priority areas discussed above, and lay a solid foundation for the realisation of children's rights. This Act is urgently required to supersede the fragmented and inconsistent laws now affecting children, both in national legislation and in customary and religious laws that prevail in many communities. A Children's Act will comprehensively codify the rights of children, establish common definitions and standards, spell out the obligations of Tanzania under the Convention on the Rights of the Child, and define the roles and responsibilities

of the diverse range of actors in the realisation of children's rights – including families in their primary care-giving role, communities, voluntary and private agents, local governments, the police and courts, and ministries and departments of the central government.

Indeed, such legal reform will represent the linchpin for a transformative strategy of social protection, by establishing the rights and obligations to protect Tanzania's youngest citizens from discretionary acts, neglect or abuse by relatives or government officials. So it comes as welcome news that the Government issued an instruction at the start of 2009 to draft and enact the Children's Act, which was tabled in Parliament for its first reading during its July session. A similar development is expected to take place in Zanzibar in the coming months.

Public consideration of the Children's Act will also facilitate open discussion of sensitive social mores and attitudes towards children. Its enactment and dissemination will provide an invaluable opportunity to raise the profile of children on the national agenda. All stakeholders will need to be actively involved to ensure that the Act is drafted and implemented in the "best interest of the child".

CONCLUSION

The robust and sustained economic growth since 2000 provides a unique opportunity to reflect on what is needed for Tanzania to realise the aspirations so cogently laid out in Vision 2020 in Zanzibar and Vision 2025 on the Mainland. Despite perceptions to the contrary, economic growth does not benefit children automatically. Whether they benefit from the growth strategies will ultimately depend on how the benefits of growth are distributed, and how resources are allocated and disbursed.

The involvement of strong advocates for children and young people will be critical in discussions of national strategies for accelerating growth, and on budget priorities associated with those strategies. For civil society organisations, the main challenge will be to foster broad public and political commitment for children's rights. It is imperative to overcome the perception that children are a private, domestic responsibility – largely of women in the family and teachers in school. There must be greater awareness of the obligations of all duty-bearers in protecting and fulfilling child rights.

Children are Tanzania's future. Investing in them – and closing the gaps that leave so many behind – is the best investment the country can make.

Appendices

APPENDIX 1: GROSS DOMESTIC PRODUCT, VARIOUS YEARS, AT 2001 PRICES.[A]

Economic Activity	Value in TShs billion				Annual growth rate				Percentage of total			
	2001	2005	2006	2007	2001	2005	2006	2007	2001	2005	2006	2007
Agriculture	**2,636**	**3,148**	**3,268**	**3,400**	**4.9**	**4.3**	**3.8**	**4.0**	**29.0**	**27.6**	**26.2**	**25.8**
Industry and Construction	**1,638**	**2,433**	**2,640**	**2,890**	**6.6**	**10.4**	**8.5**	**9.5**	**18.0**	**20.8**	**20.8**	**21.2**
of which: mining and quarrying	160	295	341	376	13.9	16.1	15.6	10.7	1.8	2.9	3.2	3.5
manufacturing	762	1,017	1,162	1,263	5.0	9.6	8.5	8.7	8.4	7.9	7.8	7.8
construction	475	752	824	904	7.6	10.1	9.5	9.7	5.2	7.8	7.8	7.8
Services	**4,140**	**5,597**	**6,036**	**6,528**	**6.4**	**8.0**	**7.8**	**8.1**	**45.5**	**42.5**	**43.3**	**43.3**
of which: trade and repairs	1,183	1,586	1,737	1,907	6.4	6.7	9.5	9.8	13.0	11.0	11.4	11.5
hotels and restaurants	251	302	315	329	4.8	5.6	4.3	4.4	2.8	2.5	2.6	2.7
transport	487	628	661	704	4.9	6.7	5.3	6.5	5.4	4.4	4.3	4.2
communications	113	201	240	288	8.7	18.8	19.2	20.1	1.2	1.7	2.1	2.3
financial intermediation	140	205	228	251	6.9	10.8	11.4	10.2	1.5	1.7	1.7	1.6
real estate, business services	936	1,227	1,316	1,408	4.2	7.5	7.3	7.0	10.3	9.5	9.6	9.5
public administration	641	971	1,033	1,103	10.5	11.4	6.5	6.7	7.0	8.0	8.0	7.9
education	189	225	236	249	11.4	4.0	5.0	5.5	2.1	1.6	1.5	1.4
health	119	164	178	193	5.6	8.1	8.5	8.8	1.3	1.5	1.5	1.6
GDP (at 2001 market prices)	**9,100**	**12,068**	**12,881**	**13,802**	**6.0**	**7.4**	**6.7**	**7.1**	**100.0**	**100.0**	**100.0**	**100.0**
Average annual exchange rate (TShs=$1)	876.4	1,128.8	1,251.9	c1,250[b]								

Sources: NBS, Revised National Accounts Estimates for Tanzania Mainland, Base Year 2001, Dar es Salaam, July 2007
Ministry of Finance and Economic Affairs, Guidelines for the Preparation of Medium Term Plan and Budget Framework for 2008-09 - 2010-11, Dar es Salaam, March 2008.

Notes: [a] for Mainland Tanzania; [b] Bank of Tanzania, Economic Bulletin Dec 2008 shows 1,244.1 as the annual average for 2007

APPENDIX 2: ADAPTATION OF GLOBAL STUDY INDICATORS TO THE TANZANIAN CONTEXT

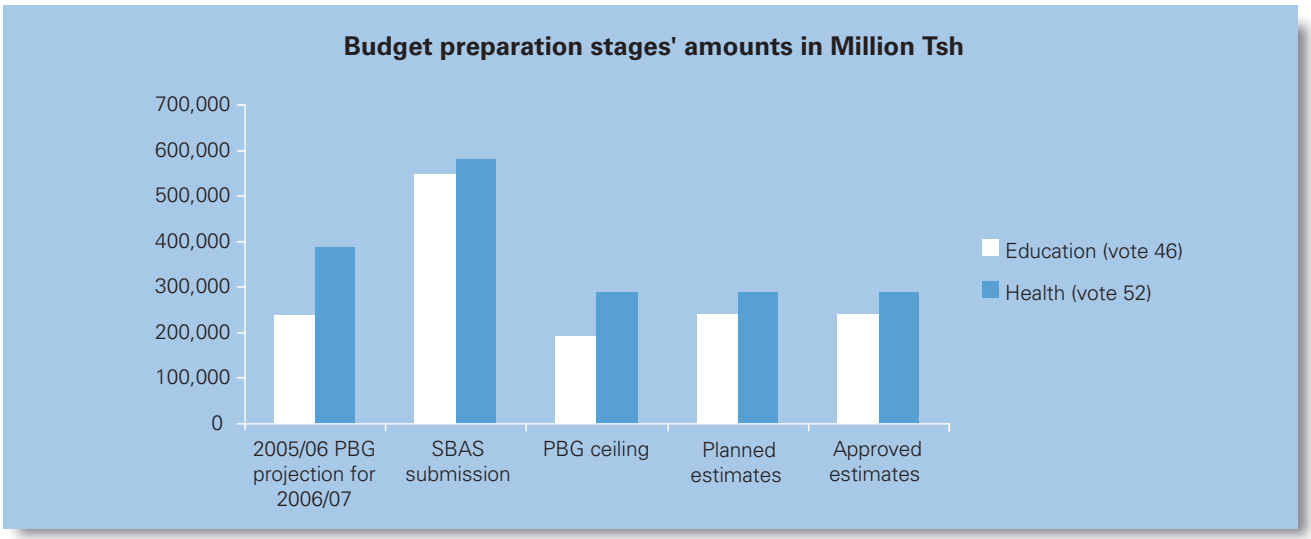
Form of Severe Deprivation	Global Study Indicator	Adaptation for Tanzania	Indicator for Future Analyses in Tanzania	MDG
Nutrition	Children whose heights and weights for their age are more than –3 standard deviations below the median of the international reference population – severe anthropometric failure.	No change. Note, however, that these are more stringent criteria for malnutrition in children than those currently used by indicators in the MKUKUTA monitoring system.	Children whose heights and weights for their age are more than –3 standard deviations below the median of the international reference population – severe anthropometric failure.	MDG 1: Eradicate extreme poverty and hunger MDG 4: Reduce child mortality
Health	Children who either have not been immunised against any diseases or young children who have a recent illness involving diarrhoea and have not received any medical advice or treatment.	No change.	Children who either have not been immunised against any diseases or young children who have a recent illness involving diarrhoea and have not received any medical advice or treatment.	MDG 4: Reduce child mortality
Shelter	Children in dwellings with more than five people per room (severe overcrowding) or with no flooring material (for example, a mud floor).	Assessed as too stringent as mud flooring is prevalent in rural homes. Therefore, quality of construction or walls and roof of dwelling are also considered.	Children in dwellings with more than five people per room (severe overcrowding) or in dwellings with no floor material and walls made of poles, mud or grass, and roof made of grass, leaves or mud.	MDG 7: Ensure environmental sustainability
Water	Children who only have access to surface water (e.g. rivers) for drinking or who live in households where the nearest source of water is more than 15 minutes away – these are indicators of severe deprivation of water quality or quantity).	Access to water within 15 minutes is not the norm in rural areas, therefore the majority of children would be labelled as severely deprived. Threshold for distance to nearest water source raised to 30 minutes.	Children who only had access to surface water (e.g. rivers) for drinking or who lived in households where the nearest source of water was more than 30 minutes away.	MDG 4: Reduce child mortality
Sanitation	Children who have no access to a toilet of any kind in the vicinity of their dwelling – no private or communal toilets or latrines.	Traditional pit latrines, which are the most common type of toilet in Tanzania, are often of very poor quality and unsanitary.	Children who have no access to a toilet of any kind in the vicinity of their dwelling, or have access to an unimproved pit latrine.	MDG 7: Ensure environmental sustainability
Information	Children aged between three and 18 who live in a household with no access to, radio, television, telephone or newspapers at home.	No change.	Children aged between three and 18 who live in a household with no access to, radio, television, telephone or newspapers at home	MDG 2: Achieve universal primary education MDG 3: Promote gender equality and empower women
Education	Children aged between seven and 18 who have never been to school and are not currently attending school (e.g. no professional education of any kind)	No change.	Children aged between seven and 18 who have never been to school and are not currently attending school (e.g. no professional education of any kind)	MDG 2: Achieve universal primary education MDG 6: Combat HIV/AIDS, malaria and other diseases

APPENDIX 3: PEFAR ON THE BUDGET PROCESS

MTEF projections are not used by the MDAs as the basis for budget planning. Instead, the MDAs prepare their initial annual submissions from an open-ended basis that are not subject to any resource constraint. In some sectors an added complexity is that budget requests are drawn from priorities from sub-sector programmes (such as the Primary Education Development and Secondary Development Programme in the education sector), which are then added up with little consideration as to whether the total amount is realistic or not. This lack of resource constraint results in requests which are unrealistic and tend to be significantly higher than projected ceilings presented in the PBG. In the team's view, the absence of prior guidance from central agencies makes the basis for MDA requests unclear and the drastic reductions required to reach affordable budget ceilings make it difficult for stakeholders to see any transparent application of clear priorities. Figure A.1 illustrates the significant fluctuations between the various stages of the budget preparation process in the following two ministries: education and health.

Justifications for the high initial requests from MDAs include: (1) a need to demonstrate performance (i.e. to demonstrate the Ministry's "capacity" to undertake work); (2) the recognition that the MTEF projection is not reliable, particularly as, as many MDAs argue, the environment and priorities have changed considerably since these projections were initially set; (3) translation of MKUKUTA strategy (a compilation of desire and wishes which is unprioritised) into implementable activities; (4) a lack of clear demarcation of roles and responsibilities between Ministry and LGAs, as such the Ministry includes activities that may be under the responsibility of the LGAs; and (5) insufficient coordination and unclear division of labour between the programme staff (i.e. for example in the case of education PEDP and SEDP staff) and budget staff within MDAs in budget preparation (PEFAR, 2007).

Figure A.1: Budget Preparation Stages Amounts (TShs million)



APPENDIX 4: PEFAR ON THE COMPLEXITY OF BUDGETING

Disconnect between budget and programme documents, lack of coordination and authority between budget and programme officers within Ministries, Departments and Agencies.

There is an additional challenge related to the lack of integration of sub-sectors programmes within an overall sector budget framework. These sub-sector programmes represent a large part of the sector's budget (i.e. PEDP and SEDP in the case of vote 46) and have a high political profile: for instance, PEDP II, finalised in January 2007, has been endorsed by the President. However, approved MDAs budgets often do not reflect the cost of the sub-sector programmes, resulting in the need to reduce the budget of these programmes: eventually, only a small percentage of the sub-sector programme is implemented.

For FY04/05, only about 23% of planned costs of PEDP and 24% of planned costs of SEDP were included in the budget. The FY06/07 Education sector annual action plan shows a financing gap of 80% between requirement for basic education (mostly based on PEDP and SEDP costed plans) and actual budget allocation. Nevertheless, in the course of execution, the programme documents and their initial costs remain the key references in the dialogue between MDAs staff, development partners and civil society.

This problem is partly the result of poor coordination between programme and budget staff within MDAs and the lack of influence of budget officers/directors. Often, the latter, during the budget preparation process, even if they recognise the unrealistic requests from within their Ministry, do not have the authority vis-à-vis the programme staff/heads of departments to adjust their (sometimes inflated) submission before they send them to MoF, which were the cases at the MoHSW and the MoEVT.

In MoEVT, it is obvious that decades of external assistance based on projects and basket funds have margin alised both the budget itself and the officers in charge of its elaboration. In the context of a move towards general budget support, overthrowing this entrenched legacy would call for a high level (Ministry and Permanent Secretary) recognition of the prominent role of the budget as a key leading instrument for policy implementation which should be reflected in a closer relationship between programme and budget officers.

Source: PEFAR, 2007.

REFERENCES

Background Papers

Dyer, K. (2008). 'Pillars of child well-being: Education, Mainland Tanzania'.

Kessy, F. (2008). 'Child poverty and disparities in Zanzibar'.

Leach, V. (2008). 'Pillars of child well-being: Nutrition, Mainland Tanzania'.

Leach, V. (2008). 'Pillars of child well-being: Social protection, Mainland Tanzania'.

Mamdani, M. (2008). 'Pillars of child well-being: Health, Mainland Tanzania'.

Mamdani, M. (2008). 'Pillars of child well-being: HIV/AIDS, Mainland Tanzania'.

Mhamba, R. (2008). 'Pillars of child well-being: Child protection, Mainland Tanzania'.

Mainland Tanzania and General References

Alderman, H., Hoogeveen, J., & Rossi M. (2005). 'Reducing child malnutrition in Tanzania', World Bank Policy Research Working Paper 3567.

Alderman, H., Hoogeveen, J., & Rossi M. (2006). 'Pre-school nutrition and subsequent schooling Attainment: Longitudinal evidence from Tanzania'. World Bank.

Anon. (2004, April). 'IMCI documentation in Tanzania. Experiences, progress, and lessons learned', Unpublished draft.

Anon. (2005). 'Report of the change agents immunization study tour to Tanzania', 25 August to 4 September 2005.

Armstrong Schellenberg, J., Abdulla, S., Nathan, R., Mukasa, O. et al. (2001). 'Effect of large-scale social marketing of insecticide-treated nets on child survival in rural Tanzania'. Lancet, 357(9264): 1241-7.

Armstrong Schellenberg, J., Adam T., Mshinda, H., et al. (2004). 'Effectiveness and cost of facility-based Integrated Management of Childhood Illness (IMCI) in Tanzania'. Lancet, 364(9445): 1583-94.

Armstrong Schellenberg, J., Victora, C., Mushi, A., de Savigny, D. et al. (2003). 'Inequities among the very poor: Health care for children in rural southern Tanzania'. Lancet, 361(9357): 561-6.

Assad, M., & Kibaja, A. (2007). 'Resource Allocation and Challenges of Education Reform in Tanzania'. Paper presented to the Education Sector Review Workshop.

Beegle, K., de Weerdt, J., & Dercon, S. (2006). 'Orphanhood and the long-run impact on children'. American Journal of Agricultural Economics, 5: 1266-72.

Bryce, J., Victora, C.G., Habicht, J.P. et al. (2005). 'Programmatic pathways to child survival: Results of a multi-country evaluation of Integrated Management of Childhood Illness'. London: Oxford University Press & London School of Hygiene and Tropical Medicine.

Bureau of Statistics [Tanzania] & ORC Macro. (1997). 'Tanzania Demographic and Health Survey 1996'. Dar es Salaam: Bureau of Statistics and ORC Macro.

Carlitz, R. (2007). 'Following the money for education: A case study in complexity', HakiElimu Working Paper 07.8. Dar es Salaam: HakiElimu

Chastre, C., & Kindness, H. (2006). 'Access to primary health care: Evidence from Singida Rural District'. Save the Children.

Commonwealth Human Rights Initiative. (2006). 'The police, the people, the politics: Police accountability in Tanzania'.

CSO. (2008, 15 January). Tanzania Civil Society Inputs. CSOs Technical Submission to the Draft of Bill Supplement on HIV and AIDS (Prevention and Control).

de Savigny, D., Kasale, H., Mbuya, C., & Reid, G. (2004). 'Fixing health systems'. IDRC in collaboration with MoHSW, Tanzania.

de Waal, A., Tumushabe, J., Mamdani, M., & Kilama, B. (2004). 'Changing vulnerability to crisis in Tanzania: Implications for children and UNICEF activities'. A report to UNICEF Tanzania.

Development Partners' Group (DPG). (2007). 'Tanzania baseline study', April 2007. Available at http://www.tzdpg.or.tz/index.php?id=116.

Devereux, S., & Sabates-Wheeler, R. (2004). 'Transformative Social Protection', IDS Working Paper 232, Institute of Development Studies, Brighton.

Devereux, S., & Sabates-Wheeler, R. (2007). 'Editorial introduction: Debating social protection', IDS Bulletin, 38(3), 1-7.

Dunn, A., & Mhamba, R. (2009). 'Situation, trends and disparities in child protection in Tanzania Mainland. Draft report for UNICEF Situational Analysis, June 2009.

Family Health International. (2006). 'Voluntary HIV counseling and testing services for youth and linkages with other reproductive health services in Tanzania'. Youth Research Working Paper No. 5., 2006.

Gordon, S., Nandy, S., Pantazis, G., Pemberton, S., & Townsend, P. (2003). 'Child poverty in the developing world'. Bristol, UK: The Policy Press.

HakiElimu. (2007a). 'Is secondary education progressing? Key findings from government reviews of SEDP implementation'. Dar es Salaam: HakiElimu.

HakiElimu. (2007b). 'Redefining quality education in Tanzania: From inputs to capabilities'. Dar es Salaam: HakiElimu.

Health Equity Group. (2007). 'Commentary on the Health Sector Budget for 2006/7'.

Health Research for Action. (2006). 'District Health Services Delivery in Tanzania: Where are we in terms of quantity and quality of health care provision? – Final Report'. Independent Technical Review of the health sector on behalf of the MoHSW, PMO-RALG and the Government of Tanzania, April 2006.

Helen Keller International (HKI) & TFNC. (2005). 'Summary of Important Findings from the Population Based Assessment.' Unpublished Report. Dar es Salaam: HKI Tanzania.

International Labor Organization (ILO) – Geneva, Social Security Department. (2008). Tanzania Mainland. Social Protection Expenditure and Performance Review and Social Budget. Executive Summary.

International Labor Organization (ILO), International Programme on the Elimination of Child Labour (IPEC). (2006). 'Independent evaluation: Supporting the time-bound programme on the worst forms of child labour in Tanzania'.

International Monetary Fund. (2009). 'World Economic Outlook Database', April 2009.

International Organization for Migration (IOM). (2008). 'IOM counter trafficking initiative in Tanzania'.

Joint External Evaluation (JEE). (2007). 'Joint external evaluation (JEE) of the health sector in Tanzania: 1999-2006', Evaluation summary.

John, T. (2005). 'Tanzania under-five mortality reduced by a quarter: Why?' Paper presented at Countdown to 2015 Child Survival, London, 13-14 December 2005.

Joint Technical Mission (JTM). (2006). 'Summary of Joint Technical Mission outcomes and progress made in country-level response to PMTCT and paediatric HIV CST Tanzania', 10-16 October 2006.

JSI Research & Training Institute, Inc. (2007). 'Evaluation of the African Youth Alliance programme in Tanzania: Impact on sexual and reproductive health behaviour among young people'. Virginia, USA.

Laterveer, L., Munga, M., & Schwerze, P. (2004). 'Equity implications of health sector. User fees in Tanzania: Do we retain the user fees or do we set the user free?' Report commissioned by Research and Analysis Working Group, Dar es Salaam.

Leach, V. (2007). 'Children and vulnerability in Tanzania: A brief synthesis'. Special Paper 07.25. Dar es Salaam: REPOA.

Leach, V., & Kilama, B. (2007). 'Institutional analysis of nutrition in Tanzania'. Report for the World Bank [Tanzania], Dar es Salaam.

Lindeboom, W. & Kilama, B. (2004). 'Trends in malnutrition in Tanzania'. Draft report submitted by REPOA to the World Bank [Tanzania], Dar es Salaam, September 2004.

Lindeboom, W., Leach V., Mamdani M. & Kilama, B. (2006). 'Vulnerable children in Tanzania and where they are.' A report submitted to UNICEF by REPOA.

Lindeboom, W., Mhamba, R., Kilama, B., & Leach, V. (2007). 'Towards revising the costed national MVC programme'. A report for the Ministry of Health and Social Welfare. Dar es Salaam: REPOA.

Maarifa ni Ufunguo. (2008). 'Cost sharing in education in Kilimanjaro III: 2008 – Gaps are widening. A follow-up to studies conducted in 2000 and 2002. Compiled on behalf of Maarifa ni Ufunguo by Kate Dyer.

Mamdani, M. (2007). 'Health insurance options for Tanzania. A review of national and international experiences'. Background paper (unpublished).

Mamdani, M., & Omondi, F. (2008). 'Social protection of vulnerable children in Tanzania Mainland: Evidence, limits and challenges'. A socio-economic policy case study submitted to Learning Group 4, Joint Learning Initiative on Children and AIDS. REPOA, Dar es Salaam.

Mamdani, M., Rajani, R., & Leach, V. (2008). 'How best to enable support for children with HIV/AIDS: A policy case study in Tanzania'. A summary of the study for the Joint Learning Initiative on Children and AIDS (JLICA), IDS Bulletin, 39(5): 52-61.

Marchant, T., Bruce, J., Nathan, R., Mponda, H., Sedekai, Y., & Hanson, K. (2008). 'Report on 2007 TNVS household, facility services and facility users surveys (a comparison across three surveys years)'. Ifakara Health Research and Development Centre (IHRDC) and London School of Health and Tropical Medicine (LSHTM), Dar es Salaam, pp. 1-36.

Ministry of Agriculture and Food Security [URT] (MAFS). (2004). 'National Food Security Policy (Draft)'.

Ministry of Community Development, Gender and Children [URT] (MoCDGC). (1996). 'Child Development Policy'.

MoCDGC. (2001). 'A national plan of action for the prevention and eradication of violence against women and children 2001-2015: Stop gender-based violence'.

Ministry of Education and Culture [URT] (MoEC). (1995). 'Education and Training Policy'.

MoEC. (2001). 'Education Sector Development Programme: Primary Education Development Plan (2002-2006)'. Basic Education Development Committee, Dar es Salaam.

Ministry of Education and Vocational Training [URT] (MoEVT). (2006). 'Basic Education Statistics Tanzania, regional data'. Dar es Salaam: MoEVT

MoEVT. (2007a). 'Education Sector Development Programme: Draft Education and Training Sector Development Programme, 2008-17'. Dar es Salaam: MoEVT.

MoEVT. (2007b). 'Basic Education Statistics Tanzania'. Dar es Salaam: MoEVT.

MoEVT. (2007c). 'A tracer study report for COBET graduates in the six selected councils'. A study conducted in Tanzania Mainland.

MoEVT. (2007d). 'Education Sector Development Programme (ESDP): Education performance report 2006/07'.

MoEVT. (2008). Basic Education Statistics Tanzania'. Dar es Salaam: MoEVT.

Ministry of Finance and Economic Affairs [URT] (MoFEA). (2007). 'Budget for fiscal year 2006/07: Quarterly budget execution report for fiscal quarter IV and Annual report July 2006-June 2007', October 2007.

MoFEA. (2008), 'Guidelines for the Preparation of Medium Term Plan and Budget Framework for 2008-09 - 2010-11',

Ministry of Health [URT] (MoH). (2002). 'Second Health Sector Strategic Plan (July 2003 – June 2008) – Reforms towards delivering quality health services and clients satisfaction', April 2003.

MoH. (2003a). 'Health Sector HIV and AIDS Strategy for Tanzania, 2003-2006'.

MoH. (2003b). 'Second Health Sector Strategic Plan, July 2003-June 2008'.

MoH. (2003). 'Assessment of CHF in Tanzania: Factors affecting enrolment and coverage'.

MoH. (2004a). 'National Food and Nutrition Policy (revised)'. Dar es Salaam: MoH.

MoH. (2004b). 'Proposals for Health Sector Reform', December 2004.

Ministry of Health and Social Welfare [URT] (MoHSW). (2006a). 'Health Sector Public Expenditure Review Update FY06 – Final Report', September 2006.

MoHSW. (2006b). 'Guidelines for Community-Based Care and Support of Orphans and Vulnerable Children'.

MoHSW. (2006c). 'National Guidelines for Pr ovision and Management of Foster Care and Adoption Services'.

MoHSW. (2006d). 'National Guidelines for the Establishment and Management of Children's Homes'.

MoHSW. (2006e). 'District Health Services Profile 2005 – Information for Council Health Management Teams 2005-2006 District Health Year and 2006 Planning Cycle.

MoHSW. (2006f). 'PMTCT summary report 2006'.

MoHSW. (2006g). 'National Health Policy (draft)'.

MoHSW. (2006h). 'Community Health Fund facilitative supervision report'.

MoHSW. (2007a). 'Health Sector HIV and AIDS Strategy II (HSHSP) 2008-2012'. Final draft, June 2007.

MoHSW. (2007b). 'National Nutrition Strategic Plan (2006/07 – 2009/10)'. Draft, September 2007.

MoHSW. (2007c). 'National MVC Plan of Action'.

MoHSW. (2007d). 'EPI annual evaluation meeting report, 19-23 March 2007, Dar es Salaam.

MoHSW. (2007e). 'Primary Health Services Development Programme, 2007 – 2017'. Dar es Salaam: MoHSW.

MoHSW. (2007f). 'Proceedings of the Joint Annual Health Sector Review', 24-26 September 2007, Dar es Salaam

MoHSW. (2007g). 'Health public expenditure review for FY08'. Presentation at the Joint Annual Health Sector Review, 24-26 September 2007, Dar es Salaam.

MoHSW. (2007h). 'MTEF FY 2007/2008'. Presentation at the Joint Annual Health Sector Review, 24-26 September 2007, Dar es Salaam.

MoHSW. (2007i). 'Making use of best practices in CHF management in Tanzania'. Documentation of the CHF Workshop, 31 January-2 February 2007, Dar es Salaam.

MoHSW. (2008a). 'National Road Map Strategic Plan to Accelerate Reduction of Maternal and Newborn Deaths in Tanzania (2006-2010)'. Dar es Salaam: MoHSW

MoHSW. (2008b). 'Health Sector Public Expenditure Review Update FY 07'. Draft report, April 2008.

MoHSW. (2008c). 'National Costed Plan of Action for Most Vulnerable Children, 2007-2010'. Dar es Salaam: MoHSW.

MoHSW. (2009). 'National Nutritional Strategy (July 2009-June 2015)', Final draft, March 2009.

Ministry of Justice and Constitutional Affairs [URT], Department of the Administrator General (Registrar General). (2007). 'Improving services to protect the rights of the most vulnerable children'. Country paper for presentation at the Eastern and Southern Africa Conference on Universal Birth Registration, 26-30 September 2007, Mombasa, Kenya.

Ministry of Labour, Employment and Youth Development [URT} (MoLEYD). (2006). 'Strategies for Elimination of Child Labour in Tanzania'. Dar es Salaam: MoLEYD.

Ministry of Labour, Youth Development and Sports [URT] (MoLYDS). (1996). 'Youth Development Policy'. Dar es Salaam: MoLYDS.

MoLYDS. (2003a). 'National Ageing Policy'. Dar es Salaam: MoLYDS.

MoLYDS. (2003b). 'National Social Security Policy'. Dar es Salaam: MoLYDS

MoLYDS. (2004). 'National Policy on Disability'. Dar es Salaam: MoLYDS.

Ministry of Planning, Economy and Empowerment [URT] (MPEE). (2006a). 'Millennium Development Goals Progress Report'. Dar es Salaam, December 2006

MPEE. (2006b). 'MKUKUTA Monitoring Master Plan and Indicator Information'. Dar es Salaam: MPEE.

MPEE. (2007a). 'Macroeconomic Policy Framework for the Plan/Budget 2007/08-2009/10'. Dar es Salaam: MPEE.

MPEE. (2007b). 'National Multisectoral Social Protection Framework (Second draft).'

MPEE & MoFEA. (2006). 'Guidelines for the Preparation of Medium-Term Plan and Budget Framework for 2006/07-2008/09'. Dar es Salaam: MPEE & MoFEA.

Ministry of Water and Irrigation [URT] (MoWI). (2007). 'Water Sector Development Programme 2006-2025'. Dar es Salaam: MoWI.

Mkenda, A. (2004). 'The benefits of malnutrition interventions: Empirical evidence and lessons to Tanzania'. Report for the World Bank.

Mujinja, P., Kirung, W., Furnivall M, et al. (n.d.). 'HIV Prevention Strategy for Tanzania Mainland and Two-Year Action Plan (2009/10-2011)'.

Nathan, R., Masanja, H., Mshinda, H., Armstrong Schellenberg, J., de Savigny, D., Lengeler, C. et al. (2004). 'Mosquito nets and the poor: Can social marketing redress inequities in access?' Tropical Medicine and International Health, 9(10): 1121-6.

National AIDS Control Programme (NACP). (n.d.). 'National Scale up Plan for the Prevention of Mother-to-Child Transmission of HIV and Paediatric HIV Care and Treatment, 2008-2012'.

National AIDS Control Programme (NACP). (2007). 'PMTCT and Paediatric HIV Care Report Card'. Report for period, January-December 2007.

NACP. 2003, 2004 & 2007. HIV/AIDS/STI Surveillance Reports No 17, 18 and 20. Dar es Salaam: MoHSW, NACP.

National Bureau of Statistics [URT] (NBS). (2002). 'Household Budget Survey 2000/01'. Dar es Salaam: NBS.

NBS. (2005). 'Agricultural Sample Census 2002-03. Preliminary Report of Basic Tables: Smallholder Data', August 2005. Dar es Salaam: NBS.

NBS. (2006). 'Population Census 2002 – Analytic Volume X'. Dar es Salaam: NBS.

NBS. (2007a). 'Tanzania in Figures 2006'. Dar es Salaam: NBS.

NBS. (2007b). 'Revised National Accounts for Tanzania Mainland, Base Year 2001'. Dar es Salaam, July 2007.

NBS. (2008a). 'Child Work and Labour in Tanzania'. Dar es Salaam: NBS.

NBS. (2008b). 'Tanzania in Figures 2007'. Dar es Salaam: NBS.

NBS. (2009). '2007 Household Budget Survey'. Retrieved 15 May 2008 from http://www.nbs.go.tz/HBS/HBS2007/7-Income%20Poverty%20and%20Inequality.pdf and http://www.nbs.go.tz/HBS/HBS2007/2-Household%20Demographic%20Composition.pdf.

NBS & Macro International Inc. (2000). 'Tanzania Reproductive and Child Health Survey 1999'. Calverton, Maryland: NBS and Macro International Inc.

NBS & Macro International Inc. (2007). 'Tanzania Service Provision Assessment Survey 2006'. Dar es Salaam: NBS and Macro International Inc.

NBS & MPEE. (2007). 'Integrated Labour Force Survey 2006 – Key Findings.' Dar es Salaam: NBS & MPEE.

NBS & ORC Macro. (n.d.) 'The Future is in Our Hands: Tanzania Youth, Reproductive Health and HIV Data from the 2004-05 Demographic and Health Survey (TDHS) and the 2003 Tanzania AIDS Indicator Survey (THIS)'. Dar es Salaam: NBS and ORC Macro.

NBS & ORC Macro. (2005). 'Tanzania Demographic and Health Survey (TDHS), 2004-05'. Dar es Salaam: NBS and ORC Macro.

National Malaria Control Programme (NMCP) (n.d). 'National ITN Implementation Plan: Achieving nation-wide ITN usage in the United Republic of Tanzania'. Dar es Salaam: MoHSW.

Nyerere, J.K. (1967). 'Education for Self Reliance'.

Oomman, N., Bernstein. M., & Rosenzweig, S. (2008). 'The numbers behind the stories – PEPFAR funding for Fiscal Years 2004 to 2006'. Washington DC: Center for Global Development.

Pathfinder International. 2006. 'Mapping of community home-based care services in five regions of Tanzania Mainland'.

President's Office (PO), Planning Commission. (1999). 'The Tanzanian Development Vision 2025'.

Prime Minister's Office [URT] (PMO). (2001). 'National Policy on HIV/AIDS'. Dar es Salaam: PMO, September 2001.

PMO. (2003). 'National Multi-Sectoral Strategic Framework on HIV/AIDS (2003-2007)'. Dar es Salaam: PMO, February 2003.

PMO. (2007). 'National Multi-Sectoral Strategic Framework on HIV and AIDS (2008-2012)'. Dar es Salaam: PMO, May 2007.

Prime Minister's Office – Regional and Local Government (PMO-RALG). 'MTEF 2007/08 – Support to Health Sector'.

PMO-RALG. (2007). 'Guidelines for the Preparation of Local Government Authorities' Medium Term Plans and Budgets for 2007/08 to 2009/10'.

PSI Tanzania. (2005). 'SMARTNET. A Tanzanian Public/ Private Partnership to Prevent Malaria'. Dar es Salaam: National Malaria Control Programme and PSI Tanzania, May 2005.

Public Expenditure and Financial Accountability Review (PEFAR). (2007). 'Review of fiscal performance and public expenditure management issues 2005/06 and first half of 2006/07 – Joint evaluation report'. Presented at the PEFAR/MKUKUTA Annual Consultative Meeting, Dar es Salaam, May 2007.

Registration Insolvency and Trustee Agency (RITA), Vital Registration Transformation Programme (n.d.). 'Vital transformation in six pilot districts'.

Research and Analysis Working Group (RAWG). (2002). 'Poverty and Human Development Report 2002'. Dar es Salaam: Mkuki na Nyota Publishers.

RAWG. (2003). 'Poverty and Human Development Report 2003'. Dar es Salaam: Mkuki na Nyota Publishers.

RAWG. (2004). 'Vulnerability and resilience to poverty in Tanzania: Causes, consequences and policy implications. 2002/3 Tanzania Participatory Poverty Assessment – Main Report'. Dar es Salaam: Mkuki na Nyota Publishers.

RAWG. (2005). 'Poverty and Human Development Report 2005'. Dar es Salaam: Mkuki na Nyota Publishers.

RAWG. (2006). 'Status Report 2006: Progress towards the goals for growth, social well-being and governance in Tanzania.' Dar es Salaam: REPOA

RAWG. (2007). 'Poverty and Human Development Report 2007'. Dar es Salaam: REPOA.

RAWG. (2008a). 'Views of the People 2007: Tanzanians give their opinions on growth and poverty reduction, their quality of life and social well-being, and governance and accountability.' Dar es Salaam: REPOA.

RAWG. (2008b). 'Tanzanian children's perceptions of education and their role in society: Views of the Children 2007'. Dar es Salaam: REPOA.

Research on Poverty Alleviation (REPOA) (2003). 'Policy and Service Satisfaction Survey 2003'. Dar es Salaam: REPOA.

REPOA. (2005). 'Social protection: Assuring a minimum income for the poorest in Tanzania'. A report commissioned by the Research and Analysis Working Group, Dar es Salaam, May 2005.

REPOA. (2006). 'Combating corruption in Tanzania: Perception and experience'. Afrobarometer Briefing Paper No.33. Dar es Salaam: REPOA.

Rubona, J.J. (2007). 'Monitoring and evaluation for health sector performance measurements for 2007'. Presentation at the Joint Annual Health Sector Review, Dar es Salaam, 24-26 September 2007.

Rwebangira, M. & Mramba, R. (2007). 'An updated reference document on policy and legal frameworks affecting the realisation of children's rights in Tanzania'. A report for REPOA, Dar es Salaam, November 2007.

Save the Children (UK). (2005). 'The unbearable cost of illness: Poverty, ill-health and access to healthcare – Evidence from Lindi rural district in Tanzania'. Dar es Salaam: Save the Children.

Sen, A. (1999). 'Development as Freedom'. New York : Knopf

Slater, R., Farrington, J. & Holmes, R. (2008). 'A conceptual framework for understanding the role of cash transfers in social protection'. ODI Project Briefing No.5, January 2008.

Smith, L. & Larsen G. (2004). 'Evaluation of GAVI immunization services support funding – Case study: Tanzania'. Washington, DC: Abt Associates, Inc. & Academy for Educational Development.

Smithson, P., Iteba, N., Mukasa, O., Mzige, A., Mapunda, M., & Minja, G. (2007). 'Performance-based financing. Report on feasibility and implementation options (Draft, version 6)'. A study coordinated by Ifakara Health and Research Development Centre on behalf of Ministry of Health and Social Welfare.

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

Sokoni, C.H., & Hambati, H. (2006). 'Transport services for primary school children in Tanzania: Implications for children's education. A Case Study in Ilemela and Magu Districts, Mwanza Region'. A research report submitted as work in progress to REPOA, October 2006.

Somi, G.R. (2007). 'The current status of HIV epidemic in Tanzania', 29 March 2007.

Songora, F.G. & Nsemwa, M. (2006). 'Let them talk: Voices from the Friends of Education Movement in Tanzania', Working Paper No. 06.5. Dar es Salaam: HakiElimu

Swai, R.O. (2005). 'Challenges of scaling up antiretroviral treatment in Tanzania'. Presentation at Annual Health Sector Review, Dar es Salaam, March 2005.

Tanzania Commission for HIV/AIDS (TACAIDS). (2008a). 'Tanzania Public Expenditure Review – Multi-Sectoral Review: HIV/AIDS (Final Report)'. Dar es Salaam, December 2007.

TACAIDS. (2008b). 'UNGASS Country Progress Report – Tanzania Mainland (Reporting period: January 2006 to December 2007). Dar es Salaam: TACAIDS.

TACAIDS, NBS & ORC Macro. (2005). 'Tanzania HIV/AIDS Indicator Survey 2003-04'. Calverton, Maryland, USA: TACAIDS, NBS & ORC Macro.

TACAIDS, Zanzibar AIDS Commission (ZAC), NBS, Office of the Chief Government Statistician [Zanzibar] (OCGS) & Macro International Inc. (2008). 'Tanzania HIV/AIDS and Malaria Indicator Survey 2007-08'. Dar es Salaam, Tanzania: TACAIDS, ZAC, NBS, OCGS & Macro International Inc.

Tanzania Food and Nutrition Centre (TFNC). (1997). 'National Vitamin A Mortality Reduction Programme: National Vitamin A Survey of 1997'. Dar es Salaam: TFNC.

TFNC. (2002). 'Baseline survey on the prevalence of low birth weight risk factors and levels of service and care provision in seven districts in Tanzania'. Dar es Salaam: TFNC.

TFNC. (2004). 'Prevention and control of iodine deficiency disorders in Tanzania – Second National IDD survey report No.2002'.

Tanzania Gender Network Programme (TGNP). (2007). 'Views on The HIV and HIDS (Prevention and Control) Act, 2007', Bill Supplement No.9, 21 September 2007.

TGNP and Swedish International Development Cooperation Agency (SIDA). (2006). 'Gender profile of Tanzania: Enhancing gender equity'.

Tanzania IMCI Multi-Country Evaluation Health Facility Study Group. (2004). 'The effect of Integrated Management of Childhood Illness on observed quality of care of under-fives in rural Tanzania'. Health Policy and Planning, 19(1): 1-10.

Tanzania Movement for and with Children. (2004). 'What children and young people are saying about poverty in Tanzania'. Dar es Salaam, June 2004.

Tanzania Social Action Fund (TASAF). (2008). 'Justification status for funds disbursed to local government authorities, Unguja and Pemba. Issued by Executive Director, TASAF. www.tasaf.org.

Tanzania Water and Sanitation Network (TAWASANET) (2008). 'Water: More for some…or some for more?'

Taylor, B. (2009). 'Water and sanitation hygiene in Tanzania'. Draft report for UNICEF Situational Analysis, June 2009.

The New School, Graduate Program in International Affairs. (2008). 'Child poverty and disparities in Tanzania: Analysis of the current situation and recent trends', Final Report. New York.

Tumbo-Masabo, Z., & Leach, V. (2008). 'What happened to the Children's Statute?' A draft report for the Joint Learning Initiative on Children and AIDS. Dar es Salaam: REPOA, February 2008.

UNAIDS. (n.d.). 'Comments on the United Republic of Tanzania's draft legislation – The HIV and AIDS (Prevention and Control) Act, 2007'.

UNAIDS & UNICEF. (2006). 'Africa's orphanhood and vulnerable generation'.

UNESCO, Regional Bureau for Education in Africa (BREDA). (2007). 'Dakar + 7 Report: Education for all in Africa – Top priority for integrated sector-wide policies'. Dakar: UNESCO, BREDA.

UNHCR. (2007). 'Annual Protection Report for Tanzania'.

UNICEF, Eastern and Southern Africa Regional Office (ESARO). (n.d.). 'Social protection in Eastern and Southern Africa: A framework and strategy for UNICEF'. Nairobi.

UNICEF [Tanzania]. (n.d.) 'Tanzania PMTCT & Paediatric AIDS Care Status'.

UNICEF. (2003). 'Basic education and life skills for adolescence (BELSA) programme summary'.

United Republic of Tanzania (URT). (Various years). 'The Economic Survey'. Available at http://www.tanzania.go.tz/economicsurveyf.html

URT. (2000). 'Constitution of The United Republic of Tanzania of 1977 with all amendments to 30 April 2000'.

URT. (2006a). 'Plus 5 review of the 2002 Special Session on Children and World Fit for Children Plan of Action'.

URT. (2006b). 'Report on Public Hearing of Child Abuse by the Commission for Human Rights and Good Governance.'

URT & International Labour Organisation. (2003). 'Baseline study and attitude survey on child labour and its worst forms'. Dar es Salaam, June 2003.

URT & UNICEF [Tanzania]. (2006). 'Country Programme Action Plan 2007-2010'. Dar es Salaam: URT & UNICEF.

Upunda, G. (2006). 'Government perspective: Progress in Tanzania'. Presentation in Ottawa, March 20-21, 2006.

USAID. (2006). 'Fact sheet – The President's Malaria Initiative (PMI)', 8 June 2006. Available at http://www.usaid.gov/press/factsheets/2006/fs060608.html

Van de Haar, F., Kavishe, F., et al. (1988). 'Public health importance of IDD in Tanzania'. Central African Journal of Medicine, 33: 60-5.

Vice President's Office [URT] (VPO). (2005). 'National Strategy for Growth and Reduction of Poverty (NSGRP)', June 2005. Dar es Salaam: VPO.

Women's Dignity Project (WDP). (2003). 'Poor people's experiences of health services in Tanzania: A literature review'. Dar es Salaam: WDP.

World Bank. (2007). 'Public expenditure and financial accountability (PEFA) indicators – the experience in Tanzania'. A presentation by Parminder Brar, Dar es Salaam, April 2007.

World Bank (2008). 'World Development Indicators database'. Retrieved 11 April 2008 from http://web.worldbank.org/WBSITE/EXTERNAL/DATASTATISTICS/0,,contentMDK:20398986~menuPK:64133163~pagePK:64133150~piPK:64133175~theSitePK:239419,00.html

World Bank. (2009). 'Key Development Data and Statistics'. Retrieved 28 June 2009 from http://web.worldbank.org/WBSITE/EXTERNAL/DATASTATISTICS/0,,contentMDK:20535285~menuPK:1390200~pagePK:64133150~piPK:64133175~theSitePK:239419,00.html

World Bank, Tanzania Food and Nutrition Centre & UNICEF. (2007). 'Advancing nutrition for long-term, equitable growth'. A report for economic sector work of World Bank.

World Health Organisation (WHO), Department of Child and Adolescent Health and Development. (2004). 'Multi-country evaluation of the Integrated Management of Childhood Illnesses – Analysis report on the costs of IMCI in Tanzania'. Geneva: WHO.

WHO, Special Programme for Research and Training in Tropical Diseases. (2006). 'Partnership for malaria control: Engaging the formal and informal private sectors'. Geneva: WHO.

WHO. (2009). 'World Health Statistics'. Retrieved from http://www.who.int/whosis/whostat/EN_WHSO9_Table7.pdf

Wuyts, M. (2006). 'Developing social protection in Tanzania within a context of generalised insecurity'. Special Paper 06.19. Dar es Salaam: REPOA.

Wylde, E., & Rutasitara, L. (2008). 'Understanding social protection policies in Tanzania'. Draft report, Dar es Salaam, February 2008.

ZANZIBAR

Bureau of Statistics [Tanzania] & ORC Macro. (1997). 'Tanzania Demographic and Health Survey 1996'. Dar es Salaam: Bureau of Statistics and ORC Macro.

Dahoma, M., Salim A.A., Abdool, R., Othman, A.A., Abdullah, A., & Ali, A.S. (2005). 'Prevalence of HIV, hepatitis B and C and syphilis infection in substance users in Zanzibar, Tanzania'.

National Bureau of Statistics [Tanzania] (NBS) & Macro International Inc. (2000). 'Tanzania Reproductive and Child Health Survey 1999'. Calverton, Maryland: NBS and Macro International Inc.

NBS & ORC Macro. (2005). 'Tanzania Demographic and Health Survey (TDHS), 2004-05'. Dar es Salaam: NBS and ORC Macro.

Research on Poverty Alleviation (REPOA) & UNICEF. (2006). 'Update of the situation analysis of women and children in Zanzibar', October 2006.

Revolutionary Government of Zanzibar (RGoZ). (1998). 'Zanzibar Development Vision 2020'.

RGoZ. (2007a). 'Zanzibar Strategy for Growth and Reduction of Poverty ZSGRP'.

RGoZ. (2007b). 'Joint Review of the National HIV Response in Zanzibar, 2004-2007', December 2007.

RGoZ, (2008). 'MKUZA Annual Implementation Report 2007/08 (MKUZA AIR)', November 2008.

RGoZ – Ministry of Agriculture, Livestock and Environment (MALE). (2008). 'Zanzibar Food Security and Nutrition Policy'.

RGoZ – Ministry of Education and Vocational Training (MoEVT). (2007a). 'Zanzibar Education Development Programme (ZEDP) 2008/09-2015/16', Draft, February 2007.

RGoZ – MoEVT. (2007b). 'Education Situation Analysis 2007', November 2007.

RGoZ – MoFEA. (2006a). 'Government Operations Report for the Year 2005/06'.

RGoZ – MoFEA. (2006b). 'Reports on Disbursements from Donors from July 2005 to June 2006'.

RGoZ – MoFEA. (2007a). 'Government Operations Report for the Year 2006/07'.

RGoZ – MoFEA. (2007b). 'Reports on Disbursements from Donors from July 2006 to June 2007'.

RGoZ – MoFEA. (2007c). 'Estimates of Recurrent and Capital Revenue and Expenditure for the Financial Years 2007/2008'.

RGoZ – MoFEA. (2007d), 'The Zanzibar Strategy for Growth and Reduction of Poverty (MKUZA) Growth Strategy'.

RGoZ – Ministry of Health and Social Welfare (MoHSW). (2008). 'Road Map to Accelerate the Reduction of Maternal, Newborn and Child Mortality in Zanzibar (2008-2015)'.

RGoZ – MoHSW & UNICEF. (2005). 'Vitamin A deficiency, growth retardation, anaemia and their correlates among children 6-59 months in Zanzibar'.

RGoZ – Ministry of Labour, Youth, Women and Children Development (MoLYWCD). (2004). 'Zanzibar National Guidelines on Child Labor'.

RGoZ – MoLYWCD. (2007). 'A brief summary on the law governing the protection and the rights of children'.

RGoZ – Office of the Chief Government Statistician (OCGS). (1988). 'Population and Housing Census 1988'.

RGoZ – OCGS. (2003). 'Population and Housing Census 2002'.

RGoZ – OCGS. (2006). 'Household Budget Survey 2004-05'.

RGoZ – OCGS. (2008). 'Zanzibar Statistical Abstract 2007'.

RGoZ – Zanzibar AIDS Commission (ZAC). (2007). '2007 Public Expenditure Review for HIV and AIDS in Zanzibar'.

RGoZ – Zanzibar Education Commission (ZEDCO). (2007). 'Education Situation Analysis 2007', Draft 3, June 2007.

TACAIDS, NBS & ORC Macro. (2005). 'Tanzania HIV/AIDS Indicator Survey 2003-04'. Calverton, Maryland, USA: TACAIDS, NBS & ORC Macro.

TACAIDS, Zanzibar AIDS Commission (ZAC), NBS, Office of the Chief Government Statistician [Zanzibar] (OCGS) & Macro International Inc. (2008). 'Tanzania HIV/AIDS and Malaria Indicator Survey 2007-08'. Dar es Salaam, Tanzania: TACAIDS, ZAC, NBS, OCGS & Macro International Inc.

Zanzibar AIDS Control Programme (ZACP). (2005). 'HIV prevalence data from antenatal clinic attendees'.

LIST OF ABBREVIATIONS

ACRWC	African Charter on the Rights and Welfare of the Child
ACT	Artemisinin-based combination therapy
ADB	African Development Bank
ADG	Administrator General
AIDS	Acquired Immune Deficiency Syndrome
AMREF	African Medical Research Foundation
ANC	Antenatal care
ARI	Acute respiratory infection
ART	Anti-retroviral therapy
ARV	Anti-retroviral
ASDP	Agriculture Sector Development Programme
BCC	Behaviour change communication
BELSA	Basic Education and Life Skills for Adolescence
BEST	Basic Education Statistics Tanzania
BoT	Bank of Tanzania
CBO	Community-based organization
CDC	Centre for Disease Control
CDW	Commercial domestic workers
CFAA	Country Financial Accountability Assessment
CGD	Center for Global Development
CHF	Community Health Fund
CFS	Child-friendly schooling
CHMT	Council Health Management Team
CIS	Community Investment Sub-projects
CMACs	Council Multisectoral AIDS Committees
COBET	Complementary Basic Education and Training
CORPs	Community-Owned Resource Persons
CRC	Convention on the Rights of the Child
CSEW	Commercial sex workers
CSO	Civil society organisation
CSPD	Child Survival, Protection, and Development
CTC	Care and Treatment Centres
DAS	District Administrative Secretary
DHMT	District Health Management Team
DHS	Demographic and Health Survey
DPG	Development Partners' Group
DPs	Development Partners
DPT-HB3	Diptheria, Pertussis (whooping cough) and Tetanus + Hepatitis B (3 doses)
DRNCD	Diet Related Non-Communicable Diseases
DSW	Department of Social Welfare
ECCD	Early Childhood Care and Development
ECCE	Early Childhood Care and Education
ECD	Early Childhood Development
EPI	Expanded Programme of Immunisation
ESDP	Education Sector Development Programme
ETP	Education and Training Policy

FBO	Faith-based organisation
FDI	Foreign direct investment
FGIS	Farmer Group Investment Sub-project
FGM	Female genital mutilation
GBS	General budget support
GDP	Gross Domestic Product
GER	Gross Enrolment Ratio
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GHIs	Global Health Initiatives
GMP	Growth monitoring and promotion
HBC	Home-based care
HBS	Household Budget Survey
HIPC	Highly Indebted Poor Countries
HIV/AIDS	Human Immuno-deficiency Virus/Acquired Immune Deficiency Syndrome
HKI	Helen Keller Institute
HMIS	Health Management Information System
HSHSP	Health Sector HIV/AIDS Strategic Plan
HSR	Health Sector Reform
HSSP	Health Sector Strategic Plan
IATT	Inter-Agency Technical Team
ICT	Information communication technology
IDD	Iodine deficiency diseases
IEC	Information, education and communication
IHRDC	Institute of Health Research and Development Centre
ILFS	Integrated Labour Force Survey
ILO	International Labour Organization
IMCI	Integrated Management of Childhood Illnesses
IMF	International Monetary Fund
IOM	International Organization for Migration
IPEC	International Programme on the Elimination of Child Labor
IPT	Intermittent preventive treatment (of malaria)
ITN	Insecticide-treated nets
IYCN	Infant and young child nutrition
JAST	Joint Assistance Strategy for Tanzania
JEE	Joint External Evaluation
JPD	Joint Programme Document
JTM	Joint Technical Mission
JTP	Joint Technical Plan
KINET	Kilombero Net Project
LGA	Local government authority
LGCDG	Local Government Capital Development Grant
LGRP	Local Government Reform Programme
LSHTM	London School of Hygiene and Tropical Medicine
MAAM	Mpango wa Maendeleo ya Afya ya Msingi (Swahili for Primary Health Sector Development Programme (PHSDP)
MCE	Multi-country evaluation
MCH	Maternal and child health
MDAs	Ministries, departments and agencies

MEMKWA	Mpango wa Elimu ya Msingi Kwa Waliokosa
MDG	Millennium Development Goal
MKUKUTA	Mkakati Kukuza Uchumi na Kupunguza Umaskini (Swahili for National Strategy for Growth and Reduction of Poverty (NSGRP))
MKUZA	Mkakati wa Kukuza Uchumi na Kupunguza Umaskini Zanzibar (Swahili for Zanzibar Strategy for Growth and Reduction of Poverty (ZSGRP))
MAFS	Ministry of Agriculture and Food Security
MoCDGC	Ministry of Community Development, Gender and Children
MoEC	Ministry of Education and Culture
MoEVT	Ministry of Education and Vocational Training (formerly Ministry of Education and Culture)
MoF	Ministry of Finance
MoFEA	Ministry of Finance and Economic Affairs (formerly Ministry of Finance)
MoH	Ministry of Health
MoHSW	Ministry of Health and Social Welfare (formerly Ministry of Health)
MoLEYD	Ministry of Labour, Employment and Youth Development (formerly Ministry of Labour, Youth Development and Sports
MoLYDS	Ministry of Labour, Youth Development and Sports
MoLYWCD	Ministry of Labor, Youth, Women and Children Development (Zanzibar)
MPEE	Ministry of Planning, Economy and Empowerment
MSD	Medical Stores Department
MTEF	Medium Term Expenditure Framework
MVC	Most vulnerable children
NACP	National AIDS Control Programme (within the Ministry of Health and Social Welfare)
NAR	Net Attendance Rate
NATNETS	National Strategic Plan for ITNs in Tanzania
NCPA	National Costed Plan of Action for Most Vulnerable Children
NGO	Non-governmental organisation
NBS	National Bureau of Statistics
NER	Net Enrolment Ratio
NISCC	National Inter-Sectoral Coordination Committees
NMCP	National Malaria Control Programme
NMMP	National Malaria Medium Term Strategic Plan
NMSF	National Multi-Sectoral Strategic Framework
NNSP	National Nutrition Strategic Plan
NNS	National Nutrition Strategy
NPA	National MVC Plan of Action
NSGRP	National Strategy for Growth and Poverty Reduction
OCGS	Office of the Chief Government Statistician [Zanzibar]
ODA	Overseas development assistance
OI	Opportunistic infection
OVC	Orphans and vulnerable children
PADEP	Participatory Agricultural Development and Empowerment Programme
PEDP	Primary Education Development Programme
PEFAR	Public Expenditure and Financial Accountability Review
PER	Public Expenditure Review
PEPFAR	President's Emergency Plan Fund for AIDS Relief
PFM	Public financial management
PHDR	Poverty and Human Development Report

PHSDP	Primary Health Sector Development Programme (see also MAAM)
PLHAs	People living with HIV/AIDS
PMO	Prime Minister's Office
PMO-RALG	Prime Minister's Office – Regional Administration and Local Government
PMTCT	Prevention of mother-to-child transmission of HIV
PPP	Public-private partnerships
PRSP	Poverty Reduction Strategy Paper
PSI	Population Service International
RAWG	Research and Analysis Working Group (of the Ministry of Planning, Economy and Empowerment
REPOA	Research on Poverty Alleviation
RFA	Regional Facilitating Agency
RFE	Rapid Funding Envelope
RGoZ	Revolutionary Government of Zanzibar
RHMT	Regional Health Management Team
RITA	Registration Insolvency and Trusteeship Agency
SACCOS	Savings and Credit Co-operative Societies
SADC	Southern Africa Development Community
SD	Standard deviation
SDC	Swiss Development Corporation
SEDP	Secondary Education Development Programme
SGBV	Sexual and gender-based violence
SGR	Strategic Grain Reserve
SIDA	Swedish International Development Cooperation Agency
SMEs	Small and medium enterprises
SOSPA	Sexual Offences Special Provisions Act
S-TBP	Support to the National Time Bound Programme (on child labour)
SMITN	Social Marketing for ITNs Project
SRH	Sexual and reproductive health
STD	Sexually transmitted disease
STI	Sexually transmitted infection
STI	Swiss Tropical Institute
SWAp	Sector-wide approach (to development)
TACAIDS	Tanzania Commission on HIV/AIDS
TASAF	Tanzania Social Action Fund
TAWASANET	Tanzania Water and Sanitation Network
TB	Tuberculosis
TDHS	Tanzania Demographic and Health Survey
TEHIP	Tanzania Essential Health Programme
TFNC	Tanzania Food and Nutrition Centre
THIS	Tanzania HIV/AIDS Indicator Survey
THMIS	Tanzania HIV/AIDS and Malaria Indicator Survey
TGNP	Tanzania Gender Networking Programme
TMAP	Tanzania Multi-sectoral HIV/AIDS Project
TMC	Tanzanian Movement for and with Children
TNVS	Tanzania National Voucher Scheme
TRA	Tanzania Revenue Authority
TRCHS	Tanzania Reproductive and Child Health Survey

TSED	Tanzania Socio-economic Database
TSPA	Tanzania Service Provision Assessment
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNICEF	United Nations Children's Fund
UPE	Universal primary education
USAID	United States Agency for International Development
URT	United Republic of Tanzania
US (PMI)	United States President's Malaria Initiative
USG	United States Government
VCT	Voluntary counselling and testing
VEO	Village Executive Secretary
VPO	Vice President's Office
WB	World Bank
WFCL	Worst forms of child labour
WFF	World Fit for Children
WFP	World Food Programme
WHO	World Health Organisation
WSDP	Water Sector Development Programme
ZAC	Zanzibar AIDS Commission
ZACP	Zanzibar AIDS Control Program
ZAWA	Zanzibar Water Authority
ZEDP	Zanzibar Education Development Programme
ZFSNP	Zanzibar Food Security and Nutrition Policy
ZMCP	Zanzibar Malaria Control Programme
ZNSP	Zanzibar National HIV and AIDS Strategic Plan
ZRB	Zanzibar Revenue Board
ZSGRP	Zanzibar Strategy for Growth and Reduction of Poverty
ZSSF	Zanzibar Social Security Fund
ZVETP	Zanzibar Vocational Education and Training Policy