

UNITED REPUBLIC OF TANZANIA



**“PLUS 5” REVIEW
OF THE 2002 SPECIAL SESSION ON CHILDREN
AND WORLD FIT FOR CHILDREN
PLAN OF ACTION**

Dar es Salaam

DECEMBER, 2006

TABLE OF CONTENTS

	Page
Table of Contents	ii
List of Tables and Figures ... ..	.iii
Abbreviations/Acronyms ... ..	.iv
1.0 Introduction	1
1.1 Background.....	1
1.2 Review and reporting process.....	1
2.0 Major actions taken for children towards WFFC targets since 2002	2
2.1 Planning	2
2.2 Promoting healthy lives... ..	2
2.3 Providing quality education... ..	5
2.4 Protection against abuse, exploitation and violence... ..	7
2.5 Combating HIV/AIDS	14
3.0 Resource trends for child development	15
3.1 Education	16
3.2 Health	16
4.0 Development and use of monitoring instruments to track WFFC/MDG targets	18
5.0 Enhancing partnerships, alliances for children and participation... ..	20
6.0 Achievement of WFFC Plan of Action and related MDG targets... ..	20
6.1 Promoting healthy lives... ..	20
6.2 Providing quality education... ..	23
6.3 Protection against abuse, exploitation and violence	24
6.4 Combating HIV/AIDS	25
7.0 Summary of lessons learned and future initiatives planned at National, sub-national or regional levels	26
7.1 Lessons learned... ..	26
7.2 Future plans	27
References... ..	29
Appendix 1	
Goal Statements of <i>A World Fit for Children</i> and Data from Tanzania... ..	31

LIST OF TABLES AND FIGURES

FIGURES

Figure 1

Budget of education sector as a percentage of total government budget (2000/01-2006/07)... .. 16

Figure 2

Percentage of budget allocated for primary and secondary Schools... ..16

Figure 3

Sector spending as a proportion of the total GoT budget, FY 2000-FY 2005... .. 17

Figure 4

Trend in infant and under-five mortality... .. 21

TABLES:

Table 1

Government health spending by level/category, FY 03-FY 04... ..18

ABBREVIATIONS/ACRONOMYS

ACRWC	African Charter on the Rights and Welfare of the Child
ANC	Antenatal Clinic(s)
CFS	Child Friendly Schools
CHRAGG	Commission for Human Rights and Good Governance
CRC	Convention on the Rights of the Child
COBET	Complementary Basic Education in Tanzania
DevInfo	Development Information
EDC	Education Development Centre
EPI	Expanded Programme for Immunization
FGM/C	Female Genital Mutilation/Cutting
GENPROM	Gender Promotion
GER	Gross Enrolment Rate
GoT	Government of Tanzania
HBS	Household Budget Survey
HMIS	Health Management Information System
ICBAE	Integrated Community Based Adult Education
ILO/IPEC	International Labour Organization/International Programme for Elimination of Child Labour
ILO	International Labour Organization
IMCI	Integrated Management of Childhood Illness
IMR	Infant Mortality Rate
IMSS	Information Management Systems
ITNs	Insecticide-treated nets
JAST	Joint Assistance Strategy for Tanzania
JCURT	Junior Council of the United Republic of Tanzania
KIWOHEDE	<i>Kiota</i> Women and Health Development
LGAs	Local Government Authorities
LMGD	Local Government Monitoring Database
MCDGC	Ministry of Community Development, Gender and Children
MDGs	Millennium Development Goals
MDAs	Ministries, Departments and Agencies
MKUKUTA	<i>Mkakati wa Kukuza na Kuondoa Umaskini Tanzania</i> (National Strategy for Growth and Reduction of Poverty)
MKUZA	<i>Mkakati wa Kuondoa Umaskini Zanzibar</i> (Zanzibar Poverty Reduction Strategy)
MLYWCD	Ministry of Labour Youth, Women and Children Development (Zanzibar)
MMR	Maternal Mortality Rate
MoEVT	Ministry of Education and Vocational Training; formerly Ministry of Education and Culture (MoEC)
MoHSW	Ministry of Health and Social Welfare
MoH	Ministry of Health
MoLEYD	Ministry of Labour, Employment and Youth Development
MVC	Most Vulnerable Children
NACP	National AIDS Control Programme
NCRC	National Committee on the Rights of the Child
NER	Net Enrolment Rate
NGOs	Non-Government Organisations
NMSF	National Multi-Sector Framework
NNOC	National Network of Organizations Working with Children
NSGRP	National Strategy for Growth and Reduction of Poverty
NPA	National Plan of Action
ODA	Official Development Assistance

OVC	Orphans and Vulnerable Children
PHC	Primary Health Care
PEDP	Primary Education Development Plan
PHAST	Participatory Hygiene and Sanitation Transformation
PHDR	Poverty and Human Development Report
PRP	Poverty Reduction Plan
PRS	Poverty Reduction Strategy
PRSP	Poverty Reduction Strategy Paper
PSLE	Primary School Leaving Examination
PEPFAR	President's Emergency Plan for AIDS Relief
REPOA	Research on Poverty Alleviation
SEDP	Secondary Education Development Plan
SVRHP	Strategic Voices for Reproductive Health Project
SWAAT	Society of Women Against AIDS in Tanzania
TACAIDS	Tanzania Commission for AIDS
TDHS	Tanzania Demographic and Health Survey
TMC	Tanzania Movement for and With Children
TOMSHA	Tanzania Output Monitoring System for HIV/AIDS
TSED	Tanzania Social and Economic Database
Tsh	Tanzanian shillings
U5s	Under Fives
U5MR	Under Five Mortality Rate
UMATI	<i>Uzazi na Malezi Bora Tanzania</i> (Family Planning Association of Tanzania)
UN	United Nations
UNFPA	United Nations Family and Population Fund
UNGASS	United Nations General Assembly Special Session on Children
UNICEF	United Nations Children's Fund
URT	United Republic of Tanzania
USDOL	United States Department of Labour
WASH	Water, Sanitation and Hygiene
WFFC	World Fit for Children
ZAC	Zanzibar AIDS Commission
ZACA	Zanzibar Association for Children's Advancement
ZAD	Zanzibar Association of the Disabled
ZASO	Zanzibar AIDS Service Organization
ZAWIO	Zanzibar Women and Children Organization
ZEMAP	Zanzibar Education Master Plan
ZSRP	Zanzibar Strategy for Reduction of Poverty
ZYEDESA	Zanzibar Youth, Education Development and Environmental Support Association

“PLUS 5” REVIEW OF THE 2002 SPECIAL SESSION ON CHILDREN AND WORLD FIT FOR CHILDREN PLAN OF ACTION

1.0 INTRODUCTION:

1.1 Background

The United Nations General Assembly Special Session (UNGASS) on Children was held in New York from 8th to 10th May, 2002. The Special Session attracted 69 summit level participants and 190 high-level national delegations, which included children.

At this memorable event, member states committed themselves to transform the world to uphold the best interests of the child. These commitments are consistent with the UN Convention on the Rights of the Child (CRC), the African Charter on the Rights and Welfare of Children (ACRWC) and the Millennium Development Goals (MDGs)

The Tanzanian delegation to the Special Session, which was led by Hon. Dr. Ali Mohamed Shein, the Vice President of the United Republic of Tanzania (URT), comprised 55 participants drawn from high levels of government, NGOs and Civil Society Organizations, including 12 children. The Vice President made a presentation on the situation of iodine deficiency, particularly among children and women in Tanzania and outlined the steps the Government was taking to reduce the prevalence of acute iodine deficiency in the country. Another presentation was on malaria, which was presented by Dr. Salim M. Abdullah, from the Ifakara Malaria Project. The delegation took part in both formal and informal deliberations during the Special Session.

Tanzania, together with most other countries in the world, signed the outcome document of the 2002 Special Session on Children, “A World Fit for Children” (WFFC), and committed itself to designing a strategy to reach the goals set for the full realization of the rights of every Tanzanian child.

On the return of the delegation, UNICEF Tanzania, in collaboration with the Government, organized a two day workshop (June 22 – 23, 2002) to provide a national briefing on Special Session proceedings, as well as to chart out the way forward. The workshop initiated preparation of the National Plan of Action (NPA) and accompanying processes that would guide the Government and other stakeholders in their commitments to WFFC goals and targets, both in Tanzania Mainland and Zanzibar. Since then, the main elements of the NPA have been incorporated into Mainland Tanzania’s *National Strategy for Growth and Reduction of Poverty (NSGRP)* and the *Zanzibar Strategy for Reduction of Poverty (ZSRP)*, which are the overarching strategies for development planning in the URT.

1.2 Review and reporting processes

The Ministry of Community Development Gender and Children (MCDGC) of the URT and the Ministry of Labour, Youth, Women and Children Development (MLYWCD) of the Revolutionary Government of Zanzibar, coordinated the process of preparation of this analytical report on the implementation of the WFFC. Consultative meetings were held with key stakeholders, which included Government Ministries, Departments and Agencies (MDAs), Non-Government

Organizations (NGOs), UN Agencies and children. Financial and technical assistance was provided by UNICEF. The final draft of the report was reviewed in a joint meeting between the two governments, i.e. URT and Revolutionary Government of Zanzibar.

The views of adult stakeholders, which were mainly based on the review and analysis of data, trends and the legal status of children, have been incorporated in the main body of the report. Children's views, on the other hand, most often expressed the more qualitative aspects of their experiences, and have been highlighted in text boxes.

2.0 MAJOR ACTIONS TAKEN FOR CHILDREN TOWARDS WFFC TARGETS SINCE 2002

2.1 Planning

Soon after the Special Session on Children, Tanzania Mainland prepared a comprehensive NPA for achieving children's goals. The NPA combined the commitments made by the URT to improving the situation of Tanzanian children by taking into consideration the CRC, ACRWC and WFFC. It was agreed at a children's stakeholders meeting - where children were represented through the Junior Council of the United Republic of Tanzania (JCURT) - that the NPA be integrated into the National Strategy for Growth and Poverty Reduction (NSGRP) popularly known as MKUKUTA [*Mkakati wa Kukuza Uchumi na Kuondoa Umaskini Tanzania*] in Mainland Tanzania, and the Zanzibar Strategy for Reduction of Poverty (ZSRP) known as MKUZA [*Mkakati wa Kuondoa Umaskini Zanzibar*] in Zanzibar. These serve as the overarching national development planning frameworks for the country. In this way, key issues for children have been included as outcomes within both MKUKUTA and MKUZA which also embrace the child focused goals and targets of the Millennium Declaration and MDGs.

It has since been decided to amalgamate all the children's issues in MKUKUTA and MKUZA into separate National Plans of Action that would include implementation frameworks for Mainland Tanzania and Zanzibar, and would be used as monitoring instruments for child-oriented targets.

2.2 Promoting healthy lives

(i) Mortality rates

The Government has achieved significant progress in reducing infant and under-five mortality rates (IMR and U5MR) which had remained stubbornly high throughout the 1990s and early 2000s. This has been possible due largely to sustained high levels of immunization and concerted efforts in the prevention and treatment of malaria, children's number one killer. The proportion of households owning bed nets in Mainland Tanzania has increased from around 25 percent in 1999, to 46 percent in 2004. Approximately 31 percent of U5s sleep under a mosquito net, though only about 16 percent of those are insecticide-treated. Some of the poor and the most vulnerable children cannot afford ITNs despite the

discount vouchers.¹ In Zanzibar, a new drug policy of Artemison combination therapy was introduced in 2002. Moreover, the use of insecticide treated bed nets (ITNs) has been scaled up in the Zanzibar Health Sector Reform Programme resulting in an increase in coverage from 3.4 percent in 2002 to 45.8 percent in 2005.

Also, worth highlighting is the provision of free medical care to expectant mothers and U5s, and significant improvements in the numbers of children receiving vitamin A and mebendazole, and consuming iodated salt. The expansion of the Integrated Management of Childhood Illnesses (IMCI) programme is also considered to have played its part in the reduction of child mortality.

In addition, the Revolutionary Government of Zanzibar in its commitment to the implementation of its Poverty Reduction Plan (PRP), developed the Zanzibar Health Policy (1999), which directs the health sector and interventions on child mortality through different programmes including malaria control, EPI, IMCI, micronutrient supplementation, HIV/AIDS control, upgrading skills of health care personnel, and expanding access to adequate and affordable drugs and other medical supplies for Primary Health Care (PHC).

Despite these improvements, around 250,000 children still die each year in Tanzania from preventable illnesses, with 80 percent of deaths occurring at home. Approximately half of all infant deaths occur in the week after birth, and neo-natal deaths account for 29 percent of the U5MR.² Moreover, malaria remains the number one killer of children under five. In Zanzibar, malaria accounts for 28 percent of hospital deaths among children under 15 years. Other causes of deaths among children are anaemia, pneumonia, diarrhoea and AIDS, with malnutrition being an underlying cause of over 50 percent of deaths. Many of these conditions occur concurrently.

The quality of health services remains a problem due to a number of factors, including human resource problems (currently only 30 percent of health posts are filled), and inadequate medical equipment. Health care charges (user fees/cost sharing) and other 'unofficial' costs also pose challenges for issues of governance and accountability, and for waiver schemes meant for the most vulnerable and disadvantaged groups.

(ii) Nutrition

Advocacy, policies and legislation on infant and young child nutrition have been in place since the 1980s. Various approaches have been followed, including production and distribution of information, education and communication materials; use of mass media; commemoration of World Breastfeeding Week; and interaction with policy makers during parliamentary sessions. Tanzania participated in the adoption of the resolution endorsing the International Code of

¹ The Government strongly endorses insecticidetreated nets (ITNs) and has introduced the Tanzania National Vouchers Scheme to provide discount vouchers to all pregnant women attending antenatal clinics and so accelerated the use of treated nets by pregnant women and young children.

² It is difficult to obtain a precise picture of causal factors for neonatal mortality in Tanzania, largely because a majority of births and early neonatal deaths occur in the home, and there is substantial underreporting. The vital registration system is still very weak: and only 7% of children have birth certificates (TDHS 2004/05).

Marketing of Breast Milk Substitutes in 1998 and enacted The National Regulation on Marketing of Breast Milk Substitutes and Designated Products in (1994). Furthermore, it has adopted the Global Strategy on Infant and Young Child Feeding, thus developing the National Strategy on Infant and Young Child Nutrition and its implementation plan (2004), as well as the National Nutrition Strategic Plan 2006 and the Maternity Protection law of 2005.

(iii) Water and sanitation

Other Government measures in providing healthy lives have been the improvement of water and sanitation facilities, including the review of the National Water Policy (2002); expansion of existing water schemes in rural areas (out of 794 water schemes which required rehabilitation and expansion, 122 were rehabilitated between 1998 and 2003); development of a client service charter for water sector service providers and for increased customer awareness on availability of quality services; adoption of Participatory Hygiene and Sanitation Transformation (PHAST) as a key methodology for community-based hygiene, water and sanitation; and promotion of rain water harvesting technologies. School WASH is part of the Child-Friendly Schools initiative involving key government departments of the Ministry of Education and Vocational Training, the Ministry of Health and Social Welfare (MoHSW), and the Ministry of Water in Tanzania Mainland. Nevertheless, greater efforts are needed in order to increase access to adequate safe water and sanitation, especially among the rural communities.

“It is advised that health centres be built near people’s residences, particularly in rural areas, to shorten the distance people have to commute to access such facilities. Also, rural health facilities should be provided with ambulances to ease referrals and free medical services should be offered to all children and not to U5s only. The number of qualified medical personnel has to be increased in rural areas to ensure quality provision of services.”

“Water supplied to schools should be treated so that pupils will be able to drink clean and safe water while in school, rather than relying on bottled water that they can not all afford.”

Comments from the Children’s Consultative Meeting on WFFC+5 held on December 6, 2006 in Dar es Salaam.

(iv) Youth and reproductive health

Increasing awareness of key health risks and issues, and translating such awareness into behavioural change, remains a serious challenge particularly among vulnerable groups such as young people. In spite of the efforts of Governmental and NGOs to educate young people on matters related to sexual and reproductive health, teenage pregnancies still remain high, as do untreated sexually transmitted infections. Life-skills training needs to be hugely increased, especially for girls and their parents and care-givers. Teachers and health workers receive insufficient training in reproductive health promotion.

A pilot project, Stronger Voices for Reproductive Health Project (SVP) has been undertaken in 6 districts, led by Government and the United Nations Population

Fund (UNFPA). The overall goal is to improve reproductive health for all individuals, including around family planning and sexual health. In addition, the URT has developed national Population Policy goals to enable the Government to monitor and evaluate development plans accurately and efficiently e.g. strengthening family planning services to promote the health and welfare of the family, community and nation and eventually reduce the rate of population growth.

2.3 Providing quality education

(i) Primary education

Mainland Tanzania has made significant progress towards universal primary education, particularly since the implementation of the Primary Education Development Plan (PEDP)³ and the abolition of school fees in 2002. Under PEDP, many new classrooms have been built. Children are entering school at an earlier age and consequently girls are encouraged to start school at age 6 or 6.5. Both net and gross primary enrolment rates (NER & GER) have increased by about 30 percentage points, surpassing the PRS target, with near gender parity.⁴ In recognition of the importance of pre-primary education in improving performance, pre-primary classrooms have been established in primary schools, increasing in number from 5,234 in 2000 to 21,108 in 2005, which is a 303 percent rise. Pre-primary enrolment of children aged 5-6 years has increased from 310,935 in 2000 to 638,591 in 2005, a 105.4 percent rise.⁵

The URT has increased the budgetary allocation for the PEDP; with a development grant of Tsh. 49.4 billion issued for procurement of equipment for construction of classrooms, teachers' residences, pit latrines and purchase of school desks. The Government has also received an administrative grant of Tshs. 31.71 billion which was added to the national budget of Tshs. 15.88 billion and used for purchase of text books. This helped raise the ratio to one book per 3 pupils (1:3).

However, the rapid increases in enrolments have outpaced the hiring of new teachers and classroom space. This is compounded by a shortage of textbooks, particularly in rural areas and lack of clean water and other basic amenities. These problems have affected the provision of quality education and retention, leading to high drop-out rates (22 percent for the 2000 – 2006 primary school cohort), with the girls' rate being slightly better (21.5 percent) than the boys' (23.0 percent). Among girls, reasons for dropping out include pregnancy, early marriage, poverty, and prevailing norms that prioritize marriage for girls over education,⁶ while boys drop out due to poverty and truancy.

In Zanzibar, notable developments have taken place towards furthering the goal of **promoting quality education** by establishing the Zanzibar Education Master Plan (ZEMAP), which aims to increase access to quality education services. Key features of the plan include: an increased number of schools; a teacher-training programme, which has increased the number of trained teachers from 5,676 to 6,584 by June 2003; and the inclusion of special classes for students with

³ PEDP is a 2002 – 2006 GoT programme.

⁴ MoEC *Basic Education Statistics in Tanzania (BEST)*, 2000 - 2006

⁵ Ibid.

⁶ Policy briefs, *Quality Education and Gender Equality*, 2004.

disabilities, including seven classes that cater to the disparate and special needs of 201 students, among whom are visually and hearing impaired, and students with learning disabilities. ZEMAP also aims to address the gender disparity in primary school enrolment through the inclusion of “a special emphasis on science classes for girls”. In doing so, the plan seeks to advance towards achieving the elimination of the gender disparity in primary and secondary education.

“In order to have quality education, teachers should work closely with students and parents through school committees to ensure availability of sufficient books, desks, sports equipment and playgrounds. Also, children living in difficult circumstances, including orphans, children with disabilities and those coming from poor families need to be assisted to complete school. All efforts must be made to curb gender discrimination. Parents should love and provide equal opportunity to all their children.”

Comments from the Children’s Consultative Meeting on WFFC+5 held on December 6, 2006 in Dar es Salaam.

(ii) The Child Friendly Schooling (CFS) initiative was developed jointly by MoEVT and UNICEF in 2000 as a pilot in 50 school communities in 5 districts to address challenges of quality and retention in PEDP. PEDP recognizes CFS as one of its strategic priorities for improving the quality of education, and describes it as a model to promote a rights-based, child friendly learning environment and school.

CFS is concerned with the child’s readiness for school in terms of health and nutritional status and social and linguistic skills. It promotes the child’s participation, creativity, self-esteem, and psycho-social well-being; helps foster a structured, child-centred curriculum and teaching-learning methods appropriate to the child’s developmental level, abilities, and learning style; seeks gender parity in the enrolment and achievement of girls and boys; and encourages children to think critically, ask questions, express their opinions and learn how to learn. It also ensures that curricular content responds to the learning needs of individual children as well as to the general objectives of the education system and the local context and traditional knowledge of families and the community.

(iii) Complementary Basic Education in Tanzania (COBET) was initiated in 1999 in two pilot districts (Kisarawe and Masasi) followed by three additional districts (Musoma Rural, Songea Rural and Ngara) in 2000. COBET is basically a strategy for providing quality basic education, life and survival skills to overage out-of-school children, most of whom are most vulnerable children (MVCs). There were 50 centres with a total of 1,560 learners in the pilot phase, of whom 45 percent were girls. By 2005, there were 548 centres with a total of 24,178 learners, of whom at least 70 percent were girls. COBET is a basic education programme that aims at providing an opportunity to out-of-school children, aged between 8-18 years. A special focus is given to girls and vulnerable children, to acquire a basic education by following a specialised three-year course of study. COBET centres exist in two age cohorts - Cohort 1 for the 8-13 year olds and Cohort 2 for the 14-18 year olds. Cohort 1 learners are expected to mainstream into the formal primary school system after sitting for the national Standard Four Examination, while Cohort 2 learners are expected to sit for the national Primary School Leaving

Examination (PSLE) and join secondary education if selected or opt for other post-primary education. These learners also have a possibility of joining the labour market or becoming self-employed. The COBET curriculum offers tailor-made educational instruction based on the real learning needs of the children and provides life skills (personality development, nutrition, hygiene, HIV/AIDS prevention) as well as literacy and vocational training.⁷

(iv) Alternative Learning Education

In Zanzibar, a good number of school-aged children do not attend school either because they have dropped out or have never enrolled. Reasons for this include early marriage, teenage pregnancies, lack of parental awareness of the importance of education, poverty and many other factors. In 2005, it was estimated that over 20 percent of primary school children dropped out before completing the basic education cycle. In order to increase the number of girls and boys completing basic education, the government introduced an alternative education programme and gender promotion (GENPROM) through which dropouts are supported to re-join schools and are given learning materials to facilitate their studies. However, participation of girls in this programme is not satisfactory. For instance, in 2005 there were 12 centres with enrolment of 407 learners, of whom 79 (19.4 percent) were girls compared to 328 boys (80.6 percent).⁸

(v) Adult literacy

With regard to adult literacy, the general picture seems to indicate that men fare better than women. In 2000, the overall adult literacy rate (for 15 year-olds and older) was 70 percent (64 percent for women and 78 percent for men), with rural women having missed out in particular (41 percent were unable to read or write) mainly because of the very low primary enrolment rates in the pre-PEDP years.⁹ The situation has remained stagnant¹⁰ despite efforts by the Government of Tanzania to provide literacy to the 19+ population through the Integrated Community Based Adult Education (ICBAE) programme. The challenge is multi-faceted and, to some extent, complicated by cultural impediments. For example, the social status of girls who become mothers or get married below the age of 18 years changes, and it becomes difficult for them to access basic services for which they would otherwise be eligible, including basic education. Partly in an effort to gain a clearer understanding of the extent and nature of the challenges, the Ministry of Labour, Employment and Youth Development (MoLEYD) has plans to initiate a survey on young people's literacy statistics, based on their locality.

2.4 Protection against abuse, exploitation and violence

The Government of the United Republic of Tanzania has developed a number of programmes and activities for prevention of and protection from child abuse, child sexual exploitation and child labour. Data remains scarce, but partial and anecdotal evidence suggest serious and widespread problems of neglect, violence, abuse and exploitation of children, including in the worst forms of child labour, with efforts to protect Tanzanian children falling short of what is required of the

⁷ UNICEF *Complementary Basic Education in Tanzania (COBET): Evaluation of the Pilot Project*, 2006

⁸ Report provided by MoEVT (Zanzibar) at the WFFC+5 meeting held in Zanzibar, December 18-20, 2006.

⁹ *Household Budget Survey (HBS) 2000/01*

¹⁰ PHDR 2005

Convention on the Rights of the Child. Children engaged in the national *Participatory Poverty Assessment* of 2002/3¹¹ voiced concern about child abuse, reporting that they are often subjected to discrimination, bullying and neglect both at home and at school. More intense forms of mistreatment such as physical abuse (rape, beatings) were also reported and were given as a reason that children take to the street. Girls are particularly vulnerable, both at home, at school and within the wider community due to gender-based discrimination and are at higher risk than boys for sexual abuse. Problems of forced marriage are also noted¹² and the practice of female genital mutilation/cutting (FGM/C) persists in a number of communities.

(i) Child labour

Since 2002/03, the Government in collaboration with social partners and with support of the United States Department of Labour (USDOL) through the International Labour Organisation (ILO/IPEC), has been implementing the Time Bound Programme as a pilot project to combat the worst forms of child labour. The programme targets children between 7-18 years of age working in the following sectors:

- (a) Commercial agriculture;
- (b) Domestic service;
- (c) Mining; and
- (d) Commercial sex.

The pilot project aimed at preventing children at risk from entering into the worst forms of child labour; withdrawing children from worst forms of child labour; and providing them with suitable alternatives such as formal education, skills training or economic empowerment for income-generating activities.

Partners in this campaign included Government Ministries/Departments; trade union organisations; Employers Association; international NGOs such as the Education Development Centre (EDC) and World Vision; and national NGOs, such as Kiota Women Health and Development Organisation (KIWOHEDE) and the Society of Women Against AIDS in Tanzania (SWAAT), ZAYEDES, ZACA, ZASO and ZAWIO. Activities carried out by these stakeholders included:

- Conducting fact finding surveys;
- Conducting awareness raising activities;
- Direct interventions (withdrawing of children from worst forms of child labour);
- Carrying out inspections targeting child labour incidence;
- Capacity building by conducting training workshops for district, ward and village officials on child labour and its worst forms; and
- Establishing a policy framework for programme implementation.

The country is now moving into Phase two of the Time-Bound Programme. To further ensure the protection of children against abuse, exploitation and violence,

¹¹ Research and Analysis Working Group (R&AWG), 2004. *Vulnerability and Resilience to Poverty in Tanzania: Causes, Consequences and Policy Implications. 2002/03 Tanzania Participatory Poverty Assessment: Main Report.*

¹² Ibid.

the Government enacted the Employment and Labour Relations Act No. 6 of 2004. This law aims at eliminating child labour and its related practices, and is part of the domestication in Tanzanian statutes of ILO Convention No. 182 on the Elimination of the Worst Forms of Child Labour and No. 138 on the Minimum Age of Employment. Strategies for eliminating child labour have been developed to guide social partners. In addition, in 2005/2006, the Government integrated child labour into the development plan, with a budget allocation for scaling up child labour interventions throughout the country. The Government has also taken keen steps to prevent children aged 9 to 18 years old from entering prostitution. By May 2003, a total of 1,200 children were withdrawn from commercial sex-exploitation. Media programmes to educate the community on the worst forms of child labour are being aired through radios and televisions in both Zanzibar and Mainland Tanzania. Newspapers and newsletters place special emphasis on dissemination of children's rights.

These actions have had the following impact:

- Increased level of awareness among the public on the hazards associated with child labour;
- Mainstreaming of child labour in MKUKUTA and MKUZA, and setting budget allocations for identified areas of intervention;
- Development of a policy and legal framework for combating child labour and its worst forms;
- Enactment of the Employment and Labour Relations Act No. 6 of 2004 and Employment Act No. 11 of 2005 in Zanzibar;
- Development of the National Child Labour Elimination Strategy for Mainland Tanzania and National Guidelines on Child Labour Elimination in Zanzibar; and
- Inclusion of child labour in the National Labour Force Survey currently underway.

(ii) Most Vulnerable Children

A variety of measures have been taken by both the Government of Zanzibar and the URT to provide care and maintenance for orphans and vulnerable children (OVCs). Such children include orphans, children living on the streets, employed children, sexually exploited children, children with disabilities and those involved in child trafficking. Orphans and Vulnerable Children are cared for in children's homes and in community based initiative programmes.

Children's Homes are established by law through the Children's Homes (Regulations) Act. In April 2006, there were 2,367 children (1043 girls and 1324 boys) in 64 Children Homes. Most homes are operated by the private sector (NGOs, faith-based organisations, etc.). There is only one Government operated children's home in Mainland Tanzania. The Social Welfare Department is responsible for registering, coordinating and developing guidelines to monitor and supervise the standard of care in the homes and provide professional advice.

In 2000, a community-based initiative programme for the Most Vulnerable Children (MVC) was adopted. This initiative was in response to the increasing

number of orphans¹³ and vulnerable children and the visible increase in numbers of children living and working in the streets. The programme focuses on protection, access to education and vocational life skills, food, shelter, clothing and psychological support. Access to justice is also addressed through the programme by Community Justice Facilitators (CJF) who ensure that children are not denied their rights through, for example, dispossession of inheritance. To date, over 190,000 children have been supported through this programme in 32 districts.¹⁴

A number of measures have also been taken by the Government of Zanzibar, NGOs and the community to provide care and maintenance for the most vulnerable children in Zanzibar. A number of Government and NGOs including Forodhani Children's Home and Children Villages known as SOS (Save Our Souls) have been established to provide orphans and children living in difficult circumstances, with their basic rights and needs. Other institutions such as the African Muslim Agency also provide care and maintenance for children in need. The MVC programme has been established through the Social Welfare Department (Zanzibar) in collaboration with UNICEF. In addition, Social Welfare Officers and child-related NGOs in all 10 Districts of Zanzibar were trained on identification of MVCs. A total of 3,422 MVCs have been reached to date.¹⁵

(iii) Legislation and policy environment

Positive steps have been taken to develop the legal and policy framework for children. The URT has ratified both the CRC (1991) and the ACRWC and acceded to the Optional Protocols on the Sale of Children, Child Prostitution and Child Pornography and Involvement of Children in Armed Conflict. Most of the provisions spelt out in the Protocols have already been incorporated in the legislation of Mainland Tanzania and Zanzibar. Trafficking of all persons, including women and children is prohibited as is child prostitution and pornography. However, current provisions lack precise definitions and do not cover all the elements and forms of trafficking, prostitution and pornography detailed either in this or other international protocols. In addition, legal redress is lacking, for despite being a criminal offence since 1998, to date no case of trafficking has been brought to the courts. Mainland Tanzania has however, drafted a new comprehensive Anti-trafficking of Persons Bill to be tabled before the Parliament.

Tanzania submitted its second periodic report on the implementation of the Convention on the Rights of the Child in 2004 and sent a high level government delegation headed by the Minister for Community Development, Gender and Children to discuss this at the 42nd session of the CRC Committee on 19th May, 2006. The initial implementation reports of the two Optional Protocols to the CRC as well as the ACRWC were prepared in 2006 and are currently under review. ILO

¹³ According to 2003/4 Tanzania HIV/AIDS Indicator Survey (THIS), around 11 percent of children below the age of 18 had lost one or both parents, implying that over 2 million children are orphaned in the country. Numbers are expected to rise to 4 million by 2010.

¹⁴ Report provided by officials of MoHSW (URT) at the consultative stakeholders' meeting on WFFC+5 held in Dar es Salaam, December 6, 2006.

¹⁵ Report provided by officials of MoHSW (Zanzibar) at the consultative stakeholders' meeting on WFFC+5 held in Zanzibar, 1820 December, 2006.

Convention No. 182 on the Elimination of the Worst Forms of Child Labour is in force, with the second phase of a time-bound programme underway. A review of legislation has been initiated with a view toward development of a unified Children's Act and plans for consultative processes have been made. The Child Development Policy of 1996 has undergone a lengthy process of revision, including consultation with children, and is now pending review and approval by the Cabinet. Current efforts are also underway to strengthen policies, strategies and implementation plans to protect MVCs.

In consideration of the recommendations made by Law Reform Commission, the Government, through the Ministry of Justice and Constitutional Affairs formulated a committee to solicit public views on the amendment or repeal of all discriminatory laws, be it statutory or customary. Among the laws which are to be amended or repealed include, but are not limited to, the Law of Marriage Act of 1971, the Adoption Ordinance Cap. 375, the Succession and Inheritance Laws, the Affiliation Ordinance Cap. 278, the Children and Young Persons Ordinance Cap. 13, the Customary Law (Declaration Order) of 1963, and the Probate and Administration Ordinance Cap. 445.

Zanzibar has amended and repealed all discriminative laws such as Education Act No.6/1986 (now education Act No.4/2005), Labour Act No. 3/97 (Now Employment Act No.11/2005); and the Spinster, widows and Divorcees Protection Act No.4/1985 (now Spinsters and Single Parent Children Protection Act No.4/2005). Other new legislation in line with child protection include the Penal Act No.6/2004 and the Criminal Procedure Act No.7/2004. The Government of Zanzibar has also taken measures to address child rights and welfare, including child participation by reviewing related policies such as Education Policy (2005), Youth Development Policy (2003), Water Policy (2003), Policy for People with Disabilities (2003) HIV/AIDS Policy (2004), HIV Strategic Plan (2004), Sports Policy (2005).

In order to have a single children's piece of legislation, there is a need to harmonize all Acts related to children, so as to safeguard their rights and welfare. The plan is for a White Paper to be prepared to take into account views of the public in general before the Bill is tabled by the Parliament. The exercise will commence in the financial year 2006/07. This exercise will include a questionnaire on the need to have a specific legislation entitled "**The Children's Act**". This legislation will be comprehensive and shall include constitutional and international standards on the rights of a child, including the CRC. The Act is envisaged to give a single definition of a child, the minimum age of criminal responsibility, marriage and employment, among other issues.

(iv) Advocacy and public enquiry conducted by the Commission for Human Rights and Good Governance

In 2005, the Commission for Human Rights and Good Governance (CHRAGG) carried out research and public hearings on child abuse in 11 regions of the country in response to the UN Secretary-General's study on violence against children. The report of this study was launched by the President of the United Republic of Tanzania, Hon. Jakaya Mrisho Kikwete, in October 2006.

Findings of the study involving 307 cases showed that child neglect or negligent treatment of children is the leading type of child abuse (32 percent). Other incidences of abuse were as follows: 29 percent of the cases were related to sexual abuse; 26 percent to violence and physical abuse; and 13 percent to emotional abuse.¹⁶ Community consultations on child abuse in 50 schools participating in the UNICEF-supported CFS Initiative also identified a number of problems, including harsh practices of corporal punishment in schools that go beyond MoEVT directives and traumatize pupils to the point of dropping out; unpaid labour undertaken at teachers' homes; the use of abusive language; and neglect and sexual abuse in both schools and homes. It was also evident that child abuse has not received due attention in Tanzania possibly because of:

- Lack of awareness and evidence of the issues which are usually regarded as taboo and family matters;
- Traditional child rearing practices that do not allow a child – particularly a girl - to speak in front of elders;
- Decadent traditions that affect realization of child rights, such as neglect of handicapped children, especially in remote areas; and
- Lack of information on legislation and policies against gender-based discrimination and violence, physical and verbal harassment and corporal punishment, particularly in the school system.

Measures to address these issues include the formulation of the NPA for the Prevention and Eradication of Violence against Women and Children, which is based on integrated approaches to elimination of gender-based violence, along with a community justice facilitation programme which functions as a community-based intervention strategy to address violence against children. A National Secretariat on the Elimination of Female Genital Mutilation exists, and the Sexual Offences (Special Provision) Act of 1998 was developed with the aim of protecting the dignity and integrity of women in matters pertaining to rape, defilement, sodomy, sexual harassment, incest, FGM, child abuse and trafficking. This outlines offences against women in a clearer manner than before and introduces new offences such as sexual harassment, abuse and trafficking, with stiff punishments set.

(v) Programmes and services for abandoned children, including children living in the streets

Activities are conducted in close collaboration with NGOs and CSOs working for and with children aiming at providing the following services:

- Drop-in centres so as to provide shelter, education and vocational skills for abandoned children, including children living in the streets, before reintegration to formal schooling and reunification with their families;
- Temporary care;
- Reunification/resettlement; and
- Establishment of National Guidelines for service to children living in the street, which gives direction on how to provide them with services and remove them from the streets.

¹⁶ Commission for Human Rights and Good Governance (2006) *Report on Public Hearing of Child Abuse*.

In Zanzibar, a programme for MVCs has been established under the Ministry of Regional Administration and the Department of Social Welfare in collaboration with UNICEF whereby about 3,422 MVCS have been identified and registered across all 10 districts of Zanzibar. The children are given services such as school uniforms and supplies, clothing, food and mosquito nets. Counselling services are provided to them by *Shehia* Development Committees during supervision exercise conducted in collaboration with Social Welfare officers and Assistant *Shehas*.

(vi) Programmes for the recovery and rehabilitation of juvenile offenders

The Department of Social Welfare on Mainland Tanzania is charged with the responsibility for dealing with children who are in conflict with the law. The Department undertakes the following:

- Probation services for children in conflict with the law; and
- Reformatory school (at present there is only one such school in Mainland Tanzania).

The Department of Social Welfare of the Revolutionary Government of Zanzibar provides the following:

- Services for the recovery and rehabilitation of juvenile offenders; and
- After care services which are provided on a voluntary basis.

(vii) Children deprived of a family environment and separated from parents

The majority of children in Tanzania (61 percent) live with both parents and only 16 percent live with neither parent. Alternative care and support systems are not widespread. Only about 4-6 percent of orphans and vulnerable children living with families are reported to have received any form of support. Such support services are more usual in urban areas. The prevalence of care and support varies erratically, but educational support in the form of school supplies and school fees appears to be more common.

(viii) Refugee Children

Tanzanian law ensures the protection of child refugees, and provides for reunion with the family and the right to primary education, health and other social services. A National Refugee Policy of 2003 has been adopted by the Government. It covers various aspects of the management of refugee matters in Tanzania. There is also in place the Refugee Act, which was enacted in 1998. This law protects the interest of the child through various provisions. Section 35 of the Act deals with reunion of the family, where the child can be reunited with his/her mother or father or his/her relative. The Act is silent on the issue of unaccompanied children. Section 31 (1) of the Act makes primary education compulsory. According to the Act, every refugee child shall be entitled to primary education and every refugee adult who desires to participate in adult education shall be entitled to do so.

(ix) Protection from the impact of armed conflict

Although in exceptional circumstances the law allows for the recruitment of persons under 18 years, that has never occurred in practice.

2.5 Combating HIV/AIDS

Prevention of Mother-to-Child-Transmission (PMTCT) is one of the major HIV prevention strategies that is advocated by the Government of the URT. In 1999, the Ministry of Health, in collaboration with UNICEF, established five initial PMTCT pilot sites in four referral hospitals and one regional hospital covering five regions, namely Kilimanjaro, Mwanza, Kagera, Mbeya and Dar es Salaam. The main aim of the pilot implementation was to determine the feasibility of integrating PMTCT within routine reproductive and child health services.

PMTCT roll-out has accelerated significantly due to the increasing support of development partners through a four phase expansion process. Currently 544 sites (10 percent) out of 5,379 in the 21 regions and 120 districts of Mainland Tanzania are providing core elements of PMTCT services: counselling and testing, antiretroviral prophylaxis, and infant feeding counselling integrated in the reproductive and child health. In addition, there are 200 care and treatment centres linked to the PMTCT programme. By the end of 2005, there were 11,435 (9 percent) HIV-positive pregnant women who were receiving nevirapine prophylaxis.¹⁷ Also, 4,936 children were on ARV treatment at the end of October, 2006.

The main challenges to the success of the PMTCT programme are the following:

- Scaling up of PMTCT services;
- Testing facilities for exposed infants;
- Spouse compliance and support; and
- Community care and support.

AIDS is also contributing to the large population of orphaned children in Tanzania, estimated at 2.5 million in 2003 (40 percent of whom are estimated to be orphaned as a result of AIDS).¹⁸ A costed National MVC Action Plan is ready for implementation. It includes community-based care and protection for children orphaned and made vulnerable by HIV/AIDS, and strengthening a national coordinating system.

It appears that there is political will to address HIV/AIDS at the highest levels of Government, but commitment is less strong at the critical levels of the regions and districts (where implementation takes place). The National AIDS Commission, TACAIDS, was created in 2001 to coordinate the national response to HIV/AIDS. The National AIDS Control Programme (NACP), which preceded TACAIDS as the coordinating body, continues to function under the Ministry of Health and Social Welfare in administering the Ministry's Strategic Plan for the health sector.

The Ministry of Education and Vocational Training implements an HIV/AIDS programme for schools. Instruction materials have been produced and guidelines for providing HIV/AIDS education have been disseminated to all district and regional education authorities. Other initiatives to support young people in prevention of HIV and AIDS include the establishment of the out-of-school Youth-to-Youth HIV and AIDS Communication Initiative.

¹⁷ MoH's Annual PMTCT Report, 2005

¹⁸ Tanzania HIV/AIDS Indicator Survey (THIS) 2003/04

In 2001, the Government of Tanzania launched a progressive HIV/AIDS Policy (the National Multi-Sector Framework on HIV and AIDS), which addresses among other things, routine HIV testing of antenatal mothers. The framework, which covers 2002-2007, is currently under revision, and the 3rd NMSF for 2008-12 shall be launched next year. Donors are providing greater funding to the national response to HIV/AIDS, in particular through the Global Fund to Fight AIDS, Tuberculosis and Malaria; the World Bank; bilateral donors (for example, through PEPFAR); and the UN system. However, despite increased funding, the overall response to the epidemic remains relatively slow and small scale due to a significant lack of capacity to absorb and utilize the extra funds.

In Zanzibar, the Zanzibar AIDS Commission (ZAC) prepared a Situation and Response Analysis Report in 2003 and a Strategic Plan is in place and being implemented. The ZAC is mandated to coordinate the implementation of the national response to HIV in the Isles. To fulfil its monitoring and evaluation mandate, ZAC and its partners developed a Zanzibar HIV/AIDS Monitoring and Evaluation system.¹⁹

“Children affected and infected by HIV/AIDS should be provided with counselling services. Such services need to be available in rural areas but are currently only in place in major urban areas. Also a law should be enacted to punish those who spread HIV deliberately by using their posts, money or any other opportunity that they possess. Also, HIV/AIDS education should be readily available to people of all ages and walks of life, particularly parents and children.”

Comments from the Children’s Consultative Meeting on WFFC+5 held on December 6, 2006 in Dar es Salaam.

3.0 RESOURCE TRENDS FOR CHILD DEVELOPMENT

A multisectoral approach has been chosen to ensure that each sector addresses key aspects of poverty within the frameworks of MKUKUTA and MKUZA. It is within MKUKUTA and MKUZA strategies that national resources are budgeted and allocated to various sectors, including those that are of prime importance to children. Specific MKUKUTA and MKUZA targets and strategies address children and young people’s issues in the areas of early childhood development; primary and secondary education; HIV and AIDS; infant and child health and nutrition; water and sanitation; social protection; support to vulnerable groups; and child protection and rights.

Both Mainland Tanzania and Zanzibar have established Mid-Term Expenditure Frameworks, which guide expenditure of national resources in alignment with MKUKUTA and MKUZA priorities. The existence of a Public Expenditure Review (PER) process that examines government expenditure in alignment with

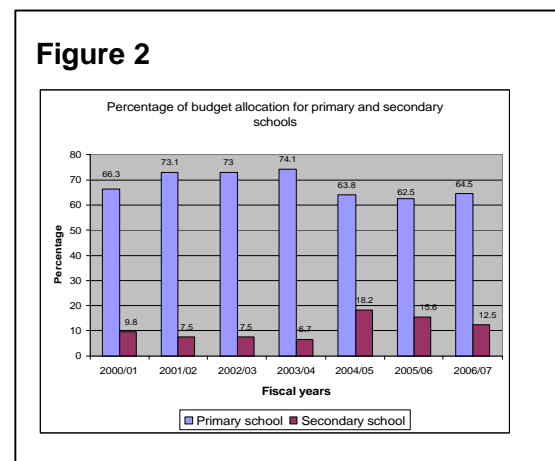
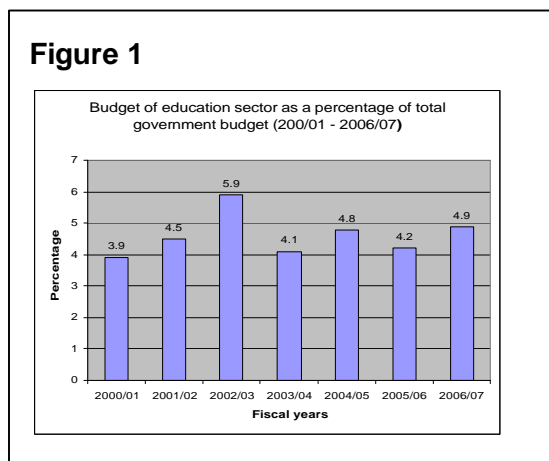
¹⁹ Report provided by officials of MoHSW (Zanzibar) at the WFFC+5 consultative meeting held in Zanzibar, 18-20 December, 2006.

government priorities and the National Planning and Budgeting Guidelines, which provide specific allocations to the priority areas, provide the checks and balances needed for effective use of scarce national resources. In addition, a cross-cutting PER Group for Children has been formulated in Mainland Tanzania to facilitate availability of the resources required to address children and young people's needs and concerns.

The Government has also outlined a Joint Assistance Strategy for Tanzania (JAST) linked to poverty reduction and incorporating principles of the 2005 Paris Declaration on AIDS Effectiveness. The JAST aims to increase national ownership and control over predictable resources, and mutual and domestic accountability. It targets up to 70 percent of Official Development Assistance (ODA) for General Budget Support, with technical assistance for capacity development de-linked from financial inputs.

3.1 Education

Budgetary allocations for the education sector as a percentage of total government budget were high in fiscal year 2002/03, fluctuating thereafter before starting to pick up in 2006/07 (see Figure 1).



Source: Public Expenditure Review (PER) 1998-2005

Allocations to primary education have been increasing since 2001/02 in response to PEDP, while those for secondary education have been falling until 2004/05, when a sharp spike occurred. This is due to change of focus from PEDP to SEDP (the Secondary Education Development Plan), in order to match at secondary school level the achievements registered in enrolment in primary education (see Figure 2).

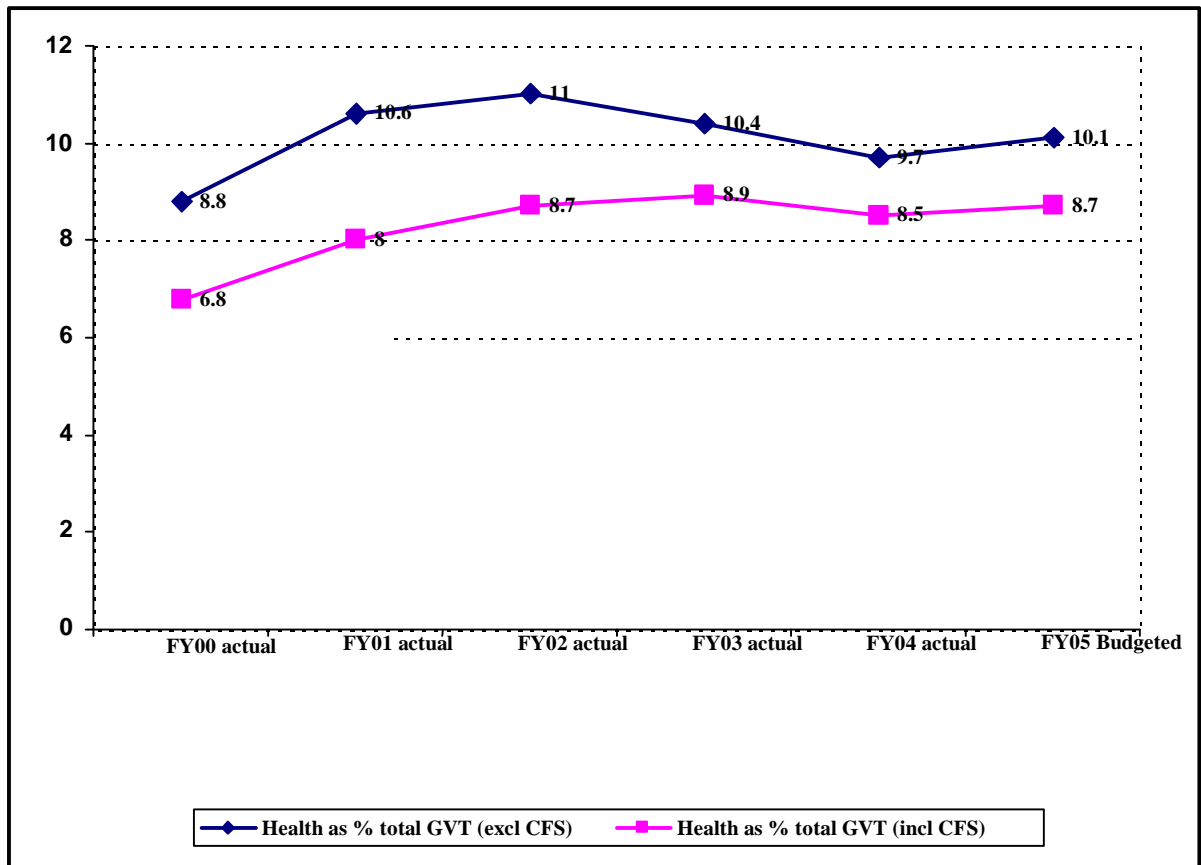
3.2 Health

Figure 3 shows that there has been a steady increase in the health sector share of the budget since fiscal year 2000/01 (FY 00). As expected, the increase is greater when excluding payment to the government debt. The increase was highest in the fiscal year 2002/03 when it reached 11 percent. Thereafter, it continued to fall until it reached 9.7 percent in 2004/05. However there has been an increase to 10.1 percent in 2005/06. This is encouraging, although it should be noted that it

still falls short of the share achieved in the early years of the PRS, which had reached as high as 11 percent, and has not reached 15 percent as per Abuja commitment.

Figure 3

Sector spending as a proportion of the total GoT budget, FY00 – FY05



Source: Health Management Information System (HMIS), Ministry of Health (MoH) 2005

There has also been a notable increase in the budgetary allocation for preventive health care, i.e. primary health care, vaccination programmes, adolescent health care, HIV/AIDS and other health care services for children, including social insurance within the health sector, between fiscal years 2003/04 and 2004/05 (see Table 1).

Table 1*Government health spending by level/category, FY 03 FY 04 Tsh billion*

Preventive primary health care	FY 03/04			FY 04/05		
	PE	OC	Total	PE	OC	Total
MoH preventive services	0.30	5.89	6.19	0.34	12.32	12.67
Regional preventive services	0.15	0.15	0.30	0.17	2.67	2.85
Council preventive	23.40	11.08	34.47	25.22	18.80	44.02
Total preventive/primary	23.85	17.12	40.97	25.74	33.79	59.53

Source: HMIS, MoH 2005

4.0 DEVELOPMENT AND USE OF MONITORING INSTRUMENTS TO TRACK WFFC/MDG TARGETS

As mentioned above, children's issues have been included as key outcomes in the MKUKUTA which also embraces the child focused goals and targets of the Millennium Declaration and MDGs. Tracking performance against key indicators outlined in the MKUKUTA is an essential part of the overall strategy, in order to obtain hard evidence on whether poverty reduction efforts are achieving the intended targets or not. The MKUKUTA Monitoring System, which has been established by URT as the key monitoring and evaluation tool, is also used to monitor progress in implementation of the MDGs, since they are integrated in the MKUKUTA.

The MKUKUTA Monitoring System provides a participatory mechanism for monitoring and for enhanced communication with all stakeholders, including children and young people. It widens the space for open and inclusive dialogue with Government, academic and research institutions, development partners, civil society forums, the private sector and the general public. In the MKUKUTA Monitoring System, Technical Working Groups facilitate data generation and analysis based on the agreed indicators and communicate new information to stakeholders. They provide a link between the aggregated Performance Reporting of Local Government Authorities (LGAs) and Ministries, Departments and Agencies (MDAs), and outcome analysis presented in key documents such as the Poverty and Human Development Report (PHDR) and Policy Briefs. There are three main technical working groups which facilitate this process.

Firstly, the Research and Analysis Technical Working Group ~ this group is responsible for setting the research agenda required to address performance of MKUKUTA and provide scientific information required for understanding or clarifying issues related to MKUKUTA monitoring. The primary objective of this group is to co-ordinate the research and analysis work around MKUKUTA on behalf of the Government. In doing so the group is accountable for setting priorities for research and analysis and coordinating the implementation of a research and analysis programme based on these priorities.

Secondly, the Survey and Routine Data Technical Working Group is responsible for ensuring that high quality data (both social and economic) is made available in a timely manner to users at local, sectoral and national levels. It is also responsible

for strengthening the quality of existing routine data systems, through various Information Management Systems (IMSSs), such as the HIMS.

Thirdly, the Communications Technical Working Group is responsible for facilitating a smooth and timely two-way communication flow of information on MKUKUTA to meet the needs of different groups of users at all levels and also to encourage better use of information in decision making; including the link between the monitoring system outputs and planning processes.

The MKUKUTA Monitoring System produces reports, some on an annual basis and others intermittently. These reports draw on data and information from Government systems such as Public Expenditure Reviews (PERs), Sector Reviews and Budget Guidelines, national surveys such as the Tanzania HIV Indicator Survey (THIS) – last conducted in 2003/04, Tanzania Health and Demographic Survey (TDHS) last conducted in 2004/05 and Tanzania Reproductive and Health Survey (TRCHS) last conducted in 1999. All national surveys are included in a survey calendar of the MKUKUTA Monitoring System.

Monitoring and reporting processes in Government include annual performance reporting by MDAs and LGAs, which provide information on outputs from activities and programmes. These results are reported in quarterly, mid-year and annual Performance Reports, as well as in Sector Reviews and PERs. One of the objectives of this MKUKUTA monitoring system is to bring these various reporting instruments closer together to inform each other, and to strengthen the overall links between planning, budgeting and reporting. The Ministry responsible for children development in the country (MCDGC), uses the national processes described above to ensure children issues are well articulated in a coordinated fashion. However, more support to the Ministry is needed to enable them to play their coordination role more effectively in the monitoring and reporting processes, and in linking child rights monitoring more closely into the national system.

The web-based Tanzania Social and Economic Database (TSED), developed from DevInfo, and incorporating key national indicators, has also been adopted as a key tool for monitoring MKUKUTA and the MDG's. Data and information in the TSED is mainly from the products of the MKUKUTA monitoring system. TSED as a national monitoring tool is also used in reporting progress on the status of poverty in the country over time, including tracking geographical disparities. Efforts are underway to develop a child-friendly TSED to allow children to understand the situation of poverty in the country as well as the status of the MDGs.

Discussions are underway to enable TSED to link with other databases such as the Local Government Monitoring Database (LGMD) and the Tanzania Output Monitoring System for HIV/AIDS (TOMSHA). The two databases are intended to facilitate the availability and utilization of data at district and ward levels. The link will improve the flow of information from sub-national to national level and its availability at national level.

5.0 ENHANCING PARTNERSHIPS, ALLIANCES FOR CHILDREN AND PARTICIPATION

The Tanzania Movement for and with Children (TMC) was officially launched in April 2001 by the President of the URT of the third Government, to underscore its commitment to the promotion and protection of the rights of the child. One of the strategies of the TMC is to strengthen networking activities among NGOs and to work closely with children and young people's own initiatives in order to strengthen their capacity and provide as much support as possible towards the full realization of their rights, as set out in the CRC and the ACRWC. Moreover, NGOs in Mainland Tanzania have formed the National Network for Organizations working for and with Children (NNOC) so as to join hands to protect and promote children's rights. NNOC has been instrumental in collecting views for the drafting of the child's bill.

Significant efforts have also been made to involve children in issues affecting their welfare. Tanzanian children have established the Junior Council of the United Republic of Tanzania at national and regional levels. Plans are now underway to establish such organs at district, ward and village levels.

During the five years of implementation of the WFFC Action Plan, the participation of children and young people in national processes and consultations has been heightened. In Zanzibar, district children councils have been established in six districts of Unguja. Youth clubs have been formed in both Unguja and Pemba Islands, which are comprised of both in- and out-of-school children and young people. Such clubs and councils are essentially used as mechanisms for children and young people to express their views, aspirations, and concerns.

The Revolutionary Government of Zanzibar has also established the National Children's Rights Committee (NCRC) in 2001. This committee is under the Ministry of Labour, Youth, Women and Children Development. The major role of this committee is to mainstream the Child Development Policy and CRC in all child related organizations and programmes.

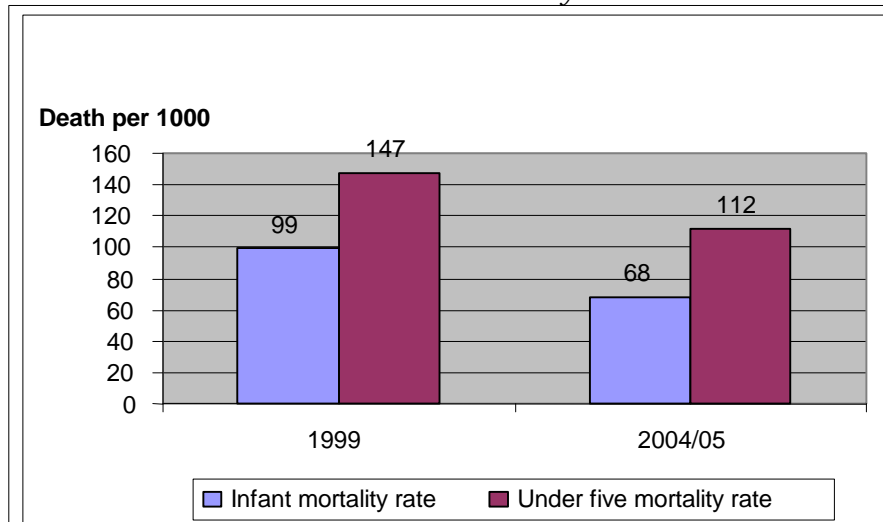
6.0 ACHIEVEMENT OF WFFC PLAN OF ACTION AND RELATED MDG TARGETS

6.1 Promoting healthy lives

(i) *Child mortality rates*

Child mortality rates remained stubbornly high in Tanzania throughout the 1990s. However, since then significant progress has been made in the decline of child mortality. Results from the Tanzania Demographic and Health Survey (TDHS) of 2004/05 indicate that the infant mortality rate (IMR) has fallen by almost a third (from 99 to 68 per 1,000 live births), while the under five mortality rate (U5MR) has dropped by nearly a quarter (from 147 to 112 per 1000 live births) over the same period.²⁰ (see Figure 4).

²⁰ TDHS 2004/05

Figure 4*Trend in infant and under five mortality rate 1999-2004/05***Source: Key Findings of Tanzania DHS 2004 -05**

Further analysis is underway to verify these figures, to understand the causative factors, and to assess the likelihood of Tanzania meeting its national and international targets including the MDGs. It is likely that sustained investments in health systems and key survival interventions have played a significant part in reducing child deaths.²¹

(ii) Nutrition

Protein energy malnutrition, nutritional anaemia, iodine deficiency disorders and vitamin A deficiency disorders are among the major nutrition problems affecting infants and young children in Mainland Tanzania. Although figures remain high, data on nutrition status of U5s show an improvement since 2000: underweight decreased from 30.6 percent in 2000 to 21.9 percent in 2006; stunting - though still widespread - has declined from 43.4 percent to 37.7 percent; and wasting from 7.2 percent to 2.9 percent. However, over 70 percent of Tanzanian children have some degree of anaemia. Breastfeeding is practiced for over 95 percent of children, though only 2 percent are exclusively breastfed for 6 months as recommended by the WHO. The medium duration of breastfeeding is 21 months.²²

According to a 2005 study conducted by UNICEF and the Ministry of Health and Social Welfare (Zanzibar), data on nutritional status of U5s in Zanzibar show that 6 percent were wasted, 23 percent were stunted and 19 percent were underweight. The data also show that 66 percent of children 6-59 months of age were anaemic and that vitamin A deficiency affects 41 percent of U5s. A special Nutrition Unit has been established in Zanzibar in order to overcome problems of micronutrients malnutrition. The Unit also provides nutritional

²¹ According to the Poverty and Human Development report 2005, almost 100 percent of the urban population and close to three-quarters of the rural population live within five kilometres of a health centre or a dispensary. One of the Government priorities is to establish, expand and strengthen community based reproductive and child health services. Children under five currently receive free primary health care and medical treatment in Government hospitals, clinics and dispensaries.

²² TDHS 2004/05

support to mothers giving birth to twins for a duration of 2 years. During 2003-2006 a total of 49 children were provided with nutritional support.

More emphasis should be given to educating parents on nutrition, especially on nutrients that combat anaemia. Also, the maternity protection law that has been introduced in Zanzibar should also be enacted in Mainland Tanzania to accord equal treatment to Tanzanian mothers.

Comments from the Children's Consultative Meeting on WFFC+5 held on December 6, 2006 in Dar es Salaam.

(iii) Maternal mortality

High maternal mortality ratios (MMR) have persisted over the past decade in Tanzania, with the current estimate at 578/100,000.²³ High MMR is related to the prevalence of early childbearing and teenage pregnancy (27 percent of young women are pregnant or have a child by the age of 19); low levels of institutional deliveries (47 percent); high prevalence of HIV infection among young women; and low attendance at birth by skilled attendants (46 percent).²⁴ Adolescent girls are disproportionately affected by pregnancy and delivery complications and are also at higher risk of death.

TDHS does not provide separate estimates on MMR for Zanzibar. However, health facility based data reported in the Zanzibar Poverty Reduction Strategy Paper II in 2004/05 show that MMR is 349/100,000 live births. This shows a slight reduction compared to 1998, when it was 377/100,000 live births. The proportion of births taking place in health facilities has increased from 33 percent in 1991/92 to 49 percent in 2004/05.²⁵

(iv) Water and sanitation

By the year 2005, only about 54 percent of the population in rural communities and 73 percent in urban areas had access to safe drinking water. Coverage of sanitation facilities was estimated to be 47 percent²⁶, with most of the existing households' sanitation facilities being of poor quality. Cholera outbreaks are reported annually in both Tanzania Mainland and Zanzibar. Adequate water supply and sanitation is in only 50 percent of schools, and most latrines are unsanitary and poorly built from temporary materials.

Zanzibar has succeeded in increasing access to clean and safe water in both urban and rural areas by over 15 percent. According to the Household Budget Survey (HBS) conducted in 2006, 59 percent of the rural population and 92 percent of the urban population have access to clean and safe water compared to 2002 data by Ministry of Water, Construction, Energy and Lands water supply projects, which indicated 41 percent and 75 percent, respectively. Meanwhile the coverage of solid waste disposal facilities was estimated at 60 percent and only 30 percent of the

²³ The figures are not significantly different from 1978/1996 ratios of 529/100,000

²⁴ TDHS, 2004-05

²⁵ MoHSW, Zanzibar 2004/05

²⁶ Ministry of Health, 2005

population had access to sanitary means of disposal. In order to improve the situation, the Zanzibar National Water Policy was developed in 2004 and the Zanzibar Water Act was passed in April 2006. Moreover, PHAST training has been conducted at national and sub-national levels.

(vi) Youth and reproductive health

It is estimated that among 15-24 year olds, one third of young women (34 percent) and three fourths of young men (82 percent) are engaged in higher risk sex.²⁷ Contraceptive prevalence has slightly, although not significantly, increased since 2000 from 25.4 to 26.4 percent in 2006. Access to condoms is often limited; currently Youth Friendly Health services reach only a fraction of the target population - an estimated 1 percent. Although adolescents constitute 31 percent of the population, services are still adult centred. Efforts are being made by the Government to promote youth friendly health services by adopting the 2005 Standards.²⁸

6.2 Providing quality education

(i) Primary education

In Mainland Tanzania, for several years the net primary education enrolment for children aged 7-13 years was at 50 percent. With the abolition of school fees, it rose sharply to 80.7 percent in 2002 and to 95 percent in 2005, with very little gender disparity (96 girls enrolled for every 100 boys in 2005).²⁹ Almost all primary schools are co-educational. However, these figures mask geographical differentials.³⁰

The Revolutionary Government of Zanzibar, through the MoEVT, has developed the new Zanzibar Education Policy (ZEP) which emphasizes and gives priority to early childhood care and education. Early childhood education is provided to children of 4-6 years by the Government, private organizations and individuals. The overall GER in early childhood and pre-primary education has increased from 14.0 percent in 2002 to 15.9 percent in 2005. Likewise the GER for both girls and boys has increased at this level (from 14.2 and 13.8 percent in 2002 to 15.7 and 16.0 percent in 2005, respectively). Compulsory basic education is provided for ten years, comprising of seven years of primary and three years of lower secondary education. At this level there is no significant gender disparity.³¹

(ii) Secondary education

On the other hand, secondary school enrolment rates remain extremely low, and a significant portion of the 14-18 year age group is left without access to the vital education, skills and training they need to assume their place in society. In 2000, the ordinary level secondary school NER was at 5.9 percent and that of the

²⁷ TDHS 2004/05

²⁸ Information and counseling on reproductive health, sexuality and safe sex ; Testing services VCT,STI and Pregnancy; Management of STIs, VCT+,PMTCT+HIV/AIDS; Focused ante-natal care; Post natal care; Post abortion care; Contraception including emergency contraception; Condom promotion and provision; Other related health issues substance abuse, violence, injuries, mental health chronic disease etc.

²⁹ *Basic Education Statistics for Tanzania (BEST) 2000 – 2006*

³⁰ *Poverty and Human Development Report (PHDR) 2005*

³¹ Report provided by officials of MoEVT (Zanzibar) at the WFFC+5 consultative meeting held in Zanzibar, 18-20 December, 2006.

advanced level was at 0.4 percent. While the NER at ordinary level secondary school almost doubled in 2005 to 10.3 percent, that of advanced level remained almost stagnant at 0.6 percent. Also, gender parity remains a concern as girls record lower pass rates than boys in the transition from primary to secondary, with gaps as high as 26 percent (in favour of boys) in some regions, and 14 percent nationally in 2005.³²

Another factor that affects the transition rate to secondary school is inadequate classroom space, particularly for girls, as most schools are gender segregated. Moreover, girls' attendance starts falling behind in junior secondary school and the situation gets worse at senior secondary school. Some of the plausible factors behind girls' poor performance include household chores and negative teacher attitudes. The HIV/AIDS pandemic still presents a major risk to all children and young people. The impact is greater among girls, with serious implications on their learning and continued school attendance. Early marriage and child-bearing are also factors.

Secondary education in Zanzibar is categorised into compulsory education (i.e. orientation secondary class (OSC), which is Forms 1-2) and privilege education (Forms 3-6). Up to March 2005, the enrolment in OSC had reached 52,332 compared to 49,949 for the year 2004, (a 4.8 percent increase), with no significant gender disparity. In 2004, girls' enrolment reached 126,176 (50.5 percent of the total enrolment). Enrolment in privilege education (Forms 3-6) reached 12,750 in 2005 compared to 10,237 for the year 2004 (a 24.5 percent increase).

6.3 Protection against abuse, exploitation and violence

(i) Birth registration

There is growing awareness of the importance of prompt birth registration as an essential means of protecting a child's right to identity – including name and nationality, and as a key for securing the fulfilment of other rights. The latest Demographic and Health Survey (TDHS 2004/5), however, indicates only 19 percent of births are registered, while the percentage of children with actual birth certificates is only 7.1 percent. More than half of all births (50.3 percent) are registered in urban areas of Mainland Tanzania compared to just 11.4 percent in rural areas. The percentage of children with birth certificates in rural areas is very low - just 4 percent. This situation has remained virtually unchanged since 1999. Key constraints on the mainland include lack of public awareness of the importance of birth registration and the process by which births are registered, and the significant cost implications for a service that is ostensibly 'free'. Costs include: late registration (after 90 days); purchase of the certificate itself (at USD 3.5); and travel-related costs. The Registrar General's office has lacked the capacity, equipment, and materials necessary to make the system work, and there is a lack of policy and legislative mandate to ensure accountability and coordination (between, for example, health facilities, schools, and village executive officer). In addition, law enforcement to make birth registration compulsory is weak.

³² Data Sources: *Basic Education Statistics in Tanzania* (BEST) figures for 1998 – 2002, and/or 2002 - 2006

In Zanzibar, on the other hand, the 2004/5 survey recorded high rates of birth registration at 63.2 percent overall (55.4 percent for Pemba and 68.2 percent for Unguja). Zanzibar has enacted a Birth and Death Registration Act of 2005 which emphasizes the compulsory nature of birth registration: according to this Act, it is the duty of a parent to register his/her child within 40 days, or she/he shall be required to pay a fine of Tsh 30,000 for late registration and is liable of conviction if the child is not registered.

(i) Child labour

With the support of ILO/IPEC project phase 1, the Government has withdrawn from worst forms of child labour 11,541 (20 percent) out of 57,731 children who were already involved in worst forms of child labour in the 11 pilot districts in 2003. By June 2006, the number of children withdrawn from worst forms of child labour was 16,682, out of whom 10,682 (64 per cent) were girls. Moreover, 9,509 boys and 9,691 girls were prevented from entering child labour.

(iii) Child prostitution

There are at least 800 children engaged in prostitution in Arusha, Dar es Salaam and Singida. Sex tourists are increasingly seeking children in these regions. Reports indicate that girls as young as 9 years prostitute themselves. Eradication of child prostitution is part of the International Labour Organisation's International Programme on the Elimination of Child Labour (ILO-IPEC) which is being carried out in Mainland Tanzania. The programme also aims at increasing awareness on child rights.

6.4 Combating HIV/AIDS

HIV/AIDS has been declared a national disaster and is now one of the Government's highest priority development issues. Overall prevalence of HIV (population 15-49) is estimated at 7 percent (7.7 percent for women and 6.3 percent for men).³³ These rates, however, differ significantly by region, with the islands of Zanzibar, for example, having a much lower prevalence than elsewhere.³⁴ Disaggregated data reveals that prevalence is relatively low among 15-19 year olds (2 percent), but rises steadily among 20-24 year olds (5 percent) and further still among 25-29 year olds (8 percent).³⁵ These figures highlight the importance of preventive interventions for children and young people, especially girls and young women, who are particularly affected.

At present only 40 percent of young men and 45 percent of young women aged 15-24 have comprehensive knowledge of HIV/AIDS³⁶; very few young men or women receive life skills training for prevention of HIV; and access to condoms is limited. Although ante-natal clinic attendance is high, only about a quarter of pregnant women (23 percent) were counselled about HIV during an antenatal care visit in 2003/4:³⁷ some 15,425 have received ARV for PMTCT. An estimated 3% of babies

³³ Tanzania HIV/AIDS Indicator Survey (THIS), 2003/4

³⁴ TDHS 2004/5

³⁵ THIS 2003/4

³⁶ TDHS 2004/5

³⁷ THIS 2003/4

are born HIV positive each year.³⁸ Furthermore, of the estimated 2.5 million children (under 18 years) orphaned in Tanzania, 40 percent are orphaned as a result of AIDS. Intensive collaborated efforts are still needed to educate, sensitize, train and disseminate information against the epidemic in order to reach the goal by 2010.

7.0 SUMMARY OF LESSONS LEARNED AND FUTURE PLANS AT NATIONAL, SUB-NATIONAL OR REGIONAL LEVELS

7.1 Lessons learned

Most of the achievements of WFFC and relevant MDG targets stem from clear Government commitment and strong partnerships with a variety of stakeholders around Child Survival, Protection, Participation and Development. The following are key results and lessons learned:

- Substantial progress has been made over the last five years in the reduction of infant and under-five mortality through provision of micronutrients, including vitamin A and implementation of child survival, protection and development programmes such as EPI, IMCI, malaria control and treatment and breastfeeding. However, more efforts need to be made in expanding PMTCT and increasing the number of births attended by trained health personnel to combat neo-natal deaths.
- Some decline in MMR has been observed in Zanzibar. Alongside the decline is the increase in births that occurred in health facilities and were attended by trained health personnel.³⁹ There is need to encourage pregnant women to deliver in health facilities and increase the number of trained health personnel and equipment.
- On children and HIV/AIDS, only about ten percent of 15 to 24 year olds have been reached with peer education, life skills and other services provided by youth networks; such efforts need to be expanded, as assessment shows positive social change, including increasing use of condoms.
- The Complementary Basic Education in Tanzania (COBET) model – designed to provide basic education opportunity to out of school children and a route back to formal schooling and other education and training avenues has had a positive impact on children’s and parents’ attitude towards education. It has since been mainstreamed into primary schooling and has influenced the revision of national curricula, including adoption of the subject “Personality Development and Sports” and incorporation of HIV/AIDS and life skills education.
- There have been notable improvements in the quality of teaching as CFS schools have adopted interactive teaching methods. These

³⁸ PMTCT scorecard 2006

³⁹ ANC surveillance 2005

improvements have resulted in better retention rates especially for girls and more support to MVCs. There is also a better school–community relationship, typified by increased community support to school projects. Other notable impacts of CFS include abolition of corporal punishment in some schools; increased participation of children in school and community decision-making through the formation of school assemblies; and community agreements and action plans on child-protection against abuse.

- Availability of reliable data is crucial in fulfilling the reporting requirements of CRC, ACRWC and the Optional Protocols to the CRC and WFFC+5. The national poverty monitoring system provides reliable data through its different working groups and the establishment of web-based Tanzania Social and Economic Data Base (TSED), which if it continues to be updated, can be a key tool for monitoring the implementation of MKUKUTA and the MDGs.
- Participatory and child-focused research was strengthened and the participation of children and young people in national processes and consultations was heightened, hence giving a voice to the voiceless.
- Support provided in protection services to over 200,000 children and women in the refugee affected areas of western Tanzania through a GoT/UNICEF Programme in close collaboration with UNHCR and WFP, enabled most indicators to surpass national figures; proving that a concerted and more holistic action is bound to bear good results.

7.2 Future plans

Future initiatives planned at national, sub national or regional levels include:

- Implementation of the costed National Most Vulnerable Children (MVC) Action Plan. The Plan includes community-based protection and national coordination systems to enhance care and services to orphans and vulnerable children.
- Development and implementation of the Integrated National Strategy on Early Childhood Development.
- Several programmes will be mainstreamed into Government systems through the new GoT/UNICEF Country Programme 2007/2010, covering all 129 districts by working through the exchequer system rather than directly with its current 57 districts. The number of “special focus” districts will be reduced from fifteen to six, converging all programmes in those districts where vulnerability is greatest.
- Establishment of a National Child Rights Committee. Currently, there is inadequate monitoring, coordination and institutional structures for child rights. The establishment of a National Child Rights Committee will enhance professional and systematic monitoring, collection, analysis of data and information and address

the issues and concerns from children's perspective. The committee will also be in a position to disseminate basic information on the situation of children, so as to strengthen implementation of the United Nations CRC Committee's recommendations.

- The PER process for children and young people will be strengthened to allow greater visibility of children in the government budgeting process and hence mobilize more resources required to address children and young people's issues.

References

- i. Ante Natal Care Surveillance, 2005.
- ii. Commission for Human Rights and Good Governance *Report on Public Hearing of Child Abuse*, 2006.
- iii. Household Budget Survey (HBS), 2000/01.
- iv. MoEC *Basic Education Statistics in Tanzania (BEST)*, 2000 - 2006.
- v. MoH *Health Management Information System*, 2005.
- vi. Poverty and Human Development Report (PHDR), 2005.
- vii. Protection of Mother to Child Transmission (PMTCT) Score Card, 2006.
- viii. Public Expenditure Review (PER) for Education and Health Sector, 1998-2005.
- ix. REPOA/UNICEF *Update of the Situation Analysis of Women and Children in Zanzibar*, October, 2006.
- x. Research and Analysis Working Group (R&AWG) *Vulnerability and Resilience to Poverty in Tanzania: Causes, Consequences and Policy Implications*, 2004.
- xi. Tanzania Health Demographic Survey, 2004/2005.
- xii. Tanzania HIV/AIDS Indicator Survey (THIS), 2003/04.
- xiii. Tanzania Participatory Poverty Assessment: Main Report, 2002/03.
- xiv. The URT second country period report on the implementation of the UN convention on the Rights of the Child (CRC) submitted to UN CRC Committee, August 2004.
- xv. UNICEF *Complementary Basic Education in Tanzania (COBET): Evaluation of the Pilot Project*, 2006.
- xvi. Zanzibar Household Budget Survey (HBS), 2006.
- xvii. Zanzibar Poverty Reduction Paper 11, 2004/05.

Appendix 1

Goal Statements of A World Fit for Children and Data from Tanzania

I PROMOTING HEALTHY LIVES			
Goals and Indicators	2000	2002	2006
1. By 2010 reduction in the infant and under-five mortality rate at least one third, in pursuit of the goal of reducing it by two thirds by 2015			
Under-Five Mortality Rate MDGS	147 ¹		112 ^{II}
Infant Mortality Rate WSC, MDG	99 ¹		68
2. By 2010 reduction in the maternal mortality ratio by at least one third, in pursuit of the goal reducing it by three quarters by 2015;			
Maternal Mortality Ratio WSC, MDG	529 ¹		578
3. By 2010 reduction of child malnutrition among children under five years of age by at least one third, with special attention to children under two years of age, and reduction in the rate of low birth weight by at least one third of the current rate;			
Underweight prevalence WSC,	30.6 ¹		21.9
Stunting prevalence WSC	43.4 ¹		37.7
Wasting prevalence WSC	7.2 ¹		2.9
Low birth weight WSC			3.7
4. By 2010, reduction in the proportion of households without access to hygienic sanitation facilities and affordable and safe drinking water by at least one third;			
Access to safe drinking water WSC, MDG	...	...	62 ^{III}
Use of sanitary means of excrete disposal WSC, MDG	...	...	47 ³
5. Development and implementation of national early childhood development policies and programmes to ensure the enhancement of children's physical social emotional, spiritual and cognitive development';			
Pre-school development WSC, EFAJ EFAD	...	...	...
6. Development and implementation of national health policies and programmes for adolescents, including goals and indicators, to promote their physical and mental health;			
Fertility rate of women 15 to 19 Optional, from WSC	138 ¹	113 ^{IV}	132 ³
7. Access through the primary health-care system to reproductive health for all individuals of appropriate ages as soon as possible and no later than 2015			
Contraceptive prevalence rate WSC, MDG	25.4 ¹	...	26.4 ³
Fertility rate of women 15 to 19 Optional from WSC	138 ¹	113 ⁴	132 ³
Total fertility rate Optional from WSC	5.6 ¹	6.3 ⁴	5.7 ³

Supporting goals for Promoting Health Lives

Goals and Indicators	2000	2002	2006
Maternal and child health			
Ensure reduction of maternal and neonatal morbidity and mortality:			
<ul style="list-style-type: none"> ➤ Ready and affordable access to essential obstetric care, maternal health-care services, skilled attendance at delivery, emergency obstetric care, post-partum care and family planning 			

Antenatal Care	WSC	...	...	94.3 ³
Childbirth care	WSC, MDG	...	...	46.3 ³
Obstetric care	WSC, WHO UNFPA/UNIC	...	...	...
<p>✍ By 2010 full immunization of children under one year of age at 90 per cent nationally, with at least 80 per cent coverage in every district of equivalent administrative unit;</p> <p>✍ Reduce deaths due to measles by half by 2005;</p> <p>✍ Eliminate maternal and neonatal tetanus by 2005; and</p> <p>✍ Extend the benefits of new and improved vaccines and other preventive health interventions to children in all countries.</p>				
DPT immunization coverage	WSC	86	88	95 ^v
Measles immunization coverage	WSC MDG	78	89	91 ⁵
Polio immunization coverage	WSC	...	...	91 ⁵
Tuberculosis immunization coverage	WSC	...	...	...
Children protected against neonatal tetanus	WSC	...	...	...
Under Five Deaths from Measles	WSC	...	...	...
Neonatal Tetanus cases	WSC	...	...	81 ⁵
Maternal Tetanus cases	...	...	...	...
Certify by 2005 the global eradication of poliomyelitis				
Polio cases	WSC	...	...	0
By 2010 eradicate guinea worm disease				
Guinea worm cases	WSC	...	...	...
<p>By 2010 intensify proven, cost-effective actions against diseases and malnutrition that are the major causes of child mortality and morbidity</p> <p>Including:</p> <p>✍ Reducing by one third deaths due to acute respiratory infections;</p> <p>✍ Reducing by one half deaths due to diarrhoea among children under the age of five</p> <p>✍ Reducing by one half tuberculosis deaths and prevalence;</p> <p>✍ Reducing the incidence of intestinal parasites, cholera, sexually transmitted infections, HIV/AIDS, and all forms of hepatitis,</p> <p>Ensure that effective measures are affordable and accessible, particularly in high marginalised areas of populations</p>				
Under five deaths from diarrhoea	WSC	...	...	...
Diarrhoea cases	WSC	...	...	12.6 ³
ORT use	WSC	...	...	62.2 ³
Home management of diarrhoea	WSC	...	...	...
Under-five deaths from acute respiratory infections	WSC	...	...	...
Care seeking for acute respiratory infections to an appropriate health provider	WSC	...	...	56.5 ³
TB prevalence/death rates	MDG	...	...	...
TB detector and care	MDG	...	...	...
By 2010 reduce by one half the burden of disease associated with malaria, and ensure that 60 per cent of all people at risk of malaria, especially children and women, sleep under insecticide-treated bed nets.				
Malaria prevalence	MDG	...	...	24.4 ³
Bednets (Any net)	WSC	...	...	31.4 ³
Malaria treatment	WSC	...	...	60.9 ³
Malarial prevention and treatment	MDG	...	...	...

Maternal and child nutrition

Protect, promote and support exclusive breastfeeding of infants for six months and continued breastfeeding with safe, appropriate and adequate complementary feeding up to two years of age or beyond.				
Provide infant-feeding counselling for mothers living with HIV/AIDS so that they can make free and informed choices				
Exclusive breastfeeding rate (< 6 month of age)	WSC	---	---	41.3 ³
Timely complementary feeding rate (6 – 9 months of age)	WSC	90.7	---	90.9 ³
Continued breastfeeding rate (12 – 15 months of age)	WSC	86.1	---	91.0 ³
Number of baby-friendly facilities	WSC	---	---	---
Tackling micronutrient deficiencies				
✍ Achieve sustainable elimination of iodine deficiency disorders by 2005				
✍ Achieve sustainable elimination of vitamin A deficiency by 2010				
✍ Reduce by one third the prevalence of anaemia, including iron deficiency, by 2010;				

Accelerate progress towards reduction of other micronutrient deficiencies, through dietary diversification, food fortification and supplementation.				
Iodised salt consumption	WSC	...	...	...
Children receiving vitamin A supplements	WSC	...	...	83
Mothers receiving vitamin A supplements	WSC	...	...	63
Anaemia	WSC	...	...	...
II. PROVIDING QUALITY EDUCATION				
Goals and Indicators		2000	2002	2006
To meet the Dakar goals and ensure that by 2015 all children have access to and complete primary education that is free compulsory and of good quality EFA Dakar MDG				
1. Expand and improve comprehensive early childhood care and education for girls and boys, especially for the most vulnerable and disadvantaged children				
Gross enrolment ratio in ECD Programmes	EFAJ EFAD			
2. By 2010, reduce the number of primary school-age children who are out of school by 50 per cent and increase net primary school enrolment or participation in alternative, good quality primary education programmes to at least 90 per cent;				
Gross intake rate	EFAJ	...	...	...
Net intake rate	EFA Dakar EFAJ	...	...	...
Gross Enrolment Ratio	EFAJ EFAD	...	88.8	112.7 ^{vi}
Net Enrolment Ratio	WSC, EFAJ EFAD, MDG	58.8	80.7	96.1
Survival rate to grade 5	WSC, EFAD, MDG EFAJ	...	...	...
3. Eliminate gender disparities in primary and secondary education by 2005; and achieve gender equality in education by 2015; with a focus on ensuring girls' full and equal access to and achievement in basic education of good quality;				
Gender ratio, primary education	EFAD, MDG	1.01	0.97	0.99
Gender ratio, secondary education	EFAD, MDG			
4. Improve all aspects of the quality of education so that children and young people achieve recognized and measurable learning outcomes especially in numeracy, literacy and essential life skills;				
Basic learning competencies	WSC, EFAD EFAJ			
Literacy rates of 15-24 year olds	EFAD, EFAJ MDG	82 ⁷	78 ⁴	
5. Ensure that the learning needs of all young people are met through access to appropriate learning and life skills programmes				
6. Achieve a 50 per cent improvement in levels of adult literacy by 2015, especially for women				
Adult Literacy	EFAD EFAJ	71 ¹	69 ⁴	
Literacy Gender Parity Index	EFAD EFAJ			
III. PROTECTION AGAINST ABUSE, EXPLOITATION AND VIOLENCE				
Goals and Indicators		2000	2002	2006
1. Protect children from all forms of abuse, neglect exploitation and violence				
Child labour	CRC, ILO Convention 138	...	...	...
Birth registration	CRC	6.4 ¹	...	19
Juvenile justice	UN Rules for Protection of	...	...	...
Children deprived on liberty	- Age - Sex - type of offence, If any	...	...	...
2. Protection of children from the impact of armed, conflict and ensure compliance with international humanitarian law and human rights law;				
Displaced children	CRC Protocol on Children % children in IDP receiving access to basic services: - immunisation coverage (children < 1 year) - schooling (children of primary school age) - % IDP having access to safe water			

-	% IDP having access to safe sanitation			
	Child soldiers armed			
3.	Protect children from all forms of sexual exploitation including paedophilia, trafficking, and abduction;			
	<i>Commercial sexual exploitation of children</i> CRC protocol on sale of children, child prostitution & pornography Stockholm Declaration			
4.	Take immediate and effective measures to eliminate the worst forms of child labour as defined in International Labour Organization Convention No.182, and elaborate and implement strategies for the elimination of child labour that is contrary to accepted international standards;			
	<i>Worst forms of child labour</i> CRC ILO Convention 182 on the Worst Forms of Child Labour			
IV. COMBATING HIV/AIDS				
Goals and Indicators		2000	2002	2006
1. By 2003, establish time-bound national targets to achieve the internationally agreed global prevention goal to reduce by 2005 HIV prevalence among young men and women aged 15 to 24 in the most affected countries by 25 per cent and by 25 per cent globally by 2010, and to intensify efforts to achieve these targets as well as to challenge gender stereotypes and attitudes, and gender inequalities in relation to HIV/AIDS, encouraging the active involvement of men and boys.				
<i>HIVPREVELENCE AMONG 15-24 year old pregnant women</i> MDG <i>Contraceptive prevalence rate</i> MDG, WSC		25.4		26.4
2. By 2005, reduce the proportion of infants infected with HIV by 20 per cent, and by 50 per cent by 2010, by ensuring that 80 per cent of pregnant women, accessing antenatal care have information, counselling and other HIV prevention services available to them, increasing the availability of and by providing access for HIV-infected women, and babies to effective treatment to reduce mother-to-child transmission of HIV, as well as through effective interventions for HIV infected women, including voluntary and confidential counselling and testing access to treatment, especially anti-retroviral therapy and, where appropriate breast milk substitutes and the provision of a continuum of care.				
<i>HIV Prevalence among infants</i>				
3. By 2003 develop and by 2005 implement national policies and strategies to build and strengthen governmental, family and community capacities to provide a supportive environment for orphans and girls and boys infected and affected by HIV/AIDS including by providing appropriate counselling and psycho-social support; ensuring their enrolment in school and access to shelter, good nutrition, health and social services on an equal basis with other children, to protect orphans and vulnerable children from all forms of abuse, violence, exploitation, discrimination, trafficking and loss of inheritance.				

Key:

WSC = World Summit for Children, 1990

EFAJ = Education For All, Jomtien, 1990

EFAD = Education For All, Dakar 2000

MDG – Millennium Development Goals, 2000

WFFC = World Fit for Children, UN Special Session on Children, 2002

International Conventions and Agreements on Children:

Convention on Rights of the Child (CRC), 1990 ILO Convention 138 on Minimum Age for Admission to Employment, 1973; ILO Convention 182 on the Worst Forms of Child Labour, 1999; Optional Protocol to the CRC on the sale of children, child prostitution and child pornography, 2000; Optional Protocol to the CRC on the involvement of children in armed conflicts, 2000; Stockholm Declaration and Agenda for Action against Commercial Sexual Exploitation of Children, 1996; The UN Rules for the Protection of Juveniles Deprived of their Liberty, 1990.

¹ Tanzania Reproductive and Child Health Survey (TRCHS) 1999

² Tanzania Demographic and Health Survey (TDHS) 2004/05

³ Joint Monitoring Report 2004

⁴ Housing and Population Census 2002

⁵ WHO/UNICEF Joint reporting form 2006

⁶ Basic Education Statistics in Tanzania (BEST) 2002– 2006

⁷ Tanzania Household Budget Survey 2000/01