Children and Women in Tanzania

Volume I
Mainland
Credits

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Children and Women in Tanzania

Volume 1 Mainland
Foreword

“A Tanzanian who is born today will be fully grown up, will have joined the working population and will probably be a young parent by the year 2025... What kind of society will have been created by such Tanzanians in the year 2025? What is envisioned is that the society these Tanzanians will be living in by then will be a substantially developed one with a high quality livelihood. Abject poverty will be a thing of the past... Tanzanians will have graduated from a least developed country to a middle income country with a high level of human development.”

These words, enshrined in the Tanzania Development Vision 2025, resonate today with the same vigour and urgency as when they were written in 2000. This report, the result of a joint collaboration between the Government of the United Republic of Tanzania and the United Nations Children’s Fund, argues that the vision of an economically prosperous Tanzania can only be realised if the survival, well-being and development of its children is assured. Indeed, every country that has made the breakthrough to middle-income status has invested heavily in children. Their development is the single most important driver of national growth.

Children also represent the foundation of a vibrant democracy and a cohesive, peaceful society. The first cohorts of children to benefit from the Primary Education Development Plan voted in national elections in 2010, while students leaving primary school this year will be eligible to vote in 2015, the target date for the Millennium Development Goals. Young people need to be supported to grow up as informed and empowered citizens. Healthy, educated children also become creative, productive adults. Since children make up over half the country’s population, it is not some distant future that is at stake. Investing in their well-being now is the soundest investment Tanzania can make to secure economic, social and political stability and prosperity.

This report highlights areas where progress has been made in securing the rights of children and women, and identifies where progress has stalled or is lagging behind. It sheds light on policies and strategies that have worked and those in need of adjustment. Undoubtedly, Tanzania has seen major progress in child health and education, as well as in some aspects of HIV and AIDS. Such progress, however, has often been uneven, and must not detract from the fact that other areas of critical relevance to children and women have received less attention from policy makers, particularly maternal and newborn healthcare, nutrition, social and child protection, disability and, until recently, early childhood development and water, hygiene and sanitation.

In the quest for accelerating progress in meeting the rights of Tanzanian children and women, the question of what ought to be done first does not lend itself to easy answers. Among many competing demands, Tanzania will need to set clear priorities, taking account of the capacity to deliver on them. A judicious mix of realism and ambition will be required. Even though rights are indivisible and interdependent, not every issue can be tackled at once. In a context of scarce resources, the fulfilment of rights demands making policy choices with a clear mindset, and delineating a critical path for their progressive realization.

We are confident that the analysis and findings of this report, along with the Children’s Agenda it delineates, will help inform the discussions and setting of priorities for the fulfilment of the rights of all Tanzanian children and of the vision of a strong and prosperous country. Twenty million children and Tanzania can ill afford to wait.

Ramadhan Khijjah
Permanent Secretary
Ministry of Finance

Dorothy Rozga
Representative
UNICEF Tanzania
Acknowledgements

The report on *Children and Women in Tanzania 2010* is the result of a joint collaboration between the Government of the United Republic of Tanzania and UNICEF. Given its breadth and scope, the report would not have been possible without the strong commitment, guidance and support of the members of the National Steering Committee set up in 2009 to advise, oversee and validate the results of the analysis, the findings and the recommendations contained in this publication.

Chaired by the Ministry of Finance and Economic Affairs and co-chaired by UNICEF, the Steering Committee had representation from a broad cross-section of Ministries, Departments and Agencies, as well as civil society organisations. Special thanks are due, first and foremost, to the Government of the United Republic of Tanzania and the Revolutionary Government of Zanzibar, and also to the many participants in the stakeholder consultations held during 2009 and 2010 to discuss the preliminary findings from the analytical work commissioned for the publication.


Background papers for the publication were produced by Paul Smithson (chapter 2), John Msuya (chapter 3), Ben Taylor (chapter 4), Suleman Sumra (chapter 5), Halima Shariff and Rugola Mtandu (chapter 6), and Andrew Dunn and Robert Mhamba (chapter 7). Kate McAlpine contributed a preliminary version of the executive summary and the introductory chapter, and also provided detailed comments and helped revise all the chapters in the report. Chapter 8 is the outcome of broad consultations with a range of stakeholders from Government, leading children’s organisations and children from across the country. Chris Daly proof read and edited the full report.

Every section of the UNICEF Office was involved in the preparation of the report. Contributions are duly acknowledged from Young Child Survival and Development (chapters 2, 3 and 4), Basic Education and Life Skills (chapter 5), HIV and AIDS (chapter 6), Child Protection and Participation (chapter 7) and Communication and Partnerships (chapter 8). Policy Advocacy and Analysis was responsible for the overall coordination, quality assurance and distillation of the key findings and recommendations of the report. For continuous support as well as the provision of specific inputs, special thanks are also given to the Office of the Deputy Representative, the Operations and Planning sections, the Emergency Preparedness and Response division and the Zanzibar sub-Office of UNICEF.

Given the wide range of contributions into this publication, its contents and conclusions may not necessarily reflect the views of every one of the contributors or the institutions they represent.
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<td>ACRWC</td>
<td>African Charter on the Rights and Welfare of the Child</td>
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<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<td>AMREF</td>
<td>African Medical and Research Foundation</td>
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<tr>
<td>ALU</td>
<td>Artemether Lumefantrine</td>
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<tr>
<td>ANC</td>
<td>Antenatal care</td>
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<td>ARI</td>
<td>Acute respiratory infection</td>
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<td>ART</td>
<td>Anti-retroviral treatment</td>
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<td>ARVs</td>
<td>Anti-retrovirals</td>
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<td>ART</td>
<td>Anti-retroviral therapy</td>
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<td>BEST</td>
<td>Basic Education Statistics in Tanzania</td>
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<td>BMI</td>
<td>Body Mass Index</td>
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<td>BWO</td>
<td>Basin Water Office</td>
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<td>CBO</td>
<td>Community-based organisation</td>
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<tr>
<td>CEDAW</td>
<td>Convention on the Elimination of All Forms of Discrimination Against Women</td>
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<tr>
<td>c-IMCI</td>
<td>Community-Integrated Management of Childhood Illness</td>
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<td>CMAC</td>
<td>Council Multi-sectoral AIDS Committee</td>
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<td>COBET</td>
<td>Complementary Basic Education in Tanzania</td>
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<td>COWSO</td>
<td>Community-owned Water Supply Authority</td>
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<td>CRC</td>
<td>United Nations Convention on the Rights of the Child</td>
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<td>CSO</td>
<td>Civil society organisation</td>
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<td>DALY</td>
<td>Disability-adjusted life years</td>
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<td>D by D</td>
<td>Decentralisation by Devolution</td>
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<td>DHS</td>
<td>Demographic and Health Survey</td>
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<td>DMS</td>
<td>Data management system</td>
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<td>DPT-HB3</td>
<td>Diptheria, Pertussis, Tetanus and Hepatitis B vaccine (3 doses)</td>
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<td>DSW</td>
<td>Department of Social Welfare</td>
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<td>Early childhood development</td>
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<td>EFA</td>
<td>Education for All</td>
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<td>EPI</td>
<td>Expanded Program on Immunisation</td>
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<td>EWURA</td>
<td>Energy and Water Utilities Regulatory Authority</td>
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<td>ESDP</td>
<td>Education Sector Development Programme</td>
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<td>FBOs</td>
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<td>Female genital mutilation</td>
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<td>GAR</td>
<td>Gross Attendance Ratio</td>
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<td>GDP</td>
<td>Gross Domestic Product</td>
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<td>Government of Tanzania</td>
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<td>Human Immuno-deficiency Virus</td>
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<td>Health Management Information System</td>
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<td>IDD</td>
<td>Iodine deficiency disorders</td>
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<td>IEC</td>
<td>Information, education and communication</td>
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<td>IHI</td>
<td>Ifakara Health Institute</td>
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<td>ILO</td>
<td>International Labour Organisation</td>
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<td>IMCI</td>
<td>Integrated Management of Childhood Illnesses</td>
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<td>Acronym</td>
<td>Description</td>
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<td>IMR</td>
<td>Infant Mortality Rate</td>
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<td>INGO</td>
<td>International non-government organisation</td>
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<tr>
<td>ITN</td>
<td>Insecticide-treated mosquito nets</td>
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<td>IPPE</td>
<td>Integrated post-primary education</td>
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<td>IPTp</td>
<td>Intermittent preventive treatment for malaria in pregnancy</td>
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<td>JMP</td>
<td>Joint Monitoring Programme</td>
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<tr>
<td>LBW</td>
<td>Low birth weight</td>
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<td>LGA</td>
<td>Local government authority</td>
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<td>MCC</td>
<td>Millennium Challenge Corporation</td>
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<td>MCDGC</td>
<td>Ministry of Community Development, Gender and Children</td>
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<td>MDG</td>
<td>Millennium Development Goals</td>
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<td>MKUKUTA</td>
<td>Mkakati wa Kukuza Uchumi na Kupunguza Umaskini Tanzania</td>
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<td>MMAM</td>
<td>Swahili acronym for Primary Health Services Development Strategy</td>
</tr>
<tr>
<td>MMR</td>
<td>Maternal Mortality Ratio</td>
</tr>
<tr>
<td>MNCH</td>
<td>Maternal, newborn and child health</td>
</tr>
<tr>
<td>MoEVT</td>
<td>Ministry of Education and Vocational Training</td>
</tr>
<tr>
<td>MoHSW</td>
<td>Ministry of Health and Social Welfare</td>
</tr>
<tr>
<td>MoLEYD</td>
<td>Ministry of Labour, Employment and Youth Development</td>
</tr>
<tr>
<td>MoWI</td>
<td>Ministry of Water and Irrigation</td>
</tr>
<tr>
<td>MVC</td>
<td>Most vulnerable children</td>
</tr>
<tr>
<td>MVCC</td>
<td>Most Vulnerable Children Committee</td>
</tr>
<tr>
<td>NAR</td>
<td>Net Attendance Ratio</td>
</tr>
<tr>
<td>NACP</td>
<td>National AIDS Control Program</td>
</tr>
<tr>
<td>NAWAPO</td>
<td>National Water Policy</td>
</tr>
<tr>
<td>NBS</td>
<td>National Bureau of Statistics</td>
</tr>
<tr>
<td>NCPA</td>
<td>National Costed Plan of Action for MVC</td>
</tr>
<tr>
<td>NER</td>
<td>Net Enrolment Ratio</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-government organisation</td>
</tr>
<tr>
<td>NSGRP</td>
<td>National Strategy for Growth and Reduction of Poverty</td>
</tr>
<tr>
<td>NMSF</td>
<td>National Multi-sectoral Strategic Framework</td>
</tr>
<tr>
<td>NSPF</td>
<td>National Social Protection Framework</td>
</tr>
<tr>
<td>NWSDS</td>
<td>National Water Sector Development Strategy</td>
</tr>
<tr>
<td>ORS</td>
<td>Oral rehydration solution</td>
</tr>
<tr>
<td>OVC</td>
<td>Orphans and vulnerable children</td>
</tr>
<tr>
<td>PEDP</td>
<td>Primary Education Development Plan</td>
</tr>
<tr>
<td>PEPFAR</td>
<td>President’s Emergency Preparedness Fund for AIDS Relief</td>
</tr>
<tr>
<td>PER</td>
<td>Public Expenditure Review</td>
</tr>
<tr>
<td>PHDR</td>
<td>Poverty and Human Development Report</td>
</tr>
<tr>
<td>PHAST</td>
<td>Participatory Hygiene and Sanitation Transformation</td>
</tr>
<tr>
<td>PLWHA</td>
<td>People living with HIV and AIDS</td>
</tr>
<tr>
<td>PMO-RALG</td>
<td>Prime Minister’s Office – Regional Administration and Local Government</td>
</tr>
<tr>
<td>PMTCT</td>
<td>Prevention of mother-to-child transmission of HIV</td>
</tr>
<tr>
<td>PO-PSM</td>
<td>President’s Office- Public Sector Management</td>
</tr>
<tr>
<td>PRSP</td>
<td>Poverty Reduction Strategy Paper</td>
</tr>
<tr>
<td>RCH</td>
<td>Reproductive and child health</td>
</tr>
<tr>
<td>Acronym</td>
<td>Definition</td>
</tr>
<tr>
<td>---------</td>
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</tr>
<tr>
<td>RDTs</td>
<td>Rapid diagnostic tests</td>
</tr>
<tr>
<td>REPOA</td>
<td>Research on Poverty Alleviation</td>
</tr>
<tr>
<td>RHMT</td>
<td>Regional Health Management Teams</td>
</tr>
<tr>
<td>SACMEQ</td>
<td>Southern and East African Consortium for Monitoring Educational Quality</td>
</tr>
<tr>
<td>SADC</td>
<td>Southern Africa Development Community</td>
</tr>
<tr>
<td>SEDP</td>
<td>Secondary Education Development Plan</td>
</tr>
<tr>
<td>SitAn</td>
<td>Situation and trends analysis</td>
</tr>
<tr>
<td>SNV</td>
<td>Dutch Development Agency</td>
</tr>
<tr>
<td>SOSPA</td>
<td>Sexual Offences Special Provisions Act</td>
</tr>
<tr>
<td>SP</td>
<td>Sulfadoxine Pyremethamine</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually transmitted infection</td>
</tr>
<tr>
<td>SWAp</td>
<td>Sector-wide approach</td>
</tr>
<tr>
<td>SWO</td>
<td>Social Welfare Officer</td>
</tr>
<tr>
<td>TACAIDS</td>
<td>Tanzania Commission for AIDS</td>
</tr>
<tr>
<td>TASAF</td>
<td>Tanzania Social Action Fund</td>
</tr>
<tr>
<td>TAWASANET</td>
<td>Tanzania Water and Sanitation Network</td>
</tr>
<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>TBA</td>
<td>Traditional birth attendant</td>
</tr>
<tr>
<td>TDHS</td>
<td>Tanzania Demographic and Health Survey</td>
</tr>
<tr>
<td>TFNC</td>
<td>Tanzania Food and Nutrition Centre</td>
</tr>
<tr>
<td>THIS</td>
<td>Tanzania HIV/AIDS Indicator Survey</td>
</tr>
<tr>
<td>THMIS</td>
<td>Tanzania HIV/AIDS and Malaria Indicator Survey</td>
</tr>
<tr>
<td>TSPA</td>
<td>Tanzania Service Provision Assessment</td>
</tr>
<tr>
<td>Tsh</td>
<td>Tanzania shillings</td>
</tr>
<tr>
<td>TVET</td>
<td>Technical vocational education and training</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on AIDS</td>
</tr>
<tr>
<td>UNDAF</td>
<td>United National Development Assistance Framework</td>
</tr>
<tr>
<td>UNDP</td>
<td>United Nations Development Programme</td>
</tr>
<tr>
<td>UNESCO</td>
<td>United Nations Educational, Scientific and Cultural Organisation</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
</tr>
<tr>
<td>URT</td>
<td>United Republic of Tanzania</td>
</tr>
<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
</tr>
<tr>
<td>UWASA</td>
<td>Urban Water Supply Authority</td>
</tr>
<tr>
<td>VAD</td>
<td>Vitamin A deficiency</td>
</tr>
<tr>
<td>VCT</td>
<td>Voluntary counselling and testing for HIV</td>
</tr>
<tr>
<td>VIP</td>
<td>Ventilated improved pit (latrine)</td>
</tr>
<tr>
<td>VMAC</td>
<td>Village Multi-sectoral AIDS Committee</td>
</tr>
<tr>
<td>WASH</td>
<td>Water, sanitation and hygiene</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organisation</td>
</tr>
<tr>
<td>WMACs</td>
<td>Ward Multi-sectoral AIDS Committees</td>
</tr>
<tr>
<td>WPM</td>
<td>Waterpoint mapping</td>
</tr>
<tr>
<td>WRM</td>
<td>Water resource management</td>
</tr>
<tr>
<td>WSDP</td>
<td>Water Sector Development Programme</td>
</tr>
<tr>
<td>WSP</td>
<td>Water and Sanitation Programme</td>
</tr>
<tr>
<td>ZSGRP</td>
<td>Zanzibar Strategy for Growth and Reduction of Poverty</td>
</tr>
</tbody>
</table>
Mainland
Overview

*Children and Women in Tanzania 2010* argues that investing in children and their mothers is the single most important investment for Tanzania’s development. Given that children under 18 years of age constitute 51% of the population, it will be their creativity and productivity that will determine if the goals of Vision 2025 are realised. Investing in their well-being now is the soundest investment Tanzania can make to secure economic, social and political stability and prosperity.

The report provides in-depth analysis of the situation of children and women in six areas: health; nutrition; water, sanitation and hygiene; education; HIV and AIDS; and child protection. It seeks to provide guidance on what needs to happen to provide an enabling environment in which children can thrive and their potential can be catalyzed for their own benefit and for Tanzania as a whole. It aims to drive evidenced-based advocacy and positive change for children and women in the country, and to serve as a reference tool for Government and non-state actors working towards development outcomes.

*Children and Women in Tanzania 2010* comes at a critical juncture. Its production has coincided with a number of important developments, such as the:

- Launch of the *National Roadmap Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania 2008-2015* (better known as the “One Plan”) by President Kikwete in 2009
- Drafting of sector and sub-sector policies that to date have represented major gaps in child well-being in Tanzania including the:
  - Integrated Early Childhood Development Policy
  - National Food and Nutrition Policy
  - National Sanitation and Hygiene Policy
- Launch of *Ajenda ya Watoto (The Children’s Agenda)* in June 2010 by the Minister for Community Development, Gender and Children.

Within the broader national context, the analysis has been used to inform the design and is expected to serve as an important reference for guiding the implementation of the second phase of the National Strategy for Growth and the Reduction of Poverty (2010-2015) (MKUKUTA II) so as to promote a strong focus on child outcomes and the development of a comprehensive social protection agenda in the country. The report highlights the significant achievements in child well-being over the last decade, and how one can learn from and build upon these gains to fully realise the rights of all Tanzanian children.
## Fast facts on Tanzanian children and women

### Demographics

<table>
<thead>
<tr>
<th>Number</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>22.2 million</td>
<td>Children under 18 years</td>
</tr>
<tr>
<td>8.1 million</td>
<td>Children under five years</td>
</tr>
<tr>
<td>8 million</td>
<td>Children living in poverty</td>
</tr>
<tr>
<td>1.8 million</td>
<td>Babies born every year</td>
</tr>
</tbody>
</table>

### Maternal and child survival

<table>
<thead>
<tr>
<th>Statistic</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.7</td>
<td>Total Fertility Rate - rural women on average have 6.5 children; urban women 3.6 children</td>
</tr>
<tr>
<td>1 in 4</td>
<td>Girls aged 15-19 years who have already begun childbearing</td>
</tr>
<tr>
<td>Nearly universal (97%)</td>
<td>Pregnant women who attended at least one antenatal care visit</td>
</tr>
<tr>
<td>Over half (54%)</td>
<td>Babies born without skilled attendants</td>
</tr>
<tr>
<td>25</td>
<td>Deaths every day of women during pregnancy or childbirth</td>
</tr>
<tr>
<td>Over 400</td>
<td>Deaths every day of children under five years</td>
</tr>
<tr>
<td>135</td>
<td>Deaths every day of babies less than one month</td>
</tr>
</tbody>
</table>

### Nutrition

<table>
<thead>
<tr>
<th>Statistic</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over 2.5 million</td>
<td>Number of children who are chronically malnourished</td>
</tr>
<tr>
<td>1 in 7 (14%)</td>
<td>Babies aged 4-5 months who are exclusively breastfed</td>
</tr>
</tbody>
</table>

### Education

<table>
<thead>
<tr>
<th>Statistic</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nearly universal (96%)</td>
<td>Net enrolment rate in primary school</td>
</tr>
<tr>
<td>Two-thirds</td>
<td>Children who complete primary school (Standard VII)</td>
</tr>
<tr>
<td>1:54</td>
<td>Pupil-teacher ratio in primary school</td>
</tr>
<tr>
<td>9 in 10</td>
<td>Children in rural areas not enrolled in secondary school</td>
</tr>
<tr>
<td>8,000</td>
<td>Girls who drop out of school every year due to pregnancy</td>
</tr>
</tbody>
</table>

### Water, sanitation and hygiene

<table>
<thead>
<tr>
<th>Statistic</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 in 5</td>
<td>Schools without functioning hand-washing facilities</td>
</tr>
<tr>
<td>3 in 5</td>
<td>Schools without an on-site water supply</td>
</tr>
<tr>
<td>9 in 10</td>
<td>Children and caregivers who do not wash their hands with soap after using the latrine or cleaning a baby or before preparing and eating food</td>
</tr>
</tbody>
</table>

### HIV and AIDS

<table>
<thead>
<tr>
<th>Statistic</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than half</td>
<td>Women who know HIV transmission to babies can be prevented</td>
</tr>
<tr>
<td>One-third</td>
<td>Infants born to HIV-positive mothers who received prophylaxis</td>
</tr>
</tbody>
</table>

### Child protection

<table>
<thead>
<tr>
<th>Statistic</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>More than 9 in 10</td>
<td>Children under five years who do not have a birth certificate</td>
</tr>
<tr>
<td>18 in 100</td>
<td>Children under 18 years who have lost one or both parents</td>
</tr>
<tr>
<td>1 in 5</td>
<td>Children engaged in child labour (rural 25%; urban 8%)</td>
</tr>
</tbody>
</table>
The Law of the Child Act 2009

The drafting of *Children and Women in Tanzania* 2010 coincided with the passage of the landmark Law of the Child Act through the Bunge on 6 November 2009, the first unified piece of national legislation aimed at comprehensively protecting the rights of children in Tanzania. The law effectively domesticates the UN Convention of the Rights of the Child (CRC) and addresses fundamental issues related to children's rights in Tanzania, including non-discrimination, the right to a name and nationality, the rights and duties of parents, the right to opinion, and a framework of protection for children at greatest risk due to loss of parents, abandonment, abuse or other causes.

Like all groundbreaking rights legislation, the new law has shortcomings reflecting adherence to long-held socio-cultural norms. For example, the Act does not address discrimination regarding the legal age of marriage, which remains at 15 years for girls and 18 years for boys. Underscoring the need for further legislative action, the Tanzania Demographic and Health Survey 2004/5 estimated that 25% of girls between 15 and 19 years of age were in child marriages, and 52% of women had commenced childbearing by the age of 19. Maternal health research unequivocally demonstrates that adolescent girls face a significantly higher risk of death from pregnancy and delivery related complications. The proportion of girls who become pregnant while attending school has been growing steadily. By 2007, around 8000 girls (about half from primary schools and half from secondary schools) became pregnant. In accordance with guidelines in force at the time, all of these students were expelled, and for most it marked the end of their education.

Corporal punishment also remains legal despite strong evidence that children who are beaten at home or school can suffer devastating physical and psychological damage that affects their sense of self-respect and self-worth. Engendering fear and anger and undermining a child’s ability to learn, corporal punishment often leads to children running away from their homes and dropping out of school. Children’s experience of violence can have profound impact on their adult lives. Victims of abuse all too frequently become abusers themselves or end up in abusive relationships. There is growing awareness of the long-lasting detriment of domestic and institutionalised violence and increasing national advocacy to bring about change.

**Child and maternal survival: Success and stagnation**

Over the last decade, Tanzania has made remarkable progress in reducing under-five mortality. Since 1999, the under-five mortality rate has declined by almost 40%, a decrease equivalent to saving the lives of nearly 100,000 Tanzanian children every year. These gains in child survival have largely been achieved through investment in effective, mostly low cost interventions, in particular, increased use of insecticide-treated mosquito nets, improved treatment of malaria, immunisation (which has reduced deaths from measles), and expanded coverage of Vitamin A supplementation (which boosts children’s immune systems).

Despite this progress, around 155,000 children under-five years are dying annually, the vast majority from readily preventable causes. Malnutrition, malaria and diarrhoea (largely caused by drinking unsafe water and poor sanitation and hygiene) are the biggest killers. Nearly 50,000 of these deaths are of children less than one month old; of which three-quarters survive for less than a week. Newborn deaths are inextricably linked to the health of the mother during pregnancy and to the adequacy of obstetric care at delivery; most can be averted if coverage of basic maternal and neonatal interventions is expanded.

Yet over the last 15 years, maternal health has stagnated. The TDHS 2004/5 estimated Tanzania’s maternal mortality rate at 578 deaths per 100,000 live births, one of the highest in the world. The proportion of women giving birth at health facilities is still less than 50%. When an emergency arises, even if a woman reaches a facility in time, the widespread lack of skilled birth attendants and essential obstetric equipment and supplies, means that a safe delivery is far from guaranteed. As a result, a woman dies in Tanzania every hour due to complications during pregnancy or childbirth.
This tragedy of so many women and babies dying during delivery or shortly after birth cannot be prolonged. The full implementation of the “One Plan” is urgently required to establish the foundation of maternal and child health in Tanzania, and meet MDG 4 for under-five mortality and MDG5 for maternal mortality.

National champions are needed for mothers and their children so that this long overdue investment becomes a reality. The benefits in terms of reduced maternal and child mortality and morbidity, long-term reductions in healthcare costs, and gains in productivity will be nothing short of formidable.

The rationale for “One Plan” is that children require a continuum of care and programmes not only within the health sector but also across sectoral boundaries. Children have needs for survival, development and protection that are inter-related and reinforce one another. But the current sectoral focus of targets and investments in children – for example, health addresses the ‘child as patient’, education addresses the ‘child as student’ and so on – tends to compartmentalise children’s needs and to divide up the child into artificial pieces. As a consequence significant gaps in outcomes persist or open up in the way duty-bearers respond to the needs of Tanzanian children.

Ministerial divisions, which are then replicated at local service delivery level, must be bridged so that children do not fall through those gaps. Coordinated programmes that are designed for the whole child are required, so that they may respond to children’s evolving developmental needs throughout their life course from conception through adolescence.

Nutrition and hygiene: Critical but overlooked

Unlike child survival, very little progress has been made in reducing chronic malnutrition. About four out of ten children in Tanzania are stunted, denying these children the opportunity to develop to their full mental and physical potential. The most harm occurs during pregnancy and in the first two years of a child’s life. Malnutrition is also linked to one-third of all under-five deaths, making it the single largest cause of under-five deaths in Tanzania. Yet, simple, cost-effective, affordable interventions are available that can have lasting impact on a child’s prospect.

Exclusive breastfeeding initiated within one hour of birth and continuing for six months is the most effective life-saving intervention. In addition, to breastfeeding – which optimally should continue until two years of age – young children from six months of age need to be fed frequently and given a variety of foods to prevent malnutrition. To facilitate change in feeding practices, women and their families must be routinely counselled and supported during antenatal and postnatal care on the importance of breastfeeding and safe weaning. The TDHS 2004/5 found that only 13.5% of infants aged 4-5 months were still exclusively breastfed.

Food fortification is another proven, low cost, effective way to reduce malnutrition. Most countries address micronutrient deficiencies by fortifying common foods such as salt with iodine, oils with vitamin A, and flour with iron. Every shilling invested in food fortification will yield an eight-fold return. Food fortification could reduce anaemia in children and women by 20% to 30%, reduce key birth defects by 30%, and vitamin A deficiency by 30%.

So too, hand-washing at critical times – after using a toilet, before preparing meals, before eating or feeding a child, and after attending a child who has defecated – is a simple, cost-effective way of saving children’s lives. Research indicates that it can reduce the risk of diarrhoeal disease – a major killer of children under-five – by up to 47%. The integration of basic hygiene education into maternal health services and the curriculum in schools are needed to facilitate behavioural change.

Improvements in basic nutrition and hygiene will have immediate and long-lasting benefits for children and the economy. Well-nourished, healthy children learn better, and, with fewer children succumbing to illness and recovering faster when they do, a significant burden is lifted from the health system.
Water and sanitation: A new momentum?

Clean and safe water, adequate sanitation facilities and safe hygiene practices in households, schools and health facilities are fundamental to women's and children's health. Diarrhoea and acute respiratory infections – which cause 40% of under-five deaths worldwide – are closely linked to poor water quality, sanitation and hygiene. In addition, one-quarter of neonatal deaths are due to infection and diarrhoea, and sepsis is a leading cause of maternal mortality, all of which are affected by use of unclean water and poor hygiene at delivery and postpartum.

Improvements in water supply and sanitation will bring enormous benefits to the lives of Tanzanian women and children. The burden of collecting water is largely borne by women and children, especially girls. And the lack of clean, private latrines in schools is a common reason for girls not to attend school or drop out altogether. Simple access to decent toilets can avert the tragic loss of education and future livelihoods for adolescent girls. Indeed, global analysis has estimated that there is an astonishing return on investment in water and sanitation: for every $1 spent on water supply and sanitation, a benefit of $11.5 will accrue in terms of time and financial savings — including more time at work, reduced medical costs, less school absence and decreased costs for hospital services.

Yet data for both urban and rural water supply in Tanzania show a decline in household access since 2000. Analysis of the Household Budget Survey reveals that poorer households pay three times more for water as a proportion of their income. In addition, three out of five schools in Tanzania have no on-site water supply, and four out of five schools have no functioning hand-washing facilities. On average, the school sanitation ratio is 61 students per latrine, compared with the target of one toilet for every 20 girls and one for every 25 boys. Almost two-thirds of health facilities lack a regular water supply and one-third have no toilets for clients.

It was hoped that the Water Sector Development Programme (WSDP) launched in 2007 will turn this deteriorating status around. Resources for Investment in water supply have almost doubled in the last few years, and funds are now allocated to all districts to improve rural water supply rather than targeted to a few major projects. For the sake of sustainability, it is very positive that the Government of Tanzania is the largest single contributor to the WSDP. But even with the increased level of funding, the resources for the sector are not able to keep up with population growth.

Despite their proven low-cost effectiveness, financing for sanitation and hygiene promotion has not yet received the attention of policy makers, donors and the public. The sub-sector receives barely 1% of the total water and sanitation budget and funds are largely spent on costly sewerage systems in a few towns and cities. Responsibility for this critical sub-sector is fragmented across the health, water and education ministries and the corresponding structures at the local government level.

Fortunately, there recently has emerged a heightened awareness of the critical importance of sanitation and hygiene for overall health and well-being. Four ministries, including the one responsible for the policy of decentralising service provision – Health and Social Welfare, Education and Vocational Training, Water and Infrastructure, and the Prime Minister’s Office (PMO-RALG) – have established a coordinating mechanism and have signed a Memorandum of Understanding that could bring new momentum to this neglected sub-sector. There is also a National Sanitation and Hygiene Policy that is being drafted and growing recognition of the need to step up investments in safe water, better hygiene and sanitation in schools and health facilities.

Improving outcomes for women and children will depend on the efficient integration of interventions to achieve broad-based coverage; water, sanitation and hygiene are three parts of the same solution.

Early childhood development: A new frontier

Along with the ‘One Plan’, integrated early childhood development (IECD) has the potential to be the vanguard in the fight against child poverty and deprivation in Tanzania. An IECD Policy has been drafted collaboratively between three ministries – Community Development, Gender
and Children, Education and Vocational Training, and Health and Social Welfare. The rationale for ECD is that gaps in individual ability widen significantly in the early years between advantaged and disadvantaged children. With a focus upon children in vulnerable households who are at the greater risk of disease and malnutrition and often have poorer educational outcomes, ECD can close these gaps.

Support for community-based parenting and ECD interventions will help ensure children grow up healthy, well nourished and well-prepared for school. Investments in early childhood have been shown to give a seven-fold return and are much more cost-efficient than remedial programmes later in a child’s life.

Recognising the importance of ECD, the second phase of the Primary Education Development Programme 2007-2011 (PEDP II) urged the establishment of pre-primary education for 5-6 year olds in every primary school using existing school facilities, and including pre-primary children in the $10 capitation grant. Little data on pre-schools is available, but the NER for 5-6 year olds rose from 24.6% in 2004 to 36.2% in 2008. However, the majority of the pre-primary schools attached to primary schools are still poorly funded and inadequately staffed, and over 80% of ECD centres that are not attached to primary schools are unregistered. Services in rural areas and poor urban areas are particularly limited.

**Education: The challenge of quality and equity**

Children’s needs change throughout their life course, so that different interventions are required at different points in time. As children age they are naturally predisposed towards increasing self actualisation and the rights that become more significant to them are those around education, participation and protection.

Tanzania has made significant progress in the education sector in the last ten years. Following the abolition of school fees in 2001 and massive investments in the construction of new classrooms, enrolment in primary schools skyrocketed to reach near universal coverage, with parity between girls and boys. Secondary education has also expanded at unprecedented rates, though coverage remains limited to better-off households and historically advantaged parts of the country. Less than one in ten children from rural area is enrolled. Beyond primary school, completion rates for girls diminish the higher the grade. Hard-to-reach and disabled children continue to be excluded from formal education.

But the very success in increasing access so rapidly may have come at the expense of learning outcomes. Less than 70% of students actually complete all primary grades and only about 52% pass the Primary School Leaving Examination. The number of primary school teachers has not kept pace with the increase in student numbers leading to overcrowded classrooms. On average, there are 54 students per teacher, and in rural areas more than 12 children share a single maths textbook.

The Government recognises that a well-educated citizenry is the lynchpin of poverty reduction and the future economic prosperity of the nation. A growing share of GDP is used to finance the sector, though the percentage is still below the recommended minimum of 20% of government spending, and there is a worrying lack of transparency around education budgets and expenditure. Infrastructure demands will continue to expand with population growth, but dedicated and skilled teachers are needed most of all. A national in-service teacher training programme together with salaries and incentives to attract talented young Tanzanians to the profession will be two key components in increasing the quality of education and convincing parents and pupils of the value of staying in school.
HIV and AIDS: Addressing the drivers of the disease

The incidence of HIV and AIDS will not be significantly reduced unless the influence of gender norms on the risk of transmission is fully recognised. Women now account for 60% of new infections. Data from the Tanzanian HIV/AIDS and Malaria Indicator Survey 2007/8 show that prevalence among young women increases sharply from 1.3% in adolescent females aged 15-19 years to 6.3% among women aged 20-24 years. This highlights the need for early prevention interventions. HIV prevalence among adolescent girls is almost twice that of boys. Lack of access to information increases the risk of HIV transmission. Less than 40% of girls aged 15-19 years have comprehensive knowledge about HIV and AIDS, and 60% are sexually active before they are 18 years old.

The vulnerability of girls and young women to sexual exploitation also derives from traditional roles of female economic dependence. The sexual partners of girls aged 15 to 19 years are usually at least four or five years older and many seem to offer greater economic security. Girls may be persuaded into sex in exchange for food, shelter, protection, and better school grades, among others. The expansion of youth-friendly health services and effective life-skills programmes will be essential to inform and empower youth, girls in particular, and reduce their vulnerability to HIV and AIDS. Every new infection in a teenager represents a failure to provide a young person with the necessary knowledge, information, skills and services to protect themselves.

PMTCT services have expanded rapidly in the last few years, albeit from a very low base. However, paediatric HIV diagnostic facilities are still extremely limited. As a result, barely one-third of infants born to HIV-positive mothers receive prophylaxis. One in every ten new infections in Tanzania occurs in babies even though more than 90% of these infections could be prevented.

Again, improved access to information will be essential in reducing infant transmissions. While about 80% of women in Tanzania know that HIV can be transmitted from mother to child during pregnancy, labor and delivery or through breastfeeding, less than half know that this can be prevented. Even fewer are aware that transmission of HIV through breastmilk is rare if infants are exclusively breastfed. HIV transmission is much more likely if a mother is giving water, juice or other foods in addition to breastmilk. Again, improving women’s access to education and information will be the key to reducing vertical transmissions of HIV.

Protection of children against abuse, neglect and exploitation: A golden opportunity

Now that the Law of the Child is in place, impetus needs to be maintained in developing a child protection system to deliver on the standards and provisions laid out in the Law. The latter recognises the need to provide children with special safeguards and care but there are no comprehensive services, structures and personnel in place. Child protection is not yet defined in Tanzanian law, nor is there a government department actively providing child protection services in all districts. Implementation of the Law will require major investment and determined political will. At present, the legislation relies on social welfare officers, which puts an unrealistic burden on an already over-stretched service, unless there is dramatic reform and strengthening of the social welfare system.

Child protection needs are immense and diverse in any country; in Tanzania, they are further magnified by widespread poverty and the impact of HIV and AIDS. One-third of households live in poverty. Over two million children are orphans (having lost one or both parents). One in five children is engaged in child labour. Only 2% of children with disabilities attend primary school. A recent national survey on Violence Against Children found that nearly one in three girls and one out of every six boys reported at least one experience of sexual violence, prior to the age of 18. Domestic violence is commonplace and many parents condone the behaviour of teachers who beat their children to enforce discipline. Therefore, millions of children either suffer or are at serious
risk of rights violations. The national response to date has focused on the provision of material support to what have been labelled the Most Vulnerable Children, rather than the establishment of systematic protective mechanisms for all children.

The responsibilities of specific duty bearers – including police, magistrates, social workers, health workers and teachers – must be clarified and coordinated. Implementation will also be uneven unless resources are made available at district level. Without formal mechanisms, human resources and funding for national coverage across all districts, an untold number of neglected, abused or exploited children will neither be detected nor assisted.

The Government must also acknowledge the scale and severity of institutionalised violence and the high incidence of transactional sex and sexual abuse in the education system. Legislation and regulations that prohibit corporal punishment and combat sexual abuse and exploitation in schools need to be enacted and enforced. Mechanisms are required for children to safely and confidentially report violence and abuse, and teachers, community members and students who are responsible for violations of children must be held accountable.

Addressing persistent disparities

Disparities in service access and in maternal and child outcomes persist across all sectors examined in this report. Large disparities are routinely found by household wealth status, by educational attainment of the mother, and by residence (between rural and urban areas and between different regions and districts of the country). TDHS 2004/5 data for rates of skilled birth attendance provide a stark example:

- For women in the lowest wealth quintile, the rate of skilled attendance at delivery was 31% compared with 87% of women in the highest wealth quintile
- For mothers with no formal education, the rate was 32% compared with 84% for mothers with secondary education or higher
- For women in Mainland rural areas, the rate was 38% compared with 81% in Mainland urban areas.

The magnitude of disparities varies by sector but significant differences in outcomes are found for children in poor and rural households from birth registration through to access to educational, reproductive health and vocational services for adolescents. Poverty impacts particularly hard on children and remains overwhelmingly rural; 83% of the Tanzanians below the basic needs poverty line reside in rural areas. For six out of seven indicators of childhood deprivation, the proportion of rural children suffering severe deprivation was estimated to be 1.75 to three times higher than the percentage of urban children (REPOA, NBS and UNICEF, 2009). Increasingly, too, migration from rural to urban areas in pursuit of economic opportunities is placing stress on urban infrastructure and services leading to the development of poorly resourced populations in major cities and towns.

To improve child and maternal well-being will require that strategies and investments address the disparities in the delivery of essential services. Causal factors underlying disparities are many-fold. Some relate to geographical and climatic variations across the country. Other factors are historical. Some regions have long attracted public, private and donor investment and continue to do so. However, it is political and socio-cultural factors that overwhelmingly define current divisions between advantage and disadvantage; it is here where solutions must be urgently identified and applied.

From evidence gathered in this report, two issues stand out prominently as factors that perpetuate and reinforce disparities in maternal and child outcomes:
Inequitable distribution of financial and human resources

Districts where maternal and child outcomes are poor are those where service providers are poorly resourced and poorly staffed. Under the Government’s Decentralisation by Devolution programme, responsibility and funding for service delivery are increasingly being devolved from central ministries, departments and agencies to local government authorities. However, budget allocations as well as staffing recruitment and deployment are still largely controlled by the central government (RAWG, 2009).

Moreover, the application of needs-based formulas to calculate allocations to local governments in six key sectors – education, health, local roads, agriculture, water and administration –, which were agreed in 2004, are not yet fully implemented. As a consequence, fiscal allocations to local governments are unequal and continue to perpetuate historical disparities in human resources and service delivery outcomes. With limited control of their finances and staffing, local governments’ autonomy and capacity to plan for and respond to local needs is severely compromised.

Current mechanisms for fiscal transfers are unnecessarily complex and lack transparency and certainty in disbursement. Taking education as an example, a capitation grant for quality improvements to schools of US$10 per enrolled pupil per annum was instituted under the Primary Education Development Program. At a surface level, the grant was a simple, equitable formula-based mechanism for allocating funds to schools. However, this single grant was disbursed by multiple ministries using multiple criteria, timeframes and mechanisms. Funds actually disbursed varied widely among districts and schools, and no consistent reason, such as enrolment figures, could be found to explain the variations (Carlitz, R., 2007).

Again, inequities were reinforced not reduced. Strengthening community-based engagement in development planning, monitoring service delivery and holding local officials and providers accountable will be a critical component in securing broad-based improvements in service outcomes within tight economic constraints.

Gender inequity

Although advances have been made in closing the gender gap in education, more than one-third of Tanzanian women aged 15-45 years are illiterate and about four in ten lack access to any form of mass media. Survey data further reveals that over 38% of married women report that their husbands make decisions about their healthcare, and nearly half that their husbands make all decisions regarding daily household purchases. A very large proportion of Tanzanian women are therefore not able to visit a clinic or to access healthcare for their children without obtaining permission and resources to do so from their husbands (NBS et al., 2005).

The relative isolation of Tanzanian women as well as the low status of young women in particular are significant factors undermining the adoption of behaviours that can prevent disease, ensure fast treatment for children when they are sick, encourage breastfeeding and influence other childcare choices and decisions over where women give birth. Discrimination against women is further evident in the limited national response to issues of domestic and sexual violence, early pregnancy and child marriage, and the greater vulnerability of girls and women to HIV and AIDS.

Gender inequity also starkly underlies the failure to invest in obstetric care to reduce maternal mortality, which in turn severely compromises the life of newborns and helps explain the more limited progress in reducing neonatal mortality in recent years compared with infant and child mortality. It is hoped that the “One Plan” launched by President Kikwete in 2009 will represent a watershed in women’s investment in Tanzania, complemented by other initiatives to empower women so that may contribute to and benefit from national growth and development.
In the child’s best interests: A universal system of social protection

In a prevailing context of generalised insecurity, life is precarious for almost all Tanzanian children. Given the absence of formal social and child protection systems, and the limited means of community structures of social assistance, children often have to experience adversity and trauma before getting help, if indeed they receive aid. The continuing high rates of child mortality and severe morbidity indicate that for many children help does not reach them in time.

Significantly the social protection agenda, which involves a set of measures seeking to protect the poorest and most disadvantaged segments of the population, aligns very closely with the objectives set by MKUKUTA, yet it remains one of the least explored areas of public policy in Tanzania. Under the first phase of MKUKUTA, a draft National Social Protection Framework was developed in 2008 but the framework has not yet been approved by the Cabinet or costed into a National Plan of Action. Nor does the draft framework acknowledge social protection as a citizen’s entitlement. Rather the system it envisages relies on civic and volunteer efforts. The three main social protection arrangements in place – pension funds which cover a small proportion of formal sector employees, the National Costed Plan of Action (NCPA) for Most Vulnerable Children, and the Tanzania Social Action Fund – all have overlapping objectives, are implemented by different institutions, operate inefficiently and have extremely limited coverage. The NCPA also relies heavily on external sources of finance, raising serious doubts as to its sustainability.

There is a clear need for a long-term domestic strategy for strengthening households’ ability to care for children. Up till now Tanzania stands out as an exception among countries in the region that have piloted large-scale social transfer programmes. Pal et al. (2005) estimated that universal social assistance requires around 3% of GDP, comprising of 1% of GDP for social pensions and 1-2% for a child allowance linked with school attendance by children of the families benefiting from the transfer. Feasibility analyses of a number of social protection instruments reveal that their cost as a proportion of Tanzania’s GDP is likely to decline over time, even as they assist in stimulating local economies, mitigating household insecurity and averting chronic deprivation.

In fact, there is a large body of evidence about the positive impact that even modest yet predictable sums of money, transferred to poor households regularly, can have on the well-being of all family members. This evidence comes from rigorous evaluations of programmes of all sizes in countries from every region of the globe, including Tanzania where, despite the novelty and limited knowledge about this approach, a few pilot projects have proliferated with promising results.

The proven benefits of cash transfer programmes are many-fold:

- Increased school enrolment, attendance, completion and transition rates;
- Improved quality of diets and caloric intake, gains in growth and body weight, and declines in anaemia and iron deficiencies;
- Greater health service utilisation, including antenatal care and facility-based deliveries, as well as higher rates of immunisation; and
- Women’s greater control over household resources.

Studies have also shown that even families that do not directly receive cash transfers still benefit from the programmes – a spill-over effect at community level akin to the fiscal stimulus package implemented by the Tanzanian Government at the macro level in 2009 in response to the global financial crisis. Evidence is also emerging that the positive results from implementing social cash transfers do not depend on the imposition of specific conditions on families to access the benefit. Even in the absence of conditions attached to the receipt of the transfer, families are utilising the extra cash they get to send their children to school, spend more on food, soap, medicines and clothing, or meet the cost of the transport to the nearest health facility.
Challenges to implementing a targeted system of social cash transfer exist, but as the experience of countries in eastern and southern Africa reveals, they are by no means insurmountable. Ultimately they are the same challenges that beset the expansion of quality social services to currently underserved groups in Tanzania, including limited financial and human resources; fragmentation and duplication of efforts within Government as well as among development partners; lack of coordination between strategies and stakeholders; and gaps in information to facilitate social planning.

Ultimately, the success of any social transfer programme will also depend on improving the quality of social services available. If a school lacks teachers, facilities and books or fails to provide a nurturing environment for students, then a social transfer will only go some way towards encouraging parents and children to attend school. Investments in service provision with a strong focus on quality – as in The Children’s Agenda – need to go hand-in-hand with any social transfer programme.

As Tanzania moves into the second phase of MKUKUTA and MKUZA, stark policy choices will have to be made, and backed up with resources at a scale. Making those choices will be difficult, and inevitably involve trade-offs given tight fiscal constraints. But in the best interests of Tanzania, investing in its children is the one investment that cannot wait.

The Children’s Agenda

The Children’s Agenda (Ajenda ya Watoto) was developed alongside this report over a period of several months from late 2009 to mid 2010. It is the result of broad consultation with Government, leading children’s organizations, and children from across the country. In a true sense, it is an Agenda for and by Tanzanian children.

Based upon the evidence collected in the analysis for this report and the consultations held over many months, the Agenda outlines Ten Investments that hold great promise for transforming the lives of Tanzanian children. It is hoped that the Top Ten Investments for Children will not only serve to inform the implementation of the second phase of MKUKUTA over the period 2010-15, but also the legislative agenda of the new Parliament sworn in after the elections of October 2010.

The Top Ten Investments are:

1. Invest to save the lives of children and women
2. Invest in good nutrition
3. Invest in safe water, hygiene and sanitation
4. Invest in early childhood development
5. Invest in quality education for all children
6. Invest to make schools safe
7. Invest to prevent HIV and AIDS in infants and adolescent girls
8. Invest to reduce teenage pregnancy
9. Invest to protect children from violence, abuse, exploitation
10. Invest in children with disabilities

Children cannot vote in the October elections and so rely upon leaders at all levels – including members of Parliament and councillors, Government officials, religious leaders, judges, police, social workers, teachers, health workers, the media and civil society organisations – to actively represent their interests. It is hoped that The Children’s Agenda will be a watershed in advancing child rights. Indeed, the measure of a nation is reflected in how it defends and protects the most vulnerable members of its society. Today is the time to invest in our children. Twenty million young lives and Tanzania can ill afford to wait.
Introduction

Since UNICEF published its last *Situation Analysis of Children and Women* in 2001, Tanzania has made significant, sometimes remarkable, progress in some indicators of child well-being, yet stagnated or regressed in others. These achievements often serve to cast light on the worrisome shortfalls and the difficult challenges ahead. For example, the steep declines in infant and under-five mortality contrast starkly with the persistently high maternal and neonatal mortality. In other instances, progress in one area gives rise to new, equally pressing challenges. This happens in education, where the rapid expansion in primary enrolments has led both to the critical need to improve the quality of education and learning outcomes and to the urgent demand for more secondary schools to accommodate the much larger cohorts of children leaving primary school.

The common tendency in development to see the glass ‘half empty’ could advantageously be replaced by a glass ‘half full’ mindset — that important gains can be learned from and be built upon. But such a mindset should not obscure the areas where policy and programmes are not working well or where inaction and lack of investment are failing children and their families. The declining access to safe and clean water, the absence of a child protection system and social safety nets, or the lack of emphasis on HIV and AIDS prevention strategies are all keen reminders that, while achievements should be acknowledged and celebrated, there is no room for complacency. It is the purpose of this situation analysis to explore the path to date and illuminate the steps ahead to fully realise the rights of all Tanzanian children.

Purpose of the report

Children under 18 years of age constitute over half (50.9%) of Tanzania’s population, but to date the investment in addressing their needs is not commensurate with their share of the population or their role as tomorrow’s adults and productive citizens. This report argues that investing in children is the single most important investment in national development. Children are the human capital of tomorrow, full of potential, and the failure to invest in all aspects of their development now will severely impact Tanzania’s ability to develop and realise the country’s economic and social goals in Vision 2025.

*Children and Women in Tanzania 2010* seeks to provide guidance on what needs to happen to provide an environment in which children’s rights are protected, where they can thrive and their potential can be catalysed for their own benefit and for Tanzania as a whole. It summarises current knowledge and helps to identify gaps in data and understanding that hamper policy design or programme implementation.

The report aims to drive evidenced-based advocacy and positive change for children and women in the country and to serve as a reference tool for Government and non-state actors working towards development outcomes. At the national level, the analysis seeks to inform the second phase of the National Strategy for Growth and Reduction of Poverty—known by its Swahili acronyms of MKUKUTA for the Mainland, and MKUZA for Zanzibar—as well as the UN Development Assistance Plan (UNDAP) and UNICEF’s country strategy for Tanzania. Throughout the report, the interpretative framework is based on the experience of being a child in Tanzania, and the data is interpreted through the lens of children and their rights.

The report also asks the hard questions as to whether the commitments made by the Government when it ratified the United Nations Convention on the Rights of the Child (UNCRC) in 1991 and the African Charter on the Rights and Welfare of the Child (ACRWC) in 2003 have translated into real change for Tanzanian children. It closely examines the role of
the state in facilitating and providing opportunities for children’s development and the factors that affect children’s ability to claim their rights and actualise their potential. It highlights the important achievements made in advancing the rights of Tanzanian children while scrutinising why progress has stagnated or reversed in areas that are critical to their well-being.

**Conceptual framework**

Children are dependent on their families, their communities and the State for the realisation of their rights. The fulfilment of children’s rights requires an enabling environment from conception to the end of adolescence. It is therefore critical to examine the immediate, underlying and structural causes that tend to perpetuate disadvantage, and the role of parents and families, communities, government authorities at local, regional and central levels, voluntary and civil society organizations, private sector actors, and development partners—in other words, what in human rights discourse are known generically as “duty bearers”—in taking action aimed to respect, protect and promote the rights of children.

*Children and Women in Tanzania 2010* weaves together three separate, though inter-related, strands which affect Government strategies and targets, the appropriateness of interventions and the discourse of civil society and donor partners in assessing progress in children’s rights. These frameworks are:

- **The poverty reduction agenda**, which in Tanzania is articulated in the National Strategy for Growth and the Reduction of Poverty (MKUKUTA) and the Zanzibar Strategy for Growth and the Reduction of Poverty (MKUZA), and internationally in the Millennium Development Goals (MDGs).
- **The rights-based approach**, which is substantially grounded on the UNCRC, the ACRWC and the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). The human rights approach examines how duty bearers execute their obligations and the participation and ability of children and women as rights-holders to demand their rights.
- **A life course perspective**, which emphasises the “changing priorities of children as they grow and develop” (UNICEF Tanzania, 2005). Basic concepts in a life course perspective are ‘cohorts’, ‘transitions’ and ‘life events’. A cohort denotes that children born at the same time experience particular changes in the same sequence, for example, the cohort of Tanzanian children who benefited from the abolition of primary school fees in 2001 and the opportunity for formal education that many of previous cohorts had missed. The concept of transitions is an important lens through which to examine entry and departure from formal education and how this is managed for children so that they move to new roles in a way that supports rather than hinders their development. Finally, the concept of life events refers to an abrupt change in the life trajectory of a child, which may affect his or her subsequent development, either creating increased stability or perpetuating adversity.

The interrelationship between these three frameworks, and more generally the linkages between child rights and development and the enabling role that the state as the primary duty bearer must play in fulfilling those rights, are depicted graphically in Figures 1 and 2.

Methodologically, the information and analysis provided in the report is based on a thorough desk review of the extensive monitoring data generated by the Poverty Monitoring System and research produced locally and internationally about Tanzania. MKUKUTA, MKUZA and MDG targets locate the analysis in current national and international development priorities. Where data is available, the report identifies and discusses disparities in age, sex and geography.
Figure 1: Relationship between child rights and development

Tanzania’s children have rights to

**Participation**
- A voice on decisions that affect them
- In their communities and families as equal citizens

**Development**
- Education
- Recreation

**Protection**
- From violence, abuse and exploitation
- Under the law and in practice
- From adult perpetrators and/or other children

**Survival**
- Healthcare
- Sanitation and hygiene
- Nutrition

**Freedom from discrimination**
- Equality before the law irrespective of gender, status or age

**An identity**
- Birth registration

MKUKUTA aims to catalyse Tanzanians’ potential and achieve economic growth by:
- Promoting opportunity
- Facilitating empowerment
- Enhancing security
Figure 2: Child rights and the role of duty bearers

The State provides an enabling environment for families
- Security: Safety nets so people do not live in abject poverty
- Information: Education and guidance on caregiving
- Opportunity: A context where one can make the most of own talents and resources for familial security and prosperity
- Redress: Clear and user friendly and effective mechanisms to hold state duty-bearers to account

The State provides an enabling environment for social service providers
- Quality Assurance: Minimum standards for performance and mechanisms to hold poor performers to account
- Infrastructure and supplies: to enable children to access rights to protection, education and health
- Legislative framework that provides access to redress
- Personnel: with the commitment, skills and managerial mechanisms to consider child’s best interests in all actions that affect them

The Institutional and Technical Response
- O&OD process, school committees etc
- Mediated through LGA and / or Sectoral Line Ministries
- Community mechanisms to mediate the relationship between family and provider
- Social service provider

Primary Caregivers = The Family

Tanzania’s Children

The nature of their relationships with adults are determined by:
- Stage of life course, familial context and individual physical, cognitive and emotional development
The child's life course

Children have needs for survival, development and protection that are inter-related and reinforce one another. We cannot divide up the child, rather we have to respond to the child's needs in a holistic fashion. Nor can we develop interventions for children without being informed by their developmental needs at certain points in the life course. Yet there seems to be a reluctance to engage with the whole child as social policies tend to compartmentalise interventions, each dealing with one aspect of the child's life without seeing the totality of his/her situation and needs.

Given the current sectoral focus of targets and investments in children – for example, health addresses the 'child as patient', education addresses the 'child as student' and so on – it should come as no surprise that significant gaps prevail or open up in the way duty-bearers respond to the needs of Tanzanian children. Ministerial and sectoral divisions are hard to bridge, and children end up falling through those gaps.

Children’s needs change throughout their life course, so that different interventions are required at different points in time. Whilst it is critical that their needs for nutrition, health care, sanitation and safe water are met in a timely manner throughout their life course, as children age they are naturally predisposed towards increasing self actualisation so that the rights that become more significant to them are those around education, participation and protection.

Yet as children age and their developmental needs become more complex and more demanding of their adult caregivers, a proportionate decline in services for them occurs. This is illustrated by the lack of services for adolescents and the under-investment in areas such as juvenile justice, mental health, recreation facilities or promotion of positive role models for young people. While Tanzania has clearly made substantial progress in basic healthcare and education, it has made less progress in areas that disproportionately affect middle childhood and adolescence—for instance, protection from violence, or provision of quality vocational training and life skills that equip youth to contribute to development as productive adults.

It is understandable that in earlier phases of socio-economic development, there is a strong focus on rolling out interventions that focus on the 'greatest good to the greatest number' of children, and on specific indicators, such as under-five mortality. But as strategies mature, this focus can marginalise or exclude the needs of older children, children without an adult to advocate on their behalf or children with special needs.

Therefore, it is important to constantly revisit the way the needs of Tanzanian children are addressed. Policies, programmes and service delivery options are required not only for the ‘average’ child but also for ‘hard to reach’ children, those children living on the margins who do not come into contact with the State, either through the school or health system. So too, strategies need to engage with the child as a whole, to recognise their diverse needs at different stages in their life course, and to strike a better balance between policies tailored to the young child and those for children up to and beyond the age of puberty.
**Figure 3: The child’s life course**

**Pregnancy, conception and birth**
- Social support for the mother so that she is physically and psychologically healthy, resulting in more favourable outcomes for the baby
- Antenatal care, including childbirth education
- Adequate nutrition for mother and unborn child
- Safety of the mother and neonate through pregnancy, labour and childbirth
- Opportunities and support to bond with the unborn child
- Access to ARVs if mother is HIV positive

**Infancy to two years**
- Attachment to a consistent, loving caregiver promotes brain and emotional development
- Need to be fed, cleaned, kept safe and comfortable
- Good nutrition and stimulation for brain development
- Affection and bonding to develop the frontal cortex
- Interactions to assist with language development
- Assistance from caregiver for emotional well-being
- Opportunities to play so as to develop cognitive, social and emotional skills

**Middle childhood (5-6 years of age to onset of puberty)**
- Participation in schooling that supports sense of identity, individual and relationship skills
- Acceptance from peers
- Stability and avoidance of disruption due to impact on a child’s development
- Opportunities to experience an expanded social world – school, community, friends
- Continued supervision from adults to mitigate the risk of injury as they explore their increased physical capacities and engage in risk-taking behaviours
- Support from adults to help them protect themselves (girls from unwanted sexual attention, all children from bullying)
- Positive and diverse learning opportunities to facilitate optimal growth and refinement of the brain
- Consistency between the moral voices of parents and adults and their actions to help the child learn moral behaviour and inter-relational intelligence
- Support to understand the complexities of group memberships and appropriate behaviours
- Supportive family systems and involvement in social and recreational activities that lead to self-affirmation and self competence

**Early childhood**
- Stability and regularity
- Exposure to activities to help them develop cognitively, to understand how their behaviour affects others
- Positive role models to teach them the difference between right and wrong
- Opportunities to discuss, practice, understand and express feelings
- Messages of love, admiration and approval
- Opportunities for leisure and play
- Protection from abuse and neglect

**Adolescence**
- Understanding that adolescence is a period of ‘storm and stress’, when hormones cause many difficulties and where individuals slowly learn internal control
- Opportunities and a safe space to contemplate their identity, their future and the nature of human relationships
- Education that develops their capacity for abstract problem formulation, hypothesis testing and solution testing, that consolidates specific knowledge into a coherent system
- Exposure to new activities and opportunities that enable them to grow into maturity
- Support to develop moral principles that transcend one’s own society: individual ethics, societal rights and universal principles of right and wrong
- Protection from, or support to protect themselves, from violence, poor nutrition, depression and suicide

NB: Children from birth to six years are at the highest risk of long-term damage if they are abused or witness domestic violence (Thomlinson, 2004)
Structure of the report
The report is structured into eight chapters. Chapter 1 provides an overview of the status and trends in realising children’s rights in Tanzania, placing the analysis within the prevailing context of generalised insecurity in the country. The chapter then discusses two foundation stones for child rights – the family and the wider societal and political attitudes towards children. It concludes with a discussion of the potential of a child-sensitive framework of social protection to be a guarantor of child rights in the face of vulnerability.

Chapters 2 through 7 provide in-depth analysis of the situation of children and women by key service sector as follows:

- Chapter 2 – Health
- Chapter 3 – Nutrition
- Chapter 4 – Water, sanitation and hygiene
- Chapter 5 – Education
- Chapter 6 – HIV and AIDS
- Chapter 7 – Protection of children against abuse, neglect and exploitation

Each chapter provides an analysis of the status and trends in women and children’s outcomes against the background of key international and domestic targets in each sector. Each chapter also discusses current laws, policies, strategies and interventions for children as well as the fiscal space and institutional frameworks devoted to improving child well-being. Key issues affecting outcomes are also presented, for example, the importance of promoting hygienic practices is central to the success of health and other interventions aimed at reducing childhood illness. Based on the foregoing analysis, the final section of each chapter identifies priority areas and recommendations to advance children’s rights.

The guiding questions across all sectors are:

- What needs to change so that children grow up healthy, educated and free from harm so that they can develop to their full potential and become creative and productive adults and citizens that contribute to and benefit from Tanzania’s development?
- What needs to be in place so that development efforts, by Government and the development community, actually serve the best interests of children?

Chapter 8, the final chapter, consolidates the key findings of the analysis and presents Ajenda ya Watoto – a comprehensive plan of Top Ten Investments for Children to rapidly improve the situation of children in Tanzania.

This volume of the report focuses on the situation of children and women in Mainland Tanzania. A separate volume addresses the same issues for children and women in Zanzibar.
Chapter 1
Establishing a foundation for child rights in Tanzania

1.1 The national context for the realisation of child rights

To examine the situation of women and children in Tanzania, the national context must first be understood, in particular, the widespread incidence of poverty as well as the prevailing gender norms in the country. Wyuts (2006) argues that the economic and social context in Tanzania is one of generalised insecurity:

“...in Tanzania, the incidence of poverty is high and social protection low, and, hence, vulnerability to impoverishment is likely to reach much higher up the ladder of income distribution than (static) poverty does, it thus makes sense to talk about a regime of generalised insecurity to refer to a society where vulnerability to impoverishment is more or less endemic in the workings of its economy, thus leaving only few pockets of robust socioeconomic security at the very top end of the income distribution.”

Robust and sustained GDP growth since 2000 has not resulted in significant reductions in household poverty rates. Data from the Household Budget Surveys (HBS) 2000/1 and 2007 show that the proportion of Tanzanians living below the basic needs poverty line declined by only two percentage points from 35.7% to 33.6% over this period. Poverty remains overwhelmingly rural; 83% of the Tanzanians below the basic needs poverty line reside in rural areas (NBS, 2002 and 2009).

Poverty impacts particularly hard on children. A recent study found that the incidence of absolute poverty among Tanzanian children—defined as the proportion of children who suffer multiple severe deprivations of basic needs—is extremely high at 71%. For six out of seven indicators of childhood deprivation, comprising health, nutrition, water, sanitation, shelter, education and information, the proportion of rural children suffering severe deprivation was estimated to be 1.75 to three times higher than the percentage of urban children (REPOA, NBS and UNICEF, 2009).

Household poverty has a significant effect on children’s development. A child’s physical and cognitive development, including the establishment of the synaptic connections fundamental to memory, are negatively affected by poor nutrition of the mother during pregnancy and the child during infancy, as well as trauma and poor attachment to a primary caregiver prior to the age of two years (Siegel, 1999). Among Tanzanian children below five years of age surveyed in the Tanzania Demographic and Health Survey (TDHS) in 2004/5, 71.8% suffered from anaemia, 37.7% were stunted and 12.8% severely stunted (NBS, 2005). As a consequence, children’s ability to actualise their potential is already compromised by the time they enter school.

Progress for children is also hampered by significant gender inequity. Although advances have been made in closing the gender gap in education, more than one-third of Tanzanian women aged 15-45 years are non-literate and about four in ten lack access to any form of mass media. Over 38% of married women reported that their husbands make decisions about their healthcare, and nearly half that their husbands make all decisions regarding daily household purchases. A very large proportion of Tanzanian women are therefore not empowered to visit a clinic or to access healthcare for their children without obtaining permission and resources to do so from their husbands (NBS, 2005).

Discrimination against women is further evident in stigma, low investment, poor response to issues of rape, violence, early pregnancy and child marriage, and the greater vulnerability of girls and women to HIV and AIDS. Gender inequity underlies the failure to achieve progress in reducing maternal mortality. At 578 deaths per 100,000 live births in 2004/5, maternal health outcomes showed no sign of improvement for two decades (NBS, 2005), and only seem to be declining slightly in recent years. The maternal mortality ratio is equivalent to 10,000 maternal deaths per year, roughly one every hour, and is inextricably linked with neonatal mortality.
### Table 1: Fast Facts: Tanzanian demographics

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<tbody>
<tr>
<td>Total population (thousands)</td>
<td>40,454</td>
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<tr>
<td>Population (thousands) - under 18 years</td>
<td>20,630</td>
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<tr>
<td>Population (thousands) - under five years</td>
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<tr>
<td>Population annual growth rate (%) (1990-2007)</td>
<td>3</td>
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<tr>
<td>Crude death rate</td>
<td>18</td>
<td>15</td>
<td>13</td>
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<tr>
<td>Crude birth rate</td>
<td>48</td>
<td>44</td>
<td>40</td>
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<td>Life expectancy (years)</td>
<td>47</td>
<td>51</td>
<td>52</td>
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<tr>
<td>% of population urbanised</td>
<td>25</td>
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<tr>
<td>Average growth rate of urban population (% (1990-2007)</td>
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<td>Total adult literacy rate (%)</td>
<td>72</td>
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<td>GNI per capita (US$)</td>
<td>400</td>
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<tr>
<td>Average annual rate of inflation (%) (1990-2007)</td>
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<tr>
<td>% of population below international poverty line of US$1.25 per day</td>
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<td>% of central government expenditure (1997-2006) allocated to:</td>
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<td>- Defence</td>
<td>16</td>
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<td>- Health</td>
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<td>- Education</td>
<td>8</td>
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<td>ODA inflow in millions US$</td>
<td>1,825</td>
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<td>ODA inflow as a % of recipient GNI</td>
<td>14</td>
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<tr>
<td>Debt service as a % of exports of goods and services</td>
<td>25</td>
<td>3</td>
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<tr>
<td>Under-five mortality rate</td>
<td>157</td>
<td>116</td>
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<tr>
<td>Infant mortality rate (under 1)</td>
<td>96</td>
<td>73</td>
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<tr>
<td>Neonatal mortality</td>
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<td>Annual no. of births (thousands)</td>
<td>1,600</td>
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<td>Annual no. of under-five deaths (thousands)</td>
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<td>Single or double orphans - Children (aged 0-17 years)</td>
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<td>- Orphaned by AIDS (estimated thousands)</td>
<td>970</td>
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<td>- Orphaned due to all causes (estimated thousands)</td>
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<td>Child labour (5-17 years) (2006)</td>
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<td>- Total</td>
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<tr>
<td>- Male</td>
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<td>- Female</td>
<td>19</td>
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<td>Child marriage (1998-2007)</td>
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<td>- Total</td>
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<td>- Urban</td>
<td>23</td>
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<tr>
<td>- Rural</td>
<td>49</td>
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<td>Birth certification (2002-2007)</td>
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<td>- Total</td>
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<tr>
<td>- Urban</td>
<td>22</td>
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<td>- Rural</td>
<td>4</td>
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<tr>
<td>Female genital mutilation / cutting among women 15-49 yrs (2002-07)</td>
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<td>- Total</td>
<td>15</td>
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<td>- Urban</td>
<td>7</td>
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<tr>
<td>- Rural</td>
<td>18</td>
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</table>

Source: UNICEF, 2009a
A projected one million children had been orphaned (lost one or both parents) by 2009 (Lindeboom et al., 2007). Roughly 12% of ‘most vulnerable children’ are separated from their siblings, and an estimated 59,000 children below 15 years of age are living with HIV and AIDS (United Republic of Tanzania (URT), 2009a), all of which severely compromise these children’s physical, emotional and intellectual development.

A study of the poor in Singida shows that, in addition to the ‘very poor’, there is an even poorer group, the ‘labour poor’ who have a high dependency ratio. These include female and elderly-headed households, and households with chronically ill or disabled adults. They have very little annual household income, lack productive assets and have limited alternative income sources, relying largely on casual labour. They spend just over 50% of income on food, mainly cereals, which leaves only 25% for purchasing basic household items (such as soap, kerosene) and the remaining 25% on health, education, leisure and productive inputs. Their ability to increase crop production is constrained by lack of land, livestock, finance and labour, which is exacerbated by the limited carrying capacity of the land and natural resource depletion (Kindness and Chastre, 2006). Compounding this situation is the HIV and AIDS epidemic, which is mature, generalised and gradually becoming a rural epidemic (UNAIDS, 2008a).

Addressing the poverty and vulnerability of women and children is complex. It is not necessarily viable to open up rural areas through infrastructural investment because so much of the land is marginal. Exploiting natural resources by deepening reliance on agriculture may reduce poverty in the short-term, but undermine long-term survival and livelihoods. Extending social services across dispersed rural villages and opening up opportunity to mobile pastoralist communities is not logistically or financially simple. Similarly rapid urban development has implications for investment priorities in infrastructure, planning and social services, along with risks of a large unemployed or unemployable urban youth population. Tanzania is vulnerable to increased crime and social unrest given the relatively recent context where young people are exposed to and aspire to wealth whilst being unable to legitimately achieve it for themselves because of limited educational and employment opportunities.

This poses urgent questions for the design and implementation of a more comprehensive social protection system, which Tanzania currently lacks despite international evidence that social protection mechanisms can prevent or mitigate unacceptable levels of socio-economic insecurity and deprivation. Policy makers must decide whether Tanzania can afford to move progressively towards provision of a universal ‘social floor’ — a basic package of services and transfers guaranteed for all but limited in its initial scope, or whether to employ targeted social protection interventions to specific groups like the chronically poor who are caught in inter-generational poverty traps. From the perspective of children, it also matters whether approaches to increase income or improve quality of life receive priority, and how to effectively identify and reach marginalised children who often lack a family or adult to advocate for them.

1.2 Child-sensitive social protection

There is an intense vocal domestic debate on the concept of social protection. A recent Joint Statement on Child-Sensitive Social Protection, endorsed by UNICEF and several other multilateral and bilateral development partners, defines it as “a set of public actions that address poverty, vulnerability and exclusion as well as provide means to cope with life’s major risks throughout the life cycle” and as “a key investment in human capital and in breaking inter-generational poverty traps” (DFID et al., 2009).
Social transfers are an integral part of social protection systems. Social transfers are:

“...non-contributory, regular and predictable grants to households or individuals, in cash or in kind. Cash transfers can take the form of income support, child grants, disability benefits, scholarships and stipends, or non-contributory pensions. They can be targeted at specific vulnerable groups, or distributed universally. Demand-side vouchers are near-cash transfers that can be redeemed for specific products or services, although they are not always received on a regular basis” (DFID, 2006, p. 2).

Such transfers need to be offered in the wider context of interventions that collectively serve to provide income security, avert destitution, protect assets and assist poor families to access basic services and entitlements.

It is now widely accepted that a comprehensive social protection system must strive to fulfil the following four functions:

- **Protective**: provide assistance for the chronically poor through relief from deprivation, support to the ‘labour poor’, and like measures;
- **Preventative**: avert poverty for those who face transitory shocks, through, for example, maternity and unemployment benefits, school feeding programmes, etc.;
- **Promotional**: enhance income and promote livelihoods, e.g. training for youth, early childhood development, childcare for employed parents or micro-credit;
- **Transformative**: address social injustice and inequity, such as in HIV and anti-stigma campaigns, laws to protect inheritance rights, and the like.

The more these functions are achieved, the more comprehensive the system will be in safeguarding vulnerable households against risks and insecurity. Box 1 outlines the principles for developing a child-sensitive social protection programme. Components of such a programme would include:

- support services for family, child protection and alternative care;
- policies to regulate and guide these services; and
- social transfers (Greenblot, 2008).

### Box 1: Principles of child-sensitive social protection

According to a Joint Statement endorsed by UNICEF and a range of multilateral and bilateral organisations in 2009, the following principles need to be considered when designing, implementing and evaluating child-sensitive social protection programmes:

- Avoid adverse impacts on children, and reduce or mitigate social and economic risks that directly affect children’s lives.
- Intervene as early as possible where children are at risk, in order to prevent irreversible impairment or harm.
- Consider the age- and gender-specific risks and vulnerabilities of children throughout their life-cycle.
- Mitigate the effects of shocks, exclusion and poverty on families, recognising that families raising children need support to ensure equal opportunity.
- Make special provision to reach children who are particularly vulnerable and excluded, including children without parental care, and those who are marginalised within their families or communities due to gender, disability, ethnicity, HIV and AIDS or other factors.
- Consider the mechanisms and intra-household dynamics that may affect how children are reached, with particular attention paid to the balance of power between men and women within the household and broader community.
- Include the voices and opinions of children, their caregivers and youth in the understanding and design of social protection systems and programmes (DFID et al., 2009).
A social protection agenda aligns with MKUKUTA

Interventions to promote human development include:
- Protection from violence and abuse
- Safety and security
- Nutrition
- Health care
- Education

Promote opportunity
By addressing barriers to accessing services:
- Addressing stigma and discrimination
- Increasing coverage
- Investing in infrastructural development

Facilitate empowerment
By improving quality and supply of services through:
- Improved skills and competence of personnel
- Responsiveness to client needs
- Providing value for money

Enhance security
Cash transfers such as:
- Income support
- Child grants
- Disability benefits
- Non-contributory pensions

Results in:
Reduction of inter-generational poverty
Significantly the social protection agenda aligns very closely with the objectives set by MKUKUTA on the Mainland and MKUZA on Zanzibar (Figure 4). In spite of this, efforts to introduce even limited social safety nets have been few and sporadic. The first phase of MKUKUTA committed to developing a National Social Protection Framework, which was completed in 2008 but has not yet been approved by the Cabinet or costed into a National Plan of Action (URT, 2008a). Nor does the draft framework acknowledge social protection as a citizen’s entitlement. Rather civic and volunteer efforts are placed at the centre of its vision of social protection.

Three disparate agendas dominate the current discourse on social protection in Tanzania:

- The social security agenda, embodied in the Ministry of Labour and Employment, and pension funds that together cover only a small proportion of the labour force;
- The Most Vulnerable Children (MVC) agenda, which is largely financed by external sources and is aligned with the Department of Social Welfare in the Ministry of Health; and,
- The public works / cash transfer agenda, linked with the Tanzania Social Action Fund (TASAF) under the President’s Office.

All have overlapping objectives, are implemented by different institutions, remain largely uncoordinated and operate under parallel financing mechanisms. The current system is inefficient, with conflicting mandates and extremely limited coverage. Lerisse, Mmari and Baruani (2004) conclude that “formal social protection arrangements are either not in place or are insufficient. Direct assistance and services come mainly from non-governmental and community-based organizations.” The current programmes for MVC, for instance, have low coverage compared to need, are weakly coordinated, rely heavily on non-state actors to distribute services and are mostly financed from external sources.

There is a need for a clear medium and long-term strategy for strengthening households’ ability to care for their children. It would seem that “simple affordability is not the only key barrier to the expansion of social protection”, but rather a deep-seated concern with “creating difficult entitlements that become a political and economic liability if badly administered and designed” (ODI and UNICEF, 2009).

Tanzania stands out as an exception among countries in the region that have piloted large-scale social transfer programmes. Pal et al. (2005) estimated that universal social assistance requires around 3% of GDP, comprising of 1% of GDP for social pensions and 1-2% for a child allowance linked with school attendance by the children of the families benefiting from the transfer. A basic health insurance would cost an additional 3-4% of GDP, whereas targeted pensions and school transfers could be provided at a fraction of the cost. This means that roughly 1% of GDP for social assistance and 2% for social insurance would be needed to provide a basic social protection package from tax revenues.

In a country with persistently high rates of poverty, options for a programme of social transfers are necessarily complex, because supply-side barriers impact upon people’s choice of services. DFID (2006) argues that unconditional cash transfers are more likely to impact on human development, but depend upon eligible groups having sufficient information and ability to act on that information when making choices about health and education.
In Tanzania, providers of public services face a real challenge in delivering high quality care and one of the main reasons for the low uptake in the Community Health Insurance Fund scheme is allegedly the low quality of care patients receive (Kindness and Chastre, 2006). Therefore, it will be critical for the success of any social transfer to improve the quality of services. Conditional transfers may be most effective in increasing access to services and addressing demand-side barriers, such as the costs of transport to clinics, schools, uniforms or discrimination against girls, especially if attendance at school or use of preventative health services is a condition of payment (DFID, 2006). But they will depend upon achieving minimum standards for social services. If a school lacks teachers, facilities and books or fails to provide a nurturing environment for students, then a social transfer will only go some way towards encouraging parents and children to attend school. Investments in service provision, with a strong focus on quality, need to go hand-in-hand with any social transfer programme.

1.3 What is in the best interests of Tanzanian children?
In a context of generalised insecurity every child is vulnerable to economic, health, environmental and livelihood shocks. Given the absence of formalised social and child protection systems in Tanzania and the reliance on community, faith-based, NGO or volunteer efforts to respond to individual cases of extreme risk, children often have to experience adversity and trauma before getting assistance – and the assistance they receive may not respond to their vulnerability or be provided by the actor with the statutory authority to do so.

The prevailing discourse about marginalised children categorises them into children with disabilities, those affected by HIV and AIDS, children living on the street or those in conflict with the law. But in reality life is, to a greater or lesser extent, precarious for all Tanzanian children. And despite constituting over 50% of the population, children are rarely listened to, have limited political or financial clout and receive little attention (McAlpine, 2008). So many children confront extreme vulnerability due to familial, often inter-generational poverty, but their status as non-adults and non-voters means that their needs and rights have remained peripheral to national development policies and strategies.

1.3.1 Children’s experience of family
The well-being of Tanzanian children depends primarily on the care provided by their families and communities. Living arrangements affect this care. Tanzania is undergoing rapid transition away from a subsistence rural economy to an increasingly urbanised, informal economy, which, compounded by the impact of HIV and AIDS, has placed tremendous pressure on traditional extended family structures and norms.

As children age, they increasingly live apart from their parents (NBS et al., 2005). Female-headed households now constitute almost 25% of all households. Women who head households tend to be widowed, divorced or separated, as opposed to those headed by men, the majority of whom are married (NBS, 2009). Women continue to carry the primary responsibility for childcare, whilst arguably taking on more responsibilities for income generation and family guidance. There is also evidence of a breakdown in inter-generational
As families become more nuclear or single-headed and/or members migrate from home villages to secure better livelihoods. An under-researched issue is the effect of these changes on women’s ability to cope and the effect of these multiple pressures on the care received by children. Grandparents, and particularly grandmothers, are being called upon to mitigate the effects on childcare of HIV and AIDS, with upwards of 40% caring for Most Vulnerable Children (MVC), registered under the framework of the National Costed Plan of Action for MVC (HelpAge, 2007; UNICEF, 2007).

Box 2: Relations between parents and children: A national opinion poll

In a national opinion poll supported by UNICEF, 65% of respondents agreed with the statement, “My child and I talk and laugh a lot together” while in about half of all households parents agreed that “My child does what he/she is told.”

In 12-13% of households, parents agreed with the statements, “My child is a lot of trouble and I am always having to use force”, “My child has got a lot of different ideas about things than me and we argue a lot” and “My child is hardly ever at home.”

Just over one-third of parents believed that boys needed to be given more freedom than girls. Almost a quarter believed that educating boys is more important than educating girls. More than 60% agreed with the statement, “Girls only have themselves to blame if they get pregnant” while almost half agreed that “boys who get a girl pregnant are just being boys.” However, over 90% of parents agreed that if a boy got a girl pregnant, his family should provide child support.

Source: UNICEF (2009b)

As the make-up of family structures shifts, there is a need for social policy to keep up and keep abreast of these changes. This is particularly so given the vulnerability of families and the absence of mechanisms, like social transfers, to help families with low incomes. As pressures on women increase and familial support weakens, social work services will need to be strengthened to educate and support parents as sole caregivers, with information about how to discipline children positively, how to promote good nutrition and hygiene, and how and where to access assistance.

1.3.2 Political and societal attitudes towards children

Attitudes towards childhood are largely culturally bound, but universal values are also apparent; for example, children need to be nurtured and guided towards adherence of social norms (Erikson, 1959). In Tanzania, however, guidance often manifests as strict discipline and outweighs nurture. Corporal punishment is commonly seen as an appropriate way to guide and educate children.

Taken together with the prevailing perspective that children have lesser capacity, status and influence than adults results in ambivalence about accountability to children and their participation in decision-making within households or other settings. It is in such a context, that institutionalised violence may be accepted as normal, and the commitment to protect children from all forms of abuse, neglect and exploitation may be undermined.

Given the existing resistance to a discourse that posits children as rights holders, it is almost inevitable that quick-win technical solutions are prioritised over the promotion of
long-term societal and behavioural change. There is no doubt that quick wins have been quite remarkable, as demonstrated by the investments in school enrolment and classroom construction, mosquito nets and vaccination campaigns. But a large part of a child’s well-being revolves around the quality of interactions with adults. It is critical, therefore to educate parents and duty bearers about their responsibilities toward children. Foremost among these duty bearers is the Government.

Yet there is continued under-investment in social services that impact children’s survival and well-being, including obstetric and postnatal care, nutrition, water supply, household and school sanitation and hygiene, preventative interventions to reduce HIV transmission, and the protection of children from poverty, abuse, neglect and exploitation. Emphasis has been placed on increasing access to services, but a key challenge remains how to improve the quality of services and deliver them at scale. There are vast disparities in the demand for, access to, utilisation and quality of services available depending on where one lives in the country and what households can afford. Invariably, poorer families and those living in rural areas get fewer, lower quality services.

Other common bottlenecks relate to the lack of policy coordination and the limitations of decentralization in areas where efforts are required from multiple stakeholders, both across sectors and at various levels from central government ministries, departments and agencies (MDAs) down to district, ward and village level. Given competing demands for investments in infrastructure and growth promotion and the country’s limited capacity to mobilise resources domestically, questions of fiscal space for children are paramount too, and will be reviewed in the following chapters.

As Tanzania moves to a new generation of MKUKUTA and MKUZA, stark policy choices will need to be made, and backed up with resources at a scale that will increase the likelihood of achieving long-lasting, sustainable outcomes. Making those choices will not be easy, and trade-offs will have to be carefully assessed. A key contention of this report is that investing in Tanzanian children is one investment that cannot wait. The following chapters will shed light on areas where investments are most needed, and how the country can most effectively honour the international and domestic commitments it has made to protect and promote the rights of its children.

The definition of a child in Tanzania

In accordance with the UNCRC, the Law of the Child Act 2009 provides that a person below the age of 18 years shall be known as a child. However, some domestic laws in Tanzania still conflict with the LCA and UNCRC, providing different benchmarks for adulthood. This creates opportunities for discrimination and confusion. For example:

- The Marriage Act of 1971 defines a male as under 18 years and a female child as under 15 years and consequently permits the marriage of adolescent girls.
- Under criminal law, children aged 16 and 17 years old are treated as adults in direct violation of international law.

Such laws remove protection for children and increase their vulnerability to abuse and violations of their rights.
Chapter 2
Maternal health and child survival

Appropriate healthcare in a child’s early years is essential for his/her well-being and development. When well-nurtured, children are more likely to grow normally, to have fewer illnesses, and to develop strong thinking, language, emotional and social skills. Their prospects for performing well at school are improved, and as adolescents, they are likely to have greater self-esteem. Later in life, they have a greater chance of becoming creative and productive members of society.

The agenda to improve early childhood development in Tanzania is indivisible from the agenda to improve child health, nutrition and survival. Assessments in Tanzania have indicated a clear need for holistic actions in early life, beginning in pregnancy. Poor nutrition and ill health of mothers increase the risks of low-birth weight, putting children at much greater risk of developmental delays, malnutrition and death. Infants and young children who are malnourished and repeatedly ill do not thrive and are likely to suffer developmental delays. Many children are also deprived of the psychosocial stimulation, the play and learning opportunities they need to develop cognitively and intellectually from an early age. Figure 5 highlights important aspects of healthcare within the child’s life course from conception through adolescence.

2.1 Status and trends

2.1.1 Maternal health: The foundation of child survival and well-being

Maternal mortality ratio

Lack of access to appropriate antenatal and delivery care multiplies the risk that women and babies will die of complications. In Tanzania, maternal health outcomes have shown no sign of improvement over the past two decades. The maternal mortality ratio (MMR) rose from an estimated 529 deaths per 100,000 live births in TDHS 1996 to 578 in TDHS 2004/05. This is equivalent to 10,000 maternal deaths per year, or roughly one every hour. The high maternal mortality rate is doubly tragic because a child’s chances of survival and well-being drop dramatically when deprived of a mother’s care. Even higher maternal mortality ratios were found in a recent population-based study in southern Tanzania: 631 in Mtwara region and 800 in Lindi region over the period July 2004-June 2007 (Schellenberg et al., forthcoming). Verbal autopsies for 489 of the 516 maternal deaths captured by that study found the leading causes of maternal death to be haemorrhage, eclampsia and sepsis.

Skilled assistance at delivery and emergency obstetric care

A recent global analysis of maternal healthcare concluded that the universal availability of basic emergency obstetric care services alone could prevent a large proportion of obstetric deaths and reduce the maternal mortality ratio to below 200 per 100,000 live births (Campbell and Graham, 2006).

However, access to skilled assistance at delivery remains low in Tanzania. Overall, about half of all births are attended by skilled health workers – with a major gap in access between urban and rural areas. Within urban and rural samples, the poorest have inferior access to skilled delivery as compared to least poor women. Thus it is poorer women in rural areas who face a “double jeopardy”. The data also indicate that for the top quintile in rural areas, wealth seems to partially overcome the inherent rural disadvantage – perhaps because women are more able to travel to hospital to deliver, have more influence over healthcare decisions, and greater access to information about how to care for themselves and their infants (see Figure 6).

Life expectancy

Projections from the 2002 Census anticipated a gradual improvement in life expectancy from 52 in 2002 to 56 years in 2008 for women, and from 51 to 53 years for men.

Life expectancy at birth is critically affected by assumptions about mortality before the age of five, and HIV and AIDS, the leading cause of adult mortality in Tanzania.

Given the very rapid improvement in under-five mortality and the modest decline in HIV prevalence, actual life expectancy trends have undoubtedly out-performed the projection.

It is plausible that the new Census 2012 will find that life expectancy for men is in the high 50s and for women is around 60 years.

1 Preliminary results from the TDHS 2009/10 suggest a decline in MMR from its peak five years ago, although the difference between the two estimates is not statistically significant, which precludes concluding that there has been a change in maternal mortality in Tanzania in the past five years.
Figure 5: The child’s life course: Health needs for survival and well-being

**Pregnancy, conception and birth**
- Nutritious food for the mother during pregnancy, including supplementation for micronutrient deficiencies
- Antenatal, delivery, post-natal and newborn care
- Education for the mother on nutritional, health and hygiene needs of the child
- The newborn needs colostrum post-birth and exclusive breastfeeding for the first six months
- Both mothers and babies need protection from malaria and prompt treatment if infected

**Infancy to two years**
- Children need to be fed, cleaned and kept safe until they can meet such needs themselves
- Good nutrition and supplements for optimal physical and cognitive development
- Frequent feeding and safe weaning practices
- Immunisation against serious childhood diseases
- Protection from malaria and prompt treatment if infected

**Early childhood**
- Screening for developmental delays
- Safe environments in which to live and play that are free from environmental hazards, overcrowding and dangers

**Middle childhood** (5-6 years of age to onset of puberty)
- A safe home, school and community environment
- Protection from environmental and physical hazards
- Access to clean, safe water and sanitation and protection of right to privacy when using toilets
- Education about healthy living, including nutrition, hygiene, and physical and sexual development

**Adolescence**
- Knowledge to avoid risky sexual behaviour
- Awareness of the importance of and access to youth-friendly reproductive health services, including family planning and contraception to allow choice and control of fertility outcomes
- Counselling and mental healthcare to help them deal with the transition into adolescence, and the temptations of drugs, alcohol and other risky behaviours

**All children need:**
- Quality healthcare
- Good nutrition
- Clean and safe water
- Adequate sanitation and hygiene
- Protection from poverty, trauma, violence and abuse
Table 2: MKUKUTA targets for health

| MKUKUTA I Targets Cluster strategies |
|--------------------------------------|---------------------------------|
| **Infant and Child Health**          |                                 |
| • Reduced infant mortality from 95 in 2002 to 50 in 2010 per 1,000 live births | Improve neonatal and infant care, and ensure screening of children under-five for development disabilities and targeted nutrition education and supplements for undernourished children |
| • Reduced child (under five) mortality from 154 in 2002 to 79 in 2010 per 1000 live births | Implement public health and primary preventative strategies such as broad access and use of insecticide-treated nets (ITNs), including increased access to longer-lasting ITNs, immunisations, safe and clean water, personal hygiene and sanitary measures, and promote cost-effective interventions to reduce water-borne diseases, including environmental health programs |
| • Reduced hospital-based malaria-related mortality amongst under-5s from 12% in 2002 to 8% in 2010 | Develop national strategy for parenting education and support to achieve improved nutritional and health status of infants and young children |

| **Maternal Health**                  |                                 |
| • Reduced maternal mortality from 529 in 1996 to 265 in 2010 per 100,000 | Increase percentage of children under two years immunised against measles and DPT from 80% in 2002 to 85% in 2010 |
| • Increased coverage of births attended by trained personnel from 46% in 2004/2005 to 80% in 2010 | Implement public health and primary preventative strategies to improve access to and proper use of ITNs; including availability of longer-lasting ITNs, use of safe and clean water, personal hygiene and sanitary measures |

| **Human Resources and Management**   |                                 |
| • Health Boards and Facility Committees in place and operational in all districts | Evaluate the human resource development strategy in the health sector to identify gaps in skills among health workers and execute a plan for immediate training in key areas, including special health needs of older or disabled persons |
| • Service delivery agreements operational and effective | Hire and equitably deploy health workers with particular attention to under-served villages / communities, including to resolve current obstacles to hiring and placement, enable councils to recruit effectively, establish an incentive package for ‘hardship posts’, and streamline transfer procedures and practices |
| • Regional Health Management Teams in place and operational | Finalise establishment of Health Boards and Health Facility Committees ensuring broad representation including marginalised groups, and effective operation of these committees to monitor quality and accessibility of health services. Enhance public-private partnership agreements in provision of quality health services |
| • Promoted knowledge-based care among health workers for attending among others, people with disabilities and the elderly | Establish Regional Health Management Teams that have the capacity to provide adequate and dynamic support to Council Health Management Teams with delineated responsibilities and authority |

Sources: HakiKazi Catalyst, 2005; URT, 2005.
Both urban residence and wealth convey an advantage in access to skilled attendance; confirming the widely-held view that there are binding constraints both on the supply side (presence of quality facilities nearby) and on the demand side (ability to afford travel and other costs of access, cultural practices and lack of knowledge). Compounding this poor access to obstetric services, most facilities where deliveries take place are not capable of providing life-saving procedures in case of delivery complications. Table 3 presents data on the proportion of rural facilities that are staffed and equipped for common obstetric interventions.

**Table 3: Place of delivery (rural only) and proportion of (all) facilities able to offer quality obstetric care**

<table>
<thead>
<tr>
<th></th>
<th>Home</th>
<th>Dispensary</th>
<th>Health Centre</th>
<th>Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion of rural deliveries 2004/5</td>
<td>61%</td>
<td>15%</td>
<td>9%</td>
<td>15%</td>
</tr>
<tr>
<td>Proportion of facilities staffed and equipped for normal deliveries</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Qualified provider on site/call 24hrs</td>
<td>n/a</td>
<td>14%</td>
<td>75%</td>
<td>99%</td>
</tr>
<tr>
<td>Infrastructure for delivery (Delivery bed, examination light, and visual and auditory privacy)</td>
<td>n/a</td>
<td>8%</td>
<td>33%</td>
<td>55%</td>
</tr>
<tr>
<td>All basic medicines and supplies for normal delivery</td>
<td>n/a</td>
<td>11%</td>
<td>33%</td>
<td>11%</td>
</tr>
<tr>
<td>Proportion of facilities that have ever conducted key emergency obstetric procedures</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assisted delivery (vacuum extraction)</td>
<td>n/a</td>
<td>1%</td>
<td>22%</td>
<td>68%</td>
</tr>
<tr>
<td>Removal of retained products</td>
<td>n/a</td>
<td>15%</td>
<td>56%</td>
<td>97%</td>
</tr>
<tr>
<td>Parenteral oxytocic drugs</td>
<td>n/a</td>
<td>2%</td>
<td>20%</td>
<td>78%</td>
</tr>
<tr>
<td>Parenteral anti-convulsants</td>
<td>n/a</td>
<td>4%</td>
<td>17%</td>
<td>70%</td>
</tr>
<tr>
<td>Manual removal of placenta</td>
<td>n/a</td>
<td>36%</td>
<td>64%</td>
<td>89%</td>
</tr>
<tr>
<td>Blood transfusion</td>
<td>n/a</td>
<td>1%</td>
<td>12%</td>
<td>99%</td>
</tr>
</tbody>
</table>

Sources: Place of delivery reanalysed by IHI from TDHS 2004/5 data; Availability of obstetric services by facility from Tanzania Service Provision Assessment 2006.
The message is clear: for rural women (comprising nearly 80% of all deliveries), even the minority of women who deliver at a health facility do so in facilities unable to provide basic emergency obstetric care. Only a quarter of facilities that offer normal delivery services have all infection control items at the service site. The items most commonly missing are running water and disinfecting solution.

**Antenatal care**

A second factor contributing to high maternal mortality is the poor quality of antenatal care. The Tanzania HIV/AIDS and Malaria Indicator Survey (THMIS) 2007/8 indicates that 97% of pregnant women in Tanzania received Antenatal care (ANC) from skilled personnel (TACAIDS et al., 2008). No significant differences were recorded by urban-rural residence, women's level of education or household wealth status. However, the quality of ANC services varied substantially. In TDHS 2004/5, only 66% of ANC users had their blood pressure measured, 54% had a blood sample taken, 42% had a urine sample taken and 47% received advice on pregnancy complications. In 2007/8, only 30% received two or more doses of preventive malaria treatment. Syphilis screening is rarely carried out. The fact that the quality of ANC services remains so poor, in spite of the introduction of “focused antenatal care”, may be due to a combination of absence of equipment and supplies at lower-level facilities (NBS, 2007), insufficient staff to be able to provide the length of ANC consultation demanded by the package, and lack of accountability in service provision.

Tanzania failed to achieve the MKUKUTA I target for a reduction of maternal mortality to 265 deaths per 100,000 live births and, given the trends in maternal healthcare delivery, it seems highly unlikely that it will be able to meet MDG 5 (MMR of 133 by 2015). Achieving this target will require rapid expansion of access to adequate antenatal and obstetric care in conjunction with concerted efforts to increase demand for and accountability in supplying improved maternal services. Increasing awareness and understanding among key family decision makers, in particular husbands and mothers-in-law about the importance of accessing care during pregnancy and childbirth is also vital.

**Gender inequities and maternal mortality**

Gender inequities are fundamental in understanding the persistently high levels of maternal mortality in Tanzania and the lack of progress in maternal health generally. Maternal death rates are intimately linked with the high fertility rates and low socio-economic status of women, especially the lack of influence that women have over their own healthcare.

The total fertility rate (TFR) in Tanzania changed marginally over the decade to 2005, from 5.8 in 1996 to 5.6 in 1999 and 5.7 in 2004/5. Rural women on average have three more children than their urban counterparts (Rural 6.5, Urban 3.6). The proportion of (married) women currently using contraception has risen steadily – from 13% in 1996 to 20% in 2004/5. Nonetheless, this falls far short of women’s stated desire for birth spacing and limiting, with the result that only 59% of demand for family planning is presently satisfied (NBS, 2005).

Teenage pregnancies – often a consequence of early marriage – carry a higher risk of maternal death. In the Tanzanian Mainland, 24% of women aged 15-19 years were pregnant or had begun childbearing, a figure that is little changed since 1996 (26%). One in three
teenagers in the poorest households had given birth at least once, which adds to the risk of maternal death in the poorest communities.

According to the TDHS 2004/5 more than 38% of all married women report no participation in decisions regarding their own healthcare, and that these decisions are made solely by their husbands. Younger women aged 15 to 24 years have significantly less influence over decisions regarding healthcare than older women (see Figure 7). Overall during the years when they are most likely to give birth and are mothers to young children, women have relatively little influence over vital decisions regarding their own health – and presumably over health-seeking decisions for their children as well.

Figure 7 also illustrates that women in the poorest quintile and those with the least education have the least influence over key decisions including those regarding their health. Women living in western and southern districts have less influence over health decisions than those living elsewhere. The ability of young women in the poorest households to influence decision making is compounded by non-literacy and a widespread lack of access to mass media – overall around 40% of Tanzanian women do not usually see a newspaper, listen to the radio or watch television. The relative isolation of Tanzanian women as well as the low status of young women in particular are significant factors undermining the adoption of new behaviours that can prevent disease, ensure fast treatment for children when they are sick, encourage breastfeeding and influence other childcare choices and decisions over where women give birth.

Figure 7: Indicators of women’s low socio-economic status in Tanzania, by age group

2.1.2 Child survival and well-being

Under-five mortality

After more than a decade of stagnation during the 1980s and 1990s, TDHS 2004/5 recorded major gains in child survival. The latest survey results (THMIS 2007/8) show that this trend has continued. Figure 8 shows that Tanzania was on a trajectory to achieve the under-five mortality target of MKUKUTA I (85 in 2010), which preliminary results from the TDHS 2009/10 confirm as having been met, and may even reach the MDG target (50 in 2015). The reduction in under-five mortality is equivalent to saving nearly 100,000 child lives every year\(^2\). Nonetheless, the toll of under-five deaths still amounts to roughly 155,000 deaths per year – more than 400 deaths in Tanzania every day.

The component of under-five mortality that has registered the greatest improvement is post-neonatal mortality (between 1 month and 11 months of age). This has been the main driver of the reduction in infant deaths (0-11 months) and in overall under-five mortality (0-59 months). The reduction in child mortality (1-4 years) is more modest, as is the reduction in neonatal mortality (first month) (see Figure 9).

Figure 8: Under-five mortality targets and actual trajectory


Fast Facts

Child Survival

- Despite a reduction in under-five mortality equivalent to saving nearly 100,000 child lives every year, the toll of under-five deaths still amounts to roughly 155,000 deaths per year – more than 400 deaths in Tanzania every day.

- Neonatal mortality now accounts for around 30% of all under-five deaths. At the current rate, nearly 50,000 children do not survive to one month of age – equivalent to 135 babies dying every day.

- Most of these newborn deaths could be averted, saving up to 34,000 lives every year if 90% coverage of basic maternal and neonatal interventions could be achieved.

Figure 9: Components of under-five mortality: 1999-2007/8


\(^2\) Assuming annual births of approximately 1.7 million, under-five mortality of 147 per 1,000 implies 250,000 under-five deaths per year; 91 per 1,000 implies 155,000 deaths per year.
Early childhood development

Every child has the inherent right to life and States must ensure to the maximum extent possible the survival and development of the child (Article 6, UNCRC). To fully realise these rights requires good healthcare and nutrition for children and mothers, clean water and proper sanitation, play experiences and other early learning opportunities, emotional security, psychosocial care, and protection from abuse and exploitation.

Recognising the multi-sectoral and diverse nature of children’s needs in early life – physical, social, emotional, cognitive and spiritual – Tanzania has embraced the concept of Integrated Early Childhood Development (IECD) which aims to coordinate key interventions that will promote their right to survival, growth, development and protection (Figure 10).

Figure 10: Components of integrated early childhood development

A principal rationale for ECD is that gaps in individual ability widen significantly in the early years between advantaged and disadvantaged children. If a child is not motivated to learn and experience they are at increased risk of disadvantage as an adult. The critical point of opportunity in addressing inequity is before the age of eight years. ‘The longer society waits to intervene in the life cycle of a disadvantaged child, the more costly it is to remedy disadvantage’ (Hackman, 2006). The type of educational provision offered to the child in their early years is related to the high rates of dropouts and exam failures in primary school.

Acknowledging this responsibility, the Government included ECD as a component within the first phase of MKUKUTA 2005-2010 with a commitment to “increasing the number of young children who are prepared for school and life”. A National Inter-Ministerial ECD Steering Committee was established to oversee the development and implementation of an inter-sectoral Integrated Early Childhood Development (IECD) Policy, as well as an integrated ECD
service delivery initiative, draft operational guidelines and minimum standards. The service delivery initiative has been in place since 2007, and a draft policy has been developed.

Beyond the development of IECD policies and strategies, Tanzania still faces the challenge of implementation. Currently, administrative and implementing responsibilities are divided between different ministries, agencies and development partners in Tanzania, and even closely related programmes, such as health and nutrition, are not well coordinated. Investment of resources in ECD remains low.

**A promising ECD pilot programme in Kibaha district**

A pilot programme for Integrated Early Childhood Development in Kibaha district has demonstrated promising results when community-based volunteers and caregivers work together to improve caring practices in the home. The main objective of the program was to enhance the capacity of families and communities to improve care practices for children (zero to six years) through improved knowledge on psychosocial stimulation, parenting, nutrition, healthcare, hygiene and sanitation.

The main strategy adopted was a community-based model, using home visits conducted by trained Community Own Resource Persons (CORPs). CORPs promoted key caring practices among parents and caregivers at strategic points in the life of a child, beginning during the pregnancy of the mother. The strategy promoted an effective communication environment, strengthening the capacity of caregivers, families and the community to provide quality care to children. During home visits, caregivers were provided with specially designed cards to monitor milestones of their child’s development, including appropriate guidance and information. The programme included pro-active identification and inclusion of the most vulnerable children and families.

**Table 4: Achievements of the pilot ECD home-based care programme in Kibaha district between 2003 and 2007**

<table>
<thead>
<tr>
<th></th>
<th>2003</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth registration</td>
<td>15%</td>
<td>45%</td>
</tr>
<tr>
<td>Pregnant mothers sleeping under ITNs</td>
<td>63%</td>
<td>85%</td>
</tr>
<tr>
<td>Children &lt;5 years sleeping under treated nets (ITNs)</td>
<td>63%</td>
<td>85%</td>
</tr>
<tr>
<td>Households with knowledge and skills on psychosocial stimulation</td>
<td>5 %</td>
<td>86%</td>
</tr>
<tr>
<td>Under five deaths</td>
<td>164</td>
<td>144</td>
</tr>
</tbody>
</table>

Source: UNICEF, 2009d.

The pilot provided important lessons.

- Effective coordination between different programme components and among partners responsible is crucial.
- The commitment of CORPS is vital – yet the programme suffered from a significant drop-out. This might have been remedied by better motivation, transport and effective supervision.
- Youth theatre groups and village health days were found to be effective channels for enhancing communication and knowledge.
Plans are underway to roll-out this program in other districts, based on the experience and lessons learned from the pilot.

**Priority areas and recommendations in ECD**

- Advocate and raise awareness on the need for a holistic, integrated approach to ECD, addressing the whole range of children’s needs and basic rights. This will involve a shift in understanding of ECD as being solely within the domestic domain into an area of public concern.

- Complete the IECD policy and mobilise support for its implementation

- Expand ECD partnerships and networks across multiple sectors to synergise interventions and maximise benefits to the child.

- Build the capacity of parents, families and community members on key care practices and protection. This will necessitate developing parenting education and curriculum guidelines that address the developmental needs of young children.

- Conduct evidence-based research to guide ECD strategies and programming, including how different child-rearing practices impact on developmental outcomes.

- Provide adequate human and financial capacity to support high quality and adequately funded ECD initiatives. ECD needs to gain status as a profession and be included on the teacher education curriculum, linked to the establishment of a national in-service training programme for ECD practitioners and a strategy developed for continuous professional development within ECD. A targeted expansion of pre-school education especially in rural and other disadvantaged areas needs to be undertaken, but only with full understanding of the benefits of pre-primary education and the adequate resourcing of these schools. ECD data needs to be included in the Education Sector Management Information System and quality assurance mechanisms need to be established for both pre-school and community based ECD.

- Strengthen coordination and implementation mechanisms at district levels. In terms of coordination the national ECD steering committee needs to be replicated at the district and ward level to ensure that ECD gains a place of concern on the local government planning and financing agenda.
Figure 11: The child’s life course: The early years

**Pregnancy, conception and birth**
- Mothers need education about pregnancy and childbirth, the basics of child development and newborn care. Mothers who are also school students need support to continue their studies and to care for their babies.
- Adequate nutrition for the mother and unborn child, including supplementation to address dietary deficiencies.
- Access to quality antenatal, delivery, postnatal and newborn care and counselling.
- Parental education on the baby’s nutritional, health and hygiene needs.
- The newborn baby needs colostrum post-birth and exclusive breastfeeding for the first six months.
- Both mothers and babies need protection from malaria and prompt treatment if infected.
- Mother and baby need protection from gender-based violence.
- Access to PMTCT services if the mother is HIV positive.
- Children need the protection of birth registration.

**Infancy to two years**
- During this stage of life the foundations are laid for physical well-being and future educational achievement.
- Children need to receive consistent, loving attachment from caregivers.
- Good nutrition is essential for physical and cognitive development. Nutritional supplements are needed where dietary intake is inadequate.
- Affection and bonding from caregivers helps to develop the infant’s frontal cortex and interactions promote language development.
- Children need to be fed, cleaned and kept safe until they can meet these needs themselves.
- Infants require frequent feeding and safe weaning practices.
- Immunisation against serious childhood illnesses.
- Protection from malaria and prompt treatment if infected.

**Early childhood**
- A safe, consistent and loving presence from parents.
- Protection from gender-based violence or abuse, unsuitable living environments and neglect.
- A child’s world starts slowly to expand. Play becomes the mechanism through which they develop cognitively and start to understand how their behaviour affects others.
- Interaction with others and role models with whom to discuss, practice, understand and express feelings. They should not be sat passively receiving didactic teaching in a classroom.
- Messages of love, admiration and approval.
- Screening for developmental delays is critical.
- Safe environments in which to live and play that are free from environmental hazards, overcrowding and dangers.
Neonatal health

Neonatal mortality has improved, but not rapidly as mortality beyond the first month. As a result, neonatal mortality now accounts for around 30% of all under-five deaths. At the current rate, nearly 50,000 children do not survive to one month of age – equivalent to 135 babies dying every day. Progress on neonatal health will be vital if MDG4 is to be achieved. An estimated 75% of neonatal deaths occur during the first week; 50% within the first 24 hours. Neonatal deaths are inextricably linked to the health of the mother during pregnancy and to the adequacy of obstetric care at delivery, as well as to inadequate management of common neonatal complications including preterm delivery, infections and birth asphyxia (Figure 12). Low birth weight, which affects 13% of newborns, carries a risk of death between 4 and 10 times that of normal-weight babies. Low birth weight is, in turn, most commonly due to growth retardation of the foetus during pregnancy, with malaria being the greatest risk factor. Most of these newborn deaths could be averted, saving up to 34,000 lives every year if 90% coverage of basic maternal and neonatal interventions could be achieved (MoHSW, 2008a).

Figure 12: Leading causes of neonatal mortality

![Figure 12: Leading causes of neonatal mortality](source: MoHSW, 2008a)

Stillbirths

Figures for under-five mortality exclude the hidden tragedy of stillbirths that are usually caused by foetal distress during labour and inadequate emergency obstetric care. According to international estimates (Stanton et al., 2006), stillbirths in sub-Saharan Africa amount to 32 per 1,000 live births – a similar magnitude to neonatal mortality in Tanzania. The rate of stillbirths is strongly correlated with maternal mortality, as well as with indicators of quality maternal care, including skilled attendance and caesarean section rate (McClure, Bann and Goldenberg, 2007).

Disparities in child survival

The 2007/8 survey results reveal significant differences in under-five mortality risk across wealth quintiles, with the top quintile experiencing a mortality rate 22% lower than the
poorest (101 and 129 per 1,000 live births respectively). An even wider gap is observed between the best educated women (secondary education or more: 78/1,000; no education 129/1,000). These disparities point to the importance of underlying, social determinants of health. Children die because of beliefs, practices and decisions made at the household level as well as due to gaps in health service provision.

It is important to note that, over the past decade, there has been dramatic narrowing of the urban-rural gap in child survival (see Figure 13). Whereas in 2004/5 there was a 30-point rural disadvantage in under-five mortality, the 2007/8 survey found that urban and rural under-five mortality rates were almost the same. One plausible explanation is the growth in household ownership of mosquito nets, which began earlier in urban areas but showed little further increase between 2004/5 (74%) and 2007/8 (79%). Meanwhile rural areas have witnessed continued growth in net ownership, albeit from a lower base (21% in 1990; 36% in 2004, 49% in 2007). Experience would suggest that households in the poorest urban areas are also less likely to be using treated nets and that different strategies may be needed to reach these groups.

Figure 13: Geographic disparities in under-five mortality

![Graph showing geographic disparities in under-five mortality between urban and rural areas from 1990 to 2007.](source: TRCHS 1999, TDHS 2004/5, THMIS 2007.)

**Fast Facts**

**Childhood illness**

- Fever is by far the most reported illness experienced by children aged 0-15 years, followed by diarrhoea and ear/nose/throat complaints.
- Children in the 6-35 month age group are at greatest risk of fever or acute respiratory illness.
- There is little difference in the incidence of ARI or fever across wealth quintiles. However, in the case of diarrhoea there is a clear difference between the least poor quintile (9%) and the rest (13%).
- There has been a systematic decline in the proportion of under-fives who suffer fever and acute respiratory infections, while no discernible change has occurred in the incidence of diarrhoea.
- However, the proportion of children sick with diarrhoea who were taken to a health facility dropped from 63 percent in 1999 to 47 percent in 2004/5.
- The reduction in fever and ARI incidence is most probably related to reduction of the malaria burden.

**Childhood illness**

The shortcomings of the Health Management Information System (HMIS) in the Tanzanian Mainland means that there are no reliable, up-to-date statistics on the main childhood illnesses that present at health facilities. However, some impression of child health can be gleaned from survey data.

According to the Household Budget Survey (HBS) 2007, roughly one-third of under-fives had experienced illness during the four weeks preceding the survey, and this fraction differed little between urban and rural areas. Among children aged 5-15 years, nearly 20% experienced morbidity. Fever was by far the most reported problem experienced by children aged 0-15 years, followed by diarrhoea and ear/nose/throat complaints (see Figure 14).
No difference was found in the leading childhood illnesses between girls and boys. The TDHS 2004/5 found little difference in the incidence of acute respiratory infection (ARI) or fever across wealth quintiles. However, in the case of diarrhoea, clear difference was found between the least poor quintile (9%) and the rest (13%). Regional variations are more striking. In the two weeks preceding the survey in Kigoma Region, 23% of children had suffered ARI; 52% fever and 27% diarrhoea. The reasons for Kigoma’s very high levels of morbidity deserve further investigation and urgent action.

Trends in morbidity can be gleaned from successive demographic and health surveys. The data indicate a systematic decline in the proportion of under-fives who suffered fever and acute respiratory infection during the two weeks prior to the survey, while no discernable change has occurred in the incidence of diarrhoea. Essentially, while families have widely adopted new behaviours in the use of insecticide-treated nets, thus reducing malaria, they have been slower to adopt behaviours that would improve hygiene and sanitation and lead to a reduction in diarrhoea. Investment in malaria prevention has been vastly higher than investment in the prevention of diarrhoea. Children in the 6-35 month age group are at greatest risk of fever or acute respiratory infection. In 2004/5, nearly 60% of under-fives suffering fever and/or ARI were taken to a health provider for treatment – although this is much more common for urban (70%) than rural (54%). The reduction in fever and ARI incidence is most probably related to a reduction of the malaria burden, discussed in more detail below.
The incidence of diarrhoea peaks among children aged 6-23 months – a pattern discussed in more depth in the chapter on water, sanitation and hygiene. In 2004/5, 70% of children with diarrhoea were treated with some form of oral rehydration therapy, whereas only 54% had oral rehydration salts prepared from sachets. Meanwhile, the proportion of children sick with diarrhoea who were taken to a health facility dropped from 63% in 1999 to 47% in 2004/5.

Malaria
The most notable progress in health over recent years is in the field of malaria. Following the adoption of a national ITN strategy in 2000, the ownership and use of bed nets has risen dramatically – although major disparities remain between rural and urban areas. Actual use of ITNs by under-fives has lagged behind use of "any net", although recent research indicates that even untreated nets have a major impact in reduction of personal and community risk of malaria. Use of nets/ITNs by pregnant women has also improved, although it is disappointing to note that coverage of this vulnerable group is no higher than that of the population in general, reflecting the lower status of younger women and children in the household. Recent survey results suggest that the proportion of pregnant women who obtain a net through the Tanzania National Voucher System (THVS) has dropped for two consecutive years. The move towards free distribution of ITNs to all children under five years, to be followed by universal free distribution of ITNs, should ensure that higher coverage is achieved for all women of reproductive age as well as children and adolescents with emphasis of net use by under-fives.

Figure 16: Trends in coverage of bed nets

A second strand to the malaria control strategy has been intermittent preventive treatment for malaria in pregnancy (IPTp). Since adoption of the national policy in 2002, the proportion of pregnant women who received 2+ doses of "SP" has risen from 22% in 2004/5 to 30% in 2007/8, while disparities persist between urban (43%) and rural (28%) areas. This is still very low considering that all of the 95% of women attending ANC are supposed to receive IPTp.

A third aspect is the change in first line drug – first from Chloroquine to SP (in 2001/2) and later to Coartem / "ALU" in 2007. Rapid diagnostic tests (RDTs) for malaria, which have been piloted in various districts, are due to be implemented across the whole country. In Zanzibar RDTs were associated with lower prescriptions for anti-malarials, higher prescription of antibiotics and lower rates of re-attendance due to perceived treatment failure – while the total treatment cost per patient was similar (Msellem et al., 2009).
Disease outbreaks and healthcare

Measles, cholera and occasionally Cerebral Spinal Meninigitis remain the most common disease outbreaks in Tanzania.

Despite the high measles coverage of 86% reached during the Integrated Measles Campaign in 2008, Tanzania has experienced several measles outbreaks, bringing into question the coverage and quality of both routine and supplemental immunisation activities.

The MoHSW has established sentinel surveillance sites for epidemic diseases such as Bacterial Meningitis through its Expanded Programme on Immunisation (EPI), and has established a surveillance system with focal points in all regions and districts to track and report occurrence of Acute Flaccid Paralysis.

Although an Emergency Preparedness and Response Unit has been established at the MoHSW, it needs to build capacity, coordinate partner actions and establish pre-positioned supplies at regional and district levels.

The combined impact of these control measures has led to measurable reductions in the burden of malaria (Smithson, 2009). In 2007/8, nearly 20% of Tanzanian under-fives tested positive for malaria – roughly half the level found in surveys from the 1980s and 1990s. There has been a decline of similar timing and magnitude in severe anaemia, fever incidence, malaria inpatient admissions and the proportion of fever cases positive for malaria. Meanwhile, available data show an order of magnitude reduction in the intensity of malaria transmission (infective bites per person) over the past ten years. The gains in malaria impact indicators correspond closely to the increase in net and ITN coverage, which the latest TDHS figures suggest has continued to rise. The fact that ITN coverage, though expanding, is as yet relatively low (particularly in rural areas) suggests that there is scope for considerable further improvement in the immediate future once universal ITN distribution gets under way. This will be of particular importance in the parts of the country that are most severely affected by malaria (see Figure 17).

Figure 17: Prevalence of malaria parasitaemia in children aged 6-59 months, 2007/8

Vaccine-preventable disease

Vaccination coverage in Tanzania compares favourably to other countries in the region, with DPT-HB3 coverage over the 80% mark since 2001 (see Figure 18). A closer examination reveals some fluctuation in performance – with a drop between 2004 and 2007. It is also possible that coverage in 2004 was not as high as reported. Survey data provided an estimate that was more than five percentage points lower than routine data captured by the Expanded Programme of Immunisation.
The EPI attributed slippage in coverage between 2004 and 2007 to logistical shortcomings in the process of partially devolving responsibility for EPI-related supplies to local government authorities. The most recent figures suggest that the downward trajectory has since been halted or reversed. Despite the annual fluctuations, Tanzania continues to exhibit fairly high vaccination coverage, at or above the national target. The main strategy to raise performance further is to focus on the minority of districts with particularly poor vaccination coverage with emphasis on promotion of routine vaccination-seeking behaviours by parents and other caregivers.

Linked to vaccination (both routine and campaigns) is the delivery of Vitamin A supplementation. Since its inception in 2001/2, the programme has achieved a dramatic increase in coverage (discussed further in the nutrition section below). This has undoubtedly made a significant contribution to health outcomes for children.

Figure 18: DPT-Hb3 vaccination coverage, 2001-2008

Source: EPI Programme, MoHSW.

Healthcare for women and children with disabilities

Tanzania’s health policy thrust – with its emphasis on maximising coverage of basic interventions for all – tends to overshadow the special needs of the disabled. Disabled children and women too often face a lifetime of social exclusion, discrimination, constrained opportunity and poverty.

While some aspects of disability occasionally receive media attention (albinos, fistula), more common causes of disability – mental health problems, congenital defects and other common disability (blindness, deafness) – receive little policy attention.

Tragically, much of the burden of disability suffered by children and women in Tanzania is preventable (fistula, trachoma, filariasis), while other disabilities (some congenital abnormalities) are amenable to surgical correction.

As a consequence of the “hidden burden” and lack of public prominence, services for the disabled (mental health, community-based rehabilitation, physiotherapy and occupational health, specialist referral services) are extremely sparse.
2.2 Human resources

For several years now the MoHSW has described the human resources situation in the health sector as a “crisis”. The chief problem is an absolute shortage of health workers, most particularly the more skilled cadres. By MoHSW estimates, the health sector in 2006 should have had 82,300 skilled health professionals, compared to 29,100 actually available – translating into a shortfall of 65%. The situation is even more alarming when the human resource requirements of the Primary Health Services Development Strategy (MMAM) are factored in. By these estimates, to fill the existing gap, staff new facilities, and off-set attrition, the sector will need to hire a staggering 144,704 new staff over the period 2007-17 – more than double the current health workforce. According to payroll records from President’s Office Public Service Management (PO-PSM), actual employment of new health sector employees (all cadres) by local government authorities between 2002 and 2008 averaged 1,600 per year, equivalent to a tenth of the new-hire requirement and barely enough to compensate for attrition, never mind achieve significant growth of the health workforce.

In this context, the projected growth of the health workforce looks optimistic at best. It will be essential that more resource-constrained options are considered – including phasing/prioritising of new facilities according to need, revisiting the staffing norms to take account of actual workload, finding ways to improve staff productivity, and “job-shifting” to train lower level workers to undertake procedures in the absence of more skilled staff. Beyond the problem of absolute shortage is the chronic problem of mal-distribution across the country. Across regions, there is a two-fold difference in the number of health workers per 10,000 population, with Kagera, Shinyanga, Kigoma and Tabora being the worst-off (see Figure 19).

Figure 19: Health worker distribution per 10,000 population, 2008

These regional averages also conceal the fact that distribution within-Region and within-District is also uneven. Thus the less popular districts, and the more remote health facilities are especially disadvantaged. The national shortage of health staff means that the “better-off” districts and regions can continue to hire staff. The inequitable distribution of human resources for health will persist until a workable package is found that motivates staff to serve in less popular districts and wards. In spite of a broad consensus that such measures are needed, no strategy has actually been
implemented to address the problem. It is also worth noting that the “formula-based” distribution of block grant funds for health has (as in other sectors) never been applied to personnel. Budgetary funds go where the health workers are, not vice versa. More equitable re-distribution of existing health staff is the most immediate measure that can and should be undertaken, given the critical and chronic shortage of health workers.

2.3 Key strategies affecting maternal and child health

2.3.1 Sector-wide strategies in health

In designing health policies and strategies, Tanzania has a well-established track record of focusing on universal access to basic health services, albeit constrained by a limited resource base. Since UNICEF’s last *Situation Analysis of Children and Women in Tanzania*, a new health policy has been published. The policy does not signal any radical change of direction, rather its main purpose is to incorporate developments in the sector that were already under way – notably user charges, the Community Health Fund and the National Health Insurance Fund. Similarly, recent changes to health-related legislation have largely been a “tidying up” exercise to bring legislative instruments up to date, particularly in the areas of regulation, including food and drugs administration and laboratory protocols. Three overarching strategies for the health sector are particularly relevant to efforts to improve national health-service promotion, capacity and delivery:

i. Health Sector Strategic Plan (HSSP) III

ii. Primary Health Services Development Strategy

iii. Human Resources Strategic Plan

**Health Sector Strategic Plan III (2009-2015)**

The new Health Sector Strategic Plan III was launched in 2009 and covers the period through to 2015, the key date for realisation of the Millennium Development Goals. The new plan is more concise than its predecessor, which is an achievement in itself considering that the plan must incorporate all aspects of health promotion and service provision. A specific section on maternal, newborn and child health (MNCH) is included. Moreover, the HSSP III is commendably clear in delineating specific areas for increased effort. The extent to which this clarity of priorities influences actual service provision will depend on effective dissemination of the new strategy to councils, translation of strategic aspirations into planning guidelines and budgetary allocation, and much more accountability for performance (monitoring and evaluation) at all levels of the health system.

**Primary Health Services Development Strategy (2007-2017)**

Forged in response to the ruling party’s manifesto commitments, MMAM has clear parallels with the education sector and initially placed the greatest emphasis on expanding health infrastructure to provide one dispensary per village and one health centre per ward. In its final form, the strategy was “rounded out” to include many aspects of health promotion and basic service delivery. The political commitment underlying the MMAM augurs well for its success. However, there are grave concerns that the construction of new facilities will outpace the Government’s ability to staff, equip and supply them. The concern is particularly acute with regard to human resources, where there is already a chronic shortage. On the other hand, it may be that the MMAM will provide the much-needed impetus to expand basic training and deployment of health workers.
Human Resources Strategic Plan (2008-2013)
This strategy was developed to address the crisis in human resources for health – an issue which has risen steadily in policy emphasis since 2002. The strategy is commendable insofar as it takes a holistic approach to human resource management, including planning, recruitment and training, distribution, motivation and productivity. The main difficulty is the ambitious scale of the plan – a tripling of the health workforce over a decade – which vastly exceeds current capacity as well as budgetary resources. This leads to the conclusion that the strategy may be more aspirational than realistic. The feasibility of the strategy is further called into doubt in light of the fact that the underlying causes of mal-distribution, productivity and motivation of government staff are multi-sectoral in nature. Until local government and public sector reforms address these fundamental issues, the resource management efforts of individual sectors will be stymied.

2.3.2 Sub-sector strategies

Maternal and neonatal health
In 2008, the MoHSW developed a National Roadmap Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania (the “One Plan”). The plan was formally launched by President Kikwete in 2009. This level of political support coupled with the technical soundness of this strategy augur well for accelerated progress.

There are opportunities for “quick wins”. In the case of maternal health, a rapid increase in availability of basic emergency obstetric care (from a very low base) should pay dividends. Over the longer term, this will need to be complemented by an increase in the coverage of skilled attendance as well as more effective referral to facilities that can provide comprehensive emergency obstetric care.

With effective implementation, similar rapid gains can be made through improved post-natal care (for both mother and baby) where the current lack of contact with healthcare services during this critical period creates a huge opportunity for better outcomes. However, it will be important that community-based interventions (both maternal and neonatal) are given equal weight to facility-based services if the strategy is to provide maximum impact.

The greatest concern – particularly in the absence of global funding on the scale of malaria or HIV – is that the strategy is able to assure the mobilisation of human, financial and physical resources required for effective implementation.

Integrated Management of Childhood Illness
Tanzania was an early adopter of Integrated Management of Childhood Illness (IMCI), a strategy which seeks to develop the capacity of child caregivers in first-level health facilities and communities to improve quality of care and address the major causes of under-five mortality and morbidity. IMCI commenced in 1997 in two pilot districts (Morogoro Rural and Rufiji) and by the end of 2005, the strategy had been rolled out to 107 districts (94% coverage of districts).

Results from a study undertaken by Ifakara – part of the international evaluation of IMCI – found that a reduction of 14% in under-five deaths was attributable to IMCI implementation. However, scaling up the strategy has proved to be a major challenge, for a number of reasons. First is the sheer number of front-line health workers that need to be trained and the time and expense that this involves. In consequence, the roll-out – first to national trainers of trainers, then to district trainers and finally to health workers – has taken longer than anticipated. Second, while IMCI has had a positive impact on clinical practice, there remains a substantial gap between treatment protocols and actual practice. This partly reflects a natural “decay” between learning and practice.
But it has also been attributed to a shortage of IMCI paper protocols and poor supervision and follow-up. The result is that IMCI-trained health workers are providing “less bad” rather than “good” clinical care, a conclusion that is borne out by the findings of an assessment of the quality of care provided in 13 paediatric wards in north-eastern Tanzania (Reyburn et al. 2008).

Finally, IMCI is supposed to have two components – one facility-based, the other community-based. The latter represents a critical adjunct since it addresses health-related knowledge, beliefs and skills of duty-bearers, caring practices in the home, recognition of danger signs and early treatment-seeking. These are particularly important in relation to care of the newborn (hygienic delivery, resuscitation, warming, cord care, eye care, skin care and recognition of danger signs), considering that only 13% of babies were examined by a health worker within two days of delivery (NBS, 2005). Community IMCI (c-IMCI) is equally important for conveying effective advice and support to pregnant women, health promotion, and home-based care for under-fives. Regrettably, implementation of c-IMCI has only recently begun in Tanzania, reflecting the health system’s emphasis on clinical services over the oft-neglected, yet vitally important area of health promotion and the engagement of communities and families as partners in reducing childhood morbidity and mortality.

Malaria

The progress in malaria control would have been inconceivable had Tanzania not developed a comprehensive National Malaria Control Strategy, and within this, a national ITN Strategy. External funding from the Global Fund and the US President’s Malaria Initiative has enabled rapid progress in implementation.

The tremendous surge of international interest, coupled with very promising results to date, means that malaria elimination is now becoming a conceivable policy goal. In a holo-endemic country such as Tanzania, this will require the deployment of multiple, complementary control strategies including ITNs, prompt and effective treatment, IPTp, improved diagnostic technologies as well as IRS and other novel vector control approaches.

Other “pipeline” developments, including Intermittent Preventive Treatment for Infants (IPTi), new treatments and even a malaria vaccine may be deployed. The prospects for significant additional health gains – particularly among pregnant women and young children – are therefore promising.

HIV and AIDS

The adoption of a National HIV/AIDS Policy (2001), the creation of TACAIDS, and the creation of a National Multi-Sectoral Strategy all significantly raised the level of policy and strategic commitment to mitigate the impact of the epidemic on the health of women and children.

These strategies per se might have made only a modest difference had it not been for a major injection of financial resources from the Global Fund and US President’s Emergency Plan for AIDS Relief (PEPFAR). These two sources of support have helped make access to care and treatment as well as prevention of mother-to-child transmission (PMTCT) a reality. However, concerns remain about the sustainability of the care and treatment programme. There remains some way to go before either anti-retroviral (ARV) treatment or PMTCT services reach the majority of people affected.

More recently (2007-8) the president’s championing of Voluntary Counselling and Testing (VCT) led to a national campaign and a quantum increase in the proportion of people who know their HIV status. Notably, the impetus and funding of the HIV and AIDS and malaria strategies are driven by international agencies and governments (particularly the Global Fund and PEPFAR) and are off-budget. This raises questions about the chances of success of One Plan. Will it be possible to achieve similar
achievements without a significant injection of funds? It also raises wider questions of the financial sustainability of Tanzania’s response to HIV and malaria, let alone broader healthcare challenges.

### 2.3.3 Challenges in health sector reform

The following areas of health sector reform have failed to exhibit significant progress, in spite of new strategies being promulgated. This may be partly attributable to the lack of international political will to put these issues on the agenda and the consequent lack of funding, but may also be a consequence of the sheer complexity of these reforms. These issues do not translate into easy quick wins, but demand a sophisticated understanding and long-term engagement with the national health system.

#### Hospital reforms

Hospital reforms were conceived more than five years ago – but have yet to be implemented on any significant scale. The reforms focused more on managerial structures (hospital boards, hospital administration), less on improving the quality of clinical care. To date, structural/management changes have seen scant progress, perhaps because of the inherent difficulties in introducing new management structures into institutions that have traditionally been dominated by the medical profession.

Other than marginal improvement in hospital services (national, regional and district) attributable to a considerably increased budget allocation, there is no reason to expect that there has been any material change in women and children’s access to hospitals, the quality of care that they receive there, or the responsiveness and dignity with which they are treated by health workers.

#### Medical supply system

Numerous initiatives over the past decade have held out hopes for a significant improvement in the quality, timeliness, adequacy and responsiveness of the system of medical supplies. Despite these efforts, pervasive dissatisfaction with the medical supplies system persists, manifest in recurring complaints by health managers and occasional adverse coverage in the media.

The “indent system”, which in turn was superseded by an effort to build a sophisticated integrated logistics system responsive to local demand, have each brought only partial improvement. Stock-outs, affecting the full range of essential commodities, remain common, as well as expiry in excess stocks. In both cases, the symptoms point towards a chronically under-performing medical supply system.

Related to this is the chronic problem with supply of adequate medical equipment – including basic items such as blood pressure machines – as well as maintenance or replacement of non-functional equipment.

The medical supply system has a direct bearing on access as well as quality of services. If women are expected to bring with them a plethora of supplies in order to deliver at a health facility, it is not surprising that many cannot afford to do so and choose to deliver at home.

#### Health management information systems

The HMIS is not functioning effectively. The only data consistently reaching national level is that which comes up through the vertical programmes (EPI, RCH, HIV and AIDS, TB/Leprosy). This is a major handicap to evidence-based planning and makes it impossible for managers at any level to identify problems with healthcare delivery that affect women and children.
The new HSSP III, with a much greater emphasis on monitoring and evaluation than its predecessor, presents some grounds for optimism. A new, costed plan to revitalise the HMIS has also been developed, although implementation has yet to get underway. A functioning HMIS is essential to the implementation of a “managing for results” culture within the health sector.

2.4 Health financing

2.4.1 User fees

Over the past decade health financing in Tanzania has undergone radical change. As the country turned from Nyerere-era socialist policies to economic liberalisation, so it followed international health policy trends. This included the introduction of user fees, community-based insurance and national health insurance. Proponents of private financing for health argue that good “free” healthcare really does not exist; where it does it is of poor quality, helps no one, and supplementary funding is essential to ensure access to quality services.

On the other hand, critics of the policy point to international evidence that user fees are regressive, dissuade those most in need of services from using them, and undermine the right to health. Exemptions from user fees (for children under five and pregnant women) are partially implemented, while waivers (ostensibly for indigents unable to pay) are effectively non-existent. Moreover, the actual level of resources raised through fees has been meagre, and some of the extra revenue has been accumulated (by community health funds at district level and the national health insurance fund at national level) rather than deployed for health service improvement. Meanwhile, the potential of insurance schemes (both community and national) to pool risk is undermined by extremely low coverage.

While it is an economic fact that a higher price may be expected to reduce demand, particularly among the poor, the Household Budget Survey 2007 indicated no decline in overall utilisation of healthcare services since 2000/01—and even shows a higher proportion using government services. Thus, while user fees almost certainly constitute a barrier to access—particularly for children and women from poor households—the policy does not yet appear to have inflicted serious damage to healthcare access in the aggregate.

2.4.2 Health sector income and expenditure

Within a period of rapid fiscal expansion in Tanzania, the health sector has received a major real increase in financial resources since 2002. Between 2004/5 and 2007/8, the Public Expenditure Review records a doubling of the total health sector budget from just over Tsh300 billion to more than Tsh600 billion. In per capita terms, this represents an increase from US$7.3 to $14.1. Expressed as a share of total government spending, the health sector has fluctuated between 9.6% and 10.8%, with no consistent upward or downward trend over the period.

Part of this increase reflects increased donor assistance, although only a part of total external aid is captured in the budget. A second part of the increase relates to salary increments under successive wage increases. After taking these factors into account, the increase in the other costs component of the health budget is relatively small. Year-on-year increases in the share of the recurrent budget allocated to regions and districts have also occurred—a trend that is in accordance with Government’s Decentralisation by Devolution policy.

The increases in “on budget” resources reflect only a part of the picture. The most dramatic change in health financing over recent years has been an unprecedented increase in the volume of external aid that is (generally) not reflected in the budget including the Global Fund grants and
US Government support for malaria and HIV-AIDS. It is these inflows of resources that have been responsible for the quantum change in HIV and AIDS programme performance, most notably the number of people able to access anti-retroviral therapy (ART) and PMTCT services. Similarly, in the field of malaria control, it would not have been possible to expand the ITN voucher scheme, consider universal distribution of ITNs, or even afford the switch to Coartem as front-line therapy. There is no doubt that these major resource inflows have generated significant advances in public health that impact significantly on children and women.

2.5 Institutional frameworks in the health sector

2.5.1 Sector-wide approach in health
The sector-wide approach (SWAp) in health sought to bring greater harmonisation among development partners, clearer alignment with government procedures and systems, greater government ownership and leadership, and reduced fragmentation and duplication. In these respects, the SWAp can be generally considered a success – a conclusion that was shared by the 2006 Health Sector Evaluation. The most tangible consequence of the SWAp was the creation of the health basket fund, providing flexible, supplementary health resources to both central and local government. The “district health basket” in particular has been credited as an important contributory factor to recent improvements in health outcomes (Masanja et al., 2008). However, a key challenge remains in ensuring that district budget allocations are consistent with agreed sector priorities.

2.5.2 Decentralisation
A central plank of the Government’s health sector reforms has been the strengthening of decentralised health planning and management. This has been complemented by the broader government policy of Decentralisation by Devolution that has resulted in a transfer of managerial and budgetary authority from central to local government. This has undoubtedly been a positive development, assisted by a significant investment in procedures, guidance and training for district health planning. Nonetheless, it may be argued that decentralisation needs to go a step further. In the education sector, the availability of funds at school level, under the control of parent-teacher committees, has improved the ability of schools to tackle local constraints. In the same way, some devolution of budgetary authority to health facilities would undoubtedly counter the dependency of facilities on their (often distant) Council health department to respond to their needs, and would provide a basis for more meaningful community participation and accountability in health management at the local level.

2.5.3 Community participation
The current strategies and structures for community participation in health are not working well, as described in a recent institutional review (Kessy, 2008). At the council level, Council Health Service Boards have been beset with political problems as they come into conflict with statutory Council sub-committees. At the facility level, the main impediment to their functioning has been apathy in the face of negligible control over resources, dependency on medical professionals’ willingness to convene meetings, and a poor track record in inclusion of their priorities in comprehensive health plans. Thus the reality, in spite of strong policy commitment from the Ministry of Health and Social Welfare, is rather poor community participation in health planning, management, promotion and accountability. In contrast, the MoHHSW has made a deliberate effort to widen participation in sector policy dialogue including representation of civil society actors in committees as well as at the formal annual sector review. Box 3 discusses the broad possibilities to enhance community networking to promote child survival.
2.5.4 Public-private partnerships

In spite of its prominence as one of the eight key health reform measures, public-private partnerships in health are limited. Some progress has been made in strengthening regulator and oversight measures for accreditation of private providers. However, little if any gains have been achieved in strengthening the collaboration between government and non-government (largely faith-based) providers. The system of financing remains essentially unchanged since the bed-grant (for voluntary agency hospitals) and direct payroll subsidy (for district designated hospitals) was first introduced in the 1970s. A new service-based funding agreement has not been implemented, the level of government subsidy to faith-based providers has declined in real terms, and the non-government sector has been affected by staff migration as public sector wages have risen. In consequence, anecdotal reports suggest that non-government providers have raised their fees – reducing still further the minority “market share” that they have in healthcare provision and biasing it more towards better-off households.

However, public-private partnerships to improve health outcomes have great promise. For example, partnerships with industry for food fortification have excellent potential to increase access to health and nutrition commodities.
2.6 Priority areas and recommendations

The status of women’s and children’s health since the publication of the last *Situation Analysis of Children and Women* shows areas of very positive change. Interventions focused on child survival have saved the lives of around 100,000 children annually compared with 1999. This is at least partly due to enormous strides in malaria control and treatment as well as an increase in coverage of Vitamin A supplementation. Incidence of childhood illness (particularly fever and acute respiratory infection) has also improved. Vaccination rates (DPT-HB3) have remained relatively high (over 80%). Similar improvements have been registered with respect to HIV and AIDS, particularly with regard to voluntary counselling and testing, care and treatment, and PMTCT.

Maternal health (with the exception of malaria interventions) shows almost no improvement. Maternal mortality remains unacceptably high due to the widespread lack of access to essential antenatal, delivery and postnatal care. The proportion of women who deliver at facilities has stagnated at around 50%. Moreover, the facilities where the majority of women deliver lack the personnel, supplies and equipment required to provide emergency obstetric care.

Recent gains have been underpinned by increase in financial resources for health from Government and donors, and increased empowerment of district level health systems through fiscal devolution and capacity strengthening. More recently, the revived policy attention and political will attached to maternal health in the “One Plan” strategy should improve service availability and quality to improve maternal outcomes.

Nonetheless, serious disparities in health outcomes and service access persist between socio-economic groups, between rural and urban areas, and between districts. The Government’s MMAM aims to boost access to healthcare, particularly in rural areas. However, the magnitude of the existing human resource gap, the demand for personnel for new facilities, and the inequitable distribution of health workers are major challenges. Unless these constraints can be overcome, the MMAM’s impact on delivering quality services will be limited. A second chronic constraint on the availability of quality care is the continued poor performance of the logistics system to assure the availability of essential medical supplies and equipment – particularly at health centres and dispensaries. Finally, service accessibility for the poor (particularly those not in exempt groups such as children over the age of five and women who are not pregnant) has not been helped by the introduction of user fees at primary care facilities.

Many recent initiatives have been undertaken to strengthen the health system. Without detracting from progress made, these gains have been held back by a lack of management for results. This in turn can be traced to outdated incentives within the civil service; supervision for “compliance” rather than performance; and the breakdown of the health information system that would otherwise enable managers to identify the poor performers within their district or region.

Priority areas for improving the healthcare of women and children have emerged from this analysis. These are divided below into “technical”, “institutional” and “policy” areas. The Government and donors are urged to consider these issues in implementing the second phase of MKUKUTA.

**Technical**

- Continue to scale up malaria control measures, including universal distribution of long-lasting nets; implementation of RDT country-wide; increased IPTp coverage and additional malaria control strategies including indoor residual spraying.

- Vigorous implementation and monitoring of “One Plan” in close collaboration with Council Health Management Team (CHMT). Allocate adequate budgetary resources and assure availability of quality antenatal, delivery and postnatal care.
• Effective implementation of nutrition interventions, with particular focus on the responsibilities of the health sector during the “window of opportunity” (up to age 24 months), including exclusive breastfeeding and appropriate infant feeding.

• Raise PMTCT coverage by ensuring universal coverage of VCT. Provide prophylaxis to all HIV-positive women and their newborns.

• Better understanding of the public health importance of gender-based violence, violence against children and sexual abuse of children. Implementation of effective, cross-sectoral strategies, including the police force and legal system, for preventing and responding to violence and abuse.

• Devise and implement strategies to improve the livelihood and welfare of women and children with physical or mental disabilities.

• Expand investment in health promotion and c-IMCI. Include men and older women as key audiences with influence over the health-seeking behaviours of younger women and children.

• Employ an evidence-based approach to communication for development, addressing key knowledge gaps and practices and working through the most effective channels.

**Institutional**

• Sequence and prioritise interventions to improve the availability of skilled human resources, with emphasis on the distribution of existing personnel to the worst-off areas.

• Re-double efforts to strengthen capacity for procurement and supply of medical supplies and equipment, particularly those required for essential maternal, neonatal and child health and nutrition interventions.

• Strengthen the HMIS, including mandatory reporting of health outputs and incorporating output measurement in supervision and monitoring at all levels, so as to increase performance and results at all levels of the health system.

• Implement hospital reforms with a focus on monitoring the quality of clinical care in district, regional and referral hospitals. Special attention needs to be paid to maternal health to assure quality service as well as dignity and safety for expectant mothers.

• Ensure that technical supervision and support for the delivery of essential nutrition interventions is embedded within the MoHSW and Regional and Council Health Management Teams.

• Devolve partial budgetary authority from the CHMT to health facilities, accompanied by local structures to provide accountability for finance and performance.

**Policy**

• Acknowledge the health sector’s lead responsibility for attainment of the nutrition MDG for children and for the nutrition of women of reproductive age. Emphasise delivery of interventions to protect children during the vulnerable “window of opportunity” up to age 24 months.

• Revisit health financing policies and strategies with emphasis on protecting service access for the poorest and most needy, fair (progressive) financing and effective risk-pooling.

• Revisit the structures and systems for community participation and accountability and devise remedial strategies to improve the functioning of health committees.

• Raise significantly the policy prominence of disability, mental health, violence and sexual abuse of children, and gender-based violence.
Nutrition

Beyond the individual human suffering, malnutrition is a major impediment to economic growth and development. It increases susceptibility to disease and mortality, impairs cognitive development and educational achievement, and reduces work capacity and productivity in adulthood. The prevention of maternal and child under-nutrition is thus a long-term investment that benefits each generation and their children.

### Table 5: MKUKUTA and MDG targets for nutrition

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<thead>
<tr>
<th>MKUKUTA Targets</th>
<th>Cluster Strategies / Indicators</th>
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<tbody>
<tr>
<td>Reduced prevalence of stunting in under fives from 43.8% to 20% in 2010</td>
<td>Promote sound feeding and weaning practices of infants, emphasising the need for parental attention and primary care, and care for infants and frequent feeding</td>
</tr>
<tr>
<td>Reduced prevalence of wasting in under fives from 5.4% to 2% in 2010</td>
<td>Roll out IMCI throughout the country including the community-IMCI strategy</td>
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</table>

**MDG Targets**

| Target 2: Halve by 2015, the proportion of people who suffer from hunger | Proportion of people living below the national poverty line (food poverty) |
|Percentage of under-weight under-five children

Sources: HakiKazi Catalyst, 2005; URT, 2005, 2006a

### 3.1 Conceptual framework for analysing malnutrition

Figure 20 presents a conceptual framework for malnutrition which illustrates the immediate, underlying and basic causes of malnutrition. Immediate causes are inadequate dietary intake and disease. In turn, these factors are influenced by three underlying factors: inadequate access to food, inadequate care for children and women, and inadequate access to essential health services and a healthy environment. While prevailing socio-economic and cultural conditions predispose a society to particular nutritional outcomes, these may be mediated by effective institutions, policies and strategies that mitigate the underlying factors.

Malnutrition has impacts across the whole life cycle (see Figure 21). Exposure of the child to the risk of malnutrition begins in the womb with intra-uterine growth retardation, caused by disease, particularly malaria, and maternal malnutrition. These factors lead to low birth weight. Subsequently, the most severe and enduring damage done to children's nutritional status occurs during the first two years of life. Malnourished girls are more likely to be malnourished as women and to give birth to low birth weight infants, thus transferring malnutrition from one generation to the next.

The reciprocal linkages between malnutrition, inadequate dietary intake and recurrent illness are well established, forming a vicious cycle in which dietary intake contributes directly to malnutrition and increases susceptibility to disease, while disease reduces dietary intake and increases malnutrition. From birth to two years of age, the period most critical for growth, breastfeeding and complementary feeding practices are key determinants of dietary intake. Inadequate intake increases susceptibility to diseases by denying the child the nutrients it needs for effective immune function. The importance of micronutrients in safeguarding health
has become better understood in recent decades. Vitamin A improves immune status and has protective efficacy against recurrent illness and mortality. Zinc has been implicated in aetiology of, and recuperation from, diarrhoea. The risks associated with anaemia in children are less well understood, although hospital-based studies have demonstrated significantly worse health outcomes in children suffering from severe anaemia.

Malaria, diarrhoea and acute respiratory tract infection are leading causes of malnutrition in Tanzania. They cause malnutrition by precipitating anorexia, malabsorption of nutrients in the gut, increased loss of nutrients and elevated requirement for nutrients.

**Figure 20: Conceptual framework of causes of malnutrition**

Figure 21: Life-cycle of malnutrition

Source: Administrative Committee on Coordination and Standing Committee on Nutrition (2000).
3.2 Status and trends

3.2.1 Nutrition status of women

Malnutrition

According to the TDHS 2004/5, 10% of women were undernourished, with a Body Mass Index (BMI) lower than 18.5 kg/m$^2$, compared with 9% in the 1996 TDHS. In turn, the more recent Tanzania Mainland Nutrition Survey 2005 (TFNC, 2006) reported a rate of 7%. Under-nutrition is highest in women aged 15 to 19 years (19%) and women in the lower wealth quintiles. Under-nutrition is also higher in rural areas (12%) than in urban areas (8%). Small stature is associated with obstetric risk. In 2004/5, 3.4% of women in Mainland Tanzania were less than 145 cm tall, although this proportion rises to 9.4% in Mtwara region and 10.7% in Ruvuma region. Malnutrition also affects maternal mortality; women of small stature and anaemic women suffer a higher risk of maternal death.

Eighteen percent of women are overweight or obese (TDHS 2004/5; TFNC, 2006), which does not differ much from the 1996 TDHS results. Obesity is linked to increase of high blood pressure, cardiovascular disease and diabetes, particularly among adults that were born with low birth weight and were undernourished in the first two years of life. The increase in over-nutrition appears to be a reflection of increased calorie consumption, changing urban dietary habits and sedentary lifestyles. Women in urban areas are more than twice as likely to be overweight or obese as women in rural areas (33 and 12%, respectively). Women in higher wealth quintiles are also more likely to be overweight or obese. The existence of both under-nutrition and over-nutrition (overweight and obesity) in the same population group has been described as a “double burden of nutrition”. While much wider interventions are necessary to reduce prevalence of under-nutrition (for example, actions to empower women socially and economically) nutrition education is also needed on how to avoid overweight and its consequences.

Anaemia

Anaemia in pregnancy is a major health problem and causes maternal mortality, spontaneous abortions, premature births and low birth weight. Pregnant women, especially those in their first pregnancy, are at greater risk because ordinary acquired immunity does not protect against placental malaria. Women in Tanzania suffer very high rates of anaemia. TDHS 2004/5 data show that pregnant women are more likely to be anaemic (58%) than women who are breastfeeding or not pregnant (47.8%). There is only little difference in anaemia between women in urban (47%) and rural areas (50%). Women with no education are more likely to have anaemia (55%) than those with at least some secondary education (41%). Similarly, women from the lowest wealth quintile have higher prevalence of anaemia than those in the highest (53% as opposed to 47%).

In spite of the very high rates of anaemia, only 30% of women received the recommended two doses of intermittent preventive treatment for malaria in pregnancy (IPTp) (THMIS 2007/8), only 31% of women attending ANC had a blood sample taken and 43% did not receive iron supplementation (TDHS 2004/5). By addressing these missed opportunities during routine antenatal clinic visits there is ample scope to dramatically improve the coverage of interventions to prevent and treat anaemia in pregnancy.

There is a need to strengthen the implementation of the integrated package for anaemia control. This should include iron and folic acid supplementation, de-worming, intermittent
preventive treatment of malaria, promotion of insecticide-treated nets (ITNs), nutrition education on appropriate diet, screening for anaemia with referral for treatment and hygiene and environmental sanitation.

**Vitamin A deficiency**

A single postpartum dose of vitamin A (200,000 IU), given to women after childbirth, replenishes vitamin A stores in the woman’s body and increases the vitamin A content of breast milk, which reduces the risk of vitamin A deficiency (VAD) among breastfed children. The Ministry of Health policy is to provide a high-dose vitamin A capsule within the first four weeks after delivery. This policy is currently under review, and the period of supplementation is likely to be extended to eight weeks postpartum.

According to the 2004/5 TDHS, only 20% of women who gave birth in the five years preceding the survey received vitamin A supplementation (VAS) within two months after childbirth. Supplementation with vitamin A is slightly higher among younger women (20-34 years) and those with fewer births. Women with at least some secondary education were almost four times as likely to have received a vitamin A supplement within two months after childbirth as mothers with no education (41 and 11%, respectively). The lack of success in reaching postpartum women is mainly because there is insufficient contact between women and health service providers within the first four weeks after delivery, when postpartum VAS is given. This calls for an extension of the supplementation period to eight weeks after delivery and efforts to increase the proportion of women who access postnatal care. The fact that only a fraction of women received supplementation within the recommended time period implies that much effort is needed in scaling up this important nutrition intervention.

**3.2.2 Nutrition status of children**

Maternal and child malnutrition are responsible for 35% of global deaths in children under five years (Black et al., 2008). In Tanzania, application of a statistical model revealed that over one-third of all under-five deaths are linked with malnutrition, making it the single greatest cause of under-five deaths in the country. These staggering statistics stand in stark contrast to the meagre policy prominence of nutrition in Tanzania.

The consequences of malnutrition in children are multiple and grave. Children born with low birth weight (<2,500g) face mortality odds of up to four times normal-weight babies, and survivors are more likely to carry a nutritional deficit throughout their lives, and even into the next generation. A child that is severely underweight is more than eight times more likely to die from an infectious disease than a well-nourished child.

Up to half of children with severe acute malnutrition (severe wasting) will die unless they receive appropriate treatment. Children with severe acute malnutrition and medical complications require inpatient treatment, while those who have not developed medical complications can be treated through outpatient care. Currently, these essential services are available in only a handful of districts and health facilities, and coverage urgently needs to be scaled up to save lives and safeguard health. The essential therapeutic supplies needed to treat severe acute malnutrition are not procured by Government nor are they included in essential drug lists.

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3 The percentage of women receiving vitamin A supplementation within two months after childbirth has since increased slightly and the gap between educated and uneducated women has narrowed, according to the preliminary results from the TDHS 2009/10.
Low birth weight

Birth weight is a major determinant of infant and child health and mortality. Low birth weight (less than 2,500g) has serious consequences for survival, health, growth and development, and increases the risk of diet-related non-communicable diseases in adulthood, such as diabetes, high blood pressure and coronary heart disease. Only around half of all births in Tanzania have a known birth weight, corresponding to the proportion of deliveries at health facilities. The two indicators of birth weight – measured weight and the mother’s perception of the size of the baby – produce different patterns, making it difficult to conclude whether there has been a change in birth weights recorded during the period under review (see Figure 22).

Figure 22: Low birth weight trend, in the five years prior to survey

Low birth weight, as represented by mother’s perception of the size of the baby, shows no systematic difference across socio-economic groups by wealth, education or residence. First order births were more likely to be small or very small (14%) or weigh less than 2,500g (7%) – corresponding closely to low birth weight for mothers under age 20 years. For measured birth weight, there is a surprising higher prevalence of low birth weight for the top quintile, women with higher education and births to women resident in urban areas. This may possibly be an anomaly, explained by a higher proportion of surviving pre-term births and Caesarian sections.

Stunting, underweight and wasting

After a period of stagnation between 1992 and 1999, these three important child malnutrition indicators show signs of improvement. However, despite some progress on stunting, the pace of change has been such that Tanzania Mainland has failed to achieve the MKUKUTA target (20% by 2010) (see Figure 23). In contrast, it may yet prove possible to halve the proportion of children underweight to meet the MDG target (reduce underweight from around 30% to 15% by 2015). Notwithstanding these modest gains, the prevalence of stunting and underweight in under-five children remains high, according to the WHO criteria.
Children in rural areas suffer substantially higher rates of malnutrition than urban children. Over the period 1999-2005, the urban-rural disparity narrowed both for stunting and underweight (see Figure 24). Over a longer time perspective, it is clear that the improvement in height-for-age (stunting) in urban areas preceded rural areas, before reaching a plateau; while improvement for rural children has been confined to the last decade. Thus over the 15-year period urban-rural disparities widened considerably before narrowing again. This phenomenon of early urban progress—followed by relative stagnation and rural “catch-up” parallels the trend in urban-rural mortality disparities discussed in the previous chapter.4

* Preliminary results from the TDHS 2009/10 show an increase in both urban and rural stunting, so that the gap between them has remained the same as in the previous survey. Trends in underweight children are more positive, even though urban-rural disparities persist.
Nutrition and emergencies

In the past, the emergency response to nutrition crisis has been fragmented.

Essential nutrition responses, including the promotion and support of breastfeeding and complementary feeding, have yet to be accepted by humanitarian stakeholders as fundamental life-saving interventions.

Actions are currently underway to establish better systems to respond to a nutrition crisis, including the formation of a national level coordination structure, addressing gaps such as the lack of prepositioned stocks, completion of relevant guidelines and partnership mapping.

The nutritional status of children is closely associated with age (see Figure 25). The prevalence of underweight and stunting is close to zero at birth. Some deterioration occurs during the first three months of life. However, the greatest and lasting damage to children’s nutritional status occurs between month 3 and month 20. The increase in malnutrition during the first two years is particularly damaging as it is during this critical period of life that irreversible damage is done to physical growth and brain development.

Figure 25: Malnutrition by age, 2004/5

The relationship between malnutrition of under-fives and household wealth shows a “top inequity” pattern (see Figure 26). In other words, it is only the top quintile (least poor), which has markedly better nutritional status than the rest. Malnutrition in the other quintiles varies only slightly according to wealth.

Figure 26: Malnutrition by household wealth, 2004/5
This relationship still holds when the data are disaggregated into urban and rural households (World Bank, UNICEF and TFNC, 2007; data not shown). The relatively weak association between wealth and nutritional status for the lower four quintiles suggests that there may be a threshold of poverty above which nutritional outcomes become markedly better. Conversely, below this threshold, malnutrition is highly prevalent whatever the relative poverty status.

**Anaemia**

Anaemia affects almost three-quarters (72%) of children aged 6-59 months in Mainland Tanzania (TDHS 2004/5). It is caused predominantly by iron deficiency and malaria; other important causes include hookworm infections, schistosomiasis, HIV and AIDS and other micronutrient deficiencies. However, the problem also begins in utero among mothers who are iron deficient and anaemic during pregnancy. Anaemia is classified as severe at less than 8 grams of haemoglobin per decilitre, while below 7 grams it is considered life-threatening. Severe anaemia peaks in children aged 12-23 months and progressively declines in older age groups. This corresponds to the epidemiology of malaria, where the greatest challenge occurs after the loss of immune protection conveyed from mother to foetus during pregnancy but before the acquisition of individual immunity.

Nationally-representative data on severe anaemia in children aged 6-59 months were available for the first time from the TDHS 2004/5 dataset, and updated in the THMIS 2007/8. Data on severe anaemia was not reported in TDHS (only total anaemia), however, the Ifakara Health Institute (IHI) reanalysed the dataset to isolate statistics on severe anaemia. Comparison of the results shows a reduction of severe anaemia from 11% to 8% between the two surveys, with the effect being most evident in younger children and in rural areas (see Figure 27). This is most likely attributable to the advances in malaria control described earlier.

Once again, as for the mortality and malnutrition indicators, a convergence in severe anaemia is apparent between urban and rural areas; urban areas showed little change between 2004/5-2007/8 while rural areas markedly improved. Spatially, severe anaemia closely mirrors malaria prevalence patterns (see Figure 28).

**Figure 27: Severe anaemia in under-fives by age (months) and residence, 2004/5 and 2007/8**

![Figure 27: Severe anaemia in under-fives by age (months) and residence, 2004/5 and 2007/8](image-url)
It seems very likely that the reduction in anaemia over the three years to 2007/8 belies a much larger decline that occurred earlier. Studies show that the prevalence of severe anaemia in children under two years of age was nearly 50% in 1997 (Abdulla et al., 2001), while by 2007 it had declined to less than 10% in all under-fives (IHI, unpublished research data). Similarly, Rubya District Designated Hospital recorded a decline in severe anaemia among fever cases – from around 60% in the late 1990s to 23% in 2008.

Anaemia of any level (<11g/dl) conveys excess risk of illness and mortality. It has also been linked to stunting, and poor cognitive and motor-skill development (Olney et al., 2009). The close association between anaemia and risk of morbidity is illustrated below, using data reanalysed from the TDHS 2004/5 (see Figure 29). The causality in this association probably runs in both directions: anaemia predisposes individuals to more frequent illness, while frequent/recent malaria also causes anaemia.

Lastly, efforts to prevent and control anaemia in children are hindered by the very low coverage of micronutrient supplementation to prevent iron deficiency and other causes of nutritional anaemia. However the coverage of de-worming tablets among children aged 12-59 months is high and the use of insecticide-treated nets is increasing.
Vitamin A and iodine deficiencies

Vitamin A deficiency (VAD) compromises the immune system of under-five children and increases their susceptibility to infectious diseases. A 1997 survey by the Tanzania Food and Nutrition Centre (TFNC) found that 24% of children aged 6-71 months had low serum retinol levels (<20 µg/dL) and 69% of lactating women had low retinol concentrations in their breast milk. However, it is likely that the prevalence of VAD in children has been reduced considerably over the last decade due to the marked increase in coverage of twice-yearly vitamin A supplementation (VAS) campaigns from less than 60% in the 1990s to over 85% since 1999. This represents a major success and should have a significant impact on children’s immunity and survival. De-worming is linked with VAS and has also achieved high coverage, and there is potential to add other health and nutrition interventions to the twice-yearly events. Important steps have been taken to sustain VAS by ensuring that local government authorities include sufficient resources in their annual plans to sustain twice-yearly distribution.

Iodine deficiency disorders (IDD) are linked to health and developmental problems including intellectual deficits, goitre and cretinism. The fortification of salt with iodine is the most common method of preventing IDD. Only 43% of households surveyed by the 2004/05 TDHS were using salt that was adequately iodised. The proportion in urban areas was twice that in rural areas (72% and 34%, respectively) and households in the higher wealth quintiles were more likely to use salt that was adequately iodised. In 2004, 7% of school children were found to have goitre (TFNC, 2004), indicating large improvements since the 1980s when the national goitre prevalence was estimated at 25%.

Food fortification has the potential to reduce the prevalence of vitamin and mineral deficiencies in the population. However, with the exception of salt iodisation and a small amount of fortified oil produced by some food processors, food fortification in Tanzania is minimal. Salt iodisation began in 1990 and the initial focus was on introducing legislation for mandatory salt iodisation.
and on developing the capacity of the private sector to iodise salt. The Salt Production and Iodisation Regulation Act of 1994 banned the marketing of un-iodised salt for human and livestock consumption. However, its enforcement remains a challenge, particularly in areas of artisanal salt production.

3.3 Feeding practices for children

Poor dietary intake and diseases, the immediate causes of malnutrition, can be explained by a set of underlying causes consisting of access to food, care provided to children and women, access to essential health services and healthy environments. There is also an important role for interventions that influence parenting behaviours and domestic practices in addressing nutrition. Clearly men play a key role in decisions concerning crops, farming choices and food purchases and need to be recognised and engaged as key actors in improving the nutrition of children and women.

Food security may be an important determinant of nutrition status in some communities and some households. Yet, it is not the most critical determinant of under-nutrition in children under two years because children of this age consume little compared with older children and adults in the household (Leach and Kilama, 2007). Many households in Tanzania are food insecure because they lack the resources to produce or purchase sufficient food for their households. But there is no evidence to indicate that access to food has changed significantly between the 2000/1 and 2007 Household Budget Surveys (NBS, 2002 and 2009).

The unacceptably high prevalence of underweight among children is caused largely by inappropriate breastfeeding and complementary feeding practices. Exclusive breastfeeding up to six months of age provides the best protection against malnutrition in early life, and is one of the most important caring practices to combat child malnutrition. Yet, only about half of children aged less than 6 months in Tanzania are exclusively breastfed. By age 2-3 months, a majority of infants are already receiving other liquids and foods, and by 4-5 months of age only a fraction of infants are still exclusively breastfed (see Figure 30). Although there has been some improvement between 1999 and the present, this is limited to the period up to 3 months of age.

The modest improvement in exclusive breastfeeding may be expected to have contributed partially to recent gains in under-five nutrition indices. However, this is not borne out by the age-pattern of malnutrition, which indicates little to no improvement in stunting or underweight over the first one and a half years of life, when the benefits of exclusive breastfeeding should already be evident (see Figure 31). Instead, all of the observed improvement occurs beyond 18 months of age. This is strongly suggestive that other causes, particularly reduction in recurrent illness, especially malaria, may explain the recent improvement in child nutrition.

Infant and young child feeding practices leave considerable room for improvement. One-third of newborns are not breastfed within the first hour of birth, which is essential for establishing mother-child bonding, facilitating subsequent breastfeeding as well as protecting the mother against post-partum haemorrhage. A similar proportion receives “pre-lacteal” feeds that limit suckling by the infant and expose her to infection. Colostrum – the true super food for newborns containing essential maternal antibodies – is perceived as dirty and is thrown away in some parts of Tanzania (Mrisho et al., 2008). Nearly a fifth of babies less than three months of age are given water, a potential source of contaminants.
Figure 30: Proportion of children exclusively breastfed by age 0-6 months

<table>
<thead>
<tr>
<th>Age in months</th>
<th>1999</th>
<th>2004/5</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;2</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>2-3</td>
<td>70%</td>
<td>50%</td>
</tr>
<tr>
<td>4-5</td>
<td>60%</td>
<td>40%</td>
</tr>
<tr>
<td>6-7</td>
<td>50%</td>
<td>30%</td>
</tr>
</tbody>
</table>

Sources: TRCHS 1999 and TDHS 2004/5, 1999 and 2004/5. Note: Preliminary results from the TDHS 2009/10 suggest that exclusive breastfeeding is improving, though again mostly in the first three months after birth.

Figure 31: Percentage of under-fives stunted by age, 1999-2004/5

<table>
<thead>
<tr>
<th>Age in months</th>
<th>1999</th>
<th>2004/5</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5</td>
<td>70%</td>
<td>60%</td>
</tr>
<tr>
<td>6-11</td>
<td>60%</td>
<td>50%</td>
</tr>
<tr>
<td>12-17</td>
<td>50%</td>
<td>40%</td>
</tr>
<tr>
<td>18-23</td>
<td>40%</td>
<td>30%</td>
</tr>
<tr>
<td>24-29</td>
<td>30%</td>
<td>20%</td>
</tr>
<tr>
<td>30-35</td>
<td>20%</td>
<td>10%</td>
</tr>
<tr>
<td>36-47</td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td>48-59</td>
<td>0%</td>
<td></td>
</tr>
</tbody>
</table>

Source: TRCHS 1999 and TDHS 2004/5 re-analysed by age by IHI.

Most infants are receiving complementary foods at age 6-9 months (91%), however, the frequency and quality of these foods is often inadequate. Because children have small stomachs, they need frequent small meals that are rich in nutrients. The predominant diet fed to children is maize-based and frequently lacks sufficient protein, minerals and vitamins to support normal growth. The multiple demands on the time of mothers mean that they often struggle to find time to prepare and give frequent meals to their young children. It is the norm in Tanzania for women to bear the responsibility for caring for young children as well as being heavily occupied in domestic and agricultural tasks. With so much to do, women have little opportunity to provide time, attention and feeding for their children, or to take sufficient rest themselves. There is no evidence of change in the indicators of women’s freedom to make independent decisions. As discussed earlier, the 2004/5 TDHS data indicate
that 41% of women are not involved in decisions concerned their own healthcare and 50% do not take decisions on daily household purchases, including food.

In recognition of the importance of exclusive breastfeeding and other infant and young child feeding practices, the Ministry of Health and Social Welfare developed a National Strategy for Infant and Young Child Nutrition in 2004. With the exception of slight gains in early breastfeeding, the strategy has yet to deliver the desired impact. A better understanding of the cultural variation across ethnic groups in Tanzania will be essential in order to target unsafe practices and promote infant and young child nutrition more effectively. Recent global analysis indicates that the lives of about one-fifth of children can be saved if there is universal coverage of optimal breastfeeding and complementary feeding practices (Bhutta et al., 2008).

3.4 Key strategies and fiscal space

The national policy framework, including development and public spending priorities, poverty reduction strategies, legislative and regulatory provisions, determines the environment in which children survive and grow. Successful national and sub-national efforts have consistently demonstrated that sustained results can only be achieved if there is support from a wide range of actors. Furthermore, this support will not be sufficient if it only results in a proliferation of small-scale projects that are not incorporated within broader programmatic efforts. Coherent, well-resourced and properly monitored components within national and sub-national development frameworks that address hunger and under-nutrition are needed to maximise the efforts of the multiple sectors and many partners involved. In Tanzania, child hunger and under-nutrition receive little attention as an integrated concept within national development frameworks, although some aspects of food security have a higher policy profile.

The development of the National Nutrition Strategy is an important step in articulating and prioritising the actions needed to ensure that all Tanzanians are properly nourished. Its translation into a costed implementation plan and the mobilisation of resources to support its implementation are pending. Legislation needed to create an enabling environment for nutrition is not yet fully developed, updated, enacted and enforced. This includes the National Regulation for Marketing of Breast Milk Substitutes and Designated Products, the Code of Hygienic Practice for Foods for Infants and Children, and legislation for the fortification of food, including salt iodisation. Nor is the existing legislation fully understood by all who have responsibilities for its implementation and enforcement.

Development partners have been supporting the Government’s efforts in social and economic development and are well positioned to mobilise the resources needed to scale up nutrition interventions in Tanzania. However, nutrition has been given low priority by many development partners even though its impact on the health, well-being and national development is well documented (World Bank, TFNC and UNICEF, 2007). Food fortification is a case in point; a national program for fortification of staple foods with essential micronutrients is a key strategy to combat micronutrient deficiencies, yet Government and development partners have invested little in these programmes.

Key decisions about priorities and resource allocations are made at the local government authority (LGA) level, where the understanding of the importance of malnutrition and how to deal with nutrition problems is limited. Very few nutritional professionals exist to provide high quality technical support to LGA efforts to address malnutrition. Currently there are
no district staff that are accountable for nutrition and who are responsible for coordinating
the design, planning and implementation of nutrition interventions. This situation is set to
change now that the MoHSW and PMO-RALG have obtained approval for the creation of
a nutrition focal person position in all Councils.

The reduction of under-nutrition and under-five mortality rate during the past decade has
coincided with the introduction of a health sector-wide approach (SWAp), health sector reforms,
including decentralised planning and resource allocation, a doubling of public expenditure on
health, and large increases in the coverage of child survival interventions. These interventions
include health interventions that impact on nutritional status such as ITNs to prevent malaria and
Integrated Management of Childhood Illness (IMCI), as well as direct nutrition interventions such
as vitamin A supplementation and promotion of exclusive breastfeeding. These health reforms
have provided an enabling environment for improvement in some underlying and immediate
causes of malnutrition. As noted earlier, however, most women in Tanzania are not exclusively
breastfeeding their infants, colostrum is frequently discarded, and infant feeding practices
during the complementary feeding period continue to put children at risk. These factors, all
of which relate to women’s knowledge, social environment and the burden on women’s time,
need urgently to be addressed.

3.5 Institutional frameworks

Given the cross-cutting nature of nutrition problems, nutrition is prone to be seen both as
everybody’s business and nobody’s responsibility. Although the MKUKUTA target lists the
Ministry of Health and Social Welfare as the lead ministry, nutrition has retained a very low
profile in its policies, strategies and plans.

Nutrition activities in the country are coordinated by the Tanzania Food and Nutrition Centre,
which acts as the implementing institution on behalf of MoHSW. TFNC was established
by the Act of Parliament No. 24 of 1973, which was later amended in 1995. Its mandate
includes nutrition policy formulation, planning and initiation of nutrition programmes,
advocacy, capacity development, harmonisation, coordination, research, and monitoring
and evaluation of nutrition services in the country. Yet the semi-autonomous status of the
Centre poses the risk that it could function on the periphery of mainstream sector policy,
strategy and power. In turn, the shortage of financial resources for the Centre means it has
focused increasingly on commissioned work, research and project work in the field, rather
than motivating and mediating change in the health sector and beyond.

Currently there is a lack of prioritisation of nutrition in Council plans, including the Comprehensive
Council Health Plans, and nutrition is not allocated adequate financial and human resources
to provide quality nutrition services. In light of the Decentralisation by Devolution process,
the institutional arrangements for nutrition need to be reviewed so that LGAs have the
organisational structure necessary to implement nutrition services and are supported by
appropriate structures at regional and national levels.

Nutrition services for children and women are largely integrated into the delivery of reproductive
and child health services. There is poor coverage of many essential nutrition interventions,
with few health facilities providing the full set of nutrition interventions that are needed to
prevent, control and manage malnutrition. This is particularly disadvantageous for addressing
nutritional problems that are multi-factorial in nature and require multiple interventions, such
as the prevention and control of anaemia and management of acute malnutrition.
Children and Women in Tanzania

Civil society organisations complement the Government’s efforts in addressing malnutrition. They work at the grassroots and intermediary levels in implementing nutrition and related activities. International NGOs tend to have a national focus and are well equipped technically and financially to support nutrition interventions. However, coherence in the delivery of nutrition interventions seems to be lacking among NGOs as well as community-and faith-based organisations because they are either inadequately informed or guided about the national governing policies, guidelines, laws and regulations, and national standards.

Box 4: Why Kilimo Kwanza cannot neglect nutrition

The Government of Tanzania and the private sector have joined forces to conceive Kilimo Kwanza, an ambitious plan to revitalise agriculture in Tanzania and transform it into a highly productive sector. Kilimo Kwanza was formulated by the Tanzania National Business Council, a forum for public-private dialogue on strategic issues related to the efficient management of resources. It comprises a set of policy instruments and strategic interventions designed to modernise and commercialise agriculture in the country.

Investing in agriculture makes good economic sense: agriculture contributes an estimated 29% of Tanzania’s GDP (at 2001 market prices) and employs approximately three-quarters of the labour force, mostly in rural areas where poverty is most severe (RAWG, 2009). Increased agricultural production is therefore critical to poverty reduction and economic growth, while ensuring that the country is more self-sufficient in foodstuffs. If implemented in a pro-poor manner, Kilimo Kwanza has the potential to lift Tanzania’s economy and the livelihoods of the poor.

But investments in agriculture will not have the expected impact on national well-being unless greater attention is paid to improving nutrition.

Good nutrition is fundamental for a productive nation. Farmers who were malnourished as children are less productive because they were unable to learn well at school, and remain stunted and weak as adults.

Today, about half of children in Tanzania are suffering from chronic malnutrition, and half of their mothers are anaemic. Most malnourished children live in rural areas and many will become farmers in later life. A malnourished child of today is a less productive citizen of tomorrow.

Recent analysis has determined that that vitamin and mineral deficiencies cost Tanzania over TZS 650 billion every year, equivalent to 2.65% of the country’s GDP (National Food Fortification Alliance (NFFA), 2009). Most of these losses are within the agriculture sector. These vitamin and mineral deficiencies reduce the value of agricultural production by around 3.6%, amounting to losses of almost TZS 400 billion annually. The country simply cannot afford to ignore the economic consequences of malnutrition. Eliminating anaemia alone could raise labour productivity by up to 17%.

Kilimo Kwanza, therefore, must not neglect actions within the agriculture sector that have clear nutrition implications. It is dangerous to assume that increased agricultural production will automatically translate to fewer malnourished children and women. In fact, evidence from developing countries has shown little nutritional impact of agricultural interventions that promoted commercialisation.

Tanzania’s national vision for self-sufficiency of five strategic crops (maize, beans, wheat, paddy and cassava) is admirable, but it must not be at the expense of the production of foods that are rich in nutrients as well as energy. With the exception of beans, these crops provide energy but little in the way of vitamins, minerals and protein. An endless supply of energy rich foods will not combat malnutrition, because other essential nutrients are needed to build muscles, bones, brain tissue and other essential organs of the body. Stunting, poor educational achievement and low productivity in adulthood will persist if little attention is paid to the quality as well as the quantity of foods produced in the country.
Concerted efforts must be made to improve the nutritional status of every Tanzanian and to ensure that communities benefit from Kilimo Kwanza instead of being displaced and further marginalised by it.

The meagre policy and program prominence of nutrition in Tanzania means that opportunities are being missed to accelerate development. With the majority of the Tanzanian population deriving their livelihood from agriculture, actions to free the agriculture workforce from malnutrition can help it meet its full potential for productive capacity. Good nutrition can also help ensure that poor households can afford nutritious food throughout the year.

Deliberate efforts are needed to ensure that poor farmers and their families are not left behind in the process of agricultural transformation. Actions that increase their disposable income will enable the poor to act on the health and nutrition advice that they receive. If the poor are to benefit from Kilimo Kwanza, there is need for mechanisms, strategies and services that explicitly seek to include poor farmers as key agents and beneficiaries.

This calls for financial services that cater to the poor, extension services that reach down to the small farmer, small-scale irrigation schemes that enhance productivity, rural road construction that link producers to markets, land tenure arrangements that secure access to land, and reliable market distribution channels.

Investments are also needed in agricultural technologies that can directly improve nutrition. The breeding and cultivation of nutrient-rich varieties of crops such as orange-flesh sweet potato must continue. The fortification of food staples (i.e., the addition of vitamins and minerals) that are produced in the country during processing, including maize flour, has huge potential for alleviating vitamin and mineral deficiencies in the population. In fact, it has recently been determined that food fortification alone could save the country over TZS 150 billion each year by averting the losses due to vitamin and mineral deficiencies (NFFA, 2009).

To date, progress in fortifying staple foods in Tanzania has been disappointingly slow.

Women in Tanzania carry the greatest burden of responsibility in agricultural production. Their intensive workload denies them the time and energy to engage in other activities to safeguard the welfare of themselves, their children and other family members. Technological advances that free their time, and preferential access to agricultural support services for women, will have dividends for their welfare. At the same time, the relative isolation of women due to insufficient schooling, low literacy and limited access to mass media must be taken into account when designing strategies to engage them as partners in agricultural transformation.

Other sectors must also uphold their responsibilities for strengthening actions to improve nutrition. The health sector is charged with delivering services to prevent and treat malnutrition. However, nutrition continues to be marginalised amidst the plethora of other health priorities. Poor access to health and nutrition services, together with an unhealthy living environment that allows diseases such as diarrhoea and malaria to flourish, and inadequate caring practices for children and mothers, mean that the battle against malnutrition is far from over.

But the good news is that simple, cost-effective solutions are available to ensure that the next generation of farmers are protected from malnutrition. Counselling on breastfeeding and complementary feeding, supplementation with vitamin A and zinc, and food fortification have great potential to impact on nutrition and child survival. These priority interventions need to be delivered at scale and with high coverage. There is also accumulating evidence from Tanzania and other developing countries to support the use of social transfers as part of a package of interventions to improve child nutrition and cushion poor households from the effect of shocks to livelihoods.

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Concerted efforts must be made to improve the nutritional status of every Tanzanian and to ensure that Kilimo Kwanza is able to deliver results for the most poor and marginalised.

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**Box 4: Why Kilimo Kwanza cannot neglect nutrition (cont.)**

Horticulture (the cultivation of fruits and vegetables) and livestock provide nutritious foods. Currently, the focus of Kilimo Kwanza on horticulture rests mainly on its potential as an export industry. But horticulture products are important to protect Tanzanians against stunting and vitamin and mineral deficiencies, as well as over-nutrition, including the risks of chronic diseases such as cardiovascular diseases and diabetes.

Greater stimulus for horticulture at all scales of production is needed to increase the availability and affordability of nutrient rich fruits and vegetables. Support for home food production (fruits, vegetables and animal husbandry) by poor households should not be overlooked so that they have better access to nutritious food throughout the year.

Deliberate efforts are needed to ensure that poor farmers and their families are not left behind in the process of agricultural transformation. Actions that increase their disposable income will enable the poor to act on the health and nutrition advice that they receive. If the poor are to benefit from Kilimo Kwanza, there is need for mechanisms, strategies and services that explicitly seek to include poor farmers as key agents and beneficiaries.

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Concerted efforts must be made to improve the nutritional status of every Tanzanian and to ensure that Kilimo Kwanza is able to deliver results for the most poor and marginalised.
3.6 Priority areas and recommendations

There have been important new developments in nutrition since the last *Situation Analysis of Children and Women in Tanzania* in 2001 including a modest increase in the prevalence of exclusive breastfeeding and progress in malaria control. Some interventions, such as vitamin A supplementation and immunisation, have been maintained at relatively high levels. But overall, very limited progress in improving nutrition outcomes for children and women have been achieved. The prevalence of stunting and underweight is still unacceptably high, while the high prevalence of anaemia is an alarming public health problem. Very little attention has been given to addressing severe acute malnutrition, and much greater focus is needed on promoting breastfeeding and complementary feeding practices. As a consequence, Tanzania has not achieved MKUKUTA I targets and will not be able to reach the MKUKUTA II or MDG targets for child nutrition unless effective nutrition interventions are vigorously scaled up.

After a period of fatalism and resignation over the effectiveness of international nutrition policy, there is now clear evidence on what works (Bhutta et al, 2008). It is essential that nutrition stakeholders are not distracted by the myriad of nutrition actions, and that resources focus only on evidence-based interventions. There is also accumulating evidence from Tanzania and other developing countries that social protection strategies, including cash transfers, should be included in the package of interventions to improve nutritional status (Hofmann, et al., 2008; Save the Children, 2009a).

The following priority areas for rapidly and sustainably improving the nutritional outcomes of women and children have emerged from this analysis. They are divided below into “technical”, “institutional” and “policy” areas.

**Technical**

- Focus resources on evidence-based nutrition services that have the greatest impact on nutritional status and child survival. Essential nutrition interventions are promotion of breastfeeding. Complementary feeding practices, vitamin A and zinc supplementation, prevention and control of anaemia, food fortification and management of severe acute malnutrition.

- Prioritise nutrition interventions during the most vulnerable period of a child’s life, beginning in pregnancy up to two years of age.

- Scale up the coverage of priority interventions urgently, and put strategies in place to ensure disadvantaged areas and populations groups are better reached.

- Emphasise facility- and community-based initiatives to protect the nutrition of women during pregnancy, including adequate feeding, reduced workload, anaemia screening, iron and vitamin A supplementation, and prevention of malaria. These initiatives also need to engage men and older women who have influence over household decisions.

- Explore how social protection interventions, including cash transfers, can be used as part of a set of interventions to improve child and maternal nutrition in Tanzania.

- Utilise multiple communication channels/networks to engage communities and increase household and individual knowledge, attitudes and practices with regard to infant and young child feeding and women’s nutritional needs during pregnancy.
**Institutional**

- Acknowledge the health sector’s lead responsibility and accountability for the provision of nutrition services for children and women, and for the attainment of the MDG target for nutrition. Put nutrition higher on the Ministry of Health and Social Welfare’s policy agenda and reposition nutrition at the centre of health sector policies, plans and budgets.

- Re-focus TFNC’s mandate and strategic plan to: strengthen coordination of nutrition actors and interventions across multiple sectors; generate national and sub-national commitment for nutrition; provide strategic direction and leadership in nutrition; provide technical support for analytical work; and improve information management for nutrition.

- Ensure that the new nutrition focal persons within local government authorities are given adequate technical guidance, and supported by relevant structures at regional and national levels. LGAs must also prioritise nutrition activities in plans and budgets, and health facilities must provide the full set of essential nutrition interventions.

- Ensure that technical supervision and support for the delivery of essential nutrition interventions is embedded within the MoHSW and Regional and Council Health Management Teams (RHMTs and CHMTs).

- Allocate adequate budgetary resources and assure the availability of adequate nutrition supplies and equipment at all health facilities, particularly for the management of acute malnutrition.

**Policy**

- Complete and ensure approval of the revision of the National Food and Nutrition Policy, and ensure that nutrition is firmly part of policies and strategies in all relevant sectors, including health, agriculture, education, community development and industry.

- Urgently complete and enact legislation, regulations and standards needed to create a supportive environment of nutrition, including for the fortification of food.
Chapter 4
Water, sanitation and hygiene

Clean and safe water, adequate sanitation facilities and safe hygiene practices are all fundamental to child survival and maternal health. Diarrhoea and acute respiratory infections (ARIs), both of which are closely linked to water quality, sanitation and hygiene, cause 40% of under-five deaths internationally. These illnesses also contribute to the high prevalence of malnutrition in Tanzania, which in turn impacts on the growth and development of children. In addition, one-quarter of neonatal deaths are due to infection, which is affected by an unclean environment and poor hygiene at delivery (WaterAid, 2008). Women and children are disproportionately affected by a lack of access to these services. Across most of Tanzania, the burden of collecting water, cooking, cleaning, childcare and care for the sick is borne largely by women and children. Consequently any improvements in service delivery will bring disproportionate benefits to them.

Table 6: MKUKUTA I and MDG targets on water, sanitation and hygiene

<table>
<thead>
<tr>
<th>MKUKUTA Targets</th>
<th>Cluster Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operational targets: Increased access to clean, affordable and safe water, sanitation, decent shelter, and a safe and sustainable environment and, thereby, reduced vulnerability from environmental risk</td>
<td></td>
</tr>
</tbody>
</table>

**Water**

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

Increase sustainable access to inexpensive and reliable sources of water in both rural and urban areas

- Sustainable management of catchment forest areas
- Apply lifeline tariffs that ensures the affordability of access to safe water, especially in rural areas and focusing on vulnerable households, including older people headed households
- Implementation of water policy and water-related regulation frameworks

**Sanitation and Waste Management**

- Increased access to improved sewerage facilities from 17% in 2003 to 30% in 2010 in respective urban areas.
- Reduced households living in slums without adequate basic essential utilities.
- 100% of schools to have adequate sanitary facilities by 2010
- 95% of people with access to basic sanitation by 2010.
- Cholera outbreaks cut by half by 2010.

Expansion, rehabilitation and construction of urban sewerage and drainage systems

- Improve solid waste management and ecological sanitation, and promote hygienic household practices, in rural areas and urban settlements
- Develop incentives for income generating opportunities and investment in waste management
- Ensure adequate sanitation facilities at all public institutions – schools, health centres, markets and public places, including access for the disabled

**MDG Targets**

- Target 10: Halve, by 2015, the proportion of people without sustainable access to safe drinking water and sanitation

Proportion of population with sustainable access to an improved water source (rural / urban)

Proportion of people with access to improved sanitation (rural/urban)

4.1 Status and trends

4.1.1 Water supply

Household access

Data for both urban and rural water supply (see Figure 32) show a declining trend in access, from 89.8% to 79.4% in urban areas and from 45.9% to 40.5% in rural areas between 2000/01 and 2007 (Household Budget Survey 2000/1, 2007; Census 2002, TDHS 2004/5).

Figure 32: Proportion of households using an improved source as main source of drinking water

There are two likely reasons. First, although water funding improved between 2000 and 2007, two major projects (in Shinyanga and Dar es Salaam) displaced funding for other water investment, which therefore failed to keep pace with population growth. Second, the sector faces a major sustainability challenge. Only two years after installation, over a quarter of rural waterpoints (WPs) are not functioning. Overall, only 54% of all waterpoints are functioning (waterpoint mapping (WPM) surveys). These issues will be discussed in more detail later in this section.

Water infrastructure

The Ministry of Water and Irrigation (MoWI) also produces data on access to clean and safe water. However, these estimates are based on data on infrastructure (urban household connections, urban public standpipes and rural waterpoints) and assumptions on how many households access water from this infrastructure. The resulting estimates are sensitive to assumptions on functionality and use, and are therefore not as reliable as survey data collected from households. The MoWI data can be better used to monitor and evaluate infrastructure, without trying to draw conclusions about household access. The latest routine data on water infrastructure is presented in Table 7.
Table 7: Recent trends in water infrastructure

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Source</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of urban household connections</td>
<td>MoWI / EWURA Utility Database</td>
<td>189,965</td>
<td>248,949</td>
<td>274,221</td>
</tr>
<tr>
<td>Number of operational urban kiosks</td>
<td>MoWI / EWURA Utility Database</td>
<td>1,446</td>
<td>1,587</td>
<td></td>
</tr>
<tr>
<td>Number of functioning public rural</td>
<td>MoWI</td>
<td>31,396</td>
<td>36,324</td>
<td></td>
</tr>
<tr>
<td>waterpoints</td>
<td>WPM (2005-8)</td>
<td>~33,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Functionality rate of public rural</td>
<td>MoWI</td>
<td>75%</td>
<td>82%</td>
<td></td>
</tr>
<tr>
<td>waterpoints</td>
<td>WPM (2005-8)</td>
<td>54%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Urban data is from the utility database of the Energy and Water Utilities Regulatory Authority (EWURA), rural data from NGOs’ waterpoint mapping (WPM) surveys and official routine monitoring data.

The lack of data prior to 2006 makes it difficult to identify trends, but two important findings emerge. First, there has been a recent, rapid increase (45% over 2 years) in the number of household connections in urban areas. This may be a sign that recent investment in the sector may be about to turn around the declining access trend. Second, there is a significant discrepancy between the two sources of data on rural waterpoints, most particularly in terms of functionality. WPM surveys report 54% functionality compared with 82% in the most recent MoWI figures. This is most probably caused by problems with the MoWI figures since routine reporting has been shown to over-report functionality.

Geographical and socio-economic disparities in water access

National level data hides significant geographical disparities. Figure 33 presents the data for rural water supply, both in terms of access and infrastructure. Though the data on infrastructure is incomplete (51 districts), it paints a similar picture to the national access data from the 2002 census (Tanzania Water and Sanitation Network (TAWASANET), 2008). North-central regions and south-eastern regions face major challenges in water access, while the north-west, the Lake zone and south-central Tanzania are relatively well served. The pattern at this level of aggregation shows no association with poverty prevalence in regions or districts (data not shown). Instead, it shows a clear relationship with hydro-geological factors and sparser water resources in dryland areas. In dryland areas of Tanzania women can walk for up to 5 hours to collect one bucket of water.

Figure 33: Water access (2002) and infrastructure (2008), by district
The foregoing observation that no association was found between poverty and water access at regional and district level does not mean that no relationship exists between poverty and water supply. A major gap in access exists between relatively wealthy urban (79%) and poorer rural (45%) areas. Even more striking is the steep gradient in access according to household wealth, particularly in rural Tanzania. Among the poorest rural households, access to safe and clean water is barely above 10% (see Figure 34). Eight percent of rural Tanzanian households collect water from a source more than 6km away from their households (HBS, 2007). Both girls and boys may lose schooling hours or miss school altogether if they have to collect water. Moreover, the heavy loads that women and children must bear in carrying water for long distances on their heads can cause physical damage, and women and girls can risk rape when walking long distances to water sources. The time that women save from not having to walk for long distances for water can be used for other activities, such as looking after their children, farming or other income-generating activities.

**Figure 34: Access to water by residence and poverty status, 2004/5**

These fundamental disparities in water access (by residence and household wealth) appear to override other dimensions of socio-economic vulnerability. The data indicate only very small differences in access between male-headed and female-headed households or households with an orphan when compared to national averages. The likely reason is that these types of households are located within communities that either have or do not have access. However, households with a sick member and those headed by older people (over 60) are both shown to have substantially lower access to clean and safe water than the average household, particularly in urban areas.

**Table 8: Access to improved water supplies, by household type and residence**

<table>
<thead>
<tr>
<th>Type of household</th>
<th>Urban %</th>
<th>Rural %</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>All households</td>
<td>79</td>
<td>45</td>
<td>54</td>
</tr>
<tr>
<td>Female-headed households</td>
<td>78</td>
<td>42</td>
<td>51</td>
</tr>
<tr>
<td>Male-headed households</td>
<td>80</td>
<td>40</td>
<td>50</td>
</tr>
<tr>
<td>Households with an orphan</td>
<td>79</td>
<td>43</td>
<td>53</td>
</tr>
<tr>
<td>Households with a sick member</td>
<td>69</td>
<td>40</td>
<td>46</td>
</tr>
<tr>
<td>Young-headed households</td>
<td>83</td>
<td>42</td>
<td>54</td>
</tr>
<tr>
<td>Adult-headed households</td>
<td>80</td>
<td>41</td>
<td>51</td>
</tr>
<tr>
<td>Old-headed households</td>
<td>76</td>
<td>39</td>
<td>45</td>
</tr>
<tr>
<td>Poorest households</td>
<td>38</td>
<td>13</td>
<td>14</td>
</tr>
<tr>
<td>Poorer households</td>
<td>67</td>
<td>47</td>
<td>48</td>
</tr>
<tr>
<td>Middle households</td>
<td>65</td>
<td>43</td>
<td>45</td>
</tr>
<tr>
<td>Richer households</td>
<td>80</td>
<td>59</td>
<td>65</td>
</tr>
<tr>
<td>Richest households</td>
<td>84</td>
<td>78</td>
<td>83</td>
</tr>
</tbody>
</table>

Source: TAWASANET, 2008, using 2004/5 DHS.

Key definitions

**What constitutes access to clean and safe water?**

**What qualifies as adequate sanitation facilities?**

The Joint Monitoring Programme for Water and Sanitation defines “improved water sources” as a proxy for “clean and safe water”.

This includes piped supplies, protected wells, protected springs, boreholes, bottled water and rainwater, but excludes unprotected springs and wells, vendor carts, tanker trucks and surface water. This is internationally recognised as a reasonably accurate proxy indicator and much easier to monitor than water quality.

Improved sources do not always provide truly clean and safe water. A survey in Same district found that water provided by over a quarter of “improved” waterpoints was unsafe for drinking.

The JMP categorises pit latrines with slab as improved (a squatting slab or platform that is firmly supported, easy to clean and raised above the surrounding ground level). Pit latrines without such slabs are categorised as unimproved and any latrine that is shared is considered unimproved.
A number of small qualitative studies have also shown that more vulnerable households face additional economic and time obstacles to access. Moreover, user financing for water is highly regressive. Looking at expenditure on water by income group (using HBS 2007 data), poorer households pay three times more for water as a proportion of their income (4.5% rather than 1.3%), although this represents a smaller amount in absolute terms (Research and Analysis Working Group (RAWG), 2009). According to different analyses of the same data (e.g. Poverty Monitoring Group 2008; WaterAid Tanzania, 2009), poorer households pay more even in absolute terms, though these studies put a value on water supplied free of charge. The analysis here (from the Poverty and Human Development Report 2009) uses actual expenditure rather than the supposed value of the water. Since poorer households have higher dependency levels, this is likely to mean that children have disproportionately low access to water (see Figure 35).

**Figure 35: Mean expenditure on water per month, by income group**

Source: Poverty and Human Development Report (PHDR) 2009 (RAWG, 2009).

### 4.1.2 Household sanitation

A systematic review of research of interventions to reduce diarrhoeal diseases in developing countries revealed that these illnesses were reduced by 43% through hand-washing with soap (which also requires water supply), by 33% through hygiene promotion, by 36% through adequate sanitation alone, and by 19% through access to a clean and safe water supply on its own (Fewtrall et al., 2005). International analysis further demonstrates that for every $1 spent on water supply and sanitation, there will be a $11.5 benefit in terms of the time and financial savings, including more time at work, reduced medical costs, less school absence and decreased costs for hospital services (Hutton and Haller, 2004). It is also estimated that every $1,000 spent on hygiene promotion saves 333 Disability Adjusted Life Years (DALYs) compared to 1 DALY saved for the same amount spent on anti-retroviral therapy and 91 saved by Vitamin A programmes (WaterAid, 2008).

**Access to latrines**

The *Mtulizi Afya* campaign of the 1970s, spearheaded with leadership from President Nyerere, was hugely successful at persuading households to construct basic latrines. Large numbers of latrines were rapidly built and the culture of latrine construction became well entrenched across most of the country. According to the HBS 2007 survey data, 90% of rural households and 98% of urban households have access to at least a basic latrine (see Figure 36).
However, recent household surveys do not provide particularly useful data on household sanitation, since the vast majority of households report having access to a “traditional pit latrine”, with no information on whether this latrine is “improved” or “unimproved”.

The clearest conclusion we can draw is that most households have access to some sort of latrine, the vast majority of these being pit latrines. The trends suggest modest improvement in sanitation in urban areas, but no consistent trend in rural Tanzania. The Joint Monitoring Programme’s reports have estimated that 33% of households have access to improved latrines (31% urban, 34% rural), though these figures are based on untested assumptions (WHO and UNICEF, 2008). A UNICEF 2009 baseline survey in 13 districts and 5,251 households suggests that these figures may be too high. Preliminary data found that only 22% of pit latrines had a cement slab and only 4% had a vent pipe.

**Figure 36: Household latrine coverage, 2002-2007**

![Figure 36: Household latrine coverage, 2002-2007](source: WaterAid Tanzania, 2009.)

**Disparities in latrine coverage**

Figure 37 illustrates major variations in latrine coverage (any latrine) between districts (TAWASANET, 2008, using 2002 census data). In six districts (largely pastoralist areas), over 50% of rural households reported not using any toilet facility, compared to the national average of 11%. No district-level survey data since 2002 is available, so analysis of trends is not possible.

**Figure 37: Rural households not using any toilet facility, 2002**

![Figure 37: Rural households not using any toilet facility, 2002](source: TAWASANET, 2008 using 2002 Census data.)
Data presented in Figure 38 shows a clear link between household wealth and basic latrine coverage (when considering both improved and unimproved latrines together). Almost one-third (32%) of the poorest households had no latrine access, compared to just 1% of the wealthiest households, and 13% of all households. Vulnerability in access to sanitation is clearly concentrated among the rural poor.

**Figure 38: Latrine access by household wealth, 2004/5**


### 4.1.3 Water, sanitation and hygiene for vulnerable groups

Aggregate figures can obscure the hardship faced by specific vulnerable groups such as the chronically ill, people with disabilities and street children.

**People living with HIV and AIDS**

PLWHA have increased need for clean and safe water to maintain higher standards of cleanliness to reduce the risk of opportunistic infections. However, a recent study found that the standard of latrines used by PLWHA was very poor. Perhaps even more worrying was the finding that care and support programmes for PLWHA had only minor water, sanitation and hygiene components. This is a significant weakness in interventions given the link between hygiene and vulnerability to infection (WaterAid and AMREF, 2009).

**Children with disabilities**

Participatory research into access to water and sanitation services for the disabled in Tanzania found that distance to water source and the cost of accessing water were major obstacles. In the case of sanitation, latrine access was a difficult challenge, with unhygienic latrines presenting an even greater risk to the physically disabled than the able-bodied (WaterAid Tanzania, unpublished).

Challenges facing disabled children in accessing school water and sanitation include poor drainage, inappropriate design, rough landscape and a lack of accessibility features (SHIVYAWATA et al., 2009). In Kahama, only 3 out of 255 schools have latrines with suitable access for disabled pupils (SNV, WaterAid and UNICEF, 2009).

In the case of people with albinism, social obstacles seem paramount. These happen when other community members refuse to collect water after a person with albinism, forcing him or her to wait until everyone else has collected their water (WaterAid Tanzania, unpublished).
The state of school latrines and hand washing

In Kahama district in 2009, only two schools met the national “minimum” standard of 20 girls and 25 boys per latrine – both were private schools and not likely to be attended by the children of the poor.

Just under 40% of schools had 50-99 pupils per latrine and just over 20% had 100-149.

Nine schools had no latrines and a further 23 had less than one latrine for every 200 pupils.

The standard of the latrines was reported to be reasonably good; the vast majority of facilities were ventilated improved pits or pit latrines with slabs, and most were constructed of cement.

But only just over half were said to provide adequate privacy (indicated by whether the facility had a door).

A tiny number had other facilities such as soap (two schools), anal cleansing materials (four schools) or functional hand washing facilities (three schools).

Only one of the schools with any of these additional facilities was a government school.

However, all three of the schools reported to have adequate latrine access for disabled pupils were government schools.

Children living on the streets

There is little Tanzania-specific information on water, sanitation and hygiene for children living on the streets, but an international study identified challenges commonly faced by those on the street, including finding a place to defecate, obtaining privacy and undertaking personal hygiene (Joshi, 2007). In a multi-country case study, menstruating girls had nowhere to wash and clean their ‘sanitary’ cloths and were unable to afford manufactured sanitary pads. They therefore would pick up cloths from the street, use them once and throw them away. Where to wash clothes is also a problem, particularly if the person only has one set of clothes. Hostels can provide access to some WASH services, but the standards vary. Where there are public toilets, the charges for using them may be too expensive for people on the street to use on a regular basis. The only alternatives are defecating in the open including in open drains. For women this poses additional challenges as they may have to delay urination / defecation until nightfall.

4.1.4 Water, sanitation and hygiene in schools

School latrines

The issue of standards for school WASH is currently promoting debate. MoEVT’s minimum educational standards for primary schools specify one drop hole per 20 girls and one per 25 boys, plus urinals. Options under discussion in the sector include a phased or interim standard for pupil-latrine ratios, or a stepped approach with a ratio for the first 100 students rising to a larger number thereafter. Other discussions are looking at developing more cost-effective facilities and aiming to provide better guidance to schools and local government on the institutional management and governance of school WASH. The needs of the disabled and menstruating girls are also being included in sector discussions.

Figure 39 presents data on pupil-latrine ratios since 2003, with the two most recent years disaggregated by sex (MoEVT, 2008a). The data show a positive trend, though with little progress over the two-year period from 2006 to 2008. Given past trends in coverage, it is no wonder that the MKUKUTA I target that every school would have adequate sanitary facilities (as per MoEVT’s minimum standards) by 2010 was not achieved.

The rapid increase in primary school enrolment and the high cost of providing school WASH, particularly the water and sanitation elements, have posed a major challenge for Tanzania.

Figure 39: School latrine coverage trends and targets

Source: Routine monitoring data, MoEVT (2008a).
The increased enrolment between the years of 2002 to 2006 of an additional six million pupils translates to a requirement for an additional 240,000 latrines using the MoEVT minimum standards. Thus the latrine-pupil ratio has been held back by the dramatic increase in pupils rather than a failure to build latrines, as is seen in Bagamoyo district (see Figure 40) (SNV et al., 2009).

Figure 40: School pit latrines by year of construction, Bagamoyo district

Source: School WASH Mapping (SNV et al., 2009).

Geographical disparities in school sanitation
Analysis of the most recent MoEVT data on school sanitation shows major variations between pupil-latrine ratios across districts (MoEVT, 2008a). Ten districts have an overall ratio of over 100 pupils per drop hole (Lindi rural, Bariadi, Temeke, Kinondoni, Muleba, Illemela, Meatu, Kigoma Urban, Bukombe and Kishapu), whereas two have an average of less than 30 pupils per latrine (Tanga Urban and Nkasi). The data does not reveal any clear regional trends, except that Dar es Salaam’s crowded schools face a particular challenge. Urban schools face additional challenges. Those that are connected to the piped water network may have their water supply cut off for non-payment of water bills. The land area that they occupy may not be adequate for the required number of latrines and other WASH infrastructure. In Temeke, a district in Dar es Salaam with the largest number of cases of cholera per year, some schools have over 7,000 pupils. High population density, and poor water and sanitation infrastructure pose a greater risk for school children in the poorest urban areas.

Sanitary needs for adolescent girls
Menstruating girls have additional sanitary needs in the school environment. They must have an adequate number of private facilities, clean water, affordable sanitary materials, supportive teachers and fellow pupils, and access to reliable information on puberty. A lack of any of these components can mean ineffective participation in class, school days lost each month or even dropping out of school altogether.

There is little quantitative data on this challenge in Tanzania, but recent qualitative work has focused on the relationship between menstruation and schooling in Kilimanjaro region (Sommer, 2009). Findings re-emphasised the importance of structural aspects of the school environment, particularly improved latrines with water supply. Girls found existing facilities in many schools to be very inadequate. Improving such facilities would go a long way towards making schools more girl-friendly. It was also found that girls themselves put a lot of attention on the challenges accompanying menstruation such as the cost of pads and the discomfort of cramps.
4.1.5 Water, sanitation and hygiene in health facilities

The water supply situation at health facilities is alarming. Almost two-thirds of all health facilities lack a regular water supply – a shocking statistic given the critical role of clean water and hygiene in infection control. In hospitals, the main challenge is the reliability of water sources: 96% of hospitals have safe on-site water sources, but only 42% have year-round supply. Reliability of supply also affects lower-level health facilities with on-site water sources. But the greater problem is that a third of health centres and almost half of all dispensaries have no safe on-site water supply at all (Table 9).

Table 9: Availability of WASH at health facilities in percentages

<table>
<thead>
<tr>
<th>Service</th>
<th>Hospital</th>
<th>Health centre</th>
<th>Dispensary</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client latrine</td>
<td>71</td>
<td>67</td>
<td>62</td>
<td>63</td>
</tr>
<tr>
<td>Any safe on-site water</td>
<td>96</td>
<td>67</td>
<td>53</td>
<td>56</td>
</tr>
<tr>
<td>(within 500m, improved source)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Regular water supply</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(safe, on-site, year-round)</td>
<td>42</td>
<td>41</td>
<td>33</td>
<td>34</td>
</tr>
</tbody>
</table>


Over one-third of all health facilities and nearly 30% of hospitals were found to have no client latrine facilities. This is a serious problem considering the long waiting times endured by women and their children. In addition to the discomfort and indignity inflicted on clients, the inadequacy of WASH at health facilities presents a clear and present danger for disease transmission and nosocomial infection due to inadequate health worker hygiene. The situation of WASH at health facilities should be an urgent priority within the infrastructure investment under the Primary Health Services Development Strategy (MMAM).

4.1.6 Health outcomes

Cholera

Analysis of cholera trends by year shows an irregular cyclical pattern with peaks in 1997, 2002, 2004 and 2006 (largely accounted for by outbreaks in Arusha, Mtwara, Mbeya and Dar es Salaam respectively) (see Figure 41). This pattern is in line with regional trends since the start of the seventh worldwide cholera pandemic; with a general increase in cases and a reduction in interval between the peaks (Oxfam GB, 2008). The reappearance of cholera represents a major threat to public health, particularly in urban areas when heavy rainfall results in overflowing effluent and widespread environmental contamination.

Figure 41: Cholera in Tanzania

Table 10 provides data on cumulative reported cholera cases for each region between 1999 and 2008, ordered by the number of (notified) cases per capita. It should be noted that only around 20% of people affected by cholera show the symptoms and not all who have the symptoms will visit a health facility. The five coastal regions are among the top eight regions by number of cases per capita. Coastal areas are known to be at risk due to the cholera vibrio’s preference for brackish or mildly saline waters. Communities dwelling along lake shores are also at elevated risk. The absence of a clear association (data not shown) between cholera incidence across regions and water and sanitation access is not surprising given that cholera outbreaks are usually highly localised, affecting those most at risk only in that immediate vicinity. Nonetheless, over-crowding, poverty, water supply, sanitation infrastructure and behavioural practices all play an important role in mediating the resilience of communities in the event of an outbreak. Infants who are exclusively breastfed are at much reduced risk of cholera since they are not ingesting contaminated fluids. As adults are as likely as children to be affected by cholera, one of the impacts of the disease is the death or severe illness of caregivers and income earners with direct repercussions for the welfare of dependent children.

Table 10: Cumulative reported cholera cases and deaths by region, 1999-2008

<table>
<thead>
<tr>
<th>Regions</th>
<th>Cases</th>
<th>Deaths</th>
<th>Case fatality rate %</th>
<th>Cases/1 million population/year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dar es Salaam</td>
<td>16,313</td>
<td>172</td>
<td>1.1</td>
<td>656</td>
</tr>
<tr>
<td>Lindi</td>
<td>3,827</td>
<td>133</td>
<td>3.5</td>
<td>486</td>
</tr>
<tr>
<td>Arusha</td>
<td>5,820</td>
<td>110</td>
<td>1.9</td>
<td>452</td>
</tr>
<tr>
<td>Mtwara</td>
<td>4,576</td>
<td>80</td>
<td>1.7</td>
<td>407</td>
</tr>
<tr>
<td>Tanga</td>
<td>4,845</td>
<td>220</td>
<td>4.5</td>
<td>296</td>
</tr>
<tr>
<td>Kigoma</td>
<td>4,639</td>
<td>105</td>
<td>2.3</td>
<td>277</td>
</tr>
<tr>
<td>Ruvuma</td>
<td>2,851</td>
<td>143</td>
<td>5.0</td>
<td>256</td>
</tr>
<tr>
<td>Pwani</td>
<td>1,915</td>
<td>86</td>
<td>4.5</td>
<td>216</td>
</tr>
<tr>
<td>Rukwa</td>
<td>2,419</td>
<td>159</td>
<td>6.6</td>
<td>213</td>
</tr>
<tr>
<td>Mbeya</td>
<td>4,079</td>
<td>193</td>
<td>4.7</td>
<td>198</td>
</tr>
<tr>
<td>Morogoro</td>
<td>3,226</td>
<td>124</td>
<td>3.8</td>
<td>184</td>
</tr>
<tr>
<td>Dodoma</td>
<td>3,076</td>
<td>132</td>
<td>4.3</td>
<td>182</td>
</tr>
<tr>
<td>Singida</td>
<td>1,955</td>
<td>88</td>
<td>4.5</td>
<td>180</td>
</tr>
<tr>
<td>Manyara</td>
<td>1,634</td>
<td>19</td>
<td>1.2</td>
<td>157</td>
</tr>
<tr>
<td>Kilimanjaro</td>
<td>1,503</td>
<td>57</td>
<td>3.8</td>
<td>109</td>
</tr>
<tr>
<td>Shinyanga</td>
<td>1,398</td>
<td>60</td>
<td>4.3</td>
<td>50</td>
</tr>
<tr>
<td>Mara</td>
<td>653</td>
<td>36</td>
<td>5.5</td>
<td>48</td>
</tr>
<tr>
<td>Iringa</td>
<td>531</td>
<td>31</td>
<td>5.8</td>
<td>36</td>
</tr>
<tr>
<td>Mwanza</td>
<td>382</td>
<td>26</td>
<td>6.8</td>
<td>13</td>
</tr>
<tr>
<td>Tabora</td>
<td>159</td>
<td>11</td>
<td>6.9</td>
<td>9</td>
</tr>
<tr>
<td>Kagera</td>
<td>77</td>
<td>11</td>
<td>14.3</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>65,878</strong></td>
<td><strong>1,996</strong></td>
<td><strong>3.0</strong></td>
<td><strong>197</strong></td>
</tr>
</tbody>
</table>

Source: Data provided by MoHSW, Epidemiology Section.

**Childhood diarrhoea**

In TDHS 2004/5, more than 10% of under-fives had suffered a bout of diarrhoea in the two weeks prior to the survey. As noted earlier, the incidence of diarrhoea is almost unchanged since 1996, and preliminary results from the TDHS 2009/10 even show a 50% increase in the proportion of children under five years who reported having diarrhoea in the two weeks preceding the survey – although the data should be viewed with caution as diarrhoea can be seasonal and the timing of a survey can thus affect its findings. Diarrhoea in young children
may be life-threatening as severe dehydration can occur very quickly. Children between the age of 6 and 23 months are at greatest risk. Exposure to contaminated food and liquids when breastfeeding ends and the increased mobility of children both probably contribute to higher diarrhea incidence in this age group. No significant correlations can be found in the TDHS survey data between diarrhea and source of drinking water, mother’s education or sex of child. However, urban children suffer less diarrhea than their rural counterparts.

Figure 42: Diarrhoea in children under five years, in percentages

4.2 Promotion of hygienic practices

4.2.1 Hand washing

None of the major household surveys in Tanzania has included questions on hand washing practices. This is a surprising omission considering that hand-washing at critical times has been shown to reduce the risk of diarrhoeal diseases by 42-47% (Curtis and Cairncross, 2003). Figure 43 presents data from two smaller surveys on hand-washing practices at four critical times: after using a toilet, before preparing meals, before eating or feeding a child, and after attending a child who has defecated. The 2006 survey covered 90 households for the World Bank’s Water and Sanitation Programme (WSP, 2006) and the 2009 UNICEF baseline covered over 5,000 households (UNICEF, 2009c). In both surveys, hand-washing after attending a defecated child and before preparing meals were clearly the weakest points, while nearly a third reported that they did not wash their hands before eating or feeding a child. The UNICEF study also found that less than 40% of respondents reported washing their hands after using the toilet. There is some evidence from Kenya that economic obstacles are undermining good hygiene practices. In households that benefit from cash transfers, children were more likely to have soap at home (HelpAge et al., 2008).
4.2.2 Disposal of children’s stools

Stools that are contained in latrines or disposed of in nappies are considered safely disposed, whereas those that are thrown outside the dwelling or yard or rinsed away are considered unsafely disposed. Nearly a quarter of disposal of children’s stools reported in TDHS 2004/5 was unsafe; with a major gap between urban (6%) and rural (27%) areas. Wealthier households and those with better-educated mothers appear more likely to safely dispose of children’s stools. Lack of even a basic latrine is a significant obstacle, with only 31% of mothers in those households reporting safe disposal of stools (Figure 44).

There is significant regional variation in disposal practices. In seven regions, over 90% of mothers reported safe disposal of stools (Kilimanjaro 99%, Morogoro 93%, Tanga 92%, Dar 96%, Pwani, 91%, Lindi 97% and Mtwara 96%), while in five others the figure was below 60% (Arusha 58%, Tabora 53%, Kagera 58%, Mwanza 56% and Mara 54%).

Source: TDHS 2004/5.
4.3 Key policies and institutions

4.3.1 Water

Several major developments have taken place in the policy environment since 2001. This includes a new National Water Policy (NAWAPO) in 2002, a National Water Sector Development Strategy (NWSDS) in 2006 and new water legislation in 2009. This reform process culminated in the launch of the Water Sector Development Programme in March 2007 (MoWI, 2006a). This represents a sector-wide approach, led by MoWI and supported by basket funding from major development partners.

A first key component of these sector reforms has been re-orientating the sector towards a more commercial approach to water supply, particularly in urban areas. Reflecting this, the former Urban Water Supply Department at MoWI has been renamed the Commercial Water Supply and Sewerage Division. Urban Water and Sewerage Authorities (UWSAs), including small town utilities, are to adopt a commercial strategy, working towards full cost recovery. This is reputedly to prepare them for some form of privatisation, though political commitment to this goal is felt to be limited. The vast majority of UWSAs, including Dar es Salaam, continue to receive operational subsidies. An independent regulator, the Energy and Water Utilities Regulatory Authority (EWURA), with the power to regulate prices, has been established as part of the shift to a more commercial approach.

A second component is aligning the sector with Decentralisation by Devolution. Responsibility for investment in rural water supply has now been devolved to local government authorities. UWSAs continue to operate as semi-autonomous bodies with close links to LGAs (particularly small town UWSAs) but are funded through MoWI and accountable primarily to MoWI and EWURA. Thirdly, the National Water Policy and the National Water Sector Development Strategy provide for strengthened community management of rural water supplies. Community Owned Water Supply Organisations (COWSOs) are to be set up, independent of Government, and given responsibility for operations and maintenance (O&M) of water schemes. O&M costs are to be paid for by user fees, collected and managed by the COWSO. Initial capital and major rehabilitation costs are borne by Government. LGAs have responsibility for providing technical and managerial support to COWSOs. And finally, the sector reforms aim to strengthen the historically weak institutions of water resource management. Basin Water Offices (BWOs) are being established in Tanzania’s nine major river basins. After initial investment, the BWOs are expected to become self-financing through the issuance of water rights to industrial, agricultural and domestic water users. With the exception of Pangani and Wami-Ruvu basins, this process remains a long way from completion. Given the likely effects of climate change on water resources, this is a significant weakness.

4.3.2 Sanitation and hygiene

Sanitation and hygiene has long been something of an institutional orphan. The fundamental role of sanitation and hygiene in preventing disease means that MoHSW is the mandated ministry for sanitation and hygiene, but it has been a persistently low profile issue within the both the health and water sectors. MoWI also has a role given the complementarity of sanitation and water supply and the traditional linking of water supply and sewerage in urban utilities. Moreover, donors generally link funding for sanitation and hygiene with water supply funding channelled through MoWI which further confuses institutional responsibility. The result is that there has until recently been no sanitation and hygiene policy, inadequate coordination, no effective monitoring strategy and no clear financing plan.
However, recent developments indicate that this situation could be about to change. Efforts to develop a National Sanitation and Hygiene Policy (NSHP) have recently gained momentum. A draft policy has been distributed for stakeholder consultations at various levels and it is expected that the policy will be approved by MoHSW and by the Technical Committee of Parliament in the first quarter of 2011. This policy is expected to enable the sector to get past several long-standing obstacles. It will introduce common definitions and will be a first step towards increasing budget allocations for the sanitation and hygiene sub-sector. The development and commitment to a Memorandum of Understanding to clarify institutional responsibilities is also expected to improve coordination.

There is a general lack of understanding of what sanitation and hygiene promotion approaches are most effective in the Tanzanian context. Participatory Hygiene and Sanitation Transformation (PHAST) has dominated previous hygiene promotion efforts, though there is no documented evidence of this resulting in comprehensive sustained behaviour change. Community-led Total Sanitation (CLTS) initiatives that have been successful in other countries (such as Bangladesh, Zambia and Sierra Leone) do not appear to always be well suited to the Tanzanian context. CLTS is more relevant where open defecation is more widespread. Other approaches have recently been developed and/or introduced, including social marketing and a range of hybrid approaches. No single approach is known to be definitively superior and the sector currently lacks a communications strategy.

Providing sanitation services in unplanned urban settlements is also not well understood, with a policy-led bias in favour of sewerage over less costly approaches. Cheaper and more efficient options (such as pit emptying services, sludge management and storm drainage) have been given little attention in policy or practice.

By contrast, there are early signs of progress towards a greater prioritisation of school WASH, though this is largely still on the side of technical level government staff, donors and international NGOs. Discussions are ongoing about improving school WASH, including improving dialogue between the various institutions involved. The MoHSW, with the involvement of other ministries and other sector actors, developed in 2008 a draft Strategic Plan for School Sanitation and Hygiene. Efforts are currently underway to gain cross-ministerial and political engagement and commitment.

### 4.3.3 Institutional capacity, monitoring and accountability

#### Institutional capacity

The water sector faces considerable capacity challenges. In rural water supply, COWSOs have been given substantial responsibilities for sustainability, but lack managerial and technical capacities to discharge these roles. At district level, water departments have responsibility for monitoring, regulating and supporting COWSOs, but lack effective tools and experience for their new role, particularly in relation to supporting community management.

The Water Resource Management sub-sector also faces capacity challenges, with institutions being established from a low base. Only two of nine Basin Water Offices are fully functioning. This affects water supply, since COWSOs struggle to obtain legal water rights to protect their sources from pollution and over-extraction by large-scale farmers, mining companies and industry (TAWASANET, 2009).
There are also weaknesses within MoWI itself. The ministry’s new coordinating rather than implementing role requires a different set of skills, with a greater focus on economics, planning and management, and less on engineering. Planning, procurement and reporting processes have so far been unsystematic and of variable quality, though efforts are underway to address this.

With regards to sanitation and hygiene, the confusion of institutional ownership and coordination is currently being worked on. In 2007 a National Steering Committee for Sanitation and Hygiene was formed. A Memorandum of Understanding between the four key Ministries (MoHSW, MoWI, MoEVT, PMO-RALG) has been developed and signed to clarify institutional roles and strengthen coordination further. However, sanitation and hygiene faces major capacity shortfalls. For example, for 2007-8 and 2008-9, all LGAs were allocated up to $20,000 per year for sanitation and hygiene promotion under the WSDP, though LGAs needed additional guidance as to how to use these funds effectively.

**Monitoring**

The water sector has long been plagued by poor quality of data. Survey data on access to water supply has improved, with now much more consistency in survey tools and indicator definitions, in line with international best practice. Routine monitoring presents a greater challenge, particularly for rural water supply. Several overly complex and incompatible databases of rural water supply infrastructure have been developed and (partially) implemented. In response, MoWI recently initiated the development of a new, simplified rural water supply monitoring system, the development of which is in process. Data on urban utility performance is collected regularly by EWURA and routinely shared with MoWI. This works reasonably well though needs adapting to make it suitable for small town utilities.

Performance monitoring for sanitation and hygiene has in the past been very weak. As already noted, survey instruments have not distinguished between improved and unimproved latrines and definitions have not been standardised. Surveys have also not included questions on key hygiene practices such as hand washing at critical times. The development of a National Hygiene and Sanitation Policy is expected to help improve this situation, by putting in place approved definitions, drawing on international best practice, and clearly stating which indicators will be targeted and monitored.

**Accountability**

Sector reforms such as decentralisation and the introduction of an independent regulator present some opportunities to increase voice and accountability, though EWURA is currently struggling to fulfil its considerable potential and will need further support. The voices of women, children and other marginalised groups are rarely heard in key sector decision-making bodies, but women’s representation in community-level water committees has improved over the last ten years (House, 2005; MoWI, 2006b; TAWASANET, 2008).

In rural areas, there is evidence that more vocal and powerful communities are prioritised for new investment, and there are significant obstacles to effective accountability in local government as regards water supply (Taylor, 2009; Tam, 2008a). This includes multiple and confusing planning procedures and a lack of transparency on available funding, planning and budgeting decisions.
In urban areas, the regulator, EWURA, has instituted a Consumer Consultative Council (CCC) to hear consumers' voices in the regulatory process. This CCC offers potential as a mechanism for consumer advocacy, although it is undermined by low representation of marginalised groups. Its actual influence on decision-making is also questionable, as it has the power only to give recommendations, not make decisions (Tam, 2008b).

4.4 Fiscal space

4.4.1 Water

The WSDP, which started in fiscal year 2007/8, represents a major shift in financing for investment in water supply. It has almost doubled the resources available for investment. It has brought about more geographical equity in budgeting, with funds now allocated to all districts for rural water supply investment on a formula basis rather than targeted at a few projects as had previously been the case. If continued to 2015, the pace of investment would meet WaterAid’s 2005 estimate of the funding required to meet the MDG for water supply (WaterAid Tanzania, 2005). The largest single contributor is the Government of Tanzania, with additional support from some major donors for the first five-year phase of the WSDP (MoWI, 2006a).

Figure 45: Water sector budgets, 2001-2009

Source: RAWG (2009), based on data from budget books (Vote 49). Note: The spike in the water sector budget 2007/8 reflects the start of the WSDP. The drop in 2008/09 was the Ministry of Finance’s response to a considerable under-spending of funds in 2007/8. Requests from the Ministry of Water and Irrigation as well as donors, in conjunction with a better utilisation rate of funds in 2008/9, led to the budget being increased again in 2009/10.

Figure 46: Budget allocations to rural water supply, 2005/6 and 2008/9

However, recent analysis has shown that the current levels of funding under the water SWAp, presently the largest water SWAp in sub-Saharan Africa, do not keep pace with population growth even without considering the high rate of breakdown in water supply infrastructure. Hence, access levels are likely to continue to decrease (Taylor, forthcoming).

The shift from a project-funding approach to basket funding under a sector-wide approach has not been straightforward. MoWI is adjusting to its new role as coordinator and enabler rather than implementer. Funding is now being channelled to LGAs and utilities that had received almost no investment funding for many years and therefore have limited capacity to absorb new funds. And there is a recognised accountability risk, with significant funding now being made available with less direct oversight by donors. A key gap in the current implementation of the WSDP is the limited focus on sustainability, which risks reducing the benefit of the programme and of existing facilities through breakdown and disrepair. At present the major development partners see these challenges largely as growing pains; a necessary process through which the sector must pass if sustainable capacity is to be developed. However, there is a danger that if monitoring and reporting do not improve, or if results are not delivered, that key donors may lose faith and discontinue funding or return to a project approach. This would be a major step backwards.

### 4.4.2 Sanitation and hygiene

Financing for sanitation and hygiene promotion is currently a confused situation. Responsibilities are split between the ministries responsible for health, water, education and local government, resulting in numerous, uncoordinated funding channels. Sanitation and hygiene are included within the WSDP, but as little more than token allocations, largely for urban sewerage. Roughly one percent of the total WSDP budget is expected to be spent on sanitation and hygiene, three-quarters of which is for sewerage systems that will serve wealthy communities in a few towns. A very small amount has so far been allocated to rural sanitation, which is not earmarked and therefore easily reallocated. Preventive health funds within the Health Sector Basket Fund can be used for sanitation and hygiene promotion, and education sector development funds can also be spent on school latrines – but there is no national coordination between these different mechanisms.

Given the fragmentation between several ministries and local government, analysing budgets and expenditure is almost impossible, and there is very little data available. A WaterAid paper (Taylor, 2008) estimated annual public sector budget allocations for sanitation and hygiene promotion at around $8m, the majority of which was allocated for urban sewerage. This is well below the $127m annual requirement estimated by the Tanzania Country Sanitation Review (WSP, 2008) and the 0.5% of GDP (approximately $70 million) per annum recommended in the 2008 AfricaSan conference. The very low level of public investment in sanitation and hygiene stands in stark contrast to figures showing the very high economic and health return on investments. In the World Bank’s Disease Control Priorities in Developing Countries (2009), hygiene promotion stands out as by far the most cost-effective intervention (Figure 47) (WaterAid, 2008).

Part of the challenge for sanitation and hygiene is that the results are not as tangible as those of water supply. As a result, political will and finance are to a greater extent directed to water compared to sanitation and hygiene. Because sanitation practice in Mainland Tanzania, in line with international good practice, is for no subsidy to be given for household latrines it is largely
forgotten in budget allocation. Little has been done in the area of small-scale credit for sanitation services, or in developing income-generating opportunities for community groups from WASH interventions. For example, public latrines could be financially self-sustaining, providing both a public service and an income-generating opportunity. This is in spite of the need for significant, sustained and effective promotion of improved latrines and good hygiene practice.

**Figure 47: Cost-effectiveness of sanitation and hygiene promotion compared with other health interventions**


4.4.3 The political prioritisation of water, sanitation and hygiene

The benefits of water and sanitation projects are manifest in reduced medical costs, time saved and deaths avoided (Hutton and Haller, 2004). Table 11 shows estimated returns on WASH investment in East Africa. The cost to Tanzania of not improving its water, hygiene and sanitation is much higher than the cost of doing so.

**Table 11: Economic return on investment in WASH in East Africa**

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Economic return on US $1 spent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Halving the proportion of people without access to sanitation</td>
<td>11.50</td>
</tr>
<tr>
<td>Halving the proportion of people without access to improved water sources and sanitation</td>
<td>12.54</td>
</tr>
<tr>
<td>Everyone has access to improved water and improved sanitation services</td>
<td>11.71</td>
</tr>
<tr>
<td>Everyone has access to improved water and improved sanitation services, plus everyone has a minimum of water disinfected at the point of use</td>
<td>15.02</td>
</tr>
<tr>
<td>Everyone has access to a regulated piped water supply and sewage connection in their houses</td>
<td>4.84</td>
</tr>
</tbody>
</table>

Yet limited attention is given to WASH within the Tanzanian Parliament, the media and civil society. For example, only a single question was asked in parliament during the aborted privatisation of Dar es Salaam’s water supply, with very little civil society engagement and inconsistent media coverage which tended to support privatisation at the outset and nationalisation at the end (WaterAid Tanzania, 2008).

This contrasts starkly with the repeatedly high prioritisation given to water and sanitation by Tanzanian citizens. In the 2005 and 2008 Afrobarometer public opinion surveys more rural Tanzanians ranked water supply among the top three issues for Government to address than for any other issue (see Figure 48).

**Figure 48: Priority issues for rural Tanzanians**

<table>
<thead>
<tr>
<th>% of rural citizens identifying selected issues among top 3 priorities for Government to address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Water supply</td>
</tr>
<tr>
<td>Health</td>
</tr>
<tr>
<td>Infrastructure / roads</td>
</tr>
<tr>
<td>Agriculture / food</td>
</tr>
<tr>
<td>Economy / employment</td>
</tr>
<tr>
<td>Poverty</td>
</tr>
<tr>
<td>Education</td>
</tr>
<tr>
<td>Electricity</td>
</tr>
<tr>
<td>Corruption</td>
</tr>
<tr>
<td>AIDS</td>
</tr>
</tbody>
</table>

Source: Afrobarometer, 2008.

In the same 2008 survey, public satisfaction at government efforts to deliver water and sanitation services was lower than other social service sectors in both rural and urban areas (Figure 49).

**Figure 49: Citizens’ satisfaction with Government efforts in key sectors**

<table>
<thead>
<tr>
<th>100%</th>
<th>75%</th>
<th>50%</th>
<th>25%</th>
<th>0%</th>
</tr>
</thead>
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<tr>
<td>Education</td>
<td>85%</td>
<td>78%</td>
<td>70%</td>
<td>63%</td>
</tr>
<tr>
<td>Health</td>
<td>70%</td>
<td>63%</td>
<td>80%</td>
<td>83%</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>80%</td>
<td>83%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Water and Sanitation</td>
<td>46%</td>
<td>45%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Afrobarometer, 2008.

There are signs that this mismatch between citizens’ priorities and political attention is changing. Parliamentary debates during 2008 included several references to water and sanitation challenges and the media has recently started giving sanitation more attention, particularly school sanitation.

Beginning in late 2007, national civil society has also been playing a much stronger role in national policy debates since the formation of the Tanzania Water and Sanitation Network. This was particularly evident at the 2008 Joint Water Sector Review, where much of TAWASANET’s analysis...
and recommendations was incorporated into the review’s statement of annual undertakings for the sector. Though TAWASANET’s capacity for policy analysis and advocacy is weak, they have the potential to develop into a major player in policy debates. The emergence of TAWASANET, other CSO networks and civil society more generally presents an opportunity to bring a wider range of actors with an interest in pro-poor reform into policy debates.

4.5 Priority areas and recommendations

4.5.1 Water supply

The water sector has undergone major policy, institutional and finance reforms in the past few years. This progress has yet to produce clear results. Survey data from 2005 predated recent investments which have resulted in a documented increase in water infrastructure. This provides grounds for optimism that the TDHS 2009/10 will demonstrate improved water outcomes, although even the new funding coming into the sector is unlikely to be enough to keep pace with population growth.

Adjusting to new institutional roles and responsibilities, while absorbing a steep increase in funding, presents major challenges. At ministry level, planning, budgeting, coordination, procurement and monitoring systems are all struggling to cope under the weight of reform. The attention of key actors both in Government and donor agencies is understandably taken up with resolving these challenges. One unfortunate result is that a number of important issues have not been given the attention they require. Sustainability of rural water supplies is not prioritised, with the effect that a quarter of all rural water points stop functioning in the first two years after installation. In the rush to spend new money, sustainability may well even decline. Equity concerns have been sidelined. Access to water supply is much lower in poorer than wealthier households, investment continues to flow to communities with relatively good existing access rather than to those without and little serious attention has been given to understanding or addressing the particular needs of vulnerable social groups. Transparency and accountability has improved greatly but still leaves a lot to be desired. And niche areas of the sector have slipped through the gaps, such as water supply in small towns and for schools and health facilities.

Water supply for the most vulnerable has not been given high priority by MoWI and other national stakeholders. It is generally argued that the priority is to serve as many people as possible before turning to more vulnerable groups. According to policy, the most vulnerable are entitled to free water, though there is no guidance on how to operationalise this and very little implementation. Some vulnerable people, particularly in rural areas, are provided with free water at the discretion of the COWSO and Water Committees, but such measures are ad hoc and susceptible to abuse.

The shift in both urban and rural areas towards user fees and cost recovery has implications for the poor. Though there is strong evidence from Tanzania and elsewhere that this approach leads to greater sustainability, it can also create obstacles to access for those who cannot afford to pay. In urban areas, however, the bigger obstacle for poorer households is network access, since the unit cost of water is much higher through vendors than metered connection. Subsidised connections are being used to help address this, particularly in Dar es Salaam, though this can only provide assistance to those within easy reach of existing infrastructure, usually the middle classes rather than the poor. Public water kiosks offer more potential for serving the poor, although a balance needs to be struck between providing a service to the poor and profitability, otherwise utilities have little incentive to make kiosks work.

A more positive interpretation is that these are longstanding challenges that had previously been hidden by the multitude of different approaches and projects at play in the sector. Only now that a sector-wide approach has been adopted and meaningful levels of finance are flowing does it...
make sense to talk about equity across districts; or to think systematically about sustainability and vulnerability at any level higher than an individual project. For that matter, even the problems with sector capacity and systems can be seen as the legacy of decades of piecemeal projects and underfunding.

Whether the sector reforms are responsible for these challenges or just for revealing them, the reformed coordination and dialogue mechanism provides the best chance of finding solutions. This provides a major opportunity to get issues of sustainability, equity, vulnerability and accountability onto the agenda and to find sector-wide solutions. The recent decision to develop a new rural water supply infrastructure monitoring system that replaces the previous array of incompatible systems is an example of what can be achieved through taking a sector-wide approach.

4.5.2 Sanitation and hygiene
Sanitation and hygiene has not progressed as far as water supply. This is partly because the issues cut across the health, water and education sectors, and have tended to be sidelined in each of the respective ministries. It is also because the impacts of poor water supply are more visible than poor sanitation and hygiene, and because water infrastructure often involves a substantial outside financial contribution, whereas sanitation and hygiene infrastructure is financed by households.

There are shocking gaps in WASH in schools – including upkeep and maintenance of school latrines and almost non-existent hand washing – and health facilities. Both of these gaps have significant implications for the health and well-being of women and children in Tanzania.

Recent steps to improve sector coordination show some promise. A National Sanitation and Hygiene Policy and a Strategic Plan for School Sanitation and Hygiene are both in development, vital first steps towards addressing the chronic under-funding of the sector. Considering the cost effectiveness of sanitation and hygiene promotion and their centrality in reducing the burden of disease, much greater investment is warranted. The key challenge now is to maintain the momentum of reform.

The following priority areas for improving water, sanitation and hygiene have emerged from the analysis. As in previous chapters, they are categorised into technical, institutional and policy areas. National progress in access to clean water, adequate sanitation and hygiene, and the adoption of safe hygiene practices will require high level political commitment. It will also require flexibility and willingness on the part of key ministries to work in partnership with development actors. The central importance of water, sanitation and hygiene to the lives, health and dignity of all Tanzanians needs to be acknowledged and acted upon. Without improvements in water and sanitation coverage and greater awareness of the importance of hygiene, the growth and development in Tanzania will be significantly hindered.

Technical
- Address the issue of sustainability of water supply by allocating sufficient resources from the WSDP to establish strong operation and maintenance systems including long-term back-up support to communities.
- Ensure that in each village with a WSDP-financed project, water supply is provided to schools and health facilities.
- Conduct a study of WASH services and hygiene practices in health facilities across Tanzania. Assess different hygiene promotion approaches used in Tanzania to better inform national interventions,
including the design of an effective evidence-based communications for development framework. Communication channels must be identified to ensure that the poorest women, who often have lower literacy and less access to the media, can receive life-saving information on water, sanitation and hygiene.

- Develop best practice guidance for institutional WASH, covering child-friendly hygiene promotion in schools, operations and management of WASH facilities, and appropriate design of WASH facilities that meet the needs of disabled people and menstruating girls.

**Institutional**

- Operationalise the Memorandum of Understanding for coordination of Sanitation and Hygiene in Tanzania between the four key ministries with responsibilities for sanitation and hygiene—MoHSW, MoEVT, MoWI and PMO-RALG—and establish the new structure for working groups for household sanitation and hygiene and school WASH as soon as possible.

- Finalise the current draft Strategic Plan for School WASH, with the involvement and commitment of the four key ministries. Establish a school WASH programme with clearly defined funding mechanisms.

- Strengthen the capacity of the Environmental Health and Sanitation Section of MoHSW to enable it to provide national leadership on sanitation and hygiene.

- Strengthen the monitoring framework for water, sanitation and hygiene, including standardisation of indicators across all national surveys and collection of data on hand-washing.

- Increase the capacity of Water Resource Management institutions.

- Strengthen TAWASANET to advocate for the needs and priorities of the vulnerable in policy discussions.

**Policy**

- Finalise and approve the National Sanitation and Hygiene Policy as soon as possible.

- Increase budget allocations to sanitation and hygiene to 0.5% of GDP, in line with the AfricaSan target. Current financial allocations do not keep pace with population growth. If sustainability challenges are not addressed access to water will continue to deteriorate particularly in rural areas. Water, health and education SWAps should be required to spend a minimum percentage of their funds on sanitation and hygiene across Tanzania, via increased financial allocations from the WSDP, PEDP II, SEDP, and funding from the Health Sector Strategic Plan (HSSP III) should be increased for this cross-cutting issue.

- Construction of new school classrooms should be matched by new latrines, hand-washing facilities, improvement of water supply at schools, and effective operation and maintenance routines. Existing and new facilities should be inspected to ensure they meet national standards.

- Similar efforts should be made to ensure that all health facilities have sufficient latrines and hand-washing facilities (including soap) for staff and patients, and that these are kept clean and well maintained.

- Expand access to information on budgets and performance to enhance accountability in the sector.

- Develop strategies to ensure that the WASH needs of the poorest and most vulnerable can be met, including the design of latrines in schools, health facilities and public places that are accessible to people with disabilities. In urban areas this includes considering the option of subsidies for public water kiosks as well as pit latrine emptying systems.
Education

Whilst the education of children has been formalised via the school system, humans learn throughout their lives, adapting their physical, cognitive and emotional responses and abilities to an increasingly complex environment as they age. The purpose of the school system is to develop a strong foundation through which a child can learn, adapt and operate most effectively in a social world. Figure 50 illustrates the educational needs of children throughout their life course. A balanced educational system encompasses not only formal institutional learning (via the school system) but also the relational form of learning that primarily takes place in the familial or domestic domain. Realising this balance requires that families are enabled to nurture and educate their children and that the formal school system is strengthened to provide the social and technical interventions that children need to thrive and develop.

Tanzania has made significant progress in the education sector in recent years. This has been guided by the Tanzania Development Vision 2025, which accords a high priority to education, and describes it “as a strategic agent for mindset transformation and for the creation of a well educated nation, sufficiently equipped with the knowledge needed to completely solve the development challenges” (URT, 1999).

5.1 Conceptual framework

This chapter examines the education sector as a whole, recognising the importance of the sector-wide approach that now prevails in Tanzania. Key factors that affect learning outcomes are discussed related to the best interests of the child, the school environment and institutional frameworks in education. Importantly, the analysis also looks at the situation of education in Tanzania through the lens of generalised insecurity. Poverty both constrains the ability of households, communities and schools to educate their children and negatively affects the child’s ability to develop their potential and to fully realise their rights. Addressing poverty, therefore, is a critical point of leverage if educational outcomes are to significantly improve.

The best interests of the child

The principle of the best interest of the child places the individual child at the centre of decision-making. School readiness is critical, and teachers have a role to play in assisting a child to overcome limitations that they may bring to school. The child’s physical and cognitive development is affected by their nutritional status in the early years. Family and community perceptions of education can affect a child’s motivation. The mother plays a critical role in preparing the child for school and her own educational background affects her ability to do this (REPOA et al., 2009 and UNICEF, 2009). Support for school provided in the home environment can improve children’s prospects in school and conversely lack of support from the family can limit enrolment, attendance and completion.

Whilst the right to compulsory free education may be universal, in practice the mode of production in many rural Tanzanian communities is still largely agrarian where human labour is the main input. In communities that depend on cattle, children play a crucial role in herding. Many families find it difficult to free children from their daily tasks so that they can attend school and see education as a distraction from the task of sustaining family security. The role of children in the production process can conflict with the requirements of formal schooling. Increasing poverty levels in recent years have exacerbated the demand for child labour, with more pressure brought on children to work in order to support household incomes. HIV and AIDS has also forced new responsibilities on children as heads of households.
Figure 50: The child’s life course - education

**Pregnancy, conception and birth**
- Mothers need education about pregnancy and childbirth, and the basics of child development and newborn care
- Young mothers who become pregnant while still in school need support to continue their studies and to care for their babies

**Adolescence**
- During adolescence, children are greatly influenced by hormonal changes and their search for a sense of identity
- Opportunities are needed to question themselves, adults and the world around them and to seek meaning about human relationships
- Support to develop abstract thinking skills, hypothesis testing and solution testing.
- Opportunities to discuss and develop moral reasoning that transcend their own experience

**Infancy to two years**
- During this stage of life the foundations are laid for physical well-being and future educational achievement
- Children need to receive consistent, loving attachment from caregivers
- Good nutrition is essential for physical and cognitive development.
- Affection and bonding from caregivers develops a child’s frontal cortex and interactions promote language development

**Early childhood**
- A child’s world starts slowly to expand. Play becomes the mechanism through which they develop cognitively and start to understand how their behaviour affects others.
- A safe, consistent and loving presence from parents
- Messages of love, admiration and approval
- Interaction with others and role models with whom to discuss, practice, understand and express feelings. They should not be sat passively receiving didactic teaching in a classroom.
- Screening for developmental delays is critical

**Middle childhood**
- During this period, children are ready for formal education that supports the development of their sense of identity skills and individual and relationship skills.
- School is only one location where children receive education; they also learn from families, friends and their community.
- Diverse learning opportunities are needed to stimulate full cognitive development.
- Discipline without corporal punishment for children to question and express themselves with confidence and without fear
- Interaction with groups and strive for acceptance from peers and other adults.
- Exposure to social and recreational activities that lead to self-affirmation and self-competence

**Education is a lifelong process that does not start or stop with school.**

**What is needed for children to learn and experience with confidence?**
The school environment

Schools should be safe places where all children, irrespective of status, are nurtured and encouraged. Schools control a large number of factors that can either push a child away from consistent attendance or encourage them to come to school. Factors that negatively impact on children and are normal for most Tanzanian children include large class sizes, a lack of basic learning materials, an absence of water and food, inadequate physical structures, high pupil-teacher ratios, teacher absenteeism, didactic teaching, and institutionalised violence where children are punished for minor infringements or are sexually abused. The nature of what children learn, as manifested in the curriculum and behaviours that are modelled by teachers are critical in influencing whether parents consider education relevant and useful and thus whether they encourage school attendance and motivation in their children.

Institutional frameworks

The delivery of education depends primarily on the capacity of the state and its institutions to achieve global and national goals. But development partners’ funding and financing modalities, their priorities and international discourses all influence what becomes Tanzania’s national priorities and provides certain opportunities to hold institutions to account. This chapter examines these macro systemic factors and tries to illustrate the impact these have on education received by Tanzanian children.

Poverty and education

Poverty is an overwhelming rural phenomenon in Tanzania, which is reflected in access to and the quality of education; educational outcomes in urban areas are consistently higher than rural areas. The children in the poorest households have very little chance of attending secondary schools, and higher education is a primarily an urban service (NBS, 2009).

Household poverty has a significant effect on children’s physical and cognitive development. This was discussed in depth in the nutrition chapter, but for the purposes of education it is critical to understand that children are entering school already handicapped by poor nutrition. They are already starting from behind. Data from the Household Budget Survey 2007 indicate that 16.6% of the population were below the food poverty line and 33.6% were below the basic needs poverty line, and the TDHS 2004/5 found that 37.7% of children under five years of age were stunted, and children in rural areas suffer substantially higher rates of malnutrition than urban children.

Poverty is also associated with inequity in indicators for education, for example, regions with higher per capita income have lower pupil-teacher ratios and students perform better in the Primary School Leavers Examinations (see Figures 51 and 52). Significantly, gender parity also improves with increases in wealth. In addition, data from the TDHS 2004/5 show that children from the poorest households are most likely to drop out of primary schools; 91.5% of children from the poorest quintile drop-out in Standard 7 compared with less than half of the highest quintile. Such socio-economic disparities have to be addressed for Tanzania to realise equal access to quality education.
Figure 51: Correlations between regional per capita income and pupil-teacher ratio

![Graph showing correlations between per capita income and pupil-teacher ratio](image)

Source: Compiled using Basic Education Statistics in Tanzania (BEST) (various years).

Figure 52: Correlation between regional per capita income and students’ performance in the Primary School Leavers Exam

![Graph showing correlation between per capita income and PSLE pass rate](image)

Source: Compiled using BEST (various years).
Table 12: Fast Facts - progress against MDGs, Education for All and MKUKUTA targets

<table>
<thead>
<tr>
<th>Millennium Development Goals</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target 3. Ensure that by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling.</td>
<td></td>
</tr>
<tr>
<td>Goal 3: Promote gender equality and empower women</td>
<td>Gender parity has almost been achieved at the primary level. In secondary school and higher education the gap between male and female enrolment increases incrementally.</td>
</tr>
<tr>
<td>Target 4. Eliminate gender disparity in primary and secondary education, preferably by 2005, and to all levels of education no later than 2015</td>
<td>Women also account for 60% of adult illiterates.</td>
</tr>
<tr>
<td>Dakar Framework for Action: Education for all (EFA) – from the World Education Forum 2000</td>
<td></td>
</tr>
<tr>
<td>Expanding and improving comprehensive early childhood care and education, especially for the most vulnerable and disadvantaged children.</td>
<td>Pre-school education has expanded since 2004, but no systematic efforts made to target the most vulnerable and disadvantaged children.</td>
</tr>
<tr>
<td>Ensuring that by 2015 all children, particularly girls, children in difficult circumstances and those belonging to ethnic minorities, have access to and complete free and compulsory primary education of good quality.</td>
<td>Despite the introduction of free and compulsory education, no overarching strategy specifically targets marginalised children and those in the most difficult circumstances. COBET has been mainstreamed by Government and has been instrumental in re-integrating primary school drop-outs into the system. An estimated 20% of children are not completing the primary cycle. According to BEST 2010, the dropout rate for 2010 is 18.6%. Learning outcomes remain poor.</td>
</tr>
<tr>
<td>Ensuring that the learning needs of all young people and adults are met through equitable access to appropriate learning and life skills programmes.</td>
<td>60% of the population is literate in Swahili. Literacy levels are higher in urban areas. Integrated Community Based Adult Education (ICBAE) and Open and Distance Learning (ODL) programme offered by the Institute of Adult Education. Many women take advantage of ICBAE, many more men benefit from ODL. Limited provision opportunities for out-of-school children and youth through COBET.</td>
</tr>
<tr>
<td>Achieving a 50% improvement in levels of adult literacy by 2015, especially for women, and equitable access to basic and continuing education for all adults.</td>
<td>Gender disparity has not been eliminated completely at primary and secondary levels. Fewer girls access secondary education and more drop out at the end of lower secondary. Incentives are available that encourage girls to complete secondary education.</td>
</tr>
<tr>
<td>Eliminating gender disparities in primary and secondary education by 2005, and achieving gender equality in education by 2015, with focus on ensuring girls’ full and equal access to and achievement in basic education of good quality.</td>
<td>The achievement of numeracy and literacy skills remains poor and may be jeopardised by rapid expansion of enrolment which is not linked to a similar expansion in expenditure on the sector.</td>
</tr>
<tr>
<td>Improving all aspects of the quality of education and ensuring excellence of so that recognised and measurable learning outcomes are achieved by all; especially in literacy, numeracy and essential life skills.</td>
<td></td>
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</tbody>
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Operational Targets for Goal I, Cluster II of NSGRP (MKUKUTA)

A: Early Childhood
Increase in the number of young children prepared for school and schools prepared ready to care for children.

B: Primary Enrolment
- Increased gross and net enrolment of boys and girls in primary schools from 90.5% in 2004 to 99% in 2010.
- Increased proportion of children with disabilities enrolled, attend in and completing schools from 0.1% in 2000 to 20% in 2010.
- Increased proportion of orphans and most vulnerable children enrolled, attending, and completing primary education from 2% in 2000 to 30% in 2010.

C: Primary Achievement and Quality
- Achieved an average daily attendance in primary schools of at least 85%
- At least 95% of cohort completed standard IV
- At least 90% of cohort completed standard VII

D: HIV and AIDS
- Effective HIV and AIDS education and life skills programmes offered in all primary, secondary schools and teachers’ colleges.

- HIV and AIDS education is provided through carrier subjects at primary and secondary levels. Time spent on topics often insufficient as is the quality of materials. Peer education is encouraged. Many of the programmes are supported by NGOs and other agencies so of variable quality. MoEVT has recently developed a National Framework for Life Skills Education.
5.2 Adult literacy

There has been very little improvement in literacy levels among the adult population since 2000/2001 (Figure 53).

Figure 53: Adult Literacy Rate by Residence, 2000/01 and 2007

Rural women are disproportionately disadvantaged; 35.3% have no formal education and more than 40% of women in rural areas are illiterate. The gender gap in adult literacy is still very significant at 13.4% in favour of men (NBS, 2009). The lower literacy level of rural women is significant as it has a potential knock-on effect on the education of children. There is evidence, for example, that a mother’s educational background is positively related to their children’s school readiness, mathematics and reading (Sabates-Wheeler et al., 2009).

5.3 Status and trends in children’s education

5.3.1 Access to education

Pre-primary education

PEDP II (2007-2011) urged the establishment of a pre-primary education programme for 5-6 year olds in each primary school using the existing school facilities and including the pre-primary children in the $10 capitation grant. There is little data on pre-schools in BEST, but the NER for 5-6 year olds rose from 24.6% in 2004 to 36.2% in 2008, 37.2% in 2009 and 37.5% in 2010 (MoEVT, 2008a; MoEVT, 2010).

There is almost gender parity in enrolment, but overall, there are high regional variations. Most ECD centres are in urban areas where they are often privately owned and better resourced than the community-based alternative models. In most rural areas there is scant provision. For example there are only 25 centres in Tabora compared to 137 in Morogoro. It is significant to note that 63.8% of 5-6 year olds are not receiving any formal education and that this may have implications for their development because it is at this stage that they learn empathy and perspective taking; which are essentially socially learnt skills (Hutchison, 2008).
It is unclear whether pre-primary education is accessible to the poorest and most disadvantaged. Currently, no government support is provided for community-based childcare programmes. A total of 2,208 children aged 5-6 with disabilities had enrolled in pre-primary programmes (MoEVT, 2009), but data on access by wealth quintile is not available. A study by Crocker (2009) found that working mothers find the hours of the community-based preschools too short and this inhibits their ability to engage in full-time work. In the Amani International Report (2008) one of the key challenges stated is the fact that children as young as five years are engaged in child labour, including trafficking to cities as house-girls and child minders. The inability of young children to communicate assertively and their powerlessness makes them particularly vulnerable to exploitation by adults and the violations of their rights can easily be ignored. The critical challenge is to reverse existing trends and make pre-school more accessible to the those who most need it, rather than the preserve of relatively better off urban children.

Factors that hinder enrolment and attendance include the limited number of pre-primary schools, their distance from children’s homes and thus the safety and cost implications for young children in getting to the schools and lack of parental awareness of importance of education in the early years.

**Primary education**

Tanzania has made significant progress towards achieving both universal primary education and gender parity. The decision to abolish fees and other monetary contributions in primary schools, coupled with the compulsory requirement for parents/guardians to send all children to school led to a significant increase in enrolment at the primary level as shown by Figure 55. In the first year of the Primary Education Development Programme (PEDP) 2002-2006, total enrolments in Standard I increased massively by 43.1% (Figure 56). However, total enrolments fell in subsequent years and did not rise again until 2007. It was expected that the first few years of PEDP implementation would clear the backlog of un-enrolled children and that any subsequent increase in enrolment would reflect natural population growth. This is
not happening. As figures for 2008 and 2009 show, the increases in enrolment are much lower than the population growth, meaning that the enrolment rate is now declining. Moreover, if attendance is taken as a true measure of enrolment the NER comes down to just over 80%. If completion is the indicator the percentage is again much lower. Figure 57 shows that the increases in enrolment are across all regions.

Of further note, Standard I enrolment comprises two groups of pupils, those who are starting primary school and those who are repeating the first grade. With the implementation of PEDP, the number of children repeating has increased considerably. On average 10% of children repeat Standard I, indicating inadequacies either in the school environment or weaknesses in pedagogy or in the school readiness of a number of pupils in their first and critical year in the formal school system.

**Figure 55: Pupils enrolled in primary schools, Mainland Tanzania, 2001–2009**

Source: BEST (various years); Note: the percentage increase is calculated using total enrolment as the denominator

**Figure 56: Pupils enrolled in Standard I, Mainland Tanzania, 2001–2009**

Source: BEST (various years). Note: the percentage increase is calculated using the number of total enrolment.
Two key challenges emerge in improving access to primary education. First, a comprehensive approach to enrolling marginalised children is not in place. PEDP aims to get as many children in schools, without addressing the specific needs of those who do not fit the picture of a “normal” child, although COBET is recognised as a complementary approach. Second, the rapid expansion in student numbers has impacted negatively on the quality of education provided to children. Learning outcomes are poor by the Government’s own standards (Mrutu et al., 2005). This is discussed in detail in Section 5.4.

Secondary education

Until recently Tanzania had one of the lowest rates of enrolment in secondary education in sub-Saharan Africa. However, the successful implementation of PEDP increased pressure to expand access to secondary education. In response, the Secondary Education Development Plan (SEDP) 2004–2009 was implemented. As with PEDP this led to a significant increase in enrolment. As shown in Figure 58, total enrolment rose from 345,441 students in 2003 to 1,466,402 in 2009.

**Figure 57: Gross and Net Enrolment Ratios in primary schools by region, Mainland Tanzania, 2009**

**Figure 58: Students enrolled in secondary schools, Mainland Tanzania, 2001-2009**

Source: BEST (various years). Note: the percentage increase is calculated using the number of total enrolment.
A massive programme of school building took place in all parts of the country due to the Government’s directive that a secondary school should be built in each ward. Communities also contributed to this process at considerable cost to themselves. Between 2004 and 2009, the number of secondary schools increased from 1,291 to 4,102; an increase of 218% (URT, 2004a, MoEVT, 2009). This is a significant achievement. However, the chance of a child in a rural area attending secondary school is only 7% compared with 18% for a child in an urban area (NBS, 2009).

Figure 59: Net Enrolment Ratio in secondary education, Mainland Tanzania, 2005-2009

Expansion of the secondary school sub-sector needs to consciously balance increasing access with maintaining quality. Alternative approaches to secondary should also be explored. The Institute of Adult Education has recently developed an Integrated Approach to Post Primary Education that may help integrate literacy, numeracy and skills-based programmes for youth. The Folk development Programme also offers alternative post-primary opportunities. Greater coordination of alternative approaches could do much to address the skills gap and employment needs of young Tanzanians.

Vocational education

Vocational education can play an important role in producing the technical skills required for economic growth in Tanzania. Vocational education is governed by the Vocational Education Training Act of 1994, which was a powerful mechanism for developing the sub-sector. Significantly, the Act ensured the financing of VETA out of a levy paid by employers. This is an example of private-public financing that has yet to been applied to other sub-sectors, but may warrant further investigation and application.

BEST 2005-2009 reported that in 2007, a total of 145,423 students were enrolled in VETA courses, of which 76,354 (53%) were males and 69,069 (47%) were females (MoEVT, 2009). Access to courses varied markedly by region ranging from less than 1,500 enrolled in long courses in five regions – Kigoma (406), Tabora (837), Shinyanga (1,071), Ruvuma (1,309) and Manyara (1,446) – to over 10,000 in Arusha (10,118) and Dar es Salaam (26,026). Both privately-owned
and VETA training centres offer a wide range of courses, that cover traditional male employment areas such as electrical installation, masonry, bricklaying, carpentry, joinery, plumbing, tailoring, road construction, machine fitting, pipe fitting and foundry. But little is offered in terms of skills for new employment areas, including information and communication technologies (ICT).

**Box 5: Education for employability**

One of the fundamental purposes of education is to equip students to either generate their own income or to become employed, thereby achieving security for themselves and their families and contributing to the economic growth of the nation. The relationship between employment and education are complex and reciprocal; educated people tend to find it easier to find employment or generate their own opportunities, but an educated population also leads to the development of employment markets. In Tanzania labour market information is not easily available to both job seekers and employers (Shintundu, 2003) but figures indicate that:

- The unemployment rate of youth aged 15-24 years at 14.9% is the highest of all age groups.
- The unemployment rate for men and women aged 15 years and above is 10.7% and 12.6% respectively,
- Nearly 1.3 million people in Tanzania are under-employed,
- 40 % of all households in Mainland Tanzania work in informal sector (URT, 2007).

A survey of businesses in Mainland Tanzania also found that 25% of the firms interviewed indicated that the lack of workers’ skills is an obstacle to enterprise operation and growth. Forty percent of tourism enterprises, 25% of manufacturing enterprises and 13% of construction enterprises reported that workers’ skills and education of workers was a major constraint (World Bank, 2004).

In Dar es Salaam and other urban areas, unemployment rates are higher for Tanzanians who have never attended school. But they are also higher for secondary graduates than for primary graduates, suggesting that there are either not many jobs requiring higher levels of education or that higher levels of education are not producing the rights skill sets.

Rural areas have the lowest unemployment rate (11.7%) and education level does not affect the unemployment rate very much in rural areas. The share of rural non-farm self-employment income has increased from about 6% in 1992 to more than 20% in 2005 and one-third of rural enterprises are growing quickly, engaging in agricultural trade (World Bank, 2007). Of note, most of the labourers in these enterprises are self-employed, although some enterprises seasonally hire employees.

Shitundu (2003) suggests that secondary education and vocational training do not provide graduates with the skills demanded by the labour market. Also employers find it difficult to recruit skilled labour especially for managers and professionals in Tanzania. Most job seekers in these positions lack the knowledge and skills as well as experience. Low levels of skills and education attainment has prevented workers and enterprises from acquiring knowledge, using superior technologies and this has therefore resulted in limited productivity growth (Chandra et al., 2005).

A review of curricula at all levels of formal education and vocational training may therefore be critical to better equip young people to secure their livelihoods. This school to work issue will requires collaboration between Government ministries, educational institutions and the private sector to increase the provision of relevant, high quality education and training opportunities.
Higher education

Higher education is the responsibility of the Union Government. Students from both the Mainland and the Isles can access institutions of higher learning in either territory. All institutions of higher learning have to be accredited by the Accreditation Council. To access higher education students must have completed six years of secondary education and passed the Advanced Certificate of Secondary Education Examinations. Most institutions require at least a Division 3 pass and this is a factor in the low numbers of candidates who are eligible for admission. In 2008, 31,225 students sat the Form 6 examinations, of which 23,106 passed with at least division three.

The higher education sub-sector remains small compared with other countries in the region. However, the sector has experienced rapid growth since the mid-1990s when the Government liberalised the provision of higher education. In fact, official statistics reveal that enrolment in tertiary institutions has increased almost three-fold in the past five years, from fewer than 20,000 students in 2004/05 to nearly 120,000 students enrolled in tertiary education in the 2009/10 academic year. The share of private institutions has, moreover, been growing steadily as a result of the 1999 National Higher Education Policy, which encouraged the establishment of private institutions to expand access to tertiary education. In 2009/10, total enrolment in private universities and university colleges was over 35,000 students (40.5% women), while enrolment in public institutions was nearly 84,000 students (33.4% women). Despite some progress, women are still under-represented in higher education; overall 35.3% of students are female (MoEVT, 2010).

5.3.2 The quality of pre-primary and primary education

Pre-primary education

A study conducted in August 2008 in four districts found that the majority of pre-primary schools attached to primary schools are poorly resourced and over 80% of ECD centres (including community-based pre-schools) are unregistered and in poor condition. Attendance at these schools may in fact do more harm than good for a child’s development. The lack of supplies and play materials, absence of trained teachers and the tendency to teach didactically and focus on literacy and numeracy skills make the learning environment developmentally inappropriate. In 2008, only 26.1% (4,489) of government pre-primary teachers had a pre-school certificate (MoEVT, 2009) and no system for professional training in ECD is available, although the University of Dar es Salaam recently introduced a bachelor degree programme in ECD. The low salaries and status of early childhood educators are likely to be key reasons preventing more Tanzanians from choosing this profession.

Primary education

Over 30% of children are failing to complete primary school. Among students who complete primary school, only 50% pass the Primary School Leavers’ Examination (PSLE) (Figure 60). For Tanzanian parents, performance in the PSLE is the critical measure of their children’s learning outcomes. There were radical improvements in the PLSE after 2002, but a marked drop in the percentage pass rate in 2008. Moreover, a study of learning outcomes among Standard 6 students found that many children were only at the pre-reading or emergent reading levels, and that a quarter of pupils had not achieved basic numeracy in mathematics (Mrutu et al., 2005).
5.4 Factors affecting learning outcomes

Factors affecting learning outcomes can be grouped into learner, pedagogic, school environment, socio-cultural and politico-administrative factors, even though these groupings are arbitrary given the constant interactions between all five sets of factors. This section, therefore, examines factors that affect learning outcomes from a systems perspective that discusses the interconnections between the micro-level of the individual child, the meso organisational level (household, school, community) and the macro-level (country, institutional frameworks, international discourses). At the individual level, the analysis focuses on: i. gender and ii. marginalised children (working children, nomadic pastoralists and children with disabilities). The analysis then moves on to examine key issues within the school environment: i. children’s participation; ii. teachers; iii. teaching and learning materials; iv. Institutionalised violence; v. school feeding; vi. school infrastructure; and vii. standards and quality assurance for schools.

5.4.1 Gender

Beyond the significant progress in achieving near to gender parity in primary school enrolments, girls’ educational outcomes in general remain worse than boys. Academically, girls’ performance is lower than boys in the PSLE, in maths and science at secondary level, and especially in the Form 4 examination. As illustrated in Figure 61, inequalities in completion and performance rates escalate from primary, through secondary to tertiary, with learning outcomes for girls diminishing the higher the grade.

Girls and boys drop out of school for different reasons. Girls may be withdrawn due to security concerns on the journey to and from school, and due to risks of violence or abuse within the school (from male teachers and students) as well as early marriage, pregnancy (see...
Box 5), a perceived lack of relevance of education by parents, poor school performance and demands on girls’ labour as caregivers to other household members. Boys are more likely to dropout due to the perceived lack of relevance of education as well as the competing demands for their labour. Cost is also a major factor influencing the continued education of both girls and boys. A recent national opinion poll supported by UNICEF suggested that more than one in five Tanzanians still believe it is more important to educate a boy than a girl (UNICEF, 2009b).

Several initiatives have aimed to address the challenges affecting girls’ education, including the World Bank supported Girls’ Secondary Education Support programme that helped girls from poor communities access secondary education. This programme is no longer operational but Camfed has carried the model forward to ten districts in Iringa, Coast, Tanga and Morogoro regions. The Tuseme (‘Let us speak out’) empowerment program initiated at the University of Dar es Salaam and expanded by the Forum for African Women Educationalists (FAWE) has also been running in Tanzania since 1996. The programme uses theatre-for-development techniques to overcome factors that hinder girls’ social and academic development. But such programmes often pay less attention to educational processes and they have not gone to scale. More data are also required on women in management within the education sector, but certainly most head teachers are men.

Positively, the Tanzania Gender in Education Initiative (TGEI) promises to bring a more coordinated approach to addressing gender issues for both girls and boys in education. TGEI is a forum composed of three government ministries (MoEVT, MCDGC and PMO-RALG), approximately 50 CSOs and development partners including CIDA and UNICEF, coordinated by the ten member TGEI Task Force. An action plan was agreed in November 2008.

5.4.2 Children on the margins
Marginalised children are often not enrolled or cannot attend school as the inadequacy of the education system and lack of sector resources combine to make it difficult to accommodate their needs. The educational situation for three groups of children on the margins – working children, nomadic pastoralists and children with disabilities – is discussed below.

Working children
Even though Article 32 of the UN Convention on the Rights of the Child mandates State parties to ‘protect children from work that is dangerous or might harm their health or their education’, the fact is that in Tanzania there are more than 350,000 children under the age of 15 years engaged in labour (NBS, 2008). They work on the family farm, in enterprises (tea estates, mines and quarries, and a myriad of small informal businesses), in commercial sex work, or sell goods and services on the streets. They work before, after and sometimes during classes. Many work as a vital contribution to household survival, but the length and nature of their work often jeopardises their rights to education and health. More critically, this situation can entrench children in long-term poverty as they are denied the qualifications and skills that would enable them to prosper as an adult.
Nomadic pastoralists

Children within communities with livelihoods derived from nomadic herding have complex needs because they frequently live in dispersed and inaccessible communities. Establishing schools using the normal government criteria for catchment areas and pupil-teacher ratios of 45:1 is not practical. Boys between the ages of seven and ten are expected to herd the family cattle during the day. The current education curriculum bears little relevance to the lives that they live nor their tribal culture and social norms. The need exists for a more tailor-made approach to education developed with elders that reflects tribal realities, aspirations and values and that is routinely accessible for their children.
Box 6: Teenage pregnancies and girls’ health and educational outcomes

Tanzania has one of the highest adolescent pregnancy rates in the world. Approximately one-quarter (23%) of girls aged 15-19 years have begun childbearing. By the age of 18 years, 39% of adolescent women are mothers or pregnant (TACAIDS et al., 2008).

Early childbearing has potentially dire consequences for adolescent girls’ health. Adolescent girls aged 15-19 years are twice as likely to die in childbirth. Globally, teenage girls account for 13% of all maternal deaths. They also suffer a disproportionate share of deaths and disability from unsafe abortion; when pregnancies are unintended or unwanted, girls may resort to dangerous abortions as procedures are illegal in many countries including Tanzania. Perinatal and infant mortality are also higher among children born to adolescent mothers (WHO, 2007).

Teenage pregnancies not only have negative health impacts but often hinder girls’ access to education and employment opportunities. At least 8,000 girls (about half from primary schools and half from secondary schools) dropped out in 2007 due to pregnancy (MoEVT statistics, 2008). Pregnant and married girls who have already given birth are also frequently expelled from school. This practice is not based on a legal framework, but rather reflects the prevailing perceptions of teachers, school administrations, local authorities and sometimes parents. These pregnancies are commonly considered to be “the girl’s fault”; girls who have fallen pregnant are considered to be immoral, deserving punishment. In many cases pregnant school girls also face discrimination from classmates, teachers, parents and local leaders. According to 2009 UNICEF opinion poll, 66% of Tanzanians think that girls only have themselves to blame if they get pregnant and 44% that boys who get a girl pregnant are just being boys.

Why do children have children?
Poverty is one of the principal underlying causes for teenage pregnancies. In order to meet their basic needs – for food, clothes, school fees and transport – or to improve their living conditions, young girls engage in sexual relationships with older men. Within these relationships, adolescent girls may lack skills and power to negotiate safe sex, thus making them extremely vulnerable to HIV and other sexually transmitted illnesses. For example, in Karagwe District, 85% of all secondary and primary school girls who fell pregnant in the last three years tested HIV-positive (AIDS Week in Review June 2010).

Another leading factor for young girls to become pregnant is the lack of appropriate and comprehensive sexual and reproductive health and rights education. Currently, only the secondary schools’ curriculum includes topics such as HIV and the reproductive system, which are taught as part of biology. And not all schools have teachers who have been trained in teaching these topics. Life skills is an extra curricula subject. Closely linked with the lack of education is the low (40%) coverage of youth-friendly sexual and reproductive health information and services and adolescents’ inadequate access to these services.

What needs to be done?
To prevent teenage pregnancies, adolescents need to have effective access to quality, youth-friendly sexual and reproductive health (SRH) information and services, including family planning. Appropriate and comprehensive knowledge about SRH and rights helps young people to make informed decisions about their lives.

To address the growing number of girls dropping out from school, the Tanzanian Government has recently developed national guidelines to allow pregnant girls to continue their education after giving birth. Implementing these guidelines is essential to protect the rights of young women to education. Allowing girls to return to school will require an enabling and supportive environment. Where needed, girls with babies may need to be provided with childcare, alternative education options and more flexible school hours.

In addition, schools must be made safe environments for adolescent girls. The following list highlights key aspects of girl-friendly schools:

- Close to communities so that parents are less worried about their daughters’ safety
- Has several female teachers
- Teaches sexual and reproductive health, life skills and rights issues as part of the core curriculum
- Provides in-school childcare facilities
- Punishes male teachers who seduce girl students
- Has separate, private sanitation facilities, latrines and clean water for girls and boys, which meet MoEVT minimum standards.
Children with disabilities

Despite the provision in Article 23 of the UN Convention on the Rights of the Child that ‘Children who have any kind of disability have the right to special care and support so that they can live full and independent lives’, the reality affecting children living with a disability is quite different. Tanzanian children with disabilities are largely excluded from schooling. Even if they attend they do not receive the most basic assistive devices. Figure 62 shows percentages of children with disabilities enrolled in primary schools, by grade. In secondary schools, 0.2% of boys and 0.4% of girls have disabilities. Overall, only 0.4% of all children enrolled in school have a disability. These percentages are extremely low compared with the estimated 7.8% of the population with disabilities in Tanzania, which indicates that most children with impairment are not enrolled (MoHSW, 2009a). One likely reason for this situation is that no national system for the identification and assessment of children with physical or mental impairments is in place and so no coherent data to track them or respond to their needs.

Figure 62: Percentage of children with disabilities in primary school, by grade, Mainland Tanzania, 2009 (% of total enrolments)

Those with physical disabilities are by far the largest group recorded at both primary (38%) and secondary level (66%) (MoHSW, 2009a). At primary level less than 42% of children with recorded disabilities are girls while at the secondary level they only constitute 35% (MoHSW, 2009a). Girls with disability are more vulnerable than boys. Many parents say they are inclined to keep children with disabilities at home, partly due to the stigma attached to disabilities, and partly due to the desire to protect them.

5.4.3 The school environment

The realisation of children’s rights including education depends to large extent on the nature of care provided by adults in their households, schools and communities (i.e. the meso level of
child interactions). Schools provide the primary day-to-day institutional setting where children come into contact with, learn from and build relationships with adult role models. The human dimension of how adults create a nurturing and safe school environment, the behaviours that they model for their students and the opportunities that they provide for young people to express themselves are critical in promoting or limiting the type and extent to which children achieve learning outcomes in education.

**Participation**

Children have few opportunities to participate as equals in their schools and there are few opportunities for them to express their views. Children are seldom consulted when school development plans are being developed yet they are the users and beneficiaries of school services, as well as rights holders. A community dialogue exercise conducted by MoEVT in seven districts supported by UNICEF (Bagamoyo, Hai, Makete, Magu, Mtwara Rural, Siha and Temanke) found that children’s perspectives were often markedly different to those of parents and teachers. For example, children often identified fear of being beaten and lack of food as their main concerns. Knowledge of such concerns and divergences in perception could be extremely important for informing interventions to reduce high truancy rates. Pupils are supposed to be represented in school committees to provide them with a forum to air their views on different matters. However, their representation is often inadequate or non-existent. This reinforces their lack of participation in their own learning with the risk of a development of apathy or alienation at an early age.

**Institutionalised violence**

State parties are required to “protect children from all forms of violence” (Article 19, UNCRC). It is the primary duty of Government to ensure that schools are safe places, especially for girls. The Tanzanian education policy sanctions corporal punishment as a last resort by a head teacher. But teachers rarely adhere to the regulations that specify only six lashes should be administered for serious breaches of discipline and that such punishments be recorded.

The Mkombozi, a child’s rights NGO in Kilimanjaro and Arusha regions, found a close link between poverty and violence and how income poverty can lead to domestic violence (McAlpine, 2005). Community members tolerate and even encourage violence against children.

“It will be a grave error for a parent to go and have a fight with a teacher if his/her child was caned at school. Whenever my child comes home complaining about teacher beating him, I cane him because I know teachers will not punish a child without a reason. Your child will not learn if every time he gets caned you go to the head teacher to complain. This idea of not caning children is from the “wazungu”. They do not want our children to learn.”

Male parent in Bagamoyo, Focus Group Discussion, 2009.

In focus group discussions conducted for this report, pupils reported receiving corporal punishment routinely at home and at school. Violence in school sometimes also manifests as sexual abuse and violence. In many countries sexual violence in schools, including transactional sex for grades between girls and their teachers, is common. In Tanzania there is little research into this issue, despite the alarming incidence of pregnancies in school, including primary
school, most of which involve older men. A household survey on Violence Against Children commissioned by UNICEF is expected to help assess the scale of the problem in schools, but further research will likely be required if the issue is to be fully understood, addressed and monitored (UNICEF et al., forthcoming).

**School feeding programmes**

Poor school achievement, repetition of grades, and dropouts may be symptoms of poor nutrition status. Heavy parasite load combined with low food intake precipitates malnutrition in school children, with consequences for poor attention and performance. Feeding programmes only operate in a few districts in Tanzania with the support of the World Food Programme and others. The introduction of morning snacks and cooked lunches can have a dramatic impact on class attendance and performance, especially when children walk long distances from home to school on an empty stomach. In these circumstances, children can be so hungry and exhausted that they fall fast asleep in class. School feeding not only relieves short-term hunger and improves enrolment, attendance and concentration, but also encourages students to continue on to secondary school.

Improving the nutrition of very young children can also significantly reduce the nutritional deficits of school-aged children. Programmes for de-worming school-age children are also vital. Schools too provide an opportunity for communication of information about sound nutrition practice, which can valuably serve the children as well as their households. For girls in upper primary especially, health programmes in schools could provide an effective means of communicating important nutrition information. Whilst donor funded school feeding such as the WFP programmes are very expensive and not scalable there have been a number of school and community-based initiatives (McAlpine, 2007a). Alternative approaches for increasing the availability of local snack foods and the frequency of meals for school-age children merit exploration. It is encouraging to note that Government is now looking at institutionalising school feeding and conducting feasibility studies for its introduction in schools around the country.

**School infrastructure**

Despite high levels of investment in infrastructure through the PEDP and SEDP, many classrooms are still drab places where children sit in rows, sometimes at desks, often on the floor. As described in chapter 4, water supply and sanitation facilities at school are often rudimentary, yet they are key components of a healthy, child-friendly environment, particularly when girls reach puberty. Apart from clean water and adequate sanitation girls also require supportive teachers, access to reliable information on puberty and affordable sanitary materials. There is little quantitative data on this challenge in Tanzania, but the structural aspects of the school environment, particularly improved latrines and accessible water supply close to the latrine would go a long way towards making schools more girl-friendly (Sommer, 2009). It is to be hoped that the new National Strategy for Water and Sanitation will lead to concrete actions to address this need.

**Teaching and learning materials**

Teaching and learning materials are critical to student-centred learning, including reading, numeracy, communication and problem-solving skills. The Government is committed to a pupil:textbook ratio of 1:1 by 2010. However, the latest data which focused on the availability
of textbooks for mathematics indicate that this target will be far from met. Specific data for the pupil:maths textbook ratio were as follows (UNICEF and SPA InfoSUV East Africa, 2009):

- In Standard 1 it was 8.7:1 for girls and 9.9:1 for boys.
- In rural areas it was 12.2:1 for girls and 13.9:1 for boys.
- In Standard 7 for English language books, it was 5.2:1 for girls and 4.9:1 for boys in English.
- In Standard 7 for books in Kiswahili, it was 5.6:1 for girls and 5.3:1 for boys.

The study also found that textbooks are not systematically used by teachers in class. If teachers are to use textbooks effectively they also require training in their applications and this has to be factored into teacher training and in-service professional development. Schools and teachers also need to model a reading culture in their own behaviour and teaching practices, which means investing in school libraries and actively supporting teachers’ own reading skills. The textbook policy is currently under review. While most countries have seen the benefit of liberalising textbook supply for reasons of quality, provided that the vetting of textbooks is rigorous, the Tanzanian Government is currently considering whether it should go back to single sourcing textbooks.

**Box 7: The language of education in Tanzania**

Are poor learning outcomes in Tanzania connected with the national language policy in education? Research has repeatedly shown that the early years of education are best conducted in the mother-tongue (ADEA, 1997; Bisong, 1995; id21 insights education, 2006; Poth, 1997; Ufomata, 1999). Ethnic languages have been marginalised in education and are not used even at the pre-primary level. This is in spite of the fact that many children do not know Kiswahili when they enter school and are disadvantaged by teachers and curricula that work on the assumption that all children know Kiswahili. This issue has not received the attention it deserves, and there is little research on how this affects the performance of children who come to school without Kiswahili.

The second aspect of inequity arising from language is the use of English as the language of education at secondary level. In 1997 the Government announced a language policy ‘Sera ya Utamaduni’ that stressed the need to use Kiswahili throughout the education system. However, there seems to be reluctance to implement the policy (Brock-Utne, Desai, and Qorro, 2003, p. 15). In 2002, the University of Dar es Salaam, the University of the Western Cape and Oslo University wanted to assess the impact on learning of using English, but permission for the research was not granted.

The current practice is to use Kiswahili in Government primary schools. When children enter secondary schools the language of education is English. The vast majority of children graduating from public primary schools have very low competence in English and therefore begin secondary education with a distinct disadvantage. While there may be serious disagreements over the way forward, few would disagree that a serious constraint to curriculum delivery in secondary education is due to the lack of competence that most teachers have in the language of instruction. “Using English as the language of instruction in Tanzanian secondary schools and institutions of higher learning does more harm than good” (Qorro, 2006, p. 14). Language policy has serious equity and inclusion issues and clearly needs to be addressed if learning outcomes are to be enhanced.
5.4.4 Teachers
The availability and capacity of the teaching force are the foundations of educational quality. In particular, in resource poor environments teachers are the most important input in the education process (Bacchus, 1996). The most likely way to improve the quality of education is therefore to invest in teachers. This involves teacher supply, distribution, competencies and remuneration.

Teacher supply
The supply of teachers at the primary school level has not kept pace with the rapid increase in enrolment associated with PEDP (Figure 63). The current pupil-teacher ratio (PTR) of 1:54 is well above the recommended PTR of 1:45 (MoEVT, 2009, p. 18). To reduce the PTR to the recommended level would require hiring an additional 32,000 (20%) more teachers. Deploying under-qualified teachers is also not a viable solution as these teachers are less able to cope with the pedagogical challenges created by large class sizes.

Figure 63: Pupil-teacher ratio in primary schools, Mainland Tanzania, 2000-2009

![Graph showing pupil-teacher ratio in primary schools, Mainland Tanzania, 2000-2009](source: BEST, various years)

Teacher distribution
Poorer regions have fewer teachers than wealthier regions (BEST data, various years) and schools in remote areas have fewer teachers than those in urban centres. As illustrated in Figure 64, wide variations in the deployment of teachers are found across regions (MoEVT, 2009). The PTR inversely correlates with a region’s wealth, and remote regions such as Kigoma and Tabora have high PTRs. For example, the PTR in Shinyanga is twice as high as in Kilimanjaro and regions in the western Tanzania have higher PTRs than eastern regions. Schools that are near the district headquarters have lower PTRs than remote schools. For example, one-third of schools in Meatu and more than a quarter of schools in Sengerema have a PTR of over hundred. In contrast, more than 80% of schools in Moshi Rural have a PTR of 49 or less, compared with only 13.6% of schools in Meatu (Sumra, 2006). Failure to deploy adequate numbers of teachers in rural schools denies children from poor families an equivalent education to their urban peers and perpetuates rural poverty. There is also need to review the deployment of ECD teachers to locate them in areas where they know the predominant ethnic language, so that children can be better supported in their acquisition of Kiswahili.
The availability of services such as health, banks and shops attracts teachers to urban areas and female teachers are reluctant to work in remote areas for lack of housing. The teacher deployment problem has remained unresolved for many years. This is partly due to teachers’ deployment preferences being followed, and the lack of discipline and incentives within the system. The Government has tried to address the issue by building teachers’ houses in remote areas to attract more teachers.
**Teacher competencies**

Teacher quality can have a positive impact on academic achievement (Coleman, 1966; Husen, 1978; Solomon, 1987). Given the current lack of teaching and learning materials in Tanzania, teaching skills assume far greater importance in quality improvement. Good teachers can mitigate the effects of poverty on learning outcomes.

Teacher “talk and chalk”, however, is the norm with little student interaction (Sumra, 2000). Pupils do not ask questions and problem solving, communication and thinking skills are not effectively promoted. Earlier initiatives to promote child-centred teaching and learning, through small-scale project approaches such as Aga Khan funded STEPS, UNICEF, UNESCO and Oxfam have not addressed structural issues and have sometimes lacked integration with other complementary interventions. The initial training that teachers receive is crucial to ensuring quality teaching and needs to be radically reviewed. The former approach of two years in college was replaced by a ‘one year in and a second out’ on teaching practice. A more flexible system with greater interface between theory and practice would have been much more cost-effective. There has now been a reversion to the old system. The current training curriculum is likely to produce a novice teacher, who complies with a single model of teaching and is rule bound. In contrast, PEDP visualised the development of teachers who are able to reflect, analyse and discuss what they do and why (URT, 2004b).

Teaching risks being de-professionalised as a result of the desire to expand teacher recruitment and the current strategy to accelerate the training programme for secondary teachers. These moves have responded to the pressure created by the rapid expansion in secondary education to accommodate the much larger student cohorts now finishing primary school as a result of the PEDP.

A concern is that talented young people will be unwilling to take up teaching as a profession. Most of the students who join teacher training come with weak academic backgrounds, many having a D grade in the subject in which they specialise in teaching (URT, 2004b). This necessarily means that Pre-service Education and Training (PRESET) will have to improve the academic standard of trainees as well as develop their pedagogical skills. Additionally the teacher training curriculum does not deal with crucial skill sets such as teaching large classes, multi-grade teaching and developing a school plan.

The quality of teaching also needs to be sustained through systems of in-service training (INSET) and continuous professional development. Teacher management issues at the school level include the need for induction, mentoring and support for new teachers. Teacher certification needs to be linked to teacher competence and performance. The new INSET strategy does however propose a national INSET system and programme designed to develop key teacher competencies. INSET and PRESET will need to be closely linked under a continuous professional development system for teachers. Many other actors, including head teachers, District Education Officers, Ward Education Co-ordinators and School Inspectors will require training to support the INSET system.

**Teacher remuneration**

The Government has recently developed the ambitious Teacher Development and Management Strategy designed to address the problems facing the teaching profession. But this strategy still has to be translated into a costed plan and funding released for its implementation. Teacher salaries in the Mainland are far from satisfactory level (Sumra,
The starting salary is Tsh 70,000 in 2003 which can only pay the basic necessities of life for a teacher who does not have a family (URT, 2003). Low teacher salaries are probably one of the reasons that Tanzania has failed to attract enough capable students to become teachers, and a negative factor in teacher motivation. Many teachers are engaged in other income-generating activities such as farming, fishing and petty business (Haki Elimu, 2008a), thus distracting them from a full commitment to their work. Figure 66 estimates the public education expenditure on wage and allowances in 2008/09. While 51% of actual public education recurrent expenditure went to salaries and allowances, only 29.9% went to personal emoluments in the LGA education budget. Teacher salaries are paid by the LGA using the transfers from the Ministry of Finance.

**Figure 66: Estimate of actual expenditures on public education, 2008/09 (Tsh billions)**

![Chart showing public education expenditure]

Source: Estimated using education expenditure data from central Government and LGAs from Ministry of Finance and Economic Affairs.

### 5.4.5 Standards and quality assurance

The MoEVT has developed minimum standards for primary education that sets out the minimum educational inputs required to ensure the provision of quality education on an equitable basis throughout the country. The standards give guidance on the design and implementation of primary education and provide a common framework to be followed by all agencies. They also provide a basis for enhancing the quality of planning at the school, ward and district levels and enhancing the quality of education monitoring and evaluation. These standards should ensure a greater level of coordination and coherence in planning and implementation and, when coupled with other interventions, should lead to enhanced learning outcomes.

MoEVT is currently developing new school inspection guidelines linked to these minimum standards. School inspection is a crucial area for monitoring inputs, processes and learning
outcomes in school. However, it has been weak in recent years, partly due to a lack of adequate resources. The budget for inspection accounts for only 0.5% of the sector budget compared to 50.1% and 10.4% for the primary and secondary sectors (Assad and Kibaja, 2009). This has seriously hampered the capacity of inspectors to cover all schools, with some districts being able to only cover 17 - 20% of schools in planned inspections. Consequently the schools in most need of inspection and support in ‘hard to reach’ areas are usually the least visited.

5.5 Fiscal space
Education is a priority sector in terms of the allocation of the government budget and expanding access to primary and secondary education has been a clear government priority. Tanzania also compares favourably with many of its neighbours in terms of expenditure as a percentage of the total government budget. In 2009/10, the Government allocated 6.2% of total GDP to education compared to 4% in 2003/4 (Figure 67). The Government has delivered on its commitment to increase funding for the sector with expenditure on education increasing by 112% in the last five years in real terms. The increase in GDP and government revenue also helped increase funds available for investment in education. But as a share of the total government budget, the allocation to education has remained more or less constant. The total education budget as a percentage of total government budget has been around 17-18% for the last several years. Further investment is still required given the growth of the sub-sectors and the need to improve quality across the sector.

Figure 67: Approved education budget as a percentage of GDP and as a percentage of the total government budget, 2001/02-2007/08


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5 Calculated using education finance data from MOEVT (2008) and MOEVT (2009), and inflation rates from IMF World Economic Outlook Database, April 2009.

6 Real GDP growth has been around 7% in the last five years (IMF World Economic Outlook Database, April 2009). Also real GDP per capita, PPP growth have been more than 4% (2003/04-2006/07).

7 Real revenue growth was 18.8% in 2006/07 and 5.8% in 2007/08 and in 2008/09.
Tanzania is heavily donor dependent with 40% of the national budget financed by development partners. Funds allocated for the education budget come from domestic revenue and donor support. Recently there has been a move away from project and basket funding modalities to General Budget Support by several major donors.

Figure 68 depicts levels of expenditure on public education by sub-sector. In the early years of PEDP implementation, nearly 60% of the sector budget was going to the primary education sub-sector. This has gradually decreased to around 50% in the 2007/8 budget. The sub-sector that has significantly increased its share of the total budget has been higher education; one-third of the education budget is now allocated to it. Few children from poor backgrounds progress to tertiary education; a 2008 assessment found that only 4% of students enrolled in tertiary institutions were from the poorest two household wealth quintiles compared with 56% of students from the least poor quintile (DPG, 2008).

Figure 68: Public education expenditure by sub-sector, Mainland Tanzania, 2002/3-2007/8

Sources: Education budget data 2002/03; NEIMACRO, 2005; Education Sector Public Expenditure Review (PER) 2005 (2005/06-2008/09); MOFEA budget books through MoEVT (2009); Public Expenditure Tracking Study for Primary and Secondary Education in Tanzania (Nominal GDP) 2005/06-2007/08; IMF Staff Report dated June 12, 2007.

Notes: * Actual expenditure ** Expenditure estimates *** Whether the numbers are actual expenditure, estimated expenditure, approved budget or proposed budget is not known.

Overall, 84.9% of total education budget goes to recurrent costs and 15.1% to development expenditures. Recurrent budget percentages within each sub-sector in 2008/09 were primary (92.2%), secondary (81.8%), teacher education (97.9%) and other basic education (71.2%).

In the past three years, less than 10% of the primary education budget has been allocated to development. This reflects stagnation in the construction of school facilities. In contrast, 40-60% of the budget for secondary education had been spent for development from 2005/06 to 2007/08 along with the rapid increase in enrolment in secondary schools. Also,
almost the entire teacher education budget has been allocated to recurrent costs in the last three years. Teacher education gets only 0.3% of the development budget. This has serious implications for the quality of education that children receive in primary education.

Rough estimates of unit recurrent costs, derived from the 2008/09 budget allocation, were:

- Tsh 62,800 for a primary school child increased from Tsh 36,178 in 2005/06. However, the actual unit (recurrent) cost for the primary school child is lower than Tsh 62,800 because the budget allocated to primary education is also used for pre-primary education. Including pre-primary school pupils, the unit (recurrent) cost for a child in either pre-primary or primary education becomes Tsh 56,814.

- Tsh 100,164 for a secondary school student, which was an increase from Tsh 81,836 in 2005/06.

- Tsh 1,094,970 for a teacher trainee, increased from Tsh 290,715 in 2005/06. This suggests that the Government is more seriously engaged in the improvement of quality of teachers, but much of this was for upgrading primary teacher certification levels and the rapid training for secondary teachers, with little support for enhancing teaching competencies through INSET.

- Tsh 4,000,000 for a student in tertiary education.

The 2009 Education for All (EFA) Global Monitoring report notes that the median per student expenditure in primary school in 2006 in sub-Saharan Africa was USD 167 compared to an average of USD 5,000 in developed countries (UNESCO, 2009). This is considerably higher than Tanzania is currently spending. A case could be made that the current level of funding for tertiary education is relatively high and disproportionately benefits the urban middle class. An increased number of highly skilled tertiary graduates are needed to improve the capacity of the public and private sectors in Tanzania, however, a balance must be struck such that all education sub-sectors receive an equitable share of the limited funding available. The provision of loans from the Higher Education Loans Board and scholarships for talented youth from poor and marginalised communities could be used to increase equity in access to higher education.

5.6 Institutional frameworks

5.6.1 Decentralisation by Devolution

The merging of the Ministry of Education and Vocational Training with the Ministry of Higher Education allows for a more integrated approach to education planning. While the issue of horizontal linkages have been substantially addressed by the merger of the ministries, vertical linkages require further attention. In the context of Decentralisation by Devolution, PMO-RALG is responsible for oversight of education delivery at the sub-national level. A Deputy Permanent Secretary position has been created in PMO-RALG to provide management oversight for primary and secondary education. From an operational perspective PMO-RALG’s base in Dodoma remains a concern as there are frequent problems in engaging in regular meetings with MoEVT and other line ministries based in Dar es Salaam.

Few would argue against the logic of the D-by-D policy which is intended to bring services closer to communities, but there are structural issues, policy ambiguities and issues of capacity
which seem to hamper effective implementation. Until recently PMO-RALG has lacked the
capacity to carry out its function effectively, as have the regions, LGAs, wards and schools.
This informed the decision to develop a Capacity Building Strategy for Basic Education, the
first draft of which was recently released (Mbando and Njoroge, 2009).

There is also tension between the proclaimed intentions of D-by-D and the continued
centralised decision making emanating from MoEVT. Few districts, if any, have well articulated
strategic education plans based on a situation analysis of their own districts. At ward level,
coordination work that is supposed to be carried out is often lacking, partly due to the weak
capacity of the Ward Education Committees. At the school level, the devolution of funding
through capitation and development grants is important in ensuring that funds actually reach
the school. But this can really be seen as an act of de-concentration rather than devolution,
as the breakdown of permissible expenditure by item is centrally prescribed and the School
Committee’s autonomy is extremely constrained. This may help account for the fact that many
school committees seldom meet, and those that do, do not produce school development
plans (ADEM, 2009). The tendency towards de-concentration rather than devolution can
also be seen in the political decision to build a secondary school in every ward, without prior
assessment of actual needs at sub-national level. This has led to many schools being unused
or poorly utilised and most schools in rural areas are seriously under-resourced.

If decision making is to be devolved down to community and district levels one prerequisite is
a robust and reliable data system at the local level. The Education Sector-wide Management
Information System (ESMIS) has been working on de-centralising data collection and monitoring
to the district level for precisely this reason. Districts should also be encouraged to carry out
research in specific issues that affect education in their localities, for example, on why certain
groups are still under-represented in schools. The central Government must also empower
inspectorates at district level to fulfil their responsibility to inspect all schools on an equal
and regular basis, rather than focus on the easy-to-reach schools where the problems may
be less than in more remote areas. Rigorous, routine Inspection reports should help inform
a regular updating of the situation analysis of education at the district level and ensure that
all schools are achieving or exceeding the minimum standards.

Box 8: Access to and use of information

This report has highlighted the need for enhanced education data and analysis. The ESMIS promises
to fill some of these gaps, but more quality research is required in many areas. For example, little is
known about the role of the private sector in primary provision, teacher competencies, or the extent
to which child abuse exists in schools. The enhanced utilisation of data for evidence-based planning at
all levels is critical. In some cases data and analyses are available, for example, from the Southern and
Eastern Africa Consortium for Monitoring Educational Quality (SACMEQ) but such surveys are not
shared and discussed systematically to inform policy and planning. UNESCO’s support to Education
Sector Analysis, which links ESMIS to sector planning through simulations and the development
doing different planning scenarios, should lead to more informed choices that ensure that access and
quality issues are closely aligned. Evidence-based planning should take place at all levels of the
system if service delivery is to be adequately targeted. A systematic review of existing data and the
identification of further studies are urgently required to close information gaps.
5.6.2 Sector dialogue and participation
The dialogue structures established in MoEVT have provided opportunity for much broader stakeholder involvement in decision making. The six Technical Working Groups (TWGs) have recently been revitalised and have a key role in reviewing new initiatives before the Education Sector Development Committee approves them. The six TWGs are:

i. Quality Improvement
ii. Enrolment Expansion
iii. Institutional Arrangements
iv. Cross-cutting Issues
v. Folk Education
vi. Resource Allocation, Cost Effectiveness and Funding (RACEF).

The Education Sector Review process is also very welcome in that it affords opportunity for CSOs, private sector and donor partners to review progress against commitments agreed in an annual Aide Memoire.

Strengthening participation at the district and sub-district levels is being encouraged through support to District Consultative Committees. Some districts also hold education stakeholder forums and others have introduced Tanzania Gender in Education Initiative (TGEI), with support from the national TGEI Forum. Institutional arrangements are also particularly important where inter-sectoral collaboration is essential, not least HIV and AIDS and Care and Support for MVCs, early childhood development, poverty alleviation, environmental sustainability, and water, sanitation and health in schools. In all these areas there have been important recent developments, including the establishment of multi-sectoral steering committees and forums. The key challenge is to ensure replication of such structures at the sub-national level to ensure that enhanced service delivery actually occurs at the school and community levels. The MoEVT governance structures and specifically the TWGs for Cross-cutting Issues and Institutional Arrangements will have a key role to play in ensuring the necessary coordination as will structures in other ministries which are supported by MoEVT, for example, ECD, which is coordinated through the Ministry of Community Development, Gender and Children.

5.7 Priority areas and recommendations
Tanzania has made very significant progress towards meeting MKUKUTA, EFA and MDG targets, particularly in terms of access to education and percentage expenditure targets for the sector. But rapid expansion of the education sector must be adequately resourced. Despite the rapid quantitative gains made, a significant number of children have their educational needs unmet. Approximately one-third of all children at primary level are failing to complete school and learning outcomes remain poor. These inequalities are frequently inter-linked to issues of gender and poverty. Among the most excluded are children with disabilities, children who have to work to support their households, orphans, children in nomadic communities, or those living in remote rural areas. These children are more likely to be poor, malnourished, less likely to enrol or attend school, more likely to dropout at an early age and less likely to progress to the next level of education. There is an indisputable intergenerational transmission of disadvantage. Specific measures targeted on such groups are required.
Three striking priorities, therefore, emerge from this situation analysis of the education sector:

i. Reaching children on the margins

ii. Improving the quality of educational outcomes

iii. Engaging parents and communities.

**Reaching children on the margins**

More effective targeting of services is required in primary education to better reach marginalised groups of children. Mindful of the persistently high dropout rates, COBET remains an important, tried and tested alternative approach, which provides accelerated ‘catch up learning’ for dropouts. However, children in COBET require continued investment, rather than premature phasing out of assistance.

Schools certainly have a role to play in attracting and keeping children in school, particularly in terms of enhancing counselling in schools, identifying MVCs, and providing additional support to disadvantaged children and their families. The situation and needs of such vulnerable children should be addressed in teacher education and integrated into school development planning. Importantly, an inter-sectoral approach is required to complement those interventions offered by the Ministry of Social Welfare and the National Action Plan for MVCs.

Supporting the ‘hard to reach’ is always a challenge and central MDAs can only provide the framework for such efforts. It is here that D-by-D needs to be realised much more effectively. Schools, communities, wards and districts should use an evidence-based approach to address inequalities in local education provision. ESMIS offers such an opportunity. Community-Based Information Systems, as established through the Opportunities and Obstacles for Development (O&OD) process may also need revitalisation, while planning at LGA level should include all stakeholders. District Education Forums should be encouraged and community participation in Whole School Development Planning linked to village development planning should be revitalised.

**Improving the quality of educational outcomes**

Quality must be enhanced in education. More needs to be understood about learning outcomes, not only numeracy and literacy, but also life skills so that all children are given the key competencies to prosper as empowered citizens. It is in the interest of both the individual and society that schools and training institutions provide young people with skills that correspond to the socio-economic needs of the country. Quality enhancement needs to be addressed holistically through improved teacher education, including INSET, and expanded provision of textbooks.

Realistic targets, linked to National Minimum Standards, should be established and monitored. For example, every school being inspected once a year is far preferable to some schools being regularly inspected and others ignored. High pupil-teacher ratios are also a major source of inequality and disadvantage to children in rural areas. Additional incentives may be required to attract teachers to remote areas but also additional discipline to ensure that
teachers fulfil the needs of their students. At the same time, teachers need to be better motivated to enhance their attitude and performance through comprehensive measures as recommended by TDMS. Learning resources need to be enhanced with more equitable distribution. For example, a textbook:pupil ratio of 1:3 for all children would at least allow pupils to share a textbook in class, until the target of 1:1 becomes more feasible. Students must also have reasonable access to safe water and sanitation in schools. This is particularly critical for girls.

At the secondary level more realistic, phased planning is required to ensure that provision is not so under-resourced that it becomes discredited by lack of quality. A phased approach to achieve 100% access to lower secondary education would be a good first step. At the same time it is encouraging to note that the Institute of Adult Education is developing a more cost-effective Integrated Approach to Post-Primary Education, which may provide the skills needed for access to the employment market, whereas secondary tends to lead to increased demand for higher education which is also struggling to maintain quality at present. Likewise Technical and Vocational Education Training remains a valuable alternative to secondary education and/or higher education, but the range of courses may need to be updated to ensure appropriate fit to current labour market needs as well as greater access to girls.

Lastly, the current language policy perpetuates both inequity and poor learning outcomes. Using Kiswahili as the only language of instruction in public primary schools and English as the language of instruction in secondary schools adversely affects many children.

Engaging parents and communities

Relations between school, home and community vary widely. Schools that reach out and engage communities and parents are likely to be better resourced and to record better learning outcomes among students. Community engagement can result in better school facilities and infrastructure and help to ensure the availability of school meals for students. Schools can also help improve learning outcomes, especially for girls, by assisting and helping parents understand the crucial role they play in helping students learn. This engagement with parents needs to begin during pre-primary education and continue throughout the child’s education. Parent engagement is especially important given the high levels of illiteracy among women and their influence over learning outcomes for their children, especially girls. Positive and supportive engagement of parents can increase their willingness to keep children in school. Relations with parents and communities should arguably be included in in-service teacher training programmes.
Chapter 6
Women, children and HIV and AIDS

The HIV and AIDS epidemic among women and children is closely intertwined. Studies have shown that infant and early childhood mortality among children living with HIV-infected mothers is two to five times higher than children with mothers who are HIV-free (African Network for the Care of Children Affected by AIDS, 2004). To avoid transmission, children primarily rely on their mothers to know their sero-status, access preventative services during pregnancy and after delivery, and later access care and treatment services. Mothers are expected to proactively follow up their own health and that of their children after birth, which is quite challenging in an environment where women carry a heavy workload of care for the family and the sick.

This chapter first provides an overview of the epidemic in Tanzania and discusses the structural, underlying and immediate causation of HIV and AIDS in Tanzania and the impact of generalised insecurity. It then identifies key targets and strategies for combating the epidemic. An analysis of the status and trends of HIV and AIDS among women and children follows, along with examination of socio-cultural and behavioural factors that heighten the risk of transmission and HIV and AIDS interventions to combat the epidemic. Finally it reviews the resources and institutional framework related to HIV and AIDS and their effectiveness, recommending changes that may assist in reversing the epidemic.

6.1 Overview of the HIV epidemic in Tanzania

The Tanzanian Mainland has a generalised epidemic with an estimated prevalence of 5.7% of adults aged 15-49 years. About 1.3 million people are currently HIV-infected, of whom approximately 10% are children below 15 years of age (TACAIDS, 2009e). The predominant mode of transmission is heterosexual contact. HIV prevalence varies across geographical regions, ranging from 14.7% in Iringa to 1.2% in Kigoma (Figure 69). Urban residents are more affected than their rural counterparts (9% versus 5%). Specific population groups, including commercial sex workers and their clients, injecting drug users (IDUs), fishing communities, miners and men having sex with men (MSM) are disproportionately affected.

Data on HIV transmission and prevalence among children is limited, however, it is estimated that 90% acquire the infection through mother-to-child transmission. An estimated 123,800 HIV-positive women deliver infants annually in the Mainland (MoHSW, 2008b).

Since 1997, the epidemic in the Mainland has stabilised around 6%. This has also been reflected in reported AIDS cases and surveillance among pregnant women and blood donors. The current national HIV prevalence of 5.7% shows a 1.3% decline from the first national Tanzania HIV/AIDS Indicator Survey (THIS) 2003-04. However, a small secondary increase has been projected due to the rise in rural incidence of HIV infections and uptake of anti-retroviral treatment (ART) services over the last five years. The number of people living with HIV is also expected to increase in rural areas where the spread of the epidemic is more pronounced because poverty and poor health service infrastructure deny people easy access to quality HIV-related services.

Building an evidence base on HIV and AIDS

Two national surveys – the Tanzania HIV/AIDS Indicator Survey (THIS) 2003-04 and the Tanzania HIV/AIDS and Malaria Indicator Survey (THMIS) 2007-08 – are providing a more reliable evidence base to inform the design and implementation of interventions to address HIV and AIDS.

To date, however, these national surveys have not captured data on children under 15 years of age. Data for these children is estimated from HIV prevalence among pregnant women aged 15-49 years, fertility rates and assumptions of survival of HIV-positive children.

UNAIDS estimates for 2009 (released June 2010) indicate that this figure has declined sharply to 86,000 women.
6.2 Gender, poverty and HIV and AIDS

Gender is a determining factor in the HIV epidemic. Prevalence in Mainland Tanzania among women is higher at 6.8% compared with men at 4.7% (THMIS 2007-08). Prevalence rates are slightly lower than those recorded in THIS 2003-04 (Figure 70), and HIV prevalence among young women aged 15-24 years is significantly higher than among young men of the same age group (7.2% of women 23-24 years compared to 2% of men).

However, HIV prevalence has increased in the two lowest wealth quintiles compared with previous surveys, while HIV prevalence in the two highest quintiles has declined. This attests to the linkage between increasing poverty, particularly at the household level, and rising HIV prevalence among the poor, the majority of whom are in rural areas. The high HIV prevalence and poverty levels in some regions have also generated higher numbers of child-headed households, particularly in poorer districts. The 2002 National Census puts child-headed households at 1.2% with the average age of the child head between 14 and 15 years.
The combination of poverty, high HIV prevalence and inequities in accessing healthcare services contributes to the epidemic in women and children. It is estimated that there are about 730,000 adult women aged 15 to 49 years living with HIV, which represents 56% of the total HIV-positive population in Tanzania. Women account for 60% of the new infections (MoHSW, 2008b).

Box 9: Disability and HIV and AIDS

People with disabilities are frequently marginalised within their families and communities, relegated to the periphery where many live in abject poverty. The majority are less educated about HIV than their peers, yet a recent study has shown that people with disabilities are sexually active, and are engaging in high-risk sexual activities. The Forgotten: HIV and Disability in Tanzania, a study conducted by TACAIDS in 2009, found that HIV prevalence among disabled women was higher than among disabled men, and that rates were higher in urban than rural areas (TACAIDS, 2009a).

Due to poverty, disabled women are more likely to engage in transactional or paid sex, and are three times more likely to be victims of physical and sexual abuse, including ‘virgin rape’ due to the common misconception that a HIV-positive individual can be cleansed of the virus if he sleeps with a virgin. Women with disabilities are also more likely to be excluded from critical HIV services. In addition, women who give birth to a child with a disability are more likely to be abandoned by their husbands leaving them in dire poverty. This in turn denies disabled children access to essential services, particularly education and healthcare, because their mother is HIV-positive and poor. In these circumstances, women and children are trapped in a vicious cycle of disability and HIV and AIDS.

Behavioural and socio-cultural factors also drive the epidemic. A general low-risk perception and inconsistent condom use, particularly among youth, contribute to high HIV prevalence levels. Multiple concurrent sexual partnerships (MCP) are a common practice and take the form of extramarital, casual, cross-generational and transactional sex. The THMIS 2007/08 reported that 3% of women and 18% of men in Mainland Tanzania had more than one sexual partner in the previous 12 months, and 30% of men and 16% of women reported having had high-risk intercourse (i.e. sex with a non-marital, non-cohabitating partner).

Figure 71 illustrates a causality framework of HIV and AIDS in women and children in Tanzania. It highlights not only the immediate causes of transmission, for example, unprotected sex and mother-to-child transmission, but also the underlying and structural causes of the epidemic, such as poverty at the household level.

6.3 Key strategies: Status of the national response to HIV and AIDS

The second five-year National Multi-Sectoral Strategic Framework (2008-2012) builds on the first (2003-2007). It provides guidance to key players, including public and private sectors, and civil society, to support the design and implementation of HIV and AIDS interventions with regards to:

- Prevention
- Care and treatment
- Impact mitigation
- Creation of an enabling environment (TACAIDS, 2009b).
MKUKUTA operational targets for HIV and AIDS emphasise the reduction of HIV prevalence, particularly among women of 15-24 years (Table 13). Though MKUKUTA recognises the reciprocal effect and relationship between the HIV epidemic and poverty, the framework falls short of incorporating the impact of the disease on the macroeconomic, household or family situation.

Despite a conducive policy environment for women’s and children’s health generally, a number of laws and policies – in particular the National AIDS Policy (2001), the National HIV and AIDS Prevention and Control Act (2007), the Education Sector HIV and AIDS Strategic Plan (2008), the Child Development Policy, (2008), and the Law of the Child Act (2009) – do include specific provisions for HIV and AIDS to enhance the national response. As such they offer only limited protection of women, vulnerable children and youth. An important critique of the National HIV and AIDS (Prevention and Control) Act 2007 (URT, 2007a) is that whilst it has been hailed as progressive, expert opinion argues that this type of legislation creates special crimes related HIV transmission in Tanzania where most transmission occurs between sexual partners unaware of their HIV sero-status (Cameron, 2008). Far from protecting women, this may victimise and endanger them. The Act is intended to promote treatment, counselling and public health for people living with HIV, but is not explicit on the issue of transmission from mother to child that under normal circumstances is unintentional. Section 47 of the Act can be abused in the context of mother to child transmission of HIV and lead to punishment of women who are essentially the main carers of children.
Table 13: MKUKUTA targets and indicators relating to HIV and AIDS

<table>
<thead>
<tr>
<th>MKUKUTA I Targets</th>
<th>Cluster Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved survival, health and well-being of all children and women and especially of vulnerable groups</td>
<td>Increase resources for effective HIV and AIDS prevention programmes, including targeted and focused peer education, scaling up of STI screening and treatment, VCT services, condom use, and address stigma and discrimination</td>
</tr>
<tr>
<td>• Reduced HIV prevalence among pregnant women aged 15-24 years from 11% in 2004 to 5% in 2010</td>
<td>Scale up proven non-ARV interventions, including therapies such as natural or food supplements, TB prevention and treatment, and treatment of opportunistic infections in PLWHA</td>
</tr>
<tr>
<td>• Reduced HIV prevalence among 15-24 year-olds from 11% in 2004 to 10% in 2010</td>
<td>Equitable, sustainable and cost-effective access for all affected households to ARVs, with emphasis on ARV education, prevention of mother-to-child transmission (PMTCT) and support for the mother after delivery</td>
</tr>
<tr>
<td>• Reduce HIV and AIDS prevalence among women and men with disabilities (aged 15-35 years)</td>
<td>Implement and support a programme of continuity of care for PLWHA including community-based initiatives such as home-based care, basic support for food, water, housing, gloves and psychosocial support. Promote and implement programmes with particular attention to women, children, PLWHA, elderly carers, widows and child-headed households</td>
</tr>
<tr>
<td>• Increased knowledge of HIV transmission in the general population</td>
<td>Link community-based initiatives to facilities within the continuity of care framework that provides long-term care and management of highly burdening chronic conditions such as HIV and AIDS, TB and cardiovascular diseases</td>
</tr>
<tr>
<td>• Reduce HIV and AIDS stigmatisation</td>
<td>Integrate measures to address gender inequalities and inequities that result in higher HIV prevalence rates among women and girls</td>
</tr>
<tr>
<td>• Effective HIV and AIDS education and life skills programmes offered in all primary, secondary schools and teachers colleges</td>
<td>Undertake reforms in primary and secondary curricula, teacher training, teaching materials, assessment and examination and school inspection to promote creative and skill-based learning to incorporate HIV and AIDS and issues of the environment, education for sustainability, health, sanitation, social equity and shelter</td>
</tr>
<tr>
<td></td>
<td>Enhance implementation of school health programmes</td>
</tr>
</tbody>
</table>

Sources: HakiKazi Catalyst, 2005; URT, 2005.

Poor health infrastructure, inadequate technical expertise and insufficient resources to address the epidemic are among key challenges in HIV programmes in African countries, including Tanzania. Children’s chances of HIV prevention, survival, care and treatment are heavily impacted by the prevalence rates among mothers and their access to prevention, care and treatment. Experience in various countries has shown that a critical cohort of children under 1 year of age is not being identified in time to benefit from anti-retroviral treatment (ART). There are limited paediatric HIV diagnostic facilities and most HIV-infected children are diagnosed very late in the course of illness, or not at all – despite the Government’s resolve to increase paediatric enrolment from 1,967 in 2004 to 18,030 in March 2009 (National AIDS Control Programme (NACP), 2009a). Positively, National Early Infant Diagnosis Guidelines (MoHSW, 2008c) have been put in place, and diagnosis of HIV in infants by the DNA-PCR test is performed in five zonal laboratories.
across the country. However, children in rural areas are at a great disadvantage as these critical services are urban-based and largely inaccessible to rural communities.

As per the law of contract in Tanzania, a person below 18 years cannot provide consent for services. A parent or guardian must do this on their behalf. Due to the low knowledge of caregivers, children are typically taken for treatment when they present multiple opportunistic infections, which make it difficult to initiate ART. Most children find out about their sero-status either accidentally or out of curiosity. And in an environment lacking supportive counseling, these children have a high tendency of defaulting or refusing to begin or continue with ART which leads to rapid progression to full-blown AIDS and death.

### 6.3.1 Prevention of mother-to-child transmission of HIV

Expanding access to prevention of mother-to-child transmission (PMTCT) services is the key to slowing down the HIV epidemic in children. Mother-to-child transmission accounts for about 18% of new HIV infections in Tanzania. In 2008, it was estimated that 8.2% of 1.56 million pregnant women were HIV-positive. However, around 40% of pregnant mothers did not have access to PMTCT which means a substantial number of children are likely to be exposed to HIV when they are born.

Based on the HIV prevalence rate of 8.2% among pregnant women in 2008, approximately 128,000 newborns annually were at risk of vertical transmission, of whom approximately 42,000 could be expected to be infected in the absence of effective PMTCT (MoHSW, 2008d). The PMTCT programme, which got underway nationally in 2000, has rapidly expanded the number of clinics offering PMTCT services, with a corresponding increase in the proportion of all pregnant women tested for HIV during antenatal care (ANC) and at delivery. This increased “reach” has unfortunately been accompanied by a decline in the proportion of women testing HIV-positive who actually received prophylaxis. The combination of these two factors means that effective coverage of PMTCT (i.e. proportion of all HIV-positive women who received prophylaxis) has risen – but not by as much as it should have if “missed opportunities” had been avoided. In fact, current figures may over-estimate coverage since they assume that all women who gave birth at home, and were given Nevirapine to take away, actually took it when in labour.

**Figure 72: PMTCT Programme performance, 2005-2008**

![Figure 72: PMTCT Programme performance, 2005-2008](source: MoHSW, 2008d)
Though PMTCT service coverage and uptake are increasing gradually, the situation has not improved with respect to HIV prophylaxis for the newborn and to infant feeding practices. In 2008, only 32% of infants born to HIV-positive mothers received prophylaxis (Figure 73) and 42% of women testing positive had opted for either exclusive breastfeeding or exclusive replacement feeding to avert transmission through breast milk, with no breastfeeding counselling or outcome recorded for the remainder (MoHSW, 2008d). The combination of low post-natal nevirapine prophylaxis and very little counselling on infant feeding will no doubt reduce the efficacy of the programme in preventing vertical transmission.

**Figure 73: Distribution of women who tested HIV+ and received ARV prophylaxis and their infants**

By December 2008, there were 3,029 healthcare facilities that offered PMTCT services, which represents about 65% of the 4,647 Reproductive and Child Health (RCH) centres in the Mainland (Figure 74), up from 1,347 sites in 2007. However, an increase in the number of HIV-positive pregnant women indicates that there is poor accessibility to services. This may be attributed to low knowledge on the significance of PMTCT and fear of being the victim of stigma and discrimination upon accessing services. Eight out of ten women and seven out of ten men aged 15-49 years know that HIV can be transmitted from mother to child through breastfeeding, but only 53% of women and 44% of men know that HIV transmission risk can be reduced if the mother takes special drugs during pregnancy (THMIS 2007-08). The lack of a supportive environment for pregnant mothers, low male involvement and inadequacies in the health system also affect PMTCT programme efficiency.
Figures on the actual impact of the PMTCT programme in averting vertical transmission are not available, pending a national PMTCT evaluation exercise commissioned in 2010. However, ample scope exists for interventions to raise the coverage and effectiveness of the PMTCT programme so that newborn babies are protected against HIV. For example, a family-centred approach to HIV and AIDS services, where all family members can access services at the same facility, may promote greater utilisation of HIV intervention services. Currently, most PMTCT centres do not have care and treatment services for women and children. Children exposed to HIV are referred to adult treatment centres for diagnosis which has led to huge attrition in follow up.

### 6.3.2 Care and treatment services

From 2004 to July 2009, the number of patients on ART increased from 2,000 to 280,227. A total number of 642,302 PLWHA were enrolled in Care and Treatment Centres (CTCs) and health facilities providing HIV care and treatment services increased from 200 to 750. Facilities include all referral, regional and district hospitals, health centres, and some dispensaries both public and private (NACP, 2009b).
The NACP has set a target that children below 15 years should constitute at least 20% of all patients on ART by 2012. However, by July 2009, only 8% of people living with HIV and AIDS (PLWHA) enrolled in care and treatment services are children below 15 years of age (18,030 children on ART by July 2009 out of 242,290 patients). Various obstacles have been encountered in achieving this target, particularly the lack of skilled health workers.

Figure 76: Children as a proportion of CTC clients

Tanzania is still grappling with inequity in care and treatment services for women living with HIV and their children. This is because the CTCs are stand-alone facilities that affect the continuum of care, which should extend from increasing access to ART for pregnant women and children, early diagnosis of HIV among infants and co-trimoxazole prophylaxis for infants and children. The CTC and PMTCT services serve the same child, but the linkage is not clearly defined. Moreover, HIV testing for children is not routine even in the presence of multiple symptoms that suggest HIV infection. Poor tracking of children of HIV mothers as a result of irregular visits to clinics contributes to poor retention of children in treatment, care and support services. Access to services to treat severe acute malnutrition in children and pregnant women is sporadic, even in the limited number of districts where services have been established.

Data collection and recording at CTCs are insensitive to children’s clinical measurement, and are more adult-focused. In addition, the retention rate and follow-up of paediatric cases is also weak according to the National AIDS Control Program. Only 65% of children aged up to 12 months and 54% aged up to 24 months are retained for treatment; the remainder are lost for follow-ups. It is not known what befalls these children – death or migration to other places. Without further data on the prevalence of HIV and AIDS among children and the survival rates of those who ever started treatment, it is impossible to estimate the proportion of children with advanced HIV infection who are receiving ARV treatment.

Some of the major challenges with respect to care and treatment services include:

- **Inconvenience and cost**
  Long queues and waiting hours at CTCs are a disincentive to most mothers and children to seek treatment. Adults have limited time and funds to travel to CTCs.
Children and Women in Tanzania

• Failure to orient services toward children
CTCs are adult-oriented and urban-centered, based mainly at regional and district hospitals. The inadequate capacity of health workers, information systems and policies do not support the routine identification, testing and care and treatment of HIV-infected infants and children. Even those who have undergone training are not comfortable in caring for HIV-infected children and paediatric patients in general. A study on paediatric HIV and AIDS showed that while paediatric ART formulations were available in facilities along with the national guidelines for PMTCT, voluntary counselling and testing (VCT), and CTC follow-up and continued care and support while on ART were immediate challenges (BASICS, 2006).

• Rights to information
Disclosure of HIV positive sero-status of children below 16 years is prohibited, which means a good number of teenagers are unaware of their status

• Stigma and discrimination
Stigma and discrimination can weaken community involvement and support to mobilise people to access HIV-related services.

• Referral systems
Links between CTCs and health facilities, such as PMTCT clinics and hospitals, do not cater for paediatric AIDS, which is a missed opportunity for children.

• Supply shortages
There is a lack of drugs for treatment of opportunistic infections, supply of test kits for VCT, nutrition supplies to treat severe acute malnutrition, home-based care services and post-treatment counselling and support services.

6.4 Key interventions to prevent HIV transmission among women and children

6.4.1 Primary prevention

For children in school
In recent years, Tanzania has significantly expanded prevention programmes for children in middle childhood and adolescence. These programmes aim to improve knowledge about HIV and AIDS and influence behaviour change. In 2007, 75% of secondary schools and 48% of primary schools provided Life Planning Skills training. By the end of 2007, 29,625 primary and 12,000 secondary school teachers had been trained to teach about HIV and AIDS. Over 90% of in-school youth are aware of HIV and AIDS (MoEVT, 2008b).

The Ministry of Education and Vocational Training has put in place guidelines that encourage creativity in conceiving and implementing activities aimed at HIV and AIDS education in schools and promoting behaviour change. In-school youth are given lessons on HIV and AIDS and sexually transmitted infections (STIs), life skills, reproductive health and gender relations (MoEVT, 2008b). These are integrated in the social studies, biology and civics subjects. Extra-curricular activities, such as sports, drama, debates and health clubs, are also used as channels to teach children how to protect themselves, to make informed decisions
and to build their communication skills. There is strong emphasis on abstinence and condom education for children from Standard 5 onwards.

In spite of this, behaviour change is yet to happen on a large scale. Existing programmes perform poorly in equipping teachers, parents, and the community with effective adult-child communication skills on sexuality. Currently efforts are underway by the MoEVT to finalise a National Life Skills Education Framework that will draw linkages between knowledge, attitudes and skills, and facilitate empowerment of children in decision-making on sexual issues. But these efforts will fall short without parallel interventions that target teachers and adults. The frequency of student-teacher sexual relationships, some of which lead to early pregnancies and the expulsion of the girls from school, is a potent indicator of the social challenges involved. This behaviour is generally condoned by the community with the penalty suffered by the girl rather than the male perpetrator. This is indicative of the structural imbalance in gender relations and power between adults and children that needs to be addressed if the epidemic, especially among adolescent girls, is to be combated.

For out-of-school youth
Targeting out-of-school youth has always been a challenge because this group is highly mobile and individuals frequently engage in risky behaviours, including unprotected, often transactional sex, and substance abuse. NGOs have been the main actors targeting this population by establishing youth groups, clubs and associations. But such efforts have remained poorly coordinated and fragmented with different actors using their own Life Planning Skills manuals and approaches.

The Ministry of Labour, Sports and Youth Development (MLSYD) acknowledges poor monitoring of such programmes and is currently developing a prevention strategy and a national Life Planning Skills manual to ensure consistency in messages and approach. Lessons from such interventions have also shown that programmes for out-of-school youth need to go hand-in-hand with livelihood skills and investment that promotes young people’s economic base. Youth capacity-building programmes funded locally or through international support rarely provide for loans or capital that would facilitate young people’s self-employment. Currently, the MLSYD is handing out grants for small projects targeting youth throughout the country, but the funding available is not enough to begin to address the problem.

Young men and women will continue to face risks of exposure to HIV due to their lack of comprehensive knowledge and prevention skills, as well as the economic instability they face as they strive for independence.

6.4.2 Reducing risky behaviours
A complex set of biological, behavioural and socio-cultural factors contributes to the spread of HIV and heightens the impact on women and children. Socio-cultural norms, customary laws and practices discriminate against women, and perpetuate inequities in gender relations that limit women’s access to education, employment, property ownership and healthcare, as well as in decision-making from the household upwards. Many women have little control over the terms of sex and the number of children they wish to have. Many do not have the same opportunities as men for education and economic independence. The TDHS 2004/5 found that 64% of men had completed primary education compared with only 58% of women, a

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**Fast Facts**

**Adolescence and HIV and AIDS**

Early sexual debut compounded by early marriage puts adolescents at risk of HIV infection:

- Approximately 11% of girls and 10% of boys aged 15-24 years reported having sexual intercourse by the age of 15.
- Among young adults aged 18-24 years, 59% of young women and 43% of young men have had sexual intercourse by the age of 18.
- Once they become sexually active, young people tend to have multiple partners.
- A third of the victims of unsafe abortions are teenagers.
gap that persists over time according to the preliminary results from the latest TDHS. In poor families, boys’ education tends to be valued more than girls, further limiting opportunities for employment for the women and increasing their dependency on men.

**Sexual health**

While vertical transmission represents the main risk to children for HIV, a small number of children acquire HIV sexually. In 2004/5, 3.5% of girls and 6.8% of boys between the age of 15 and 19 reported having experienced an STI or STI symptoms in the past 12 months (TDHS 2004/5). The STI status of younger children was not included in the survey. However, in the THMIS 2007/8, 11% of girls and boys reported having sexual intercourse by age 15. These figures, based on self-reported sexual debut, are almost certainly an under-estimate. Meanwhile, 59% of girls and 43% of boys reported that their sexual debut occurred before the age of 18 (THMIS 2007-2008). This age group is particularly at risk of HIV and STIs because their level of knowledge about risk factors is systematically lower than older men and women (THIMS 2007-2008). The situation of young girls is particularly acute as they are less able to negotiate safe sex with older sexual partners, especially where social, physical or monetary coercion is involved.

**Condom use and HIV**

Prevailing socio-cultural and socio-economic factors make primary prevention of HIV among women of childbearing age an extremely difficult challenge. Family planning and reproductive health services are not universal. TDHS 2004/5 estimated that the contraceptive prevalence rate was only 23% and unmet family planning needs run at 17%. In a stigmatising environment, women living with HIV are unlikely to access family planning services to prevent unintended pregnancies, and seldom get appropriate care and treatment. Currently, there are no specific programmes targeting them.

The gender disparity in HIV prevalence is further reflected in two areas: comprehensive knowledge of HIV prevention and condom use in high-risk sexual relationships. Both contribute to the differential impact of HIV and AIDS among 15-24 year-olds (Table 14). HIV appears to rise sharply with age from 1% of females aged 15-19 years to 6% of those aged 20-24 years. Young women (20-24 years) are 33% more likely to be HIV-positive than their male counterparts in the same age category. Of note, the sharp increase in HIV prevalence among women in this age group coincides with a decrease in condom use in high-risk relationships (THMIS 2007/8).

**Table 14: Knowledge and condom use among young people**

<table>
<thead>
<tr>
<th>Comprehensivel knowledge of HIV prevention among young people</th>
<th>Age</th>
<th>2003-2004</th>
<th></th>
<th>2007-2008</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Women (%)</td>
<td>Men (%)</td>
<td>Women (%)</td>
<td>Men (%)</td>
<td></td>
</tr>
<tr>
<td>15-19 years</td>
<td>38.5</td>
<td>42.6</td>
<td>35.1</td>
<td>38.8</td>
<td></td>
</tr>
<tr>
<td>20-24 years</td>
<td>50.4</td>
<td>56.5</td>
<td>43.9</td>
<td>45.7</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Condom use in high-risk sexual relationships</th>
<th></th>
<th></th>
<th>2007-2008</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Women (%)</td>
<td>Men (%)</td>
<td>Women (%)</td>
<td>Men (%)</td>
</tr>
<tr>
<td>15-19 years</td>
<td>36.9</td>
<td>37.7</td>
<td>48.2</td>
<td>41.3</td>
</tr>
<tr>
<td>20-24 years</td>
<td>46.9</td>
<td>54.0</td>
<td>43.9</td>
<td>54.7</td>
</tr>
</tbody>
</table>

The THMIS 2007-08 also found that HIV prevalence had risen among Tanzanians with no education but had declined significantly among individuals who had completed primary education and even further among those who had secondary education or higher (Figure 77). Related to this, data show that 18% of women with no education who had sex in the 12 months preceding the survey reported having sex with a man who was 10 or more years older than they were. The corresponding proportion for women with secondary or higher education was 3%. This disparity underscores the need for increasing education opportunities for young women to build their knowledge and capability to engage in effective decision-making on sexual matters as well as broaden their options in life.

**Figure 77: Trends in HIV prevalence by level of education**


### Gender-based violence

HIV and AIDS and gender-based violence (GBV) “have a dangerous complex relationship and may increase the risk and impact of the other” (USAID, 2008). Although growing recognition of gender discrimination and gender inequity has been noted in the Tanzanian Mainland, many forms of gender-based violence including intimate partner violence and rape are usually under-reported. A WHO multi-country study found that 41% of women in Dar es Salaam and 87% of women in Mbeya had suffered sexual violence at the hand of their partners in some points in their lives. At least 15% of women surveyed reported that their first sexual encounter was coerced (WHO, 2004). In another study, 30% of adolescent girls reported their first sexual experience as being a forced one, perpetrated by adults including teachers (Matasha et al., 1998). Studies have also shown that not only are women and girls blamed for provoking violence, but that they also rarely report abuse to the authorities for fear of a backlash (USAID, 2008). Such findings are confirmed in the Tanzania National Panel Survey (NPS) 2009, which found that one third (33.8%) of women aged 15-50 years have been abused at some point, including 8.0% who report having being forced by a partner to have sexual intercourse against their will, but only a fraction of the victims ever go to the police (4.4%) or to hospitals and health centres (7.3%) to report the abuse.

Women’s civil rights are limited by the existence of a dual legal system which includes statutory and religious/customary laws. Tanzania does not have a specific law on domestic violence. Neither the National Multi-sectoral Strategic Framework nor the AIDS Law (2007) addresses
the prevention and response to gender-based violence, and no protocols or guidelines exist for healthcare providers on the treatment and care of violence survivors.

Despite ongoing efforts by NGOs and advocacy groups, gender-based violence remains a serious obstacle to HIV prevention initiatives. Female genital cutting alone affects between 15% and 18% of women aged 15-49 years (NBS, 2005; USAID, 2008). A few NGOs including the Tanzania Gender Networking Programme, Tanzania Media Women’s Association and Women’s Dignity have aggressively advocated for gender equality and an end to GBV. Such efforts have seen the establishment of GBV desks in some police stations through the efforts of Tanzania Police Female Network. However, Tanzania has yet to finalise and endorse the National Plan of Action for Prevention and Eradication of Violence Against Women and Children, as well as the National Plan of Action on the Eradication of FGM, both of which are in draft form.

**Substance abuse**

Data on substance abuse in Mainland Tanzania is scarce, but it has been documented that women and men who drink alcohol have HIV prevalence two and three times higher than those who do not drink, and an estimated 27% of male injecting drug users in the Tanzanian Mainland and 58% of females are HIV-positive (TACAIDS, 2009c, 2009d). This group practices high-risk sexual and social behaviours, such as sharing needles, multiple concurrent partnering, transactional sex and unprotected sex. In spite of this, it is a group that is not only marginalised and stigmatised but also poorly addressed with respect to prevention, care and treatment services.

**6.5 Fiscal space**

A 2009 review of HIV epidemiology, prevention programmes and resources in Mainland Tanzania shows that, in 2007/08, the total expenditure on HIV and AIDS prevention, care, treatment, and support services was Tsh 595.7 billion (Table 15). This is more than 100% increase from 226 billion shillings in 2005/06. About 95% of these resources are overseas development assistance from multilateral and bilateral development partners, most of which is not channelled through the budget of Tanzania. Overall, 74% of HIV and AIDS funds from external sources are off-budget which means the national machinery does not have control over the expenditure of the funds (TACAIDS, 2009e). Although off-budget implementers work within national frameworks, they have their own system of responding or contributing to the HIV and AIDS national response based on their respective standards and interests. Because planning is not conducted jointly with national bodies such as TACAIDS, this parallel approach is likely to lead to over or under-funding of interventions and poor accountability. The impact of these funds may also be difficult to assess. On the other hand, off-budget HIV funding has proved to be rapid in reaching the target population, as it does not have to go through the government bureaucracy.

Whilst the Government has strived to mobilise internal resources to finance HIV and AIDS interventions, the national response has continued to be dependent on donor funding. Domestic initiatives to ensure sustainability in HIV programmes could take a few years to realise, for example, the HIV and AIDS Fund, a pooled funding arrangement to support National Multi-sectoral Strategic Framework (NMSF) and current financing modality of the Government of Tanzania for prioritising needs in the national response to the epidemic. It has been used mainly to strengthen district and community response following the phasing out of Tanzania Multi-sectoral AIDS Project (TMAP) funds from the World Bank. Discussions are also underway to explore the possibility of local government authorities setting aside funds for HIV prevention from locally generated revenue.
Table 15: Public and donor expenditure on HIV and AIDS, by funding mechanisms (TSh billions)

<table>
<thead>
<tr>
<th></th>
<th>Actual 2005/6</th>
<th>Budget 2006/7</th>
<th>Actual 2006/7</th>
<th>Budget 2007/8</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. MDA recurrent</td>
<td>21.8</td>
<td>24.0</td>
<td>21.4</td>
<td>21.6</td>
</tr>
<tr>
<td>2. MDA development</td>
<td>96.9</td>
<td>36.8</td>
<td>29.3</td>
<td>107.0</td>
</tr>
<tr>
<td>-Of which, GOT funded</td>
<td>0.3</td>
<td>0.0</td>
<td>0.0</td>
<td>5.9</td>
</tr>
<tr>
<td>3. Transfers to regions and districts</td>
<td>1.2</td>
<td>10.9</td>
<td>11.3</td>
<td>28.6</td>
</tr>
<tr>
<td>4. Total budget expenditure on HIV and AIDS (=1+2+3)</td>
<td>119.9</td>
<td>71.7</td>
<td>62.0</td>
<td>157.2</td>
</tr>
<tr>
<td>5. Of which, ODA financed</td>
<td>98.1</td>
<td>47.4</td>
<td>40.6</td>
<td>129.7</td>
</tr>
<tr>
<td>6. Off-budget ODA for HIV and AIDS</td>
<td>106.1</td>
<td>283.2</td>
<td>337.2</td>
<td>438.5</td>
</tr>
<tr>
<td>7. Total ODA for HIV and AIDS (=5+6)</td>
<td>204.2</td>
<td>330.6</td>
<td>377.8</td>
<td>568.2</td>
</tr>
<tr>
<td>8. Estimated total public and donor expenditure on HIV and AIDS (=4+6)</td>
<td>226.0</td>
<td>354.9</td>
<td>399.2</td>
<td>595.7</td>
</tr>
</tbody>
</table>

Total HIV spending as a % of:

<table>
<thead>
<tr>
<th></th>
<th>2005/6</th>
<th>2006/7</th>
<th>2007/8</th>
<th>2008/9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total government spending</td>
<td>5.8</td>
<td>7.4</td>
<td>8.3</td>
<td>10.9</td>
</tr>
<tr>
<td>GDP</td>
<td>1.6</td>
<td>2.2</td>
<td>2.5</td>
<td>3.3</td>
</tr>
<tr>
<td>HIV aid as % of total aid</td>
<td>15.1</td>
<td>21.8</td>
<td>24.9</td>
<td>32.9</td>
</tr>
<tr>
<td>HIV aid as % of high scenario aid</td>
<td>11.2</td>
<td>16.1</td>
<td>18.4</td>
<td>24.5</td>
</tr>
<tr>
<td>ODA as % of HIV and AIDS expenditure</td>
<td>90.4</td>
<td>93.2</td>
<td>94.6</td>
<td>95.4</td>
</tr>
<tr>
<td>% of HIV and AIDS aid included in government budget</td>
<td>48.0</td>
<td>14.3</td>
<td>10.8</td>
<td>22.8</td>
</tr>
</tbody>
</table>


An analysis of the funds captured in the government budget shows that only 5% of it was directly channelled to the districts and regions in 2007/08. This is a very small portion that cannot facilitate implementation of strategic interventions and locally based responses. With this low district allocation, the majority of the population who are poor and rural will continue to be marginalised and denied HIV-related services. It is critical to engage in deliberate efforts to reverse the trend and to ensure that off-budget funds are tracked and equitably allocated to benefit women and children. In addition, HIV services that target women and children, including PMTCT and Paediatric AIDS, are not reflected in Council Comprehensive Health Plans and so these sectors receive inadequate funds from the Government.

Resource utilisation has also been lopsided with care and treatment taking the lion’s share of over 60%, while prevention accounts for 31% of the HIV and AIDS expenditure. Even though the trend of increasing resources may be encouraging, its allocation is undoubtedly targeted to addressing the results of the epidemic as opposed to its causes.

6.6 Institutional frameworks and monitoring systems

The HIV/AIDS Policy 2001 entrusted the Tanzania Commission for AIDS with the task of providing strategic leadership and coordination in the implementation of the national multi-sectoral response to HIV and AIDS. This was aimed at reducing new infections and addressing the adverse socio-economic effects of the epidemic. However, TACAIDS also implements advocacy and behaviour change interventions at national and district level.

At the same time the National AIDS Control Program (NACP) under the Ministry of Health and Social Welfare (MoHSW) is mandated to:
• Scale up the health sector response to HIV and AIDS and strengthen the health system capacity to support HIV and AIDS interventions
• Promote access and utilisation of affordable and essential interventions and commodities for HIV and AIDS
• Improve the quality of HIV and AIDS interventions to the general public, PLWHA, healthcare providers and other vulnerable populations
• Support prevention and care interventions (STI, VCT, hospital, home-based care, behavioural surveillance and laboratory services)
• Conduct surveillance and research
• Ensure commodity distribution, such as condoms.

There has been a significant growth and development of civil society organisations, NGO networks and FBOs over last five years that has complemented government efforts to broaden coverage of HIV services. Yet key informants note that linkages and interaction between government structures and the NGO community are poor, which generates a host of underlying inadequacies in terms of supply of ARTs, diagnostic facilities and condoms.

Different M&E systems exist for collection, analysis and use of HIV and AIDS data for policy dialogue and programmatic decision making (Global Fund, Southern African Development Community and TACAIDS). Though an evidence base is critical for planning and implementation, parallel systems are likely to omit critical information. In particular, M&E for HIV and AIDS interventions is weak at district level, due to inadequate human resources, low staff capacity, inadequate funding and poor infrastructure (UNAIDS, 2009). Key informants say that the current Health Management Information System (HMIS) does not yet capture HIV-related information and data disaggregated by age categories.

The Tanzania Output Monitoring System for non-medical HIV/AIDS (TOMSHA) is not yet fully operational, but is expected to include linkages with other M&E systems to produce a national set of HIV indicators. TOMSHA and HMIS are the major systems capturing non-medical and medical information but they lack specific information on women and children. For example, the HMIS depends on programme specific systems such as PMTCT and CTC, but data on children receiving ARVs is not captured. Moreover, there is no clarity on how these systems are linked to the monitoring of MKUKUTA, which therefore means poor or inadequate representation of views and inputs from the grassroots to national level.

To exacerbate the situation, many services such as PMTCT, MCH, and care and treatment clinics function vertically, with weak linkages and referral systems. This can lead to double reporting which, in turn, can result into poorly focused plans.

6.7 Priority areas and recommendations

The Government has made immense strides in ensuring that HIV and AIDS interventions address the needs of the population in Mainland Tanzania, including women and children. The greatest risk to ongoing HIV and AIDS programming in Tanzania, however, arises from the current high level of donor dependency, if domestic strategies and budgets are not put in place to match development partners’ commitments.

Existing national policy, legal frameworks and plans related to HIV and AIDS are also weak in their implementation, lack child-specific interventions, and do not adequately underpin women’s rights. Except for the National PMTCT programme, the country lacks a comprehensive HIV and AIDS Care and Treatment Policy for children. Despite national frameworks to combat the epidemic, poor coordination among TACAIDS and NACP, between Government, NGOs and development partners
compromises the quality of interventions and denies women and children a more holistic approach to prevention and treatment. Inadequacies in both the number and capacity of health workers particularly at lower levels, and a paucity of HIV-related child-specific data are further limiting factors in HIV and AIDS service planning and provision. A better coordinated effort is required at all levels.

The following policy and programmatic recommendations have emerged from this analysis.

**Policy recommendations**

- Health related policies, laws, guidelines and frameworks should prioritise women and children’s needs.
- HIV and AIDS should be integrated in legal frameworks to ensure a more consistent policy approach to the epidemic. Coordinated advocacy and policy dialogue must be sustained to ensure rapid implementation of laws and policies that promote gender equality as well as equitable access to high quality HIV and AIDS services.

**Programmatic recommendations**

**Short-term**

- Integrate services – PMTCT, Reproductive and Child Health and Paediatric CTC – into one delivery point. Paediatric AIDS should also be integrated into other routine care to minimise stigma and enhance referral systems.
- Maximise efforts to identify high-risk mothers and infants at critical health entry points, including antenatal visits, at delivery and post-natal checkups, and when necessary enrol women and their children for treatment.
- Implement early prevention programmes, particularly among adolescent girls.
- Strengthen coordination and capacity within and between national and district level structures to ensure smooth implementation and resource mobilisation.
- Promote resource tracking to facilitate equity in allocation and sustainability.
- Strengthen advocacy for increased attendance and frequency of ANC visits at Reproductive and Child Health facilities.
- Strengthen the provision of infant feeding counselling and nutrition support.
- Conduct a mapping of stakeholders to ensure equity in HIV-services and to reduce duplication of interventions.
- Build community capacity in HIV-related interventions to create a conducive environment for prevention.
- Use available evidence-based data and information for policy decisions and action. Child specific HIV data is integral for effective planning and response.
- Strengthen provider-initiated testing and counseling (PITC) services to facilitate early diagnosis and follow-up.
- Develop guidelines on how to disclose the HIV status of minors.

**Long-term**

- Ensure adequate resources are mobilised and equitably allocated for women and children.
- Conduct research into effective communication and behaviour change for children and adolescents and develop approaches that are sensitive to gender, age and the needs of rural and urban children.
- Strengthen the HMIS to capture child-specific HIV and AIDS data.
- Invest in health system strengthening.
- Advocate for a family-centred approach to prevention, care and treatment interventions to promote family and community support and access to services.
Chapter 7
Protection of children against abuse, neglect and exploitation

Children can only realise their rights to survival and development and become healthy, productive adults if they are safe from harm. The well-being of Africa’s children depends first and foremost on the well-being of their families and communities. In turn, families and communities will be better enabled to support and protect their children if national laws and policies are developed in harmony with the United Nations Convention on the Rights of the Child (UNCRC) and the African Charter on the Rights and Welfare of the Child (ACRWC) that underpin the delivery of high quality essential services to all Tanzanian children. In addition, specific child protection services are important when the child lives outside family care, or when the family cannot or does not protect the child from harm.

Whilst there is now a greater level of awareness of children’s rights in society, urban migration, HIV and AIDS, and an increase in single parent and elderly-headed households has placed traditional extended family structures in Tanzania under great strain. Family breakdown in turn can often lead to heightened risk of child neglect, abuse and exploitation. Figure 79 illustrates some of the key protection needs of children from conception through to adolescence.

It is evident that the rights and well-being of children need to be actively safeguarded at all points of the child's life course; the nature of the child’s exposure to risk changes as the child develops. For example, in adolescence, the child’s experience of the world expands and they may come into contact or conflict with the law. The importance of adult behaviour and institutional systems in reinforcing the child’s sense of a moral and just world is critical at this point in the life cycle.

7.1 International instruments and domestic laws and targets for child protection

There is a detailed international legal framework for the protection of children from violence, abuse and exploitation and for the protection of children in conflict with the law. Tanzania has ratified the majority of these international agreements, committing itself to ensuring that the rights of children are respected. However, the gap between international standards and the situation for children in the country remains considerable. Child labour and exploitation, early and forced marriages, and violence against children, particularly against girls, are still the reality for large numbers of children in Tanzania. The Government of Tanzania, in partnership with UNICEF and other child rights organisations, has been grappling with the challenge of how to turn the rights of children on paper into reality on the ground.

7.1.1 International instruments on child protection

Since the publication of the previous situational analysis in 2001, Tanzania has ratified the following significant international and regional child rights instruments:

Figure 78: Protection and the child’s life course

**Pregnancy, conception and birth**
- Birth registration is a fundamental right to establish the child’s legal identity and claim the protection of the law

**Infancy to Two Years**
- During this highly vulnerable period, where children are totally dependent on caregivers, children must be nurtured and protected from all forms of abuse and neglect

**All children and mothers must be protected from witnessing or being victims of violence, neglect, abuse or exploitation**

**Adolescence**
- During adolescence, children extend the boundaries of their lives, which can expose them to physical hazards and social risks, including conflict with the law
- As they develop universal principles of right and wrong, they need to experience the law as a just humane force not an arbitrary one.
- They need to feel protected within their communities and able to express their views and contribute their talents
- Adolescents need additional protection from risky sexual activity, including unintended pregnancies, sexual abuse and violence, and transmission of HIV and STIs. They also face higher exposure to drug abuse
- Protection from hazardous or exploitative labour
- Protection from harmful cultural norms, such as early marriage and childbearing
- In cases of teenage pregnancies, girls need to be supported to continue their education, not expelled from school

**Early childhood**
- A secure, consistent and loving presence from parents
- Safe living environments to begin to experience the world and develop their personalities and skills

**Middle childhood (5-6 years of age to onset of puberty)**
- Over this period, children need to establish trust in adults and peers.
- They need safe places to study and to play, free from harassment, violence and danger.
- Adults need to model non-violent ways of resolving problems and conflicts, and to demonstrate consistency between the moral values they hold and their own behaviour
- Discipline in school and at home should avoid corporal punishment so that children feel able to question and express themselves with confidence and without fear
- Protection from harmful cultural practices such as female genital mutilation.
- Children need support to handle situations of bullying by peers and to learn appropriate group and relationship behaviours
- Protection from hazardous or exploitative labour

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- Protection from harmful cultural practices such as female genital mutilation.
- Children need support to handle situations of bullying by peers and to learn appropriate group and relationship behaviours
- Protection from hazardous or exploitative labour
While this demonstrates Tanzania’s commitment to child rights, ratifying such instruments is only the first step to better protecting and providing for children. Tanzania needs to incorporate these standards into national law and ensure their implementation. The Law of the Child Act, adopted in 2009, has been a significant step in this process.

### 7.1.2 The Law of the Child Act 2009 and other significant national laws

The passage through the Tanzanian Parliament of the Law of the Child Act (LCA) on 6 November 2009 is a landmark piece of national legislation aimed at protecting children. It enshrines fundamental rights of children, defined as any person below the age of 18 years, including:

- non-discrimination;
- the right to a name and nationality;
- that a child's best interests shall be the primary consideration in all actions taken concerning him/her;
- the right of children to an opinion, to be listened to and to participate in decisions impacting them;
- the right to protection from torture and degrading treatment;
- the right to be protected from economic exploitation;
- the right to know and be cared for by their parents; and
- the right that their parents must uphold – to guarantee their children life, dignity, respect, leisure, liberty, health, education and shelter.

The LCA, however, does not guarantee a number of key children's rights. Most strikingly, it does not address discrimination regarding the legal age of marriage, which remains at 15 years for girls and 18 years for boys, and does not prohibit corporal punishment of children.

Significantly, for the first time in domestic legislation, the law provides the framework for a child protection system, obliging a range of bodies to prevent and respond to violence, abuse and exploitation of children. The law prioritises family-type care over institutionalisation for children who are unable to remain with their family. The LCA also strengthens the protection for children appearing in court, whether they come into contact with the legal system as offenders, witnesses or victims.

To make a difference to children’s lives, the Law of the Child needs to be brought into practice. However, there are a number of significant challenges to tackle. Child protection is not a well understood concept among government institutions and ministries or civil society. While the LCA provides a framework for child protection, it does not provide sufficient detail to allow duty bearers to understand how they will fulfil their obligations under the Act. The Government has recently begun developing much needed regulations, rules and minimum standards, which will set out the roles and responsibilities of the key bodies responsible for protecting children from abuse and provide detailed guidance to front line workers on their specific obligations. The Government also needs to embark on a major country-wide training initiative to equip front line workers with the skills and knowledge they need to implement the law. To carry out training on this vast scale it will be necessary to coordinate and collaborate with civil society organisations, which have already begun to disseminate information on the new law.

### A brief history of legal reform for Tanzanian children

Reform is needed to bring Tanzanian laws into alignment with the UNCRC (ratified in 1991) and the ACRWC (ratified in 2003).

Discussions to enact a children’s statute to bring Tanzanian laws into alignment with the UNCRC and ACRWC date from 1994 when the Tanzania Law Reform Commission compiled a wide-ranging report (URT, 1994).

In 2001, the CRC Committee encouraged Tanzania to adopt a comprehensive children’s code with a view to enhancing a rights-based approach for children.

In 2003, the National Network of Organisations Working with Children produced a report on the ‘Basic Elements and Principles to be Incorporated in a New Children Statute in Tanzania’ for the Government Draftsmen.

In 2005, a draft law was presented to Cabinet, but never presented to parliament.

In 2006, the CRC Committee reiterated the need for Tanzania “as a matter of priority to engage all efforts and resources necessary for the enactment of the Children’s Act.”

In 2008, UNICEF was invited to assist the government team responsible for writing the first draft of a new Act – which was first read in Parliament in July 2009.

The Law of the Child Act passed into law on 6 November 2009.
Now that the LCA is in place, impetus needs to be maintained in developing minimum standards to regulate child protection programmes. In particular, the new law heavily relies on social welfare officers to implement its provisions. However, social welfare officers are under resourced and already overstretched. Significant investment will be needed to build the capacity of this service, if social welfare officers are going to be able to fulfil their obligation to prevent and respond to abuse of children. Child protection is not defined in the Tanzanian law, nor is there a government department actively providing child protection services in all districts. Child protection appears missing from the national agenda. It has been conceptually absorbed into social protection with the emphasis on the Most Vulnerable Children (MVC) programme being considered sufficient as a child protection intervention. It is not. The consequences for abused and exploited children are considerable. To achieve meaningful change, much greater investment in structures, systems, personnel and resources for child protection will be required. In addition, there are few services for children who have suffered violence, exploitation and abuse. Investment is urgently required to develop child protection services at the district level, to ensure that children who suffer abuse can access the support and care that they need.

7.1.3 Domestic targets for child protection

The first phase of MKUKUTA lacked a comprehensive framework of indicators, targets and strategies for child protection. Table 16 shows that the only specific target for child protection under Cluster 2 related to child labour. MKUKUTA also set two operational targets under Cluster 2 that are relevant to child protection:

i. 20% of children and adults with disabilities reached by effective social protection measures by 2010 and

ii. Increased number of orphans and vulnerable children reached with effective social protection measures by 2010, which is discussed in greater detail in Section 7.5.

In addition, under Cluster 3 related to “Governance and Accountability”, the Government established the operational target to “ensure timely and appropriate justice for all especially the poor and vulnerable groups.” While awareness of rights to protection and a desire to claim those rights may have increased at community level, services have not been put in place. Families, particularly women and children, are unaware of what violations of rights and abuses can be reported, whom they should report to and what standards of service they can expect. Unlike some other SADC countries there is no coordinated national structure available at district level to which women and child can report abuse and seek both justice and protection.

Without strong representation in MKUKUTA, resources and support flowing to interventions were extremely limited. Nor do the MDGs have reference to child protection. This further weakens the claim of child protection for resources from governments and donors, sidelining it as a national priority.

7.2 A conceptual framework for child protection

All children have the right to protection from violence, neglect, exploitation and abuse, including sexual abuse, as enshrined in articles 19, 34, 35 of the United Nations Convention on the Rights of the Child. The right to be protected applies to all children and is indivisible from other rights in the UNCRC. Children require special safeguards and care because of their physical and mental immaturity and because the complex and often criminal nature of protection violations leave them especially vulnerable to harm.
While all children require protection, greater vigilance is needed to protect those at greatest risk, including children who are affected by poverty, loss of parental care, disability and emergencies. Special attention should be paid to the particular risks faced by girls and children with disabilities. Protection of children is a foundational right, since the failure to realise rights to survival and development, education and health may place a child in greater need of protection and a child who is unprotected may be less able to realise their other rights.

Given the incidence of generalised insecurity and the marginalisation of children discussed in Chapter One it is critical that greater attention is dedicated to building a protective environment for children. Poverty puts a child at risk of abuse, neglect and non-realisation of their rights to healthcare, education and play. As such a programme of social protection that lifts families out of chronic poverty also serves to protect children. Children’s patterns of resilience and their participation in decisions that affect their lives are important factors in building children’s capacity to better protect themselves and speak out against violations of their rights. Figure 79 illustrates a conceptual framework for creating a protective environment for children.

7.3 Status and trends in child protection

7.3.1 Birth registration

Birth registration is a fundamental right of the child. Article 7(1) of the UNCRC stipulates that children are to be registered immediately after birth. However, the THMIS 2007/08 estimated only 20% of children under five years of age in Mainland Tanzania whose births are registered, a marginal increase from 18% in 2004/05. There are significant socio-economic disparities in birth registration rates. Registrations rates in urban areas (46%) are three times higher than rural areas (15%), and children from households from the highest wealth quintile (60%) are six times more likely to be registered at birth than children in the lowest quintile (10%). As low as the birth registration numbers are, the number of registrations that turn into birth certifications is considerably lower. MKUKUTA I specifically monitored the percentage of children under five years with birth certificates; only 6% of children under five years of age in Mainland Tanzania had a birth certificate (urban 21%; rural 3%).

<table>
<thead>
<tr>
<th>MKUKUTA targets</th>
<th>Cluster strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce proportion of children in labour countrywide from 25% to less than 10% by 2010 and avail to them alternatives including enrolment in primary education, COBET and employable vocational education skills training</td>
<td>Develop and implement sector-based programmes for reducing worst forms of child labour</td>
</tr>
<tr>
<td></td>
<td>Educate communities on basic rights of a child including the flight against child labour; develop and implement programmes targeting reduction of child labour and rights of orphans and vulnerable children (OVC)</td>
</tr>
<tr>
<td></td>
<td>Review and amend laws, policies and national strategies to the best interests of children, and develop action plan for the implementation of the forthcoming Children’s Act</td>
</tr>
</tbody>
</table>


Table 16: Specific targets for child protection under MKUKUTA
Figure 79: A conceptual framework for creating a protective environment for children

- **A Protective Environment for Children**
  - Political will (National Government and donor partners)
  - Legal Reform to domesticate international commitments
  - Institutional relationships and responsibilities of professionals working within the CP system
  - Budget allocation, leakage of funds, investment in children who are vulnerable
  - Social and legal support to children in contact / conflict with the law
  - Judicial and social service mechanisms to respond to child abuse
  - Alternative care
  - Services for children in need of care – child laborers, trafficked children, those on the street, with disabilities, mental health problems, orphaned

**Government commitment and prioritising**
- Skilled and committed professionals / duty bearers
- Monitoring and reporting
- Financing

**Legislation**
- Identification of vulnerable children and offer of appropriate assistance
- Birth registration as a fundamental entitlement that enables a child to access other services

**Monitoring and infrastructure**
- Protective behaviours
- Children's ability to protect themselves
- Children's lifestyle

**Social Services and Referral mechanisms**
- Attitudes to violence, abuse and children
- Capacity of family and community
- Protective behaviours

**Financing**
- Budget allocation, leakage of funds, investment in children who are vulnerable

**Legislation**
- Open discussion and challenge of stigma
- Discrimination faced by girls and children on the margins
- Parenting / care approaches
- Public attitudes towards violence and child abuse
- Children's scope to participate in decisions affecting them, freedom of expression and access to information
- Leisure, recreation, cultural activities and role models
- Exposure to drugs / Involvement in crime
- Attitudes to children living on the margins - with disabilities, labourers, on the street etc

**Identification of vulnerable children and offer of appropriate assistance**
- Children’s ability to protect themselves
- Children’s lifestyle
- Children’s scope to participate in decisions affecting them, freedom of expression and access to information
- Leisure, recreation, cultural activities and role models
- Exposure to drugs / Involvement in crime
- Attitudes to children living on the margins - with disabilities, labourers, on the street etc

**Birth registration as a fundamental entitlement that enables a child to access other services**
- Budget allocation, leakage of funds, investment in children who are vulnerable
- Social and legal support to children in contact / conflict with the law
- Judicial and social service mechanisms to respond to child abuse
- Alternative care
- Services for children in need of care – child laborers, trafficked children, those on the street, with disabilities, mental health problems, orphaned

**Monitoring and infrastructure**
- Protective behaviours
- Children's ability to protect themselves
- Children's lifestyle

**Social Services and Referral mechanisms**
- Attitudes to violence, abuse and children
- Capacity of family and community
- Protective behaviours

**Financing**
- Budget allocation, leakage of funds, investment in children who are vulnerable

**Legislation**
- Open discussion and challenge of stigma
- Discrimination faced by girls and children on the margins
- Parenting / care approaches
- Public attitudes towards violence and child abuse
- Children's scope to participate in decisions affecting them, freedom of expression and access to information
- Leisure, recreation, cultural activities and role models
- Exposure to drugs / Involvement in crime
- Attitudes to children living on the margins - with disabilities, labourers, on the street etc

**Identification of vulnerable children and offer of appropriate assistance**
- Children’s ability to protect themselves
- Children’s lifestyle
- Children’s scope to participate in decisions affecting them, freedom of expression and access to information
- Leisure, recreation, cultural activities and role models
- Exposure to drugs / Involvement in crime
- Attitudes to children living on the margins - with disabilities, labourers, on the street etc
Birth registration in Tanzania is compulsory and a two-step process whereby, upon birth, the event is entered into the official log kept at the health facility where the birth occurred and the notification paper is issued. The registration — in the sense of recording bio data in the register and being issued with a notification — is free if done within 90 days of delivery. However, the notification paper is not an official birth certificate and therefore does not complete the registration process. An application for a birth certificate must be submitted subsequently, with a processing fee of Tsh 3,500 (US$ 2.50) if done within 90 days of delivery or Tsh 4,000-10,000 (US$ 3 to US$ 7.50) depending on how late the application is submitted. Delays usually result in additional fees and longer verification procedures if no prior notification was obtained. The issuance of birth certificates therefore marks the completion of registration of birth.

High rates of home births, low awareness among parents, the cost of registration and costs of transportation to get to the district headquarters for certification are among the factors that prevent children from being registered or obtaining birth certificates. There is potential with the development of health insurance schemes, social transfer systems or cash transfers to poor families to provide conditions to families to obtain birth certificates before they can join such schemes.

The Registration, Insolvency and Trusteeship Agency (RITA) is the government agency with the legal mandate over the birth registration function. Under its Vital Registration Transformation Programme, the agency implemented a pilot programme whereby the legal framework and business processes were improved and catch-up campaigns on birth registration were tested in selected districts.

It is estimated that, in 2010 alone, there will be 1,476,223 new births, which will then increase exponentially to hit 1,623,125 by the year 2014. However, it has become clear from lessons learnt during implementation of the pilot system that the mobile catch-up campaign’s model could not keep up with the pace of increased births. RITA has therefore decided to develop a National Strategic Framework that seeks to maximise the registration of all birth events, with a priority given to children below five years, building on the potential of updated technology. It is anticipated that the National Strategic Framework will launch the New Birth Registration System for the whole country in the near future.

### 7.3.2 Child labour

The Integrated Labour Force Survey estimated that 21.1% of Mainland Tanzania children aged 5-17 years are engaged in types of time-excessive work or hazardous/exploitative occupations that meets the definition of child labour (NBS, 2007). Boys (23.2%) are more likely than girls (18.9%) to be working in these conditions. Child labour is more common among rural children (25.9%) compared to urban children (7.7%).

Most children engage in some economic activity and housekeeping work. Domestic chores, caring for younger children and farming contribute to the household economy and are considered by adults to be part of growing up, but are not “employment” in the standard definition of the term (NBS, 2007). Girls (90%) do more housework, than boys (82%). Rates are similar for boys and girls in agriculture (around 62%), but this work can become child labour when housekeeping hours are added to the ‘economic’ hours.

The gender profile for Tanzania shows that girls are particularly vulnerable as commercial sex workers and domestic workers (Tanzania Gender Networking Programme and Sida, 2006). Rural children are enticed to go to work in urban areas with the promises of a better life, but end up as domestic workers or sex workers. Some of this movement of children for the
purposes of exploitation may be trafficking, highlighting the links between child labour and child trafficking.

7.3.3 Child migration, trafficking and children living on the streets

Child migration and trafficking is not an issue that has garnered much media coverage and reached the public eye. But in reality, children are frequently trafficked to the towns for engagement as domestic workers and children migrate in search of work and often end up on the streets. About 23% of households had male children who had migrated out and 17% had female children who migrated (Deshingkar and Grimm, 2004). Children are also part of large population movements from the rural parts of Tanzania, where life conditions are difficult and basic schooling or medical services often not available. They move to towns in search of education and opportunities. Often they are handed over by their family or guardians, through the traditional African fostering system, to new guardians or far away relatives living in towns. These foster families, living in urban environments, do not always respect the customary tradition of caring for the new child and they might use the child as a worker or abuse him or her. In several cases, children end up in the streets of the largest towns.

There is no precise data on the number of children living or working on the street. Certain NGOs like Mkombozi in Moshi are assisting 1,000 children but this is only a fraction of the problem. In a 2000 survey by Mkombozi, the cause of 22% of children migrating to the streets was school exclusion linked to inability to pay school fees. Mkombozi has also studied how children are forced out of poor families when family pressures lead to domestic violence and alcoholism. The boys leave home for a life on the streets while girls are less visible and become engaged in domestic labour or are pressured into sex work or other forms of sexual exploitation (McAlpine, 2007a).

From September 2005 to May 2009, IOM and partners provided immediate help and reintegration assistance to 246 victims of human trafficking (76% were girls and 24% boys). The average age of the children ranged between 12 and 15 years for both girls and boys. The main types of exploitation were domestic labour for girls and petty trade for boys, while 10% of the children were trafficked into prostitution. Most of these children were exploited in urban areas and were coming from rural parts of the regions of Iringa, Morogoro, Kilimanjaro and Dodoma. Of extra concern to child protection agencies is that 75% of the children were recruited and exploited by a family member to whom they were fostered by the parents or a guardian.

7.3.4 Children in conflict with the law

The system for children in conflict with the law in Tanzania does not fully implement international juvenile justice standards, which call on States to establish a separate system for under-18s from adults – separate laws, procedures, dispositions and institutions. The Committee on the Rights of the Child was emphatic in its Concluding Observations in 2006 that the juvenile justice system needed significant improvement to bring it into line with the UNCRC.

While the Law of the Child Act does improve protection for young offenders, it does not address the concerns that the Committee raised. The minimum age of criminal responsibility at 10 years remains very low. Further, children aged 16-18 years are tried through the adult system in direct contravention of the UNCRC. There is limited specialism within the justice system, with children’s cases being handled by the same police, prosecutors and magistrates
that deal with adult cases, with only limited additional safeguards in place that recognise the vulnerabilities of children. There is only one Juvenile Court in Tanzania, which is based in Dar Es Salaam. However, the Law of the Child Act does allow for the establishment of additional Juvenile Courts nationwide, which will be governed by new procedures that enshrine fundamental rights for children and allow for more child-friendly proceedings.

Data on juvenile offending and the passage of children through the criminal justice system is fragmented and limited. It is difficult, therefore, to analyse trends or to follow outcomes for children passing through the justice system. However, available data shows that the majority of children brought to trial are boys. The vast majority of cases do not lead to convictions. This raises questions about the processing of children’s cases and whether a specialised children’s unit within the police or the prosecution department could reduce the number of juvenile cases reaching court by a greater use of diversion.

There are five remand homes for 10-15 year olds and only one Approved School. This has led to under-18s being held pre and post trial in adult prisons. However, data on the number of child detainees is limited. A planned study by the Commission on Human Rights and Good Governance in 2011, supported by UNICEF, will assess the numbers of, flows of and conditions for children held in detention.

There are few alternatives to custodial sentences – the Law of the Child Act provides Courts with the options of conditional sentencing, fines for the child or the parent, and Supervision Orders. Corporal punishment, permissible under the Corporal Punishment Act 1930, is the most common type of non-custodial punishment imposed by the courts on persons under the age of 18, for almost all kinds of offences except homicide. The Law of the Child Act does not prohibit corporal punishment as a sentence. A juvenile (for the purposes of this Act a person under 16 years of age) may receive up to 12 strokes of the cane. A youth above that age may receive 24 strokes (URT, 2006b). Females are excluded from corporal punishment. Caning is a degrading punishment that violates international law and needs to be abolished as a permissible sentence. In order to reduce the use of trial, detention and caning, it is essential that diversionary measures and non-custodial sentences be promoted through the nationwide development of community rehabilitation programmes for young offenders. Such services are also essential to support young people to stop offending.

Children who are victims of violations of their rights and who have been subjected to violence, exploitation and abuse struggle to obtain justice. Police stations are not child-friendly places, putting off children from reporting cases and treatment that some children experience in police stations – leading to their re-victimisation. Cases that are prosecuted are subject to long delays, and children and their families are not able to travel the often long distances to the nearest court that can hear the case. Further, stigma and community pressure often dissuade families from lodging cases, with the community preferring that the case be handled outside the justice system. This leads to impunity for the perpetrators of this abuse.

However, steps have been taken to try to improve accessibility for victims of violence. The police, over the past few years, have trained police from 94 police stations and established pilot gender desks in Dar es Salaam to handle cases of gender-based violence against women and girls. These desks, staffed by trained and dedicated officers, are designed to provide more accessible complaints mechanisms for women and children to encourage reporting of cases and to ensure women and children are not re-victimised by the process. It is planned that these desks be rolled out nationwide over the coming five years. The police are also planning to develop guidelines for their officers on investigating child abuse in 2011.
Access to justice for children whose rights have been violated is also hampered by the dearth of lawyers in the country to provide legal help, assistance and representation. Lawyers tend to be based in major cities, and costs for legal help are beyond most people’s means. The majority of children can obtain legal assistance only using the resources of civil society initiatives being run in a few areas of the country. The Government recognises the major problem people have accessing justice, and the Ministry of Constitutional Affairs and Justice is currently working with legal aid providers to improve the system of legal assistance as part of the Legal Sector Reform Programme.

The Children’s and Young Persons Act did not separate out procedures for children in conflict with the law and those for children in need of care and protection, which made the provision of care and justice difficult. The Law of the Child Act 2009, which replaced it, does make this distinction, through the use of supervision and care orders for protection. However, the court can still send a child to the Approved School, which means mixing children in need of protection with offenders. The police, detention facilities, prisons and the court system are functions of central Government. Comparatively, children commit fewer crimes, making it difficult to establish specialised services for children in conflict with the law in all districts. It may be necessary for local councils to become more concerned with providing services for children in conflict with the law. The Committee on the Rights of the Child was emphatic in its Concluding Observations in 2006 that the juvenile justice system needed improvement and to be brought up to standards in line with the UNCRC. These recommendations remain pertinent (UN Committee on the Rights of the Child, 2001). In essence, Tanzania needs to develop the role of the Juvenile Court, abolish corporal punishment, avoid treating children as adults and develop alternatives to custody.

7.4 Societal attitudes and behaviours that put children at risk

Preliminary findings from a survey on violence against children

- Nearly one out of every three girls and one out of every 6 boys reported at least one experience of sexual violence prior to the age of 18.
- Nearly 6% of girls have been physically forced to have sexual intercourse before the age of 18.
- Approximately 30% of girls and 15% of boys reported that their first sexual intercourse was forced.
- Almost three-quarters of children, both boys and girls, experienced physical violence prior to age 18.
- 70% of perpetrators of sexual violence against girls are older but 35% of them are more than 10 years older.
- Approximately one half of Tanzanian girls and 66% of Tanzanian boys who experienced sexual violence prior to age 18 did not disclose it.
- Almost three-quarters of all Tanzanian males who experienced sexual violence in childhood and sought services did not receive any.

Tanzanian children are subjected to sexual, physical and emotional violence at home, at school, in their communities and on the street. Preliminary results from a groundbreaking national Study
on Violence Against Children (2010/11) in Tanzania show that nearly one out of three females and one out of six males experience sexual abuse prior to the age of 18 (UNICEF Tanzania et al., forthcoming). A total of 30% of female respondents and 15% of male respondents reported that their first sexual intercourse was forced. The majority of perpetrators of sexual violence against females were reported to be older than the victim; males reported the perpetrator to be the same age. Nearly two-thirds of females who experienced childhood sexual violence (62.9%) reported being victimised by a perpetrator who was 10 or more years older. The study also highlighted an association between exposure to sexual violence and HIV risk behaviours: children who had experienced sexual abuse and violence were more likely to engage in transactional sex, less likely to have an HIV test and use condoms and more likely to have multiple partners as they grew older.

7.4.1 Gender-based violence

Gender-based violence is common in Tanzania. In a WHO study, 41% of ever-partnered women in Dar es Salaam and 56% in the Mbeya District had experienced physical or sexual violence at the hands of a partner at some point in their lives. In both areas, 29% of those experiencing physical intimate partner violence experienced injuries, with over a third of them having been injured in the previous 12 months (WHO, 2005). A more recent study found that many forms of gender-based violence, including intimate partner violence and rape, are seen as normal and are met with acceptance by both men and women, while women and girls are frequently blamed for causing or provoking gender-based violence (USAID, 2008). In part due to blame and shame, but also due to fear of family repercussions, women and girls rarely report gender-based violence to authorities or seek other kinds of treatment or support.

A particularly harmful form of gender-based violence is female genital mutilation (FGM). FGM is defined by the World Health Organization (WHO) as all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs, whether for cultural or for other non-therapeutic reasons. The Tanzania Sexual Offences Special Provisions Act 1998 stipulates that FGM on anyone under the age of 18 is illegal. The procedures are irreversible and their effects last a lifetime. About 18% of Tanzanian women have been subjected to FGM. About 50% of regions in Tanzania Mainland practise FGM, with Arusha leading by 81%. Kigoma region does not practice FGM. In Tarime and Kilosa, FGM is practised openly, and it is estimated that about 85% of girls in rural areas are mutilated. Nearly all Maasai women are estimated to undergo mutilation in Arusha region (Legal and Human Rights Centre, 2002).

Another important consequence of gender-based violence and gender inequality is child marriage and subsequent early pregnancies. Child marriage refers to formal marriages and informal unions in which a girl lives with a partner as if married before the age of 18 (UNICEF, 2005). The TDHS 2004/5 estimated that 25% of girls between 15 and 19 years of age were in child marriages. Of these women, 12% were in a polygamous union. The TDHS also found that 52% of women were pregnant or had given birth by 19 years of age. Adolescent girls face a significantly higher risk of death from pregnancy and delivery-related complications, but commonly give birth at home without skilled assistance. As discussed in chapter 2, only 47% of deliveries take place in health facilities and only 46% of births are attended by skilled health staff (NBS, 2005).
7.5 The National Costed Plan for Most Vulnerable Children

In Tanzania, the primary response to addressing vulnerability and poverty, but particularly the effects of HIV and AIDS on children and families, has been articulated in the National Costed Plan of Action (NCPA) for Most Vulnerable Children (2007-2010) (MoHSW, 2007).

Box 10: The right to be heard and child participation

Child participation is about providing children with the opportunity to be involved in decision-making and to express views on matters that affect and impact their lives, according to their evolving capacities. This is one of the fundamental principles of the UNCRC. Participation and respect for the views of the child is also one of the 12 overarching recommendations of the UN Secretary-General’s Study on Violence against Children. Among the rights addressed in the Tanzanian Law of the Child Act are children’s rights to have an opinion, to be listened to and to participate in decision-making.

However, while laws, policies, government and NGO initiatives supporting child participation exist, there is no systematic inclusion of children’s perspectives to inform, where appropriate, processes that affect their development and well-being – especially at the household level and in the community. Listening to children and involving them can be at odds with cultural and religious conceptions of the role of the child. The Committee on the Rights of the Child often highlights traditional and cultural attitudes towards children as the major obstacle to acceptance of the child as a holder of rights. Specifically in relation to Tanzania, the Committee observes that children’s right to free expression and to participation is still limited, partly because of traditional attitudes.

Being able to express oneself and feeling a valued member of society can reduce a child’s risk of exploitation and harm. Children are often unaware of or unable to access services that can help them. Children’s Councils and other child-focused peer groups can help children identify and avoid harmful situations and support them to play an active role in their communities. Through such groups, children are engaged in discussing their rights and where to access services, and in reporting violations of their rights to duty bearers. If genuine participation occurs, these associations and subsequent friendships build a child’s self-confidence and sense of worth, and provide protective factors that counteract the effects of abuse and shocks. They can provide opportunities for children to build positive relationships with adults, gain adults’ respect and offer a space for children to confide instances of violence and abuse and seek redress so their issues can be appropriately addressed or referred (Henley and Colliard, 2005; McAlpine, 2009). By understanding and respecting children’s views and experiences, better and well targeted protection mechanisms can be created, and children themselves can become active agents in their own protection.

However, most of the child-focused structures that currently exist in Tanzania are supported by NGOs and the voluntary sphere, and therefore face sustainability challenges. The creation of children’s participation projects has not really brought about substantial change in how Government, families and communities work with, and for, children. In many respects, children remain the outsiders in genuine decision-making processes affecting their lives.
This is indicative of Tanzania’s aspiration to:

- Meet UNGASS goals on HIV and AIDS for orphans and vulnerable children (OVC)
- Uphold Articles 65, 66, and 67 of the CRC
- Realise MDGs by 2015
- Meet the Africa Union agreement to ensure orphan and vulnerable children (OVC) have universal access to essential services by 2010.

The MVC systems and structures are mainly a social protection intervention. The NPCA for MVC (2007–2010) moved away from the concept of orphan and vulnerable child and developed a standard classification for the identification of “most” vulnerable children. But critically there is still no comprehensive view of what child vulnerability means (Wylde and Mutembei, 2008). The use of the term MVC is more expansive and an improvement on OVC, but it does not help to distinguish between the child’s needs for income support, social support and protection support.

Data from the 2002 Census and the Household Budget Survey of 2000/1 informed the estimation of numbers of MVC, which was close to 930,000 in 2006 or 5% of the child population. The NCPA, supported by donor-funded international NGOs and NGOs, has established a system to identify and support “most vulnerable children” down to village level mainly through the use of community volunteers and informal and NGO sectors. It is a considerable achievement and is part of an emerging social protection system rather than a child protection system per se.

In the actual identification processes, more boys than girls are identified as MVC and very few children below school age are identified as MVC. Most children are considered vulnerable if carers cannot meet primary or secondary education costs. Very few young children are identified as being vulnerable which is surprising when there are high rates of infant mortality and malnutrition. The MVC programme does not identify all children who may be at risk and have the right to protection from violence, mistreatment, exploitation and abuse, but it may be the case that assisted MVC are less exposed to early marriage, pregnancy and sexual exploitation.
District MVC structures are managed by social welfare or community development staff but the delivery of support to MVC is by NGOs with funding from PEPFAR or the Global Fund. According to MVC data, a total of 700,230 children had been identified by the end of 2009, with 578,050 of those receiving at least one basic service. At present the NGO role seems to be very important to the MVC system. The support delivered to MVC is usually predetermined by donor objectives and supplies in the warehouse, which does not always meet local needs. At the present time only a few agencies are piloting cash transfer schemes, which are more flexible in addressing household needs. Most of the delivered support is directed towards education, followed by clothing and food. In 2006, 53% of MVC over the age of six reported to have received educational support, 47% of all MVC reported having received support of clothing and 41% received support on food (Mhamba et al., 2007).

There has been considerable investment with high transaction costs in capacity building volunteers in communities to identify and refer MVC, to provide care and support and to set up systems for delivering assistance. The two groups of volunteers – Community Justice Facilitators and Para-Social Workers (PSW) – have received short but intensive periods of training in an attempt to bring social and legal support closer to the family and community. These volunteers have a role in referring cases of abuse and preventing family separation. The programmes are not national in coverage and their effectiveness will have to be evaluated.

While not all of these voluntary systems are functioning perfectly and coverage is not comprehensive they are the only mechanism whereby MVC can be assisted with social transfers and support from community members. Unfortunately a similar level of investment has not been made in the provision of district social work or child protection services. It seems that there is an increased level of awareness about child abuse through the dissemination of the UNCRC and the capacity building of community structures. However the policies, laws and service delivery mechanisms are not sufficiently in place to both prevent and assist children who are at risk. As yet the lack of baseline data means that there is no evidence of MVC structures reducing levels of violence, early marriage, teenage pregnancy, street children or children living in residential care. In general the available resources for MVC are not being used specifically to prevent or respond to child protection problems, but are potentially useful for making child protection referrals to ward or district staff.

Collaboration between MVC Committees (MVCC) and local government structures need to be improved. The challenge is to ensure the system is sustainable and to develop a mechanism for management. There are high transaction costs involved in training and maintaining volunteers. The training schedule to identify MVC and establish community structures is considerable and expensive, and the Social Welfare Officer or Community Development Officer cannot effectively support and manage all MVCC within their districts.

The reliance on volunteers can be understood as a short-term emergency response. The question is how to move forward into a sustainable and systemic child protection system that is professionally staffed, and that supplements volunteer and community efforts with a cohort of skilled personnel who can build carers’ ability to respond to children’s multi-faceted needs, including working with traumatised children, and that provides the financial support so that these volunteers are not out of pocket from their efforts.
Parents, families and communities all have direct responsibility for the care and nurture of children, but it is the state under the UNCRC that is the principle duty bearer for ensuring the protection of children. Tanzania has ratified the majority of key international agreements and frameworks for the protection of children from violence, abuse and exploitation and for the protection of children in conflict with the law. Thus, the State is committing itself to ensuring the rights of children are respected. However, the gap between international standards and the situation for children remains considerable. The Government of Tanzania, in partnership with UNICEF and other child rights organisations, has been grappling with the challenge of how to turn the rights of children on paper into reality on the ground.

The Law of the Child Act, which passed through the Tanzanian Parliament on 6 November 2009, is a landmark piece of national legislation aimed at protecting children. It enshrines fundamental rights of children. Significantly, for the first time in domestic legislation, the law provides a framework for a child protection system, obliging a range of bodies to prevent and respond to violence, abuse and exploitation of children. The law improves protection for young offenders and allows for the establishment of additional Juvenile Courts nationwide, which will be governed by new procedures that enshrine fundamental rights for children and allow for more child-friendly proceedings. The LCA enshrines a key role for the Ministry of Health and Social Welfare to develop and implement this system. In particular, the Ministry has a duty to further legislate to operationalise the system (by developing regulations and guidance) and to regulate out-of-home care options. The law prioritises family-type care over institutionalisation for children who are unable to remain with their family. The LCA also strengthens protection for children appearing in court, whether they come into contact with the legal system as offenders, witnesses or victims.

Since the LCA does not provide details of how the child protection system will operate in practice, a multi-sectoral response is imperative for implementing the Law of the Child Act, and guidance on how agencies will work together to prevent and respond to child abuse and violence is vital for an effective system. The imminent publication of a survey of the magnitude and nature of violence against children in Mainland Tanzania and Zanzibar, which

**Box 11: A community-based initiative for the support of orphaned children**

The Mama Mkubwa initiative is an informal day care scheme for the care and support of orphaned children that is based on traditional family and community care. In some districts it is supported by NGOs while in others the development has been spontaneous. These “aunts” care for children who have either no parents, or a carer who is facing difficulties of poverty, old age or ill health. In Makete the care is home based and children are referred through local agreement systems often including the Most Vulnerable Children Committee (MVCC). In most cases the children only benefit from daytime support and assistance and do not reside with the Mama Mkubwas. Mama Mkubwas are challenged to reconcile the needs of children with their limited income and respond to the needs of children (including judicial redress) who have or are being abused. There may be scope to evaluate and consider the scale up the Mama Mkubwa programme (Mwaipopo, 2007).
was overseen by a Multi-Sectoral Task Force (MSTF) consisting of Government ministries, police, NGOs, CSOs and UN agencies, will be indispensable for elaborating the child protection system (UNICEF Tanzania et al., forthcoming). The Government has recently begun developing much-needed regulations, rules and minimum standards that will set out the roles and responsibilities of the key bodies responsible for protecting children from abuse and provide detailed guidance to front line workers on their specific obligations. These will use MSTF coordination to develop a multi-sectoral programmatic framework for prevention and response, building on and into existing initiatives the potential for a national plan of action to prevent and respond to abuse and violence against children. Alongside this, a multi-sectoral response to protection of children from abuse and violence is being piloted through selected District Councils to build knowledge and an evidence base that can be scaled up to generate a national child protection system.

A complicating factor is that an institutional framework of child protection involves several ministries. Departments dealing with child protection issues exist in the Ministry of Community Development, Gender and Children (Child Development Department) and the Ministry of Health and Social Welfare (Department of Social Welfare). The Child Development Department has more policy responsibility for children and the Department of Social Welfare is better placed to provide welfare services. However both are under-funded and lack human capital to deliver child protection services.

Whilst there has been an investment, albeit of relatively short-term project nature, in identifying and responding to MVC under the NCPA, a similar level of investment has not been made in the provision of district social work or child protection services. As described earlier, structures under the NCPA are able to identify MVC, to provide educational and physical support, and to make referrals to child protection services. However, these structures are not able to fill gaps in essential social services or child protection services. The current institutional structures for child protection to respond to child labour, sexually exploited children, children with disabilities, and children without family or kinship care are discussed in the following sections.

7.7 Current responses to priority child protection concerns

7.7.1 Interventions to eliminate child labour and sexual exploitation

The Government, with the support of the International Labour Organization (ILO), has reduced the number of children involved in hazardous work, commercial sexual exploitation, domestic labour, mining and commercial agriculture. In 11 districts from January 2002 to March 2005 the ILO estimates that 11,178 children (6,255 girls; 4,923 boys) were prevented from becoming involved in hazardous work and that 9,620 (6,255 girls; 3,365 boys) were withdrawn from hazardous occupations. The Ministry of Labour, Employment and Youth Development in collaboration with Kiota Women and Health Development also withdrew a total number of 6,083 children from child prostitution for the years 2005, 2006 and 2007 (URT, 2007b). However, in spite of success registered under this programme, the districts covered and the number of children reached is small compared to the estimated number engaged in child labour (MoHSW, 2007). The MKUKUTA operational target of a reduction in the proportion of children in labour country wide from 25% to less than 10% by 2010 has not been met.
7.7.2 Legal framework and services to protect children with disabilities

Tanzania has taken a number of legislative steps to protect the rights of children with disabilities. The LCA enshrines the rights of children with disabilities to special care, treatment, affordable facilities for rehabilitation and equal opportunities to education and training wherever possible. The Law also prohibits discrimination of a child on the grounds of disability and prohibits those caring for children with disabilities from treating them in an undignified manner.

Tanzania ratified the Convention on the Rights of Persons with Disabilities in 2009 and adopted the Persons with Disabilities Act in May 2010 to incorporate the Convention into national law and to bring together the rights and provisions for persons with disabilities into one comprehensive act. The Act contains specific provisions on children, including imposing a duty on community members to report infringements of the rights of children with disabilities to the relevant authorities. The Act, moreover, grants equal rights to admission to the public or private schools.

There are 41 long-term caring facilities for people with disabilities, including children, of which 17 are government owned, some by DSW and others by the Ministry of Education. However those that are government owned lack resources (some have closed) and there is minimal monitoring. Initially all centres caring for people with disabilities were specialised, but since 2005 they have become generalised in approach. Most of the institutions catering for children under five years of age are managed by NGOs and FBOs. Occupational therapy, community-based rehabilitation and other home-based support services are run by NGOs where they exist. The real issue with regard to protection for children with disabilities is that abuse is more frequent, largely hidden and the child is less able to escape or report the abuse.

7.7.3 Childcare services and provision of alternative care

The impacts of the HIV epidemic and poverty have put pressure on individuals to migrate to secure livelihoods, meaning families are increasingly dispersed and fragmented. This has care implications for children. Single-parent, child-headed and elderly-headed households may not be able to provide for the survival and development needs of children, resulting in dropout from school, child labour or exposure to other forms of exploitation.

This sub-section examines semi-formal and formal services that are available for children who are not cared for by the family or kinship care. The main form of alternative care is a growing supply of residential care homes run by the voluntary sector that are largely unregulated, understaffed and under-resourced. This is in spite of a clear consensus that good practice is to use institutional care as only a last resort (Save the Children, 2009b). The Law of the Child Act provides welcome and necessary provisions to strengthen the regulation of foster care, adoption and institutional care.

Residential care

There is one government children’s home in Mainland Tanzania - the rest are managed by faith based organisations (FBOs) or NGOs. The Children’s Homes (Regulation) Act 1968 and the National Guidelines 2006 require that the Commissioner of Social Welfare must license children’s homes. Under the National Guidelines: “The social welfare officer shall approve admission of a child in the children’s home” (URT, 2006c). Countrywide 84 children’s homes have been registered by DSW, and at least 25 homes have sent in applications for registration. However, many more residential care facilities are not licensed and operate outside the law.
The Law of the Child Act places more stringent regulations on children’s homes. This is welcome because the procedure for regulation and supervision has not been followed in the past as village officials may place children in homes directly without referral to the DSW. Many children are accepted into children’s homes, often unregistered, without the knowledge or approval of the DSW. Every home should send monthly reports to DSW with a list of their resident children, stating admissions, discharges, ages of children, those attending and not attending school and recently added was those children who need foster-care. To date only 40 of the 84 have done this and the total number of children for those 40 homes is 1,903.

A comprehensive assessment of children in residential care is planned by the Department of Social Welfare, with UNICEF support, in 2011 and will review particularly:

- The number of unregistered homes and concerns that children are not being properly assessed before admission.
- Whether there are quality standards or guidelines to guarantee good care for children.
- Case management standards and whether the placements of these children have been sanctioned by courts and are in children’s best interests.
- Whether placements are being periodically reviewed.

**Foster care**

It is not clear why the establishment of children’s homes by NGOs and FBOs is preferred to supporting families to look after their children or to the development of formal foster care schemes. Until last year, Tanzanian law defined fostering as a prelude to adoption, rather than as a care intervention in itself (Moledina, 2007). In comparison with the number of children in family or kinship care, formal fostering is practiced infrequently. The process involves the District Social Welfare Officer reporting to the Commissioner to approve the suitability of a foster parent as a prospective adopter. Formal fostering is not available as a placement for children who need to live temporarily in a substitute family. This legal imposition to fostering may be a driver of the reliance on institutional care described above. Positively, the new Law of the Child Act now defines it in line with international practice as “a temporary measure provided on voluntary basis by the family and individual who is not related to a child to discharge care and protection to the child” and the rules and regulations under development should improve practice in this area.

**Adoption**

The emphasis is primarily on domestic adoption. In order to adopt a child an applicant must be a bona fide resident of Tanzania. Non-Tanzanian citizens must have a resident permit, which is normally for a minimum of two years. Although not specifically mentioned in the Adoption of Children Act, which again has been repealed by the Law of the Child Act 2009, Tanzania allows international adoptions where adopting parents are residents. Tanzania has not ratified the Hague Convention on Inter-country Adoption, although this is being considered (Communication from the Assistant Commissioner of DSW). For inter-country adoption the DSW asks for a Home Study Report from International Social Services.

Table 17 shows DSW data on the number of adoptions by Tanzanians and non-Tanzanians, for the years 2006 through 2008.
There are an unknown number of abandoned babies currently waiting to be adopted living in babies and children’s homes. If these children are not adopted by the age of three they will be moved to another institution. The adoption of these children is a priority as research indicates that babies regress emotionally, cognitively and in motor development in an institutional setting (European Commission DAPHNE Programme, 2005).

### 7.8 Fiscal space for child protection

It is not simple to disentangle the budgets of the government departments in the medium-term expenditure framework (MTEF) as regards what is available for child protection. However, the limited funds available to the Department of Social Welfare are mainly used for the upkeep of juvenile justice and residential institutions. Additionally, there has been an incremental decrease in the proportion of the Ministerial budget that is remitted to the Department over the period 2001/2 to 2008/9; from 37.3% of the Ministerial budget to 1.7%. This drop occurred at the point when the Department moved from the Ministry of Labour, Youth Development and Sports to the Ministry of Health and Social Welfare in 2005/6. A 2009 capacity assessment of the Department found that:

“The (DSW) receives financial support from the United Nations Children’s Fund, Legal Sector Reform Programme and Global Fund. It also receives technical support and support in kind from Abbott Fund and United States Agency for International Development through its partners including Family Health International, PACT, Management Science for Health and American International Health Alliance. A large amount of donor funds lie with NGOs working with bilateral donors. This is the case for funds from USAID, which are channelled through different programs such as PEPFAR.” (Ernst & Young, 2009).

There is a risk that this off-budget support may undermine Government commitment to establish, fund and deliver a comprehensive set of child protection services, and may distort interventions to the volunteer realm of NGO efforts. One of the major issues is that off-budget donor funds for MVC are not used for building the capacity of government services. Whilst social welfare or community development staff manages district MVC structures, the delivery of actual support to MVC within the NCPA is by NGOs who receive funding from PEPFAR or Global Fund.

NGOs are therefore critical in delivering services to MVC, but their support to date has been limited to enabling children to access education, receive clothing, food and other inputs. The challenge is that most vulnerable children face a complex and interacting set of vulnerabilities.

| Year | Number of requests | Number granted | | |
|------|-------------------|----------------|---|---|---|
|      | Tanzanian | Non-Tanzanian | Total | |
| 2006 | 65 | 21 | 6 | 27 |
| 2007 | 50 | 19 | 7 | 26 |
| 2008 | 52 | 22 | 1 | 23 |

Table 17: Adoption data from the Social Welfare Department
and whilst access to food or healthcare or education is often needed, PEPFAR and the Global Fund finance little in the way of child rights work per se and particularly interventions directed at raising community awareness of child rights, improving structures for child protection or responding to children who have faced abuse or other rights violations. This means that the support offered to MVC tends to be skewed in favour of handing out goods rather than helping children and communities to protect and enable the whole child to thrive.

The majority of recent social protection interventions to assist children are in the form of donor-funded social transfers assessed by volunteer community structures and delivered by NGOs. The majority of protection services for children are also provided by voluntary organisations. These comprise preventive actions to reduce vulnerability and keep families together by delivering services including food, shelter, home-based care and advocacy for the specific rights of the child. The coverage of NGOs is not uniform; NGOs try to work where there is greatest need and to avoid duplication, but coverage of care for children in dire need remains far from universal.

Little systematic investment has been made to develop national or local government social work services or infrastructure. Neither has the growth in size of urban settlements been matched by recruitment of social work staff or development of child protection services. According to the institutional capacity assessment of the DSW, Social Welfare Officers (SWOs) are only present in 61 of Tanzania’s 133 districts (Ernst and Young, 2009). National coverage of services is therefore limited with many districts relying on regional staff or the community development staff. Graduate social workers are more inclined to seek employment in the private or NGO sector and generally the DSW has insufficient resources or capacity to run and maintain effective child protection services across the country.

Budgetary allocations to the Department of Social Welfare (DSW) have been insufficient to cover their activities over the years. Table 18 shows the difference between actual needs of the DSW and funds released for utilisation. The situation is alarming with regard to development expenditure whereby the DSW has been receiving on average 28% of actual requirements in the last three financial years. Likewise in the budget for non-wage expenditure, the DSW has been receiving on average 51% of the actual requirements.

**Table 18: Actual requirements Vs Funds released for other charges and Development budget 2006/07 - 2008/09**

<table>
<thead>
<tr>
<th>Financial year</th>
<th>Actual requirements</th>
<th>Funds released</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Other charges Tsh million</td>
<td>Development expenditure Tsh million</td>
</tr>
<tr>
<td>2006/07</td>
<td>4 000</td>
<td>8 000</td>
</tr>
<tr>
<td>2007/08</td>
<td>4 500</td>
<td>8 000</td>
</tr>
<tr>
<td>2008/09</td>
<td>5 500</td>
<td>8 000</td>
</tr>
<tr>
<td>TOTAL</td>
<td>14 000</td>
<td>16 000</td>
</tr>
</tbody>
</table>

Source: DSW Budget Requests and Fund Releases.
Figure 80: DSW Budgetary allocation against Ministerial budget

Trends show great differences in percentage of allocation between the Ministry that hosted the department formerly and the one hosting it now. When the department was in the Ministry of Labour it was allocated a significant percentage of the overall budget (although in nominal terms, the amount was less than the current Ministry). The reduction in percentage allocation started in fiscal year 2004/05 when the Department changed Ministries and has not increased since. In terms of percentages, the amounts allocated to the department within the Ministry of Health and Social Welfare has been significantly reduced from a range of 30% formerly provided in the Ministry of Labour to the current 0.8 - 2.9% provided by the Ministry of Health and Social Welfare.

7.9 Priority areas and recommendations for child protection

Improving the evidence base
There is insufficient reliable national data being collected on children in need of care and protection and the outcomes of interventions. This is particularly the case in respect to children who are living outside of family care, in child-headed households or who are subject to child abuse. There is also insufficient information collected on children in conflict with the law, the needs of children with disabilities and children exposed to exploitation like child labour, trafficking and commercial sexual exploitation. It is important for the Ministry of Community Development, Gender and Children, the Ministry of Health and Social Welfare and PMO-RALG to come together to develop an information and knowledge management system. The survey on violence against children (UNICEF Tanzania et al.,
A way forward on child protection

- Strengthen child protection in the MKUKUTA policy agenda.
- Develop the rules and regulations to the LCA to set out the roles and responsibilities across sectors for a child protection system.
- Develop a 5 year multi-sectoral National Plan of Action to prevent and respond to Violence Against Children.
- Strengthen the social welfare workforce with increased staffing, improved conditions of service and clearly defined roles and responsibilities with appropriate training as defined in the LCA.
- Evaluate the NCPA MVC 2007-2010 and use the findings to develop the new NCPA for MVC 2011-2015 with a clear and measurable focus on child protection, in line with the LCA.
- Pilot a child protection system across selected districts, document and cost to inform advocacy for a nationally scaled up child protection system.
- Support government efforts to implement a Social Protection Framework that will address the basic needs of families in poverty and enable frontline social welfare staff to address social vulnerability, including children’s exposure to abuse, violence and exploitation.

forscoming) has set new ground on exposing the scale and scope of children’s exposure to abuse and violence; it is critical to build on this moving forward by developing systems to track children at risk and integrate child protection into existing national surveillance and survey tools.

Harmonising laws with UNCRC and AFCWRC

The enactment of the Law of the Child Act 2009 represents a real breakthrough and an opportunity to strengthen the protective environment for children. The emphasis now should be on translating the Act’s provisions into practice. In particular the responsibilities of specific duty bearers for child protection must be clarified. A culture of change needs to be developed within national and district departments to take on the role of child protection. Without this, the intention of the law to protect children from abuse and exploitation risks being disconnected from clearly defined statutory and parental obligations. Implementation is likely to be uneven unless resources are made available for enabling regulation and implementation at district level.

Child protection must be embedded into the political agenda; there is room for optimism on this with the specific attention in MKUKUTA II on child protection that was quite lacking in its predecessor. Reducing violence, abuse and exploitation of women and children can be achieved if measurable indicators and operational targets are defined and acted upon. Child protection would also be improved if one Ministry had the policy mandate for child protection and provided comprehensive guidelines to district councils to establish child protection mechanisms.

Implementing social protection measures to reduce abuse and exploitation

Families are best placed to care for children and promote their welfare. The majority of parents seek the best for their children. It is the State’s obligation to support vulnerable households to look after their children through a comprehensive and funded social protection framework. Cash transfers, grants, social transfers (e.g., user charge waivers) and improving housing, nutrition, health and education services will all contribute to improving outcomes for children. Improving access to secondary education for girls and supporting poor families to keep them enrolled could go a long way towards reducing child marriage and early pregnancies. Livelihood policies that prevent migration for employment and improve incomes can avert deprivation, neglect and prevent the need for alternative care. Continued support to RITA to develop a national birth registration strategy is also critical.

Delivering social and child protection services at the district level

During the last few years considerable efforts have been made to support MVC but the structures put in place have not necessarily led to improved systems to protect children from harm. Without strong management of children’s social services at district level with clear mandates and lines of accountability it will be difficult to sustain existing MVC structures and improve child protection.

A child protection service is needed at district level, which could be developed from existing community development, social welfare, NGO and voluntary resources but managed by a
district social services committee. Existing Community Development Officers and Social Welfare Officers working on children’s issues could be brought together at district level to form District Child Protection Teams as a functional body within a social services department. Guidelines for district personal social service teams and specific child protection teams should be developed. There is a need to strengthen district and ward professional child protection capacity and ability to monitor and supervise before further work on community justice facilitators and parasocial workers is undertaken. It is recommended that donors providing assistance to voluntary systems turn their attention to assisting the Government to build professional well-managed social service structures at national, district and ward levels. Case management should also be introduced into all areas of child protection. There is an urgent need to review all cases of children who are overstaying in residential care.

**Justice for women and children**

Initiatives to strengthen access to justice by making police stations and courts more accessible, by developing the legal aid system and by improving witness protection need to take into account the specific needs of children in order to ensure they can challenge violations of their rights and secure justice. Significant reforms also need to be undertaken to bring the juvenile justice system in line with international standards, to promote diversion, non-custodial sentences, separation of children from adults, community rehabilitation and reintegration schemes, and to prohibit imprisonment and corporal punishment. Urgent alternatives need to be found for children languishing in adult detention centres.
Chapter 8
The Children’s Agenda

The vision of an economically prosperous Tanzania can only be realised if the survival and well-being of its children is assured. Healthy, educated children become creative, productive adults. Indeed, every country that has made the breakthrough to middle-income status—the overarching goal of Vision 2025—has invested heavily in children. Beyond the societal obligation to nurture and protect children, their development is the single most important driver of national growth.

Children also represent the foundation of a vibrant democracy and a cohesive, peaceful society. Young people need to be supported to grow up as informed and empowered citizens. The first cohorts of children to benefit from the Primary Education Development Plan voted in national elections in 2010. And students leaving primary school this year will be eligible to vote in 2015, the target date for the MDGs. It is not some distant future that is at stake. Children make up over half the population so they will necessarily have a powerful socio-economic and political impact in Tanzania over the next decade.

This report has highlighted areas where progress has been made in securing the rights of children and women in Tanzania, and identified where progress has stalled or is lagging behind. It sheds light on policies and strategies that have worked and those in need of adjustment. This final chapter brings together the main findings and messages from the report, in an effort to chart an ambitious yet realistic agenda for Tanzania’s children.

The Children’s Agenda was developed alongside this report over a period of several months from late 2009 to mid 2010. The Agenda outlines Ten Investments that hold great promise of making a difference in the lives of Tanzanian children. The choice of the investments is the result of thorough fact-finding and analysis, and broad consultation with Government, leading children’s organizations, and children from across the country. It provides a platform for future policy setting.

Mindful that investing in children is tantamount to investing in Tanzania’s present and future, it is hoped that The Children’s Agenda will serve to inform not only the roll-out of the next MKUKUTA over the period 2010-2015, but also the legislative agenda of the new Parliament sworn in after the elections of October 2010.

I. Invest to save the lives of women and children

The under-five mortality rate has declined by almost 40% over the last ten years. This decrease is equivalent to saving the lives of nearly 100,000 Tanzanian children every year. As a result, Tanzania is on track to achieve the Millennium Development Goal for child survival. This remarkable success in reducing child deaths has been achieved through investment in effective, mostly low cost interventions, in particular, increased use of insecticide-treated mosquito nets, improved treatment of malaria, immunisation (which has reduced deaths from measles), and expanded coverage of Vitamin A supplementation, which boosts children’s immune systems.

Despite this progress, over 400 children under five years are still dying every day, the vast majority from readily preventable causes. Of these, 135 children are less than one month old; three-quarters of whom survive for less than a week. Neonatal mortality now accounts for around 30% of all under-five deaths. Newborn deaths are inextricably linked to the health of the mother during pregnancy and to the adequacy of obstetric care at delivery; most can be averted if coverage of basic maternal and neonatal interventions is expanded.

Yet maternal and newborn health has not received urgent attention. The National Roadmap Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania (the “One Plan”), formally launched by President Kikwete in 2009, is an important first step, but the
costing of the strategy is not yet completed. The proportion of women giving birth at health facilities is still less than 50%. When an emergency arises, even if a woman reaches a facility in time, the widespread lack of skilled birth attendants and essential obstetric equipment and supplies means that a safe delivery is far from guaranteed. As a consequence, there has been no improvement in maternal mortality in the last fifteen years. A woman dies in Tanzania every hour due to complications during pregnancy or childbirth. This tragedy of so many women and babies dying during delivery or shortly after birth cannot be prolonged.

Compounding the lack of obstetric and postnatal care, the limited availability of quality reproductive health services deprives Tanzanian women of their right to information and family planning services to decide the number and spacing of their offspring. Fertility remains very high, contraceptive prevalence low. With no significant decline since the mid-1990s, current fertility rates will continue to undermine government efforts to provide sufficient schools and hospitals, trained personnel and supplies for an ever expanding population.

What is most needed?

• A stronger health system with more trained clinical and administrative staff, better equipped health facilities, and effective monitoring and supervision.

• Universal access to quality maternal and child health services. The full implementation of ‘One Plan’ is required to establish the foundation of maternal and child health.

• Essential nutrition interventions (see Investment 2) and clean and safe water, adequate sanitation facilities and safe hygiene practices (see Investment 3). Tens of thousands of children die each year from malnutrition and diarrhoea; the overwhelming majority of deaths are avoidable.

• Universal coverage of inexpensive, effective childhood interventions including:
  ○ Routine antenatal and postnatal counselling on the importance of exclusive breastfeeding until infants are six months old, and safe weaning and feeding practices
  ○ Distribution of long-lasting insecticide-treated mosquito nets to all households
  ○ Childhood immunisation
  ○ Education to parents on preventing and treating killer illnesses, like diarrhoea with ORS and zinc

• For families and communities – including schools, faith-based institutions and village health structures – to be mobilised as active partners in health promotion and to hold providers accountable for the delivery of quality health services.

• Ensuring that women have access to the best information and are empowered to act to protect their own health as well as that of their children.

2. Invest in good nutrition

Unlike child survival, very little progress has been made in reducing chronic malnutrition. About four out of ten children in Tanzania are stunted, denying these children the opportunity to develop to their full mental and physical potential. Infants and young children who are deprived of essential nutrients are often trapped in a cycle of malnutrition, disease and impaired development that causes irreversible damage. The most harm occurs during pregnancy and in
the first two years of a child’s life, therefore, action must focus on this highly vulnerable period of life. Malnutrition is also linked to one-third of all under-five deaths, making it the single largest cause of under-five deaths in Tanzania.

Despite its critical importance to childhood and national development, nutrition receives little national priority and very limited funding. Essential interventions are available in only a handful of districts and health facilities. Yet, simple, cost-effective, affordable interventions are available that can have lasting impact on a child’s prospects for survival, development and well-being. Moreover, improvements in basic nutrition necessarily underpin national investment in education; well-nourished children learn better. Progress towards better nutrition will also relieve a significant burden on the health sector; well-nourished children succumb to illness less and recover faster if they do.

Exclusive breastfeeding initiated within one hour of birth and continuing for six months is the most effective life-saving intervention. At present, the vast majority of infants are given water, juice, porridge or other foods before they are three months old, which exposes them to harmful bacteria and parasites. Some babies are even given water before they taste their mother’s milk, while in certain ethnic groups, the misconception persists that colostrum is dirty and should be discarded. In addition to breastfeeding, young children from six months of age need to be frequently fed and given a variety of foods to prevent malnutrition.

Most countries address micronutrient deficiencies by fortifying common foods such as salt with iodine, oils with vitamin A, and flour with iron. Food fortification is a proven low cost and effective way to reduce malnutrition. Every shilling invested in food fortification will yield an eight-fold return. It could reduce anaemia in children and women by 20% to 30%, reduce key birth defects by 30%, and vitamin A deficiency by 30%.

The widespread production and distribution of nutritious fruits and vegetables are also essential to protect children against stunting and vitamin and mineral deficiencies. Kilimo Kwanza, the new national agricultural strategy, is an opportunity for nutrition to be placed at the heart of Tanzanian progress. Currently, however, the focus of Kilimo Kwanza on horticulture is upon its potential as an export industry, when development of a healthy and productive workforce must begin from within.

What is most needed?

• Routine counselling for pregnant women and their families during antenatal and postnatal care on the importance of breastfeeding.

• Essential nutrition services for children and women at all health facilities, including vitamin A and iron supplementation, information and counselling on child feeding practices, and treatment for malnutrition. Every district should budget for and recruit a nutrition focal person who has overall responsibility for the delivery of nutrition services.

• Support for domestic horticulture (fruits and vegetables) and animal husbandry (meat and milk) so that households have better access to nutritious food all year round.

• Wide availability of inexpensive fortified foods. The relevant legislation, regulations and standards must be urgently completed and enacted.

• Safety nets and social cash transfers for vulnerable pregnant women and children under the age of two so that resources reach children at the most critical age for ensuring healthy development.
• Completion and approval of the revision of the National Food and Nutrition Policy, and the integration of nutrition in policies and strategies in all relevant sectors, including health, agriculture, education, community development and industry. The health sector should be given the capacity to adopt lead responsibility and accountability for the provision of nutrition services for children and women.

3. Invest in safe water, better hygiene and sanitation in schools and health facilities

Global analysis has estimated that for every $1 spent on water supply and sanitation, a $11.5 benefit will be accrued in terms of the time and financial savings – including more time at work, reduced medical costs, less school absence and decreased costs for hospital services – an astonishing return on investment. Yet three out of five schools in Tanzania have no on-site water supply, and four out five schools have no functioning hand-washing facilities. On average, the school sanitation ratio is 61 students per latrine, compared with the target of one toilet for every 20 girls and one for every 25 boys. The ratio in some schools can be as high as one latrine for every 200 students. Some schools have no latrines at all.

Health facilities face a similar situation; almost two-thirds of facilities lack a regular water supply, and one-third have no toilets for clients. Improving water supply, hygiene, and sanitation in schools will reduce illness, improve attendance and help to ensure that more children, especially girls, complete their education. Water supplies and toilets in health facilities are essential for infection control which saves lives.

Investment in water supply – improving sources and building or repairing waterpoints – has increased in recent years, but is not keeping pace with population growth. Household access to safe drinking water has declined since 2000, in rural as well as urban locations, but hopefully with the introduction of the Water Sector Development Program will halt and turn this around.

Unlike water, sanitation and hygiene are still to capture the attention of policy makers, donors and the public. The sub-sector receives barely 1% of the total water and sanitation budget, and funds are largely spent on costly sewerage systems in a few towns and cities. Yet one in four neonatal deaths can be traced to poor hygiene, and diarrhoea remains one of the major killers of children. Hand-washing at critical times is one of the most cost-effective ways of saving children’s lives, and can reduce the risk of diarrhoeal disease by up to 47%. In contrast to fever and acute respiratory infections, the incidence of diarrhoea has remained unchanged in recent surveys.

What is most needed?

• Improved water supply, and sanitation and hygiene services, especially in the poorest communities. In urban areas, this may include subsidies for public water kiosks and improved pit latrine emptying systems.

• Training and ongoing support to communities for the operation and maintenance of water systems so as to ensure sustained access to clean, safe water.

• Functioning toilets and hand-washing facilities that meet government standards in all schools and health facilities. Every financed water project at village level should include water supply for schools and health facilities. Construction of new classrooms or health facilities should be matched by new latrines, hand-washing facilities and improved water supply.
• Specially designed sanitary facilities that are accessible to children with disabilities in all public institutions and places.

• Integration of basic hygiene education into maternal health services and the curriculum in schools.

• Completion of the National Sanitation and Hygiene Policy and the Strategic Plan for School WASH.

• Increased budget allocations to sanitation and hygiene to reach 0.5% of GDP, in line with the AfricaSan target.

• Completion and operationalisation of the Memorandum of Understanding for coordination of sanitation and hygiene in Tanzania between the four responsible ministries – Health and Social Welfare, Education and Vocational Training, Water and Infrastructure, and the Prime Minister’s Office (PMO-RALG) – and establishment of working groups for household sanitation and hygiene and school WASH as soon as possible.

4. Invest in early childhood development

Integrated early childhood development (IECD) has the potential to be the vanguard in the fight against child poverty and deprivation in Tanzania. From antenatal care to birth registration to pre-school, ECD programmes can provide a continuum of care and services that give children a better start in life. Children who are encouraged from very young to talk, explore, create and share are far more likely to reach their physical, intellectual, social and economic potential – and bring greater benefits and prosperity to their families, communities and the nation.

The principal rationale for ECD is that gaps in individual ability widen significantly in the early years between advantaged and disadvantaged children. With a focus upon children in vulnerable households who are at the greater risk of disease and malnutrition and often have poorer educational outcomes, ECD can close the gap between rich and poor.

An IECD Policy has been drafted collaboratively between three ministries – Community Development, Gender and Children, Education and Vocational Training, and Health and Social Welfare. Momentum is building to increase early childhood investments. Support for community-based parenting and ECD interventions will help ensure that children grow up healthy, well-nourished and well-prepared for school. Investments in early childhood have been shown to give a seven-fold return and are much more cost-efficient than remedial programmes later in a child’s life.

Recognising the importance of ECD, the Primary Education Development Programme urged the establishment of pre-primary education for 5–6 year olds in every primary school using existing school facilities. However, the majority of the pre-primary schools attached to primary schools are poorly funded and inadequately staffed. In 2008 only one in four pre-primary teachers had a pre-school certificate. Over 80% of ECD centres that are not attached to primary schools, including community-based pre-schools, are unregistered. Services in rural areas and poor urban areas are particularly limited.

No system for professional training in early childhood development is available, although the University of Dar es Salaam recently introduced a bachelor degree programme in the subject. Low salaries and the low status of early childhood educators undermine the appeal of the profession. Currently, most pre-school and ECD centres lack supplies and play materials. Staff adopt a didactic teaching style with emphasis on literacy and numeracy skills and not enough learning through play and discovery.
What is most needed?

- Education of parents and leaders at all levels on the crucial role that ECD has on child well-being and on poverty reduction.
- Design and use of appropriate curricula for parent education, and early learning centres and pre-primary classrooms to support the development of young children.
- Integration of psychosocial stimulation into the package of interventions and services provided through community-based Integrated Management of Childhood Illness (c-IMCI) programmes.
- Local committees at district and ward level to monitor the availability and help improve the quality of ECD centres. Community-based childcare facilities are often the most appropriate because they bring services closer to home.
- Inclusion of early childhood development into teacher education curriculum, and creation of a national in-service training programme for ECD practitioners. Training should be prioritised to professionals working in the poorest communities.
- Prompt approval of the Integrated Early Childhood Development Policy, and budget allocations to support its implementation at scale.
- Capacity building for the Ministry of Community Development, Gender and Children to advocate for and coordinate a scaled-up national ECD programme.
- Partnerships with civil society, faith-based groups and the private sector alongside investment in government capacity to expand quality ECD programmes to poor and disadvantaged areas.

5. Invest in quality education for all children

Tanzania has made significant progress in the education sector in the last ten years. Following the abolition of school fees in 2001 and massive investments in the construction of new classrooms, enrolment in primary schools skyrocketed to reach near universal coverage, with parity between girls and boys. Secondary education has also expanded at unprecedented rates. Enrolment for secondary education quadrupled between 2003 and 2009, while the number of schools serving these new cohorts more than tripled. Coverage, however, remains limited to better-off households and historically advantaged parts of the country. Less than one in ten children from rural areas is enrolled. Beyond primary school, completion rates for girls diminish the higher the grade. Hard-to-reach and disabled children continue to be excluded from formal education.

The very success in increasing access so rapidly may have come at the expense of learning outcomes. Less than 70% of students actually complete all primary grades and only about 52% pass the Primary School Leaving Examination. Many students reaching Standard 6 do not learn the basics of reading and competency levels are even lower in mathematics (Haki Elimu, 2008b). About 10% of pupils enrolled in Standard I are repeating the year – a substantial increase since the introduction of free primary education.

The number of primary school teachers has not kept pace with the increase in student numbers leading to overcrowded classrooms. On average there are 54 students per teacher. Schools in poorer and more remote areas have far fewer teachers than those in urban centres. An additional 32,000 teachers are needed to reach the recommended ratio of 45 students per
teacher, however low pay discourages many from joining the profession. Most teaching methods are didactic and do not encourage active learning. Textbooks are also in desperately short supply. On average 8 to 9 children in Standard I share one maths textbook—in rural areas more than 12 children share a single maths textbook.

The Government recognises that a well-educated citizenry is the lynchpin of poverty reduction and the future economic prosperity of the nation, and a growing share of GDP is used to finance the sector. It has endeavoured to retain and attract new teachers, build an ever larger number of schools and classrooms, equip them with adequate facilities including latrines, and provide teaching and learning materials for a rapidly expanding pool of students. However, investment in education remains below the recommended minimum of 20% of government spending. More worryingly, there is little transparency around education budgets and many discrepancies between funds pledged for education programmes, compared to funds released and actual expenditures ‘on the ground.’

What is most needed?

• A substantial increase in funding for primary and secondary education, especially for better teacher training, salaries and incentives and for more textbooks.

• Non-formal educational options for children on the margins, such as working children, the disabled and children in nomadic pastoralist communities.

• Incentives to attract teachers to serve in difficult or remote areas.

• A national in-service teacher training programme that promotes child-centred teaching and learning methods and reduces over-crowded classrooms. Active learning in the classroom will improve student-teacher relations and motivate more students to complete their education.

• Implementation of the new National Minimum Standards for Primary Education and the introduction of annual inspection for all schools. Accountability of head teachers and teachers should include attendance, completion, performance and the adoption of child-centred teaching methods. These issues should be tracked through routine school monitoring.

• Transparency of education budgets at every level. Promoting parental and community involvement in school planning and monitoring will enhance accountability.

• A phased approach for all students to access post-primary education including expansion of lower secondary enrolment and appropriate technical and vocational education and training for girls and boys.

6. Invest to make schools safe

All children have the right to be safe at school. However, too many children experience beatings, humiliation, bullying, coercion, sexual abuse and exploitation. Corporal punishment is a common form of discipline in schools. Challenged by massively overcrowded classrooms, teachers may be predisposed to beating students even for minor infringements. The psychological and physical damage inflicted by beatings and abuse can be devastating, causing humiliation, undermining the child’s sense of self-worth and self-respect, and affecting children throughout their lives. It engenders fear and anger, undermines learning, and often leads to children abandoning school.
Unfortunately, official guidance for schools allows corporal punishment though only under restricted conditions. Corporal punishment may only be carried out by the head teacher or a teacher specifically assigned to the task. Legally, beatings should only be applied to the hands with a maximum of six strokes using a flexible stick. While data is limited, informal reports from children reveal that many beatings fall outside these parameters. Teachers are known to slap or hit children on parts of their bodies other than the hands and to use a variety of implements. Some teachers routinely carry a stick while teaching.

Sexual abuse and transactional sex in schools is a growing concern, especially given the rising number of pregnancies among female students. Sometimes girls are sexually exploited by teachers in exchange for higher or passing grades or reduced punishment. Teachers have also been reported to use extra classes as an opportunity to sexually abuse their students. At times, girls are blamed for seducing teachers; however, it is always the duty of the adult to protect the child.

Long distances between home and school can also expose children to sexual violence. Lack of food in schools or transport to and from school means that children, especially girls, can fall prey to adults or peers who exchange food or transport for sex.

When excessive violence and abuse occurs at school, children rarely report it because of stigma and the fear that teachers will always be believed first. Many children cannot even rely on the support of their families. The home environment is often as or more violent than the school environment. The THDS 2004/5 found that about 40% of men and almost 60% of women believe that men have the right to beat their wives. Many parents likewise condone teachers to beat their children.

What is most needed?

• Recognition by the Government of the scale and severity of school violence.

• Legislation and regulations that prohibit corporal punishment, sexual abuse and exploitation in schools need to be enacted and enforced. Teachers, students and community members responsible for violence and abuse must be held accountable.

• Provision of appropriate care and support for children affected by violence in schools.

• Establishment of student councils and elected student representation in school governance in primary and secondary schools. School councils enable students to participate in resolving conflicts, and to learn about and exercise their rights and their responsibilities within the school community.

• Mechanisms for children to safely and confidentially report violence and abuse by other students and teachers.

• Re-admission into school of girl students who are expelled after becoming pregnant. This will give them a chance of completing rather than cutting short their education prematurely.

• Integration and expansion of sport in the school curriculum and into in-service teacher training programmes, which can help reduce violence and improve discipline, student-teacher relations and school attendance among other benefits.

• More skilled teachers to reduce over-crowded classrooms. Experience also shows that an active learning approach reduces discipline problems in the classroom.
7. Invest to protect infants and adolescent girls from HIV

Tanzania has made important advances in combating HIV and AIDS among children. PMTCT services have expanded rapidly in the last few years, albeit from a very low base. However, paediatric HIV diagnostic facilities are still extremely limited.

The health system’s lack of capacity to provide routine identification, testing, care and treatment of HIV-positive children means that most of those infected are diagnosed late, if at all—and when they are, their poor tracking conspires against their retention in treatment and support services. As a result, barely one-third of infants born to HIV-positive mothers receive prophylaxis; vertical transmission continues to spread. One in every ten new infections in Tanzania occurs in babies even though more than 90% of these infections could be prevented.

While about 80% of women in Tanzania know that HIV can be transmitted from mother to child during pregnancy, labour and delivery, or through breastfeeding, less than half know that this can be prevented. Even fewer are aware that transmission of HIV through breastmilk is rare if infants are exclusively breastfed. HIV transmission is much more likely if a mother is giving water, juice or other foods in addition to breastmilk. Moreover, over half of all births in Tanzania occur at home without skilled birth attendance, where women cannot access appropriate treatment to prevent HIV transmission at delivery.

Adolescent girls and young women are also much more vulnerable to HIV infection than boys. HIV is twice as common in girls aged 15 to 19 years, and more than three times more frequent among young women aged 20 to 24 years than in boys and men of the same age. Less than 40% of girls aged 15-19 years have comprehensive knowledge about HIV and AIDS – meaning 60% are insufficiently aware of the risk of contracting the disease. One in seven girls is sexually active before they are 15 years old and 60% before they are 18 years old.

The vulnerability of girls and young women to sexual exploitation also derives from traditional roles of female economic dependence. The sexual partners of girls aged 15 to 19 years are usually at least four or five years older and many seem to offer greater economic security. Girls may be persuaded into sex in exchange for food, shelter, protection or better school grades.

Lack of access to information further increases the risk of HIV transmission. Almost one-third of girls and women aged 15 to 24 years are unable to read or write and over 20% have had no education at all. Nearly 40% have no regular access to any mass media—no radio, no TV and no newspapers. Women are also at a severe disadvantage in decisions regarding their own welfare. About 40% of women have no final say in decisions regarding their own health care — this rises to almost 50% among women aged 20 to 24 years and 70% for girls aged 15 to 19 years.

What is most needed?

• Services and treatment to eliminate mother-to-child transmission of HIV by 2015. All children with HIV and AIDS must be diagnosed rapidly, enrolled on treatment and stay on ARVs.

• Resources for the national HIV prevention programme to protect young people, especially adolescent girls, from HIV and AIDS.

• Greater focus on the drivers of HIV transmission: low and inconsistent condom use, risky sexual behaviours, multiple concurrent partners, early marriage and transactional sex, stigma and discrimination. The overwhelming emphasis on treating infected people
has diverted attention and resources away from prevention interventions focused on the drivers of HIV transmission.

• Support for the establishment of youth-friendly health services and effective life-skills programmes that will inform and empower youth, girls in particular, and reduce their vulnerability to HIV and AIDS. Every new infection in a teenager represents a failure to provide a young person with the necessary knowledge, information, skills and services to protect themselves.

8. Invest to reduce teenage pregnancy

Tanzania has one of the highest adolescent pregnancy rates in the world; almost a quarter of all girls aged 15-19 years have begun childbearing. Girls in the poorest households are three times more likely to begin childbearing as teenagers that their peers in the wealthiest quintile. In addition, girls with no education are more than twice as likely to become pregnant than girls who have completed primary school, and are ten times more likely to become pregnant early than girls in secondary school. Early pregnancy endangers the lives of young mothers and their infants. Almost one in four maternal deaths occurs among adolescent girls. Pregnancies in unmarried adolescent mothers are also far more likely to be unintended and are therefore more likely to end in induced illegal abortion which is a primary cause of death in young mothers.

Underlying causes of teenage pregnancy include early or child marriage—about 46% of teenage mothers are married. In turn, poverty and gender discrimination are significant factors in early sexual debut, marriage and childbearing.

Social norms and attitudes tend to encourage early marriage and childbearing, despite the harmful impact on children’s physical, mental and emotional development. Girls and their families may neither be aware of the significant health and educational benefits of delaying marriage and childbearing, nor have the social or economic means to pursue different choices. Sexual and reproductive health education in schools is limited and adolescent-friendly health services are rare. Many communities retain the perception that the primary value of girls is in their roles as wives and mothers. A recent survey found that about a quarter of Tanzanians believe that educating boys is more important than educating girls.

Girls from poor households may also be coerced into sex by older men in exchange for protection, food, shelter, clothing or money. Teachers too are responsible for some pregnancies after pressuring female students into sex in exchange for better grades. The pregnancies, however, are commonly considered to be “the girl’s fault”; girls who have fallen pregnant are considered to be immoral, deserving punishment, even if they are victims of rape. Questions of gender violence and intergenerational or transactional sex are either taboo or accepted under the cloak of child marriages into which girls are often forced in the face of early, perhaps unwanted pregnancy.

The proportion of girls who become pregnant while attending school has been growing steadily. By 2007, around 8,000 girls (about half from primary schools and half from secondary schools) became pregnant. In accordance with guidelines in force at the time, all of these students were expelled, and for most it marked the end of their education. In 2009, the Ministry of Education issued new guidelines directing schools to allow girls who are pregnant to sit their exams, and to enable them to return to school after giving birth. However, most girls who wish to continue their education after childbirth must overcome considerable stigma. Many girls cannot continue
because of a lack of childcare. Reducing teenage pregnancies, therefore, is a critical component of ensuring the rights of all girls to health, education and opportunity.

**What is most needed?**

- Access to quality, youth-friendly sexual and reproductive health information and services, including family planning. Appropriate and comprehensive knowledge about sexual and reproductive health and rights helps young people to make informed decisions about their lives and avoid high-risk behaviour. Girls and boys must be engaged in programmes to reduce teenage pregnancy.

- Support for schools to implement the new guidelines enabling girls who have become mothers to continue their education.

- Vocational training for all out-of-school children to combat poverty and the economic dependence that can lead to high-risk behaviour.

- Safe school environments for adolescent girls. Key aspects of a girl-friendly school are: i) close to their community; ii) has several female teachers; iii) teaches sexual and reproductive health, life skills and rights issues as part of the core curriculum; iv) provides in-school childcare facilities; v) punishes male teachers who seduce girl students; and vi) has clean, private sanitation facilities.

**9. Invest to protect children from violence, abuse and exploitation**

Child protection needs are immense and diverse in any country; in Tanzania, they are further magnified by widespread poverty and the impact of HIV and AIDS. One-third of households live in poverty. Over two million children are orphans. One in five children is engaged in child labour. Almost one in three girls and one in six boys are victims of child sexual abuse (UNICEF et al., forthcoming). Millions of children either suffer or are at serious risk of violations.

The Law of the Child enacted in 2009 is a significant step towards the creation of a more protective environment for children. It recognises the need to provide children with special safeguards and care but implementing the Law will require major investment and determined political will. No comprehensive child protection system is in place to defend children’s well-being and rights. The national response to date has focused on the physical needs of children identified as most vulnerable rather than the establishment of systematic protective mechanisms for all children, such as services geared to preventing, responding to and referring cases of abuse and violation of child right promptly and effectively.

Government responsibility for child protection is also splintered between several Ministries, none of which has sufficient financial or human resources to manage its part in child protection. Capacity to manage and respond to child protection issues is severely lacking at district level and in the judicial system. Only half of the country’s districts have social welfare officers on the ground. Many districts, therefore, have to rely on local volunteers and externally funded NGOs, community development staff or their regional offices to assist children in need of care and protection. Community structures and volunteers are able to identify vulnerable children, offer care and deliver assistance or refer them to the appropriate services when needed. But they are not able to fill the gap in the provision of district social work or child protection services.
Access to services remains limited and uncoordinated, concentrated in urban areas and utilised by better-off, more educated households. For example, less than one in ten Tanzanian children have birth registration — the foundational right for children to establish their legal identity — despite the widespread coverage of measles and DPT-HB3 vaccinations which could be used as a platform for registering children not registered at birth. Given the absence of child protection services in most parts of the country, an untold number of neglected, abused or exploited children are neither detected nor aided.

**What is most needed?**

- All children must have birth certificates which establishes their legal identity, secures their rights to vital services, and helps protect them from trafficking and exploitation.

- The development of a national child protection system and a costed operational model based upon the Law of the Child 2009. Police, lawyers, judges, social workers, prison wardens, residential home staff and other duty bearers will need to be trained to prevent and respond to cases of violence and abuse against women and children.

- Services for children that will protect the most vulnerable including:
  - Family-based support for children living in poverty that will help reduce exploitation of children in child labour and commercial sex work, and minimise institutionalisation of children.
  - Specialist services to prevent and respond to child abuse. This includes sufficient qualified social workers and counselors to assist children who have experienced violence.

- Child-sensitive procedures in the justice system and, where appropriate, diversion of juvenile offenders from the formal judicial process. No child should be placed in prison with adults.

- Adoption of alternative community-based prevention and rehabilitation for children who commit offenses to reduce or avoid custodial sentences.

- Regular and public release of data on the incidence of child abuse and exploitation, and on children in the criminal justice system.

10. **Invest in children with disabilities**

The Tanzania 2008 Disability Survey estimated that four million people in Tanzania are living with a disability; nearly half are children. Around 13% of households have at least one member with a disability. Available statistics suggest that only 1 in 40 children with a disability uses a device to help improve their abilities or to increase their mobility. However, it is very likely that most of the figures on disability are much higher. Getting accurate data on disability is very difficult given the inaccessibility of many rural communities, and the reluctance of many families to discuss the issue.

Taboos against disability mean that parents can be ashamed or reluctant to seek treatment for babies born with impairment. Many are not aware that services are available that can vastly improve their children’s lives, or they face barriers in accessing them, such as prohibitive transport or surgical costs. As a result, conditions that can be easily treated in childhood become more restrictive, harder-to-treat impairments in adulthood. Clubfoot is a good example.
example. About three in every 1,000 babies are born with clubfoot each year in Tanzania. Clubfoot is a congenital deformity that can be successfully treated in very young children using a manipulative technique. However, the treatment can only work while the child is young because the bones are not yet set. After the age of six years, treatment becomes more difficult. Early intervention is vital.

Children with disabilities and their families and caregivers face a host of challenges. Children with disabilities face extreme discrimination with 22% of parents and caregivers reporting negative attitudes at home, in the community and from educational institutions. In numerous cases, mothers are left to bring up their disabled child alone as many fathers abandon their families. The broader impact on the family is significant. Caregivers, usually mothers, cannot take paid employment. Research shows that mean consumption of households in which a member has a disability is 60% lower than average, clearly demonstrating the link between poverty and disability. Without access to timely rehabilitative services and education, employment opportunities in adulthood are extremely limited. Untreated childhood disability can perpetuate and deepen poverty.

The majority of children with disabilities are denied their right to education. It is estimated that 98% of children with disabilities do not attend primary school on a regular basis, and very few enrol in secondary schools. Those who do attend schools typically have teachers who are not trained to cater for their special needs. Learning materials are often inappropriate and children whose disability affects their mobility commonly face accessibility problems. Only 42% of schools in Tanzania are accessible to children with disabilities. Lacking basic services and the means to participate socially, too many children are also locked away and kept in inhuman conditions. Children who are placed in institutions often receive very low quality care. Many are neglected and are especially vulnerable to abuse and exploitation both physically and mentally.

The recent passing of a Disability Act is an example of progressive legislation that should serve the best interests of children with disabilities. It must now be properly resourced in order to facilitate its prompt implementation.

**What is most needed?**

- Urgent implementation and enforcement of the Disability Act, including the establishment of a national coordination body on disability, in collaboration with partners to ensure appropriate budget allocation in all ministries and at all levels.

- Disability-specific services, including community-based rehabilitation programmes, rehabilitation centres and specialised medical services, and trained staff so that all children with disabilities can access the necessary rehabilitative services and devices.

- Programmes and services in schools, health facilities, transportation and communications, that are accessible to and inclusive of persons with disabilities as full participants and beneficiaries. In particular, schools need buildings that are physically accessible, trained teachers and appropriate teaching and learning materials.

- Public education on disabilities - the causes, ways to prevent and services to treat or rehabilitate different disabilities to enable them to have as full a life as possible. Addressing misconceptions will reduce stigma.
Empowering families to care for children: A universal system of social protection

The Children’s Agenda already shows promise as an advocacy strategy for promoting critical investments to advance the rights of all Tanzanian children. To support these investments and to catch those children who inevitably slip through gaps in sector-based services and interventions, a universal system of social protection is urgently needed. A universal system of social protection can create an enabling environment for households to provide for the needs of children, and can act as a final guardian to protect children’s well-being when shocks overwhelm the capacity of families or communities.

The goal of comprehensive system of social protection is multi-faceted. It aims to:

• prevents unacceptable levels of socio-economic insecurity and deprivation
• smooth consumption and protect poor households from depleting their meagre assets in the face of a livelihood shock
• enable access to social services for those who cannot afford the direct, indirect or opportunity costs of those services
• promote economic growth through income support, enhanced productivity and risk-taking behaviour.

As a set of measures – ranging from laws and policies, programs, services and transfers that seek to protect the poorest and most disadvantaged segments of the population – social protection remains one of the least explored areas of public policy in Tanzania. The development of a new Child Development Policy in 2008 and the passing of the Law of the Child Act in 2009 are moves in the right direction; if fully implemented and aligned with sectoral policies and budgets, they will have a profound impact on the lives of Tanzanian children.

A key challenge will be to scale up services so that they reach all children whilst maintaining a quality that encourages parents and caregivers to access and utilise them. Yet no matter how quickly service provision may expand towards universal coverage, children from poor families are always bound to be reached last, especially if they live in remote rural areas. Because of financial and time constraints, many may not be able to afford the services even when they become nominally available. Or the services may not be tailored to cater for children living on the margins or excluded from society, including street and disabled children.

Exploring the feasibility of a social protection system will be vital step in protecting children’s well-being and their households, and stimulating broad-based, more equitable economic development. To begin, a dual track approach is needed:

• Continued expansion in the supply of – and in turn demand for – quality social services for all Tanzanians
• A more limited system of social cash transfers for poor families with children who are young enough for the transfer to have the largest possible impact on their prospects for survival and development.

A large body of evidence exists about the positive impact that even modest yet predictable sums of money, transferred to poor households regularly, can have on the well-being of all family members. This evidence comes from rigorous evaluations of programmes of all sizes in countries from every region of the globe, including Tanzania where, despite the novelty and limited knowledge about this approach, a few pilot projects have proliferated with great results.
The proven benefits of cash transfer programmes are many-fold:

- Increased school enrolment, attendance, completion and transition rates
- Improved quality of diets and caloric intake, gains in growth and body weight, and declines in anaemia and iron deficiencies
- Greater health service utilisation, including antenatal care and facility-based deliveries, as well as higher rates of immunisation
- Women’s greater control over household resources.

Studies have also shown that even families that do not directly receive cash transfers still benefit from the programmes – a spill-over effect at community level akin to the fiscal stimulus package implemented by the Tanzanian Government at the macro level in 2009 in response to the global financial crisis. Evidence is also emerging that the positive results from implementing social cash transfers alongside quality service provision do not depend on the imposition of specific conditions on families to access the benefit. Even in the absence of conditions attached to the receipt of the transfer, families are utilising the extra cash they get to send their children to school, spend more on food, soap, medicines and clothing, or meet the cost of the transport to the nearest health facility.

Challenges to implementing a targeted system of social cash transfer exist, but as the experience of countries in eastern and southern Africa reveals, they are by no means insurmountable. Ultimately they are the same challenges that beset the expansion of quality social services to currently under-served groups in Tanzania, including limited financial and human resources; fragmentation and duplication of efforts within Government as well as among development partners; lack of coordination between strategies and stakeholders; and gaps in information to facilitate social planning.

Measures to address these gaps are being taken, and will require time to reach scale. Most important is the recognition that it is investments right now that will make the most difference—in ensuring that newborns survive and thrive, that they get a chance to develop to their full potential, that poverty traps and rights violations are averted, that the transmission of disadvantage to a new generation of Tanzanians is avoided.

Today is the time to invest in our children. Twenty million young lives and Tanzania can ill afford to wait.
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