Children and Women in Tanzania

Volume 2
Zanzibar
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Volume 2

Zanzibar
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.”

“Poverty is the single greatest burden for the people. It is not merely the lack of income that determines poverty; it is also the lack of accessibility to basic needs... The challenge, therefore, is to eradicate absolute poverty and set the Zanzibaris free from poverty so that they can participate effectively in the mainstream of social, economic and political life, survive and lead a decent life.”

These words, enshrined in the Tanzania Development Vision 2025 and the Zanzibar Vision 2020, 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 Revolutionary Government of Zanzibar and the United Nations Children’s Fund, argues that the vision of economic and social prosperity captured in those two seminal documents can only be realised if the survival, well-being and development of all Zanzibari, and indeed all Tanzanian, children is assured. In fact, every country that has made the breakthrough to middle-income status has invested heavily in children. Their development is amongst the most important drivers of sustainable 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 Zanzibar’s population, investing in their well-being now is arguably the soundest investment that Zanzibar can make to secure economic, social and political stability and prosperity for years to come.

This report highlights areas where progress has been made in advancing the rights and well-being of children, 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, Zanzibar has seen major progress in child health and education, as well as in 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 still need attention from policy makers, particularly maternal and newborn healthcare, nutrition, social and child protection, disability and, until recently, early child development and water, hygiene and sanitation.

In the quest for accelerating progress in advancing the rights of Zanzibar’s children and women, the question of what ought to be done first does not lend itself to easy answers. Among many competing demands, Zanzibar will need to further refine its 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 realisation.

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. Zanzibari children and the future of the Isles can ill afford to wait.

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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.

Among those who took part in the steering committee and the consultations carried out over the course of several months were representatives from the following institutions: Ministry of Agriculture and Food Security, Ministry of Community Development, Gender and Children, Ministry of Education and Vocational Training, Ministry of Health and Social Welfare, Ministry of Infrastructure Development, Ministry of Justice and Constitutional Affairs, Ministry of Labour, Employment and Youth Development, Ministry of Water and Irrigation, Planning Commission, Prime Minister’s Office, Commission for Human Rights and Good Governance, National Bureau of Statistics, Office of the Chief Government Statistician, Tanzania Commission for AIDS (TACAIDS), Tanzania Social Action Fund (TASAF), Tanzania Food and Nutrition Centre (TFNC), Tanzania Education Network (TEN/MET), Tanzania Federation of Disabled People’s Organisations (SHIVYAWATA), Tanzania Gender Network Programme (TGNP), Tanzania Water and Sanitation Network (TAWASANET), Tanzania Women Lawyers’ Association, CCBRT, Christian Social Services Commission, Family Health International, Ifakara Health Institute, PACT International, Save the Children, SNV, UK Department for International Development (DfID), UNAIDS, UNFPA, USAID, WaterAid, Youth Action Volunteers and Youth Peer Education Network.

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, as well as the Zanzibar sub-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 Planning and Operations sections, and the Emergency Preparedness and Response division 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>ALU</td>
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<td>ILO</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>IPTp</td>
<td>Intermittent preventive treatment for malaria in pregnancy</td>
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<td>Most-at-risk population</td>
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<td>Millennium Development Goals</td>
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<td>MLYWCD</td>
<td>Ministry of Labour, Youth, Women and Children’s Development</td>
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<td>MMR</td>
<td>Maternal Mortality Rate</td>
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<td>National AIDS Control Program</td>
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<td>National Strategy for Growth and Reduction of Poverty</td>
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<tr>
<td>NMSF</td>
<td>National Multi-sectoral Strategic Framework</td>
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<tr>
<td>NSPF</td>
<td>National Social Protection Framework</td>
<td></td>
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<tr>
<td>ORS</td>
<td>Oral rehydration solution</td>
<td></td>
</tr>
<tr>
<td>OVC</td>
<td>Orphans and vulnerable children</td>
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<tr>
<td>PEPFAR</td>
<td>President’s Emergency Preparedness Fund for AIDS Relief</td>
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<tr>
<td>PER</td>
<td>Public Expenditure Review</td>
<td></td>
</tr>
<tr>
<td>PHDR</td>
<td>Poverty and Human Development Report</td>
<td></td>
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<tr>
<td>PHAST</td>
<td>Participatory Hygiene and Sanitation Transformation</td>
<td></td>
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<tr>
<td>PLWHA</td>
<td>People living with HIV and AIDS</td>
<td></td>
</tr>
<tr>
<td>PMTCT</td>
<td>Prevention of mother-to-child transmission of HIV</td>
<td></td>
</tr>
<tr>
<td>PRSP</td>
<td>Poverty Reduction Strategy Paper</td>
<td></td>
</tr>
<tr>
<td>RCH</td>
<td>Reproductive and child health</td>
<td></td>
</tr>
<tr>
<td>RDTs</td>
<td>Rapid diagnostic tests</td>
<td></td>
</tr>
<tr>
<td>REPOA</td>
<td>Research on Poverty Alleviation</td>
<td></td>
</tr>
<tr>
<td>RGoZ</td>
<td>Revolutionary Government of Zanzibar</td>
<td></td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
<td></td>
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</tr>
<tr>
<td>SACMEQ</td>
<td>Southern and East African Consortium for Monitoring Educational Quality</td>
<td></td>
</tr>
<tr>
<td>SADC</td>
<td>Southern Africa Development Community</td>
<td></td>
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<tr>
<td>SHACCOM</td>
<td>Shehia AIDS Coordinating Committee</td>
<td></td>
</tr>
<tr>
<td>SP</td>
<td>Sulfadoxine Pyremethamine</td>
<td></td>
</tr>
<tr>
<td>STI</td>
<td>Sexually transmitted infection</td>
<td></td>
</tr>
<tr>
<td>SWAp</td>
<td>Sector-wide approach</td>
<td></td>
</tr>
<tr>
<td>SWO</td>
<td>Social Welfare Officer</td>
<td></td>
</tr>
<tr>
<td>TACAIDS</td>
<td>Tanzania Commission for AIDS</td>
<td></td>
</tr>
<tr>
<td>TB</td>
<td>Tuberculosis</td>
<td></td>
</tr>
<tr>
<td>TDHS</td>
<td>Tanzania Demographic and Health Survey</td>
<td></td>
</tr>
<tr>
<td>THIS</td>
<td>Tanzania HIV/AIDS Indicator Survey</td>
<td></td>
</tr>
<tr>
<td>THMIS</td>
<td>Tanzania HIV/AIDS and Malaria Indicator Survey</td>
<td></td>
</tr>
<tr>
<td>Tsh</td>
<td>Tanzania shillings</td>
<td></td>
</tr>
<tr>
<td>TVET</td>
<td>Technical and vocational education and training</td>
<td></td>
</tr>
<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on AIDS</td>
<td></td>
</tr>
<tr>
<td>UNDAF</td>
<td>United National Development Assistance Framework</td>
<td></td>
</tr>
<tr>
<td>UNDP</td>
<td>United Nations Development Programme</td>
<td></td>
</tr>
<tr>
<td>UNESCO</td>
<td>United Nations Educational, Scientific and Cultural Organisation</td>
<td></td>
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<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
<td></td>
</tr>
<tr>
<td>URT</td>
<td>United Republic of Tanzania</td>
<td></td>
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<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
<td></td>
</tr>
<tr>
<td>VAD</td>
<td>Vitamin A deficiency</td>
<td></td>
</tr>
<tr>
<td>VCT</td>
<td>Voluntary counselling and testing for HIV</td>
<td></td>
</tr>
<tr>
<td>VET</td>
<td>Vocational education and training</td>
<td></td>
</tr>
<tr>
<td>VIP</td>
<td>Ventilated improved pit (latrine)</td>
<td></td>
</tr>
<tr>
<td>WASH</td>
<td>Water, sanitation and hygiene</td>
<td></td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organisation</td>
<td></td>
</tr>
<tr>
<td>WPM</td>
<td>Waterpoint mapping</td>
<td></td>
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<tr>
<td>WSP</td>
<td>Water and Sanitation Programme</td>
<td></td>
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<tr>
<td>WUA</td>
<td>Water User Association</td>
<td></td>
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<tr>
<td>ZAC</td>
<td>Zanzibar AIDS Commission</td>
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<tr>
<td>ZACP</td>
<td>Zanzibar AIDS Control Programme</td>
<td></td>
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<tr>
<td>ZAPHA+</td>
<td>Zanzibar Association of People Living with HIV</td>
<td></td>
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<tr>
<td>ZAWA</td>
<td>Zanzibar Water Authority</td>
<td></td>
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<tr>
<td>ZSGRP</td>
<td>Zanzibar Strategy for Growth and Reduction of Poverty</td>
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</tbody>
</table>
Overview

The Zanzibari population is young. According to the 2004/05 Zanzibar Household Budget Survey, 55.8% of the population are below 20 years of age. The median age is just 17 years. Meeting the goals of Zanzibar Vision 2020 will therefore depend upon realising the full potential of Zanzibar’s youth. The islands too are increasingly a destination for international trade and tourism which engenders high professional and lifestyle aspirations. Investing in the health, education and well-being of young people now — and establishing the foundation for their future creativity and productivity — is the soundest investment Zanzibar can make to secure economic, social and political stability and prosperity. Beyond the societal obligation to nurture and protect children, their development will be the single most important driver of national growth.

To inform and enable strategic investments in children, Children and Women in Tanzania 2010 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 environment in which Zanzibari children can fully participate in and benefit from the rapid economic development in the Isles. 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 Zanzibari children. It aims to drive evidenced-based advocacy and positive change for children and women, and to serve as a reference tool for Government and non-state actors working towards development outcomes.

A defining moment in children’s rights

Children and Women in Tanzania 2010 comes at important juncture. The report coincides with the passing of the Children's Act 2011 by the Zanzibar House of Representatives. The primary focus of the legislation is to develop a coordinated child protection system in Zanzibar to effectively respond to cases of violence and abuse and to better promote and protect the rights of children in conflict with the law. The Bill also contains provisions relating to custody, guardianship, access and maintenance, foster care and adoption, children and health services and children in residential establishments.

The development and effective implementation of comprehensive legislation protecting the rights of children can go a long way in helping the Revolutionary of Government of Zanzibar in meeting its obligations under international treaties such as the UN Convention on the Rights of the Child (UNCRC) and the African Charter on the Rights and Welfare of the Child (ACRWC) and in promoting the best interests of all children in Zanzibar.

The ongoing implementation of the second phase of the Zanzibar Strategy for Growth and the Reduction of Poverty 2010-2015 (MKUZA II) also represents a critical opportunity to promote the broad-based and sustained investment in children necessary to achieve the Millennium Development Goals (MDGs) by 2015.

MKUZA serves as the national strategy for realising international commitments, such as the MDGs, and it strives towards achieving poverty alleviation and equity in service delivery and outcomes. Interventions include expanding access to essential services, such as education, healthcare, HIV and AIDS, shelter, food security, water and sanitation. However, greater recognition is required of the inter-relationships between children’s needs for survival, development and protection. Policies are needed that bridge Ministerial and sectoral divisions, and programmatic responses that support children throughout their life course — from conception through adolescence — so that they do not fall through gaps in service delivery between sectors and at different ages.
## Fast facts on Zanzibar children and women

### Demographics

<table>
<thead>
<tr>
<th>Metric</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of population aged 0-19 years</td>
<td>55.8%</td>
</tr>
<tr>
<td>Median age of population</td>
<td>17 years</td>
</tr>
</tbody>
</table>

### Maternal and child survival

<table>
<thead>
<tr>
<th>Metric</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Fertility Rate (women on Unguja)</td>
<td>5.1%</td>
</tr>
<tr>
<td>Girls aged 15-19 years who have begun childbearing</td>
<td>6.0%</td>
</tr>
<tr>
<td>Pregnant women who attended antenatal care</td>
<td>99.4%</td>
</tr>
<tr>
<td>Babies born without skilled attendants</td>
<td>46.4%</td>
</tr>
<tr>
<td>Maternal mortality rate for Tanzania</td>
<td>454 per 100,000 live births*</td>
</tr>
<tr>
<td>Under-five mortality rate</td>
<td>73 per 1,000 live births</td>
</tr>
<tr>
<td>Babies who received post-natal check-up</td>
<td>32.5%</td>
</tr>
</tbody>
</table>

### Nutrition

<table>
<thead>
<tr>
<th>Metric</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of women of reproductive age who are anaemic</td>
<td>42%</td>
</tr>
<tr>
<td>Children under five years who are stunted</td>
<td>30.2%</td>
</tr>
</tbody>
</table>

### Education

<table>
<thead>
<tr>
<th>Metric</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of women aged 15-49 years with no education</td>
<td>23.6%</td>
</tr>
<tr>
<td>Net enrolment rate in primary schools</td>
<td>78%</td>
</tr>
<tr>
<td>Pupil-teacher ratio in primary schools</td>
<td>30:1</td>
</tr>
</tbody>
</table>

### Water, sanitation and hygiene

<table>
<thead>
<tr>
<th>Metric</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Households with access to clean water</td>
<td>79.4%</td>
</tr>
<tr>
<td>Percentage of rural households without access to latrine</td>
<td>24.9%</td>
</tr>
</tbody>
</table>

### HIV and AIDS

<table>
<thead>
<tr>
<th>Metric</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV prevalence</td>
<td>Under 1%</td>
</tr>
<tr>
<td>Percentage of reproductive and child health sites with PMTCT services</td>
<td>19%</td>
</tr>
</tbody>
</table>

### Child protection

<table>
<thead>
<tr>
<th>Metric</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children under five years with birth registration (Mainland)</td>
<td>79%</td>
</tr>
<tr>
<td>Children engaged in child labour</td>
<td>9%</td>
</tr>
</tbody>
</table>

* This figure refers only to deaths recorded in health facilities and does not include mothers who die giving birth at home.
Child and maternal survival: Success and stagnation

Under-five mortality has declined steeply in Zanzibar. According to the recently published Tanzania Demographic and Health Survey (TDHS) 2010, the under-five mortality rate for Zanzibar stands at 73 deaths per 1,000 live births. This means that the target of under-five deaths under the first phase of MKUZA (71 deaths per 1,000 live births) was virtually achieved, although the rate in Pemba is almost 30% higher than Unguja. The gains are largely attributable to malaria control interventions, including more widespread use of insecticide-treated nets and residual spraying, as well as better treatment, particularly the roll-out of rapid diagnostic tests and the early introduction of artemesinin combination therapy. The introduction of universal Vitamin A supplementation from 2005 has also contributed, and vaccination rates are slightly higher than the Mainland.

However, also like the Mainland, neonatal mortality (deaths in the first 28 days following birth) remains high (29 per 1,000 live births), and now accounts for nearly 40% of under-five deaths. Newborn deaths are inextricably linked to the health of the mother during pregnancy and at delivery. A recent study found that facility-based maternal mortality was still very high at 450 deaths per 100,000 live births. This figure does not include women who died during births at home. Only 49.2% of births take place at health facilities, and the rate of skilled attendance at birth is only slightly higher at 53.6%. The proportion of deliveries by Caesarean section (4.7%) is well below the international norm of 5-15%.

Most maternal and newborn deaths could be averted with universal access to quality obstetric care at delivery, and the adequate management of common neonatal complications including preterm delivery, infections and birth asphyxia. Progress on maternal and neonatal health will be vital if the MKUZA II and Millennium Development Goals are to be achieved in the Isles by 2015. The Road Map to Accelerate Reduction of Maternal, Newborn and Child Deaths was launched in 2009, and maternal death audits have been instituted in all facilities conducting deliveries since July 2008. But the very high level of institutional maternal deaths indicates that much remains to be done to improve birth services in Zanzibar. On the positive side, postnatal check-ups for newborns in the first two days after birth rose exponentially in the last five years, from a low 5.8% in 2004/5 to 32.4% in 2010. The almost universal attendance among pregnant women for antenatal care provides a key entry point for clinical care and counselling to encourage confidence in, planning for and use of facility-based delivery services.

Nutrition: Critical but overlooked

Since the 1990s, malnutrition among children under-five years in Zanzibar has decreased significantly; between 1992 and 2004/5 the incidence of stunting, underweight and wasting was roughly halved. Extrapolating that trend suggests that Zanzibar can meet the MDG target of halving the proportion of underweight children by 2015. Data from the 2010 TDHS are based on a different reference population, and are therefore nor comparable with previous figures. Still, according to the most recent figures almost one in three Zanzibari children under five years is stunted. Stunting is higher in Pemba (35.5%) and children in the poorest quintile are about twice as likely to be stunted as those in the least poor quintile. Rates of malnutrition and anaemia among women in Zanzibar are also higher than the Mainland, even though the gaps have been closing in recent years.

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 a major contributing factor in child deaths.
Exclusive breastfeeding initiated within one hour of birth and continuing for six months is the most effective life-saving intervention. 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. However, early weaning and giving pre-lacteal feeds, which are known to be a major cause of diarrhoea during infancy, are still common practices in Zanzibari households. The latest data also show an exclusive breastfeeding period of only 15 days. 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.

Anaemia and vitamin A and iodine deficiencies are also common among women and children, though the prevalence of anaemia has fallen recently as a result of better malaria prevention and treatment. 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%.

Improvements in basic nutrition 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, sanitation and hygiene: A mixed picture**

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 (especially for girls) and decreased costs for hospital services – an astonishing return on investment. 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 sepsis is a leading cause of maternal mortality, both of which are affected by use of unclean water and poor hygiene at delivery and postpartum. Improving water supply, sanitation and hygiene in schools will reduce illness, improve attendance and help to ensure that more children, especially girls, complete their education.

The TDHS 2010 found that 79.5% of Zanzibari households have access to clean, safe water, a much higher proportion than on the Mainland, but access is much lower on Pemba and in rural parts of the islands. Sustainability of water supply remains a major challenge as resources and skills at community level for operations and maintenance are limited. Access to piped, pump-driven sources is also highly vulnerable to power outages.

Sanitation is more problematic; nearly one in four Zanzibari households (24.9%) has no access to any latrine.

Unlike water, sanitation and hygiene are still to capture the attention of policy makers, donors and the public. The development of an Environmental Sanitation Policy for Zanzibar is an opportunity to raise the profile and investment in this critical sub-sector. Recent interventions promoting simpler technologies over expensive Ventilated Improved Pit (VIP) latrines in areas with low access and low incomes are also proving a valuable interim measure. In addition, the integration of basic hygiene education into maternal health services and the curriculum in schools can save lives and dramatically reduce childhood illness. Hand-washing at critical times is one
of the most simple, cost-effective ways of improving child well-being; international research indicates that it can reduce the risk of diarrhoeal disease by up to 47%.

**Early childhood development: A new frontier**

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, and help ensure that children grow up healthy, well-nourished and well-prepared for school. 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. 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.

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. Community-based childcare facilities are often the most appropriate: closer to home, easier to access and able to be adequately monitored. To achieve uptake of services, the education of parents and leaders is required at all levels on the crucial role that ECD has on child well-being and on poverty reduction. To improve the quality of tuition, all centres need to be appropriately registered, and pre-primary teachers trained as a core cadre in the education sector.

Momentum is building to increase early childhood investments. Early Childhood Care and Development is included as one of MKUZA II’s core cluster strategies for education. The strategy aims to develop and implement an integrated ECD policy by 2012, and to increase net enrolment for preschool from 20.1% in 2010 to 50% in 2015. Partnerships with civil society, faith-based groups and the private sector alongside investment in government capacity will be necessary to expand quality ECD programmes to poor and disadvantaged areas.

**The challenge of quality and equity in education**

Vision 2020 sees education and training to promote sustainable livelihoods as fundamental to achieving its overall development goal of eradicating abject poverty in the Isles. To this end, the Zanzibar Education Policy 2006 aims to make 12 years of education compulsory for all children: two years of pre-primary, six years of primary and four years of secondary. But much remains to be done to make this ambitious policy a reality for Zanzibari children. In 2008, the gross enrolment rate in primary schools was close to 100%, but the net enrolment rate was only 78%, indicating that children are not starting school at the prescribed age or high dropout rates. Almost all districts achieved gender parity. However, net enrolment rates are much lower in Pemba and in rural areas. There is also an acute shortage of classrooms. Double shift schools still operate in nine out of ten districts.

Disabled children continue to be excluded from formal education. 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. Lacking basic services and the means to participate socially, too many children are also locked away and kept in inhuman conditions.
The overall pupil-teacher ratio (PTR) at 30:1 is much lower than the Mainland but teachers prefer to be located in the more urbanised areas of Urban, West and Central districts, so rural areas are under-served. Indeed, there is an over-supply of primary school teachers in Zanzibar but they are poorly distributed and many lack competence in the subjects they teach. As a result, approximately two-thirds of Standard 6 pupils did not reach a ‘minimum’ level of mastery in reading, writing and numeracy. Moreover, when tested using the same questions, only 80% of teachers reached a ‘desirable’ level of mastery. There are few skilled teachers in mathematics and science leading to high PTRs or classes being taught by teachers not trained in these subjects.

Incentives to attract teachers to serve in difficult or remote areas will be required as well as improved teacher training to promote child-centred active learning. Community outreach and non-formal educational options for children on the margins, such as working children and the disabled, are urgently needed to convince parents of the value of education and enable youth to attend and stay in school.

**HIV and AIDS: Addressing the drivers of the epidemic**

The overall prevalence rate in the Isles is much lower than on the Mainland, having stabilised at 0.6% since 2002. However, the prevalence rate among women aged 15-29 years is reported to be almost five times higher than their male counterparts (0.9% compared with 0.2%). 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.

Among adolescent women in Zanzibar surveyed by the THMIS 2007/8, over one in five (22%) reported having had sex before the age of 18, but only one in ten women (10%) aged 15-24 years used a condom at first sexual intercourse. Early marriages, sexual abuse and gender biases leading to unequal negotiation and decision-making powers also increase youth, specifically girls’, vulnerability to the virus. Life skills education has been offered in Zanzibar for over 15 years but programmes have usually been short-lived and focus on abstinence only. Beyond the current focus on expanding care and treatment prevention interventions are urgently needed to address the drivers of HIV transmission as well as broader social change that challenges the inequities that put girls and women at far greater risk.

Improved access to information will also be essential in reducing infant transmissions. While about 80% of women in Zanzibar 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. Again, improving women’s access to education and information will be the key to reducing vertical transmissions of HIV in conjunction with expanded supply of quality maternal healthcare, including PMTCT services.

PMTCT services are now offered at 19% of the reproductive and child health (RCH) sites in Zanzibar, which means that a high number of women deliver without knowing their HIV status thereby increasing the risk of transmission to their babies. This is further complicated by the high proportion of women delivering at home. The health system also lacks the capacity to routinely and rapidly identify, diagnose and treat HIV-positive children. Most of those infected are diagnosed late, if at all. And if they are found to be HIV-positive, poor tracking and follow-up leads to low retention in treatment and support services.
Protection of children against abuse, neglect and exploitation

In recent years Zanzibar society has become more aware of the problem of child abuse and the need for further investment in child care and family support services to respond to child abuse and welfare concerns. In 2009 the Revolutionary Government carried out the first survey on violence against children in Zanzibar. The findings of this survey, launched in 2011, report that violence against children, sexual exploitation and abuse are a significant problem and occur at home, in communities and at school. Over one in 20 of females and almost one in ten males reported experiencing at least one incident of sexual violence before the age of 18. About one in ten children in Zanzibar who have sex before turning 18 say that their first intercourse is unwilling, and that they are either tricked, pressured, threatened, physically forced or coerced some other way to have sex. According to the survey, moreover, the percentage of children who seek services after an experience of sexual violence is low, at 19% for girls and 11% for boys. Not all of those who seek services receive them: only six out of 11 girls and boys are successful in receiving those services. Overall, this means that only about one in ten children who experience childhood sexual violence receive services afterwards.

In the past, the child protection response in Zanzibar has been fragmented and uncoordinated with no clear identified primary reference point and services stretched across different ministries, departments and national agencies, including police, hospitals, schools and community organisations. This uncoordinated approach has had significant implications in relation to service delivery for victims of abuse. Nevertheless, significant progress has been made recently in an effort to develop a more strategic approach towards building a national child protection system. In 2011 the Zanzibar House of Representatives passed the Children’s Act 2011. The primary focus of the legislation is to develop a coordinated child protection system to effectively respond to cases of violence and abuse and to better promote and protect the rights of children in conflict with the law. The Act also contains provisions relating to custody, guardianship, access and maintenance, foster care and adoption, children and health services and children in residential establishments.

The new Children’s Act establishes procedures and outlines the roles and responsibilities of national institutions and professionals in providing child protection services. It seeks to provide a clear route of access for referral and coordinated responses in cases of children in need of care and protection. The Act also seeks to link the child welfare and care system and criminal matters so as to better protect and promote the rights of all children.

Likewise, in 2011 the Department of Social Welfare under the Ministry of Social Welfare, Youth, Women and Children Development developed National Guidelines for the Protection and Welfare of Children. These guidelines aim to create a clear route of referral for cases of abuse concerning children in Zanzibar and establish the Department of Social Welfare as the appropriate responsible body with the mandate for coordinating the necessary response and providing support services for children and their families. The Department has established a Child Protection Unit which provides a safe space for dealing with specific cases of abuse against children, and is responsible for coordinating national child protection services.
To fulfil its mandate the Department of Social Welfare will require significant strengthening of its capacity and a concentrated investment in terms of technical, financial and human resources for the effective operationalisation of the provisions of the Children’s Act and the National Guidelines. Intensive human resource and capacity development is required to increase the quantity and quality of social workers throughout Zanzibar.

Positively, Zanzibar has made great progress in birth registration; 88% of children in Unguja but only 65% in Pemba are registered. This provides a foundation for the identification and support of children at risk and in need of protection, even though progress in Pemba needs to be accelerated.

**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). The magnitude of disparities varies by sector but significant differences in outcomes are found for children in poor and rural households from antenatal and obstetric care through to access to education, health and water services. Poverty impacts particularly hard on children and remains overwhelmingly rural. A recent analysis of data from the Tanzania Demographic and Health Survey 2004/5 found that the incidence of two or more severe deprivations of basic needs among children in rural areas of Zanzibar was 49% compared with 10% in urban areas (REPOA, NBS and UNICEF, 2009).

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. 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.

Significant variations in poverty levels and delivery of services persist by island and by district. This is starkly illustrated by the situation in Micheweni district on Pemba. Three-quarters of the district’s population lives below the basic needs poverty line and one-third below the food poverty line. At the same time, Micheweni comes last on all educational indicators, including enrolment, dropout and literacy rates. Service delivery options are needed to sustainably reach under-served areas to improve maternal and child outcomes.

Although advances have been made in closing the gender gap in education, 16% of Zanzibari women reported having no formal education in 2010 compared with 6% of men. Survey data further reveals that only 54% of Zanzibari women have, alone or jointly, the final say in their own healthcare – up from 41% five years earlier. A very large proportion of 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, 2010).

The relative isolation of women as well as the low status of young women in particular undermine 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.

The impact of disability is a further significant factor underlying persistent disparities in outcomes for children and their families. 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. Caregivers, usually mothers, often cannot take paid employment, and without access to timely rehabilitative services and education, employment opportunities for adults with disabilities are extremely limited. Programmes and services in schools, health facilities, transportation and communications that are accessible to and inclusive of persons with disabilities as well as public education on the causes and nature of disabilities are required to enable people with disabilities to be full participants and beneficiaries within society.

**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 Zanzibari 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 MKUZA. Among its core cluster strategies, Goal 6 of Cluster II aims to establish the policy frameworks and implement the intervention packages necessary to support poor families and households to provide care and protection to children. The recent passage of a Children’s Act through the House of Representatives is another significant step. If fully implemented and aligned with MKUZA II and sectoral policies, budgets and regulations, the Act will have a profound impact on the lives of Zanzibari children. So too, the recent publication of the Zanzibar Social Protection Expenditure Review and Social Budget is an important advance towards establishing a social protection “floor” in Zanzibar.

Internationally, 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. 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. They are the same challenges that beset the expansion of quality social services to currently under-served groups in Zanzibar, 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 outlined below – need to go hand-in-hand with any social transfer programme.

The Children’s Agenda

This report has highlighted areas where progress has been made in securing the rights of children and women in Zanzibar, 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. The final chapter brings together the main findings and messages from the report, in an effort to chart an ambitious yet realistic agenda for Zanzibar’s children.

The Children’s Agenda was developed alongside this report over a period of several months during 2010. The Agenda outlines Ten Investments that hold great promise for transforming the lives of Zanzibari children. The choice of the investments is the result of thorough fact-finding and analysis, and broad consultation with Government, leading children’s organisations and children from across Tanzania, including Zanzibar. It provides a platform for future policy setting.

Mindful that investing in children is tantamount to investing in Zanzibar’s present and future, it is hoped that The Children’s Agenda will not only serve to inform the implementation of the
second phase of MKUZA over the period 2010-2015, but also the legislative agenda of the new Parliament sworn in after the elections of October 2010. The Top Ten Investments outlined in the Ajenda ya Watoto 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 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. Children represent the foundation of a vibrant democracy and robust economy, and need to be supported – and inspired – to grow up as informed and active citizens. Indeed, the measure of a nation is reflected in how it defends and the most vulnerable members of its society. Today is the time to invest in Zanzibar’s children. They, and the future of the Isles, can ill afford to wait.
Introduction

Since UNICEF published its last Situation Analysis of Children and Women in 2001, Zanzibar 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. For example, 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 absence of a child protection system and 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 situational analysis to explore the path to date and illuminate the steps ahead to fully realise the rights of all Zanzibari children.

Purpose of the report

Children and adolescents aged 0-19 years constitute 55.8% of Zanzibar’s population (RGoZ, 2006a), 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 Zanzibar’s ability to develop and realise the country’s economic and social goals in Vision 2020 (Revolutionary Government of Zanzibar (RGoZ), 1998a).

The analysis 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 Zanzibar 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 acronym of MKUZA—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 Situation Analysis of Children and Women 2010 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 Zanzibari 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 Zanzibari 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 organisations, private sector actors and development partners. In other words, the responsibilities and actions of “duty bearers” need to be assessed to ensure that the rights of children are respected, protected and promoted.

The Situation Analysis 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 Zanzibar is articulated in the Zanzibar Strategy for Growth and the Reduction of Poverty (MKUZA), and internationally in the Millennium Development Goals (MDGs).

• The rights-based approach, as articulated in 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. 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 interrelationships 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 are based on a thorough desk review of the data generated by the Poverty Monitoring System and research produced locally and internationally about Zanzibar. MKUZA and MDG targets locate the analysis in current national and international development priorities. Where data is available, the situation analysis 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

MKUZA aims to catalyse Tanzanians’ potential and achieve economic growth by:

- Promoting opportunity
- Facilitating empowerment
- Enhancing security

An identity
Freedom from discrimination
Survival
Protection
Participation
Development
Tanzania’s children have rights to

Introduction
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

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 interrelated 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 their lives. Yet there seems to be a reluctance to engage with the whole child. Social policies tend to compartmentalise interventions, each of which deals 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 children in Zanzibar. 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 timely manner throughout their life course, as children age they are naturally predisposed towards increasing self actualisation and the rights of education, participation and protection become more pressing and important to them.

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 Zanzibar 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 for 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, and children with special needs.

Therefore, 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

**What children need to develop**

**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**
- 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

Volume 2 is structured into eight chapters.

Chapter 1 provides an overview of the status and trends in realising children’s rights in Zanzibar, 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 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 – Maternal health and child survival and development
- 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 sectoral 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 the WASH interventions in 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 Zanzibar’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 Ten Investments in Children to rapidly improve the situation of children in Zanzibar.
Chapter 1
Establishing a foundation for child rights in Zanzibar

1.1 Legal and policy environment

The United Republic of Tanzania comprises the Government of Mainland Tanzania and the Revolutionary Government of Zanzibar (RGoZ). Under the Constitution, the Union Government is responsible for making laws applicable to the Republic, including foreign affairs. Of particular pertinence to child rights, the Union Government is responsible for accession to international treaties, including the United Nations Convention on the Rights of the Child (UNCRC), the African Charter for the Rights and Welfare of the Child (ACRWC) and the Millennium Development Goals (MDGs).

The Revolutionary Government is responsible for all internal matters on the Isles; legislation is enacted through the House of Representatives and administered by ministries of the RGoZ. The ministerial structure of the Isles is similar to the Mainland. Of important note, statutory and Sharia law function concurrently in Zanzibar which can impact the translation of legislative and policy instruments into behavioural change at community and family levels to extend and expand the rights for women and children. The Ministry of Health and Social Welfare has reported that statutes and policies are not always consistent with each other, nor are they consistent with the internationally recognised rights of children. For example, the Children and Young Persons Decree is incompatible with provisions in the Child Survival, Protection and Development Policy (2001), as well as provisions in the HIV/AIDS Policy (2001), the Education Policy (2006) and the United Nations Convention of Rights of the Child (RGoZ, 2007a).

Like the Mainland, Zanzibar has instituted measures to reduce high levels of poverty through the Zanzibar Strategy for Growth and Reduction of Poverty (ZSGRP or MKUZA to use its common Swahili acronym). MKUZA serves as the foundational strategy for realising international commitments, such as the MDGs, and it strives towards achieving poverty alleviation and equity in service delivery and outcomes. Interventions include expanding access to essential services, such as education, healthcare, HIV and AIDS, shelter, food security, water and sanitation. Aspirations to eliminate poverty are also enshrined in the Zanzibar Development Vision 2020 and sectoral policies (RGoZ, 1998b, 2002, 2004a, 2005a, 2006b, 2006c). The sectoral policies that are particularly relevant to children – education, water, health, and HIV and AIDS – are grounded on the assumption that increased access to basic services and entitlements build human capital and will ultimately lift Zanzibaris out of poverty (RGoZ, 2000, 2001a, 2001b, 2004b, 2006d, 2007c).
1.2 Generalised insecurity

Despite recent years of robust economic growth, 49% of the population live below the basic needs poverty line and 13% below the food poverty line. There are large geographic and rural-urban disparities in poverty incidence. More than 60% of the population on Pemba live below the basic needs poverty line and 22% below the food needs poverty line. In contrast, on Unguja, 42% live below the basic needs poverty line and 10% below the food poverty line (RGoZ, 2006a). Almost one-third (31%) of the poorest households in Zanzibar have reported that they frequently face food insecurity (REPOA and UNICEF, 2006). The majority of poor households have a larger number of dependents with the household head having little or no formal education.

There is an increased recognition of the nexus between generalised insecurity, widespread poverty and vulnerability to impoverishment. They are all drivers of violations of children’s rights to survival, development, protection and participation (RGoZ, 2007a, 2009a; Save the Children, 2009). Almost two-thirds (62%) of children in Zanzibar suffer from at least one severe deprivation of basic needs with the majority of those being children who live in rural areas (REPOA, NBS, and UNICEF, 2009).

1.3 Child-sensitive social protection

There has been an intense debate on the concept and remit 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).

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;
- **Promotional**: enhance income and promote livelihoods, e.g. training for youth, early childhood development, childcare for employed parents or micro-credit;
Transformative: address social inequity, such as in HIV and anti-stigma campaigns, or laws to protect inheritance rights.

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).

Currently, no social protection framework exists to support the most vulnerable groups in Zanzibar. Despite the mainstreaming of social policy issues into MKUZA, Vision 2020 and other sectoral policies, social welfare services remain inadequate and limited in reach.

Moreover, neither legislation nor MKUZA articulate social protection as an entitlement of citizens, and so do not guarantee a minimum level of well-being through social provisioning. Social service delivery to address vulnerability in Zanzibar is premised on targeting the “deserving poor” rather than universal access. As a result social provisions are perceived as charitable or moral obligations rather than a legal right that the poor can claim from the government. Social security provisions are limited to non-statutory measures to improve access to health and education and to ad hoc contributions of food and materials or exemptions from user fees for services.

The Most Vulnerable Children (MVC) Programme is the primary instrument through which social protection is conceptualised and implemented, by offering cash and in-kind transfers.
to children who are identified through a community-based identification procedure and meet MVC criteria. This programme, however, excludes children and women who may be considered poor but not vulnerable. Many of the limitations of this programme are similar to those of the Mainland MVC initiative. Namely, that the support offered is neither regular nor takes a holistic view of the child’s situation. The programme is also reliant on external donor support that is framed within the emergency response to HIV and AIDS, not in wider context of protecting and advancing children’s rights and well-being. The Most Vulnerable Children Committees (MVCCs) that have been established at district and shehia levels are not statutory entities and are constrained by the limited volunteer time and resources that community members are able to contribute (RGoZ, 2009a). To date, the system has evolved in haphazard manner; very few districts and shehias currently have functioning MVCCs. Where they do exist they do not receive any material support from any national agency.

Whilst such interventions may partially avert the risk of severe child deprivation, they fall well short of facilitating any developmental change for children and their families. Interventions do not enhance income or human capabilities and thus do not lift families out of poverty, or break inter-generational cycles of poverty. To do this would require addressing systemic factors that underlie extreme poverty. Programmes would need to address inequality (between genders, age groups and wealth quintiles) and social exclusion through progressive legal and judicial reform as well as budgetary analysis and re-allocation. The responsibility for ensuring children’s rights and well-being must be extended outside the domestic domain into the public domain where cultural norms that negatively impact women and children can be challenged and held to account.

To date, implementation of MKUZA has not put in place systems an effective social protection framework. To do so will require the identification and development of interventions that accurately target vulnerable children. The UN has made a commitment to working with the government and national partners to advance social protection systems as part of the UN Joint Programme on Capacity Building Support to Zanzibar (JP5), an initiative implemented under the leadership of the Revolutionary Government of Zanzibar since 2008 aiming to improve national capacity and service delivery for sustained, pro-poor growth in Zanzibar (UNICEF, 2009a). Social protection interventions will be grouped into the following cross-cutting areas:

- **Mechanisms**, including establishment of a social protection technical working group to provide leadership;
- **Research and information** to fill current information gaps;
- **Policy and strategy development** at the national level including action plans with budgets for social protection interventions such as cash transfer schemes. In addition, consensus will be built on identifying the minimum standards required of social protection interventions.

As illustrated in Figure 4, a social protection agenda aligns closely with the growth and poverty reduction goals of MKUZA. A clear medium and long-term strategy is required to strengthen households’ ability to improve the outcomes 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).
Box 2: A national social protection strategy in Zanzibar

In 2010, the International Labour Organisation in collaboration with the Ministry of Labour, Youth, Women and Children Development published a Zanzibar Social Protection Expenditure Review and Social Budget. Based on the findings from the review, a set of actions are proposed, closely linked to MKUZA objectives and targets, to develop a national social protection strategy in Zanzibar. The review outlines the need to establish of social protection “floor” consisting of two elements: i) Access to services; and ii) a set of social transfers in cash and in kind paid to the poor and vulnerable. The report looks at three policy options for Zanzibar which would go some way to addressing the income needs of the elderly, children in poverty and households in extreme poverty. The report presents a ‘minimum package’ of benefits:

- A universal pension for all persons aged 60 and over
- A universal child benefit for the first child for seven years
- A targeted social assistance scheme intended to identify the most vulnerable households in Zanzibar

If the package is implemented, it would represent the foundation of a national social protection framework in the Isles (ILO, 2010).

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.

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 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.

1.4 What is in the best interests of Zanzibari 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 Zanzibar 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.
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. 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.

1.4.1 Children’s experience of family

The well-being of children depends primarily on the care provided by their families and communities. Living arrangements affect this care. Zanzibar like Mainland Tanzania is undergoing rapid transition away from a subsistence rural economy to an increasingly urbanised, informal economy, which has placed tremendous pressure on traditional extended family structures and norms.

A larger proportion of children in Zanzibar live with both parents (68.1%) compared with the Mainland (59.0%), but more children do not live with either parent (13.7% compared with 11.5% on the Mainland). 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 support, as families become more nuclear or single-headed and/or members migrate from home villages to secure better livelihoods.

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.

1.4.2 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 Zanzibar, 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 can result in ambivalence about accountability to children and their participation in decision-making within households or wider 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 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 decentralisation 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 Zanzibar moves to a new generation of 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 Zanzibari 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.
Chapter 2
Maternal health and child survival

Appropriate healthcare in a child’s early years is essential for their 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 Zanzibar is indivisible from the agenda to improve child health, nutrition and survival. Assessments in Zanzibar have indicated a clear need for holistic actions in early life, beginning in pregnancy. Poor nutrition and ill health of mothers increases 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 4 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

Maternal mortality
Lack of access to appropriate antenatal and delivery care multiplies the risk that women and babies will die of complications. A recent study (Lund, 2008) examined records of maternal deaths in all health facilities in Zanzibar over the period 2005-2007. Over the three-year period, 244 maternal deaths and 54,262 live births were recorded, giving a facility-based maternal mortality ratio of 450 deaths per 100,000 live births which roughly matches the latest maternal mortality data from the 2010 TDHS for the entire Union (454 per 100,000 live births). Haemorrhage and hypertensive disease together accounted for 54% of institutional maternal deaths, while abortion was the leading cause of complications among surviving women. The maternal mortality ratio for women who died at home is unknown, and the authors speculate that sepsis and abortion-related complications may be more common in maternal deaths that occur outside health facilities. Among women who gave birth in health facilities and suffered haemorrhage and eclampsia/pre-eclampsia, the case fatality rates were 3.7% and 4.7% respectively, compared with an international “maximum” of 1%. The proportion of deliveries by Caesarean section (1.9% of all deliveries; 3.4% of facility deliveries) is also well below the international norm of 5-15%.

From July 2008, maternal death audits have been instituted in all facilities conducting deliveries in Zanzibar. This system of routine investigation of maternal deaths in health facilities will provide an ongoing evidence base for the design of maternal health interventions. During 2007/8, nine primary healthcare units were upgraded to provide delivery services, ten facilities were equipped to provide post-abortion care services, and staff across the Isles were trained in life-saving skills, including use of misoprostol for post-partum haemorrhage. Nonetheless, the very high level of institutional maternal deaths and the very low level of post-natal follow-up

Data for health in Zanzibar

Zanzibar has taken steps to improve its health management information system (HMIS) and is now able to produce national, zonal, district and facility statistics on a wide range of health indicators.

Health data are published in an annual Health Information Bulletin. This provides a solid evidence-base for decision making by managers at all levels.

Unless otherwise stated, data cited in this chapter is sourced from:

- Tanzania HIV/AIDS and Malaria Indicator Survey (THMIS) 2007/8
- Tanzania Demographic and Health Survey (TDHS) 1996, 2004/5 and 2010
- Tanzania Reproductive and Child Health Survey (TRCHS) 1999
Children and Women in Tanzania

Figure 4: 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

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

**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

**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
show how much remains to be done to make delivery safer for women and newborns. 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.

**Fertility rates and contraceptive use**

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. Teenage pregnancies – often a consequence of early marriage – carry a higher risk of maternal death.

At 5.1, fertility rates are slightly lower in Zanzibar than the Mainland, though a significant disparity in the Total Fertility Rate (TFR) exists between Pemba (TFR = 6.4) and Unguja (TFR = 4.6). Adolescent fertility (i.e., women who are pregnant or have begun childbearing by age 19) shows a declining trend in Zanzibar, as compared to little or no change in Mainland Tanzania over the past decade (Figure 5).

**Figure 5: Adolescent fertility trends 1996-2010**

![Graph showing adolescent fertility trends 1996-2010.](image)


TDHS 2010 data show that barely one in every eight married women in Zanzibar (12.4%) was using a modern contraceptive method, which is less than half the proportion on the Mainland (27.8%). Median age at marriage (19.6 years) is only marginally higher than the Mainland (18.9 years) while median age of sexual debut is almost two years higher in Zanzibar (19.2 years) than on the Mainland (17.4 years).
### Table 1: Zanzibar’s health targets

<table>
<thead>
<tr>
<th>MKUZA I targets</th>
<th>Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve health status, including reproductive health, survival and well-being of children, women, men and vulnerable groups</td>
<td><strong>Infant and child health</strong>&lt;br&gt;• Reduced infant mortality from 61/1000 in 2005 to 57/1000 in 2010&lt;br&gt;• Reduced mortality of children under five from 101/1000 in 2005 to 71/1000 by 2010&lt;br&gt;• Increased proportion of fully immunised children from 85% in 2005 to 95% by 2010</td>
</tr>
<tr>
<td></td>
<td><strong>Maternal health and reproductive health</strong>&lt;br&gt;• Reduced maternal mortality from 377/100,000 in 1999 to 251/100,000 in 2010&lt;br&gt;• Increased percentage of births delivered in health facilities from 49% in 2005 to 60% in 2010&lt;br&gt;• Improved contraceptive prevalence rate from 10% to 15% for modern methods, and from 1% to 20% for any method by 2010</td>
</tr>
<tr>
<td></td>
<td><strong>Communicable Diseases</strong>&lt;br&gt;<strong>Malaria</strong>&lt;br&gt;• Increased percentage of children under five years of age having prompt access to and receiving appropriate management for febrile illness within 24 hours from 13% in 2005 to 70% in 2010&lt;br&gt;• Increased percentage of children under five years of age sleeping under insecticide treated nets (ITNs) from 37% in 2005 to 90% in 2010&lt;br&gt;• Reduced case fatality rate from 2.1% in 2005 to 0.5% in 2010</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MDG targets</th>
<th>Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal 4: Reduce child mortality&lt;br&gt;Target 5: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate</td>
<td><strong>MDG targets</strong>&lt;br&gt;Under-five mortality rate (per 1,000 live births)&lt;br&gt;Infant mortality rates (per 1,000 live births)&lt;br&gt;Proportion of children vaccinated against measles</td>
</tr>
<tr>
<td>Goal 5: Improve maternal health&lt;br&gt;Target 6: Reduce by three-quarters, between 1990 and 2015, the maternal mortality rate</td>
<td>Maternal mortality rate (per 100,000 live births)&lt;br&gt;Births attended by skilled health personnel</td>
</tr>
<tr>
<td>Goal 6: Combat HIV and AIDS, malaria and other diseases&lt;br&gt;Target 8: Halt and begin to reverse the spread of malaria and other major diseases</td>
<td>Number of malaria cases and incidences (cases per 100,000)&lt;br&gt;Number of tuberculosis cases and incidences (cases per 100,000)</td>
</tr>
</tbody>
</table>

Source: RGoZ, 2007b.
Antenatal care and malaria prevention
Use of antenatal care (ANC) services in Zanzibar is nearly universal (99.4% of women made at least one ANC visit). However, women in Pemba were less likely to receive key ANC components (Table 2).

Table 2: Coverage of selected ANC components, 2004/05 and 2010, in percentages

<table>
<thead>
<tr>
<th></th>
<th>Blood pressure measured</th>
<th>Urine sample taken</th>
<th>Blood sample taken</th>
<th>2+ tetanus toxoid injections last pregnancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mainland</td>
<td>65.5</td>
<td>67.5</td>
<td>41.2</td>
<td>50.8</td>
</tr>
<tr>
<td>Zanzibar</td>
<td>82.2</td>
<td>92.9</td>
<td>69.5</td>
<td>88.8</td>
</tr>
<tr>
<td>Unguja</td>
<td>94.8</td>
<td>97.8</td>
<td>93.1</td>
<td>97.4</td>
</tr>
<tr>
<td>Pemba</td>
<td>58.6</td>
<td>84.2</td>
<td>25.4</td>
<td>73.9</td>
</tr>
</tbody>
</table>


Malaria control improvements are evident for women. In 2004/5, the proportion of women of reproductive age sleeping under an insecticide-treated net (ITN) was the same in Zanzibar and the Mainland. By 2007/8, ITN coverage for this group in Zanzibar had risen to 43.5% while on the Mainland it rose to only 24.5%. Coverage of intermittent preventive treatment in pregnancy (IPTp) (two or more doses) also improved more in Zanzibar (from 14% to 47% from 2004/5 to 2010) than on the Mainland (22% to 26%) in the last five years. Likewise, ITN coverage for pregnant women rose dramatically in Zanzibar from 2004/5 to 2007/8 (from 20% to 51%) compared to a much slower rate of expansion on the Mainland (15% to 26%), but the gap closed again in the last three years as ITN coverage for pregnant women more than doubled on the Mainland, to 57%, while it remained essentially constant (49.5%) on the Isles (NBS, 2010).

Skilled attendance at delivery and post-natal 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 rate to below 200 per 100,000 live births (Campbell and Graham, 2006). However, access to skilled assistance at delivery remains low in Zanzibar; just over half of all births are attended by skilled health workers with a major gap in access between Unguja and Pemba (67.6% to 33.6% respectively). By contrast, attendance for post-natal care during the first two days after delivery increased more than five-fold from a very low base in the five years since 2004/5 (from 6% to 32%), even though coverage in Unguja still remains two thirds as high as on Pemba (NBS, 2010). As on the Mainland, in the absence of high quality basic and comprehensive emergency obstetric care, skilled attendance or facility-based delivery are no guarantees of a safe delivery for the mother or baby.
2.1.2 Child survival and well-being
The most dramatic changes in the health status of children in Zanzibar relate to improvements in malaria control. These gains are attributable mainly to preventive interventions, notably ITNs and residual spraying, while the early introduction of combination therapy in 2000 and the roll-out of rapid diagnostic tests have improved diagnosis and treatment. Progress in combating malaria has been made possible through an unprecedented level of external support, principally from the US President’s Malaria Initiative, and funds have been allocated under a sound malaria medium-term strategic plan (2003-08, updated in 2007).

Under-five mortality
Child survival trends in the Isles follow a similar pattern to the Mainland, with a steep reduction in under-five mortality since 1999 (Figure 6), although the rate in Pemba remains higher than in Unguja (84% and 65%, respectively). Nearly 40% of under-five deaths in Zanzibar are now attributable to deaths in the first 28 days after birth (neonatal mortality).

Figure 6: Under-five mortality rate, per 1,000 live births, 1996-2010

![Graph showing under-five mortality rate (per 1,000 live births) from 1996 to 2010 for Mainland and Zanzibar. The rates show a decline over time, with Mainland having a higher rate than Zanzibar in 1996, but a lower rate by 2010.](source: TDHS 1996, TRCHS 1999, TDHS 2004/5, THMIS 2007/8, TDHS 2010.)
Malaria control is almost certainly the main driver of recent improvements in child survival. Another contributor is the expansion of coverage of Vitamin A supplementation from 2005, which achieved a three-fold increase from 13% in 2004/5 to 39% in the latest TDHS – though again with differences between Unguja (45.1%) and Pemba (28.3%).

The most recent figures, as displayed in Table 4, indicate that Zanzibar achieved the MKUZA goal of reducing infant mortality to 57 deaths per 1,000 live births and barely missed the under-five mortality target of 71 deaths per 1,000 live births. These are both major achievements, even though challenges remain with regard to child survival during the first month after birth.

**Table 4: Under-five mortality rates for the ten-year period preceding the TDHS 2010, per 1,000 live births**

<table>
<thead>
<tr>
<th></th>
<th>Neonatal</th>
<th>Post-Neonatal</th>
<th>Infant</th>
<th>Child</th>
<th>Under-five</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Zanzibar</strong></td>
<td>29</td>
<td>25</td>
<td>54</td>
<td>20</td>
<td>73</td>
</tr>
<tr>
<td><strong>Unguja</strong></td>
<td>33</td>
<td>20</td>
<td>53</td>
<td>13</td>
<td>65</td>
</tr>
<tr>
<td><strong>Pemba</strong></td>
<td>25</td>
<td>31</td>
<td>56</td>
<td>29</td>
<td>84</td>
</tr>
</tbody>
</table>

Source: TDHS 2010.

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, access to quality obstetric care at delivery, and the adequate management of common neonatal complications including preterm delivery, infections and birth asphyxia (Figure 7). Most newborn deaths could be averted if universal coverage of basic maternal and neonatal interventions could be achieved. Low birth weight carries a risk of death between four and ten 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.

**Figure 7: Leading causes of neonatal mortality in Tanzania**

Source: MoHSW [URT], 2008.
Childhood illness, malaria prevention and other parasite control interventions

Childhood illness shows rapid improvement in Zanzibar over recent years. In the THMIS 2007/8, only 0.8% of children under five years in Zanzibar tested positive for malaria, compared with 18% on the Mainland (Figure 8). Significant declines in the incidence of fever were also recorded between 1999 and 2007/8, from 49% to 13% in Pemba and from 29% to 11% in Unguja. In both cases, the gains were likely the consequence of major gains in malaria control. The proportion of under-fives sleeping under ITNs rose steeply between 2004/5 and 2007/8 (21.7% to 58.5%) before stagnating in the last three years, so that the 24 percentage point gap in coverage that existed in favour of Zanzibar compared to Mainland quickly vanished and even reversed; ITN coverage for children aged 0 to 5 years is now higher on the Mainland than Zanzibar (64% and 55%, respectively). Other strategies successfully employed in Zanzibar include four rounds of residual spraying (91% of houses sprayed in the six months before the 2007/8 THMIS survey), and introduction of rapid diagnostic tests (piloted in 2004 and rolled out to all clinics in 2006). Meanwhile, artemisinin combination therapy (ACT) was introduced earlier in Zanzibar (2004) than on the Mainland (2007).

Figure 8: Trends in incidence of fever in children under five years, in percentages

Similar gains have been made with respect to acute respiratory infections, where again the improvement is greater in Pemba (from 23% in 1999 to 7% in 2010) than Unguja (14% to 10%). However, the proportion of under-fives with diarrhea in Zanzibar showed no improvement during the last decade, and even increased in Pemba (though the sample size is small) (Table 5).

A campaign to control schistosomiasis and soil-transmitted helminths was carried out in the most affected areas (Pemba and Northern Unguja), reportedly achieving high success. A control programme for lymphatic filariasis is also ongoing.

According to the Health Information Bulletin (2007), the leading causes of illness among children under five years during out-patient department consultations were pneumonia (21%), upper respiratory tract infections (20%), malaria (17%), diarrhea (10%) and skin diseases (6%) (RGoZ, 2008a).

### Childhood immunisation

The immunisation status of Zanzibari children aged 12-23 months surpasses that of children on the Mainland, even though differences are not large with the exception of DPT-HB3 (95% vs. 88% coverage in 2010). Coverage rates in Pemba lagged well behind Unguja in 2004/5, but the gap has narrowed considerably since 1999 and again between the last two surveys. Coverage of DPT-HB3 in Pemba, for instance, rose ten percentage points from 71.6% to 81.3% between 1999 and 2004/5, and another 14 percentage points up to the present. Similar improvements can be traced in the coverage of three doses of immunisation against polio, measles and all basic vaccinations in Pemba (Table 6).
2.2 Priority areas and recommendations

The health indicators in Pemba generally lag behind those of Unguja, reflecting both an underlying difference in socio-economic status as well as poorer health service supply, especially human resources in Pemba.

The essential health care package (EHCP) has been elaborated, including revision of the “pyramid” of health facilities and re-design of norms for services available, personnel requirements and financial arrangements for each level of the system. Referral procedures are also to be strengthened and a community health strategy has been designed and approved. Although plans were at an advanced stage for the introduction of user charges, this policy has not received high level endorsement and its implementation has been put on hold indefinitely.

The principal constraints to the performance of the health system have been elaborated in the (draft) health sector performance report (2008). These include:

- Stock-outs of supplies, which originate with failure to replenish stocks at the Central Medical Stores;
- Weak integration of vertical programmes and services; and
- Sub-optimal planning capacity and practice at district and national levels.

The availability of sufficient skilled human resources is clearly a problem, particularly in Pemba. The report also points to inefficient working practices among civil servants at the national level, including irregular absence from duty, short working hours and low productivity. In spite of efforts to establish a “pooled fund” for development assistance, this has yet to take off, although all partners attempt to coordinate their support around the Zanzibar Health Sector Reform Strategic Plan II (ZHSRSP II) and the annual programme of work (RGoZ, 2009b).

**Table 6: Vaccination coverage, 1999, 2004/5 and 2010 (children 12-23 months)**

<table>
<thead>
<tr>
<th></th>
<th>BCG</th>
<th>DPT-HB3</th>
<th>Polio3</th>
<th>Measles</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zanzibar</td>
<td>98</td>
<td>95</td>
<td>98</td>
<td>83</td>
<td>89</td>
</tr>
<tr>
<td>Unguja</td>
<td>100</td>
<td>98</td>
<td>98</td>
<td>96</td>
<td>94</td>
</tr>
<tr>
<td>Pemba</td>
<td>96</td>
<td>92</td>
<td>98</td>
<td>72</td>
<td>81</td>
</tr>
</tbody>
</table>

Medium-term priorities set out in the ZHSRSP II related to child health include:

- Maintain momentum in malaria control to reduce the burden by 70% compared to 2006 and raise coverage of long-lasting insecticidal nets (LLINs), indoor residual spraying (IRS), IPTp and ACT to over 80%;

- Increase and sustain childhood vaccination at 95% coverage;

- Complete roll-out of facility-based Integrated Management of Childhood Illnesses (IMCI) to the three remaining districts;

- Design and implementation of a community-IMCI programme;

- Emphasise breastfeeding counselling, infant and young child feeding practices and the prompt and effective treatment of diarrhoea using oral rehydration solution (ORS).

As regards maternal healthcare, the main challenge lies in expanding the availability of quality obstetric care, both in terms of the number of facilities offering delivery services, and the capability of facilities to provide life-saving interventions to avert maternal deaths. Malaria in pregnancy should be curtailed through raising the coverage of ITNs and assuring that all women receive IPTp. The ZHSRSP II aims to screen all women for syphilis in pregnancy and the number of sites offering PMTCT services will be expanded. Post-abortion care has also been identified as an important unmet need, which requires that manual vacuum aspiration be made more widely available.
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.

Nutrition goals, targets and interventions were included both in MKUZA I and in the Health Sector Strategic Plan (ZHSRSP II) 2006/7-2010/11 (Table 7). The MKUZA targets did not mention routine micronutrient supplementation, although this was included in the ZHSRSP. Both documents omitted the need to improve infant and young feeding practices.

A supportive legislative environment for nutrition that includes the regulation of the marketing of breast milk substitutes and the fortification of foods including salt iodisation is not yet in place. Strong civil society organisations that could complement the government’s efforts in addressing malnutrition or serve as pressure groups for nutrition advocacy are also missing in Zanzibar.

Table 7: Zanzibar’s nutrition targets

<table>
<thead>
<tr>
<th>Cluster 1:</th>
<th>Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Reduced population under the food poverty line from 13% (2005) to 10% (2010)</td>
<td></td>
</tr>
<tr>
<td>- Effective food insecurity warning and response system developed</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cluster 2:</th>
<th>Indicators for children</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Improve food and nutrition security among the poorest, children and most vulnerable groups</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Indicators for children</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Reduced level of under-nutrition amongst children under the age of five years</td>
</tr>
<tr>
<td>• Reduced number of children under the age of five years with stunting from 23% in 2005 to 10% in 2010</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Indicators for women</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Reduced level of under-nutrition among women and mothers</td>
</tr>
<tr>
<td>• Reduced number of women with BMI &lt; 18.5 from 17% in 2004 to 10% in 2010</td>
</tr>
<tr>
<td>• Reduced prevalence of anemia among women and mothers from 63% in 2005 to 50% in 2010</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MDG targets</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target 2: Halve by 2015, the proportion of people who suffer from hunger</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Proportion of people living below the national poverty line (food poverty)</td>
</tr>
<tr>
<td>• Percentage of underweight under-five children</td>
</tr>
</tbody>
</table>

Source: RGoZ, 2007b.
3.1 A conceptual framework for analysing malnutrition

Figure 9 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.

Figure 9: Conceptual framework of causes of malnutrition

Inadequate food, health and care

Higher maternal mortality

Lower maternal mortality

Inadequate food, health and care

Inadequate foetal nutrition

Inadequate catch-up growth

Frequent infections

Impaired mental development

Increased risk of adult chronic disease

Untimely/inadequate weaning

Reduced mental capacity

Reduced capacity to care for baby

Chapter 3 • Nutrition
Malnutrition has impacts across the whole life cycle (see Figure 10). 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 a poor diet 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 presenting with 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.

### 3.2 Status and trends

#### 3.2.1 Nutrition status of women

**Malnutrition**

Data from the 2010 TDHS shows that the overall mean Body Mass Index (BMI) among non-pregnant women in Zanzibar is 23.4 kg/m², marginally higher than the Mainland (22.6 kg/m²). About 14% of women were malnourished (BMI <18.5 kg/m²) – compared with 11% in Mainland Tanzania – and 3.6% were severely malnourished (BMI <17 kg/m²). The percentage of malnourished women varies by district; malnutrition rates are highest in Pemba North (19.6%) and lowest in Unguja South (9.6%). Thirty percent of Zanzibari women are overweight or obese, ranging from 18% in Pemba North to 39% in Town West.

The existence of a ‘double-burden of malnutrition’ – under-nutrition and over-nutrition in the same population – among women appears to be more severe in Zanzibar than in Mainland Tanzania. Effective promotion efforts will be needed to modify diet and exercise in population segments at risk of obesity.

**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. Iron status can be improved by means of iron supplements for women along with improved diets and control of parasites and malaria. Iron supplementation (daily tablets...
for at least 90 days) is necessary for pregnant women because their needs are usually too high to be met solely by food intake. The 2010 TDHS found that anaemia (<11g/dl) rates among women of reproductive age in Zanzibar were much higher than on the Mainland (42.3% and 28.6%, respectively) (Table 8). This possibly reflects poorer quality of antenatal care. Although utilisation of ANC in Zanzibar is high, the TDHS 2010 reveals that more than one quarter of all antenatal consultations on the Isles are with a Maternal and Child Health (MCH) Aide, almost four times higher than on the Mainland and reaching up 70% in Pemba North. Unlike Mainland, the proportion of women who reported receiving iron supplementation at ANC rose considerably in Zanzibar between the last two demographic and health surveys, even though the numbers are still lower in Pemba (77.1%) than in Unguja (81.1%). It is also puzzling that coverage of iron supplementation in pregnancy is so poor in the relatively affluent and well-educated Town West district (75.5%).

Table 8: Iron supplementation for pregnant women, in percentages

<table>
<thead>
<tr>
<th></th>
<th>Percentage of women of reproductive age who are anaemic</th>
<th>Percentage of pregnant women who received ANC from MCH Aide</th>
<th>Percentage of pregnant women who received iron supplementation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>TDHS 2004/5</td>
<td>TDHS 2010</td>
<td>TDHS 2004/5</td>
</tr>
<tr>
<td>Mainland</td>
<td>47.9</td>
<td>28.6</td>
<td>15.2</td>
</tr>
<tr>
<td>Zanzibar</td>
<td>62.8</td>
<td>42.3</td>
<td>50.0</td>
</tr>
<tr>
<td>Unguja</td>
<td>62.8</td>
<td>41.0</td>
<td>33.0</td>
</tr>
<tr>
<td>Pemba</td>
<td>62.9</td>
<td>44.8</td>
<td>81.0</td>
</tr>
</tbody>
</table>

Source: TDHS 2004/5; TDHS 2010.

On a more positive note, Zanzibar (47%) has performed better than the Mainland (26%) in raising the coverage of intermittent preventive treatment for malaria in pregnancy (2 or more doses), although with large gaps between Unguja (52%) and Pemba (39%).

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 VAD among breastfed children. According to the 2010 TDHS, only four out of ten (38.9%) Zanzibari women who gave birth in the five years preceding the survey reported having received a vitamin A dose post-partum within two months of childbirth (Unguja 45.1%, Pemba 28.3%). While low, this percentage is three times as high as in the previous survey. Yet a study conducted by Ifakara Health Institute in 2004 indicates that vitamin A deficiency (VAD) affects a large proportion of women of reproductive age. Figure 11 illustrates that the rates varied by district, perhaps reflecting the different availability and consumption of vitamin A rich foods. The fact that one in every three women of reproductive age had VAD implies that much greater effort is needed to scale up this important nutrition intervention.
The poor coverage of vitamin A supplementation (given to infants and mothers post-partum) and low consumption of iodated salt at the time of the TDHS 2004/5 survey catalysed a twice-yearly VAS campaign that started in January 2005, which has made it possible to achieve some gains in the coverage of de-worming and Vitamin A supplementation, while the new Health Strategy has a VAS target of 95%.

### 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.

### 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. The TDHS 2010 reports that 10% of Zanzibari mothers considered that their infant was ‘small’ or ‘very small’ at birth, down from 19% five year earlier. Actual birth weights were known for only 51% of infants, which corresponds closely to the proportion of facility-based births (49%). Among the infants who were weighed, 6.9% were low birth weight.

**Malnutrition in children under five years of age**

In Zanzibar, there has been a remarkable reduction of malnutrition among children who are under-five years from the 1990s to the present. Overall, stunting is much lower in Zanzibar than Mainland, but the opposite is true for wasting. The gap in child malnutrition between Pemba and Unguja has narrowed over time, although differences remain with stunting prevalence in Pemba at 36%, compared to 27% in Unguja. Despite important progress, the extent of child malnutrition remains high, with one in every eight Zanzibari children being severely stunted.

Reductions in malnutrition are largely attributable to the success in fighting childhood diseases. The reduction in malaria and anaemia (described in the health chapter) is probably the greatest contributor, although the campaigns to eliminate schistosomiasis and soil-transmitted helminths have also helped.

**Figure 12: Trends in stunting and underweight for children under five years, 1990-2005**

Extrapolating the current trend suggests that Zanzibar can meet the nutrition MDG target of halving the proportion of underweight children by 2015. This is true for both Unguja and Pemba, even though current malnutrition rates are higher in Pemba. Significant disparities, however, persist in child nutrition across socio-economic groups (Figure 13). Based on data from the Union as a whole (since no specific data for Zanzibar exist), one can observe that the prevalence of stunting and underweight among children in the poorest quintile is about twice as large as compared with children in the least poor quintile. In contrast, there is no clear association between acute malnutrition (wasting) and wealth.
Shorter birth interval (<36 months) carries elevated risk of child mortality as well as risk of poorer nutrition. It is worth noting that birth intervals in Pemba (28.4 months) are much shorter than in either Unguja (35.0 months) or the Mainland (34.0 months). This in turn may relate to very low levels of modern family planning use. Compared to the Mainland, where 27.8% of married women were currently using a modern method, the corresponding figure for Zanzibar was 12.4% (Unguja 14.9%, Pemba 8.1%).

**Micronutrient deficiency in children**

*Iodine deficiency*

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. Zanzibar and Pemba Island in particular, suffers a serious problem of iodine deficiency in children. A survey conducted in 2001 and reported by Assey (2006) found that the total goitre rate among children aged 6-12 years was 18%. The Nutrition Unit of the Ministry of Health and Social Welfare of Zanzibar reported prevalence of goitre among school children 8-17 years to be 26% (MoHSW and TFNC, 2001). The study noted great variation between Unguja (21%) and Pemba (32%).

Iodised salt, a good source of iodine, is consumed by 70% of households in Zanzibar. Again, differences between the two islands are stark, with only 44% in Pemba as compared to 86% in Unguja. The 2010 TDHS also shows that only 49% of surveyed households in Zanzibar were actually using adequately iodised salt (Unguja 64%; Pemba 24%), fewer than on the Mainland where 59% of households consume salt with adequate iodine. With such rates of household consumption of adequately iodised salt, it is not surprising that prevalence rates of iodine deficiency disorders (IDDs) are quite high.
**Vitamin A deficiency**

A 2004 study in Zanzibar by the Ifakara Health Institute reported prevalence of vitamin A deficiency among 6-59 months children to be 41%. Vitamin A is an essential micronutrient for the immune system and plays an important role in maintaining the epithelial tissue in the body. Vitamin A deficiency, therefore, increases the severity of infections such as measles and diarrhoeal diseases in children and slows recovery from illness. Periodic dosing (every six months) with vitamin A supplements is a rapid and low-cost method of ensuring children do not develop vitamin A Deficiency (World Bank, UNICEF and TFNC, 2007).

Data in Table 9 reveal that, in the past five years, there has been a remarkable increase in the percentage of children who consume adequately iodised salt, eat nutrient-rich foods or otherwise receive Vitamin A supplements. Previous gaps between Mainland and Zanzibar, as well as between Unguja and Pemba, have also closed, except for iodised salt where children’s consumption on the Mainland (56%) is still higher than in Zanzibar (44%), as is in Unguja compared to Pemba (59% and 23%, respectively). By contrast, the percentage of children receiving Vitamin A supplements is now almost one third as large in Zanzibar as on the Mainland.

**Table 9: Consumption of iodised salt, vegetables and fruits rich in vitamin A, and vitamin A supplements among children under five years of age, 2004/5 and 2010**

<table>
<thead>
<tr>
<th></th>
<th>% of children in households using adequately iodised salt</th>
<th>% of children who consumed fruits and vegetables rich in vitamin A</th>
<th>% of children who consumed vitamin A supplements</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2004/05 2010</td>
<td>2004/05 2010</td>
<td>2004/05 2010</td>
</tr>
<tr>
<td>Mainland</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Zanzibar</td>
<td>40.7 55.5</td>
<td>53.9 61.5</td>
<td>46.1 60.3</td>
</tr>
<tr>
<td>Unguja</td>
<td>18.3 43.7</td>
<td>46.1 63.1</td>
<td>22.4 78.7</td>
</tr>
<tr>
<td>Pemba</td>
<td>23.4 58.7</td>
<td>50.2 62.3</td>
<td>27.4 78.8</td>
</tr>
</tbody>
</table>

Source: TDHS 2004/5; TDHS 2010.

**Anaemia**

The 2010 TDHS found anaemia (<11g/dl) prevalence in under-fives of 32.2%, marginally higher than on the Mainland (27.2%). Prevalence of severe anaemia (<7g/dl) was 1.4%, about one fourth of the figures reported five years ago (Table 10). By 2007/8, prevalence of severe anaemia had dropped by nearly three percentage points, the improvement being greatest in Pemba. The reduction in anaemia and the favourable comparison to the Mainland are both the result of the successes in malaria control. Malaria prevalence among under-fives in Zanzibar was 0.8% (Unguja 0.8%, Pemba 0.9%), compared to 18.1% on the Mainland.
Table 10: Severe anaemia (<7g/dl) in under-fives (6-59 months)

<table>
<thead>
<tr>
<th></th>
<th>2004/5</th>
<th>2007/8</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mainland</td>
<td>11.1%</td>
<td>7.8%</td>
<td>1.9</td>
</tr>
<tr>
<td>Zanzibar</td>
<td>6.4%</td>
<td>4.7%</td>
<td>1.4</td>
</tr>
<tr>
<td>Unguja</td>
<td>5.4%</td>
<td>4.4%</td>
<td>1.4</td>
</tr>
<tr>
<td>Pemba</td>
<td>7.9%</td>
<td>5.2%</td>
<td>1.4</td>
</tr>
</tbody>
</table>


3.3 Feeding practices for children

Poor dietary intake and diseases, which are the immediate causes of malnutrition, can be explained by a set of underlying causes consisting of access to nutritious 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. But, 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). The unacceptably high prevalence of underweight 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.

However, early weaning and giving pre-lacteal feeds are still common practices among households in Zanzibar. Early weaning is known to be a major cause of diarrhoea during infancy. Although the WHO advises exclusive breastfeeding for a period of six months, 2010 survey data for Zanzibar indicates an exclusive breastfeeding period of only 15 days (up from 12 days in 1999), compared with a median of 72 days in Mainland Tanzania (NBS, 2010). The practice of giving pre-lacteal feeds is discouraged because it limits the frequency of suckling by the infant and exposes the baby to the risk of infection. The data show that 33% of infants are given pre-lacteal feeds.

A better understanding of cultural norms across ethnic groups in Zanzibar 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 Priority areas and recommendations

Zanzibar has made important strides in reducing protein-energy malnutrition rates in children, although the prevalence of malnutrition in Pemba remains much higher than in Unguja. On the current trend, Zanzibar will meet its malnutrition targets for the MKUZA (2010) and the MDG (2015).

Severe anaemia has also reduced, although mild and moderate anaemia remain very common. Vitamin A supplementation for children and IDD showed very poor status up until the time of the 2004/5 survey. More recent remedial actions indicate that this situation has since improved.

The major gaps in service delivery seem to be in the routine administration of post-partum vitamin A for mothers and in promotion of better infant and young child feeding practices. The following priority areas for rapidly and sustainably improving the nutritional outcomes of Zanzibari women and children have emerged from this analysis. Notwithstanding the recent convergence of malnutrition indicators between the two islands, more emphasis is still required on improving nutritional outcomes, especially in Pemba.

- 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 and 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.

- 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.
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 proportionately greater benefits to women.

MKUZA I gave due attention to issues of water supply and sanitation (Table 11). In particular, it noted that access to clean and safe water was relatively high on the islands but was unevenly distributed and highly vulnerable to environmental pollution. The strategy also mentioned that sustainability is a major challenge, in particular past maintenance has been sporadic and left much infrastructure in a dilapidated state, and the skills for operations and maintenance are lacking. Given the recent shift to a cost recovery policy, operations and maintenance at community level are likely to be a major challenge.

On sanitation, MKUZA I recognised the high number of households with no latrine access and appropriately aimed to increase the proportion of households with access to “basic” sanitation to 83% by 2010. However, this focus on basic household sanitation was undermined by the decision to promote Ventilated Improved Pit (VIP) latrines at household level – an expensive option that is likely to be out of reach of most households since costs for improved latrines tend to be from Tsh 350,000-500,000 per latrine. Promoting simpler technologies as an interim approach in areas with low access to even very basic latrines could be useful and more affordable to those on lower incomes.

MKUZA I also recognised the particular needs of vulnerable groups, though this did not translate into specific strategies or targets in the WASH sector.

Table 11: Zanzibar’s targets for water supply, sanitation and hygiene

<table>
<thead>
<tr>
<th>MKUZA I targets</th>
<th>Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase access to clean, safe and affordable water especially to poor men and women, and most vulnerable groups</td>
<td>• Increased access to clean, safe and sustainable water supply in urban areas from 75% in 2004/5 to 90% in 2010</td>
</tr>
<tr>
<td></td>
<td>• Increased access to clean, safe and sustainable water supply in rural areas from 51% in 2004/5 to 65% in 2010</td>
</tr>
<tr>
<td>Improve sanitation and sustainable environment</td>
<td>• All schools and other public places have adequate sanitary facilities by 2010</td>
</tr>
<tr>
<td></td>
<td>• Increased proportion of households with access to basic sanitation from 66.8% in 2005 to 83% by 2010</td>
</tr>
<tr>
<td></td>
<td>• Increased provision and management of sewerage facilities</td>
</tr>
<tr>
<td></td>
<td>• Reduced environmental degradation</td>
</tr>
<tr>
<td></td>
<td>• Zanzibar Waste Management Master Plan developed and implemented by 2010</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MDG targets</th>
<th>Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target 10: Halve by 2015, the proportion of people without sustainable access to safe drinking water and sanitation</td>
<td>• Proportion of population with sustainable access to an improved water source (rural/urban)</td>
</tr>
<tr>
<td></td>
<td>• Proportion of people with access to improved sanitation (rural/urban)</td>
</tr>
</tbody>
</table>

Source: RGoZ, 2007b.
4.1 Status and trends

4.1.1 Water supply

The figures below present data on household access to clean and safe water, first comparing data from the 2002 census and the 2004/5 and 2010 TDHS (Figure 14), and then examining urban and rural data from 2002 (Figure 15). In each case, the equivalent data for the Mainland is also presented as a benchmark, though given the different environmental and cultural contexts these comparisons should not be interpreted as stronger or weaker performance.

Figure 14: Access to clean and safe water in Zanzibar and Mainland, 2002, 2004/5 and 2010


Figure 15: Access to clean and safe water in Zanzibar (total, rural and urban), 2002

![Access to clean and safe water in Zanzibar (total, rural and urban), 2002](source: Census 2002)
Three main conclusions can be drawn:

1. Across both surveys and all areas, Zanzibar has much higher access to clean and safe water than the Mainland, particularly to piped sources. This high proportion of piped sources is a legacy of a long-standing policy in favour of piped supplies, which is also likely to have worked against both rural areas and poorer communities. Recent relaxation of this policy over the past 5-10 years, in favour of point sources (with UNICEF’s encouragement) could help speed up the spread of access in poorer and more remote areas. Initial signs are promising in Pemba, with high sustainability rates.

2. Access to water from other protected sources rose in Zanzibar between 2004/5 and 2010, from 2.3% to 5.4%, matched by a six percentage point decline in access to piped sources of water. On aggregate, access to clean and safe water expanded in Zanzibar from 72.2% in 2002 to the present 79.5%.

3. Based on data from the 2002 Census, there is significant disparity between access in urban and rural parts of the islands. The 2012 Census will furnish new data to assess whether existing disparities have continued to widen or, instead, are narrowing as a result of the renewed emphasis on other protected sources of water at the expense of piped connections.

Given the high proportion of piped water supplies, access to reliable power supplies is vital. On both Pemba and Unguja power is a problem and therefore water supplies also have been irregular. Power supply in Pemba is currently run fully from generators; there is no mains power. Projects to improve power supplies on both islands are currently underway. However, since both these projects will be providing power via undersea cables from the Mainland, the islands’ vulnerability to emergencies will continue. In 2008, Unguja Island faced a whole month with no power due to the marine cable breaking and hence no pumped water, which led to UNICEF making an emergency purchase of generators to run strategic pumps.

4.1.2 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 (Fewtrell et al., 2005). International analysis further demonstrates that for every $1 spent on water supply and sanitation, an $11.5 benefit is accrued in 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).

Data from the 2002 census and the 2004/5 and 2010 TDHS are used to assess access to adequate sanitation (Figures 16 and 17). In the case of Zanzibar, data on household latrines is more useful than on the Mainland as a much larger number of households do not have access even to a basic latrine. Despite positive changes in the last five years in the percentage
of Zanzibari households with access to a basic latrine, still one in four continues to be deprived of this most basic form of sanitation. The difference is accounted for entirely in rural Zanzibar, where the 2002 census reported that over half (54%) of rural households in Zanzibar did not have access to any latrine, compared to 4% of urban households on Zanzibar and 11% in rural areas of the Mainland. In urban areas, neither Zanzibar nor the Mainland appears to have widespread open defecation, though urban Zanzibar has more households with flush toilets than the Mainland.

Recent detailed mapping of the WASH situation in Mainland schools is yet to be completed in Zanzibar. Hence the scale of the problem and areas of concern are not known. However, it is likely the situation is similar to the Mainland, meaning that many schools still lack an on-site water supply as well as latrines and hand-washing facilities that meet minimum government standards.

Efforts over the past few years have led to almost all shehias on the island of Pemba having representatives trained in Participatory Hygiene and Sanitation Transformation (PHAST) and a structure of supervision and follow up. So far there is only partial coverage in Unguja. Between 2007 and 2009, artisans also received sanitation training in all 103 shehias in Pemba and 126 shehias in Unguja. The MoHSW in Pemba reported an increase in latrine coverage from 22,902 to 25,443 (out of total of 73,498 households in Pemba) from the year 2007 to June 2009.

**Figure 16: Household latrine access, Zanzibar and Mainland, 2002, 2004/5 and 2010**

```
<table>
<thead>
<tr>
<th></th>
<th>Census 2002</th>
<th>DHS 2004/5</th>
<th>DHS 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zanzibar</td>
<td>34.4%</td>
<td>32.0%</td>
<td>24.9%</td>
</tr>
<tr>
<td>Mainland</td>
<td>8.6%</td>
<td>12.9%</td>
<td>13.9%</td>
</tr>
<tr>
<td>Zanzibar</td>
<td>50.4%</td>
<td>51.6%</td>
<td>43.1%</td>
</tr>
<tr>
<td>Mainland</td>
<td>86.6%</td>
<td>80.6%</td>
<td>71.6%</td>
</tr>
<tr>
<td>Zanzibar</td>
<td>2.5%</td>
<td>7.9%</td>
<td>4.0%</td>
</tr>
<tr>
<td>Mainland</td>
<td>12.6%</td>
<td>8.4%</td>
<td>0.9%</td>
</tr>
</tbody>
</table>

The 2002 census also reports household access to water and sanitation services for Zanzibar by region, revealing significant geographical disparities (Table 12). In particular, Zanzibar’s higher level of access to improved water sources was limited exclusively to Unguja. The two regions of Pemba had much lower levels of access.

Table 12: Household access to water and sanitation services, Zanzibar, by region, 2002

<table>
<thead>
<tr>
<th>Region</th>
<th>Water supply</th>
<th>Latrine access</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Piped/protected</td>
<td>Unprotected</td>
</tr>
<tr>
<td>North Unguja</td>
<td>80.5</td>
<td>18.5</td>
</tr>
<tr>
<td>South Unguja</td>
<td>62.1</td>
<td>38.2</td>
</tr>
<tr>
<td>Urban West</td>
<td>95.2</td>
<td>4.2</td>
</tr>
<tr>
<td>North Pemba</td>
<td>40.4</td>
<td>59.6</td>
</tr>
<tr>
<td>South Pemba</td>
<td>48.8</td>
<td>51.2</td>
</tr>
<tr>
<td>Zanzibar</td>
<td>72.1</td>
<td>27.4</td>
</tr>
<tr>
<td>Mainland</td>
<td>53.4</td>
<td>45.2</td>
</tr>
</tbody>
</table>

Source: Census 2002.
Second, substantial regional disparities were recorded in the proportion of households lacking access to even a basic latrine. Again North and South Pemba had lower levels of access to household latrines (73% and 62% of households, respectively, without access) than most of Unguja. On Unguja, only North Unguja (51% households with no latrine access) had significantly lower access to latrines than on the Mainland.

4.2 Institutional framework and fiscal space

Water supply and water resource management in Zanzibar are under the remit of the Zanzibar Water Authority (ZAWA), established under the Ministry of Water, Construction, Energy and Land. This body was established in 2006 under the Water Act (2006). Prior to this Act, water had been supplied without any user charges, but this legislation allows ZAWA to sell water to residents, at a price regulated by the Minister responsible for water. The introduction of these charges is just starting, and it is therefore too soon to judge whether it has affected access. Water accessed from public water kiosks will be charged at a lower level and some discussions have been held on how to ensure water for the poorest. One consideration being that the Ministry of Community Development, Gender and Children could issue tokens for the poorest to access free water from kiosks.

As on the Mainland, the institutional mandate for sanitation and hygiene is held outside the Ministry of Water, Construction, Energy and Land, under the Environmental Health Unit in the Directorate of Public Health of the Ministry of Health and Social Welfare. The currently applicable legislation on sanitation and hygiene dates from 1932, and is expected to be reviewed in the near future, as part of the forthcoming development of a new Environmental Health Policy.

Zanzibar has not followed the example of their Mainland counterparts in adopting a sector-wide approach for WASH. However, a number of significant projects have been initiated in recent years (Table 13).

### Table 13: Funding for WASH in Zanzibar, 2003-2010

<table>
<thead>
<tr>
<th>Donor</th>
<th>Project Focus</th>
<th>Timeline</th>
<th>Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>UNICEF</td>
<td>Integrated water, sanitation and hygiene on Pemba</td>
<td>2003-2010</td>
<td>$1.8m</td>
</tr>
<tr>
<td>United Nations Development Programme (UNDP)</td>
<td>Capacity strengthening for ZAWA</td>
<td>2008-9</td>
<td>$1m</td>
</tr>
<tr>
<td>Millennium Challenge Corporation (MCC / US)</td>
<td>Urban water supply (Pemba); urban sanitation (Zanzibar town); rural water supply (Unguja and Pemba)</td>
<td>2008-2011</td>
<td>$35m</td>
</tr>
<tr>
<td>African Development Bank (AfDB)</td>
<td>Water supply for urban, peri-urban and rural communities; capacity building for ZAWA</td>
<td>From November 2009</td>
<td>$42m</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>$78m</strong></td>
<td></td>
</tr>
</tbody>
</table>
4.3 Priority areas and recommendations

Overall access to clean and safe water on Zanzibar is relatively high, though substantial disparities between the islands persist. In particular, access on Pemba is much lower than on Unguja, and access in rural areas is much lower than in urban areas. The sustainability of this access is also questionable, given high vulnerability to power outages and pollution. The introduction of cost recovery policies, though likely to benefit sustainability in the medium term, may have short-term negative effects before local level capacity for operations and maintenance can develop. These same policies may have a negative effect on access for poorer households.

Access to sanitation is low on Zanzibar, with one-fourth of households having no latrine access. Again the challenge is greater in rural areas and on Pemba. This has been recognised in policy debates, though the strategies that have been identified to combat latrine shortages are arguably unlikely to succeed. The prioritisation of “basic sanitation” in targets is undermined by a focus on high latrine standards (VIP latrines) in sanitation promotion strategies. Acceptance of intermediate levels of service would be beneficial for Zanzibar.

The forthcoming development of an Environmental Sanitation Policy for Zanzibar presents an opportunity to address policy shortcomings. The emerging cost recovery policy also represents an opportunity to build on best practices for operations and maintenance learnt on the Mainland and elsewhere.

In sanitation and hygiene, two priority areas for engagement are the promotion of an intermediate standard of latrines in rural areas and improved performance monitoring. The cost recovery policy, together with the associated mechanisms for countering any anti-poor effect this may have, should be monitored closely. Two particular areas to watch are the impact of the policy on the poorest households and capacity for operations and maintenance at local levels.
Chapter 5
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 18 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 fully develop their potential.

Zanzibar Vision 2020 guides education development in Zanzibar. The Vision sees education as fundamental in the eradication of poverty and it sets the target of 100% primary school enrolment by 2015 (Lexow, Wirak, and Salim, 2007). The broader educational goal of the Vision is ‘to guide educational development for promoting academic and intellectual excellence by nurturing sound cognitive development, as well as providing education that promotes self-reliance. Vocational training should be established in all districts to provide training skills to out-of-school youths.’ Policy objectives in the Vision include ensuring access to quality education especially by the poor, women and people with disabilities. The intention is to improve and maintain high educational standards and skills development in a cost-effective manner. Objectives also include eradicating illiteracy, promoting higher education and tertiary institutions, and upgrading teachers’ competence and productivity.

Zanzibar has embarked upon an ambitious education policy to make 12 years of education compulsory for all children (RGoZ, 2006d). The Zanzibar Education Policy 2006 is founded on two major principles:

i. the recognition of the importance of pre-school education; and

ii. the extension of basic education to encompass four years of secondary education.

This is grounded in the belief that twelve years of education is the minimum requirement to achieve Zanzibar’s social and economic goals. The education sector has been the first to opt for a sector-wide approach with the support of donors and development partners.

The main reforms proposed by the policy include:

• A new structure for formal education with two years of pre-primary, six years of primary, four years of secondary, two years of higher secondary and three years of tertiary education. For the primary level the entry age is six years, for lower secondary 12 years and for higher secondary 16 years.

• English will be introduced as a language of instruction in mathematics and science from Standard Five in primary schools.

• A re-entry policy for girls who become pregnant while still at school to continue their education after the birth of the child. 

• Commitment to re-structuring educational management and the devolution of decision making to the lower levels of the system.

• The inspectorate becoming an independent body, working in close collaboration with teacher training centres.

• The need to address different forms of child abuse including the use of corporal punishment so as to make learning more child-friendly.
Figure 18: 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.

**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.

**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.

**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** *(5-6 years of age to onset of puberty)*
- 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**
- Education is a lifelong process that does not start or stop with school.

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

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

- 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.
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- Opportunities to discuss and develop moral reasoning that transcend their own experience.

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**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.
As MKUKUTA is on the Mainland, MKUZA is the overarching strategy guiding the implementation of development objectives, including education. Table 14 provides an overview of educational targets under MKUZA and achievements to date.

### Table 14: MKUZA targets and achievements in education

<table>
<thead>
<tr>
<th>Level</th>
<th>Targets</th>
<th>Achievements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early childhood care and development</td>
<td>• Increased gross enrolment rate (GER) for pre-school from 159% in 2005 to 35% in 2010</td>
<td>• The GER in 2008 was 209%; a positive trend but not on track for target</td>
</tr>
<tr>
<td>Primary education</td>
<td>• Increased net enrolment rate (NER) from 77% in 2005 to 90% in 2010</td>
<td>• In 2008, the GER in primary schools was 1044% while the NER was around 80%; Much needs to be done</td>
</tr>
<tr>
<td></td>
<td>• Increased proportion of children with disabilities, enrolled, attend and completing schools by 5% annually</td>
<td>• No data available</td>
</tr>
<tr>
<td>Secondary education</td>
<td>• Increased transition rate after Form Two examinations to Form Three from 46% in 2005 to 70% by 2010</td>
<td>• Current transition rate from Form Two to Form Three is 509%; (2007) Well off track</td>
</tr>
<tr>
<td></td>
<td>• Increased NER from 361% in 2006 to 75% in 2010</td>
<td>• NER for secondary school level (Form I-IV) has increased to 382% in 2010</td>
</tr>
<tr>
<td></td>
<td>• Increased proportion of girls who join low and higher secondary education from 46% in 2005 to 50% by 2010</td>
<td>• The proportion of girls joining lower secondary education has increased to 528% and 470% for upper secondary level</td>
</tr>
<tr>
<td></td>
<td>• Increased percentage of qualified secondary school teachers</td>
<td>• Currently only 10% and 06% of teachers are qualified to teach in secondary schools; These are teachers who have attained bachelors and masters degrees respectively</td>
</tr>
<tr>
<td></td>
<td>• Improved quality of secondary education and promoted acquisition of knowledge</td>
<td>• Quality of basic education is not satisfactory; Evidence suggests overall performance by students is poor, especially in science and mathematics</td>
</tr>
<tr>
<td></td>
<td>• Increased proportion of orphans and vulnerable children and children with disabilities who join secondary education</td>
<td>• Six schools, three in Unguja and three in Pemba, are part of the inclusive education project in Zanzibar</td>
</tr>
<tr>
<td></td>
<td>• Increased proportion of graduates from tertiary education institutions</td>
<td>• Out of three universities in Zanzibar, a total of 454 students graduated last academic year from the University of Zanzibar and State University of Zanzibar. No data for University College, Chukwani</td>
</tr>
<tr>
<td>Science and technology</td>
<td>• Enhanced teaching of science, mathematics and technology in schools</td>
<td>• No data available</td>
</tr>
<tr>
<td></td>
<td>• Promoted the use of information and communications technology (ICT)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Expanded access to ICT for education development</td>
<td></td>
</tr>
<tr>
<td>Non-formal education</td>
<td>• Increased literacy rate from 758% in 2005 to 100% in 2010</td>
<td>• Current literacy rate overall is 773%</td>
</tr>
<tr>
<td></td>
<td>• Increased literacy rate of women from 698% in 2005 to 100% in 2010</td>
<td>• Literacy level among women is 710% (no updated information available)</td>
</tr>
<tr>
<td></td>
<td>• Enhanced entrepreneurial skills among the youth</td>
<td>• No data available</td>
</tr>
<tr>
<td>Tertiary education</td>
<td>• Increased proportion of graduates of tertiary education institutions</td>
<td>• Only 01% of population have graduated from tertiary education</td>
</tr>
<tr>
<td>Quality education</td>
<td>• Improved quality of education at all levels</td>
<td>• See discussion in Section 53 below</td>
</tr>
<tr>
<td>Institutional reform</td>
<td>• Improved efficiency in the delivery of educational services</td>
<td>• The Ministry of Education and Vocational Training (MoEVT) is going through a rigorous development process, including both professional and institutional changes</td>
</tr>
<tr>
<td></td>
<td>• Integrated cross-cutting issues into education system (gender, environment, population, HIV and AIDS, employment and disaster preparedness)</td>
<td>• A National Life Skills Framework is being developed Primary school starts earlier to assist girls to complete Re-entry policy for girls after pregnancy and marriage exists</td>
</tr>
</tbody>
</table>

Source: RGoZ, 2007b.
5.1 Status and trends

5.1.1 Education provision amidst generalised insecurity
Poverty is a major constraint to accessing education, particularly the indirect costs that are incurred by families. Access to education and achievement of learning outcomes needs to be understood within the context of students and communities living in poverty. 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 may begin school already handicapped by poor nutrition. They are already starting from behind.

Thirteen percent of Zanzibaris live below the food poverty line and nearly a half of the Zanzibar population is unable to meet their basic needs (RGoZ, 2006a). Poverty rates are higher in rural areas. There are significant regional variations in the levels of poverty and poverty is higher in Pemba than in Unguja. Nearly one-third of people in Micheweni district and nearly a quarter of people in Wete district live below the food poverty levels. The association between high poverty rates and educational indicators is starkly illustrated by the situation in Micheweni. Micheweni comes last on all educational indicators including enrolment, dropout and literacy rates.

5.1.2 Literacy rates and educational attainment
Gender and location have a critical bearing on literacy rates. More than 40% of women in rural areas are illiterate in Swahili, compared to only 5.7% of men in urban areas. Literacy is higher among older people than among younger people. At all age levels female literacy rates are lower (Figure 19). More than 95% of women in the age range of 75-79 years in rural areas were illiterate compared to 74% of the women in the same age range in urban areas. Figure 20 shows that 40% of women in rural areas had no education compared to 16% in urban areas. People in urban areas tend to be better educated; men tend to be better educated than women in both urban and rural areas.

Figure 19: Literacy rates of population aged 15 years and over in Zanzibar, by residence, gender and language, 2005

Source: RGoZ, 2006a.
Table 15: Education attainment among population aged 15-49 years, Zanzibar, 2010

<table>
<thead>
<tr>
<th></th>
<th>No education</th>
<th>Completed primary</th>
<th>Secondary+</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Female</td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>Zanzibar</td>
<td>15.7</td>
<td>5.4</td>
<td>12.6</td>
</tr>
<tr>
<td>Unguja</td>
<td>10.1</td>
<td>3.0</td>
<td>14.3</td>
</tr>
<tr>
<td>Pemba</td>
<td>25.9</td>
<td>11.3</td>
<td>9.3</td>
</tr>
</tbody>
</table>


5.1.3 Access to education

Early childhood development and pre-primary education

Pre-primary schools are divided into three levels; nursery (for children aged 4-5 years), junior (5-6 years) and senior (6-7 years). More children are enrolled at nursery level than in junior and senior levels. Pre-school enrolment has grown since 1988 but has slowed recently. The Gross Enrolment Ratio was 15.6% in 2007 (RGoZ, 2007d) and 20.9% in 2008 (RGoZ, 2008b). The government aims to increase this to 35% by 2010. Enrolment varies between districts. While 37% of the children in the 4-6 year age group are attending pre-primary in Unguja, only 3-4% of them attend pre-primary in North “A” and “B”. The distribution of pre-schools is highly skewed; most pre-schools are in urban areas. Pre-school enrolment is slightly higher for girls than for boys (RGoZ, 2007d).

Pre-primary education is provided mostly by the private sector. In 2008, there were 26 government owned and 209 privately owned pre-schools in Zanzibar. Overall, 81.4% of enrolments were in private sector institutions (RGoZ, 2008b). There are four types of private
centres providing pre-primary education namely: Quranic schools, private commercial pre-schools, community-based registered pre-schools and community-based non-registered pre-schools. There is great variety in the costs incurred by parents sending their children to pre-primary schools. In government schools parents usually pay Tsh2,500 a month; some religious schools are free and others charge up to Tsh30,000 (RGoZ, 2007d). Contributions usually cover a snack meal prepared at school and operational costs. Teachers usually make teaching resources from local materials.

Public school teachers are employed by the government and paid according to their qualifications. If they are qualified as primary school teachers, they retain the same salary when they transfer to pre-primary school. Government policy is to have one teacher per 20 children, but the data on pre-school pupil-teacher ratios varies considerably between districts and is higher in government than private pre-schools. A pre-school curriculum has recently been developed.

Box 3: 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 – Zanzibar 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.

Components of integrated early childhood development
Box 3: Early childhood development (cont.)

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.

Acknowledging this responsibility, the new MKUZA II identifies Early Childhood Care and Development as one of the core cluster strategies for achieving the goal of “equitable access to quality education”. The MKUZA has two operational targets for ECD: 1) Develop and implement an integrated ECD policy by 2012, and 2) Increase net enrolment for preschool from 20.1% in 2010 to 50% in 2015. These ambitious targets will be carried out through the following three core strategies:

(a) Promote gender sensitive and diversified child friendly ECD programmes
(b) Ensure equitable access to quality pre-school education for all children at the age four and five
(c) Strengthen capacity to implement and monitor effectively programs that promote child- friendly and girls’ education

The proposed intervention package for ECD in MKUZA II includes the following:

• Develop minimum standards for conducive learning environment that are gender-sensitive and child-friendly
• Develop and implement effective policy guidelines, to eliminate gender-based violence and improve child-friendly environment
• Non-state actors and communities to establish ECD centres especially in rural and hard-to-reach areas
• Provide relevant, appropriate and gender-responsive early childhood care especially to vulnerable and disadvantaged children with special needs
• Improve capacity of teachers, teacher training colleges and teacher centres, as well as caretakers
• Provide Health care and nutrition services in all ECD centres
• Establish a training college for pre-primary teachers
• Construct and furnish new classrooms and associated facilities to meet expanding demand in consideration to people with disabilities
• Introduce pre-school classes in existing primary schools.

With these key strategies and the set of interventions, Zanzibar is on the right track to achieve the first goal of the Education for All (EFA) initiative: Expanding and improving comprehensive early childhood care and education, especially for the most vulnerable and disadvantaged children. Beyond the development of ECD policies and strategies, Zanzibar still faces the challenge of implementation. Currently, investment of resources in ECD remains low, while administrative and implementing responsibilities are divided between different ministries, agencies and development partners, and even closely related programmes, such as health and nutrition, are not well coordinated.
Primary education

Zanzibar was one of the first countries in sub-Saharan Africa to implement a ten-year basic education cycle, comprised of seven years of primary and three years of lower secondary. Recently the main thrust of government plans have been directed towards providing basic education to all children, from primary Standard 1 to Form 2 secondary. The vast majority of children are in government schools. In 2008, the GER for basic education was around 100%; a considerable achievement given the high rates of poverty. However, the NER (almost 80%) is much lower, an indication either that children do not start school at the prescribed age, or of relatively high dropout rates. Both GER and NER are higher in urban areas than in rural areas (Figure 21). In urban areas, the GER for both male and female is above 100. The differences in NER and GER between Unguja and Pemba are stark. None of the districts in Pemba had a GER of 100 and above, while Micheweni has the highest proportion of the poor, the lowest GER (around 80%) and an NER of only 51.4%. Almost all districts achieved gender parity in the basic education NER, except for Micheweni which recorded a gender parity index (GPI) of 0.95 and the GER with the exceptions of Kusini and Micheweni whose GPIs are around 0.90.

Figure 21: Basic education Net and Gross Enrolment Ratios, by gender and residence, Zanzibar, 2008

(a) Net Enrolment Ratio
As shown in Figure 22, children in Zanzibar tend to drop out early, especially in Standards 2, 3, 4 and 5. Boys drop out earlier than girls, whose drop-out rate is higher in higher classes. The high and early dropout rate is largely attributed to the ‘unfriendliness’ of the school environment; children often experience overcrowded classrooms and little attention from teachers. Very few children drop out in Orientation Secondary Class (OSC) and secondary classes, the small percentage that do are students not sitting the exams.

**Figure 22: Number of children aged 7-16 years who dropped out of school, by grade, residence and gender, Zanzibar, 2008**
Secondary education

Until 2007, there were two parallel structures for secondary education, namely 4-2-2 and 3-2-2. The 4-2-2 structure caters for talented students who are selected to join secondary schools that focus on natural and social sciences, commercial studies, technical education, Arabic/Islamic studies, French language and computer science. The students entering these schools do so after passing the national Standard VII examinations. These students receive four years of continuous secondary education, after which they sit for the Tanzania National Certificate for Secondary Education Examinations. Those who qualify are selected to continue with two years of advanced secondary education.

Most students follow the 3-2-2 structure. The first three years are part of compulsory basic education and constitute the orientation secondary class (OSC), Form 1 and Form 2. After completing Form 2, students sit for the Zanzibar National Form 2 Examinations and those who qualify are selected to continue with Form 3 and Form 4. The transition rate to Form 3 was around 43% in 2004. OCS classes were abolished in 2007, leading to a large increase in Form 1. Nearly 50% of the students completing Form 1 then entered Form 3.

Technical and vocational education and training

In the absence of a coherent and organised system, it is difficult to map the various activities, projects and programmes, both formal and informal, under vocational education and training (VET). For instance, the name ‘Centre’ is used for institutions at various levels of the system, with different criteria for intake and training content. Therefore, it is also difficult to present data about enrolment or completion of VET.

One technical college (Karume) and two secondary schools (Kengeja in Pemba and Mikunguni in Unguja) specialise in technical education. Karume Technical College (KTC) provides a technician’s certificate in areas such as electrical and civil engineering, transportation, telecommunications and auto mechanics. The college is in the process of transformation to become the Karume Institute of Science and Technology which will have the capacity to offer diplomas and degrees in science and technology. In addition to the formal stream, informal training is taking place in technical schools, Karume Technical College and other institutions. Several institutions also provide post-secondary education for specific sectors under different line ministries. These are the College of Health Science, College of Agriculture, Zanzibar Institute of Finance Administration and College of Hotel and Tourism. In addition, various private institutions offer courses in fields like computing.

Table 16: Net school attendance ratio and gender parity, primary and secondary school, Zanzibar, 2010

<table>
<thead>
<tr>
<th></th>
<th>Primary school</th>
<th>Secondary school</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Net attendance</td>
<td>Gender Parity</td>
</tr>
<tr>
<td></td>
<td>ratio (%)</td>
<td></td>
</tr>
<tr>
<td>Unguja North</td>
<td>80.7</td>
<td>1.25</td>
</tr>
<tr>
<td>Unguja South</td>
<td>92.6</td>
<td>1.05</td>
</tr>
<tr>
<td>Town West</td>
<td>91.5</td>
<td>1.02</td>
</tr>
<tr>
<td>Pemba North</td>
<td>77.2</td>
<td>0.97</td>
</tr>
<tr>
<td>Pemba South</td>
<td>79.1</td>
<td>1.1</td>
</tr>
</tbody>
</table>

and information technology. There are several other vocational training centres under the line ministries and others supported by private sector and religious organisations.

**Higher education**

The tertiary and higher education sub-sector has recorded significant progress. More Zanzibaris are attending tertiary and higher education than ever before and this number will keep increasing as the institutions of higher education expand. There are two levels of training institutions in tertiary and higher education provision; academic institutions such as universities and intermediate professional education, and training institutions. Universities are expected to concentrate on research, teaching and public service or consultancy, and the latter focus on human resource development for middle and intermediate level occupations, including teaching, instructing and career training. These tertiary courses are available in Zanzibar post-secondary institutions like the Islamic College (or Muslim Academy), the former Nkrumah Teacher Training College (NTTC), the Karume Technical College (KTC) and the Institute of Kiswahili and Foreign Languages (IKFL). Several institutions provide tertiary education in Zanzibar. The government-run State University of Zanzibar (SUZA) has degree programmes in areas such as education, general science and social science. A private college, University College of Education, provides degree courses in subjects such as history, geography, chemistry, and physics. Zanzibar University, a private institution, provides courses in law and business administration.

The provision of tertiary education is constrained by the small number passing Form 6 examinations. Most of the best students enrol at the University of Dar es Salaam. Universities in Zanzibar then tend to take the lower quality candidates who remain. Consequently all universities in Zanzibar, both public and private, have to offer pre-university entry programme for under-qualified students to upgrade their skills. No recent data on enrolment is available. The latest data, drawn from the 2010/2011 MoEVT budget, shows the total student population in the three universities in Zanzibar to be 3572. Unlike in the primary and secondary education sub-sectors where gender parity has been achieved, female access to tertiary education remains very low and is even more pronounced in technical subjects, engineering sciences and mathematics.

### 5.2 Factors affecting learning outcomes for children

The MoEVT in Zanzibar faces a major challenge in maintaining and improving quality in learning outcomes as the number of pupils increases while the number of adequately skilled teachers is not keeping pace with demand. This requires paying particular attention to teacher preparation, teacher management, teacher supervision and support, curriculum management, and student examination and testing. Learning outcomes and Ministerial management of educational delivery are closely linked. Pupils being taught by under-qualified teachers in a system that has weak local management cannot lead to success. Addressing teacher quality and reorganising the ways in which teachers are managed will go a long way to achieving the quality goals MoEVT has set.

### 5.2.1 Teacher supply and quality

**Primary level**

The pupil-teacher ratio (PTR) in Zanzibar is much lower than on the Mainland Tanzania at less than 30:1. It could be argued that there is an overall over-supply of teachers, taking resources away from other necessary areas of investment. About 70% of the primary school teachers are female. Most prefer to be located in the more urbanised areas of Urban, West and Central districts. Consequently, these three districts have a higher proportion of female teachers and relatively low pupil-teacher
ratios (PTR). However, at the same time, high PTRs are experienced in specific subjects, such as science and maths as there are few skilled teachers for these subjects. Most primary teachers are qualified: 85% of public school primary teachers have a certificate-level qualification, 13% are unqualified, and less than 2% have higher qualifications (diploma or degree level).

Importantly, this low PTR has not translated into improved learning outcomes. Between 62.7% and 67.9% of Standard 6 pupils did not reach a “minimum” level of mastery in reading, writing and numeracy, and between 96.62 and 98.18% did not reach the “desirable” level (Mrutu, et al., 2005). When teacher literacy was assessed using the same test items, the Southern and East African Consortium for Monitoring Educational Quality found that only 80% of teachers tested reached the desired level for Standard 6 (SACMEQ, 2005). Furthermore, the shortage of teachers trained in mathematics and science results in some classes being taught by teachers who are untrained in these subjects. There are also reports of difficulties arising from the language policy, as teachers who were trained in English struggle to translate some concepts into Kiswahili, particularly in mathematics.

**Secondary level**

The current pupil-teacher ratio of 30:1 is adequate in terms of quantity, but there is a great shortage of qualified secondary school teachers particularly in science, mathematics and English. About 50% of secondary teachers are under-qualified, including those who are qualified to teach primary. By qualifications, 49% of teachers at secondary level have a diploma, 9% have a degree or higher, while 41% are unqualified high school leavers who were employed directly to teach without undergoing any professional training. The majority of qualified teachers have been trained only to teach to Form 2.

In rural areas, the situation is exacerbated by the fact that most schools have no staff houses. Urban areas have a greater proportion of both qualified and female teachers. Unguja has a lower PTR and more qualified and female teachers than Pemba. There are also stark differences in the distribution of teachers of particular subjects, such as mathematics. In Micheweni district there are only two qualified teachers with mathematics as their major subject, giving a ratio of over 1,900 students for each. By contract, in urban districts there is a qualified mathematics teacher for every 467 students. Low entry-level qualifications, inadequate training, and limited professional development opportunities and professional support and supervision contribute to poor motivation and poor teaching quality.

**Vocational education and training**

There are inadequate numbers of instructors in training centres and in many cases staff are unqualified. There is considerable need for capacity building for new and existing staff in the schools and in the ministerial offices.

**5.2.2 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.
Primary level
Many classes, especially those at the lower levels are overcrowded. The pressure for places in primary schools has resulted in a considerable backlog in most schools. Only 29.4% of seven year-olds actually start school at the right age. Zanzibar will face considerable difficulty in implementing the policy that requires all children to be enrolled at 6 years of age. Classroom construction is urgently required to ensure to accommodate student numbers. In overcrowded schools, many schools run on double shifts, some on triple.

Secondary level
A major constraint to increased access at lower secondary level is the poor school environment. Schools, especially most community schools, have limited facilities and are actually extensions of existing primary schools. There is often a lack of sanitation and piped water and furniture, let alone more sophisticated learning spaces such as science laboratories, libraries and computers. Classes are overcrowded with an average of 60-70 students. Since most of schools already operate on double shift basis, the expansion of existing facilities and construction of new schools is required. There is also an acute shortage of teaching and learning materials, including textbooks, reference books and laboratory equipment. These constraints, particularly in rural areas, have contributed to low achievements levels.

Vocational education and training
The VET sector suffers from a serious lack of tools and materials. They therefore have to rely primarily on theoretical training, whereas students learn better through hands-on experience with raw materials and equipment. MoEVT’s contribution to VET is mainly support to trainers’ salaries and, in some cases, books. There is no relationship between enrolment and financial contribution to the schools.

5.2.3 Curriculum and examinations

Primary level
The government is in the process of revising the primary school curriculum to compress the seven-year curriculum to six years. The new curriculum to be implemented in 2010 will aim to improve children’s learning outcomes in subjects such as science and mathematics. While the textbook situation has improved considerably in the last year, the system still depends too much on donor support. The planned Textbook Policy and Financial Sustainability Consultancy (MoEVT/World Bank) that the Government is renewing will hopefully allow Zanzibar to develop a long-term, sustainable textbook strategy.

Secondary level
The curriculum is examination-oriented with no provision for local flexibility and adaptability, and the examination system is used primarily to select a few for further education and fails the majority. Consequently, secondary education does not prepare students for employment. Most graduates do not have sufficient knowledge and the vocational skills that are required in the formal and informal sectors of the economy. The curriculum needs to be adapted to current labour market demand, especially in the areas of ICT, English and broader life-skills. A more reliable and continuous system of assessing students while in the classroom is desirable and would enhance efficiency if staff had the capacity to implement continuous assessment. The new education policy with instruction in English that will be introduced in Standards 5 and 6 then incrementally throughout the system may be the greatest challenge. A major language enhancement strategy,
focused on English language proficiency will be essential before the new policy can be attempted. The use of radio and other electronic media should feature strongly in the strategy.

**Vocational education and training**

MoEVT has assessed the VET curriculum and found it to be outdated, having not been reviewed for more than 20 years. The training offered was considered largely irrelevant to labour market needs. An external monitoring team found that there was no curriculum development activity in any of the institutions surveyed. Instruction was done with no proper planning, monitoring or evaluation. This was indicated to be one of the most crucial weaknesses facing skills development centres.

**5.3 Fiscal space for education**

The share of the education sector as a proportion of the GDP and of the total budget in Zanzibar compares well with Mainland Tanzania and with neighbouring countries. In 2007/08, expenditure on the education sector was almost 19% of total government expenditure. The RGoZ has shown strong commitment to supporting education as a key strategy in poverty reduction in the Isles. According to the MoEVT, the Ministry has enjoyed strong support from the President and from the Ministry of Finance, with a steady increase in nominal education expenditure since 2003/4 (see Figure 23).

*Figure 23: Education expenditure (Tsh millions) as % of GDP and of Government expenditure, Zanzibar, 2003/4-2007/8*

Out of the total development budget of Tsh 16,504m, the education development budget is Tsh 1,340m or 4.6% of total education expenditure. However, dependence on external funding, including both grants and loans, is very high at nearly 85% of total estimated government education development expenditure. Loans from development partners constitute 77%; the greatest contributors being the Arab Bank for Development in Africa (BADEA), the World Bank and USAID.
Compared to the Mainland, Zanzibar devotes a much larger proportion of its education budget to salaries and allowances, which constituted approximately 80% of the recurrent budget in 2006/7 and 2007/8 (Figure 24). This can be attributed to efforts to improve teacher salaries. According to MoEVT, the teacher salary is now higher than any other salaries of employees of other ministries. Nonetheless, Zanzibar has not been able to improve the image of the teaching profession and still faces difficulties attracting quality teachers (Interview with MoEVT, 2009). Only 0.3% of the education budget is also allocated to teaching materials, thereby undermining a key input required for quality learning outcomes.

**Figure 24: Percentage of salaries and allowances and teaching materials in recurrent education budget, Zanzibar, 2006/7 and 2007/8**

![Percentage of salaries and allowances and teaching materials in recurrent education budget, Zanzibar, 2006/7 and 2007/8](source: RGoZ, 2008c)

Financing higher education

The Higher Education Student’s Loan Board is a cost-sharing mechanism and was introduced by the Tanzanian Government in 2005 to relieve the government from bearing the full cost of higher education. It provides loans to those studying at accredited higher education institutions in and outside the country. The Zanzibar Higher Education Loan Board (ZHELB) was also established specifically for Zanzibari students. All students enrolled in tertiary institutions qualify for loans from ZHELB including diploma, degree and post-graduate students. Funding for universities is very limited and budgets for research and staff development are solely dependent on donor funds, which are scarce and unpredictable.

### 5.4 Institutional framework

Preparation of the Zanzibar Education Development Programme (ZEDP) included a study to assess management capacities at all levels in the Ministry of Education, and to make proposals to address those needs (MoEVT, 2007b). The study found that:

- Given the small size of Zanzibar, the government has fewer ministries and units than the Mainland and as a result some people have several functions. The horizontal rationalisation
of functions is not reflected at sub-national government administrative levels. At regional and district levels, administrative tiers persist and few responsibilities have been devolved to the lower levels. The study recommends that more autonomy and decision-making power, with corresponding financial allocation, be given to schools and School Committees and that efforts be made to upgrade their planning and management capacities. This would be real decentralisation to the local level.

- Too many actors are intervening without coordination and roles are not well defined. Working conditions in District Offices are generally poor, including a lack of transport, computers and IT capacity at all levels. The lack of operational funds directly affects all other factors. The study recommends that the supervision system should allow the creation of a more coherent and efficient system in which district officers have a more useful role and that decentralisation should be properly addressed through ZEDP and the sector-wide approach.

Staffing: The Ministry of Education is over-staffed in terms of support level staff, but there is a critical shortage of well-qualified professional staff. It is a challenge to attract and retain qualified staff. MoEVT should review its recruitment procedures to make them proactive and search-oriented. A clearer definition of roles and responsibilities would also enhance efficiency and synergy between officers.

Capacity in educational planning and management: The development and the use of the new comprehensive computerised Education Management Information System (EMIS) is both an opportunity and challenge for the Statistics Division. Only a few officers are competent computer users and few are able to develop indicators, or interpret, analyse and present statistical information in user-friendly ways. Efforts should be made to promote the use of data for planning and management but staff capacity will need to be significantly upgraded to achieve this goal.

Implementation of plans: To ensure implementation, the Strategic Medium-Term Plan will have to be translated into yearly operational plans and budgets. Practical questions such as planning the supply and demand of teachers, making decisions about school location, and carrying out physical development plans will also have to be addressed. Yearly operational plans need to be programme-specific, results-oriented and accompanied by specific budget allocations. The Policy and Planning Division and District Education Officers should project teacher supply and demand with specific local conditions informing plans. There is also a need for results-based budgeting and the development of precise indicators for monitoring and evaluation.

Skill development: There is a need for reinforcement of three sets of skills:

- Generic skills; essentially skills in leadership, communication and the use of computers;
- Basic planning skills; the use of data and projections, programme design, preparation of operational plans and monitoring of programme implementation; and
- Specialised planning skills such as data management and making projections, budgeting and financial management, programme design and monitoring, school mapping and physical planning, teacher management and deployment.

The improvement of management systems and financial and regulatory procedures should link to one overall goal, which is the improvement of learning outcomes in the classroom.
5.5 Priority areas and recommendations

Many of the issues facing the Mainland are also apparent in Zanzibar. Poverty is largely associated with location. There are significant differences between Pemba and Unguja and between districts, with some districts having very low development indicators across the board. Gender inequity is marked and revealed in the disparities in adult literacy.

There is an over-supply of primary school teachers in Zanzibar, but they are poorly distributed and many lack competence in the subjects they teach. This is exacerbated by the fact that many primary-trained teachers are now teaching in secondary schools. Similarly, many secondary school teachers are either under-qualified or unqualified. Urban-rural imbalances in teacher supply are also evident and female teachers tend to be the most reluctant to work in the rural areas so increasing the deployment imbalance. Also, there is an acute shortage of classrooms. Double shift schools still operate in nine out of ten districts of Zanzibar. Teaching materials are inadequate due in part to inadequate resources but also wastage.

For a small population, Zanzibar has well-developed educational structures from pre-primary to the university level. In spite of the positive policy and planning framework and the 19% of Government budget in 2007/8 devoted to education, the financial and material resources available to support quality learning and teaching are very limited. Consequently, learning outcomes are far below the standards set by government. The quality of pupil learning is due in part to the large class sizes in urban areas and the shortage of qualified teaching staff. Government resources to support quality learning and teaching are inadequate in terms of buildings and equipment available, transport and facilities for supervisory staff and in terms of the levels of training and preparation of a variety of professional and school-level staff. In terms of teacher development a national system for teacher support provided by Advisory Teachers at Teachers’ Centres seems to work fairly well. Poverty is also a critical issue, especially in terms of indirect and opportunity costs. Parental contributions are high, but are crucial for the survival of schools. Although the expanding enrolment rates suggest that schooling remains attractive to parents and pupils.

A comprehensive educational structure with many positive aspects is in place in Zanzibar. However, rapid expansion and restructuring that is planned through the proposed SWAp and the Basic Education Improvement Project will place great strain on the existing system. The capacity to maintain and extend quality in learning and teaching as numbers of pupils increase while the teaching force remains inadequate will be a major challenge for MoEVT.

There is also clearly a mismatch between the education outcomes that are being produced by the system and labour market needs in Zanzibar. There is a real need to enhance the economic development of the Isles given the very high level of donor dependency that persists. There is also an urgent need to address issues of decentralisation and enhance community involvement in education decision making, as well as the participation of children themselves. The expansion of higher education is welcome but more thought needs to be given to enhancing the provision of alternative forms of post basic education and ensuring relevance and quality of delivery. Institutional capacity is weak at many levels, indicating the need for high quality technical assistance and training if the quality of the Zanzibar Education Sector development programme is to produce concrete results for all children in all schools.
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 PMTCT 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.

Figure 25 illustrates a causality framework of HIV and AIDS in women and children, which 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.

Figure 25: Causality framework of HIV and AIDS in women and children

- **Immediate causes**
  - Unsafe sex/casual sex
  - Injecting drug use (or by partners)
  - Low condom use at high risk sex (sex workers)

- **Underlying causes**
  - Inadequate access to services by most at risk population (MARPs) such as prevention, condoms, treatment of STIs, harm reduction
  - Low knowledge and poor access to information
  - Traditional/cultural practices; Early sexual debut

- **Structural causes**
  - Poverty at household level
  - Gender relations
  - Weak data systems
  - MARPs not recognized
  - Political commitment
  - Community participation

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6.1. Overview of HIV and AIDS

6.1.1 HIV prevalence
The first AIDS case was reported in 1986 and by 2006-07 it was estimated that between 3,500 and 9,000 adults and children were living with HIV. Current estimates from the THMIS 2007/8 show that HIV prevalence in Zanzibar has stabilised at 0.6% since 2002. Over 80% of new infections occur in people aged between 24 and 49 years, and the prevalence rate among women aged 15-29 years is reported to be five times higher than their male counterparts (0.9% versus 0.2% respectively). An estimated 90% of transmission is through sexual intercourse (Zanzibar AIDS Commission (ZAC), 2008a).

Zanzibar’s HIV epidemic can be described as “concentrated” rather than “generalised”. The THMIS 2007/8 estimated the prevalence rate at under 1% in the general population but above 5% in certain sub-populations known as most-at-risk populations (MARPs), which include sex workers (prevalence rate of 10.1%), drug users, particularly injecting drug users (15.1%) and men who have sex with men (12.3%) (ZAC, 2008a).

Young people are regarded as being at heightened risk of contracting HIV not only due to risk behaviours related to early sexual debut, unprotected sex with multiple concurrent partners and experimentation with drugs but also due to low awareness of risk of HIV transmission. Early marriages, sexual abuse and gender biases leading to unequal negotiation and decision-making powers also increase youth, specifically girls’, vulnerability to the virus. Data on the number of children living with HIV and paediatric AIDS is scarce and not easily available. This complicates the possibility of reaching all children requiring services. Disaggregated data at care and treatment centres (CTCs) is needed to strengthen understanding and to inform an improved response to the epidemic in children.

6.1.2 Most-at-risk populations
As illustrated above, Zanzibar has a concentrated epidemic where levels of HIV infection are alarmingly high among MARPs. Substance users, particularly injecting drug users (IDUs), have been identified as a MARP in Zanzibar for a number of reasons. Not only is HIV prevalence among injecting drug users alarmingly high (15.1%), but Zanzibar is located along an important corridor for drug trafficking and increasing numbers of young people are using drugs (MoHSW, 2007). High numbers of injecting drug users engage in risky behaviour from sharing needles, using inappropriately sterilised equipment and practicing flash blood1 to having multiple sexual partners and participating in group sex (ZAC, 2007a).

HIV prevalence rate among sex workers is reported at 10.1% and a pilot project covering 240 sex workers (male and female) in 2006 revealed that high-risk behaviour is common: 19% practiced dry sex, 28% reported anal sex, 39% did not use a condom (as clients were ‘regulars’) and sexual violence seemed to be frequent (ZAC, 2007a).

Studies conducted among men who have sex with men show infection rates of 12.3%. Many men who have sex with other men also have sex with women and do not necessarily associate themselves with homosexuality. Indeed, a study conducted into HIV risk factors and injection drug use among men who have sex with men in Zanzibar in 2007 found that out of the 509 respondents interviews, 28.8% were married and 71.7% had had sex with males and females in the last year.2

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1 The practice of ‘flash blood’ or ‘blood sharing’ is where two IDUs exchange blood. One IDU injects a drug, such as heroin, then draws blood immediately afterwards and gives this to another IDU to inject, thereby receiving a second-hand hit or high.

2 Presentation on the topic at the Mexico City HIV and AIDS Conference, August 2008.
Poverty, low levels of education and lack of sex education combined with inadequate parental care are all causal factors that put young people at risk of engaging in high-risk behaviours, increasing their vulnerability to HIV.

Table 17: Prevalence of selected diseases among MARPs in Zanzibar

<table>
<thead>
<tr>
<th>Disease</th>
<th>Injecting drug users</th>
<th>Female sex workers</th>
<th>Men having sex with men</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV</td>
<td>15.1%</td>
<td>10.8%</td>
<td>12.3%</td>
</tr>
<tr>
<td>Hepatitis C</td>
<td>28.1%</td>
<td>2.0%</td>
<td>14.7%</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>6.1%</td>
<td>5.3%</td>
<td>4%</td>
</tr>
<tr>
<td>Syphilis</td>
<td>0.3%</td>
<td>1.3%</td>
<td>0.2%</td>
</tr>
</tbody>
</table>

Source: ZAC, 2008c.

6.1.3 The policy and legal environment

The Zanzibari Government’s policies and regulations reflect its commitment to providing an enabling environment for interventions that address HIV and AIDS. This includes the establishment of the Zanzibar National Strategic Plan, and the mainstreaming of HIV into Vision 2020 and MKUZA 2006-2010 (Table 18). In addition, most Government Ministries have Technical AIDS Committees (TACs) and HIV and AIDS Focal Points whose task is to coordinate and implement sectoral HIV and AIDS plans. Programmatically, the national HIV response is guided by the Zanzibar Health Sector HIV Strategic Plan 2005/6 - 2010/11 and the Zanzibar National Strategic Plan (ZNSP) 2003/4-2008/9.

Table 18: MKUZA I targets and indicators for HIV and AIDS

<table>
<thead>
<tr>
<th>MKUZA I targets</th>
<th>Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve health status including reproductive health, survival and well-being of</td>
<td>• Reduced HIV prevalence among pregnant women aged 15-24 years from 1% in 2005 to 0.5% in 2010</td>
</tr>
<tr>
<td>children, women, men and vulnerable groups</td>
<td>• Increased proportion of population with comprehensive correct knowledge of HIV and AIDS from 44% of women and 20% of men to 80% of the general population by 2010</td>
</tr>
<tr>
<td></td>
<td>• Increased condom use among women engaged in high-risk sex from 34% in 2005 to 80% in 2010</td>
</tr>
<tr>
<td></td>
<td>• Reduced stigma surrounding HIV and AIDS from 76% in 2005 to 60% in 2010 (measured as the inverse of the proportion of the population expressing acceptance of 4 measures as per TDHS)</td>
</tr>
</tbody>
</table>

Source: RGoZ, 2007b.

At policy level, the Zanzibar National Multi-sectoral HIV and AIDS Policy (2005) promotes human rights, equal gender relations, greater involvement of people living with HIV and AIDS (PLWHA), and adheres to international standards and declarations. However, there is a need to review the policy in light of new evidence relating to the epidemic in Zanzibar and to ensure that it adequately addresses sub-populations now known to have higher levels of infection than the general population. In addition, different sectors include HIV and AIDS in their respective policies. For example, the Zanzibar Education Policy (2005) speaks of HIV and AIDS as an emerging challenge, however it advocates for abstinence only. The Zanzibar Tourism Sector
Strategic Plan (2008), on the other hand, promotes condom use and calls for intensified efforts within the tourism industry for HIV awareness and sensitisation.

There are no laws that speak specifically on HIV and AIDS. Zanzibar, recently, conducted a legal audit, which recommended for development of a new HIV Law. Prior to that there’s a need to ensure that HIV is adequately addressed in the current processes of the development of the Child Bill and the review of the Education Act.

6.2 Socio-economic and cultural drivers of the epidemic

Socio-economic and cultural factors are seen as drivers of the epidemic in Zanzibar. In the predominantly Islamic setting, in which polygamy is culturally accepted, sexuality is an extremely sensitive issue and intercourse is prohibited outside of marriage. HIV infection is often seen as proof of promiscuity and extra-marital affairs, both forbidden in the Quran. Condom use is discouraged outside of marriage and, again, associated with promiscuity. Although significant progress has been made, national prevention strategies and the work of institutions formed to combat the epidemic – the Zanzibar AIDS Commission and Zanzibar AIDS Control Programme (ZACP) – are still hampered by a general lack of political and religious support towards prevention strategies other than abstinence and faithfulness.

In addition, Zanzibar has low secondary school enrolment. Only 24% of youth of secondary school-going age are in school which results in high youth unemployment. Cultural ceremonies such as Mwaka Kogwa and Uhuru torch rallies that bring large numbers of people together for extended periods as well as cultural practices, such as widow cleansing, influence individuals’ behaviour and their risk of being exposed to HIV. The impact of polygamy on increasing risk of transmission (or alternatively protecting particularly women) needs to be explored further. Other drivers of the epidemic include:

i. Higher risk behaviour and accompanying low perception of transmission risk;

ii. Stigma and discrimination;

iii. Population mobility; and

iv. Gender inequity.

6.2.1 High risk behaviour and low perception of transmission risk

The THMIS 2007/8 found that the percentages of women and men who had higher risk sexual intercourse in the 12 months prior to the survey were 6.2% and 11.9% respectively. Only 30.3% of women and 32.9% of men used condoms at last high risk sexual intercourse (TACAIDS et al., 2008). Data for condom use show a decline from 2004/5 when 34.5% of women were reported to have used a condom (NBS, 2005). Compounding the low contraceptive use, not all people in Zanzibar consider themselves at high risk of contracting HIV. An impact assessment for the education sector (MoEVT, 2007) indicates that less than 50% of respondents felt they were at risk, whilst more than 25% of persons interviewed in a tourism sector assessment did not perceive to be at risk of ever being HIV positive (RGoZ, 2007e).

Among adolescent women surveyed by the THMIS 2007/8, 3.4% reported having had sex before the age of 15, with the figure rising to 22% in women below 18 years. For adolescent men, 1.7% reported having had sex before the age of 15 and 12.6% before the age of 18. Only
10.4% of women and 14.8% of men aged 15-24 years used a condom at first sexual intercourse, whilst 19.9% of women and 79.2% of men in this age group reported higher-risk intercourse in 12 months prior to the survey.³

6.2.2 Stigma, discrimination and knowledge of HIV and AIDS
As is common in countries with concentrated epidemics, HIV-related stigma and discrimination in Zanzibar is high and acts as a barrier to VCT as well as to the effectiveness of HIV prevention and care services. For example, only 48.6% of women and 66.9% of men in Pemba and 69.8% of women and 79.1% of men in Unguja would buy fresh vegetables from PLWHA (THMIS 2007/8). Stigma can have a major impact on people living with HIV and those at risk of infection. It has been shown to be “associated with stress, depression, and lower perceived quality of life” among PLWHA (Maman et al., 2009). Stigma can manifest in many ways from loss of employment and denial of healthcare to social isolation and lack of family support. People living with HIV can be blamed by their families for becoming infected due to the burden that the disease places on households. A wealth of anecdotal evidence exists on children and young people being stigmatised and discriminated against in schools, communities and families due to their own or parents’ HIV status.

Stigma is usually compounded in areas where knowledge and awareness about HIV and AIDS is low and people have had little contact with PLWHA. Studies such as the 2008 life skills education assessment show that levels of HIV and AIDS awareness among school children are low, including basic knowledge on HIV transmission (ZAC, 2008d). The THMIS 2007/8 also found alarmingly low rates of comprehensive knowledge of HIV and AIDS in Zanzibar (29% among women and 30.1% among men). Because of the nature of its epidemic, Zanzibar also exhibits layered stigma, where HIV-related stigma is compounded by other socially stigmatised conditions or behaviours, such as same-sex sexual relations, transactional sex, and drug use (Genberg et al., 2009).

6.2.3 The impact of population mobility
Internal population mobility in Zanzibar is common, particularly during agricultural peak seasons, for example, during cloves harvesting. It is also common among fishermen, traders, people involved in the public transport system and those working in the tourism industry. Whilst mobility in itself is not a driver of the HIV epidemic, it becomes one when combined with higher risk sexual behaviour or substance use when individuals spend considerable time away from their families. External mobility is also common, for example a survey on hotel workers in 2007 revealed that 27% were not from Zanzibar (ZAC, 2007a).

6.2.4 Gender inequity
Gender inequity in Zanzibar is high, manifesting in fewer women being employed, women having less power to make decisions about their health or economic situations, and women and girls being subjected to frequent gender-based violence and exploitation with very little formal follow up or disciplinary action against perpetrators. According to a study in 2007, 43.2% of women reported a rise in domestic and sexual violence, which continues to be normalised through social norms (MoLYWCD, 2007a).

³ It must be noted, however, that sample sizes for THMIS 2007/8 in Zanzibar were often very low.
6.3 Status of the response to HIV and AIDS
Zanzibar has made immense strides in the last five years in addressing the epidemic by putting in place a HIV and AIDS policy, strategic plan, monitoring and evaluation framework and advocacy strategy that will underpin interventions. Achievements include the increased involvement of the private sector, greater participation of people living with HIV and AIDS, mainstreaming HIV in MKUZA, increasing the capacity of the ZAC, engaging religious bodies and strengthening community participation in promoting HIV prevention. But these efforts have fallen short in adequately addressing some of the drivers of the epidemic, particularly those that are culturally sensitive such as gender inequity, prevention of transmission by PLHWAs, and stigma and discrimination.

Zanzibar has prioritised HIV prevention services at health facilities, including voluntary counselling and testing (VCT), prevention of mother-to-child transmission (PMTCT), HIV care and treatment services and anti-retroviral therapy (ART). Coverage and uptake of services has increased along with public awareness of the significance of these services in HIV prevention. But most services are not yet comprehensive due to the low participation of civil society organisations (CSOs), faith-based organisations (FBOs) and the private sector, inadequate funding and drug shortages. A great challenge also remains to make services accessible to MARPs, who have not been targeted and are subjected to stigma and discrimination by community members and health workers. In failing to address the factors that lead people to become MARPs, Zanzibar risks the rapid spread of HIV in coming years.

Voluntary counselling and testing and provider-initiated testing and counselling
Voluntary counselling and testing (VCT) is available at 44 sites, including services offered by hospitals (public and private), clinics and NGOs. In 2009, at least 40,000 clients accessed services at these sites (ZACP, 2009). Provider-initiated testing and counselling (PITC) was introduced in 2006 to complement VCT and to ensure that clients accessing other services were reached. According to a recent situation analysis of PMTCT, VCT services, and care and treatment centres (CTC), more needs to be done to make facilities more youth- and MARPs-friendly, enhance privacy for counselling sessions and improve audio-visual facilities (ZACP, 2009). The location of centres in urban and peri-urban areas is a constraint in reaching rural populations as are shortages of testing kits at outreach service points.

Pre-marital testing is largely seen as a best practice in Zanzibar, but needs to be closely assessed from a human rights perspective. Since positive test results usually lead to the dissolution of the engagement, one can argue that in a society where early and trans-generational marriages are common, the practice protects younger women from HIV transmission. However, the testing is often done in the presence of family members so the rights to confidentiality and informed consent are undermined. There is anecdotal evidence of religious leaders refusing to marry couples when one person is HIV positive.

Prevention of mother-to-child transmission
Prevention of mother-to-child transmission (PMTCT) services are now offered at primary health care level. Out of the total of 154 reproductive and child health (RCH) sites in Zanzibar, PMTCT services are available at 39 sites (25%). Approximately 40,000 pregnant women attending ANC in Zanzibar were accessing PMTCT services in 2010 (Universal Access: Health
Sector Report on HIV Prevention, Care and Treatment Services in 2010, Zanzibar). Service coverage has steadily increased from 0% in 2004 to 25% in 2010 but this remains well short of the target of 100% coverage. The lack of universal coverage of PMTCT services means that a high number of women deliver without knowing their HIV status which increases the risk of transmission to their babies. This is further complicated by the high rates of home births (over 50%).

An estimated 1% of women seeking services test positive for HIV and 100% of enrolled clients for PMTCT receive Nevirapine. More efficacious treatment regimens are planned to be introduced by the end of 2009, with the revision of PMTCT guidelines and trainings of health care workers taking place at the moment. Currently, HIV exposed infants together with their mothers are given medical appointments within one week of delivery and the mother is asked to come with her child for additional visits 28 and 42 days after delivery.

A recent assessment of PMTCT services discovered that only a few providers include infant feeding in the information given to HIV-positive mothers, and even fewer are clear on the importance of post-test counselling for HIV-positive mothers in relation to infant feeding (ZACP, 2009). Similarly, only 22% of health facilities offering the minimum package for preventing HIV in infants and young children had specific guidelines on how to make referrals to facilities offering long-term care and support services (ZAC, 2007b). There is also a need to address stigma at health centre and community level. A baseline study conducted in 2002 showed that there is great pressure for mothers to breastfeed, potentially leading to HIV-positive mothers choosing mixed feeding practices (breastfeeding and other supplements) and infecting their children (MoHSW, 2002). A family-centred approach to HIV and AIDS needs to be adopted to increase male involvement in PMTCT services and to ensure that PMTCT services reach all eligible women in Zanzibar.

Primary prevention for in-school and out-of-school youth
Young people are recognised as a high risk group in Zanzibar due to their propensity to engage in risky behaviours – including early sexual debut, unprotected sex with multiple, often concurrent, partners, and substance use – coupled with low awareness of transmission risk. Prevention and behaviour change initiatives are mainly carried out through distribution of IEC materials, mass media (radio, TV) and peer educator programmes that function in and out of schools, at healthcare sites and at more targeted settings such as bars and hotels. In 2007-8, an estimated 4,574 peer educators worked in the communities in Zanzibar (ZAC, 2008a).

Life skills education has been offered in Zanzibar for over 15 years by relevant Ministries as well as national and international NGOs. It has been conducted in schools (public and religious) and in out-of-school settings. Whilst anecdotal evidence indicates that young people welcome life skills initiatives, no systematic progress or impact monitoring has taken place. To date, programmes have been largely delivered in an ad hoc, unsustainable manner. They have usually been short-lived (depending on donor funds) and have not been adequately monitored, especially in terms of their impact. The pedagogy of participatory teaching and learning has also to a large extent not been observed; both teachers and pupils in schools, for example, seem to be uncomfortable with participatory techniques.

The focus on abstinence only, especially in school-based programmes, is a concern in face of evidence that young people are engaging in sexual relations amongst themselves and that
teachers are initiating sex with students. Positively, a National Steering Committee for Life Skills was established in June 2009, comprising key decision makers from relevant ministries, national and international CSOs and development partners. The Committee is mandated to coordinate life skills initiatives throughout Zanzibar. In addition, a National Life Skills Education Framework is currently under construction to guide interventions.

Adequately funded, long-term interventions are required that follow children through the different stages of their lives, rather than ‘losing’ them once they leave school. To achieve this, greater emphasis needs to be placed upon the intensive training of older youth peer educators and teachers. Initiatives that target parents are also of crucial importance to build parents’ openness, confidence and capacity to discuss sexuality and other issues related to adolescence with their children. With the support of the UN Joint Team on HIV and AIDS, Zanzibar has recently developed a communication guide for parents and is in the process of producing a documentary on the same topic.

MARP-specific prevention efforts, including condom promotion and training in usage of condoms, need to be intensified. However, the environment is currently not conducive to primary prevention interventions such as needle exchange programmes for IDUs.

**Care and treatment centres**

Zanzibar follows the National Guidelines for Clinical Management of HIV/AIDS for the management of children and adults with HIV and AIDS. Care and treatment services are offered by five sites in Unguja and three in Pemba. However, CD4 machines are only available at Mnazi Mmoja Hospital in Unguja and at Chake Chake Hospital in Pemba. Nearly 4,000 PLHIVs were enrolled at care and treatment centres (CTCs), of whom 2,066 were on ART. Among clients on ART in 2010, 206 children below 15 (around 10%) were receiving treatment (Universal Access; Health Sector Report on HIV Prevention, Care and Treatment Services, Zanzibar 2010). The target is to enrol approximately 300 new clients per year on ART. According to ZACP, 84.5% of adults and children living with HIV were alive one year after initiation of ARV.

Paediatric HIV is integrated into existing IMCI and RCH services; if a child is diagnosed with TB or malnutrition, a HIV test is recommended but is not a routine test. If a child is diagnosed with HIV, s/he will be referred to care and treatment services. However, because of the high numbers of women delivering at home in Zanzibar (over 50%), and low coverage of PMTCT services infected children are less likely to be identified.

Early infant diagnosis is usually provided through sending dry blood samples of exposed infants (at four weeks of age) from healthcare facilities first to Mnazi Mmoja Hospital and then to Dar es Salaam for a DNA PCR HIV tests. There are often delays in receiving the results (minimum six weeks, but could take over eight weeks), which may lead to the drop out of some infants from care and treatment programmes.

**HIV and AIDS mitigation services**

According to the ZAC’s Annual Monitoring and Evaluation Report for 2006-07 (ZAC, 2007b), a total of 5,393 MVC received basic external support, including educational support (2,644), food and shelter (815), and emotional support (1,934). Based on the estimated number of 90,000 MVC in Zanzibar (RGoZ, 2009a), less than 10% were reached with support. Income generation activities (IGAs) were also promoted among PLWHA, unemployed youth and
MVC where appropriate, but data on the exact numbers of recipients and types of IGAs are not known. In addition, 8,695 vulnerable households were supported with food, shelter, medication, IGAs and psychosocial support. The 2006-07 M&E Report acknowledges that “the elderly, widows and widowers were sometimes forgotten by the AIDS response” (ZAC, 2007b). This could have serious implications for children being cared for by the elderly and the widowed.

Support to HIV-infected or affected children must be part of a response continuum where specific assistance is given to the relatively small number of extremely vulnerable children (including children with disabilities, abused children, children without adult support) and the government puts in place adequate social protection systems across all sectors including health, education and social welfare. In relation to HIV and AIDS, the MVC response needs to be holistic, encompassing prevention, care and treatment. The focus should be keeping parents and caregivers alive in the first instance and then mitigating parental death by enabling caregivers to secure economic and social resources to provide for children’s protection and care (Richter and Sharma, 2006).

Home-based care services, informed by the National Home Based Care (HBC) Guidelines, are provided by trained volunteers contracted either directly by ZACP or attached to NGOs such as the Zanzibar Association of People Living with HIV and AIDS (ZAPHA+). However, these services currently reach only 10% of the estimated number of adults and children living with HIV. Cash transfer mechanisms have been proven to work elsewhere and need to be seriously explored in Zanzibar.

6.4 Fiscal space

Zanzibar’s HIV and AIDS response is donor-dependent with funding from the World Bank, the Global Fund, the US Government, United Nations and other bilateral partners. Donor income accounted for 96% of actual expenditure in 2005/06 and 92% in 2007/08. This signifies sustainability challenges, especially for the period beyond 2010 for which only a fraction of HIV funding has been secured. According to a recently completed Health Sector Strategic Plan, HIV-related costing suggests that there is a 95% funding gap in delivering the health sector HIV strategies defined in the plan (including development partner contributions up to the end of 2008) (RGoZ, 2009a).

Table 19: Relative contribution of all stakeholders to the HIV and AIDS response in Zanzibar, 2004/5 to 2006/7

<table>
<thead>
<tr>
<th></th>
<th>Budget 2004/05</th>
<th>Actual 2004/05</th>
<th>Budget 2005/06</th>
<th>Actual 2005/06</th>
<th>Budget 2006/07</th>
</tr>
</thead>
<tbody>
<tr>
<td>Govt expenditure as % of total public sector expenditure</td>
<td>9%</td>
<td>4%</td>
<td>5%</td>
<td>4%</td>
<td>11%</td>
</tr>
<tr>
<td>Donor funding as % of total public sector expenditure</td>
<td>91%</td>
<td>96%</td>
<td>95%</td>
<td>96%</td>
<td>89%</td>
</tr>
<tr>
<td>% of public sector HIV expenditure captured in government budget</td>
<td>9%</td>
<td>4%</td>
<td>5%</td>
<td>24%</td>
<td>11%</td>
</tr>
<tr>
<td>Donor funds channelled to CSOs as % of total expenditure on HIV</td>
<td>10%</td>
<td>16%</td>
<td>13%</td>
<td>19%</td>
<td>26%</td>
</tr>
</tbody>
</table>

6.5 Institutional frameworks

Government structures
The two key bodies in Zanzibar – the Zanzibar AIDS Commission and the Zanzibar AIDS Control Program – share similar mandates with their Mainland counterparts. Neither ZAC nor ZACP have clear operational procedures on how to execute their mandates and both face structural challenges that impact on their functions (Swasti Health Resource Centre, 2009). As Zanzibar develops its next multi-sectoral strategic plan for HIV and AIDS it is imperative that modalities are sought to streamline functions and minimise overlap between the two institutions.

At district and shehia levels the AIDS response is coordinated by District AIDS Coordinating Committees (DACCOMs) and Shehia AIDS Coordinating Committees (SHACCOMs). Despite attempts to formalise these structures, with the exception of a few particularly active committees, DACCOMs and SHACCOMs do not significantly impact the response to the epidemic. Both suffer from uncoordinated interventions and limited capacity in terms of financial and human resources. The inadequate representation of PLWHA on these committees has been raised as an issue by ZAPHA+.

Civil society participation
Civil society has a significant role in the response to HIV and AIDS in Zanzibar, in service delivery (prevention and home-based care) as well as in stigma reduction initiatives. NGOs and FBOs also play a crucially important role in ensuring the well-being of MVC, and civil society organisations are key partners in the MARPs-targeted response to HIV. NGOs such as the Zanzibar NGO Cluster (ZANGOC) and Zanzibar Youth Education Development and Environment Support Association (ZAYEDESA) attend to large numbers of clients seeking prevention information and VCT services. Zanzibar Association of People Living with HIV has over 1,000 members and carries out weekly support group meetings for PLWHA where issues such as positive living and nutritional support are discussed. ZAPHA+ is also in the process of establishing a VCT site.

In addition, ZAPHA+ runs a programme targeting children and young people aimed at building resilience and coping mechanisms among those infected or affected by HIV. With UNICEF support, ZAPHA+ has recently employed a youth worker to coordinate ZAPHA+ children’s support groups and to ensure adequate provision of psychosocial support. Other NGOs such as Zanzibar Association for Children’s Advancement (ZACA), Zanzibar Muslim Women’s AIDS Support Organisation (ZAMWASO) and WAMATA are also active in providing services for children infected or affected by HIV. NGOs such as ZAYEDESA and Zanzibar Youth Forum (ZYF) play a key role in reaching out to MARPs through peer educators and outreach programmes that target drug users and sex workers. NGO engagement with MSM has so far been minimal.

Religious leaders play a huge role in shaping opinions and advocating for behaviour change. HIV and AIDS education is carried out in mosques, churches and religious schools, and faith-based organisations have recently come together to form the Zanzibar Interfaith Association for Development and AIDS (ZIADA), which carries out HIV prevention sensitisation work, but also includes organisations that work with substance users. Religious
leaders and organisations will be crucial in creating an enabling and protective environment for work with MARPs, as well as for prevention strategies including comprehensive condom programming. They should be one of the main targets of lobbying and advocacy by government and development partners.

6.6 Priority areas and recommendations

Based on the evidence collected by this report, it is clear that the Zanzibari response to HIV and AIDS will have to undergo major changes in programming and funding allocations so that MARPs and those most vulnerable to the virus can be adequately reached with prevention, care and treatment, and impact mitigation interventions. The following priority areas and recommendations are proposed to strengthen the response to the epidemic:

- Strengthen data collection - more comprehensive data on MARPs and on the sexual behaviours of both women and men. The size of these sub-populations needs to be more accurately measured, and linkages and modes of HIV transmission between MARPs and the general population identified to enable the design of effective interventions.

- Adapt the policy and legal framework for HIV and AIDS to more closely reflect the realities of the epidemic and create an enabling environment where PLHWA and those engaged in behaviours traditionally considered immoral are protected and supported.

- Address stigma and discrimination related to HIV and AIDS, substance use, sex work and same-sex sexual relations at scale in religiously and culturally appropriate ways. Key community stakeholders, including religious leaders, need to be sensitised as a priority. Government institutions, civil society and networks of PLHWA need to promote prevention to reduce the risk of transmission and to fight stigma and discrimination.

- Review the impact of interventions targeting in-school and out-of-school youth. Interventions to target young people as a group are that is especially vulnerable to HIV infection need to be coordinated and appropriately targeted.

- Promote a family-centred approach that aims to increase male involvement in health, including HIV prevention, care and treatment, to ensure that all potentially affected family members receive appropriate services.

- Expand and coordinate interventions that target parents (prevention, sexual education, parent-child communication) and caregivers (impact mitigation).

- Systematically monitor and evaluate HIV and AIDS interventions, including those that target children. The M&E system should be strengthened (both through capacity building of the institutions responsible for gathering and analysing data and by improving data tools) to ensure that information on HIV and AIDS is captured and responded to.

- Strive for universal access to PMTCT and to enhance paediatric AIDS interventions

- Address the inadequacies in the current condom programming. Advocacy for the use of condoms as an effective prevention mechanism outside of marriages needs to take place strategically and with cultural and religious sensitivity.

- Integrate global evidence on programmes that work (particularly lessons learned in settings similar to Zanzibar) into the national response.

Evidence based interventions to combat HIV and AIDS

Stakeholders interviewed for this study stated that the Monitoring and Evaluation framework for HIV and AIDS is inadequate. It only captures quantitative programmatic data and does not fully integrate research, surveillance and financial information.

Weaknesses in data management deny opportunities for evidence-based interventions. The National HIV M&E operational framework recommends that surveys, including surveys of behaviour among the general population and among MARPs, and of the quality of HIV and AIDS health services, be undertaken every two years, but to date this is yet to happen.

The size of the MARP population is unknown, which makes it difficult to inform the design of interventions. Routine data collection needs to be strengthened from the district level up.
Chapter 7
Protection of children against abuse, neglect and exploitation

The abuse and exploitation of children, together with the different forms of violence they experience constitutes one of the most challenging problems facing Zanzibari society today. The true extent of child abuse and violence is not known because of a lack of comprehensive data, and because of the silence and stigma surrounding the issues. While there is little official information on the prevalence of abuse in Zanzibar, reports from professionals working in child protection and anecdotal evidence suggests that violence against children, sexual exploitation and abuse is a significant problem, occurring at home, in the workplace and at school. Support services for victims of violence and abuse are severely limited. Victims and their families struggle to access legal aid, health services or social welfare, the formal justice system has little capacity to deal with juvenile cases. In Zanzibar, sexual abuse is often considered a hidden crime and families often prefer to deal with cases within the household or community, and police frequently encourage that cases be dealt with in this way. National, district or shehia authorities are rarely involved.

The physical and psychological effects of violence, abuse and exploitation affect a child’s well being and development and are likely to influence the child’s behaviour and attitudes throughout their childhood and into adulthood. There has been growing recognition of the need to address child protection issues in Zanzibar and steps have been taken in recent years to improve the policy and legal instruments for the protection of children and to identify the most vulnerable children in need of basic social services. Recent initiatives to strengthen child protection include the establishment of local committees to identify MVC, the creation of a child protection unit within the Department of Social Welfare, and the commitment to improve the legal framework for protecting child rights through the passing of the Children’s Act. Nevertheless, violations of children’s rights are an ongoing reality.

The rights and well-being of children needed to be actively safeguarded at all points of the child’s life course, but the need for protection increases during middle childhood and adolescence as the child increasingly interacts with and is at risk from wider society. As the child’s experience of the world expands 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. Figure 26 illustrates some of the key protection needs of children from conception through to adolescence.

7.1 International instruments and domestic legislation for child protection


As stipulated by the Constitution of the URT, the Revolutionary Government of Zanzibar is bound by international treaties ratified by the Union Government and, as the executive body responsible for introducing legislation on the islands, is required to enact and enforce domestic legislation to give full force to the provisions of the UNCRC, ACRWC and Optional Protocols. As on the Mainland, however, large gaps remain in the legislative framework for the protection of children in Zanzibar. The extent to which Zanzibar’s laws correspond to these instruments is complicated by the haphazard development of child-related laws to date, with many different
Figure 26: Protection and the child’s life course

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

**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

**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

**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

**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

**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.**
sources of law preventing a coherent picture of the legal entitlements and rights of children. The legislative framework is particularly weak in relation to violence, abuse, neglect and exploitation of children, the provision of alternative care, and juvenile justice.

A new Children’s Act was approved during the first legislative session of the new Zanzibar Government of National Unity, following national elections in October 2011. Divided into 12 different chapters, the Zanzibar Children’s Act was developed after a process of national legislative reform that was led by the Ministry of Social Welfare, Youth, Women and Children Development with support from the Office of the Attorney General and UNICEF and included a programme of national consultation, community dialogue, communication activities and innovative approaches for ensuring child consultation and participation.

The development and effective implementation of comprehensive legislation protecting the rights of children can go a long way in helping the Revolutionary of Government of Zanzibar in meeting its obligations under international treaties such as the UN Convention on the Rights of the Child (UNCRC) and the African Charter on the Rights and Welfare of the Child (ACRWC) and in promoting the best interests of all children in Zanzibar.

The primary focus of the legislation is to develop a coordinated child protection system in Zanzibar to effectively respond to cases of violence and abuse and to better promote and protect the rights of children in conflict with the law. The new Children’s Act will establish procedures and practices and identifies the roles and responsibilities of national institutions. It will provide a clear access route for referral and coordinated response for child protection concerns and to link the child welfare and care system and criminal matters so as to better protect and promote the rights of all children. The Act also contains provisions relating to custody, guardianship, access and maintenance, foster care and adoption, children and health services and children in residential establishments.

The enactment of a Children’s Act represents a unique opportunity for the protection and promotion of children’s rights in Zanzibar. However, considerable efforts will be required to strengthen and expand the institutions responsible for enforcing provisions of the new law and to ensure increased coordination between all organisations working with children in Zanzibar.

7.2 A conceptual framework for child protection

All children have the right to protection from violence, mistreatment, 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
Figure 27: A conceptual framework for creating a protective environment for children

Figure 27: A conceptual framework for creating a protective environment for children

A Protective Environment for Children

- **Government commitment and prioritising**
  - 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

- **Legislation**
  - Skilled and committed professionals / duty bearers
  - Monitoring and reporting
  - Financing

- **Social Services and Referral mechanisms**
  - Alternative care
  - Identification of vulnerable children and offer of appropriate assistance

- **Capacity of family and community**
  - Children’s ability to protect themselves
  - Children’s lifestyle

- **Protective behaviours**
  - Protective infrastructure
  - Attitudes to violence, abuse and children

- **Open discussion and challenge of stigma**
  - Children’s scope to participate in decisions affecting them, freedom of expression and access to information
  - 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

- **Discrimination faced by girls and children on the margins**
  - Parenting / care approaches

- **Birth registration as a fundamental entitlement that enables a child to access other services**
  - Services for children in need of care – child laborers, trafficked children, those on the street, with disabilities, mental health problems, orphaned

- **A Protective Environment for Children**
  - Political will (National Government and donor partners)
out of chronic poverty also serves to protect children. Children’s patterns of resilience, their right to participate in decisions that affect their lives, and whether decisions are made in his/her best interests are important factors in building children’s capacity to better protect themselves. Figure 27 illustrates a conceptual framework for creating a protective environment for children.

Social and cultural attitudes and behaviours that protect children
While officially a secular state, the overwhelming majority of Zanzibaris are Muslims, and society and public life are strongly influenced by Islamic values. The protection of children is a paramount concern of Islam as well as international human rights law and the analysis of the situation of children in Zanzibar must take into account the cultural and social environment in which they live.

The concept of child protection recognises the importance of family and community networks as a first line of strategic safety net and looks to support rather than replace these customary arrangements in support of children in Zanzibar. The issue of childhood is at the core of the first Islamic objective, namely safeguarding children and immunising them against dangers and on this theme Islam introduces bountiful and precise laws. The framework for child protection in Zanzibar can draw on the fundamental principles of the Islamic tradition that exhort parents and caregivers to nurture and care for children, and to keep them away from what may harm their health, psychological and social condition. In this way, the child can grow into a righteous citizen who has a sense of belonging to his or her people, society and homeland.

Child protection interventions can be employed as a means of providing support for the vulnerable and marginalised children in society and can help complement existing religious and cultural beliefs and doctrines in supporting vulnerable children. While parental care is the primary foundation for providing protection for children and enabling them to enjoy their rights, society and state institutions have a crucial role that is no less important. It is on this concept of a shared responsibility and interest in ensuring the protection and development of all children in Zanzibar that an appropriate child protection response can be designed and implemented. Low status of women increases child vulnerability.

7.3 Status and trends

Birth registration
Article 7(1) of the CRC sets forth the rights of a child to be registered immediately after birth to promote and recognise the child’s legal identity. In Zanzibar, section 9(1) of the Birth and Death Registration Act 2006 established birth registration offices in all districts and shehias. Registration is required within 42 days of the birth of the child. In stark contrast to the Mainland, Zanzibar has demonstrated great progress in this area. In Unguja, 88% of children have birth registration. Among these children, 71% have received birth certificates and 17% are registered but lack a certificate. In Pemba, 65% of children have birth registration, of whom 51% have certificates and nearly 14% do not (TDHS 2010). The high levels of birth registration can be attributed to the political will to ensure that every person in Zanzibar is registered. The Government has introduced identification cards for all Zanzibaris and birth registration is an important component in the process of enabling children to get their National IDs.

Information on child protection in Zanzibar
Trends in child protection are difficult to observe, especially the extent of violence, abuse and exploitation. Data for analysis are lacking.

In many respects there is now a greater level of awareness of the children’s rights in society and among children themselves, but this has not yet translated into increased protection of the well-being of children in Zanzibar.
Child neglect and abandonment

Reported cases of child neglect and abandonment in Zanzibar for the years 2004/05 and 2005/06 were 65 and 67 respectively (MoLyWCD, 2006; 2007b). However, these official figures are likely to significantly under-estimate incidence. For single parents, the reasons reported for child neglect and abandonment include poverty and lack of support from the father of the child. Disinheritance of widows by the relatives of the deceased husband is also reported to contribute to the weakening of the capability of single mothers to provide care. For married women, reasons for abandonment include being in polygamous relationships and the husband’s inadequate income or unemployment.

State welfare services are currently inadequate and there is no provision for social assistance to vulnerable families. While the Spinsters and Single Parent Children Protection Act 2005 stipulates a duty of the father to maintain their children, the lack of enforcement procedures and appropriate identification of the responsible institution means that this law has little practical effect.

Evidence indicates an increasing trend in the use of residential care for children in Zanzibar. While the Department of Social Welfare is responsible for children in need of care and protection, in practice, its budget and operational mandate is limited to the maintenance of one residential facility for vulnerable children. The Department supports one orphanage situated at Forodhani, Stonetown. It is used for the care of orphans and other vulnerable children up to 14 years old. In 2005, 40 children (19 boys and 21 girls) were living at the facility. In 2006, this number had increased slightly to 44 children (21 boys and 23 girls) (RGoZ, 2009a). The Department of Social Welfare is currently collaborating with the Clinton Foundation to promote the development of children at Forodhani, whereby resident children will be provided with life skills and health education.

No government-sponsored facilities or services are available in Pemba or at regional or district levels. In reality, civil society organisations look after the largest number of children living in institutionalised care. In 2005, the number of children living in institutional facilities run by CSOs was 262 (199 males and 63 females); in 2006, the number had increased to 281 (218 males and 63 females). Civil society organisations working in the area of institutionalised care in Zanzibar include SOS, African Muslim Agency (AMA) and Istikama. These organisations work completely independent from the Department of Social Welfare with no existing procedures for supervision or guidance on implementation of minimum standards.

Corporal punishment

Corporal punishment is one of the major types of violence reported at home, in Madrassa and in schools in Zanzibar. While not included as a penalty under the criminal code, corporal punishment is permitted under the Education Regulations Act 1988. It is reported that physical violence is widely used in Zanzibar schools with little or no regard to stipulated guidelines and that the use of excessive force is a source of conflict between teachers and parents, in addition to teachers and students (RGoZ, 2005b). The use of corporal punishment has contributed to non-friendly school environments and can drastically affect levels of school performance and attendance.

Reasons cited for the use of corporal punishment in Zanzibar schools include overcrowded classes, double shifts, inadequate community support, the perception of teachers that corporal punishment is a part of local culture, and the lack of alternative types of discipline. While there has been some Government attempts to date to address corporal punishment including the introduction of child-friendly schools, these have been inadequate. A national legislative and policy response is urgently required to drastically reduce and ultimately eliminate this institutionalised form of violence against children.
Child marriage

Few reliable figures are available on the number of child marriages in Zanzibar, but available data suggest that the incidence is high. It is reported that the percentage of girls aged 15-19 years who are married in Zanzibar is 18.5% while the corresponding figure for boys is 1.2% suggesting that young girls tend to marry older men (Ministry of Labour, Youth, Women and Children Development). The percentage of women aged 15-19 years who are mothers or are pregnant with their first child in Zanzibar is 7.6% (TACAIDS et al., 2008). The marriage of young girls often occurs either as an arranged union to an older man or where a marriage is arranged as a consequence of a pregnancy where the girl is forced to marry the father of the child irrespective of the nature of their relationship. In some cases child marriage may be considered to have an economic motivation. Often a family’s decision to have a child married – be it a boy or a girl – is a survival strategy to relieve the family of what they perceive to be a financial burden in the face of acute poverty. Girls are considered to be ready for marriage on reaching puberty and girl child marriage is perpetuated for a number of reasons, many of which relate to traditional gender relations and the values assigned to women and girls in society. Marriage may reflect the value placed on a girl’s virginity and be regarded by parents as a means to prevent premarital sexual relations and pregnancy. It may also be perceived to afford a girl protection from HIV/AIDS and other sexually transmitted infections. However, adolescent girls rarely have the power or knowledge to negotiate safe sex with their husbands.

Zanzibar law is silent on the minimum age for marriage and the relevant operational reference is Sharia law which allows for the marriage of girls on attaining puberty. International human rights instruments ratified by Tanzania, including the CRC, ACRWC, the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) contain provisions relating to child marriage, including the right to choose freely a spouse and to enter into marriage only with free and full consent, the right to decide freely and responsibly on the number and spacing of children, and the right to have access to information, education and the means to exercise these rights.

Support for girls already married is also essential. This may be achieved by enhancing their access to education (including non-formal education programmes), by raising awareness of the health risks associated with early childbearing, by improving access to effective contraceptive methods, and by developing support structures for young mothers.

Child labour

The most recent data on child labour comes from the Integrated Labour Force Survey (ILFS) 2006 which estimates that 34,442 or 9.2% of children aged between 5 and 17 years in Zanzibar were engaged in child labour. Of this figure, boys constituted 51.6% and girls 48.4% (NBS [URT], 2007). The consequences of child labour on child welfare and development as documented in the ILFS includes poor progress in school; over 12% of children in Zanzibar dropped out of school temporarily and almost 1% were unable to attend school at all. Other reported consequences associated with child employment included physical, emotional and sexual abuse, poor health and injuries. An estimated 8,000 children were reported to be suffering from permanent disability as a result of work.

The main documented causes of child labour in Zanzibar include poverty, low quality of education, and perceptions of lack of relevance and low returns in educational investment. Inadequate preventive measures have been identified as contributing to the problem as well
as a lack of community awareness on the negative consequences of child employment and the absence of accessible alternatives. In addition, law enforcement agencies have limited capacity and accountability in dealing with the problem of child labour in Zanzibar.

The national response to child labour has so far included the Employment Act, No. 11 of 2005. Section 7 of the Act prohibits the worst forms of child labour. Section 8 outlines conditions for employing children and clearly states that any person employing a child who attends or is required to attend compulsory education is punishable by law. The Education Policy of 2005 establishes compulsory education of ten years (for children aged 6-15 years). In addition, an action plan for the elimination of child labour in Zanzibar was launched in 2009. However, systems and structures for addressing child labour in the Isles are still weak and government departments and district and shehia structures that have a mandate to deal with child labour have limited effectiveness and reach. Strengthening the institutional framework to address child labour issues should be given priority.

In the longer term, just as child labour is closely associated with poverty, so too reducing the burden of work on children depends on ensuring that children and their families, particularly the poorest, benefit from poverty reduction. For as long as work remains an economic necessity among children in some households, the Government should focus on ensuring economic activity undertaken is appropriate for the age and capacity of the child and in no way compromises his or her survival, health, education or development.

**Children living with disability**

Until recently, the 2002 population census was the only data source on disability status of the population in Zanzibar. According to census data, 1% of the population aged 0-18 years was classified as disabled – just over 5,000 children, a figure that was considered too low. The 2008 Tanzania Disability Survey sought to correct for this problem, using a definition and data collection methods widely seen as better suited to capture disability status. According to the survey, 5.9% of Zanzibaris were found to have activity limitations (compared to 7.8% for the Mainland). Further analysis of the TDS data suggests that approximately 3.5% of Tanzanian children are at risk of disability, a higher figure than revealed by the census but still low in comparison to other countries (NBS, 2011).

Stigma may lead to under-reporting and registration of specific disabilities, and mild forms of disability may go unnoticed or are not interpreted as disabilities. Different types of physical and mental disabilities may often remain undetected due to a lack of diagnostic capacities within health services. According to the 2002 census, most recorded disabilities were physical handicaps (40%), followed by mental handicaps (19%), multiple handicaps (14%) and speech/hearing impairments (13%).

Article 23 of the CRC requires that children with disabilities be entitled to the same rights and entitlements as children without disabilities. The RGoZ has a responsibility to ensure that children with disabilities have access to health and rehabilitation services as well as education, training and recreational opportunities. While progress has been made with the establishment of a department dealing with disability within the Chief Minister’s office, the Government still has considerable work to do in meeting its obligations under Article 23. Priority should be given to addressing the needs of disabled children through national policy and legislative action and developing and improving access to disability-specific social provision support and services.
Children in contact with the law

For children in contact with the law in Zanzibar, either charged with committing offences or as witnesses in court, there is a serious lack of appropriate protection of their basic human rights. Little reliable information exists on the situation of children in contact with the law, but all available evidence suggests that the current system does not afford these children protection in line with the minimum standards enshrined in international instruments including the CRC (Articles 37 and 40), the Beijing Rules for the Administration of Juvenile Justice (1985) and the Riyadh Guidelines for the Prevention of Juvenile Delinquency (1988).

The justice system in Zanzibar suffers from many gaps of coverage, lacks adequately trained staff and the court infrastructure is minimal. There is no provision for legal representation for children before the courts and no system for the application of the principle of diversion or restorative justice in line with international standards and guidelines. The relevant legislation concerning juvenile justice is the outdated Children and Young Persons Decree 1958.

Adherence to juvenile justice laws and child protection mechanisms remain unclear. There is no separate residential facility for children in conflict with the law and the prison conditions they endure, whether on remand or following sentencing are in direct violation of their rights. Child inmates are not separated and often share rooms with adults, exposing them to abuse and violence.

One of the key focus areas of the new Children’s Act is children in conflict with the law. Part 5 of the Act seeks to reform the system for juvenile justice in Zanzibar with the objective of ensuring that children in conflict with the law as well as child victims and witnesses are dealt with in accordance with the principles of due process and in recognition of their rights. Significant investment in terms of technical training and capacity strengthening will be required for the effective implementation of provisions relating to building a system of justice for children in contact with the law that meets international obligations and standards.

Children in emergencies

Zanzibar is prone to both chronic and sudden onset emergencies, including food shortages, disease outbreaks (notably cholera) and natural disasters such as flooding. A recent disaster included flooding caused by heavy rains in 2004, which completely submerged several hundred houses and destroyed infrastructure in six Shehias. Approximately 150 families were rendered homeless and were provided with temporary accommodation in three schools. The damaged infrastructure included five bore holes which affected access to water in the disaster areas (IFRC, 2005).

In an emergency context, the protection of children is a particular challenge as such situations can lead to increased reliance on negative coping strategies, reduced access to basic social services or the displacement of children from their families. In addition, an absence of accountability can mean that the very people responsible for the protection of children may become their abusers.

The Zanzibar Government and development partners have implemented various measures to strengthen emergency response. These include the establishment of the Department of Disaster Management within the Office of the Chief Minister, the drafting of a national policy and the ongoing development of a national emergency operational centre and a national emergency preparedness operational plan. It is necessary that these initiatives take into account child protection concerns in framing the national emergency response. Efforts need to be taken...
to train emergency response officers on issues surrounding sexual abuse and exploitation of children and to support community-based surveillance systems for the monitoring of child rights. There is a need, in addition, for ongoing advocacy and social mobilisation around the vulnerability of children in times of emergency.

**Child trafficking**

The trafficking of children removes them from the protective environment of their family and increases their vulnerability to child labour, violence, sexual exploitation and abuse. There is a significant absence of evidence or data relating to child trafficking in Zanzibar. Anecdotal evidence indicates that child trafficking does occur within Tanzania and that it is generally domestic involving the movement of children between different regions. According to the International Organisation for Migration (IOM), Zanzibar along with Dar es Salaam are becoming the main destinations for child trafficking with sexual exploitation and domestic work mentioned as the main reasons that children are trafficked to the Isles. It is reported that trafficked children are more likely to come from rural areas and foster families and that factors of vulnerability to trafficking, include non-enrolment or dropping out of school, death of parents, and lack of family or community support.

**Box 4: The impact of gender inequities on child well-being and rights**

The low status of women in Zanzibar means that they are significantly disadvantaged in their access to health and education services, access to information and their capacity to influence decisions regarding their own welfare and that of their children. There are also significant disparities between Unguja and Pemba with regard to the situation of women that directly or indirectly influences the welfare of their children.

Women in Pemba give birth to more children than their peers in Unguja. By contrast, recent years have seen major changes in the percentage of girls in Pemba who have begun childbearing by age 19, so that they now tend to begin childbearing later than girls aged 15 to 19 years in Unguja (Table 20). It is likely that fertility levels are influenced by the lower education, low literacy and lower access to media among women in Pemba. While men in Pemba are better off with regard to education, literacy and access to media than women, they are significantly disadvantaged in comparison with men in Unguja (Table 21).
Box 4: The impact of gender inequities on child well-being and rights (cont.)

Table 21: Educational attainment of men and women in Zanzibar, by island, 2010

<table>
<thead>
<tr>
<th></th>
<th>Unguja</th>
<th>Pemba</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Women</td>
<td>Men</td>
</tr>
<tr>
<td>No primary education</td>
<td>10.10%</td>
<td>3.00%</td>
</tr>
<tr>
<td>Incomplete primary education</td>
<td>13.70%</td>
<td>17.10%</td>
</tr>
<tr>
<td>Unable to read</td>
<td>11.70%</td>
<td>7.20%</td>
</tr>
<tr>
<td>No media (no radio, TV, newspapers)</td>
<td>16.80%</td>
<td>2.20%</td>
</tr>
</tbody>
</table>

Source: TDHS 2010.

It is also telling that nearly 60% of women in Unguja and 50% of women in Pemba do not have the final say in decisions regarding their own healthcare. Moreover, four out of every five women on both Unguja and Pemba report that they do not have final say over daily household purchases.

The low status of women in Zanzibar severely limits their ability to protect their children, especially their daughters, from violence and abuse. Women in Zanzibar who are victims of rape receive very little support through the legal system. While all efforts to promote the survival, development and protection of children need to take the status of women into account, concerted efforts by the government and partners must engage men as partners in the empowerment of women as a core strategy for Zanzibar development.

7.4 Child-centred approaches to improve well-being and safeguard rights

Child participation

Structures and systems that provide opportunities for freedom of expression and access to information by children are limited in Zanzibar. However, there have been efforts by civil society organisations to establish children’s forums, including 100 Children’s Clubs (60 in Unguja and 40 in Pemba) established by Save the Children. The clubs provide space for teenagers to exchange ideas and access information on life skills. The drawback of these clubs is that they are supported by NGOs and not integrated into government structures.

The views and concerns of children have also been captured in a recent study conducted by Save the Children. The research found that protection issues are important for children in Zanzibar. Children want an end to corporal punishment, forced marriages, blaming children who have been abused, and to discrimination against children and families affected by HIV and AIDS. Children are willing to work to help their families but they cannot do work that is too hard for them (Save the Children, 2009).

Developing the skills to keep oneself safe

Youth face challenges protecting themselves from unintended pregnancies, unsafe abortions, sexually transmitted infections, and sexual violence and coercion. Although HIV and AIDS prevalence is much lower in Zanzibar than on the Mainland, unsafe sexual behaviour and drug
use pose high risks to adolescents. Early pregnancy is linked to low school completion rates for girls and unmarried pregnant girls face stigma and discrimination.\textsuperscript{4}

The education system has a role to play in helping children, especially girls, to keep themselves safe. Young people often do not possess the right information, have no access to reproductive health services and lack the self-esteem and the assertiveness to remain safe and responsible. Life skills education is one mechanism that supports the development of physical, emotional and mental well-being.

The Ministry of Education and Vocational Training (MoEVT) in Zanzibar has been running life skills training using a peer education programme, and 92 better health clubs have been formed across Zanzibar, which are managed by school children, to provide information on HIV and AIDS issues. Additionally, the MoEVT has developed a unified life skills training manual to be used by all stakeholders supporting life skills education.

**Strengthening national child protection services**

To date in Zanzibar, child protection systems and services have been uncoordinated and fragmented among different national institutions. The national capacity to identify and respond to cases of violence and abuse is severely limited and victims and their families struggle to access support services, whether legal, health or social welfare. The present situation has been exacerbated by the fact that there is no clear access route or referral pathway for those support services which are available to victims and their families. This uncoordinated approach has had significant implications in relation to service delivery for victims of abuse. According to the 2009 survey of violence against children, little more than one in ten girls and one in 20 boys who experienced sexual violence prior to age 18 reported that they received support services.

The government restructuring process that has established the new Ministry of Social Welfare, Youth, Women and Children Development extends a significant opportunity to create a clear focal point for the protection of children in Zanzibar. The District Social Welfare Officers and the Women and Children Officers represent the two departments dealing with child protection at the district level. However, there is a weak capacity to respond to child protection issues, with district staff sharing many of the challenges experienced at the central level: inadequate training, lack of procedures, systems and support structures for reporting of and responding to child protection concerns. While district child rights committees have been established by the DWCD, in practice their operation is extremely limited. Where they exist, these committees are not supported by a legislative framework and they lack the legal mandate to enforce decisions on reported cases of violence, abuse and exploitation against children. In reality most child protection concerns are dealt within informal community structures or are reported to local Khadi Courts, which are conducted in accordance with interpretations of Sharia law and relate to personal legal matters such as marriage, polygamy, divorce, inheritance, custody and guardianship of children. However, this legal system operates with a minimum level of supervision and has a severely limited capacity to provide a child friendly environment or respond effectively to child protection concerns.

\textsuperscript{4} In the 2010 Budget session, MoEVT reported to the House of Representatives 40 cases of teenage marriages, 44 cases of teenage pregnancies as well as eight cases of rape involving school girls. Caution, however, is needed in interpreting these figures as neither MoEVT, nor MoHSW or the police has fully and accurately documented the true extent of the problem of child rape and teenage pregnancies or marriages among the school-age population.
The institutional capacity for child protection in Zanzibar is still weak; inadequate financial and human resources are often cited as main reasons. In recent years, the entire budget allocated to the Department of Social Welfare that has been earmarked for children—less than a quarter of its overall budget—is spent on social provisioning for children at the Forodhani children’s residential facility in Stonetown. This means that the Department has no budget for child protection, which is why there are few, if any, child protection interventions within its workplan. At the district level, control and spending of the entire budget for the social welfare officers is decided not by the DSW, but depend entirely on the discretion of the District Commissioners. This has severely constrained implementation of their child protection and social provisioning roles at district levels.

There has, however, been progress on developing consensus on the recognition of a need to build national capacity in relation to child protection services and to achieve a concerted effort in building awareness of the Department of Social Welfare as the appropriate agency with the mandate to coordinate child protection services.

UNICEF and Save the Children, in collaboration with other development partners, are currently working to help build the child protection capacity of the DSW. The Department has established a Child Protection Unit at the central level, which provides a safe space for dealing with specific cases of abuse against children and coordinates child protection services on the Isles. UNICEF is further assisting the Department to draft National Guidelines that will outline the national child protection response and help in identifying and reporting child abuse and improve professional practices in both statutory and voluntary organisations that provide services to children and their families. UNICEF and Save the Children are also providing training and developing manuals to strengthen the capacity of DSW staff to deal with cases of child abuse. To fulfil its child protection mandate the Department of Social Welfare will require a concentrated investment in terms of technical, financial and human resources.

### 7.5 Social protection for most vulnerable children

A broad but limited policy framework for most vulnerable children has been developed in Zanzibar. The Zanzibar Strategy for Growth and Reduction of Poverty aims to improve the equality and the quality of growth by ensuring that resources reach the most vulnerable groups in society. MKUZA recognises that few and weak safety nets for vulnerable groups are currently in place. Youth, orphans, neglected children and those infected and affected by HIV and AIDS are identified as important target groups under MKUZA and there is an express commitment under Cluster II of the strategy to ensure access to basic social services and the design of social protection and safety nets for these vulnerable groups.

The challenge, however, is to make these policy commitments a reality for children in Zanzibar. A situation analysis of MVC in Zanzibar carried out by the Department of Social Welfare estimated the number of vulnerable children to be 93,640 in 2008 (RGoZ, 2009a). The characteristics used to identify vulnerable children in Zanzibar are similar to those employed in Mainland Tanzania. They include:

- Children from very poor families
- Orphans
- Children living with sick parents and or caregivers living with HIV/AIDS
Other pertinent factors considered include the age of caregivers and the level of household vulnerability, for example, income, shelter, assets (including bedding, household equipment, clothing and school uniforms).

The characteristic of MVC in Zanzibar is extreme poverty without access to necessary support structures. The challenges typically facing vulnerable children outlined in the situation analysis include:

- Limited access to basic services (such as health, education, food, legal, financial and psychological services);
- Very limited choices of livelihood strategies and means of generating income;
- Reliance on negative coping strategies, such as early marriage and exploitation of children including child labour;
- Lack of support structures and heavy responsibility for children, especially those who are heads of households, for the survival and well-being of other household members of the household.

In addition to these challenges, children that are made vulnerable as a result of HIV and AIDS are often forced to live with the social stigma and discrimination and potentially face expulsion from their communities with the extended family unit.

The analysis concluded that the response to MVC has been unsatisfactory with little improvement in the living circumstances of vulnerable children. The reasons identified included:

- Lack of social protection interventions due to inadequate mainstreaming of MVC issues in government strategic plans and budgets
- Inadequate or no financial resources allocated to MVC responses at ministry, department and district level. Interventions to meet the social protection needs of vulnerable children in Zanzibar are expected to be met by communities, local NGOs, religious institutions and development partners.
- Inadequate human resources allocated to work on MVC issues and lack of capacity and training opportunities for existing staff.
- Unclear mandate between government departments in responsibility for addressing and responding to MVC issues.

To improve coordination and implementation, the Department of Social Welfare, with the support of development partners, is developing a national social welfare policy and MVC plan of action to articulate a comprehensive set of mechanisms for the social protection of most vulnerable children at the national level.
7.6 Fiscal space
Inadequate financial and human resources are often cited as significant factors contributing to weaknesses in the child protection system in Zanzibar. The Department of Social Welfare has received a meagre 2% of the budget of the Ministry of Health and Social Welfare for the last five years (Table 22).

Of the DSW budget, less than one-quarter is allocated to children and is spent on the Forodhani children’s home. Children at Forodhani are budgeted for pocket allowance (in 2008/09, the allowance was 7,000 Tsh per child per month) and for food and other non-food material support. They are also provided with a bank account where half of their pocket money is preserved for them until they are 17 years old and ready to start living independently. Such financial support does not exist for other children in Zanzibar that may be facing the same problems. This indicates that DSW does not currently have funds for child protection or other forms of alternative care.

At district level, the budget for district social welfare officers is under the control of the District Commissioner not the DSW, and decisions for expenditure on child protection are entirely at the discretion of the District Commissioner. The low priority given to the social welfare department at national and district levels has severely constrained implementation of child protection and social provisioning.

The Department of Women and Children (DWC) in the MLYWCD has received around 11% or less of the Ministry’s budget over the period 2002-2007. This small budgetary allocation is another contributing factor towards a lack of focus on child protection. However, an underlying cause, especially at the lower levels, is that civil servants are not been able to translate policies into costed plans and interventions to protect to the best interests of children (RGoZ, 2009a).

Table 22: Budget allocations for children in Zanzibar, MoHSW and MLYWCD, 2002/03-2006/07

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Total MoHSW Other Charges budget (Tsh millions)</th>
<th>DSW budget for Other Charges (Tsh millions)</th>
<th>Budget for children at DSW (Tsh millions)</th>
<th>DSW budget as (% of MOHSW)</th>
<th>Budget for children as (% of DSW)</th>
<th>Total MLYWCD budget (Tsh millions)</th>
<th>DWC budget (Tsh millions)</th>
<th>DWC budget as (% of MLYWCD budget)</th>
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<td>2006/07</td>
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<td>2005/06</td>
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<td>119.2</td>
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<td>2</td>
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<td>547.9</td>
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<td>813.0</td>
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<td>2003/04</td>
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<td>108.0</td>
<td>14.8</td>
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<td>932.2</td>
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<td>11</td>
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<td>2002/03</td>
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<td>78.5</td>
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<td>443.6</td>
<td>39.0</td>
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7.7 Institutional framework
An enabling environment is one of the critical requirements for protecting children. Such an environment consists of legislation, policies and organisational structures that put children’s best interests first and invest in services that protect children. In addition, mechanisms and processes are required to ensure that children receive a coherent and integrated package of services and are treated by sensitive and skilled professionals.
To date in Zanzibar, child protection systems and services have been uncoordinated and fragmented among different national institutions. The capacity to identify and respond to cases of violence and abuse is severely limited and victims and there is no clear route of access or referral pathway to support services for victims and their families.

Under the new Children’s Act 2011 and the National Guidelines for the Protection and Welfare of Children in Zanzibar, the Department of Social Welfare is identified as the appropriate responsible body with the mandate for coordinating the necessary response and providing support services for children and their families. While different institutions will continue to play a key role in providing support services to children who are victims of abuse all child protection responses will be streamlined under the mandate of the Department of Social Welfare.

To fulfill this mandate the Department of Social Welfare will require a significant strengthening of its capacity and a concentrated investment in terms of technical, financial and human resources will be necessary for the effective operationalisation of these National Guidelines. Intensive human resource and capacity development is required to increase the quantity and quality of social workers throughout Zanzibar.

UNICEF and Save the Children, in collaboration with other development partners, are working to build the child protection capacity of the DSW by providing child protection training for staff and developing professional manuals. UNICEF is also assisting the department to draft national guidelines. The guidelines will outline the national child protection response, assist people to identify and report child abuse in Zanzibar, and improve professional practices in both statutory and voluntary organisations that provide services to children and their families. It is envisaged that the publication of the guidelines will be accompanied by a targeted national training strategy aimed at building and improving the child protection capacities of staff working within key national services.

7.8 Priority areas and recommendations

The following priority areas for improving child protection in Zanzibar have emerged from the analysis.

Implementing the Children’s Act

The government’s commitment to develop a Children’s Act represents a significant opportunity to improve the environment for the protection of children in Zanzibar. A single law provides a sound basis to meet obligations under international law and creates a focal point for children’s rights. There is now a responsibility on the Revolutionary Government of Zanzibar to ensure effective implemention of the new legislation through the development of rules, regulations, and a national plan of action.

Mainstreaming child protection within the planning and budget allocation process for the Zanzibar Strategy for Growth and Poverty Reduction (MKUZA)

The development of the second phase of MKUZA represents a significant opportunity to mainstream child protection into the national development agenda. UNICEF in collaboration with other stakeholders should provide a guiding conceptual framework including child protection indicators and targets to inform the development of MKUZA II strategy and its M&E framework. Efforts are also required to increase budget allocations for child protection in key ministries, and to establish comprehensive, periodic analysis of budget mechanisms, allocations and expenditures relating to child protection.
**Strengthening the child protection capacity of government at national and district levels**

The analysis shows that significant, sustained investment is required to strengthen the institutional capacity for child protection at national and district levels. To fulfill its child protection mandate, the Department of Social Welfare will need technical and financial assistance together with greater human resource support. At district and shehia levels, child protection structures with defined and legally binding mandates, roles and responsibilities will need to be established, and be provided with both human and financial resources, mentoring and training, and implementation guidelines.

The appropriate roles of the Department of Social Welfare vis-à-vis the Department of Women and Children must be clarified. While different institutions will continue to play important roles in providing support to children with protection needs, the national response should be the mandate of the DSW to ensure coordination and efficiency of interventions.

**Implementing social protection interventions for Most Vulnerable Children**

Programmes for the identification of vulnerable children in Zanzibar need to be carefully designed with in-built review systems that strengthen accountability and transparency of interventions. Protective measures, such as cash transfers, give households the flexibility to cover expenditure on essential family needs as a pre-condition to benefit from other social protection schemes, which focus on access to basic services, such as health or education. Any cash transfer scheme in Zanzibar should include the disbursement of grants to benefit MVC directly, systematising the mechanism in place for their delivery and ensuring optimal social provisioning and coverage.

To enable accurate identification of vulnerable children and design of social protection programmes, reliable data on children, disaggregated by sex and other relevant variables, must be routinely collected to show disparities in outcomes and remove barriers to access to basic social services.

**Strengthening data collection on child protection**

Little information is available on many aspects of child protection in Zanzibar, including the nature, causes and extent of violence against children, sexual abuse and exploitation of children, including trafficking, and children in contact with the law. Systems for routine collection and monitoring of child protection indicators need to be developed at both district and national level to enable government and non-government stakeholders to build a more protective environment for children.

The Ministry of Labour, Youth, Women and Children’s Development, in collaboration with UNICEF and the Centre for Disease Control (CDC), has undertaken the first national household survey on violence against children in Zanzibar. There are many other areas where better data collection is needed to form a more complete picture of the child protection challenges in Zanzibar.

**Developing a national child protection communication strategy**

This analysis highlights a lack of awareness of child rights and protection in Zanzibar. A national communication strategy would be an important tool to disseminate information, mobilise communities and promote social behaviour change to better protect children. The strategy will need to be sensitive to Zanzibari cultural practices and attitudes, and use a variety of communication channels which are accessible to communities, such as children groups and radio networks.
Chapter 8
The Children’s Agenda

The vision of an economically prosperous Zanzibar 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 2020—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. 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 Zanzibar over the next decade.

This report has highlighted areas where progress has been made in securing the rights of children and women in Zanzibar, 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 Zanzibar’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 Zanzibari children. The choice of the investments is the result of thorough fact-finding and analysis, and broad consultation with Government, leading children’s organisations and children from across Tanzania, including Zanzibar. It provides a platform for future policy setting.

Mindful that investing in children is tantamount to investing in Zanzibar’s present and future, it is hoped that the Children’s Agenda will not only inform the roll-out of the second phase of MKUZA over the period 2010-2015, but also the Party Manifestos of the key contenders in the national election in October 2010 and beyond.

1. Invest to save the lives of women and children

As on the Mainland, under-five mortality has declined steeply since 1999 in Zanzibar. For the five-year period preceding the TDHS (circa 2006-2010) the under-five mortality rate for Zanzibar was estimated at 73 deaths per 1,000 live births, although the rate on Pemba (84 deaths per 1,000 live births) is over 25% higher than Unguja (65 deaths per 1,000 live births). These gains are largely attributable to malaria control interventions, including more widespread use of ITNs and residual spraying, as well as better treatment, particularly the roll-out of rapid diagnostic tests and the early introduction of combination therapy. The introduction of universal Vitamin A supplementation from 2005 has also contributed, and vaccination rates are slightly higher than the Mainland. If this trend has continued since 2007, it is likely that Zanzibar has already achieved the 2010 targets for infant and under-five mortality set by the first phase of MKUZA.

However, also like the Mainland, neonatal mortality (deaths in the first 28 days following birth) remains high, and now accounts for nearly 40% of under-five deaths. Newborn deaths are inextricably linked to the health of the mother during pregnancy and at delivery. A recent study found that facility-based maternal mortality was still very high at 450 deaths per 100,000 live births and this figure does not include women who died during births at home. Only 49.2% of births take place at health facilities, and the rate of skilled attendance
at birth is only slightly higher at 54%. Most maternal and newborn deaths could be averted with universal access to quality obstetric care at delivery, and the adequate management of common neonatal complications including preterm delivery, infections and birth asphyxia. Progress on maternal and neonatal health will be vital if MDG4 and MDG5 are to be achieved in the Isles.

What is most needed?

• Increased availability of basic and comprehensive emergency obstetric care and neonatal interventions at health facilities together with rapid referral systems to avert maternal and newborn deaths.

• Further progress in malaria control, including expanded coverage of long-lasting insecticidal nets, indoor residual spraying, intermittent preventive treatment of malaria during pregnancy, and artemisinin combination therapy

• Universal childhood vaccination

• Completion of the roll-out of facility-based Integrated Management of Childhood Illnesses (IMCI) and design and implementation of a community-IMCI programme

• Routine counselling during antenatal and post-natal care on breastfeeding, infant and young child feeding practices, and the prompt treatment of diarrhoea using oral rehydration solution (ORS).

• 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

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 a major contributing factor in child deaths.

Exclusive breastfeeding initiated within one hour of birth and continuing for six months is the most effective life-saving intervention. 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. However, early weaning and giving pre-lacteal feeds, which are known to be a major cause of diarrhoea during infancy are still common practices in Zanzibari households. The latest data also show an exclusive breastfeeding period of only 15 days. 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.

Since the 1990s, malnutrition among children under-five years in Zanzibar has decreased significantly; between 1992 and 2004/5 the incidence of stunting, underweight and wasting were roughly halved. Extrapolating the current trend suggests that Zanzibar will meet the MDG target of halving the proportion of underweight children by 2015. Much though remains to be done; almost one in three (30%) of Zanzibari children under-five years are stunted, stunting is higher in Pemba (32%) and children in the poorest quintile are more than three times more likely to be stunted than among those in the least poor quintile. Rates of malnutrition and anaemia among women in Zanzibar are also considerably higher than the Mainland, 13.9% of Zanzibari women are malnourished (Mainland 11.3%), and 58.7% of women of reproductive age are anaemic (Mainland 39.5%).
Anaemia and vitamin A and iodine deficiencies are also common among women and children, though the prevalence of anaemia has fallen recently as a result of better malaria prevention and treatment. 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%.

**What is most needed?**

- Investment in proven, effective nutrition interventions for women and children: promotion of breastfeeding and complementary feeding practices, vitamin A and zinc supplementation, prevention and control of anaemia, food fortification and management of severe acute malnutrition. For children, priority must be given to interventions during the most vulnerable period of a child’s life, beginning in pregnancy up to two years of age.
- Scaled up coverage of nutrition services to ensure disadvantaged areas and groups are better reached.
- 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.
- Multiple communication channels/nets 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. Men and older women who have influence over household decisions should be engaged in facility- and community-based nutrition initiatives.

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 (especially for girls) and decreased costs for hospital services — an astonishing return on investment. 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.

The TDHS 2010 found that 79.5% of Zanzibari households have access to clean, safe water, a much higher proportion than on the Mainland, but access is much lower on Pemba and in rural parts of the islands. Sanitation is more problematic; a third of households overall and over half of all rural households do not access to even a basic latrine. Data is not yet available on the sanitation and hygiene situation in Zanzibar’s schools and health facilities, but the situation is likely to be similar to the Mainland, that many schools and facilities do not have latrines and hand-washing facilities.

Unlike water, sanitation and hygiene are still to capture the attention of policy makers, donors and the public. 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%. The development of an Environmental Sanitation Policy for Zanzibar is an opportunity to raise the profile and investment in this critical sub-sector.

**What is most needed?**

- Training and 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 shehia 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, where required improved on-site water supply.
- Specially designed sanitary facilities that are accessible to children with disabilities.
- Integration of basic hygiene education into maternal health services and the curriculum in schools.

**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. 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.

Momentum is building to increase early childhood investments. Early Childhood Care and Development is included as one of MKUZA II’s core cluster strategies for education. The strategy aims to develop and implement an integrated ECD policy by 2012, and to increase net enrolment for preschool from 20.1% in 2010 to 50% in 2015.

**What is most needed?**

- Gender-sensitive and child-friendly ECD programmes. Relevant, appropriate and gender-responsive care is needed, especially to vulnerable and disadvantaged children with special needs.
- Equitable access to quality pre-school education for all children at the age four and five.
- Education of parents and leaders at all levels on the crucial role that ECD has on child well-being and on poverty reduction.
• 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.
• Establishment of a training college for pre-primary teachers.
• 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
Poverty undermines access to education, particularly if families perceive the indirect and opportunity costs incurred by to outweigh the benefits of continued schooling. Therefore, beyond access to education, the quality of tuition and the relevance of the curriculum to future livelihoods are of paramount importance. The Zanzibar Education Policy 2006 seeks to make 12 years of education compulsory for all children: two years of pre-primary, six years of primary and four years of secondary. But much remains to be done to make this ambitious policy a reality for Zanzibari children.

In 2008, the gross enrolment rate in primary schools was close to 100%, but the net enrolment rate was almost 80%, indicating that children are not starting school at the prescribed age or high dropout rates. Almost all districts achieved gender parity. However, net enrolment rates are much lower Pemba and in rural areas. The number of primary school teachers has also not kept pace with the increase in student numbers leading to overcrowded classrooms. The overall pupil-teacher ratio (PTR) at 30:1 is much lower than the Mainland but teachers prefer to be located in the more urbanised districts and so rural areas are under-served. Despite the low PTR, approximately two-thirds of Standard 6 pupils did not reach a ‘minimum’ level of mastery in reading, writing and numeracy. Moreover, when tested using the same questions, only 80% of teachers reached a ‘desirable’ level of mastery. There are also few skilled teachers in mathematics and science leading to high PTRs or classes being taught by teachers not trained in these subjects. In Micheweni district there are only two trained secondary mathematics teachers, giving a ratio of over 1,900 for each teacher.

What is most needed?
• Better teacher training and incentives to attract teachers to serve in difficult or remote areas.
• More classrooms equipped with adequate facilities including latrines, and teaching and learning materials.
• Promotion of child-centred teaching and learning methods. Active learning in the classroom will improve student-teacher relations and motivate more students to complete their education.
• Non-formal educational options for children on the margins, such as working children and the disabled.
• Promotion of parental, community and children’s involvement in school decision-making, planning and monitoring to 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 performance, and often leads to children abandoning school.

While not included as a penalty under the criminal code, corporal punishment is permitted under the Zanzibar Education Act 1982, and it is reported that physical violence is widely used in madrassa and schools. While there have been some Government attempts to date to address corporal punishment including the introduction of child-friendly schools, a national legislative and policy response is urgently required to drastically reduce and ultimately eliminate this institutionalised form of violence against children.

Sexual abuse and transactional sex in schools is a growing concern. Sometimes girls are sexually exploited by teachers in exchange for higher or passing grades or reduced punishment. 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 2010 found that about 38.8% of men and almost 54.5% of women believe that men have the right to beat their wives. Many parents likewise condone teachers beating 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.
• 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

Young people can face a heightened risk of contracting HIV due to their engagement in risky behaviours – early sexual debut, unprotected sex, and experimentation with drugs – but also due to low awareness of risk of HIV transmission. Among adolescent women surveyed by the THMIS 2007/8, over one in five (22%) reported having had sex before the age of 18, but only 10.4% of women and 14.8% of men aged 15-24 years used a condom at first sexual intercourse. Early marriages, sexual abuse and gender biases leading to unequal negotiation and decision-making powers also increase youth, specifically girls’, vulnerability to the virus. Life skills education has been offered in Zanzibar for over 15 years by relevant Ministries as well as national and international NGOs. It has been conducted in schools (public and religious) and in out-of-school settings, but programmes have usually been short-lived and focus on abstinence only.

PMTCT services are now offered at 19% of the reproductive and child health (RCH) sites in Zanzibar. This low coverage of PMTCT services means that a high number of women deliver without knowing their HIV status which increases the risk of transmission to their babies. This is further complicated by the numbers of women delivering at home. The health system also lacks the capacity to routinely and rapidly identify, diagnose and treat HIV-positive children. Most of those infected are diagnosed late, if at all. And if they are found to be HIV-positive, poor tracking and follow-up leads to low retention in treatment and support services. Overall in Tanzania, one in every ten new HIV infections occurs in babies even though more than 90% of these infections could be prevented.

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.
• Greater focus on the drivers of HIV transmission: low and inconsistent condom use, risky sexual behaviours, multiple concurrent partners, early marriage and transactional sex, injecting drug use, 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. Adequately funded, long-term interventions are required that follow children through the different stages of their lives, rather than ‘losing’ them once they leave school.
• Initiatives to build parents’ openness, confidence and capacity to discuss sexual and reproductive health with their children.

8. Invest to reduce teenage pregnancy

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 Zanzibar. Perinatal and infant mortality are also higher among children born to adolescent mothers (WHO, 2007).

In Zanzibar, 6% of women aged 15-19 years have commenced childbearing. There are limited data on child marriage but available figures suggest that the incidence is high; the Ministry of Labour, Youth, Women and Children Development reported almost one in five Zanzibari girls aged 15-19 years (18.5%) are married.

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. Zanzibar law is silent on the minimum age for marriage and the relevant operational reference is Sharia law which allows for the marriage of girls on attaining puberty. Often a family’s decision to have a child married —be it a boy or a girl — is a survival strategy to relieve the family of what they perceive to be a financial burden in the face of acute poverty. Marriage may also reflect the value placed on a girl’s virginity and be regarded by parents as a means to prevent premarital sexual relations and pregnancy. However, adolescent girls rarely have the power or knowledge to negotiate safe sex with their husbands.

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.

**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.

- 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.

- Education to families on the health and educational benefits of delayed marriage and childbearing, and the serious health risks of teenage pregnancy.

- Support for schools to implement the new policy 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.
9. Invest to protect children from violence, abuse and exploitation

In recent years Zanzibar’s society has become more aware of the problem of child abuse and the need for further investment in child care and family support services to enable national services to respond to child abuse and welfare concerns. In 2009 the Revolutionary Government of Zanzibar carried out for the first time a national survey on Violence Against Children in Zanzibar. The findings of this survey report that violence against children, sexual exploitation and abuse is a significant problem and occurs at home, in communities and at school.

The Violence Against Children Survey specifically indicated that issue of sexual violence is a serious problem in Zanzibar. According to the Survey, over one in 20 of females and almost one in ten males reported experiencing at least one incident of sexual violence before the age of 18. About one in ten children in Zanzibar who have sex before turning 18 say that their first intercourse is unwilling, and that they are either tricked, pressured, threatened, physically forced or coerced some other way to have sex.

Furthermore, the percentage of children who seek services after an experience of sexual violence is low, at 19 per cent for girls and 11 per cent for boys. Not all of those who seek services receive them: only six out of 11 girls and boys are successful in receiving them. Overall, this means that only about one in ten children who experience childhood sexual violence receive services afterwards.

In the past, the child protection response has been fragmented and uncoordinated with no clear identified primary reference point and services stretched across different ministries, departments and national agencies (including police, hospitals, schools and community organisations). This uncoordinated approach has had significant implications in relation to service delivery for victims of abuse.

Nevertheless, significant progress has been made in recent years in an effort to develop a more strategic approach towards building the national child protection system. In 2011 the Zanzibar House of Representatives passed the Children’s Act 2011. The primary focus of the legislation is to develop a coordinated child protection system in Zanzibar to effectively respond to cases of violence and abuse and to better promote and protect the rights of children in conflict with the law. The new Children’s Act establishes procedures and outlines the roles and responsibilities of national institutions and professionals in providing child protection services. The Bill also contains provisions relating to custody, guardianship, access and maintenance, foster care and adoption, children and health services and children in residential establishments.

In 2011, the Department of Social Welfare, under the Ministry of Social Welfare, Youth, Women and Children Development developed National Guidelines for the Protection and Welfare of Children in Zanzibar. These guidelines aim to create a clear route of referral for cases of abuse and coordinate national services concerning children in Zanzibar and establish the Department of Social Welfare as the appropriate responsible body with the mandate for coordinating the necessary response and providing support services for children and their families. The Department of Social Welfare has established a Child Protection Unit within the Department which provides a safe space for dealing with specific cases of abuse against children and is also responsible for coordinating national child protection services.
Furthermore, Mnazi Moja hospital under the coordination of the Department of Social Welfare is currently working to establish a Pilot Violence Recovery Centre to provide emergency and follow up services to victims of violence and abuse. The Pilot Recovery Centre will provide 24 hour health, legal, para-legal and psycho-social services to victims of violence and abuse and seek to strengthen the national capacity for a coordinated national response to cases of women and children in need of care and protection. The Department of Social Welfare has plans to extend the pilot model to Chake Chake in Pemba and eventually to health facilities at the district level across the isles.

To fulfil its child protection mandate the Department of Social Welfare will require a significant strengthening of its capacity and a concentrated investment in terms of technical, financial and human resources will be necessary for the effective operationalisation of the provisions of the Children’s Act and the National Guidelines. Intensive human resource and capacity development is required to increase the quantity and quality of social workers throughout Zanzibar.

**What is most needed?**

The protection of children from violence and abuse requires a multi-sectoral approach. No one sector or profession has the skills, knowledge or resources necessary to comprehensively meet all the requirements of a child’s protection needs. It is essential therefore that a coordinated response is made by all sectors and professionals involved in working with children and families in need of care and protection. This action plan therefore addresses recommended actions across a number of sectors including; justice and police, health, education, social welfare, civil society, community and media. Priority recommendations for child protection in Zanzibar include:

- The development of a national child protection system implementation plan based upon the Children’s Act 2011 and the National Guidelines for the Protection and Welfare of Children in Zanzibar.
- 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.
- 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.
- Improved data collection systems on the incidence of child abuse and exploitation, and on children in contact with the law.
- A national communication strategy to disseminate information, mobilise communities and promote social behaviour change to better protect children.
- Universal birth registration which establishes children’s legal identity, secures their rights to vital services, and helps protect them from trafficking and exploitation.
10. Invest in children with disabilities

Getting accurate data on disability is very difficult given the reluctance of many families to discuss the issue. Stigma and taboos may lead to under-reporting of specific disabilities, and mild forms of disability may go unnoticed or are not interpreted as disabilities. The 2002 population census suggested that a mere 1% of the population aged 0-18 years was classified as disabled – just over 5,000 children in Zanzibar, but more recent figures reveal a prevalence of disability of 5.9% for the population aged seven years or more.

Apart from the problems associated with stigma, parents can be reluctant to seek treatment for babies born with impairment, may not be aware that services are available that can vastly improve their children’s lives, or 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. For example, each year across Tanzania, about three in every 1,000 babies are born with clubfoot. But 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.

The majority of children with disabilities are denied their right to education. 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. 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 broader impact of disability 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.

What is most needed?

• The development and enforcement of legislation and a policy for the realisation of the rights of children living with disabilities in Zanzibar.

• Support for the newly established department dealing with disability within the Chief Minister’s Office.

• 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:

• prevent 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; and
• 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 Zanzibar. The expected passage of a Children’s Act through the House of Representatives will be a significant step. If fully implemented and aligned with MKUZA II and sectoral policies, budgets and regulations, the Bill will have a profound impact on the lives of Zanzibari children. So too, the recent publication of the Zanzibar Social Protection Expenditure Review and Social Budget is a vital step towards establishing a social protection “floor” in Zanzibar.

A key challenge will be to scale up essential 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.

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; 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 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 importantly, 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 in Zanzibar is avoided.

Today is the time to invest in our children. Half a million children and Zanzibar can ill afford to wait.
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