



**The RISE Institute**

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**Policy Analyses and Recommendations on  
Early Childhood Development and HIV/  
AIDS in Mainland Tanzania and Zanzibar**

Emily Vargas-Barón

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**Policy Analyses and Recommendations**  
**on Early Childhood Development and HIV/AIDS in**  
**Mainland Tanzania and Zanzibar**

*Emily Vargas-Barón, Ph.D.*  
*Consultant to the*  
*Country Support Team for ECD and HIV/AIDS*

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This Policy Analysis was prepared in my role as Consultant to the Country Support Team for Early Childhood Development and HIV/AIDS (CST). My goal has been to provide a detailed analysis of policies related to young children in order to assist the CST's Planning Team to develop effective Policy Frameworks for Early Childhood Development and HIV/AIDS in Mainland Tanzania and Zanzibar.

Because my commission is to help the CST serve the children of Tanzania, I have felt free to make candid observations on current policies. Errors of analysis or omission are completely mine. I welcome your comments and suggestions.

*Emily Vargas-Barón*

# TABLE OF CONTENTS

Acknowledgements	2
Acronyms	5
Executive Summary	9
0.0 Introduction	13
2.0 Policy Analysis: Mainland Tanzania	26
3.0 Policy Analysis: Zanzibar	79
4.0 Recommendations	106
Annex I: Mainland Tanzania Agencies, Policies and Documents	126
Annex II: Zanzibar Agencies, Policies and Documents	133

## LIST OF ACRONYMS

AO	AIDS Orphans
AHD	Adolescent Health and Development
AKF	Aga Khan Foundation
ANC	Antenatal Clinics
ANE&C	Antenatal Education and Care Programme
ARV	Anti-Retroviral Therapy
ARH	Adolescent Reproductive Health
ART	Antiretroviral Therapy
CAC	Council AIDS Committee
CACC	Council AIDS Control Coordinator
CARF	Community AIDS Response Fund
CBD	Community Based Distributors
CBHC	Community Based Health Care
CBMIS	Community Based Management Information System
CBOs	Community Based Organisations
CDP	Child Development Policy
CDO	Community Development Officer
CEDAW	Convention on the Elimination of all Forms of Discrimination against Women
C-IMCI	Community Integrated Management for Childhood Illnesses
CHF	Community Health Fund
CHMTs	Council Health Management Teams
CMAC	Council Multi-Sectoral AIDS Committee
CMO	Chief Minister's Office, Zanzibar
CMT	Council Management Team
CORPS	Community Own Resource Persons
CSPD	Child Survival, Protection and Development
CRC	Convention on the Rights of Children
CSOs	Civil Society Organisations
CST	Country Support Team for ECD and HIV/AIDS
DAC	Development Assistance Committee
DACC	District AIDS Control Coordinator
DC	District Council
DHS	Demographic and Health Survey
DMT	District Management Team
DOVCCC	District OVC Coordinating Committee
DPLO	District Planning Officer
ECD	Early Childhood Development
ECI	Early Childhood Intervention
EFA	Education for All
EPI	Expanded Programme of Immunization
FANC	Focused Antenatal Care
FBOs	Faith Based Organisations

FDCs	Folk Development Centres
FGM	Female Genital Mutilation
GFATM	Global Fund for HIV/AIDS, Malaria and TB
GTZ	German Technical Assistance Agency (translated)
HAC	Hamlet AIDS Committee
HBC	Home Based Care
HIPC	Highly Indebted Poor Countries
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HMIS	Health Management Information System
IEC	Information, Education and Communication
IECD	Integrated Early Childhood Development
IIEP/UNESCO	International Institute for Educational Planning/UNESCO
ILO	International Labour Organisation
IMCI	Integrated Management for Childhood Illnesses
IMR	Infant Mortality Rate
IPT	Intermittent Preventive Treatment
ITNs	Insecticide Treated Nets
JCD	June Child Day
KABP	Knowledge, Attitudes, Behaviour and Practice
LGAs	Local Government Authorities
M&E	Monitoring and Evaluation
MAFS	Ministry of Agriculture and Food Security
MCDGC	Ministry of Community Development, Gender and Children
MCH	Maternal and Child Health
MDAs	Ministry, Department or Agency of Government
MDGs	Millennium Development Goals
MLDW	Ministry of Livestock Development and Water
MLYDS	Ministry of Labour, Youth Development and Sports
MOECS	Ministry of Education, Culture and Sports, Zanzibar
MOFEA	Ministry of Finance and Economic Affairs, Zanzibar
MOHSW	Ministry of Health and Social Welfare, Zanzibar
MOJCA	Ministry of Justice and Constitutional Affairs
MORASD	Ministry of Regional Administration and Special Departments, Zanzibar
MOW	Ministry of Works
MOYEWCD	Ministry of Youth, Employment, Women and Children Development
MMR	Maternal Mortality Rate
MTCT	Mother to Child Transmission
MTEF	Medium-Term Expenditure Framework
MTP	Medium Term Plan
MOEC	Ministry of Education and Culture
MOF	Ministry of Finance
MOH	Ministry of Health

MOHA	Ministry of Home Affairs
MVC	Most Vulnerable Children
MVYC	Most Vulnerable Young Children
MTEF	Medium Term Expenditure Framework
NACP	National AIDS Control Programme
NBS	National Bureau of Statistics
NGOs	Non-Governmental Organisations
NPES	National Poverty Eradication Strategy
NSC	National Steering Committee (for OVC)
NSF	National Strategy Framework
NSGRP	National Strategy for Growth and Reduction of Poverty (current title for second draft of PRS II)
NSHP	National School Health Programme
NTC	National Technical Committee (for OVC)
NTRC	National Teacher Training Centre, Zanzibar
NYP	National Youth Policy
O & OD	Opportunities and Obstacles to Development
OCGS	Office of Chief Government Statistician
OVIC	Orphans and Vulnerable Infants and Children Fund
OVC	Orphans and Vulnerable Children
OVYC	Orphans and Vulnerable Young Children
PCP	Parent Child Programme
PER	Public Expenditure Framework
PAW	Pregnant Adolescents and Women
PHE	Peer Health Educator
PLWHA	Persons Living with HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
PMO	Prime Minister's Office
PMS	Poverty Monitoring System
PORALG	Presidents Office Regional Administration and Local Government
PRP	Poverty Reduction Paper
PRSP	Poverty Reduction Strategy Paper
PRS II	Poverty Reduction Strategy II
RACC	Regional AIDS Control Coordinator
RCH	Reproductive and Child Health
RHMTs	Regional Health Management Teams
RGOZ	Revolutionary Government of Zanzibar
SMAC	Street Multi-Sectoral AIDS Committee
SO	Strategic Objective
STIs	Sexually Transmitted Infections
TAC	Technical AIDS Committee
TACAIDS	Tanzania Commission for AIDS
TAS	Tanzania Assistance Strategy
TASAF	Tanzania Social Action Fund
TB	Tuberculosis

TBA	Traditional Birth Attendants
TMAP	Tanzania Multi-Sectoral AIDS Programme
TFR	Total Fertility Rate
TOT	Training of Trainers
U5MR	Under Five Mortality Rate
UNDP	United Nations Development Programme
UNESCO	United Nations Education, Scientific and Cultural Organisation
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
UPE	Universal Primary Education
URT	United Republic of Tanzania
USAID	United States Agency for International Development
VDC	Village Development Committee
VHD	Village Health Day
VCT	Voluntary Counselling and Testing
VHWs	Village Health Workers
VPO	Vice-President's Office
WIN	Women, Infants and Children Nutrition Programme
WMAC	Ward Multi-Sectoral AIDS Committee
WDC	Ward Development Committee
WHO	World Health Organisation
ZAC	Zanzibar AIDS Commission
ZACP	Zanzibar AIDS Control Programme
ZANGOC	Zanzibar Non-Governmental Organisation Cluster
ZAD	Zanzibar Association for the Disabled
ZAUC	Zanzibar AIDS Unit Control
ZEMAP	Zanzibar Education Master Plan
ZEP	Zanzibar Education Policy
ZNSP	Zanzibar National HIV/AIDS Strategic Plan
ZPRP	Zanzibar Poverty Reduction Plan

## EXECUTIVE SUMMARY

To prepare the *Policy Analyses and Recommendations on Early Childhood Development and HIV/AIDS in Mainland Tanzania and Zanzibar*, a total of 33 policies and policy-related plans, strategies, and guidelines were reviewed for the Mainland and 14 for Zanzibar. A few other child-related policies and documents exist but they could not be found in time for this study. Because of the difficulties all encounter in accessing existing policies, it is imperative that a national office for policy archives, distribution and advocacy be developed soon.

Given the dramatic and urgent needs of Tanzania's young children and gaps in current policies and programme services, it is recommended that Mainland Tanzania and Zanzibar conduct the following four activities to improve the status of pregnant adolescents and women (PAW) and orphans and vulnerable young children (OVYC) from birth to eight years of age, and especially those affected or infected by HIV/AIDS:

1. Develop, with the full participation of communities, districts, regions and national ministries, comprehensive **Policy Frameworks for Early Childhood Development (ECD) and HIV/AIDS**;
2. Prepare **annual Action Plans** to carry out activities under each strategy of the Policy Frameworks;
3. Reinforce or prepare new **guidelines** for implementing the programmes of the annual Action Plans at all levels, from national and regional to district, ward and community, and
4. Enact **legislation** to enforce the Policy Frameworks and annual Action Plans.

At all levels of policy consultation and development, in addition to the public sector the **Civil Society Working Group for ECD and HIV/AIDS** should be fully involved. The Policy Frameworks, annual Action Plans, guidelines and legislation should be fully accountable through establishing a **transparent system for evaluation, monitoring and reporting** managed by designated Executive Agencies or Offices. This system would permit the flexible adjustment of plans to meet evolving needs of PAW and OVYC.

Other important findings include:

- ∞ In both Mainland Tanzania and Zanzibar, policies for health, nutrition, education, sanitation and juridical protection related to PAW, OVYC, and especially those affected by HIV/AIDS, have not taken into account requirements for well-coordinated and integrated services.
- ∞ Zanzibar has a quite complete array of education policies for young children; however, these valuable policies and plans have not been fully implemented. They require and merit substantially increased funding and material support.
- ∞ Although many sectoral and cross-sectoral policies refer to children's rights and periodic rights reviews have been prepared, it is clear that current policies do not fully reflect all areas of the Convention on the Rights of Children, and significant work will be needed to ensure adequate policies are developed.
- ∞ Several major points exist for policy harmonization, and although various ministries are beginning to address these areas, increased efforts are needed. The

- preparation of new Policy Frameworks for ECD and HIV/AIDS present an excellent opportunity for achieving greater policy harmonization.
- ∞ The new draft of the **National Strategy for Growth and Reduction of Poverty (NSGRP)** represents a major step forward because it includes an integrated approach to ECD as a programme strategy for achieving PRS targets. However, the early childhood sections need to be adequately funded, implemented and evaluated to achieve Strategy goals. The proposed Policy Frameworks for ECD and HIV/AIDS are needed to help ensure these provisions are implemented.
  - ∞ The **National Multi-Sectoral Strategic Framework on HIV/AIDS, Tanzania 2003 – 2007** represents a good beginning for addressing the needs of OVC but it needs to be complemented by Policy Frameworks for ECD and HIV/AIDS.
  - ∞ Issues regarding the placement of services for children from birth to four years of age and from five to six years of age should be resolved in the Policy Frameworks.
  - ∞ At present, Early Childhood Intervention services to identify, assess, serve and track fragile infants or young children with developmental delays or disabilities do not exist in Tanzania although some valiant efforts have been made to begin them. This is a major gap area in health, nutrition and educational services.
  - ∞ Multi-sectoral parent and caregiver education is another major gap area that is essential to ensuring healthy pregnancies, good child development, and adequate community health, nutrition and sanitation. Also largely absent are guidelines regarding the monitoring, evaluation and accountability of family services.
  - ∞ Given Tanzania's high levels of child malnutrition, high rates of school drop out and repetition, and low national productivity, food and nutrition education programmes for PAW and OVYC are urgently required, along with a system of reliable, transparent and accountable community networks to ensure that foods reach and are consumed appropriately by target groups.
  - ∞ Standards regarding early childhood care and education, preschool and pre-primary education need to be set and enforced to improve educational quality, along with transition programmes with parent involvement in the schools.
  - ∞ Draft guidelines for community-based care, support and the protection of OVC should be reviewed carefully. The Policy Framework for ECD and HIV/AIDS should reinforce elements of the OVC Policy and Plan with respect to PAW and OVYC and also fill in any remaining gaps regarding these vulnerable populations.
  - ∞ National policies for adolescent health, management of adolescent pregnancies, adolescent rights, health and nutrition status, and risk-taking behaviours should be reinforced in the Policy Frameworks for ECD and HIV/AIDS.
  - ∞ Policy clarification is required regarding communities' roles in identifying, planning, and managing resources to meet local child health, nutrition, education and sanitation needs. Pre- and in-service training is a major issue, not only for preparing community health committees but also for ensuring that Village Health Workers are able to provide quality services.

**The major recommendations** of these policy analyses include:

- ∞ Improve Tanzania's process and format for developing policies, policy frameworks and annual action plans to include elements that will favour achieving policy goals and improving holistic services for PAWS and OVYC.

- ∞ Link policy development to the preparation of annual action plans, supportive legislation and operational guidelines to improve the attainment of policy results.
- ∞ Give special attention to developing a national and decentralised training system that will help to ensure all levels of service providers for PAW and OVYC receive pre- and regular in-service training and technical support.
- ∞ Ensure that consensus are reached regarding institutional leadership, coordination, roles and responsibilities, and present them clearly in the Policy Frameworks for ECD and HIV/AIDS.
- ∞ Greater priority should be given to PAW and OVYC by **filling specific gaps** found under the following policy topics:
  - Antenatal, delivery and immediate post-natal services
  - Services for infancy to three years of age
    - Linked child assessment systems
    - Parent education and support system
    - Early Childhood Intervention programme
    - Nutrition and health
  - Services for children three to six years of age
    - Child assessment systems (and others above)
    - Pre-school, early care services and Quranic schools
  - Services for children six to eight years of age
    - Transition to school, and child and parent friendly schools
  - Pre- and in-service training in all areas
- ∞ Further work on **policy harmonization** is needed in the following areas:
  - *Parent education and children birth to three years of age.* New options are needed for multi-sectoral collaboration to build an integrated system for parent education.
  - *Pre-school and day care centres and pre-primary schools.* Differing regulations for day care centres, pre-schools and pre-primary schools need to be harmonized and enforced to improve the quality of care and education, pre- and in-service training, supervision and administration.
  - *Management of services for orphans and other vulnerable young children.* Several ministries seek to ensure that OVYC receive specialised services, and yet they have tended to “fall through the cracks.” Inadequate budgets have been allotted for meeting these children’s needs.
  - *HIV/AIDS policies.* These policies will need to be modified to ensure they will be consistent with the Policy Frameworks for ECD and HIV/AIDS.
  - *Contributions of CSOs and private sector groups.* An unnecessary duplication of services is reported to be occurring among government services, CSOs, and private sector groups working with PAW and OVYC. Care should be taken to avoid this through engaging all parties in regular dialogues for building improved co-ordination and partnerships.
- ∞ Mainland Tanzania and Zanzibar should consider options for establishing well-funded central offices in a ministry OR founding Executive Agencies (parastatal centres) for ECD, PAW and OVYC.

- ∞ The proposed Policy Frameworks for ECD and HIV/AIDS should include policy-related research, policy advocacy and social communications, an investment plan and budget, donor and partnership co-ordination.
- ∞ Areas for **policy-related legislation** are also recommended:
  - Establish a national priority for vulnerable children.
  - Legislate an administrative structure for vulnerable young children.
  - Ensure the provision of priority services for OVYC and PAW, including:
    - Free primary health care and regular well-child checkups for all children under five years of age.
    - Developmental, nutritional and health assessments and continuous system of identification, assessment, services, and tracking for OVYC.
    - Free day care, pre-school, pre-primary and primary education with special attention to equity regarding the Community Health Fund.
    - Universal Antenatal Education and Care Programme beginning with risk assessments initiated during the first trimester of pregnancy.
    - Pre-service training and regular in-service training mandated for all birth attendants, both certified and traditional.
    - Provision of a National Parent Education Programme (PEP) with Early Childhood Intervention Services (ECI).
    - Establishment of a system for forging equitable partnerships between government and NGOs, FBOs, CBOs, other CSOs, private sector and other relevant groups.
    - Provision of a Women, Infants and Children's Nutrition Programme that channels surplus food and funds to high-risk PAW and OVYC.
    - Development of an Orphans and Vulnerable Infants and Children Fund (OVIC) would provide essential basic support to AIDS infected parents who are unable to work, HIV-infected and affected children, and other orphans with caregivers who are living in poverty.
    - Support provided under OVIC would include funds to meet children's survival, developmental and educational needs. Services would include the provision of enriched pre-school education centres.
  - Special legislation for child and family protection would include child support and paternity, inheritance rights, foster care and adoption, guidelines regarding child labour, protection of adolescent girls, women's and children's rights, assistance for refugees and internally displaced persons, and others.

## 1.0 Introduction

These Policy Analyses were commissioned by the Country Support Team for Early Childhood Development and HIV/AIDS (CST). The CST is convened by the Prime Minister's Office and TACAIDS in Mainland Tanzania and the Chief Minister's Office and Zanzibar AIDS Commission in Zanzibar. It is led on the Mainland by the Ministry of Community Development, Gender and Children. In Zanzibar the lead ministry is the Ministry of Youth, Employment, Women and Children Development.<sup>1</sup>

The objectives of these Policy Analyses are to:

1. Identify and assess existing policies, plans, guidelines and laws related to young children in Mainland Tanzania and Zanzibar;
2. Consider if they are inclusive of the rights and well-being of young children;
3. Assess the extent to which early childhood development (ECD) is integrated into HIV/AIDS frameworks and vice-versa, and
4. Provide recommendations for planning **National Policy Frameworks for ECD and HIV/AIDS** for Mainland Tanzania and Zanzibar.

These Policy Analyses will be complemented by two other studies. Dr. Sareer Ara is conducting a Needs Assessment on the Status of Children. Consultants yet to be selected will conduct a Resource Assessment that will identify institutional, human, training and financial resources devoted to ECD and HIV/AIDS for orphans and vulnerable young children (OVYC) and pregnant adolescents and women (PAW). A synthesis of these studies will be presented in the Situation Analysis section of the Policy Frameworks for ECD and HIV/AIDS in Mainland Tanzania and Zanzibar.

This report begins with a general introduction, followed by an analysis of policies and related documents regarding ECD and HIV/AIDS in Mainland Tanzania, and then by a similar policy analysis for Zanzibar. A final section presents recommendations for the Policy Frameworks for ECD and HIV/AIDS.

One of the findings of these Policy Analyses is the difficulty everyone experiences in searching for copies of national policies, plans, guidelines and laws. Copies of these documents are seldom placed in central repositories. Because few copies were printed when they were prepared, many ministerial officials, UNICEF staff, Amani personnel and others kindly printed them from their computers, gave me electronic copies or photocopied them for me. The lists of policies provided in this document are not

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<sup>1</sup> CST members include technical leaders in the Ministry of Health, Ministry of Education and Culture, and PORALG the Mainland, and the Social Welfare Department, Ministry of Health, Nutrition and Social Welfare, Ministry of Education, Culture and Sports, Ministry of Regional Administration and Special Departments. In both areas, CSOs participate including NGOs, universities, professional associations, FBOs, private sector agencies and legal institutions. Government at all levels send representatives, including local government authorities, wards, villages, hamlets and families. Development partners include UN agencies, the World Bank, bilateral donors and international NGOs. The CST is expected to grow over time.

exhaustive because it proved to be impossible to locate all of them. A few were available only in Kiswahili, were currently being drafted or simply were unavailable for review.

This exercise was very instructive with respect to current limitations in securing policy documents. It revealed that major needs exist for improving ministries' systems of policy dissemination, policy advocacy and programme utilization of policy mandates. Many people in ministries, regions, districts, villages, CSOs, including NGOs, FBOs, universities, and institutes, who need policies and plans for programme planning stated they are unable to access them. As a result, some of them believe the policies lack certain provisions that, in fact, they have. In the Policy Analyses below, some readers will be surprised to learn about important policy mandates that already exist.

At the same time, striking policy gaps and some major requirements for policy harmonization were found. Many Tanzanian specialists are aware of certain needs for policy harmonization but dialogues to resolve them have not been undertaken. It is hoped that the review of these Policy Analyses and the opportunity for planning the Policy Frameworks for ECD and HIV/AIDS will help to build new consensus for strong collaboration. Vulnerable children of Tanzania will be the beneficiaries of this difficult but essential task.

But first, it is important to review some basic concepts with respect to the integrated approach to early childhood development, resource requirements for young children, definitions of vulnerability, the challenges of HIV/AIDS, and general policy contexts in Mainland Tanzania and Zanzibar.

## **1.1 Integrated Approach to Early Childhood Development (ECD)**

The integrated approach to ECD includes providing support to meet infants' and children's basic needs for good development: timely health care; balanced and adequate nutrition; early childhood stimulation activities in the home from birth to school entry; quality pre-school education; clean water and adequate waste disposal; children's rights, and juridical protection for vulnerable children and their mothers. For a child to develop well and be ready to achieve success in school, parents or caregivers need support and culturally appropriate parental education from before an infant's birth to school entry.

It has become abundantly clear from research in many world regions that illiterate mothers living in extreme poverty who begin to rear children when they are adolescents, usually lack essential parenting skills to promote good child development. They tend to have children who are malnourished, become chronically ill, and exhibit damaging delays in their mental, social, emotional, physical development that in turn lead to poor learning outcomes. These are the children who start school late, are slow learners, repeat grades, and drop out before finishing primary school. As a result, these children tend to be illiterate or seldom read or write. They become unskilled youth, some of whom will be involved in conflicts, develop into juvenile delinquents, and contribute little to national

productivity. They ultimately become the parents of the next generation of children who repeat the cycle of entrenched poverty.

Recent research has demonstrated that most of the brain's pathways for learning and for balanced social and emotional functioning are developed during the critical period of pregnancy to age three.<sup>2</sup> **To help children achieve their potential, developmental delays must be prevented or identified and reversed to the extent possible during this period of very rapid brain growth. It is much more difficult to reverse delays after a child becomes two to three years of age.**

Parent education and support is essential during this early stage of development, especially for parents or caregivers of vulnerable and high-risk children who live in poverty or are affected by HIV/AIDS, family violence, conflicts, malnutrition, or chronic diseases such as malaria and anaemia.

**Parents are the first and most important teachers of their children in all areas of development**, including perceptual, social, emotional, language, cognitive, and physical development. Programmes for parents of children from birth to three years of age have demonstrated some impressive gains in child development, many of which resulted in improved school achievement, health and nutritional status, and economic productivity.<sup>3</sup>

Evaluations of pre-school programmes have also demonstrated positive results. For example, in Nepal, 90 percent of the children who attended non-formal pre-schools enrolled in primary school, in contrast to only 70 percent of those who did not. By grade two, some 80 percent of the children who had attended pre-school were still in school whereas only 40 percent of those who had not were still enrolled. Interestingly, girls benefited more from pre-school attendance than boys, although both profited from attending.<sup>4</sup> In India, the Mahila Samakhya pre-school programme of Bihar State especially for scheduled castes and other low-income families, achieved increased child enrolment in pre-schools and later in primary school, parental involvement in schools, improved immunization records, and improved treatment of diarrhoea.<sup>5</sup> Recently, the 40 year follow-up study on the High/Scope Perry Preschool Project revealed that for every dollar invested in quality pre-school education, a return of \$12.90 was attained in terms of reduced welfare costs, better educational achievement, increased taxes on larger

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<sup>2</sup> Shonkoff, J.P. & Phillips, D. (Eds.). (2000). *From Neurons to Neighborhoods: The Science of Early Childhood Development*. Committee on Integrating the Science of Early Childhood Development. Washington, DC: National Academy Press.

<sup>3</sup> John M. Love et al, *Making a Difference in the Lives of Infants and Toddlers and Their Families: The Impacts of Early Head Start*, Administration on Children, Youth and Families, U.S. Department of Health and Human Services, Washington, DC, June, 2002.

Campbell, F. A., Ramey, C. T., Pungello, E. P., Sparling, J., & Miller-Johnson, S. (2002). Early Childhood Education: Young Adult Outcomes from the Abecedarian Project. *Applied Developmental Science*, 6, 42-57. Barnett, W. S. (1996).

<sup>4</sup> *What's the Difference? An ECD impact study from Nepal*. (2003). Save the Children. Kathmandu, Nepal.

<sup>5</sup> Janssens, Wendy. (May, 2004). Social Capital and Early Childhood Development. Amsterdam Institute for International Development. PowerPoint presentation at the World Bank.

earnings, and reduced juvenile delinquency and crime.<sup>6</sup> Reduced crime represented the largest return on investment. As was found in Nepal, the greatest educational effect was on girls' educational achievement.

From research conducted in developing nations on programmes for malnourished young children, we know that antenatal and post-natal education, nutritional supplementation, and health care must be combined with infant psycho-social stimulation from birth to age three to improve child development outcomes.<sup>7</sup> Essentially, in order for vulnerable children to maintain an improved nutritional status, in addition to appropriate food, micronutrients, and health care, stimulating activities provided by caring parents or caregivers also are required.

Given the emphasis in Poverty Reduction Strategies of Mainland Tanzania and Zanzibar on ensuring women, especially single mothers, gain access to increased opportunities to work, the rapid recent growth in working mothers and the steep increase in orphans, especially due to HIV/AIDS, *providing quality child care and pre-school* becomes an essential strategy for ensuring Tanzanian young children, and especially vulnerable children, are prepared for success in school and do not drop out or repeat grades. Attrition and grade repetition cause high costs to education systems and lead to low rates of return on educational investments.

**The World Bank estimates that the money saved through reducing primary school grade repetition and attrition would pay for most national community early childhood and pre-school systems.<sup>8</sup>**

When mothers work long hours outside of the home, quality child care and pre-school education becomes essential to ensure their children will be nurtured and well developed. In Tanzania, many mothers are the main family workers and they are expected to care for their children at the same time. Several studies reveal they often work long hours. If high-risk, vulnerable children lack consistent and caring adults in their lives, not only cognitive but also social and emotional delays will occur. Studies have shown that the quality of child care for families living in poverty is extremely important. Therefore, quality standards for centre-based early care and education should be provided and enforced through regular in-service training, incentives for good achievement, and regular unannounced inspections.

As HIV/AIDS has spread throughout the communities of Tanzania, it has become clear that orphans and vulnerable young children (OVYC) and pregnant adolescents and women (PAW) require special attention. In order to provide appropriate services for young children affected or infected by HIV, basic national systems for meeting needs of

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<sup>6</sup> Larry Schweinhart and Jeanne Montie. (November 27, 2004). The High/Scope Perry Preschool Study to Age 40. High/Scope Educational Research Foundation.

<sup>7</sup> Charles M. Super, M. Guillermo Herrera and Jose O. Mora. (1992). "Long-Term Effects of Food Supplementation and Psychosocial Intervention on the Physical Growth of Colombian Infants at Risk of Malnutrition," *Annual Progress in Child Psychiatry and Child Development* 1991. Bruner/Mazel, Publishers, New York, NY. pp. 160-189.

<sup>8</sup> Jaramillo, Ibid.

ALL OVYC must be developed and expanded rapidly. Excellent guidance for such services may be found in the *Operational Guidelines for Supporting Child Development (ECD) in Multi-Sectoral HIV/AIDS Programmes in Africa*.<sup>9</sup>

Orphans and children caught in situations of extreme poverty, affected by HIV/AIDS, family violence, neglect, abusive labour or other difficult situations can develop life-long psychological scars. Later they tend to repeat these violent or neglectful behaviours in their own homes. However, as has been shown several Latin American countries, investment in effective, community-based and culturally appropriate parent education and integrated ECD programmes can reverse the cycle of poverty, increase national productivity, and prevent the further suffering of young children.<sup>10</sup>

National attention focusing on Tanzanian orphans and young children (OVYC) and pregnant adolescents and women (PAW) is essential and long overdue. The Policy Frameworks for ECD and HIV/AIDS should propose new and expanded systems for meeting their needs.

## **1.2 Critical Resource Needs for Infants and Children**

To ensure a nation's children develop well, adequate investment in ECD is essential. However, a study by the Child and Family Policy Center (CFPC) showed that although brain growth is most important during the initial stages of life up to six years of age, the amount of public spending for that period in six states of the United States tended to be vastly inferior to that for later years devoted to formal schooling.<sup>11</sup> Their studies have demonstrated that up until recently, public investment patterns have followed institutional traditions rather than research results on child development. This situation is beginning to change as policy and decision makers become increasingly aware of the economic, public security and social benefits that accrue to investment in services for vulnerable, high-risk young children and pregnant adolescents and women.

These results from CFPC mirror those in many other nations, including Mainland Tanzania and Zanzibar where emphasis has been placed on investing in formal education from age seven onward rather than on children from birth to age six.

It is clear from the most cursory review of budget projections in Mainland Tanzania and Zanzibar that funding for the earliest and most important period of child development in both areas is inadequate. As of this writing it appears that investment in ECD may be less than 2 percent of the budget for primary education. Yet, by greatly increasing investments in ECD, vulnerable children would develop better, their parents and

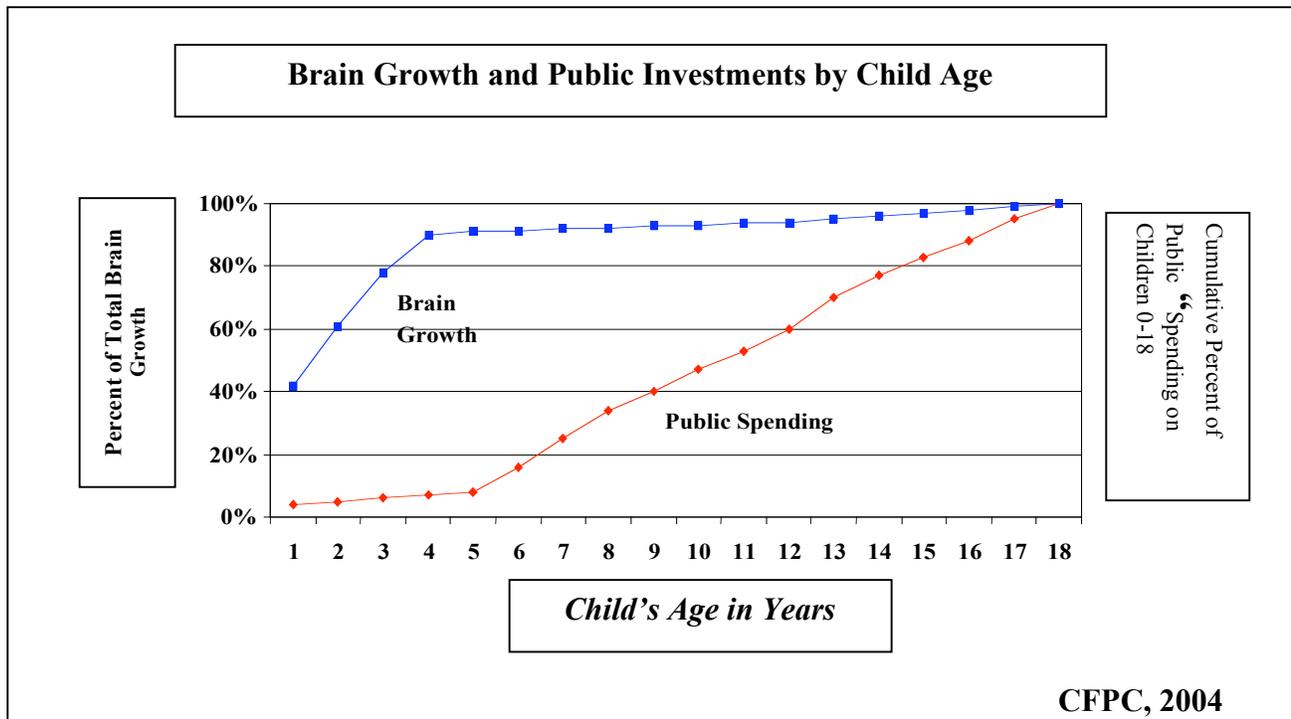
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<sup>9</sup> Richard Seifman and Amber Surrency. (2003). *Operational Guidelines for Supporting Early Child Development (ECD) in Multisectoral HIV/AIDS Programs in Africa*. UNAIDS, World Bank and UNICEF.

<sup>10</sup> Ricardo Moran, ed. (2003). *Escaping the Poverty Trap: Investing in Children in Latin America*. Inter-American Development Bank: Washington, DC.

<sup>11</sup> Bruner, Charles, et al. (February, 2004). *Early Learning Left Out: An Examination of Public Investments in Education and Development by Child Age*. Child and Family Policy Centre: Des Moines, Iowa.

caregivers would be able to prepare them for success in school, and targets for primary school enrollment and completion would be attained.



From this chart it is clear that public spending is far greater for children’s older years in spite of the fact that brain development mainly occurs from birth to age three. Because so little is invested in the early years in some nations, children are not ready for school, and often have severe delays in their development. These children tend to repeat grades and drop out, causing educational costs per child to rise dramatically, thereby ultimately reducing the amount of funds that could be devoted to improving the early child development. **However, the World Bank has estimated that in African nations, the funds that would be saved by reducing repetition would cover the costs of providing quality parenting education and pre-school programmes for vulnerable young children.**<sup>12</sup>

**This “virtuous cycle of investment in young children could help Tanzania overcome poverty, achieve universal basic education, improve national productivity, reduce juvenile delinquency, prevent social instability and improve national security.**

According to the study by the World Bank, “Since community-based pre-school programmes and community and family based care for health service delivery are clearly less costly in terms of public finance than traditional approaches, while producing results

<sup>12</sup> Jaramillo, A. and A. Mingat. (2003). “Early Childhood Care and Education in Sub-Saharan Africa; What would it take to meet the Millennium Development Goals?” The World Bank. Washington, DC.

that appear to be at least equivalent or even reach better outcomes like in the case of household and community based interventions for modifying health indicators, there is a clear message that in times of stringent constraints on public resources, community-based integrated health, nutrition and early education programmes are to be preferred.”<sup>13</sup>

In rural communities and urban neighbourhoods of Tanzania with high rates of poverty, HIV/AIDS, OVYC, infant and child mortality, low birth weight, child morbidity, developmental delays, malnutrition and chronic ill health, parent/child programmes or centres should be considered. These programmes would:

- 1) Conduct home visits for screening, identifying, assessing and tracking high-risk and developmentally delayed children, newborn to age five;
- 2) Identify, support and track high-risk pregnant adolescents and women and their children;
- 3) Offer parent and caregiver education and support with psycho-social ECD activities;
- 4) Provide universally accessible programmes and intensive early childhood intervention activities for high-risk families and fragile orphans and other vulnerable children, from zero to three or five years of age;
- 5) Ensure effective referrals and linkages are made to primary health, nutrition, education and sanitation services and special services for HIV/AIDS (e.g., ART, PMTCT, and others);
- 6) Link parents and caregivers to schools and community resources for parental support;
- 7) Conduct regular monitoring surveys of families’ service requirements, access and utilization, and
- 8) Assist parent to become self-sufficient through integrated literacy and skills training and other measures such as credit facilities.

### **1.3 Toward Defining Vulnerability**

It is essential to define the types of children that are to be included under the label of “vulnerable children.” In Mainland Tanzania and Zanzibar there is a great deal of confusion about which children are considered to be vulnerable. For some authors of policies, vulnerable children are defined very narrowly to be orphans, abused or neglected children, or the children of divorced mothers. For others, they are only those children who are infected or affected by HIV infection. For most authors, they also include children who live in severe poverty, are developmentally delayed, have disabilities, were under 2,500 grams at birth, are malnourished, have chronic ill health and diseases or another type of vulnerability.

It is impossible to serve all OVYC and PAW affected or infected by HIV/AIDS without well-designed services for identifying, assessing, serving and tracking them over time. The list below presents some of the types of vulnerable children from birth to eight years of age found in Tanzania. Additional types of vulnerable children can be added to this list.

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<sup>13</sup> Jaramillo, Ibid.

It would be valuable to provide accurate statistics on orphans and all types of vulnerable infants and children in Mainland Tanzania and Zanzibar, but after an extensive search of policy documents, national databases, studies and technical reports by Dr. Sareer Ara and me, it is abundantly clear that many of these statistics do not exist. Furthermore, some statistics that currently are being used actually are “notional.” Better data on OVYC and PAW will be needed in the near future for national and regional planning purposes.

Following is a list of the main types of vulnerable children in Tanzania:

- ∞ **Children living in abject poverty in high-risk areas for child mortality and morbidity**, whose parents earn less than \$1 per day and total 21 percent of the world’s population, vary from 50 percent in sub-Saharan Africa to virtually no child in industrialized nations.<sup>14</sup> For Tanzania, 36 percent of the population live below the basic needs poverty line, and from that, it could be inferred that a similar rate pertains to young children.<sup>15</sup> Special attention should be given to minority cultures living in poverty, including pastoralists, hunters and gatherers and others. At the same time, cultural diversity can be a strength.
- ∞ **Low birth weight infants (<2,500 grams)** are fragile and they are at very high risk for developmental delays and disabilities. The world average is 16 percent, but statistics range from 30 percent in countries of South Asia to 7 percent for industrialized countries.<sup>16</sup> In Tanzania, at least 16 percent of children are low in birth weight, and this rate undoubtedly is low due to many unreported infant deaths during home delivery, and infants who are not weighed at birth or are unregistered at birth.<sup>17</sup>
- ∞ **Children with chronic illnesses** in Tanzania include especially those with malaria (55 percent of all cases reported), pneumonia (16 percent), anaemia (13 percent), diarrhoeal diseases (9 percent) and acute respiratory infections (4 percent).<sup>18</sup> “As many as 90 percent of the children under five in Tanzania may have anaemia.” “Some 54 percent of all hospital admissions of children under five are due to both anaemia and malaria.”<sup>19</sup>
- ∞ **Malnourished children** usually become developmentally delayed and chronically ill. Using only one measure of malnutrition “stunting,” the world-wide average is very high: 31 percent. Stunting ranges from 44 percent in South Asia to 38 percent in sub-Saharan Africa.<sup>20</sup> In Tanzania, 43 percent of the children are stunted, 29 percent are underweight, and 5 percent are acutely malnourished.<sup>21</sup>
- ∞ **Children with developmental delays or disabilities** often lack early childhood intervention services that would help them to improve their early development

<sup>14</sup> *The State of the World’s Children*. Ibid.

<sup>15</sup> *Reproductive and Child Health Survey*. (1999). Ministry of Health.

<sup>16</sup> *The State of the World’s Children*. Ibid.

<sup>17</sup> Salgado. Ibid.

<sup>18</sup> *Health Abstracts*. 2000. Ministry of Health.

<sup>19</sup> Salgado. Ibid.

<sup>20</sup> *The State of the World’s Children*. Ibid., (below minus two standard deviations from medium height for age of reference population)

<sup>21</sup> RCHS, 1999. Ibid.

- and attend schools devoted to inclusive education. Tanzania lacks statistics on these children. The Department of Social Welfare uses the international 10 percent rule for children with disabilities, but believes the rate may be much higher.<sup>22</sup> The rate of children with developmental delays can be tagged with the rate for stunting, at a minimum, which is 43 percent. Most of these delays can be largely overcome with good early childhood intervention services and parent education and support.
- ∞ **Children infected or severely affected by HIV/AIDS** include infants who appear to be infected at birth but test as normal later on, infected infants who are or will become ill, AIDS orphans lacking one or both parents, and children whose parents are so ill with AIDS they can no longer care for them. “About 25 – 40 percent of infants born to infected mothers will also be infected with HIV. Most of these babies will develop AIDS and die within two years. Few will survive past the age of five.”<sup>23</sup> The most precarious time of life for orphans is the period from birth to five years of age yet most attention is given to school-age orphans. UNICEF estimates that 11 million children have been orphaned by HIV/AIDS in sub-Saharan Africa.<sup>24</sup> In Tanzania, the cumulative number of AIDS cases in children under five is probably over 100,000 through birth or breastfeeding.<sup>25</sup> For children under 15 years of age, by 2000, 1.1 percent had lost both parents, 6.4 percent had no father and 3.5 percent had no mother.<sup>26</sup> In 2000 the number of orphans was estimated to be around 1.2 million “mostly due to the HIV/AIDS pandemic.”<sup>27</sup> It is also noted that in some districts, the occurrence of orphans is very high, such as in Makete where almost 40 percent of the children are orphans due to HIV/AIDS. Another document estimates that by 2005, there will be two million orphans in Tanzania. The Eastern and Southern African Universities Programme estimates there may be as many as 2.5 million orphans already.<sup>28</sup>
  - ∞ **Other orphans lacking one or both parents** whose needs for both survival and good development cannot be met by their caregivers. No national level data are available on these orphans.
  - ∞ **Children affected by conflicts, famines and other natural disasters.** Such children may live in communities affected by violence, camps for internally displaced persons (IDPs), refugee camps, or guerrilla camps as child soldiers. Over 80 percent of the civilian population impacted by conflict are children and women. In 2004, over 76 nations were experiencing conflict or post-conflict

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<sup>22</sup> N’nyapule R. C. Madai, Assistant Commissioner, Department of Social Welfare estimates that from 10 to 20 percent of children have disabilities. *Disability and Poverty Reduction*. Paper presented at a Workshop on Policy Perspectives on the Vulnerable. 21 October 2003.

<sup>23</sup> *HIV/AIDS in Southern Africa: Background, Projections, Impacts and Interventions*. (August 20002). Policy Project for Bureau for Africa, Office of Sustainable Development, US Agency for International Development.

<sup>24</sup> *The State of the World’s Children*. Ibid.

<sup>25</sup> Salgado, 2004. Ibid.

<sup>26</sup> *AIDS in Africa During the Nineties: Tanzania*. (2001). Measure.

<sup>27</sup> Tatu Limbumba. (August 2003). *Reaching the Most Vulnerable Child: The Process*. Social Welfare Department and UNICEF, Dar es Salaam.

<sup>28</sup> Frederick J. Kaijage. (January 2004). *National Policy on the Care of Orphans*, Department of Social Welfare and TACAIDS, Dar es Salaam.

- transition.<sup>29</sup> These children require special attention for developmental delays, disabilities, malnutrition and ill health. The majority of over 121 million unschooled children<sup>30</sup> live in these countries with conflicts. No data could be found on children living in camps for refugees or internally displaced persons in communities or camps in Tanzania but such data sets may exist in the field.
- ∞ **Children in abusive labour** may live at home or with employers but all of them lose their childhood, and most do not attend school. The percentage of child labour among children five to 14 years of age is especially high in sub-Saharan Africa, ranging from 65 percent in Niger to 30 percent in Madagascar.<sup>31</sup> No reliable data were found on the rate of young children in abusive labour in Tanzania.
  - ∞ **Street children** who spend their days on the streets or who are orphans or have fled homes with family violence, severe poverty or hunger require a variety to types of programmes. Reliable statistics on the rate of street children rarely are available, but they form a significant proportion of the population in many countries from Brazil to India and Viet Nam. No reliable estimates were found for Tanzania.
  - ∞ **Abused and neglected children** who suffer especially from family violence and lack attention to their needs have become a way of life in some communities. No reliable data could be found regarding the rates of reported child abuse and neglect.

#### 1.4 HIV/AIDS

There is a high prevalence of HIV/AIDS in Mainland Tanzania. In Zanzibar prevalence rates are much lower but care is being taken to prevent the spread of infection. A cumulative total of 722,490 cases have been reported in Tanzania since 1983.<sup>32</sup> However, due to under-reporting and inadequate testing, it is believed that as of 2003, over 2 million people out of a total population of 33.5 million people are estimated to be living with HIV/AIDS. Prevalence rates vary from an average of 13 percent of women 25 to 34 years of age to 7.6 percent of women 15 to 24 years. In Mainland Tanzania, some 9.6 percent of pregnant women have tested positive for HIV infection. Women with HIV/AIDS are estimated to range from 4.2 to 32.1 percent in sentinel sites;<sup>33</sup>

It is important to note that many teachers have become infected, accounting for 80 percent of the deaths in the public sector. Because many teachers and public administrators have been infected, special attention is being paid to preventive education with these cadres throughout the government and civil society.

<sup>29</sup> *The State of the World's Children*. Ibid.

Vargas-Barón, E. and H. Bernal Alarcón. (to be published in 2005). *The Future of Children and Youth in Countries with Conflicts: Education and Social Reconstruction in Latin America and Asia*. Inter-American Development Bank. Washington, DC.

<sup>30</sup> *State of the World's Children*, Ibid.

<sup>31</sup> *The State of the World's Children*. Ibid.

<sup>32</sup> *HIV/AIDS Strategy, 2003 – 2006*. President's Office for Regional Administration and Local Government.

<sup>33</sup> *National Multi-Sectoral Strategic Framework on HIV/AIDS, 2003 - 2007*

Due to the HIV/AIDS pandemic, **high-risk and infected pregnant and lactating adolescents and women** also need to be clearly defined and provided for in the Policy Frameworks for ECD and HIV/AIDS. They usually include:

- ∞ Adolescents and women from 11 to 17 years of age whose bodies are not ready to bear children;
- ∞ Adolescents and women living in severe poverty;
- ∞ Single or divorced mothers without family support for meeting their basic needs;
- ∞ Adolescents and women who are malnourished with anaemia or other nutritional deficits whose bodies are not prepared for pregnancy;
- ∞ Adolescents and women with other chronic diseases, including especially malaria, tuberculosis, and STDs, and
- ∞ Infected adolescents and women lacking access to quality antenatal education and care, VAT, AVT, and to trained birthing specialists and post-natal care programmes.

In summary, it is essential that the Policy Frameworks for ECD and HIV/AIDS in Mainland Tanzania and Zanzibar include clear definitions of all children considered to be: 1) young orphans; 2) vulnerable young children, and 3) high-risk pregnant and lactating adolescents and women. Furthermore, because statistics are lacking regarding the frequency of orphans, other vulnerable children and high-risk pregnant adolescents and women, the Policy Frameworks should include sections regarding indicators, measures and research plans with budgetary provisions to secure more complete data sets for use in national planning and reporting.

## 1.5 Policy Context

In both Mainland Tanzania and Zanzibar, promising programmes for decentralisation, local level empowerment, and support for Village Councils and Village Funds, have the potential of bringing financial and technical resources directly to the people, thereby enabling them to guide their own development. However, many problems have been encountered. Some promising pilot programmes including the Community Based Management Information System (CBMIS) and the Opportunities and Obstacles to Development (O&OD) planning methodology are demonstrating that communities can be trained to manage their own development effectively.<sup>3435</sup> All policies, plans, guidelines and laws must be viewed in relation to this nationwide decentralisation process.

Tanzania possesses 26 regions, with 5 in Zanzibar and 21 on the Mainland. The Regions are divided into 114 local government authorities (LGAs) that correspond mainly to districts. The district level is critical to using the integrated approach to ECD, especially because representatives of most relevant sectors are present and potentially could form

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<sup>34</sup> *Community Based Management Information System (CBMIS) in Tanzania: Resource Guide, Version 5.* (July, 2003). UNICEF, Dar es Salaam.

<sup>35</sup> *The Opportunities and Obstacles to Development: A Community Participatory Planning Methodology: Training Manual.* (April 2004). Presidents Office, Regional Administration and Local Government (PORALG). Dodoma, Tanzania.

**multi-sectoral teams for conducting joint programme planning; combined training and local services; and joint evaluation and monitoring.** This would help to maximise the use of very limited resources for administration, supervision, monitoring and evaluation, in-service training, transportation, supplies, and equipment.

**The districts have a unique opportunity to focus on the needs of PAW and OVYC. However, it is unclear that this will occur in any consistent way.** Planning and reporting frameworks such as O & OD and CBMIS could play fundamental roles in improving ECD and serving OVYC. However, leadership will be needed at national and regional levels to ensure that vulnerable groups are given priority attention at district, ward, municipal, village and hamlet levels.

Both Mainland Tanzania and Zanzibar are signatories to the Convention on the Rights of Children (CRC). Through their many policies, plans and legislation for young children and women, Mainland Tanzania and Zanzibar explicitly state that they seek to meet children's rights for good psycho-social care and learning, pre-school education, health and survival, nutrition, water, sanitation and hygiene, and juridical protection. The general goals, content, and targets of most policies and plans fit within the CRC and they are laudable. What is on the books can be perfected, but it is clear that if what has been adopted or enacted were to be fully implemented, both regions would have largely overcome childhood diseases, malnutrition, developmental delays, disabilities and abuse. Some important policy gaps need to be filled, and they will be discussed in this document. However, major requirements exist for greatly increased investments in children, as well as for policy harmonization, implementation, co-ordination, evaluation and monitoring, enforcement, and flexible revision over time.

Tanzania's policies that concern OVYC and PAW, and especially those affected or infected by HIV/AIDS, vary from highly developed and complete policy and planning documents to brief policy statements that provide general goals and some strategies. Policy statements tend to lack essential elements for policy implementation and enforcement. Some policies clearly specify how they should be implemented and establish strategies, indicators and programme priorities, while others simply call for people to pay attention to them. As was astutely noted in The National Development Vision 2025, "Tanzanians have developed a propensity to prepare and pronounce plans and programmes and ambitions which are not accompanied by effective implementation, monitoring and evaluation mechanisms. As a result, implementation has been weak. This situation has given rise to the erosion of trust and confidence among the people on their leaders." For these reasons, the recommendations provided in these Policy Analyses will focus on ways to help ensure that the Policy Frameworks for ECD and HIV/AIDS in Mainland Tanzania and Zanzibar will be comprehensive and well-structured for effectiveness and accountability.

The following elements frequently are lacking in Tanzania's policies dealing with young children:

- ∞ Strategies that deal with children's age ranges and types of OVYC or PAW, rather than sectors;

- ∞ Strategies that are linked to programme areas or activities and indicators;
- ∞ Policy indicators with measures, targets and baselines;
- ∞ Organisational structures (frameworks) that are completely described, with roles and responsibilities specified for Policy implementation and accountability;
- ∞ Pre- and in-service training systems and related requirements (curriculum, methods and materials development);
- ∞ Monitoring and evaluation systems;
- ∞ Policy research plan;
- ∞ Policy advocacy and social communications plan;
- ∞ General investment plan, and
- ∞ Donor and partnership co-ordination plan.

These Policy sections are especially important when they are tied to annual Action Plans that help to ensure Policies will be implemented. Some Policies have been effectively linked to legislation that over time has helped to ensure basic services will be provided. This comprehensive approach to policy implementation in Tanzania blends policies with action (strategic) plans, guidelines, budget planning, laws and accountability measures.

**It is important to note that those policies in Tanzania that have taken a comprehensive approach to policy implementation have tended to achieve greater success.**

## **2.0 Policy Analysis: Mainland Tanzania**

This analysis includes a review of policies, plans, some guidelines and references to legislative acts that are relevant to OVYC and PAW. As noted above, not all policies could be secured but most of the important documents were obtained and reviewed. Next, policy gaps and needs for harmonization are discussed. Then brief sections provide an overview of: multi-sectoral and sectoral structures, co-ordination and integration; pre- and in-service training systems; policy indicators and targets; evaluation, monitoring, accountability and enforcement; policy-related research; policy advocacy and social communications; investment plans; donor and partnership co-ordination, and annual action planning.

### **2.1 Policies and Plans: Their Contents, Cultural Dimensions and Observance of Children's Rights**

Tanzania's Mainland has experienced not only rapid population growth and very high rates of HIV/AIDS infection but also a lamentable decline in major indicators of child well-being. In addition to HIV/AIDS, this appears to be due to high fertility rates, early marriage, adolescent pregnancies, a lack of effective family planning practices, counterproductive traditional health, nutrition and child rearing practices, and especially to structural problems in the provision of health, nutrition, education, and sanitation services. Tanzania has a high infant mortality rate (IMR). It is important to note that IMR is the variable most correlated with a propensity for national conflict and state failure. As such, IMR functions as a "weathervane" advising not only that the nation's children are at risk but also that the nation itself could be fragile.

Many national policies regarding children and HIV/AIDS allude to cultural realities in Tanzania, focusing usually on "cultural problems" rather than on "cultural strengths" including traditions that favour good support for parents and children. Cultural strengths abound as can be seen in the warmth with which people care for their own and for others' children. Cultural diversity is notable in Tanzania. However, few references in national policies are found regarding minority ethnic groups who currently lack culturally appropriate programming in areas such as parent education, child development and health and nutrition education. Although Tanzania has 126 different cultures, most of their members are able to speak Kiswahili or English. However, their home language is the language within which children are reared, and there is a lack of culturally-derived parent education and support materials in the fields of health, nutrition and child development in those languages. This need cuts across all service areas and the lack of appropriate learning materials limits service effectiveness. Systems for using local languages for parent education have been developed in Asia and Latin America, and they could be used in Tanzania. At a minimum, effective parent education, early childhood intervention, health and nutrition education materials will be required in Kiswahili, and over time progressively in more and more mother tongues.

This section presents brief analyses of key multi-sectoral and sectoral policies, plans and some guidelines that are relevant to OVYC and PAW.

### **2.1.1 President's Office Regional Administration and Local Government (PORALG) and the Ministry of Regional Administration and Special Department (MRASD)**

PORALG has produced a series of documents relevant to ECD and HIV/AIDS, beginning with the nation's guiding long-term vision:

- ∞ The Tanzania National Development Vision to 2025
- ∞ Rural Development Policy, December 2003
- ∞ HIV/AIDS Strategy, 2003 – 2006

In addition, PORALG has prepared new Public Expenditure Guidelines creating a cross-cutting HIV/AIDS budget as a “priority sector” that provides guidance for the utilization of USD\$58.7 million during 2004-2005. It is separate from USD\$171 million of Health Sector funding. PORALG also conducts the annual HIV/AIDS Public Expenditure Review (PER), with orphans and vulnerable children as one of foci of the PER. Above all, PORALG plays a leading role in guiding the decentralisation of Tanzania's public and civil society services that will assist OVYC and PAW. For this reason some of the main points of PORALG's policies will be reviewed below.

#### **The Tanzania National Development Vision to 2025**

Tanzania's National Development Vision to 2025 is a very general policy statement that is intended to “guide economic and social development efforts.” Consultations for preparing the Vision were held at all levels throughout the nation. It seeks to create an “enabling environment” that will overcome the “scourge of poverty” such that “abject poverty will be a thing of the past.” The Vision embraces all actors, from governmental institutions to the private sector, NGOs, CSOs, co-operative societies, villages and all other social groups.

Vision 2025 is declared to be “people-centred” but surprisingly no mention is made of the current or expected future status of Tanzania's children, except for a listing of goals for “high quality livelihood” that include goals that could fit within the integrated approach to early childhood development:

- ∞ Food self-sufficiency and food security (could imply overcoming infant and child malnutrition);
- ∞ Universal primary education (could imply good holistic ECD, improved readiness for success in school, and greatly reduced school drop-out and grade repetition);
- ∞ Gender equality and the empowerment of women in all socio-economic and political relations and cultures (could imply girls' and women's education and improved services for PAW);
- ∞ Access to quality primary health care for all (could suggest universal health care especially for under-fives, orphans, and PAW);

- ∞ Reduction in infant and maternal mortality rates by three-quarters of current levels (implies expanded and improved antenatal education and health and nutrition care, birthing services and post-natal health care and nutrition services);
- ∞ Universal access to safe water (implies safe water in or near homes, pre-schools, schools, and other services for PAW and OVYC).

Later sections call for the “transformation” of the education system, including the overhauling of the curriculum and the use of education as a “strategic agent for mindset transformation.” **Although the Vision does not provide a framework for supporting a special priority on the nation’s children, there is nothing in the Vision that would negate the development of the Policy Frameworks for ECD and HIV/AIDS in Mainland Tanzania and Zanzibar.**

PORALG has led the national effort to implement the general goals of Vision 2025 by guiding the development of decentralised administrative and programme services, according to the government’s reform agenda of 1996 to 2000. One of PORALG’s main policies to achieve decentralised services is the Rural Development Policy.

### **Rural Development Policy, December 2003**

The basic objectives of the Rural Development Policy (RDP) “are achieving a broad based, widely shared and dynamic rural economic growth, eradicating poverty, consequently raising the living standards of the population.” This general policy statement does not include specific references to children apart from noting their vulnerability and reiterating the types of general objectives listed above. However, it is an important statement with respect to PORALG’s mandate to develop local government authorities (LGAs). The Rural Development Policy is to “act as a co-ordination platform for sectoral ministries” not replacing them but rather providing a holistic view of the “whole rural development process.” It seeks to meet the “need for harmonisation, co-ordination, integration and multi-sectoral interaction of policies strategies and development initiatives due to unsatisfactory performance of the past and current policies and strategies which have been implemented in isolation.” It observes that “hierarchical controls emerging have unclear relations with the local councils,” and notes that some sectoral ministry reforms “do not reflect the philosophy of decentralisation,” and there is a “serious overlap of mandates.”

These observations are particularly important for the Policy Frameworks for ECD and HIV/AIDS because the pre-eminence of LGAs is clearly established in the RDP. It calls for implementing “planning methodologies such as Opportunities and Obstacles to Development (O&OD) which require participation of all villagers...in all villages.”

The RDP notes that “inadequate attention [is given] to issues of gender, environment and HIV/AIDS.” It calls for “intensifying the fight against HIV/AIDS” and for LGAs to “develop a strategic framework to support planning, co-ordination and implementation of the national multi-sectoral HIV/AIDS response at local levels.” However, most of the RDP is devoted to economic growth and decentralisation issues. Formal education is given major emphasis, as are health provisions, the need to overcome disease levels,

lower health costs, and water issues. The RDP notes repeatedly the importance of developing partnerships with the private sector, NGOs and other CSOs, stating, the “objectives of the RDP can only be achieved if the government cooperates and collaborates with other development partners and stakeholders in a consultative and participatory manner.” Finally, it states emphatically that, “The government’s rural development efforts will, therefore, be centred on provision of public services that cannot be provided by the private sector, playing a regulatory role and assisting local authorities in developing their capacities to perform their roles and responsibilities. In addition, the government will promote and support initiatives by individuals, NGOs, rural associations to provide essential rural development services.” The government is slated for a role of providing “an enabling environment to facilitate people’s involvement in planning and implementing development programmes and projects. They are also responsible for ensuring service delivery and provision of socio-economic infrastructures.” Finally, the RDP calls for monitoring and evaluation and co-ordination mechanisms, although no details are given regarding how this is to occur.

It is surprising that the RDP does not give greater attention to OVYC and PAW because without adequate services to meet their dramatic health, nutrition and developmental needs in rural areas, they will hold back future rural development.

### **HIV/AIDS Strategy, 2003 – 2006**

PORALG’s HIV/AIDS Strategy seeks to harmonize policies and provide a structure for ensuring that LGAs identify, plan, implement, monitor and report HIV/AIDS-related programme results and financial investments. Given expected USD\$70 million support for HIV/AIDS programmes (\$65 million for Mainland Tanzania and \$5 million for Zanzibar) from the World Bank through the Community AIDS Response Fund (CARF), the Public Sector Response Funding (PSF) and other funds from the Global Fund, TASAF II, Clinton Foundation, and several other external partners, PORALG is attempting to improve local participation, planning, monitoring and evaluation while building a system of support from national and regional levels for districts and communities.

PORALG’s HIV/AIDS Strategy seeks to:

- ∞ Complement TACAIDS HIV/AIDS National Strategy Framework, 2003 - 2007 (NSF) and further encourage “mainstreaming HIV/AIDS” through an “effective multi-level, multi-sectoral, comprehensive and integrated response;”
- ∞ Outline a communication and co-ordination plan;
- ∞ Explain how information should reach district and local levels;
- ∞ Improve the flow of funds to LGAs and improve expenditure levels given inadequate flows and spending patterns to date (only 71 percent of 2001/02 funds were expended, much of the funding never reached the district level, and district councils only expended 1 percent instead of the expected 10 percent of local revenues);
- ∞ Streamline processes and reduce duplication and overlap between sectors and other actors dealing with HIV/AIDS;

- ∞ Improve plans for training of PORALG personnel (for workplace HIV prevention and for programme roles and responsibilities), Regional and District groups, and partner NGOs, FBOs, CSOs and private groups;
- ∞ Harmonize monitoring and reporting guidelines through establishing performance indicators with minimal data for routine collection and reporting;
- ∞ Ensure regional Technical AIDS Committees (TAC) collaborate with Regional Facilitating Agencies (RFA) to provide technical support to the Council Multi-sectoral AIDS Committee (CMAC);
- ∞ Recommend the use of Opportunities and Obstacles to Development (O&OD) process for participatory planning of HIV/AIDS responses at local levels, and
- ∞ Set, in collaboration with TACAIDS, the Ministry of Health and others, the “essential HIV/AIDS package to guide the allocation of resources to priorities generated out of the participatory planning processes.”

Very little is mentioned in PORALG’s HIV/AIDS Strategy regarding OVYC or PAW and their inclusion in Comprehensive District Council Health Plans. Orphans are mentioned once as one of a type of activity area that could be undertaken. With regard to behavioural risks, child labour is listed along with drug abuse, child abuse and alcoholism but no mention is made of: PAW with HIV who have not been identified and treated, infected infants, children or orphans. Vulnerable children and orphans are not overtly mentioned – although they clearly are implied – in the “basket” of components:

- a) Health interventions such as VCT, treatment of opportunistic infections, blood safety, STI management, home based care, PMTCT, ART and surveillance;
- b) Workplace interventions;
- c) School based HIV/AIDS prevention;
- d) Advocacy campaigns for the public and leadership;
- e) Support to vulnerable groups;
- f) Co-ordination of interventions.

Although, PMTCT is mentioned, many more services are required for PAW. This list needs considerable refinement in order to provide an adequate array of multi-sectoral programmes and services at local levels. **This policy provides a useful umbrella for the Policy Frameworks for ECD and HIV/AIDS but considerably more detail will be essential.**

### 2.1.2 Vice-President’s Office

The Vice-President’s Office (VPO) leads national planning for the reduction of poverty in Tanzania. It is currently in the process of developing its second National Strategy.

The VPO has prepared the following drafts and other policy papers:

- ∞ National Strategy for Growth and Reduction of Poverty (NSGRP), 2<sup>nd</sup> Draft, Wednesday, 27<sup>th</sup> October 2004
- ∞ First draft of Revised Poverty Reduction Strategy II and Annex II for second round of consultations, 16 August 2004
- ∞ NGO Act
- ∞ Participatory Poverty Assessment Report, 2003, Research and Analysis Working Group

- ∞ Poverty and Human Development Report, 2002, 2003
- ∞ Public Expenditure Review (PER), Socio-Economic Survey
- ∞ Poverty Mainstreaming in District Planning, Tracer Study and Training Needs Assessment Mainstreaming Poverty in Council Plans, 2003
- ∞ Tanzania Assistance Strategy (TAS) 2000 (Tanzania's donor co-ordination strategy)

**First draft of the Revised Poverty Reduction Strategy II and Annex II for the second round of consultations, 16 August 2004**

The first draft of what initially was called PRS II lacked an emphasis upon ECD, and especially on OVYC and PAW. Yet it is critically important to note that a full 40 percent<sup>36</sup> of the operational outcomes of PRS II are related to improving the status of pregnant adolescents and women and of children from birth to eight years of age. **To achieve these outcomes related to OVYC and PAW, it will be necessary to provide a few bold, practical and effective strategies using the integrated approach to ECD that are additional to current practice in Tanzania.**

Most systems for child health and nutrition have been in place for many years. Although some promising pilot programmes are yielding positive results, it is clear that even these systems are not yet comprehensive. They are not meeting the urgent needs of OVYC and PAW throughout the nation. A new system for ECD services, co-ordination and integration is needed to reverse negative trends in birth outcomes, the status of children and school readiness.

In the first draft of PRS II, "children" were designated as a "cross-sectoral theme." **However, a danger always exists that a cross-sectoral theme will become "invisible" if major cross-sectoral strategies for reaching and serving OVYC and PAW are not proposed. The strategies are needed to attract essential investments that will help to achieve PRS II goals and operational outcomes.** The only way to "mainstream" leading cross-cutting issues is to provide strategies and targets, as was done in the HIV/AIDS section of the draft PRS II.

Furthermore, the cultural dimensions of poverty were rarely mentioned in the document, and yet they are critical to achieving improved PRS targets related to children and families. Also, no mention was made of the need for Multi-sectoral Policy Frameworks for Mainland Tanzania and Zanzibar to guide work in ECD related to PRS targets for OVYC, PAW and HIV/AIDS.

A national PRS Goal for ECD is needed such as: Achieve school readiness and reduce costs related to high levels of school drop-out and grade repetition through improving parenting skills and early childhood development. To achieve this goal, new programmes

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<sup>36</sup> According to my count, 37 of the 93 operational outcomes currently deal with issues and problems routinely included in the integrated approach to ECD. Several additional operational outcomes could be considered, depending upon goals and strategies actually adopted so this percentage could rise to close to 50 percent. In some nations, the ECD indicators included in PRSPs have exceeded 65 percent.

for parent education, early childhood intervention for OVYC, and antenatal education and expanded services for PAW are required.

### **National Strategy for Growth and Reduction of Poverty (NSGRP), 2<sup>nd</sup> Draft, Wednesday, 27<sup>th</sup> October 2004**

On the basis of considerable consultation, the new PRS draft has changed its name to the National Strategy for Growth and Reduction of Poverty (NSGRP). This new draft reflects several of the points mentioned above regarding ECD. Under Cluster 2, Improvement of Quality of Life and Social Well Being, the following **Goals** are listed:

1. Improvement of equitable access for boys and girls to quality primary and secondary education, universal literacy among women and men and expansion of higher, technical and vocational education.
2. Improved health and well-being of all children, women, especially vulnerable groups through reducing infant, child and maternal mortality and malnutrition and increased prevention and treatment of HIV/AIDS.
3. All men, women and children are able to access clean, affordable and safe water, sanitation, decent shelter and a safe and sustainable environment, and thereby reduced vulnerability from environmental risk.
4. Adequate social protection and rights of the most vulnerable and needy groups with basic needs and services.
5. Effective systems to ensure universal access to quality and affordable public services.

#### **Broad Outcomes are presented:**

1. Improved quality of life and social well-being, with **particular focus on the poorest and most vulnerable groups**.
2. **Reduced Inequalities** (e.g. education, survival, health) across geographic, income, age, gender and other groups.

Under Goal 1, an Operational Target is provided for “**Early Childhood: Increase in the number of young children prepared for school and life.**” This Operational Target is not yet a Goal, but with a bit of work it could become a Goal with concrete indicators and operational targets.

Pre-school and Kindergarten are listed, reflecting the authors’ initial emphasis on formal education, even though parent education is central to achieving this Operational Target. Parent education is included later on in the text of the chart. The authors may have been unaware that the Ministry of Education and Culture’s (MOEC) Education and Training Policy (ETP) delegates to the MOEC services only for children five to six years of age through the provision of pre-primary education classes. The MOEC in Mainland Tanzania appears to lack a policy mandate for providing either ECD services for children from birth to age four or for conducting parent education programmes.

#### **The following Cluster Strategies are then provided:**

***A.1 Expand primary education system to develop quality pre-primary programmes that link with existing early childhood provision – health, nutrition, parenting education etc.***

Pre-primary education is already mandated in the ETP but it has not been carried out as yet. The linkage of these services with health, nutrition and parenting education could improve them greatly, but special emphasis is needed on the period of children from birth to ages three or up to five, as possible.

***A.2 Develop an inter-sectoral policy framework to guide early childhood development and promote pre-school learning.***

This is an excellent strategy and greatly needed if it includes children from gestation to age eight. This would provide another mandate to develop the Policy Frameworks for ECD and HIV/AIDS in Mainland Tanzania and Zanzibar.

Thus, this NSGRP Goal now calls for an ECD provision that includes parenting education and a Policy Framework for ECD. Quality home- and community-based ECD programmes tend to be more cost-effective than centre-based programmes, but both are needed. The Intervention Package slated for achieving the Operational Target under Goal One includes:

- ∞ **Early childhood development interventions**
- ∞ **Pre-school infrastructure**
- ∞ **Pre-school teachers training**
- ∞ **Pre-school books and learning aids**

Sectors or areas of collaboration include leadership by Education in collaboration with the following actors: MOEC, MOH, MWLD, MOW, private sector, CSOs, FBOs. This is a bit confused but the next draft should be clearer.

***For Primary Enrolment, Operational Targets have become more inclusive of OVYP:***

- 1.1 Increased gross and net enrolment of boys and girls in primary schools from 90.5% in 2004 to 99% in 2009. (This should be designated as gross or net enrolment.)
- 1.2 Increased proportion of children with disabilities enrolled, attend in and completing schools from 0.1% in 2000 to 20% in 2010. (This is a noble objective, but one that may prove very hard to attain, especially considering the lack of baseline statistics regarding children with disabilities.)
- 1.3 Increased proportion of orphans and most vulnerable children enrolled, attending and completing primary education from 2% in 2000 to 30% in 2010. (Issues regarding definitions are critical, and the base line is questionable and care should be taken regarding this projection.)

The also draft states, “Ensure all (boys and girls) children, including those with disabilities, pregnant school girls, orphans and other most vulnerable children (e.g. child labourers, street children) are able to effectively access and complete high quality, child friendly and gender sensitive primary education.” This could represent a considerable step forward.

**Goal 2 states:** Improved health and well being of all Tanzanians with special emphasis to children, women, especially vulnerable groups through reducing infant, child and

maternal mortality, morbidity and malnutrition, and increased prevention and treatment of HIV/AIDS. Targets include:

- 2.1 Reduced infant mortality from 95 in 2002 to 50 in 2010 per 1,000 live births. (This will require intensive antenatal education and care plus greatly improved birthing services.)
- 2.2 Reduced child (under five) mortality from 154 to 79 in 2010 per 1000 live births. (Again, comprehensive ECD services from birth to at least age five will be essential to achieve a major reduction in child mortality.)
- 2.3 Reduced hospital-based malaria-related mortality amongst under fives from 12% in 2002 to 8% in 2010. (This will require strong parent education programmes, the repeated provision of ITNs, and related medicines and health care.)

**Cluster Strategies include:**

- A.1 Improved neo-natal care and infant care and **ensure screening of under-5s for development disabilities and targeted nutrition education and supplementation for undernourished children.**
- A.2 Public health and primary preventive strategies such as broad access and use of ITNs, immunization, use of safe and clean water, personal hygiene and sanitary measures, and promote greater awareness and emphasize cost-effective interventions for reduction of water-related diseases, including environmental health.
- A.3 **National strategy for parenting education and support to achieve improved nutritional and health status of infants and young children.**
- A.4 Increased percentage of children under 2 years immunized against measles and DPT from 80% in 2002 to 85% in 2010.
- A.5 Explore options for more effective control of malaria: prompt treatment, especially for children under five and pregnant women, and older persons; and strategies to increase re-treatment rates.

All of these strategies are excellent. Nutritional supplements for PAW and OVYC will be a key intervention combined with high-quality parent education, nutrition education and infant stimulation. Targets could be provided for each of these strategies and other strategies could be offered relating to improved rates of child development through Early Childhood Intervention services (ECI) and Parent Education services combined with existing c-IMCI and other bundled health services.

**Intervention Packages** aligned with these cluster strategies are presented in the NSGRP, including:

- ∞ **Nutrition programme** (For PAW and OVYC? Does it include nutritional supplements in terms of food vouchers or just micronutrients?)
- ∞ **Infant and under five health care** (Will this include c-IMCI plus other currently missing elements for comprehensive well-child checkups, assessments and primary health care?)
- ∞ **Neo natal Integrated Package** (Same comments as above.)
- ∞ **Child nutritional programmes** (Same)
- ∞ Increased use of ITNs especially among infants, children and pregnant women.

- ∞ Environmental health programmes
- ∞ **Parenting education and health programmes** (This is excellent if the programmes are well-designed, rich in curricular contents and provided effectively to all PAW and parents and caregivers of OVYC.)
- ∞ Improve access to malaria treatment and step up environmental management to control mosquito breeding
- ∞ Immunisation programmes

It is important to integrate as many of these services as possible at the local level, and to plan overtly for that integration to occur at district, ward and community levels.

In addition, in a separate section, special provisions were made for children trapped in abusive child labour: “Educate communities on basic rights of a child including the fight against child labour; develop and implement programmes targeting reduction of child labour.” This topic could be expanded in order to place greater priority attention on the exploitation of young children, and especially those from four to eight years of age, while ensuring they are enrolled in quality pre-school, pre-primary, and primary education.

**All in all, this new NSGRP draft represents a major step forward because it appears to include the integrated approach to ECD as a programme strategy for achieving PRS targets. If well designed, adequately funded and faithfully implemented and evaluated, this PRS approach could become a notable achievement not just for Tanzania but also provide helpful guidance for other countries that are preparing or revising their PRS documents.**

### **2.1.3 Prime Minister’s Office Tanzania Commission for AIDS (TACAIDS)**

As has been the case in many countries, initially the HIV/AIDS pandemic in Tanzania was treated solely as a health sector issue. The National HIV/AIDS Control Programme had Short-Term Plans (1985 – 1986), and three five-year Medium Term Plans from 1987 to 2002. Soon, Tanzanian leaders realised that HIV/AIDS was a multi-sectoral issue. In 2001, TACAIDS was established to lead the nation’s multi-sectoral response to HIV/AIDS. Official documents related to TACAIDS include:

- ∞ National Policy on HIV/AIDS, September 2001
- ∞ National Multi-Sectoral Strategic Framework on HIV/AIDS, Tanzania 2003 – 2007
- ∞ Public Expenditure Review HIV/AIDS Multi-sectoral Update for 2004 (October 2003) (Draft Report 12/12/03)

The following documents are reported to be currently under preparation, and they should become available soon for use in developing the Policy Frameworks for ECD and HIV/AIDS.

- Participatory Situation Analysis (by October 2004)
- Development of National Monitoring and Evaluation Framework (by October 2004)
- Development of National Plan of Action (to be costed by September 2004?)

- Guidelines for Better Service Delivery to Children via Government, LGAs and NGOs (expected date unknown)

### **National Policy on HIV/AIDS, September 2001**

The National Policy on HIV/AIDS states in its first section, “The children under the age of ten years bear the brunt of the impact of AIDS and for them the impact is much longer lasting than for adults.” It also notes that infant and child mortality has risen as well as the number of orphans. However, the Policy focuses mainly on issues other than children infected or affected by AIDS. It does note the “critical importance of community based interventions including home care and support to orphans and PLHAs.” It stresses the importance of mobilising “funds for the support of community based interventions.” The Policy provides valuable guiding principles, an overall goal for multi-sectoral response, and specific objectives for prevention, testing, care, sectoral roles and financing. It includes references to the roles of CSOs, NGOs, FBOs and others, policy research, and legislation and legal issues, such as inheritance. Emphasis is given to safeguarding PLHAs’ rights and improving the quality of their lives while minimizing stigma.

Communities are encouraged to “develop appropriate approaches to reduce the HIV infection and care for the PLHAs and orphans in their localities.” PMTCT is mentioned and voluntary counselling and testing (VCT) of pregnant women is promoted. Prenatal transmission is addressed through providing education on the risks of transmission, counselling, information and education on alternative options including ART for infected pregnant women. Health professionals are asked to use prenatal and delivery options that will minimize the risk of HIV transmission. Postnatal transmission prevention is emphasized including counselling on breast-feeding, counselling of family members, and sensitizing the community on the “support needs of the HIV positive mother in her own care and prevention of transmission of the infection to the child, counselling on healthy baby feeding options or practices for infected mothers, and the economic empowerment of women to enable mothers to provide nutrition supplements for their children.” The latter is unclear because programmes of nutritional supplements generally are not available. Gender and other cultural issues are mentioned. Yet in another section, the policy notes, “Individuals requesting voluntary HIV testing may be required to contribute to the cost of counselling and testing.” Given the importance of VCT and the cost-effective nature of prevention measures, it is surprising that people living in poverty would be charged for what could be a life-saving procedure. This fee could deter many PAW from being tested.

The few mentions of OVYC that are found in the Policy are made in connection with childbirth, breastfeeding or their status as orphans. The Policy does not discuss the needs of children who are infected or affected by HIV/AIDS for comprehensive child development services, health and nutrition care, pre-school support, school attendance, as well as many other issues that are related to the HIV/AIDS pandemic. The Policy states that LGAs and local communities “shall be supported to facilitate and sustain support services to PLHAs, widows and orphans in their communities” although no statement is made with respect to how that assistance would be given. The reality in most of

Tanzania's poor communities is that they are unable to provide the care and support OVC need. The communities will require additional child development and caregiver services and special "safety net" financial and material resources to do so. The Policy states, "The necessary support and protection from HIV/AIDS shall be given to orphans and children in special institutions including street children and those with disabilities that are at risk of HIV infection." On the one hand, this is an excellent point because many of these children could become especially vulnerable to acquiring HIV infections as they mature. On the other hand, virtually all observers want to avoid institutionalising children. Both CSOs and government personnel state they prefer to support families and communities to provide direct assistance to orphans and vulnerable young children. The Policy states, "Orphans in sibling headed households shall need support from both the Central Government and Local Council and the community to minimize the impact of HIV/AIDS on their lives. Such support shall address the rights of children." However, no statement is provided about the type or amount of support that the Central Government could provide.

The Policy then states, "The definition of an orphan, within the context of a Tanzania society as far as the AIDS epidemic is concerned is a child between the ages of 0 to 15 years who has lost both parents." However, 1) the nation now defines a child as "under 18 years of age," 2) from an economic point of view, the loss of the household head may be just as devastating as the loss of both parents, and 3) the illness of a remaining parent may render a child virtually parentless. Later documents have remedied this point to some degree but this restricted definition of orphan status could be used as an exclusionary tactic in some resource-poor communities or by some governmental programmes. **Although the Policy is very general, it does provide a basis for preparing expanded Policy Frameworks in Mainland Tanzania and Zanzibar that will fill some of its many gaps related to OVC and PAW.**

### **National Multi-Sectoral Strategic Framework on HIV/AIDS, Tanzania 2003 – 2007**

The National Multi-Sectoral Strategic Framework (NMSF) was drafted on the basis of studies, literature reviews, and three important but somewhat limited consultations. It appears that mainly national-level actors were consulted, rather than the residents of communities and districts. Nonetheless, it is a valuable policy framework. The NMSF states, "Each sector, public, non-governmental organisations, faith based organisations and communities in rural and urban areas, are required to plan and implement cost effective HIV/AIDS interventions according to their comparative advantage." Government is slated to "continue to provide an enabling environment for strategic leadership in multi-sectoral response, co-ordination, advocacy, resource mobilization, monitoring and evaluation and provision of right information to the public." However, the NMSF states, "The concrete organisation and the institutional structuring of the response to the epidemic at Local Government Authority level is still under review. Whatever the outcome will be, capacities for planning, implementation, monitoring and review need to be strengthened at district/municipality as well as village and community level for these tasks." This is a major gap because clear guidance is needed for programme and service development at community, ward and district levels. The NMSF

notes that regions are to play an intermediate role. The NMSF is expected to guide government allocation of resources under the MTEF to “targeted HIV/AIDS interventions.” But the process for the allocation of governmental resources remains unclear.

The Framework is intended to “translate the National Policy of HIV/AIDS by providing strategic guidance to the planning of programmes, projects and interventions...” It seeks to overcome past difficulties of the NACP that “...were constrained by structural factors: low implementation rate; lack of human and financial resources; inadequate capacity of the implementing institutions; excessive bureaucracy and centralisation; insufficient co-ordination; and limited integration of development partner activities.” However, as noted above processes at the community, ward and district levels are still not clearly defined.

The NMSF presents a Vision, Mission, Approaches and Guiding Principles, Strategic Goals and Targets. **Nine Goals** are presented along with indicators, five of which are related to OVYC and PAW:

- ∞ Goal 1: Reduce the spread of HIV in the country. Indicator: percentage of young people aged 15 to 24 years who are HIV infected. Target: By 2007, reduction by 30 percent. (This target can only be achieved if youth receive HIV/AIDS community education and children in primary school receive HIV/AIDS education, especially since many over-age children are enrolled in primary school.)
- ∞ Goal 2: Reduce HIV transmission to infants. Indicator: Percentage of HIV-infected infants born to HIV-infected mothers. Target: By 2007, reduction by X percent. (Target to be set.) (This requires better preventive services, early identification, VCT, antenatal education, health care, nutritional supplementation, improved birthing, ART, and continuous postnatal education, health and nutritional care.)
- ∞ Goal 7: Increase the knowledge of HIV transmission in the population. Indicator: Percentage of young people aged 15 to 24 years who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission. Target: by 2007, 95 percent. (Once again this target cannot be achieved without instituting strong community education programmes and improving primary education curricula and methods.)
- ∞ Goal 9: Reduce the adverse effects of HIV/AIDS on orphans. Indicator: Ratio of current school attendance among orphans to that among non-orphans in the age-range of 10 to 14 years. (Due to the fact that most AIDS orphans are living in severe poverty and are malnourished, chronically ill, and developmentally delayed, there is little possibility that this goal will be attained without a comprehensive programme for OVYC from birth through school entry, at a minimum. Furthermore, expenses related to formal education rarely can be borne by their caregivers, and all school fees should be suspended for OVYC.)

Separately, four thematic areas are presented, each with a set of strategic objectives and core strategies. The four areas are:

1. Cross-cutting issues including the enabling environment;

2. Prevention including gender;
3. Care and support, and
4. Mitigation of socio-economic impact.

One of the strategic objectives is related to PMTCT during pregnancy, at birth and during initial feeding, along with an outcome indicator: Percentage of HIV-infected pregnant women receiving a complete course of antiretroviral prophylaxis to reduce risk of MTCT. Another strategic objective calls for empowering children, girls and women to protect themselves again HIV infection that requires a wide array of community and school education efforts.

For mitigation, the NMSF recognizes the support needs of families impacted by HIV infection. “Loss of breadwinners in the family, female and child-headed households are some of the consequences of the AIDS impact. In the overall context of poverty reduction, new regulations like adapted health insurance schemes, social security measures and even direct assistance including provision of food may in many cases be necessary.” It includes the following strategy, “Develop a social and economic policy framework to address the needs of the affected persons and communities.” The preparation of this policy framework is the “expected outcome.”

In the following section on “Supports to Orphans,” it states, “Among the persons and groups heavily affected by the epidemic, the orphans are probably the most vulnerable group which are threatened in their survival and the development of life-perspectives. Traditional support structures (extended families etc.) may no longer be capable to absorb this challenge. Orphans unprotected may be extremely exposed to a variety of social/economic degradations (street children, delinquency, economic sexual survival activities, drugs, etc.), including increased risks of HIV transmission.”

There is a call for “new social and charitable programmes to be developed respecting also the needs of non-AIDS related causes of child survival problems. (This should read: child survival and development problems.) The Strategic Objective is: “Increase the proportion of AIDS orphans having access to adequate integrated, community-based support.” Strategies include:

1. Study the extent of the issue under different scenarios.
2. Develop policy guidelines and co-ordination of interventions for orphans.
3. Strengthen and expand integrated and innovative programmes for orphans especially at the district and community level (education, health care, shelter, psychosocial counselling, life skills training, etc.)
4. Support NGOs, CBOs, and FBOs in developing and sustaining support activities wherever possible in close relation with existing traditional family and community systems.
5. Address stigma and discrimination against HIV/AIDS orphans.

The Expected Outcome is vague but important, “AIDS related and other orphans have developed their capacities to lead a productive life and are guided by social policy measures.” It is unclear whether or not the Government will provide funding for these services or if CSOs are expected to develop their own resources. This issue should be

addressed in the Policy Frameworks for ECD and HIV/AIDS, for the provision of essential social services is a public responsibility that should be carried out in close collaboration with CSOs.

**These last two thematic areas help to justify the preparation of the National Policy Framework for ECD and HIV/AIDS. Clearly, the NMSF represents a good beginning. The full range of supports required by OVYC and PAW can be included in the future Policy Frameworks for Mainland Tanzania and Zanzibar.**

Monitoring and evaluation is stressed in the Framework, although more work is still needed to select more and better measurable indicators and their targets. Provisions for pre- and in-service training need to be made. Finally, general guidance regarding co-ordination, management and financial planning processes is presented, but it is clear that as of the time of the preparation of the NMSF, all pertinent details had not yet been worked out.

### **Public Expenditure Review: HIV/AIDS Multi-Sectoral Update for 2004 (October 2003) (Draft Report 12/12/2003)**

The Public Expenditure Review (PER) reveals the achievements and challenges the Government faces as it seeks to fulfil its policies and strategic plans. Even though all ministries, departments or agencies of Government (MDAs) are called upon to develop sectoral HIV/AIDS plans, as of the time of the preparation of the PER, most had not done so. Also, from a budgetary point of view, only three government agencies have been active in the HIV/AIDS fight. With 99 percent of the Government budget disbursed in 2002/3 (a major accomplishment in itself), these agencies expended the following proportions of available funds:

- ∞ TACAIDS (64 %)
- ∞ MOH (26%)
- ∞ MOEC (8%)
- ∞ All other MDAs (2%)

This is astounding because other ministries, such as the Ministry of Labour, Youth Development and Sports whose Department of Social Welfare that has the mandate for guiding, implementing, coordinating, monitoring and evaluating services for OVYC, have been given very small budgets. According to the PER, if other MDAs were to prepare good HIV/AIDS strategies and related MTEFs, they would receive greater amounts of funding. The PER notes "...the budgets are low in part because the agencies have yet to define their role in a clear strategy and costed action plan that would unlock financial resources from MOF and other financiers." This is often true for general investments in ECD in many countries. Good policy frameworks and action plans build confidence in a ministry's capacity or in a multi-sectoral approach to conduct effective programmes. Therefore, the PER calls for technical support to be given to MDAs to prepare their HIV/AIDS plans, and it encourage them to give "serious attention" to meeting HIV/AIDS challenges that are within their mandates.

**The PER states that investments in preventive services are much more cost-effective than investments in care and treatment.** It notes an African study found that the rapid scaling up of prevention has the potential to prevent 58 percent of new infections.<sup>37</sup> Based on this, the authors state that, “A very crude calculation also suggests that, unlike spending on care and treatment, the benefits of effective expenditure on prevention should be self-financing in the medium-long term. They do not call for eliminating support for care and treatment but rather they call for a better balance. They state, “There is already some evidence that the pattern of spending is becoming unbalanced, with a big increase in commitments to care and treatment while prevention interventions remain too small scale and localised, and **mitigation** [for children and orphans affected by HIV/AIDS] continues to lack policy direction or significant funding.” It states, “...the first priority must be to ensure that the prevention effort is fully funded, to prevent infection among those entering the sexually active age groups, and among as many as possible of the 88 percent of the adult population currently free of infection.”

Therefore, the PER calls for mainstreaming HIV/AIDS in the curriculum and ensuring all teachers and children are reached with effective educational components. Unfortunately, at present, the authors found that, “The budget is dominated by the cost of books and teaching materials and the training of teachers, but the budget allocated in the current MTEF will meet only a fraction of the demand: spending of TSh500mn p.a. on training teaches will enable just 2 percent of the primary and secondary school teachers to receive training by the end of the current MTEF period, and supply of books and teacher guides is similarly inadequate. The envisaged budget of TSh180mn p.a. would provide books to just 5 percent of primary school pupils by 2005/6 before allowing for wastage. There are similar shortfalls on teachers’ guides and workbooks at higher levels.” It is clear from this review that investment in HIV/AIDS education requires careful review and increased resources. Such resources should also be made available for parent and caregiver education programmes throughout Tanzania. This effort could be included in the Policy Frameworks for ECD and HIV/AIDS in the strategies for the six to eight year age range.

The report, “recommends a substantial increase in spending via LGAs. It notes that some districts are receiving much more funding support than others, and it calls for **greater equity**. They found that “Initial HIV/AIDS Action Plans have been prepared by most LGAs, but the quality has been weak, confirming the need for “capacity building support” for planning. They state, “Achieving the required scaling up of the district and community response, while also improving the balance between prevention, care and mitigation, and the balance between districts, requires significantly increased funding that can be allocated to districts and communities on the basis of need and of capacity.” No mention is made of the amount of funding per area, but other verbal reports from CSOs reveal that funding for mitigation and OVYC and PAW is very meagre. The authors state that, “Low planning capacity at LGA level, poor guidance on how to prepare plans, and lack of [their] own resources to undertake activities contributed to the poor quality of the plans.”

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<sup>37</sup> Stover, J. et al. (July 6, 2002). Lancet.

The role of LGAs in planning, resource allocation, co-ordination and monitoring is critically important; however, it is observed that, “most spending programmes will be undertaken using NGOs, CBOs and FBOs.” The authors note that “In its PRSP (2000) GOT made clear its intention to support vulnerable groups.” Thus, the reduction of vulnerability was to be adopted as one of the interventions in the fight against poverty. For this to be effective, local communities were expected to play a major role in identifying the needs of the most vulnerable groups, namely the orphans and handicapped. However, until 2002, not much had been done. And then the authors state, “The ability of the government to protect and help the vulnerable, including those made vulnerable through ill health or orphaned, is limited by the non-availability of concrete safety-net programmes and more so by non-availability of financial resources.” Most distressingly, they also observe that, “Given the non-availability of concrete government plans and resources to private support resources, a substantial proportion of the most vulnerable members of society have been left unattended so far.” **This revealing report underlines the importance of ensuring that an effective Policy Framework for ECD and HIV/AIDS provides concrete guidance on how communities should plan for and serve OVC and how they can access the financial, material and human resources they will require.**

#### **2.1.4 Ministry of Community Development, Gender and Children (MCDGC)**

Due to its mandate for policy preparation for children, the Ministry of Community Development, Gender and Children currently is designated as the lead ministry of the Country Support Team for ECD and HIV/AIDS. The MCDGC has been charged with preparing and disseminating policy statements and guidelines in its assigned areas of work, developing programmes, conducting workshops, monitoring and evaluating policies, preparing reports, and guiding 58 Folk Development Colleges and four community development colleges. **This decentralised training capacity might be helpful for preparing multi-disciplinary teams for 1) home-based Parent Education and Support services, and 2) Early Childhood Intervention activities.**

In recent years, the MCDGC has developed some policy statements and documents, and currently it is preparing several new and revised policies:

- ∞ Child Development Policy, 1996 (This policy statement is currently being revised. The new draft is being prepared in Kiswahili and was not provided for this review.)
- ∞ Implementation Framework for the Child Development Policy (This is under preparation and also is unavailable.)
- ∞ Community Development Policy, June 1996
- ∞ Women and Gender Development Policy, 2000
- ∞ Women in Development Policy, 1992
- ∞ Public Expenditure Review, Proposed Section for Cross-cutting Issues in the Plan and Budget Guidelines: Children, Adolescents and Young People, 2004
- ∞ Population and Family Life Education Programme: POFLEP Document 2004 – 2007, February 2004

- ∞ The Country Second Periodic Report on the Implementation of the Convention on the Rights of the Child (CRC), 1998 - 2003
- ∞ Strategy to Protect Women and Children against HIV/AIDS (This title may change. It is under preparation and is unavailable at this time.)

Other pertinent documents related to the MCDGC include:

- ∞ HIV/AIDS and its Impact on ECD in Tanzania, Mombassa, Kenya, 2002
- ∞ Draft Report for Revision of National Programme of Action for Children, 2002/3
- ∞ National Plan of Action (to combat violence against women and children, 2003)

With respect to laws, the following recent laws merit special mention for their importance to child rights, protection and welfare:

- ∞ Sexual Offences Special Provisions Act of 1998 (amends the Children and Young Persons Ordinance)
- ∞ Ratification of the African Charter on the Rights and Welfare of the Child and two optional protocols to the CRC (Optional Protocol on the Involvement of Children in Armed Conflicts and Optional Protocol on the Sale of Children, Child Prostitution and Child Pornography, March 2003).

### **Child Development Policy, 1996**

This brief policy statement is general and currently it is being revised. In line with the CRC, the 1996 Child Development Policy defines a child as “a person below the age of eighteen,” but notes that this is at variance with labour and marriage laws that permit marriage and employment at age 15. (The latter may not be a problem in some cases if the work is not abusive.) This Policy statement focuses on children’s rights, survival, development and protection at a general level. It places some emphasis on young children. It makes brief references to OVYCs or PAW with respect to birth outcomes and parenting skills but a separate section for young children is not provided. The Policy recommends that research be conducted on child development and issues regarding child survival and protection.

The Policy statement calls for ensuring the safety of the mother and child before and after delivery and the provision of basic services for children from birth to five years of age, and from five to 13 years; however, specific measures are not provided. It calls for a review of existing laws and the enactment of new ones in all CRC areas. Regarding orphans, it calls MCDGC and MOLYDS to work together to conduct research and consider the possibility of “establishing villages for orphans and abandoned children as well as a host families system.” It decries abuses against children but no concrete measures are advanced.

Regarding day care centres and pre-schools, their poor quality is noted but only general recommendations are provided. The Policy calls for advocacy for the “establishment of pre-schools and day care centres and improvement of their services; as well as to establish a system of education for parents on the importance of pre-school education and assist in developing a conducive learning environment for the child.” At another point, the Policy states, “The ministry responsible for Education in collaboration with ministries

responsible for Social Welfare, Children Affairs, Local Government, other institutions and communities should raise the standards of pre-school education.” However, no concrete guidance is given. It delegates to MCDGC the responsibility of educating and mobilizing “the community on the rights of the child in Tanzania and how to put them into practice” and it, “should mobilize, advocate and educate parents on breastfeeding and weaning of children, and on harmful traditions and customs which adversely affect nutrition, health and the survival of children and pregnant mothers.” This would seem to imply that MCDGC should help to provide parent education but no plan is advanced. The MCDGC also is given the responsibility to “...issue guidelines, rules and regulations and coordinate implementation of all programmes and measures to promote child survival.” However, no explanation of its relationship to the Ministry of Health is given. Finally, it states that the MCDGC “in collaboration with other institutions, should mobilize and sensitize parents, guardians and communities on their responsibility for child development.” However, the Ministry responsible for Social Welfare is asked to “ensure that children in difficult circumstances receive their rights and basic services.” There is scant mention of HIV/AIDS in the policy in spite of its major impact upon young children in Tanzania.

It is interesting to note that on 5 November 2004, The Minister of MCDGC, Dr. Asha Rose Migiro said in *The Guardian*, that “66,371 children in Mainland Tanzania and 246 in Zanzibar had been left to fend for themselves in addition to taking care of their siblings.” She stated that, “the government planned to establish committees charged with assisting AIDS orphans and families depending on minors.” Apart from the fact that it is generally conceded that many children in these situations have not yet been identified, it is unclear where the responsibility for assisting these children actually lies. Increasing public interest, as reflected in this recent article, should help to bring about a clarification of roles and responsibilities.

Throughout the Child Development Policy, there is a major overlap of ministerial responsibilities and no clarification of roles is provided.

**This confusing situation contributes to the continuation of orphans and vulnerable young children “falling through the cracks” because no clear national institutional leadership exists in Tanzania for young children, and especially for vulnerable young children. There is a major need for a clarification of roles and responsibilities regarding young children between not only MCDGC and the Ministry of Labour, Youth Development and Sports (Department of Social Welfare) but also with the Ministry of Health and the Ministry of Education and Culture. Fortunately work has begun to clarify this situation, and once developed, the Policy Framework for ECD and HIV/AIDS will contribute further to ensuring OVYC will be well served.**

No mention is made of any nation-wide consultation that may or may not have been conducted to formulate the Child Development Policy. The policy statement itself lacks the following basic elements: major goals, objectives, strategies and programme areas; provision for co-ordination structures and their roles and responsibilities; an evaluation

and monitoring plan with indicators and targets; a pre- and in-service training system; a policy advocacy and social communications plan; an investment plan, and provisions for donor and partnership co-ordination. Undoubtedly these gaps will be taken care of in the new draft of the revised Child Development Policy.

**Finally, it is hoped that the Policy Framework for ECD and HIV/AIDS for Mainland Tanzania will be fully consistent with and will help to supplement the new Child Development Policy when it is produced by MCDGC.**

### **Community Development Policy, June 1996**

This Policy statement provides a context for MCDGC activities to prepare community development personnel who help with community planning, management and development activities in all areas, from health, nutrition and education to infrastructure, sanitation, and other communal projects. The roles of Folk Development Colleges are mentioned. Few statements are made regarding young children but a strong focus is given to family development for community progress. Subsequent guidelines of PORALG have contributed greater specificity regarding O & OD and other planning and structural issues that supersede elements presented in the Community Development Policy. As such, this policy appears to be less relevant now than some others to the formulation of the Policy Frameworks for ECD and HIV/AIDS.

### **Women and Gender Development Policy, 2000**

This revision of the Women in Development Policy of 1992, states “Women, especially rural women, who constitute 80% of the labour force and produce 60% of the food, are excluded from deciding on the wealth that they have created. Also, women have no say in reproductive issues, such as how many children the family should bear, though they are the bearers and perform a major role in child rearing.” The situation analysis of the status of women in this policy statement appears to be valuable and it reflects many of the challenges ahead in developing effective services for PAW and OVYC. However surprisingly, the statement does not have many references to PAW issues, thereby leaving a policy gap in this area. It wisely calls for creating “awareness on the importance of proper child upbringing as a basis for eliminating gender discrimination in the future.”

The Policy notes that 24 percent of the households are headed by single females. It emphasises the heavy workload especially of rural women, and it states they often work from 16 to 18 hours per day thereby lacking time to provide adequate child care. After childbirth, they are reported to be unable to recuperate well, and work causes them to experience difficulties with breastfeeding. Yet there is little call in the Gender Policy for greatly expanded quality child care and pre-school centres to help working women with childrearing and child development. One mention exhorts, “Improve social services, day care centres and health care.” Although there is some mention of HIV/AIDS, it is not commensurate with its generalised impact on adolescent girls, women and PAW. **Girls’ education and the prevention female of school drop out are given strong consideration in this document and provide a good basis for emphasizing this area**

**in the strategies for the six to eight year age range of the Policy Frameworks for ECD and HIV/AIDS.**

**Population and Family Life Education Programme: POFLEP Document 2004 – 2007, February 2004**

Although presented as a programme plan, this document includes an implementation framework that presents issues, programme objectives, activities, output indicators and responsible parties. It deals with the following fields that are related to OVYC and PAW:

- ∞ Gender inequality;
- ∞ Sexual reproductive health problems;
- ∞ Family problems, and
- ∞ Poverty factors.

The Policy Framework for ECD and HIV/AIDS could note this contextual work and could refer to recommended inter-ministerial collaborations.

**Public Expenditure Review, Proposed Section for Cross-cutting Issues in the Plan and Budget Guidelines: Children, Adolescents and Young People, 2004**

Although this document is very general, it is the result of a potentially useful effort to view budgets across ministries from the vantage point of children. It notes that a “newly formed **PER Working Group for Children** will be responsible for auditing the inclusion of these critical issues.” Programmes are listed that are relevant to young children, and a few of them are selected for mention below. This PER section represents a beginning effort to review programmes for children throughout Government ministries.

- ∞ Children’s rights and related policy dissemination (MCDGC);
- ∞ Mainstreaming young people’s issues into policy programmes such as PRS and HIV/AIDS initiatives (MCDGC);
- ∞ Implementation of NPA for the eradication of FGM (MCDGC);
- ∞ Provision of professional counselling on psychosocial support for 500 OVYC and young people infected and affected by HIV/AIDS (MLYDS);
- ∞ Facilitate 7,500 OVYC to access and gain awareness of HIV/AIDS prevention measures (MLYDS, PORALG);
- ∞ Mainstream expansion of programme support of MVC in 10 districts and ministries (MLYDS, MCDGC, MJCA, MOEL, MOH, PORALG);
- ∞ Develop comprehensive data system for MVC, including monitoring and supervision (MLYDS, OO-PP, NBS, PORALG, POPP);
- ∞ Develop strategies and guidelines for ECD, including to print and disseminate 20,000 National Integrated Early Childhood and Development guidelines across age ranges (MLYDS, MCDGC, MOEC, MOH);
- ∞ Train 100 parents/families/caregivers in each district in six districts on early child stimulation for early intervention (MLYDS, MOH, PORALG);
- ∞ Advocate and sensitise on ECD in 20 districts (MLDS, MCDGC);
- ∞ Review and print all existing ECD training curricula for 0 to 6 years and develop integrated and holistic training curricula across the age range (MLYDS, MCDGC, MOEC, MOH);

- ∞ Ensure vital child registration (MDCGC, MLTDS, MOH, MOJCA), and
- ∞ Facilitate 5,000 to 30,000 OVC to access health care and treatment (MLYDS, MOH).

Several other provisions relate to large on-going programmes for children provided by the MOH and MOEC. It is clear from this list that considerable overlap exists with respect to programmes for OVYC and PAW, even though funding for them is very limited. However, new emphasis is being given to critically important ECD programme areas in spite of stringent budget situations. **It will be essential for consensus to be built regarding institutional leadership, roles and responsibilities, and for this to be presented in the Policy Frameworks for ECD and HIV/AIDS.**

### 2.1.5 Ministry of Education and Culture (MOEC)

The Ministry of Education and Culture developed the **Cultural Policy** of 1997 that designates the national language as Kiswahili, with English a compulsory second language in pre-primary, primary and secondary schools. This Policy also reaffirms children's rights and includes the family as "basic and important institution for fostering ethics, education, training and culture." Other relevant MOEC policies include:

- ∞ Education and Training Policy, ETP, 1995
- ∞ Primary Education Development Plan, 2002-2006 (April 2003)
- ∞ Minimum Standards for Pre-Primary Education: Working Paper, 2000
- ∞ Medium Term Expenditure Framework, Ministry of Education and Culture, 2003/04
- ∞ Joint Review: Primary Education Development Plan (September – October 2004)
- ∞ Strategic Plan for HIV/AIDS, 2003 – 2007 (May 2004)

Other education documents potentially germane to services for OVYC and PAW include:

- ∞ Adult and Non-formal Education Sub-sector Medium Term Strategy, 2003 – 2007, (February 2003)
- ∞ Education Sector Development Programme, 2000
- ∞ Basic Education Master Plan, 2001
- ∞ Secondary Education Development Plan, 2004-2008
- ∞ Minimum Standards for Education on Service Delivery in the District, Department of Planning Working Paper, 2000
- ∞ Guidelines for registration of schools – private and government
- ∞ Education Indicators in Tanzania, 1999
- ∞ National Higher Education Policy, February 1999

#### **Education and Training Policy (ETP), 1995**

**The ETP of 1995 guarantees access to pre-primary for children five to six years of age, primary education and adult literacy to all citizens as a basic right.** It re-opened partnership with private sector education institutions, NGOs and FBOs while describing a more decentralised system that delegates greater authority and responsibility to schools, local communities, districts and regions. It focused on improving educational quality,

integrating formal and non-formal education systems, and increasing access and equity, especially for girls and women, disadvantaged groups and geographical areas.

The ETP notes that “Infants and young children (0 to 6 years old) are cared for and receive initial education both at home and in the few existing day-care centres, kindergartens, nursery and other pre-schools located mainly in urban areas.” After this declaration, it states, “While taking cognizance of the importance of pre-school education, it would not be economically feasible to formalize and systematize the entire education spectrum of this age group. **The nursery, day care centres, kindergarten, etc., for ages 0 – 4 years will continue to be not part of the formal education and training system.**”

However, the ETP states, “**The Government shall guarantee access to pre-primary, primary and adult literacy as a basic right.**” It also pledges, “**The Government shall promote pre-school education for all children, 0 to 6 years.**” The Government promises to “give incentives and liberalize the establishment and management of pre-primary schools.” At the same time, it states that “**Pre-primary school education for children aged between 5 and 6 years shall be formalized and integrated in the Formal School System.**”

The ETP states that **both “pre-school and pre-primary will be used to identify children with special learning abilities or difficulties and take appropriate corrective measures.”** However, **no provision is explicitly made for testing before, during or after pre-primary.** The Tanzania Institute of Education is declared to be responsible for preparing curriculum guidelines for pre-primary education, along with their dissemination, and pre-primary monitoring and evaluation. **However, when all is said and done, it is declared that compulsory basic education begins at age seven, not at age five.**

The curricular guidelines prepared to date for pre-primary education are reported by many people working in preschool education to be relatively unknown in many pre-school settings throughout the country. **There is reported to be no curriculum for centres serving children from birth to age four, and that these centres are nominally under the supervision of the MOLYDS.** Adequate statistics are not kept on all of the centres and schools serving children from birth to six years of age. It is generally agreed that these centres are fragmented with some participation by various ministries, local communities, NGOs, CBOs and FBOs. Overall co-ordination of pre-schools, child care centres and pre-primary education currently is reported to be non-existent.<sup>38</sup> **Without attributing problems of communication and coordination to any one agency, the co-ordination of all child care, pre-school education and pre-primary education is a major area that should be dealt with in the Policy Frameworks for ECD and HIV/AIDS.**

### **Primary Education Development Plan, 2002-2006, April 2003**

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<sup>38</sup> Naomi Katunzi and Oliver Mhaiki. (February 2002). *Curriculum Issues in Early Childhood Development: the Case of Tanzania*. Mombassa, Kenya.

The PEDP focuses on educational quality improvement with the goal of reducing very high rates of school drop out, especially through teacher training, eliminating school fees, and improving testing. However, surprisingly the PEDP does not include any provisions for:

- ∞ Pre-primary education as a strong measure to improve school retention;
- ∞ Parent education and early childhood development to achieve improved school readiness;
- ∞ Services to help ensure a smooth transition from home to primary school, and
- ∞ Assessments of the entering competencies of children.

**Significant additional attention needs to be given to pre-primary and pre-school education in relation to primary education and to the development of transition programmes with effective parent involvement in the schools from before their children's enrolment.**

### **Minimum Standards for Pre-Primary Education: Working Paper, 2000**

This brief document lists some basic items such as school environment, classroom size, teacher/pupil ratio, 2 adults per class, washroom with one toilet per 15 pupils, furniture, materials, water, first aid, communications, power supply, fire extinguisher, sports and recreation equipment, and food for providing at least one meal per day. No statement is provided with respect to training headmasters and school personnel, pre-primary curricula, teaching methods or learning materials. **Much more work is needed to improve the standards and overall quality of pre-primary education and this work should be extended downward to infant and early childhood care and education.**

### **Medium Term Expenditure Framework, Ministry of Education and Culture, 2003/04\***

The Education MTEF notes a major improvement of the Net Intake Ratio which increased from 18 percent in 2000 to 85 percent in 2003. Classroom performance is also reported to have improved. It observes that expanded scholarships will be needed to meet the needs of students from poor families and orphans. It underlines the importance of addressing HIV/AIDS in schools, and filling the gap caused by tuition fees that are to be reduced by half per student for day schools beginning 2004/5. It states that there has been increased participation on the part of the private sector in pre-primary education.

With respect to pre-primary education the MTEF states, "About 10 percent of the target population of age 5 – 6 have access to this level of education." Enrolment is reported to stand at 744,750 students (2003) in government and non-government pre-primary schools countrywide.<sup>39</sup> It states that the MOEC intends to attach one pre-primary class to each primary school. The Ministry has the responsibility for training pre-primary school teachers, providing the necessary policy framework for pre-primary education, and

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<sup>39</sup> George Kameka. (February 2002). "General Overview of ECD in Tanzania." Ministry of Labour, Youth Development and Sports, Dar es Salaam, Tanzania, and others report that only 3 percent of the appropriate age range currently are served by pre-primary education.

guidelines. It also “encourages the private sector and communities to establish, own and manage pre-primary schools.”

No indicators or targets were found for pre-primary education in this or any other MOEC document, although they may exist in other MOEC documents that simply were not found. Without widely accepted targets, it is highly likely that budgetary levels will remain low and that the MOEC will give little attention to children under 7 years of age.

**If the MOEC does not plan to fulfil or is unable to fulfil its mandate to serve children five to six years of age and younger through pre-school and pre-primary education, then perhaps discussion should be undertaken to search for other provisions through another ministry or Executive Agency (parastatal agency) devoted to early childhood development. Even though the pre-primary issues may be resolved, this would still leave the developmental needs of children from birth to four also without a competent institutional home. Issues regarding services for children from birth to four years of age as well as from five to six years of age should be resolved in the Policy Frameworks for ECD and HIV/AIDS.**

#### **Joint Review: Primary Education Development Plan (September – October 2004)**

This review contains no reference to pre-primary education. It does detail many shortcomings of the PEDP, and provides a less positive view of current initial primary school enrolment at age seven. Careful reviews of enrolment, attendance and completion rates for pre-primary and the first years of primary school will be required to establish baselines for measuring the impact of ECD and HIV/AIDS services once they are in place.

#### **Strategic Plan for HIV/AIDS, 2003 – 2007 (May 2004)**

Given PORALG’s call for ministerial HIV/AIDS plans as well as the severe loss of teachers due to HIV/AIDS, the rapid increase of orphans infected and affected by HIV/AIDS, and requirements to expand education on prevention to primary and secondary schools as well as to non-formal education programmes, the MOEC prepared a very good Strategic Plan for HIV/AIDS. The Plan states, “The MOEC is a supplier of trained and educated human resources for all social and economic development. Society is being deprived of this potential. Teachers and other education personnel are slowly and irreversibly being depleted, leaving a weak base not only for the MOEC but also for the entire social and economic development system.” It also notes that, “Many orphans are failing to attend school or have miserable school lives because of wide spread stigma and discrimination which affects their performance. Erratic school attendance of orphans and sick children is likely to result into lower achievement among the affected children and the schools.”

Recently the International Institute for Educational Planning (IIEP/UNESCO) began a multi-national study on the impact of HIV/AIDS on the education sector and included Tanzania’s MOEC in the study. A preliminary report noted the absence of a Ministry-specific policy on HIV/AIDS, and recommended it be formulated within the framework

of the ETP. It also made recommendations regarding leadership issues, advocacy, instructional materials, staff training and replacement, and improvement in MIS systems.<sup>40</sup>

The MOEC Strategic Plan for HIV/AIDS calls for partnerships with other agencies. It reconfirms and expands the structure developed previously by the MOEC to deal with its HIV/AIDS response. It includes an AIDS Steering Committee that makes decisions, an AIDS Education Co-ordination Unit, and a Technical AIDS Committee at the national levels, as well as committees at zonal, regional and district levels. It calls for grass roots collaboration with schools, Community AIDS Committees and other collaborating partners at all levels.

The following thematic areas are listed, each with a strategic objective (SO), strategies and outputs, justification, opportunities, constraints, activities, and “target indicators:”

- ∞ **Prevention SO:** Strengthen the implementation of comprehensive, gender responsive and inclusive HIV/AIDS/STIs prevention education in schools, non-formal education centres and teachers colleges.
- ∞ **Impact Mitigation SO:** Establish a mechanism to mitigate the impact of HIV/AIDS on the MOEC.
- ∞ **Care and Support SO:** Increase the provision of care and support services.
- ∞ **Addressing Cross-Cutting Issues SO:** Improved response mechanism for better management and co-ordination of the HIV/AIDS Education Programme.

Implementation matrices are provided for each thematic area. The Strategic Plan adds a rich section on evaluation and monitoring related to lists of target indicators for each thematic area. Research is called for regarding socio-cultural behaviours that influence vulnerability and risk; provision of care, support services and coping mechanisms, and the impact of HIV/AIDS on the MOEC as the Government institution with the largest number of civil service employees.

**However, this Strategic Plan focuses on education personnel, OVC and other students seven years of age and older, leaving children six and under without a similar plan. This is a major gap area regarding the impact of HIV/AIDS on children from birth to age six that needs to be filled in the Policy Frameworks for ECD and HIV/AIDS.**

### 2.1.6 Ministry of Health (MOH)

The Ministry of Health has made a significant effort to develop policies, plans, guidelines and programmes to meet critical OVYC and PAW health needs in Tanzania. Among pertinent documents, the following have been reviewed or are considered to be especially relevant:

- ∞ Strategic Health Plan for 1995 – 1998

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<sup>40</sup> *The Impact of HIV/AIDS in the Education Sector in Tanzania: Study 1 – Exploring Policy, Leadership and Advocacy Response.* (2003). MOEC/IIEP-UNESCO.

- ∞ Action Plan, 1996 – 1999
- ∞ Health Sector Development Programme (HSDP), 2000 – 2011
- ∞ Second Health Sector Strategic Plan, July 2003 – June 2007
- ∞ National Environmental Health and Sanitation Policy Guidelines, April 2004
- ∞ Reproductive and Child Health Strategy 2004 – 2008 (January 2003)
- ∞ National Policy Guidelines for Reproductive and Child Health Services (May 2003)
- ∞ National Adolescent Health and Development Strategy, 2004 – 2008
- ∞ National Immunization Programme, Financial Sustainability Plan, revised November 2003
- ∞ Strategy for Reproductive and Child Survival, 1997 – 2001
- ∞ Proposed Framework for the Implementation of Community Based Health Initiatives (CBHI) in the Context of Reforms in Tanzania, April 2000
- ∞ National Health Policy, 1990
- ∞ Health Sector Strategy for HIV/AIDS, 2003 – 2006
- ∞ National Malaria Medium Term Strategic Plan, 2003 – 2007
- ∞ National Plan of Action for Prevention of Female Genital Mutilation and other Harmful Traditional Practices, 2001 – 2015
- ∞ National Reproductive and Child Health Communication Strategy, 2001 – 2005
- ∞ EPI Strategic Plan, 2002 – 2007
- ∞ IMCI Strategy, 1998 – 2003
- ∞ Prevention of Mother to Child Transmission (PMTCT) Guidelines
- ∞ Community Based Reproductive and Child Health Strategy
- ∞ URT, Acts Supplement No. 1, The Community Health Fund Act, 6 April, 2001
- ∞ School Health Programme Guidelines
- ∞ Malaria Control Programme Guidelines
- ∞ National AIDS Control Programme Guidelines
- ∞ Paediatric Department Guidelines
- ∞ Baby Friendly Hospital Initiative (BFHI) Guidelines and other Guidelines

Other strategies and communications approaches currently are underway or being prepared, including those for IMCI and child nutrition. Future studies should review these strategies as they become available.

### **Strategic Health Plan for 1995 – 1998, Action Plan 1996 – 1999, and the Health Sector Development Programme (HSDP), 2000 – 2011**

The Strategic Health Plan and Action Plan are based upon but in effect superseded the 1990 Health Policy that sought to reform the Health Sector when the downturn in health statistics for PAW and OVYC made it clear that health services were declining, especially but not solely due to the impact of HIV/AIDS. The main thrust of these plans was to decentralise services to LGAs and establish partnerships with CSOs, FBOs and private health providers while reducing government personnel for health. Subsequently, the Health Sector Development Programme was drafted, with three three-year segments. This programme provides a long-term plan for health and places emphasis on the provision of primary health services, especially in rural, under-served areas. It also seeks

to strengthen central services, establish a health insurance fund, expand the Community Health Fund, and provide block grants to districts.

Most MOH programmes are supported under the Health Sector Wide Approach (Health SWAp) and other external donors fund programmes that are closely aligned with “Health Basket” funds. The SWAp has supported the decentralisation of health services to LGAs, an effort that continues to require substantial organisational work to ensure high-risk PAW and OVYC receive government-guaranteed services for antenatal health care, skilled birthing clinics, and post-natal primary child health care. The Health SWAp is reported to be working quite well due to the leadership of the Directorate of Policy and Planning in the MOH.

With regard to child health, emphasis is placed upon:

- ∞ Reducing infant and maternal mortality;
- ∞ Providing adequate accessible health services, and
- ∞ Sensitizing communities to prevailing health problems and improving their ability to analyse and create actions to meet them.

**However, concern has been expressed both by ministerial personnel and CSOs regarding communities’ abilities to identify, plan, manage resources, and secure appropriate services to meet local child health needs. Also, pre- and in-service training is a major issue not only for preparing community health committees but also for ensuring that Village Health Workers and others are able to provide quality services. It is also clear that a major service gap is parent and caregiver education for ensuring healthy pregnancies, good child development, and adequate home health, nutrition and sanitation.**

**Also largely absent are clear guidelines regarding monitoring, evaluation and accountability**, except for in special programmes such as Community Own Resource Persons (CORPS) or the Tanzania Health Interventions Project (TEHIP) that have had promising results in improving management at the district level.

#### **National Environmental Health and Sanitation Policy Guidelines, April 2004**

These comprehensive Policy Guidelines were inspired by WHO. They are based upon and further current Tanzanian health and sanitation policies dealing with sanitation, water and wastewater as well as other environmental contaminants. They also fill many gaps in current and past policies, and they provide guidance on service delivery and the roles, responsibilities and expected activities of stakeholders. Topics included are: water supply; food; waste management; control of pollution and chemicals; improvement of human settlements; prevention and control of preventable diseases and HIV/AIDS; environmental health education, and relevant legislation and enforcement. **These comprehensive guidelines should be the subject of manuals for LGAs, for schools and personnel training in all areas, and especially for education on home and community sanitation for parents, caregivers, pre-schools and schools. These Guidelines could be embraced by the Policy Frameworks for ECD and HIV/AIDS.**

## Reproductive and Child Health Strategy 2004 – 2008 (January 2003)

This well-organised and comprehensive strategy includes a critical situation analysis on reproductive and child health issues citing many statistics that reflect the grim realities of maternal and child health in Tanzania. It reveals that although the ANC coverage rate in 1999 was 98 percent with 70 percent of pregnant mothers making at least four visits, they tend to begin their antenatal care late in their pregnancies. Only 44 percent of births occur in health facilities, and referral systems for birth complications are weak. Multiple references are made to inadequate numbers of trained and competent personnel at all levels. Only 12 percent of postnatal mothers make at least one postnatal visit. FGM is reported to be 18 percent, but in some regions it is over 70 percent. EPI has been successful in achieving an 89 percent average immunization rate, and Vitamin A has been integrated into this programme. IMCI however, has not been so successful. The Strategy states that malaria, measles, diarrhoea, pneumonia and malnutrition contribute to more than 70 percent of under five deaths. It states, “The main problem in controlling childhood diseases has been the limited knowledge among parents and caregivers to recognise early signs of illness, causes, danger signs and control measures.” Malnutrition levels remain high, “44 percent of children are stunted, 5.4 percent are wasted and 29 percent are underweight. Furthermore, approximately half of under five children are affected by Protein Energy Malnutrition (PEM) and micronutrient deficiencies.” Such levels of malnutrition mean that most of the children also have developmental delays even though they may have been born normal. Breastfeeding is widespread but the analysis notes that early and inappropriate weaning has reduced its benefits. However, no mention is made of doubtful breast milk quality of malnourished lactating women. It does state, “...inadequate knowledge among the community on nutritional issues and men participation in the entire area of infant feeding is still a challenge.” Statistics are provided for HIV/AIDS and STIs, noting that approximately 72,000 infants become infected annually through mother to child transmission and notes plans for stepping up the PMTCT programme. Adolescents from 14 to 19 years represent 20 percent of births, and the need for adolescent health and education services is noted, including the NSHP. This situation should demonstrate the importance of improving services for PAW.

Inadequate and inaccessible health services are blamed for these lamentable health data. However, other observers have found the availability of community health services to be fairly well distributed and better than in some other African countries.<sup>41</sup> It is recommended that they should have:

- ∞ Improved co-ordination especially at district, ward and community levels;
- ∞ New and expanded in-service training programmes for field personnel;
- ∞ More community outreach and parent education through home visits, and
- ∞ Improved evaluation and monitoring.

The RCH Strategy presents a Vision, Mission, Core Values, and a Goal with **six key categories of care**: maternal health; child health; family planning; adolescent reproductive health; male involvement and participation in reproductive health; and elderly reproductive health. Each Key Category has specific objectives that actually are

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<sup>41</sup> Salgado, Ibid.

targets to be achieved by 2008. The Strategic Implementation Framework provides roles and responsibilities at the following levels: national, zonal, regional, district, health facilities, and community. It also presents guidance in brief sections regarding: advocacy and social mobilisation; promotion of reproductive health behaviour; equitable access to quality health services; capacity building; research, monitoring and evaluation; collaboration and partnership; and financial resources. An implementation matrix is provided with strategies listed for each priority area and objectives regarding: advocacy and mobilisation; promotion of healthy reproductive behaviour; equitable access to quality health services; capacity building, and monitoring and evaluation.

The National Package of Essential Reproductive and Child Health Interventions (NPEHI) to reduce mortality and morbidity is reconfirmed in this Strategy. It includes:

- ∞ Antenatal care;
- ∞ Care during childbirth and obstetric emergencies;
- ∞ Care of the newborn, postpartum care and post abortion care;
- ∞ Family planning;
- ∞ HIV/AIDS and STD diagnosis and management;
- ∞ Prevention and management of infertility;
- ∞ Prevention and management of cancer;
- ∞ Prevention and management of childhood illness;
- ∞ Prevention and management of immunizable diseases, and
- ∞ Nutrition care.

**This valuable Strategy deserves to be reinforced in the Policy Frameworks for ECD and HIV/AIDS. However, inadequate provision is made for parent and caregiver education even though the situation analysis clearly notes that KABP are the major stumbling block for improving RCH care.** Some mention is made of Community Based Health Care (CBHC) and community health workers including peer educators. However, rich curricular contents and methods for parent and caregiver education are needed to ensure behavioural changes and new decision making styles occur at the home level.

### **National Policy Guidelines for Reproductive and Child Health Services (May 2003)**

These National Policy Guidelines mirror the Strategic Plan and provide additional information about priority programmes for Reproductive and Child Health. **It would appear, however, that major emphasis has been placed on the reproductive side and somewhat less on the child health side.** It is laudable that both are considered together, but adequate emphasis upon children, and especially an expanded c-IMCI and nutritional supplements and education to prevent and overcome malnutrition are needed in order to ensure children's health and nutrition status will improve as rapidly as possible. **Very little provision is made for assessing child development, identifying fragile children, and serving children with developmental delays and disabilities. This is a major gap area in health services that needs to be complemented by multi-sectoral parent and caregiver education.**

## **National Adolescent Health and Development Strategy, 2004 – 2008**

The National Adolescent Health and Development Strategy also features a good and quite complete structure for a policy document. Beginning with a situation analysis that includes cultural issues, it reviews some current policies and laws that influence adolescents' health and development. It notes gaps, constraints, and opportunities. The Strategy Description includes a Vision and Strategic Objectives, their guiding concepts and principles. Key areas and components are presented along with Strategic Objectives. Cross-cutting Approaches include: advocacy; behaviour change communication; adolescent participation; gender mainstreaming; research and monitoring and evaluation.

The **Implementation Plan** presents five priority areas:

1. Policy and legal framework;
2. Access, participation and utilization of services and programmes;
3. Attitudinal and behavioural change among adolescents, parents and communities;
4. Livelihood skills development, and
5. Management, resource mobilization and scaling up.

The Implementation Plan includes roles and responsibilities for the following levels: national; regional; district; and community. Key indicators are then listed and provision is made for partnership, co-ordination and collaboration. For each priority area and its corresponding strategic objective, the Implementation Framework presents: output; selected strategies at each level, operational targets (which groups); the time frame over a five-year period; lead agencies and partners; and assumptions and risks. A lot is packed into these charts but it works, and the colour coding helps the reader to focus on each strategy.

The strength of this Strategy is its comprehensive approach, organisation, clarity and coherence. **The sections that pertain to adolescent health, the management of adolescent pregnancies, HIV/AIDS, adolescent rights, health and nutrition status, and risk-taking behaviours deserve to be reinforced in the Policy Frameworks for ECD and HIV/AIDS.**

## **National Immunization Programme Financial Sustainability Plan, November 2003**

This document provides a good example of a plan for ensuring the financial sustainability of an essential programme for GAVI and TT provision under EPI. It presents projections of financial needs, recommendations for improved efficiency through the control of vaccine wastage, advocacy for the programme, and fundraising. As a model, it demonstrates an approach to cost projections and the maximization of funding that could be of value for other areas of children's services in health and related fields. **This Plan should be embraced by the Policy Frameworks for ECD and HIV/AIDS.**

### **2.1.7 Tanzania Food and Nutrition Centre (under MOH)**

The Tanzania Food and Nutrition Centre (TFNC) currently is reviewing and updating its main policy regarding the nutritional status of Tanzanians, the **National Food and Nutrition Policy of July 1992**. In addition to its policy, the TFNC states that its implementation frameworks should be reviewed for details related to ECD and HIV/AIDS.

This Policy has many valuable sections but it is clearly dated and requires revision. It notes the main problems of malnutrition and their causes:

- ∞ **Protein-Energy Malnutrition (PEM)** that leads to mental retardation, with 5 percent of children under five severely affected, 47 percent moderately affected and 3 percent of pregnant and lactating women are severely affected with 10 percent moderately affect contributing to low birth weight infants that at the time were assessed to be 14 percent of all births.
- ∞ **Nutritional Anaemia** that leads to maternal mortality and affects 45 percent of children under five years of age and 80 percent of pregnant and lactating women.
- ∞ **Iodine Deficiency Disorders** that lead to goitre and developmental delays affecting 25 percent of the population with 40 percent living in iodine deficient areas of the country.
- ∞ **Vitamin A Deficiency (VAD)** leading to blindness or reduced vision that affects 30 percent of children under five years of age.

The Policy deals with a broad set of reasons for food insecurity in terms of agricultural practices, nutritional knowledge, food availability, distribution, consumption and diet. Young children and pregnant and lactating women are given special attention. For children birth to six years of age, the Policy calls for maternal rest and the maintenance of breastfeeding from birth to at least two years of age (but does not discuss issues of breast milk quality); nutrition education for parents and guardians; enforcing rules regarding child day care centres and the provision of primary health care. For children 7 to 14 years of age, nutritional supplementation through school lunches is called for as well as better nutrition in the home. For pregnant and lactating women, it calls for raising the legal minimum age for marriage from 15 to 18 years, better antenatal nutrition and rest, the strengthening of MCH and family planning services and monitoring anaemia.

Even though these statistics are somewhat dated, malnutrition rates remain very high in Tanzania. Given the epidemic proportions of malnutrition and considering the critical periods of pregnancy and early development from birth to age five, it is astounding that no call has been made for a **programme of food vouchers or food supplementation for pregnant and lactating women and young children**. Some micronutrient programmes have been developed by the Ministry of Health with the support of some external partners; however, no programme currently appears to exist for nation-wide supplementation for vulnerable PAW and OVYC. Women, Infant's and Children's Nutrition Programmes have been very successful in preventing and overcoming malnutrition in many countries. Currently food is provided to through some school feeding programmes. Both food and monetised food from the World Food Programme, USAID/USDA and other nations also could be used to provide nutritional supplements for groups of PAW and OVYC. At the same time, expanded national efforts for long-

term food security should be developed. To establish food programmes for PAW and OVYC, a system of reliable, transparent and accountable community networks will be needed in order to ensure that appropriate foods will reach and be consumed by target groups. These networks could be managed by community-level parent educators and health services. **Such a system should be considered for inclusion in the Policy Framework for ECD and HIV/AIDS, along with the requisite programme guidelines. As is often said, “Eight is Late” for preventing occurrence of malnutrition as well as the thousands of deaths, hundreds of thousands of children with developmental delays and disabilities, and low national productivity caused by malnutrition.**

#### **2.1.8 Ministry of Labour, Youth Development and Sports (MLYDS): Department of Social Welfare**

The Department of Social Welfare has jurisdiction over services for Mainland Tanzania’s most vulnerable children. These services traditionally have included: children in day care centres, orphans in community-based care and in institutions, children with disabilities in institutions, and other vulnerable children. With the rise in numbers of OVC affected by HIV/AIDS, abuse, neglect, disabilities and developmental delays due to increasing malnutrition, chronic ill health and other diseases, the Department has embarked upon an ambitious effort to reformulate existing policies with the goal of meeting needs for expanded and improved services for children.

Pertinent policies or policy statements, plans and acts include:

- ∞ Reaching the Most Vulnerable Children (August 2003)
- ∞ Draft National Policy on the Care of Orphans (January 2004)
- ∞ Proposed National Framework for Management and Co-ordination of the OVC Programme in Tanzania (August 2004)
- ∞ National Guidelines for Community Based Care, Support and Protection of Orphans and Vulnerable Children (2003/04 in preparation)
- ∞ National Guidelines for the Care, Support and Protection to Orphans and Vulnerable Children Living in Institutions (2003/04 in preparation)
- ∞ Draft National Policy on Disabilities in Tanzania, 2004 (in preparation)
- ∞ Day Care Centres, Act No. 17 of 1981
- ∞ Children’s Homes (Regulation) Act (Act No. 4, 1968)
- ∞ Children’s Home, for Purposes Connected Therewith and to Amend the Adoption Ordinance (1968)
- ∞ Adoption Chapter 335 of the Laws 1950 – 54 Edition (1956)

The Policies, Guidelines, Framework and Strategic Plan currently being prepared are intended to amplify or replace legislation of 1956, 1968, and 1981. However, new legislation will be required to complement the new policy documents.

The Department of Social Welfare states that it is “responsible for polices, guidelines, registration of services and supervision of programmes for **day care centres** for children 2 – 6 years of age, including facilitation of *training of day care attendants*; as well as issues related to children, ages 0 – 6 years of age, in difficult circumstances and in need

of special protection.”<sup>42</sup> *This contrasts with the statement of the MOEC in the EPT which states that the MOEC is responsible for pre-primary education for children five to six years of age.*

**Centre-based child care, pre-school education and pre-primary education need to be harmonized. The roles, responsibilities and management of these institutions will require considerable additional discussion and consensus building with the goal of presenting a clear strategy in the Policy Framework for ECD and HIV/AIDS.**

### **Reaching the Most Vulnerable Children (August 2003)**

This sensitive document is not a policy but it provides important guidance based on results from extensive field activities conducted with the help of UNICEF and District Councils to help districts and villages to:

- ∞ Identify which are the most vulnerable children (MVC);
- ∞ Assess their salient needs;
- ∞ Consider barriers and challenges entailed in assisting them, including children’s rights and cultural issues;
- ∞ Learn participatory planning methods appropriate for supporting MVC;
- ∞ Promote and assess various types of village-led responses, including the formation of a Village MVC Committee under the Social Services Committee of the Village Council;
- ∞ Assess the results of Village MVC Committees;
- ∞ Help villagers create MVC Funds using local resources, thereby assisting them to build a sense of shared village responsibility for these children, and
- ∞ Assist Village MVC committees to compile data, conduct monitoring activities, and report on results and financial management.

As a result of initial field activities, the author of *Reaching the Most Vulnerable Children* feels confident that villages can be involved in all stages of the development process for serving MVC and that they can intervene successfully to meet their multiple needs. Mention is also made of malnutrition and chronic ill health, but they are noted more as a result of vulnerability than as a cause of vulnerability. The types of MVCs identified by villagers include HIV/AIDS orphans, abused and neglected children, and street children. However, it has been found by many observers that villages’ weak economic bases, recent environmental stresses due to drought and worsening soils, and general lack of alternative income generating activities may well preclude total village self-support with respect to MVCs, as is advocated in this document. The roles of Village Health Workers (VHW), NGOs and FBOs are mentioned frequently but their linkages with planning and programme development remain vague. Reports of village-level activities are to be given to the District Social Welfare Officer (DSWO) or the Community Development Officer (CDO) although it would appear to be important for VHWs and DHWs to receive them as well. However, only 40 DSWO currently are in place to serve 114 LGAs. The document also calls for a District Facilitation Team to support, follow-up, coordinate, compile reports and advocate for funds for MVC activities in the district. **The Social Welfare Department is stipulated to be the agency in charge of MVC activities in**

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<sup>42</sup> George Kameka. (2002). *General Overview of ECD in Tanzania*. Mombassa, Kenya.

**Tanzania through its roles for developing policies, maintaining a data bank, mobilizing resources, collaborating with external partners, and providing technical support to the districts.**

**No effort is made in this document to separate out the specific needs of infants and children under eight years of age.** However, many of its observations would apply to younger children. Some mentions are made regarding the needs of very young or very old caregivers and of neglectful parents. From the text, it is clear that they should be given extensive parenting education and support, for example: “There should be sensitization and education to poor/vulnerable families and communities on the proper care of children,” and “Caretakers did not have any psychosocial skills or adequate knowledge of how to cope with ill children.” “They ... need to be provided with care-taking skills and basic education so that children’s welfare can improve...” This study provides a valuable context for reviewing the policies and related documents currently being prepared by the Department of Social Welfare.

#### **Draft National Policy on the Care of Orphans (January 2004)**

This policy statement provides an overview of some of the activities that will be required to improve the lives of OVC, and especially school-age OVC. Although its title emphasizes orphans, Policy contents also deal with vulnerable children. To reflect Policy contents better, the title probably should be revised to include vulnerable children.

Because of its central importance to OVYC, this draft policy will be reviewed in some detail below. No mention is made of consultation in the draft and it appears to need considerably more consultation and consensus building. Many experienced people at community, district, regional and national levels would have useful elements for inclusion. Furthermore, they need to feel the policy reflects their concerns and priorities for action.

**Unfortunately, the document lacks an emphasis on infants or young orphans and vulnerable children. The text clearly refers mainly to older children because it focuses heavily upon access to school and vocational skills training. This gap should be filled by the Policy Frameworks for ECD and HIV/AIDS.**

Noting that no policy for OVC exists apart from guidelines that were prepared in 1994 on the care of orphaned children, the draft Policy outlines some of the major challenges Tanzania faces in providing for OVC and especially those who are living in poverty. The main objective of the policy is declared to be: “to put in place a set of measures and mechanisms that will evolve lasting solutions...” A Strategic Framework is called for to implement the Policy but it has not been prepared as yet. An organizational Framework and two new Guidelines regarding community-based and institutional services for OVC that complement this Policy are discussed below. The draft Policy notes that a National Strategic Committee for Orphans and Other Vulnerable Children was planned to be

created in 2001 but has not been put in place due to the lack of regulatory framework establishing the Committee.

The responsibility for Policy implementation is declared to the “the Ministry responsible for social welfare in collaboration with local governments and NGOs.” The Ministry is to conduct overall co-ordination, prepare minimum standards and guidelines, put in place structures and guidelines for identifying orphans and other vulnerable children,” manage a national database, conduct “skills training programmes for adolescent and young-adult orphans and vulnerable children,” manage policy monitoring and evaluation, produce reports for review by the National Technical Committee on Orphans and Vulnerable Children, and conduct “advocacy and training activities aimed at increasing public awareness and understanding of the policy.” No mention is made of Ministerial roles – of which there could be many – regarding vulnerable infants and young children from birth to eight years of age.

Of particular concern is the call for the placement of the national list of OVC on the Internet for all to use. Although the goal of service provision is laudable, privacy and protection issues should require the design of a “need to know” system for database access. Such precautions will become increasingly important in the future.

The draft Policy notes many gaps in current policies and legislation, and then presents objectives to:

- ∞ Create a framework for ensuring the protection, human and legal rights of orphans and other children rendered vulnerable by HIV infection;
- ∞ Provide measures that will ensure access to meet basic needs, such as diet, clothing, housing, education, health care and other services;
- ∞ End flagrant acts that violate orphans’ inheritance and property rights;
- ∞ Create and continuously update a database on orphans and vulnerable children;
- ∞ Raise public awareness of OVC needs;
- ∞ Strengthen modes of orphan care through new quality initiatives;
- ∞ Enhance capacities of ministries, local governments, communities and families;
- ∞ Develop a coordinated approach to service delivery with assignment of responsibilities;
- ∞ Mobilize public and private resources and make them accessible by orphans and their caregivers, and
- ∞ Promote legislation that will reform existing child development and protection laws.

The text takes a right’s based approach, referring not only to the CRC but also to a host of other international and regional instruments that guarantee children’s and human rights.

The definition of vulnerability is unclear. An orphan is defined “as a child aged below 18 years who has lost one or both parents. However, this definition is not meant to be exclusionary. Other vulnerable children, especially those rendered so by HIV infection and AIDS will be eligible for care and support.” Later in the text, it says that children orphaned by other means should be included, and other sections refer to vulnerable children who are not orphans. No direct reference is made to children made vulnerable

due to extreme poverty, developmental delays, disabilities, child labour, malnutrition, other diseases, neglect, child abuse, conflicts, and similar situations. The text calls upon LGAs to identify OVC according to guidelines that are to be drafted. However, this is such an important point that the Policy and the Guidelines should include a complete listing of major types of vulnerable children.

Recommendations for legislation for orphans and vulnerable children wisely include:

- ∞ Foster care and adoption fitness;
- ∞ Care and maintenance of children to age 18;
- ∞ Residential care as a last resort and with provision for reintegration into society;
- ∞ Education to provide free and unimpeded access to primary education with Government financial sponsorship of orphans and vulnerable children;
- ∞ Free vocational education;
- ∞ Free and unimpeded access to health care;
- ∞ Minimum age for child care would become school-leaving age;
- ∞ Protection against early marriage, and
- ∞ Rights of inheritance ensured.

It is also recommended that legal services be provided, and parents throughout Tanzania would be encouraged to write legally recognised wills.

A list of issues to be addressed is presented including: “material and emotional deprivation; psychological trauma; stigma; discrimination; denial of inheritance and physical and sexual abuse.” Although this is a good list, it leaves out many of the issues pertaining to ECD, such as: regular infant and child assessments, health and nutrition services; nurturing care, psycho-social stimulation and early education; home and pre-school or day care sanitation issues; parental and care giving knowledge, behaviours and skills, etc.

The draft policy calls for strengthening “family-based support systems as the primary arrangement for the care and support” of children. The household is identified as the central focus of the intervention for OVC support. If this recommendation is to be followed, an extensive system for home outreach and caregiver education will be required, and once mounted it should not be limited only to orphans but also provided for other young vulnerable children and PAW. In addition, the text calls for the “Provision of resources, skills training, technical assistance and financial facility to enhance the income generating capacities of orphan-caring households as well as of orphans and vulnerable children themselves when they come of age.” The Government is asked to design training modules and produce training materials for those involved in OVC care. However, the training system is not described.

To meet the needs of OVC, all relevant ministries are called within the framework of their MTEFs to include a mandatory budget line for implementing activities for the care and support of OVC. In addition, a “National Orphans Fund” is to be created by “imposing a compulsory levy,” with the Ministry of Finance as custodian through a special multi-sectoral committee. Orphans’ Trust Funds are advocated and local governments are to develop systems for mobilizing resources. However, clear guidance

regarding how the levy or the Funds will be designed and managed is not provided. It is recommended that CSOs and FBOs be given the logistical and other support necessary to use their resources for OVC. Does this imply that government will not provide them any funds for their services? Donor support is to be sought, as well. Regarding disbursement, the draft Policy states that administrative costs should be kept as low as possible, and every effort should be made to ensure OVC receive most of the resources.

The draft Policy calls upon the Ministry of Local Government and Regional Administration to enhance the capacity of local governments and “ensure that every district is able to engage the services of a District Social Welfare Officer.” Local governments are to: identify OVC in accordance with guidelines and ensure “adequate financial provision” to underwrite free access by OVC to “social services, in particular health, education and shelter.” This would appear to imply that all services would have to be locally funded.

The Ministry of Justice and Constitutional Affairs is asked to facilitate the revision and/or enactment of laws. The Vice-President’s Office is asked to ensure OVC issues “form an integral part of the nation’s poverty reduction strategy.” The Ministry of Finance is to ensure adequate financial provision as well as act as custodian of the proposed National Orphans Fund. The Ministry of Community Development, Gender and Children is asked to ensure OVC are included in the revision of the Child Development Policy and collaborate with the Ministry responsible for social welfare to “specify standards and issue guidelines” for implementing the OVC Policy. The Ministries of Health, Education and Agriculture and Food Security are asked to ensure the provisions for education, health and nutritional needs are met.

**In summary, this draft Policy includes many important elements, but it needs considerably more consultation and consensus building. It should be amplified and extended to meet the special developmental needs of infant and young OVC from birth to eight years of age. It lacks essential elements including: pre- and in-service training, strategies with indicators and targets, evaluation and monitoring system, a feasible investment plan and policy advocacy and social communications plans. Consideration should be given to uniting it with the documents discussed below, perhaps through the development of the Strategic Framework that is yet to be drafted.**

### **National Guidelines for Community Based Care, Support and Protection of Orphans and Vulnerable Children (2003)**

The National Guidelines provides further information on the Policy and presents a vision, objectives, and general measures and responsibilities with respect to: basic rights and health services; basic rights of children with disabilities and those affected by HIV/AIDS; OVC’s developmental needs; rights for legal protection, abuse protection, participation, sustainable livelihood; and institutional care, including foster care and adoption. It then calls for the establishment of a **National OVC Fund** (that was called a “National Orphans Fund” in the Policy). **This change is important because both orphans and**

**vulnerable children should be considered for support and this amplification should be made in the draft Policy as well.** This Fund requires substantial further consideration to ensure it is well managed and reaches the children who most need it. The Guidelines provide for a system of “Partnerships, Networking and Co-ordination” that is superseded in part by the next document discussed below that presents a Co-ordination Framework for the Policy and its Guidelines. There is a brief mention in the Guidelines regarding monitoring and evaluation requirements although no specifics are provided on how the system would work, and no indicators, targets, mechanisms or tools are mentioned. All is left for a “National Technical Committee” to define in the future.

Again, the definition of vulnerability provided in the Guidelines leaves out significant types of vulnerable children in Tanzania. The Guidelines states: “A vulnerable child is any child, who is currently experiencing or likely to experience lack of adequate care and protection. The following three aspects are listed as causes of vulnerability:

- ∞ Reduced capacity to cope with calamities;
- ∞ Resilience weak points, e.g. education, health, welfare, safety, play and participation, and
- ∞ Inadequate caring services.

Although these definitions may be intentionally vague, the infant and young child could be left out or given little attention. Characteristics such as developmental delays, disabilities, malnutrition, chronic ill health, abuse, neglect, and even children infected or affected by HIV/AIDS are not mentioned in conjunction with the definition. However, later on in the document, “Children with disabilities” along with “children affected and infected by HIV/AIDS” are noted. Also, “Neglect, abuse, violence, both physical and psychological, exploitation, stigmatization and discrimination” are mentioned as consequences of vulnerability rather than as definitions of vulnerability. While this can be the case, the occurrence of such events usually merits their listing as conditions of vulnerability. For example, a child who is neglected but normal in development rapidly can become malnourished, developmentally delayed and ultimately disabled for life.

Hopefully this definitional situation will be remedied before guidance is given to communities in order to ensure they do not overlook any vulnerable young children and their parents or caregivers. Basically, communities need to know what types of children can be considered for services and how to identify them, or they will tend not to list them. In some communities where malnutrition or other situations are endemic, these conditions tend to become “accepted.” Stunted children with red-tinged hair are often considered to be “normal” even though they are severely malnourished. Therefore, it becomes necessary to provide community education about how to identify various types of vulnerability.

A section is provided in these Guidelines on children’s rights to survival, and it includes many critical health, nutrition and sanitation areas. However, it leaves out essential assessment services, developmentally appropriate infant and child development services, parenting and caregiver education, and family support. Mentions regarding education pertain solely to pre-school education and school-based services but not to early childhood development from birth to three years of age. A programme for nutritional

supplementation for OVYC that is urgently needed is implied but not clearly delineated – perhaps because it is considered to be beyond the ministerial jurisdiction of MLYDS. Overall, greater specificity would be helpful with respect to systems for building partnerships with CSOs, NGOs, FBOs, private agencies and international donors and NGOs.

The Guidelines ask the MLYDS to “empower communities and families to facilitate early identification of children with disabilities to ensure early interventions.” It would be good to add developmental delays, malnutrition, chronic illnesses, child abuse and neglect, street children, IDP and refugee children, and child labour, at a minimum. The Guidelines do not state how early identification would occur but they imply the development of a parent education and early childhood intervention programme to meet the needs of children affected and infected by HIV/AIDS and other vulnerable children. By calling for parents, guardians and caregivers to “be empowered in care taking skills,” the Guidelines appear to be calling for a national programme for parent and caregiver education. A subsequent section presents measures and responsibilities to ensure OVC developmental needs are met, including psycho-social support. Another section states that local communities, religious denominations, families and parents/caregivers “shall provide OVC with parenting skills,” but greater specificity is needed with regard to their own parents and caregivers. Although surprisingly the period of birth to three is not mentioned, the Guidelines call upon parents, caregivers, communities and district councils to “ensure that four to six year old OVC have access to pre-school programmes like nursery schools, day care centres and kindergarten.” The Ministry of Health is asked to provide “correctional and rehabilitation services to children with disabilities free of charge.” Early Childhood Intervention services for children with developmental delays or disabilities usually include integrated services wherein health is one wing, complemented by parent education, psycho-social stimulation, nutrition education and supplementation and sanitation services.

The MLYDS has dedicated personnel with valuable experience in developing pilot programmes for parent education through home visiting services, early childhood assessments, training, and referral systems. To achieve the goals of the OVC Policy and to carry out the proposed programmes, the Department will require greatly expanded budgetary support and more trained personnel. External technical support will be needed to design early childhood systems, programme contents, methods, and tools as well as to conduct programme pilots for subsequent widespread replication.

In Annex A of the Guidelines, special attention is not given to OVYC from birth to eight years of age. Rather, it focuses on school-age children and unemployed youth. Although the Guidelines call for parent and caregiver education, no provision for such a programme is made in the section regarding NGOs and the private sector. The MLYDS is called upon to develop: guidelines; a monitoring mechanism; indicators; tools for data collection and reporting. It is to: provide technical advice; oversee implementation; strengthen the capacity of LGAs; and develop, issue and provide “skills training on the identification and targeting process of the MVC and households to all stakeholders implementing community-based programmes for care, support and protection of OVC.”

It would appear that: 1) either these roles should be amplified and strengthened to include programme design and implementation and the funding to undertake this work, or 2) that other provision should be made to ensure the final Policy will not become a document that will never be implemented.

**Successive versions of these Guidelines should be reviewed carefully in order to embrace those elements that will be included in the Policy Frameworks for ECD and HIV/AIDS and to fill in remaining gaps in services for PAW and OVYC.**

### **Proposed National Framework for Management and Co-ordination of the OVC Programme in Tanzania (August 2004)**

This document, usually part of a national policy, presents a structural framework for carrying out the draft National Policy on the Care of Orphans. If it is kept as a separate document, it needs to be harmonised with the Policy, the Guidelines, and the Strategic Plan. It proposes a co-ordination structure for the care, support and protection of OVC, and proposes the bodies, their membership, functions, and roles and responsibilities. The structure includes:

- ∞ National Steering Committee;
- ∞ National Technical Committee;
- ∞ The **Council Multi-Sectoral AIDS Committees (CMAC)** would be strengthened to function as **District OVC Coordinating Committees** by incorporating Social Welfare Officers or experts responsible for the care, support and protection of OVC;
- ∞ Ward OVC Co-ordination Committees, and
- ∞ Village/Street (Mtaa) OVC Co-ordination Committees and Hamlet OVC Coordinating Committees;

The intent of the Framework is to avoid duplicating existing decentralised structures and to strengthen them. However, care should be taken to avoid overloading local structures while also training community members to undertake the work that is designated to them. **Unfortunately, no provision has been made as yet in the Framework, Policy or Guidelines for designing and establishing a decentralised training system that will be essential to developing and sustaining all proposed programme services.**

**A National Strategic Plan is called for but it has not been drafted as yet. It would be good to consider the draft documents already prepared as constituting discussion elements for developing a more robust National OVC Policy and annual Strategic (Action) Plan. The Policy Framework for ECD and HIV/AIDS should reinforce elements of the OVC Policy and Plan with respect to PAW and OVYC and fill in gaps regarding them.**

### **National Guidelines for the Care, Support and Protection to Orphans and Vulnerable Children Living in Institutions (2003)**

Although this document merits careful review, just a few comments will be provided. It presents a general situation analysis, objectives, some definitions, and guidance with

respect to the establishment, management and monitoring of children's homes, foster care and adoption. It calls for changes in existing laws; however, it does not focus on this aspect but rather on providing minimum service standards, institutional management, roles and responsibilities, training, and the roles of various ministries. It also has a valuable section on the importance of using institutions as the "measure of last resort."

The section on "Education and Staff Qualification" does not provide requirements for qualifications but it does ask proprietors of establishments "to identify trainers/personnel to be trained, facilitate training courses and ensure monitoring and evaluation." A good list of areas for training is presented. The Commissioner of Social Welfare is called upon to "prepare training curriculum, programme and training manuals, together with supervision, monitoring and making evaluation." However, it appears that the system for pre- and in-service training require considerably more attention. Also as currently presented, training depends upon proprietors to cover all training costs. This may be an inadequate approach for achieving the stated goal of providing good training all personnel working with OVC. **A unified training system for services to OVYC should include special pre-service courses as well as regular in-service training for personnel serving OVYC in institutions and in communities.**

#### **Draft National Policy on Disabilities in Tanzania, under preparation in 2004**

An early draft of the National Policy on Disabilities was kindly made available. It is an enlightened document that places a strong emphasis on prevention and early intervention as well as on treatment and ancillary services. The Draft Policy will call for rehabilitation in terms of medical, psychological, educational, vocational and social rehabilitation. It emphasizes the integration of persons with disabilities into schools and society through inclusive education as well as promoting greater social acceptance, free health care services, and a barrier free environment. Three special target groups are mentioned: women with disabilities, children with disabilities, and older persons with disabilities.

With regard to young children, it states, "Early intervention services have the capacity to forestall onset of disability later in life. The government shall therefore ensure that early intervention services are available to children with disabilities. Families of children with disabilities shall be provided with information about services available to their children." Preventive approaches mentioned include clean and safe water, good nutrition, and immunizations as well as good care for expectant mothers and good delivery services, early identification of children with disabilities and "intervention measures taken to forestall onset of disability."

Thus, the Disability Policy calls for early assessment and Early Childhood Intervention (ECI) services in order to prevent developmental delays that can result in needless life-long disabilities. It calls for the government to "take measures that children aged 0 – 6 years are assessed for disabilities," and with the Ministry of Health ensuring that "appropriate services are available to children with disabilities." Under staff development, the Policy states, "The government shall ensure adequate professional

training of personnel who provide services for people with disabilities.” At present, Tanzania appears to have major training needs in this area.

**This important effort to provide assessment and early childhood intervention services for children with disabilities and developmental delays could become a focal programme under Tanzania’s future services for OVYC. It also should be included and given strong emphasis within the National Policy Framework for ECD and HIV/AIDS.**

## **Child Labour**

The MLYDS also has responsibility for child labour. With respect to child labour, important work is proceeding to identify children in abusive labour and place them in basic education services. Some programmes for children in abusive labour are under way in both Mainland Tanzania and Zanzibar. Relevant policies and related documents include:

- ∞ Employment and Labour Relations Act, 2004
- ∞ National Employment Policy 1997
- ∞ Integrated Labour Force Survey (ILFS)
- ∞ Child Labour Survey, 2000/01
- ∞ Gender Promotion Programme Guidelines (GENPROM) that includes child labour.

The Child Labour Survey of 2000/01 and the Integrated Labour Force Survey (ILFS) have been conducted but many report that substantially more work is needed to identify children in abusive child labour. By including the young child in abusive labour under the label of OVYC, attention will be given to identifying them and to helping parents, caregivers and communities to guide them into pre-primary and primary school rather than a life of hard labour.

### **2.1.9 Ministry of Home Affairs**

The Ministry of Home Affairs developed the **National Refugee Policy** in September 2003. It deals only with refugees and not with internally displaced persons or families. It is a general document that stipulates core governmental policies regarding refugees. It seeks to meet international and constitutional obligations while also placing emphasis upon national interests and priorities. The preponderant approach is to encourage the repatriation of refugees to their homes, safe zones within their countries of origin or to third countries. The Government of Tanzania’s roles include: supervision; co-ordination; maintenance of law and order; control of refugee movements outside of designated areas; administration of justice and sensitizing the public not to harbour refugees. All services are left to be provided by UN Agencies, NGOs, donors and local communities. One small section deals with primary education stipulating that the curriculum should be that of the refugees’ country of origin.

Children and women, who usually conform 80 percent of the refugee population, are not overtly mentioned. Thus, the issues regarding OVYC and PAW who are refugees,

internally displaced persons or are otherwise affected by violence are not discussed in the National Refugee Policy. HIV/AIDS is not mentioned in this Policy although the incidence of infection tends to be high in refugee camps and areas affected by conflict. Children's and women's rights and major needs are not discussed in the Policy.

**Therefore, the Policy Frameworks for ECD and HIV/AIDS should include a special strategy for PAW and OVYC who are refugees, internally displaced or living in communities affected by conflicts.**

## **2.2 Discussion of Policy Gaps and Some Needs for Harmonization**

It is clear that except for some focused health services in certain regions of Tanzania, most of the needs of PAW and especially OVYC and their parents and caregivers are not being met. The gap in integrated services for young children is dramatic. It should be remedied quickly because children cannot wait.

Leadership is needed urgently to build a national consensus for young children. Even though the potential availability of health services is judged to be relatively good, it is clear that access is low and utilization is often inappropriate. Many children are suffering needlessly and some are dying due to inadequate health care, nutrition, and psycho-social stimulation. Parents and caregivers of young vulnerable children and orphans from birth to at least five years of age require education and support. Furthermore, better service co-ordination is needed at all levels, along with effective systems for pre- and in-service training, assessment, monitoring and evaluation, and policy advocacy and social communications. Above all, leadership for championing the expansion of national investment in children is required to secure the financial, material and human resources needed to greatly improve child survival and development.

### **2.2.1 HIV/AIDS**

As noted before, PORALG's HIV/AIDS strategy lacks an adequate emphasis on OVYC and PAW affected or infected by HIV. It is reported that often they are not included in Comprehensive District Council Health Plans and Village Plans. Furthermore, attention needs to be given to preparing Guidelines for HIV/AIDS planning and programme development not only at national levels but especially at the level of Regional Secretariats "to enhance planning and HIV/AIDS mainstreaming at the local council level," for District Councils, and Community/Ward implementation. Guidelines should include guidance for NGOs, FBOs, other CSOs and private organizations regarding programme development. They should also clearly outline expected performance indicators, monitoring and evaluation procedures including essential tools, reporting mechanisms and formats. Each item should include lists of needs assessment items, types of programme activities and descriptions of what could be included in those activities, especially with respect to OVYC and PAW. Without adequate Guidelines there is a potential for great sums of money to be spent without addressing child and maternal needs of families and villages.

PORALG has developed a useful Training Manual on O&OD to promote community participatory planning. It contains many exercises on topics such as improving education, achieving gender equality, improving health care, reproductive services, reducing infant and maternal mortality, safe water, and HIV/AIDS – which is considered also to be a “cross-cutting” issue. However, in the document, orphans are depicted as adolescents, and little emphasis is given to OVYC, *per se*. The O&OD approach could be used to prepare a complementary ECD and HIV/AIDS Training Manual that would help guide District Council and Village planning with respect to PAW and OVYC from birth to eight years of age.

A Resource Guide entitled, Community Based Management Information System (CBMIS) in Tanzania, contains formats that request information on three types of “most vulnerable children” without reference to age: orphans, children with disabilities and children living in the street. Malnourished under fives are listed, as are births, low birth weight and children with birth registration, immunisations, child deaths, pregnant women below or over 18, number of maternal deaths and education enrolment, as well as safe water indices. The CBMIS could be used in conjunction to the training manual recommended above. It is clear that to analyse and utilise thoroughly the data that will be gathered using the CBMIS, a database and reporting system is critically needed. In the Resource Guide, preparers are urged to send their reports “to PORALG.” Certainly, more guidance will be needed to ensure there is a good link between CBMIS and planning, programme development, monitoring and reporting systems.

The new PRS II (now called the NSGRP) gives strong support to HIV/AIDS alleviation. As noted above, it includes a sub-section on ECD with reference to OVYC. A Goal is needed for ECD with operational targets and a more complete list of service packages.

### ***2.2.2 Parent Education and Support***

The NSGRP calls for a parent education programme and one is urgently needed. Recently, emphasis has been placed on preparing Guidelines for services for OVYC who require community-based or centre-based services. However, it is clear to many administrators that centre-based early care and education will not be expanded sufficiently rapidly to meet greatly rising demand for parental and caregiver support.

New interest has been expressed in moving the current emphasis toward developing District-level training centres for Community Parent Educators who will serve parents and other caregivers who are responsible for the care of orphans and other vulnerable children, and especially those from birth to three years of age. At the District level, currently fragmented services should be coordinated and integrated to the degree possible to ensure a network of parent education support is developed to assist those who most need it.

A major gap area is policy decision making with respect to the location, roles and responsibilities for designing, implementing and evaluating parent education and support programmes. Special attention should be given to ensuring that high quality, culturally

appropriate curricula, learning materials, methods, and assessment and evaluation tools are designed. Also a comprehensive nation-wide training system will be needed along with training guides for trainers to prepare community-based parent educators, CORPS, Village Health Workers, CBDs and others working at the community level. Children's rights should be taught in practical ways through both parent education and mass media approaches.

### ***2.2.3 Pre-school and Pre-primary Education***

Considerable policy harmonization is needed between the Department of Social Welfare and the Ministry of Education and Culture with respect to roles and responsibilities, guidelines, training and supervisory support for pre-schools, day care centres and pre-primary education. Each is currently delegated services under separate Acts, and policies such as the Day Care Centre Act for children two to six years of age and the MOEC's EPT. At present, services are fragmented and largely unsupervised or supported.

Harmonization is needed but also a strong plan is required for the design, development, expansion and improvement of centre-based child development in Mainland Tanzania. Quality standards need to be established including not only physical infrastructure but also curricula, teaching methods and materials. Children should be assessed upon entry and regularly during the school year to ensure they are developing normally. Parents should be prepared to assess their children's services. Given scarce resources, it would seem to be logical to bring the services of both the Department of Social Welfare and the Ministry of Education and Culture together along with leading ECD specialists in CSOs. Strong technical working committees could be established that would ensure that the nation's best minds in early childhood development and education would be devoted to improving and expanding centre-based services for working mothers and their young children from (in some cases) infancy to school entry.

### ***2.2.4 Orphans and Vulnerable Children***

The definitions of "orphans and vulnerable children" need considerably more work. Policies, guidelines and plans contradict one another in this regard. A national consensus should be forged as a basis for the Policy Frameworks for ECD and HIV/AIDS. This consensus is emerging but it needs to be established.

No clear national leadership for OVYC was found. The MLYDS's Department of Social Welfare has a mandate to provide services for OVYC but its budget is very small. Either it or another institution will be required to design, implement and evaluate the programmes needed urgently to meet OVYC needs.

In general, OVYC tend to be "invisible" in most national policies that will have a direct effect upon them. It will be important for the Policy Frameworks for ECD and HIV/AIDS to fill in these notable gaps.

Special attention should be paid to identifying and assessing these children, along with building a system for serving, evaluating and tracking them over time. In many areas of Tanzania, these children have become “invisible” and considerable sensitization will be needed to help community members spot and link them to services.

It is clear from the PER: HIV/AIDS Multi-sectoral Update for 2004 that communities have not prepared good plans that include OVYC and PAW. Communities and CSOs will need considerable technical assistance, good guidelines and focused training to remedy this situation.

### ***2.2.5 Primary Education***

Primary education is clearly within the mandate of the MOEC. However, a greater focus is required on OVYC, with special attention to their school readiness and positive transition from home to school. Training for teachers regarding HIV/AIDS needs to be stepped up considerably, as well as training on how to assess children’s development, how to achieve inclusive education, and how to ensure vulnerable children receive the health and nutrition services they require. Primary and pre-primary schools also need to place adequate emphasis upon child health, safety and security. Parent involvement in many aspects of community schools will also be an important area for greater attention. All of these topics could be included in strategies in the Policy Frameworks for ECD and HIV/AIDS for the six to eight year age range.

### ***2.2.6 Health Planning***

Health planning is perhaps the strongest policy area regarding OVYC and PAW. However, declining health statistics reveal that considerable re-thinking is required to improve birth outcomes, maternal well-being and the status of Tanzania’s children. Health services need to be better linked to nutrition, parent education, sanitation, and services for protecting and serving OVYC. The c-IMCI programme needs to be expanded both in terms of contents and coverage to overcome high levels of young child morbidity and mortality.

The Policy Frameworks for ECD and HIV/AIDS should seek to build integrative, comprehensive services through achieving a consensus regarding the roles and responsibilities for forging partnerships between ministries and with CSOs at district, ward and community levels throughout the nation.

### ***2.2.7 Nutrition***

From national statistics related to stunting and other measures of malnutrition it is clear that many Tanzanian children are malnourished. Rates run as high as 40 percent of the children from birth to five years of age and they are even higher in some food insecure regions of the country. Abundant international research has shown that malnutrition is closely correlated with preventable developmental delays and disabilities.

Although valuable materials for nutrition education have been developed, micronutrients have been successfully provided in some regions, and useful nutrition research has been conducted, it is clear that many families living in poverty are food insecure. It appears that at present food supplements are being provided solely to school-age children.

It is time for Tanzania to consider providing nutritional supplements for pregnant and lactating women and for children from birth to at least five years of age in order to ensure they grow and develop well. This support should be coordinated with parent and caregiver education for infant and child psycho-social stimulation, early learning and health education and care. This gap area in nutrition services could be considered for inclusion in the Policy Frameworks for ECD and HIV/AIDS.

### ***2.2.8 Social Welfare Gaps or Areas for Reinforcement***

The Department of Social Welfare is attempting to formulate policy, plans and guidelines for OVC. This work is extremely important for OVYC, but many gaps were found in the current drafts of the documents. Considerably more work is needed to consult stakeholders throughout the nation, and to ensure that the following elements are consistent and presented clearly: definitions of OVYC, major strategies, programme areas, co-ordination structures, roles and responsibilities, indicators and targets, training systems, evaluation and monitoring, financial planning and policy advocacy and social communications are covered. If they are well treated in the OVC Policy, then those points should be reinforced in the Policy Frameworks for ECD and HIV/AIDS. If not, then the gap areas should be filled in the Policy Frameworks.

### ***2.2.9 Early Childhood Intervention***

Infants and young children with developmental delays and disabilities, those affected and infected by HIV/AIDS, and malnourished and chronically ill children who will develop delays and disabilities if not served in time should be given priority for Early Childhood Intervention services. If at least 12 percent of the children from birth to age eight are disabled and at least 30 percent have severe developmental delays that are correlated with malnutrition and chronic ill health, then at least 42 percent of Tanzania's children require ECI services. Many of the OVYP who are infected or affected by HIV/AIDS will be included in this 42 percent, but if they are not, then they too should be prioritised for attention along with children assessed to be abused, neglected, street children or children thrust into abusive child labour.

### ***2.2.10 Financial Planning***

In Tanzania, few policies or action plans include an investment plan. Rather, they leave this to five-year strategic plans or frameworks or to MTEF and PER documents. Unfortunately, the strategic plans tend to have such a long, five-year time horizon. They are very general and lack the elements needed for detailed annual planning. The MTEF documents rarely are closely linked to national policies or strategic plans. The result is a disjunction between lofty goals and investment in annual activities. This situation should

be remedied with respect to OVYC and PAW because to assist them focused and sustained investments will be required. The five-year approach is unwieldy. For the Policy Frameworks for ECD and HIV/AIDS, a general investment plan should be advanced and then in the two-year annual Action Plans, detailed financial planning should be undertaken to ensure funding is focused on priority strategies.

### ***2.2.11 Regional and Local Planning Gaps***

Tanzania is going through a period of intense decentralisation. Many gaps were found in the structures for ECD and HIV/AIDS. In addition to structural needs, the roles and responsibilities at each level need to be harmonised. Some effort has been made to achieve this but major inconsistencies were found. In addition, so much work has been decentralised to villages and communities but it is not clear that they have the training and personnel required to make sound judgements, prepare adequate plans and manage large-scale service programmes.

The Policy Frameworks for ECD and HIV/AIDS should place a major emphasis upon building stakeholder support for a strong structure of programme activities at each level: regional groups, districts, wards and communities. At the same, all roles and responsibilities should be negotiated with care not to overload any one level. Above all, regional, district and community-level planning activities must be synchronised with pre- and in-service training systems, and also with monitoring and evaluation systems.

## **2.3 Multi-Sectoral and Sectoral Structures, Co-ordination and Integration**

A major need exists in Mainland Tanzania for coherent multi-sectoral policy planning to address the holistic development, rights, and support needs of OVYC and PAW. Joint programming between ministries and CSOs will be essential in order to streamline existing services, develop new ones to fill gap areas, and ensure that all of them reach OVYC.

At present there is a major fragmentation of policy roles and services between a series of ministries. Each ministry tends to work separately even though PORALG and others call for well-coordinated and integrated services at district, ward and/or village levels. Basically, most ministerial personnel tend to work mainly according to their ministerial plans, budgets and organisational structures. They appear not to be searching for ways to collaborate with other ministries or CSOs in order to try to maximize the impact of current infrastructures and human, financial and material resources. Some striking examples of attempts to bridge these gaps were noted in a PER exercise of the MCDGC and in the Department of Social Welfare's attempt to expand the mandate of existing administrative structures rather than to create new, duplicative structures.

As a basic principle, systems developed for serving OVYC and PAW should be designed for achieving sustainability. All potential actors and stakeholders need to be included in

the design phase, and systems must be streamlined and eliminate unnecessary duplication to the extent possible.

Multi-sectoral policy planning should occur at all levels, with special emphasis upon the village/hamlet, ward and district levels. District Councils and District Management Teams should be supported to ensure that OVYC and PAW are assisted appropriately. The proposals of the Department of Social Welfare should be given serious consideration in this regard but much more dialogue and consensus building at all levels will be needed before a functional co-ordination structure can be proposed along with the pre- and in-service training, monitoring and evaluation systems that will be required to make it effective and efficient.

A major tendency in the MCH Package of the Ministry of Health is to emphasize issues dealing with youth and adults rather than young children. Essentially, reproductive health is the focus along with EPI and some c-IMCI. Issues related to the assessment of infant and child development (apart from growth measurement) are not included as yet. Primary health care from immediate postnatal visits onward are not clearly delineated and require considerable additional attention. Well-child check ups should be regular, frequent and keyed to health and immunisation cards that parents use and keep carefully in their homes.

Assessments currently are not conducted on infant and child development, parenting needs, knowledge, and behaviours. No focused and consistent effort is undertaken in Tanzania to identify vulnerable infants and children with developmental delays, disabilities, malnutrition, chronic ill health and other high-risk situations such as abuse, neglect and hunger. Many PAW are not identified during the first trimester and not linked in a timely manner with health facilities and approved birthing centres with well-trained personnel. Early identification and assessment should be linked with tracking systems. Many observed that OVYC have not been identified in most regions of the country. This comprehensive identification and assessment system would remedy this need and also provide a rich source of baseline data for later evaluation and monitoring activities.

With adequate pre- and in-service training programmes, District Teams could be prepared to train Ward Development Committee members, Village/Hamlet committees, and Home Visitors to manage a full range of activities for OVYC and their parents and caregivers, with referrals as necessary. At this time, various community outreach workers are engaged in discrete health activities, including: Traditional Birth Attendants, Community-Based Distributors, Village Health Workers, CORPS, Peer Educators, Village AIDS Counsellors, and others. It may be that these people, who usually are villagers, are overloaded with their current activities. If that is the case, then Home Visitors for OVYC and PAW may have to be separate individuals who form a local interdisciplinary team for Child Development at village/hamlet and ward levels. These Home Visitors would be engaged in activities such as the following:

- ∞ Local programme planning;
- ∞ Identifying OVYC and PAW;

- ∞ Conducting regular child assessments;
- ∞ Providing parenting education activities including demonstrating infant stimulation and early childhood development skills and teaching good nutritional and health prevention behaviours;
- ∞ Making referrals to health and other facilities;
- ∞ Collaborating with Village Health Days;
- ∞ Managing parent/family drop-in centres and classes;
- ∞ Receiving regular in-service training;
- ∞ Preparing simple monitoring reports on daily activities, and so forth.

They would seek to achieve positive behavioural change at the household level to ensure the good development of high-risk infants and young vulnerable children.

Valuable experiences in building programmes for children with developmental delays and disabilities have been conducted in specific districts by personnel of the Department of Social Welfare. Lessons from these programmes should help with the design of the multi-sectoral system to ensure OVYC are identified, assessed, served and tracked over time. At the present time, there are only 40 District Social Welfare Officers when, at a minimum, each district would appear to need a person who could guide activities for OVYC and PAW. The mandate of the Department is immense but its resources are too few to be effective given the major needs of OVYC and OVC of all ages.

Considerable attention should be given to building a consensus regarding how services will be coordinated and integrated to ensure OVYC and PAW are well-served in the future.

#### **2.4 Pre- and In-service Training Systems**

The policy analysis revealed that there is a lack of policy for pre- and in-service training for services dedicated to OVYC and PAW. Indeed, there is a lack of national training services for ECD services in general, and specifically, for Early Childhood Intervention services. This situation can be remedied through the provision of short to medium-term advisory services for designing and developing an effective national, regional and district-level training system. The Policy Frameworks for ECD and HIV/AIDS should include strong sections that present Pre- and In-Service Training Plans.

One of Tanzania's strengths is its university and training centres, including the Institute of Social Work and several health training facilities. Also, if resources were to be ensured for Folk Development Colleges and other district-level teaching facilities, they could be used to provide decentralised pre- and in-service training. Designs for programme organisation, curricular contents, methods, teaching/learning materials and media for both trainers of trainers and programme personnel will be required to build the ECI service programme. Programme and training designs should play special attention to issues of sustainability, and workload to ensure that planned activities will be implemented in the field, incentives will be provided at all levels and multi-sectoral teamwork will be achieved.

## **2.5 Policy Indicators and Targets**

Although attempts have been made by the Department of Social Welfare to identify and quantify children with disabilities and developmental delays through the 2002 census, the results were disappointing due to a notable undercount. Tanzania is using the international 10 percent rule with respect to children with disabilities, but from the prevalence of low birth weight, stunting and chronic illnesses, it is likely that disability rates are in excess of 12 percent. With respect to developmental delays, the number of children is probably in excess of 30 percent due to the frequency of malnutrition, chronic illnesses, and abuse and neglect. At present, no reliable statistics could be found related to child neglect or abuse of any type (physical, sexual or emotional).

Policy indicators apart from a few health and nutrition indicators also were not found. However, it is reported that the Department of Social Welfare expects to develop a list of indicators for OVC, including OVYC, in its Strategic Framework for OVC.

Of particular concern is the fact that Tanzania is reported to lack a technical capacity in the field of child assessment. Trainers in child assessment are needed to train Home Visitors and others how to assess children with respect to developmental milestones as well as basic growth measurements. Assessments could be conducted relatively easily through either of two approaches: 1) in conjunction with MCH and other services that include some child monitoring for health and growth using an expanded child monitoring card and an age appropriate assessment form, or 2) as a normal function of a new home-visiting Early Childhood Intervention Programme – or preferably, by both approaches.

## **2.6 Evaluation, Monitoring, Accountability and Enforcement**

With few exceptions, the structures and mechanisms for policy monitoring and evaluation are rarely specified in Mainland Tanzanian policies and plans. Exceptions include some PRS documents, health sector plans and education plans. In addition, funding for evaluation and monitoring appears to be seldom provided in MTEF documents. This situation has led to the formation of many expectations for various policies but there has been a lack of built-in monitoring and evaluation systems that could assess programme results. Basically, the policies are not accountable and they lack systems for policy enforcement. Where enforcement has been achieved, it appears that policies have been linked to specific legislation. Court cases have been used to bring attention to the importance of compliance. The linkage of policies and strategic plans or frameworks to related legislative acts appears to be essential for achieving certain policy goals in Mainland Tanzania.

The Policy Frameworks for ECD and HIV/AIDS should include plans for functional evaluation and monitoring systems that will be keyed to the indicators and targets of the policies and will be supportive of achieving Policy goals. It may well be important to develop a series of legislative acts to complement the Policy Frameworks.

## **2.7 Policy-Related Research**

Topics for policy-related research on OVYC and PAW abound in Mainland Tanzania. A major need exists for a study on the childrearing values, attitudes, roles, behaviours and goals of various cultures in Tanzania. Also, high priority should be given to urgently required research on:

- ∞ Prevalence of developmental delays and disabilities;
- ∞ Identification of orphans and other vulnerable children and their salient service needs;
- ∞ Maternal and paternal knowledge about developmental delays and disabilities;
- ∞ Stigma issues regarding HIV/AIDS, disabilities, malnutrition and chronic ill health;
- ∞ Services of various ministries and CSOs in terms of their results, challenges, needs and potential for scaling up.

Many other topics could be considered but these were noted repeatedly.

## **2.8 Policy Advocacy and Social Communications**

Only one policy included a strong section for policy advocacy and social communications. It is clear that this is a major gap area especially because so few people actually have read national policies and know what they say. In order to have a high level of impact, the Policy Frameworks for ECD and HIV/AIDS should include a strong plan for policy advocacy and social communications.

## **2.9 Investment Plan, Donor and Partnership Co-ordination**

As noted above, investment plans tend to be left out of Tanzanian policies. Also lacking are donor co-ordination plans – with the exception of Health and Education SWAs. No plans for partnership co-ordination were found. The Policy Frameworks for ECD and HIV/AIDS should include investment plans as well as donor and partnership co-ordination plans.

## **2.10 Annual Action Planning**

Five-year strategic (action) plans abound in Mainland Tanzania. Because these five-year plans tend to be put to one side for annual planning that is not directly related to national policies, it may be preferable for policy makers to prepare annual action plans for the implementation of the future Policy Frameworks for ECD and HIV/AIDS.

### 3.0 Policy Analysis: Zanzibar

Zanzibar faces major child and maternal health challenges, as reflected in its high neonatal mortality rates of 45 per 1000, infant mortality rates of 83 per 1000, under five years mortality rates of 114 per 1000, a maternal mortality rate of 114 per 100,000, and a life expectancy of only 48 years.<sup>43</sup>

Zanzibar has a number of policies and plans for women, young children, and HIV/AIDS, several of which have been skilfully prepared and are of good quality. The major issue facing Zanzibar appears not to be a lack of planning ability or leadership skills but rather the need to secure sufficient financial, human and material resources to carry out their comprehensive policies and plans. Some policy gaps exist and they will be noted below, but it must be recognized that Zanzibar has included far more in their policies for young children than have many other nations in sub-Saharan Africa. With adequate national investment in programmes for PAW and for OVYC from birth to eight years of age, and with complementary funding support from international sources, Zanzibar's future Policy Framework for ECD, OVYC, and HIV/AIDS affected children, and its future annual Action Plan and programmes could become models for the region.

In this first section, policies and plans relevant to PAW and OVYC will be reviewed.

#### 3.1 Policies and Plans: Their Contents, Cultural Dimensions and Observance of Children's Rights

Zanzibar continues to exhibit high fertility rates, and therefore faces rapidly growing demands for basic health, nutrition and education services. In addition to trying to expand access to limited health services, national health planners and specialists also are dealing with some health and nutrition practices that are detrimental for PAW and OVYC. Some of these cultural factors are well delineated in the National HIV/AIDS Strategic Plan (2003 – 2007) and the Women's Development Policy, (2001). However, ministerial and CSO specialists noted that Zanzibar lacks sufficient **culturally appropriate** parent education and support materials in the fields of infant and child stimulation, health and nutrition education, pre-school curricula and methods, manuals and materials for trainers of trainers, and educational materials and guidance for service personnel at district, ward and Shehia levels.

In general, Zanzibar's policies for children attempt to observe children's rights issues and try to ensure the CRC is implemented through the nation's policies, plans, legislation and guidelines. The report on compliance with the CRC is reviewed briefly below. In general it is gratifying to find that efforts are being made to review laws and practices that may be injurious to children and to reinforce child and maternal protection.

Viewed historically, the design, development and improvement of policies and social services for PAW, OVYC and persons affected by HIV/AIDS, is remarkable. Since

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<sup>43</sup> Rene Salgado. (Draft 21 September 2004). *Tanzania Child Health Assessment: Will the Child Health Millennium Development Goals Be Achieved in Tanzania?* BASICS II, USAID, Tanzania.

independence in 1964, in spite of major economic reverses, Zanzibar has made significant progress in all child-related areas. In many cases, Zanzibar's policies have been in advance of the provision of sufficient financial and human resources to carry them out.

### **3.1.1 Ministry of Finance and Economic Affairs (MOFEA)**

The following MOFEA policies pertain to ECD and HIV/AIDS areas:

- ∞ Zanzibar Vision 2020, January 2000
- ∞ Zanzibar Poverty Reduction Plan, January 2002
- ∞ Zanzibar Medium Term Expenditure Framework (MTEF) Estimate for Vote 19 (2003/4 – 2005/06), June 2003

#### **Zanzibar Vision 2020**

This long-range national policy document, prepared in January 2002 by MOFEA has as its main goal the eradication of absolute poverty in Zanzibar by 2020. It includes the HIV/AIDS area but it is mentioned only once under the Ministry of Health for preventive education through a “popular mass education programme that will lead the people to change their unsafe sexual behaviours.” HIV/AIDS is not viewed as a cross-cutting, multi-sectoral issue in Vision 2020. The implications for treatment, testing, and other sectors are not considered, and other ministries are not called to action. This gap was filled in part by the Zanzibar National Situation and Response Analysis of HIV/AIDS, National HIV/AIDS Strategic Plan (2003 – 2007), and National HIV/AIDS Action Plan that will be described below in the section for the Zanzibar AIDS Commission.

Vision 2020 includes a section on children, emphasizing the importance of access to sufficient good-quality nutrition and basic education. It calls for protecting children's safety, “strengthening community and household capacity to provide health care and schools' care to children,” improving maternal and child health services, reducing infant mortality rates to 20 per 1000 by 2020, promoting women's rights, protecting vulnerable children including orphans and the disabled, and revising laws and regulations for the protection of children and women.

Thus, Vision 2020 as the nation's premier guiding document pays special attention to key CRC issues. However, it does not specify any educational, health or nutrition interventions for ECD. There is one reference to planned motherhood and child survival as well as to giving emphasis to child immunization. Also, attention is given to improving water quality and accessibility as well as to improving wastewater situations. This document has a few general indicators and targets but it mainly provides general goals.

**The Policy Framework for ECD and HIV/AIDS would be in line with Vision 2020, and reference to the Vision should be made in the Zanzibar Policy Framework for ECD and HIV/AIDS.**

## Zanzibar Poverty Reduction Plan (ZPRP)

The Zanzibar Poverty Reduction Plan, originally prepared in January 2002, currently is being revised. The indicators listed at that time also are being reconsidered, presenting an opportunity to ensure indicators related to ECD, PAW, OVYC, and HIV/AIDS will continue to be included in the new ZPRP.

A participatory process was used to develop the ZPRP, including consultation with major stakeholders, such as representatives of civil society. Some people who were invited to consultation meetings stated they rarely received meeting reports and draft plans for review and comment. Stakeholders from CSOs and communities said they were unsure their comments had been taken into account during consensus building sessions. These observations reveal a keen interest on the part of stakeholders to be included in and contribute to the entire policy planning process.

The ZPRP presents HIV/AIDS rates, and at risk groups are listed. However OVYC and PAW are not included in the list. However, high rates of infant, child, maternal mortality and malnutrition are mentioned, and limited access to safe water and good waste disposal is also presented. Under “Human capabilities, survival and social well-being,” the following areas are included: expanded access to improved primary and secondary education including for children with disabilities; immunizations, MCH, reproductive health services and preventive services to combat diseases including “Awareness Campaigns” on HIV/AIDS; nutrition, safe water, and sanitation. No mention is made of parent education or of other needs of children from birth to school entry. Gender promotion, disadvantaged groups and HIV/AIDS issues are presented as cross-cutting areas that must be given attention to achieve ZPRP objectives. Revisiting laws and regulations that discriminate against women is encouraged as well as other issues, but no mention is made of PAW and the antenatal education and care they require to lower maternal mortality rates and improve birth outcomes. In contrast to Vision 2020, the ZPRP recognizes that several sectors must become involved in providing “social services, education, community action and family support” for persons with HIV/AIDS. **However, although the ZPRP calls for targeting youths, and especially females, no mention is made of OVYC and PAW. Under vulnerable groups, persons with disabilities are mentioned but no reference is made to young children with developmental delays and disabilities. These gaps need to be filled by the Policy Framework for ECD and HIV/AIDS.**

The ZPRP appears to be a formative document because it does not include a list of strategies and targets. However, recently a long list of indicators prepared for the ZPRP was made available. It is extremely comprehensive and to somewhat repetitious. This list presents 384 indicators which is far too many for a PRP because the cost of gathering and analyzing data to assess that number of indicators would be prohibitive for Zanzibar or any nation of sub-Saharan Africa where the focus must be on expanding and improving services. Of the 384 indicators, some 97 (25 percent) of them are related to integrated ECD, from the antenatal period to eight years of age. Undoubtedly, MOFEA will reduce the number of indicators. Many of them can be subsumed under others as

sub-indicators. Hopefully, drafters will retain very useful indicators such as infant low birth weight and others related to ECD, OVYC and PAW. It will be important for members of relevant ministries, CSOs, FBOs and other stakeholders to be vigilant and help ensure enough of the best indicators are retained for ZPRP II. What is clear is that activities proposed under the current ZPRP are not capable of achieving the types of targets that undoubtedly will be set for the indicators that are chosen. Zanzibar will need to reflect on how to expand its range of services and increase significantly its investments for PAW and OVYC in order to achieve ZPRP objectives.

### **Zanzibar Medium Term Expenditure Framework (MTEF) Estimate for Vote 19 (2003/4 – 2005/06), June 2003**

The Medium Term Expenditure Framework provides administrative budget estimates for MOFEA's units and programmes. The MTEF reveals the Government's major resource requirements and its lack of adequate revenues. Of particular interest is a statement that of the three "key MOFEA issues," the "HIV/AIDS epidemic" is listed as one. HIV is noted as a serious threat to Zanzibar. However, no programme related information about how this statement is to be translated into budgetary allocations is presented in the document. Conversations with competent MOFEA staff conveyed a sincere interest in promoting the well being of young children and overcoming the threat of HIV/AIDS. Further discussions are needed to explore ways to allocate funds for HIV/AIDS programmes for parents and young children.

As noted above, MOFEA is currently preparing a new ZPRP within which HIV/AIDS will be considered as a cross-cutting theme. This review presents an opportunity to include a much stronger section on HIV/AIDS and to present a set of high-impact strategies for serving PAW and OVYC from birth to eight years of age.

Finally, MOFEA specialists are preparing a thematic document with diagnostic studies linked to the **local government reform**. There are three reform areas:

1. Economic and financial reform;
2. Institutional and human resources reform, and
3. Good governance reform.

This activity presents several opportunities for ensuring that ECD issues are mainstreamed, and that Shehias and Districts place a strong emphasis in their local plans on topics such as:

- ∞ ECD health services with special attention on comprehensive services for early childhood survival, assessment and good development;
- ∞ Nutrition supplementation and education;
- ∞ Home-based parent education and support from antenatal, birth to three or five years of age;
- ∞ Quality pre-schools and day care centres;
- ∞ Home-based programme for school readiness and transition to school;
- ∞ Improved water and sanitation for homes, pre-schools and schools, and
- ∞ Protection for all vulnerable children, pregnant adolescents and women and mothers.

### **3.1.2 Ministry of Employment, Youth, Women and Children's Development (MOEYWCD)**

The MOEYWCD is the Lead Ministry for early childhood development issues. It prepares policies and action plans, manages donor co-ordination and proposal formulation, coordinates with other ministries, provides direct services especially in rural areas, and has a counselling unit for families with an array of difficult situations.

MOEYWCD is mandated to guide policy development for ECD, in collaboration with all other relevant ministries. This Ministry also houses the National Children's Rights Committee (NCRC), and it prepared the most recent Periodic Report on the Implementation of the Convention on the Rights of the Child (CRC) in Zanzibar, (January 2004). This Report provided abundant information about child rights and development efforts in Zanzibar. Of special interest is the appended chart of "cross-cutting issues" with lists of indicators and poverty reduction initiatives related to children, street children, youth, women, employment, vocation education and training, community development, and micro credit. As such, it groups together children of all ages. It might be valuable to prepare a future CRC report on juridical protection for the following age groups: pregnant women and birthing; children zero to three years of age; three to six years; and six to eight years. This type of analysis was conducted in Burkina Faso with striking results.

The services the MOEYWCD provides for children include:

- ∞ Conducting vocational skills training for youth and women;
- ∞ Helping women remove their children from child labour, giving them material help such as uniforms for school;
- ∞ Providing activities for women's development, and
- ∞ Managing child protective services with a focus on counselling for mothers and fathers.
- ∞ Providing television and radio programmes for children.

However, this Ministry currently does not provide parent education and child development services, and it appears not to have any plans to do so. It does not offer services focused on the needs of OVYC and PAW *per se*, although some young children are included under child labour programmes, women's development activities, and counselling services. Rather, ministerial leaders say they look to the MOECS and the Ministry of Health and Social Welfare to provide these services.

#### **Policy Statement for Child Survival, Protection and Development Programme (October 2001)**

The Programme for Child Survival, Protection and Development (CSPD) of the Ministry of Finance was developed with the financial support of UNICEF and is monitored by the MOEYWCD. Ministerial representatives observed that its emphasis is on child survival

and protection issues including sexual abuse, health and nutrition.<sup>44</sup> They stated they plan to review it soon to assess gaps related to ECD, PAW and OVYC.

### **Women's Development Policy, 2001**

The Ministry also prepared a Women's Development Policy which is a very sensitive and well-written paper. It lacks some of the essential attributes of an enforceable policy, but it clearly explains many of the striking needs of women in Zanzibari society. Some focus is given to pregnancy, single motherhood, child and maternal support, and inheritance issues that can have a negative impact on ECD, OVYC and maternal development.

**The Women's Development Policy could serve as an "umbrella" for specific strategies regarding PAW.** Also, an annual Action Plan for Women's Development would help to reinforce Policy recommendations for improving the status of women and assisting them to achieve their rights.

Currently, MOEYWCD personnel are preparing the following policy documents but in October 2004 none of the drafts was ready for review or distribution:

- ∞ Child Labour Guidelines;
- ∞ Youth Policy;
- ∞ Gender Policy, and
- ∞ Policy for Vocational Training.

### **3.1.3 Zanzibar AIDS Commission (ZAC)**

Established in June 2002, the ZAC is the leading co-ordinator for HIV/AIDS in Zanzibar. It has produced the:

- ∞ Zanzibar National Situation and Response Analysis of HIV/AIDS
- ∞ National HIV/AIDS Strategic Plan (2003 – 2007)
- ∞ National HIV/AIDS Action Plan

These documents are of high quality. They include valuable discussions of critically important cultural dimensions regarding HIV/AIDS and its transmission. Various types of stigma are noted that appear to be major barriers to preventive education, behavioural change, testing, and treatment. Official statistics of HIV reveal a 0.6 percent infection rate among sexually active people. This is a very low rate for sub-Saharan Africa, but one cannot help but wonder if this is due in part to peoples' unwillingness to be tested, the lack of testing kits, and the unavailability of trained medical personnel and facilities in some areas.

### **Zanzibar National Situation and Response Analysis of HIV/AIDS, August 2003**

The authors focus mainly on prevention and service needs for what is believed to be a relatively small number youth and adults. They note that as of 2003, "Nearly 500 AIDS orphans have been registered in NGOs dealing with HIV/AIDS and around 6,000 adults

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<sup>44</sup> A copy of this policy could not be found.

and children are estimated to be living with HIV/AIDS.” Some four percent of HIV transmission is believed to be vertical in nature from mother to child, including breast-feeding. At least 3.1 percent of children under five years of age are HIV positive. Although there are some mentions of orphans, pregnant adolescents and women in some sections of the Situation Analysis and Strategic Plan, very little is proposed in the way of interventions for them.

The Situation Analysis notes the following gaps that pertain to the ECD area:

- ∞ Denial and stigma plus national leadership unaware of needs, leading to inaction;
- ∞ Gender factors exposing child bearing age women especially to infection;
- ∞ Lack of teaching guidelines for communicable diseases including HIV/AIDS in the primary school curriculum;
- ∞ Lack of knowledge among teachers;
- ∞ Absence of clearly defined terms of reference for school counsellors;
- ∞ Health sector incapacity to deal with PAW and others for testing, counselling and follow-up treatment;
- ∞ Absence of adequate co-ordination at all levels, and most of concern, and
- ∞ Lack of human and technical resources to meet targeted needs and conduct continuing research to guide actions.

### **The National HIV/AIDS Strategic Plan, 2003 – 2007, (November 2003) and the National HIV/AIDS Action Plan, 2003 – 2007, (October 2003)**

The National HIV/AIDS Strategic Plan and the Action Plan provide well-structured plans for priority areas including: prevention; health treatment care, and support; surveillance and research; organisational strengthening, and improved programme implementation. Attention is given to cross-cutting issues and short-term planning, with objectives, activities/strategies and outputs provided for each major area. It is reported that these documents were based upon an extensive consultation period that involved 1,150 people at all levels, from Shehias to CSOs, and the richness of the document reflects this participatory planning process.

The Plan includes a Vision, Mission, and an Overall Objective of “reducing HIV infections by 50 percent by 2007 and to provide treatment, care and support for PLWHA and their affected families.” This Objective has a series of discrete strategies. The Strategic Plan calls for a national multi-sectoral HIV/AIDS Policy and for instituting co-ordination mechanisms for capacity building, networking, social communications and training. A detailed co-ordination framework is provided, along with the roles and responsibilities of each entity involved for conducting well-coordinated work at all levels. It lists all collaborating ministries and institutions and notes their general roles. The evaluation and monitoring plan needs further delineation but this critical area is mentioned. For each main strategy of the Strategic Plan, the Action Plan presents detailed Activities, responsible agencies, duration, output, indicators, measures (means of verification), a time frame (over a five-year period), and the financial resources required.

Attention is paid to PAW and to the prevention of mother to child transmission (PMTCT) due to the fact that women in this age range have higher disease rates. The Plan calls for introducing PMTCT. However, relatively few other interventions are recommended for them. ECD is not defined as a major target area in spite of presence of high-risk mothers, orphans, and children infected with HIV. Some mention is made of them with regard to family counselling programmes, identifying and tracking AIDS orphans “and other MVC,” and the need for economic and material support in the homes of poor relatives as well as the development of sustainable support systems. However, most of the strategies in the Plan relate to older children. The Plan calls for developing a “guideline/policy on AIDS orphan care and support,” and the ECD and HIV/AIDS Policy Framework in Zanzibar could help to fill part of this need in conjunction with developing systems for attending to all OVYC.

The Zanzibar AIDS Commission, that is working assiduously to coordinate HIV-related services and activities, has stated that it intends to fill these gaps by means of including them in the new Zanzibar HIV/AIDS Policy that currently is being drafted. **The preparation of the Zanzibar ECD and HIV/AIDS Policy Framework and the Zanzibar HIV/AIDS Policy represent important opportunities for ensuring that PAW, their infants, orphans and other children infected or affected by HIV/AIDS will be given a special priority for assessment, service provision, tracking and support. Furthermore, Policy Guidelines and an annual Action Plan plus sufficient funding will be needed to ensure that a well-planned service and support system for OVYC and PAW is put into place in Zanzibar.** In this regard, Zanzibari CSO representatives have expressed their strong interest in helping both with policy formulation and planning as well as with service provision at the District and Shehia levels.

#### **3.1.4 Ministry of Education, Culture and Sports (MOECS)**

The Ministry of Education, Culture and Sports has developed three documents of special relevance to OVYC:

- ∞ Zanzibar Education Master Plan for 10 Years, 1996-2006, (December 1996)
- ∞ Five Year Action Plan for Integrated Early Child Education and Development, Zanzibar, 2003 – 2007, (January 2003)
- ∞ Education Sector Country Status Report, Zanzibar, (June 2003)

#### **Zanzibar Education Master Plan for 10 Years, 1996-2006, (December 1996)**

Based upon the 1991 Education Policy, the Zanzibar Education Master Plan (1996 – 2006 ZEMAP) that was prepared in 1996 states that the Ministry of Education has been delegated two major roles with regard to early childhood education, care and development:

1. Home-Based Parent Education for children birth to three years of age, and
2. Early childhood development through Quranic schools, pre-school centres and child care centres.

**At present the Ministry of Education, Culture and Sports does not provide as yet any home or centre-based services for and with the parents of children from birth to three years of age.** The Master Plan calls for “establishing sustainable community-based and managed programmes and services and expand the existing ones.” “For children 0 to 3, parents and communities will be encouraged, supported, and trained to initiate home and centre-based care which will provide adequate care and stimulation for these young children.” It is stated that the emphasis for this age group is upon “home-based care for young children of ages 0 to 3.” **Parent awareness of child development needs, better nutrition and health care and the provision of a stimulating home environment are all mentioned as key objectives. This laudable goal for parent education should be given high priority by MOECS in order to improve school readiness and achievement.**

ZEMAP’s first objective is: *“The institutionalization of early childhood education, care and development as a basic service for all children in the country. The target is to have all children aged 4 – 6 enrolled in early childhood institutions including Quranic schools by the year 2006.”* Thus, all children ages four to six years are to be enrolled in Years 1 to 3 of the formal school system, with Primary School beginning at Standard I when children are seven years of age. Currently consideration is being given to lowering the age of entry into Primary School to six years of age.

Since the Master Plan estimates that 90 percent of children four to 16 years of age are enrolled in over 1,700 Quranic schools, in a way this first objective may be attainable in terms of coverage. By learning the basic elements of reading, writing and arithmetic in Quranic schools, children who are as young as two or three years of age could not only learn key religious concepts and be cognitively stimulated but also gain early literacy. If initial literacy in Arabic were to include learning to read and write in Kiswahili and perhaps in English, today’s children could become the first fully literate generation in Zanzibar. A review of Quranic education would reveal a wide variety of quality and curricular contents. Some Quranic schools are reported to provide balanced pre-school education, such as in the internationally recognized Madrassa programme supported by the Madrassa Resource Centre. A network of Quranic schools in Pemba is developing quality initiatives for pre-school education. The Master Plan calls for upgrading pre-school teacher competencies, improving curricula and involving and educating parents, as well as expanding the pedagogy of Madrassas and Quranic schools and developing “integrated pre-school curriculum guidelines that will cater for both religious and secular studies.” The Master Plan calls for standards setting, training and co-ordination with other sectors, with communities, NGOs and other organisations. These important initiatives could provide considerable guidance for Madrassas in other parts of Africa.

Although the Master Plan emphasizes Primary Education, the section on the Programme for Early Childhood Education, Care and Development (PECECD) is one of the longest in the document. This reflects the strong emphasis that education specialists in Zanzibar place upon their youngest citizens. The quality of public and private pre-schools is not fully addressed in the Master Plan but is later attended to in the Five Year Action Plan for Integrated Early Child Education and Development, Zanzibar.

Children accessing Primary School face issues related to teacher and educational quality. Furthermore, some parents do not send their children to school and high levels of child labour are found in Zanzibar precluding entry into basic education and causing high levels of school drop out. In addition, developmental delays caused by malnutrition, chronic ill health and disease and disability, contribute to school attrition and grade repetition. As a result, the education system experiences major unnecessary costs as a result of high levels of internal inefficiency. In 1996, a review of the net enrolment rate revealed that approximately 50 percent of the children ages seven to 16 years were attending school in 1996. This wastage comes at a high cost that Zanzibar can ill afford. By involving parents in their children's early learning, in pre-schools and Quranic schools, and later in their schools, primary school drop out can be radically reduced as has been the case in many other nations. Furthermore, because the Education Ministry is mandated to manage both early childhood education and primary schools, cost savings at the Primary level can be invested in the early childhood programmes laid out in the Master Plan and the Five-Year Action Plan for Integrated Early Child Education and Development.

### **Five Year Action Plan for Integrated Early Child Education and Development, Zanzibar, 2003 – 2007, (January 2003)**

This Five Year Action Plan is a model of comprehensive planning for improving pre-school education in a resource-scarce environment. It has a simple format that becomes a bit repetitious. However, it subtly and skilfully covers all key issues required for improving a pre-school system. Some 44 pre-schools were included in a baseline survey that served as a situation analysis. Half of the pre-schools were public and the other half were private. The authors state that government pre-schools had better quality buildings and teacher qualifications but private pre-schools tended to provide better class stimulation, resources and methods. However, the study found that across all pre-schools in Zanzibar:

- ∞ No assessment of child development and progress was found.
- ∞ Standards were low.
- ∞ Little in-service training was provided.
- ∞ No continuity existed between pre-school and primary school.
- ∞ Sanitation was lacking
- ∞ Nutrition education and provision were absent.
- ∞ Children with special needs were not well served and there was a lack of understanding about inclusive education.
- ∞ Parents were unaware of the importance and value of good nutrition and health standards.
- ∞ Few schools were linked to their communities.
- ∞ The schools did not help parents with their children's transition from home to school.
- ∞ Communities were unaware of the importance and value of pre-school education and inclusive education.

The Action Plan is very ambitious and well balanced. From discussions with Zanzibari education specialists, it is clear that due primarily to resource constraints, some sections of the Action Plan have not been implemented as yet. However, it is a very good general plan and merits strong support. It covers all aspects of the school environment including buildings, play areas, classroom stimulation, safety, and monitoring and evaluation. The training section includes curriculum development, in-service training workshops, developing and utilizing child assessments, and recording and reporting them along with individual student plans, particularly for special needs children. The plan calls for cascade training, parent and community involvement, and training for teachers and the community regarding children with special needs, including those infected and affected by HIV/AIDS and other vulnerable children. It calls for a full parent education programme on children's rights, psycho-social stimulation, health care, nutrition, and sanitation. Drop-in centres for parents are to be developed for parent education in addition to promoting "awareness of links between levels of hygiene and cognitive development." A section for collaboration with the Ministry of Health includes promoting health care. It underlines actions to ensure an integrated approach is taken including health, safety, immunizations, first aid, training on HIV/AIDS for personnel and parents, child assessments and progress profiles including health care. Other sections focus on inclusive education including children affected by HIV/AIDS. Parent and community involvement is highlighted not only for school maintenance but also the Plan calls for workshops for parents and parental help with making learning resources for children. The Plan wisely recommends a wide dissemination and promotion of its annual plans, the establishment of a Monitoring Team, and the development of school-level annual plans. It is very important that this Plan be given careful review each six months and updated annually. It merits strong financial and material support. **If this Plan were implemented along with home outreach programmes of the Ministry of Health and the proposed MOECS integrated programme for parent education, birth to age three, the status of Zanzibar's children would improve rapidly. ZEMAP and the Five Year Plan should be supported in Zanzibar's Policy Framework for ECD and HIV/AIDS.**

### **Education Sector Country Status Report, Zanzibar, (June 2003)**

However, investment in young children is a key issue in the MOECS. The Education Sector Country Status Report clearly notes that one of the 17 priorities of the MOECS is early childhood care, education and development. However, the Status Report then slides to a statement that the Zanzibar Poverty Reduction Plan has three main overall objectives related to: 1) primary school enrolment and attendance, 2) educational quality in rural and urban schools, and 3) curriculum development, leaving out the ECD area. It then provides a cost simulation that projects costs only for "these priority programmes" and does not include the ECD area. The result of this budgetary exercise is that ECD and all of the foregoing plans of the MOECS are left out. Therefore, implicitly ECD programmes from birth to three years of age and preschool programmes from four to six years of age are not recommended for funding. Yet to achieve primary school enrolment and attendance targets, and to reduce wastage and grade repetition, young children need to be ready for school, well developed, well-nourished, and healthy. Furthermore,

integrated ECD programmes are essential for meeting at least 25 percent of the other ZPRP goals and targets. It is hoped that educational planners in Zanzibar will reflect upon the need for increasing investments in ECD programmes for parent education for the parents of children from birth to three years of age, and improving and expanding pre-school education for children from four to six years of age, along with continuing parent education and support.

### **3.1.5 Ministry of Health and Social Welfare (MOHSW)**

MOHSW policies identified as germane to ECD and HIV/AIDS and OVYC include:

- ∞ Health Policy, 2000
- ∞ Medium Term Expenditure Framework, 2004/05 – 2006/07
- ∞ Social Welfare Policy, 2002 (available only in Swahili)

New draft policies on Social Welfare and on Persons with Disabilities currently are being prepared.

#### **Health Policy, 2000**

The MOHSW Health Policy provides a valuable historical review of health development in Zanzibar. However, it lacks certain elements usually found in effective policy documents and it lacks the rigour of the HIV/AIDS documents discussed above. It presents major health reform areas, policy statements, objectives and strategies. Strong emphasis is placed upon: “family planning and Safe Motherhood Services” (including immunisation, Safe Motherhood/reproductive health, health education and training for traditional birth attendants), water and sanitation efforts, malaria control programmes, health issues of persons with disabilities, nutrition education, and HIV/AIDS.

The Policy notes that HIV/AIDS has received national priority “because HIV infection cuts across all sections of the Nation.” Note is made of the importance of screening pregnant women but young children or orphans infected or affected by HIV are not mentioned. Reference is made to the importance of working with NGOs. However, the lack of enough trained health personnel, facilities and supplies of drugs and equipment are of concern. Without greatly increased external support, it appears that the health system will be unable to meet primary health care needs. Yet major efforts are being made to provide pre- and in-service training for health care workers and expand essential programmes for disease prevention. A neonatal ward for premature infants has been established, but it was reported that the nation currently lacks a Neonatologist.

The Health Reform focused on developing a decentralised health system with appropriate management, co-ordination mechanisms and guidelines at all levels, a training policy including basic and post-basic training, continuing education, a new emphasis on partnership with the civil society and private sector, the creation of a “Social Welfare Coordinating Committee,” quality health care improvement, the development of “Community Health Funds,” a National Health Development Fund, and social and private health insurance. The Reform calls for reducing morbidity and mortality due to malaria, with special attention to the most vulnerable groups of children under five,

pregnant women and the poor. Reproductive health and education services are emphasized, along with some unusual strategies rarely found in health plans such as reducing the divorce rate in Zanzibar society and raising the income level of women and youth – topics that are beyond the competence of the MOHSW. It calls for raising HIV/AIDS risk awareness, promoting safe sex behaviours among vulnerable population groups, and providing home-based care and support for people living with or affected by HIV/AIDS. Basically, the Policy asks communities to take care of these people. The MOHSW includes strategies to provide support to orphans, ensure clinical support by making anti-retroviral drugs available, strengthen HIV/STD surveillance, and track infection levels of HIV and STDs and related behaviours while increasing the quality and accessibility of health services for children, including IMCI.

Finally, the Health Policy calls for the MOHSW to conduct donor co-ordination and manage health sector resources and the reform process. This section of the Policy clearly is intended to place the control of health care system in the hands of Zanzibari health leaders, build their capacity to manage the reform, and establish a system for monitoring, coordinating work and a mechanism for working with donors. Finally, the Policy calls for advocacy and public relations activities for the Reform to all stakeholders.

**Although the Health Policy lacks some essential details and a clear Action Plan, nonetheless it provides a very good “umbrella” for developing the health, nutrition and sanitation aspects of the Zanzibar Policy Framework for ECD and HIV/AIDS.**

#### **Medium Term Expenditure Framework, 2004/05 – 2006/07**

The Medium Term Expenditure Framework (2004/05 – 2006/07) does not provide a special focus on infants infected or young children affected by HIV/AIDS, PAW with HIV/AIDS, or orphans with health and nutritional needs. Regarding OVC, it mentions, “provide support for orphans” which is similar to the general statement in the Health Policy. Clearly, additional guidelines will be needed for OVYC.

Generally, the Health MTEF is a good document that calls for service decentralisation, participatory approaches, and integrated primary health care. It continues to stress MCH, health education, programme monitoring and evaluation, sexual and reproductive education, and HIV/STD risk generating behaviours. It is recommended that District Health Management Teams receive more training with regard to their roles and responsibilities. Again, partnerships with CSOs and the private health sector are emphasised. The Health MTEF reinforces the need to involve the community in the care of people with HIV/AIDS. It includes VCT and the provision of anti-retroviral drugs, work that is going forward with the help of the Zanzibar AIDS Unit Control (ZAUC). It calls for strengthening the IMCI Unit, improving the nutritional status of children and initiating health and nutrition education (but it does not specify for whom). It includes some health research. The Ministry remains concerned about co-ordination, funding, and budgetary flows, the shortage of skilled health personnel, and “weak integrated planning.” The latter is a promising observation for building comprehensive and multi-sectoral collaborations that, if well handled, could help to maximize scarce resources.

However, note is made of “inefficient monitoring and evaluation mechanisms” and a lack of donor co-ordination in spite of calls for it to occur. Finally, the MTEF notes “internal religious, political and other societal interference in health issues” and expresses general concern over “cultural beliefs” without a clear specification of what should be done.

Discussions in Zanzibar revealed that the MOHSW includes a Technical Committee to address HIV/AIDS that is well linked to ZAC. However, currently no continuous HIV/AIDS testing of pregnant women is taking place. What testing is conducted is not routine. It was stated that testing kits and advanced equipment are needed to do studies of pregnant women.

Inconsistent efforts currently are being made to identify pregnant women during their first trimester and to provide them with timely antenatal education, nutritional supplements, and health care services. Antenatal clinics are provided for PAW but some ministerial staff members report that use is low while others state they are used fairly consistently. Although no data exist on antenatal service coverage, health personnel believe it to be close to 90% but they do not know when women first begin to use these services. Given the high rates of maternal and infant mortality, this would appear to be an important research area. It was noted that training is required in the field of mother to child transmission and STDs but the Ministry lacks reagents and other items. The Baby Friendly Hospital and breast feeding programmes are just beginning. Above all, there is a major shortage of trained medical personnel and facilities. It would appear that the policies are positive and the will is there but resources are inadequate.

Day care centres currently are overseen by the MOHSW. The Ministry hopes to prepare a policy on day care centres for children three years of age and older whose mothers are working. The few day care centres that exist are reported to include some educational and feeding services but no child development, health or nutrition assessments are made. Most of the day care centres are private or community managed. **It is unclear whether the administration of day care centres should be under the Social Welfare Department or the Ministry of Education. Policy decisions and quite likely legislation are needed regarding this issue and for establishing minimum standards for both pre-schools and day care centres.**

Currently, persons with disabilities generally lack government support, although increasing attention is being paid to them. There is one school for the blind under the Ministry Education but the deaf are reported to be sent to the Mainland. Entry into Primary School at age seven is the first time that children are assessed for disabilities. **At present, no Early Childhood Intervention services exist in Zanzibar to identify, assess, serve and track fragile infants or young children with developmental delays or disabilities.**

With regard to orphans, it is reported they are cared for by relatives or they become wards of the state. At this time, three orphanages are run by the government, SOS and a Muslim centre.

The Ministry's system of Maternal and Health Aides is noteworthy. These outreach workers are field health professionals that receive two to four years of pre-service training plus in-service training. It was reported that soon they will be called Public Health Nurses. They monitor pregnancies, conduct deliveries, identify problematic deliveries, make referrals, provide child health care in "under fives clinics," monitor child development, give immunizations to mothers and children, and offer counselling services regarding HIV/AIDS. Traditional Birth Attendants are provided training, and it was stated that mothers can select where and with whom they wish to give birth. In addition, there are 200 Community Based Distributors (CBD) who are supervised by Maternal and Health Aides. They were trained initially to provide Family Planning services, making home visits to teach family planning. Now CBDs teach parents about child health, nutrition, and early childhood development. It is estimated that from 400 to 500 CBDs are needed to reach all homes with mothers and young children in Zanzibar. No assessment has been made of their impact and this is an area for future evaluation research.

**Potentially, the work of CBDs and other community health workers could be enriched by parent education materials and activities developed by the MOECS that has a policy mandate in the Master Plan to provide home-based and centre-based stimulation and parent education for the parents of infants and young children ages zero to three. This is an area for future policy harmonization and it should be dealt with in the Zanzibar Policy Framework for ECD and HIV/AIDS.**

### **3.1.6 Ministry of Regional Administration and Special Departments (MORASD)**

The MORASD is in charge of local government, including Regional Commissioners, District Commissioners, Secretaries of Towns or Villages and one Municipal Council. There are 141 wards and 284 Shehias in Zanzibar. Legislation for decentralisation began with Act I, 1988 that set up regional administrative authorities, and Act III and IV of 1995 that established district, town and township councils.

District Development Committees coordinate, supervise and implement regional and district development plans. At this time, there is no comprehensive regional planning system although sectors sometimes have regional-level administrations. The Shehias plan and prioritize their plans, sending them to the Districts that gather, appraise, prioritize and send them to the regional level. The regional levels prioritize them further and send them to the relevant ministry. Ministerial officials report that villages have been given extensive PRA training wherein parents play review roles. It is reported that District Health Management Teams include youth in their sub-committees. MORASD officials report that these Teams are well aware of the health concerns of their villages and include major health issues in their Shehia Plans.

MORASD officials report that they work closely with CSOs. CSOs are playing key roles in field programmes especially for young children and PAW with HIV/AIDS and OVYC. They report that they are seeking to be better linked to ministerial programmes and from

the comments of ministerial personnel, the door to collaboration appears to be open to CSOs in the ministries. It is less clear that the ministries have enough funds to support CSO services at the local level.

### **3.2 Discussion of Policy Gaps and Some Needs for Harmonization**

**Greater leadership and co-ordination appear to be urgently needed in Zanzibar in order to unite all who are devoted to ECD in general with those who are dedicated to ECD with an emphasis on Zanzibar's most vulnerable children.** Vulnerable children represent a large sub-group – perhaps up to 45 percent of all young children. Given current statistics on severe poverty, disease and malnutrition, and the lack of services for vulnerable children, a special emphasis on them and on pregnant adolescents and women would appear to be essential.

#### **3.2.1 HIV/AIDS**

As noted above, ECD, PAW and OVYC were inadequately addressed in high-quality Report on Situation and Response Analysis of HIV/AIDS in Zanzibar, the Zanzibar HIV/AIDS Strategic Plan, and the Zanzibar National HIV/AIDS Action Plan. Representatives of the Zanzibar AIDS Commission feel that this was due to an inadequate awareness at the time of the potential impact of HIV on the status of young children, and especially on child survival and development. It is now appropriate to place greater emphasis upon sensitizing national decision makers about the needs of PAW and OVYC. ECD children's issues need to be prioritised in Zanzibar's programmes for HIV/AIDS and vice versa. Fortunately, the Five Year Action Plan for pre-school education of the MOECS already includes a strong emphasis on HIV/AIDS issues and its provisions can be reinforced in the Policy Framework on ECD and HIV/AIDS.

It is reported that many in Zanzibar feel that stigma related to HIV/AIDS is doubled when a child in the family is affected. This stigma needs to be overcome slowly but surely. Furthermore, from many discussions it is abundantly clear that many of the OVYC and PAW that need access to appropriate care and treatment, knowledge, prevention and treatment services have not been identified as yet in Zanzibar due to a lack of testing and counselling capacity.

**The Zanzibar Policy Framework for ECD and HIV/AIDS should be built upon strong statements presented above regarding the importance of assisting OVYC that are found in the HIV/AIDS Strategic Plan. Major gaps should be filled regarding antenatal education and care and integrated services for the parents of children from birth to three. The MOECS Action Plan should be enforced and supported for children from three to six, with close collaboration with the MOHSW and its policies.**

#### **3.2.2 Parent Education and Support**

Parent education is essential in all societies but generally it is unavailable in Zanzibar. It is reported that some parents still do not perceive ECD as important, and they do not realize that by acquiring good parenting skills they can help ensure the good development of their children. Because many women were very young when they had their first child, they did not learn traditional methods of child rearing much less research-based parenting skills. The major gap areas in parent education and support include the psycho-social stimulation of children, child assessment, health education and care, nutritional education and supplementation, home sanitation, and child rights and protection. **MOECS leaders expressed strong interest in developing a parent education system and in collaborating with other ministries to ensure it will use an integrated approach. MOECS could help to ensure that there are strong components for psycho-social stimulation, child development stages, and children's rights complemented by health, nutrition, and sanitation components.**

### *3.2.3 Pre-school Education*

Even though a very good Five Year Plan for pre-schools for children four to six years of age has been prepared, it is reported that some private pre-schools are about to collapse, and parents do not know how to help improve them. The MOECS currently has a first draft of **Pre-school Guidelines** that was unavailable. The Guidelines should be helpful in setting quality standards and in guiding pre-school improvements. **The MOECS should seek to coordinate this work with the nation's public and private pre-schools and day care centres currently within the purview of the MOHSW. During the preparation of the Zanzibar Policy Framework for ECD and HIV/AIDS, attention should be given to consensus building to bring these laudable efforts together.**

Quranic schools admit children between two to three years of age as well as older children. It is reported that as many as 54 percent of Zanzibar's children of these ages attend Quranic schools. However, little is known about the quality of education that these schools provide for such young children. This too could be the subject of special attention in the Policy Framework for ECD and HIV/AIDS. Curricula and teaching methods for very young children could be developed that would attend to their holistic development as they gain early literacy skills and religious concepts. If well managed, this could lead to greatly improved child development in Zanzibar.

### *3.2.4 Orphans*

At present, apart from some orphanages, no special programmes exist in Zanzibar for orphans or orphans affected by HIV/AIDS. Three orphanages are linked with the MOECS, but this is not the same as an overall catchment programme for young orphans and especially those affected by HIV/AIDS. It is reported that most orphans are taken in by relatives. However, if orphans are placed with poverty-stricken relatives or should they come to live in an abusive situation, they may well need focused health, nutrition, nurturing and educational support. If in addition they are infected by HIV/AIDS, they need specialized health services. **By linking the work in ZAC, MOHSW and MOECS with the programmes of many CSOs and FBOs that are dedicated to serving these**

**children, a comprehensive plan for orphans from birth to eight years of age could be prepared and included in the Zanzibar Policy Framework for ECD and HIV/AIDS.**

### ***3.2.5 Primary Education***

Primary schools in Zanzibar have high drop out and repetition rates. Yet few services have been developed to improve “school readiness” through parent education and quality pre-school education. Some good plans exist but resources have been meagre. No programme currently exists for ensuring a good transition from home or pre-school to primary school. However, school committees with parents have been formed and potentially they could be used as a base for developing school readiness and transition programmes.

**Because a new Education Policy is reported to be under current preparation, the MOECS strategies for parent education and pre-school education, plus expanded collaborations with MOHSW and the MOEYWCD could be developed to improve school readiness and success in school. As noted above, currently the MOECS does not provide services for children from birth to three years of age but it is interested in doing so. These issues should be included in the Policy Framework for ECD and HIV/AIDS.**

### ***3.2.6 Health Planning***

Representatives of the MOHSW noted that no current linkage exists between the Health Policy and PAW and OVYC affected by HIV/AIDS. They stressed the need to focus on vulnerable children, with an emphasis upon HIV/AIDS. **Furthermore, they noted that legislation and regulations are not coordinated, and that new legislation will need to be related to the future Policy Framework for ECD and HIV/AIDS. Also Guidelines will be required for health services for children birth to three/five years of age, with special provisions for health assessments in pre-schools for children four to six years of age.**

Concern was expressed over the lack of comprehensive antenatal education services covering pregnancy, nutrition, health, childbirth, and preparation for positive parenting. Some counselling for vulnerable populations regarding the prevention of HIV/AIDS and early marriages does occur, but several specialists stated that much more is needed. Although many efforts have been made to upgrade the skills of birthing specialists, nonetheless there was general agreement that more trained personnel are needed. Furthermore, the system for well-child checkups is inadequate and many of the most vulnerable children are not receiving regular assessments. Although there is some assessment soon after birth, usually it occurs two days after birth, if at all. Finally, at present only 70 percent of children are estimated to be registered at birth. **In general, fragile and vulnerable infants and children need to be better identified, assessed, registered and provided comprehensive services during their first years of life. Community Development Committees should be strengthened to ensure they**

**include comprehensive health, nutrition and parent education services for young children in their Plans.**

### ***3.2.7 Social Welfare Gaps or Areas for Reinforcement***

Representatives of the MOEYWCD noted many policy and programme needs:

- ∞ Child labour identification and expansion of current pilot services;
- ∞ Improved child development in early years;
- ∞ Pre-school and child care quality improvement;
- ∞ Early screening of children for disabilities and developmental delays;
- ∞ Increased knowledge about disability during the early stages of life and building disability awareness since many such children are “closeted”, and
- ∞ Programmes for young children affected by HIV/AIDS.

**This list demonstrates that there will be many areas for positive policy dialogue between MOEYCD, MOECS, ZAC and MOHSW during the preparation of the Policy Framework for ECD and HIV/AIDS.**

### ***3.2.8 Early Childhood Intervention (ECI)***

From all of the foregoing, it is clear that the gaps in services for young vulnerable children are felt by all concerned ministries. Because so many children are developmentally delayed, disabled, low in birth weight, malnourished and chronically ill, Early Childhood Intervention services are urgently needed. These services provide early and continuing child and family assessments thereby identifying high-risk children and families. It is clear that tools are required to assess, identify, serve, track, monitor, evaluate, and follow-up OVYC over time. CSOs would like to contribute to this work but they will need technical and financial support in order to do so. They will need continuous in-service training at the Shehia and District levels for community Home Visitors who can provide focused services in accordance with each child and family’s needs. Referrals can be made for specialised health and nutrition services, as possible. Such programmes require a general design and then a phased development plan in order to expand population and geographical coverage each year. **This type of ECI system would be capable of working closely with the MOHSW, MOEYWCD, ZAC and MOECS and interested CSOs in order to provide a continuity of care and support.**

### ***3.2.9 Financial Planning***

MOFEA strategies for young children currently are established through the ZPRP. MOFEA Planners stated that they will conduct a resource allocation exercise in one year’s time, and then prepare a Medium-Term Framework that will be three years in duration. Annual Plans are to be prepared by each Ministry that will play a role in the overall poverty reduction plan. **By preparing the Policy Framework for ECD and HIV/AIDS in time, the relevant ministries will have a better opportunity to ensure that funding that should be channelled through the PRPII will include greatly expanded investments in ECD for OVYC.**

### 3.2.10 MORASD Gaps

Leaders of MORASD stated they believed that policies developed in a participatory and decentralized manner are needed to improve the status of young children. They said they felt it is important to empower people in communities to advocate for their children. They urged that child development become a demand driven priority, thereby giving the people a greater voice in their own improvement. They recognized that policy consultation with CSOs, and especially with NGOs, has been inadequate in the past. Both MORASD and the CSOs have called for a greater enabling environment that will help ministries to understand them and their critical needs, and lead to developing better mutual relations.

### 3.3 Multi-Sectoral and Sectoral Structures, Co-ordination and Integration

Although all of the policy “hooks” exist in Zanzibar for building multi-sectoral responses to the holistic needs of the young child, it is clear that as yet no sector has sought to lead a multi-sectoral effort for young children.

In the HIV/AIDS area, the Zanzibar AIDS Commission has demonstrated that multi-sectoral planning can be undertaken quite successfully. Several of the policies reviewed appear to favour a multi-sectoral approach but the structure, strategies, programmes, training systems and contents, guidelines, co-ordination mechanisms, monitoring and evaluation systems for co-ordination and multi-sectoral programme design and implementation have not been thoroughly discussed as yet.

Zanzibar has developed a central coordinating body for HIV/AIDS. The Zanzibar AIDS Commission has a capable and dedicated Secretariat and a multi-sectoral Board of Commissioners, including representatives from MOECS, MOEYWCD, MOHSW, MOFEA, MORASD, FBOs, and CSOs. Co-ordination is still an issue because each ministry and organisation tends to work independently. In an attempt to deal with co-ordination issues, recently ZAC revived the Technical AIDS Committees (TACs) that were to be established in each ministry. ZAC also works closely with Health Committees at all levels. A grid of coordinating committees has been established, but it appears to be working, although somewhat imperfectly. This grid includes:

1. Shehia AIDS Coordinating Committees;
2. District AIDS Committees;
3. Ministries’ Regional Administrations;
4. Technical AIDS Committees in the Ministries, and
5. ZAC and the Zanzibar NGO Cluster.

**However as noted above, a structure for identifying and serving OVYC and PAW currently does not exist in Zanzibar.** An Office for ECD, OVYC and PAW could be placed within one of the following agencies or could be established as a separate entity:

1. MOESC for parent education and pre-school education that requires, in any case, close co-ordination with the ministries above;
2. Health Ministry/Social Welfare Department, which has an normative and implementation role in collaboration with other ministerial health services, or

3. MOEYWCD, that coordinates children's policies, facilitates communication with other sectors and prepares guidelines but has relatively few direct services.

**During the development of the Policy Framework for ECD and HIV/AIDS, attention should be given to holding widespread consultations and consensus building meetings with respect to future programme co-ordination and integration.**

The NGO Network and CSOs devoted to families affected by HIV/AIDS should continue to help provide services for young children at the District, Ward and Shehia levels, and their responsibilities could be expanded as resources become available. The MOEYCD noted that it works well with Districts and Shehias through their Women and Children's Officers who come to the Ministry once a week. These field workers could also play a useful role based on responsibilities they now have. Their work with young children and PAW should be harmonized with outreach workers from other ministries and NGOs.

Currently MOFEA is setting up a Poverty Monitoring System with five groups:

1. Research and analysis;
2. Information, evaluation and communications;
3. Census survey and routine data;
4. Stakeholders' Forum, and
5. Secretariat.

The work of MOFEA permanent staff is impressive. They accomplish quality work with very few specialists. However, the Poverty Monitoring System's Secretariat's capacity currently is very limited because it lacks permanent staff members and depends upon the provision of personnel seconded from other ministries. Two persons may be funded by UNDP. **This Poverty Monitoring System, if well supported, might be able to assist the Office designated for co-ordination, monitoring and evaluation of programmes for ECD and HIV/AIDS leading to a "virtuous circle" of support for OVC and PAW.**

MORASD leaders noted that policy co-ordination is major gap in and of itself in Zanzibar. They stated that the dissemination and implementation of policies is disjointed. They recommended the creation of a coordinating institution that would review and coordinate all policies, conduct policy advocacy, and help ministries to develop new policies. In this regard, they noted that Acts II and III of 1995 need to be reviewed and revised to account for district revenue roles for Districts. For example, the Districts and Ministry of Finance both are attempting to use some of the same types of revenue collection as funding sources. This situation could lead to confusion that could have a negative impact on services for children. Policy harmonization on this point probably requires policy consensus building in a venue separate from the Policy Framework for ECD and HIV/AIDS.

Currently, according to reports, co-ordination with NGOs appears to be inadequate. New and improved planning, programme implementation, and communication systems are needed. District level supervision and incentives are required to plan coordinated programmes and link field outreach personnel, including Community Based Distributors,

Health service providers, Women and Children's Officers, and others who serve young children and PAW.

### **3.4 Pre- and In-Service Training Systems**

In general, pre- and in-service training systems were not well described in Zanzibar's policies. No comprehensive Pre- and In-service Training Plan was presented in any of the policies, with the exception of the Five-Year Plan for Pre-School Education of the MOECS.

Although it was neither possible to discern all existing training systems through reading current ministerial policies nor to conduct an analysis of training resources on the ground, certain potential resources for training were mentioned, from the Health Training Centre, to the Madrassa Resource Centre that provides valuable ECD training for pre-school and child care centres. The NGO Forum helps train its members in techniques for strengthening their organisations. However, no comprehensive system exists for pre- and in-service training for personnel serving OVYC and PAW.

A Pre-school Resource Centre is managed by MOECS, and they are seeking to expand and improve it. It includes some pre-service training with a certificate after a 10 month course of two days a week for six hours each. It focuses mainly on providing in-service training. Potentially it might be used by people from other ministries and organisations serving children with HIV/AIDS and children with disabilities. Classes are provided on how to work with children with disabilities. Their in-service training system is supported by Aga Khan Foundation, and additional funding sources are needed. It is expected that the Centre will evolve into a full pre-service training centre, and potentially it could provide more attention to OVYC affected by HIV/AIDS and other high-risk situations.

MOEYWCD specialists noted their interest in expanding their training workshops for women and youth. MOFEA provides some training on planning to Technical Working Groups in line ministries, stakeholders and NGOs. Apart from preparing its community health workers, MOHSW gives training to social workers, caregivers in orphanages, and especially those serving HIV affected children. MORASD promotes birth registration and has given seminars to train Shehias as the focal point for gathering data and sending them to District levels and Zanzibar's Chief Registrar. CSOs said they need more training opportunities for themselves and the people they serve. For example, they noted that vocational training is needed for women and parents, especially for those whose families reject them when they become pregnant, divorced, and/or are HIV positive.

**In summary, a comprehensive Pre- and In-Service Training System is needed to address the multiple levels of capacity building required to prepare people for serving PAW and vulnerable young children and their parents. This training system should be described in the Zanzibar Policy Framework for ECD and HIV/AIDS.**

### **3.5 Policy Indicators and Targets**

At present, many policy indicators related to ECD may be found in the ZPRP. However, the current Strategy Plan for HIV/AIDS lacks indicators. ZAC representatives stated that they are preparing lists of possible indicators as they draft the monitoring and evaluation framework for the HIV/AIDS Policy. MOEYWCD has a beginning list of indicators related especially to the CSPD but reported that none have been adopted officially as yet.

MOFEA's indicators for the ZPRP II currently are being selected with the help of a UNDP Advisor, and they expect to have a new list very soon. People participating in preparing the new list of ZPRP indicators are in line ministries and they collaborate with two specialists from the Statistical Agency. However, at the present time it was stated that no stakeholders representing ECD are working with the indicators team. This presents a major opportunity for stakeholders in the ECD and HIV/AIDS areas to participate in selecting national indicators that will deal with OVYP and PAW.

A series of health indicators are used by MOHSW, but ministerial representatives state they feel they need to expand their current database. They said they believe their actual data base on ECD and HIV/AIDS is very limited and should be expanded. **The Zanzibar Policy Framework for ECD and HIV/AIDS should include a list of indicators, measures and targets.**

### **3.6 Evaluation, Monitoring, Accountability and Enforcement**

In general, policies in Zanzibar do not include provisions for policy evaluation and monitoring. Some efforts have begun in this regard. It is important to note that ministry-wide annual Performance Evaluation Reviews are prepared by some ministries. Some of the PERs appear to need strengthening. They should be linked better to expected annual targets and programme results.

ZAC leaders reported that they are drafting a monitoring and evaluation framework for the policy they are preparing on HIV/AIDS. The Strategic Plan and Action Plan lack adequate provision for accountability, although they call for building an evaluation, monitoring and reporting system.

In the MOECS, some evaluations are conducted of their pre-service training classes. In addition, visits are made to schools that include observations and assessments of teacher competence. The supervisory unit has 10 pre-school supervisors who conduct reviews in various areas: arts and crafts, language and reading, religion, mathematics, environment, children with disabilities, etc.

In Zanzibar, children's development and health status is assessed upon entry to Primary School, and teachers and parents are informed of results. If needed, children are referred to a health centre or to an NGO that serves children with special needs. This is usually the first time that children are assessed although MOECS representatives state that they encourage pre-schools to assess the children attending them. However, it appears that few of them do so. MOEYWCD representatives reported they have not conducted any

evaluations and lack required personnel and a monitoring system. MOHSW noted that they have conducted some evaluations but they feel they are not all they would wish them to be. Representatives of the MORASD affirmed that greater evaluation, monitoring and feedback processes are needed. CSOs also stated that evaluations are needed of current health, HIV/AIDS and all other services for vulnerable young children. **A strong and comprehensive Evaluation and Monitoring Plan linked to policy indicators, measures and targets should be included in the Zanzibar Policy Framework for ECD and HIV/AIDS.**

### **3.7 Policy-Related Research**

Many research topics were listed in Zanzibar's policies and additional themes were recommended by ministerial representatives and CSO leaders during on-site conversations. Interestingly, MOFEA was interested in pursuing research on a series of topics related to infant low birth weight, school repetition and drop out rates, young children in child labour, antenatal use rate, rates of pregnant adolescents and women and newborns with HIV/AIDS, teachers infected with HIV/AIDS, and research on all orphans and assess their status. The list of policy-related research topics mentioned includes:

#### ***HIV/AIDS Studies on OVYC and PAW (These topics were mentioned by virtually all ministries and CSO groups):***

- ∞ Study of HIV/AIDS prevalence in pregnant women and the feasibility of PMTCT. Current statistics are based on samples and they lack follow-up and support in some cases. Research is needed in order to develop a comprehensive system for serving high-risk PAW (with HIV/AIDS, malnourished, affected by STDs and other health concerns, very young pregnant women, severely impoverished women, and women with high-risk life styles).
- ∞ Identification of all vulnerable young children and orphans, birth to eight years of age, assessing their status in all areas: nutrition, health, education, developmental levels, home conditions, potential abuse or other concerns. Again, current studies were based on samples. In order to provide comprehensive services and identify children who may be malnourished, poorly nurtured or cared for, out of school, abused, etc., not only is a thorough study is needed but also a reliable, continuous assessment, service and tracking system should be developed.
- ∞ Incidence of teachers and school children infected with HIV/AIDS.

#### ***Parent Education and Support and Vulnerable Children***

- ∞ Vulnerability study: status and reasons for infant developmental delays and disabilities, malnutrition, chronic ill health, school drop out and repetition.
- ∞ Range and prevalence of child rearing practices by age of child and type of family.
- ∞ Parent and caregiver needs for rearing children well from birth to school entry.
- ∞ Study of parenting skills that should be taught to caregivers in homes, day care/pre-school centres and institutions.
- ∞ Action research for parent education and sensitization of parents about the importance of pre-school education for their children's good development.

### ***Pre-school and Primary Education***

- ∞ Quality and extent of coverage of pre-school education on a continuing basis.
- ∞ Child assessment in pre-schools.
- ∞ Consider ways to build on the Child to Child Programme of the Madrassa Resource Centre.
- ∞ Quranic schools: their learning activities, coverage of children two to eight years of age, and impact on later school achievement.
- ∞ Incidence and reasons for Primary school repetition and drop out rates.

### ***Child Health and Nutrition***

- ∞ Incidence of infant low birth weight and the needs of fragile infants.
- ∞ Assessment of the coverage of antenatal services, antenatal use rate, duration of service use, and periodicity.
- ∞ The rate of testing of PAW and newborns for HIV/AIDS, results and follow-up.
- ∞ Evaluate the activities, acceptance, impact and coverage of CBDs.
- ∞ Reasons for child malnutrition and study of best practices of programmes that have achieved success in improving child nutrition.

### ***Child Labour, Women's and Family issues***

- ∞ Prevalence of children eight years of age and younger in abusive child labour and the needs of children and their families. At present only sample studies are available.
- ∞ Study on the reasons for and needs of street children who roam by day.
- ∞ Study of current marriage sustainability and what appear to be rising divorce rates.
- ∞ Complementarity of inheritance rights – this is a legal issue under Sharia law.
- ∞ Role of FBOs in developing community support for children under five years of age, because community support for orphans appears to be dropping. On the basis of study results, consider how best to reinforce community support for young children.
- ∞ Incidence and reasons for adolescent pregnancies and marriage in order to consider new types of programme interventions.

It is clear that Zanzibar lacks the funds and specialists to support all of these studies. However, the high level of interest in research underlines the serious commitment of ministerial and CSO personnel to understanding their reality and improving and expanding services. This list is far from exhaustive but all of the topics presented above were mentioned several times by different groups. **External donor and foundation support for these studies would not only help policy planning activities but also future programme development in priority areas for PAW and OVYC.**

## **3.8 Policy Advocacy and Social Communications**

### ***Policy Advocacy***

Although ministerial personnel in Zanzibar were very generous with their time and helped to secure policy documents, it was clear from many discussions that few people

outside of the ministries are aware of what Zanzibar's policies say about the services young children should be receiving. CSO representatives observed that currently policy documents are not well distributed. They noted that they must go to ministries to request copies, and even then, they may have to wait a long time to get a copy. As a result, they said they rarely know the contents of official government policies. Clearly, better policy advocacy and communications is required.

Keenly aware of this need, MOFEA has established a Working Group on Information, Education and Communications which has developed a good policy advocacy plan for the ZPRP. The Working Group seeks to:

- ∞ Inform the Cabinet and conduct inter-ministerial communications;
- ∞ Prepare a quarterly newsletter that is circulated widely including to communities;
- ∞ Present sensitization seminars to grass roots organisations including religious leaders on how to combat poverty;
- ∞ Include journalists as Working Group members, and
- ∞ Provide easy to understand versions of policy papers, such as: *Zanzibar without Poverty!*

MOEYCD representatives noted their need to disseminate information about the Policy for Child Survival, Protection and Development, and to do so they reported that they conduct training sessions on the Policy.

### ***Social Communications***

With regard to social communications, it was noted that some parents living in poverty do not perceive ECD services to be important. They have not been told about what the integrated approach to ECD can do to improve the development of their children. It is clear that a **major social communications programme is needed for building parental support** for participating in child development programmes especially for the antenatal and birth to three periods as well as for pre-school education for children from four to six years of age, school readiness and transition to Primary School.

### **3.9 Investment Plan, Donor and Partnership Co-ordination**

ZAC personnel recently finalized a resource mobilization plan, and they found that US\$10 million will be needed for their overall HIV/AIDS effort. Within this plan, it is hoped that sufficient funds will be designated to meet the urgent needs of PAW and OVYC.

Virtually all ministries noted the severe resource constraints under which they are trying to implement their programmes. CSOs stated that they wish to create partnerships with ministries in order to build collaborative programmes. Several ministries noted that they would like to have plans for donor co-ordination but their situation is of such resource scarcity that they are proceeding on a programme by programme basis. MOHSW, for example, not only lacks adequate funding to meet urgent health care needs but also appears to require imported doctors, and many more medical supplies, equipment and

drugs. Health sector requirements for PAW and OVYC are truly compelling and deserve special attention on the part of external partners.

MOFEA established a Donor Assistance Committee, but due to the fact that Zanzibar receives a flat 4.5% of external funds given to Tanzania, recently the Committee has not been able to play a major role. However, UN agencies, some bilateral donors and foundations give support in addition to the 4.5%. If external investment in Zanzibar rises during coming years as hoped, some guidance will be needed to help Zanzibar with its donor co-ordination work. **Donor and Partnership Co-ordination Plans should be included in the Policy Framework for ECD and HIV/AIDS.**

### **3.10 Annual Action Planning**

The Zanzibar National HIV/AIDS Action Plan (2003 – 2007) is quite detailed but it covers a five-year period, and as such it and other five year plans in Zanzibar tend not to guide planning and activities. **For this reason, once the Policy Framework for ECD and HIV/AIDS is prepared, it may be appropriate to consider preparing two-year plans with the second year up-dated at the end of the first year. This approach helps to adjust annual plans and ensure they will be more operationally useful.**

## 4.0 Recommendations for the Comprehensive National ECD and HIV/AIDS Policy Framework for Action

### 4.1 GENERAL POLICY RECOMMENDATIONS

A recent study on *Research on Poverty Alleviation*, correctly states that in Tanzania, “There is no Plan of Action for the most vulnerable children.”<sup>45</sup> The nation lacks adequate policies, plans, guidelines and laws for OVYC and PAW that would clarify positions, fill gaps, ensure the design and implementation of priority programmes, and enable consistent programme co-ordination and integration, particularly at district and local levels.

#### *General Recommendations*

Given the dramatic needs of Tanzania’s young children and the gaps found in current policies and programme services, it is recommended that Mainland Tanzania and Zanzibar conduct the following four activities to improve the status of pregnant adolescents and women, orphans and other vulnerable young children from birth to eight years of age:

5. Develop, with the full participation of communities, districts, regions and national ministries, comprehensive **Policy Frameworks for Early Childhood Development and HIV/AIDS**;
6. Prepare **annual Action Plans** to carry out activities under each strategy of the Policy Frameworks;
7. Reinforce or prepare new **guidelines** for implementing programmes of annual Action Plans at all levels, national, regional, district, ward and community, and
8. Enact **legislation** to enforce Policy Frameworks and annual Action Plans.

**At all levels of policy consultation and development, the Civil Society Working Group for ECD and HIV/AIDS should be fully involved.** The Policy Frameworks, annual Action Plans, guidelines and legislation should be fully accountable through establishing a **transparent system for evaluation, monitoring and reporting** that would be managed by designated Executive Agencies or Offices. This system would permit the flexible adjustment of annual Action Plans to meet evolving needs of PAW and OVYC.

#### *Policy Frameworks for ECD and HIV/AIDS*

ECD Policy Frameworks, rather than Policies, are recommended for Mainland Tanzania and Zanzibar. Because both the Mainland and Zanzibar have several policies or sections of policies in relevant sectors and multi-sectoral areas that provide a series of “hooks” for the Policy Frameworks, it is best to embrace helpful aspects of those policies and not try to begin from a blank slate. Each Policy Framework should serve as an “umbrella” that

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<sup>45</sup> Cooksey, B and M. Mamdani. (2004). *Research on Poverty Alleviation: Summary of conclusion from recent research and synthesis of key issues on poverty in Tanzania*. Dar es Salaam, Tanzania.

will: 1) reinforce other policies or sections of policies; 2) provide a way for policy gaps to be filled, and 3) through consensus building, meet needs for policy harmonization.

It is essential that the Policy Frameworks be developed on the basis of extensive consultation and consensus building with public agencies, communities, CSOs, and private groups at all levels.

A series of sections should be included in the Policy Frameworks in order for them to be effective and enforceable:

1. ECD and HIV/AIDS Situation Analysis:
  - a. *The Status of Children, Families and Their Priority Needs;*
  - b. *Analysis of Current Services and Resources Devoted to Children and Families, Noting Gaps and Needs;*
  - c. *Review and Analysis of Policies, Plans, Guidelines and Laws to be Embraced within the Policy Framework, Gaps to be Filled and Areas for Policy Harmonization;*
2. The Policy Vision;
3. Goals and Objectives;
4. Policy Strategies;
5. Programme or Service Areas per Strategy;
6. Policy Indicators, Measures and Targets per Strategy;
7. Organisational Structure, Roles and Responsibilities for Implementing and Coordinating the Policy;
8. Pre- and In-service Training Plan;
9. Monitoring and Evaluation, Reporting and Follow-up for Co-ordination, Supervision and Revision of ECD Policy and/or annual Action Plan;
10. Policy Research Plan;
11. Policy Advocacy and Social Communications Plan;
12. General Investment Plan, and
13. Donor and Partnership Co-ordination Plan.

### ***Annual Action Plans***

Annual Action Plans are usually two-year plans wherein the first year is approved for immediate implementation and Year Two is reviewed and revised at the end of Year One to reflect emerging needs, work accomplished, activities yet to be completed and new activities that reliably can be undertaken in Year Two. This type of action planning helps ensure accountability and the continuity of programme design, implementation and evaluation.

The annual Action Plan establishes the programmes, activities, and steps required to implement Policy strategies. It should be derived not only from the draft Policy Framework but also from information and recommendations gained through consultations and consensus building exercises. It should include planning details inappropriate for inclusion in the long-term Policy Framework, including:

- ∞ Reaffirmation of Policy's organisational structures, roles and responsibilities as well as its vision, goals and objectives, strategies, programme areas and indicators that will guide the Action Plan;
- ∞ Basic information on each programme to be expanded, improved, or developed, including the organisation responsible, objectives and expected results, main activities, coverage and phases, evaluation and monitoring and co-ordination plans;
- ∞ Charts providing a timeline, programme-level indicators and targets, plans for co-ordination, total estimated financial, human and material resources, noting, current and expected sources of funding, shortfalls and plans for filling them
- ∞ Integrated pre- and in-service training programmes;
- ∞ Plans for policy advocacy and activities under the Social Communications Plan;
- ∞ Plans for co-ordination, collaboration, partnerships and networks;
- ∞ Annual monitoring and evaluation activities;
- ∞ Action research or studies to be undertaken to guide future planning and programme development, and
- ∞ Total general annual budget estimates across sectors and programmes.

### ***Guidelines***

To help ensure activities are conducted in a relatively uniform manner at all levels, Guidelines need to be reaffirmed or developed where they are needed. Many needs for Guidelines were spotted during the Policy Analyses in Mainland Tanzania and Zanzibar and are noted in relevant sections. These Guidelines are meant for the use of programme personnel at all levels: national, regional (when appropriate), district, ward and community.

There are several comprehensive Guidelines in Tanzania for specific programmes. They should be reviewed carefully in light of the Policy Frameworks, once they are completed, by focus groups that include personnel who are implementing the Guidelines. Where new Guidelines are needed, their preparation should be listed as activities under the annual Action Plan in conjunction with their respective programmes. All Guidelines

should be linked closely with the section of the annual Action Plan for pre- and in-service training. They should be drafted, field tested and revised before being distributed widely through training workshops.

With respect to the inclusion of OVYC and PAW in HIV/AIDS Guidelines, rapid attention needs to be given to preparing new Guidelines for regional, district, ward and community levels, with a special emphasis upon the district level. They should include guidance for District Councils, NGOs, FBOs, other CSOs and private organizations regarding programme development. They should also clearly outline performance indicators, monitoring and evaluation procedures, including essential tools, reporting mechanisms and formats. Guidelines will be required for all needs assessments, training workshops and programme activities for OVYC, PAW and HIV/AIDS.<sup>46</sup>

### ***Legislation***

Legislation is essential in those instances where existing policies have not been fully implemented or where ministries require such support to implement specific new programme initiatives. Examples of types of legislation that could be undertaken in Tanzania to meet major current needs are presented in the recommendations below. This list is far from exhaustive, and many other types of legislation could be considered to assist PAW and OVYC in Mainland Tanzania or Zanzibar.

Although resources for children could be better maximized, nonetheless, additional resources are needed in Mainland Tanzania and Zanzibar through the internal reallocation of certain budgets and through expanded international assistance in key areas. These changes are difficult to bring about when traditional budgets and “basket funds” tend to include only recurrent expenditures rather than funds for flexible programme innovation and systems reforms. If legislation is not fully effective at first, then in some cases, it may be necessary for legislation to be enforced through the justice system. What is clear is that children under five years of age who are dying or suffering unnecessarily from chronic diseases, malnutrition, neglect and abusive situations need greatly expanded help. To ensure developmental delays and disabilities are prevented and largely overcome, new services for parents and infants from birth to age three/five urgently are required. These and other complementary measures for children ages four to six will help to ensure that Tanzania’s children are healthy, well-nourished and ready for success in school.

## **SPECIFIC POLICY RECOMMENDATIONS**

### **4.2 Situation Analysis, Policy Content, Cultural Dimensions and Children’s Rights**

In general, some important references were found existing policies regarding aspects of ECD and the impact of HIV/AIDS on young children in current policies in Mainland

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<sup>46</sup> Special attention should be given to the World Bank’s Child Needs Assessment Tool Kit for communities affected by HIV/AIDS: <http://www.worldbank.org/children/cnahome.html>.

Tanzania and Zanzibar. However, many major gaps exist. Policy strengths identified in the Policy Analyses above can serve as a basis for building the future Policy Frameworks for ECD and HIV/AIDS.

At present in Tanzania, policies for areas of ECD and HIV/AIDS tend to be fragmented, and with a few important exceptions noted above, their texts rarely refer to co-ordination across sectors. In addition, several major needs for policy harmonization were found between ministries in Mainland Tanzania and in Zanzibar.

At this time, both Mainland Tanzania and Zanzibar are preparing policies closely related to OVYC and PAW: Child Development Policies for children under 18 years of age, HIV/AIDS Policies for persons of all ages, and in Mainland Tanzania's MLYDS's Department of Social Welfare, a policy and related documents for orphans and vulnerable children of all ages. Other policies are under consideration in related fields that will include references to young children.

Many of Tanzania's policies have been developed without the benefit of widespread consultation and consensus building. After approval, they tend to be little known outside of their ministries of origin. In some cases, policies do not appear to be guiding ministries' programme priorities and development. In other cases, there appears to have been a lack of financial resources to implement some existing policy elements.

In addition, funds appear not to be flowing consistently to district, ward and village levels where the plans and the needs for services are located. Local governmental authorities appear to be swamped with responsibilities. Many report that at district, ward and community levels, they lack adequate training to carry out their mandates. CSOs and private organisations, that are expected to provide many of the services, report that they too lack access to training and sufficient authority and financial support to conduct their programmes.

### **Future Policy Harmonization**

Concern has been expressed about a potential lack of harmonization between the Policy Frameworks for ECD and HIV/AIDS and other policies currently being prepared in Mainland Tanzania and Zanzibar in the fields of Child Development and HIV/AIDS. These are valid concerns.

**Recommendation:** Every effort should be made to ensure that the Policy Frameworks for ECD and HIV/AIDS present strategies for PAW and OVYC that will be consistent with and reinforce other more general policies for child development and HIV/AIDS. In turn, the general policies for Child Development and HIV/AIDS currently being prepared in Mainland Tanzania and Zanzibar should seek to be consistent with the Policy Frameworks.

## **Situation Analyses**

Situation Analyses have been conducted for some policies but not for most policies. It is apparent when a policy lacks an effective Situation Analysis.

**Recommendation:** The situation analyses currently being conducted, including this Policy Analysis should be used as a basis for the Situation Analysis section of the Policy Framework, and along with results of nationwide consultations, provide strong arguments for each of the Goals, Objectives and Strategies of the Policy Frameworks.

## **Child Rights and Protection**

Each sector has made major efforts to embrace child rights issues, and the recent reviews of the CRC in both Mainland and Zanzibar are quite thorough. However, from prevailing statistics and the situation analyses placed in policies of both areas, it is clear that children's rights are not well known or observed. The issues are, as usual, rights-based education, acquisition of knowledge, adoption of new behaviours and practices, coupled with enforcement and measurement of results with respect to children's rights, development and protection.

**Recommendation:** The Policy Frameworks should embrace essential elements of the CRC as well as the CRC Reports for Mainland Tanzania and Zanzibar. They should also provide a strategy for advocacy in order to ensure leaders and citizens throughout the nation are fully aware of children's and women's rights.

## **Cultural Contexts**

Some Tanzanian policies provide very good cultural contexts, especially in the Women's Policy and the HIV/AIDS Strategic Plan of Zanzibar. Authors attempt to explain why certain issues are very difficult given prevailing cultural norms, values and attitudes, health and nutrition behaviours and beliefs, and child rearing practices. Child rearing is intensely affected by cultural traditions and norms. Therefore, it is essential to place a strong emphasis upon culture in policies. Zanzibar and Mainland Tanzania together have over 125 cultural groups, some significantly different from others.

**Recommendation:** Brief descriptions of relevant cultural contexts should be provided in the Policy Frameworks to illustrate certain needs. Provisions for the cultural derivation and adaptation of programmes should be included in order that they will fit cultural ideals that promote positive parenting and good child development.

## **4.3 Policy Strategies: Participation, Age Ranges, Policy Gaps and Harmonization**

### **Consultation and Consensus Building**

With the exception of a few policies, there tends to be a lack of fully participatory policy planning in Tanzania. Some policies and plans, such as the NSGRP, ZPRP, Strategic Plan for HIV/AIDS, and the Five Year Action Plan for Integrated Early Child Education and Development were developed on the basis of consultation. Others were prepared by ministerial planners or consultants without the benefit of other minds and experience. In some cases, people who were consulted expressed concern that they never received reports on the consultations or copies of the final policies.

**Recommendation:** Because the people who carry out programmes for PAW and OVYC usually work at community and district levels, it is critically important that they, NGOs, FBOs, other CSOs and private sector groups be thoroughly consulted as well as all ministries and others concerned with children. Sincere efforts to build a national consensus should be made, with reports on all consultations and copies of the draft Policy Framework provided to all people who participate in consultations. This participatory process will help to build a sense of “ownership” in the Policy Framework that in turn will help to ensure it will be implemented effectively.

### **National Priority for Early Childhood Development**

Early childhood development is included as a passing topic in several major policies of Mainland Tanzania and Zanzibar. Yet the development of children’s during their earliest years is of critical importance to national development. Therefore, ECD should be given greater attention in future policies.

**Recommendation:** Priority ECD activities should be mainstreamed in all ministries with programmes related to young children. Ministries should become more open to service co-ordination and local programme integration, as possible.

### **Policy Gaps**

Many policy gaps regarding PAW and OVYC in the fields of education, nutrition, health, sanitation and juridical protection and child rights are noted in the Policy Analyses for Mainland Tanzania and Zanzibar. They are synthesized in the recommendation below.

**Recommendation:** Greater priority should be given to PAW and OVYC by filling the following major gaps in policy topics. These gaps exist either in terms of topic areas and/or in the implementation of services. Provisions are made in a few policies for aspects of the following areas; however, the services they mandate have inadequate geographical and population coverage. Therefore, they are included in this list.

### **Antenatal/Delivery/Immediate Post-Natal Services**

- ∞ Antenatal education and care services re-designed with care given to issues of curricular content, access, quality, monitoring, and tracking.

- ∞ Improved birthing services along with immediate neonatal assessment, and a clear transition for newborns to well-child check-ups.
- ∞ Improved birth registration systems including the removal (or subvention) of fees that tend to reduce birth registration.
- ∞ Identification and assessment of fragile and low birth weight infants, special services for them and their parents as well as continuous tracking and assessment to help ensure good development.
- ∞ Neonatology requirements, including hospital provisions for fragile newborns requiring special care.
- ∞ Routine testing for newborns for the possible presence of HIV and other infections, maternal VCT, PMTCT, ART, and other comprehensive services for both mother and child.

## **Services for Infancy to Three Years of Age**

### ***Linked Child Assessment Systems***

- ∞ A system for early and continuous infant and child assessment during well-child checkups or home visits on a quarterly basis during the first year and every six months thereafter.
- ∞ A tracking database system linked to assessments and well-child check-ups and later assessments.
- ∞ Attention and specialized health, nutrition and nurturing services to meet the holistic needs of young children apparently infected with HIV.
- ∞ Priority for OVYC and PAW in HIV/AIDS Policies as well as in other policies for children, youth and women in Mainland Tanzania and Zanzibar.

### ***Parent Education System***

- ∞ A parent education system for comprehensive home visits and community meetings to prepare expectant parents for positive parenting (for PAW) and to provide culturally appropriate parent education and support from birth to three/five years of age.
- ∞ Inclusion, as possible, of existing home and community outreach workers, such as CBDs, CORPS, Village Health Workers and others, with care to ensure adequate training, guidance and support is provided for each Home Visitor.
- ∞ Quality curricula, methods and materials and training provided at all levels for:
  - Infant and toddler stimulation and early learning activities to ensure all children achieve their full potential and are ready for success in school,
  - Health care and education;
  - HIV/AIDS prevention and treatment options;
  - Nutrition education and supplementation;
  - Child rights and protection;
  - Home and community sanitation, and
  - Pre-school and day care quality.
- ∞ Regular assessments of infants and children for development, nutrition and health, and linked to primary and specialised health services, as needed.

- ∞ Community ECD Drop-In Centres providing group sessions for parents, learning toy libraries and toy making sessions, integrated adult literacy and women's empowerment and skills training programmes, and referrals to essential health and nutrition services, as needed.
- ∞ Promotion of parent involvement in day care and child care centres, pre-schools, pre-primary and primary schools.
- ∞ Activities to improve children's transition from home/pre-school to primary school.

### ***Early Childhood Intervention Programme***

- ∞ As a component of the parent education system, holistic parent and caregiver education services for infants and young children identified to have developmental delays and disabilities, with services initially from birth to three years of age, and then extending up to five years of age.
- ∞ A national level Interdisciplinary Team that would design, train and guide district-level multi-sectoral teams who in turn would guide and train village level Home Visitors who provide developmental assessments, psycho-social stimulation for vulnerable infants and young children, and parent education on child development, health, nutrition and sanitation education.
- ∞ Co-ordination with existing community Home Visitors who potentially could join the ECI programme.
- ∞ Pre- and regular in-service training of new Home Visitors selected by communities.
- ∞ Phased programme development, beginning with a limited number of districts with high indices of vulnerable children, and then scaled up for nation-wide coverage.
- ∞ Sensitization programmes reaching all parents to emphasize their roles as their children's first and most important teachers.

### ***Nutrition and Health***

- ∞ Nutrition education and supplementation services, with a special focus on children birth to age five who suffering from malnutrition.
- ∞ Well child check-ups conducted routinely and in a timely manner for all children in collaboration with c-IMCI services, from birth to age six.
- ∞ A Women's Infants and Children's Programme (WIC) providing nutritional supplements for PAW and OVYP from birth to five years of age, with communities and NGOs providing networks to ensure that food reaches those who need it.

### **Services for Children Three to Six Years of Age**

#### ***Child Assessment Systems***

- ∞ Assessments of child development, health and nutrition required in all day care, child care, pre-schools and pre-primary schools.
- ∞ Referral systems for linking assessments in child care centres with health and nutrition services, as needed.

- ∞ Special support for OVYC to attend enriched pre-schools and pre-primary schools.
- ∞ Assessments maintained and reinforced at the school level for all children, and especially OVYC.

### ***Pre-school, Day Care Services and Quranic Schools for Young Children***

- ∞ Quality child care and education guaranteed for working mothers, and especially single mothers, and for orphans and other vulnerable children.
- ∞ Coordinated improvement of pre-school, day care and pre-primary services through setting quality standards, building and expanding existing training systems, and implementing fully Zanzibar's Five Year Plan.
- ∞ Reaffirmation and provision of pre-school health, nutrition and sanitation standards.
- ∞ Assistance to communities for materials to construct pre-school centres, train local teachers, and essential supplies and materials not locally available.
- ∞ Unified training system for early education personnel serving children of all ages from infants to school entry that will be culturally appropriate and ensure quality child care and education services throughout Tanzania.
- ∞ Incentives system to ensure the maintenance of trained pre-school and pre-primary personnel (partial salary payments, community services for teachers, social recognition, opportunities for advancement, etc.)
- ∞ Parent involvement in the schools and centres, including basic planning, setting budgets and work schedules, programme implementation, annual evaluations, teaching local traditions, etc.
- ∞ Preparation of children in early reading, mathematics and other cognitive skills as well as provision of a nurturing, exploratory, safe, healthy and secure environment.

### **Services for Children Six to Eight Years of Age**

#### ***Transition to School and Child and Parent Friendly Schools***

- ∞ Plan for a Transition Programme from home, pre-school or pre-primary school to Primary School, building on existing education policies and parent/teacher activities developed to date.
- ∞ Children with special needs included and the importance of inclusive education emphasized.
- ∞ Integrated services for children infected with HIV/AIDS in schools re-emphasized.
- ∞ Education for HIV/AIDS prevention for teachers and administrative personnel rapidly expanded.

#### **Pre and In-Service Training**

- ∞ A unified and comprehensive system for pre- and continuous in-service training for all sectors, building on existing training systems and improving upon them, as possible.
- ∞ Evaluation and monitoring of training programmes, including programme results reviews.

Given extreme resource constraints in Zanzibar, it may become necessary to develop a **Vulnerability Analysis** regarding both critical populations and geographic areas with greater needs than others. If so, a **Phased Programme** of service development would be required. Under such a Phased Programme, comprehensive services for PAW and OVYC under three or five years of age would begin first in areas of greatest need, and then move to those with less dramatic requirements with the firm goal of nation-wide coverage.

## **Harmonization**

Major issues for policy harmonization include:

### ***Parent Education and Children Birth to Three Years of Age***

The provision of parent education services for parents of children from birth and to three or five years of age is an issue for dialogue among representatives of MOECS, MOHSW and MOEYGCD in Zanzibar. Since CBDs are already in the field, they may wish to utilize new programme components for child development. However, if incentives issues are resulting in systems changes, the MOHSW may not be able to expand the programme at this time. It may be essential to consider some **new options for multi-sectoral collaboration for building a unified, integrated system for parent education**. An innovative programme design with high quality and culturally appropriate curricular contents, methods and materials for parent education would help to avoid unnecessary administrative costs that frequently result from developing parallel systems. A similar system would be the subject of considerable dialogue in Mainland Tanzania within the purview of current education, health, nutrition, social welfare and child development activities.

### ***Pre-school and Day Care Centres and Pre-Primary Schools***

Different regulations for day care centres, pre-schools and pre-primary schools are being prepared by MOEC and MOLYDS and by MOEYWCD and MOECS, respectively. Questions of quality of care and education, pre- and in-service training, supervisory jurisdiction and administration hang in the balance. Also, discussions should be undertaken with the goal of avoiding costly unnecessary duplication of administrative, training and supervisory structures.

### ***Management of Services for Orphans and Others Vulnerable Young Children***

At the present time, several ministries have been called upon to ensure that orphans and other vulnerable young children receive specialised services. These ministries range from those that mainly set policy and regulatory standards, to those committed to issues of social welfare, education, health and sanitation. Due in part to overlapping mandates, OVYC have tended to “fall through the cracks.” Furthermore, inadequate budgets have been allotted for meeting these children’s needs.

Intensive dialogue is needed and is being undertaken in Mainland Tanzania and Zanzibar to reach consensus regarding which existing ministry (or a new Executive Agency) should lead this effort. Furthermore, greatly expanded investment in OVYC urgently is required. Without a credible policy, annual action plan and provisions for human resources, it is unlikely that expanded funds will be forthcoming. Thus, the decision regarding the location of leadership for ECD and HIV/AIDS affected children and other vulnerable young children will be the most important one of all.

### ***HIV/AIDS Policies***

All current policies, plans and guidelines from HIV/AIDS in ZAC and TACAIDS and in line ministries essentially lack an adequate emphasis on the needs of OVYC and PAW. Some mentions of these groups and specialised services they require are found but comprehensive, integrated ECD services are not proposed. Considerable dialogue and work will be needed to expand these policies to ensure that they will be consistent with the Policy Frameworks for ECD and HIV/AIDS in Mainland Tanzania and Zanzibar.

### ***Contributions of CSOs and Private Sector Groups***

Unnecessary duplication of services is reported to be occurring among government services, CSOs, and private sector groups working with PAW and OVYC. Care should be taken to avoid unnecessary duplication through engaging all parties in regular dialogues for building improved co-ordination, collaboration and partnerships. Provision for this should include NGO and CSO Networks and should be clearly stated in the Policy Frameworks for ECD and HIV/AIDS.

## **4.4 Multi-Sectoral and Sectoral Structures, Co-ordination and Integration**

### **Co-ordination and Leadership**

Services for PAW, OVYC and HIV/AIDS currently are not adequately coordinated in either Mainland Tanzania or Zanzibar. No agency or office for ECD, OVYC and children affected or infected by HIV/AIDS currently exists in either area. The Policy Frameworks for ECD and HIV/AIDS could help to fill this vacuum through building a consensus regarding central bodies that would ensure the Policy Frameworks and their annual Action Plans are implemented.

***Recommendation:*** Mainland Tanzania and Zanzibar should consider establishing a well-funded central offices in ministries OR founding Executive Agencies (parastatal centres) for ECD, PAW and OVYC.<sup>47</sup> These Executive Agencies or central offices would include activities such as the following:

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<sup>47</sup> Executive Agencies (parastatal or semi-autonomous institutes as they are often called) can provide national leadership through receiving seconded staff member from line ministries as well as specialists from universities, institutes and CSOs. They usually are funded through receiving core support in the form of percentages of the budgets of other agencies, such as the Presidency, each participating ministry of

- ∞ Implement the Policy Frameworks;
- ∞ Prepare the annual Action Plan;
- ∞ Guide cross-sectoral pre- and in-service training programmes for home-based and centre-based services including community Parent Educators;
- ∞ Conduct cross-ministerial co-ordination and lead programme integration efforts;
- ∞ Develop partnerships between and among government programmes as well as NGOs, FBOs, other CSOs and the private sector.
- ∞ Evaluate and monitor all programmes under the Policy Framework and Action Plan and ensure all stakeholders receive reports;
- ∞ Guide and promote action research projects;
- ∞ Conduct policy advocacy and social communications activities in accordance with the annual Action Plan;
- ∞ Review budgetary processes, budget utilization and help to ensure funds, training, supplies and materials for programmes for vulnerable children reach intended districts and community programmes;
- ∞ Manage, in collaboration with relevant ministries, donor and partnership co-ordination as called for under the Policy.

If offices for ECD, PAW and OVYC, including those affected by HIV/AIDS were to be preferred, then discussions should proceed regarding their best placement within the Government of Mainland Tanzania and of Zanzibar. It would be essential to consider budgetary and leadership issues as well as policy matters in seeking to ensure the best possible placement for such offices.

### **Building Integrated Programmes**

Relatively few multi-sectoral programmes are mentioned in Tanzania's policies for children, although some striking examples exist in the HIV/AIDS field especially with respect to health, HIV/AIDS, pre-school education (in Zanzibar), and primary education. Programme integration is largely ignored, except in such frameworks as ZPRP and NSGRP. Usually policies are sectoral in approach, with a general note made of the importance of consulting others and creating partnerships with NGOs, CSOs and FBOs.

***Recommendation:*** Study opportunities for developing cost-effective integrated programmes for community services between and among sectors in order to meet the holistic needs of children, families and communities.

### **Inter-Ministerial Co-ordination Systems (Frameworks)**

Inter-ministerial co-ordination is vague in several policies, although some attempt has been made in many of them. The Strategic Plan for HIV/AIDS in Zanzibar provides a detailed organizational system, and because of its specificity, it has attained a degree of success in building requisite structures.

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health, education, nutrition, sanitation, as well as short-term support from external donors and foundations. An example of a highly successful parastatal for young children is the Colombian Institute for Family Welfare. Its website in English is: <http://www.icbf.gov.co/ingles/general.asp>.

**Recommendation:** Include clear organisational charts with precise roles and responsibilities at all levels for inter-ministerial co-ordination, collaboration and communication to meet the objectives of the Policy Frameworks for ECD and HIV/AIDS. Call for detailed guidelines as needed, and provide for their development under annual Action Plans.

#### **4.5 Pre- and In-service Training Systems**

Most policies in Tanzania tend to leave out the design and development of pre- and especially in-service training systems that are needed to achieve policy goals and strategies. When training is mentioned, it tends to be sporadic rather than continuous.

**Recommendation:** Undertake inter-ministerial dialogues to consider ways to build a unified and decentralised training system for field workers that can be used by **all sectors** serving PAW, OVYC and HIV/AIDS services. Involve NGOs, FBOs, other CSOs and private sector groups to ensure their needs and views are taken into account.

#### **4.6 Policy Indicators and Targets**

Many of Tanzania's policies do not provide policy indicators, measures and targets. Exceptions have been noted in the Policy Analyses above. Indicators, measures and targets are essential for policy accountability.

**Recommendation:** Assist with the selection of indicators, measures and targets related to PAW and OVYC for ZPRP II and NSGRP. Then, through extensive consultation, develop a list of indicators, measures and targets for the Policy Frameworks for ECD and HIV/AIDS, including the ZPRP II and NSGRP indicators plus additional ones essential for health, nutrition, education (including parent education, child development, pre-school education and primary education), sanitation and juridical protection. No more than 60 to 70 indicators should be selected.

#### **4.7 Evaluation, Monitoring, Accountability and Enforcement**

Similarly, evaluation and monitoring systems are largely absent from most policies in Mainland Tanzania and Zanzibar. Sometimes, evaluation and monitoring is called for but details are not given regarding how the systems and processes will be conducted.

**Recommendation:** Include a detailed Evaluation and Monitoring Plan in the Policy Frameworks and list relevant activities in the annual Action Plans.

#### **4.8 Policy-Related Research**

As noted in the Policy Analyses above, high priority research topics have been suggested. Many of these topics will be essential to programme design and development over time.

**Recommendation:** Conduct a consensus building exercise to select the highest priority research topics and prepare a phased plan for research that would be included in the Policy Frameworks. Topics should be combined to the degree advisable. National researchers should request external funding support and technical assistance, if needed.

#### **4.9 Policy Advocacy and Social Communications**

In general, inadequate attention has been given in the past to policy dissemination and public education about policy goals, strategies and programme initiatives.

**Recommendation:** A strong section for policy advocacy and social communications should be included in the Policy Frameworks and annual Action Plans. In Zanzibar, this effort could be linked with MOFEA plans for policy advocacy for PRSII, and in Mainland Tanzania, with NSGRP dissemination activities.

**Recommendation:** The Policy Frameworks for ECD and HIV/AIDS should be made universally accessible through sending them to all government employees, CSOs, and private providers working with PAW and OVYC. Workshops should be held throughout the nation on its contents. Checklists including the major goals, objectives, strategies and directives could be prepared and distributed widely. Mass media announcements could accompany the holding of a National Forum for ECD and HIV/AIDS. In addition, all policies, plans and guidelines and key legislation related to ECD and HIV/AIDS should be placed on the Internet and in central documentation units that are easy to access and widely advertised.

#### **4.10 Investment Plan**

General investment plans are largely absent in Tanzania's policies, with the exception of MTEFs that tend to be more reflective of administrative rather than programmatic needs. Some Action Plans present schematic investment plans.

**Recommendation:** A general Investment Plan should be included in the Policy Frameworks for ECD and HIV/AIDS. It should seek to maximize the use of current resources while projecting funding needs for programmes that are required to fill important gaps in services for PAW and OVYC. The annual Action Plans should be more detailed and based on realistic possibilities for national and international funding support. An unrealistic Action Plan would lead to frustration and disappointment.

#### **4.11 Donor and Partnership Co-ordination**

Donor co-ordination mechanisms were included in some policies but they appear to have been used less than expected with the exception of Health and Education SWAs. Nonetheless, it is important to ensure that unnecessary duplication in donor supported programmes be avoided. No provisions for partnership co-ordination were found, although many policies call for such partnerships to be developed.

**Recommendation:** Include a Plan for Donor and Partnership Co-ordination in the Policy Frameworks for ECD and HIV/AIDS, with an emphasis upon building an **ECD Fund** and possibly within it, a **Partnership Fund** for forging collaborations among government agencies, NGOs, FBOs, other CSOs and private sector groups.

#### 4.12 Annual Action Planning

Many policies in Tanzania lack annual Action Plans (also sometimes called strategic plans or operational plans). Those policies that have Strategic Plans or Action Plans tend to have long, five-year horizons, and they tend to be overly general. If drafted, some of the Plans have not been implemented, especially when resources have been very limited. When ministries have long-term Action or Strategic Plans and they fall behind in implementing them, they tend to feel defeated and abandon the entire exercise. It may be advisable to engage personnel in meeting shorter-term annual Action Plans.

**Recommendation:** In order to try to ensure that the ECD and HIV/AIDS Policy Framework will be implemented, two-year Action Plans should be prepared and revised annually. This should lead to a greater sense of accomplishment and ultimately to more productive and dedicated personnel.

#### 4.13 Requirements for Legislation

Unfortunately, some of the mandates that have been proposed in Tanzania's policies for child development, health, nutrition, education and HIV/AIDS have gone unheeded. This may be due to a lack of precision in the policy statements, insufficient funds and personnel, a lack of widespread commitment to policy mandates or to other reasons. In some cases, it appears that policy strategies simply were not considered when ministries prepared their programme plans and budgets. Indeed, in all world areas, ministries that face major resource limitations tend to maintain existing structures rather than reform them and introduce new programmes to meet policy goals. For this reason, it may well be advisable to consider legislation that will be linked to the Policy Frameworks and will give precise guidance for meeting children's needs.

**Recommendation:** The following types of legislation favouring orphans and vulnerable young children and high-risk pregnant adolescents and women could be considered:

∞ **Establishing a National Priority for Vulnerable Children**

- ⇒ Based on the constitutional rights of children to life, good health and nutrition, education and protection, the Policy Frameworks for ECD and HIV/AIDS would be designated as priority mandates in national planning for young children.
- ⇒ Broad and inclusive definitions of orphans, vulnerable children and high-risk pregnant adolescents and women would be provided.
- ⇒ Initial emphasis could be placed on developing programmes for children from birth to three years of age when the most important brain, physical, emotional and social development occurs. Programmes would then be

extended from three to five or six years of age until all vulnerable young children in each geographical area are receiving services.

- ⇒ A vulnerability map could be mandated that would be the basis for developing a national plan for the phased development of programmes, with priority given initially to those geographical and population groups that are the most vulnerable and lack access to essential education, health, nutrition, sanitation and protective services.

∞ ***Legislated Administrative Structure for Vulnerable Young Children***

- ⇒ The co-ordination structure of the Policy Frameworks for ECD and HIV/AIDS, embracing all elements of ECD and HIV/AIDS services for young children, would be reaffirmed and officially established.
- ⇒ A new **Executive Agency** (a parastatal centre) or a new well-funded ministerial **Office for ECD and HIV/AIDS** would be designated along with a core team of specialists with seconded personnel and core budgetary support from the national budget, relevant participating ministries, and shorter-term support from external bilateral and multilateral partners and foundations.
- ⇒ The roles and responsibilities of the Executive Agency or ministerial Office would be outlined to include those listed above.

∞ ***Services for Vulnerable Children and Women***

Specific services may need legislation to help ensure all vulnerable children will be served. Due to current service and budgetary limitations, a phased process of coverage may be needed, wherein the children living in areas of greatest vulnerability and service need would be prioritized to receive the first comprehensive services. Following is a list of priority areas for legislated service development to improve the status of Tanzania's children:

- ⇒ Provision of **free primary health care and regular well-child checkups for all children** under five years of age that would include the provision of **developmental, nutritional and health assessments** (each three months during the first year of life and every six months thereafter) and **continuous system of identification, assessment, services, and tracking for orphans and vulnerable young children.**
- ⇒ **Free day care, pre-school, pre-primary and primary education, including the provision of any fees and payments of other expenditures** for OVYC.
- ⇒ Special attention should be given to **issues of equity regarding the Community Health Fund.** Currently, communities are to receive government grants that complement the funds they raise locally on a 50/50 basis. As Community Health Funds are developed, it will be essential to ensure that poor communities (that can give less to their funds) will receive equitable support in comparison to other communities that have

higher incomes, lower levels of vulnerable families, and therefore, larger Health Funds. A formula for ensuring Community Health Fund equity in relation to high-levels of maternal and child vulnerability should be developed and included in legislation.

- ⇒ **Universal Antenatal Education and Care Programme (AECPP)** would begin with risk assessments that are initiated before the end of the first trimester of pregnancy. Components would include: health education and care, nutritional supplements, birthing and positive parenting as well as specialised services for PAW identified to have certain health or nutritional needs, such as HIV/AIDS, malaria, anaemia or STDs.
- ⇒ **Pre-service training and repeated in-service training should be mandated for all birth attendants**, both certified and traditional. This measure is required due to the high level of maternal mortality in Tanzania.
- ⇒ Provision of a **National Parent Education Programme (PEP) with Early Childhood Intervention Services (ECI)**. These activities would provide culturally appropriate components. Home Visitors selected by the community would be trained on how to conduct infant and child assessments, psycho-social early childhood stimulation activities, parent education on child and family development, and education on health care, good child nutrition, and home sanitation practices. The ECI wing of the programme would focus especially on high-risk and vulnerable young children who are assessed to have: developmental delays; disabilities; malnutrition; HIV/AIDS infection or other chronic illnesses such as malaria or tuberculosis; orphans and children of parents affected by AIDS; street children or other vulnerabilities related to family circumstances such as abuse or neglect. Parents of low-risk children would be invited to community **drop-in centres** where they would receive guidance on how to ensure good child development, health, nutrition, and home sanitation practices. Learning toy development and lending libraries would be a part of this service. A national multi-sectoral team would train district-level teams who would in turn support community-level Home Visitors, receive referrals, provide case management services for especially challenging situations, and make referrals to health and other services such as Women, Infants and Children's Nutrition Programme (see below) and antenatal education and care services. The programme would seek to embrace existing outreach systems of CBDs, CORPS, Village Health Workers, and other community-level services for health, nutrition, sanitation, social welfare and child protection. It would fill in service gaps and complement existing services, with a mandate to develop integrated services through planning at the district, ward and community levels. Provision would be made for a **system for forging equitable partnerships** between government and NGOs, FBOs, CBOs, other CSOs, private sector and other relevant groups.

- ⇒ Provision of a **Women, Infants and Children's Nutrition Programme (WIN)** that would channel surplus food and funds from food monetization through existing networks of CSOs and public services devoted to high-risk and vulnerable pregnant adolescents and women, mothers of young children, and vulnerable children from birth (in cases of HIV infected mothers who should not breastfeed) or six months of age to six years.
- ⇒ Development of an **Orphans and Vulnerable Infants and Children Fund (OVIC)** that would be guided by the MOF or MOFEA but would be managed by communities in collaboration with local CSOs with oversight from the proposed Executive Agency or ministerial Office. It would provide essential basic support to AIDS infected parents who are unable to work and have young children, HIV-infected and affected children and other orphans with caregivers who are living in poverty. Support provided under OVIC would include funds for meeting children's survival, developmental and educational needs. Thus, services could include the provision of enriched pre-school education centres, as needed.

∞ *Special Legislation for Child and Family Protection*

- ⇒ **Child Support and Paternity** to help ensure vulnerable children of single mothers develop well and are appropriately supported and nurtured.
- ⇒ **Inheritance Rights** continue to be a major problem in various cultural zones. Additional laws will be needed to deal with this issue in order to benefit orphans and widows.
- ⇒ **Foster-Care and Adoption** rules revision for ensuring children under 18 years of age who are orphans or who are suffering from an abusive or neglectful home environment are placed with caregivers able to provide essential nurturing care, good nutrition, health care and education.
- ⇒ **Guidelines regarding Child Labour** to ensure that children under 17 years of age cannot be conscripted into abusive child labour, with clear definitions provided and guidance to promote basic education and preparation for remunerative work.
- ⇒ **Guidelines to Protect Adolescent Girls** through curtailing early marriage and adolescent pregnancies, and mandating family life education for parents, men, boys and adolescents.
- ⇒ **Women's and Children's Rights** with special attention to specific themes that appear in Zanzibar and Mainland policies, especially with regard to PAW, OVYC and HIV/AIDS.

- ⇒ **Children's Rights Laws** to fill in gap areas regarding abusive child labour, street children and abused children.
- ⇒ **Guidelines for Refugees and Internally Displaced Persons** with a focus on the special needs of PAW and OVYC and those that are affected by HIV/AIDS that were generally not mentioned in the National Refugee Policy.
- ⇒ Other special areas for legislation will be suggested by people through holding nation-wide consultations at all levels.

## **Conclusion**

Mainland Tanzania and Zanzibar are facing dramatic needs for improving child development. Fortunately both possess outstanding national specialists who have extensive experience, strong NGO networks, leading CSOs devoted to children, and significant international support for achieving their goals. By building on national strengths and conducting widespread dialogues for early childhood development, great achievements are within reach.

The most important next step will be to include all stakeholders in the preparation of the Policy Frameworks for ECD and HIV/AIDS. National and international support will be required for this policy planning process that will include nation-wide consultations, consensus building exercises, and convening a National Forum. The lives of hundreds of thousands of Tanzanian children depend upon the commitment of wise national leaders. Each caring adult can achieve great results by joining the movement for Tanzania's most vulnerable children.

## ANNEX I

### MAINLAND TANZANIA AGENCIES, POLICIES AND DOCUMENTS

#### **Parliament**

Children's Law (under preparation by House of Representatives/draft unavailable)

#### **Prime Minister's Office**

##### **Tanzania Commission for AIDS (TACAIDS)**

- ∞ National Multi-Sectoral Strategic Framework on HIV/AIDS, Tanzania 2003 – 2007\*
- ∞ National Policy on HIV/AIDS, September 2001\*
- ∞ Public Expenditure Review HIV/AIDS Multi-sectoral Update for 2004 (October 2003)\*
- ∞ Milestones for Multi-sectoral HIV/AIDS Response:
  - Participatory Situation Analysis (by October 2004)
  - Development of National Monitoring and Evaluation Framework (by October 2004)
  - Development of National Plan of Action (costed by September 2004)
  - Guidelines for better service delivery to children via Government, LGAs and NGOs

#### **Vice-President's Office**

- ∞ **National Strategy for Growth and Reduction of Poverty (NSGRP), 2<sup>nd</sup> Draft, Wednesday, 27<sup>th</sup> October 2004\***
- ∞ First draft of Revised Poverty Reduction Strategy II and Annex II for second round of consultations, 16 August 2004\*
- ∞ NGO Act\* (CD Rom)
- ∞ Participatory Poverty Assessment Report, 2003, Research and Analysis Working Group
- ∞ Poverty and Human Development Report, 2002, 2003
- ∞ Public Expenditure Review (PER), Socio-Economic Survey
- ∞ Poverty Mainstreaming in District Planning, Tracer Study and Training Needs Assessment Mainstreaming Poverty in Council Plans, 2003
- ∞ Tanzania Assistance Strategy (TAS) 2000 (Tanzania's donor co-ordination strategy)

#### **President's Office Regional Administration and Local Government (PORALG)**

##### **Ministry of Regional Administration and Special Department (MRASD)**

- ∞ National Development Vision to 2025\*
- ∞ Rural Development Policy, December 2003\*
- ∞ PORALG HIV/AIDS Strategy, 2003 – 2006 (to harmonize policy)\*

- ∞ The Opportunities and Obstacles to Development: A Community Participatory Planning Methodology: Training Manual (April 2004)\*
- ∞ Community Based Management Information System in Tanzania, Draft, (July 2003)\*
- ∞ Local Government Laws, revised, 2000
- ∞ Acts Supplement No. 12, 21 March 2003, Subsidiary Supplement

## **HIPC**

- ∞ Multilateral Debt Relief Fund

## **Local Government Reform**

- ∞ Joint Government/Donor Review of the Local Government Reform Programme, 23 June 2001
- ∞ Legislative Road Map. A guide for Civil Society Organizations in Tanzania
- ∞ Part One; Policy, Law and Governance, Part Two Civil Society and the Law Making process
- ∞ Village Governance in Tanzania, 2003
- ∞ Department of Administrator General (registration of births, TOT training programmes, implementation of the Registration of Births and Deaths Ordinance, Civil Registration Programme in Local Government Authorities)

## **Ministry of Finance**

- ∞ New Public Expenditure Guidelines creating a cross-cutting HIV/AIDS budget as a “priority sector.”
- ∞ Annual HIV/AIDS Public Expenditure Review (PER), with OVC reported to be one focus of the PER

## **TANZANIA’S IECD AGENCIES:**

### ***Designated Lead Ministry***

#### **Ministry of Community Development, Gender and Children (MCDGC)**

- ∞ Child Development Policy, 1996 (This Policy is currently being revised and the draft is available only in Kiswahili.)\*
- ∞ Implementation Framework for the Child Development Policy (This is under preparation and is unavailable.)
- ∞ Community Development Policy, June 1996\*
- ∞ Women and Gender Development Policy, 2000 (originally Women in Development Policy, 1992)\*
- ∞ Population and Family Life Education Programme: POFLEP Document 2004 – 2007, February 2004\*
- ∞ Public Expenditure Review, Proposed Section for Cross-cutting Issues in the Plan and Budget Guidelines: Children, Adolescents and Young People, 2004\*
- ∞ The Country Second Periodic Report on the Implementation of the Convention on the Rights of the Child (CRC), 1998 - 2003\*

- ∞ Strategy to Protect Women and Children against HIV/AIDS (This title may change. It too is under preparation and unavailable at this time.)

Other pertinent documents include:

- ∞ HIV/AIDS and its Impact on ECD in Tanzania, Mombassa, 2002\*
- ∞ Draft Report for Revision of National Programme of Action for Children, 2002/3
- ∞ National Plan of Action (to combat violence against women and children, 2003)

With respect to laws, the following merit special mention for their importance to child rights, protection and welfare:

- ∞ Sexual Offences Special Provisions Act of 1998 (amends the Children and Young Persons Ordinance)\*
- ∞ Ratification of the African Charter on the Rights and Welfare of the Child and two optional protocols to the CRC (Optional Protocol on the Involvement of Children in Armed Conflicts and Optional Protocol on the Sale of Children, Child Prostitution and Child Pornography, March 2003).

#### **Ministry of Agriculture and Food Security**

- ∞ Agriculture and Livestock Policy, 1997 (Currently under review in 2004; linked to Tanzania Food and Nutrition Centre.)
- ∞ National Food Security Policy (Currently under review and also linked with the TFNC).

#### **Ministry of Education and Culture**

- ∞ Education and Training Policy, ETP, 1995 (CD Rom)\*
- ∞ Primary Education Development Plan, 2002-2006 (April 2003) (CD Rom)\*
- ∞ Minimum Standards for Pre-Primary Education: Working Paper, 2000 (CD Rom)\*
- ∞ Medium Term Expenditure Framework, Ministry of Education and Culture, 2003/04\*
- ∞ Joint Review: Primary Education Development Plan (September – October 2004)\*
- ∞ Strategic Plan for HIV/AIDS, 2003 – 2007 (May 2004)\*

Other education documents potentially germane to services for OVYC and PAW include:

- ∞ Adult and Non-formal Education Sub-sector Medium Term Strategy, 2003 – 2007, (February 2003) (CD Rom)\*
- ∞ Education Sector Development Programme, 2000
- ∞ Basic Education Master Plan, 2001
- ∞ Secondary Education Development Plan, 2004-2008
- ∞ Minimum Standards for Education on Service Delivery in the District, Department of Planning Working Paper, 2000
- ∞ Guidelines for registration of schools – private and government
- ∞ Education Indicators in Tanzania, 1999

- ∞ National Higher Education Policy, February 1999 (CD Rom)\*

### **Tanzania Institute of Education**

- ∞ Curriculum Issues in ECD: The Case of Tanzania, 2002, Dr. Naomi Katunzi, Director TIE, Mr. Oliver Mhaiki, Director, Primary Education (CD Rom)\*

### **Ministry of Health**

- ∞ Strategic Health Plan for 1995 – 1998
- ∞ Action Plan 1996 – 1999
- ∞ Health Sector Development Programme (HSDP), 2000 – 2011
- ∞ Second Health Sector Strategic Plan, July 2003 – June 2007
- ∞ National Environmental Health and Sanitation Policy Guidelines, April 2004\*
- ∞ Reproductive and Child Health Strategy 2004 – 2008 (January 2003)\*
- ∞ National Policy Guidelines for Reproductive and Child Health Services (May 2003)\*
- ∞ National Adolescent Health and Development Strategy, 2004 – 2008\*
- ∞ National Immunization Programme, Financial Sustainability Plan, revised November 2003\*
- ∞ Proposed Framework for the Implementation of Community Based Health Initiatives (CBHI) in the Context of Reforms in Tanzania, April 2000\*
- ∞ National Health Policy, 1990\*
- ∞ Health Sector Strategy for HIV/AIDS, 2003 – 2006
- ∞ National Malaria Medium Term Strategic Plan, 2003 – 2007
- ∞ National Plan of Action for Prevention of Female Genital Mutilation and other Harmful Traditional Practices, 2001 – 2015
- ∞ National Reproductive and Child Health Communication Strategy, 2001 – 2005
- ∞ EPI Strategic Plan, 2002 – 2007
- ∞ Strategy for Reproductive and Child Survival, 1997 – 2001
- ∞ IMCI Strategy, 1998 – 2003
- ∞ Prevention of Mother to Child Transmission (PMTCT)
- ∞ Community Based Reproductive and Child Health Strategy
- ∞ URT, Acts Supplement No. 1, The Community Health Fund Act, 6 April, 2001
- ∞ School Health Programme Guidelines
- ∞ Malaria Control Programme Guidelines
- ∞ National AIDS Control Programme Guidelines
- ∞ Paediatric Department Guidelines
- ∞ Baby Friendly Hospital Initiative (BFHI) Guidelines and other Guidelines

### **Tanzania Food and Nutrition Centre (under MOH)**

- ∞ National Food and Nutrition Policy, July 1992 (under review) (CD Rom)\*
- ∞ National Guide on Nutrition Care and Support for PLWHIV/AIDS
- ∞ Micronutrient Deficiency Control Policy Guidelines, April 1997
- ∞ National Strategy on Infant and Young Child Feeding

### **Ministry of Labour, Youth Development and Sports, Department of Social Welfare**

- ∞ Reaching the Most Vulnerable Children (August 2003)\*
- ∞ Draft National Policy on the Care of Orphans (January 2004)\*
- ∞ Proposed National Framework for Management and Co-ordination of the OVC Programme in Tanzania (August 2004)\*
- ∞ National Guidelines for Community Based Care, Support and Protection of Orphans and Vulnerable Children (2003)\*
- ∞ National Guidelines for the Care, Support and Protection to Orphans and Vulnerable Children Living in Institutions (2003)\*
- ∞ Draft National Policy on Disabilities in Tanzania, 2004 (in preparation)\*
- ∞ Day Care Centres, Act No. 17 of 1981\*
- ∞ Children's Homes (Regulation) Act (Act No. 4, 1968\*
- ∞ Children's Home, for Purposes Connected Therewith and to Amend the Adoption Ordinance (1968)\*
- ∞ Adoption Chapter 335 of the Laws 1950 – 54 Edition (1956)\*

### ***Child Labour***

- ∞ National Employment Policy 1997
- ∞ Employment and Labour Relations Act, 2004
- ∞ Gender Promotion Programme Guidelines (GENPROM) (combats child labour)

### **Ministry of Home Affairs**

- ∞ National Refugee Policy (September 2003)

### **Ministry of Justice and Constitutional Affairs**

- ∞ Possible review following additional legislation if time permits:
  - Laws on Marriage
  - Laws on Inheritance
  - Laws related to children

### **Ministry of Water and Livestock**

- ∞ National Water Policy, 1991, revised 27 July 2002

## **STATISTICAL AND MONITORING AGENCIES AND REPORTS**

**National Bureau of Statistics (NBS): Household Budget Survey, 2000/01\* (CD Rom)**  
**Tanzania's Socio-Economic Database (TSED) with 330 indicators!**

**CSPD Technical Committee and District Management Teams (DMTs):** CSPD Information Gathering (obtain all data gathering forms)  
**CSPD:** Community-based Management Information System

**Additional Documents ECD and HIV/AIDS Reviewed:**

Guidelines for the Community HIV/AIDS Response Fund (CARF), (a component under TMAP)\*

***Country Support Team for the ECD and HIV/AIDS Initiative (CST) \****

Tanzania Commission for AIDS: Report of the Retreat of the ECD/HIV Country Team Oasis Hotel, Morogoro, 19 – 21 May 2004, TACAIDS, ZAC, World Bank, UNICEF

Tanzania ECD Network, AGM, 29-31 March 2004: Summary (CD Rom)\*

Toward Tanzania's ECD EFA Action Plan, 2003 – 2015, December 2002, (CD Rom)\*

National ECD Forum: Toward Tanzania's ECD EFA Action Plan, 2003 – 2015, Tanzania ECD Network, 24-25 June 2003 (CD Rom)\*

**Country Programme on Child Survival, Protection and Development (CSPD) 2002-2006 (UN/Government)**

- ∞ Civil Society Consultation Report to Inform PRS Review, May 2004\*
- ∞ Tanzania ECD Network: ECD Consultations Report on Poverty Reduction, February 2004\*
- ∞ Research on Poverty Alleviation (Brian Cooksey and Masuma Mamdani, 2004\*
- ∞ Break the Poverty Cycle in Tanzania: Invest in ECD, 2003 Amani ECD\*
- ∞ Opportunities and Obstacles for Development (O&OD) community based planning methodology/need to help communities to prepare Community Action Plans with ECD HIV interventions (need for a facilitation team)

**Bernard van Leer Foundation documents reviewed:**

Partners' Consultation Conference Report on Children and HIV/AIDS, 2003 (CD Rom)\*

Young Children and HIV/AIDS: A Cross-Regional Strategy, BT/104/5 (CD Rom)\*

Early Childhood Care and Development in Tanzania: An Analysis of the Situation of Children, Zero to Seven Years of Age in the Context of Families and Communities, July 2001, Amani ECCD (CD Rom)\*

**Other Documents reviewed:**

Rene Salgado, Tanzania Child Health Assessment: Will the Child Health Millennium Development Goals Be Achieved? Child Survival Partnership/BASICS II Project, USAID (draft Sept. 21, 2004)\*

ECD HIV/AIDS Operational Guidelines, World Bank/UNICEF\*

The Brainstorming Workshop for Research Programmes about and with Children in Tanzania, January 2004 (CD Rom)\*

Public Expenditure Review, Consultative Meeting, NGO Commentary, May 2003 (CD Rom)\*

George Kameka, General Overview of ECD in Tanzania, Ministry of Labour, Youth Development and Sports, February 2002 (CD Rom)\*

## ANNEX II:

### ZANZIBAR AGENCIES, POLICIES AND DOCUMENTS

#### *Lead Ministry for ECD:*

#### **Ministry of Employment, Youth, Women and Children's Development (MOEYWCD)**

- ∞ Policy for Child Survival, Protection and Development (CSPD) October 2001, monitored by the Ministry of Youth, Employment, Women and Children's Development (not accessible)
- ∞ Periodic Report on the Implementation of the Convention on the Rights of the Child (CRC) in Zanzibar, January 2004\*
- ∞ Women's Development Policy, 2001\*
- ∞ Child Labour Guidelines (not accessible)

#### **Zanzibar AIDS Commission**

- ∞ Report on Situation and Response Analysis of HIV/AIDS in Zanzibar, August 2003\*
- ∞ Zanzibar HIV/AIDS Strategic Plan, 2003 – 2007, November 2003\*
- ∞ Zanzibar National HIV/AIDS Action Plan, 2003 – 2007, October 2003\*

#### *Other Ministries and Programmes:*

#### **Ministry of Finance and Economic Affairs (MOFEA)**

- ∞ Zanzibar Vision 2020, January 2000\*
- ∞ Zanzibar Poverty Reduction Plan, January 2002\*
- ∞ Zanzibar Medium Term Expenditure Framework (MTEf) Estimate for Vote 19 (2003/4 – 2005/06), June 2003\*
- ∞ Zanzibar PRP Indicators List\*

#### **Ministry of Education, Culture and Sports (MOECS)**

- ∞ Zanzibar Education Master Plan for 10 Years, 1996-2006, December 1996\*
- ∞ Education Sector Country Status Report, Zanzibar, June 2003\*
- ∞ Five Year Action Plan for Integrated Early Child Education and Development, Zanzibar (2003 – 2007), January 2003\*

#### **Ministry of Health and Social Welfare (MOHSW)**

- ∞ Health Policy, 2000\*
- ∞ Medium Term Expenditure Framework (2004/05 – 2006/07)\*
- ∞ Social Welfare Policy, 2002 (in Swahili)\*

#### **Ministry of Regional Administration and State Development (MORASD)**

- ∞ Zanzibar: Births and Deaths Registration Decree of Zanzibar

***Currently under preparation and unavailable as yet:***

- ∞ Poverty Reduction Paper II (MOFEA)
- ∞ Water and Sanitation Policy (Ministry of Water, Works, Energy and Lands)
- ∞ HIV/AIDS Policy (none exists at present) (ZAC)
- ∞ Youth Policy (in advanced draft stage) (MOEYWCD)
- ∞ Early Childhood Policy (to be prepared) (MOEYWCD)
- ∞ Pre-school Guidelines being developed (MOECS)
- ∞ Policy for Vocational Training (MOEYWCD)
- ∞ Gender Policy planned (MOEYWCD)
- ∞ Reviewing Spinsters, Widows and Female Divorcees Protection Act. 4 of 1985 (MOEYWCD)